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HEALTH
MARKET INQUIRY

FINAL FINDINGS AND RECOMMENDATIONS REPORT

September 2019

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Glossary

A

"Access" refers to the ability of an individual or a defined population to obtain or receive appropriate healthcare. This involves the availability of programmes, services and facilities. Access can be influenced by such factors as finances (insufficient monetary resources) and geography (distance to healthcare providers).[1]

"Accreditation" refers to certification by a qualified neutral agency that an organisation meets defined criteria for participation in a programme.[2]

"Actuarial insurance" refers to commercial insurance arrangements where insurers are permitted to load the premiums of the insured based on the risk of claiming, either on a group or individual basis.

"Acute disease or illness" refers to a disease which is characterised by a single or repeated episode of relatively rapid onset and short duration from which the patient usually returns to his/her normal or previous state or level of activity.[3]

"Acute facility" a type of hospital that provides acute care through a broad spectrum of clinical care services for acutely ill or medically complex patients who sometimes require longer in-patient stay.

"Admission" follows a clinical decision that a patient requires same-day or overnight hospital care or treatment.[4]

"Admission privileges/rights" the authorisation given by a health facility's management to medical practitioners who request the privilege of admitting and/or treating patients in the facility.[5] Privileges in South Africa are granted based on factors such as a practitioner's registration with the HPCSA, experience, training and education.

"Adverse event" is any undesirable or unwanted consequence of a preventive, diagnostic or therapeutic procedure.[6]

"Adverse selection" is the problem of attracting members who are sicker than the general population (specifically, members who are sicker than was anticipated when the budget for medical costs was developed).[7]

"Affordability" means that payment for healthcare services must be based on the principle of equity to ensure that healthcare services whether privately or publicly provided, are affordable for all, including the socially disadvantaged.[8]

"Asymmetric information" arises when market participants do not have the same information about goods or services involved in a transaction.[9]

B

"Balance billing" is the practice of a provider billing a patient for all charges not paid by the insurance plan. [10]

"Basket of care" includes all aspects of treatment for a particular medical condition such as clinical procedures, laboratory tests, medical supplies, and medicines.

"Behavioural barriers" also known as strategic barriers are intentionally created or enhanced by incumbent firms in the market, possibly for the purpose of deterring entry. [11]

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1 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
2 Kongstvedt, P.R. 2013. Essentials of Managed Health Care. 6th edition. Burlington: Jones and Bartlett Learning.
3 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
4 Organisation for Economic Co-operation and Development. Definitions for Health Care Quality Indicators 2014-2015 HCQI Data Collection.
5 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
6 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
7 Kongstvedt, P.R. 2013. Essentials of Managed Health Care. 6th edition. Burlington: Jones and Bartlett Learning.
8 International Covenant on Economic, Social and Cultural Rights (ICESCR), E/C.12/2002/11, 20 January 2003. See also General Comment 14, The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4, 11 August 2000.
9 Mankiw, G.N. and Reis, R. (2010). Imperfect information and Aggregate Supply, p.2. publication details?
10 Kongstvedt, P.R. 2013. Essentials of Managed Health Care. 6th edition. Burlington: Jones and Bartlett Learning.
11 Organisation for Economic Co-operation and Development. 2007. Accessed from: http://www.oecd.org/competition/37921908.pdf.

"Benefit design" the exercise of designing a benefits package to compete effectively in the market by balancing the level of benefits and the costs. [12]

"Benefit option" is a specific plan provided by a medical scheme. Members are able to select from a range of options which have varying cover and benefits.

"Board of trustees" means the people charged with managing the affairs of a medical scheme, and who have been elected or appointed under its rules.[13]

"Broker" means a person whose business, of part thereof, entails providing broker service[14] (see broker services).

"Broker services" mean:[15]

a. the provision of service or advice in respect of the introduction or admission of members to a medical scheme;

b. the ongoing provision of service or advice in respect of access to, or benefit or services offered by, a medical scheme.

"Burden of disease" is the total significance of the disease for a society or population beyond the immediate cost of treatment.[16]

C

"Care" There are various levels of care, namely:[17]

a. Intermediate care: a short period of intensive rehabilitation and treatment to enable people to return home following hospitalisation or to prevent admission to a healthcare facility;

b. Primary care: basic or general healthcare focused on the point at which a patient ideally first seeks assistance from the medical care system and it is the basis for referrals to secondary and tertiary level care;

c. Secondary care: specialist care provided on an ambulatory or inpatient basis, usually following a referral from primary care;

d. Tertiary care: the provision of highly specialised services in ambulatory and healthcare facility settings.

"Capitation" a method of payment for healthcare services in which an individual or provider is paid a fixed amount for each person served in a set period of time, without regard to the actual number or nature of services provided to each person.[18]

"Care pathway" is an agreed and explicit route an individual takes through healthcare services. Agreements between various providers involved will typically cover the type of care and treatment, and where treatment or care will take place.[19]

"Case management" refers to a continuous process of planning, arranging and coordinating multiple healthcare services across time, place and discipline for persons with high-risk conditions or complex needs in order to ensure appropriate care and optimum quality, as well as to contain costs.[20]

"Case mix" refers to a mix of illnesses and severity of cases for a provider. Case mix adjustment refers to a methodology of using case mix to evaluate the performance of a provider or to project potential costs.[21]

"Catastrophic health conditions" refer to complex or severe health conditions requiring prolonged hospitalisation or recovery. A catastrophic health condition usually has substantial financial implications.

"Catchment area" is the geographical area from which a healthcare facility draws its patients.[22]

"Certification" the process by which a government or nongovernmental agency or association evaluates and recognizes an individual, institution or educational programme as meeting predetermined

12 Kongstvedt, P.R. 2013. Essentials of Managed Health Care. 6th edition. Burlington: Jones and Bartlett Learning.
13 Medical Schemes Act No. 131 of 1998.
14 Council for Medical Schemes. 2012. Accessed from: http://www.medicalschemes.com/files/Circulars/Circular44Of2012.pdf.
15 Council for Medical Schemes. 2012. Accessed from: http://www.medicalschemes.com/files/Circulars/Circular44Of2012.pdf.
16 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
17 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
18 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
19 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
20 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
21 Kongstvedt, P.R. 2013. Essentials of Managed Health Care. 6th edition. Burlington: Jones and Bartlett Learning.
22 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.

standards. One so recognized is said to be "certified". It is essentially synonymous with accreditation, except that certification is usually applied to individuals and accreditation to institutions.[23]

"Chronic condition or disease" refers to a disease which is permanent or may be expected to require a long period of supervision, observation or care.[24]

"Claims" the term used to describe a bill for services from a healthcare provider to the organisation or person responsible for payment.[25]

"Clinician" is a healthcare professional such as a GP, physician or nurse involved in the care of patients.[26]

"Community rating" refers to the practice of charging a contribution to all members on a specific benefit option within a medical scheme that does not discriminate against them unfairly. In other words, all members on a particular option pay the same contribution, regardless of their age or health status or any other arbitrary ground. Community rating is the opposite of individual risk-rating, where the latter describes the practice of distinguishing between "high risk" and "low risk" individuals and charging an individual more if he/she is more likely to claim a benefit and therefore poses a high insurance ris.[27]

"Consumer" one who may receive or is receiving services.[28]

"Coordinated care" refers to a collaborative process that promotes quality care, continuity of care and cost-effective outcomes. It includes assessing, planning, implementing, coordinating, monitoring and evaluating health-related service options.[29]

"Co-payment" refers to a portion of a claim or medical expense that a member must pay out of pocket.[30]

"Cost" refers to actual expenses incurred to provide a healthcare product or service. Cost can be divided into a number of types including:[31]

a. Average cost: the average cost per unit; equals the total cost divided by the units of production;

b. Avoided cost: cost caused by a health problem that is avoided by a healthcare intervention;

c. Direct cost: cost borne by the healthcare system, the community and families, e.g. diagnosis and treatment costs; a cost that is identifiable directly with a particular activity, service or product;

d. Fixed cost: costs that, within a defined period, do not vary with the quantity produced, e.g. overhead costs of maintaining a building;

e. Incremental cost: the difference between marginal costs of alternative interventions;

f. Indirect cost: cost which cannot be identified directly with a particular activity, service or product of the programme experiencing the cost and which are usually apportioned among the programme's services in proportion to each service's share of direct costs;

g. Intangible cost: the cost of pain and suffering resulting from a disease, condition or intervention;

h. Marginal cost: the additional cost required to produce an additional unit of benefit (e.g. unit of health outcome);

i. Operating cost: in the health field, the financial requirements necessary to operate an activity that provides health services and which normally include costs of personnel, materials, overheads, depreciation and interest;

j. Opportunity cost: the benefit foregone, or value of opportunities lost, by engaging resources in a service, usually quantified by considering the benefit that would accrue by investing the same resources in the best alternative manner;

k. Recurrent cost: an item of expenditure that recurs, such as the remuneration of health workers and other staff, the cost of food and other goods and services, the cost of vaccines, medicines, appliances and other supplies, the replacement of equipment, and the maintenance of buildings and equipment;

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23 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
24 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
25 Kongstvedt, P.R. 2013. Essentials of Managed Health Care. 6th edition. Burlington: Jones and Bartlett Learning.
26 Competition and Market Authority. Accessed from: https://assets.publishing.service.gov.uk/media/5641d00eed915d566a000018/Appendices_and_glossary_PFs.pdf.
27 National Treasury. Accessed from: http://www.treasury.gov.za/public%20comments/Demarc/Annexure%20B.pdf.
28 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
29 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
30 Kongstvedt, P.R. 2013. Essentials of Managed Health Care. 6th edition. Burlington: Jones and Bartlett Learning.
31 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.

l. Tangible cost: objective elements in the production of care, i.e. number of personnel, beds, consumables, technologies, staff qualifications;

m. Total cost: the sum of all costs incurred in producing a set quantity of service.

"Council for Medical Schemes (CMS)" is a statutory body established by the Medical Schemes Act (131 of 1998) to provide regulatory supervision of private health financing through medical schemes.

"Creeping Mergers" encompass a range of situations. While it can refer to a series of acquisitions over time that individually do not raise competitive concerns, but which when taken together, have a significant competitive impact, the term creeping acquisition also refers to a firm with existing substantial market power enhancing its market power through one (or more) acquisitions which individually do not substantially lessen competition.[32]

D

"Day cases" refer to patients admitted to the facility and discharged without requiring an overnight stay.

"Day facility" refers to a healthcare establishment providing non-residential medical care, usually during the day. In some instances, a day facility is attached to an acute facility.[33]

"Deductible" is a portion of a member's healthcare expenses that must be paid out of pocket before any insurance coverage applies.[34]

"Derived demand" a demand for a product or service, which is a consequence of the demand for something else.

"Demarcation" refers to regulations that were enacted on the 1 April 2017 by the Minister of Finance, the objective of which is to clearly demarcate the responsibility of regulatory supervision of medical scheme and health insurance products and to the prevent the operation of harmful health insurance products that potentially undermine the principles and provisions of the MSA. This is to ensure that products that fall within the definition of a 'medical scheme' are subject to the same underlying principles as medical schemes.

"Designated Service Provider (DSP)" a healthcare provider or group of providers selected by the medical scheme concerned as the preferred provider or providers to provide to its members diagnosis, treatment and care in respect of one or more prescribed minimum benefit conditions.[35]

"Diagnosing healthcare practitioner" this refers to practitioners such as GPs, oncologists, and obstetricians. See definition for Non-diagnosing healthcare practitioner.

"Diagnosis-Related Groups (DRGs)" a statistical system of classifying any in-patient stay into groups for purposes of payment. [36]

"Dispensing fee" the fee paid to a pharmacy for that part of the cost of a prescription that is not the ingredient cost. It is usually a flat Rand amount not tied to the cost of the drug.[37]

E

"Emergency" refers to a sudden unexpected onset of illness or injury which requires immediate care.[38]

"Emergency Medical Condition" Medical Schemes Act Regulation 7 defines these as the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy.

"Equilibrium" is when the price adjusts until quantity of a product demanded equals the quantity supplied.

"Evergreen contract" an agreement that continues in force unless one or both parties give notice of cancellation. Some evergreen contracts require a year's notice, while others use shorter terms. [39]

"Externalities" are the costs or benefits arising from an individual's production or consumption decision which indirectly affects the well-being of others.

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32 Robb, G. 2014. Creeping mergers – should we be concerned? A case study of hospital mergers in South Africa. Accessed from: http://www.compcom.co.za/wp-content/uploads/2014/09/Creeping-mergers-conference-paper-Final.pdf.
33 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
34 Kongstvedt, P.R. 2013. Essentials of Managed Health Care. 6th edition. Burlington: Jones and Bartlett Learning.
35 Medical Schemes Act Regulation 7.
36 Kongstvedt, P.R. 2013. Essentials of Managed Health Care. 6th edition. Burlington: Jones and Bartlett Learning.
37 Kongstvedt, P.R. 2013. Essentials of Managed Health Care. 6th edition. Burlington: Jones and Bartlett Learning.
38 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
39 Kongstvedt, P.R. 2013. Essentials of Managed Health Care. 6th edition. Burlington: Jones and Bartlett Learning.

F

"Facility beds" are beds for accommodating patients admitted to a hospital.

"Facility Group" is a private facility operator that operates more than one healthcare facility. See the definition for independent facility.

"Fee" a payment made to a professional person or to a professional or public body in exchange for advice or services.

"Fee-For-Service" method of billing for health services under which a medical practitioner or other practitioner charges separately for each patient encounter or service rendered. Under a fee-for-service payment system, expenditures increase if the fees themselves increase, if more units of service are provided, or if more expensive services are substituted for less expensive ones.[40]

"Formulary" refers to a list of drugs, usually by their generic names, and indications for their use. A formulary is intended to include a sufficient range of medicines to enable medical practitioners, dentists and, as appropriate, other practitioners, to prescribe all medically appropriate treatment for all reasonably common illnesses. In some health plans, providers are limited to prescribing only drugs listed on the plan's formulary. [41]

G

"Gap cover" is a type of health insurance that covers the shortfall between medical scheme benefits and the rates that private medical service providers may charge.[42]

"Gazette" is a tool to communicate messages of national importance to the general public. It contains information of a legal, administrative and general nature.[43]

"General waiting-periods" means a period in which a medical scheme beneficiary is not entitled to claim any benefits. [44]

"General practice" is a form of practice in which medical practitioners provide a wide range of primary healthcare services to people.

"Global payment/fees models" refer to a single fixed payment for an episode of care and is most commonly used for well-defined types of care such as maternity and surgery.[45]

"Good-risks" refers to individuals or groups with a low probability of claiming health benefits, such as those who are young and healthy.

"Group practice" refers to a group of healthcare practitioners providing health services. Income from the practice is pooled and redistributed to the members of the group according to a prearranged plan. [46]

H

"Healthcare coverage" refers to a measure of the extent to which the services rendered cover the potential needs of a community.

"Health establishment" means the whole or part of a public or private institution, facility, building or place, whether for profit or not, that is operated or designed to provide in-patient or out-patient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative or other health services.[47]

"Health event" is used in the insurance legislation to refer to some health-related events that initiates an insurance benefit payment or claim.

"Healthcare expenditure" refers to the total final consumption of health goods and services, plus capital investment in healthcare infrastructure and includes spending on medical goods and services and on administration.

"Healthcare facilities" are establishments for the diagnosis, treatment or care of individuals suffering from illness and injury. There are different types of healthcare facilities, namely: acute facilities, sub-acute facilities, day facilities, specialised facilities, healthcare centres and clinics.

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40 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
41 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
42 National Treasury. Accessed from: http://www.treasury.gov.za/legislation/regulations/FinalDemarc2016/2016122301%20-%20Demarcation%20press%20statement.pdf.
43 Government Printing Works. Accessed from: http://www.gpwonline.co.za/Gazettes/Pages/default.aspx.
44 Medical Schemes Act No 131 of 1998.
45 Kongstvedt, P.R. 2013. Essentials of Managed Health Care. 6th edition. Burlington: Jones and Bartlett Learning.
46 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
47 National Health Act No. 61 of 2003.

"Healthcare financers" refers collectively to medical schemes, medical scheme administrators, Managed Care Organisations (MCOs) and healthcare insurers.

"Healthcare insurers" mean a person or firm that is not registered as a medical scheme but offers insurance products designed for healthcare services.

"Health Ombudsman" is an independent statutory body, linked to the OHSC, established in terms of section 81 of the National Health Act to investigate complaints related to healthcare norms and standards, and to make findings and recommendations.

"Health outcome" refers to changes in health status which result from the provision of health (or other) services. [48]

"Healthcare practitioners" means any person, including a student, who is registered with the Health Professions Council of South Africa (HPCSA) in a profession registerable in terms of the Health Professions Act 56 of 1974.

"Health Professions Council of South Africa (HPCSA)" is a statutory body established in terms of the Health Professions Act 56 of 1974.

"Health Professions Council of South Africa ethical rules" are rules and regulations which govern the conduct of practitioners and practitioner relationships with others involved in the delivery of healthcare.

"Healthcare provider" means a person providing health services in terms of any law, including in terms of the:[49]

a. Allied Health Professions Act, 1982 (Act No. 63 of 1982)
b. Health Professions Act, 1974 (Act No. 56 of 1974)
c. Nursing Act, 1978 (Act No. 50 of 1978)
d. Pharmacy Act, 1974 (Act No. 53 of 1974)
e. Dental Technicians Act, 1979 (Act No. 19 of 1979).

"Healthcare services" a term generally used to refer to the services that a healthcare professional or institution provides, for example services from a physician at a hospital. [50]

"Health technology" means machinery or equipment that is used in the provision of health services but does not include medicine as defined in section 1 of the Medicines and Related Substances Control Act, 1965 (Act No.101 of 1965).[51]

"Health technology assessment (HTA)" the systematic evaluation of the effects or other impacts of healthcare technology. HTA is intended to inform decision-makers about health technologies and may measure the direct or indirect consequences of a given technology or treatment.[52]

"Herfindahl-Hirschman Index (HHI)" is one of the most commonly accepted measures of market concentration calculated by summing the squares of the market shares of all the firms active in the market. The HHI potentially reflects both the number of firms in the market and their relative size in a defined geographic market.

"Horizontal integration" refers to merging of two or more firms at the same level of production in some formal, legal relationship.[53]

"Hospital cash plans" refers to a type of health insurance product that provides pre-defined benefits in the event of hospitalisation. The length of stay in a healthcare often determines the benefits, usually paid for a specified set of illness or specific hospitalisation event.

I

"Imperfect information" arises when market participants have a lack of information about prices or the quality of services.

"Indemnity" health insurance benefits provided in the form of cash payments rather than services. An indemnity insurance contract usually defines the maximum amounts which will be paid for covered services.[54]

"Independent facility" is a private facility not belonging to a facility group.

"Independent regulator" is an institution that must behave and act objectively, impartially, and

48 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
49 National Health Act No. 61 of 2003.
50 Kongstvedt, P.R. 2013. Essentials of Managed Health Care. 6th edition. Burlington: Jones and Bartlett Learning.
51 National Health Act No. 61 of 2003.
52 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
53 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
54 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.

consistently, without conflict of interest, bias or undue influence.[55]

"Informed consent" is a patient's explicit agreement to the care and treatment to be provided, based on full information on his or her condition/diagnosis, the existing options for treatment and the possible beneficial and adverse effects of those options.[56]

"In-hospital treatment" includes any instance where a hospital submitted a claim irrespective of the treatment provided.

"Innovative healthcare models" are other forms of healthcare delivery which are new to the healthcare system. The innovative healthcare models are generally aimed at increasing healthcare access and reducing costs.

"In-patient care" refers to services requiring admission and overnight stay in a healthcare facility.[57]

"Intensive care" is an advanced and highly specialised care provided to medical or surgical patients whose conditions are life-threatening and require comprehensive care and constant monitoring.

"Internal Rate of Return" is the discount rate that would give a net present value (NPV) of zero.

"International Classification of Diseases (ICD)" was developed by the World Health Organisation as a standard diagnostic tool for epidemiology, health management and clinical purposes. It is used for reimbursement and resource allocation decision making. It is also used to monitor the incidence and prevalence of diseases and other health problems, providing a picture of the general health situation of countries and populations.[58]

"International Competition Network (ICN)" is a global body devoted exclusively to competition law enforcement and its members represent national and multinational competition authorities. It facilitates a dialogue that serves to build consensus and convergence towards sound competition policy principles across the global antitrust community. Members produce work outputs through their involvement in flexible project-oriented and results-based working groups. Working group members work together largely by internet, telephone, teleseminars, and webinars.

"International Consortium for Health Outcomes Measurement" ICHOM's mission is to unlock the potential of value-based healthcare by defining global Standard Sets of outcome measures that really matter to patients for the most relevant medical conditions and by driving adoption and reporting of these measures worldwide.[59]

L

"Late joiner penalty" is a "fine" by way of additional contributions, imposed on persons joining a medical scheme when they are 35 years of age or older and were not a member of one or more medical schemes before 01 April 2001, without a break in membership exceeding three consecutive months since 01 April 2001. Penalties may be imposed on the late joiner according to a prescribed formula in the Regulations that determines a maximum penalty according to the applicant's penalty band. The formula takes previous creditable coverage with other medical schemes into consideration. Late joiner penalties are imposed indefinitely and do not expire after a certain period and the purpose is to place the late joiner and the other members who have been contributing towards a medical scheme from a young age on the same level as they receive the same benefits.[60]

"Lavielle algorithm" an approach used to determine catchment areas for a local market. It is part of the family of algorithms dealing with "change point analysis" which measure sudden changes in surface area and select the optimal value for the largest surface break with the smallest population increment. This calculated value is used to create the spatial catchment area by excluding the "outliers".

"Length of stay (LOS)" the total number of days spent in the hospital for an inpatient admission. [61]

"Licensing" refers to granting legal permission to do something, such as to produce a product or provide a service. The license confers a right which the person or firm did not previously possess. Some licenses are granted free of charge, but most require payment.

55 Organisation for Economic Co-operation and Development. Accessed from: http://www.oecd.org/publications/being-an-independent-regulator-9789264255401-en.htm.
56 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
57 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
58 National Department of Health. Accessed from: www.health.gov.za/index.php/nhi?download=2257:white-paper-nhi-2017.
59 https://www.ichom.org/faqs/.
60 Council for Medical Schemes. Accessed from: https://www.medicalschemes.com/Content.aspx?141.
61 Kongstvedt, P.R. 2013. Essentials of Managed Health Care. 6th edition. Burlington: Jones and Bartlett Learning.

Licenses are legal agreements which may contain restrictions as to how the license is employed.[62]

"Logit Competition Index (LOCI)" an alternative technique for assessing concentration and market power without the need to define relevant geographic markets. It computes market shares in each identified submarket and weighs these market shares and calculates one average market share as an indicator for each firm's market power in the entire area that covers its submarkets. To use this approach, we calculate the minimum convex polygon (MCP) area (in km2) in increments of 5% around the facility. The Index is defined as one minus the average market share, and varies between zero and one, where zero represents pure monopoly in the area identified.

M

"Maldistribution" refers to either a surplus or a shortage of the type of health providers (typically healthcare practitioners) needed to maintain the health status of a given population at an optimum level. Maldistribution can occur both geographically and by specialty.[63]

"Malpractice" is a professional misconduct or failure to apply ordinary skill in the performance of a professional act.[64]

"Managed healthcare" defined in Medical Schemes Act Regulation 15 as clinical and financial risk assessment and management of healthcare, with a view to facilitating appropriateness and cost effectiveness of relevant health services within the constraints of what is affordable, through the use of rules-based and clinical management-based programmes.

"Managed Care Organisations (MCOs)" refer to a person or firm that has entered into an arrangement or contract with a medical scheme, insurer, provider or consumer to provide managed care services and is accredited by the Council of Medical Schemes to operate as an MCO. MCOs are commercial entities that determine if the treatment being sought by the patient and his/her healthcare provider is indeed necessary and appropriate, and whether the scheme should fund the treatment or recommend alternative treatment.

"Mandatory membership" is the legislated requirement to be a member of a medical scheme.

"Market concentration" refers to concentration within an industry refers to the degree to which a small number of firms provide a major portion of the industry's total production or services. If concentration is low, then the industry is considered to be competitive. If the concentration is high, then the industry will be viewed as oligopolistic or monopolistic.

"Market Definition" is a widely applied analytical framework to examine and to evaluate competitive constraints that a firm faces and the impact of its behaviour on competition. The relevant market is usually defined by applying the hypothetical monopolist test (also known as the SSNIP test), according to which a 'market' comprises all the products and regions for which a hypothetical profit maximising monopolist would impose a small but significant non-transitory increase in price.[65]

"Medical Practice Variation (MPV)" refers to the differing medical styles, approaches and methods of treatment existing in healthcare systems.

"Medical record" is a file kept for each patient, maintained by the hospital (medical practitioners also maintain medical records in their own practices), which documents the patient's problems, diagnostic procedures, treatment and outcome.[66]

"Medical savings account" refers to the tax-exempt savings account available on some benefit options. Contributions are capped, and funds can only be spent on medical items.

"Medical scheme" means any Medical Scheme registered in terms of section 24(1) of the Medical Schemes Act No 131 of 1998.

"Medical Schemes Act (MSA) Regulations" the regulations governing medical schemes in South Africa as prescribed by the Minister of Health in terms of the MSA.

"Medical scheme administrator" means a person or firm accredited by the Council for Medical Schemes.[67]

62 OECD. Accessed from: https://stats.oecd.org/glossary/detail.asp?ID=3245.
63 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
64 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
65 OECD. Accessed from: http://www.oecd.org/daf/competition/Marketdefinition2012.pdf.
66 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
67 In terms of section 58 of the Medical Schemes Act No 131 of 1998.

"Medical scheme beneficiaries" includes principal members and dependants that make the total membership of medical scheme.[68]

"Medical scheme contribution" is the monthly premium paid to a medical scheme as a condition of membership.

"Medical scheme dependant" means:[69]

a. the spouse or partner, dependant children or other members of the member's immediate family in respect of whom the member is liable for family care and support; or

b. any other person who, under the rules of a medical scheme, is recognized as a dependant of a member.

"Medical scheme principal member" member responsible for paying contribution(s) to medical scheme; may have adult and/or child dependant/s.[70]

"Medical Scheme Rate" this refers to the scheme tariff. It is contextual in that each scheme has their own scheme tariff at which they are willing to pay for specific healthcare services.

"Medical treatment" a medical treatment includes medical, surgical and/or diagnostic/ pathology treatments.

"Medicine" or **"Pharmaceuticals"** means any substance or mixture of substances used or purporting to be suitable for use or manufactured or sold for use in the diagnosis, treatment, mitigation, modification or prevention of disease, abnormal physical or mental state or the symptoms thereof in man (sic); or restoring, correcting or modifying any somatic or psychic or organic function in man (sic), and includes any veterinary medicine.

"Moral hazard" refers to changes in behaviour of an insured individual (or organisation) caused by the existence of the insurance itself, and for that behaviour change to increase costs to the insurer.[71]

"Mortality" means death and is used to describe the relation of deaths to the population in which they occur.[72]

N

"National Health Insurance" is a financing system designed to ensure that all citizens (and legal long-term residents) are provided with essential healthcare, regardless of their employment status and ability to make a direct monetary contribution to the NHI Fund.[73]

"National Health Reference Price List" was the reference tariff schedule developed by the Council for Medical Scheme applicable to the years 2005 and 2006.

"Net Present Value" of an activity or project is the sum of all the discounted cash flows associated with that activity or project, less the initial investment.

"Network" is an affiliation of providers through formal and informal contracts and agreements. Networks may contract externally to obtain administrative and financial services.[74]

"Non-diagnosing healthcare practitioner" refers to practitioners providing auxiliary healthcare services such as laboratory tests by pathologists or x-rays by radiographers. See also diagnosing healthcare practitioner.

"Non-healthcare expenditure" refers to the portion of medical scheme expenditure that is not related to the direct provision of healthcare services by providers. It consists mainly of administration expenditure, managed healthcare, management services (fees for managing healthcare benefits), commissions and service fees paid to brokers, other distribution costs and impaired receivables.

"Nurse" means a person registered under the Nursing Act 33 of 2005 in order to practice nursing or midwifery.

O

"Occupancy rate" is a measure of the use of facilities, most often in-patient health facility use, determined by dividing the number of patient days by the number of bed days (or places) available, on average, per unit of time, multiplied by 100.[75]

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68 Council for Medical Schemes. Annual Report 2016/17. Accessed from: https://www.medicalschemes.com/files/Annual%20Reports/CMSAnnualReport%2020162F17.pdf.
69 Medical Schemes Act No 131 of 1998.
70 Council for Medical Schemes. Annual Report 2016/17. Accessed from: https://www.medicalschemes.com/files/Annual%20Reports/CMSAnnualReport%2020162F17.pdf.
71 Kongstvedt, P.R. 2013. Essentials of Managed Health Care. 6th edition. Burlington: Jones and Bartlett Learning.
72 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
73 National Department of Health. Accessed from: http://www.health.gov.za/index.php/nhi.
74 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
75 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.

"Office of Health Standards Compliance (OHSC)" is an independent body established in terms of the National Health Amendment Act of 2013 to ensure that both public and private health establishments comply with the required health standards.[76]

"Open-enrolment" is a social security principle that requires every open medical scheme registered in South Africa to accept as a member or dependent any and every person who wishes to join that medical scheme. Put differently, the principle of open enrolment ensures non-discriminatory access to private healthcare financing. Every person who applies for membership, as well as any member who applies for the membership of a dependent, is guaranteed membership of an open medical scheme. Applicants must be accepted into the scheme regardless of factors such as their age or past and present medical history.[77]

"Open medical schemes" are registered competing medical schemes that are subject to the open-enrolment requirement.

"Out-of-hospital treatment" includes instances where a claim is not submitted against a hospital but for other healthcare services such as emergency services which are not offered by the hospital and usually operated separately by practitioners.

"Out of pocket (OOP) payment" is a fee paid by the consumer of health services directly to the provider at the time of delivery.[78]

"Outpatient care" refers to a patient treated in a healthcare facility, consulting room or clinic, who is not admitted to a hospital. [79]

"Over-servicing" means the supply, provision, administration, use or prescription of any treatment or care (including diagnostic and other testing, medicines and medical devices) which is medically and clinically not indicated, unnecessary or inappropriate under the circumstances or which is not in accordance with the recognised treatment protocols and procedures, without due regard to both the financial and health interests of the patient.[80]

"Over-utilisation" refers to the use of a service or healthcare facility above its potential or capacity. See the definition for under-utilisation.

P

"Patient" a person in contact with the health system seeking attention for a health condition. [81]

"P-value" calculated probability used in hypothesis testing to determine whether to accept or reject the null hypothesis. The p-value is a number between 0 and 1. A small p-value (typically ≤ 0.05) indicates strong evidence against the null hypothesis.

"Protection of Personal Information Act 4 of 2013" to promote the protection of personal information processed by public and private bodies.[82]

"Perverse incentive" means money, or any other form of compensation, payment, reward or benefit which is not legally due or which is given on the understanding, whether express, implied or tacit, that the recipient will engage or refrain from engaging in certain behaviour in a manner which is:[83]

a. illegal; and/or

b. contrary to ethical or professional rules; and/or

c. which, in the opinion of the HPCSA, may adversely affect the interests of a patient or group of patients.

"Pharmacist" means a person registered as such under the Pharmacy Act 53 of 1974.

"Pooled data" refers to data that are combined after being previously split into different categories. Data sources may be related or come from different populations.[84]

"Poor-risks" refers to people who are in higher need of health services, e.g. people with disabilities or chronic diseases.

"Poor-risk groups" refer to poor-risks specified as a group, for instance older people.

"Practice code numbering system (PCNS)" is a list of unique practice billing codes for providers of healthcare services in South Africa. The practice number allocated to all registered healthcare providers is a legal requirement for the process of reimbursement of a claim to either a medical scheme member or service

76 Office of Health Standards Compliance. Accessed from: http://ohsc.org.za/.
77 National Treasury. Accessed from: http://www.treasury.gov.za/public%20comments/Demarc/Annexure%20B.pdf.
78 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
79 Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
80 Health Professions Council of South Africa. Guidelines on Overservicing, Perverse Incentives And Related Matters.
81 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
82 https://www.gov.za/documents/protection-personal-information-act
83 Health Professions Council of South Africa. Guidelines On Overservicing, Perverse Incentives And Related Matters.
84 Verma et al (2009); On pooling of data and measures http://www.econ-pol.unisi.it/quaderni/84DMQ.pdf.

provider. This is in accordance with the requirement of the Medical Schemes Act 131 of 1998 under which a medical scheme may only reimburse a member or a provider of relevant healthcare services for services rendered against a valid practice code number. [85]

"Practitioner Incentives" refer to the inducements given by the facility groups to attract and retain practitioners in their facilities. For example, shareholding schemes, subsidised rentals, scholarships and grants, loans and relocation fees.

"Pre-existing condition" is a term normally used for a condition developed prior to applying for a health insurance policy or joining a medical scheme.[86]

"Pre-existing condition waiting-period" refers to the waiting period permitted in the Medical Schemes Act for any person joining a medical scheme for the first time or with a break in membership longer than 90 days. The maximum period is twelve months. Once exhausted, no further waiting period can be applied, even when moving between options or schemes. Unregulated health insurance markets permit insurers to determine their own pre-existing condition waiting periods. In such markets, exclusions are typically for a lifetime.

"Prescribed Minimum Benefits (PMBs)" refer to a set of defined medical benefits that all medical schemes are mandated to cover to ensure that all their members have access to certain minimum health services, irrespective of the particular benefit option to which they belong.[87]

"Prescribed minimum benefit Chronic Disease List (PMB-CDL)" refers to the chronic Diagnosis-Treatment Pairs as specified in Annexure A of the Medical Schemes Act Regulations (arguably the acronym should be PMB-DTP-CDL, but common usage in the industry is the shortened PMB-CDL).

"Prescribed minimum benefit condition" is defined as a condition contemplated in the Diagnosis and Treatment Pairs listed in Annexure A of the MSA Regulations, or any emergency medical condition found in Annexure A to the MSA Regulations. [88]

"Prescribed minimum benefit diagnosis" while a PMB diagnosis must occur in order to identify the existence of a PMB condition, in practice the two terms are often used interchangeably.

"Prescribed minimum benefit Diagnosis Treatment Pair (PMB-DTP)" refers to the acute Diagnosis-Treatment Pairs as specified in Annexure A of the Medical Schemes Act Regulations. There are 270 acute PMB-DTPs.

"Prescribed minimum benefit treatment" while not separately defined in Medical Schemes Act Regulation 7, it refers to the treatment counterpart of the PMB diagnoses found in Annexure A to the MSA Regulations.

"Price" refers to the value placed on a product or service.

"Primary healthcare insurance policies" are policies that provide limited medical service benefits (often to employee groups or bargaining councils) including services such as general practitioner visits, acute and chronic medication, emergency medical care, dentistry and optometry. [89]

"Principal Officer" means the principal officer appointed in terms of section 57(4) of the Medical Schemes Act no 131 of 1998.

"Private healthcare facilities" refers to any establishment providing medical treatments on an in-patient, day-case and/or out-patient basis which charges fees for its services.

"Private patient" is a patient who is charged for healthcare services either as a self-paying patient or as an insured patient.

R

"Radial method" refers to a more traditional criterion for determining catchment areas for a local market. It measures the radial area from which the hospital under consideration draws 80% of its patients, based on road distance between patient home postcodes and hospital postcodes.

"Rand Conversion Factor (RCF)" represents an average cost per minute and is calculated by taking into account the cost of the resources required to perform a healthcare intervention, including the professional income of the healthcare professional. The reference price of each of the items in a schedule is determined through a multiplication of the Relative Value Units (RVUs) of each concept by the RCF. The

85 Board of Healthcare Funders. Accessed from: https://www.pcns.co.za/bhf_global/pcns.
86 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
87 National Department of Health. Accessed from: www.health.gov.za/index.php/nhi?download=2257:white-paper-nhi-2017.
88 Regulation 7 of the Medical Schemes Act No. 131 of 1998.
89 National Treasury. Accessed from: http://www.treasury.gov.za/legislation/regulations/FinalDemarc2016/2016122301%20%20Demarcation%20press%20statement.pdf.

RCF needs to be scientifically determined and cannot merely be a selected random number.[90]

"Readmission rate" refers to the proportion of a hospital's patients (or a subset, such as those with asthma) who are readmitted to the hospital, following discharge, with the same diagnosis. It is used as a performance measure where a higher rate indicates lower quality of care.[91]

"Referral" is the direction of patients to an appropriate healthcare facility or practitioner in a health system.[92]

"Regression analysis" refers to the statistical process of estimating or assessing relationships among variables (dependent and independent variables).[93]

"Regulatory barriers" refer to legal and administrative barriers to start-ups, in the healthcare sector, these include licensing, certification and accreditation.

"Reimbursement" is a term commonly but incorrectly used to refer to payment of healthcare providers. Reimbursement is more applicable to an employer reimbursing an employee's out-of-pocket travel costs. The accurate term therefore is payment, not reimbursement.[94]

"Relative Value Units (RVUs)" are numeric values used as multipliers in order to calculate the payment to a provider. It may be used for time units such as for anaesthesia, but its most common use is the resource-based relative value scale. [95]

"Remunerative Work outside the Public Service (RWOPS)" is allowed by government and is a policy that makes it possible for practitioners in full-time public service to earn extra income in the private sector. [96]

"Return on Capital Employed" is a measure of profitability whereby the profit for a period is divided by the net assets relevant to the same period and is expressed as a percentage. This percentage is benchmarked against the relevant cost of capital.

"Restricted medical schemes" refers to medical schemes, the rules of which restrict the eligibility for membership by reference to:[97]

a. employment or former employment or both employment or former employment in a profession, trade, industry or calling;

b. employment or former employment or both employment or former employment by a particular employer, or by an employer included in a particular class of employers;

c. membership or former membership or both membership or former membership of a particular profession, professional association or union; or

d. any other prescribed matter.

"Revenue" refers to the gross amount of earnings received by an entity for the operation of a specific activity. It does not include any deductions for such items as expenses, bad debts or contractual allowances.[98]

"Risk adjustment mechanism" is a methodology used to account for the health status of patients when predicting or explaining costs of healthcare for defined populations or for evaluating retrospectively the performance of providers who care for them.[99]

"Risk-groups" refer in general to categories of people with characteristics in common that are correlated with a certain level of average health insurance claims experience.

"Risk-pool" in the case of premiums, a risk pool means a group of individuals who all put in the same amount of money, thereby spreading out the risk even though some are healthier and some are sicker.[100]

"Risk-pooling" refers to the practice of bringing several risks together for insurance purposes in order to balance the consequences of the realization of each individual risk.[101]

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90 Health Professions Council of South Africa. Accessed from: http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/service_feestariff/submissions/sappf_e_medical_coding_billing_2013_03_19.pdf.
91 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
92 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
93 Alan Sykes; An introduction to regression analysis http://www.law.uchicago.edu/files/files/20.Sykes_.Regression.pdf.
94 Kongstvedt, P.R. 2013. Essentials of Managed Health Care. 6th edition. Burlington: Jones and Bartlett Learning
95 Kongstvedt, P.R. 2013. Essentials of Managed Health Care. 6th edition. Burlington: Jones and Bartlett Learning
96 Health Professions Council of South Africa. Accessed from: http://www.hpcsa-blogs.co.za/abuse-of-the-rwops-programme-unacceptable/.
97 Medical Schemes Act No. 131 of 1998.
98 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
99 Kongstvedt, P.R. 2013. Essentials of Managed Health Care. 6th edition. Burlington: Jones and Bartlett Learning.
100 Kongstvedt, P.R. 2013. Essentials of Managed Health Care. 6th edition. Burlington: Jones and Bartlett Learning.
101 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.

"Risk-rating" means that high-risk individuals will pay more than the average premium price.[102]

"Risk-selection" is the practice of singling out or disaggregating a particular risk from a pool of insured risks.[103]

S

"Service" is a result of a provider's actions aimed at meeting the needs of a consumer.[104]

"Service Level Agreement (SLA)" is the part of a contract specifying performance standards. It is also a common part of a contract between a payer and a company providing outsourced services.[105]

"Social Health Insurance (SHI)" is one of the possible organisational mechanisms for raising and pooling funds to finance health services, along with tax-financing, private health insurance, and community insurance.[106]

"South African Health Products Regulatory Authority (SAHPRA)" is the National Medicines Regulatory Authority established in terms of the Medicines and Related Substances Act, 1965 (Act 101 of 1965) as amended, to provide for the monitoring, evaluation, regulation, investigation, inspection, registration and control of medicines, scheduled substances, clinical trials, medical devices, and related matters in the public interest.

"Specialist facility" a hospital that admits only certain types of patients or those with specified illnesses or conditions. Examples include psychiatric hospitals and rehabilitation hospitals for the older population.[107]

"Specialists" refer to healthcare practitioners that meet the HPCSA's requirements to be considered as specialists and are registered as such. A specialist is trained in a certain branch of his/her profession related to specific services or procedures.[108]

"Specialties" refer to different disciplines of healthcare, for example, gynaecology, obstetrics, dermatology, oncology, cardiology, dentistry, optometry and orthopaedics.

"Strategic Purchasing" is described by the WHO as active, evidence-based engagement in defining the service-mix and volume and selecting the provider-mix in order to maximise societal objectives. Strategic purchasing requires information on a range of issues such as prioritisation, cost-effectiveness, staff and facilities, price, quality and projections on available resources. It is aimed at improving the performance of the health system and advancing progress towards universal health coverage. It is undertaken by an active purchaser that pools funds on behalf of a population and purchases health services from accredited and contracted providers.[109]

"Structural barriers (or intrinsic barriers)" arise from basic industry characteristics such as technology, costs and demand. Structural barriers may exist due to conditions such as economies of scale and network effects.[110]

"Sub-acute facility" refers to a health establishment that is a step down from an acute care facility. It may be a nursing home or a facility that that provides medical care but not surgical or emergency care. [111]

"Supply or 'supplier' Induced Demand (SID)" refers to the economic theory describing a phenomenon where the demand for a product or service is created after it is supplied; i.e. it is assumed that the supply of a product/ service 'induces' the demand for that particular product/service.

"Sunk costs" are retrospective (past) costs that have already been incurred and cannot be recovered when a firm leaves the market.

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102 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
103 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
104 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
105 Kongstvedt, P.R. 2013. Essentials of Managed Health Care. 6th edition. Burlington: Jones and Bartlett Learning.
106 Doetinchem et al. 2010. Thinking of introducing social health insurance? Ten questions. Accessed from: http://www.who.int/healthsystems/topics/financing/healthreport/26_10Q.pdf.
107 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
108 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
109 National Department of Health. Accessed from: www.health.gov.za/index.php/nhi?download=2257:white-paper-nhi-2017.
110 OECD. 2007. Competition and Barriers to Entry. Accessed from: http://www.oecd.org/competition/37921908.pdf.
111 Kongstvedt, P.R. 2013. Essentials of Managed Health Care. 6th edition. Burlington: Jones and Bartlett Learning.

T

"Tariff" is used by medical schemes as a basis for determining their levels of reimbursement.[112]

"Tax expenditure subsidies" involve subsidies constructed through the tax system such as tax deductions, rebates and credits.

"Treatment algorithms" or **"Benchmarks for treatment"** are the minimum standards of treatment for prescribed minimum benefit conditions as published in the Government Gazette. The medical scheme may pay for additional treatment (as per their own developed treatment protocols) but these treatment protocols cannot be less than the standards published in the treatment protocols.

"Treatment guidelines" refer to statements that include recommendations intended to optimize patient care. Such guidelines are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.[113]

"Truncated internal rate of return (TIRR)" is the rate used in capital budgeting to measure and compare profitability of investments. The methodology places more weighting on the earlier years of the Relevant Period while other measures such as the return on capital employed (ROCE), place equal weighting on each of the years of the Relevant Period.

U

"Universal Health Coverage (UHC)" is defined by the World Health Organisation (WHO) as ensuring that all people can use promotive, preventative, curative, rehabilitative and palliative services which they need, which are of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.[114]

"Utilisation" refers to the 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 facility care, healthcare practitioner visits or prescription of drugs.

"Under-utilisation" the use of a service or facility below its potential.[115]

V

"Vertical integration" in healthcare can take many forms, for example, it can imply that providers such as healthcare practitioners and facilities have combined their processes in some manner to increase efficiencies, increase competitive strength, or improve quality of care.

W

"Waiting Period" is the period during which members pay contributions without being entitled to any benefits.[116]

"Water-bed effect" the water-bed theory involves offering a discounted price to a buyer with market power, which results in an increase in the wholesale price to other buyers. The increase in the price to other buyers raises their costs downstream, leading either to their exit or giving them an incentive to raise their downstream price.[117]

112 Council for Medical Schemes. Accessed from: https://www.medicalschemes.com/files/Health%20Price%20Determination/DiscussionDocOnPriceDetermination.pdf.
113 National Department of Health. Accessed from: www.health.gov.za/index.php/nhi?download=2257:white-paper-nhi-2017.
114 National Department of Health. Accessed from: www.health.gov.za/index.php/nhi?download=2257:white-paper-nhi-2017.
115 World Health Organization. 2004. A Glossary of Terms for Community Health Care and Services for Older Persons. Accessed from: http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf.
116 Council for Medical Schemes (http://www.medicalschemes.com/Error.aspx?aspxerrorpath=/consumer/FAQ.aspx#Q5)
117 Organisation for Economic Co-operation and Development. Accessed from: https://www.oecd.org/daf/competition/44445750.pdf.

Abbreviations

AHRQ
Agency for Healthcare Research and Quality

ARMs
Alternative reimbursement models

AGMs
Annual General Meetings

AWP
Any willing Provider

AFSA
Arbitration Foundation of South Africa

AASA
Association of Arbitrators of South Africa

BOTs
Board of Trustees

CDL
Chronic Disease List

Competition Act
Competition Act 89 of 1998

Competition Amendment Act
Competition Amendment Act 18 of 1028

Commission
Competition Commission of South Africa

Tribunal
Competition Tribunal of South Africa

CPI
Consumer Price Index

CMS
The Council for Medical Schemes

DSP
Designated service provider

DTPs
Diagnosis treatment pairs

DRG
Diagnosis Related Group

DICA
Dutch Institute for Clinical Auditing

FAIS
Financial Advisory and Intermediary Services

FFS
Fee-for-service

FSB
Financial Services Board

GP's
General practitioners

GCI
Gross Contribution Income

HPA
Health Profession's Act 56 of 1974

HPCSA
Health Professionals Council of South Africa

HQA
Health Quality Assessment

HTA
Health Technology Assessment

HHI
Herfindahl Hirschman indices

HMI
Health Market Inquiry

ICD
International Classification of Diseases and Related Health Problems

ICPC
International Classification of Primary Care

ICU
Intensive Care Unit

ICN
International Competition Network

ICHOM
International Consortium for Health Outcomes Measurement

LOS
Length of Stay

LOC
Level of Care

LOCI
Logit Competition Index

MCOs
Managed Care Organisations

MSA
Medical Scheme Act 131 of 1998

MSAB
Medical Schemes Act Bill 2018

Minister
Minister of Health

MLNF
Multilateral tariff negotiation forum

NDOH
National Department of Health

NHA
National Health Act 61 of 2003

NHI
National Health Insurance

NHRPL
National Health Reference Price List

NPV
Net Present Value

OHSC
Office of Health Standards Compliance

OECD
Organization for Economic Co-operation and Development

OMRO
Outcome Measurement and Reporting Organisation

PBPM
Per beneficiary per month

PMBD
PMB diagnosis

PCNS
Practice Coding Numbering System

PPNs
Preferred Provider Networks

PMBs
Prescribed Minimum Benefits

PO
Principle officer

PDOH
Provincial Departments of Health

PFR
Provisional Findings and Recommendations Report

PPPs
Public Private Partnerships

RCF
Rand Conversion Factor

RMIH
Rand Merchant Investment Holdings Limited

RVU
Relative Value Unit

RWOPS
Remunerative Work Outside the Public Service

ROCE
Return of Capital Employed

ROS
Return on Sales

RSOI
Revised Statement of Issues

RAM
Risk adjustment mechanism

RMBH
RMB Holdings Limited

SEP
Single Exit Pricing

SARS
South African Revenue Service

SOI
Statement of Issues

SBP
Supplementary benefit packages

SID
Supplier Induced Demand

SSRH
Supply-Side Regulator of Health

TTG
Technical task group

TOR
Terms of Reference

TIRR
Truncated internal rate of return

VAT
Value added tax

WACC
Weighted average cost of capital

Executive Summary

1. In our review of the South African private healthcare market we found that it is characterised by high and rising costs of healthcare and medical scheme cover, and significant overutilization without stakeholders having been able to demonstrate associated improvements in health outcomes.

2. We have identified features that alone or in combination, prevent, restrict or distort competition. The market is characterised by highly concentrated funders and facilities markets, disempowered and uninformed consumers, a general absence of value-based purchasing, practitioners who are subject to little regulation and failures of accountability at many levels.

3. We are concluding our work at a time when South Africa is embarking on a journey to establish a National Health Insurance Fund (NHI), a means to achieve universal health coverage. Based on the latest version of the NHI Bill, Gazetted on 26/7/2019 (Gazette no. 42598), it is envisioned that the NHI will create: a unified health system by improving equity in financing; reduce fragmentation in funding pools; and by making healthcare delivery more affordable and accessible, eliminate out-of-pocket payments when individuals need to access healthcare services; and ensure that all South Africans[118] have access to comprehensive quality healthcare services.

4. Full implementation of the NHI is some years away, with the Fund scheduled to be operational by 2026 at the earliest. The private sector will continue to operate in the interim and also after 2026. We have taken this into account in the implementation of our recommendations which will provide a better environment in which a fully implemented NHI can function. Nonetheless, we have always had regard to the mandate reflected in the Term Of Reference: to primarily focus on issues that affect the private sector.

5. We have found there has been inadequate stewardship of the private sector with failures that include the Department of Health not using existing legislated powers to manage the private healthcare market, failing to ensure regular reviews as required by law, and failing to hold regulators sufficiently accountable. As a consequence, the private sector is neither efficient nor competitive.

6. A more competitive private healthcare market will translate into lower costs and prices, more value-for-money for consumers and should promote innovation in the delivery and funding of healthcare. As the state becomes a purchaser of services (from the private sector as indicated by the NHI Bill), it will be able to enter a market where interventions like the establishment of a supply side regulator, a standardised single obligatory benefit package, risk adjustment mechanism, and a system to increase transparency on health outcomes have already led to greater competition and efficiency.

7. Competition should occur on price, cost and quality, not on risk avoidance. The risk adjustment mechanism is a regulatory component designed to eliminate fragmented risk pools but, more importantly, it is an essential market mechanism to ensure that purchasing in the market becomes more effective, by forcing funders to compete on value and, therefore, stimulate competition between and the efficiency of providers. The resultant competitive environment will benefit the NHI. The proposed RAM includes income

118 All South Africans, permanent residents and other registered users as defined in Chapter 2 of the NHI Bill will be covered by the fund.

cross subsidisation an important move towards greater equity and it will build technical capacity in running health funds. We are aware that the RAM is contested but we reiterate that it is a vital regulatory component to eliminate risk rating. It will create a single risk pool ready for integration with the NHI Fund in due course as appropriate.

Facilities

8. Three hospital groups; Netcare, Mediclinic and Life, dominate the facilities market. In 2016, their market shares based on beds (and admissions) were 31% (33%); 26.8% (28.6%); and 25.3% (28.5%) respectively. A fringe of independent hospitals, mostly part of the National Hospital Network, exerts some competitive constraint in part due to an exemption from the Competition Act enabling them to negotiate with funders collectively. The market shares for NHN and independent hospitals in 2016 based on beds (and admissions) were 13.6% (7.7%) and 2.3% (2.2%) respectively. Using the compound annual growth rate (CAGR,) the NHN registered a market share growth of 4.7% for all registered beds between 2010 and 2018 and a growth of 3.9% in acute beds.

9. Concentration in the facilities market occurs at both the national level, where contracting with funders takes place, and at the local level, where funders contract with hospitals to form Designated Service Provider networks. The majority (approximately 60%) of local facility markets are highly concentrated. National concentration levels are higher than the threshold for markets defined as "highly concentrated", even against the most conservative (US) enforcement standards. Even using stakeholders' own estimates, national markets are highly concentrated against benchmarks proposed by the International Competition Network.

10. The level of concentration in facilities markets raises two concerns. First, concentrated markets are more vulnerable to collusion, both formal (cartels) and informal, and collusion in these highly complex healthcare markets is very hard to detect. Secondly, local level concentration limits the extent to which funders can employ DSP networks to effectively discipline hospital groups.

11. We have found that the three large hospital groups, both individually and collectively, are able to secure steady and significant profits year on year. The hospital groups make it very hard for newcomers and fringe-players to grow and to compete on merit. The three groups are able to distort and prevent competition by binding the best medical specialists to their hospitals with lucrative inducement programs, with associated exclusionary effects on innovative newcomers. There are few, if any, DSPs which do not include at least two of the big three hospital groups – they dominate DSP arrangements relative to other hospitals. Further, the three largest groups all but dictate year-on-year price and costs increases for funders. They facilitate and benefit from excessive utilization of healthcare services, without the need to contain costs, and they continue to invest in new capacity beyond justifiable clinical need without being disciplined by competitive forces.

12. Additionally, facilities operate without any scrutiny of the quality of their services and the clinical outcomes that they deliver because there are no standardised publicly shared measures of quality and healthcare outcomes to compare one against the other. It is impossible for patients, funders or practitioners to exercise choice based on value (quality and price).

13. We, therefore, find that competition has largely failed in the facilities market. The market is highly concentrated – both nationally and locally - and incumbent facilities are not forced to innovate or to compete vigorously. This failure is exacerbated by the fact that neither the public hospital system nor individual independent facilities exert an effective competitive constraint on the large facility groups. Public hospitals are not able to compete with private hospitals, since they do not consistently provide the quality of care required to compete against the large hospital groups.

14. Independent hospitals' ability to compete is hampered by a number of factors, including limited bargaining power in tariff and network negotiations, a lack of information to implement effective performance-based reimbursement contracts (ARMs), and an inability to attract specialists to their facilities. They, therefore, do not provide significant competitive constraints. This is not likely to change significantly without a change in the regulatory environment designed to promote a more competitive market.

15. Independent hospitals have received some regulatory assistance from the temporary exemption granted by the Competition Commission (most recently with strict conditions not currently applied to the big three groups) enabling the NHN network to negotiate tariffs and conditions collectively. In all other respects, NHN is not a hospital group since individual facilities remain strategically and operationally independent and compete with each other. Nonetheless, the Competition Commission's exemption has led to a marginal improvement in competition and a slight decrease in overall

market concentration. As highlighted above, the NHN registered a Compound Annual Growth Rate of only 4.7% between 2010 and 2018 based on total registered beds.

16. However, more action is needed. Competition and competitive bargaining pressures from funders has to be increased significantly. Facilities' market concentration must be reduced. The Competition Commission's review of "creeping mergers" has, to date, not been effective enough in reducing high levels of concentration. We note that the recent amendments to the Competition Amendment Act may improve this situation.

17. Most importantly, regulatory oversight must be improved. The supply side of the market is largely unregulated, with negative consequences for competition and for the consumer. We recommend that regulation of the supply-side of the market is essential and ideally administered through a new regulatory authority that we have called a supply-side regulator for health. We have considered with great care the establishment of this regulator and have made a proposal where the net number of regulators will not change. We further consider it to be a positive contribution to the private and public sector. The United Kingdom National Health Service has shown that even a mature single public purchaser system requires regulatory oversight of suppliers by an industry-specific regulator. Moreover, those suppliers are, and need to be, subject to competition laws and to enforcement action by competition authorities.

18. One prominent responsibility of the new regulator will be the formulation of a new needs-based system of licensing which will be more rational, effective, inclusive, and can be oriented to promote innovation. Importantly, licensing will be applied consistently across all provinces with the aim of balancing capacity across the country by reducing or redirecting overcapacity and overinvestment to areas with lower capacity which could contribute to curbing excessive utilization. This new system of licensing, which is consistent with the National Health Act, will be guided by national policy and implemented by the supply-side regulator in close collaboration with provincial departments of health which will have further responsibilities for ongoing monitoring of performance of the system at local level and reporting obligations to the supply side regulator for health and the National Department of Health.

Practitioners

19. In all healthcare markets, healthcare professionals are central to the consumption of healthcare services. They have more, and often untransferable, knowledge about disease diagnosis and treatment and must advise patients on what care is needed. They also order investigations, refer to other providers and, in the case of medical doctors, admit patients to hospital and other care centres.

20. In order to make the inquiry feasible, we focused on General Practitioners and Specialists (collectively called practitioners) as they directly and indirectly contribute the most to expenditure when compared to other health professionals and are the main decision-makers about healthcare consumption.

21. There are 1.75 private practitioners per 1000 insured population. General practitioners (GPs) are distributed relatively evenly across the insured population at just under one per thousand. Specialists are more concentrated in provincial capitals and metropolitan areas, and in some areas, there are no specialists at all. We have found that the purported scarcity of practitioners does not explain market outcomes, rather it is how healthcare professionals operate in response to incentives in the market that has greater impact.

22. We found no reliable up-to-date data base documenting the number and location of practitioners, and we have made a recommendation to remedy this failure through an adaptation of the existing practice code numbering system.

23. Barriers to entry for practitioners were found to be justified when related to registration and training standards to protect the public. Other barriers were found surmountable, given that over the five-year period studied almost 1000 new practitioners entered the market. Practically all entry that took place followed conventional models. Innovative business models, however, were almost absent and were reported to be obstructed by funders, and by some practitioner associations and limited by the rules of the Health Professional Council of South Africa.

24. The 2004 Competition Commission prohibition on collective negotiating created what has been called a price vacuum and what is charged is either what the market can tolerate or, when patients cannot afford co-payment, practitioners (in the main general practitioners) accept scheme rates. The pricing vacuum has extended to relevant parties avoiding meetings where potentially competition sensitive information could be exchanged, including meetings that would review clinical codes, leading to an out-of-date coding (and related payment) system and unilateral code changes.

25. The private healthcare market is characterised mainly by stand-alone single practices or, in some disciplines, single-speciality group-practices but multidisciplinary teams are not a feature of the market. This absence limits up and down referral leading to an irrational use of care where specialists are performing functions that other practitioners may do without any loss of quality.

26. There is no standardised method to measure and to report on quality and health outcomes in the practitioner markets. The public is uninformed and cannot compare outcomes across interventions and practitioners. Practitioners too cannot benchmark their own practice nor judge on objective criteria to whom to refer. Funders too cannot contract on value for money.

27. We found that practitioners can influence to their own benefit how networks are remunerated or can avoid joining a network and can afford to ignore tenders.

28. Practitioners are often members of professional associations which perform a number of functions to ensure professional development and business support. The format of these associations is a concern and needs to change. These associations have been seen to provide quasi-collusive forums where advice on charging, coding and participation in networks are shared leading to co-ordinated behaviour on the part of individual practitioners.

29. Overall, we are of the view that many practitioners and their associations either are not aware of, or otherwise deliberately ignore, restrictions placed on all private sector players with regard to horizontal cooperation. The evidence that we have examined indicates that some market participants behave anti-competitively to the detriment of consumers.

30. We have found that utilisation rates (that is hospital admission rates, level of care (admissions to High Care and Intensive Care Units) and length of stay) were higher than can be explained by the burden of disease of the population being cared for. We found that excessive utilisation was a significant driver of healthcare costs.

31. Over servicing, or using higher levels of care than required, is not necessarily better care. It leads to a waste of resources and may even be disadvantageous to patients' health. It pushes up the cost of care and, if it is high enough, it will make it unaffordable and threaten the sustainability of the healthcare market.

32. We have also found that when holding all other factors constant, where there is a greater number of practitioners (in particular specialists with the exception of obstetricians) more admissions to hospitals occur. Thus, we have concluded that there is evidence of supply-induced demand.

33. Incentives in the market promote overutilization. In particular fee-for-service means that the more services practitioners provide, the greater their income, which creates a perverse incentive for profit maximising individuals or groups. Mandatory cover of prescribed minimum benefits, payable at cost, creates an opportunity for practitioners to determine their own degree of intervention and rates which must be paid for in full by funders. Benefit design, in particular almost guaranteed payment of most costs associated with hospitalisation and decreasing cover for out-of-hospital care, has encouraged the admission of patients to hospital to ensure payment is guaranteed which benefits both patients and practitioners in the short term.

34. Current regulation of practitioners through the Health Professionals Council, in particular on fee-sharing, multidisciplinary group practices,[119] and employment of doctors, has significantly inhibited the evolution of innovative and integrated models of care that practitioners provide in other jurisdictions. What is increasingly becoming the standard of care internationally – multidisciplinary group practice with a range of reimbursement models – is undeveloped and discouraged at worst, or made difficult at best, by fear of sanction (warranted or not) by the HPCSA.

Funders

35. Funders compete in an environment which is characterised by an incomplete regulatory framework, so distorting the parameters of competition. Our recommendations are designed to complete the regulatory framework, and to create a market environment conducive to effective competition on pro-consumer metrics.

36. The social solidarity principles of open enrolment (schemes must accept all applicants) and community rating (schemes must charge a contribution price for a particular plan which is

119 Multidisciplinary group practices refer here to a group of healthcare practitioners of different disciplines, each providing specific services (e.g. medical and allied professionals) to the patient. It should be differentiated from group practices which refers to a group of healthcare practitioners providing health services (e.g. in the same discipline). Income from the practice is pooled and redistributed to the members of the group according to a prearranged plan.

identical for all members no matter age, sex or pre-existing conditions) were always meant to be implemented alongside a risk-adjustment mechanism (schemes with above average risk-profiles are balanced through funds received from schemes with below average risk-profiles) and mandatory membership. Absent a RAM, and having to pay PMBs at cost, has meant schemes' costs, and, therefore, member premiums, are highly correlated to the overall risk-profile of their members, which has resulted in schemes competing on the risk-profile of their members, for example by designing benefit options to attract younger and healthier members. This competition on benefit design is at the expense of competition on metrics which improve consumer welfare, such as procurement of value-for-money healthcare services, increasing benefits, adopting innovations, improving service quality, and/or directly competing on premiums.

37. A consequence of this competition on benefit design has been the proliferation of generally incomparable benefit options. The inability of consumers to easily compare options across funders has meant that consumers do not readily switch schemes in response to better offers from rivals. Absent this disciplining effect arising from consumers, schemes have no pressure to compete on pro-consumer metrics and to offer better products. This is exacerbated by the principal officers and trustees of schemes having remuneration policies which are not linked to beneficiary-centred performance metrics. Principal officers and trustees receive their full compensation irrespective of scheme performance.

38. These factors clearly do not foster an environment conducive to competition on metrics which would result in positive consumer welfare outcomes.

39. On the supply side, prescribed minimum benefit regulations, while having had a positive impact in ensuring a minimum level of coverage for members, have had unintended effects on competition. Regulation 8 of the Medical Schemes Act specifies that PMBs must be paid in full without deductibles or co-payments which has shifted market power towards practitioners who are able unilaterally to set prices for PMBs which funders must then reimburse in full.

40. Further, the focus of PMB provisions on catastrophic cover to the exclusion of primary healthcare, has promoted hospi-centric care. In the face of rising costs and declining membership growth, funders have attempted to offer the lowest-cost, lowest-benefit plans possible. As schemes are mandated to cover the catastrophic conditions included in the PMB regulations, funders have created bare-minimum hospital-plans. Instead of saving money, this approach has had the unintended consequence of raising costs as members are hospitalised unnecessarily in order to have treatment paid for.

41. Under open enrolment and community rating but where participation is optional, consumers can engage in anti-selective behaviour. Consumers have an information advantage over funders concerning expected health expenses (e.g. when deciding to become pregnant or being diagnosed with a chronic illness). Using this advantage, and the regulatory environment, consumers may opt to forego joining a medical scheme until it becomes necessary or they may adjust their level of coverage in response to their anticipated need. This behaviour can result in an individual member's claims outweighing their contribution, necessitating higher premiums for all members.

42. We believe that anti-selection exists and is already entrenched in premiums charged by funders. However, we do not believe that anti-selection has continued to be a factor that contributes to the increasing costs and premiums. We acknowledge the concern but note that tools to mitigate anti-selection, (waiting periods and late joiner fees), exist and that their impact has, as yet, not been fully evaluated.

43. In principle, we agree that mandatory membership will address anti-selection. However, before mandatory cover is introduced, the industry needs to show clear indications of closer alignment to consumer interests and better cost containment. We have not recommended mandatory membership at this point but believe that at a future date it would be appropriate.

44. We are of the view that the broker market is operating sub-optimally. Most members do not derive value from brokers and there is no incentive, such as an opt-in system, to align brokers' interests with those of scheme members.

45. We have found that the high barriers to entry in the administrator market has meant there has been little-to-no entry for several years, despite some incumbent administrators earning very high profits while assuming limited risk relative to either the funders or providers. Discovery Health has, over a sustained period, earned profits that are a multiple of those of its main competitors with no sign of effective challenge from incumbents or new firms. The existing administrators do not seem to impose a significant competitive constraint on Discovery Health.

46. The principal officers and trustees of schemes could be more active in ensuring that beneficiary interests are protected. There is often a very close relationship between administrators and the schemes they administer. While the interests of administrators and members of schemes are not always misaligned, there is nevertheless a need to strengthen the role played by the boards of trustees and principal officers to ensure the member is always put first. Therefore, we recommend that the board members and principal officers should be sufficiently trained and incentivised to ensure that they are receiving appropriate value for money and quality from both administrators and healthcare providers.

Recommendations

47. Based upon our findings, we recommend a set of interrelated interventions designed to promote systemic change to improve the context within which facilities, funders, and practitioners operate, and create a shift towards a pro-competitive environment. These recommendations must be seen as a package. Market failures may persist if a partial approach to the implementation of our recommendations is adopted.

48. We recommend that the Competition Commission review their approach to creeping mergers to address high levels of concentration through effective merger review and that they provide guidance to practitioner associations about what constitutes pro-competitive conduct and have suggested a method to evaluate the functioning of associations.

49. For effective and efficient regulatory oversight of the supply-side of the healthcare market, we recommend the establishment of a dedicated healthcare regulatory authority, referred to here as the SSRH. The role of the SSRH will include regulation of suppliers of healthcare services, which includes health facilities and practitioners. The SSRH will have four main functions: healthcare facility planning (which includes licensing); economic value assessments; health services monitoring; and health services pricing.

50. The SSRH will have the following duties:

50.1. Be responsible for capacity planning and issuing of facility licences following national guidelines which will be developed by a technical team. Licences will be issued after facilities have Office of Health Standards Compliance approval. Licensing will be undertaken in conjunction with Provincial Departments of Health who will collect, collate and publish facility data which will include bed data, occupancy rates, and quality measures. We have recommended new mechanisms and timelines for applying for licences and that licences to develop a new facility should not be evergreen.

50.2. Set up a multilateral negotiating forum for all practitioners to set a maximum price for PMBs and reference prices for non-PMBs which will ensure PMB prices for practitioner services balance market forces and that the regulations do not artificially shift market power to either participant with an arbitration mechanism to break deadlocks.

50.3. Maintain an "intelligent" health professionals' numbering system linked to required annual reporting of current working address, area of speciality, full/part-time status and requirements to report on health outcomes.

50.4. Run a committee to set and regularly review codes, which will include meaningful consultation with relevant practitioners and funders.

50.5. Set up committees or other processes as part of the research function to advise on best practice for particular medical conditions. The SSRH will provide support to enable this research but it will contract out this work if practitioner associations do not fill this information gap with credible evidence-based guidelines.

50.6. Conduct or contract out health technology assessments to guide cost-effective practice.

50.7. Liaise with the proposed Outcomes Measurement and Reporting Organisation to ensure that practitioners report on health outcomes and use these data for Health Technology Assessments where appropriate.

51. We have recommended the following interventions to promote competitive contracting and a move away from fee-for-service contracts:

51.1. Practitioners who do not want to engage in fee-for-service contracts will be encouraged to enter into bilateral negotiations with funders. In this case practitioners will not be bound by the Multi Lateral Negotiating Forum tariffs as long as the bilateral contracts include a value component, include risk transfer, and are not in contravention of the Competition Act. Both funders and practitioners will be required to submit these contracts to the CMS and the SSRH (respectively) for approval.

51.2. Bilateral negotiations between facilities and funders will continue and facilities will not participate in the MLNF. Facility-funder contracts

will have to demonstrate that they include risk transfer, include a value component, and are not in contravention of the Competition Act. Both funders and practitioners will be required to submit these contracts to the Council for Medical Schemes (CMS) and the Supply Side Regulator for Health (SSRH) (respectively) for approval. Within three years the bilateral negotiations between funders and facilities are to focus exclusively on ARM contracting. Contracts between funders and facilities will be approved by the CMS and the SSRH. The submissions to the CMS and SSRH will be confidential.

51.3. Fee for service practitioner networks will be open to any willing provider and will be evergreen, subject to a 3-6-months' notice period by providers seeking to leave a network, or when funders seek to change terms of network. In any eventuality, patients must be protected during these transition periods.

51.4. Value-based contracts with practitioners and facilities may be closed networks because upfront negotiation of contract terms is essential. However, they must also be transparent and be limited to 3 years before new contracts must be initiated.

52. We recommend the creation of an Outcomes Monitoring and Reporting Organisation as a platform for providers, patients and all other stakeholders in the provision of healthcare to generate patient-centred and scientifically robust information on outcomes of healthcare. The OMRO will be an independent, private organisation in which key actors such as providers (doctors and hospitals) and patients co-operate to generate relevant and standardised outcome information for two purposes: to provide practitioners and hospitals with relevant outcome information and ways to improve clinical quality, and, secondly, to provide patients and funders with relevant choice information on health outcomes.

53. In the first phase of its development, participation of providers in the OMRO will be voluntary, but in the second phase, reporting of outcome data by providers will be a condition of receiving a practice number.

54. Separation of the academic and business functions of practitioner associations and formalisation of their role as a registered organisation or juristic person must be introduced.

55. Changes are needed to HPCSA ethical rules to promote innovation in models of care to allow for multidisciplinary group practices and alternative care models so that fee-for-service ceases to be the dominant payment mechanism

56. We have proposed guidelines for Associations to ensure that they are not at risk of potentially anti-competitive behaviour. Further, the various functions of the SSRH such as the forum to establish reference pricing and to set prices for what is currently known as a PMB, and coding and related functions, will provide certainty and guidance which will obviate the need for associations to perform some of their current functions which are anti-competitive.

57. We propose that the HPCSA makes mandatory that curriculums for all health practitioners at both undergraduate and postgraduate level include training to ensure that graduates are aware of the cost implications of their decisions, are able to assess and use HTA findings, and best practice guidelines, and are aware of how health system financing models impact on individual health decisions and on ethics.

58. To increase comparability between schemes and to increase competition in the funders market, we recommend, the introduction of a single, comprehensive, standardised base benefit option, which must be offered by all schemes. It will enable consumers to compare products, reward those funders which are able to innovate to offer lower prices and/or higher quality, and, thereby, both discipline and reward the market.

59. We recommend the introduction of a risk-adjustment mechanism linked to the single, comprehensive, standardised base benefit option to remove any incentive by schemes to compete on risk. Schemes should compete on metrics designed to attract new members, irrespective of their age, health, or risk profile. Regionally-based medical schemes should be allowed through a temporary reinsurance facility to mitigate their exposure to demographic and claims risk.

60. We recommend that scheme Boards of Trustees and Principal Officers should be sufficiently trained and incentivised to ensure that schemes receive value for money from both administrators and healthcare providers, subject to performance-based remuneration.

61. We recommend an active opt-in system for brokers.

Chapter 1
Terms Of Reference And Background

FEATURES OF THE SOUTH AFRICAN PRIVATE HEALTHCARE SECTOR

1. On 29 November 2013 the Competition Commission (the Commission) took a decision to initiate a Market Inquiry into the state of competition in the private healthcare sector (HMI). Following this decision, the Commission published the Terms of Reference (ToR) as required by the Competition Act, 98 of 1998 (the Act).[120]

2. In initiating the HMI, the Commission relied upon the provisions of subsections 43B(1)(i) and (ii) of Chapter 4A of the Act. Section 43B(1)(i) of the Act empowers the Commission to initiate a market inquiry "if it has reasons to believe that any feature or combination of features of a market for any goods or services prevents, distorts or restricts competition within that market". We construe a "feature" of the market to refer to any notable characteristics of a market, in particular, its interconnections with other markets, and the conduct of participants within the market. A "feature" may be intrinsic to the structure of a market or may arise from the conduct of participants within a market.

3. Section 43B(1)(ii) of the Act empowers the Commission to conduct a market inquiry in order to achieve the purposes of the Act. Section 2(b) of the Act sets out, as one of the purposes of the Act, "to provide consumers with competitive prices and product choices". This purpose is informed by the objectives of the Act which, as the Preamble to the Act states, include "to provide for markets in which consumers have access to, and can freely select, the quality and variety of goods and services they desire". We construe subsection 43B(1)(ii) as empowering the Commission to initiate a market inquiry in order to promote competition so that consumers have access to quality and variety of goods and services at competitive prices.

4. At the conclusion of an inquiry, the Commission is required to submit a report to the Minister, with or without recommendations. The recommendations may include "recommendations for new or amended policy, legislation or regulations; and recommendations to other regulatory authorities in respect of competition matters".[121] In addition, based on the information that it has gathered during the inquiry, the Commission may initiate enforcement proceedings or take any other action within its powers in terms of the Act.[122]

5. In construing the market inquiry provisions of Chapter 4A, we are guided by the interpretive injunction contained in section 1(2)(a) of the Act. That provision requires the provisions of the Act to be interpreted in a manner that is consistent with the Constitution and which gives effect to the purposes of the Act.

6. This provision echoes section 39(2) of the Constitution which requires "every court, tribunal or forum" to interpret any legislation, including the Competition Act, to "promote the spirit, purport and objects of the Bill of Rights". One of the objects of the Bill of Rights is to guarantee to everyone

120 The terms of Reference are contained Government Notice No. 1166 of 2013 published in Government Gazette No 37062, 29 November 2013.
121 Section 43C (1).
122 Section 43C (3).

the right of access to healthcare services[123] and to impose a constitutional obligation on the State "to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of [the right in the Bill of Rights].[124]

7. Our task is to construe the provisions of subsections 43B(1)(i) and (ii) of Chapter 4A of the Act in a manner that will promote competition in the private healthcare markets while ensuring that the fundamental right of access to healthcare services, which is guaranteed by the Constitution, is not impeded. Our mandate is, therefore, not only to investigate whether there is any feature or combination of features of markets in the private healthcare sector which harm competition or have an adverse effect on competition within those markets, but it is also to facilitate the achievement of the purpose of the Act as set out in section 2(b).

8. This report sets out our findings and recommendations based on the evidence that we reviewed and the analysis that we carried out. In this Chapter we set out the background to the HMI and provide an overview of the process followed in the conduct of the inquiry.

Background to the HMI

9. The HMI was prompted by the Commission's observation that prices in the private healthcare sector are "at levels which only a minority of South Africans can afford"[125] and that "healthcare expenditure and prices were rising above headline inflation".[126] The Commission made this observation after conducting preliminary research into private healthcare markets. It noted that various explanations were offered for these increases which ranged from information asymmetries, distorted incentives, market power to utilisation.[127]

10. Given the number of possible explanations for these increases, the Commission considered it necessary to inquire into the factors that drive the observed increases in private healthcare expenditure and prices in South Africa, and to identify all factors that prevent, distort or restrict competition. The Commission hoped that the inquiry would provide a factual basis upon which it could make recommendations to promote competition in the private healthcare sector to ensure affordable, accessible, innovative and good quality private healthcare.

11. In its initial observation, the Commission identified a number of features of the private healthcare markets that could impact negatively on competition and which appeared to determine the price, quality and outcomes of patient experience. These features included structural barriers such as information asymmetries resulting in lack of access to information on healthcare services, regulatory frameworks which could undermine competition, consolidation in key markets such as hospitals, and medical schemes and expenditure increases in the private sector which were above headline inflation, and prices that had reached a level that allowed access to only a minority of South Africans.

12. The Commission's preliminary research, and its initial observations, raised various concerns about the functioning of the private healthcare markets and gave rise to a suspicion that there might be factors that undermine competition. The Commission, therefore, initiated the HMI. It published the ToR for comments by stakeholders. Based on its preliminary research and comments from the stakeholders on the draft ToR, the Commission determined the subject-matter of the HMI and its ToR. Against this background, the Commission initiated the HMI and defined the subject matter of the HMI as:

    "[To] probe the private healthcare sector holistically to determine the factors that restrict, prevent or distort competition and underlie increases in private healthcare prices and expenditure in South Africa".[128]

13. The Commission's objectives in initiating the HMI are set out in the ToR. They are to:

    - Evaluate the nature of price determination in private healthcare with reference to:
    - the extent of competition between different categories of providers and funders;
    - the extent of countervailing bargaining power between different providers and funders; and
    - the level and structure of prices of key services, including an assessment of profitability and costs;

123 Section 27(1) of the Constitution.
124 Section 27(2) of the Constitution.
125 ToR p. 80.
126 ToR p. 80.
127 ToR p. 80.
128 ToR p. 80.

- Evaluate and determine what factors have led to observed increases in private healthcare prices and expenditure;
- Evaluate how consumers access and assess information about private healthcare providers, and how they exercise choice;
- Conduct a regulatory impact assessment to review the current regulatory framework and identify gaps that might exist. Examples include the interpretation of Prescribed Minimum Benefits (PMBs), and the introduction of a risk equalization fund etc.;
- Make recommendations on appropriate policy and regulatory mechanisms that would support the goal of achieving accessible, affordable, innovative and quality private healthcare; and
- Make recommendations with regard to the role of competition policy and competition law in achieving competitive outcomes in healthcare, given the possibly distinctive nature of the market.

14. The Commission appointed a panel of five experts to conduct the HMI. We were ably assisted by a team of researchers and external experts. The market inquiry provisions of the Act, together with the subject-matter of the inquiry as set out in the ToR, as well as the objectives of the HMI, define our mandate.

15. The HMI was due to commence on 6 January 2014 and the inquiry was due to be finalised on 30 November 2015.[129] The period of the HMI was, however, extended until 30 September 2019. The extension of the deadline was due to a number of reasons, including the limited technical resources available to the Panel, the delays in securing data from stakeholders, and requests for extensions of time received from stakeholders. These delays must be viewed against the complexity of the issues involved in the private healthcare sector, and the need to afford stakeholders a fair opportunity to dispute issues raised by the HMI and to present countervailing evidence where necessary, as required by the principles of fairness.

Conduct of the Inquiry

16. This section of the report provides an overview of the process followed in the conduct of the inquiry, including the gathering and the analysis of the evidence and data. As pointed out in the PFR, while the analysis that was conducted was fundamentally economic in nature, it had to be conducted within the legal framework contemplated in the Act. In particular, we had to ensure that participants had a fair opportunity to dispute the findings and recommendations of the Panel and, where necessary, that they had a fair opportunity to present countervailing evidence. Details of this process are set out in the PFR.[130]

17. As this was the first market inquiry to be conducted under Chapter 4A of the Act, the process commenced with the publication of key documents for the conduct of the HMI, which included the Statement of Issues (SoI) for initial investigation, Guidelines for the Conduct of the Inquiry, Guidelines for Submission of Technical Data and Analysis documents and the Administrative Timetable. These documents were published on 1 August 2014 after receiving comments from stakeholders. In publishing these rules of engagement, we sought to ensure transparency and fairness in the inquiry process as well as clarity on the process to be followed. Further process documents were published in the course of the inquiry.

Statement of Issues

18. The SoI was the key initial document providing stakeholders with a framework for our approach to the inquiry. It ensured that participants in the inquiry focused on issues that we considered to be most relevant to answering the questions arising from the ToR. We identified a wide range of issues that we intended to probe during the initial stages of the investigation. Apart from setting out issues on which we required stakeholders to comment, the SoI also identified market power, barriers to entry and expansion, imperfect and asymmetric information and the regulatory framework as areas of potential harm to competition. The SoI formed the basis of our initial call for written submissions.

19. During February 2016 we issued a Revised Statement of Issues (Revised SoI) based on the information and evidence which we had received at that stage as well as the limited analysis that we had conducted. We also updated our theories of harm.

Theories of Harm

20. For the purposes of assessing competition, we identified from the academic literature several theories of harm that we proposed to test in the course of the inquiry. A theory of harm is essentially a hypothesis about how harm to competition might

129 In terms of section 43B(5) the Commission may amend the ToR including the period within which it is to be completed.
130 See PFR, 5 July 2018, pp 16-19.

arise in a market to the detriment of consumers and to the detriment of efficient and innovative outcomes in that market. The concept of theories of harm is a tool adopted in competition analysis globally.

21. In developing these theories of harm, we were mindful that the theories of harm we had identified were not exhaustive, and that they may not necessarily address all factors that have an impact on access and affordability. Thus, we urged stakeholders not to confine their submissions to addressing only the theories of harm identified in the SoI.

22. We identified for consideration the following relevant theories of harm:

    - theory of harm 1: market power and distortions in healthcare financing;
    - theory of harm 2: market power and distortions in relation to healthcare facilities;
    - theory of harm 3: market power and distortions in relation to healthcare practitioners;
    - theory of harm 4: barriers to entry and expansion at various levels of the healthcare value chain;
    - theory of harm 5: imperfect information;
    - theory of harm 6: regulatory framework.

Prioritisation

23. In approaching our mandate, we were mindful that it was neither practical nor feasible to attempt to explore fully every possible factor that may play a role in driving outcomes in the private healthcare sector. Therefore, we decided to prioritise our work based on two criteria: substance and practical considerations. In relation to substance, we focused on costs, affordability, access, innovation, quality and availability of data and information as well as the extent to which competition could be promoted. In assessing practical considerations, we focused on the availability of resources, data and information.

24. As an initial step in the prioritisation process, we identified focus areas such as consumers, providers of healthcare financing, and providers of healthcare products and services.

Collecting Evidence, Information and Data

25. On 1 August 2014, the HMI invited submissions on the issues raised in the SoI. We received 68 written submissions totalling more than 1500 pages. Non-confidential versions of these submissions were published for comments by stakeholders. We also invited 175 service providers to submit data. As pointed out in the PFR, this process presented the HMI with one of its most challenging problems. Details of the challenges that we faced in collecting data are set out in the PFR.[131] The process was characterised by inexplicable delay and by reluctance to make data available to us. Eventually, we collected over 545GB of data and this dataset represents the largest ever collected on the private healthcare market in South Africa. However, as we observed in the PFR:

    "[The challenges we faced in collecting data for stakeholders] underscore the need to develop a comprehensive national health information system which will require stakeholders to provide information relating to health financing, the pricing of health services, business practices involving hospitals and healthcare providers, and the publication of various types of information in the public interest and for the purpose of improving access to and the effective and efficient utilisation of health services as envisaged by the National Health Act."[132]

26. In the course of the inquiry, we held extensive consultations with, and received extensive submissions from, a wide range of stakeholders including hospital groups, medical specialists, general practitioners, professional organisations, national and provincial Departments of Health, medical schemes, medical scheme administrators, patients and non-governmental organisations. We also held public hearings between 16 February 2015 and 19 May 2015. In addition, a number of workshops and seminars were organised on a wide range of topics relevant to the inquiry including licencing of hospitals, regulatory frameworks pertaining to healthcare financing, tariff determination, health outcomes, measurement and reporting, Health Outcomes Quality and Reporting, Supplier Induced Demand and the contents of the PFR.

131 PFR, 5 July 2018, pp 9-10
132 PFR, 5 July 2018, p10

Assessment of Competition

27. We were anxious to establish a sound factual and analytical basis for our findings. We sought to ensure that the methodologies or models used in analysing data supported rigorous analysis and were consistent with best practice. In considering appropriate methodologies, we were mindful of the various techniques available for assessing competition issues such as profitability, and market power as well as the difference of opinion on the appropriateness of these techniques in a given situation. Our choice of appropriate methodologies was informed by pragmatic considerations such as data limitations, resource requirements, and practical applicability of the methodology.

28. Three methodology papers were published setting out methodologies that we proposed to apply in the conduct of our analysis:

28.1 during September 2015 we published the Profitability Analysis Methodology;

28.2 during August 2016 we published the Approach to Assessing Market Power of Health Facilities; and

28.3 during November 2016 we published the Market Definition for the Financing of Healthcare.

29. Prior to the finalisation of these methodologies, we invited comments from stakeholders to ensure clarity, transparency and a fair process regarding the methodologies that we proposed to use in assessing profitability and market power.

Analytical Process

30. With the assistance of HMI experts, we ran various models and analytical processes to determine, among other things, expenditure and costs trends, profitability and market power. The results from the analytical work, including the input of the technical team and panel members, formed part of comprehensive reports on each set of service providers. These reports, which were published between December 2017 and January 2018, included the Descriptive Statistics Report; Attribution Analysis Report; Prescribed Minimum Benefits Analysis Report; Facility Analysis Report; Practitioner Analysis Report; Funder Analysis Report; Associated Projects and Various Case Studies. These reports reflected our preliminary conclusions on competitive dynamics in relation to each set of service providers.[133]

The Provisional Report

31. These reports, together with the evidence and information that we had received, formed the basis of our provisional findings and recommendations. On 5 July 2018, we published our PFR setting out our preliminary findings and recommendations. A number of stakeholders responded with varying degrees of both support for, and disagreement with, our findings and recommendations. It should be noted that we did not receive any submission from the Department of Health.

32. On 9, 10 and 12 April 2019, we held seminars on some of the key issues arising from the comments by stakeholders on the PFR. These seminars covered a wide range of issues, including excessive utilisation and supplier induced demand, facilities' market concentration and remedies, and funders' market concentration and remedies. In order to ensure maximum benefit from these seminars, we published in advance notes identifying points of difference with stakeholders and invited comments from them.

33. This report, together with its Appendices, constitutes our final report setting out our findings and recommendations based on our analysis of the evidence received during the course of the inquiry. Where appropriate, we refer to materials published on the Inquiry website.

Structure of Final Findings and Recommendations Report

34. This report is structured as follows:

- **Chapter 2** Overview of the Private Healthcare Sector
- **Chapter 3** Competitive Assessment Framework
- **Chapter 4** Competition analysis for facilities
- **Chapter 5** Competition analysis for funders
- **Chapter 6** Competition analysis for practitioners
- **Chapter 7** Bargaining and tariff determination
- **Chapter 8** Healthcare data, quality and Outcomes
- **Chapter 9** Recommendations

133 PFR, 5 July 2018, p10.

Chapter 2
Overview Of The Private Health Sector

OVERVIEW OF THE PRIVATE HEALTH SECTOR

Health Sector in South Africa

1. In this chapter, we set out a brief overview of the health sector and locate its position, the healthcare pathway, the regulatory framework, and within the overall healthcare system.

2. The provision of healthcare goods and services must be understood in the light of the right of access to healthcare services, guaranteed by section 27(1) of the Constitution, and the obligation on the state to take reasonable legislative and other measures, within its available resources, in order to achieve progressive realisation of this right.[134] The state fulfils this obligation by providing healthcare goods and services and by enabling the private sector to provide healthcare goods and services, subject to the requirement that privatisation does not constitute a threat to the availability, accessibility and quality of healthcare facilities, goods and services.[135]

3. The public health sector refers to the healthcare services provided by the state and funded by public funds while the private health sector refers to that portion of healthcare services that are funded by private patients themselves, either through medical schemes, insurance or through out-of-pocket payments. As noted in the ToR, the healthcare system is characterised by many challenges, in particular, the uneven distribution of coverage and of access to funding, by poor infrastructure and by human resource constraints.[136]

4. The public health system is funded by general taxation and by public social insurance schemes. In 2018, the public healthcare facilities served approximately 83% of the population who were largely without medical insurance.[137] The private healthcare facilities served approximately 16.3% of the population with medical insurance. Access to general public healthcare system is subject to a means-test.

5. Public social insurance schemes, such as the Compensation Fund and the Road Accident Fund which, respectively, offer mandatory coverage for occupational injuries and diseases for employees in the formal sector, and partial (third- party) coverage for road accidents. In both instances, coverage is limited. Treatment is usually provided in the private sector.

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134 Section 27(2) of the Constitution.

135 United Nations General Comment No 14 on the Right to Healthcare. The Right to the Highest Attainable Standard of Health (Art. 12). Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000 (Contained in Document E/C.12/2000/4) p12. Accessed at https://www.refworld.org/pdfid/4538838d0.pdf on 9 September 2019.

136 The ToR indicates that in 2012, 42.5 million South Africans were dependent on the public sector for the provision of healthcare services, while 8.7 million were serviced by the private sector. Per capita expenditure on healthcare in the private health sector in 2011/2012 was R13 800, compared to per capita expenditure in the public healthcare sector of R2 880. Private health sector funding equated to 48.6% (R120.8 billions) of total healthcare expenditure and covered 17% of the population, while public sector funding equated to 49.3% (R122.4 billion) of the total healthcare expenditure which covered 83% of the population. The remaining 2.1% of healthcare expenditure (R5.3 billion) could be attributed to donor and NGO spending. According to the latest available information, the number of beds in the public sector was equivalent to about 2.1 per 1 000 of the population, whilst in the private sector the ratio was 3.5 per 1 000 of the population. See ToR paragraphs pp. 76-77.

137 Stats SA, General Household Survey, 2018, p.119. Available at http://www.statssa.gov.za/publications/P0318/P03182018.pdf, accessed on 19 June, 2019. The 83% of South Africans without medical aid excludes those who indicated that they did not know if they had medical aid, and those classified as 'unspecified'.

6. The private health system is funded by private social insurance schemes which are provided through medical schemes, voluntary actuarial health insurance, and direct payments by patients. Although membership is voluntary, medical schemes must comply with statutory access and benefit requirements that have a social purpose and distinguish this system from markets for conventional actuarial insurance. Contributions to medical schemes attract tax credits.[138]

7. Voluntary actuarial health insurance is available on a non-indemnity basis to supplement other forms of coverage. Actuarial health insurance includes any form of health insurance that can discriminate on the basis of health status.[139] In addition to public and private insurance markets, patients pay, "out of pocket" for services rendered in both the public and private health sector. While "out of pocket" expenditure has not been systematically examined, it is estimated that in 2015 "out of pocket" payments amounted to about 0.6% of GDP. [140]

8. The focus of this report is the private health sector.

The Private Health Sector

9. The private health sector has two components: the provision of healthcare goods and services by healthcare practitioners, and healthcare facilities, and the funding of healthcare goods and services. Within these two components, there are various interrelated markets.

Healthcare practitioners

10. Healthcare services are provided by practitioners such as general practitioners, specialists, nurses, pharmacists and other professionals. These health professionals are subject to regulation by various professional regulatory bodies, such as the Health Professions Council of South Africa (HPCSA), the South African Nursing Council (SANC), the South African Pharmacy Council (SAPC) and the Allied Health Professions Council of South Africa (AHPCSA).

11. The total number of healthcare practitioners registered with the HPCSA in 2014 was 221,508 which included healthcare practitioners, assistant practitioners, counsellors, scientists and interns. [141]This figure is likely to be inflated as HPCSA data includes all registered practitioners, not simply those in active practice. It includes those who are retired as well as those who live and work outside of South Africa, both of whom are entitled to their HPCSA registration.[142]

12. Medical practitioners play a central role in the provision of healthcare services and provide guidance to consumers on the care required and on the healthcare pathway. Primary care providers act as care coordinators responsible for making referrals to specialists, ordering medical tests and prescribing medication. Generally, consumers rely heavily on the advice given by medical practitioners on healthcare goods and services needed. Medical practitioners are thus central decision-makers in the provision of healthcare services.[143] Our investigation focused on general practitioners and medical specialists (collectively called practitioners) who are registered with the HPCSA. General practitioners and medical specialists contribute the most to expenditure when compared to other health professionals and are also the main decision-makers about healthcare consumption.

13. The data compiled reveals that the number of practitioners[144] in the private sector has increased year-on-year from 7, 702 GPs in 2010 to 8, 000 GPs in 2014, and from 6, 565 specialists in 2010 to 7, 513 specialists in 2014. Nationally, there are 1.75 medical practitioners in the private sector per 1 000 insured population. These practitioners are not evenly distributed nationally, with more practitioners in Gauteng, the Western Cape and KwaZulu/Natal than in other provinces. Overall there is a relatively even distribution of GPs per 1 000 insured population with specialists skewed towards the more heavily urbanised provinces.

14. Medical practitioners generally operate individually in their own private practices. However, there are some group practices which work according to business models approved by the HPCSA. These groups are confined to either specialists belonging to the same discipline or general practitioners; specialists and general practitioners do not work in the same group

138 Ibid.
139 Ibid at para 4.4
140 Ibid
141 Table 3.3 of the PFR p.41. The figures were compiled from data received from the HPCSA and collected by the Health Market Inquiry.
142 Ibid.
143 PFR, 5 July 2018, p300.
144 The report has used unique practice number interchangeably with practitioner. This is not strictly correct given the points made in para 25 of the PFR but it is likely close enough and makes for easier reading.

practice. Some medical practitioners form corporate practices, such as pathologists and radiologists with the permission of the HPCSA. Most practitioners are paid using a fee for service model.

Healthcare Facilities

15. Healthcare facilities include acute hospitals, sub-acute hospitals, day hospitals, specialised hospitals, and healthcare centres and clinics. There are 814 healthcare facilities nationally, with 405 facilities operating in the public sector and 409 facilities operating in the private sector. [145] Public healthcare facilities serve approximately 83% of the population who are largely without medical insurance.[146] Unlike healthcare practitioners and healthcare funders, healthcare facilities do not have a dedicated regulatory body.

16. There are three main private hospital groups operating in the private sector: Netcare, Mediclinic and Life Healthcare. In 2016 they accounted for approximately 84% of general acute beds with Netcare providing 31.4%, Life Healthcare 27%, and Mediclinic at 25.6%. The National Hospital Network (NHN) and other independent hospitals which are not affiliated to the NHN, operate as fringe players providing in 2016, 16% of general acute beds. In December 2018, the NHN had 210 members located in major urban areas and in historically disadvantaged and low-income areas. The NHN operates under an exemption from the Commission which permits it to bargain collectively with medical schemes on behalf of its members on tariffs and other matters.[147]

Healthcare funders

17. There are a number of funders in the private sector. Our investigation has focused on the main funders, namely, medical schemes, medical scheme administrators, and brokers. Medical schemes are not-for-profit entities that provide healthcare financing to individuals for a monthly contribution. Medical schemes may either administer their day-to-day activities or outsource administration to third-party administrators. Third-party administrators are for profit entities that provide a variety of services, such as managing member records, contributions, claims, financial reports, information and data control, and actuarial services. Medical schemes that conduct all of their administration services are known as self-administered medical schemes. Brokers advise and guide consumers and employers in selecting private health insurance cover. They provide consumers and/or employers with information on benefits and services offered by medical schemes and/ or health insurers.

18. Medical schemes and administrators are regulated by the Council for Medical Schemes (CMS), a statutory body established in terms of the Medical Schemes Act, 1998. Its statutory duties include protecting the interests of medical scheme members, overseeing and co-ordinating the running of medical schemes, monitoring their solvency and financial soundness, and investigating complaints against schemes.

19. Government agencies that fund the provision of healthcare services under certain conditions, such as the Road Accident Fund (RAF) and the Compensation Fund, are also considered as part of the funding landscape.

Healthcare Pathway

20. The pathway to private healthcare for most people commences with a visit to a GP, who will assess the patient's condition and, if necessary, refer to a specialist in the treatment of the condition that the GP has diagnosed or refer for further investigation, diagnosis and treatment. Invariably, patients rely on GPs for advice on specialists to consult. Once the patient has decided which consultant to see, either the GP will contact the consultant, setting out the preliminary diagnosis and reasons for the referral, or will provide the patient with a letter of referral. If the condition requires hospital admission, the choice of hospital is influenced by where the specialist has practicing rights.

21. Some patients may know which specialists to consult or a have a preferred hospital. Such knowledge might be gathered from friends or relatives or by research. There is no readily available information on medical practitioners, the quality of their services or the fees that they charge. GPs too do not have access to such information and have to rely on their own knowledge of specialists and hospitals.

22. Other factors that influence the choice of GPs, specialists and hospitals, include networks initiated by providers and funders, and whether the medical practitioner concerned is contracted to a medical scheme.

145 PFR, 5 July 2018, p66.
146 Stats SA, General Household Survey, 2018, page 119. Available at http://www.statssa.gov.za/publications/P0318/P03182018.pdf, accessed on 19th of June 2019. The 83% of South Africans without medical aid excludes those who indicated that they don't know if they have medical aid, and those classified as 'unspecified'.
147 PFR, 5 July 2018, p169

23. Provider-initiated networks serve one or a combination of the following purposes: provision of a platform for tariff negotiations, discussions on coding, care coordination, encouragement of preventative care among scheme beneficiaries, management of utilisation, information dissemination and member welfare protection. Funders contract with providers or product suppliers who provide healthcare services to members of their medical schemes.

24. For Designated Service Provider (DSP) contracts, there is often an agreement between the specific funder and a provider or product supplier to channel patients to the network of providers, whilst for Preferred Provider Networks (PPNs), funders would have a list of preferred providers to whom they channel their members without formal payment arrangements in place.[148]

25. Funders enter into network arrangements to agree on prices, to ensure compliance with formularies, and to reap the benefits of cost savings. The network may also have a direct advantage for members who have a guarantee that they would not be liable for any balance billing. Third-party entities, such as managed care organisations, establish network arrangements to ensure reduced administrative costs, care standardisation, risk-sharing, risk-transfer and that a patient's particular care pathway is followed.

26. Consumers wishing to receive private healthcare services may fund it in one of three ways: by self-payment, by reimbursement from their medical schemes, or by reimbursement from their private insurance. Patients who seek healthcare services outside of the network are likely to pay the service provider personally and to seek reimbursement from the scheme. The scheme will only reimburse the patient based on what a service provider who is part of the network would have charged.

The Regulatory Framework

27. The private health sector is subject to a myriad of statutes, regulations and by-laws which together constitute the regulatory framework for the provision of healthcare services. There are 107 statutes that are administered by the National Department of Health (DoH).[149] In this section we set out an overview of the regulatory framework. A detailed regulatory framework is set out in Chapter 2 of the PFR.

28. The regulatory framework governs the provision of healthcare services by healthcare facilities (hospitals) and medical doctors as well as other health professionals, the funding of healthcare services by medical schemes and administrators of medical schemes, and the sale and distribution of medicines and drugs by manufacturers, distributors, pharmacies and doctors permitted to dispense medication.

29. While the national DoH bears primary responsibility for enacting framework legislation, all three spheres of government are, subject to the Constitution, responsible for administration of these legislative measures. In administering this regulatory framework, the state is assisted by a number of regulatory bodies.

The regulatory bodies

30. The regulators have a significant role to play in the implementation of the regulatory framework. It was important to understand the role and mandate of these regulators, and to assess their effectiveness in order to make appropriate recommendations. The key regulators include:

    (a) the Council for Medical Schemes (CMS);

    (b) the Health Professions Council of South Africa (HPCSA);

    (c) the South African Nursing Council (SANC);

    (d) the South African Pharmacy Council (SAPC);

    (e) the Dental Technicians' Council;

    (f) the Allied Health Professions Council of South Africa (AHPCSA);

    (g) the Office of Health Standards Compliance (OHSC);

    (h) the National Health Research Ethics Council; and

    (i) the Health Ombudsman.

31. The next section provides an overview of the key statutes.

148 See PFR, 5 July 2018, p 52

149 South African Law Reform Commission Consultation Paper, *Statutory Law Revision: Legislation Administered by the Department of Health*, Project 25, December, 2015, p.14.

Overview of the regulatory framework

32. The key legislation which regulates the provision of healthcare goods and services is (a) the National Health Act, 2003 (NHA)[150], whose purpose is "to provide a framework for structured uniform health system within the Republic; (b) the Medical Schemes Act, 1998 (MSA)[151], which regulates the funding of healthcare services; and (c). the Medicines and Related Substances Act, 1965[152] which regulates the provision and supply of medicines and devices. Healthcare professionals are regulated by various statutes.[153]

The National Health Act

33. The NHA is the first post-apartheid statute to regulate comprehensively the provision of healthcare services. One of the objects of the act is to "regulate national health and to provide uniformity in respect of health services across the nation by among other things, protecting, respecting, promoting and fulfilling the rights of the people of South Africa to the progressive realisation of the constitutional right of access to healthcare services."[154] It thus establishes the national health system comprising the public and private healthcare services providers.[155]

34. The Act covers:

    (a) responsibility for healthcare services;

    (b) access to healthcare services;

    (c) the rights and duties of consumers, and healthcare personnel;

    (d) the gathering of information on healthcare services, including the creation of a comprehensive national health information system;

    (e) the keeping and protection of health records;

    (f) the creation of health establishments which includes hospitals;

    (g) the determination of non-mandatory reference price list for services rendered and consumables utilised;

    (h) the determination of norms and standards for the provision of health services; and

    (i) the establishment of statutory bodies that are responsible for monitoring and enforcing compliance with norms and standards.

35. While the primary responsibility for healthcare services resides with the national DoH, there is a shared responsibility with the provincial and local health departments.[156] The role of the national department is to develop national health policy[157] as well as norms and standards on health matters[158] and to evaluate health services.[159] The Minister of Health is advised by the National Council on matters such as the responsibility for health by the public and private sectors.[160] Provincial health departments are responsible for the implementation of national health policy norms and standards,[161] planning and managing health information system,[162] monitoring and evaluating health services[163], and control of the quality of health services.[164] Members of the Executive Council for Health in each province may assign health functions to a municipality. The National Consultative Health Forum coordinates provincial and national activities.

36. The Minister is assigned extensive powers: to make regulations covering the norms and standards for national health systems,[165] for gathering national

150 Act No. 61 of 2003.
151 Act No. 131 of 1998.
152 Act No. 101 of 1965.
153 These include the Health Professions Act, 1974 (Act No. 56 of 1974) which regulates medical practitioners, the Dental Technician Act, 1979 (Act No. 19 of 1979) which regulates dental technicians and technologists, the Pharmacy Act, 2000 (Act No. 1 of 2000) which regulates the provision of pharmaceutical services, the Nursing Act, 2005 (Act No. 33 of 2005) which regulates the nursing profession, and the Allied Health Professions Act, 1982 (Act No. 63 of 1982), which regulates healthcare professionals who provide allied healthcare services.
154 Section 2(c)(i).
155 Section 2(a)(i).
156 Section 3(2).
157 Section 21(1)(a).
158 Section 21(1)(b).
159 Section 21 (1)(h).
160 Section 23 (1)(a)(i).
161 Section 25.
162 Section 25(2)(b).
163 Section 25(2)(f).
164 Section 25(2)(n).
165 Section 90(1)(c).

health information system data;[166] to obtain information on health financing, the pricing of healthcare services, and the publication of such information;[167] and for the determination and publication of reference price lists for services rendered, procedures performed, and consumables used by hospitals for use "by medical scheme[s] as a reference to determine [their] benefits,"[168] and "by health establishments, healthcare providers or health workers in the private health sector as a reference to determine their own fees, but which are not mandatory."[169]

37. The availability of such information will ensure that consumers are enabled to make informed choices and to "have access to, and [can] freely select, the quality and variety of goods and services they desire."[170] This intended practice is in line with the objectives of the Competition Act.

38. We are concerned that although the NHA was enacted 16 years ago, its key provisions, in particular, those relating to the licensing of facilities, reference lists, the creation and publication of a national database on financing and pricing of healthcare goods and services, have not yet been implemented.

The Medical Schemes Act

39. The Medical Schemes Act consolidates all laws relating to the medical schemes industry. It establishes the Council for Medical Schemes (CMS) as the regulatory body for medical schemes, medical scheme administrators and managed care organisations, provides for the appointment of a Registrar of medical schemes, makes provision for the registration and control of certain activities of medical schemes, and seeks to protect the interests of medical scheme members[171].

40. Chapter 5 of the MSA deals with the rules of medical schemes. These rules are particularly pertinent to the assessment of competition in the private health sector as they prescribe the services that schemes must provide and the manner in which the schemes must operate. Two sections are of particular importance.

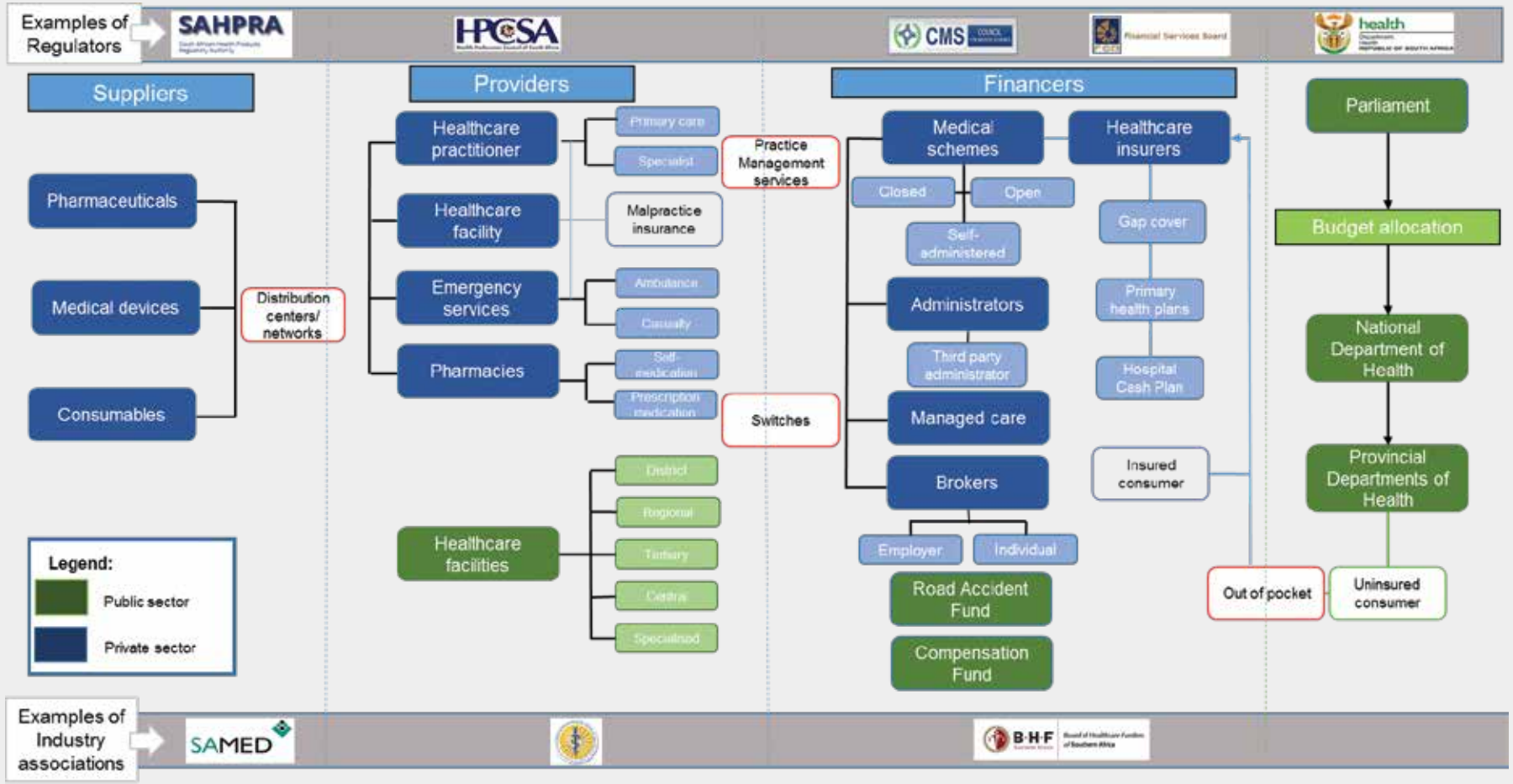
    Section 29 (n), specifies that a scheme cannot vary its contributions on the basis of any factor other than income and the number of dependants. This provision protects potential members from discrimination on the basis of age, sex, past or present state of health, and the frequency of utilisation of healthcare services. Schemes must be open to all (colloquially referred to as "open enrolment") and cannot vary contributions on the basis of individual risk factors but must set contributions on the basis of global risk (referred to as "community rating").

41. Section 29 (o), specifies that each benefit option offered by a scheme should provide for certain minimum benefits. These prescribed minimum benefits (PMBs) are set out in more detail in Regulation 8, made in terms of section 67 of the MSA. Regulation 8 specifies that PMBs must be paid in full without deductibles or co-payments but permits schemes to specify that treatment for a PMB be sought from a designated service provider. Should the scheme member choose not to make use of a designated service provider, the scheme may impose a deductible or co-payment on that member.

42. This chapter serves to introduce sector stakeholders and the interrelationships are best summarised in Figure 2.1.

166 Section 90(1)(t.)
167 Section 90(1)(u).
168 Section90(1)(v)(i).
169 Section 90 (1)(v)(ii).
170 See Preamble to the Competition Act 89 of 1998.
171 Preamble to the MSA 131 of 1998.

FIGURE 2.1: OVERVIEW OF THE SOUTH AFRICAN HEALTHCARE SECTOR



Source: Compiled by HMI

Chapter 3
Competitive Assessment Framework

FEATURES OF THE MARKET THAT MAY HARM COMPETITION

1. In the Terms of Reference for the Health Market Inquiry (HMI) published by the Competition Commission (Commission) on 29 November 2013, the Panel is required to:

   "conduct an analysis of the interrelationships of various markets in the private healthcare sector, including examining the contractual relationships and interactions between and within the healthcare service providers, the contribution of these dynamics to total private expenditure on healthcare, the nature of competition within and between these markets, and ways in which competition can be promoted."

2. This requirement included the position of consumers as patients, members of medical schemes, health insurance policyholders, and beneficiaries, in each of these markets.

3. A market feature may be intrinsic to the structure of the market or may arise from the conduct of any market participants. "Prevent, distort or restrict competition" covers any effect adverse to the realisation of more competitive outcomes for consumers.

4. In our Statement of Issues of 1 August 2014, we identified market power, including coordinated conduct and vertical relations, barriers to entry and expansion, imperfect and asymmetric information, and the regulatory framework as possible features that may prevent, distort or restrict competition. These features may reinforce one another and, therefore, need to be evaluated in combination.

THEORIES OF HARM

5. The various theories set out below were used to assist the analysis of the markets under investigation. The Revised Statement of Issues (RSOI), published on 11 February 2016, set out an updated number of theories.

6. The theories of harm must be understood to apply to competitive harm only. They may not necessarily address all factors that have an impact on access and affordability.

7. The six theories of harm identified, may be overlapping in their effect on competition.

THEORY OF HARM 1:

Market power and distortions in healthcare financing

8. The potential occurrence of market power and distortions in financing are:

8.1. market power of medical schemes and other health insurance providers over members or policy holders;

8.2. market power of medical scheme administrators over medical schemes, or vice versa;

8.3. market power of medical schemes and administrators over providers of healthcare facilities;

8.4. market power of medical schemes and administrators over healthcare practitioners;

8.5. the relationship between not-for-profit medical schemes and for-profit administrators; and

8.6. the relationship between brokers, medical schemes and consumers.

THEORY OF HARM 2:

Market power and distortions in relation to healthcare facilities

9. We identified the following areas of potential harm to competition in relation to facilities:

9.1. market power of facilities during negotiations with medical schemes and/or administrators in both national and local markets;

9.2. market power of facilities over the relationship of funders and the providers of medicines and medical devices;

9.3. market power in local markets that may have an adverse effect on patients;

9.4. the relationships between practitioners and healthcare facilities; and

9.5. the relationships between healthcare facilities and suppliers of medicines and medical devices.

THEORY OF HARM 3:

Market power and distortions in relation to healthcare practitioners

10. The evaluation of market power and distortions in relation to healthcare practitioners includes:

10.1. the effectiveness with which healthcare practitioners direct patients along the healthcare pathway;

10.2. the scarcity of skills and absence of local rivalry;

10.3. possible coordinated conduct among healthcare practitioners;

10.4. market power of practitioners during negotiations with medical schemes and administrators, including the role of practitioner groupings and networks; and

10.5. the relationships between healthcare practitioners and suppliers of medicines and medical devices.

THEORY OF HARM 4:

Barriers to entry, expansion and innovation

11. Entry and the threat of entry play an important role in defining competition in any sector. This theory of harm hypothesises that several structural and behavioural barriers to entry, expansion and innovation relating to healthcare providers, funders and practitioners, are harmful to competition, specifically:

11.1. *barriers applicable to financing,* including economies of scale and large financing requirements, regulatory requirements and constraints (such as reserve requirements and contractual arrangements between existing medical schemes or administrators and providers);

11.2. *barriers applicable to healthcare facilities,* including substantial investments and sunk costs, licensing and other regulatory requirements and contractual or informal relationships between existing healthcare facilities and practitioners; and

11.3. *barriers applicable to practitioners,* including rules and regulations promulgated by the Health Professions Council of South Africa and the National Department of Health, contractual arrangements between medical schemes or their administrators and practitioners and agreements and arrangements between facilities and practitioners.

THEORY OF HARM 5:

Imperfect information

12. The absence of appropriate market transparency may harm competition and distort outcomes of healthcare markets, specifically:

12.1. patients may not be able to choose the most appropriate provider and treatment;

12.2. members' choices of medical schemes may be compromised by an inability to make value-for-money decisions;

12.3. healthcare funders may be unable to compare costs and quality of providers;

12.4. patients may lack information available to facilities and / or funders on whether certain treatments and technologies represent value-for-money; and

12.5. imperfect and asymmetric information, in the context of a third payer (insured healthcare) system may distort the incentives of consumers and providers and give rise to anti-competitive behaviour.

THEORY OF HARM 6:

Regulatory framework

13. Possible deficiencies, distortions and unintended consequences of otherwise beneficial regulation may affect competition, raise barriers to entry and expansion and maintain, create or reinforce positions of market power, as may the way the law has been implemented and enforced.

Framework for the Competitive Assessment of the Inquiry

14. Effective competition comes from firms already operating in the market, from firms that could readily enter the market and from buyers that exercise effective disciplinary pressure on suppliers.

15. Conversely, competitive harm may result from unilateral market power of an existing firm or firms in a market, collective market power exercised through coordinated conduct, vertical relations between existing firms, high barriers to entry, expansion and innovation, and from buyers not disciplining suppliers through their responses. Market regulation may influence all five these factors positively or negatively.

Unilateral market power

16. One important indicator of a single firm's market power can be its market share in terms of sales or production which are expressed in physical (e.g. tonnes, beds) or monetary units. Monetary units are used when production or sales are heterogeneous and cannot be easily compared across the industry.

17. A large market share is an indirect indicator of possible market power. It reveals something of the extent to which the firm's market power or dominance is limited by existing competitors, and it tells us of the "outside options" buyers or consumers have should an attempt to abuse market power occur. Proxy indicators of market power include measures such as a firm's loci index[172] or various concentration ratios.

18. Although concentration ratios (e.g. the market share of the top four firms in a market or "C4" index) and the Herfindahl-Hirschmann index are not generally used to assess unilateral market power of a firm, the information contained in these indices may reveal something about the context in which the assessment of single firm dominance takes place. A market share of 30% with competitors each producing or selling less than 1% of the market is significantly different to a market in which three competitors each command 30% of the market.

19. 1Market concentration, market share and the exercise of market power are not necessarily linked to the position of a single firm in a market. In an oligopolistic market, and a fortiori when that market is protected by high entry barriers, all firms may possess and exercise unilateral market power. There are a range of possible outcomes in oligopolistic markets. Depending on the type of competition, an oligopolistic market may result in high prices and low quantities with no coordination between firms. In a differentiated products market, firms may avoid competition by differentiating their products. In addition, if there is a high level of transparency in the market, firms can maintain coordinated conduct without any kind of explicit agreement. Firms may be collectively aware of each other's business interests, and they may all independently acknowledge the fact that "rocking the boat" of competition in the market may not be in their interest, and act accordingly. Firms may also choose explicitly to collude.

20. Market share, as an indirect indicator of market power, should always be considered in the context of other, complementary evidence including the ease of entry, expansion and innovation of competitors. A large market share may not guarantee market power if an attempt to raise prices would immediately attract new and efficient competitors or would be offset by actual competitors that immediately react by expanding the volume of production and sales in the market.

21. Direct indicators of market power should also be sought, such as the way the firm engages with its customers, its suppliers and its direct competitors. If a firm does not respond to the needs of its buyers, without substantially losing turnover to competitors or attracting new entry and innovation, that may provide a powerful direct indication of market power.

22. Current market shares are, therefore, informative, as are trends, including data on successful entry or a history of forced exit. These indicators will deepen any understanding of the competitive conditions in the market. Significant and frequent shifts in market shares may also be indicative of healthy competition. Conversely, if a firm has consistently maintained or increased its market share, this may reinforce an interpretation that high market shares reflect market power.

23. It is, however, imperative to be very cautious about interpreting consistently high and growing market shares. While these may be related to market power, they may also be the result of superior management of a company and of its ability to stay ahead of its rivals in terms of innovations and the development of products and services.

172 Loci indicators will be dealt with in the chapter on Facilities. Definition required here and accurate reference

BARRIERS TO ENTRY, EXPANSION AND INNOVATION

Why is entry, expansion and innovation important?

24. Entry by new firms into an industry or expansion of existing firms may take several forms. A firm may enter an industry de novo and may build new and additional capacity or a firm may take over an existing firm or capacity in the industry. Incumbent firms may also expand their existing capacity by building new plants or capacity. Firms can also invest in new products and production capacity in adjacent markets or in upstream or downstream markets.

25. The credible threat of entry, expansion and innovation – without entry or expansion taking place – may have the same or similar effects on existing firms and on competitive conditions than actual entry and expansion.

26. Entry, or the threat of entry, may have several effects:

26.1. entry distorts and upsets existing patterns of market conduct, and can make it more difficult for possible dominant or collusive firms to exercise their market power;

26.2. entry generates competition and forces incumbent firms to improve in terms of efficiency, price, quality and service to consumers;

26.3. entry may introduce new forms of production, distribution, design, and service (innovation) into an industry, and

26.4. entry may force older, less efficient firms to leave the market.

27. Entry, or the potential of entry, is generally seen as a positive contribution to greater, more effective competition in a market and to the provision of better products and services at better prices for the consumer.

28. Conversely, the lack of successful entry over a prolonged period of time in an industry may signal high structural or regulatory barriers or strategic conduct by incumbents that discourage entry.

What are barriers to entry?

29. We have defined barriers to entry as any features of the market that gives incumbent suppliers an advantage over efficient potential entrants or rival incumbent firms.

30. Although barriers to entry, expansion and innovation are generally seen as impeding competition, some are unavoidable and intrinsic to an industry. For example, in any mode of production that requires large scale and significant sunk costs, scale and sunk costs would be considered a natural barrier to entry.

Types of barriers to entry

31. There are three broad classes of barriers to entry:

31.1. *natural or intrinsic barriers to entry*, sometimes also referred to as structural barriers, such as scale economies and sunk costs;

31.2. *behavioural or strategic barriers,* sometimes referred to as conduct-related barriers, such as comprehensive and exclusive distribution or supplier networks of incumbent firms which newcomers may find hard to replicate.

31.3. *Regulatory barriers,* which, for example, include licensing requirements to operate in a particular industry.

32. The concept of barriers to entry is closely related to the concept of 'barriers to exit'. The latter, the costs of exit from the market, enriches the analysis of barriers to entry. An entry barrier may be created where a firm cannot exit the market without losing a substantial part of its investment. Conversely, if entry can take place almost overnight, and the entrant may leave the industry without significant costs (i.e., "hit-and-run-entry"), then elements like large scale of production may lose significance as a barrier.

Natural or intrinsic barriers to entry

33. The most important natural barrier to entry in any given industry is *the minimum efficient scale of production* relative to the size of the market. If production technology is such that only a few companies can produce at minimum efficient scale, then this in itself presents a barrier to entry. The barrier is heightened if large economies of scale are combined with upfront investment largely consisting of sunk costs. In this case the combination of scale requirements, large investments, and sunk costs may both serve as a powerful barrier to exit for incumbent firms and as a barrier to entry for new firms.

34. Any assessment of barriers to entry must, therefore, include an assessment of scale and capital requirements and of sunk costs.

35. Sunk costs may be connected to the physical production or distribution capacity of a firm, but also to intangible elements such as irrecoverable

investments in research and development, and advertising.

36. Natural barriers may also stem from dynamic factors such as *the effect of learning* in a given industry. In healthcare, the more interventions a particular team of specialists or a hospital conducts, the more experienced, expert and faster they become, often resulting in better quality and lower average costs. This feature may serve as a natural barrier to entry for newcomers.

37. Other natural barriers may be *first-mover advantages,* the advantages that the first companies in an industry enjoy in terms of brand and customer loyalty. Consumers, once used to a product or producer, may show a (natural) reluctance to change. A lack of *transparency* on product comparability and *imperfect and asymmetric information,* all features that are generally acknowledged to exist in healthcare, may reinforce these factors and serve as a barrier to entry for new entrants.

Behavioural or strategic barriers

38. Whilst structural or natural barriers to entry are largely intrinsic to a given industry, behavioural or strategic barriers mostly stem from business practices and investments that explicitly aim at, or have as an effect, the protection of the business by incumbent producers against successful entry of newcomers to the industry.

39. Investing in over-capacity may seem irrational from a narrowly defined costs perspective but may nevertheless be rational if viewed from a strategic perspective. By making strategic investments in additional capacity, the incumbent firm *signals* to the competitor that it will aggressively protect *its market* and that it is able to do so by lowering its price locally and rapidly expanding production.

40. Investments in *vertical relationships* with critical distributors or vital suppliers, particularly if these contracts are exclusionary, may serve as a powerful barrier to entry for potential newcomers. Industry-wide national networks of designated healthcare providers, although triggered by the need to control expanding costs of treatment, have as a by-product that newcomers and smaller local providers may be excluded or cannot compete effectively. Another example may be investment in broker contracts and in exclusive relationships with broker companies by medical schemes, their administrators and related corporate groups.

41. A firm may also invest in advertising its products as somehow superior which may be seen as investments in increasing the *perceived switching costs* of consumers, especially if the product and its quality is not transparent to the consumer and meaningful comparative information is scarce. For example, investments in *wellness programs* may increase switching costs to members of medical schemes.[173]

Regulatory barriers to entry

42. The regulatory framework of an industry may impact the ease of entry and expansion of firms and may even have as its objective to regulate entry for good reasons. Examples are solvency requirements for medical schemes, spatial planning requirements, quality standards and certificates of needs.

43. The regulation of competitive structures or competitive behaviour may be required for a variety of reasons. Competition principles may compete with other socio-economic imperatives, for example, healthcare systems worldwide are known to be highly regulated due to the unique products and services they provide, in combination with serious problems related to imperfect and asymmetric information.

44. Quality, health and safety, and training requirements are examples of regulations that may affect both incumbents and (potential) entrants alike. Licenses, spatial regulation and solvency requirements for schemes may however impact potential newcomers more than existing firms. It is therefore necessary to make a distinction between the general impact of rules and regulations on businesses and the impact of the regulatory framework of an industry on barriers to new entry, expansion and innovation.

Effects of barriers to entry

45. The mere existence of barriers to entry in an industry is not enough to conclude that there is a competitive problem.

46. Barriers to entry may have different impacts on the position of incumbent firms and on the decision to invest in a new firm or new capacity, depending on the circumstances in an industry. It is important to identify the level of sunk costs involved, and, whether demand in an industry is likely to be stagnant over a prolonged period or characterized by growth.

173 Wellness programs in healthcare generally contain fidelity elements akin to deferred (fidelity) rebate systems in other industries. Consumers who wish to switch between schemes, lose credit points and are thereby disincentivised from switching.

47. Both these factors largely define the likely competitive reaction of incumbents to entry: the more pronounced sunk costs elements are, and in cases of stagnant or decreasing demand the reaction of incumbents to entry is likely to be aggressive and the post-entry price and profit levels are likely to deteriorate. On the other hand, in an industry with growing demand and rapidly changing production technology, entry barriers may prove to be less important and effective.

48. There is no single element of proof of the competitive impact of barriers to entry and expansion. Persistent levels of profits above the competitive level may signal competitive problems and barriers to entry but are neither necessary nor sufficient proof of such. Industries with high barriers to entry may show persistent levels of production inefficiencies and stagnant and even problematic profitability levels. Our impact analysis, in addition to analysing profitability levels, has examined history of entry, exit and market share growth.

Coordinated conduct, including vertical relations between firms

49. We were interested in any form of horizontal or vertical coordination in the market, whether forbidden by competition law or not, if it reduced strategic uncertainty of market participants and affected competition and access. Our task was to investigate the existence and effects of coordination or cooperation in the private healthcare market, rather than whether the conduct of a specific firm's was unlawful.

Horizontal coordination

50. Horizontal coordination of the conduct of participants in the same market – also called cooperation - may affect all aspects of competition, including prices, markets, outputs, quality, investment, innovation and service.

51. Although forms of coordination between competitors in the same market may be beneficial to competition (e.g. information sharing on patients' conditions, medical coding, and standardisation of quality standards), the negative impact of horizontal coordination on consumers and consumer choice can be severe, particularly if it involves price setting, market sharing, allocation of customers and collusive tendering. Even the reduction of the normal commercial uncertainty that a firm faces, and the sharing of information around these parameters of competition, can dampen competition.

52. A necessary condition for successful horizontal coordination of competitive conduct is that participants must be able to understand and monitor the terms of coordination. The more homogeneous products and services are in terms of quality and specifications, the easier it is to understand and monitor the behaviour of competitors. If the market is transparent in this respect, the firms may not need to enter into a formal agreement in order to effectively coordinate. The sharing of strategic information may facilitate the monitoring of cooperation. Of interest in this respect may be the role of business or trade associations and the sharing of information for the benefit of its members or of consulting companies' publications of strategic information on their websites.

53. A further important condition for successful horizontal cooperation is that the coordination needs to be sustainable among the coordinating group. Horizontal cooperation, for example on prices, tends to be highly unstable over time, because insiders have an incentive to cheat in order to increase their sales. Outsiders may also make higher profits under the protective umbrella of the cooperation agreement, if they can remain free to increase sales, which the participants to the agreement cannot. A successful horizontal agreement, therefore, needs an explicit incentive structure to maintain cooperation, or, conversely an explicit disincentive to compete.

54. Firms that are relatively symmetric may be more successful in sustained horizontal coordination. In practice, horizontal coordination is seldom perfect or completely stable. Nevertheless, the negative consequences for competition and the consumer may be severe.

55. Lastly, as with unilateral market power, the effectiveness and stability of horizontal coordination depends on how effectively the cooperating group can resist reactions from buyers/consumers or can prevent buyers/consumers from turning to alternative sources, including new firms that may enter the industry. Therefore, for horizontal coordination to be sustainable, the group's market share amongst existing participants in the industry must be significant and barriers to entry for newcomers must be relatively high.

56. Firms with cross-shareholdings, or with common ownership connections, may be more successful, sustainable and effective in attempts to dampen competition or in reaching an understanding to coordinate commercial conduct.

Vertical coordination

57. Vertical coordination includes vertical integration, i.e. upstream and downstream activities brought under common ownership and control, and vertical agreements, which can take a wide variety of forms – including resale price agreements, exclusive distributorships and sales contracts.

58. Generally, vertical agreements are contracts between trading parties at different levels of the supply chain which are meant to align the interest of the parties. Most vertical agreements and vertical integration are competition neutral or pro-competitive and have beneficial effects for the economy and the consumer. They may reduce market failures, improve coordination between parties and reduce transaction costs. However, in the case where one of the parties possesses market power at one or more stages of the vertical supply chain the vertical arrangement may, on balance, be anti-competitive. The most common form of harm to competition from vertical relations is foreclosure by the vertically integrated firm which restricts (or removes) rivals' access to key inputs or customers.

59. Foreclosure can only happen successfully when the contracting firm has the market power to contract input suppliers or distributers while forcing these suppliers or distributors to not supply / distribute, or supply / distribute under less favourable terms to competitors of the integrated firm, thereby guaranteeing its own competitive advantage. Put differently, the advantage thus arrived at is not achieved by superior performance, but rather by leveraging market power at one stage of the production chain to the upstream or downstream market.[174] This practice, therefore, damages competition.

60. Some of the commercial practices in vertical arrangements that may cause competitive harm are *tying and bundling, exclusive supply and exclusive purchasing*.

61. T*ying and bundling* are common commercial practices in which the firms make the sale of a product conditional upon the purchase of another distinct product, and bundling refers to the situation in which tying takes place in fixed proportions. These practices may lead to significant cost savings in production and distribution but may also lead to reduced competition in the tied market and to raising entry barriers for firms that produce or distribute one, but not the other product.

62. E*xclusive supply* contracts may force a supplier to supply exclusively its products to a dominant downstream firm, which may then be used to foreclose competitors of the downstream firm from essential supplies. For example, a dominant hospital in a local market may require exclusivity from their admitting doctors, which might make it more difficult for a new hospital to enter the market or for existing smaller hospitals to compete successfully in that market for patients. The exclusivity effect need not be in the form of an explicit obligation to supply only the dominant incumbent. Financial incentives may be used to reach the same effect.

63. *Exclusive purchasing* is the opposite of exclusive supply in that a downstream company is obliged by contract to buy exclusively from an upstream firm. There may be good reasons for the requirement, but if the upstream supplier possesses market power the result may be that other suppliers of the same good or service cannot compete effectively or even survive in that upstream market and that new entrants are obstructed. The result may be reduced competition in both markets and higher barriers to entry.

64. Even if market power at one or more stages of the supply chain does not present itself, but vertical agreements and/or vertical integration are wide-spread, the result may still be a dampening effect on competition and a general disincentive to enter the markets affected by newcomers and on expansion for existing suppliers.

Consumers' responsiveness and buyer power

65. For competition to be effective, consumers need to have both the incentive to react to better quality, prices or service and the ability to do so, for example, by having access to relevant information on prices and quality. If incentives are weak, as in the case of healthcare services that are largely covered and paid for directly by medical insurance schemes, then the responsiveness of consumers to price or quality differentials may be low. If the consumer is not able to react, for example, because there are no *outside options* so the buyer cannot shift demand, or because no timely, relevant and reliable information is available with respect to

174 It is important to note here that where a firm has market power in one market, it is not straightforward that it will have an incentive to leverage this power into adjacent, upstream or downstream markets – and this combined with the fact that vertical arrangements are much more likely to have efficiency benefits than horizontal arrangements, account for their different treatment under competition law and in economics.

products or services, then again this may reduce choice, responsiveness and competition.

66. Consumers' responsiveness to relative changes in prices and quality acts as a *competitive constraint* to suppliers with market power that attempt to raise prices or reduce quality and service. A market inquiry, therefore, needs to investigate how consumers can and will react, and to what degree this may represent *countervailing power* in cases of a possible attempt to abuse market power by a supplier or group of suppliers. Also, in the case of healthcare, the role of agents such as brokers and GPs to support consumer choice must be understood, including possible agency problems that might distort competition.

67. The availability of *outside options* and how that determines the outcomes of bargaining processes between suppliers and buyers in a market may be influenced by the structure of the market, i.e. by market concentration and barriers to entry. In a situation of largely atomistic supply and demand, outside options of both suppliers and buyers are abundant, and, therefore, the exercise of market power is unlikely. In a bilateral oligopolistic situation, with few sellers and a few large buyers, the market outcomes are largely undetermined. Much then depends on the circumstances in which bargaining takes place.

68. Information availability and the incentives to act upon it, are vital in any market. We have formulated a separate theory of harm focussed on imperfect and asymmetric information. Generally, when access to information is problematic, either because information on price and quality parameters is not available, is insufficient, or because there is a significant gap between the information available on one side of the market compared to the other, there is danger of the market not providing competitive outcomes but rather providing outcomes that, on balance, benefit the supplier.

69. Buyer power may be beneficial or may be harmful, depending on the structure of the market. In the case of buying power that counteracts or forms countervailing power to seller power, the result may be beneficial to the competitive process and outcomes. However, buyer power can also have a negative effect, in the case of large buyers and a host of small suppliers with insufficient countervailing power. An example would be general practitioners who are individually contracted by much larger schemes and administrators and do not individually generate enough turnover to influence the terms and conditions of the contracts.

Profitability analysis in the context of a market inquiry

70. We have performed profitability analyses to evaluate trends in levels of profits and what, along with other data available to us, reveals about competitive conditions in the market. If any firm is able to earn very high profits over a long period, the question arises whether it is the result of superior efficiency or innovation or of constraints to competition that may protect the position of profitable incumbents against entry and competition.

71. We have considered profitability in the context of its overall assessment of the market. For several reasons, profitability analyses alone cannot provide conclusive evidence of the abuse of market power of a firm or a group of firms. Firms may be very innovative and thus profitable for a limited period, in which case high profits may be compatible with effective competition.

72. Conversely, lower profits do not necessarily indicate effective competition. Lower profits may in fact be concealing ineffective competition, for example, caused by:

72.1. inefficient markets in which customers cannot compare competitive propositions on the merits for lack of comparable information which then allows operators to have higher costs and higher prices without necessarily showing consistently higher profits;

72.2. structural or strategic barriers to entry and growth that effectively protect incumbents from competitive challenges which may cause incumbents to become inefficient and operate with higher costs than under competitive constraints.

73. We acknowledge that price comparisons in healthcare, both at a national and an international level, are difficult to perform and to interpret, given the diversity of the products and services involved, the complexities of correcting for the influence of different methods of cost allocation over these products, and, for international comparisons, the influence of purchasing power comparators and the differences in legal, societal and fiscal settings.

74. Volumes, both in terms of the number of admissions and in terms of the intensity and methods of treatments, can be more meaningfully measured and compared nationally and internationally, and do contain valuable indications of the effectiveness of the competitive process and possible (in)efficiency

and market power in the delivery of healthcare when considered in combination with profitability indicators.

75. It is important that profitability be analysed over a long enough period to negate the bias that may arise from random factors (including economic upswings or downswings) influencing profitability results. Though a longer period may be useful, there are challenges with the availability of sufficiently consistent data. In determining an appropriate period for analysis, it is necessary to balance the potential benefits of examining a longer period with the practical difficulties of doing so. We have concluded that a ten-year period (2006-2015) is sufficient for a robust profitability analysis.

76. Profitability analyses in the context of a market inquiry are inquisitional and not accusatory. We have sought to determine whether there are firms (or a firm) that earn extraordinary profits over and above the long term costs of capital over a prolonged period, the possible causes of these profits (including whether it is market power or innovativeness) and why competing firms or efficient entrants are not able to bring these profits more in line with what is expected in competitive markets.

Chapter 4
Competition Analysis For Facilities

INTRODUCTION

Description of healthcare facilities

1. Healthcare facilities are establishments for the diagnosis, treatment and care of individuals suffering from illness and/or injury. They offer a range of medical, nursing, and other related services including acute facilities, sub-acute or step-down facilities, day facilities, specialised facilities, healthcare centres and clinics (collectively referred to as facilities).[175]

2. There are 405 public facilities reporting to provincial and local government authorities. Public healthcare facilities serve approximately 83% of the population who are largely without medical insurance.[176] In contrast, there are 409 private facilities distributed across all provinces, which predominantly serve those insured through medical schemes, health insurance products, and an insignificant number of the population who pay out of pocket. In 2018, approximately 16,4% of South Africans had medical insurance, essential for accessing private healthcare.[177] The percentage of the insured population varies between provinces and districts.[178] For example, a higher proportion of individuals are covered by medical aid schemes in the Western Cape (25.1%) and in Gauteng (23.9%), with only 8.2% having cover in Limpopo and 10% in the Eastern Cape.[179]

3. Figure 4.1 shows the total number of facilities and hospital beds in 1998, 2010 and 2016. It reveals that there has been an increase in the total number of private beds and facilities from 1998 to 2016, while the total number of public beds and facilities has remained largely stagnant.

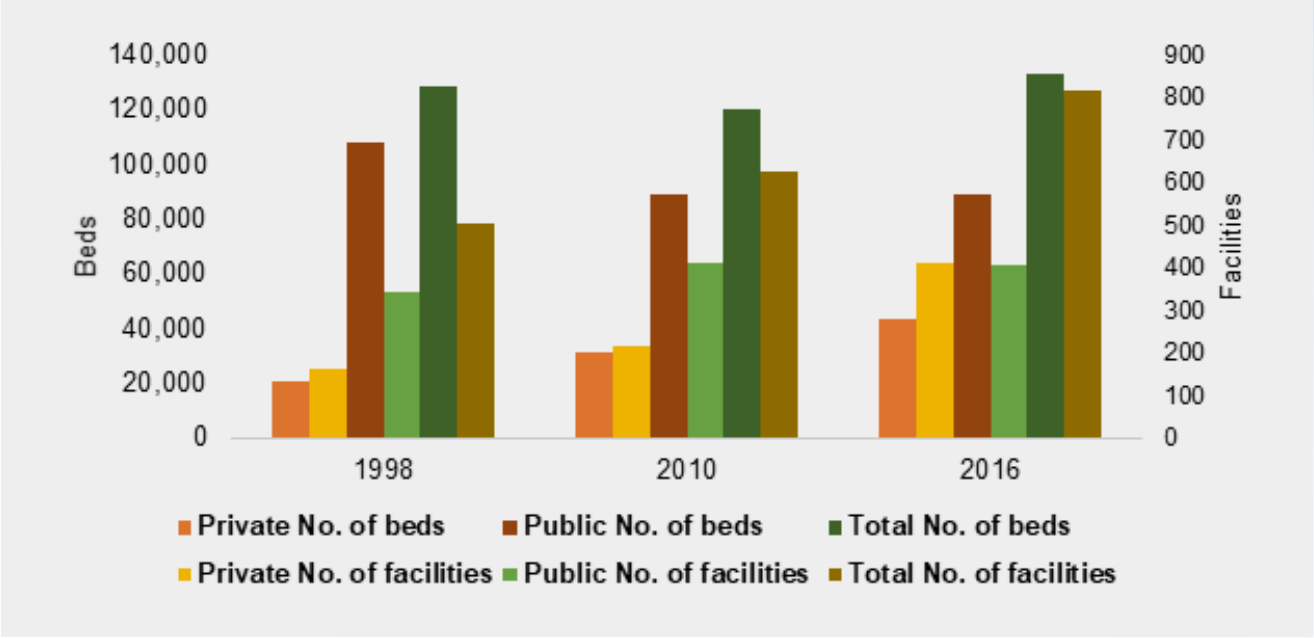
Structure of the private hospital industry in South Africa

4. There are three large corporate facility groups (Netcare, MediClinic and Life Healthcare) in the private sector. The National Hospital Network (NHN) is the next largest player and is a co-operative grouping of independent hospitals which has an exemption from the Competition Commission to negotiate tariffs and procure surgical consumables and medical devices collectively.[180] Beyond this exemption, the hospitals within the NHN compete with each other.

5. There are also a number of independent hospitals and day hospitals not affiliated to NHN. These include Clinix Health Group Ltd, Lenmed Health Group, Joint Medical Holdings (JMH), and RH Bophelo Investments. The latter is expanding

175 World Health Organisation, "Health Topics: Hospitals," 2015. [Online]. Available: http://www.who.int/topics/hospitals/en/ [Accessed 18 August 2015].
176 Stats SA, General Household Survey, 2018, p.119. Available at http://www.statssa.gov.za/publications/P0318/P03182018.pdf, accessed on 19th of June 2019. The 83% of South Africans without medical aid excludes those who indicated that they do not know if they have medical aid, and those classified as 'unspecified'
177 Stats SA, General Household Survey, 2018, Table 5.2. Available at http://www.statssa.gov.za/publications/P0318/P03182018.pdf, accessed on 19th of June 2019.
178 https://www.hst.org.za/publications/District%20Health%20Barometers/DHB+2017-18+Web+8+Apr+2019.pdf
179 Stats SA, General Household Survey, 2018, Available at http://www.statssa.gov.za/publications/P0318/P03182018.pdf, accessed on 19th of June 2019.
https://www.hst.org.za/publications/District%20Health%20Barometers/DHB+2017-18+Web+8+Apr+2019.pdf
180 Further to being granted exemption to negotiate tariffs collectively in 2018, NHN also received exemption to procure collectively surgical consumables and medical devices enabling economies of scale which would allow NHN to negotiate the best prices from manufactures and suppliers on behalf of its members to enable them to compete more effectively with the big three hospitals

Figure 4.1: Estimated total number of public and private facilities and hospital beds (1998, 2010 and 2016) [181] [182]



**Private facilities and private beds include acute, non-acute, day beds/clinics, psychiatric and sub-acute facilities and beds. We do not have credible and continuous time series data hence we have used data for 1998, 2010 and 2016.*

through the acquisition of facilities that have recently been divested as a result of merger conditions imposed by the competition authorities. Mining companies such as Aflease Gold Mine, Blyvooruitzicht Gold Mine, Dorstfontein Coal Mine and Glen Douglas Mine also operate healthcare facilities and provide services predominantly to their employees.

Industry associations

6. There are two main industry associations in the facilities market: the Hospital Association of South Africa (HASA) and the Day Hospital Association of South Africa (DHASA). The membership of HASA predominately comprises the three largest hospital groups and NHN. DHASA mainly represents the interests of independent day facilities and those that are part of the NHN.

The regulatory framework

7. There is no sector regulator for private healthcare facilities. The National Health Act, administered by the National Department of Health (NDoH), is the principal governing legislation in the sector. However, the NDoH delegates responsibility over hospitals to the nine provincial departments through provincial regulations such as Regulation 158 and Regulation 187. These regulations mandate the provinces to oversee the issuing of licences to facilities as well as other matters related to facilities (e.g. inspections) and the provision of public healthcare services. The regulations are used by all provinces except the Free State and the Western Cape that have formulated their own regulations.

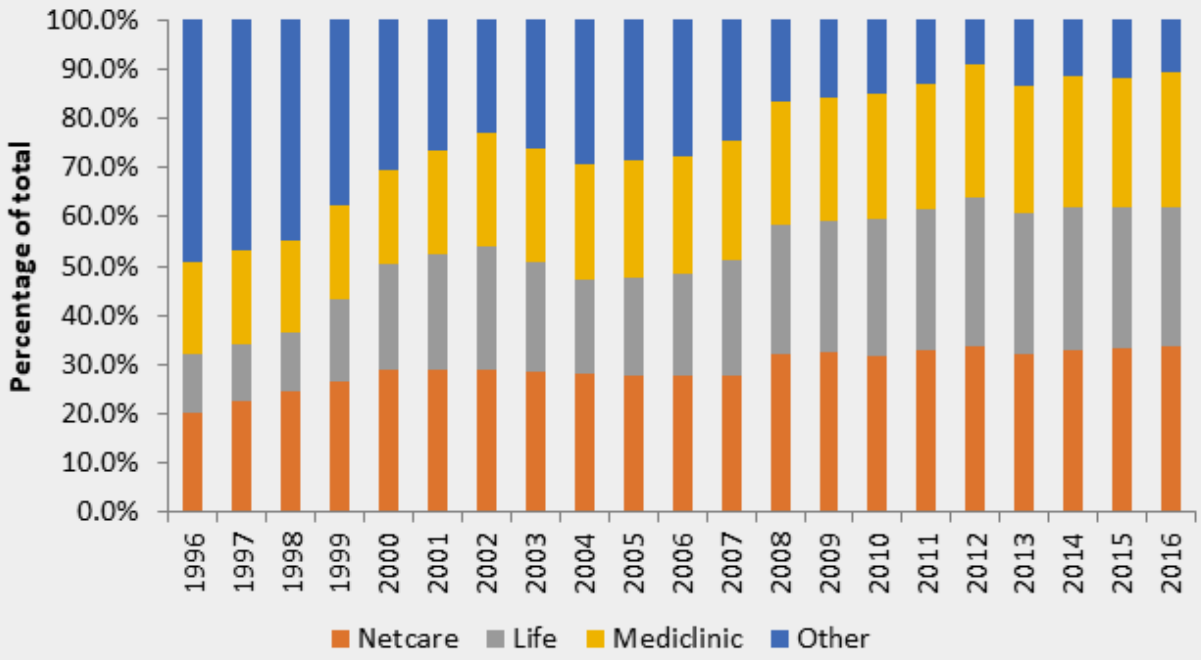
8. Facilities are also subject to the regulatory authority of the Office of Health Standards Compliance (OHSC) which was created by the National Health Amendment Act of 2013 and the Competition Act insofar as it relates to competition issues, i.e. merger transactions, enforcement and exemption investigations and market inquiries. The facilities market is indirectly governed by the regulatory authority of the Health Professions Council of South Africa (HPCSA), which is mandated to oversee the conduct of healthcare practitioners and their relationships with hospitals.

Distribution of facilities and hospital beds

9. As noted in the PFR, our analysis has focused primarily on general acute facilities as they account for the largest share of the market based on the number of beds, admissions and expenditure.

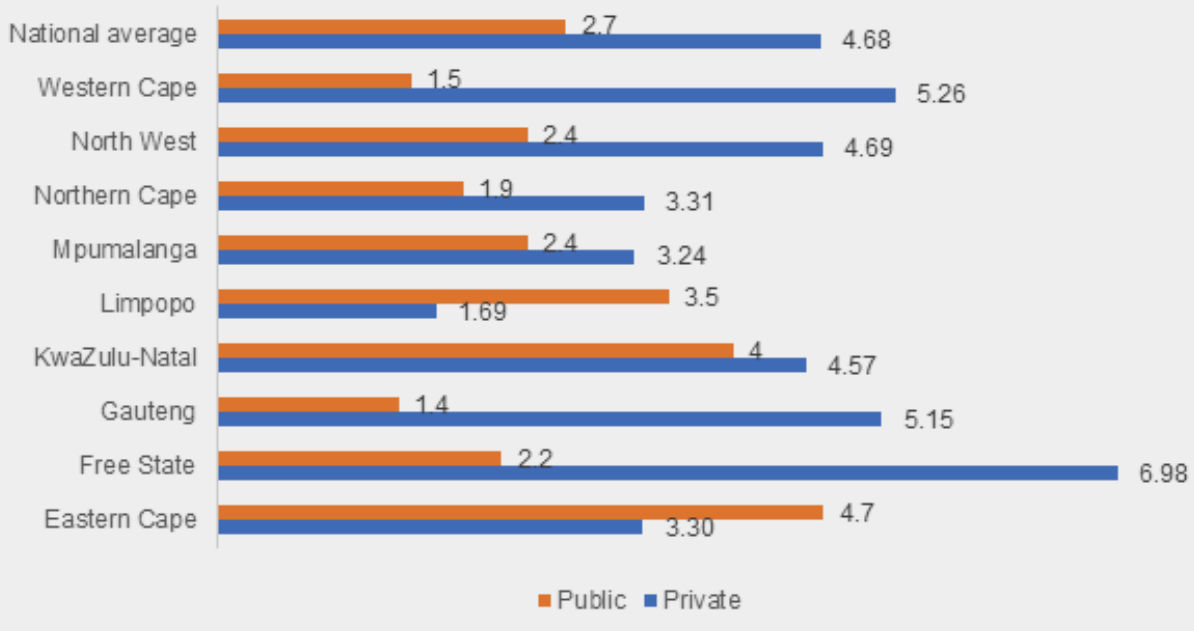
181 Van den Heever AM. The role of insurance in the achievement of universal coverage within a developing country context: South Africa as a case study. BMC Public Health. 2012;12 Suppl 1:S5. doi: 10.1186/1471-2458-12-S1-S5. Epub June 22, 2012.
182 Health Market Inquiry data compiled from various sources.

FIGURE 4.2: ESTIMATED HOSPITAL BEDS BY HOSPITAL GROUP (1996- 2016)



Source: HMI's own dataset developed by compiling information from various sources. The methodology used to develop the dataset is attached. ***See Annexure 4.2: Hospital Database Methodology.***

Figure 4.3: Estimated ratio of beds per 1 000 of the population in the private and public sectors (2016)



Source: HMI data compiled from various sources. Data on insured population was sourced from 2016/2017 Council for Medical Schemes (CMS) Annual Report, Table 4, p. 134. Bed data was sourced from HMI's own dataset.

10. Figure 4.2 illustrates the market shares of hospitals groups in terms of hospital beds from 1996-2016.[183] Netcare, Life Healthcare and Mediclinic collectively accounted for 90% of the market based on 2016 registered general acute beds. NHN members and other independent hospitals not affiliated to NHN accounted for the remaining 10% of the market.

    Figure 4.3 shows the ratio of distribution of beds per thousand population in the private and public sector respectively.

11. There are marked differences in the distribution of public and private sector and dynamics across provinces. In the poorer provinces of Limpopo and the Eastern Cape, the ratio of private beds to insured population is well below the national average but the ratio of public sector beds to population is well above the national average. In wealthier provinces such as the Western Cape, Gauteng and Free State, the private bed ratio is well above the private national average and the public sector ratio is below the public national average. It is only the Northern Cape, SA's most sparsely populated province, and Mpumalanga where both public and private bed to population ratios are both below the respective national averages.

12. We do not have data on occupancy rates, and, therefore, do not have evidence on whether there is equity in the healthcare sector. We recommend a change in regulation to make it compulsory to report occupancy information.

13. There are indications of overcapacity in the private healthcare sector. We have received information that in KwaZulu Natal, some medical schemes and administrators have started to intervene to stop more capacity being added in private healthcare by informing investors that they will be refusing to fund scheme members who use new facilities as there is sufficient capacity in the province.[184] [185] In the Medicross & Prime Cure Merger, the Tribunal also highlighted that "the private sector is structurally over capacitated". [186]

Assessment of competition in the facilities market

14. To assess the state of the market, we conducted the following assessment of: (a) market definition, including whether the public sector is a competitive constraint on the private sector; (b) concentration; (c) creeping mergers; (d) the distribution of private facilities across provinces; (e) relationships between practitioners and facilities; (f) bargaining and tariff determination; (g) expenditure analysis in hospitals; (h) utilisation and supply-induced demand analysis; (i) profitability analysis; and (j) barriers to entry, expansion and exit in the market.

15. We have subsequently received stakeholder comments on these thematic areas and have taken them into account in the final report. The remainder of the chapter briefly considers the main inputs received, and provides our final findings on:

15.1. market definition and concentration analysis, including facility/funder tariff negotiations, barriers to entry and exit, licencing and creeping mergers;

15.2. relationships between practitioners and facilities;

15.3. expenditure analysis;

15.4. supplier induced demand (SID); and

15.5. profitability analysis.

MARKET DEFINITION AND CONCENTRATION ANALYSIS

Market definition

16. We have assessed both the product and geographic dimensions of the private healthcare market. Considering the difficulties of applying price-based tests in healthcare markets, given the third party payers system, we note that in the context of a market inquiry precision on market definition may not be feasible nor necessary.[187] Our primary interest is in overall market concentration ratio's and developments over the observation period, and in what can be expected in the near future.

Product market

17. In defining the relevant product market, we considered whether the different types of private facilities are in the same product market, and whether public facilities exercised a competitive effect on private facilities.

183 HMI's own dataset developed by compiling information from various sources. The methodology used to develop the dataset is attached. **See Annexure 4.2: Hospital Database Methodology.**
184 Discovery Health presentation at the Health Market Inquiry Seminar, 12th April, 2019.
185 GEMS presentation at the Health Market Inquiry Seminar, 12th April, 2019.
186 Medicross & Prime Cure Merger. Case No: 11/LM/Mar05. Accessed from: https://www.comptrib.co.za/assets/Uploads/Case-Documents/11LMMar05.pdf on 19 February 2018.
187 HMI methodology paper for the facilities published for public comments on the 26th of August 2016, see http://www.compcom.co.za/wp-content/uploads/2014/09/CCHMI_FacilityMethod_F-3.pdf. para 27 – 28, p.7.

18. The healthcare facilities sector consists mainly of general acute care hospitals which offer a wide range of specialities though there are significant similarities in the range of specialties offered by all general acute hospitals. Other actors in the facilities segment include outpatient medical clinics, day hospitals for outpatient surgery and treatment, chronic disease facilities, psychiatric facilities and post-acute (rehabilitation or skilled nursing) facilities.

19. Our analysis focused primarily on general acute facilities (typically classified as 057 and 058)[188] which account for the majority of the market.[189]However, the growth of day hospitals emerged as a notable change in the facilities market, and the extent to which they affect competition in the facilities sector is assessed in detail.

20. We considered both demand side substitution and supply side substitution to inform our product market definition. We note that demand substitution between medical specialties is not possible. Therefore, the product markets must, in principle, be distinguished according to specialty and in some cases sub-specialty. Supply substitution between specialties at different acute care hospitals is also considered negligible. It would take a significant amount of time and investment to add a specialty to a facility meaning that entry would neither be timely nor sufficient to constrain incumbents. Though we find that acute private hospitals compete on the basis of specialties and sub-specialties, it is nonetheless not necessary to breakdown the analysis to the speciality level, as private acute facilities compete on the same broad set of specialties and services. We have concluded that it is sufficient to analyse *"in-hospital[190] healthcare services as generally provided by general acute hospitals"*.

21. We have excluded specialised facilities,[191] PPPs and mining hospitals from the relevant market because they provide are a narrow range of healthcare services and as such there is limited demand substitution with general acute facilities.

22. In the Provisional Findings Report, we included stand-alone day facilities that provide a limited choice of outpatient healthcare services, such as eye care, orthopaedic care and urology (all typically classified as 077)[192] in the product market, noting that day hospitals only compete with general acute hospitals to a limited extent. For example, even if an eye care day hospital competes with the ophthalmology department of a general acute hospital nearby, it only does so for the standard treatments it offers which do not require overnight stays. For more complicated eye care, with a chance of complications, the patient may need services of different disciplines offered in general acute hospital and access to specialised care in the case of complications arising. Conversely, general acute hospitals compete fully with, and, therefore, fully constrain, the competitive conduct of stand-alone day hospitals on the total range of treatments offered in day hospitals. It is much easier for a general acute hospital to expand into the outpatient day care segment, than the other way around. This is an asymmetric competitive constraint. Despite the fact that there is only limited competition between day facilities and general acute hospitals, we contend that, for the purposes of a market inquiry, the analysis of competitive dynamics in the facilities market must include day facilities. We do so because, as we show in the section ***Inclusion or exclusion of day facilities in the general acute facilities market,*** there is significant strategic competition between these two segments showing that the emergence of day hospitals is fundamental to understanding the general state of competition in the facilities market.

23. We did not consider public healthcare facilities to be a reasonable alternative to the services of private facilities (see PFR page 175; para 54-56). While it is difficult to conduct an objective analysis of quality, due to the lack of defined quality norms and standards in both the private and public sector[193], the common perception is that quality of care in

188 As per the Board of Healthcare Funders' (BHF) Practice Code Numbering System (PCNS), the facilities classified as "057" are the Private Hospitals-Multi Sub-Discipline ('A' - Status) and the facilities classified as "058" are Private Hospitals ('B' - Status).
189 Source: HMI's own dataset developed by compiling information from various sources.
190 Our approach is in line with the Tribunal's approach. Although the Tribunal has not so far established an appropriate method for defining markets in the context of a market inquiry, the Tribunal has nevertheless adjudicated on several hospital mergers in which it has based its findings on a relevant product market. In previous private hospital merger reviews, the Tribunal has consistently based its findings on a relevant product market for the provision of private hospital services, which includes a cluster of medical services.
191 This includes facilities that provide a limited array of specialised products with overnight stay. They focus on providing specific healthcare specialties such as eyecare services, cardiological services, paediatric health services, obstetrics and gynaecology, psychiatry, anaesthetics, diagnostic radiology and rehabilitation services.
192 The facilities classified as "077", as per the BHF's PCNS are the day facilities, which provide a range of healthcare services.
193 It was not until the creation of the Office of Health Standards Compliance (OHSC) that the public sector started making some efforts to manage quality. The OHSC is still not a full-fledged institution to measure quality as it currently only acts as an inspectorate of quality.

public facilities is generally poor when compared to the private facilities.[194] [195] [196] The Tribunal has also found that public healthcare facilities generally do not pose a competitive constraint on the private healthcare facilities though some examples of high-quality public hospitals and services are known to exist. We observe that possible constraints from public hospitals on private facilities, where that should happen, must be taken into account on a case by case basis.

Stakeholder inputs

24. There were no objections from stakeholders with respect to (i) the lack of competitive constraint between public and private healthcare facilities, and (ii) our approach to aggregate healthcare services offered in general acute facilities. Some of the larger hospital groups raised objections to the exclusion of some individual healthcare facilities.[197] [198] Also, the inclusion of day facilities in the definition of general acute hospital market received some comments.[199] One of the hospital groups favours an approach that includes specialised facilities and has criticised the exclusion of other facilities such as specialist hospitals and PPPs and mining hospitals, favouring the inclusion of all facilities.[200]

25. Having considered submissions, we maintain that specialised hospitals which offer care that is outside the realm of what generally is offered at general acute care hospitals, should not be included in the relevant market of general acute hospitals. Specialised hospitals, both from a demand and supply substitution standpoint, do not pose any real competitive constraint to the multidisciplinary acute facilities, certainly not across the full spectrum of the specialties offered by general acute hospitals. We, therefore, do not see a good reason to include specialised facilities in the product market.

26. On day facilities, Netcare recommended an approach that excludes them,[201] [202] an approach similar to that taken by the UK authorities recently in their market investigation.[203]

27. We have noted that there is a degree of asymmetry in competition between stand-alone day hospitals and acute facilities. Day care is not nearly as developed as it is in many comparable healthcare markets abroad, but it is on the rise in South Africa. There are significant strategic dynamics in the day hospital segment with facilities within the NHN network and with other smaller groups expanding their presence in day facilities. Some of the three big hospital groups have responded aggressively to emerging competition from day facilities, both by splitting existing activities to form day facilities or by acquiring independent day facilities.

28. Depending on the purpose of the analysis, there are reasons for and against the inclusion of the day facilities segment in the same product market as general acute facilities. For the purposes of understanding the general state of competition in the facilities sector, we have included stand-alone day hospitals in the relevant product market for general acute healthcare services. We are interested in both the market as is, but also in what developments are taking place from a longer term, strategic perspective. We have, therefore, conducted a local concentration analyses of the general acute facilities' market, including day facilities and for comparison, the results excluding day facilities. This differential analysis allows us insight into developments with respect to these two segments of the market.

Geographic markets

29. In defining the relevant geographic market, we have assessed competition and market power at the national or local level, or both. This approach takes into account the fact that national contracting between funders and hospitals implies competition at the national level but also acknowledges that there is competition for patients at the local level.

30. Our geographic market approach is consistent with the Tribunal's approach in merger reviews. In several hospital mergers, the Tribunal's position has been to assess the transactions at both a

194 DNA Economics. 2013. Regulating the Quality of Health Services: Benchmarking of Approaches, Institutions and Systems. Accessed from: http://www.dnaeconomics.com/assets/Usealexconstantinoudnaeconomicscom/OHSC-Regulating-the-Quality-of-Health-Services.pdf on 5 February 2018.
195 National Department of Health. Public Hearing Transcript 11 March 2016. P.267.
196 Discovery Health. Submission to the Statement of Issues dated 17 November 2017, p.ix.
197 Netcare Submission to the HMI's PFR by Compass Lexecon, para 2.2.2 p.2.
198 Compass Lexecon Submission "Market Definition and Relevant Markets: Assessment of Competitive Alternatives" dated 30 October 2014, p.31.
199 Netcare Submission to the HMI's PFR by Compass Lexecon, para 2.2.2 p.2.
200 Compass Lexecon Submission "Market Definition and Relevant Markets: Assessment of Competitive Alternatives" dated 30 October 2014, p.31.
201 Netcare Submission to the HMI's PFR by Compass Lexecon, para 2.2.2 p.2.
202 Compass Lexecon Submission "Market Definition and Relevant Markets: Assessment of Competitive Alternatives" dated 30 October 2014, p.31.
203 See CMA case site, available online at: https://www.gov.uk/cma-cases/private-healthcare-marketinvestigation.

local and national level.[204] The Tribunal also acknowledged that price competition between the major hospital groups occurs at a national level through bargaining with medical schemes, while local competition exists in terms of non-price competition to attract specialists and patients.[205]

31. There have been no material objections to our approach to assess competition at both the national and local level. Some concerns have been raised with the designation of catchment areas (local markets) and with the indicators and thresholds of market concentration which we have applied to arrive at an assessment of facility concentration in local markets.

Concentration measures

32. In our Provisional Findings Report, we applied three methods to measure national concentration and local concentration: a fascia count (competitors count), the Herfindahl-Hirschman Index (HHI) and the Logit Competition Index (LOCI) indicators. LOCI has the benefit of not having to define relevant markets before applying the method which is advantageous in healthcare markets in which undisputed definitions of relevant markets are notoriously difficult to establish. The fascia counts are a useful indicator of local areas which are potentially of concern in terms of concentration, such as markets in which a facility has one or no competitors in a local catchment area. The HHI and the LOCI go a step further than the fascia count and provide more depth by accounting for market shares of competing hospitals in the respective markets. We provided a further discussion of these concentration measures in the PFR.[206]

33. We received criticisms of the three methods that we used to measure national and local concentration. Both Netcare and LHC have argued that all concentration measures (fascia count, HHI and LOCI) are poor measures of local competition.[207] [208]

34. We responded to the criticism of the concentration measures in detail in the PFR.[209] No measure is perfect. We are cognisant of the shortcomings of the respective measures, and have, therefore, used all three measures in order to triangulate the results and arrive at a robust picture of concentration. Furthermore, as emphasised from the outset of the inquiry, we are aware that concentration analysis is not a fully-fledged competition analysis. We have thus considered a wider range of analyses and evidence before arriving at conclusions regarding the level of competition in the general acute facilities market. The analyses include an assessment of market power and distortions in healthcare with respect to funders, facilities and practitioners; barriers to entry, expansion and innovation; coordinated conduct, including vertical relations between firms; and levels of profitability in the market.[210]

Thresholds of the concentration measures

35. Using fascia counts, we consider local markets with fascia counts equal to or below 1 to be highly concentrated. Using LOCIs, we consider a market to be highly concentrated if LOCI < 0.6 or weighted average market share (WAMS) > 0.4. Using HHIs, we consider a market to be (i) less concentrated if HHI is below 1500 (ii) moderately concentrated if the HHI is between 1500 and 2500 and (iii) highly concentrated if the HHI is above 2500.[211] More details on the respective thresholds of the concentration measures are set out in the PFR.

36. Criticisms have been made of the respective thresholds of the concentration measures. LHC has criticised the thresholds applied with respect to the fascia count and HHIs, and argues that there is no empirical evidence that locally determined competitive outcomes are poorer in areas with two competing hospitals than in areas with three competing hospitals.[212] LHC has also criticised the use of an HHI threshold of 2500 indicating that it is not appropriate to interpret an HHI of above 2500 as problematic, or indicative of ineffective competition, in and of itself.[213]

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204 See Commission case number 2013Dec0598; Tribunal case number 11/LM/Mar10 & Commission case number: 2010Mar0463; Case number 122/LM/Dec 05; Life/Amabubesi merger, case number 11/LM/Mar10; 2011May0041
205 See Tribunal merger review case number 122/LM/Dec 05.
206 See PFR, 5 July 2018, pp.181-183.
207 Netcare Presentation at HMI seminar titled "Facilities Concentration and Remedies by Compass Lexecon, on the 9th of April 2019.
208 Life Healthcare Group Response to PFR on the 15th of October 2018, p.6.
209 See PFR, 5 July 2018, pp.177-185
210 For further information, **see Chapter 3: Competitive Assessment Framework.**
211 See PFR, 5 July 2018, pp.182-183.
212 RBB Economics "Annexure C: Response to the PHMI's Provisional Findings: Facilities Concentration Analysis" dated 15 October 2018, p.16.
213 RBB Economics "Annexure C: Response to the PHMI's Provisional Findings: Facilities Concentration Analysis" dated 15 October 2018, p.17.

37. In merger reviews the Competition Authorities[214] rely largely on the HHI thresholds stipulated in the International Competition Network (ICN) merger guidelines.[215] [216] Therefore, the Competition Authorities are likely to regard any market with an HHI in excess of 2000 as highly concentrated, and any market with an HHI between 1000 and 2000 as concentrated. In a merger review, while making reference to absolute HHI levels, Competition Authorities additionally rely on the changes (delta) in HHI to identify whether a merger is likely to pose competition concerns. In essence, a merger investigation is a dynamic analysis. In the Health Market Inquiry, we have chosen to rely on the HHI thresholds as stipulated by the US Department of Justice (DOJ) and Federal Trade Commission (FTC).[217] We have outlined this approach in the HMI Methodology paper[218]. Our main reason for adopting this approach is that the DOJ and FTC thresholds generate more conservative estimates of market concentration compared to the absolute values of HHI in the International Competition Network (ICN) thresholds. Furthermore, the ICN threshold combines a static and a dynamic element in pre and post-merger analysis; the latter dynamic element is not realistically applicable in a market inquiry. There simply is no ex ante and ex post situation in an inquiry. However, to address the concerns of thresholds raised by the stakeholders, the HMI has continued to apply the 'conservative' FTC HHI thresholds, and to compare the results with the situation in which – at the national level - we apply the absolute levels from the ICN HHI thresholds as well as from the thresholds applied by the UK competition authorities in their market inquiry.[219] By using the conservative FTC thresholds together with the thresholds used by the ICN and UK Competition Authorities, our approach is aligned with international standards and, therefore, considered to be reasonable.

Concentration Analysis

38. When assessing private facility concentration, we use admissions and registered bed data.

Registered bed data

39. Our analysis is based on registered bed data for 2016. We have developed this bed data from multiple sources as described in detail in ***Annexure 4.2: Hospital Database Methodology.*** We are concerned that there does not exist a comprehensive, timely and reliable data base with bed and occupancy data. The lack of credible data has been confirmed by several stakeholder submissions and in merger proceedings. [220] [221] [222] [223] [224] [225]

40. In developing the dataset, we had to contend with challenges such as hospital name changes and changes in ownership. We have made certain assumptions to develop the historical bed figures, as described in ***Annexure 4.2: Hospital Database Methodology.***

214 We refer to the Competition Commission South Africa and the Competition Tribunal as the Competition Authorities.
215 See the merger between NA CO Ltd and Nissan Diesel Motor Company (CASE NO: 28/LM/Mar07); the merger between Imperial Holdings Limited and U Drive Car and Van rental (2008Nov4107); the merger between Wesbank and Barloworld Leasing (2002Nov300); the merger between JD Group Limited and Ellerine Holdings Limited (78/LM/Jul00); the merger between Mutual and Federal Insurance Company Limited and Credit Guarantee Insurance Corporation of Africa Limited (2003AUG614); the merger between Goal Acquisitions Ltd and Allied Domecq Pic (2005Jun1626); the merger between Medi-Clinic Investments and Phodiso Health Services (2005Oct1917); the merger between JD and Ellerines (78/LM/JUL00); the merger between Nampak Ltd and Malbak Ltd (29/LM/MAY02); the merger between Tongaat-Hulett and Transvaal Suiker Beperk(83/LM/JUL00).
216 According to ICN merger guidelines, competition authorities state they are unlikely to identify competition concerns where: (i) the post-merger HHI is below 1000; (ii) the post-merger HHI falls between 1000 and 1800-2000, and the change, or delta, is below a range of 100-250; and (iii) the post–merger HHI is above 1800-2000, and the delta is below 50-150. See the ICN Merger Guidelines Workbook (2006).
217 According to the US merger guidelines, a market is considered to be (i) not concentrated if HHI is below 1500 (ii) moderately concentrated if the HHI is between 1500 and 2500, and (iii) highly concentrated if the HHI is above 2500
218 HMI methodology paper for the facilities published for public comments on the 26th of August 2016, see http://www.compcom.co.za/wp-content/uploads/2014/09/CCHMI_FacilityMethod_F-3.pdf.
219 The UK Competition Authorities – Office of Fair Trade (OFT) has regard to the following HHI thresholds: any market with a post-merger HHI exceeding 1,000 may be regarded as concentrated and any market with a post-merger HHI exceeding 2,000 as highly concentrated. In a concentrated market, a horizontal merger generating a delta of less than 250 is not likely to give cause for concern. In a highly concentrated market, a horizontal merger generating a delta of less than 150 is not likely to give cause for concern.
220 Discovery Health. Submission, 21 February 2018 in response to the HMI's "Proposed Regulatory interventions for Licensing of Health Facilities Document", pp.2-4.
221 Mediclinic. Submission dated 21 February 2018 in response to the HMI's "Proposed Regulatory interventions for Licensing of Health Facilities Document", p.6.
222 South African Society of Physiotherapy. Submission dated 21 February 2018 in response to the HMI's "Proposed Regulatory interventions for Licensing of Health Facilities Document", p.7.
223 Netcare & Akeso Group Merger Case No: LM017Apr17 "Hearing Transcript 26th February 2018", pp.103-104.
224 Western Cape DoH. Submission dated 26 February 2018 in response to the HMI's "Proposed Regulatory interventions for Licensing of Health Facilities Document", p.5.
225 Free State DoH. Submission in response to the HMI's "Proposed Regulatory interventions for Licensing of Health Facilities Document", p6.

41. The bed data was drawn largely from the HASA publications (2000 to 2010) which offered a substantial amount of information, though the data were inconsistently recorded. Over the period 2011 to 2015, total beds per hospital were available only for 2014. The data for 2016 were obtained from key stakeholders and we consider these data to be more reliable compared to bed data for other periods. For instance, a HASA data file representing membership was available for March 2016. Individual hospital groups (Netcare, Mediclinic and LHC) and NHN provided bed data separately in 2016. We were able to verify bed data provided by Netcare, Mediclinic and LHC. With respect to registered beds for the NHN members and other independent facility groups, we were only able to verify the total registered beds. In a recent submission of NHN, following the April 2019 seminars, the NHN has clarified its actual bed data.[226]

42. We have received comments on the 2016 bed data that we use as highlighted in the provisional findings report.[227] The stakeholders, however, did not provide alternative bed data and while hospital groups suggest that data on licences can be used, we do not consider licences to correlate with actual beds. We consider our approach in developing the bed data for 2016 to be sufficiently credible and robust and, therefore, continue to rely on it in our analysis.

Admissions data

43. In the PFR, we used the only complete admissions data at our disposal.[228] The dataset covers the period 2010-2014. We used admissions data for LHC, Mediclinic and Netcare and claims data for NHN and independent hospitals in conducting the analysis. We combined the two sets of data in the analysis because there was no complete admissions data for NHN and independent hospitals. To be more robust, we used average admissions for the period 2010-2014.

44. Despite the criticisms that we have received on the use of the 2010-2014 admissions and claims data, we continue to rely on the data because no alternative or more credible data was provided. Our data is, thus, to the best of our knowledge, the latest and most credible data available.

Concentration at the national level

45. At the national level, we calculated market shares and the associated HHIs to assess private facility concentration levels. To determine market shares and the associated HHI concentration indices we made use of admissions and bed data.

46. For the purposes of this inquiry, we defined the product market as general acute hospitals, including day facilities, i.e. all facilities classified as 057, 058 and 077. We do not distinguish between the types of beds but rather use the total registered beds for each facility for the analysis.

47. In the PFR, the three large hospital groups were found to have a substantial combined share of the national market. Netcare accounts for the largest proportion of the private hospital market with 33% and 31.1% of the market using admission and bed numbers respectively. LHC accounts for 28.6% (admissions) and 26.8% of beds, and Mediclinic accounts for 28.5% (admissions) and 25.3% (beds). NHN accounts for 7.7% (admissions) and 13.6% (beds) with the independent hospitals accounting for 2.2% (admissions) and 2.3% (beds) of the private hospital market.[229]

48. The HHI and concentration ratio (CR3)[230] for the national private facilities' market is 2784 and 90.1% based on admissions data and 2521 and 83.2% based on registered beds respectively. Based on this analysis, we conclude that the market is highly concentrated at the national level.

49. The NHN seems to account for a more substantial proportion of the market in terms of registered beds (7.7%) than in terms of admissions (13.6%) which may indicate a lower occupancy rate for NHN beds relative to the three large hospital groups. It may be precipitated by the funders reluctance to fund new or intended new facilities in the market in order to manage increasing capacity and excessive utilisation.

226 The NHN Submission to the HMI's Information Request, 17 July 2019.
227 See PFR, 5 July 2018, pp.178-184
228 The admissions data is in terms of occupancy rates not revenues generated.
229 While these market shares pertain to the selected facilities, they are comparable to market shares calculated for all the facilities using general acute beds. For all the facilities, the market shares are as follows: Netcare (33.8%), LHC (28.3%), Mediclinic (27.4%), NHN and Independents (10.4%).
230 The concentration ratio (CR3) measures the aggregate market share of the leading three firms in a market. See ICN Merger Guidelines Workbook, April 2006. Accessed on 3 September 2019, Available at http://www.ftc.gov.tw/icnmerger2009/images/ICNMergerGuidelinesWorkbook.pdf.

50. In Table 4.1 below, we present the HHIs calculated using our own dataset, including day hospitals, and compare our results with some of the stakeholders' results for the comparable period.

Table 4.1: HHI Indices Calculated by the HMI, including day hospitals, compared with submissions by stakeholders for comparable periods[231]

	HHI results	Period considered	Type of data used to calculate HHI
HMI	2 784	2010-2014 (average)	Admissions
	2 521	2016	Registered beds
Discovery Health[232]	2 503	2015	DH in-hospital admissions
	2 631	2015	DH claims paid
Medscheme[233]	2 182	2014	Medscheme admissions
Netcare[234]	2 422	2016	Registered beds
Mediclinic[235]	2183	2016	Registered beds
	2210	2014	Admissions

51. In considering Table 4.1, it must be noted that these results are from different databases. We have used both registered beds for 2016 and average admissions for 2010-2014. Discovery Health uses both claims and admissions data for 2015. Medscheme uses admissions data for 2014. Mediclinic used registered beds for 2016 and admissions for 2014. Netcare uses registered beds for 2016. The table shows our HHI results, including day hospitals, to be 2 784 based on admissions and 2 521 based on registered beds. [236]The HHIs presented by the respective stakeholders range from 2 182 to 2 631.

52. Only Medscheme and Mediclinic's results indicate a moderately concentrated market, when based on the conservative FTC threshold of 2500. Leaving aside the validity of Medscheme's data and analyses, if we compare these results to the HHI thresholds of the ICN, or to the thresholds that the Competition authorities in the UK apply in their market investigations, and combine the results with our own findings against any of the three standards, there is no doubt that the national private facilities market in South Africa is highly concentrated. Therefore, our conclusion stands that the facilities market is highly concentrated.

53. The main areas of comments and criticisms that we received on this analysis were: (i) inclusion or exclusion of day facilities in the general acute facilities market, (ii) the need to and effect of extending the observation period, (iii) divergent views on the definition of beds, admissions and claims data, the inclusion of duplicates, and the aggregation of independent hospitals, and (iv) the rationale for the exclusion of a number of individual hospitals. We set out below our assessment of the criticisms and provide our conclusions on the issues raised.

Inclusion or exclusion of day facilities in the general acute facilities market

54. We note that the main disagreement with stakeholders is whether the facilities market should include or exclude day facilities. We maintain that for the purpose of a market inquiry, inclusion of day facilities in the general acute facility market is appropriate. However, as noted, a comparison of results including and excluding the day facilities in the market over time provides some valuable insights as to the market dynamics. We have therefore re-calculated the market shares and HHIs based on our own data base, excluding day hospitals. Table 4 2 below shows recalculated market shares based on registered beds and admissions for the acute facilities only.

231 We acknowledge that the period of analysis used by the stakeholders and the HMI is not the same. We make comparisons even though the period of analysis is not exactly the same because these are the closest periods that we have from the information submitted by the stakeholders.
232 Discovery Health post-seminar submission to the HMI, dated 26 April 2019.
233 Medscheme Presentation to the HMI Facilities Workshop, 9th April 2019.
234 Netcare Response to PFR by Compass Lexecon calculations, dated 15 October 2018, p.14 - Replication and Correction Based on designated data from HMI.
235 Mediclinic Presentation at HMI seminar titled "Facilities Concentration and Remedies by Econex, 9th April 2019.
236 The HHIs results in the PFR are calculated based on acute facilities and day facilities.

Table 4.2: Market Shares and the HHI, excluding day hospitals, based on the Number of Registered Beds (2016) and Number of Admissions (2010-2014)

	Market shares		HHIs	
	Registered Beds	Admissions	Registered Beds	Admissions
Life Healthcare	27.0%	28.6%	2 545	2 800
Mediclinic	25.6%	28.6%		
Netcare	31.4%	33.2%		
National Hospital Network	12.9%	7.4%		
Independent	3.1%	2.1%		

55. Table 4.2 shows that the three largest hospital groups account for 84% and 90.4% of the market based on registered beds and admissions respectively, compared to 83.2% and 90.1% of the market based on registered beds and admissions respectively when excluding and including day facilities in the general acute hospital market. The HHI's increase slightly from 2 521 and 2 784 based on registered beds and admissions respectively when including day facilities in the general acute hospital market to 2 545 and 2 800 based on registered beds and admissions respectively when excluding day facilities in the general acute hospital market. The difference in market concentration as a result of either including or excluding day facilities in the general acute hospital market appears to be marginal, which adds to the conclusion that day facilities, although expanding in the market, are still underdeveloped.

The effect of extending the observation period

56. The larger hospital groups and Medscheme have criticised the Inquiry for ignoring market entry, particularly by new NHN related hospitals, which they claim results in an increasing share of NHN and independent hospitals in the private facilities market and substantial market de-concentration. The larger hospital groups and Medscheme argue that the NHN has grown significantly over time, and is now a credible fourth alternative facilities group.[237] [238] [239] [240] The larger hospital groups and Medscheme argue that the growth of NHN has implications for funders in negotiations with the three large groups at a national level, and in local markets. The figures presented by both Discovery Health and Medscheme at the HMI seminar showed that NHN registered growth of approximately 2-3% between 2014 and 2018 using in-hospital admissions data (Medscheme) and in-hospital admissions and claims data (Discovery Health).[241] [242] Netcare submits most of the additional new entry and expansion in the private hospital sector will be by NHN and independents based on licence applications and approvals.[243] According to Medscheme, about 2000 beds will be introduced in the market in 2019.[244]

57. The NHN and Discovery Health argue that NHN does not offer the same level of competition with the big three hospital groups mainly because the hospitals negotiating under the NHN umbrella are independent and compete with one another even within the NHN setting. They, therefore, cannot rely on cross-subsidies between hospitals and they cannot benefit from a single management structure as can the big groups.[245] [246] This assessment was supported by Mediclinic's seminar presentation submission to the HMI.[247] In their submission, Mediclinic opposed the breaking up of facility groups on the grounds that the facility groups would lose the advantage of operating as a group, such as quality initiatives existing at different hospitals, scale advantages,

237 Netcare post-seminar submission titled "*Medscheme submission on the HMI Seminars (9 – 12 April 2019)* 26 April 2019.
238 Mediclinic presentation at the Health Market Inquiry Seminar: Session 3, 9 April 2019.
239 Econex and Percept Comments: Health Market Inquiry Provisional Findings and Recommendations Report,15 October 2018, p.40.
240 Medscheme presentation at the Health Market Inquiry Seminar: Session 3, April 2019.
241 Discovery Health presentation at the Health Market Inquiry Seminar: Session 3, 9 April 2019.
242 Medscheme presentation at the Health Market Inquiry Seminar: Session 3, 9 April 2019.
243 Netcare post-seminar submission titled "Medscheme submission on the HMI Seminars (9 – 12 April 2019) 26 April 2019.
244 Medscheme presentation at the Health Market Inquiry Seminar: Session 3, 9 April 2019.
245 See transcript of the HMI seminar held in Pretoria between 9th and 12th April 2019.
246 Discovery Health post-seminar submission to the HMI, dated 26 April 2019.
247 Mediclinic seminar presentation by Econex titled HMI Seminar: Facilities Market Concentration and Remedies, dated 9 April 2019.

cost-efficiencies, central procurement, innovative risk adjustments and general innovations and technological improvements.[248] Mediclinic's submission reinforced the view that NHN lacks these advantages and confirms the competitive advantages of the three larger facility groups over NHN.

58. Discovery's submission downplays NHN's growth in the market. As Discovery points out, the trend in the distribution of admissions and claims by hospital networks between 2015 and 2018 has remained largely unchanged across the period, with the three larger hospital groups continuing to treat most Discovery patients.[249]

59. To assess the issue raised by stakeholders on the growth of NHN and the effect on concentration in the market, we requested data from the NHN on the number of NHN facilities and the registered beds. We acknowledge that the latest data received from the NHN is different from the data that we used for the PFR and also different from the data submitted by NHN to the Commission for the exemption application. The data inconsistency is one of the main reasons we recommend the mandatory submission of data in a defined format to a centralised database to enable market analysis.

60. We have therefore relied on the latest data submitted by NHN to clarify the growth of the NHN. Table 4 3 and Table 4 4 below show the respective number of NHN facilities and the registered beds, and the registered bed growth for the period 2010 to 2018. The compound annual growth rate (CAGR) is shown in Figure 4.4.

Table 4.3: number of NHN facilities and registered beds (2010 to 2018)

	Totals		Acute Hospital		Day Hospital		Sub-Acute Hospital		Ophthalmology		Others[250]	
Period	No. of Facilities	No. of Beds	No. of Facilities	No. of Beds	No. of Facilities	No. of Beds	No. of Facilities	No. of Beds	No. of Facilities	No. of Beds	No. of Facilities	No. of Beds
2010	**92**	**6105**	38	4491	19	344	11	350	11	172	13	748
2011	**110**	**8047**	44	6125	22	348	16	490	12	192	16	892
2012	**124**	**7380**	45	5129	29	459	21	595	13	202	16	995
2013	**145**	**8056**	50	5242	32	496	28	854	13	225	22	1239
2014	**163**	**8221**	52	4981	37	754	31	928	18	247	25	1311
2015	**177**	**8645**	54	5297	41	666	35	1029	18	250	29	1403
2016	**198**	**9547**	58	5707	50	821	39	1131	18	266	33	1622
2017	**216**	**10622**	61	6258	56	892	43	1252	18	278	38	1942
2018	**210**	**10799**	68	7167	52	829	39	1059	21	312	30	1432

Source: The NHN Submission to the HMI's Information Request, dated 17 July 2019

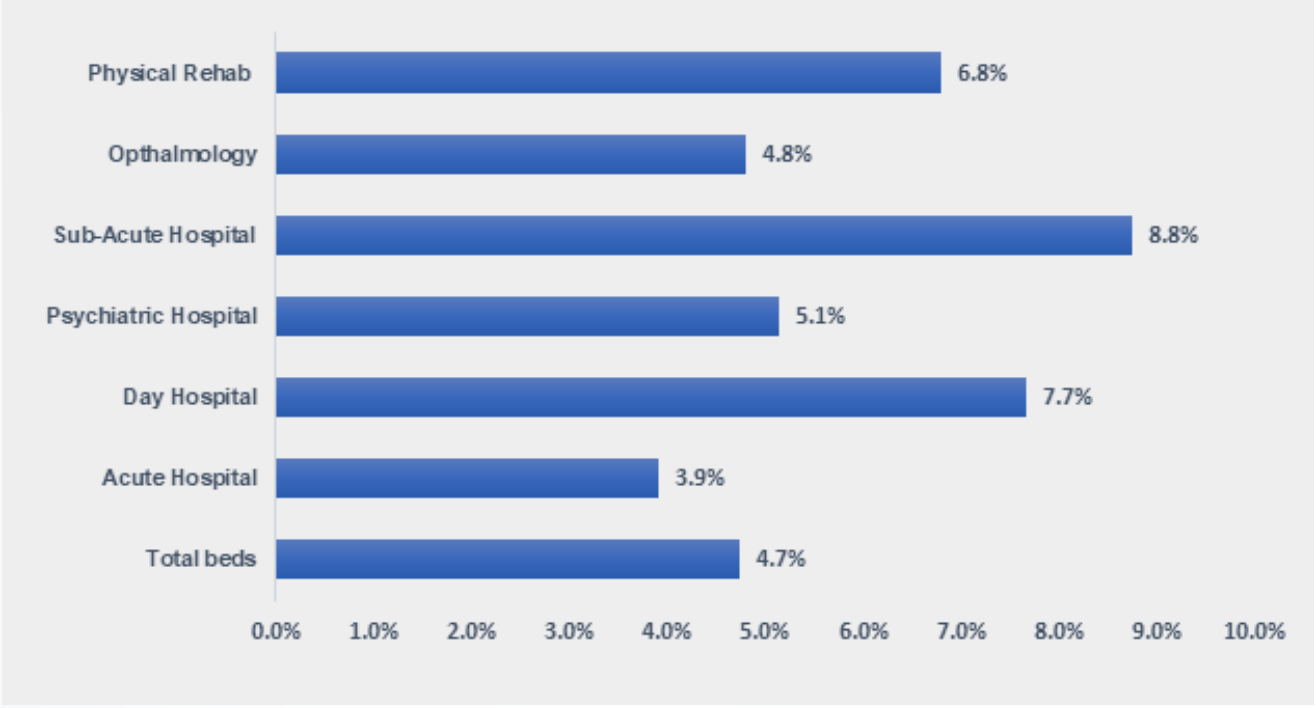
248 Mediclinic seminar presentation by Econex titled HMI Seminar: Facilities Market Concentration and Remedies, dated 9 April 2019.
249 Discovery Health post-seminar submission to the HMI, 26 April 2019.
250 Others comprise of Physical Rehab hospitals and Psychiatric Hospitals.

Table 4.4: NHN registered bed growth (2010 to 2018)

Period	Total	Acute	Day	Sub-acute	Ophthalmology	Psychiatric	Physical Rehab
2011	**32%**	**36%**	1%	40%	12%	16,6%	-
2012	**-8%**	**-16%**	32%	21%	5%	11,8%	0,0%
2013	**9%**	**2%**	8%	44%	11%	25,0%	0,0%
2014	**2%**	**-5%**	52%	9%	10%	7,5%	-100,0%
2015	**5%**	**6%**	-12%	11%	1%	6,1%	-
2016	**10%**	**8%**	23%	10%	6%	13,9%	208,3%
2017	**11%**	**10%**	9%	11%	5%	20,2%	0,0%
2018	**2%**	**15%**	-7%	-15%	12%	-26,8%	0,0%

Source: The NHN Submission to the HMI's Information Request, 17 July 2019

Figure 4.4: Compound Annual Growth Rate – CAGR - (2010-2018)



Source: The NHN Submission to the HMI's Information Request, dated 17 July 2019

61. Based on this information, our analysis shows that the NHN has registered bed growth over the period (2010-2018). In other years, growth was either marginal or negative. For instance, the NHN registered significant total beds growth of 31.8%, 10.4% and 11.3% in 2011, 2016 and 2018 respectively but only marginal total beds growth of 2% and 1.7% in 2014 and 2017 respectively. There was a decline in total registered beds of 8.3% in 2012. The negative growth in some years probably confirms the exit of some facilities from the NHN to become independent or acquisitions by particularly the three big hospital groups. The growth in NHN is more substantial in 2016 and 2017, mainly driven by the growth in sub-acute beds, day care beds and physical rehabilitation beds.

62. Our analysis shows that the average growth in acute beds was 3.9%. The average growth is more significant in non-acute beds, particularly in sub-acute beds (8.8%), in day care beds (7.7%) and in physical rehabilitation beds (6.8%) which reflects the NHN strategy to enter mostly historically disadvantaged and low-income areas, which are generally not covered by the larger players. Therefore, the NHN has expanded its footprint mainly in low-cost facilities, mostly in day care and non-acute services which may be the reason that the NHN hospitals are gradually beginning to be selected for anchor status for non-acute service offerings in historically disadvantaged and low-income areas, making them more eligible for networks in markets where the big three have less presence. However, if we were to isolate acute facilities, the NHN do not have the anchor status claimed by some stakeholders. This was also confirmed by the NHN.[251] This is reflected in their lower numbers in admission rates reflected in the Discovery submission and HMI analysis.

63. Several other factors compromise the anchor status for NHN. It's emergence and development into a fourth major player and DSP partner continues to be undermined by what we have called the creeping mergers problem. For example, based on the data alone we note that the NHN's share of the day hospital bed reduced by 7% in 2018, which could be the impact of the Mediclinic/Intercare transaction. We have also noted that the NHN is not a full competitive constraint for the big three hospital groups. NHN hospitals are independent hospitals that set their strategies independently and compete with one another within the NHN network for the same doctors and patients, and for inclusion in the same DSP networks. They are not allowed to internally cross-subsidise as the larger hospital groups do when negotiating rates nationally. Thus, despite its growth over time, the NHN remains in a comparatively weak bargaining position when negotiating with funders, and, therefore, cannot be seen as a full competitive constraint on the dominant three hospital groups.

64. Further, while the three larger hospital groups, and Medscheme, claim that based on approved licences, more beds will be introduced by NHN and other independents in the market, our view is that it is inappropriate to project entry and market de-concentration solely based on plans, not on realised investments because, hospital licences do not always translate to physical hospitals built or to increases in admissions. Some of the licences are not operational or funders refuse to take on board those facilities because they consider the market to be saturated.[252] [253] Further, some of these licences could end up being bought by the three big hospital groups.[254] [255] Despite reported licences commissioned, relatively few hospitals have entered the market. Negotiations on tariffs are based on existing facilities and not those that might be introduced to the market in future or on licences possessed. Thus, licences without an existing facility do not confer any bargaining power on the part of NHN. Further, the provincial departments informed us that they do not know the exact number of licences that they issued.[256] [257]

65. We conclude that contrary to some stakeholder submissions, the NHN growth in the market is modest, particularly in general acute hospital care. The market, therefore, both when considered over the observation period and during the most recent developments, is not self-correcting. The concentration of market shares has remained high and the distribution of market shares has remained relatively stable. Despite some growth of NHN, the national market remains highly concentrated with an entrenched market position of the three largest facility groups. We, therefore, do not consider the NHN as a fourth comparable competing hospital grouping.

Divergent views on beds, data, duplicates and the aggregation of independent hospitals

66. We received criticisms on: (i) using admissions and claims data together in conducting the analysis, (ii) using total registered beds and not beds in use, (iii) the inclusion of duplicates in the HMI analysis, and (iv) the aggregation of independent hospitals.

67. Mediclinic and LHC argue that using admissions and claims data together in conducting the analysis leads to inconsistent results in the calculation of catchment areas for the three large hospital groups as compared to NHN and independent hospitals and impacts on the quality of the geolocation data

251 Teleconference between the NHN and the HMI,10 July 2019.
252 Medscheme presentation at the Health Market Inquiry Seminar, 9-12 April 2019.
253 Discovery Health presentation at the Health Market Inquiry Seminar, 9-12 April 2019.
254 Presentation by Gauteng Department of Health, Week 4 Public Hearings, 08 -11 March 2016, Cape Town.
255 Presentation by KZN Department of Health, Week 4 Public Hearings, 08-11 March 2016, Cape Town.
256 Presentation by Gauteng Department of Health, Week 4 Public Hearings, 08-11 March 2016, Cape Town
257 Presentation by KZN Department of Health, Week 4 Public Hearings, 08 -11 March 2016, Cape Town.

used and the results of the analysis.[258] [259] It is also argued that calculating market shares based on admissions may not provide a true reflection of the competitive constraint imposed by different firms because admissions represent the allocation of patients based on current prices, or tariffs.[260]

68. We note the criticism of the use of admissions and claims data together in conducting the concentration analysis. We recognise that we had no complete admissions data for NHN and independent hospitals, hence the use of admissions data for LHC, Mediclinic and Netcare and claims data for NHN and independent hospitals. This approach, although not entirely flawless, enabled us to conduct concentration analysis at the local level with the available information.

69. Netcare argued that we have used registered beds, as opposed to active or beds in use, in the market share calculations.[261] We disagree and argue that the registered beds reflect existing capacity within facilities and provide the metric to use when conducting a market share and concentration analysis. The hospital groups also provided us with registered beds to be used for the analysis, as they argued that the number of in-use beds do not stay the same, and that other beds in delivery rooms and emergency centre are not counted as beds.[262] [263] In their own analysis, stakeholders such as Discovery Health, Netcare and Mediclinic also used registered beds.[264] [265] [266]We, therefore, consider that it is appropriate to include the number of registered beds, as opposed to the number of beds in use.

70. A number of stakeholders raised the issue of the inclusion of duplicates in our analysis.[267] [268] [269] [270] [271] Mediclinic, for instance, argued that there are data entries which record zero claims and yet a positive PMB amount paid.[272] The effects of including duplicate facilities in the analysis is to overstate the market shares, and possibly the concentration levels in the market. We note the merit of the criticisms on the inclusion of duplicates and have now excluded them in the second scenario analysis.[273] However, even after taking out duplicates, the results remain largely the same.

71. On the aggregation of market shares of other independent hospitals and the bed numbers used by the HMI, LHC argued that while it is appropriate to aggregate the market shares for hospitals that form part of the NHN, since they engage in collective negotiations with funders, it is incorrect to aggregate the market shares of other independent hospitals that negotiate with funders on an individual basis. [274]

72. We note the submissions by some stakeholders that the aggregation of the market shares of other independent hospitals is inappropriate. However, we aggregate independent hospitals considering that there are many independent hospitals which individually have small market shares. We conclude that aggregating independent hospitals' market shares does not have any impact on the market shares of LHC, Mediclinic and Netcare, nor on the analysis of competitive dynamics, and hence that it does not affect the overall findings of the analysis.

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258 RBB Annexure C: Response to the PHMI's Provisional Findings,15 October 2018.
259 Cliffe Dekker Hofmeyr, Mediclinic's Comments on the Provisional Findings and Recommendations of the Health Market Inquiry, para 2.3.2 p.5.
260 RBB Annexure C: Response to the PHMI's Provisional Findings,15 October 2018, p.14.
261 Netcare Submission in response to the PFR titled "Comments on the Competition Commission Health Market Inquiry's Provisional Findings and Recommendations Report" prepared by Insight Actuaries,12 October 2018, p.45.
262 Netcare/Compass Lexecon submission, 30 October 2014, p.31.
263 Cliffe Dekker Hofmeyer/Mediclinic submission to the HM, 26 May 2016.
264 Discovery Health presentation at the Health Market Inquiry Seminar: day 1 session, 9 April 2019.
265 Mediclinic Presentation at HMI seminar titled "Facilities Concentration and Remedies by Econex, 9 April 2019.
266 Netcare Presentation at HMI seminar titled "Facilities Concentration and Remedies by Compass Lexecon, 9 April 2019.
267 JMH Group Submission to the HMI, 22 September 2016, p.13.
268 Lenmed Submission to the HMI, 29 September 2016, p.32.
269 Life Healthcare Submission to the HMI, 16 August 2016, p.31.
270 Netcare Submission to the HMI,15 September 2016, p.24.
271 Econex and Percept Comments: Health Market Inquiry Provisional Findings and Recommendations Report,15 October 2018, p.54.
272 Econex and Percept Comments: Health Market Inquiry Provisional Findings and Recommendations Report,15 October 2018, p.54.
273 Possible duplicates were identified by using the addresses geo-coded to street level and the postal code level. We determined the possible duplicates by Gender, Scheme, Plan, Date of Birth, EA_Category and EA_Code. We then confirmed that these possible duplicates' discharge and admission dates aligned. Hence, the patients discharged date was on the same day as a possible duplicates admission date. It is important to note that for Mediclinic there was no EA category column to identify possible duplicates.
274 RBB Economics "Annexure C: Response to the PHMI's Provisional Findings: Facilities Concentration Analysis" 15 October 2018, pp.11-12.

The rationale for the exclusion of individual general acute facilities from the analysis

73. Mediclinic and Netcare argued that we excluded a number of acute hospitals from the final list of 195 hospitals, particularly from NHN, thereby understating the market shares of NHN and inflating the market shares of the larger groups.[275] [276] Mediclinic also argued that we have not applied any clear, objective empirical rules in excluding particular types of facilities from our facilities database.[277] Netcare reports that after correcting for errors, and replicating the calculations for the 195 hospitals, the HHI decreases from 2 521 to 2 422.[278]

74. We argue that there are valid reasons for the exclusion of the respective hospitals. For instance, the facilities that entered the market post-2014 were excluded as there was no claims data to enable analysis. We also observed that certain facilities used the same practice numbers and we have merged such facilities as part of the data processing and cleaning process. Such facilities included Mediclinic's Gariep and Kimberley facilities and Life Healthcare's St Joseph's and Entabeni facilities. There were also certain acute facilities that existed prior to 2014 were excluded from the analysis for a variety of reasons. For instance, some facilities were excluded because of misclassification whereby a facility could be registered as an acute facility, yet the facility mainly provided specialist and/or sub-acute medical services. Facilities classified as Public–Private Partnerships (PPP) were also excluded from the analysis.

75. We note that while Netcare argued that we excluded fifteen hospitals (largely classified as 057 and 058 facilities) from the list of 195 hospitals used in the PFR,[279] it does not mention particular facilities which would enable us to be specific in our response.

Conclusions on national concentration

76. After reviewing stakeholders' comments, and, in addition, reviewing two more concentration thresholds applied by the ICN and the UK's competition authorities, we maintain our earlier conclusion that the private facilities market for general acute care in South Africa is highly concentrated.

Local facilities market concentration

77. Catchment areas were determined using patient flow data derived from hospital admission data and medical schemes claims data for 2010-2014. As outlined in the PFR[280], we have used both the Lavielle algorithm and the more arbitrary (although internationally accepted) radial method of applying an 80% cut-off ratio to derive catchment areas. Although the Lavielle algorithm and radial model were both used to derive catchment areas, but our preferred method is the Lavielle algorithm.[281] Netcare criticises use of the Lavielle method arguing that it has not been used before in market definition in South Africa or internationally.[282] While we accept that the Lavielle algorithm has not been tested, we do not believe that the novelty of a methodological approach is sufficient reason for not using it. The Lavielle method brings the potential advantage that it does not use arbitrary cut off points. Nonetheless, we have used the more traditional, simpler and well tested method, the radial model, to complete the Lavielle analysis. [283]

78. 195 catchment areas (clusters) have been identified from which we calculate fascia counts, LOCIs and HHIs as concentration measures against the thresholds used previously.

79. The fascia count results show that there are 28 local markets (14%) that are highly concentrated, 12 markets (6%) with only one competitor and 16 hospitals (8%) are considered solus hospitals. Using the HHI, and adjusting for network membership, the results show 88 (45%) highly concentrated markets with 25 (13%) of the total local markets being served by solus hospitals. Using LOCI, and adjusting for network membership, 114 hospitals (58%) are in highly concentrated local markets. We draw broadly similar conclusions from the three approaches of high levels of concentration at the local level. The consistency in the results, regardless of methodological approach, provides, in our view, reassurance that the results are robust.

275 Mediclinic Presentation at HMI seminar titled "Facilities Concentration and Remedies by Econex, 9 April 2019.
276 Netcare's combined submissions in response to the PFR,15 October 2018.
277 Cliffe Dekker Hofmeyr, Mediclinic's Comments on the Provisional Findings and Recommendations of the Health Market Inquiry, para 2.2.4 pp.2.
278 Netcare reports that for all the private hospitals, the HHI declined between 2010 and 2014 from 2,302 to 2,226 using the NMG Admissions Dataset used by the HMI for every analysis other than the HHI calculations.
279 Netcare Response PFR by Compass Lexecon, 15 October 2018.
280 See PFR, 5 July 2018, pp. 182.
281 See PFR, 5 July 2018, pp. 185-186.
282 Netcare Presentation at HMI seminar titled "Facilities Concentration and Remedies by Compass Lexecon, 9 April 2019.
283 A more detailed response on the use of the Lavielle method is provided in the PFR, pp.177-178.

80. After adjusting the definition of the product market to focus primarily on the general acute hospital market, thus excluding day hospitals, we arrive at the results set out in Table 4 5, Table 4 6 and Table 4 7 below.

Table 4.5: Comparative fascia results for the respective local markets including day facilities and excluding day facilities, adjusted for network membership (2010-2014)

	Acute and day facilities	Acute facilities only
Proportion of local markets with fascia count =/< 1	14%	16%
Proportion of local markets that are solus hospitals	8%	9%
Proportion of local markets with 1 competitor	6%	7%

Table 4.6: Comparative HHI results (cluster overlaps) for the respective local markets including day facilities and excluding day facilities, adjusted for network membership (2010-2014)

HHI ranges	Acute and day facilities		Acute facilities (excluding day facilities)	
	Number of hospitals	Proportion of hospital groups	Number of hospitals	Proportion of hospital groups
<1500	69	35%	57	32%
1500 - 2499	13	7%	14	8%
2500 - 9999	88	45%	85	47%
10000	25	13%	24	13%
TOTAL	**195**	**100%**	**180**	**100%**
TOTAL 2500-10000	**113**	**58%**	**109**	**60%**

Table 4.7: Comparative LOCI results for the respective local markets including day facilities and excluding day facilities, adjusted for network membership (2010-2014)

LOCI ranges	Acute and day facilities		Acute facilities (excluding day facilities)	
	Number of hospitals	Proportion of hospital groups	Number of hospitals	Proportion of hospital groups
<= 0.1	8	4%	8	4%
>0.1-0,2	17	9%	15	8%
>0,2-0,4	32	16%	33	18%
>0,4-0,6	57	29%	58	32%
>0,6	81	42%	66	37%
TOTAL	**195**	**100%**	**180**	**100%**
TOTAL less 0.6	**114**	**58%**	**114**	**63%**

81. The tables show that the exclusion of day facilities from the analysis resulted in increased concentration levels, in terms of fascia counts, HHIs and LOCIs. The percentage of local markets with HHIs equal to and greater than 2 500 changed from 58% to 60% while the percentage of local markets with LOCI's less than 0.6 changed from 58% to 63%. The effect of excluding all day hospitals is relevant and, as expected, increased overall concentration levels observed. However, the increase is marginal and has no bearing on concentration levels in the facilities market.

We, therefore, reach the same conclusion as in the provisional findings report that the majority of private local facilities markets are highly concentrated. We find that the high market concentration at the national level has an adverse effect on facility/funder tariff negotiations, and that local market concentration influences admissions and expenditure.

Effects of high concentration on facility/funder tariff negotiations

82. Funder/facility negotiations are examined in ***Chapter 7: Bargaining And Tariff Determination***, and the key findings and recommendations are summarised here for convenience.

83. With the hospital groups (including NHN) on the one side and the largest negotiators on the funder side, we consider both markets to be highly concentrated and dominated by a small number of negotiators.

84. We have found size to be an important consideration in funder / facility negotiations, though not the only factor, and there is evidence of smaller funders being able to negotiate effectively with the hospital groups.

85. Where DSP networks have been successfully implemented by funders, they have clearly fostered competition amongst hospital groups which has resulted in lower tariffs. However, we have found this pro-competitive tool to be constrained by two features:

86. While the hospital groups argue that solus facilities account for a relatively small proportion of national admissions and are unlikely to convey material bargaining power to hospital groups during national negotiations, the fact remains that solus hospitals represent instances where funders have no outside options. Regional facility dominance prevents network negotiations from being an option for funders.

87. Hospital groups use the national bargaining dynamic to mitigate regional revenue loss where funders seek to exclude individual groups from a network. As confirmed by funders, there are repercussions for excluding larger facilities from participating in certain schemes or networks.

88. There is evidence of an uptake of ARMs by facility groups, but the market overall continues to be dominated by FFS models. Where there are facility ARMs, these often have no substantial risk transfer, and it is unclear whether funders are receiving value for these contracts. We believe that while not necessarily a market failure per se, the slow uptake of ARMs, and an over-subscription to FFS reimbursement relative to international standards, is a clear indication that the current market structure is not conducive to effective competition or innovation on ARMs.

89. We note that hospitals in the current environment have not been able to influence doctor behaviour which can drive costs and may be a hurdle to greater ARM adoption. However, we also note that hospitals have invested in infrastructure that facilitates doctor-initiated high-cost care.

90. The facility market does not suffer from the same absence of negotiation that characterises the practitioner market. Therefore, when compared to the practitioner market, facility tariffs are formed through a relatively more competitive process. We do not believe that the additional costs associated with the imposition of the multilateral forum will outweigh the benefits, particularly considering the issues raised by stakeholders and the existence of alternative interventions.

Effects of local facilities market concentration on admissions and unexplained expenditure

91. Excessive utilisation and supplier induced demand have been linked in our findings to the availability of beds and doctors per insured population. There is consensus between the Inquiry and the stakeholders that the year-on-year growth of utilisation, what has been identified as excessive utilisation, and supplier induced demand, do exist and are a great concern in terms of costs for the beneficiary and the sustainability of the healthcare system in general.

92. Internationally much of the evidence on excessive utilisation revolves around the role of the doctor. The role of facilities and the effect of competition between facilities on utilisation is underexplored, yet it is obvious that hospitals benefit from supply induced demand, irrespective of whether they actively participate in it or not. Doctors may be the primary decision-makers in determining admissions, but admissions and treatment happen in hospitals. Facilities facilitate and undoubtedly benefit from excessive admissions and treatments.

93. We have considered what, if any, is the role of local competition in explaining excessive utilisation and costs of treatment? The hypo*thesis explored in its PFR was that "Local facilities in competitive markets (low levels of local market concentration in terms of lower HHIs), must invest - possibly overinvest - in bed and ICU capacity, state of the art equipment, rooms, and nurses to induce doctors to admit to their hospitals. Conversely, facilities with no or almost no competing facility in its vicinity (mostly in rural/remote areas) need not*

compete with other hospitals for doctors and need not overinvest in capacity and equipment etc. These rural (and solus) hospitals may in fact have problems finding a range of specialists willing to move to these areas for reasons beyond hospital facilities and thus overinvestment in bed capacity and equipment is not a rational strategy."

94. Our hypothesis is that through competition for the patronage of admitting doctors we expected to find higher levels of costs and admittances per insured population in more competitive areas, compared to areas with lower levels of market concentration. This result would establish a first crude correlation between local market concentration and excessive utilisation, and possibly supplier induced demand. This somewhat counterintuitive finding could be turned around once DSPs become effective, as effective DSPs select local facilities on the basis of cost-efficiencies in the delivery of services. In other words, a finding that admissions and costs are lower (instead of higher) in competitive areas may demonstrate that DSPs in competitive areas have succeeded in redressing some of the inefficiencies involved in competition for doctors at the local level.

95. The tests performed broadly confirmed the hypothesis that locally concentrated markets are showing lower than average admission rates and unexplained costs compared to moderately concentrated and concentrated (solus) markets. The context of where these solus or highly concentrated hospitals are likely to be found must inform any interpretation of this finding. It would also point to a finding that DSPs in South Africa are not yet effective enough to turn this correlation of competition and admissions/unexplained expenditure levels into a more positive outcomes for consumers. The tests were conducted on a subsection of markets (12%).

96. Our study on local market concentration and its effect on admissions and unexplained costs, as published in the provisional findings report, and discussed in the seminars in April 2019, received significant comments from stakeholders.

96.1. It was claimed that the sample size was too small and hence unrepresentative.[284] [285] Netcare argued that the results are sensitive to changes in sample or model specification,[286] while for LHC, a small sample size, which reflects only 12% of the total number of hospitals considered in our concentration analysis, affects the accuracy and reliability of the inferences that can be drawn from the analysis. Mediclinic argued that the results of the analysis are likely to be subject to a high degree of statistical error and hence unlikely to be generalizable.[287] [288]

96.2. Stakeholders argued that our analyses show that moderately concentrated areas, although showing results consistent with the main thesis when compared to concentrated areas, also show higher admissions rates and slightly higher unexplained levels of costs than non-concentrated areas, which is not consistent with our thesis.[289] Further, Netcare and Mediclinic conducted their own analysis on all regions and found no consistent relationship between concentration, admissions and costs.[290] [291]

96.3. Stakeholders criticised the local concentration analysis for not taking the issue of access to facilities in under-serviced or geographically disparate areas into account.[292] It is argued that concentration results should be considered together with a medical scheme population density map to interpret the results more accurately.[293]

97. Our analysis in the PFR of the effects of local market concentration on competitive behaviour, i.e. on competing for doctors locally and the impact on admissions and unexplained costs, has not provided definitive conclusions. The analyses and findings received some relevant criticism from stakeholders. We agree that our findings were based on too small a sample and were not consistent enough to provide solid proof of the argument. Our initial research should have been followed up with a broader analysis on the competitive effects of local market concentration, on the impact on doctors' behaviour, and on the

284 LHC presentation at the seminar organised by HMI, 9 -12 April 2019; Mediclinic presentation at the seminar organised by HMI, 9 -12 April 2019.
285 Netcare post-seminar submission to the HMI titled HMI Seminars: Response Paper on Behalf of Netcare Limited, 26 April 2019.
286 Netcare post-seminar submission to the HMI titled HMI Seminars: Response Paper on Behalf of Netcare Limited, 26 April 2019.
287 LHC presentation at the seminar organised by HMI, 9 -12 April 2019.
288 Mediclinic post-seminar submission to the HMI, 26 April 2019.
289 LHC presentation at the seminar organised by HMI, 9 -12 April 2019.
290 Netcare presentation at the seminar organised by HMI, 9 -12 April 2019.
291 Mediclinic presentation at the seminar organised by HMI, 9 -12 April 2019.
292 Econex and Percept Comments: Health Market Inquiry Provisional Findings and Recommendations Report Prepared for Mediclinic (Pty) Ltd FINAL REPORT; 15 October 2018, p.42.
293 Econex and Percept Comments: Health Market Inquiry Provisional Findings and Recommendations Report,15 October 2018, p.40.

investments of local facilities in bed capacity and admitting doctors. We lacked the time to conduct these analyses.

98. Several indications suggest that local market concentration has had an impact on local competition for doctors, on networks participation, on network prices and on effectiveness in dealing with efficiencies and utilisation. National market power allows facilities to expand local capacity in an inefficient manner. During the April seminars, Discovery Health and Medscheme, for example, stated that in their experience local concentration levels do have an impact on tariff negotiations. Discovery Health supported our view that the concentration in the private hospital market provides a significant strategic advantage to the three large facility groups. Discovery Health also agreed that the high concentration and market power of hospital groups - nationally and locally - has had a significant impact on competitive dynamics, constraining the development of effective DSP's, ARMs and day clinics.[294] Discovery stated that hospital groups have the market power to threaten that the national price for all their hospitals would have to increase if there was a threat that a hospital in their group might be excluded from a local network.[295] Medscheme argued that different discounts for different hospitals from the same group in the same network are being offered depending on local concentration levels in the market and that "Solus hospitals would allow for the lowest discounts".[296] Thus where markets are highly concentrated, discounts that can be achieved through DSP inclusion are relatively lower. We also discuss this in detail in ***Chapter 7: Bargaining And Tariff Determination***, and in the section ***Effects of local facilities market concentration on admissions and unexplained expenditure.***

99. Whilst robust conclusions cannot be drawn from our research, there is quantitative indication, which was confirmed by qualitative evidence from the submissions of key funders, that local concentration affects competitive behaviour and that DSPs and ARMs may currently be ineffective in curtailing inefficient investments in local bed capacity and excessive utilisation. It would advisable for the Competition Commission to invest in further research in this area.

Barriers to entry and growth

100. Our conclusions on barriers to entry are based on several stakeholder submissions as detailed in the PFR.[297] There have been few entrants in the facilities market, particularly in underserved areas. While there has been some entry[298], the market is characterised by limited expansion by existing players and, particularly, limited participation by previously disadvantaged people. The entry that has taken place has not been innovative but largely follows existing models which means that the status quo is not disrupted but the entry simply adds to excess capacity. We discuss barriers to entry in the facilities market in terms of (i) structural barriers, (ii) regulatory barriers, (iii) behavioural barriers, and (iv) other barriers.

101. The main structural barriers include access to capital, as well as land, infrastructure and equipment costs. We found that after obtaining the required licences, potential entrants, particularly previously disadvantaged persons, struggle to obtain financial backing,[299] [300] hence only a fraction of the licence approvals are converted into the actual construction of hospitals. Due to difficulties in accessing capital, some of the licences from the smaller players are sold to the larger facility groups who are better placed to access capital. We have found that while land is expensive in urban areas, it is relatively cheaper in townships and rural areas, but the development of specialised health infrastructure is very expensive across the board, thus raising barriers to entry. [301]

102. The main regulatory barriers in the facilities market include facility licensing and Health Professions Council regulations. We found that the manner in which the relevant regulations are drafted make them more prone to supporting the establishment of general acute facilities, thus limiting the establishment of other facilities such as day facilities.[302] The licensing process does not consider innovation and competition in its assessment and does not set rules that encourage competition against large incumbent groups. The effect is that the licensing process has failed to address current levels of concentration. The large three hospital groups

294 Discovery Health Submission on the PFR of Findings of the Health Market Inquiry of 5 July 2018, 15 October 2018.
295 Discovery Health post-seminar submission to the HMI, 26 April 2019 p.2.
296 Medscheme presentation at the Health Market Inquiry Seminar.
297 See PFR, 5 July 2018, pp. 252-269.
298 See PFR, 5 July 2018, p260.
299 Free State Department of Health, Public Hearing Transcript 18 May 2016, p.15.
300 Limpopo Department of Health, Public Hearing Transcript 18 May 2016, p.193.
301 Mediclinic, Public Hearing Transcript 10 March 2016, p.146.
302 National Hospital Network, Public Hearing Transcript 9 March 2016, p.299.

continue to be granted licenses to open facilities, including day hospitals, which enables them to strengthen their market position. We also find that the issuing of evergreen licences which do not expire until a facility is constructed is problematic. Such licences may continue to 'float' in the market and given the financial difficulties faced by smaller and historically disadvantaged persons (HDPs) entrants, such licences may end up being sold to the larger hospital groups contributing to further concentration in the market.

103. Behavioural barriers in the facilities market in South Africa include (i) the relationship between facility groups and healthcare practitioners, and (ii) the difficulty of gaining recognition as an approved service provider by medical schemes. New entrants and smaller facilities compete with large hospital groups to attract practitioners. We found that in order to be competitive, new entrants and smaller facilities offer incentives to attract and retain admitting doctors but cannot match the incentives offered by large incumbents.[303] [304] [305] Thus, even if new entrants and smaller facilities do provide some incentives, the large incumbents have an edge.

104. We have found other barriers to entry in the facilities market, particularly recognition and reimbursement by medical schemes. Smaller facilities and new entrants are often excluded from designated service provider contracts (or preferred provider networks) set up by medical schemes.[306] [307] [308] This will be discussed in more detail in ***Chapter 5: Competition Analysis For Funders.***

105. We have concluded that entry barriers in the facilities market exist but are not insurmountable. What is of more concern is that the licensing process does not facilitate competition and that there has been limited entry by HDPs. The barriers to entry are particularly skewed against HDPs and innovative modes of care, such as day hospitals, which would challenge the market position of the three large incumbents.

Developments in mergers and acquisitions in the facilities market

106. We are concerned with the history and cumulative effects of mergers and acquisitions in the facilities market. "Creeping mergers" refers to a series of acquisitions over time that individually do not 'substantially prevent or lessen' competition on a case by case basis, but when taken together, have a significant impact on competition.[309]

107. Concentration in the private hospital market has increased substantially over time through a number of transactions by the big three hospital groups (Life, Netcare and Mediclinic), frequently involving the acquisition of smaller hospitals. Between 1995 and 1999, the three groups acquired 125 hospitals.[310] We found that there were several transactions which were not notified as they are classified as small mergers, as well as where idle and un-commissioned licences changed ownership or were sold to incumbent hospital groups. These transactions are not subjected to competition scrutiny, and often only notified to the provincial licensing authorities after the fact. We also noted that the well-intended moratorium by the national department of health on new hospital licences may have fuelled concentration in that market participants used mergers and acquisitions as a way to circumvent licensing restrictions. [311]

108. The extent of consolidation is demonstrated by the fact that the three groups accounted for 51% of acute beds in 1996 but 90% of the market in 2016 based on general acute beds.[312] Several merger transactions continue to be notified implying continued consolidation in the market.

109. Although hospital mergers are often justified by parties as bringing about efficiencies and synergies in the healthcare system,[313] they have resulted in a considerable increase in the concentration levels in the facilities market. We have seen minimal proof of pro-competitive outcomes for the consumer in terms of prices, costs and quality. One of our main concerns with "creeping mergers," is that

303 Lenmed, Meeting Transcript 29 September 2016, p.15.
304 Kiaat, Meeting Transcript 28 September 2016, pp.16-17.
305 Joint Medical Holdings, Meeting Transcript- 22 September 2016, p.2
306 Clinix, Public Hearing Transcript 04 May 2016, p.32.
307 Kiaat, meeting transcript 28 September 2016, pp. 22-23.
308 Lenmed, meeting ttranscript 29 September 2016, pp.3-4.
309 Genna Robb, Creeping Mergers – Should we be concerned? A case study of hospital mergers in South Africa, Centre for Competition Economics University of Johannesburg, 2014, p.1. Accessed on 3 September 209 at http://www.compcom.co.za/wp-content/uploads/2014/09/Creeping-mergers-conference-paper-Final.pdf.
310 PFR…p 193.
311 This was also observed by the Competition Tribunal in the Phodiclinics (Pty) Ltd & Protector Group Medical Services Merger Report, pp.43-44. Case No: 122/LM/Dec05. Accessed from: https://www.comptrib.co.za/assets/Uploads/Case-Documents/122LMDec05.pdf
312 HMI's own dataset developed by compiling information from various sources.
313 This was also observed by the Competition Tribunal in the Phodiclinics (Pty) Ltd & Protector Group Medical Services Merger Report, pp.43-44. Case No: 122/LM/Dec05. Accessed from: https://www.comptrib.co.za/assets/Uploads/Case-Documents/122LMDec05.pdf

they are not controlled for properly in the current merger regime. Cumulatively they may increase concentration in the longer term and adversely affect competition. For example, "creeping mergers" may have a negative effect on the development of the NHN into a fourth major player and DSP partner in the facilities' market. In general, "creeping mergers" may also negatively affect the emergence of new and innovative hospitals and groups. We conclude that "creeping mergers" incrementally undermine competition in the facilities market. Whilst the temporary NHN exemption from section 4 of the Competition Act aims to strengthen competition, "creeping mergers" potentially weaken the NHN and undermine the effectiveness of its exemption.

110. We have concluded that the competition authorities' approach to "creeping mergers" has not addressed the problem of year-on-year increasing concentration in the facilities market. In approving mergers, the authorities have often considered the short-term merits of an individual transaction and taken a static approach to "creeping merger" analyses. As a result the authorities have not always considered the cumulative and long-term effect of such transactions.[314] Further, we note that the application of the inquisitorial powers and the broad discretion that the Competition Tribunal enjoys in conducting its proceedings[315] could be used more robustly to address the trend of "creeping mergers". We acknowledge that the authorities have also been hamstrung in their work by the lack of accurate data on current facility and bed distribution, capacity and, importantly, occupancy rates. The absence of explicit provisions in the Act to deal with "creeping mergers" and reliance on the "substantially preventing or lessening" provision in the law has also hindered the ability of competition authorities to deal with "creeping mergers".

Stakeholder views on "Creeping Mergers"

111. We received several submissions on our findings on "creeping mergers".

112. The stakeholders who disagreed with our findings include the BHF and LHC. The BHF submitted that the consolidation of private hospital groups that we lamented is the result of competition (not its absence) in the fragmented regulatory environment created by provincial licensing of private hospitals and the failure to implement a centralised national need licensing system.[316]

113. LHC argued that the competition authorities already have an effective merger regime in place that subjects all notifiable transactions to a stringent review and includes both an assessment of the competition and public interest aspects of a transaction. [317]

114. The stakeholder submissions which agreed with our findings include Discovery Health, SAMA, Clinix, NHN and the HFA.

115. The NHN submitted that "creeping mergers" largely affect its membership as their members are bought by the large groups. NHN is further concerned with the increased concentration that has taken place since 2014, as a result of transactions that were not notified to the competition authorities for various reasons, including failure to notify by the merging parties and transactions that fall below the notification threshold.[318]

116. The NHN supports the observation that the merger regime is not effective in identifying and assessing dominance in hospital markets and that it is weak in dealing with "creeping mergers".[319] Advanced Health, a member of the NHN and the Day Hospital Association, in particular raised concerns with the Commission's recent approval of the *Mediclinic/ Intercare* merger that took place in 2018, which we address in the ***Mediclinic/Intercare merger*** section below. Discovery Health states that more appropriate measures should be employed by competition authorities to assess the longer-term impact of mergers and acquisitions on competition in the hospital market[320].

117. Stakeholders indicated that the amendments to the Competition Act are a positive step in dealing with market concentration, and the cumulative effects of mergers over time.[321] We expect the recent amendments to the Act to empower the

314 This was also observed by the Competition Tribunal in the Phodiclinics (Pty) Ltd & Protector Group Medical Services Merger Report, Case No: 122/LM/Dec05. Accessed from: https://www.comptrib.co.za/assets/Uploads/Case-Documents/122LMDec05.pdf.
315 See section 52 (1), 55. Also, Competition Commission of South Africa vs. Senwes Limited: Case no: CCT61/11(2012) ZACC 6 in which the Constitutional Court expressly stated that the Act "gives the Tribunal freedom to adopt any form it considers proper for a particular hearing, which may be formal or informal. Most importantly, it also authorises the Tribunal to adopt an inquisitorial approach to a hearing. Confining a hearing to matters raised in a referral would undermine an inquisitorial enquiry." [Paragraph 50 of the Concourt Judgment].
316 Board of Healthcare Funders Submission in response to the PFR, 7 September 2018, p.3.
317 Life Healthcare Group Response to PFR ,15 October 2018, p.31.
318 NHN Response to PFR, 7 September 2018, pp.5-6.
319 NHN Response to PFR, 7 September 2018, p.5.
320 NHN Response to PFR, 7 September 2018, p.14.
321 NHN Response to PFR, 7 September 2018, p.3.

competition authorities to deal more effectively with "creeping mergers"[322]. However, there are still questions about how precisely the new provisions will work as the amendments have not yet come into effect and the Commission is thus still to issue guidelines on the amendments. We propose that when developing guidelines, the Commission take into consideration strategies by large incumbent firms to acquire smaller players as a way to entrench their dominance.

Mediclinic/Intercare merger

118. The Commission unconditionally approved the acquisition of Intercare's day hospitals and sub-acute hospitals by Mediclinic in August 2018 on the basis that the transaction was unlikely to result in a substantial lessening of competition and that there were no public interest concerns likely to arise from the transaction.

119. We believe that the Commission did not properly consider the high market concentration emphasised in our PFR in its assessment. In such a highly concentrated environment, the Commission also seems to have placed less consideration on the rationale provided by the merging parties. We believe that the rationale provided for the proposed merger by the merging parties, such as closer collaboration and better alignment of care could have been achieved without the merger.

120. In addition, the Commission established that factors such as tariff differences between the two types of hospitals would be likely to limit the extent to which the two hospitals could be considered substitutes. However, we noted in our discussion of market definition that there is some demand and supply side substitution between day care and general acute care, in particular between a multi-disciplinary day care facility and a general acute hospital, albeit that it is asymmetrical. The Commission also seems to ignore the overarching strategy pursued by the larger hospital groups of trying to curb the growth of smaller players in day facilities which disrupts the status quo that favours the larger hospital groups. By acquiring day facilities, larger hospital groups seem to be removing competition from innovative, more cost-effective models of care, emerging from the NHN's entry.

121. The Commission also seems to have been swayed in its decision by the limited market share accretion resulting from the merger. It is our view that however small the market share accretion by Mediclinic, it will be increasing its presence in the provision of day care services by eliminating an effective competitor, in a highly concentrated market. We, however, note that there are other mergers such as the Mediclinic/Matlosana merger where competition authorities were more cautious.[323]

Conclusion on "creeping mergers"

122. Most of the mergers and acquisitions in the private hospital market arise from the big three hospital groups acquiring smaller hospitals. These "creeping mergers" are a significant driver of increased concentration levels in the general acute facilities market. We are concerned by this phenomenon.

123. Although there is broad acknowledgement that "creeping mergers" drive consolidation in the facilities market, there is no explicit clause that can be used by the competition authorities to address such mergers at present. While amendments to the Competition Act seek to address the issue of "creeping merger" more effectively[324], it is important to interrogate how these provisions will be applied. We also believe that the Tribunal should use its inquisitorial powers to overcome the current legal shortcomings. In some international jurisdictions, mechanisms have been instituted to address "creeping mergers" either directly or indirectly.[325]

124. Our recommendation to introduce a central licensing system that takes into account concentration and diversity of ownership amongst other things, would go some way to addressing "creeping mergers".

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322 NHN Response to PFR, 7 September 2018, p.3.

323 See Tribunal case number LM124Oct16

324 The proposed amendments, among other issues, seek to ensure evidence-based inquiry into and explicit scrutiny of concentration when mergers are considered. The amendments require disclosure of mergers activity engaged in by the merging parties in the preceding three years. This will ensure that transactions which give rise to creeping concentration are appropriately investigated and considered by the competition authorities. This would be a welcome addition to merger assessment in the private healthcare sector.

325 In some jurisdictions, "creeping mergers" are addressed under competition provisions either directly or indirectly. In Australia, for example, the Competition and Consumer Act 2010 (CCA) was amended with respect to the assessment of mergers and acquisitions to deal directly with "creeping mergers" but later abandoned. The amendments by the CCA subjected mergers or acquisitions to an assessment of whether they are likely to result in a substantial lessening of competition in "any" market, with no requirement that the relevant market be a "substantial" market. The jurisdictions that attempt to address "creeping mergers" include the USA, the EU and the UK. Under the American competition law, each individual transaction is examined by considering whether that particular transaction will give rise to anti-competitive effects; where two or more transactions take place between the same undertakings, within a two-year period, such transactions will be treated as a single transaction. In the UK legislation although transactions need not be examined in isolation, they may be considered in a wider historical context. The EU, in Article 5(2) of the European Community Merger Regulation (ECMR), has passed regulations which allow the Authority in its calculation of turnover thresholds to consider historical transactions in their analysis

LICENSING IN THE FACILITIES MARKET

Introduction

125. The weaknesses in the licensing regime for healthcare facilities and how it affects competition in the private healthcare sector were subjects canvassed extensively during the conduct of the Health Market Inquiry.

126. Most stakeholders raised concerns that the current licensing regime stifles competition and innovation and further heightens barriers to entry and expansion in the market. Concerns were raised about the fragmentated nature of the licensing regulations, with each province applying its own regulations and even where the same regulations apply, execution was inconsistent while there is no alignment with national policy objectives. Importantly, concerns were raised about the lack of a needs-based system of licensing which results in overcapacity and overinvestment in certain areas and under-capacity and under-investment in others.

Observations Relating to Regulatory Failures in Health Facility Licensing

127. Prior to 1993, licensing of facilities was administered centrally by the National Department of Health (NDoH) under Section 44 of the Health Act of 1977. This changed when the interim Constitution (Act 200 of 1993) devolved the licensing process to provincial governments. The decentralised licensing process was retained in the final Constitution.

128. Regulation 158 of the Health Act (63 of 1971) regulates the process of licensing private health facilities. It is used by seven of the nine provincial departments of health, aside from the Western Cape and Free State. The Western Cape uses Section 44 of the old Health Act to enact its own regulations, Regulation 187. The Free State repealed Regulation 158 and has, since 2014, relied on the Provincial Health Act to introduce its own licensing regulations.

129. We find that the use of different regulations by provincial governments creates inconsistencies in the interpretation and application of regulations. Provincial departments follow different approaches and use different criteria to evaluate applications for development or expansions of health facilities. Even for the provincial departments that use Regulation 158, there are variations in the application of the regulation across different provincial departments.

130. Regulation 158 in its current form is not compatible with current market conditions. It is relevant primarily for the establishment of acute based facilities, thus limiting the establishment of novel models of healthcare delivery. Further, while day hospitals may deliver care at a much more cost-efficient level, these efficiency arguments are not considered under the current licensing regime.

131. We further observe that the current licensing framework is not based on current or projected need. There is no national and centralised system of capacity planning to assess market need based on demographics, of epidemiological information. Further, it does not seem that equitable distribution of facilities is embedded in the licensing process, as we observe many underserviced markets, alongside overcapacity in other areas.

132. The reporting and accountability with regard to current market capacity, i.e. facility distribution and occupancy rates, is also weak. There is no central and verified database, either nationally or provincially, of current facilities (including types) and numbers of beds, areas of distribution, and the extent of use by market players. It has been suggested by some stakeholders that there are obligations within the licensing system to report on occupancy rates and that information on facility beds is available from the provincial authorities. However, the provisional authorities when asked, could not provide this information, pointing to the lack of capacity to collect the information and alleged lack of cooperation from stakeholders.

133. There is no requirement that new licences be commissioned and operationalised within a clear timeframe, and no follow-through of issued licences by the licensing authorities, thus creating a sub-market for the sale of licenses which may impact on competition, the objective of broad-based black economic empowerment, and distort market entry and transformation.

134. The rationale behind the issuing of practice numbers and practice types by the Board of Health Funders (BHF) is also not entirely understood, particularly as this information is regarded as proprietary and confidential. We understand that this information is used by the funders for billing purposes and, as such, facilities without this information could be hampered from billing. The process upon which these numbers are allocated is not transparent for potential entrants. We do not believe that this function should be undertaken by market participants,

but that it should rather form part of the licensing process.

135. The actual licensing process is not transparent to the public and to potential new entrants. This lack of transparency was cited as a significant barrier by stakeholders. The reasons for granting and/or denying licenses are allegedly not clearly communicated and explained. Another concern raised was that the regulations are often framed widely which gives the authority too much leeway for discretion, with the effect of affecting consistency in application.

136. Stakeholders also raised concerns about the duration of the licensing process. Several stakeholders stated that applying for a license, whether to develop a new facility or for extensions and amendments, is a long process and can take 2-3 years and in some instances even longer. We note that this lack of clear timeframes in the process, may discourage potential new entrants.

Proposed Regulatory Interventions

137. Regulatory failures relating to facility licensing impacts on competition, entry, innovation and the balanced distribution of capacity across provinces and districts. We therefore propose an overhaul of the current licensing system with specific proposals presented below. These proposals were accepted by the majority of stakeholders during seminars and in submissions, who emphasised that they should be implemented urgently.

Central Licensing System

138. One of the main recommendations with respect to the delivery of healthcare in the PFR was that a standardised, centralised licensing regime should be implemented by provincial departments consistent with the principle of universal health coverage in line with the objectives of the NHI to address inequity in access to healthcare facilities.[326] The proposed Supply Side Regulator of Health (SSRH) should be responsible for developing the central licensing model. The role of the provincial governments should be limited to the implementation of the prescribed licensing model.

139. Crucial elements of an improved licensing framework include, inter alia, assessment and projections of market need per specialty, per means of delivery (inpatient, outpatient, day-care), assessment of competitive impact, and assessment of clinical impact. The issuing of practice numbers and facility type classifications should form part of this process to enable monitoring. This central system should apply to both public and private facilities.

140. The majority of stakeholders, including the Department of Health and provincial authorities, were overwhelmingly in support of a centralised licensing framework, and highlighted the need to urgently address the fragmented nature of the current framework. Some stakeholders however disagreed that the proposed SSRH should be the custodian of the licencing system, and instead argued that it should be allocated centrally at the level of the national Department of Health. In addition, stakeholders emphasised that the framework should incorporate mechanisms to assess current and projected health service needs. However, other stakeholders criticised the proposal to include a needs-based assessment arguing that it is likely to introduce vague and uncertain criteria in the process, and that it should rather be left to the economic judgment of investors. Although recognising the need for an improved and standardised practice code and classification system, some stakeholders criticised our proposal that the process be moved from its current custodian, the BHF, to the proposed SSRH.

141. It appears to us that there is consensus that an urgent review of the licensing regime is critical and that a central licensing framework should be developed. We believe that that the proposed SSRH is ultimately the most suitable body to undertake this process to build independence and accountability. The development of the licensing model must be guided by national policy objectives (including NHI) and co-ordinated by the national department of health.

142. We recognise that the formation of the SSRH is likely to be a long-term process and, therefore, that an interim position should be developed. We propose that the department of health and the provincial authorities urgently use existing provisions of the NHA to establish a working committee led by the National Department of Health. Other members of the working group should include representatives of PDoHs, CMS, OHSC, HPCSA, the Competition Commission, Statistics South Africa (StatsSA), COGTA and independent consultants to serve as members of the working group. The working group should engage meaningfully with private sector

326 The HMI has learnt that a centralised licensing regime was also being considered internally by the NDoH, although we have not established the status of this process.

stakeholders to develop a licensing framework that will be applied. More details on this are provided in the sections ***Motivation for a new Independent SSRH*** and ***Functions of the Supply Side Regulator.***

143. We view a needs assessment framework as a critical pillar of any healthcare system, for purposes of national planning and provision of health services, as is recognised internationally. We are not persuaded that this function should be left to investor markets and believe that it should be embedded in a regulatory process. We note that provinces such as the Western Cape and Free State have recognised the importance of needs assessment, which is precisely one of the motivations for amending their legislation and licensing approach. Therefore, we conclude that the proposed framework should include a clear policy objective of ensuring more equitable and efficient distribution of health facilities, guided by accurate data on population characteristics and needs, and should importantly consider competition and diversity of ownership.

144. We recognise the CMS legal mandate regarding the current practice numbering system. We, however, believe, as highlighted by a number of stakeholders, that the current relationship with the BHF is inefficient and exclusionary. We propose that the task of issuing practice code numbers after facilities have been certified by the OHSC or outsource partner should be managed by the BHF in the interim until the function can be transferred to the SSRH as recommended. More details on this are provided in the section ***Interim Solution for Facility Licensing and Practice Code Numbering.***

Mandatory reporting framework

145. A mandatory reporting framework should be embedded in the regulations so that provinces are compelled to report to the national authority (SSRH) to enable it to exercise effective oversight over the licensing process. Continuation of licence agreements should be dependent on meeting reporting requirements. Facilities should be compelled to provide figures on changes to bed allocation and occupancy rates so that rational planning for any new facilities can take place. There was general stakeholder consensus on this recommendation.

Introduction of innovative models of care

146. We recommend that the licensing regime should give preference to licensing new models of care that have the potential to cut costs and improve quality. The accreditation process should prioritise applicants that demonstrate innovative and cost-effective structures of healthcare delivery with excellent clinical outcomes over and above business-as-usual licensing requests to expand beds and capacity. Preference should also be given to underserviced areas to ensure equitable distribution of health facilities. The majority of stakeholders agreed with this recommendation.

147. To achieve these objectives, we believe that greater coordination is required between regulatory bodies such as the OHSC, CMS and the HPCSA. Importantly, as highlighted by many stakeholders, a review of the HPCSA rules is urgent to enable innovation. The inspection mandate of the OHSC needs to be extended and a clearer process for following through on quality should be identified, coupled with a framework for appropriate sanctions for non-compliance.

Transparency and Accountability

148. All licensing processes and timeframes should be published to increase transparency. Penalties should be imposed for non-compliance with licensing requirements (including non-reporting or inaccurate reporting of changes to bed allocation and occupancy rates). Serious and continuous infringements should lead to revocation of a facility's license.

RELATIONSHIPS BETWEEN FACILITIES AND PRACTITIONERS

Introduction

149. Private healthcare facilities and practitioners are important agents in the delivery of healthcare services. Practitioners and facilities provide complementary services. For instance, general practitioners refer patients for specialised medical treatment and medical specialists admit patients to a facility and provide care in these facilities. Facilities thus rely on referrals from practitioners while medical specialists, in turn, require the infrastructure provided by facilities to provide care. This is described in detail in ***Chapter 5: Competition Analysis For Practitioners.***

150. The relationship between practitioners and facilities is governed by contracts and arrangements which may directly or indirectly affect the incentives of practitioners. The arrangements include:

150.1 facilities granting preferential shareholding to high admitting specialists which may incentivise specialists to increase admissions;

150.2 facilities offering practitioners various rental agreements to attract them to their facilities, including:

150.2.1 discounted rentals relative to the general property market or lower than prevailing office/retail rentals;

150.2.2 exempting newly qualified practitioners from paying rentals for a period while setting up their practice;

150.2.3 exempting group practices running 24-hour emergency services from paying rent until their income reaches a break-even point

150.3 facilities also offer practitioners other forms of incentives, including:

150.3.1 relocation fees to assist practitioners moving from a different area, province or facility group;

150.3.2 furniture and equipment loans allowances;

150.3.3 various hotel services;

150.3.4 retainers or guaranteed income are offered to some types of practitioners, for instance, to emergency room practitioners to provide a 24-hour service;

150.3.5 direct loans, sometimes provided to practitioners to purchase necessary equipment or alternatively, to assist the practitioner to obtain a loan from a third-party supplier by standing surety;

150.3.6 hospitality, including leisure events such as year-end functions, trips, and retirement and farewell gifts; and

150.3.7 scholarships and grants.

151. We assessed whether there are any aspects of the relationship between practitioners and facilities, including incentives, that have an impact on increasing expenditure and/or show evidence of abuse of market power by facilities and/or practitioners.

Findings

152. In the PFR,[327] we presented detailed findings on the relationships between facilities and practitioners in the private healthcare sector which are summarised below. We also explain this in detail in the section ***Adverse Market Outcomes.***

Shareholding mechanisms

153. We have found that large facility groups, at the individual facility level, grant admitting specialists preferential shareholding in facilities and that this negatively impacts the ability of independent facilities to attract practitioners.[328] [329] In order to compete with the larger hospital groups, we found that NHN and other smaller hospitals also offer shareholding to specialists. However, we have found that Independent facilities' shareholding models are different to those of the larger groups and are primarily driven by the need to attract start-up capital to establish facilities. While we were informed that facility shareholding can be bought from the open market, we find that admitting specialists prefer to buy shares where they practice to grow their dividends in these.[330] This practice gives the larger hospital groups a competitive edge relative to NHN and the smaller hospitals. There is anecdotal evidence that admitting specialists get preferential financing in terms of loan servicing rates and repayment rates to buy shares from larger hospital groups. Although we did not explore this alleged phenomenon, it is within the mandate of the HPCSA to institute an investigation to establish the exact shareholding and associated activities of admitting specialists.

Competition between facilities for practitioners

154. We have found that competition between private healthcare facilities is mainly driven by the need to attract specialists, particularly at a local level. Some of the incentives offered to admitting specialists by facilities, for example volume targets, can influence admitting specialists to be more responsive to their own financial interests at the expense of patients' interests. Some of the arguments raised in favour of such incentives is that they may be pro-competitive and promote consumer welfare. For example, favourable rental agreements may encourage more efficient allocation and utilisation of resources. While such agreements may be beneficial, our analysis shows that some of the incentives, for example, those linked to patient volumes and shareholding may not be aligned to patients' interests and may distort competition outcomes.[331] For instance,

327 See PFR, 5 July 2018, pp. 210-218.
328 Clinix. Public Hearing Transcript 4 May 2016, p.28.
329 Kiaat, Meeting Transcript 28 September 2016, pp.16-17.
330 Meeting between HMI and Advanced Health on 20 June 2019 at HMI offices.
331 See PFR, 5 July 2018, p.216.

we have received a complaint that a certain hospital has allegedly been preventing doctor shareholders from working in other hospitals through sanctions that include refusing theatre time or threatening doctors with losing their shares.[332]

155. We have considered inputs received from stakeholders on the effects of competition between facilities to attract specialists. Discovery Health has argued that incentives offered by private hospitals to doctors (as highlighted in the PFR) are inappropriate and may drive expenditure, with a detrimental effect on competition and consumer welfare.[333] In their submissions on our provisional findings, the facilities argue that the shortage of practitioners justify the provision of the incentives.[334] [335] We are not in a position to confirm whether there is an absolute oversupply or undersupply of specialists, as will be explained in the section ***Supply and distribution of Practitioners in the private healthcare market.*** However, both in the situation of over or under supply, the incentives provided by facilities must not affect the volume and intensity of treatments and the overall costs of healthcare.

Exclusionary effects

156. We have found that the arrangements between facilities and practitioners may foreclose potential competition, particularly for new facilities and independent or smaller facilities and historically disadvantaged individuals. New facilities and independent or smaller facilities have raised concerns about their inability to attract specialists to their facilities given the incentives, contracts and technology provided by the three largest facility groups. Historically disadvantaged individuals have also raised concerns about the exclusionary conduct that prevent them from gaining admission privileges at private facilities. We find that clauses in the contracts between facilities and practitioners, particularly those of the large facility groups, may have the potential for exclusionary effects, thereby deterring entry and entrenching incumbents' dominance.[336]

157. We have considered the views of stakeholders on the exclusionary effects of the agreements between facilities and practitioners. The South African Medical Association (SAMA) submits that current practice marginalises previously disadvantaged doctors.[337] Mediclinic argues that there is no evidence that incentives to practitioners lead to over-servicing in order to drive the profits of the facilities.[338] Life Healthcare justifies the incentives provided to practitioners on the need to achieve greater integration to align the parties with respect to the objectives of cost efficiency, clinical quality and patient experience. [339]

158. Our analysis of the contracts and other documents submitted shows that the incentives provided by the facilities to the practitioners may result in practitioners manipulating demand which can result in patients receiving unnecessary care. Contrary to the arguments of LHC, we have also not observed, or been provided with, any empirical evidence of the efficiencies from these facility-practitioner relationships. Further, given the level of information asymmetry, and lack of quality measurement in the private healthcare sector, consumers/patients are poorly positioned to access relevant information concerning the value-for-money (cost and quality) of hospital-doctor alignment. Therefore, our finding remains that some of the incentives provided by facilities to practitioners may result in practitioners manipulating demand which can result in patients receiving unnecessary care and drive market failures.

The role of the HPCSA

159. The HPCSA has the legal mandate to adjudicate complaints about the incentives that practitioners receive. A detailed discussion on the overall role of the HPCSA and the ethical rules is provided in the section ***Regulatory Governance in the practitioner sector***. In this chapter, we discuss our findings on the effects of the HPCSA's role on the relationship between practitioners and facilities.

160. We have found that the HPCSA has never been able to assess the contracts between practitioners and facilities and has no knowledge of the exact nature and structure of the contracts or the impact they may have on practitioners' conduct. We have found that the HPCSA's

332 Day Hospital Association (DHA) Submission to the HMI, 19th April 2018.
333 Discovery Health Submission in response to the PFR, 5 July 2018, 15 October 2018, p.17.
334 Life Healthcare Submission in response to the PFR, 15 October 2018, p.65.
335 Mediclinic Submission in response to the PFR, 15 October 2018, p.2.
336 See PFR, 5 July 2018, p.218.
337 South African Medical Association Submission in response to the PFR,1 October 2018, p.23.
338 Life Healthcare Submission in response to the PFR,15 October 2018, p.65.
339 Mediclinic Submission in response to the PFR,15 October 2018, p.12.

regulatory role is not executed in the interest of consumer welfare but largely in the interests of practitioners. For instance, while the HPCSA has a rule about shareholding and a requirement that doctors have to report such shareholding they do not monitor this practice. The HPCSA is, however, quick to review other interventions such as global fees which may interfere with doctors' financial autonomy. This selective implementation of their mandate can lead to the conclusion that the HPCSA is more interested in protecting professionals than the patients.

161. Stakeholder inputs on the HPCSA's effect on competition in the private healthcare sector are discussed in detail in the section ***Regulatory Governance in the practitioner sector.*** Overall, stakeholders agree with the report that the application of the ethical rules by the HPCSA are to a large extent failing to address the challenges that have been identified in the relationships between practitioners and facility groups.[340] BHF for instance, submits that it is highly unlikely that the HPCSA will be able to review its own rules to the benefit of the patients given its inherent failures.[341] BHF further submits that the application of the prescriptive rules by the HPCSA is, to a large extent, to blame as it fails to address the relationships between the professional providers and the hospital groups[342]. SAMA believes the HPCSA needs to examine the perverse relationships,[343] as they are not aligned with patients' interests.[344]

162. Stakeholders also made inputs on the need to review and amend the HPCSA rules.[345] [346] [347] [348] [349] Discovery Health argued that amending the HPCSA rules to permit private facilities to employ doctors will encourage the development of more transparent and legitimate contracts between hospitals and doctors, to the benefit of competition. It also supports the recommendations regarding the obligation on practitioners and facilities to be transparent regarding the nature of their relationships.[350] WHO also agrees with the amendment of HPCSA rules, especially those relating to provider payment mechanism, multidisciplinary practice and employment of doctors by hospitals[351]. Profmed agrees with the amendment but cautions that any meaningful changes in the HPCSA's rules may inhibit the earning power of healthcare providers.[352]

163. We conclude that there is lack of effective oversight by the HPCSA in the interest of patients. After reviewing inputs from stakeholders on the PFR, our view is that the application of the ethical rules by the HPCSA are, to a large extent, failing to instil competition in the market and hence need to be reviewed and amended in order to ensure consistent implementation.

Utilisation and Supply Induced Demand (SID)

164. We have assessed several contracts and internal documents submitted by different parties and found evidence that some incentives were used to influence clinical utilisation by practitioners. The wording of some of the contracts suggests that the practitioners were encouraged to "make full/ maximum use of the facilities" or ensure that they "treat a minimum proportion" of their patients in the facility. We observe that the contracts between practitioners and facilities set specific volume targets for practitioners; who are urged to use underutilised capacity, with monitoring and penalties for low utilisation. We observe that these provisions are sometimes accompanied with penalties such as "cancellation of the leases", or "the reduction in shareholding" should the regular admissions by medical practitioners plummet.[353] We find that facilities tend to scrutinise practitioners' contributions to their facilities not only on clinical utilisation but also in terms of monetary and financial performance. While facilities argued that this procedure is to ensure that practitioners are using resources efficiently, we find that the basis for measuring practitioner efficiency in clinical utilisation of resources is unclear. There is little evidence that the incentives improve clinical and patient

340 Board of Healthcare Funders Submission in response to the PFR dated 7 September 2018, pp.21-22.
341 Ibid, see p.21.
342 Ibid, see p.22.
343 Our understanding is that perverse relationships in this case refer to financial incentives.
344 South African Medical Association Submission in response to the PFR, 1 October 2018, p.23.
345 Netcare Submission in response to the PFR,15 October 2018, p.144.
346 Discovery Health Submission in response to the PFR, 15 October 2018, p.17.
347 South African Medical Association Submission in response to the PFR,1 October 2018, p.24
348 WHO Submission in response to the PFR, 21 September 2018, see p.6.
349 Profmed Submission in response to the PFR, 1 October 2018, p.9.
350 Discovery Health Submission in response to the PFR,15 October 2018, p.17.
351 WHO Submission in response to the PFR, 21 September 2018, see p.6.
352 Profmed Submission in response to the PFR,1 October 2018, p.9.
353 See the PFR, 5 July 2018, p.216.

outcomes. We also find significant unexplained utilisation suggesting the prevalence of SID.[354]

165. Stakeholders agree with the proposed recommendation that, to the extent that the HMI believes that SID is prevalent in the private healthcare sector and is linked to perverse incentives in the contracts between these two parties, the most direct and efficient action would be for the HPCSA to evaluate the merits of incentives to practitioners by facilities.[355] [356] [357]

Conclusion

166. Overall, after evaluating stakeholder submissions and inputs to the PFR, we believe that our findings on the existence of perverse incentives between facilities and practitioners remain valid. We find that the incentives offered by facilities may result in patients receiving unnecessary care. We also find that the application of the ethical rules by the HPCSA are, to a large extent, failing to address the perverse relationships between practitioners and facility groups, and failing to instil competition in the market and need to be reviewed and amended.

EXPENDITURE ANALYSIS

Introduction

167. Healthcare expenditure has two components: a volume (utilisation) component and a price (tariff) component. Our research shows that the increases in both are above what can be explained by demographic and clinical factors. Increasing utilisation includes increases in admissions, in average length of hospital stay (LoS) and in level of care (LoC) and explains the bulk of the increase in hospital expenditure. While the volume component presents a relatively greater concern than the price component of expenditure, we are also concerned about the latter.[358]

168. In our discussion, we first highlight the volume (utilisation) component and then address the price (tariff) component. We also assess stakeholder submissions where appropriate. Most of the stakeholder comments were addressed in the technical reports drafted by WTW and in the PFR.[359] The technical reports contain detailed analysis designed for a technical audience and address issues raised in the preceding data rooms and submissions.

Findings

169. To assess the factors behind the increasing expenditure in private healthcare, we have analysed the trends in costs and expenditure patterns across hospitals based on detailed claims and membership data,[360] sourced from the medical schemes and their administrators over a five-year period (2010 – 2014).

Trends in in-hospital costs

170. The total in-hospital cost increases reflect the cost increases attributed to CPI and the cost increases above CPI. The former averaged 5.60% between 2010 and 2014. The latter are attributed to explained factors and unexplained factors. The bulk of the cost increase above CPI are attributed to unexplained factors (3.20%) while explained factors account for 2.04%.[361]

171. The majority of the increase in in-hospital costs above CPI, explained and unexplained, is attributable to increases in admission rates (2.17%), followed by length of stay (1.48%) and level of care (0.60%).[362] Below, we present a summary of the trends in admissions, length of stay and level of care.[363]

Trends in admissions

172. The admission rate of day admissions between 2010 and 2014 has increased from 112 per 1 000 lives in 2010 to 121 per 1 000 lives in 2014 while the overnight admissions per 1 000 lives has increased by 2.07% from 137 in 2010 to 149 in 2014. [364]

173. This trend is consistent with the observation, contrary to international trends, that care

354 See the PFR, 5 July 2018, p.217.
355 Netcare Submission in response to the PFR,15 October 2018, p.144.
356 Discovery Health Submission in response to the PFR,15 October 2018, p.17.
357 South African Medical Association Submission in response to the PFR,1 October 2018, p.24.
358 We note that we have only analysed the period 2010-2014 and that, therefore, prevents an assessment of inefficiencies that were included in the base price prior to this period.
359 WTW Expenditure Analysis Report 4, 21 November 2016; WTW report on Analysis of Medical Schemes Claims Data – A Focus on Facilities, 15 December 2017.
360 The data are presented at an individual beneficiary level and contain demographic information about each beneficiary in each year.
361 See the PFR, 5 July 2018, p.227.
362 See the PFR, 5 July 2018, p.228.
363 For more details on these trends, see the PFR (pp.228-232)
364 See the PFR, 5 July 2018, p.228

continues to be provided predominately in acute facilities which generally provide overnight care, and to a lesser extent in day facilities.

174. The admission rates have increased on average by 2.17% per year, of which 1.00% is attributable to the explanatory factors, mainly population ageing, and the remaining 1.17% to unexplained factors.[365] The changes suggest that admission rates are increasing in the medical scheme population beyond that expected using the demographic indicators calculated. This effect is contributing over one third of the total unexplained increase.

Length of stay (LoS)

175. The average length of stay in hospitals increased at an average of 1.48% between 2010 and 2014, of which 0.84% is attributed to explained factors, mainly ageing population (0.56%) and changes in admission profiles, (0.24%) while 0.64% is attributed to unexplained factors.

176. LoS is considered separately for medical and surgical admissions. The analysis shows that the length of stay has increased at a faster rate for surgical admissions (2.89%) than for medical admissions (1%).[366]

177. Although the increases in the average LoS in hospitals seem to be marginal, the cumulative effect on costs and accrued monetary benefits to facilities and practitioners may be significant. There was a significant increase in the total cost per admission from R32 395 in 2012 to R45 233 in 2014,[367] representing a yearly increase of 13.2%, and an overall increase of 39.6% between 2012 and 2014.

178. Longer LoS can indicate care of poor value, inefficient hospital processes or poor quality and co-ordination of care while shorter LoS might reflect improved health outcomes. However, a decrease in LoS that is not accompanied by lower readmission rates does not necessarily yield positive outcomes for patients. Our analysis of overall readmission rates and overnight readmission rates between 2010 and 2014 shows that overall readmissions rates and overnight readmission rates remained broadly unchanged. We also find that the trends of readmission rates do not differ by scheme. We, therefore, conclude that the decreasing levels of LoS over the observation period, were not accompanied by an increase in readmission rates, probably indicating relatively good quality of care. [368]

179. Although the analysis shows that there was a decrease in LoS during the analysis period, the level of LoS per admission in the private healthcare sector remains relatively high, compared to OECD countries.[369] A study comparing South Africa and OECD countries found that the average length of stay for medical services was 3.9 days, in comparison to 5.1 days in OECD countries. For surgical services, the study reported 2.9 days average length of stay compared with 4.4 days in OECD countries. While the differences may reflect, to some extent patient severity, it is remarkable that this trend is across all conditions studied, including deliveries and routine procedures.[370]

Level of care (LoC)

180. The number of admissions where intensive care or high care fees have been claimed has been increasing. LoC has increased on average by 0.60%, of which 0.45% is attributed to explained factors, mainly an ageing population (0.36%) and changes in admissions as determined by the admission type grouping, i.e. case mix (0.15%). 0.15% is attributed to unexplained factors. [371]

181. LoC is also considered separately for medical and surgical admissions. The analysis shows that the level of care has increased at 0.75% and 0.56% for surgical and medical admissions respectively.[372] This observation is consistent with some of the stakeholder submissions that care is increasingly provided at inappropriate levels.[373]

182. We also find a significant increase in ICU or HC beds which was more pronounced between 2004 and 2010. The growth slowed between 2010 and 2014, becoming more pronounced again between 2014 and 2017. The pronounced increase in ICU and HC beds could be explained

365 See the PFR, 5 July 2018, p.230
366 See the PFR, 5 July 2018, p.230
367 Ibid, p.231.
368 Ibid, p.231.
369 Although South Africa is not a member of the OECD, it is a designated key partner of OECD countries.
370 Lorenzoni, L. and T. Roubal (2015), "International Comparison of South African Private Hospitals Price Levels", *OECD Health Working Papers,* No. 85, OECD Publishing, Paris. p.30, Accessed on 3 September 2019, Available at http://dx.doi.org/10.1787/5jrrxrzn24wl-en.
371 See the PFR, 5 July 2018, p.231.
372 See the PFR, 5 July 2018, p.231.
373 See submissions by Discovery, Medscheme, NdoH, 2016.

by the convenience[374] of admitting patience to ICU and HC beds while there are a number of procedures that could be undertaken at primary level in practitioner rooms, or on an ambulatory basis. This is discussed further in ***Chapter 6: Competition Analysis For Practitioners.***

183. In the public hearings, a number of practitioners suggested that the shortages of nursing staff in general wards was contributing to unnecessary ICU and HC admissions to ensure patient safety.[375] This may exacerbate the alleged high nursing costs as staffing ICUs requires more staff per bed and, if appropriately qualified, higher salaries.

184. We find that increased admissions at higher levels of care, therefore, raise cost of healthcare, thereby reducing access to private healthcare at primary levels of care.

Other factors

185. The increases in unexplained costs due to other factors accounts for 38% of the unexplained costs.[376]

186. While we do not have the data to determine the content of this factor, we agree with a number of stakeholders that this could be due to factors associated with medical technology, and with currency changes.

187. There is no systematic data on expenditure on health technology in South Africa. To arrive at a sense of expenditure trends on health technology, we examined expenditure on medical devices, which can be used as a proxy for health technology. Total expenditure on medical devices increased from $1 048 million in 2010 to $1 102 million in 2016,[377] [378] or a compound annual growth rate of 0.84%. Since South Africa's medical device industry is underdeveloped, imports make up a large percentage (90%) of medical technology and devices.[379] South Africa's national (public and private) per capita expenditure on medical devices is comparable to other BRICS countries.[380]

188. We attribute the increase in expenditure on medical devices to the lack of appropriate health technology assessments in South Africa. Although this relationship was not tested directly in our expenditure analysis, the unexplained factors could be attributed to cost of technology. This is explained in the section ***Incentives promoting excess utilisation increasing costs and supply induced demand***. Therefore, the absence of regulations on HTA is a significant regulatory failure.

189. We have received criticisms from stakeholders of our assessments of 'explained' and 'unexplained' portions of expenditure increases.[381] [382] [383] Netcare argues that the increase in utilisation can be explained almost entirely by age and disease profile,[384] and that when using the "narrow" definition for disease burden, more than half of the increase in admissions cannot be explained. However, using the broad disease burden, which most parties consider to be more appropriate, explains more than 90% of the increase in admissions.[385] Relatedly, LHC's argues that the underlying disease burden of the insured population has deteriorated significantly, continues to deteriorate, and drives this utilisation.[386] Mediclinic submits that no rational conclusions can be reached in respect

374 In ICU, patients have frequent nursing care. Patients are also concentrated in one place making it convenient for the doctor to monitor them frequently.
375 Health Market Inquiry Public Hearing Transcript, 10 March 2016, pp.65-66.
376 See the PFR, 5 July 2018, p.232. The remainder of the increase in unexplained costs are attributed to increase in admission rates (37%), increase in length of stay (20%) and increase in levels of care (5%).
377 The South African Medical Device Industry.
378 S. Embassies abroad. 2018. South Africa - Medical Devices. [ONLINE] Available at: https://www.export.gov/article?id=South-Africa-medical.
379 See the PFR, 5 July 2018, p.233
380 Deloitte. "Research to guide the development of strategy for the Medical Devices Sector of South Africa".
381 RBB Economics, titled ***Response to the PHMI's Provisional Findings: Expenditure Analysis, 15 October 2018*** marked Annexure F, and to the report prepared by Cadiant Partners titled HMI's Draft Findings and Recommendations, prepared for Life Healthcare Group, 15 October 2018 marked Annexure G.
382 Mediclinic Submissions to the PFR prepared by Econex and Percept Comments: Health Market Inquiry Provisional Findings and Recommendations Report, 15 October 2018.
383 Netcare presentation at the seminar organised by HMI, 9 -12 April 2019.
384 RBB Economics, titled ***Response to the PHMI's Provisional Findings: Expenditure Analysis, 15 October 2018*** marked Annexure F, and to the report prepared by Cadiant Partners titled HMI's Draft Findings and Recommendations, prepared for Life Healthcare Group, 15 October 2018 marked Annexure G.
385 Mediclinic Submissions to the PFR prepared by Econex and Percept Comments: Health Market Inquiry Provisional Findings and Recommendations Report, 15 October 2018.
386 RBB Economics, titled ***Response to the PHMI's Provisional Findings: Expenditure Analysis, 15 October 2018*** marked Annexure F, and to the report prepared by Cadiant Partners titled HMI's Draft Findings and Recommendations, prepared for Life Healthcare Group, 15 October 2018 marked Annexure G.

of the 'explained' or 'unexplained' portions of expenditure increases as the analysis fails to take account of the input costs faced by hospitals. [387]

190. We do not agree with these criticisms. The increase in utilisation cannot be explained almost entirely by age and disease profile. We compared the broad and narrow approaches and the difference made to our attribution analyses. Our models on expenditure analysis includes age and disease profile, and yet we still have unexplained expenditure. We find that the narrow definition has a systematically higher rate of an unexplained component in relation to utilisation rates but not to cost per admission. On the other hand, the broad definition has a systematically lower unexplained component relating to utilisation, but a similar unexplained component in respect of cost per admission. Our analysis also includes input costs. It is incorrect for Mediclinic to argue that no rational conclusions can be reached in respect of the 'explained' or 'unexplained' portions of expenditure increases as the analysis fail to take account of the input costs faced by hospitals.

Assessing the price component of expenditure

191. As highlighted in the ***Introduction*** section, we have assessed the pricing component of expenditure although it accounts for a relatively lower proportion of the expenditure increase compared to the volume component. We contend that the pricing models adopted after the end of the anticompetitive bargaining period did not correct the base price, and that hospital tariffs remain linked to a collectively negotiated, collusive price. Further, some tariff items (ward and theatre fees) contain historical inefficiencies as explained below.[388] The persistence of fee-for-service (FFS) as a model of pricing and reimbursement further entrenches the inefficiencies in the system.

Analysis of hospital price trends

192. We have assessed hospital price trends across all 38 schemes for which data were available. The analysis shows that the tariff increases appear to be within CPI increases, however, it may be mistaken to assume that tariffs have been increasing within acceptable ranges since we contend that the current prices contain inefficiencies flowing from the previous anticompetitive price determination mechanism. We note that the collusive outcome may not have been above, or much higher than, the competitive price, this is discussed in more detail in the ***Assessing the price component of expenditure*** section below.

193. The larger hospital groups criticise our argument that that the pre-negotiation baseline price was too high. Netcare argues that no empirical evidence is offered to support the claim and that at best it is only circumstantial.[389] LHC contends that the arguments regarding past and present-day anticompetitive price levels are highly flawed, and that we do not provide any evidence to suggest that prices prior to 2004 were substantially above competitive levels. LHC further submits that we fail to provide any kind of counterfactual as a reference for what competitive prices should have been. [390]

194. We disagree. Before 2004, tariffs were determined through collective bargaining, and after 2004, on an inflationary increase. It may be argued that collective bargaining could yield efficient outcomes in the sense that it unifies healthcare tariffs, with both sides exercising bargaining power, thus simplifying tariff-setting in a complicated industry with many players. Notwithstanding this argument, our view remains that collective tariff determination was anti-competitive and that a collusive approach to the tariff setting prior to 2004 implies that the base tariff on which successive inflation adjustments have been affected was based on an inherently anticompetitive process, characterised by collusion between industry stakeholders.[391]

195. The persistent reliance on FFS tariffs, and the lack of meaningful diversion towards ARMs, exposes the inefficiency inherent in the hospital tariffs. The concentrated nature of the hospital market, and lack of effective competition from smaller hospital groups and public hospitals, and the ineffective countervailing constraints from most medical schemes, suggest that this inefficient price is likely to persist, in the absence of any meaningful intervention.

196. We regard the argument that tariff increases are within CPI increases, and, therefore, increasing within acceptable ranges, cautiously. Our concern is that the prices are based on past

387 Mediclinic Submissions to the PFR prepared by Econex and Percept Comments: Health Market Inquiry Provisional Findings and Recommendations Report, 15 October 2018.
388 See the PFR, 5 July 2018, p.235
389 LHC presentation at the seminar organised by HMI, 9 -12 April 2019.
390 LHC Response to the PFR,15 October 2018.
391 For more detail on the history of tariff determination in the facilities sector, see the PFR, pp.235-236.

illegal collusive negotiations, which may explain why participants are happy to maintain price increase at a level equal to CPI.

Conclusion

197. After reviewing stakeholder submissions, we have drawn four conclusions on the volume (utilisation) component and price (tariff) component of private healthcare expenditure.

197.1 The bulk of the increase in healthcare expenditure is due to the increase in admissions which suggests that the increases in healthcare expenditure reflect increasing utilisation over time. This conclusion aligns with stakeholder submissions which largely attribute the increased expenditure to demand side factors, especially increased utilisation. The observed increase in bed capacity further coincides with this excessive utilisation, which may, in part, be due to supplier induced demand (SID). Hospitals profit from this process and can afford not to be too concerned about it.

197.2 Cost trends show a significant difference between the total in-hospital cost increases and the cost increases attributed to CPI. The cost increases above CPI are attributed to explained factors and unexplained factors with the bulk of the cost increase above CPI attributed to unexplained factors. Much of the increase in in-hospital costs above CPI is attributable to increases in admission, length of stay and the level of care.

197.3 The increase in unexplained costs over time is explained by the increase in utilisation, the increase in average length of hospital stay, the increase in the level of care, and other unspecified factors. Most of the increase in unexplained costs is due to increases in other factors followed by increase in admission rates, increase in length of stay and increase in levels of care. The increases in costs are reflective of excessive utilisation over time which in part may be due to SID. Excessive utilisation and SID is discussed in the section ***Supply-induced demand and excessive utilisation in the private facilities of the healthcare sector*** below. This conclusion is also supported by our analysis on concentration which shows that facilities in less concentrated markets face perverse incentives to over-invest and drive utilization.

197.4 Although we find that the increase in expenditure is attributed largely to increased utilisation and, to a lesser extent, to increases in prices, this conclusion may downplay the market power of hospitals. Overall, we observe that healthcare costs are high, and healthcare is becoming increasingly unaffordable. While tariff increases are within headline inflation increases, healthcare is still expensive. We also observe that there are no efforts to achieve tariffs lower than the headline inflation. Our view, therefore, is that consumer harm may be precipitated by systemic features in the healthcare market.

SUPPLY-INDUCED DEMAND AND EXCESSIVE UTILISATION IN THE PRIVATE FACILITIES OF THE HEALTHCARE SECTOR

Introduction

198. We assessed the likelihood that excessive utilisation and supplier induced demand (SID) exist in the private facilities market. We do not necessarily draw a distinction between facilities and practitioners in the analysis of SID and excessive utilisation as both facilities and practitioners are required for SID to occur. We have examined holistically the entire system.

199. We have conducted a qualitative analysis using information submitted by stakeholders including provincial health departments in the Western Cape and in Gauteng. We conducted a comprehensive quantitative study to assess the likelihood that SID might be a significant cause of increased utilisation of healthcare services in private facilities. We present below our findings and assess stakeholder submissions on excessive utilisation and SID.

Findings

200. The quantitative study assesses the likelihood that SID might be a significant cause of the increased utilisation of healthcare services in private facilities and is comprehensively described in Chapter (8) of the PFR. Rates of hospital admission are positively associated with levels of supply of hospital beds, after adjusting for clinical and demographic factors. Where there is a greater proportion of hospital beds to the population, there is higher rate of admissions and greater utilisation. We also find that the supply of ICU beds is significantly positively correlated with ICU admissions, suggesting that excessive utilisation is more likely to be experienced in areas where there is discretion around whether or not to admit a patient. We also find that the supply of practitioners is significantly positively associated with a higher rate of admission in eight to nine out of ten specialties where the level of discretion around admission is exercised. We

have concluded that there is excessive utilisation and SID in the private facilities market.

201. The findings from the quantitative analysis are corroborated by qualitative information submitted by stakeholders including some provincial health departments in the Western Cape and in Gauteng which submitted that there is over-servicing in the private sector.[392] [393] They claim that excessive utilisation is attributed to the over-supply of beds and contributes to cost escalation in the private healthcare sector. We find these sentiments to be aligned to the expenditure analysis conducted by WTW.[394] The expenditure analysis shows that the increases in usage account for the bulk of the increase in hospital costs over time with unexplained factors accounting for the majority of the healthcare cost increases above CPI. We believe that SID may be the cause of the increases in usage and consequently costs.

202. With the exception of the hospital groups, stakeholders have agreed with our argument that overutilization is prevalent in the private healthcare sector. The objections put forward by the hospital groups revolve around two major issues: (i) the ability of hospitals to directly influence demand, and (ii) questions about the technical soundness of our analyses.

203. Stakeholders have differed on the attribution of "fault" whether it is caused by practitioners or hospitals. LHC and Mediclinic for instance, criticise our failure to distinguish between facilities and practitioners in terms of SID.[395] [396] In our view given the complementary role played by facilities and practitioners in the supply of healthcare, it would be remiss not to consider holistically the entire system. In contracts and internal documents submitted by different parties, we find some evidence that the conduct of practitioners may be related to agreements entered into with facilities. For instance, the wording of some of the contracts suggests that facilities set specific volume targets for practitioners. We also find evidence that practitioners are monitored and that there are penalties for low utilisation rates.[397] Here we do not distinguish between facilities and practitioners in the analysis of SID and excessive utilisation as both are required to participate for SID and excessive utilisation to occur.

204. The large hospital groups criticise the technical soundness of our analyses on the basis of an alleged weak relationship between bed supply and utilisation in the specialist specific model, the goodness of fit of the model, and the causality between local concentration and SID.

205. They contend that the analysis reveals only a weak relationship between bed supply and utilisation in the specialist specific model. We argue that they ignore significant relationship found between all admissions (which are predominantly those initiated by specialists in aggregate) and total beds. The reason for the lack of a clear relationship between specific specialists and all beds is that no bed per speciality information was available to conduct a more specific analysis.

206. Concern was raised with the goodness of fit of the models. We contend that the hospital groups have specifically chosen the goodness of fit findings that suit their argument and ignored others. Any statistical model must include all available, valid, relevant data. To follow best practice, it is necessary to investigate a specific hypothesis, rather than building multiple models that "fish" for possible associations. Data "fishing" may well produce associations which are often not scientifically plausible. Plausibility is central to rational conclusions. A statistical model tries to capture characteristics that are associated with a certain observed outcome which in this case is admission to hospital. A very well-fitting model explains all of the variation in observed outcomes; in this case, we would know with 100% certainty whether someone would or would not be admitted to hospital in a given year. Clearly this is not possible. While there are many features that increase risk of hospitalisation, for example, age or chronic disease, the vast majority of hospital admissions remain random. The poor model fit in this instance simply reflects the randomness of hospital admissions. There is a degree of variation that the model will not explain and the more natural variation that exists the more likely it is that there are some variables for which there is no data that, even if included, would explain more of the variation. However, even where the degree of variation that is explained is small it does not follow that the associations found are uncertain. The p-value explains if the association

392 Presentation by NDOH at an HMI Seminar on Discussion between Health Market Inquiry, National Department of Health, Provincial Departments and Relevant Stakeholders on 28 February 2018.
393 Presentation by Western Cape PDoH at an HMI Seminar on Discussion between Health Market Inquiry, National Department of Health, Provincial Departments and Relevant Stakeholders on 28 February 2018.
394 Willis Towers Watson Analysis on behalf of HMI,15 December 2017.
395 Life Healthcare Group Response to PFR 15 October 2018.
396 Mediclinic Submission in response to the PFR,15 October 2018.
397 See the PFR, 5 July 2018, p.216.

that is described in the model could have come about by chance, rather than being a true association. From our data we have presented findings that have a very high probability that the association is true (>99.99%) – principally because our sample size is so large. In summary, the associations found are real irrespective of the goodness of fit.

207. Hospital groups have also raised the question of causality. We do not find any technical deficiencies with our conclusions on causality. Causality is a conclusion that is reached based on a number of criteria including statistical model results. Interventions in healthcare have generally been assessed and accepted on the basis of strong association. These interventions have saved lives (through vaccination) or prevented poor health outcomes (by treating hypertension to prevent stokes). To clarify this point, in randomised controlled trials, often regarded as the gold standard of research, decisions to use a particular drug are based on a finding that the difference between groups (those taking the drug of interest compared to a control group not taking the drug or taking an alternative drug) is larger than the within-group variation.

208. It is further claimed that our findings do not reproduce the findings of Discovery and GEMS, that supported the conclusion of utilisation being related to supply of new hospitals. The study conducted by GEMS shows that following the opening of two new hospitals, Netcare Pholoso and Mediclinic Day Clinic in Polokwane, admission rates in Polokwane increased,[398] suggesting that the increase in supply side capacity (additional hospital beds) contributes to an accelerated increase in the hospital admission rate which may be evidence of SID. The study conducted by Discovery found that once a new hospital becomes operational, it leads to an increase in demand as measured by utilisation[399] in the region where the new hospital is located.[400] As stated at the seminar[401] we could not repeat these findings because we did not have access to those data. However, it is also the case that in science where different analytic techniques result in the same conclusions, this strengthens the common findings of each individual approach.

209. Some hospitals have concluded that the local concertation study does not support the existence of SID.[402] [403] This is an erroneous conclusion. There is no reason to expect that overutilization should be related to local concentration findings, although we tested this association. Facility concentration is a function of the number of hospitals in the respective market while SID is a function of the supply of beds relative to the insured population in the respective market. It is, therefore, practically possible to have an excess supply of beds and consequently SID in highly concentrated markets and vice versa. The lack of relationship between concentration and admissions levels does not rule out overutilization. They do not have to be related and a simple logical argument makes this clear.

210. The issues raised by the stakeholders have not altered our position. We conclude that SID may be one of the causes of increased utilisation of healthcare in the private facilities market. We received encouraging information that in KwaZulu Natal some of the funders have begun to take active steps to manage excessive utilisation.[404] [405]

PROFITABILITY ANALYSES OF LIFE HEALTHCARE, MEDICLINIC AND NETCARE

Approach and Methodology

211. A profitability analysis can provide an indication of the possible exertion of market power or collusion by hospitals. Returns persistently above what can be considered normal for an activity could indicate that competition is not operating effectively and might be indicative of the exertion of market power. As part of the comprehensive analysis of competition, a profitability analysis was conducted on the three largest private healthcare facility groups referred to below as the "relevant firms".

212. We consider a period of ten years from 2006 to 2015 to be appropriate for the profitability analysis. Life Healthcare's profitability analysis has effectively been calculated over a nine-year period since 2005 data were not available.

398 Government Employees Medical Scheme. Submission to the Healthcare Market Inquiry (HMI) on Increases in Hospital Utilisation Submission,10 October 2016.
399 Utilisation is defined as admissions, length of stay (LOS) and case mix.
400 Discovery Health. The financial impact of new private hospitals on medical schemes, 2016.
401 Health Market Inquiry Seminars on Facilities and Funder Concentration and Supplier Induced Demand (9-12 April 2019).
402 LHC presentation at the seminar organised by HMI, 9 -12 April 2019.
403 Netcare post-seminar submission to the HMI titled HMI Seminars: Response Paper on Behalf of Netcare Limited, 26 April 2019.
404 GEMS presentation at the Health Market Inquiry Seminar, 9 -12 April 2019.
405 Discovery Health presentation at the Health Market Inquiry Seminar, 9 -12 April 2019.

213. We adopted the return on capital employed (ROCE) and the truncated internal rate of return (TIRR) methodologies for assessing profitability. The methodologies and definitions were discussed extensively with the relevant parties, prior to the analyses. In estimating an appropriate cost of capital for the relevant parties, the capital asset pricing model was utilised to arrive at an appropriate weighted average cost of capital (WACC) estimation. The profitability of each hospital group was then assessed by comparing the profits earned over the relevant period (ROCE/TIRR) to the weighted average cost of capital (WACC) over that same period. The detailed discussion of these methodologies, and the main discussions that we have held with the relevant firms on details of the proposed methodology, i.e. on asset valuation (land and buildings), on revaluation gains and losses, and on working capital, are presented in the PFR.[406]

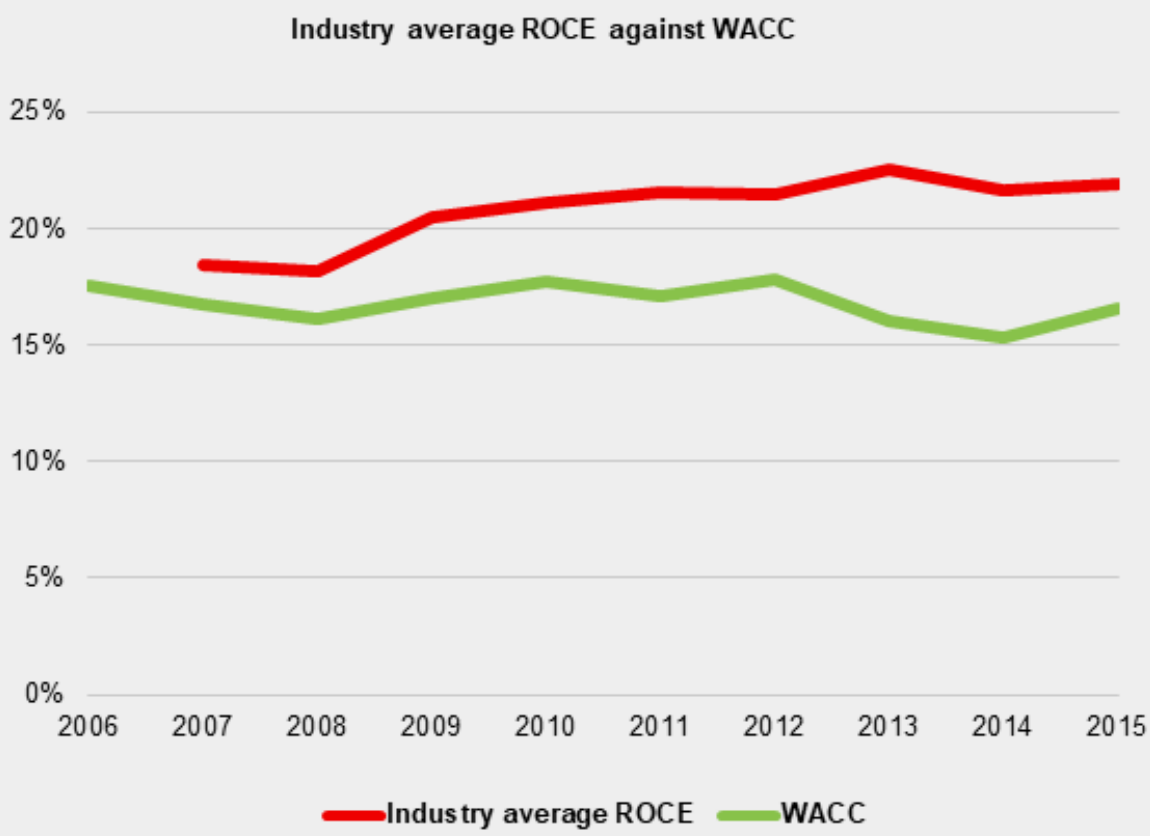
Findings of the profitability analyses

214. Table 4.8 (6.15, 6.16 of the PFR) and Figure 4.5 (6.17 of the PFR) summarize the findings of our profitability analyses. Full reports have been published on our website, and a detailed presentation of results and submissions are set out in the provisional findings report. [407]

Table 4.8: Industry ROCE analysis

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
ROCE (average)	-	18.4%	18.1%	20.5%	21.1%	21.6%	21.5%	22.5%	21.6%	21.9%
WACC (average)	17.5%	16.7%	16.1%	17.0%	17.7%	17.1%	17.8%	16.0%	15.3%	16.6%

Figure 4.5: Average WACC against ROCEs of the relevant firms



406 See the PFR, 5 July 2018, pp. 246-252.
407 See the PFR, 5 July 2018, pp. 246-252.

215. Table 4.9 provides a summary of a ten-year average per the relevant firms' submissions, compared to the WACC, ROCE and TIRR as calculated by the HMI.

Table 4.9: Summary of results (10-year average)

Summary of results						
	Healthcare Facilities			HMI		
	ROCE (Average)	TIRR	WACC (Average)	ROCE (Average)	TIRR	WACC (Average)
LHC	12.6%	-	13.6%	22.0%	20.6%	16.8%
MEDICLINIC	15.2%	-	14.7%	22.5%	20.9%	16.7%
NETCARE	17.4%	18.8%	16.2%	18.5%	19.1%	16.8%
Average	15.1%		14.7%	21.0%	20.2%	16.8%

216. Table 4.10 provides the relevant firms' specific average of the summary findings (WACC, ROCE and TIRR) for the relevant period broken down into two five-year periods.

Table 4 10: TIRR and ROCE analysis

TIRR & ROCE Analysis: Relevant Firms						
	2006 - 2010			2011 - 2015		
	ROCE (Average)	TIRR	WACC (Average)	ROCE (Average)	TIRR	WACC (Average)
LHC	19.2%	13.8%	17.1%	24.2%	30.7%	16.6%
MEDICLINIC	23.5%	19.2%	16.9%	21.5%	23.5%	16.5%
NETCARE	17.2%	18.0%	17.1%	19.8%	20.9%	16.6%

217. As Table 4 10 shows, the relevant firms achieved average ROCEs over the relevant period of 22.5%, for Mediclinic, 22.0%, for Life Healthcare, and 18.5%, for Netcare compared to the benchmark WACC for the same period of 16.7% to 16.8% which amounts to a return on capital employed (profits) between 1.7% and 5.8% above a normal return on capital to be expected in a competitive market.

218. The TIRRs achieved by the relevant firms ranged between 19% and 20.9%, between 2.2% and 4.2% above the WACC. However, the TIRR places more weight on the earlier years of the relevant period while the ROCE places equal weighting on each of the years of the relevant period. The ROCE is, therefore, a more representative indication of the profitability of the relevant firms during the evaluation period.

219. The profitability analyses suggest that the relevant firms consistently show profitable margins over and above the long-term cost of capital. The profits of the three hospital groups do not appear to be excessive when compared to the WACC. The average results of the profitability analyses indicate that the relevant firms are consistently making stable profits.

220. As Table 4 10 shows, when comparing the developments over the second half of the observation period, compared to the first five years, the profits of Mediclinic in terms of ROCE reduced from 23.5% to 21.5%. Compared to the WACC of somewhat below 17%, this nevertheless represents a significant profit margin. A decrease of 2 percentage points, however, is consistent with some competitive pressure. Netcare has relatively stable profitability, with 17.2% ROCE on average over the first five years and 19.8% over the second half. Life Healthcare appears to gain traction over the observation period, with ROCE

of 19.2% on average over the first four years[408] and 24.2% ROCE over the second half. Compared to the average WACC of 16.8% (or 16.6% over the last five years), Life Healthcare's profitability with a ROCE/WACC margin of almost 8% over the most recent years is high.

221. The relevant firms' profitability appears to be just within tolerable levels. Life Healthcare's noteworthy financial success over the most recent years, and Mediclinic's slowing down, may signal some competitive dynamics in the industry.

222. The profitability analyses indicate an industry in which the three largest players have enjoyed a fairly consistent profitable life over a ten-year period. We have not found any indication – in the context of the profitability analyses or otherwise – that these fairly stable profits, despite some tendencies up and down, have been seriously challenged. In our provisional findings report, we observed that there were no signals of challenges to these consistent profits in the foreseeable future. When considering the profitability of the three main groups together, we have concluded that they have been consistently increasing their profits over the observation period, with the last five years seeing the ROCE's levelling off to 21% to 22% on average.

223. High profits may indicate lack of competition is failing but are not, in and of themselves, sufficient proof. The relevant firm may be remunerated for excellent management or innovation in the market. Conversely, normal or low profits are not necessarily proof that competition is working satisfactorily; productive efficiency may be suboptimal, or companies may produce more than necessary to cope with society's needs. Our analysis of supply-induced demand (SID) and expenditure have revealed levels of inefficiency, in particular with respect to the high number of admissions, and the intensity and frequency of treatments. Admission rates increased significantly in the private sector between 2010 and 2014 and were higher than the majority of the OECD countries.[409] The findings of a profitability analysis must be considered in combination with other findings.

Stakeholder Submissions

224. Following the publication of the PFR, we received stakeholder responses on the findings of the profitability analysis.[410] [411] The main responses relate to (i) the extension of the period of analysis, and (ii) the treatment of associate companies. These stakeholder responses and our responses are summarised below. Having taken into account the stakeholder objections, we note that most of the comments that stakeholders continue to raise have been addressed previously, particularly in the PFR.[412] These include the appropriateness of the methodologies proposed and subsequently adopted by the Inquiry, including calculation of revaluation gains and losses and calculating the gross replacement costs of assets.

Extension of the period of analysis

225. LHC has proposed to extend the period of analysis by an additional two years in order to demonstrate a declining trend in returns.[413] Netcare also has considered extending the relevant period by a further two years to demonstrate a decrease in returns in recent years.[414] If the relevant period were to be extended, it should apply to all relevant firms in order to draw any conclusions. We do not think that we can place reliance on the LHC scenario without a significant amount of extra work to consider the accuracy and reasonableness of the figures and assumptions made. Time is, however, lacking to conduct such an analysis.

Treatment of an associate

226. LHC submits that the inclusion of the proceeds from the disposal of its investment in its associate, Joint Medical Holdings, is incorrect as the fair value of the investment in JMH and the earnings from JMH were not included in the period in which this investment was made.[415] While we agree with LHC that in principle JMH should be included, LHC failed to provide the necessary information on JMH for the ROCE and TIRR to be updated, despite our requests. The small investment involved, compared to LHC's other assets, suggests that the analysis and conclusions would not have been significantly impacted.

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408 The Financial Year 2006/07 is presented as year 2007 in Life Healthcare's data.
409 Accessed from https://data.oecd.org/healthcare
410 LHC Response to the HMI's Provisional Findings – Profitability Analysis (Annexure E), prepared by RBB Economics, 15 October 2018.
411 Netcare Response in response to the PFR dated 15 October 2018, prepared by FTI,15 October 2018.
412 See PFR, 5 July 2018, pp. 435-449.
413 LHC Response to the HMI's Provisional Findings – Profitability Analysis (Annexure E), prepared by RBB Economics, 15 October 2018.
414 Netcare Submission in response to the PFR dated 15 October 2018, prepared by FTI, 15 October 2018.
415 LHC Response in response to the PFR dated 15 October 2018– Profitability Analysis (Annexure E), prepared by RBB Economics, 15 October 2018.

Conclusion on profitability analysis

227. Overall, after evaluating stakeholder responses, our findings on the profitability analysis remain valid. We concluded that based on the profitability analysis, the profits of all three hospital groups are not excessive. However, the analyses also show significant unchallenged profits over a longer period across the hospital groups. We have found solid indications, either in the context of the profitability analyses or otherwise, that these fairly stable profits, despite some variations, are being seriously challenged.

228. While the results of the profitability analysis are important, we have situated our conclusions and observations in the context of the wider report and also considered changes in competitive balance such as the effectiveness of DSPs and ARMs and the efficiencies in the delivery of services. We acknowledge the growing importance of DSPs in the recent history of market developments. Although the implementation of DSPs has started to be noticeable, we also note the persistence of overinvestments, regional overcapacity and inefficiency in terms of overutilization and supplier induced demand in the market. These factors have been taken into account when reaching our final conclusions.

Conclusions and Recommendations

229. We have found that the following distortions and failures in the facilities market that impede the competitiveness of the market and negatively affect the access to healthcare of patients.

229.1. The facilities market is highly concentrated at both the national and local level with the three largest hospital groups dominating the market with a consequent significant strategic advantage in bargaining.

229.2. The current licensing fails to address the high levels of concentration in the facilities market. The licensing regime for facilities is not clearly formulated; it is fragmented and poorly enforced. The licensing framework operates without access to basic data such as the number of people in the catchment area, number of beds per speciality and ward type, thereby contributing to oversupply of hospital beds with negative consequences on health utilisation and expenditure. It also hinders strategic licensing of innovative and disruptive models of care that expand access and improve affordability.

229.3. There are indications of overcapacity in the private healthcare sector with negative consequences on health utilisation and expenditure, whilst the public sector is generally overburdened.

229.4. "Creeping mergers" are a significant driver of increased concentration levels in the facilities market. The merger regime is ineffective in dealing with such mergers and in regulating the transfer of licences in the market, thus potentially weakening the bargaining ability of the NHN and independent hospitals and incrementally undermining competition in the facilities market.

229.5. There is lack of effective oversight by the HPCSA with inadequate and inconsistent enforcement of its rules. This weakness has resulted in the maintenance of the status quo in the provision of high-cost healthcare, prevented the formulation of multidisciplinary models of care, and stifled innovation and competition to the detriment of patient welfare.

229.6. There is no standard mechanism for measuring the performance and outcomes of practitioners and facilities. Individual providers do not have the necessary information and data to analyse and compare outcomes of services, whilst patients, practitioners and funders lack information on outcomes of healthcare.

230. We have considered stakeholders' extensive submissions and we propose interlocking interventions to address the specific concerns identified. Below, we briefly summarise our proposed holistic recommendations in relation to the facilities market. The comprehensive recommendations are provided in ***Chapter 9: Recommendations.***

Licensing

231. To deal with the fragmented licensing regime, with the influx of beds not matched by needs, excessive utilisation, and the high market concentration, we propose the implementation of a stricter needs-based centralised licensing system that takes into account competition and market concentration can address the observed concentration levels. This would ensure a coordinated supply of beds based on diversity of ownership, capacity and capacity needs. It would also enhance strategic licensing of innovative and disruptive models of care that expand access and improve affordability.

232. The appropriate regulator(s) particularly the Competition Commission, the SSRH and the PDOHs – develop a set of criteria for assessing local concentration. The assessment framework

should specify the maximum allowable level of concentration of private hospitals at the local level according to local conditions such as available public hospital capacity and insured population capacity and strategic NHI purchasing.

233. We propose a two-phased private facility licensing with the application that does not meet need among other criteria declined at the first stage. At the first stage, a temporary licence, will be issued for no longer than two years. This enhances transparency and accountability on the number of licences floating in the market. It also curbs evergreen licences and curtail arbitrage on existing licences. A permanent licence will only be issued before the expiry of the temporary licence if the applicant satisfies further requirements which include proof of funding, comprehensive project plan with construction timelines and practitioner recruitment plan.

Practice Code Numbering

234. We recommend that in the interim, the CMS should manage the practice code numbering service. In the long term, the PCNS should however be handed over to the SSRH and not be managed by an industry player. More details are provided in the chapter on Recommendations.

Strategic and effective purchasing by the public sector

235. To augment limited public sector capacity in some local markets, we propose strategic purchasing of available private capacity. Strategic purchasing potentially alleviates the pressure on the public system, improves the performance of the health system and contributes to addressing excessive utilisation. The process of strategic purchasing need not wait for the NHI and Government could, and should, already contract with the private sector where it needs capacity.

236. To support strategic public purchasing from private providers within the NHI framework, and vice versa to support inclusion of public hospitals in private funders' provider networks, we propose that practice code numbers must be allocated to both public and private facilities.

Review of the merger regime

237. We propose the prohibition of "creeping mergers" in the facilities market. While the introduction of a central licensing system that takes into account concentration and diversity of ownership would go some way to addressing "creeping mergers", we propose that given the current concentration in the market all transactions including the sale of licences be jointly notified to competition authorities, the SSRH and the PDoHs. The competition authorities should assess the effect of any sale on competition and the public interest. We acknowledge that the amendments to the Competition Act are a positive step in dealing with both the "creeping mergers" and high market concentration in the facilities market. We propose that the Commission should take into consideration strategies by large incumbent firms to acquire smaller disruptive players when developing guidelines to implement the amendments.

HPCSA regulatory oversight

238. To instil effective and efficient regulatory oversight of the private healthcare market, we recommend the establishment of a dedicated healthcare regulatory authority, the Supply Side Regulator for Healthcare (SSRH). The SSRH should independent and transparent with work to set up the SSRH beginning immediately.

Monitoring and Compliance

239. To ensure greater transparency, and more objective benchmarking, regular monitoring by PDoHs, inspection and reporting will be embedded in the licensing framework. This will ensure that minimum standards are met, and a reliable database of supply side services is established. PDOHs should report quarterly to the SSRH on the data and information collected from health establishments. This should culminate to a national database accessible to NDoH and all PDoHs and be available in the public domain. We propose penalties on facilities that do not comply with issued regulations, such penalties to be determined by the SSRH. We further propose revocation of a facility's license for serious and continuous infringements, as determined by the SSRH.

Chapter 5
Competition Analysis For Funders

INTRODUCTION

1. The incomplete regulatory framework has led to several concerning market characteristics which arouse concern. There has been benefit option proliferation, rising costs, reduced access, and very little competition on positive metrics such as innovation, patient outcomes, provider contracting, and premiums. There is a need to move to a more competitive environment within which the status quo is frequently challenged as firms compete to offer consumers better products and value for money.

2. To achieve this goal, we have assessed where impediments have prevented effective competition and provided appropriate recommendations, the chapter is structured as follows:

2.1. The first section of this chapter provides an overview of the industry, ownership structure, and reimbursement models in the funders market.

2.2. The next section discusses how funders are competing on risk selection and on a proliferation of benefit options which are neither standardised nor comparable and how a single, standardised base benefit package will contribute to advancing competition.

2.3. The next three sections deal with the incomplete regulatory framework, discussing the current PMB structure and the extent to which PMBs contribute to increasing healthcare expenditure, the importance of implementing RAM in the market to ensure that competition between medical schemes occurs on factors that benefit consumers, and describes the anti-selection that is occurring in the medical scheme market and its effect on increasing healthcare expenditure.

2.4. This is followed by a discussion on whether the incentives of brokers align with the medical scheme/administrator or with the interests of the consumers and how recommendations may ensure the latter alignment.

2.5. The next section discusses the profitability of the three largest administrators in the market. And,

2.6. The last section examines how medical scheme governance is functioning and proposes recommendations to strengthen incentives to ensure that the board of trustees (BOTs) and principal officers (POs) promote medical scheme members' interests.

Industry structure, ownership structure, and reimbursement models

3. This section discusses the main stakeholders in the funder market: schemes, administrators, managed care organisations, the CMS, and brokers.

4. Schemes are not-for-profit entities that undertake liability for the risk of ill-health in exchange for a premium contribution. Members of schemes can access medical treatment by private providers of healthcare and the cost of treatment is covered by the medical scheme based on scheme rules. Schemes are governed by the MSA. The MSA requires a scheme to be managed by a BOTs and a PO, which should act in the best interest of the scheme. Each scheme is governed by a set of rules which state the duties of the BOTs and PO.

5. Schemes may elect to self-administer the day-to day activities of the scheme or contract these responsibilities to third-party administrators. Unlike schemes, administrators are for-profit entities. The services rendered by administrators include, but are not limited to, membership

management, information and data control, processing of claims, actuarial services, and benefit design.

6. Schemes also utilise managed healthcare services. These services are either performed by independent MCOs or may be provided by the administrator. Managed healthcare services encompass a range of activities from pre-authorisation, financial risk assessment, and management of healthcare through the establishment of clinical management and rules-based programs.

7. Brokers offer an advisory service to individuals providing information on the benefits and services offered by the scheme. Scheme brokers require accreditation in terms of the MSA and must also comply with the FSB and FAIS General Code of Conduct (Board Notice 80 of 2003). Thus, both the FSB and the CMS regulate scheme brokers. Brokers who lose accreditation in terms of the MSA automatically lose their licence in terms of the FAIS Act and *vice versa*.

8. Broker commission is governed by law which sets out the maximum possible remuneration. Independent brokers have contracts with many schemes whereas tied brokers are employed by a particular scheme or group of schemes and market those products only. Individual members do not always choose a broker. For corporates the employer may choose the brokerage service. In open schemes a member may or may not enter the scheme via a broker, but each member is allocated to a broker who can provide advisory services. Broker fees are included in the scheme contribution charged to all members.

9. The CMS is a statutory body established in terms of the MSA to regulate schemes, administrators, MCOs, and brokers in South Africa. The statutory duties of the CMS include protecting the interests of scheme members, overseeing and co-ordinating the running of schemes in a way that is aligned with national health policy, monitoring the solvency and financial soundness of schemes, investigating complaints, resolving disagreements about the affairs of schemes, and making recommendations to the Minister of Health on criteria for the measurement of quality and outcomes of health services.

Medical scheme market

10. There are two types of schemes, open and restricted. Anyone can join an open scheme whereas membership in restricted schemes is limited to a selected group of individuals. Examples of selected groups are the employees of a certain industry or organisation, or members of a professional association or union. We have found that open and restricted schemes primarily compete in separate markets, although some limited competition for the same consumers may occasionally occur. For example, employees may opt to join a spouse's open medical scheme rather than an employer's restricted medical scheme. However, we have concluded that these circumstances are rare and do not materially alter competitive dynamics, and our judgement of these markets as separate.

11. For the purpose of the inquiry, we defined the geographical dimension of the market for scheme products to be national, with the recognition that some schemes may have a predominantly regional presence.

12. In terms of the market structure, since 2000 the scheme market has experienced significant consolidation. The total number of schemes decreased from 163 in 2000 (consisting of 47 open, 97 restricted, and 19 exempted medical schemes) to 81 (consisting of 21 open and 60 restricted) in 2017. In the open scheme market, Discovery Health Medical Scheme (DHMS) has consistently been the largest scheme, with its market share increasing from 35% in 2005 to 56% in 2017. The next largest scheme, Bonitas Medical Fund (Bonitas), had 10% market share in 2005 and 15% in 2017. The remaining 19 medical schemes each have less than 6% of the market. [416]

13. The restricted medical scheme market structure is similar to the open medical scheme market but is comprised of more schemes. In 2017, Government Employees Medical Scheme (GEMS) had a market share of 46% with South African Police Service Medical Scheme (POLMED) being the next largest restricted scheme with 13%. The remaining 58 schemes each have a market share below 6%. For the most part, restricted schemes do not compete for members and will only experience growth if the employer group or industry in which they operate grows.[417]

Administrator market

14. The administrator market consists of third-party administrators as well as self-administered schemes which administer only their own scheme. Administrators and self-administered

416 Council for Medical Schemes Annual Report 2000-2001 and Annual Report 2017-2018.
417 Council for Medical Schemes Annual Report 2017-2018.

schemes perform the same duties such as maintaining membership records, data control, customer service, providing actuarial services to advise medical schemes on claims and financial management, designing the benefit options for schemes, and reporting of information. In addition, mainly for open schemes, they may provide marketing and distribution services. When third-party administrators compete for scheme business, they compete against each other as well as self-administered schemes. Therefore, we have considered third-party administrators and self-administrated schemes to be in the same market.

15. Administrators are not limited geographically to providing services to their scheme clients. Therefore, the geographic market for administration services has been defined as national.

16. The administrator market is highly concentrated. In 2017, the two administrators, Discovery Health (PTY) LTD (Discovery Health) and Medscheme Holdings (PTY) LTD (Medscheme) accounted for 79% of the market (based on GCI), comprising 40% and 39% of the market respectively. MMI Health (PTY) LTD (MMI Health) is the third largest administrator with 5% market share. The 14 self-administered medical schemes collectively account for 10% of the market. The administrator market has experienced significant consolidation between 2005 and 2017 – a trend that is interrelated with consolidation of the market for schemes. For the period 2005 to 2017, the top three administrators (Discovery Health, Medscheme, and MMI Health) combined market share increased from 57% to 84%. [418] [419]

Ownership structure in the funder market

17. In 2017 we reviewed the ownership structure in the funder market. While recognising that there may have been subsequent changes in both the ownership structure and composition of directors since 2017, the concerns identified are likely to have persisted. Any subsequent changes in the ownership structure will not have changed the incentives that may have existed in the market.

18. The ownership structure in the private healthcare market is highly complex. Two holding companies, Remgro and Afrocentric Investment Corporation (Afrocentric), have a number of shareholdings across multiple facets of the private healthcare market.

19. Remgro is an investment holding company that holds assets in a wide range of industries. Remgro owns 28.2% of RMB Holdings Limited (RMBH) and 29.9% of Rand Merchant Investment Holdings Limited (RMIH). RMIH in turn has a 25.5% and 25% share ownership in MMI Holdings and Discovery Limited (DL) respectively. This implies that Remgro has an indirect share ownership of 7% and 7.5% in MMI Holdings and DL respectively. MMI Holdings has interest in three administrators, Metropolitan Health, Momentum and MMI Health. Remgro directly owns 42.0% of Mediclinic, one of the three largest hospital groups in South Africa (Figure 5 1 below).

20. In total, 56.9% of the total scheme beneficiaries under administration are administered by entities (administrators) in which the Remgro corporate group has a stake. The Remgro corporate group has interests in four medical scheme administrators, six MCOs, and four brokerages.

21. AfroCentric has a complex group structure. Its business include Medscheme the healthcare administrator, managed care services, pharmaceutical manufacturing, wholesaling and dispensing, short- and long-term insurance, brokering, and HIV and AIDS disease management (managed care) (Figure 5 2 below).

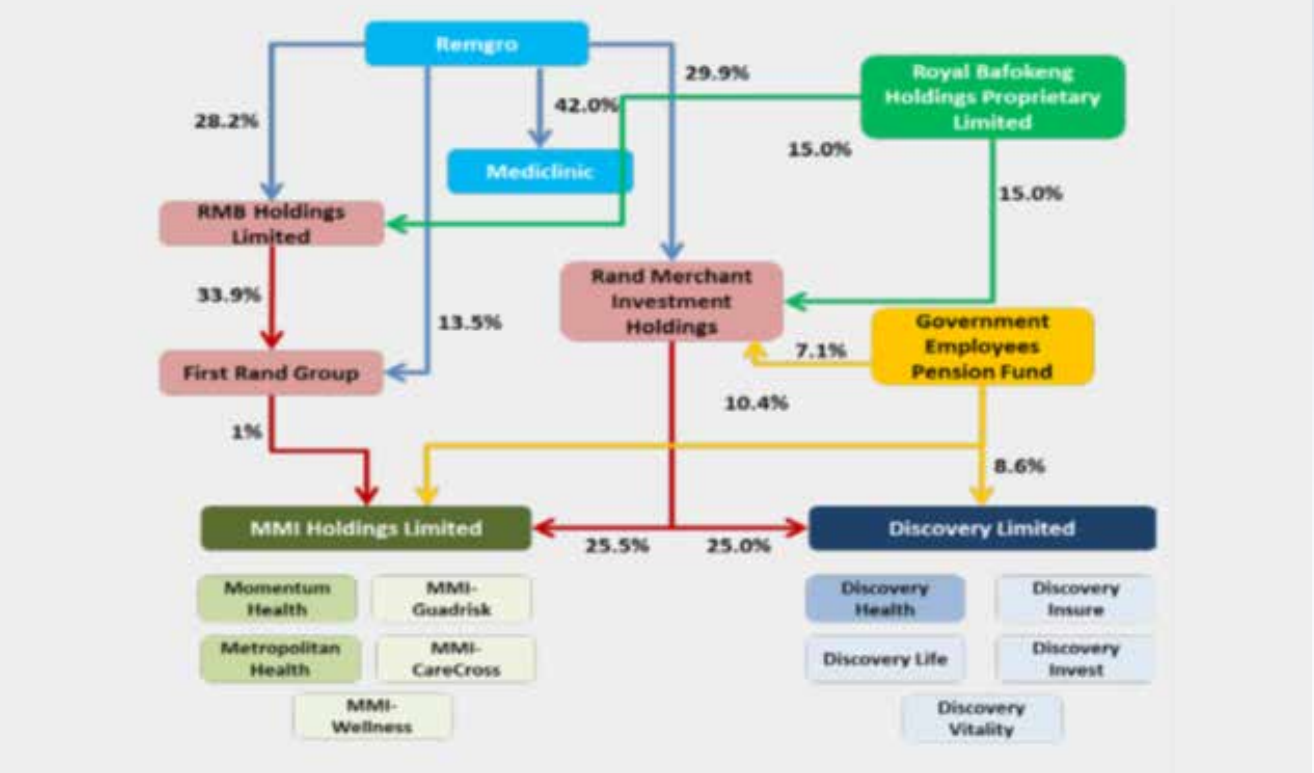
22. Just over twenty two percent (22.6%) of the total scheme beneficiaries under administration are administered by entities in which the Afrocentric corporate group has a stake. AfroCentric controls one administrator, one brokerage and two MCOs. Further, Sanlam, which has a 23.7% share in AfroCentric Health Investments, has a stake in a further two administrators, one MCO and one brokerage.

23. The ownership structures of both Remgro and Afrocentric indicate highly concentrated and complex financial ownership between firms. Common shareholding and cross-directorships may distort or prevent vigorous competition as firms seek not to disadvantage returns to other companies within the group. We are concerned about the conflict of interests which

418 The CMS uses the number of beneficiaries belonging to medical schemes under administration in its calculation of market shares. The CMS includes the GEMS membership for both Medscheme and Metropolitan which means that they are counting the GEMs beneficiaries twice. Our preferred method is to calculate the market shares based on Gross Contribution Income (GCI) which assumes that the fees paid by GEMS to both the administrators are representative of the extent of services and thus allows a way of calculating a more representative market share.

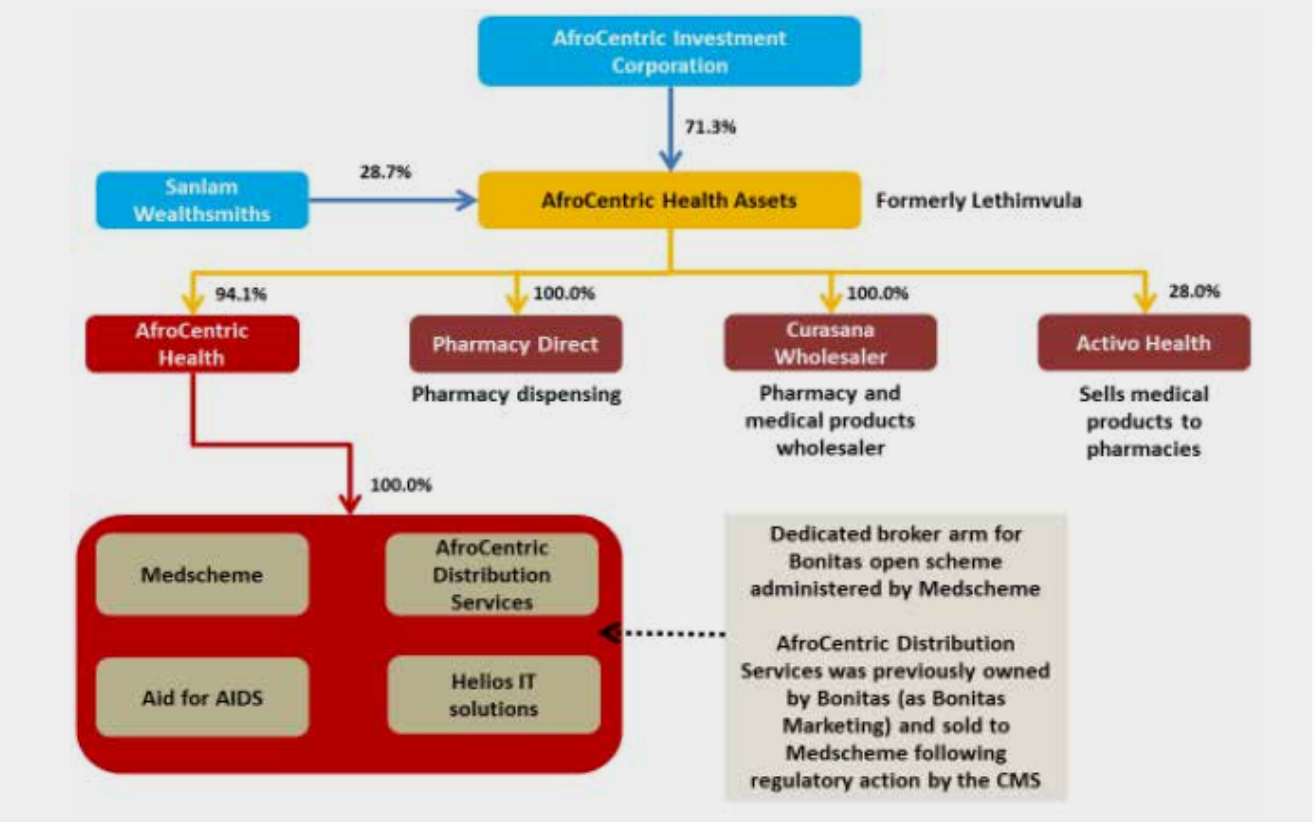
419 Council for Medical Schemes Annual Report 2000-2001 and Annual Report 2017-2018.

Figure 5.1: Remgro shareholding



Source: Compiled from Remgro website and Annual Reports, accurate for 2017.

Figure 5.2: Afrocentric ownership structure[420]



Source: Company Annual Reports, accurate for 2017.

420 The structure is a high-level overview reflecting the main components of relevance to the HMI. Excluded are companies focused on foreign countries or smaller entities.

may arise and the potentially adverse effect that extended cross-directorships may have had on competition.

24. Stakeholders have provided their views on the findings in the PFR on the ownership structure in the funders market. They have argued that the report has presented no evidence to show that shared ownership has resulted in harmful conduct that damages competition or is otherwise to the detriment of the consumer. Reference is made to the Companies Act, which requires directors to act in an ethical manner and sets out the standards of conduct for directors.[421] [422] [423] [424]

25. However, we maintain our position that the structure of cross holdings may have the potential to undermine competitive outcomes. A market inquiry demands consideration of the general nature of the market and the incentives that operate in it. The incentives may have been different if an administrator was accountable only to the scheme that it administers rather than to its holding company's shareholders that have interests on the supply-side of the market. We believe that the healthcare market will benefit from a structure that precludes the possibly of this kind of potential conflict of interest.

Reimbursement models

26. The FFS reimbursement model is currently the predominant payment mechanism for healthcare in South Africa. Under FFS practitioners are remunerated for each (element of) treatment, irrespective of outcomes. This creates an incentive for providers to over-service patients, to over-invest in generously remunerated services, and under-invest in poorly remunerated services. This behaviour may result in underinvestment in services which may be cheap and have a positive impact on patient outcomes. With FFS, the risk of escalating costs remains with the funder as each additional cost (e.g. volume, utilisation, length of stay, complexity of treatment, technology used, consumables, etc.) is billed to the funder. In response to escalating costs, funders may deny care, require pre-authorisation to limit exposure for new or expensive treatments, or simply pass on any additional costs to consumers.

27. In terms of negotiating these FFS tariffs – after the prohibition of collective tariff negotiations in 2004/05 - the CMS published a reference price schedule, the NHRPL. Thereafter the NDOH adopted a similar approach as the CMS, publishing the RPL. Since 2006 no new NHRPL or RPL has been published. In the current tariff vacuum, schemes and administrators set reimbursement fees and practitioners either accept these tariffs or charge a multiple thereof. Any shortfall in payment results in customers being liable for the balance, subject to it being disclosed in full to patients prior to care.

28. There is information asymmetry in the market with funders having access to transaction/claims data from all providers, while providers have clinical information and claims information but only for themselves. This does not lend itself to fair negotiations and may be a contributor to the reduced uptake of risk transfer arrangements.

29. Our recommendations on tariff determination are set out in detail in Chapter 7: Bargaining and Tariff Determination, but for convenience the key findings relating to funders are summarised here. To address the practitioner tariff vacuum, we recommend a multilateral tariff negotiation forum overseen by the SSRH. The SSRH will create a framework that sets out the negotiation process and will also facilitate the negotiations between the funders and practitioners (including pathologists and radiologists). The negotiation process will result in the setting of a national maximum FFS tariff for PMB conditions and a reference tariff for non-PMB conditions. In addition, to remove the information asymmetry currently present in the negotiations, we recommend that the parties share the data that will be used to inform their position in the multilateral tariff forum.

30. Importantly, this procedure is distinct from the collective negotiations that the Competition Commission prohibited as it is facilitated under a regulatory body which has a mandate to safeguard against collusive behaviour among competitors, foreclosure of new entrants, and to set terms of reference which includes consumer welfare objectives.

31. We propose bilateral negotiations to encourage the development of innovative ARMs. ARMs can take several forms, each associated with a different degree of risk-transfer from the funder to the service provider and can also incorporate outcomes measures. ARMs align the incentives of the two negotiating parties and are beneficial to both, funders receive a degree of certainty

421 Discovery Health submission in response to the PFR dated 15 October 2018, p.7.
422 Mediclinic's submission in response to the PFR dated 15 October 2018, Annexure B, p.1-2.
423 MMI submission in response to the PFR dated 01 October 2018, p.1.
424 Medscheme submission in response to the PFR dated September 2018, p.9.

in costs and providers are remunerated for accepting risk. For example, when the risk of additional costs is shifted to the provider this removes the incentive for the provider to over-service. We recommend that the FFS tariffs determined during the multilateral negotiation forum can vary in subsequent bilateral negotiations provided those negotiations result in value-based contracts. These agreements must be submitted to the CMS and SSRH for approval.

32. We have concluded that there is less of a tariff vacuum in terms of funder and facility negotiations and recommend that the current bilateral negotiations continue. However, to push the market towards greater transparency and greater adoption of ARMs, we recommend that these agreements are submitted to the CMS and SSRH for approval. These regulatory bodies will have the responsibility to ensure that, after a period of three years, all facility agreements focus exclusively on ARM contracting.

STANDARDISED BASE BENEFIT OPTION

Introduction

33. Consumers wishing to purchase medical cover, face a daunting task of selecting from 21 open schemes and 181 benefit options[425] that are neither standardised nor comparable.[426] In addition, benefit options have a variety of features such as savings plans, co-payments, deductibles, exclusions, formularies, and networks which all contribute to the complexities of benefit options.

34. A consequence of too many incomparable options is that consumers are generally unable to make informed comparisons when selecting a benefit option. This removes the ability of consumers to discipline schemes by switching to a scheme that offers a better product. Therefore, schemes are not incentivised to compete on factors that benefit members.

35. This situation is exacerbated by the incomplete regulatory framework (see the section ***Risk Adjustment Mechanism and Income Cross-subsidisation***), lack of incentives for the BOTs and POs of schemes (see the section ***Medical Scheme Governance***), and the lack of consistent and comparable outcomes measurements (see ***Chapter 8: Healthcare Data, Quality and Outcomes)***. While this section looks at how a standardised benefit option may contribute to a market structure which fosters pro-consumer competition, it, like many other recommendations, should be read in conjunction with the entire body of recommendations of the report.

Findings on standardised base benefit option

36. We have concluded that the lack of uniformity when classifying benefit options across the industry creates confusion for members, since the CMS, health actuaries, brokers and administrators all have distinct and varied ways of classifying benefit options. Consumers agree that the process of selecting a benefit option and the information available from schemes is complicated. Consumers receive a substantial amount of information, often described in terminology that is not easily understandable. [427]

37. Stakeholders share our concern that members are confused by multiple benefit options and lack of comparability.[428] [429] From a consumer welfare perspective we acknowledge that there may be advantages and disadvantages arising from product differentiation. On the one hand, it allows adminstrators/schemes to better serve the large variety of consumer needs through differentiated offerings. On the other hand, too large a selection of diferentiated products could render consumers powerless as they are unable to make effective or informed choices.[430]

38. We understand how product differentiation has arisen in response to the incomplete regulatory framework. However, product differentiation also serves as an oligopolistic market strategy to avoid direct price competition – especially where products (or services) cannot be compared easily and meaningfully. The inability of individuals to effectively compare options means schemes have limited incentives to contract effectively or innovatively with providers.

39. The lack of transparency on what providers charge reduces the ability of scheme members to monitor prices and quality. Further, the lack

425 Council for Medical Schemes Annual Report 2016-2017, p.109. This figure includes Efficiency Discount Options.
426 If consumers join medical schemes through their employers, this is reduced as the benefit options are limited to the employer selected medical scheme options.
427 Health Market Inquiry 'Summary of Results from the Healthcare Consumer Survey dated 18 November 2016, p.8.
428 Health Funders Association submission in response to the PFR dated 07 September 2018, p.3.
429 Actuarial Society of South Africa's submission in response to the PFR dated 10 October 2018, p.3.
430 While typically more choice increases consumer welfare, there exists a well-known paradox of choice wherein past a certain threshold (depending on the product and consumer) too much choice can result in lower levels of consumer welfare.

of transparency means members only become aware of the details of the product that they purchased (i.e. the particular medical scheme and benefit option) when they try to claim from the medical scheme. Typically, this situation occurs when their claim is partially paid or not paid at all.

40. An additional concern regarding benefit options, is that the MSA requires that each benefit option must be self-sustaining such that the gross contribution income generated from each option should be sufficient to cover members claims in that benefit option. However, in practice, this does not occur as risk pooling occurs at a scheme level. In many cases, schemes create both risk and income cross-subsidies. Furthermore, the CMS has been unable to enforce risk pooling at an option level.

41. We have concluded that the current benefit option environment is characterised by a lack of transparency, unnecessary complexity, and benefit options that are not self-sustaining. Not only do members not fully understand the product they are purchasing but they are unable to easily compare options within or across medical schemes. These conditions are not suitable for effective competition. Instead, the regulatory environment has meant that funders are incentivised to use benefit option design to compete on risk and proxy risk-rate beneficiaries, ostensibly under the guise of catering for diverse consumer needs.

Review of PFR Recommendations

42. We strongly believe that the introduction of a comprehensive standardised base benefit option will increase transparency, allow consumers to readily compare options, and, along with a risk-adjustment mechanism, foster a greater degree of competition on metrics such as innovation and quality of care.

43. To achieve these goals, we made the following recommendations in the PFR:

43.1. there should be one standardised benefit package that must be offered by all schemes (the obligatory 'base benefit option');

43.2. every person joining a scheme must purchase the base option;

43.3. the base option would cover catastrophic expenditure as well as some level of out-of-hospital and primary care;

43.4. schemes can offer supplementary benefit packages, but these can only be sold to those who have bought the base benefit option;

43.5. risk rating will be allowed on supplementary benefit packages (SBPs) provided that base cover is comprehensive;[431]

43.6. supplementary benefit packages should be easily comparable across schemes, conforming to rules set by the CMS as the appropriate regulatory body.

44. Stakeholders have suggested that the introduction of a base benefit package should be preceded by the establishment of a tariff setting mechanism.[432] [433] [434] While preferable, we do not believe that this should be a pre-requisite to the establishment and offering of the standardised benefit package. Determining the structure of the package, including which services will be covered, will take some time during which the interim tariff determination solution may provide certainty.[435]

45. Given that the CMS has already begun to work on a standard benefit option, the type of services to be included in the standardised benefit package is to be left to the CMS with the provision that it will cover for catastrophic expenditure and must include provisions for primary and preventative care as well as in-hospital and out-of-hospital care. Also, a specific list of items (medicines and devises) that must always be covered where there is an appropriate diagnosis must be included. A list of diseases together with appropriate treatments must be provided.

46. This must be coupled with a negative list of those conditions not covered by the package.

47. Where the treatment of conditions is prescribed, these will be considered the minimum requirements schemes must provide to members. This will create scope for schemes to compete to offer better quality treatment. However, where schemes seek to expand coverage of conditions not covered by the base benefit option, this must be achieved through the supplementary packages. This is to avoid a situation where multiple schemes expand coverage on the base

431 This caution is required as the base cover is yet to be defined.
432 BCIMA submission in response to the PFR dated 07 September 2018, p. 5.
433 GEMAS submission in response to the PFR dated 07 September 2018, p.3.
434 Massmart submission in response to the PFR dated 07 September 2018, p. 2.
435 See ***Chapter 7: Bargaining and Tariff Determination*** for more details.

option to varying degrees and the market once again becomes incomparable.

48. The base benefit package must be reviewed by the CMS every two years. This will ensure that additional conditions and treatments are slowly added, and coverage is uniformly expanded as and when efficiency makes additional care affordable and as technology advances.

49. The introduction of the base package must be accompanied by a system of risk adjustment,[436] which will remove schemes' incentives to compete on risk factors such as age and will instead encourage schemes to compete on value for money and innovative models of care.

50. Some stakeholders have submitted that this recommendation may benefit from having multiple packages targeting different groups or a low-cost option to increase affordability and therefore coverage.[437] [438] We have concluded that there should only be one base package offered by schemes as this is the most procompetitive approach. It also is in line with the principles envisioned by the NHI and social solidarity that ensures comprehensive quality healthcare services are available to all members irrespective of their income status.

51. In terms of innovation, we have concluded that the standardised option will enable a greater degree of competition as consumers will be able effectively to compare options and thereby discipline or reward innovative initiatives. This competition will drive funders to innovate upstream in how services are provided and contracted for, rather than the current environment where innovation is limited to complex benefit design.

52. A concern was raised that a 'one-size fits all' approach may not be appropriate to cover the variety of consumer needs.[439] We believe that should consumers have a demand not met by the base benefit option, funders would be free to innovate through the supplementary cover that is offered. To facilitate this innovation, we recommend that the SBPs can be customised for the regional population in terms of size and disease burden. This will allow innovative models to start small and, if successful, be rolled out to cover more regions and members.

53. The standardised benefit option along with supplementary cover will remove the need for gap cover. Members will receive comprehensive care with the standardised option and the supplementary cover will cater for additional needs.

54. Given that the report envisages regional supplementary options and does not wish to limit the potential for innovation, no limit is proposed to the number of supplementary options offered by funders. However, while funders should have flexibility in designing supplementary cover, we recommend that the CMS provides a high-level framework for presenting the supplementary benefits to ensure members can easily understand what they are purchasing.[440] [441]

55. In additional to regional supplementary cover, we also recommend the entry of regional based medical schemes. Most stakeholders do not support this recommendation as it is not clear on how it will encourage competition. Stakeholders are also concerned that it may lead to fragmentation of risk pools and conflicts with the CMS agenda of consolidating the medical scheme market.[442] [443] However, we consider regionally based medical schemes to have the potential to introduce innovative healthcare measures in the market. These small schemes can take into account regional variations in population, disease burden, and delivery of care models, and potentially offer the standardised benefit option based on alternative reimbursement contracts with local providers to address their unique demographic and risk profiles. The small geographical size of regionally based schemes will allow regular interactions with members to gain a better understanding of concerns, issues and needs.

56. Regionally based entrants would initially only have a few members exposing the scheme to demographic and claims risk. To mitigate this risk, we propose reinsurance for small new entrants. Stakeholders are not in support of this recommendation as these agreements were

436 See section ***Risk Adjustment Mechanism and Income Cross-subsidisation.***
437 Discovery Health Workshop 2: Funders' market concentration and countervailing power dated 10th April 2019, slide 12.
438 Life Healthcare Group submission in response to the PFR dated 15 October 2018, p.19.
439 GEMAS submission in response to the PFR dated 01 October 2018, p. 2.
440 BCIMA submission in response to the PFR dated 07 September 2018, p.5.
441 GEMS submission in response to the PFR dated 07 September 2018, p.8.
442 CompCare submission in response to the PFR dated 07 September 2018, p.3.
443 Discovery Health submission in response to the PFR dated 15 October 2018, p.31.

severely abused in the past and used to remove reserves from medical schemes.[444] Stakeholders are also of the view that reinsurance should not only be available for new entrants, but also existing medical schemes.[445] [446]

57. We reaffirm our position that, provided the base package is comprehensive, supplementary cover should be risk-rated. While a stakeholder indicated a concern that risk-rating will undermine the principle of social solidarity,[447] the HMI believes that this will not be the case where the base option is comprehensive enough to relegate supplementary cover to an optional extra.

PRESCRIBED MINIMUM BENEFIT PACKAGE

Introduction

58. PMBs are a set of defined benefits to ensure that all scheme members have cover for certain conditions. The list of PMB was introducted in January 2000 and currently contains 270 acute conditions described as DTPs such as certain types of cancer and meningitis as well as 25 chronic conditions such as diabetes and asthma.

59. Since the introduction of PMBs there have been a number of developments including:

59.1. inclusion of all emergency medical conditions in the definition of PMBs (January 2003);

59.2. the introduction of diagnosis, treatment and medicine according to therapeutic algorithms for the 25 defined chronic conditions on the CDL (January 2004);

59.3. publication of a PMB code of conduct in response to compliance issues described in CMS circular 45 of 2010; and

59.4. a PMB definition project as described in the CMS circular 45 of 2010.

60. PMBs are governed by Regulation 8 of the MSA[448] which requires medical schemes to pay in full for any services/treatment associated with acute or chronic condition on the PMB list, as long as services are procured in line with the treatment protocols and are from a DSP.[449] By law, the source of payment must be derived from the medical schemes' risk pool as opposed to members' medical savings accounts.

Methodological concerns

61. Our analysis used the consumer survey, desktop review, stakeholder inputs, and PMB diagnosis treatment claims data to assess the impact of prescibed minimum benefits in the private healthcare sector.

62. Submissions to the PFR argued, that analyses which rely on the PMB ICD10 coded list to identify PMB claims do not provide a perfect picture of the impact of PMBs on expenditure. This is because PMBs are defined as diagnosis-treatment pairs so each diagnosis must be associated with a specific treatment to qualify as a PMB. Further claims data for some provider groups does not provide detailed diagnosis information (ICD10 codes) for various reasons.

63. While recognising these limitations, given the inherent lack of clarity in the PMB definitions and the major problems in seeking to code the diagnosis treatment pairs, the approach adopted was the only practical one available.

64. Further, the analyses are repeated using the PMB indicator which was provided to the inquiry by the schemes themselves through their administrators. We note that the data specification in our understanding asked schemes to indicate claims paid as PMBs by their systems. However, the Health Funders Association (HFA) submission indicates a different understanding. It would appear from the data that schemes used different definitions to provide these flags which rendered the PMB flags trend analyses unstable.

65. Based on the methodological issues raised above stakeholders argued that:

65.1. the conclusions drawn relating to lower compliance on out-of-hospital PMBs with payment from savings is incorrect [450] ; and

65.2. the level of PMB expenditure noted by the HMI is inaccurate.

444 CMS submission in response to the PFR dated 07 September 2018, p.74.
445 CompCare submission in response to the PFR dated 07 September 2018, p.3.
446 Discovery Health submission in response to the PFR dated 15 October 2018, p.31.
447 Life Healthcare Group submission in response to PFR dated 15 October 2018, p.19.
448 The Minister of Health gazetted on 26 June 2015, the intention to amend the Medical Scheme Regulations. Proposed amendments directly affecting Regulation 8 regarding PMBs may affect the requirement to pay PMBs in full.
449 Regulation 8(2)(a) of the MSA.
450 DHMS submission in response to the PFR dated 15 October 2018, p. 32.

66. Despite these objections, we are of the view that the approach taken was consistent and logical and offered broad indications of the relative contribution of PMBs to cost drivers.

Findings on PMBs

67. We have concluded that PMBs are an essential component of universal health coverage and the most successful mechanism to prevent catastrophic health expenditure. However, the private healthcare market is characterised by conditions which are not conducive to an effective PMB environment namely:

67.1. the requirement to pay PMB's in full and the absence of tariff setting regulation for health practitioners, where bilateral negotiations are not feasible (between funders and health practitioners);

67.2. the absence of standardised coding;

67.3. the predominance of fee for service reimbursement;

67.4. the absence of supporting regulation, in particular a RAM;

67.5. while schemes can (and do) set up DSP arrangements with providers, they often struggle to secure specialists treating PMB conditions to join the schemes, and focus on price rather than value based contracts with network providers;

67.6. members lack clarity about the type of cover to which they are entitled once they are diagnosed with a PMB condition, and about the treatment protocols that the providers should follow to ensure that the scheme pays the PMBs in full;

67.7. providers have difficulty adapting the treatment offered to comply with the benefit relevant to their patients' scheme and option;

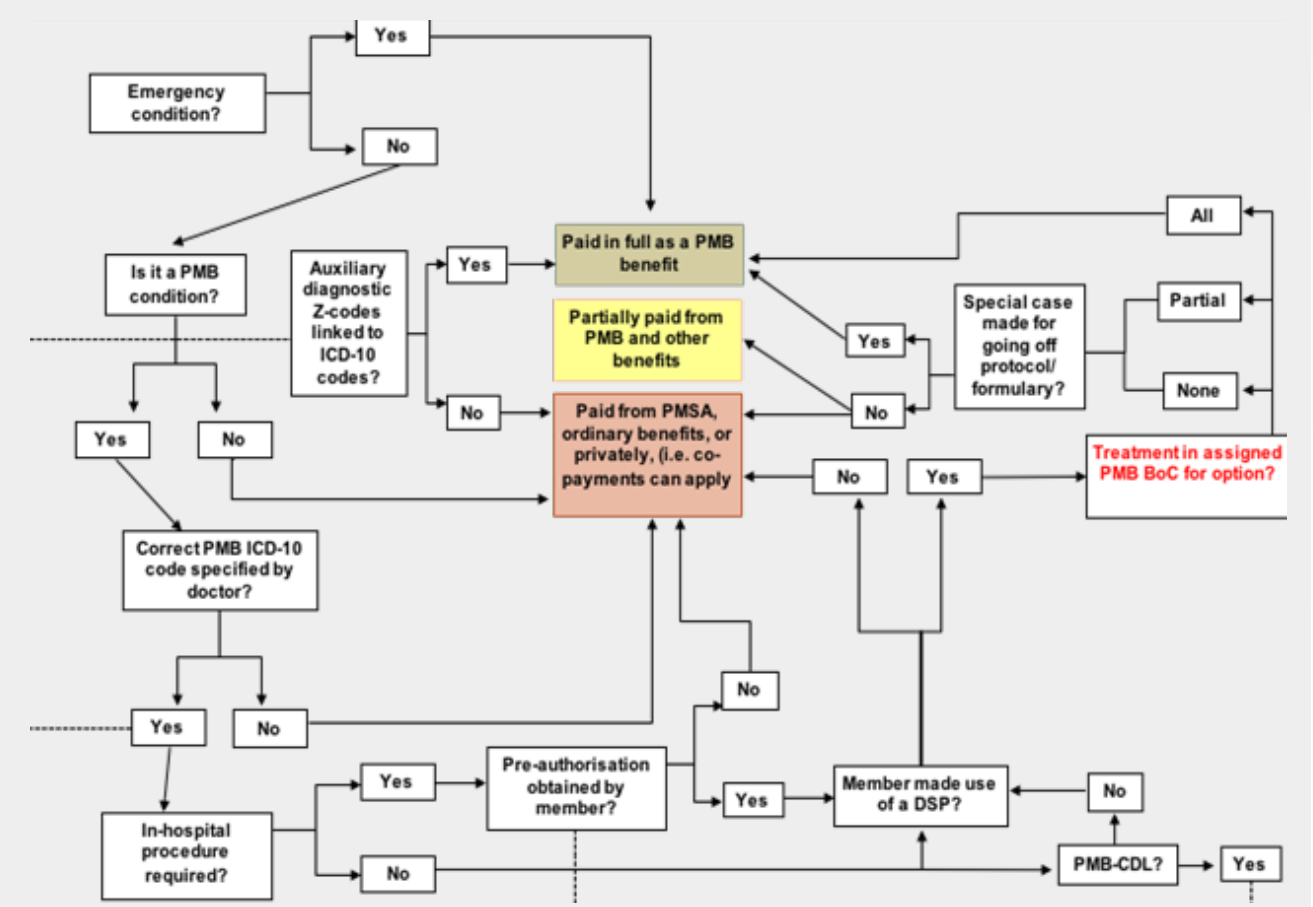
67.8. there is no mechanism to review schemes' compliance on paying for PMBs from the risk pool and not from the scheme members' savings account or members paying out of pocket; and

67.9. the failure to meaningfully review the PMB structure, developed almost 15 years ago, despite the legal obligation to do so every two years. (The CMS is currently in the process of reviewing PMBs and has undertaken extensive stakeholder engagement to date.)

68. In addition to the non-conducive environment for effective PMB implementation, we have found that the hospicentric nature of PMB's, their complexity, and the requirement to pay PMBs at costs has resulted in adverse effects on competition.

69. The process of claiming for a PMB has multiple steps and involves many players. Figure 5.3 below illustrates the complexity of the system. Failure at any point of the claim process will result in the liability being passed onto the member. The complexity of the PMB system places members in an unfavourable position that reduces their chances of having their claims paid as PMBs. For example, schemes/adminstrators will often alert the patient that a claim is invalid (e.g. relevant codes have not been supplied) and expect the patient to engage with the provider to rectify such omission.

Figure 5.3: PMB flow diagram



70. We found high compliance levels amongst the funders in paying for in-hospital PMB cover. For instance, 96.34% of in-hospital claims were paid from risk, only 0.37% from savings and 3.29% unpaid.[451] These results were not surprising since medical schemes typically cover in-hospital events in full irrespective of PMBD status.

71. The proportion of out-of-hospital claims for PMBDs increased from 21% in 2010 to 25.28% in 2014. In 2014, 85.82% of these claims were paid from risk, 9.12% from savings, and 5.06% remained unpaid.[452] Payments from risk are increasing over time and payment rates from savings and rates of unpaid claims are decreasing. It was raised in a submission that unpaid claims do not always result in member liability, with one estimate showing almost 50% of 'unpaid' claims not resulting in member liability. Either because unpaid claims can include contractual savings (where contracts do not allow balance billing) or where no balance is actually collected from the member by the provider. [453]

72. In relation to the shift between 2010 and 2014 in the diagnosis of PMB versus non-PMB conditions, SAMA suggested that the shift could purely be due to awareness of the PMB entitlement, and as a result of the Code of Conduct published by CMS in 2010.[454]

73. The analysis of claims data from 2010 to 2014 did not show that PMBs are a primary driver of cost escalation in healthcare. The findings showed that the increase in cost per admission on average from 2010 to 2014 has been 8.79%, with CPI contributing 5.6%, all other explanatory factors contributing 1.20%, and unexplained factors 1.99%.[455] Increasing proportions of PMB diagnoses

451 Health Market Inquiry Report on analysis of medical schemes claims data - a focus on prescribed minimum benefit dated 08 December 2017, p7, Table 2.
452 Health Market Inquiry Report on analysis of medical schemes claims data - a focus on prescribed minimum benefit dated 08 December 2017, p7, Table 1.
453 DHMS submission in response to the PFR dated 15 October 2018, paragraph 8.3
454 SAMA submission in response to the PFR dated 01 October 2018, p. 15.
455 Other explanatory factors included, age, gender, disease profile, and case mix.

contributed 0.11%.[456] The period for which this analysis was conducted (2010 to 2014) may not fully reflect the impact of PMBs on expenditure. PMBs had been in existance for 10 years prior to our data analysis period and, therefore they may already be priced into the market. Some stakeholders' dispute the finding that PMBs are not a primary driver of cost escalation,[457] particularly as PMBs are found to be an increasing component of medical scheme expenditure,[458] and argue that the evidence of the significant impact of PMB regulations on medical inflation has been ignored.[459]

74. Despite the finding that PMBs may not be responsible for a significant increase in costs, they nevertheless determine the overall cost of healthcare cover in South Africa. The scope and price of PMBs create a minimum price for which scheme cover can be offered. Furthermore, the hospicentric approach to defining both PMBs and benefit packages means that primary and preventative care are not routinely included in the codes covered by PMB regulations, preventing some PMB care being delivered by cheaper, but no less effective, primary care providers.

75. The PMB regulations have therefore played an important part in shaping benefit design in the market, particularly the move towards benefit-limited hospital plans. These plans lead to additional costs as patients are unnecessarily admitted to hospitals in order to qualify for treatment. In other words, PMBs in conjuction with in-hospital treatment may drive utilisation and this in turn drives total costs, but they do not necessarily drive cost per admission.

76. We are satisfied that the PMB regulations in their current form are distorting competition in the market and contributing to undesirable market outcomes.

77. Nonetheless, we consider PMBs to be effective in preventing catastrophic health expenditure and is an essential component towards achieving the NHI goals of providing access to a defined package of comprehensive health services.

Review of PFR Recommendations

78. Some stakeholders' submissions on our provisional recommendations highlighted areas of ambiguity, and insufficient detail. In some instances, stakeholders suggested remedies that we had not considered and aspects of the recommendations that might be difficult to implement. In drafting the final recommendations our intention was to eliminate ambiguity, and to provide sufficient detail to the potential implementers of our recommendations, as well as to the industry.

79. Stakeholders are in support of expanding the current PMB package to include primary and preventative care. They made several suggestions that we believe were aimed at addressing coverage of essential care, affordability of the package, and challenges with interpretation. These include introduction of compulsory care coordination,[460] retaining all the PMB conditions without increasing the cost of the PMB package,[461] include primary and preventative care,[462] [463] [464] affordability test of the revised package of care for both the insured and non-insured population. [465] [466]

80. Stakeholders agree that members should be provided with more information to facilitate a better understanding of PMBs.[467] [468] [469] However, providing members with ICD10 codes and formularies for each PMB is too complex for members to fully understand. The manner in which PMBs are defined in the regulations makes it difficult to identify PMBs prior to treatment, rendering it very difficult for funders to advise patients during the pre-authorisation process if any costs will or will not be covered by the scheme.[470]

456 Health Market Inquiry Report on analysis of medical schemes claims data - initial cost attribution analysis dated 08 December 2017, p. 32, Table 25.
457 DHMS submission in response to the PFR dated15 October 2018, p. 32.
458 Health Funders Association submission in response to the PFR dated 07 September 2018, p. 8.
459 Discovery Health submission to in response the PFR dated 15 October 2018, p. 2.
460 GEMS submission in response to the PFR dated 07 September 2018, p. 8.
461 Health Funders Association submission in response to the PFR dated 07 September 2018, p. 9.
462 Medscheme submission in response to the PFR dated September 2018, p. 10.
463 Profmed submission in response to the PFR dated 01 October 2018, p. 4.
464 DHMS submission in response to the PFR dated 15 October 2018, p. 40-41.
465 Medscheme submission in response to the PFR dated September 2018, p.11.
466 Actuarial Society of South Africa's submission in response to the PFR 01 October 2018, p. 9.
467 Health Funders Association's submission in response to the PFR dated 07 September 2018, p. 11.
468 MMI submission in response to the PFR dated 01 October 2018, p. 8.
469 CMS position document on competition and regulatory issues within the South African private healthcare industry dated 07 September 2018, p. 30.
470 Discovery Health submission in response to the PFR dated 15 October 2018, p. 29.

81. Stakeholders support the proposed process for the development and review of treatment plans and formularies,[471] [472] whilst it was also argued that the developement of treatment plans and formularies are complex and costly.[473]

82. To some stakeholders it was not clear what the report intended by stating that treatment plans and formularies should not be binding on schemes. One stakeholder indicated that treatment plans and protocols are necessary cost levers and as such they must be binding.[474]

Conclusion on PMB recommendations

83. We recommend that:

83.1. the list of conditions covered by the PMBs must be revised to make provision for out-of-hospital and cost-effective care. In other words, care which is determined by best-practice treatment guidelines. By providing for out-of-hospital care, the base benefit package will remove the current incentive to admit patients to hospital, often at higher cost;

83.2. the CMS should develop this package, in conjunction with stakeholders as part of the PMB review process they are currently undertaking;

83.3. a simpler, less ambiguous design of the benefit package will help members to understand their cover, particularly if the standardised benefit package and the conditions which are covered by the PMB regulations are one and the same which will obviate the requirement for schemes to provide additional PMB information to consumers;

83.4. compulsory care coordination should form part of the benefit package in the form of primary care provider and primary care provider-to-specialist referral;

83.5. The savings generated by these inclusions will allow the benefits covered in the standardised benefit package to be expanded over time as the benefits are routinely reviewed;

83.6. that treatment plans and formularies (Health Economic Value Assessments) should be developed for all services covered by the base benefit option. The CMS can draw from international examples and engagement with local academic institutions and practitioner associations to develop these protocols; and

83.7. PMBs be reviewed regularly and updated, as provided for in legislation and supported by stakeholders,[475] [476] every two years as proposed by the CMS which is in phase 2 of the implementation of the NHI. [477] [478] [479]

84. In addition to the specific PMB recommendations in this section, we have recommended the introduction of a single, stand-alone, standardised, obligatory 'base' benefit package which will replace the current PMBs but will retain the same philosophy, these are the minimum conditions/ services that must be covered and paid for in full by medical schemes. We have also recommended multilateral negotiations between the funders and providers to set a maximum, competitive price to be charged for these services. These recommendations are discussed further in ***Chapter 9: Recommendations.***

RISK ADJUSTMENT MECHANISM AND INCOME CROSS-SUBSIDISATION

Introduction

85. The current regulatory environment does not include a risk equalisation mechanism. Substantial work had been undertaken since 2003 on the design of a risk equalisation formula.[480] [481] By 2007 the CMS had developed a shadow REF process that allowed the CMS to test how the fund would work in practice. However, this work stalled when the focus shifted towards the provision of universal health coverage and NHI.

471 DHMS submission in response to the PFR dated 15 October 2018, p. 41.
472 CMS position document on competition and regulatory issues within the South African private healthcare industry dated 07 September 2018, p. 30.
473 Profmed submission in response to the PFR dated 01 October 2018, p. 5.
474 Life Healthcare Group submission in response to the PFR dated 15 October 2018, p. 20 & 21.
475 Health Funders Association's submission in response to the PFR dated 07 September 2018, p. 11.
476 Discovery Health submission in response to the PFR dated 15 October 2018, p. 31.
477 DHMS submission in response to the PFR dated 15 October 2018, p. 40.
478 World Health Organisation submission in response to the PFR dated 21 September 2018, p. 3.
479 CMS position document on competition and regulatory issues within the South African private healthcare industry dated 07 September 2018, p. 29 & 30.
480 Van den Heever, AM. (2014). Evaluation of the draft Demarcation regulations applicable to the short – and long-term insurance acts. Written submission to the National Treasury, p 11.
481 Ministerial Task Team on SHI, July 2005.

86. Early indications suggest that the earliest full implementation of the NHI will be 2026.[482] In the meantime, the private sector will continue to operate alongside the public sector. A more competitive private healthcare market will translate into lower prices and better value-for-money for consumers. As the state becomes a purchaser of services (from the private sector as indicated by the NHI Bill), it will be able to enter a market where interventions like RAM have already forced greater competition. Competition should be occurring on cost and quality and the RAM will eliminate fragmented risk pools thus making purchasing in that market more efficient for the NHI.

87. Members of schemes currently benefit from a tax subsidy on contributions. However, the tax subsidy is inequitable since it has no impact on the people earning below the tax threshold and has the biggest impact for the highest income groups. The proposed regulatory framework was intended to replace the tax subsidy with a direct income subsidy per person equivalent to the amount spent per person in the public sector. It was envisaged that this would provide substantial relief to lower income groups and make contributions more affordable. The direct subsidy per person would be sourced from tax revenue and paid from government to the RAM. The RAM would in turn make monthly risk adjusted payments of this amount to schemes.

88. A RAM, together with a contribution subsidy arrangement, will make adjustments based on both risk and income. It will equalise the risk profile across schemes and create an opportunity for income cross subsidisation across the whole population. A RAM allows high risk schemes (where risk arises, not from operational inefficiencies or mismanagement, but due to the community profile of the scheme membership) to be cross subsidised by low risk schemes. In effect it creates a virtual single risk pool which will be a first step towards the implementation of the NHI fund. The RAM will allow for a transfer of funds between schemes based on an ongoing evaluation of the risk and income profile of each of the schemes. Schemes with older, sicker, and poorer members will be net receivers in the system, while schemes with younger, healthier, richer members will be net payers into the system.

89. The absence of a RAM is causing competition in the scheme market to occur on the basis of demographics, rather than on factors that benefit members such as lower contributions and richer benefits.[483] A RAM removes the need for schemes to compete for the desired demographic risk pool (young and healthy members) through discriminating either directly or indirectly against individuals, families and groups. A scheme will have to compete on the attractiveness of the benefits offered which will be influenced by the efficiency of its purchasing and in delivering quality care to its members. There is a concern that the RAM will not be an effective long-term solution to cost inflation pressures, unless there are also measures in place to effectively address anti-selection. [484]

Findings on the RAM

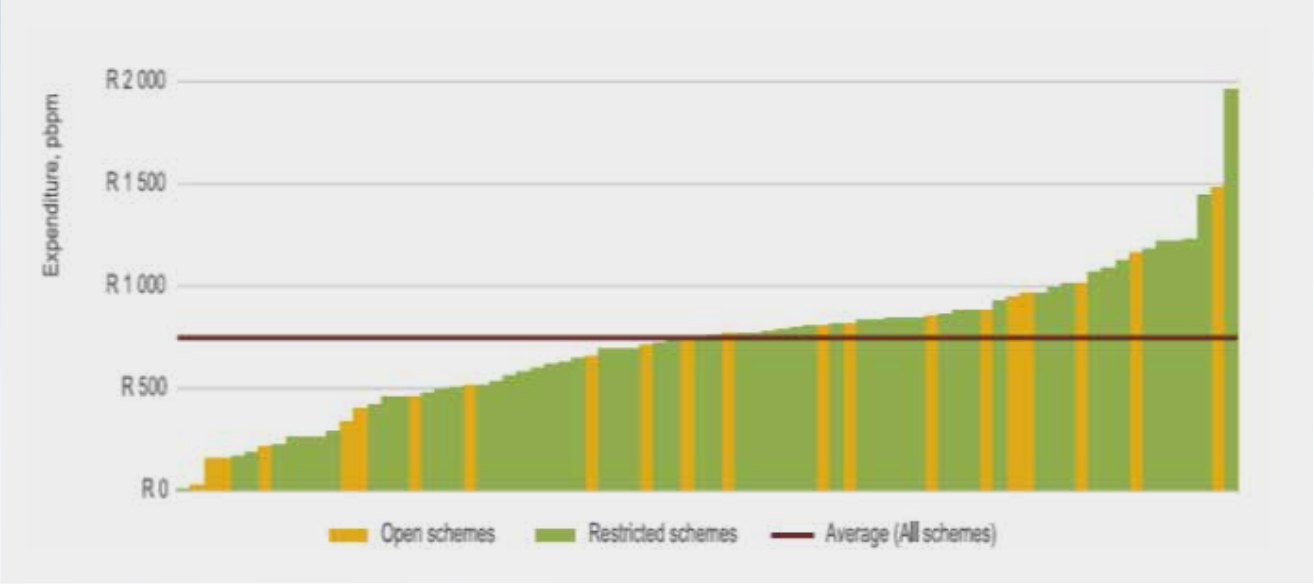
90. We have concluded that in the absence of a RAM many funders have chosen to proxy risk-rate by offering a large number of different options which in effect forces members to choose an option based on their health profile. The older and sicker applicants self-select into more comprehensive coverage options and the younger and healthier into less comprehensive options.

91. Even within these segments, medical schemes have an incentive to compete for younger and healthier members. The older or sicker members will have higher costs necessitating higher contributions which makes the schemes less competitive regardless of how efficient they might be in procuring services or contracting with providers.

92. The impact of the lack of a RAM is illustrated in Figure 5.4 below, reproduced from the CMS's 2016/2017 annual report. It shows 12 schemes reporting PMB expenditure below R300 per beneficiary per month.[485]

482 The National Health Insurance Bill 2018 sets out three phases for implementation, with the final phase being complete by 2026.
483 Mediclinic's submission in response to the PFR dated 15 October 2018, p. 18.
484 Discovery Health submission in response to the PFR dated 15 October 2018, p. 31.
485 Council for Medical Schemes Annual Report 2016//2017, p. 139.

Figure 5.4: PMB expenditure by medical scheme for 2017



Source: Council for Medical Schemes, Annual Report 2017/2018 p 137.

93. The variation in these costs determines how competitive a scheme can be relative to its rivals. The PMB expenditure of schemes creates a price floor for premium contributions below which the scheme would not be sustainable. Given that PMB expenditure can be largely correlated to demographic risk factors (i.e. age), they must compete on demographic risk. This competition on risk will inherently be biased against high-risk demographics (the old and sick). The incentive in the market due to the lack of a RAM promotes competition on demographic risk and shifts competition away from competing on efficiencies and pro-consumer innovations.

94. To remove health status as a basis for benefit design and inter-scheme competition and to allow for competition on positive features, such as the cost and quality of healthcare services, our PFR recommended that:

94.1. a risk adjustment mechanism be implemented for the comprehensive base benefit package to be offered by all schemes;

94.2. to be initially facilitated by the CMS before migration to a separate authority established for this purpose with full independence from the executive to avoid a conflict of interest with the CMS's regulatory role; and

94.3. the current tax credit regime be reconstituted to take the form of a contribution subsidy administered through the RAM to cater for low income members.

Review of the Recommendations of the PFR

95. Submissions of stakeholders to our provisional recommendations have provided additional information to consider. It was suggested that the HMI should consider the impact of the RAM on smaller medical schemes, and that the restricted scheme market should not cross subsidise the open scheme market as the restricted market may have a better risk profile.[486] [487]

96. Stakeholders agreed that the RAM should be initially facilitated by the CMS before migration to a separate authority,[488] and that it should be independent from any party with a commercial interest.[489]

97. Stakeholders supported having contribution subsidies for low income members to prevent lower income members from being prejudiced.[490]

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486 It was suggested that the HMI should consider the impact of the RAM on smaller medical schemes, and that the restricted scheme market should not cross subsidise the open scheme market as the restricted market may have a better risk profile and there are some efficiencies achieved in the restricted market.
487 GEMAS submission in response to the PFR dated 07 September 2018, p. 2.
488 World Health Organisation submission in response to the PFR dated 21 September 2018, p. 3.
489 MMI submission in response to the PFR dated 01 October 2018, p. 7.
490 GEMS submission in response to the PFR dated 07 September 2018, p. 18.

[491] It has been suggested that SARS should collect the income information to avoid duplication of work and that SARS should share the information with RAM.[492]

Conclusion on the RAM recommendations

98. To achieve the overall objectives of a RAM, all medical schemes must participate and the adjustments will be calculated on the obligatory standardised benefit option.

99. We have concluded that all schemes whether closed or open should belong to the RAM. That closed schemes may benefit from a form of mandatory membership and therefore have a reduced risk profile is an insufficient basis to argue for separate risk pools. The purpose of the RAM is to equalise risk across low and high-risk schemes. Multiple pools are likely to increase administrative costs, be less effective in pooling risk, and not be aligned with the principles envisaged in the NHI.

100. Based on previous work done during the shadow Risk Equalisation Fund process, it was determined that approximately 80% of variation in risk can be attributed to age and gender factors alone. As age is correlated to income, the implementation of a RAM would mean healthy, younger, low-income individuals would be subsidising higher-income groups. This is an outcome which goes against the social solidarity principles of health insurance. To avoid this outcome, the low-to-high income subsidisation effect of RAM needs to be mitigated as far as possible by an offsetting income related cross-subsidization.

101. To address the needs of low-income scheme members, it is recommended that the current tax credit regime be reconstituted to take the form of a contribution subsidy. It is crucial to integrate both risk and income adjusted subsidy. We recommend that the CMS determine an appropriate and feasible model for the South African context.

102. We recommend that the proposed RAM be initially facilitated by the CMS but will migrate to a separate authority established for this purpose with full independence from the executive to avoid a conflict of interest with the CMS' regulatory role.

103. For the RAM to operate efficiently, the following measures must be in place:

103.1. all medical schemes, both open and restricted, must, by law, be required to belong to the RAM;

103.2. legislation needs to be changed to allow the administrator of the RAM to develop a database of all insured beneficiaries and the relevant demographic information to determine the prospective risk status of each beneficiary. This must be developed and maintained by CMS;

103.3. similar information on members' income needs to be obtained, stored securely, and subject to suitable confidentiality provisions;

103.4. a set of mandatory minimum benefits that all insurers must offer (the "base package) must be defined and implemented;

103.5. the administrator of the RAM (the CMS at the initial stage) must establish technical capability to provide within-financial-year financial transfers between schemes and the central fund based on the extent to which schemes' inherent risk profile vary from the average for the industry;

103.6. similarly, the technical capability to provide income cross-subsidisation to off-set the inherent low-to-high income substitution of the risk-adjustment must be established; and

103.7. the administrator of the RAM must have legislated structural independence from any party with a commercial interest in the risk adjustment outcomes (which may include other regulators, the government executive, medical schemes and related parties, healthcare providers, etc.).

104. one of the first and key tasks of the administrator of RAM will be to develop relationships and memorandums of agreement with key stakeholders such as SARS, Treasury, National Department of Health, administrators and medical schemes, the financial sector, etc.

ANTI-SELECTION

Introduction

105. Anti-selection includes a broad range of behaviours, including:

105.1. individuals join medical schemes when in need of care, i.e. when they expect healthcare expenses and leave the scheme once treatment has been completed; and

491 DHMS submission in response to the PFR dated 15 October 2018, p. 43.
492 Life Healthcare Group submission in response to the PFR dated 15 October 2018, p. 18.

105.2. people not joining medical schemes (or leaving if they are already members) when they believe they will not need access to care;

106. Above inflationary increases in healthcare expenditure means some members may 'buy-down' to cheaper plans while retaining the same claiming behaviour or leave when a scheme becomes unaffordable. This behaviour is not considered to reflect anti-selection but rather a reflection of consumer budget constraints. The definition of anti-selection assumes affordability. Plan-movement as a result of budgetary considerations reflects the inability for funders to negotiate affordable provision and not anti-selection.

107. Funders currently have three mechanisms through which they are able to mitigate the impact of anti-selection. Firstly, members are only able to change their plans at certain times during the year. Secondly, there is a mandatory waiting period subsequent to joining a scheme during which some benefits are restricted. Lastly, there are late-joiner penalties for members joining medical schemes past a certain age to compensate to some degree for the years that they have not been contributing.

108. Anti-selection creates a risk for medical schemes as these individuals' claims for healthcare expenditure can exceed their contributions to the scheme, leading to higher premiums for all members.

Findings on Anti-selection

109. Previous publications have set out our analysis of anti-selection in the private healthcare market.[493] The objective of the analysis was to assess whether there is anti-selection against schemes and, if so, whether anti-selection is becoming more problematic over time. In other words, has anti-selection been contributing to the higher annual increases?

110. For anti-selection to contribute to higher claims, we would expect to see a greater proportion of new joiners relative to other cohorts as individuals continuously enter, receive treatment, and leave.[494] We assessed the claims per beneficiary for the different membership duration bands.[495] The analyses did not show a greater proportion of new joiners relative to other cohorts or that claims were higher for longer-term members relative to new joiners, with, The analyses did not show a greater proportion of new joiners relative to other cohorts or that claims were higher for new joiners relative to longer term members. All claim inflation rates fall within a reasonably narrow band for all the groups.[496]

111. However, the analysis on claims cost for new joiners is likely to be biased downwards for two reasons. First, waiting periods may prevent new joiners from claiming as much as they would absent this intervention. Secondly, new joiners do not necessarily join at the start of the year, therefore the average number of months covered is lower relative to other cohorts.

112. While the analyses did not show that anti-selection does not exist, the decreasing number of new joiners and the lower claims inflation suggests that systemic anti-selection is unlikely to be the cause of the high claims increases experienced by schemes. Since the beneficiaries that stay on a scheme will age and likely experience an increase in claims, and there has been a decrease in new joiners, this might have accelerated the claims inflation.

113. We have concluded that anti-selection is likely in a market environment which allows consumers to opt-in or out of health insurance alongside policies of open enrolment and community rating. The SID analysis confirms this and shows that there is an anti-selection effect. [497]

114. While this has likely contributed to the average cost of members' contributions, given that it has been stable and entrenched in the market for a long time, it has not contributed materially to the claims increases experienced over the period analysed.[498] A stakeholder agrees with the finding that while anti-selection may exist in the market, it is not the main factor contributing to the annual increases in healthcare expenditure to, A stakeholder agreed that the extent of anti-selection is not as bad as other cost push factors. They further noted that it is not optimal to propose recommendations that ignore anti-selection.[499]

115. To the extent that anti-selection exists in the market it is likely to have been mitigated to some extent though the late joiner penalties and waiting periods. However, evidence provided by stakeholders has indicated that these tools are

493 See Funders Report on Analysis of Medical Schemes Claims data: A focus on funders dated 15 December 2017 for further detail and methodology..
494 Funders Report on Analysis of Medical Schemes Claims data dated 15 December 2017, p. 15
495 Funders Report on Analysis of Medical Schemes Claims data dated 15 December 2017, p. 19.
496 Funders Report on Analysis of Medical Schemes Claims data dated 15 December 2017, p. 28 table 26.
497 PFR, 5 July 2018, p400.
498 Funders Report on Analysis of Medical Schemes Claims data: A focus on funders dated 15 December 2017, p. 20 & 26.
499 BHF submission in response to the PFR dated 07 September 2018, p.16.

insufficient adequately to protect funders from the costs associated with anti-selection.[500] Further, given the limited protection provided by waiting periods, several stakeholders have indicated that we have underestimated the extent to which anti-selection occurs in the market.[501] [502] [503]

Review of the PFR Recommendations

116. Our focus has not been on identifying the extent to which anti-selection has already contributed to the base cost of medical aid premiums. Rather, we have recognised that anti-selection exists in the market and made recommendations that address this concern.

117. The first concern to be addressed is the movement of members from the more benefit-rich and costly options to the lower cost, less benefit-rich options. This causes fragmentation in the risk pool, affecting the sustainability of schemes. Particularly if the members 'buying-down' are considered relatively low-risk in the original benefit-rich option and comparatively high-risk in the new low-cost option. This movement would serve to worsen the risk-profile of both options.

118. We have addressed this concern in our recommendation to have one standardised benefit package, along with the introduction of a RAM which would remove the fragmented risk pools within a scheme and equalise risk across schemes. This is discussed further in the sections ***Standardised base benefit option and Risk Adjustment Mechanism and Income Cross-subsidisation.***

119. We agree with stakeholders that a discount to encourage younger joiners may have unintended consequences.[504] [505] [506] [507] The consequence of a discount for younger members is that older members will pay a higher contribution and younger beneficiaries will pay less. While this may encourage younger members to join, it might make it unaffordable for pensioners to stay. We therefore do not recommend this intervention.

120. Despite Discovery Health raising a valid issue regarding their option design and the risk associated with savings accounts,[508] particularly for plans with above threshold limits, we agreed that this is a direct consequence of complex benefit designs we wish to eliminate. Schemes are free to develop plans as they like; if they choose to introduce a medical savings account then they must have the ability to manage it and any associated risks.

Mandatory Membership

121. There is a debate between stakeholders on anti-selection. Some argue that it is very prevalent and is evidenced by the 'twin-peak' age profile of the scheme population.[509] However, some argue that the assumptions underlying this analysis are incorrect.[510]

122. We have concluded that the twin-peak population profile is likely to be evidence of anti-selective behaviour but that its effect has been overestimated by stakeholders who have not considered the potential for this behaviour to be driven by other considerations. One such consideration is affordability. Instead of comparing the medical aid population profile against the entire South African population profile to find evidence of anti-selection, the comparison should exclude those who are unable to afford medical aid. This will likely exclude those young and healthy potential members who have just joined the workforce thereby reducing any estimate of the number of individuals engaging in anti-selection.

123. Many stakeholders argue for mandatory membership and some indicate that not introducing this immediately will be an example of an incomplete regulatory framework that the report seeks to avoid. We agree that mandatory membership is one of the internationally accepted elements of a complete social solidarity insurance system but have significant reservations about such a recommendation in the current market environment.

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500 Discovery Health SID presentation for the Excessive utilisation and Supplier Induced Demand, dated 12 April 2019, slide 13.
501 Health Funders Association submission in response to the PFR dated 07 September 2018, p. 7-8.
502 Discovery Health submission in response to the PFR dated 15 October 2018, p. 25.
503 Actuarial Society of South Africa's submission in response to the PFR dated 1 October 2018, p. 8.
504 MMI submission in response to the PFR dated 01 October 2018, p. 9.
505 Profmed submission in response to the PFR dated 01 October 2018, p. 6.
506 Health Funders Association's submission in response to the PFR dated 07 September 2019, p. 12.
507 Makoti medical scheme submission in response to the PFR dated 07 September 2018, p. 3.
508 DHMS submission in response to the PFR dated 15 October 2018, p. 46.
509 Prof Heather McLeod, Expanding Health Insurance Coverage, NHI Policy Brief 2, Innovative Medicine South Africa, available online at: http://heathermcleodnz.com/imsa-nhi-policy-briefs/4580334234
510 Alex van den Heever Note on Age And Population Group, 2016 commissioned by the HMI. Figure 9

124. While mandatory membership may potentially reduce demand-side cost pressures, it will not help to address the supply-side cost drivers which we believe to be a more urgent and pressing concern, which currently attract no regulation as compared to the demand-side which has regulatory relief. Without system-wide changes that address the current incentive structure in the market (for example, fee for service, unmanaged over utilisation, poorly designed benefit packages that promote unnecessary hospitalisation, irrational supply, absence of quality measures, payment at cost for PMBs, and inappropriate use of technologies) will simply see a larger fund in the hands of schemes being spent without guaranteed consumer health benefits or prudent use of scheme members' funds. Addressing these issues will enable funders to lower prices, attracting more members who will voluntarily opt to join the private medical market.

125. We are in favour of increased membership and recognise that short term gains, such as immediate decrease in premiums, may be achieved through mandatory membership. It should be noted that this decrease would only be realised if a significant proportion of the formally employed population in fact bought cover. We believe that the figures put forward by several stakeholders are likely to be overestimates as they ignore several crucial factors. For example, household income does not measure or reflect household expenditure and many formally employed individuals support multiple households. Incomes may be too little to both house and feed a family as well as being able to afford medical aid, even if the membership fee was decreased. These households would be forced to choose who in their family to cover as it is unlikely that they would afford cover for all members.

126. Further there is the practical difficulty associated with imposing any regulation which reduces already stretched household budgets. Such difficulty can be inferred from the failure of government to establish a moratorium on cashing-in of pensions funds.

127. Evidence suggests that the stakeholder contention that mandatory membership will have an ongoing effect in reducing premium increases is also likely to be overestimated. Mandatory membership may have an ongoing impact on the aging effect of the medical scheme population but, based on the expenditure report figures, this is likely to be, at most, 1-0.5%. This argument assumes that the South African workforce is not aging, and that economic growth is bringing in new and younger workers, assumptions which are unlikely to hold in the current economic climate.

128. Some stakeholders are concerned that without mandatory membership anti-selection will persist in the market as long as membership to a scheme remains voluntary.[511] [512] Noting this concern, the HMI is of the view that mandatory membership cannot be introduced into the current market given the inefficiencies identified throughout the inquiry. Several stakeholders acknowledge that these inefficiencies should be addressed before mandatory membership is implemented. [513]The HMI believes a phased approach may be the most appropriate recommendation wherein progressive income bands are regulated to join the scheme market as and when the HMI's recommendations are successfully implemented.

Anti-selection recommendations

129. To address anti-selection, the HMI recommends that the CMS reviews the existing tools available to funders, namely waiting periods and late joiner fees, with the view of strengthening them.

130. The HMI affirms that non-risk benefits (such as medical savings accounts) should not attract any waiting periods as schemes do not bear any risk for any claims paid from non-risk benefits.

131. The HMI in principle agrees that mandatory membership will address anti-selection. However, the HMI is of the view that before mandatory cover is introduced, the industry needs to show clear indications of closer alignment to consumer interests and better cost containment, which must be expressed in three conditions:

131.1. Inflation corrected contributions stabilise or decrease;

131.2. More than 50% of beneficiaries are covered by plans which make use of preferred provider networks and these contracts must include performance-based remuneration; and

131.3. OMRO is operational and more than 25% of hospital outcomes are measurable and available to the public/schemes.

511 CompCare submission in response to the PFR dated 07 September 2018, p. 4.
512 Makoti submission in response to the PFR dated 07 September 2018, p. 3.
513 Profmed submission in response to the PFR dated 01 October 2018, p. 6.

132. The HMI recommends that mandatory scheme membership, when introduced, should start with the highest income bands and progressively include additional income groups as more of the HMI's recommendations are successfully implemented and the cost of joining a scheme decreases.

133. This approach has several attractive features. The highest income bands will be most able to afford the increased monthly expenditure. Assuming these members are of average health, their inclusion should improve the overall risk pool and help to reduce premiums and make scheme membership more attractive to lower income bands.

134. The inclusion of successive income bands should be contingent on stakeholders implementing the HMI's recommendations. This will provide an incentive for stakeholders to remove the market inefficiencies identified by the HMI. Through these actions medical cover should become more affordable and will result in members voluntarily entering the scheme market and the phased implementation of mandatory membership will impact fewer individuals.

BROKERS

Introduction

135. Brokers, in return for a monthly commission, assist potential members in selecting a scheme and benefit option, and also provide on-going advice and assistance after their clients have purchased health cover. For corporates the employer may choose the brokerage service. In open schemes a member may or may not enter the scheme via a broker, but each member is allocated to a broker to provide advisory services. Broker fees are included in the scheme contribution charged to a member whether the member uses a broker or not.

136. This raises concern in the funders market as members are paying for services that they aand may not even be aware of this cost. Also, through advising clients on their scheme selection, brokers can channel members to certain schemes which may not offer the best value to the members, but rather the incentives may be derived from selling other products within the corporate structure of the medical scheme/administrator.

137. Therefore, brokers can influence competition amongst healthcare funders. The inquiry sought to determine whether the incentives of brokers align with the medical scheme/administrator or with the interests of the consumers.[514]

Findings on Brokers

138. We have found that brokers play an important role within the current complex benefit option environment in channelling patients but may have incentives which are not aligned to the consumers whom they represent. Stakeholders generally agree that brokers play an important role in helping consumers, both individuals and businesses, to select the appropriate package.[515] [516] Some stakeholders agree that there may be perverse incentives in the broker market and that there is a need to address incentives and transparency of broker remuneration.[517] Others disagree with this finding and argue that the report has not provided evidence to support these findings.[518] Brokers, in particular, insist that they serve the interest of the members of schemes,[519] [520]are able to provide the independent advice that schemes cannot,[521] and that they promote financial inclusivity by promoting schemes across different socio-economic sectors.[522]

139. We have concluded that whilst there is no anti-competitive or illegal conduct on the side of brokers, the market is operating sub-optimally. We highlight below areas in the current system that result in misalignment of broker incentives and consumers.

140. We have found that, given that the scheme contracts with and pays the broker, members often are unaware that their monthly contribution includes a broker fee, irrespective of whether they use a broker, and that brokers can and should provide them with ongoing advice. In the HMI's consumer survey, 56% of respondents who said they used brokers rarely communicated with them, and 16% had not communicated with their

514 Health Market Inquiry Statement of Issues dated 2014, p 11.
515 Marsh submission in response to the PFR dated 07 September 2018 p. 9.
516 Atfin Consulting submission in response to the PFR dated 06 September 2018, p. 1.
517 SAMA submission in response to the PFR dated 01 October 2018, p. 19.
518 Discovery Health submission in response to the PFR dated 15 October 2018, p. 6.
519 Attooh submission in response to the PFR dated 2018, p.1.
520 Marsh submission in response to the PFR dated 07 September 2018, p. 13.
521 Marsh submission in response to the PFR dated 07 September 2018, p. 11.
522 Marsh submission in response to the PFR dated 07 September 2018, p. 3 – 4.

brokers at all during the previous 12 months.[523] In spite of this evidence, brokers are adamant that our conclusions do not provide evidence that brokers function sub-optimally.[524] They argue that brokers engage with clients on an annual basis,[525] and some clients are visited on a weekly basis.[526] However, they provided no evidence to substantiate these claims.

141. For a medical scheme to pay commission to a broker, the broker must have a contract with the medical scheme. The medical scheme will remunerate the broker the lower amount of either 3% plus value added tax (VAT) of the member's contribution amount, or R90 plus VAT per main member (family) per month.[527] No contribution or premium discounts apply if a consumer goes directly to the medical scheme. These members are, unknowingly, subsidising broker fees for other members.

142. In the current market environment, funders are reliant on brokers to channel potential clients, either individuals (open schemes) or businesses (restricted schemes), in order to grow. Administrators have an incentive to grow the schemes under their administration. The greater the number of beneficiaries being administered, the greater the administration fees. Therefore, administrators are incentivised to have close relationships with the brokers who channel potential clients and thereby influence scheme growth. It is important that brokers who are paid, albeit indirectly, by members have incentives which are aligned with their clients, rather than with the administrators.

143. While scheme brokers' commission may be standardised, brokers may supplement their income by earning commission from the sale of a variety of other insurance and non-financial products provided they have all of the necessary licences. The payment of co-branded products (such as wellness and loyalty programmes, health insurance products, and gap cover) have different commission structures which fall outside of the oversight of the MSA and therefore of the CMS'.

144. This feature is particularly relevant for tied brokers who earn recognition through remuneration linked to the company's share price and other incentives such as gaining access to conferences and events. This recognition is based on complex formulas including components of scheme products sold combined with other products in the group. Other companies in the group pay for these forms of recognition so payment does not come from the scheme directly or indirectly from the administrator.

145. These practices demonstrate one way that schemes and administrators circumvent limitations on broker remuneration and may distort incentives by placing the emphasis on the group of products at the expense of individual medical scheme products.

146. In light of the above additional revenue streams, neither the CMS nor the FSB collect data on the total remuneration brokers receive. The CMS reports broker remuneration combined with other non-healthcare expenditure including marketing and distribution costs which are not restricted and regulated to the same extent as broker remuneration. The lack of uniform reporting on broker fees makes comparison across schemes challenging.

147. We have concluded that:

147.1. there is a sub-optimal use of brokers by members who are paying for these services;

147.2. brokers play an important role in channelling clients, both individuals and employer groups;

147.3. the incentives of tied brokers may not be aligned with the best interests of consumers; and

147.4. as a condition of registration, schemes must also be able to deal directly with the public without the use of brokers. This would include administering membership applications.

Recommendations for brokers

148. To ensure that broker incentives are aligned with scheme members' interest and their use by schemes is improved, we recommend the following:

149. Firstly, members should have the option whether or not to make use of a broker. Should members opt out, their fees should reflect the lower cost. Several stakeholders raised concerns regarding the opt-in system, namely that member

523 Health Market Inquiry Summary of Results from the Healthcare Consumer survey dated 18 November 2015, p 15.
524 Alexander Forbes submission in response to the PFR dated 07 September 2018, p. 5.
525 Marsh submission in response to the PFR dated 07 September 2018, p. 6.
526 Marsh submission in response to the PFR dated 07 September 2018, p. 14.
527 Section 28 of the Regulations in terms of the Medical Schemes Act, 1998, Circular 69 of 2017: Adjustment to fees payable to brokers with effect from 01 January 2018.

choices will be less informed, members will not benefit from ongoing advice, and that this will disproportionately disadvantage low-income earners.[528] [529] [530]

150. At the same time, we appreciate the concerns raised regarding the frequency of opting in and how this may create an administrative burden.[531] [532] The scheme/administrator and CMS should notify all members annually of the services that brokers provide and that they can opt out of the system. It can then be up to the member who has previously opted to pay a broker or to be proactive and opt-out, if so desired.

151. A standardised benefit package consistent across schemes will significantly reduce the need for brokers at the point of purchase. A standardised benefit package should simplify the claims process and the choice between schemes as the benefits should be clear, consistent, and all covered by risk, and reduce some of the need for the additional services provided by brokers. It should also be noted that many consumers are unaware that brokers offer these services. The restricted scheme members who do not have brokers have managed without access to brokers' advice.

152. Rather than low-income earners being disproportionately impacted, our view is that the role of brokers will largely be directed towards providing information and advice relating to supplementary cover. In other words, brokers would be proportionally providing advice to higher income individuals who would be able to afford their services.

153. Schemes must report broker fees separately to the CMS from distribution and other marketing fees.[533] The CMS must publish broker fees separately in their annual report.

Funders' profitability

154. The report acknowledges that firms with persistent high profits does not imply that firms are raising prices above the level that would prevail in a competitive market. However, persistent high profits provide a useful indication of possible exertion of market power by firms. A profitability analysis can provide an indication of competitive conditions in a market. An efficient firm in a competitive market would generally be able to earn no more than a "normal" rate of profit, being the minimum level of profits required to keep the factors of production in their current use in the long run. Persistent returns above what should be considered normal for that activity could indicate that competition is not operating effectively.

155. The three largest administrators, Discovery Health, Medscheme and Metropolitan account for approximately 80% of the administrator market.[534] Medical scheme administrators with substantial market share that persistently earn high profits over a prolonged period, without the realistic threat of competitive challenges and entry, may have a degree of market power. They may potentially have the ability to control prices and member volume. They may also use their market power, if any, to maximise their administration and managed care fees as well as other fees they charge the schemes and its beneficiaries under their administration business to maximise their income and profits.

156. A profitability analysis for the three largest administrators was conducted for the period 2006 to 2015 to provide a preliminary indication of the level of competition in the market. In September 2015, the HMI published a paper detailing the proposed approach to our profitability analysis (methodology paper).[535] This paper set out the proposed methodology for assessing profitability, namely the ROCE, TIRR, and the proposed methodology for estimating an appropriate cost of capital for entities providing healthcare services in South Africa. The WACC. ROCE and TIRR pose some challenges in a market with mainly intangible assets. Intangible assets are assets that a firm has acquired or developed with the expectation that they will generate economic over time. With companies like administrators, the main category of capital employed are intangibles such as brand name and reputation, IT systems, intellectual property and investments in the workforce. To lesson some of the limitations of a ROCE based profitability

528 Alexander Forbes submission in response to the PFR dated 07 September 2018, p. 7-8.
529 Marsh submission in response to the PFR dated 07 September 2018, p. 19.
530 DHMS submission in response to the PFR dated 15 October 2018, p. 47.
531 Universal Administrators submission in response to the PFR dated 07 September 2018, p. 8.
532 Alexander Forbes submission in response to the PFR dated 07 September 2018, p. 9.
533 Alexander Forbes submission in response to the PFR dated 07 September 2018, p. 9.
534 Market shares calculated on GCI calculations. Metropolitan had significantly higher share of the market based on the GCI when the HMI started the profitability analysis compared to what it has now.
535 Commission Methodology Paper titled: Market Inquiry into the Private Healthcare Sector Profitability Analysis dated September 2015.

analysis for service-based industries and as recommended by some of the administrators, we conducted a ROS analysis. It is important to note that the ROS test does not provide an objective criterion to measure the results. The main reason for applying a ROS analysis was to test whether relative results obtained from the ROCE/ TIRR are consistent with the preferred method, of the relevant firms, the ROS.

157. The results of the profitability analysis show that the administrators achieved average ROCEs over the Relevant Period of ✂ for Discovery Health, ✂ for Medscheme and ✂ for Metropolitan Health. These figures were compared to the benchmark of an average WACC of 20.9% for the same period. Even looking with a degree of tolerance, Discovery Health's results are very high, and are a multitude of its next best competitor.

158. The average TIRRs for the Relevant Firms were ✂ for Discovery Health, ✂ for Medscheme and ✂ for Metropolitan Health. This amounts to the TIRR again being significantly above the WACC for Discovery Health, while being moderately, that is ✂ and ✂ over the WACC for Medscheme and Metropolitan Health respectively. We note that ROCE and TIRR offer the same sequence in terms of profitability across the relevant firms and the same order of magnitude of returns over and above WACC.

159. Table 5.1 shows the ROS for the three administrators. Over time, there has been a clear upward trend in Discovery Health's ROS results from 26.2% in 2006 to 36.1% in 2013. In 2014 and 2015 Discovery Health ROS decreased slightly to 33.8% and 32.4% respectively. In 2006 Medscheme had a negative ROS of -12.2%, but this gradually and consistently improved to an average of 8.9% for the 10-year period (11.3% if 2006 is left out of the average). Metropolitan Health experienced significant lower results over the last three years and an average ROS of 15.4%. The ROS for Discovery Health was 33%, Medscheme's was 8.9% and Metropolitan Health's was 15.4%. Discovery Health's average ROS was significantly higher than the other two administrators. We concluded that the observed level of profits for Discovery Health point to a degree of market power, certainly with respect to its main competitors.

160. Discovery Health did not agree with the methodology used by the HMI to calculate the ROS. They argued that calculating the ROS of the administration business on its own is invalid and suggested that the ROS should consider the total premium paid, rather than simply the administration fee component. However, we have retained the ROS calculation. We believe that the methodology used is appropriate to calculate ROS in the administrator market. There are clear and important lines of separation between Discovery Health and DHMS. They are separate legal entities where one is for profit and the other is not for profit. DHMS carries the liability because the medical scheme, and not the administrator, is responsible for members' healthcare claims. DHMS is also responsible for holding Discovery Health accountable based on the requirements set out in their contract. Including the medical schemes premiums in the administrator profitability analysis will blur these clear and important lines of separation, which have a direct impact on the administrator's profit levels.

161. The degree to which the ROS, ROCE and TIRR of Discovery Health exceeds that of the other administrators is persistent and significant. While recognising the shortcomings of the ROCE methodology and the degree of tolerance with which these figures must be interpreted, regardless of the measure used to assess profitability, the same pattern is observed with Discovery Health's results being significantly higher than those of its main competitors. Discovery Health has over a sustained period, earned profits that are a multiple of its main competitors, with no sign of effective challenge from incumbent or new firms.

162. We recognise that much of Discovery Health's success is due to strategy, innovativeness and a highly competent management team, but

Table 5 1: ROS of administrators

Summary of ROS of the Relevant Firms											
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Average
Discovery	26.2%	28.9%	32.2%	33.4%	36.2%	34.6%	36.1%	36.1%	33.8%	32.4%	33.0%
Medscheme	-12.2%	7.1%	8.6%	11.2%	10.3%	12.4%	14.4%	12.5%	12.5%	12.3%	8.9%
Metropolitan	18.2%	15.9%	18.2%	17.2%	15.0%	20.5%	17.7%	11.6%	7.6%	12.1%	15.4%

we do not think these factors alone explain the significant gap in profitability when compared to its direct competitors. Higher than necessary service fees given economies of scale, a "locked-in" DHMS that does not source services from any other industry stakeholder, risk selection, and broker management contribute to its profitability. Under normal competitive conditions, Discovery Health's profitability would attract new competitors and stimulate competition from direct competitors, which would erode the significant profit gap Discovery Health enjoys. On the contrary, we see Discovery Health growing stronger, larger and more profitable over time. Therefore, we suggest that the observed level of profits for Discovery Health point to a degree of market power on the downstream market.

MEDICAL SCHEME GOVERNANCE

Introduction

163. The MSA,[536] provides the legal framework for the governance of schemes. It states that the BOTs and PO are the representatives of the scheme members and are legally responsible for the administration of the scheme on behalf of its members.[537]

164. According to the requirements laid out in the MSA, the BOTs is to ensure that the interests of beneficiaries are protected at all times. The BOTs are required to act with due care, diligence, skill and good faith and take all reasonable steps to avoid conflicts of interest.[538] The BOTs and the PO are in a position to influence how the scheme interacts with members, purchases services, and contracts with service providers. Both the BOTs and PO have the ability to influence the performance, sustainability and efficiency of the scheme and to influence competition in the scheme, administrator and managed care markets.

165. We have examined whether scheme governance is functioning, whether the BOTs and PO promote members' interests, and whether the governance model used by the industry is adequate to ensure that the BOTs and PO have sufficient incentives to drive competition in the administrator and scheme markets.

Findings on Scheme Governance

166. We have found that there is limited competition between schemes on factors that increase the value of scheme cover (in terms of both cost and quality).[539] Two contributing factors to the lack of effective competition in the funders market were lack of accountability to scheme members, and a governance model that fails adequately to address the interaction between not-for-profit schemes and for-profit administrators, and which aligns scheme interests too closely with that of administrators rather than scheme members.[540] The lack of incentives weakens schemes' resolve to hold administrators to account for delivering value to members. We have concluded that this has contributed to increasing healthcare and administration costs while at the same time benefit packages are covering less care.

167. Ideally the trustees of schemes should be acting on behalf of members to ensure that they receive value for money and that administrators are delivering the best possible value to scheme members.

168. We examined the scheme governance framework by assessing how the BOTs interact with members, the trustee election process, the skills and competence of trustees, trustee remuneration, and the manner in which medical schemes contract with administrators and managed care organisations.[541]

169. With regard to trustee interaction with members, we found that more could be done by schemes to improve communication with members. This breakdown in communication between members and the schemes can be traced to the trustee election process. The election process is the most direct way in which members can be involved in the scheme. Elections take place at AGMs and are usually poorly attended by members. If members do not participate in the election process, they lose the opportunity to have a say over who represents them and furthermore they are unaware of who eventually is elected to the BOTs. We found member participation at closed schemes to be more vigorous and that employees belonging to restricted schemes knew who their trustees are and generally approached them for assistance with issues.

536 Medical Schemes Act no 131 of 1998.
537 Section 57 of the MSA.
538 Section 57(6) of the MSA.
539 PFR dated 05 July 2018, Chapter 10, HMI Recommendations.
540 PFR dated 05 July 2018, Chapter 10, HMI Recommendations.
541 See PFR dated 05 July 2018, Annexure 5.2 Medical Scheme Governance.

170. During the public hearings we were alerted to the fact that most members of open schemes are not aware that there is a difference between the scheme and its administrators and usually associate both entities as one and the same when making inquiries or complaints. Most members appear not to be aware that they can engage with trustees regarding scheme related queries which can lead to members channelling complaints away from the scheme to consumer watchdogs.[542] Ineffective communication in general, also negatively affects the ability of members to hold trustees accountable for the manner in which they run the medical scheme. [543]

171. We found that the information members receive is not necessarily sufficient to assess the quality of the services that they receive from their scheme. Although some schemes provide some useful information to members regarding PMBs and chronic conditions more could be done to ensure that members are well enough informed to navigate the system without facing unnecessary co-payments and to help members understand why the scheme did not pay a particular claim. Members should also receive information in relation to the providers that schemes contract within the form of outcomes measures and how the medical scheme selected the providers onto their networks.[544]

172. We have concluded that the current trustee election process is not ideal and that more could be done to make the process transparent to decrease the possibiliy of abuse. Currently, while the MSA requires the appointment or election of the BOTs, it does not prescribe the manner or form of the election process. Holding trustee elections at AGMs has been proven to be ineffective given low member turn out. We support, therefore separating trustee elections from AGMs and would encourage more innovation in the way in which elections are held such as voting stations at places of employment, electroninc voting and allowing for greater campaigning activity by nominated trustees. The trustee election process and the close alignment between trustees and administrators needs to be addressed.[545] [546] [547] [548] [549]With regard to schemes being closely aligned with administrators, it has been submitted that this can be attributed to certain schemes being created by administrators as 'cash cows' for their upstream for-profit business. Accordingly, there will always be very powerful incentives for administrators to influence the election of trustees of these large open schemes.[550]

173. We found that the skills and competence of trustees varied widely across the medical schemes, and that there were no clear standard criteria for appointing candidates for trusteeship. A BOTs that is lacking in skills and competence may rely heavily on third-party administrators, and consequently may not provide adequate oversight or review of their services. Some stakeholders submitted that the findings correctly identify inadequate or poor oversight by BOTs in the management of schemes and a significant skills gap between the BOTs and the administrators.

174. We further found that the BOTs and PO earned the stipulated remuneration regardless of the performance of the scheme. There is, therefore, little incentive for the BOTs or PO to ensure that the scheme grows, or that healthcare and non-healthcare costs are appropriately maintained, or that value contracts ensure the best care at the lowest cost.

175. A unique feature of the South African private healthcare market is that not-for-profit-schemes are administered by for-profit administrators. Our overall observation is that the interests of the for-profit administrators are dominant; accordingly, trustees are not able to act on behalf of members.

176. Ultimately the BOTs must ensure that the scheme receives value for money in respect of services it receives. The BOTs, therefore, have a duty to hold administrators and other third-party service providers to account in any service level agreement. Where the administrator is not providing any value-added to the scheme, the scheme should terminate or not renew the contract. It is important to note that by outsourcing

542 This was the narrative of a number of scheme members at the public hearing who were discussing the problems they encountered with complaints against medical schemes. Health Market Inquiry Public Hearing 1 Day 1; Angela Drescher Presentation p.95-96; Health Market Inquiry Public Hearing 4 Day 2; Jessica Narunsky Presentation p. 37-38.
543 PFR dated 05 July 2018, Annexure 5.2 Medical Scheme Governance.
544 PFR dated 05 July 2018, Chapter 5, p. 111.
545 BHF submission in response to the PFR dated 07 September, p. 8.
546 Life Healthcare Group submission in response to the PFR dated 15 October 2018, p. 16.
547 SAMA submission in response to the PFR dated 01 October 2018, p. 18.
548 CMS submission in response to the PFR dated 07 September, p. 81.
549 University of Fort Hare submission in response to the PFR dated September 2018, p. 3.
550 BHF submission in response to the PFR dated 07 September 2018, p.10.

administrative services, the scheme does not relinquish its management responsibilities to the administrator. The administrators perform specific contracted operational activities, but management, oversight and decision-making rests within the control of the scheme. Where there is governance failure through the BOTs abdicating their responsibilities by not holding the administrator to account, this may be detrimental to competition as well as members' interests.

177. Stakeholders involved in the administrator market disagreed with the finding that funders fail to deliver value to consumers, that schemes lack accountability to members and that there is any evidence of a "*failure in governance that aligns scheme interests too closely with that of administrators.*"[551] Some administrators argue that it is important for schemes and administrators to be closely aligned, particularly in the context of a regulatory regime that requires schemes to operate on a not for profit basis.[552] It was also submitted that the success of the system depends on shared values, cost, process and outcomes of the entities.[553] According to stakeholders involved in administration and managed care services they experience significant pressure from all schemes clients.[554]

178. We have considered the extent to which the BOTs are invested in the business of the scheme and, as an extension, to what extent the members of a scheme are protected by the trustees when they interact with third parties. We have found that, in some instances, it appeared that the medical schemes abdicated their duties to the administrators.[555] A number of schemes took exception to the implication that their BOTs are not holding administrators and managed care organisations to account or that they abdicate their responsibilities,[556] [557] [558] with some stating that the HMI provided no evidence of this allegation.[559] These stakeholders argue that the BOTs are heavily involved in overseeing the business of the scheme, receive regular reports from administrators and managed care organisations which include information on cost savings by administrators.[560]

179. The CMS agrees with our findings that scheme governance is an issue that requires intervention.[561] It submits that S57(1) and (2) of the MSA is problematic because it is limited in terms of addressing abuse and manipulation of the election processes, prolonged trusteeship, and fraud and corruption within some schemes as well as between the scheme and their contracted parties. These problems are also compounded by conflict of interest and unregulated remuneration of trustees.[562] The CMS has observed several issues relating to misappropriation of members money at a level of the trustee boards and executive management of schemes.[563] The CMS also highlighted irregular and exorbitant remuneration for trustees and scheme executives as a concern.[564] In addition to the CMS a number of other stakeholders, welcomed our findings of the failings in the governance of medical schemes and administrators and supported recommendations towards strengthening scheme governance.[565] [566] [567] [568] [569] [570] [571]

180. We maintain our view that scheme governance should be improved to ensure that member's interests are fully protected and that they are able to hold their schemes and administrators accountable. The governance framework should place members' interests at the front and centre of the scheme's responsibilities.

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551 Discovery Health submission in response to the PFR dated 15 October 2018, p.27.
552 Discovery Health submission in response to the PFR dated 15 October 2018, p.27.
553 Medscheme submission in response to the PFR dated 06 September 2018, p. 7.
554 Medikredit submission in response to the PFR dated 07 September 2018, p. 2.
555 PFR dated 05 July 2018, Annexure 5.2 Medical Scheme Governance.
556 Makoti submission in response to the PFR dated 07 September 2018, p. 2.
557 Massmart submission in response to the PFR dated 7 September 2018, p.1.
558 Profmed submission in response to the PFR dated 01 October 2018, p.3.
559 DHMS submission in response to the PFR dated 15 October 2018, p.13.
560 Massmart submission in response to the PFR dated 07 September 2018, p. 2.
561 CMS submission in response to the PFR dated 07 September 2018, p.75-80.
562 CMS submission in response to the PFR dated 07 September 2018, p.75.
563 CMS submission in response to the PFR dated 07 September 2018 at p.75 -76.
564 CMS submission in response to the PFR dated 07 September 2018 at p.76.
565 Western Cape Department of Health Submission in response to the PFR dated 27 September 2018, p. 4.
566 Section 27 Submission in response to the PFR dated 01 October 2018, p. 14.
567 Life Healthcare Group submission in response to the PFR dated 15 October 2018, p. 16 (non-confidential version)
568 University of Fort Hare submission in response to the PFR dated September 2018, p. 2.
569 World Health Organisation submission in response to the PFR dated 21 September 2018, p. 2.
570 SAMA submission in response to the PFR dated 01 October 2018, p.18.
571 Commission for Gender Equality submission in response to the PFR dated 07 September 2018, p. 3.

181. Overall there were mixed reactions to the recommendations on governance. While some supported the recommendations to improve governance.[572] [573] [574] [575] there were stakeholders who disagreed with the HMI's findings on governance.[576] [577] [578] The consensus among these stakeholders are that the majority of schemes are well governed with only a few exceptions.[579] In general stakeholders who disagreed with the HMI's findings on governance are of the view that the medical schemes industry is a highly regulated industry and that most schemes have implemented various governance tools such as Codes of Conduct, Remuneration Policies, etc.[580] Submissions also stated that there are adequate regulations pertaining to governance in both the MSA and King IV and that schemes already abide by these regulations.[581] The HMI is of the view that the regulations in place should be strengthened through appropriate incentives, particularly around trustee and principal officer remuneration, creation of a metrics to measure trustee performance, strengthening the election process as well as conflict of interest policies.

182. One stakeholder specifically provided insight into the current state of affairs where administrators are not accountable to members yet they make crucial discretionary decisions that affect members and that should rather be made by the BOTs.[582] In order to close this governance gap and ensure that trustees do not abdicate their responsibilities, the stakeholder suggests that the Panel should directly address the artificial separation between schemes and administrator by recognizing the reality that administrators, just like trustees, occupy a relationship of trust vis a vis medical scheme members and therefore the Panel must take this line of thought to its logical conclusion by imposing fiduciary responsibilities on administrators.[583] With regards to the Discovery Health submission that administrators and schemes should be closely aligned, particularly in the context of non-profit schemes. We do not disagree with this contention. Rather our point is that the alignment of the scheme and administrator should not occur in isolation from the member. The recommendations put forward by the HMI attempt to align all parties but importantly seek to put the members' interests first.

Recommendations related to Governance

183. Given our findings that administrators generally make crucial decisions on behalf of schemes, it is clear that administrators stand in a fiduciary relationship with scheme members and should be expected to comply with fiduciary duties and be accountable for those decisions. [584]

184. With regard to linking trustee and PO salaries to performance, there are stakeholders who would support this recommendation[585] [586] [587] and some who partially support it.[588] One stakeholder warned against the possibility of trustees serving limited terms being incentivised to support or propose measures to obtain excellent short-term performance to the detriment of long-term sustainability.[589] While many stakeholders support having clearly defined quantitative objectives, they emphasise that due regard must be given to all factors that determine scheme sustainability, including healthcare expenditure and investment return.[590] The balance should be between affordability, access and quality of care and outcomes.

185. Some stakeholders support the recommendation to implement a remuneration framework that seeks to cap trustees and PO remuneration

572 LHC submission in response to the PFR at page 2.
573 CMS submission in response to the PFR at page 80.
574 Section 27 submission in response to PFR at page 14.
575 The WHO submission in response to PFR at page 2.
576 Discovery Health (Pty) Ltd submission in PFR at page 27.
577 Makoti submission in response to the PFR at page 1.
578 Massmart Health Plan submission in response to the PFR at page 1.
579 Discovery Health (Pty) Ltd submission in response to the PFR at page 27.
580 Makoti submission in response to the PFR at page 2.
581 GEMS submission in response to the PFR at page 19.
582 University of Fort Hare submission in response to the PFR at page 19.
583 University of Fort Hare submission in response to the PFR at page 19.
584 University of Fort Hare submission in response to the PFR dated September 2018, p. 19.
585 BHF submission in response to the PFR dated 07 September 2018, p. 13.
586 Life Healthcare Group submission in response to the PFR dated 15 October 2018, p. 16.
587 CompCare submission in response to the PFR dated 07 September 2018, p. 2.
588 GEMS submission in response to the PFR dated 07 September 2018, p. 20.
589 DHMS submission in response to the PFR dated 15 October 2018, p. 37.
590 MMI submission in response to the PFR dated 18 October 2018, p. 4.

and align remuneration with performance on appropriate metrics.[591] [592] Stakeholders who partially support the recommendation propose that available practice notes regarding the remuneration of Independent Non-Executive Directors be studied and incorporated into the CMS proposed remuneration framework and the recommendation should also be aligned with King IV.[593]

186. Stakeholders who reject this recommendation argue that remuneration should be directed by market conditions in a free market system.[594] The BOTs and PO carry risk in their own personal capacities. If trustees are not sufficiently remunerated, they will not be available.[595]

187. SAMA argues that we should retain this recommendation because the current remuneration packages do little to incentivise PO and trustees to manage costs and improve scheme growth.[596] However the remuneration framework suggested by some stakeholders, will have to be carefully constructed to ensure that there is not an overall increase in scheme non-healthcare expenses[597] and that the framework must take absolute indicators of scheme performance into account not only improvements.[598] Care is needed to avoid a situation where a cap is seen as a target resulting in a sudden increase in expenses as a result of schemes' remuneration being set at the cap as soon as it is introduced. [599]

188. We adhere to our view that by linking salaries to clearly defined, comparable, and appropriate performance metrics, the behaviour of schemes will be closely aligned to the benefit of consumers. The CMS is well placed to develop clear guidelines and standards of how to assess the performance of trustees in relation to the scheme's performance. Guidelines should take into account the long-term performance of the schemes to prevent the BOTs from taking decisions that show immediate benefits, but potentially inflict long-term harm.

189. There are also mixed views with regard to the recommendation that the CMS should publish performance metrics. Stakeholders who fully support this recommendation agree that administrators should be able to demonstrate value for money through their ability to address adverse selection and moral hazard.[600] The CMS is currently finalising the non-healthcare expenditure project which seeks to explore value propositions for non-healthcare costs.[601] Some stakeholders support the recommendation on condition that the metrics for performance measurement are clear, detailed and unambiguous, apply uniformly to all stakeholders, and are regularly updated in line with developments in healthcare, evidence-based medicine and patient member expectations.[602] Stakeholders who partially support the recommendation highlight that this sort of reporting is complex and that it will be critical to develop standardized definitions and analytic methods for all metrics.[603] Furthermore, since some information may be commercially sensitive and reporting may hinder bargaining with providers consideration should be given to the protection of commercially sensitive information and to the imposing of administrative burdens on scheme and administrators.[604]

190. Some stakeholders reject this recommendation on the basis that information on value and costs savings are contained in administrator reports to schemes,[605] [606] [607] [608] and that additional reports in addition to annual and quarterly returns to the CMS will take time and resources. [609]

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591 CMS submission in response to the PFR dated 07 September 2018, p. 81.
592 Life Healthcare Group submission in response to the PFR dated 15 October 2018, p. 16.
593 GEMS submission in response to the PFR dated 07 September 2018, p. 20.
594 Profmed submission in response to the PFR dated 01 October 2018, p. 3.
595 Profmed submission in response to the PFR dated 01 October 2018, p. 3.
596 SAMA submission in response to the PFR dated 01 October 2018, p. 18.
597 Health Funders Association submission in response to the PFR dated 07 September 2018, p. 5.
598 MMI submission in response to the PFR dated 18 October 2018, p. 5.
599 MMI submission in response to the PFR dated 18 October 2018, p. 5.
600 GEMS submission in response to the PFR dated 07 September 2018, p. 20.
601 CMS submission in response to the PFR dated 07 September 2018, p. 54.
602 Medscheme submission in response to the PFR dated 06 September 2018, p. 13.
603 Discovery Health submission in response to the PFR dated 15 October 2018, p.30.
604 Discovery Health submission in response to the PFR dated 15 October 2018, p.30.
605 Profmed submission in response to the PFR dated 01 October 2018, p. 3.
606 Universal Care submission in response to the PFR dated 07 September 2018, p. 3.
607 CompCare submission in response to the PFR dated 07 September p, 2.
608 Universal Administrators submission in response to the PFR dated 07 September 2018, p. 5.
609 Profmed submission in response to the PFR dated 01 October 2018, p. 3.

191. We believe that having performance metrics establish incentives to act in the interest of consumers to assess value for money, and the scheme to explore administrators where necessary. Our recommendation, therefore, stands. The BOTs and PO's comparative performance on metrics should be published annually for each administrator compared to a national average by the CMS.

192. In terms of a biannual report by the CMS, we acknowledge that there is already considerable regulation governing healthcare funders, and that the CMS is already under pressure to ensure that the regulations are equally applied. Stakeholders who do not support the recommendation submit that due to the highly regulated environment, various reports have to be submitted to the CMS.[610] Stakeholders who support this recommendation do so on the basis that it will introduce transparency into the managed care industry. [611] [612] [613]

193. Stakeholders however provided a number of considerations that should be taken into account if the recommendation is to be viable. One stakeholder submitted that CMS should be doing more to support the value of risk management initiatives that schemes implement,[614] and highlighted that analysis to assess cost savings is complex and requires consistent definitions and methodologies.[615] It would be important to ensure that managed care intervention are evaluated consistently between schemes and that methodologies are dynamic and responsive to changes in technological environments, exposure to health risks and regulation.[616] A collaborative industry process (such as ITAP) could be used to develop the appropriate reporting framework. This type of reporting should not weaken the bargaining power of funders in future negotiations.[617]

194. Accordingly, we believe that it is important to provide comparable metrics for the industry to benchmark itself as well as provide an impetus for improvement. We acknowledge that reporting by administrators/ MCOs and the CMS should be done in such a way that it does not hamper competition by revealing information that could be commercially sensitive or facilitate collusion. In this regard, the CMS' non-healthcare expenditure project will assist in determining a standardized comparator for non-healthcare expenses across schemes.

195. The CMS, as well as number of other stakeholders, support recommendations that seeks to encourage measures to increase member participation at AGMs.[618] [619] [620] [621] Profmed rejects the recommendation because as it stands schemes struggle to achieve participation by members. The introduction of technology to facilitate attendance will not have the desired affect but will impose additional costs on schemes' non-health costs.[622] Ironically though, Profmed introduced electronic voting a number of years ago which has benefited the scheme by increasing participation and transparency. Profmed also raises the concern that the MSAB (Medical Schemes Act Bill) proposes to entrench historic practices by insisting that elections are held at AGMs.[623] We note the contradiction in its recommendation regarding AGMs and the MSAB (Chapter 11A Governance). We believe that a review of the election process to encourage and facilitate greater participation and transparency in the appointment of trustees is in the best interests of members and schemes. By making it mandatory to elect trustees at the AGM, as proposed by the MSAB, the inefficiencies of the current system would be entrenched.

196. The recommendation to publish the CMS' contact number on membership cards is supported widely by many stakeholders,[624] [625] [626] [627] although GEMS rejected the recommendation since it believes that the sheer number of

610 MediKredit submission in response to the PFR dated 07 September 2018, p. 2.
611 Health Funders Association submission in response to the PFR dated 07 September 2018, p. 10.
612 Medscheme submission in response to the PFR dated 06 September 2018, p.13.
613 Life Healthcare Group submission in response to the PFR dated 15 October 2018, p.16.
614 Discovery Health submission in response to the PFR dated 15 October 2018, p. 31.
615 Discovery Health submission in response to the PFR dated 15 October 2018, p. 31.
616 MMI submission in response to the PFR dated 18 October 2018, p. 6.
617 Discovery Health submission in response to the PFR dated 15 October 2018, p. 31.
618 CMS submission in response to the PFR dated 07 September 2018, p. 80.
619 World Health Organisation submission in response to the PFR dated 21 September 2018, p. 2.
620 Health Funders Association submission in response to the PFR dated 07 September 2018, p. 4.
621 Life Healthcare Group submission to the PFR dated 15 October 2018, p. 16.
622 Profmed submission in response to the PFR dated 01 October 2018, p. 4.
623 Profmed submission in response to the PFR dated 01 October 2018, p. 4.
624 CMS submission in response to the PFR dated 07 September 2018, p. 80.
625 Profmed submission in response to the PFR dated 01 October 2018, p. 4.
626 MMI submission in response to the PFR dated 18 October 2018, p. 5.
627 Makoti submission in response to the PFR dated 07 September 2018, p. 3.

medical scheme beneficiaries makes this recommendation impractical unless the CMS is able to establish significant call centre capability. The recommendation is useful because it enhances members' consumer rights and makes them aware of a complaints system beyond that of the scheme and administrators.

197. Several stakeholders support the recommendation to develop a set of core competencies for trustees, considering the diversity of expertise required.[628] [629] [630] [631] It has, however, been submitted that trustee training should be flexible and relevant to meet the needs of trustees.[632] Stakeholders who partially support the recommendation sought clarification on competencies and argued that there should be a window period for current trustees to improve their competencies, where there are gaps, to ensure a retention of institutional knowledge.[633] The competencies should be broadly defined and schemes should be allowed a period to up-skill trustees in these competencies.[634] Restricted schemes agreed that the recommendation may not be practical as the trustees are elected from the existing pool of members. [635] [636]

198. We recommend regulating and mandating a set of core competencies for trustees and principal officers before they can be eligible to manage a scheme. This process is similar to that being proposed within the pension fund industry and similar reasoning can be applied across both industries.

628 GEMS submission in response to the PFR dated 07 September 2018, p. 13.
629 Life Healthcare Group submission in response to the PFR dated 15 October 2018, p. 16.
630 CMS submission in response to the PFR dated 07 September 2018, p. 81.
631 MMI submission in response to the PFR dated 18 October 2018, p. 5.
632 DHMS submission in response to the PFR dated 15 October 2018, p. 38.
633 Massmart submission in response to the PFR dated 07 September 2018, p. 2.
634 Makoti submission in response to the PFR dated 07 September 2018, p. 3
635 GEMAS submission in response to the PFR dated 07 September 2018, p. 3.
636 BCMI submission in response to the PFR dated 07 September 2018, p. 5.

Chapter 6
Competition Analysis For Practitioners

INTRODUCTION

1. In all healthcare markets, healthcare professionals are central to the consumption of healthcare services. Beyond their own services, doctors are central decision-makers in the use of healthcare services through the investigations they order, hospitalisation of patients and the services and treatments provided by various colleagues to whom they refer.

2. There is significant information asymmetry in all healthcare markets. Doctors generally have more medical knowledge and training and patients must trust their decisions. In South Africa, this is made worse as there is no public data available on the quality of care that a particular practitioner or hospital provides nor is there any public data available to inform whether a particular intervention or technology is associated with better health outcomes. This worsens information asymmetry and increases patients' reliance on practitioners' advice. This lack of information also inhibits rational referral by practitioners as well as value-based purchasing by funders.

3. In order to focus the inquiry, our analysis concentrated on general practitioners (GPs) and medical specialists registered with the Health Professions Council of South Africa (HPCSA) who we refer to collectively as practitioners. These practitioners were chosen because they account for the greatest proportion of the professionals' healthcare spend and also drive other consumption in the private health market. We recognise however that they are only part of the range of health professionals that study, counsel, or provide precautionary, remedial, rehabilitative, and health-improving healthcare services based on factual and theoretical information in the diagnosis and treatment of diseases and other health problems. We note that our findings on practitioners may be equally applicable to other healthcare professionals.

4. The HMI found that the context in which private practitioners operate in South Africa makes this market prone to competition problems. Incentives inherent in the private healthcare market influence behaviour that may not be in the best interest of patients.

5. The context can be characterised as one in which:

5.1 the predominant method of payment is fee-for-service which creates a perverse incentive in particular in profit maximising individuals or groups;

5.2 mandatory cover of prescribed minimum benefits payable at cost creates an opportunity for practitioners to determine their own degree of intervention and their rates which must be paid for in full by funders;

5.3 benefit design almost guarantees payment of most costs associated with hospitalisation and decreasing cover for out-of-hospital care, which has encouraged the admission of patients to hospital to ensure payment is guaranteed;

5.4 There is no standard approach to the coding of treatment/interventions and codes that do exist have not been updated which allows for the unilateral introduction of new codes, changes in coding behaviour and, in some cases, misuse of codes.

6. It is this context and the way in which practitioners operate in it that influences costs and access to care in the private sector. The HMI is not interested in ascribing fault to any stakeholder, rather we have focused on the system overall to assess if systemic remedies are available to increase effective competition to the benefit of consumers.

7. We have investigated various features of the practitioner market including: the market power of practitioners; incentives that may influence the behaviour of practitioners; vertical relationships between practitioners and facilities that may influence utilisation and expenditure and regulations that limit competition. Our findings were set out in the PFR.

8. We have reviewed responses to the PFR, conducted further engagements with stakeholders and considered their views in compiling this final report.

Supply and distribution of Practitioners in the private healthcare market

9. Many of the initial stakeholder submissions referred to an undersupply of medical practitioners in South Africa. According to stakeholders, the claimed shortage of medical practitioners, especially specialists, limits access to healthcare and contributes to the bargaining power of medical practitioners who can increase prices and resist designated supplier networks and alternative (performance based) reimbursement methods intended to increase efficiency in the use of resources, reduce costs and prices and thereby increase access. [637] [638] [639]

10. Describing the number and distribution of practitioners is an essential component of understanding the market. However, there is no central registry of practitioners in South Africa that provides reliable information about the number of medical practitioners, where and in what sector (public and/or private) they work, if they are currently practising, and whether they work full-time or part-time.

11. Using publicly available data we established that there are 0.30 medical practitioners (public and private) per 1 000 total population in South Africa and 0.10 medical specialists per 1 000 total population.[640] While we agree with stakeholders that these numbers are low,[641] we find that this is not the relevant market. The inquiry is focused on the number of medical practitioners operating in the private market and the population served by these practitioners. We took the view that the ratio of doctors known to be active in the private sector to the insured population (rather than the total population) is the relevant market.[642]

12. We have used public data and claims data for the period 2010-2014 to describe the number and distribution of medical practitioners in the private sector. A full approach to this analysis was presented in the PFR.[643] From the claims data, the inquiry could identify each unique practitioner practice number that generated a claim submitted to a medical scheme in the five-year period studied. To make the data more robust, we averaged the number of practices that billed in each year and generated a simple five-year average of the number of practices billing. The format of the practice number defines the doctor type (GP, specialist discipline, other providers). The location of the practitioner was determined from the address associated with each practice number. Addresses were assigned to individual enumerator areas which were then collated into districts and provinces.

13. This approach presented some challenges. It is possible that some addresses are out of date (the practitioner moved the practice but did not change their address in the data base). Some doctors have more than one practice number or are members of a group practice and a single practice number may in fact refer to more than one practitioner.

14. Nevertheless, we concluded that these numbers are sufficiently robust to draw meaningful conclusions. Some stakeholders believe that the number being used is likely to be an underestimate of the total number of practitioners operating in the market. However, we also note that people who are not working full-time are included, and there is thus both under- and over-counting. We have assumed that these differences cancel each other out and thus do not influence the general conclusions.

15. In the period studied we found that there is a five-year average of 14 951 unique practices in the

637 Profmed's submission to the HMI, 30 October 2014; Netcare submission to the HMI, Netcare overview paper, submitted on 30 October 2014; Mediclinic submission to the HMI, 31 October 2014; BHF response to submission to the HMI, 7 September 2014.
638 Department of Health Submission to the HMI, 17 November 2014.
639 Mediclinic, submission to the HMI 31 May 2013.
640 Padarath A, Barron P, editors. South African Health Review 2017. Durban: Health Systems Trust; Table 48 p. 309. 2017. URL: http://www.hst.org.za/publications/south-african-health-review-2017. Certain assumptions are made in calculating these data as explained in the reference cited; this only underlines the need for better data.
641 See Paragraph 37 for comparative data.
642 The HMI acknowledges that out-of-pocket-payments by uninsured members of the population may be important for certain practitioners such as GPs but there is no data available and it is thus not something that the HMI can take account of in our analyses. We assume a-priori that for specialists out-of-pocket-paying patients make up an insignificant proportion of their patients.
643 PFR, 5 July 2018, p304.

private sector that bill schemes, 53% of which are from GPs. Moreover, the number of practitioners in the private sector has increased year-on-year from 7702 GPs in 2010 to 8 000 GPs in 2014 and from 6 565 specialists in 2010 to 7 513 specialists in 2014 (see Table 6.1).[644] These practitioners are not evenly distributed, with more practitioners in Gauteng, the Western Cape and KwaZulu/Natal than in other provinces.

16. Nationally, there are 1.75 medical practitioners in the private sector per 1 000 insured population. As a comparison (noting that the number of practitioners in any health system depends on how that health system is organised and funded) the number of practitioners per 1 000 population is 2.8 in the UK, 1.7 in Brazil, 3.2 in France, and 4.2 in Sweden.[645]

17. The distribution of practitioners per 1 000 insured population by province is summarised in Figure 6.1. Overall there is a relatively even distribution of GPs per 1 000 insured population at about one GP per 1 000 insured population. The Northern and Eastern Cape provinces have lower coverage rates.

18. Specialists, however, are skewed towards the more urbanised provinces, with the Western Cape having the highest ratio of specialists at 1.21 per 1 000 insured population and, therefore also the highest number of total practitioners at 2.12 per 1000 insured population.

19. The distribution of all medical practitioners per district indicates the large differences across the country. For example, Figure 6.1 shows that there are 2.68 medical practitioners per 1 000 insured population in iLembe north of Durban, compared to 0.54 in Alfred Nzo in the Eastern Cape. The distribution of GPs by the proportion of the insured population is relatively even across all districts. However, some variation is evident with iLembe again standing out as different to the rest of the country, see Figure 6.2.

20. Figure 6.3 shows the distribution of specialists per 1 000 insured population and shows that there is a high degree of variation with the highest concentration in metropolitan areas and provincial capitals. It is reasonable to assume that some concentration of specialists should occur in urban areas and that these specialists may be seeing patients referred to them from further afield than the immediate area. Nevertheless, other factors (infrastructure, schooling for children, desirability of the neighbourhood, income of residents) may be relevant as well. For example, Eden, which is not a metropolitan area, has a high number of specialists at 1 per 1000 insured population, whereas other districts have no specialists at all.

Table 6.1: Medical Practitioners per 1000 insured population 5-year average 2010-2014 by Province

Province	GP's per 1 000 insured pop	Specialists per 1 000 insured population			Total practitioners per 1 000 insured pop
		Surgical specialists	Medical specialists	Total	
Eastern Cape	0.88	0.28	0.16	0.44	1.32
Free State	0.94	0.42	0.28	0.70	1.64
Gauteng	0.91	0.62	0.43	1.05	1.95
Kwazulu-Natal	0.99	0.44	0.30	0.74	1.73
Limpopo	0.96	0.14	0.09	0.23	1.19
Mpumalanga	0.85	0.19	0.09	0.28	1.13
North West	0.98	0.27	0.18	0.45	1.43
Northern Cape	0.74	0.20	0.11	0.31	1.05
Western Cape	0.91	0.71	0.50	1.21	2.12
Total National	**0.92**	**0.49**	**0.34**	**0.83**	**1.75**

644 The HMI is using unique practice number interchangeably with practitioner. While this may not be strictly correct, it is likely close enough and makes for easier reading.

645 World Health Organisation Global Health Observatory data repository. http://www.who.int/gho/health_workforce/physicians_density/en/ Accessed 30 March 2018.

Figure 6.1: Five-year average number of medical practitioners per 1000 insured population by district in South Africa 2010-2014

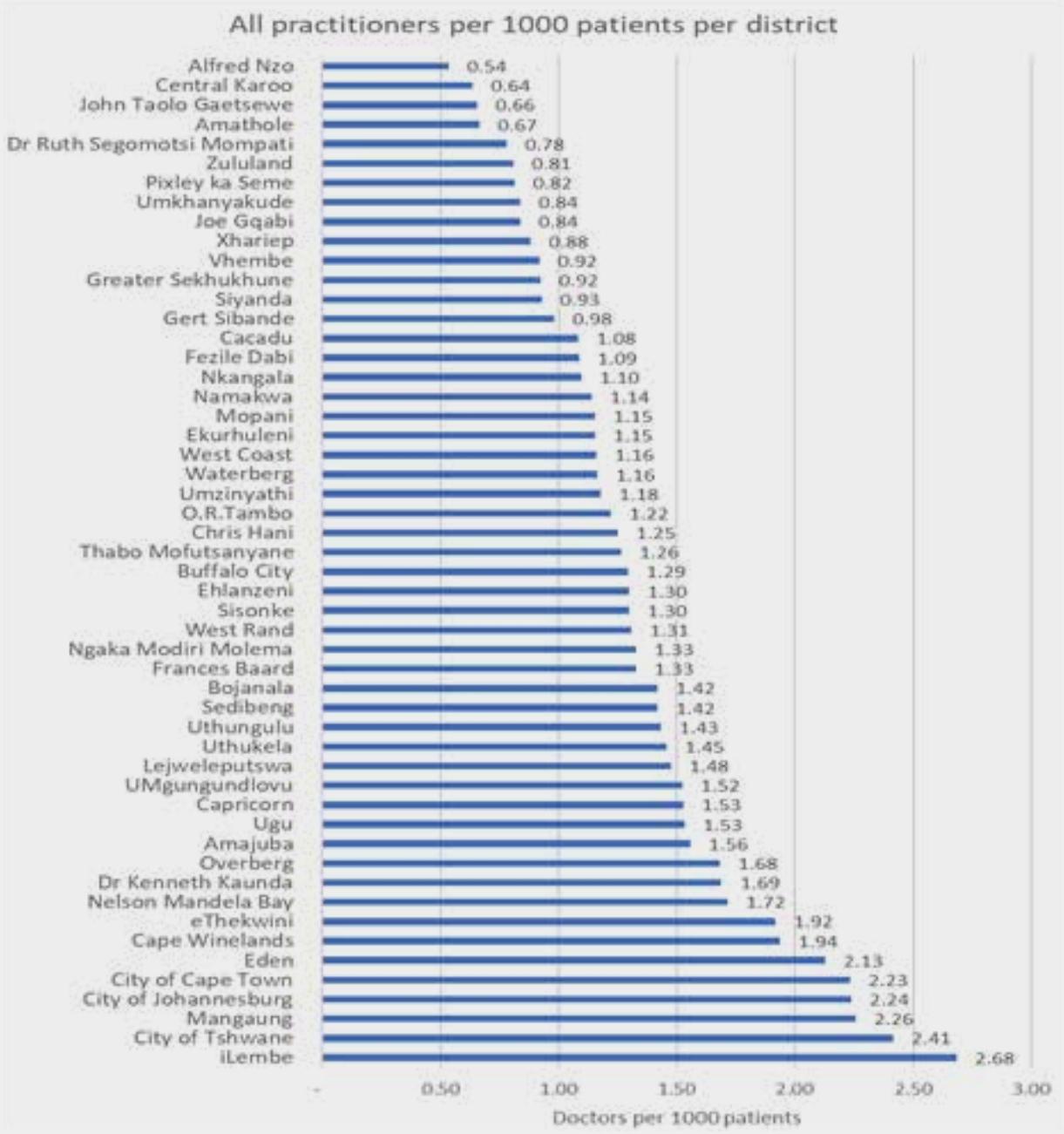


Figure 6.2: Five-year average number of GPs per 1000 insured population by district in South AfricaSouth Africa 2010-2014

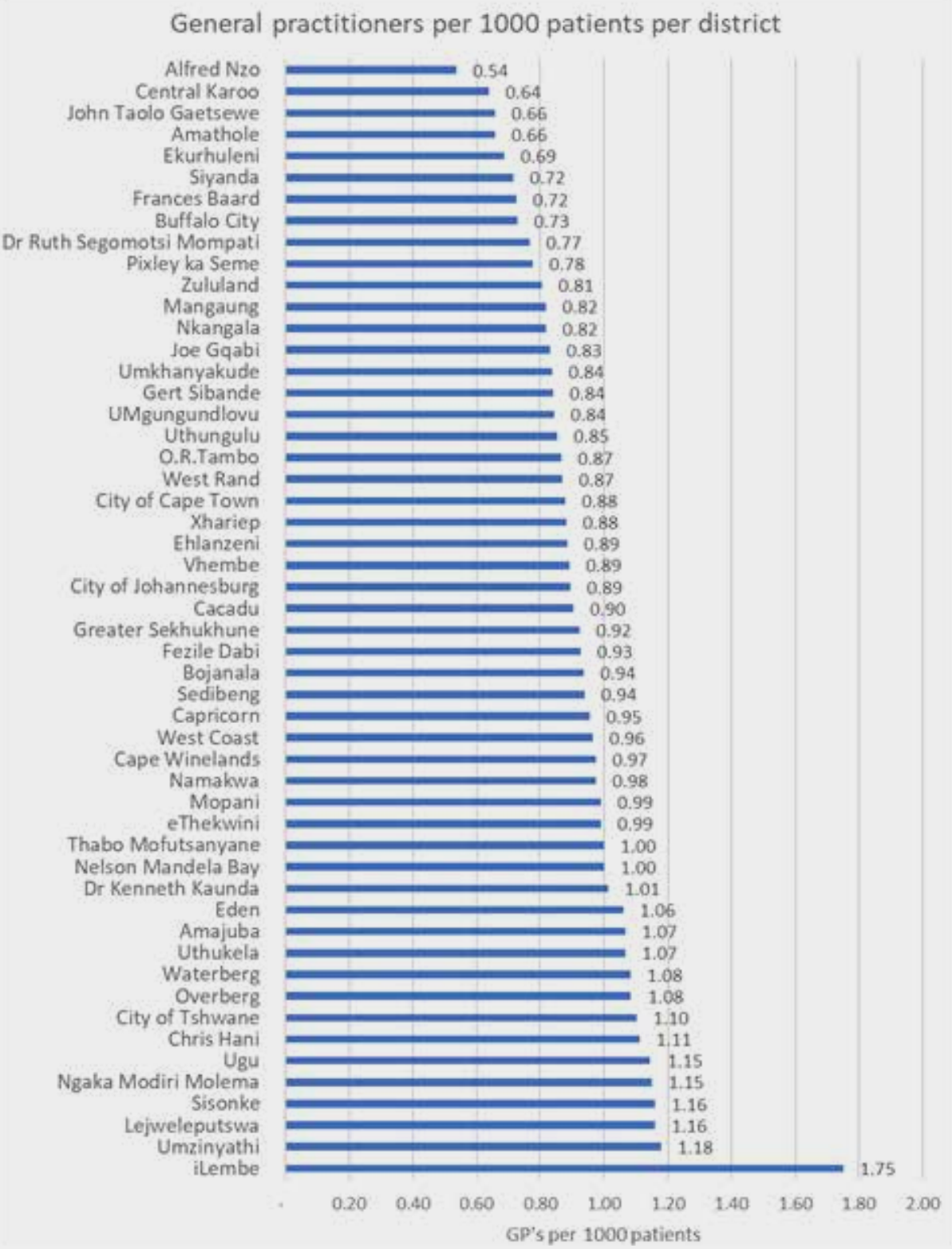
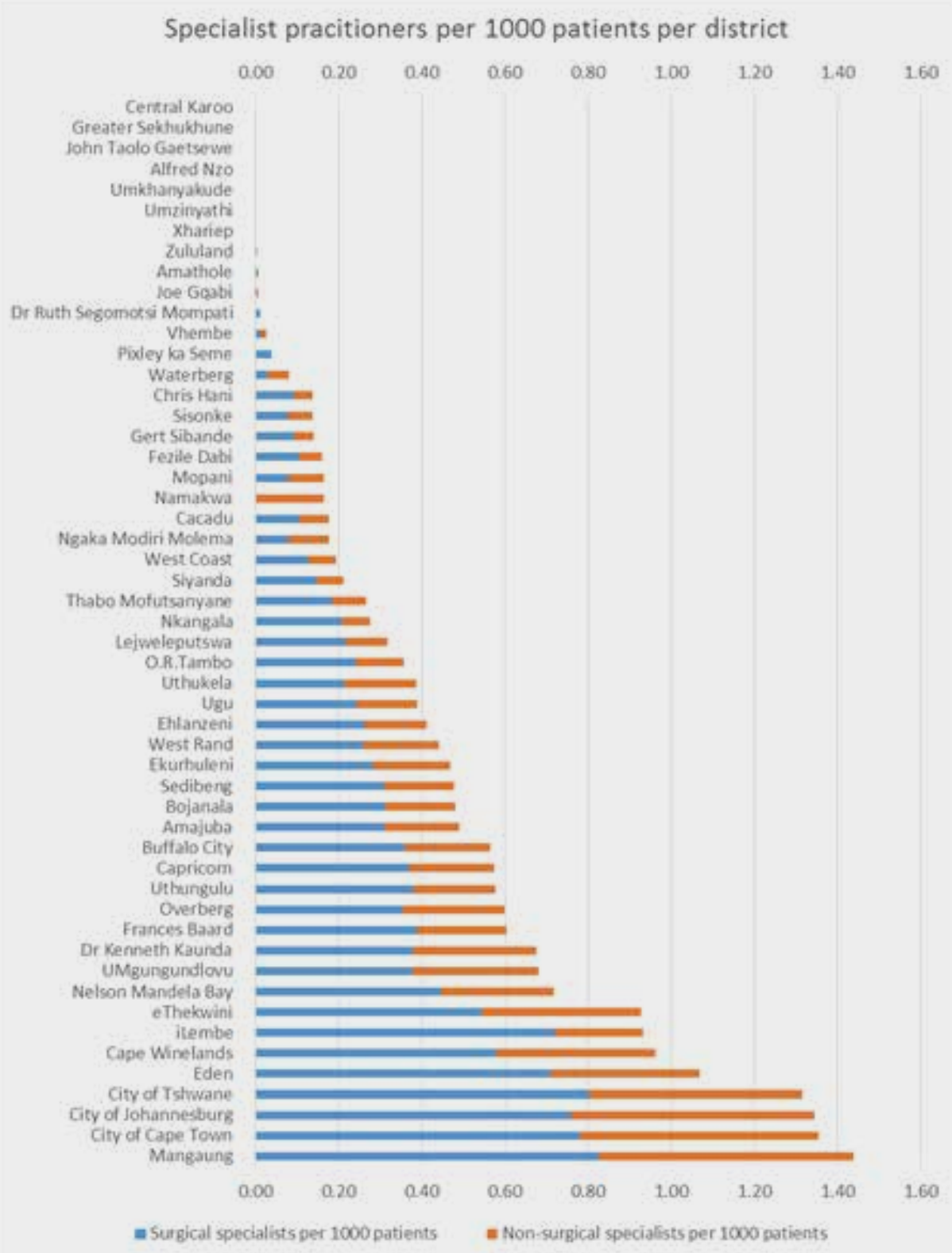


Figure 6.3: Five-year average number of specialists per 1000 insured population by district in South Africa 2010-2014



21. Access to medical practitioners in the private sector (1.75 per 1 000 insured population) is in stark contrast to access in the public sector (0.3 per 1 000 non-insured population).[646]

22. A conclusion about the "appropriate" number of providers in a market is always contentious and is a product of how a particular market works. The ratio of GPs to specialists also varies. In a doctor-oriented hospi-centric market, there are usually more doctors and the ratio of specialists to GPs can be high. This is the case in Sweden, for example, where there are a higher number of specialists to GPs compared to Norway which is more primary care oriented and has a higher ratio of GPs.

Supply of practitioners is not the most important cost driver

23. Determining the right number of practitioners for a market is not helpful not least since it is hard to intervene immediately to change this. The PFR therefore did not make a finding about the absolute number of practitioners in the private market. We considered this statistic to be less relevant and rather focused on if those practitioners who are operating in the private market are being used in the most efficient and effective manner to promote quality affordable care that improves health outcomes and increases access.

24. Overall, we find that: the impact of a fee-for-service environment, the way practitioners are regulated, the predominance of solo practices and absence of multidisciplinary teams, the relative absence of up- and down-referral across levels of care, the requirement to pay PMBs at cost, the way that some practitioner associations operate and our finding that some practitioners can ignore tenders or significantly influence the terms of funder networks, are more important than scarcity in influencing market outcomes.

25. We have had to analyse whether the number of practitioners in the private sector was driving costs. Our conclusion is that, while it may be that for some specific specialities there may be a relative shortage, and that it may well be desirable to have greater access to practitioners, overall it seems that scarcity is not an important factor driving costs The following features of the private sector lead us to this conclusion.

25.1 Fee-for-service and an obligation to pay for PMBs at cost have allowed specialists to determine their own level of intervention (amount of services and types of services provided) and their own rates of reimbursement. This incentivises specialists to see patients with PMBs when they could be seen by a GP, nurse, or medical associate.

25.2 Benefit design has resulted in a continual diminution of the out-of-hospital and preventive cover meaning that patients may run out of cover for GP-based out-of-hospital care before the year is out and that almost all hospital-based care is covered which would logically result in both patients and practitioners making use of hospital-based care.

25.3 Fee-for-service combined with benefit design incentivises hospitalisation and additional care. We have demonstrated Table 6.7 and Table 6.8 that specialists have kept patients in hospital longer, and/or use higher levels of care, and/or do more tests and or order more expensive tests than can be explained by the level of illness of the patient. This lends credence to our conclusions that fee-for-service influences behaviour and more so for specialists as they are currently seeing most of the PMBs and/or admit patients to hospital.

25.4 We have demonstrated in Table 6.7 and Table 6.8 an increase in utilisation, in particular, hospitalisation, that is beyond what can be explained by the level of illness of the population and the degree of sickness of the individual at the time of admission. This supports our conclusion that there are systemic reasons that promote over-utilisation.

25.5 We have also demonstrated that for the majority of hospital admissions by a specialist, there is no prior consultation pre-hospitalisation indicating that specialists admit patients directly to hospital and it seems unlikely that every consultation with a specialist would result in justified hospitalisation.

25.6 Patients often by-pass GPs and consult specialists directly and GEMS have demonstrated considerable savings when mandatory GP-referral to a specialist was introduced without a decrease in quality.[647]

26. All of these factors have lead us to conclude that there is not an absolute scarcity of specialists (while there may be some real scarcity in some specific disciplines) but rather that specialists are seeing patients that could be seen at other

646 Padarath A, Barron P, (editors). South African Health Review ,2017. Durban: Health Systems Trust; Table 48 p.309. 2017.
647 GEMS SMC. Emerald Value Option: care coordination in practice, submission 3, September 2018

levels of care, and are over-servicing at least a proportion of patients that they do see.

27. We have noted that hospitals compete for specialists in order to secure a range of services at their facilities and to attract admissions as only healthcare practitioners, and more so specialists, admit patients. Hospitals argue that this competition is fierce and related to scarcity as it is not always possible to find the required specialists. This may be true. However, in public hearings, we also heard from specialists who complained that they were not given admissions privileges. It is also possible, therefore, that there is a mismatch between where there are vacancies and where specialists are willing to work, and/or that there is an oversupply of facilities, or that there is a concentration of facilities in one location competing for practitioners in that location.

Responses to the PFR on the supply of practitioners

28. Overall, there were no objections to the findings and conclusions that we reached on practitioner supply. While both funders and facilities had put forward a scarcity argument, they did not object to the conclusion that that the scarcity or otherwise of practitioners is less relevant, and that their conduct is of greater importance. Practitioners too did not raise particular objections to this idea. It is noted, however, that not all practitioner groups engaged with the PFR. Overall, however, scarcity was not raised as an issue.

29. SAMA did note that the disease burden in South Africa was high, but their presentation dealt with total population which was not the subject of this inquiry. Similarly, pathology groups suggested that we ignored the quadruple burden of disease in South Africa, but this is, in fact, included in all of our analyses and specific responses to these objections can be found in a previously published response by the HMI.[648]

30. While none of the submissions offered alternative data on the number of practitioners or suggested that our findings were wrong the SAMA noted that the HMI had used Discovery Health data and thought that this was inappropriate.

31. All our preliminary analysis used the claims data to identify the number and distribution and entry of practitioners into the market. The PFR also noted that HPCSA and BHF data were not appropriate data sets to use as they do not provide data on 'active' practitioners.[649] The analysis conducted with Discovery data was conducted to test our conclusions on the entry of practitioners into the market. Discovery had a longer series related to new entry than the inquiry. The longer time series would be more accurate, and the HMI wanted to take advantage of that. The conclusions from both were the same: there has been significant growth in the number of practitioners entering the private healthcare market. This is in spite of the fact that the number of people being served by the private sector (total scheme membership) has been largely static since 2012.[650]

32. A number of stakeholders raised the issue of insufficient training of doctors. Hospital groups in particular were keen to train doctors. However, at the public hearings when questioned about how they would contribute to increasing the number of doctors, hospital groups responded that they are able to train specialists. Our view was that it is not clear how further training of already qualified doctors would increase the total number of practitioners. Further, the HPCSA said it had not received requests from private institutions to train doctors suggesting that this is not an urgent issue for hospital groups.

33. It was recommended by some stakeholders during the HMI seminar on Excessive Utilisation and Supply Induced Demand that GPs should be obligatory care coordinators. The South African Society of Physiotherapy submitted a response to the seminar that physiotherapists have been recognised as First Line Practitioners by the HPCSA since 1985 and can diagnose, triage and refer patients as required with good outcomes and healthcare savings and recommended that physiotherapists should be included as coordinators of care in certain conditions.[651] We support this view. As new models of care evolve it may well be that midwives or physiotherapists or a range of providers could provide first line care, conditional on maintaining or improving quality outcomes. It would be imprudent of funders not to take heed of this possibility to the benefit of scheme members.

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648 See Seminar Note on Excessive utilisation and Supplier Induced Demand. 4 April 2019. http://www.compcom.co.za/wp-content/uploads/2019/04/SID-Seminar-Discussion-Note.pdf

649 PFR, 5 July 2018, pp 302-303.

650 Scheme membership comprised 8.68 beneficiaries in 2012 and rose to 8.87 by 2017.

651 SASP submission following the seminars in April 2019, 29 April 2019.

Conclusions on the supply of practitioners

34. Despite claims of shortages of practitioners, we maintain that both evidence and argument support a conclusion that better use of available practitioners could result in improved access and decreased costs.

35. We have concluded that there is stronger evidence that the way practitioners spend their time influences costs and competition in the market, and that the structure of the market at a system level does not result in optimal market outcomes.

36. We note too that lack of innovation in models of care, in particular, multidisciplinary group practices, prevents up and down referral between various practitioners. In a well-structured group practice, a patient sees the most cost-effective, most appropriate provider that delivers the best quality outcome. This lack of innovation may be a result of HPCSA ethical rules, lack of pressure on providers to change their approach, lack of investment from funders (either in their administration systems or through failure to have any pressure to be brought upon them to fund new cost-effective models) to promote new forms of care. We note that internationally, in comparable systems, multidisciplinary integrated care is common, and evidence suggests it provides better health outcomes. In the UK, a primary care nurse is frequently part of the healthcare team seeing patients who then do not need to see doctors, while in the USA, use of medical assistants as primary care providers is common. In South Africa, in the exceptional cases where some new models have been introduced, they have resulted in a better quality of care and in decreased costs and increased access.[652]

Practice Code Numbering System (PCNS) as a method to measure supply

37. Closely related to knowing the distribution of practitioners is the practice code numbering system. Currently this is managed by the BHF on behalf of the CMS. Funders use Practice Codes to identify and pay practitioners; they have become essential. Using practice codes, we were able to assess which practitioners are active in the private market. While all practitioners have a licence number from the HPCSA which indicates that they have met the professional requirements, this is not used beyond this function.

38. We identified various inadequacies with the PCNS including that it is not updated with regard to the current status of the practitioner, or where the practitioner is physically located. We also identified that useful information can be imbedded in the number such as if the practitioner is part-time or full-time and if the practitioner is also employed by the public sector.

39. The requirement to have such a number in order to be paid creates a useful incentive in the market.

40. We have recommended that this system becomes a public good under the auspices of the SSRH and that it be renewed annually, subject to reporting requirements and other conditions that are explained further in the Recommendations Chapter.

41. The CMS disagrees with our recommendation for the PCNS to be moved to the SSRH. According to the CMS, regulatory oversight over the PCNS sits with the CMS and is also in the Medical Schemes Amendment Bill. Fraud, waste, and abuse and its related regulation falls within the broader regulatory ambit of the CMS. They do, however, agree that the PCNS should be issued to both private and public facilities and with annual renewal.[653]

42. We believe that the function of issuing practice numbers should be linked with other aspects of supply-side regulation. We have, therefore, recommended that the function be moved from the BHF (who is conducting this on behalf of the CMS), who represent the funding side of the market.

43. We have further recommended that private premises be required to have a practice number. Intercare disagrees with this recommendation. They state that extending practice numbers to practitioners' premises is yet another form of licencing. Instead, Intercare recommends that facilities where practitioners practice should be linked to an individual's practice number. [654]

44. We recognise that previously the practice number codes were used only for billing purposes and believe that this is a missed opportunity. Practitioners in the private sector are hardly regulated as individuals beyond maintaining their registration with the HPCSA, and that there is no oversight of the premises from which they

652 See the discussion of Innovative Entry by Improved Clinical Pathway Services (ICPS) and Professional Provider Organisation Services (PPOS) in the PFR, paragraph 59 to 77.
653 CMS submission in response to the PFR, 7 September 2018.
654 Intercare submission in response to the PFR, 7 September 2018.

work. Assessing the quality of the rooms from which private practitioners work can and should be a function performed by the OHSC. NHI will require that anyone contracted by government will have to meet a minimum standard. Linking practice numbers to both individual practitioners and their premises is an efficient way to ensure proper data is collected, to encourage practitioner participation in OMRO and will be an advantage for those practitioners who contract through the NHI. We firmly believe that such regulation is necessary, minimally invasive, aligns the private sector with NHI and most importantly ensures practitioners are providing care in quality environments and allows systems to promote the best outcomes for patients. Other stakeholders agree with this recommendation.[655]

45. A risk of linking the individual practitioner practice code numbers to their premises may occur if a physical practice is deemed below standard but the practitioner themselves are in good standing. The decision can be left to the SSRH but a different number, one for the practitioner and one for the private physical premises, may be the easiest solution.

46. We envisage that there will be no duplication of roles: the SSRH will liaise with the HPCSA and the OHSC to ensure that a practitioner and their premises are in good standing before issuing a practice number. While the linking of the practice number to HPCSA registration will be immediate, the link to OHSC certification and OMRO reporting will be incremental, as these bodies develop the capacity to regulate premises in the case of the OHSC and as OMRO develops. At the outset, OMRO will not apply universally to all practitioners.

47. The linking of these reporting and certification functions to practice numbers is deliberate. Because the number is required for billing, it creates an incentive for practitioners to comply. The overall purpose of this system is to promote quality care and to build a national database of healthcare practitioners and facilities. It is more than reasonable to expect that a country would have knowledge of how many and where healthcare practitioners are located, and that they are delivering quality care. In fact, this is arguably an existing legal obligation.

Barriers to Entry Affecting Practitioners In South Africa

48. We have examined the number of practices submitting claims over a 5-year period (2010 – 2014). We have found that the number of GPs increased steadily by 1% per year (and 3.9% overall) and the number of specialists increased by 3.4% per year (14.4% overall).[656]

49. The entry of practitioners over the period for which data are available has been consistent, with particularly high entry by physicians, anaesthesiologists, psychiatrists, and orthopaedic surgeons. While barriers to entry are clearly, therefore, not insurmountable, we have considered the barriers cited by stakeholders, namely regulatory barriers, start-up costs, and innovative entry.

50. We set out below our findings and recommendations for each barrier examined.

50.1 *Regulatory barriers to entry* (training of practitioners). Although this is a barrier to entry, regulatory control over training standards, curricula and registration is necessary to protect the public and is not only unavoidable but is, on balance, beneficial to consumers and society.

50.2 *Start-up costs*. Though stakeholders indicate that start-up costs are significant (especially for specialists), we found that there are a number of methods of mitigating the effect of start-up costs on entry. These include guaranteed income from the hospital when setting up new emergency units, loans from hospitals, relocation costs covered by hospitals, hospitals purchasing equipment on behalf of practitioners, low rentals and shared costs amongst specialists.

50.3 *Innovative entry*. While innovative entry has occurred, as demonstrated in the PFR, it has been insubstantial. This has been influenced by the interpretation of the HPCSA rules which has restricted multidisciplinary group practices and global billing. Innovation was reported to be obstructed by funders and some practitioner associations. The market is characterised by lassitude among providers, and comfort with existing models by the majority of funders, practitioners and facilities.[657] [658] Therefore, disruptive innovative entry – the kind that

655 Submissions to the PFR from the Western Cape Department of Health, 27 September 2018 and HFA, 7 September 2018.
656 Comparing the compound annual growth rate it is interesting to note that more than three times more specialists have entered the market than GPs
657 Competition to make the Healthcare market work for all South African communities', Dr Brian Ruff Durban Public Hearing, 17-19 May, 2016.
658 Improved Clinical Pathway Services (ICPS)'s presentation on 'A standardised care pathway with global billing: second level technology', Durban Public Hearing, 17-19 May, 2016.

stimulates competition and expands access to healthcare services in the private healthcare sector - is - almost absent.

Responses to findings and recommendations on barriers to entry and the response of the Inquiry

51. On the whole, stakeholders agree with our assessment of barriers to entry for medical practitioners. SAMA attributes some of the growth in the number of private practitioners to push factors from the public sector and the progressive decrease in the number of posts in the public sector in recent years. SAMA bases this conclusion on the PERSAL (Personnel Salary System) and government expenditure.[659]

52. We note that there may be a number of factors that have influenced the patterns demonstrated by the numbers of claiming practitioners. However, we believe that many of the barriers cited by stakeholders are not insurmountable.

53. In the period 2010-2014 about one thousand practitioners (GPs and specialists combined) entered the private market during a period when the number of people belonging to schemes was static. This increasing entry of practitioners has been ongoing for a longer period.

54. Stakeholders have also disputed our assertion that there has been little innovative entry in the market but have provided no evidence to the contrary. We remain concerned about innovative entry. Examples of innovative entry by Improved Clinical Pathway Services (ICPS) and Professional Provider Organisation Services (PPOS) remain limited, and some have been embraced only during the time of inquiry, once a lack of innovative entry was highlighted in public hearings. We note that while innovative entry has occurred, it has been slow and difficult, and has not been embraced by funders and by some practitioner associations. [660]

55. The relative absence of innovative forms of entry such as multidisciplinary practices, and practitioners who initiate new payment models, is noted with concern. We draw attention to the role of the HPCSA and, in particular, to its lack of attention to the impact of rules and regulations on competition below.

Prices and Practitioners

56. Historically, tariffs were set collectively with practitioners' interests represented by SAMA or its predecessor(s). This ended in 2003/4 when the Commission indicated that collective tariff determination conducted amounted to collusion. Since then practitioners' fees have been determined in one of four ways:

56.1. a medical scheme/administrator will determine the fees that it is willing to pay practitioners and provide this information to practitioners;

56.2. a practitioner grouping may negotiate fees with a medical scheme/administrator on behalf of its members;

56.3. a practitioner grouping publishes guideline tariffs and coding for use by its members; and/or

56.4. a practitioner may determine the fees that he/she will charge to patients individually.

57. The general approach seems to be that medical schemes set a rate for each billing code, but that practitioners choose whether or not to accept the scheme rate. Practitioners who do not accept the scheme rate have greater discretion in what they charge, but this comes with a higher administrative burden and greater risk as they need to collect fees from patients directly.[661] However, in practice, many practitioners (particularly specialists) continue to charge above the scheme rate indicating that these risks are likely to be insignificant.

58. The current situation is described by many stakeholders, including practitioners, as a "price vacuum". Practitioners ask advice on what to charge, those they ask do not reply to escape sanction from the Competition Commission and many practitioners will charge what the market will bear and, as in any market, practitioners, respond to the various incentives inherent in the market. Practitioner associations of various types have played a role and are discussed in further detail below.

Coding as an integral part of price determination

59. Coding is integrally linked to prices. In order to come to a price in a fee-for-service environment each activity performed by a practitioner has to be labelled and this process is called coding.

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659 SAMA states that until 2013, posts were increasing, but for the period, which was examined, posts in the public sector decreased annually in real terms. This has been as a result of budget cuts and the freezing of posts by provincial departments. SAMA submission in response to the PFR, 1 October 2018.

660 See PFR, dated 5 July 2018, Table 7.2 , p.310.

661 We note that the implementation of funder networks increases the number of practitioners who accept scheme rates.

60. Clinical coding translates medical information of a patient's interaction with healthcare providers into alphanumeric codes. It provides a form of standard communication that identifies which procedures, diagnoses or services have been delivered. Codes form the basis on which prices are determined.

61. However, coding is a separate process from tariff determination. Codes do not translate directly to fees that will be paid. Codes are ascribed relative value units (RVUs) which indicate how complex or time consuming a service is and differentiate between simple and more complex interventions. RVUs can also incorporate aspects of practitioner value such as degree of experience (often measured in the number of years in a particular position which assumes that a practitioner becomes more skilled over time). Thereafter, a rand conversion factor (RCF) is applied to the RVU and this determines the fee of each particular service.

62. The 'vacuum' created by the Competition Commission prohibition on collective bargaining left practitioners and various associations and funders unsure about meeting collectively on any issue. The close relationship between codes and reimbursing makes clear why formal discussions on codes have been avoided and have not been officially reviewed. New interventions have not been given standardised codes, old interventions still carry sometimes outdated RVUs, codes have been unilaterally suggested and accepted or not by funders and practitioners and some associations have unilaterally redefined codes.

63. Further some of the coding systems are proprietary and thus owned by groups such as SAMA who, we have found, have a vested interest in how codes are defined.

64. We recommended in the PFR that a standard coding system that is publicly owned was required. In making this recommendation for products (medicines and devices), diagnoses (ICD / ICPC), procedures (CPT) and also DRGs codes, we concluded that all coding systems in the healthcare sector would need to be independent, centralised and standardised across both the private and public sectors in order to ensure consistency and allow for billing across both sectors. Even where codes need to be updated regularly this does not preclude them from undergoing a process of standardisation. We recommend that this function fall under the auspices of the SSRH.

65. Stakeholders agree with the finding that coding may be abused for the benefit of the practitioner, and with the recommendation that there is a need for an independent, centralised and standardised coding system.[662]

66. There was disagreement that one single system would suffice. Medikredit pointed out that there is currently no available coding system that is able to cater for procurement, supply and distribution as well as billing and patient administration, which may make it impossible to use the same coding standard since certain attributes and standards may be different for these two purposes. Medikredit proposed that the NAPPI coding system would be an ideal coding standard across the entire healthcare sector for billing, patient administration and other applications requiring electronic transmission of healthcare information for pharmaceutical, surgical and consumable healthcare products.[663] SAOA, on the other hand, is of the view that any standardised coding would be limited to procedural codes and not include product-related codes based on volumes which may change during the course of each year.

67. SAMA has argued that clinical coding should remain the intellectual pursuit of clinical professionals and clinical coding experts, that there should be a separation between the development of codes and price determination and that funders and hospital groups should not lead the processes pertaining to clinical coding because of the incentives at play.[664] Some stakeholders indicated that the SSRH may not be the appropriate custodian for the coding systems. NHC submitted that if the SSRH does not take over the coding function, there would at least need to be some collaboration between the custodian thereof and the SSRH since the SSRH will seem to be the forerunner in the determination of fees, whether it be FFS or alternative models.[665]

68. The CMS noted that the recommendation that the functions should reside in a unit in the SSRH conflicts with the NHI Health Systems Reform Forum Structure and is not aligned with the NHI Bill. They also raise the issue that it is unclear what will happen in the sector while the SSRH is being established and what its role will be under the NHI.[666]

662 See, inter alia, submissions to the PFR by the CMS, Medikredit, Profmed, RSSA, SAOA, WHO and the Western Cape Department of Health and HFA.
663 Medikredit submission in response to the PFR, 7 September 2018.
664 SAMA submission following the seminars in April 2019, 2 May 2019.
665 NHC submission in response to the PFR, 5 September 2018.
666 CMS submission in response to the PFR, 7 September 2018.

69. The WHO has pointed out that the provision of the standardized coding system is articulated under NHI Bill under Section 34(3). Hence, they are of the view that the recommendations on procedural and disease coding for healthcare should be aligned with NHI Bill. The WHO also argued that the ownership of the coding system should be with the Government. It noted that our recommendation should articulate the mode of transition to the new system of coding with minimum financial implications and disruption for the healthcare industry.[667]

Conclusions regarding coding

70. We believe that the SSRH should remain the custodian of a coding unit.

71. Existing structures are recognised. We suggest that expertise from entities (such as Medikredit and SAMA) that are currently involved in developing coding should be fully utilised and coding must be done in consultation with appropriate experts in each discipline. However this is a function that must be overseen and owned by the supply side regulator as practitioners may have a vested interest in determining and in some cases manipulating codes.[668] We believe that national coding systems cannot be proprietary to any private entity and that ownership of such systems should be transferred to the custodian entity (SSRH). The current private owners should be compensated at a reasonable cost, in order to take into account the investments that have been made thus far.

72. The benefit of a single coding system throughout the health sector, public and private, will facilitate the greater integration envisaged under the NHI. We believe that alignment with the NHI can be achieved through relevant and appropriate enabling legislation. A prescribed coding system is required by section 34(3) of the NHI Bill and our recommendation will align properly with the requirements of the NHI.

73. We have noted the point made that there should be a separation of the coding and the tariff determination processes. We believe that because these functions are maintained within the SSRH, they can be conducted by different units within the organisation.

74. In this regard, and to provide clarity, we recommend that the determination of the codes, their descriptions and determination of RVU should be conducted by a unit that includes coding experts and academics under the custodianship of the SSRH as proposed above. Further to this process, the multilateral forum that will be run by the SSRH should use of the RVUs determined and develop an RCF to determine a reference price list for practitioners.

75. A transitional arrangement can be agreed in which current custodians of coding systems prepare these for handover to the SSRH. In this regard, the government should fund the development of a coding system. This should be put out to tender to academic institutions that have such capacity and the required medical expertise. The work would include defining codes and RVUs and ensuring appropriate consultation takes place, including exploiting the expertise that exists within coding entities such as SAMA and Medikredit which should ensure minimal disruption to the industry, and until the SSRH is fully functional.

76. Finally, in relation to coding we recognise the contribution of Ms Patricia Holburn, who is a consumer and medical scheme member, who requested more transparency around the ICD10 codes. She stated, and we agree, that codes need to be accompanied by wording so that members have a clearer understanding of what they have been charged for. Statements that only use codes should be disallowed.[669]

Practitioners and Competitive Constraints

77. The competitive assessment framework in ***Chapter 3: Competitive assessment Framework*** noted that effective competitive pressure typically comes from firms already operating in the market, firms that could readily enter the market, and from buyers that exercise effective disciplinary pressure on suppliers. Absent competitive pressure, firms in a market are able to act unilaterally to raise prices, reduce output, reduce quality, and/or limit innovation.

78. We are concerned that within the private healthcare market, practitioners do not face intense competition. Rather, the practitioner market is characterised by a number of features which serve to benefit practitioners at the expense of patients and medical schemes. This has created an environment where practitioners can increase prices and avoid innovation without the threat of losing customers.

667 WHO submission in response to the PFR, 21 September 2018.
668 See PFR, dated 5 July 2018, Chapter 7 p. 341 paragraph 167.
669 Patricia Holburn submission in response to the PFR, undated.

79. The following factors serve to create an imbalance in practitioner relationships with patients and their funders.

79.1 Information asymmetry between patient and practitioner means patients, as consumers, have little-to-no countervailing power when seeking treatment and are unable to negotiate prices.

79.2 This lack of countervailing power is exacerbated in insurance markets where sensitivity to price is muted because the client is not paying for the service directly and patients are unable or unwilling to seek cheaper alternatives.

79.3 Instead, patients may assume higher prices and higher levels of care (or simply more care) are indications of better care and are thus are willing to pay more, and to follow their practitioners' advice where unnecessary additional treatment is recommended.

79.4 Often expensive unnecessary treatment is requested by patients where hospital-plans require hospitalisation to ensure that a patient's insurance product will cover the costs. And,

79.5 Patients often by-pass GPs and go directly to specialists as they believe specialist care is better care. This can be the case, but it is also the case that specialists may not offer holistic care and may provide an inappropriate level of treatment for a relatively minor condition.

80. The above factors serve to create an environment where practitioners are able to operate relatively independently from any competitive constraints. Practitioners can charge high fees and claim to be erring on the side of caution when prescribing treatment and, under these market conditions, patients are unable and often unwilling to discipline providers.

81. The lack of data on quality and effectiveness of care in the South African context compounds this problem further as there is no objective information to indicate what course of action (investigation, treatment) has a better health outcome. Absent competitive pressures, there is also no incentive for practitioners to adopt innovations.

Adverse Market Outcomes

The effectiveness with which healthcare practitioners' direct patients along the healthcare pathway

82. Practitioners are professionals with greater, often untransferable, information which they hold relative to consumers. They wield this information advantage over funders when they argue that their particular patient is unique and thus requires deviation from formulary or other standard practice. Funders often have similar knowledge to practitioners and so can counter their arguments. However, this is at the heart of the conflict between practitioners and funders where practitioners claim that funders undermine their professional autonomy.

83. Practitioners are meant to guide patients to an appropriate healthcare pathway. We have noted that patients may be receiving care at inappropriate levels of care and that practitioners, specifically specialists, are seeing patients that could be treated at another level of care (e.g. by GPs, as an outpatient, or in a general ward rather than in High Care or an ICU).

84. We conclude that practitioners are able to direct patients to any level of care even inappropriately. The current imbalance of power between medical specialists and funders is such that the corresponding waste of resources cannot be prevented by payers, or by patients who may not know their own best interests.

The purported scarcity of skills and absence of local competition

85. We have noted that there is a narrative about a purported scarcity of practitioners, especially specialists in the private sector. We find this to be less important than the way that practitioners spend their time, this perception may influence specialists market power.

86. We have found that facilities largely compete for specialists to practice from their hospitals. As outlined in the ***Chapter 4: Competition Analysis For Facilities*** the relationship between practitioners and facilities is governed by contracts and arrangements which may directly or indirectly provide certain incentives for practitioners. These incentives include facilities granting preferential shareholding to high admitting specialists; facilities offering practitioners various rental discounts; facilities offering practitioners other forms of incentives such as relocation fees to assist practitioners moving from a different area, province or facility group and other allowances, loans, scholarships and grants.

87. While scarcity may contribute, there may be a number of other factors at play, including an oversupply of facilities in specific areas which reinforce the perception of a scarcity of specialists. However, what is clear is that the perceived scarcity has placed specialists in a position of market power where facilities are willing to invest in high-care capacity and offer other incentives

in order to attract specialists to their facilities. The harm comes when these investments result in increased costs to consumers without a concomitant increase in treatment quality and patient outcomes.

Avoidance of network arrangements

88. Pathology groups, which enjoy higher levels of market concentration than other practitioners, have been able to opt out of tenders which indicate that the potential loss of revenue when ignoring such business opportunities is not a concern for them.

89. Individual practitioners can opt out of preferred provider networks completely; the only deterrent is the administrative difficulty of raising the co-payment that patients are required to pay over and above the scheme determined rate. However, the common practise of expecting payment at the time of consultation, thus avoiding administrative problems of recouping the balance of the payment from patients, indicates that this is not a serious deterrent. Funders have resorted to paying tariffs in excess of scheme rates in order to entice practitioners, and, more so, specialists, to opt-in to network arrangements despite the guarantee of additional volumes which comes with being a network practitioner.

Lack of innovation in the practitioner market

90. Fee-for-service is the dominant payment model in the practitioner market. This model has a number of drawbacks and is generally accepted as an inferior payment model in healthcare relative to ARMs which transfer risk and can incorporate outcomes measurements.

91. We acknowledge that there have been legal restrictions in adopting innovative models. In particular, the HPCSA's ethical rules on sharing of fees (ethical rule 7), business models (ethical rule 8) and sub-contracting (ethical rule 18).

92. However, the existence of global fee arrangements and other models being successfully implemented within the South African context, despite these rules, provides evidence that the HPCSA rules argument may be a convenient scapegoat. In a more competitive environment, innovations are rapidly and aggressively pursued in order to maintain or gain market share. In the absence of other competitive advantages, a failure to adopt to new innovations may result in an exit from the market. This is clearly not the case amongst healthcare practitioners.

Conclusion on practitioner market relations with patients and funders

93. Our conclusion is that practitioners, more so specialists, in the absence of effective competition are in a position to exploit their advantageous power dynamic vis-à-vis patients and funders in order to benefit themselves. This has been seen to occur through practitioners controlling the healthcare pathway, obtaining (often non-healthcare related) concessions from facility groups, the charging of fees in excess of medical scheme rates, and maintaining a fee-for-service environment at the expense of innovative reimbursement models.

94. We note that other factors contribute to this state of affairs, namely the market regulations regarding payment of PMBs at cost, and the lack of countervailing power on behalf of funders, which have helped to strengthen the position of practitioners relative to patients and funders.

Practitioner groups and collective market power

95. The PFR noted that practitioner groupings can take different structural forms. For instance, there are discipline-specific associations for some specialities, Independent Practitioner Associations (IPAs) consisting of GPs, and multi-disciplinary associations. A practitioner may also be a member of more than one practitioner group or association and some associations conduct themselves as MCOs or network managers. This makes it difficult to classify associations into any one category for the purposes of regulatory oversight.

96. Practitioners may also participate in funder networks for the delivery of treatment. Funders set up preferred provider networks (PPNs) and networks of designated service providers (DSPs) by either contracting with practitioners individually or contracting with an association.

97. The Commission and Inquiry have received a range of formal and informal complaints regarding the conduct of practitioners, through their associations and groupings, related to tariff setting, billing, and coding practises. The overarching allegation was that these associations provided a platform for collusion between practitioners. It is alleged that this collusion is done both indirectly, by issuing guidelines or providing advice on fees, coding and billing, or directly, by advising members whether or not to accept tariffs offered by funders or making overt changes to the codes that practitioners use.

98. During the course of the inquiry, we have determined that professional associations provide support to members in ways that can broadly be classified as academic support (our description), e.g. professional development, guidance on ethics and maintenance of professional/clinical standards, which includes hosting of local and international conferences.

99. We have further noted that the same associations also provide what we refer to as "business support" to members. For example, the introduction of new codes (sometimes unilaterally) and/or modification of existing codes in a manner that ultimately affects pricing of services, tariff and provider network development, and/or negotiation with funders.

100. While we recognise that academic and business support are essential, in the PFR we indicated our concern about the implications of these distinct services being managed in an integrated manner by the same associations. We believe this arrangement is not ideal and lends itself to contravention of competition laws.

Practitioner Associations' Impact on Competition

101. We have considered the current practices and concerns related to practitioner groupings and determined that these mostly relate to horizontal coordination or collusion between practitioners in relation to tariff and fee determination,[670] coding and billing practices, and network negotiations.

102. As described in the PFR, we have developed an analytical tool to assess if the operations of associations are pro- or anti-competitive. This competition assessment tool or framework is explained below.

103. The assessment framework takes into account lessons from the United States and from European jurisdictions. The three-stage framework provides an approach to determine whether or not an arrangement is likely to lead to anti-competitive effects and also provides a mechanism for balancing potential efficiencies. The framework provides a useful way of assessing the conduct of associations.

104. The framework is summarised below.

104.1 Stage 1 of the framework requires an assessment of whether the conduct amounts to a contravention of section 4(1)(b) of the Competition Act. Thus, it is necessary to identify if the following elements exist:

104.1.1 that the parties are in a horizontal relationship, and

104.1.2 that the parties have entered into an agreement, concerted practice, or decision, which involves:

104.1.3 directly or indirectly fixing a purchase or selling price or any other trading conditions;

104.1.4 dividing markets by allocating customers, suppliers, territories or specific types of goods and services; or

104.1.5 collusive tendering.

104.2 If the elements of section 4(1)(b) of the Competition Act can be proven the conduct is considered as per se illegal and no efficiency defences can be raised. If, however, the contravention of section 4(1)(b) cannot be proven, then one proceeds to stage 2 and 3.

104.3 Stage 2 of the framework requires an assessment of whether the conduct is likely to lead to a substantial lessening or prevention of competition. Considerations may be given to the levels of concentration in the market or the proportion of practitioners covered by the agreement, the restrictiveness of the agreement, the alternatives available, the barriers to entry and expansion created, and the type of information exchanged.

104.4 Stage 3 requires an assessment of whether there are efficiency benefits which outweigh any anti-competitive effects. We provided some guiding questions to determine if there are any efficiencies:

104.4.1 Are there efficiency gains arising from the agreement?

104.4.2 Do consumers share in the benefits?

104.4.3 Are restrictions indispensable to achieve the benefits?

104.4.4 Is competition eliminated as a result of the agreement?

104.5 The HMI provided an illustrative assessment using this framework, in the Annexure to Chapter 7 of the PFR.

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670 Horizontal coordination refers to co-operation between market players who are supposed to be in competition. Once practitioners choose to work in the private market then, for example, a cardiologist or orthopaedic surgeon is in competition with other cardiologists or orthopaedic surgeons respectively.

105. We have found that the activities of practitioners, through associations and through their arrangements with third-party management groups in relation to the dissemination and publication of tariffs/fees, determination coding and billing practices amounts to collusion. We have found that some of the conduct of associations can be found to be in contravention of section 4(1)(b) of the Act. Where conduct of associations cannot be found in contravention of section 4(1)(b), we found that it is still likely to be a contravention of section 4(1)(a) in that the conduct would lead to a substantial prevention or lessening of competition that is not outweighed by the efficiencies and other procompetitive gains. Over and above this consideration, we believe that the conduct would certainly have an effect of preventing, distorting or restricting competition in the practitioner market (the standard required in the Competition Act).

Practitioner negotiations with medical schemes and administrators

106. The Commission (and subsequently the HMI) has received a range of complaints in relation to practitioner conduct with regard to the tariff setting, billing and coding practices as well as network and other arrangements. The practitioner conduct which has been the focus of these complaints relates to the behaviour of professional associations, management groups and other forms of groupings in their negotiations with funders.

107. The two examples cited in the PFR include a complaint that the South African Paediatric Association (SAPEADS) and SAMA amended the wording of Modifier 0019 so as to add another category of neonatal care (intensive care) for which neonatologists or paediatricians could bill an extra 50% to the tariff payable for neonates,[671] and that the obstetrician society changed its guidance to members on charging for delivery. It was stated that there appeared to be no justification for this change and the consequence was that doctors were able to charge more than previously.

108. In addition, the PFR cited several examples of associations explicitly indicating that they advise on matters of coding and billing and/or advise members whether or not to accept tariffs offered by funders. [672]

109. Further, we have provided a case study of Healthman's publication of guideline tariffs which it believes has contributed to a chilling effect on competition between practitioners.[673] These guideline tariffs remove the uncertainty of competition and provides a benchmark tariff towards which practitioner tariffs will gravitate, regardless of the bargaining and contracting efforts of schemes.

110. Network membership and conditions are often (usually) negotiated with associations rather than individual practitioners. When associations negotiate provider networks, they can and do force payment from funders at much higher rates than the scheme rate that is available to non-network providers.

111. Overall, we believe that many practitioners and their associations are not aware of, or otherwise deliberately ignore, restrictions placed on all private sector players with regard to horizontal cooperation. The evidence that we have examined offers several indications that some market participants behave anti-competitively.

Responses by stakeholders to the competitive assessment tool

112. In response to our analysis using the competitive assessment framework, IPAF disagrees with statements made in the PFR relating to the contracting process by IPAF, PPN, and Iso Leso. Iso Leso also stated that it does not require its members to commit to each of the negotiated network provider contracts rather each individual

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671 Case No. 2012May0243. The descriptor of Modifier 0019 by the NHRPL and the HPCMP provides that: "Surgery on neonates' (aged up to and including 28 days after birth) and low birth weight infants (weighing less than 2 500g) under general anaesthesia (excluding circumcision) is calculated per fee for procedure + 50% for surgeons and a 50% increase in anaesthetic time units for anaesthesiologists." SAMA and SAPA allegedly added a paragraph of the descriptor of the NHRPL and the HPCMP Modifier 0019 in the Doctors Billing Manual (DBM) ("DBM Modifier 0019") which provides that: "Neonates requiring intensive care: per fee for the intensive care items +50% for neonatologist and/or paediatricians."

672 As an example, Surgicom (a surgeon management group managed by HealthMan) states on its website that part of its mission is *"Ongoing contact with the funding industry to attempt to achieve an appropriate level of remuneration, and to establish a strong voice when decisions are made". In a letter to doctors published on its website dated 15 August 2016, Surgicom further states that it "facilitates the consolidation of surgical claims data to negotiate coding and reimbursement with Medical Schemes". Similarly, on its website, the South African Society of Anaesthetists (SASA) stated that "SASA's Private Practice Business Unit continuously engages in tariff negotiations. SASA was the first society to benchmark private practice costs, resulting in a substantial improvement in remuneration. SASA is also the only organisation that has negotiated successfully with health funders on behalf of all its members"*

673 See PFR, dated 5 July 2018, Annexure 7 to Chapter 7, page 364

member has the choice to be bound or not in respect of each provider contract.[674] [675]

113. We wish to clarify that we do not consider tariffs to form part of the negotiations, especially with regard to IPAF as may have been suggested in the PFR.[676] The point being illustrated rather is that it is very likely that a member of such a grouping will adhere to the terms agreed upon between the network and the funder. It is important to note that even if these terms of agreement are not on price or tariffs, they may include other trading conditions which may still raise a competition concern.

114. Overall, we remain concerned about the role of associations in the private healthcare market and believe that modifications are required.

Recommendations to improve the structure and function of associations

115. We recommend that associations keep separate the management of academic and business functions. Associations must be registered appropriately so that they have a legal identity with formal founding documents, constitutions, terms of reference and memoranda of incorporation, as appropriate. This will immediately determine the body whose laws, regulations and rules each entity should abide by. For example, a private company will be registered as for profit or non-profit with the CIPC and be subject to the Companies Act with all the attendant requirements by which the organisation must abide. The same would apply to those that are registered as voluntary associations with all the attendant requirements.

116. This approach would enable professional associations (e.g. Ophthalmological or Orthopaedic or Anaesthetic Society of South Africa) to provide "academic support" with a clear mandate to promote ethical, high quality ophthalmological practice to practitioners in the private and the public sectors.[677]

117. "Business support" must be provided through appropriately registered entities that would be best placed to provide services in line with their legal identify (e.g. Pty Ltd with directors and shareholders as appropriate). [678] [679]

118. In all cases the entities must adhere to competition law governing actors in the private sector. In this regard, we recommend groupings and associations self-assess their behaviour based on the report's framework outlined above.

119. It is beyond the scope of the report to determine the legal form that these organisations need to assume, but this recommendation does mean that practitioner associations must reconfigure or change their practice to avoid contravention of the competition and other relevant laws when engaging in procurement, tariff negotiations, network development, and other activities on behalf of their stakeholders.

120. We have differentiated associations from single or multidisciplinary group practices which are legal entities of another type, and which, when pooling and redistributing revenue among partners, are legally able to coordinate their actions.

121. The recommended establishment of the SSRH and the allocation of coding, development of RVU to it will mitigate some of the anticompetitive activities that some associations engage in. The SSRH will also provide a procompetitive tariff determination forum where RCF and the fees will be negotiated.[680]

122. We recommend that the associations use the assessment tool described in paragraph 104 to assess if their actions are anti-competitive.

123. We further recommend that the Competition Commission reviews this framework and puts out clear guidance to market players so that they understand how associations may operate legally in the private healthcare market.

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674 IPAF submission in response to the PFR, 3 September 2018.
675 Leso Optics Limited submission in response to PFR, 5 July 2018.
676 See PFR, 5 July 2018, Annexure 7 to Chapter 7, p.374.
677 Such academically oriented groupings may play a role in activities recommended by the HMI such as OMRO, HTA, development of medicines formularies, practice guidelines/treatment protocols and ensuring uniformity of clinical practice between practitioners in private and public sectors.
678 These entities may be involved in the proposed SSRH only as far as determining the codes, descriptors and relative value units.
679 The extent to which this type of organisation is resourced to do its work internally or on an outsource basis to a third party (e.g. Healthman) would be up to its governing and executive structures. How such entities are allowed to operate would depend largely on the legal form they assume on formal registration.
680 An important feature that distinguishes the MLNF process from prior tariff determination processes, which were deemed anti-competitive, is that the MLNF process is to be embedded in a public negotiation framework provided for by the SSRH, which will be guided by a legislative and mandated process. The negotiation framework will define the conditions, rules of engagement and outcomes which will ensure that the process is fair and as pro-competitive as can be, and outcomes are consistent with the public interest.

124. As stated in PFR and explained in paragraph 105 we are of the view that the conduct of some practitioner associations may amount to a contravention of the Competition Act. However, while the HMI recognizes the anti-competitive conduct and possible contravention of the Competition Act by practitioner associations, we recommend that the Competition Commission develop guidelines for practitioners and practitioner associations to enable them to become compliant with the Act.

EXPENDITURE, EXCESSIVE UTILISATION AND SUPPLY INDUCED DEMAND

Provisional Findings and Recommendations

125. One of the objectives of the inquiry was to understand the trends in expenditure and identify the major drivers of increases in expenditure over time. The industry claims data obtained by the inquiry provides an opportunity to describe quantitatively and understand expenditure trends in the private health market. In this section, the inquiry focuses on expenditure attributed to practitioner behaviour.

126. We described patterns and explained them based on our understanding of the private healthcare market. Through various recognised and standard approaches to statistical analysis, we attribute likely explanations for the observations arising from the data.

127. The combined claims data available was restricted to five years but nonetheless constituted a very large data set. We described the overall picture and avoided being distracted by incidental or minor findings.[681]

Utilisation rates over time

128. Overall, there is an increase in the utilisation of services provided by practitioners.

129. In general, 3 people out of 10 saw a practitioner out-of-hospital in 2014 and the number of visits increased by 0.5% from 2010 to 2014. The number of visits to psychiatrists (5.01%) physicians (4.79%) and ophthalmologists (4.16%) increased the most between 2010 and 2014 and well above the average increase in number of visits over this period. The cost per visit increased the most for general surgeons where the average year on year inflation adjusted increase in cost per visit from 2010 to 2014 was 11.82%. See Table 6.2.

Table 6.2: Out-of-hospital visits per 1 000 population, cost per visit 2014, and cost trends (% increase per year) 2010-2014 [682]

Practitioner type	Visit per 1000 insured population in 2014	Average annual increase in visits 2010- 2014	Average cost per visit in 2014	Average annual increase in costs 2010 – 2014
GPs	2 494	0.43%	379.79	5.23%
Gynaecologists	128	-2.36%	819.21	8.18%
Physicians	93	4.79%	1 003.32	8.13%
Paediatricians	76	-1.85%	609.02	6.94%
Ophthalmologists	54	4.16%	1 211.46	8.80%
Psychiatrists	45	5.07%	994.74	8.00%
Orthopaedic Surgeons	45	0.73%	615.16	6.92%
Dermatologists	36	-1.20%	702.97	7.55%
General Surgeons	32	-0.08%	994.19	11.82%
Otorhinolaryngologists	28	-2.13%	646.94	5.29%
Other Medical Practitioners	99	1.91%	1 840.36	4.58%
All Medical Practitioners	**3 131**	**0.48%**	**507.39**	**6.21%**

681 Report on analysis of medical schemes claims data – a focus on practitioners 15 December 2017 http://www.compcom.co.za/wp-content/uploads/2014/09/Practitioners_Report-on-analysis-of-medical-scheme-claims-data.pdf

682 Expenditure analysis report 5: Practitioner analyses. Table 10.

130. For day admissions:

130.1. there has been an average increase in day admissions of 1.8% over time from 2010 to 2014 for all admission both in general acute and standalone day-facilities;

130.2. physicians rate of day-admission over time has increased the most, on average by 7.3% over the five years studied; and,

130.3. the biggest contribution to this increase in day admissions (54%) has been from those patients admitted by GPs and this is likely to be admissions to emergency rooms for which a facility fee has been charged as in general GPs do not admit to wards.

Table 6.3: Day-admission rates by year and annual average trend in admission rates by admitting discipline and the percentage that discipline contributes to all admissions[683]

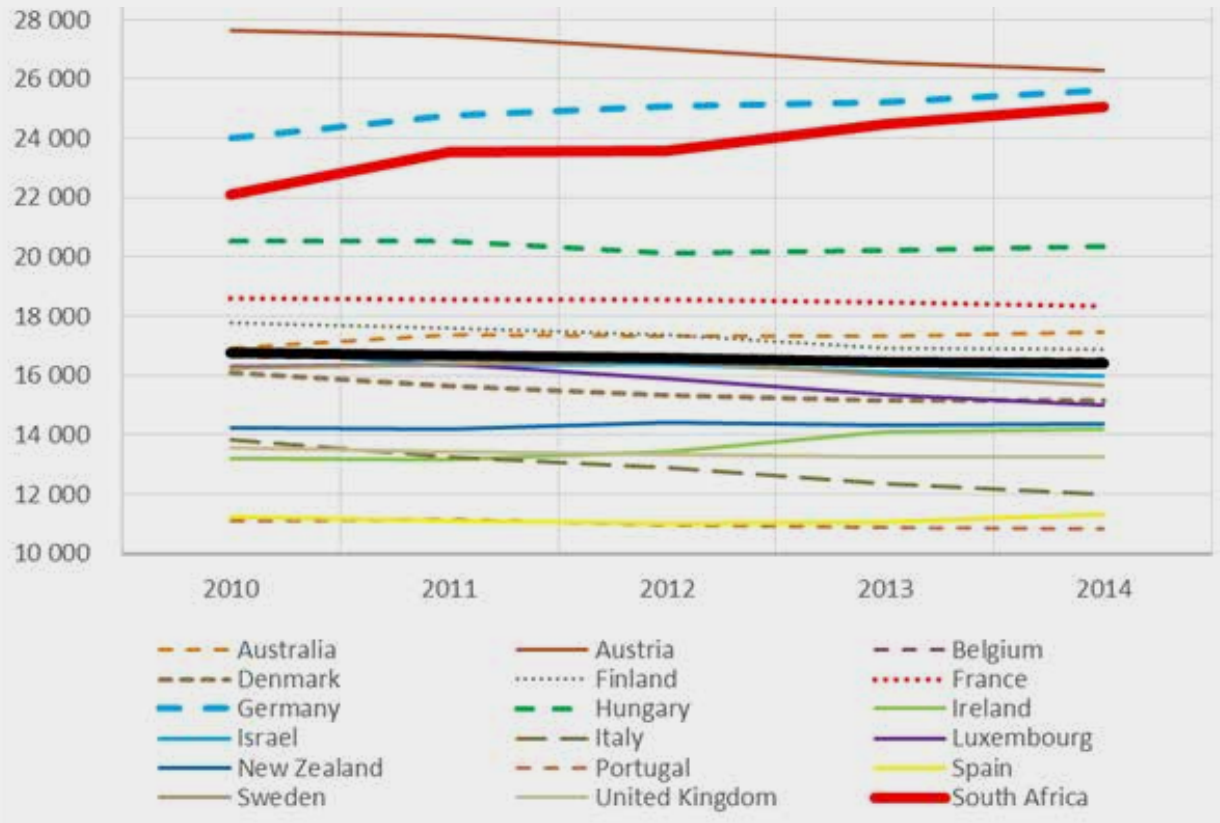
	Day Admissions per 1 000 Lives						
Admitting Discipline	2010	2011	2012	2013	2014	Trend	% of total admissions
General Practitioners	61.74	64.48	66.15	65.56	65.49	1.49%	54.35%
General Surgeons	9.45	8.78	8.88	9.58	9.58	0.35%	7.95%
Ophthalmology	7.40	7.66	8.33	9.01	9.15	5.46%	7.59%
Orthopaedic Surgeons	6.49	5.91	6.07	6.50	6.64	0.54%	5.51%
Otorhinolaryngologists	6.29	5.82	5.82	6.22	6.07	-0.87%	5.04%
Gynaecologists	5.56	5.28	5.14	5.37	5.25	-1.42%	4.36%
Urologists	4.98	4.86	5.08	5.43	5.74	3.61%	4.77%
Physicians	3.21	3.20	3.47	3.87	4.26	7.34%	3.54%
Gastroenterologists	1.24	0.91	0.95	0.98	1.00	-5.33%	0.83%
PAEDIATRICIANS	1.15	1.03	0.99	1.09	1.11	-0.94%	0.92%
CARDIOLOGISTS	0.63	0.49	0.58	0.57	0.58	-2.40%	0.48%
Psychiatrists	0.22	0.11	0.12	0.12	0.16	-7.90%	0.13%
Other Disciplines	3.84	3.61	4.07	4.83	5.49	9.33%	4.55%
All Disciplines	112.20	112.15	115.64	119.14	120.51	1.80%	100.00%

683 Expenditure analysis report 5: Practitioner analyses. Table 17.

Table 6.4: Overnight-admission rates by year and annual average trend in admission rates by admitting discipline and the % that discipline contributes to all admissions

	Overnight Admissions per 1 000 Lives						
Admitting Discipline	2010	2011	2012	2013	2014	Trend	% of total admissions
Physicians	23.24	25.33	26.35	28.06	29.27	5.93%	19.73%
Gynaecologists	20.02	20.55	20.22	19.77	19.92	-0.11%	13.43%
General Practitioners	18.09	18.63	18.30	17.77	17.53	-0.80%	11.82%
General Surgeons	17.35	18.52	18.62	18.79	19.23	2.61%	12.97%
Paediatricians	15.44	16.01	15.39	15.71	15.93	0.78%	10.74%
Orthopaedic Surgeons	12.37	13.21	13.41	13.54	14.09	3.30%	9.50%
Psychiatrists	5.56	5.90	5.96	6.04	6.17	2.63%	4.16%
Urologists	4.99	5.53	5.59	5.53	5.82	3.92%	3.92%
Cardiologists	3.48	3.30	3.17	3.06	3.03	-3.43%	2.04%
Otorhinolaryngologists	3.31	3.79	3.58	3.23	3.24	-0.49%	2.19%
Ophthalmologists	1.19	1.27	1.29	1.24	1.29	2.04%	0.87%
Gastroenterologists	1.02	1.06	0.95	0.79	0.72	-8.54%	0.48%
Other Disciplines	11.03	11.37	11.50	11.75	12.07	2.29%	8.14%
All Disciplines	137.09	144.46	144.33	145.29	148.30	1.99%	100.00%

Figure 6.4: Age-standardised hospital admission rates for South African private sector and a subset of 17 OECD countries



131. For overnight admissions:

131.1. there has been, on average, an increase of 1.99% for all admissions from 2010-2014;

131.2. the increase in admission rate by those admitted by physicians has increased by 5.9%; by those admitted by urologists by 3.9%, by those admitted by orthopaedic surgeons (3.3%); by psychiatrist 2.6% and general surgeons 2.6%; and

131.3. physicians account for the greatest percentage of total admissions at just under 20%.

132. We have benchmarked the level of hospital admissions against available OECD data sets for total hospital admissions, and for specific interventions (see Figure 6.5 for specific interventions).

133. Total days of hospital stay per person per year were chosen as the measure of utilisation. Rates were standardised by five-year age bands.

134. In all the comparator countries citizens have universal coverage through publicly funded national health or insurance schemes. Since all of them have a significantly higher GDP that South Africa, it was felt that utilisation rates in each should represent a relative "high water mark" for demand unconstrained by resources.[684]

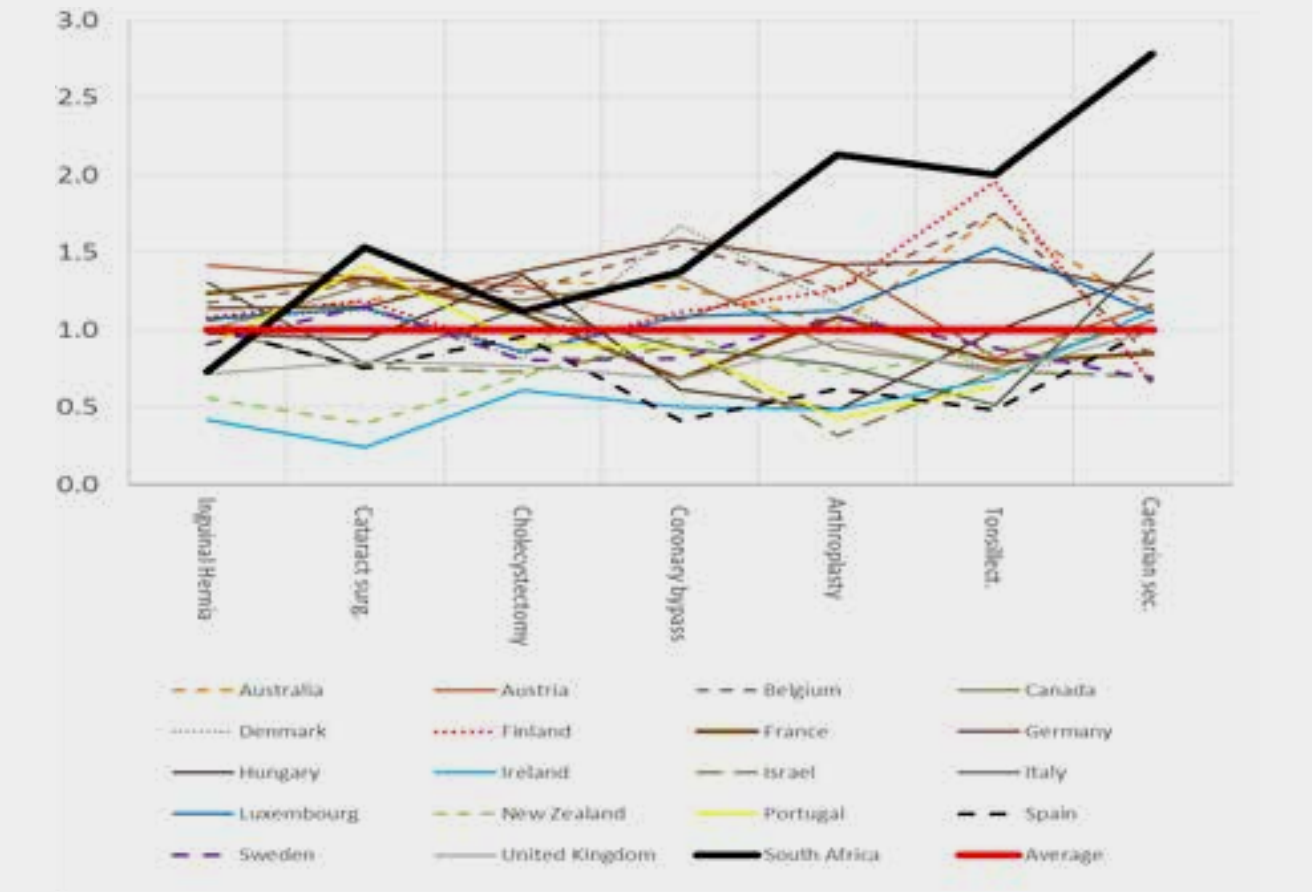
135. Overall hospitalisation rates increased significantly for the South African private sector over the period 2010-2014 and were higher than all but 2 of the OECD countries for which complete data were available over this period. The absolute level and rate of increase of admissions in South Africa are, in combination, very worrying. See Figure 6.4 below.

136. We have considered whether some of this utilisation is in the areas that are more "Influenceable" by healthcare providers, and whether it is growing over the period studied. For this we defined discretionary procedures: cholecystectomy; tonsillectomy; major joint arthroplasty (hip, knee and other); non-strangulated inguinal hernia repair; cataract surgery; coronary artery bypass grafting (CABG) for coronary ischaemia; and caesarean section. For these conditions there is significant discretion (and disagreement) on the part of treating practitioners as to whether an intervention is warranted.

137. These seven reasons for admission were examined and compared to rates in a range of other developed countries as collated by the OECD. Specific conditions were matched on the basis of similar text descriptors in the OECD data, thus limiting the number of event types that could be compared. Figure 6.5 shows relative admission rates compared to a sample of OECD countries for discretionary procedures. Rates are indexed to the average for all comparator countries – so values above the red line (i.e. above one) indicate a figure higher than the benchmark. South African private rates are above the benchmark for 6 out of seven conditions and are higher than any other country for three procedures – arthroplasty, tonsillectomy and caesarean section. While these procedures are not necessarily suggestive of all of healthcare, they suggest no indication of systemic underservicing in the South African context, and if anything, a tendency towards over-servicing.

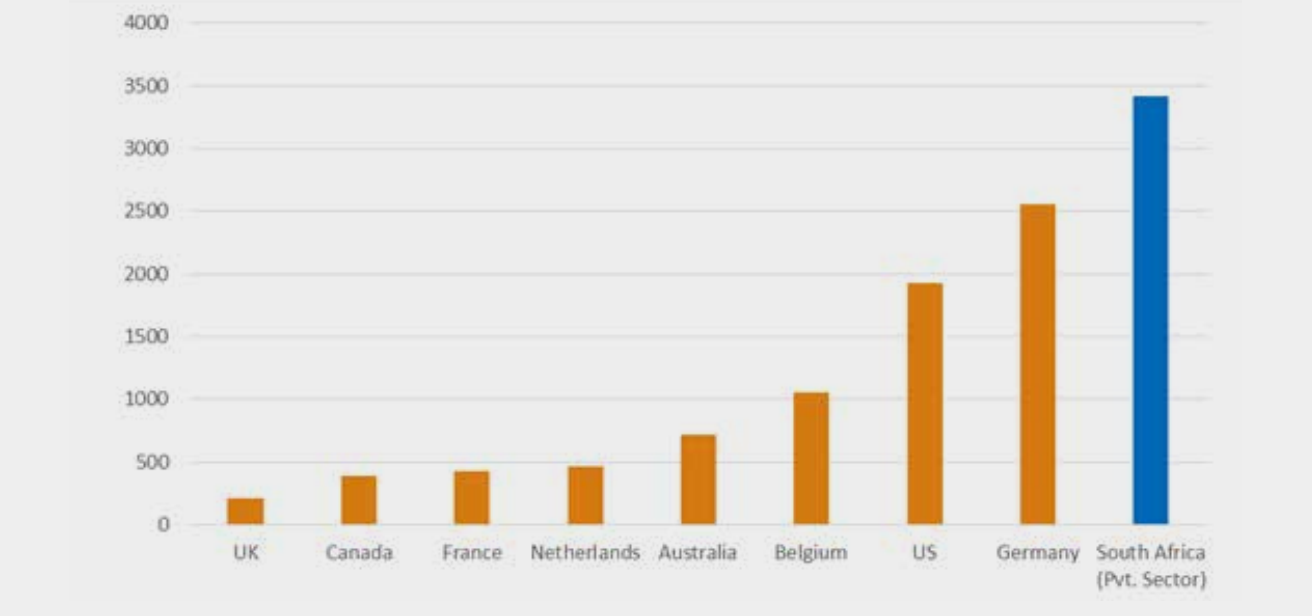
684 Details of the approach and methods are described in Chapter 8 of the PFR and are not repeated here. Responses to critique of the approach are also available http://www.compcom.co.za/healthcare-inquiry/

Figure 6.5: Relative age-adjusted admission rates (indexed to 1) for seven common discretionary admissions in South Africa and a selection of documented OECD countries.



138. Age adjusted ICU admission rates were also compared with data available from other countries. South African ICU admission rates did not increase substantially between 2010-2014 but they appear significantly higher than those experienced elsewhere. See Figure 6.6 below.

Figure 6.6: Age-adjusted rate of ICU admissions per 100 000 population per annum



139. Of all our findings, this is perhaps most startling given its cost implications. For the same length of stay, patient age, chronic and illness profile and procedures provided, an admission that includes an ICU stay costs approximately R38 000 more than one that does not involve ICU.[685] If the ICU admission rate per head of population was reduced to half of its current level (i.e. to a rate between that of Belgium and the USA) and half of the costs associated with these avoided ICU admission costs were reinvested in better ward care, approximately 2.7 billion rand would still be saved annually. This amounts to 2.3% of the total annual cost of private healthcare over the period studied, or 4.1% of total in-hospital claims.

Cost of care

140. Doctors admit patients to hospitals and see and charge for their individual services. They also refer to other providers who could be doctors or physiotherapists and order various investigations. The admission of a patient to a ward incurs a cost that the hospital charges. This is usually called a ward fee which includes the bed, the nursing care and all the services that go with being in hospital. If there are surgical disciplines this also will likely incur theatre costs. Admitting practitioners therefore drive what is consumed. Three kinds of costs impact of doctor behaviour on costs:

140.1. Total costs – called cost per admission which include all costs, the hospital cost, the doctor and other practitioner costs and the various tests or special investigations, e.g. pathology, radiology etc.

140.2. The costs attributable to the admitting doctor only; and,

140.3. The cost to the medical scheme overall which is the cost per life covered. This cost determines how much members of a scheme pay. Schemes have to work out how much to charge each member for their annual membership to make sure that they have enough money in any year to cover the total costs for all scheme members. In some years an individual will pay in less than they consume but, in another year, (when they are sick which is often related to age) they will claim more than they contribute in that year. If a person is very ill, they can claim, in a few weeks or months, many multiples more than they contributed over any year.

141. Total Cost of Admission has increased in the following way

141.1. On average by 8.8% per year for the period 2010-2014 for all day admissions, with the greatest increases being seen in those admitted by

141.1.1. Paediatricians – 15.8%

141.1.2. Physicians – 11.7%

141.1.3. Orthopaedic surgeons – 9.9%

141.2. On average by 8.4% per year for overnight admissions over the same period, with the greatest increases being seen in those admitted by

141.2.1. Psychiatrists 10.5%

141.2.2. ENTs (Otorhinolayringologists) 9.1%

142. Cost increase over time for doctor only costs have increased in the following way (see Table 6 5 and Table 6 6)

142.1. For day admission costs have increased on average by 8.8% per year over the 2010-2014 period, with the greatest increases being seen in those admitted by:

142.1.1. paediatricians 12.9% (rounded up)

142.1.2. orthopaedic surgeons 10.8%

142.1.3. gastroenterologists 10.4%

142.1.4. GPs are below average at 7%.

142.2. For overnight admission, doctor-only costs have increased on average by 9.36% per year 2010-2014 with the greatest increases being seen in those admitted by:

142.2.1. physicians – 11%

142.2.2. orthopaedic surgeons – 10.1%

142.2.3. ENTs (Otorhinolayringologists) – 9.9%%.

143. Cost per life covered, or cost to the medical scheme overall, shows that for:

143.1. day admission costs have increased by 10.76% per year for the entire admission, and by 10.84% for the doctor only costs. And,

143.2. overnight admissions total costs have increased by 10.58% per year for the entire admission and by 11.53% for the doctor only costs.

685 This includes all excess costs, including hospital, professional and equipment fees

Table 6.5: Day admissions trends: % of admissions by provider discipline, average annual change per year in admission rates, cost per admission and cost per[686]

Day Admissions Trends by Discipline 2010-2014					
Discipline	% of admissions attributable to this provider	Average annual admission rates change per year	Average annual change in total cost* per admission	Average annual change in practitioner cost per admission	Average annual change in contribution to cost per life for this practitioner
GPs	54.35%	1.49%	8.54%	7.01%	8.60%
General Surgeons	7.95%	0.35%	8.93%	8.67%	9.05%
Ophthalmology	7.59%	5.46%	6.64%	6.46%	12.28%
Orthopaedic Surgeons	5.51%	0.54%	9.92%	10.83%	11.43%
Otorhinolaryngologists	5.04%	-0.87%	7.01%	6.59%	5.67%
Gynaecologists	4.36%	-1.42%	7.15%	10.11%	8.54%
Urologists	4.77%	3.61%	7.82%	8.17%	12.08%
Physicians	3.54%	7.34%	11.74%	9.39%	17.42%
Gastroenterologists[687]	0.83%	-5.33%	8.33%	10.44%	4.55%
Paediatricians	0.92%	-0.94%	15.81%	12.95%	11.98%
Cardiologists[688] [689]	0.48%	-2.40%	8.98%	9.39%	6.76%
Psychiatrists	0.13%	-7.90%	7.07%	4.52%	8.97%
Other Disciplines	4.55%	9.33%	6.92%	6.40%	15.76%
All Disciplines	100.00%	1.80%	8.80%	8.88%	10.84%

Total cost refers to all costs associated with the admission: practitioner, hospital, consumables etc.

686 Data for this table is drawn from table 27: Day Admissions Summary Trends by Medical Practitioner Discipline, Average 2010-2014 plus trend data from table 25. Report on analysis of medical shecmes claims data – a focus on practitioners 15 December 2017

687 The HMI has been informed that it some gastroenterologists submit claims under their general specialisation that is physician rather than under their sub-specialty that is gastroenterology. It is not impossible therefore, that the data for gastroenterologists are underestimated and physicians values are too high.

688 The HMI has been informed that it is not unusual for cardiologists to submit claims under their general specialisation that is physician rather than under their sub-specialty that is cardiologist – it is not impossible that the data for cardiologists are underestimated and physicians values are too high.

689 Similar to gastroenterologists the HMI has been informed that cardiologists may claim as physicians rather than cardiologists - it is not impossible that the data for cardiologists are underestimated and physicians values are too high.

Table 6.6: Overnight admissions trends: percentage of admissions by provider discipline, average annual change per year in admission rates, cost per admission and cost per life [690]

Overnight Admissions Trends by Discipline 2010-2014					
Discipline	% of admissions attributable to this provider	Average annual admission rates change per year	Average annual change in total cost* per admission	Average annual change in practitioner cost per admission	Average annual change in contribution to cost per life for this practitioner
Physicians	19.73%	5.93%	8.41%	11.01%	17.60%
Gynaecologists	13.43%	-0.11%	6.85%	7.76%	7.63%
General Surgeons	12.97%	2.61%	7.23%	7.76%	10.58%
GPs	11.82%	-0.80%	8.13%	9.16%	8.29%
Paediatricians	10.74%	0.78%	7.46%	8.21%	9.06%
Orthopaedic Surgeons	9.50%	3.30%	8.21%	10.15%	13.78%
Psychiatrists	4.16%	2.63%	10.55%	9.33%	12.21%
Urologists	3.92%	3.92%	7.88%	7.76%	11.98%
Otorhinolaryngologists	2.19%	-0.49%	9.12%	9.95%	9.41%
Cardiologists[691]	2.04%	-3.43%	6.92%	8.18%	4.47%
Ophthalmologists	0.87%	2.04%	7.17%	7.20%	9.39%
Gastroenterologists[692]	0.48%	-8.54%	5.25%	8.88%	-0.41%
Other Disciplines	8.14%	2.29%	7.80%	9.18%	11.68%
All Disciplines	**100.00%**	**1.99%**	**8.42%**	**9.36%**	**11.53%**

Total cost refers to all costs associated with the admission: practitioner, hospital, consumables etc.

690 Table 7.10 in the PFR at page 329.

691 The HMI has been informed that it is not unusual for cardiologists to submit claims under their general specialisation that is physician rather than under their sub-specialty that is cardiologist – it is not impossible that the data for cardiologists are underestimated and physicians values are too high.

692 Similar to cardiologists the HMI has been informed that some gastroenterologists may claim as physicians rather than gastroenterologists.

Drivers of increased costs

144. These data above describe changes in claims costs over time. The next approach was to understand how much of the increase can be explained by known drivers of healthcare costs, and to assess the size of the residual increase which cannot be explained by these factors.

145. The factors that would logically make a difference in healthcare claims costs are "explained factors" and are age, gender, the disease profile of the covered population (the proportion of illness in the population), and the severity of problem for which healthcare is provided (case mix). Our analyses also account for a CPI-linked increase in the prices of individual healthcare services or 'tariffs'.

146. Once the explained factors are accounted for, an "unexplained" portion of claims costs remains. This is the proportion of cost changes over and above that which could be caused by inflation, the age and sex of the population served, the state of ill-health, and the severity of the person/condition being treated.

147. In undertaking these analyses, it was important to find a way to estimate the state of ill-health of a population in a way that neither over- nor underestimates it. In the analyses we defined the state of ill-health of the population served by noting all those who have healthcare provider-identified diagnoses (and related codes). This allowed us to take into account how much ill-health the population served has. If they have a lot of ill-health (for example diabetes or asthma) then they may logically be more costly to treat even when being treated for another condition. By including this factor in the analyses it is possible to control for this effect.

148. The analysis considered different categories of specialism divided into 17 specialist groups set out in tables 7 and 8 below. For each specialist category the amount of costs that are explained (that is the biological/medical reasons have been taken into account and these costs are thus explained) and not explained can be seen. The unexplained costs are those that are not related to the degree of illness treated.

149. We then investigated the unexplained care/costs. From the data available we investigated the statistical association between the unexplained care/cost and: admission rates, level of care (high care and ICU), length of stay in hospital, and what we termed "other". Other is a combination of factors on which we did not have specific data, but could be the use of costlier technology, more interventions (extra tests) higher salaries paid and so on. While we could not define exactly what the effect of these were, they were included in our analysis.[693]

150. These data are presented in tables 7 and 8 below. The tables are complicated, but it is worth explaining what they illustrate in some detail. They illustrate: the percentage of admissions over five years in the claims data that are attributed to a specific specialist group; the percentage of total costs attributable to the specialist group; the percentage increase per year in total costs by that specialist group; the proportion of those cost increases that is explained by inflation (CPI); and then the proportion of the total cost increases that are explained by the factors analysed and the proportion that are not explained.

151. The tables then examine the proportion of explained and unexplained costs attributable to admissions rates, length of stay, and level of care. In these analyses a section called 'Other' is also included and for this we can only give a total ascribed to it and not describe the proportion explained or unexplained.

152. In other words, we have tried to assess what specific practices are driving costs. So in table Table 6.7 below for specialists classified as internal medicine specialists' (column 5) the way to understand the table is as follows:[694] Internal medicine specialists account for 12.8% of admissions; for 21.4% of the total in-hospital expenditure per year on average over the 5 years; their admissions have gone up by 14.67%. Of this increase of 14.67%, 5.6% is due to inflation, 3.49% are explained by the condition of the people they are treating, and 5.58% is unexplained.

693 Some of the critiques levelled at our analyses or interpretations were that we did not include these factors in our analyses but that is not correct, they are captured in the category that we have called "other". Our association of unexplained to possibly unnecessary admission rates, level of care or length of stay is not overestimated by ignoring other changes in technology or costs which have been taken into account in the analyses.

694 This is a broad category that depends on which practice code number the practitioner outs on their bill. The "Internal medicine" category could include a cardiologist or a gastroenterologist who is using their general internal specialist practise code number rather than their super specialist practise code cardiology/gastroenterology number on the bill.

Table 6.7: Medical disciplines: Percentage of admissions and contribution to total costs, and description of proportion admission rates, level of care, length of stay that are explained and unexplained in the attribution[695]

	Cardiology	Derma-tology	GP	Internal Medicine	Medical – Gastroen-terology	Neurology	Paediatrics	Psychiatry
Proportion of total admissions attributable to this speciality	1.36%	0.07%	31.08%	12.81%	0.64%	1.12%	6.34%	2.37%
Proportion of total in-hospital spend by schemes on this on this speciality	2.84%	0.04%	5.96%	21.41%	0.40%	1.49%	6.78%	3.20%
Average annual increase in costs per year attributable to this speciality	3.29%	12.21%	8.36%	14.67%	-1.55%	17.65%	8.55%	13.49%
Proportion of annual increase in costs attributed to CPI	5.60%	5.60%	5.60%	5.60%	5.60%	5.60%	5.60%	5.60%
Proportion of total annual increase in costs that was attributable to "Explanatory Factors"	2.52%	1.04%	-0.15%	3.49%	0.58%	1.79%	-0.46%	0.60%
Proportion of total annual increase in costs that was attributable to 'Unexplained Factors'	-4.82%	5.57%	2.90%	5.58%	-7.74%	10.26%	3.41%	7.29%
Annual Increase in Admission Rates	-3.25%	3.57%	1.03%	5.87%	-6.64%	7.97%	0.76%	2.74%
Annual admission rate increases that are attributed to 'Explanatory Factors'	2.65%	0.48%	-0.06%	2.66%	0.80%	0.53%	-1.56%	0.54%
Annual admission rate increases that are attributed to 'Unexplained Factors'	-5.90%	3.09%	1.09%	3.21%	-7.45%	7.44%	2.32%	2.19%
Annual Increase in Length of Stay	0.60%	1.54%	0.06%	0.69%	-1.27%	0.80%	1.26%	4.14%
Annual length of stay increase that is attributed to 'Explanatory Factors'	0.18%	0.33%	0.02%	0.25%	-0.48%	0.72%	0.42%	-0.02%
Annual length of stay increase that is attributed to 'Unexplained Factors'	0.43%	1.21%	0.04%	0.43%	-0.79%	0.08%	0.84%	4.16%
Annual Increase in Level of Care	-1.08%	0.78%	-0.43%	0.33%	-1.50%	1.02%	1.48%	0.05%
Annual increase in level of care that is attributed to 'Explanatory Factors'	-1.00%	-0.17%	-0.20%	0.21%	-0.31%	0.48%	0.50%	-0.15%
Annual increase in level of care that is attributed to 'Unexplained Factors'	-0.08%	0.96%	-0.23%	0.12%	-1.19%	0.54%	0.98%	0.20%
Annual increase that is attributed to 'other' factors	1.60%	0.26%	1.93%	1.54%	2.69%	1.33%	-0.72%	0.40%

**percentage of total costs per year attributable to admissions by this speciality*

***average increase in cost per year for each discipline both for the practitioner and for associated hospital and other costs e.g. X rays, pathology costs*

695 Day and overnight admissions combined, specialist physicians have been grouped with a number of the less frequently used consulting disciplines into 'Internal Medicine'; plastic surgeons have been combined into the general surgery group; medical and radiation oncologists have been combined into an 'Oncology' category; and to the extent that any are registered, paediatric cardiologists have been combined into the 'Cardiology' category.

153. We then assessed the degree to which admission rates, length of stay, and level of care are explained (by the factors analysed i.e. age, gender, disease profile, 'case mix' rates of PMB diagnosis) and unexplained.[696] The other category has been explained above. (Please note that this analysis uses a geometric mean and not an arithmetic mean so simply adding the numbers for unexplained does exactly equal the total of 5.58% unexplained but is a close approximation.)

154. To understand the drivers of care when examining Table 6.7 and Table 6.8 let us take as an example ophthalmologists in Table 6.8. Their costs have increased over the 5 years by 11.98%. Approximately 10.42% of the increase of costs is attributable to the 'Other' category. But some costs have decreased over this same period when it comes to level of care. This makes sense since more and more eye surgery is happening in day hospitals as out-patient procedures so the level of care is not as expensive and this cost is negative (has gone down) over time. The length of stay too has gone down and this too contributes a negative amount to the costs. Note that this move to day-care is irrespective of how ill the person is or how severe the problem they are being treated for, that is most of the decreases are unexplained. The approach to ophthalmic surgery has become sophisticated enough to be safe to do on an outpatient basis even for relatively ill people (say people with high blood pressure or diabetes) and even if it is a serious problem such as retinal surgery. Their admission rates are up which contributes about 5.13% to the cost increase indicating more procedures. The 'other' in all likelihood has to do with use of technology and the cost of lenses that are used for example during cataract surgery. This is the way to understand all the practitioner groupings in the tables.

696 'Explained' refers to those biological factors that are likely to affect the cost of care and include age, sex, co-morbidities present, the severity of the illness being treated, and in some analyses we could also include the kind of cover held which may allow more/less care to be purchased. 'Unexplained' is the residual increase in costs or admission or length of stay or level of care which is unrelated to the level of illness of the patient being treated.

Table 6.8: Surgical disciplines: Percentage of admissions and contribution to total costs, and description of proportion admission rates, level of care, length of stay that are explained and unexplained in the attribution [703]

	Cardio Thoracic Surgery	General Surgery	Neuro-surgery	Obstetrics and Gynae-cology	Onco-logy	Ophthal-mology	Ortho-paedics	Otorhi-nolaryngol-ogy	Urology
Proportion of total admissions attributable to this speciality	0.56%	11.59%	1.49%	9.37%	0.84%	3.89%	7.71%	3.46%	4.30%
Proportion of total in-hospital spend by schemes on this speciality	4.28%	14.85%	4.28%	8.96%	1.39%	3.16%	13.65%	2.33%	3.76%
Average annual increase in costs per year attributable to this speciality	10.13%	10.38%	9.23%	6.62%	9.09%	11.98%	11.69%	7.51%	12.04%
Proportion of annual increase in costs attributed to CPI	5.60%	5.60%	5.60%	5.60%	5.60%	5.60%	5.60%	5.60%	5.60%
Proportion of total annual increase in costs that was attributable to "Explanatory Factors"	2.34%	3.03%	2.54%	0.01%	3.60%	5.21%	3.16%	0.18%	2.40%
Proportion of total annual increase in costs that was attributable to 'Unexplained Factors'	2.19%	1.74%	1.09%	1.01%	-0.12%	1.17%	2.93%	1.72%	4.04%
Annual Increase in Admission Rates	1.90%	2.15%	2.12%	-0.35%	3.02%	5.13%	2.42%	-0.66%	3.79%
Annual admission rate increases that are attributed to 'Explanatory Factors'	2.61%	1.71%	1.64%	0.06%	4.00%	4.63%	1.72%	-0.31%	2.03%
Annual admission rate increases that are attributed to 'Unexplained Factors'	-0.71%	0.44%	0.48%	-0.41%	-0.97%	0.50%	0.70%	-0.35%	1.77%
Annual Increase in Length of Stay	1.71%	1.70%	-0.03%	0.47%	2.10%	-3.82%	0.87%	2.00%	0.84%
Annual length of stay increase that is attributed to 'Explanatory Factors'	-0.12%	1.04%	0.50%	0.30%	-0.31%	-0.31%	0.77%	0.38%	0.55%
Annual length of stay increase that is attributed to 'Unexplained Factors'	1.83%	0.66%	-0.53%	0.17%	2.41%	-3.51%	0.09%	1.62%	0.29%
Annual Increase in Level of Care	-0.69%	-0.02%	2.41%	0.20%	-0.40%	-5.02%	0.87%	-0.20%	-0.19%
Annual increase in level of care that is attributed to 'Explanatory Factors'	0.23%	0.38%	0.78%	0.07%	0.38%	0.26%	-0.05%	-0.26%	0.03%
Annual increase in level of care that is attributed to 'Unexplained Factors'	-0.93%	-0.41%	1.63%	0.13%	-0.78%	-5.28%	0.93%	0.06%	-0.22%
Annual increase that is attributed to 'other' factors	1.32%	0.64%	-1.07%	0.65%	-1.40%	10.42%	1.49%	0.67%	1.56%

697 Day and overnight admissions combined, specialist physicians have been grouped with a number of the less frequently used consulting disciplines into 'Internal Medicine'; plastic surgeons have been combined into the general surgery group; medical and radiation oncologists have been combined into an 'Oncology' category; and to the extent that any are registered, paediatric cardiologists have been combined into the 'Cardiology' category.

155. Thus, from these data one can establish what is driving cost changes for each practitioner grouping. We have accounted for CPI and can assess the proportion of the residual that is due to increases (or decreases) in admission, level of care, length of stay, and other. For admission rates, level of care and length of stay we can assess the degree to which these changes are accounted for (explained or not explained) by the illness of the patient or the severity of the conditions being treated. For 'Other' we cannot differentiate explained from unexplained using the current data. We cannot assess if the spend was worthwhile or not.

156. For 14 of the 17 practitioner types, other factors contributed to the increased costs. This ranged from 10.2% for ophthalmologis[698] (very close to the total increase of 11.98%) and 2.69% for gastroenterologists to 0.26% for dermatologists. In other words 10.2% of the total 11.98% increase in costs for ophthalmologists is due to "other factors" (which may be use of expensive technology as an example). So other factors accounted for a large proportion of costs increases for ophthalmologists but a smaller proportion of increased costs for dermatologists.

157. We cannot assess if the increased costs related to 'other' is explained (required by the patient) or unexplained (extra unneeded care). This can only be concluded from knowing the health outcomes of a large group of patients. To be able to differentiate explained vs unexplained in this 'other' category the following is required. Again, by example: an ophthalmologist may use an extra more expensive more sophisticated machine to measure diffraction to a 0.001 level instead of 0.1 level in choosing a lens for a patient having a cataract operation or use a more (or less) expensive replacement lens. The only way to know if this is a necessary intervention is to have data on all cataract patients and compare those who did and did not have this extra test (or more expensive lenses).

158. With a large enough group, it is possible to assess if the extra test was worthwhile or not. This is the function of health outcomes monitoring and also falls into the work of a Health Technology Assessment function. If a more expensive lens improves eyesight by a small percentage at a very high cost and a less expensive lens improves eyesight well at a lower cost, it may be reasonable to say that the less expensive lens is a better use of the collective health expenditure. In South Africa we do not have such information so we cannot assess if the money spent on "other" is well spent or not. It may be that it is a good idea for less expensive lens (as long as it works well) to be paid for by a scheme's basic package but if a patient wants the more expensive lens and knows the degree to which it makes a difference, they can pay a co-payment for it or have it covered in their supplementary scheme option if they buy this over and above the basic benefit package. Both patients would have their eyesight significantly improved by having a cataract operation.

159. For 11 of the 17 practitioner types unexplained admission rates contributed to costs increases. This ranged from 7.44% in neurology to 0.44% in general surgery. For 9 of the 17 practitioner types level of care contributed to costs increases and this ranged from 1.63% for neurosurgery to 0.06% for ENT. In four of the 17 specialists types the unexplained costs were associated with length of stay and this ranged from 4.16% for psychiatric admissions to 0.04% for GPs.

160. All these factors operate differently in each specialist type. The reasons for unexplained costs often occurred together and each contributed a different proportion of the unexplained costs in each specialty type.

160.1. For psychiatry, dermatology, internal medicine, orthopaedics and neurology all four modalities were in operation – that is for these specialists they admitted more, used higher levels of care, and had longer length of stay than can be explained by the level of illness of the patients and they also used expensive technology or charged more in salaries or some other component of 'other' that our data cannot define.

160.2. Three of the modalities were in operation in ENT, paediatrics, general surgery, urology, O&G and GPs.

160.3. Two of these modalities were in operation in cardio thoracic surgery, cardiology, neurosurgery and ophthalmology. And,

160.4. One modality was operational for gastroenterology and oncology.

161. We have concluded that a feature of the private health sector is that practitioners admit patients, and or keep patients in hospital longer, and or use higher levels of care, and/or do more tests

698 For ophthalmologists their costs over time increased by 11.98%. Of that increase approximately 10.42% is due to "other" reasons. Note again that these are geometric means and thus the sum of the changes does not equal exactly the total cost increase.

and/or order more expensive tests than can be explained by the sickness of the patient being treated. They may also be using costly techniques, the value of which is not measurable.[699]

162. Because there is no monitoring or reporting on health outcomes in South Africa it is not possible to assess if these additional expenses resulted in any improved outcomes.

163. The value of expenditure on factors described as 'other' (more expensive care due to additional tests, more expensive interventions, higher priced care) can only be ascertained by a health technology assessment capacity. The development of this capacity is urgently needed in the health market, both public and private.

164. Actions that drive up costs contribute significantly to making healthcare insurance unaffordable and decrease access to healthcare.

Supply Induced Demand[700]

165. Our analysis demonstrated definitively that there is increased utilisation that is not in line with the disease burden, and that this utilisation in some areas is significantly higher than comparable populations in other countries. The over-utilisation of ICU is particularly stark.

166. The data also indicate the degree to which care that appears to imply over servicing (a large unexplained component attributable to admissions, length of stay and level of care) leads to increased costs, and, importantly, these increased costs are distributed among the entire medical scheme population as illustrated by the increase in costs per person per year. This makes purchasing health insurance more expensive for everyone and unaffordable for many.

167. Rapidly increasing rates of consumption of a good or service are, of course, not problematic in and of themselves. In healthcare, however, some of the natural constraints on demand do not apply.

168. Most costs are borne by insurance, and thus have a very low or zero cost to the consumer at the point of service so price has a significantly muted effect on demand, a so called "moral hazard". The vast majority of consumers of private healthcare in South Africa have medical scheme coverage so we would expect this feature to apply.

169. For both providers and consumers there is uncertainty – regarding the diagnosis, the best therapy and the amount of that therapy needed. Since the results of an incorrect decision can be significant and irreversible, natural risk aversion would tend to drive more service demand. Litigation (or the fear of it) might worsen this uncertainty.

170. Notwithstanding the uncertainty on both sides, practitioners typically have far more information than the payers for, or recipients of, a health service. In most cases the health practitioner both advises on the need for a service and then provides that service. Since providers are typically paid by volume of services provided, hence, a revenue-maximising professional will tend to recommend more, rather than fewer services. This is called supplier-induced demand.

171. In healthcare it is likely that consumers imagine that any limitation on what they consume is to their detriment. However, this is not always the case, and sometimes treatments are unnecessary. According to J Cromwell and JB Mitchell: "Surgical operations of doubtful marginal utility drive up healthcare expenditures both through physicians' fees and through hospital charges. At best, such operations may be a misallocation of scarce health resources; at worst, they may endanger the health and well-being of patients who undergo them".[701]

172. Evidence based on analysis of the medical schemes dataset from 2010 to 2014 suggests that rates of hospital admission are positively associated with levels of supply of both doctors and hospital beds, after adjusting for clinical and demographic factors.

173. While this finding does not imply intentional misrepresentation by either doctors or hospitals, it does suggest that supply-induced demand exists in areas where there is discretion around whether or not to admit a patient.

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699 It should be noted however that in other jurisdictions outcomes research have indicated that for example only some patients who fit very clear criteria would likely benefit from a TAVI (Eur Heart J. 2016 Jul 21;37(28):2217-25. doi: 10.1093/eurheartj/ehv756. Epub 2016 Jan 26 and Braz J Cardiovasc Surg. 2019 Jun 1;34(3):318-326. doi: 10.21470/1678-9741-2019-0073.) and that the value of robotic prostatectomies is still not established (Prog Urol. 2017 Mar;27(4):244-252. doi: 10.1016/j.purol.2016.10.008. Epub 2016 Dec 6.), that, while there is debate, the benefit of annual breast mammography for health women under 50 is not clear and is most likely harmful. The absence of this kind of research in South Africa can lead to wasteful and perhaps even harmful expenditure.

700 The logic and approach to analysis and data used is described in detail in Chapter 8 of the PFR. Here we present the major findings only.

701 Cromwell J, Mitchell JB Physician-induced demand for surgery. J Health Econ. 1986 Dec;5(4) pp.293-313.

174. The supply of doctors was significantly positively associated with a higher risk of admission in nine out of eleven specialties examined.

Methods

175. We sought to associate levels of utilization with the supply of facilities and practitioners. To confirm our hypothesis of supplier-induced demand we looked for a significant positive correlation between utilisation and levels of supply, after adjusting for expected causes of higher utilisation such as patient age and gender, chronic disease prevalence, and level of medical scheme cover.

176. We combined medical schemes claims data with the best available data on the supply of doctors and hospital beds over the five-year period from 2010 to 2014.

177. We used a logistic regression model to test supplier-induced demand for hospital utilisation. Our hypothesis was that, after adjusting for patient characteristics – age, level of coverage, chronic illnesses, year of treatment, and potential adverse selection markers – residual demand variation could be explained by the supply of both hospital beds and doctors in geography.

178. Figure 6.7 shows the relative effects of individual specific factors on an individual's risk of admission. A positive log-odds value for a certain effect denotes that an individual possessing that trait is more likely to be admitted to hospital (and a negative score the converse). Within each variable, the magnitude of this effect can be compared, e.g. a beneficiary with CNS disorders is more likely to be admitted to hospital than a beneficiary with diabetes, holding all else equal. However, caution must be taken in comparing effects between variables, especially numerically encoded ones such as the doctor and hospital supply factors, where the size of the effect has less meaning than the narrowness of confidence limits.

179. From these results we have established the following key observations:

179.1. This variable captures the change in the rate of admissions over time after adjusting for member characteristics and supply factors affecting each individual, i.e. the residual temporal trend. The overall admissions model shows that there was an increasing likelihood of admission observed over the period from 2010 to 2014, all other factors being equal.

179.2. *Years since joining scheme*. People who had more recently joined a medical scheme were more likely to be admitted to hospital than those who had been a member for 2 or more years. This suggests that adverse selection may be operating – with some people joining a scheme only when they knew they were going to need hospitalisation.

179.3. *Gender*. Males (2 in Figure 6.7 above) were overall less likely to be admitted to hospital compared to females (1).[702]

179.4. *Age group*. The age effect is characteristic of a typical age specific health costs curve. New-born babies had high rates of admission, but this rate quickly fell through childhood to a minimum between ages 10 and 19 and increased afterwards. There was a bump in the curve between ages 20 and 40, which can be explained mainly by (female) admissions related to pregnancy and childbirth. Beyond the age of 40, the rate of admissions steadily increased to reach peak admission rates after age 90. Limited data points representing members exceeding 90 years of age required data beyond this point to be grouped.

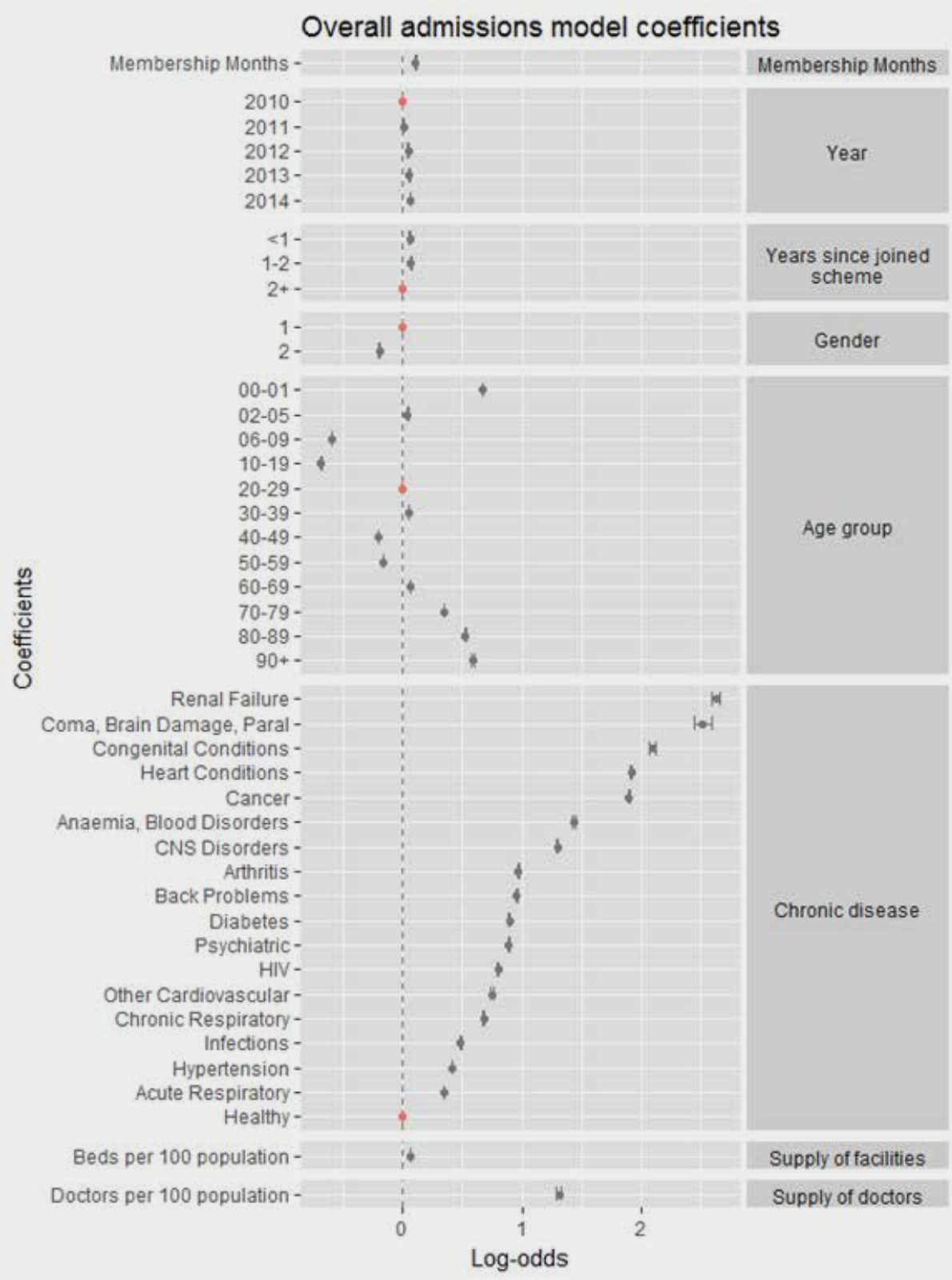
179.5. *Chronic disease*. The effects of chronic diseases were also typical. All chronic conditions were associated with significantly higher rates of admission compared to the baseline status of "healthy". The highest increases in rates of admissions were generally associated with having the most severe and debilitating conditions requiring frequent hospital-based treatment, e.g. "renal failure" and "coma, brain damage and paralysis" while lower but still elevated rates of admission were associated with "hypertension" and "respiratory" conditions.

179.6. *Beds per 100 population*. After adjusting for the above effects which pertain to the medical condition of the member, the per capita supply of hospital beds in a geographic region is seen to be a significantly positive predictor of hospital admissions. Therefore, the greater the proportion of hospital beds to the local population, the higher the rate of admissions in a given region. This provides evidence to support the argument that supplier-induced demand operates for private hospital beds. And,

179.7. *Doctors per 100 population*. Having also adjusted for the physiological/medical factors pertaining to each member, the number of doctors operating in a municipality is also

702 This is largely (perhaps completely) explained by only women accessing maternity care.

Figure 6.7: Relative age-adjusted admission rates (indexed to 1) for seven common discretionary admissions in South Africa and a selection of documented OECD countries.



a significant driver of admissions. A greater proportion of doctors to the population in an area is linked to a higher rate of admission in that area. Therefore, there may again be a supplier-induced demand effect on hospital utilisation due to having an excess of doctors in a given region.

180. Fundamentally what was found that there is a significant relationship between the number of practitioners and the chance of being admitted to hospital and that there was also an independent relationship between the total number of hospital beds and the chance of being admitted to hospital.[703]

Incentives promoting excess utilisation increasing costs and supply induced demand

181. The question now is to explain the patterns that we have observed from the data. Why is there more care provided than can be explained by the degree and severity of illness being treated and what factors make supply induced demand possible? We have placed these patterns in the context of the incentives that operate in the healthcare market in order to understand what may induce this kind of behaviour. We noted that the following incentives operate and indicate how they would influence the behaviour of a rational person.

181.1. Fee for service – the more services provided the more can be billed which may motivate providers to offer more services

181.2. Regulation 8 of the Medical Schemes Act on paying for PMBs at cost in full means that all interventions will be covered by schemes. Where such interventions are not essential, or there is no evidence of benefit, or where a practitioner or patient is being cautious or a practitioner increases their rate of pay, this can lead to increased costs without concomitant health benefits. Providers operate in an environment with an absence of stewardship which could be provided by reference pricing or significant competition that fully functional alternative reimbursement models may offer.

181.3. Benefit design and Hospital plans – once in hospital payment for consultations (by the admitting doctor and any doctor asked for a consultation plus other service providers e.g. physiotherapy) and various tests (often subject to some limit or co-payments) will be paid for. This is also the case for any person who has used up their out-of-hospital cover but once admitted will have access to in-hospital benefits. These two factors incentivise admitting patients to hospital which is only problematic if the patient could be treated out-of-hospital. Another example that illustrates how benefit design can motivate admissions is that of psychiatric care which from evidence given at the public hearings indicates that while out-of-hospital psychiatric care is possible in some benefit options, it is hard to access. In this psychiatric example, this incentive operates in combination with the way PMBs are defined. In summary, PMBs and benefit design result in the possibility of admitting patients up 21 days in hospital which could explain the increased (unexplained) length of stay for psychiatric patients.

181.4. The funding industry believes that there may be a buy-down effect at play and that as a consequence an increasing proportion of people have hospital plans necessitating admission if care is to be covered.[704] This too can explain increased admissions. It may be that the administrative requirements to ensure payment without hospitalisation are too burdensome for individuals and practitioners,[705] in spite of the inflationary effect on the market as a whole.

181.5. The ease of access to high care beds and an absence of any disincentives to avoid unrequired levels of care which is facilitated by hospitals providing an adequate supply of high care beds combined with a perception of poor-quality general wards in private hospitals can motivate practitioners to admit to high care facilities

181.6. Owning sophisticated new technologies will induce practitioners to want to use them both because they have to pay back the purchase or cover the leasing costs, and also to gain value from what these new technologies may offer. The absence of reporting on health outcomes and no system to assess if the health technology

703 The relationship between Obstetricians was different, where there were fewer obstetricians there were more caesarean sections. This we explain as a consequence of individual practices where an obstetrician is working alone without another obstetrician nearby to refer to they are more likely to schedule their deliveries to make their time more manageable. Deliveries by caesarean sections allow for such scheduling.

704 Discovery Health's submission to the HMI, 17 November 2014; Council for Medical Schemes (CMS), comments on the HMI's Draft Statement of Issues, 30 June 2014; Medscheme Holdings (Pty) Ltd's submission to the HMI, October 2014; MMI Holdings, comments on the Revised Statement of Issues, 11 February 2016.

705 A number of presentations at the public hearings indicated that this was the case for both practitioners and patients.

is cost effective means that there is no objective way to assess if the investment is worthwhile

181.7. No obligatory requirement to report on measures of quality of hospitals (general wards or ICU wards) and of practitioner's impact on health outcomes results in there being no way to assess if the way current treatment is offered is beneficial so patients and their schemes are not able to challenge common practice. This problem is further increased in that practitioners operate in an environment where beyond CPD linked education of there is no stewardship by the professional societies on health outcomes. In addition, the absence of a health technology assessment function to guide cost effective use of care also means that providers, patients and funders are ignorant of the value of particular tests and procedures

182. Another explanation for increasing costs could be that the convenience for both doctor and patient to access a range of services from a variety of providers in one admission is attractive. It may also be more convenient for the practitioner who can rely on ward nurses to clerk the patient and have the patient ready for care when the practitioner arrives, allowing the practitioner to schedule his or her day efficiently. This is possible because of the above incentives or lack of disincentives. This relates in particular to the way in which care is provided and the absence of multidisciplinary teams and value based purchasing which is discussed in more detail in paragraphs 185 - 192.

183. Defensive medicine and related to this litigation or the fear of it, may drive over servicing.

184. Our conclusion is that increased admissions and activities related to these admissions are driving costs. Ageing and a large increase in the disease burden are not rational explanations over the short period of five years that have been analysed. The factors described above seem to provide a rational explanation for why this is happening. Having uncovered these features, we propose recommendations to mitigate them.

Forms of provider care and their contribution to costs

Patterns of provider use

185. Care in many systems is organised to make most efficient use of resources. In public systems triage from primary level to tertiary care is supposed to ensure access for all to primary level care and referral up the system for the far fewer number of patients needing more specialised, more expensive, and rarer services available at tertiary and sometimes even more specialised centres of care. In some systems, both public and private, use is made of nurses, midwives, medical assistants, (also podiatrists, physiotherapists, and psychologist) and again patients are triaged and referred to specialists when needed or specialists refer patients who are well managed down the referral chain for care maintenance or for care that other providers are simply better at providing. This allows for a rational use of resources.

186. Through its assessment of the private sector in South Africa, as well as information from stakeholders, we hypothesised that in many instances direct use of specialists is common practice.

187. The data allowed us to assess this hypothesis to some extent by investigating if patients went directly to specialists or if they first consulted a GP. We could assess if patients had a prior out-of-hospital consultation with a specialist practitioner before they were hospitalised. The data indicate that many patients see specialists directly without a referral from a GP and that in a majority of cases patients who saw specialists saw them for the first time once they were hospitalised. We interpreted this as a preference to admit a patient before seeing them. Hospitalisation by specialists as the first choice in treatment seems to be highly prevalent. The convenience factor as well as guaranteed payment for the practitioner and cover for the patient were discussed above and provides both a logic and an incentive for this behaviour.

188. We note that some practitioners believe there is a shortage of at least certain providers.[706] Nonetheless we still hold the view that there are efficiency gains to be made in the private health market.

189. We conclude that more efficient use of providers seems more than possible but that the incentives in the current market are perverse. A corollary is that specialists are also using their time to see patients who could be seen by other providers, thus creating a false scarcity of specialist time.

190. This notion was supported by numerous presentations made at various public hearings and seminars during the course of the Inquiry.

706 SAAA submission following the seminars in April 2019, 29 April 2019.

191. Another aspect of the organisation of care highlighted by a number of stakeholders is the absence of multidisciplinary team-based care and the absence of incentives to keep patients out of hospital. Again, the incentives in the market, in particular fee-for-service and a lack of funder nimbleness in developing new payment systems that can reward value-based offerings, were highlighted as obstacles.[707]

192. Another important obstacle was the injunction by the HPCSA on employment of doctors, fees sharing and the sharing of premises. While these ethical rules are meant to prevent perverse cross referrals and supply induced demand, they also discourage if not prevent integrated practices and use of global fees.

Responses to excessive utilisation and SID and HMI response

193. At various stages in the Inquiry stakeholders questioned the way in which we defined the burden of disease of the population served by the private sector and argued that this definition influenced the conclusions on cost attribution and on supply induced demand.

194. We have been mindful of the need to take into account the general burden of disease prevalent in the population served by the private sector. Beyond just age and sex, we sought to include a range of diseases that may make providing care potentially more complicated and/or costly. Treating someone with a co-morbidity (a disease such as high blood pressure) alongside the problem the patient is being seen for (for example diabetes or repairing a broken bone) can require more monitoring or incur more interventions or costs.

195. This issue was also raised in responses to the Report on the analysis of claims data at the initial cost attribution analysis, dated 1 December 2016. In responding to stakeholder comment at that time we took two approaches to measuring co-morbidities defined as a 'narrow' and a 'broad' approach.

196. We undertook a thorough reanalysis and presented responses to this issue in two documents to which readers are referred. [708]

197. After the April 2019 seminars, there were still objections (IPAF[709], SAMA[710], PathCare[711]) from some stakeholders to our decision to use the narrow burden of disease in our analyses though support for the HMI approach came from others particularly DH.[712]

198. Notwithstanding previous explanations, we reiterate our reasoning below.

198.1. Both the narrow and broad definition include in them if the patient, prior to admission, had any disease ("chronic disease or pre-existing condition") for which they were being treated by a medical practitioner. This was taken into account in the analyses, both in our attribution analyses of admissions and costs and in the analyses of excessive utilisation. What this means is that in the findings, if someone was more ill prior to admission, then that was taken into account in the analysis and costs related to this greater degree of illness would have been allocated to the category "explained". Some stakeholders (SAMA) imagine that only age, sex and HIV status were used in our analyses, but this is not the case.

198.2. What differed between the broad and narrow categories was how the co-morbidities were defined. In the narrow definition, the patient required evidence in the claims data that they had a medical practitioner-determined condition for which they were being treated prior to hospitalisation.

198.3. The 'broad definition' included illnesses that were diagnosed after admission, as well as those for which ongoing medicine is taken but no medical practitioner visits were recorded.

199. We compared these two methods to assess what difference it made in our attribution analyses.

200. We found that the narrow definition had a systematically higher rate of the unexplained component in relation to utilisation rates but not to cost per admission. The broad definition had a systematically lower unexplained component relating to utilisation, but a similar unexplained component in respect of cost per admission.

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707 Presentations by PPO & GEMS, SID seminar 12 April 2019. Stan Eisner submission in preparation for SID seminar, 14 March 2019.
708 Expenditure analysis overview of approach and general observations published 8 December 2017 http://www.compcom.co.za/wp-content/uploads/2017/12/1-Panel-Overview-and-Observations-of-Claims-Data-Analyses.pdf ; and Response-to-Data-Rooms-Technical-Annexure.pdf published 8 December 2017 http://www.compcom.co.za/wp-content/uploads/2017/12/3-Response-to-Data-Rooms-Technical-Annexure.pdf
709 IPAF submission in response to the PFR, 3 September 2018.
710 SAMA submission in response to the PFR, 1 October 2018.
711 Pathcare submission in response to the PFR, 7 September 2018.
712 Discovery Health Post seminar submission, 26 April 2019, p.3.

201. It is clear that if admission is the point at which care is deemed necessary and required then being admitted will lead to a decrease in the unexplained component of admission rates. But without a similar finding relating to the cost of admissions – that the person really was more ill and needed more care – the only logical conclusion is that the degree of illness had already been taking into account appropriately in the narrow definition.

202. This is the basis on which the narrow definition was used. One cannot investigate whether admissions are required if one starts a priori with a definition that implies every admission is required. It is circular in nature. While some stakeholders express a preference for the broad definition (without proving a logical reason), there are some stakeholders who concur with the HMI.[713]

203. We have considered carefully the submissions about the narrow and broad definition of disease and are convinced that our use of the narrow definition is correct, logical and can withstand critical scrutiny.

204. There were a range of responses to excessive utilisation and supply induced demand. Some were presented in responses to the PFR, some at the April Seminar and some in documentation sent after the April Seminars. We have responded to those submitted before the seminar in a document already published.[714] We do not intend to publish a further rejoinder.[715]

205. We note that, with the exception of the hospital groups, stakeholders have agreed with the Inquiry that overutilization is prevalent in the private healthcare sector.

206. The Ophthalmological Society of South Africa objected to the assertion that supply and demand is related. However, we had presented data to illustrate that as supply increased so did delivery of services in particular in relation to cataract operations. These data stand. We have noted that the degree to which this may be acceptable is not easily ascertained as there is no outcome measurement. The OSSA also noted that in the UK rates of cataracts operations were lower than South Africa because of long waiting times in the UK. We do not take issue with this point except to note that waiting time for discretionary procedures may be acceptable. Further, the comparison with the UK does not explain how South African rates are higher than every other comparison country.

207. Practitioners or practitioners groups such as SAOA, have differed on the attribution of fault.[716] We are not concerned with attributing blame but have rather sought to understand what incentives operate in the market that may promote overutilization, and if these can be modified through changes in the system.

208. The objections put forward by the hospital groups revolve around two major issues: the ability of hospitals to influence directly demand, and questions about the technical soundness of the analyses that we have undertaken. Our response is set out in ***Chapter 4: Competition Analysis For Facilities.***

209. In conclusion, we believe that the data and the conclusions presented are not only valid but strong and we stand by our finding that supply induced demand is highly prevalent in the private healthcare market. The causes are multifactorial. Some stakeholder submissions confirmed the likely reasons for overutilization that we have set out.[717] As with international experience, a multifactorial approach is necessary.

REGULATORY GOVERNANCE IN THE PRACTITIONER SECTOR

Findings as presented in the PFR and Recommendations

210. The primary regulatory body for practitioners is the HPCSA which derives its powers and competencies from Section 3(c) of the Health Profession's Act, 1974 (Act No. 56 of 1974). The HPCSA determines strategic policy in accordance with national health policy as determined by the Minister, and makes determinations about

713 Discovery Health post seminar submission, 26 April 2019.
714 SEMINAR NOTE Excessive utilisation and Supplier Induced Demand 4 April 2019. http://www.compcom.co.za/wp-content/uploads/2019/04/SID-Seminar-Discussion-Note.pdf.
715 The OSSA submission in response to the PFR, 1 October 2018, on underutilisation is addressed in the Seminar note, as is the SAMA question about the inclusion of municipality fixed effects term in the model to assess SID. Some of the critique post the seminar by PathCare on ignoring the burden of disease are answered in this document in the section dealing with broad and narrow definition of disease as well as in paragraph 66 and 67 of the Seminar note.
716 SAOA submission following the seminars in April 2019.
717 Discovery Health Submission in response to the PFR, 15 October 2018 & GEMs submission in response to the PFR, 7 September 2018.

education, training, registration, ethics and professional conduct, disciplinary procedures, scope of practice of the professions, inter-professional matters and maintenance of professional competence. It also has a duty to assist in the promotion of the health of the population of the Republic.

211. We found that the HPCSA has over the period 2010 to 2017 received numerous complaints about overcharging or charging for services not rendered from members of the public. We also found that there was a large backlog in responding complaints which the HPCSA has been trying to address. It was clear from our analysis that the HPCSA lacks the capacity to enforce sanctions that have been ordered by its disciplinary committees. We also found that the penalties levied by the HPCSA were inadequate.

212. We considered the HPCSA's Ethical Rules and identified the following rules that give rise to competition concerns:

212.1. Rule 7 – Fees and commission;

212.2. Rule 8 and 8A – Partnership and juristic persons & Sharing of rooms;

212.3. Rule 18 – Professional appointments; And,

212.4. Rule 23A – Financial interests in hospitals.

213. We recommend that the HPCSA's Ethical Rules should be reviewed in order to bring them in line with competition principles. We are particularly concerned about the manner in which the ethical rules have been applied which has limited innovative models of care in the market.

214. We have noted the concerns raised by the HPCSA regarding the perverse incentives that may arise as a result of some of the new models of care such as multidisciplinary practices. The HPCSA also raised the issue of maintaining practitioner autonomy through some of the relationships that may be created should the rules be relaxed.

215. We have recommended significant changes to the wording of the ethical rules to make them more permissive to ensure that they encourage actions that promote value for consumers. In particular the rephrasing of rules should:

215.1. encourage multidisciplinary group practices;

215.2. allow for global fees; And,

215.3. allow conditional employment of doctors to allow innovative and alternative models of care that have positive outcomes but prevent revenue maximisation.

216. We have also recommended that the HPCSA should improve its oversight of pro-competitive rules and should review its requirements for approval of training institutions to include coding, cost and value implications, and understanding of HTA-like bodies.

Responses to governance by practitioners

217. Stakeholders largely agree that the HPCSA's Ethical Rules require review. Medscheme, however, pointed out that no timelines have been proposed for when the review should be completed.[718] Some stakeholders argue that recommendations requiring the allowance of multi-disciplinary practices and fee sharing (especially in a FFS environment) may not be appropriate for certain disciplines such as radiology and pathology as these may lead to over servicing and perverse incentives.[719] The BHF state that it is highly unlikely that the HPCSA will be able to review its own rules to the benefit of the patients given its inherent failures. BHF recommends that the rules of the HPCSA be reviewed through a multi-stakeholder panel that includes key stakeholders such as other regulatory bodies, the NDoH, the funders, and the hospital groups.

218. We remain of the view that the HPCSA Ethical Rules should be reviewed, and that such a review can start with the rules that we have identified as being anti-competitive. This review should not take longer than one year from the publication of the final report. In fact, it is our understanding that the HPCSA has started a process of review. We agree that such a review will require the involvement of all relevant stakeholders.

219. The RSSA points out that Annexure 6 of the Ethical Rules, Rule 3(2)(b) and (c), only allows radiologists to form practices with nuclear medicine physicians and radiographers and no other practitioners. The RSSA supports this restriction in fee for service environments as there could be over-servicing for financial gain if radiology was allowed to form multi-disciplinary group practices. RSSA supports team-based care, but not funding models that include radiology.

718 Medscheme submission in response to the PFR, September 2018.
719 See PASA submission in response to the PFR and Pathcare submission to PFR, 7 September 2018.

They state that radiologists in a fee-for-service environment create the risk of over-servicing or in a budget sharing environment under-servicing.[720]

220. We note that there are specific disciplines in which multi-disciplinary practices may not be appropriate. However, this will be exception rather than the rule. We still argue for a position that generally allows multi-disciplinary practices unless the circumstances are not appropriate.

221. Stakeholders support mechanisms to facilitate ARMs and to encourage group practices, and others further abolition of the HPCSA rules that prevent employment of doctors by private health facilities.[721] The FMF agrees with the abolition of the restrictions on employment.[722] SAMA on the other hand, argues that employment of practitioners by current profit-making entities is neither desirable nor necessary, and claim that corporate profits will be advanced at the expense of clinician remuneration and quality of care to patients. SAMA is of the view that full employment is not necessary if other innovative business models can be explored.[723]

222. On the issue of employment, we believe that there should not be any absolute position in any direction. For instance, any form of employment would have to be conditional to meeting certain conditions that can be monitored by the HPCSA. By the same token, any form of innovative business model would need to undergo scrutiny by the HPCSA in order to ensure that the interests of the patients are prioritized over any profit maximising incentive. We believe that if practitioners are required to report on outcomes, as discussed in ***Chapter 8: Healthcare Data, Quality and Outcomes***, then information would be available that would allow the regulators to determine whether an employment relationship is perverse or appropriate for patient outcomes.

223. The HFA state that the HPCSA regulations frustrate innovation. They point out that HFA members have struggled to set up effective networks for specialists and dispute the lack of innovation is on the part of funders but rather reflects environmental barriers.[724]

224. We reiterate the point made earlier that innovative entry in the sector has been limited by the interpretation of the HPCSA's Ethical Rules. We believe that the interpretation of these rules should be undertaken in a pro-competitive manner. It is of concern that there seems to be selective priority that is given to the well-being and autonomy of healthcare providers themselves rather than a focus on cost-effective quality care and innovation to improve health outcomes for patients. Overall, it is our view that the HPCSA needs to play a better stewardship role in promoting the health of the population and the protection of consumers.

225. The WHO points out that the monitoring of the implementation of these rules would still be very important because a relaxation of the rules may lead to cartel conduct and supplier induced demand. The Western Cape Department of Health also supports the need for reform,[725] as well as the improvement of governance and monitoring mechanisms by the HPCSA, specifically making available the latest figures with respect to the number of practitioners active in both public and private sectors.[726]

226. We believe that through improved monitoring mechanisms, the HPCSA can still meet its objectives of protecting patients while allowing for a competitive environment where practitioners compete on the appropriate factors such as quality of care and outcomes. This may require a rethinking of how the HPCSA fulfils its mandate, and even how it is structured and resourced. Over and above the review of the Ethical Rules, we recommend that there is a broader review of the HPCSA itself, and a redefinition of its role, functions, operations and governance.

227. In relation to the Ethical Rules themselves, we have been in correspondence with the HPCSA. Our opinion on rule changes were sought and below we provide some guidance on how the rules may be amended to take into account competition. These rules and their wording however are the prerogative of the HPCSA.

228. Rule 7- Fees and Commission

The rule currently reads:

"7 (4) "A practitioner shall not share fees with any person or with another practitioner who has not

720 RSSA submission in response to the PFR, 7 September 2018.
721 Actuarial Society submission to PFR, 30 September 2018; SAOA submission in response to the PFR and SASP submission following the seminars in April 2019, 29 April 2019.
722 FMF submission in response to the PFR, 7 September 2018.
723 SAMA submission in response to the PFR, 1 October 2018.
724 HFA submission in response to the PFR, 7 September 2018.
725 Western Cape Department of Health submission in response to the PFR, 27 September 2018.
726 WHO submission in response to the PFR, 21 September 2018

taken a commensurate part in the services for which such fees are charged.

(5) A practitioner shall not charge or receive fees for services not personally rendered, except for services rendered by another practitioner in his or her employment or with whom he or she is associated as a partner, shareholder or locum tenens."

We propose the following possible wording:

Rule 7(4)

"A practitioner may share fees with another practitioner who has taken a commensurate part in the services for which such fees are charged and is subject to an express agreement, arrangement, or model of rendering multi-disciplinary services that is consistent with the guidance provided by council to ensure the protection of the profession and to provide value to patients, cost effective care, and high quality care that improves health outcomes and promotes access to healthcare services."

229. We propose that Rule 7 be crafted permissively. The HPCSA must still retain its monitoring function over the ethical problems associated with the rule by setting out clear principles and guidelines to curb conflict of interest and other problems associated with fee sharing, such as wasted care or inappropriate levels of care.

230. Rule 8 and 8A- Partnerships and Juristic persons/ sharing rooms

The rule currently reads:

"Rule 8

(1) A practitioner shall accept a professional appointment or employment from employers approved by the council only in accordance with a written contract of appointment or employment which is drawn up on a basis which is in the interest of the public and the profession.

(2) A written contract of appointment or employment referred to in sub rule (1) shall be made available to the council at its request."

We propose the following possible wording:

"Rule 8

A practitioner may provide collaborative health-care services with other practitioners subject to an express agreement, arrangement, or model of rendering multi-disciplinary services that is consistent with the guidance provided by council to ensure the protection of the profession and to provide value to patients, cost effective care, and high quality care that improves health outcomes and promotes access to healthcare services."

231. We propose that Rule 8 be crafted permissively with reference to the guidelines and principles of professional autonomy and independence that should be adhered to, and any other type of ethical practice which the HPSCA would sanction. The underlying principle is patient protection.

232. Rule 8A:

The rule currently reads:

"8A. Sharing of Rooms.— A practitioner shall not, without the prior written consent of council, share his or her rooms with a person or entity not registered in terms of the Act, or in terms of any other legislation regulating nursing, pharmacy, allied health and other similar professions or a juristic person who is exempted from registration in terms of section 54A of the Act."

We propose the following possible wording:

"A practitioner may share his or her rooms with a person or entity registered in terms of the Act, or in terms of any other legislation regulating nursing, pharmacy, allied health and other similar professions or a juristic person who is exempted from registration in terms of section 54A of the Act, provided that this is consistent with the guidance provided by council to ensure the protection of the profession and to provide value to patients, cost effective care, and high quality care that improves health outcomes and promotes access to healthcare services, and subject to approval and oversight by council."

233. Our view is that this role can be drafted permissively while ensuring protection of the patients.

234. Rule 18 - Professional Appointments

The rule currently reads:

"*Rule 18*

(1) A practitioner shall accept a professional appointment or employment from employers approved by the council only in accordance with a written contract of appointment or employment which is drawn up on a basis which is in the interest of the public and the profession.

(2) A written contract of appointment or employment referred to in sub rule (1) shall be made available to the council at its request."

We propose the following possible wording:

"Rule 18

A practitioner may accept a professional appointment or employment from employers approved by council in accordance with a written contract of appointment or employment that is consistent with the guidance provided by council to ensure the protection of the profession and to provide value to patients, cost effective care, and high quality care that improves health outcomes and promotes access to healthcare services."

235. The HPCSA can set out clear guidelines and principles to ensure that such appointments would not be harmful to patients exposing them to increased costs or over treatment over-servicing, and that the practitioners' clinical independence, ethical or professional responsibilities and duties would not be compromised.

236. Rule 23A - Financial interests in hospitals

The rule currently reads:

"23 A.

A practitioner may have a direct or indirect financial interest or shares in a hospital or any other healthcare institution: Provided that –

(a) such interests or shares are purchased at market-related prices in arm's length transactions;

(b) the purchase transaction or ownership of such interest or shares does not impose conditions or terms upon the practitioner that will detract from the good, ethical and safe practice of his or her profession;

(c) the returns on investment or payment of dividends is not based on patient admissions or meeting particular targets in terms of servicing patients;

(d) such practitioner does not over-service patients and to this end establishes appropriate peer review and clinical governance procedures for the treatment and servicing of his or her patients at such hospital or healthcare institution;

(e) such practitioner does not participate in the advertising or promotion of the hospital or healthcare institution, or in any other activity that amounts to such advertising or promotion;

(f) such practitioner does not engage in or advocate the preferential use of such hospital or healthcare institution;

(g) the purchase agreement is approved by the council based on the criteria listed in paragraphs (a) to (f) above; and

(h) such practitioner annually submit a report to the council indicating the number or patients referred by him or her or his or her associates or partners to such hospital or healthcare institution and the number of patients referred to other hospitals in which he or she or his or her associates or partners hold no shares."

We propose the following possible amendment:

Ethical Rule 23A: substitution of sub paragraph (h) of the following sub paragraph:

"(h) such practitioner annually submits a report to the council with the following supporting information and documents:

(i) the number of patients referred by him or her or his or her associates or partners to such hospital or healthcare institution and the number of patients referred to other hospitals in which he or she or his or her associates or partners hold no shares;

(ii) the agreements concluded in relation to the acquisition and/or ownership of the interests of shares in the hospital or healthcare institution;

(iii) how the acquisition of the financial interest is funded and whether there are other ancillary contractual relationships between all the parties to the transaction or with related parties and entities and if so, the nature of such contractual relationships;

(iv) policies or peer review protocols for admission of patients into such hospital or healthcare institution and quality monitoring mechanisms which serve to ensure that practitioners will comply with the ethical rules of council;

(v) Any other information or document which the council may deem relevant."

237. This rule and its related guidance should consider that:

237.1. there be mandatory reporting by the practitioner and publication of shares held in facilities;

237.2. where employment of the doctor is allowed, the doctor may not hold shares in the hospital (unless shares are brought from the open market); And,

237.3. where the practitioners fail to submit the required records, the HPCSA should enforce compliance and take necessary action against the practitioner. Though it needs to be considered whether council has enough capacity to monitor and assess the relationship between hospitals and practitioners who have shareholdings in hospitals or whether this can be a shared responsibility with an appropriate body (e.g. recommended OMRO or SSRH for example).

SPECIFIC RECOMMENDATIONS IN THE PRACTITIONER CHAPTER AND RESPONSES TO THESE

Stewardship from practitioners themselves

238. The PFR suggested that practitioners themselves (either through the HPCSA, the Colleges of Medicine, specialists' associations, and, most importantly, academia), could play a role in ensuring that best practice was promoted. The PFR also indicated that certain practitioner groups (pathology and radiology) were in possession of large data sets that if analysed could guide cost effective best practice in healthcare.

239. RSSA objected to a proposal in the PFR which suggested that radiologists may be in a position to advise practitioners about which radiological tests are most reliable or relevant or cost effective in any particular circumstance. They indicated that they are in a position to advise additional tests if an abnormality was detected. However, they are not in a position to second-guess a referring doctor when the indications are correct for the referral. RSSA believes that fee for service remains the appropriate billing method for radiology.[727]

240. We note the reluctance of some associations to use their knowledge and data to promote cost efficient quality care. A similar reluctance was expressed by the Colleges of Medicine when during the inquiry they were asked if they saw a role for themselves in promoting best practise.[728] We consider this to be an unusual position for medical professionals to hold and note that associations and various bodies internationally do in fact provide exactly this kind of guidance. We thus reinforce our recommendation that this function should be a funded mandate of the SSRH and that this body should be collating in the first instance international guidance on best practise, and using local resources, in particular academia, to assess the relevance of that best practice for the South African context, for both public and private sectors. There was support for this view from some specialist associations.[729] This function should be part of the Health Technology Assessment that is already incorporated in the conceptualisation of the SSRH.

Benefit Design

241. While not repeating what is already in the chapter on funders, it is clear that it is hard for practitioners to be conversant with benefits, treatment protocols and treatment formularies that every scheme and option provide. This frustrates both practitioners and patients. The single base benefit package will go a long way to resolving this problem.

242. There were differences on what should be encompassed in this base package.[730] [731] In particular the absence of primary care services and screening services were highlighted as well as who should be legitimately recognised as a referring practitioner.[732] We have recommended that the contents of the base package be defined in consultation with relevant bodies/professionals and under the auspices of the CMS.

Monitoring quality

243. There was significant support across the board for reporting on quality and health outcomes.

Conclusion

244. Significant improvement in competition in the private healthcare practitioner market can be achieved.

245. Reporting on quality is an urgent requirement so that value-based networks and purchasing can be realised.

246. Changes to the way that practitioner associations operate are essential as they are at risk of being in contravention of competition law.

247. The introduction of a supply-side regulator for health will provide a forum for transparent and procompetitive ascertainment of clinical codes,

727 RSSA submission in response to the PFR, 7 September 2018
728 Email from the Chief Executive Officer of the Colleges of Medicine to the HMI, 5 December 2016.
729 RSSA submission following seminars in April 2019, 26 April 2019
730 SAPS submission following the seminars in April 2019, 29 April 2019
731 NEHAWU submission following the seminars in April 2019, undated.
732 SAAA submission following the seminars in April 2019, 29 April 2019.

relative value units and rand conversion factors and will provide a forum for negotiation of fee-for-service reimbursement.

248. The longer-term linkage between practice code numbers for billing purposes with quality reporting and participation by practitioners in ARMs will promote value-base improved quality care.

249. Changes to the HPCSA rules will promote new forms of care beyond single discipline providers that is currently prevalent.

Chapter 7
Bargaining And Tariff Determination

TARIFF SETTING BETWEEN FUNDERS AND PRACTITIONERS

Introduction

1. Until 2003 negotiations between funders and practitioners occurred centrally between the South African Medical Association (SAMA) and the Board of Healthcare Funders (BHF). This practice ceased following the intervention by the competition authorities to prohibit collective bargaining.

2. The current practice is for schemes unilaterally to revise the tariffs that they are willing to pay and health professionals either accept these terms in return for direct payment, or charge at a higher rate. In the latter case, the higher rate is generally collected from the patient who is liable for any portion not covered by their scheme. From stakeholder submissions, it seems that this approach generally applies across the industry.

3. We have determined that this approach to practitioner tariff determination has had a negative impact on the market. Consumers are faced with uncertainty on prices, potential balance billing, and tariffs which are not determined through a competitive process. We have, therefore, recommended changes to improve market outcomes.

Findings on Funder and Practitioner Tariff Setting

4. We have not concluded definitively on which party is likely to have the greater bargaining power when setting tariffs as the balance is likely to vary by discipline, funder, and geography. Instead we are of the view that across the market there is a lack of effective, competitive negotiations resulting in non-competitive practitioner tariffs. Stakeholders themselves have indicated that the current situation is untenable for practitioners, funders, and patients and needs to be addressed. [733] [734] [735]

5. The vacuum in tariff determination, along with other market features (such as PMBs at cost), has been a contributing factor to scheme expenditure on specialists increasing over time, a view which is acknowledged by several stakeholders.[736] These costs are passed on to consumers through higher premiums, decreasing levels of cover, and/or balance billing by practitioners.

6. In addition, the lack of transparency on prices has meant that patients live in a world of price uncertainty. And, absent an ability for funders to negotiate meaningfully with numerous practitioners, the default payment mechanism of fee-for-service continues to dominate the market. We have concluded that a greater uptake of alternative reimbursement models will allow for beneficial patient outcomes as contracting can occur on additional performance metrics.

7. The ability for practitioners to not only set prices but also, by regulation, be reimbursed at cost for all PMB conditions has created a reluctance by specialists to opt-in meaningfully to provider networks. Networks which cap PMB expenditure

733 SAMA submission in response to the PFR dated 01 October 2018, p.15.
734 SASA submission in response to the PFR dated 01 October 2018, p.11.
735 BHF submission in response to the PFR dated 07 September 2018, p.20.
736 Submissions in response to PFR: Building and Construction Medical Aid dated 07 September, p.2, Health Funders Association dated 07 September 2018, p.6, GEMAS dated 07 September 2018, p.1, Council for Medical Schemes dated 07 September 2018, p.86.

in return for volumes and/or higher tariffs help to create price certainty but have faced resistance from practitioners. Networks would serve to address price transparency, prevent balance-billing, and allow for the introduction of ARMs which include meaningful risk transfer and quality measurements / reporting.

Review of the PFR Recommendations

8. There does not seem to be any dispute that some form of managed tariff determination process between funders and practitioners is required.[737] [738] However, there is disagreement on how this process should work practically.

9. We proposed one negotiating model wherein stakeholders submit information for the SSRH to make a final determination on tariffs. While the Single Exit Pricing model is a successful example of how this proposal may work, we believe that the funder / practitioner environment is more complex, with many more stakeholders, often with different business models, all directly involved.[739]

10. Convincing arguments have been put forward by stakeholders in support of the report's proposed second negotiation forum, wherein the SSRH facilitates a multilateral tariff negotiation forum (MLNF) for stakeholders to negotiate collectively. Since it requires less technical expertise from the regulator side it could therefore be implemented in a shorter period, and participation should ensure a greater degree of stakeholder acceptance.[740] [741] [742] It is important that the SSRH remains independent, impartial and able to perform an oversight role to ensure negotiated outcomes are tested for affordability and industry sustainability.[743]

11. The only notable concern regarding the multilateral negotiating forum is that the facilitated negotiations may be open to abuse by larger participants. However, as negotiations will be undertaken collectively, we believe that the relative size of the negotiators will be less of a determining factor. The combined funder market will be negotiating against practitioner associations and practitioner groupings, allowing for evenly balanced negotiations.

12. We agree with stakeholders that the body charged with overseeing the negotiations must be independent but do not believe existing regulators can act in this role. Existing regulators (e.g. CMS, HPCSA) will be conflicted as they will be responsible for overseeing the practitioner / funder tariff negotiations while being responsible for regulating either group of stakeholders.

13. Therefore, we have recommended a multilateral tariff negotiation forum overseen by the SSRH.

14. The standardised base benefit package, OMRO, and tariff determination will create an enabling environment for strategic purchasing and value based contracting and performance-based reimbursement and contracting linked to quality health outcomes.[744]

15. We believe that bilateral negotiations are important for developing innovative ARMs and recommend that these are both allowed and encouraged. This proposal is supported by several stakeholders.[745] [746] While we seek to direct bilateral negotiations towards more ARM based contracts, we are aware that an immediate ban on bilateral FFS contracts may cause significant disruption.

16. The CMS notes that contracting with specialist networks requires close engagement with the specialist societies, due to the large number of individual practitioners and the influence the societies have over their membership. We recommend that bilateral negotiations between funders and all practitioners and/or practitioner groupings are to be allowed and encouraged provided that the Competition Act is adhered to and the overarching guidelines set by the SSRH are observed.

17. Despite the concerns raised by some stakeholders regarding down-coding,[747] we maintain that the tariffs determined through the multilateral tariff determination process should result in maximum

737 CMS Discussion Document, The Determination of Health Prices in the Private Sector, dated 28th October 2010.
738 BHF submission in response to the PFR dated 07 September 2018, p. 20-21.
739 See annual SEP adjustment - Regulation 8 (1) of the Regulations Relating to the Transparent Pricing System for Medicines and Scheduled Substances of the Medicines and Related Substances Act,1965 (No.101 of 1965) as promulgated on 30 April 2004
740 BHF submission in response to the PFR dated 07 September 2018, p.20.
741 DHMS submission in response to the PFR dated 15 October 2018, paragraph 19.16.3.
742 Discovery Health submission in response to the PFR dated 15 October 2018, paragraph 183.
743 Medscheme submission in response to the PFR dated 06 September 2018, p.16.
744 CMS submission in response to the PFR dated 07 September 2018, p.89.
745 HFA submission in response to the PFR dated 07 September 2018, p.14.
746 Medscheme submission to PFR dated September 2018 p.16.
747 GEMS submission in response to the PFR dated 07 September 2018, p.17.

tariffs for PMBs and reference tariffs for non-PMB conditions. Down-coding to non-PMB conditions does not result in the same distortion as up-coding as funders are not mandated to reimburse non-PMB conditions at cost.

18. Further, we do not believe that opportunities for identifying PMB conditions as non-PMBs are likely, particularly in respect of chronic conditions. Clarity and standardisation of codes as well as a revised PMB list corresponding to the base benefit package, will further mitigate this concern.

19. Maximum PMB tariffs will achieve our goal of eliminating the market power distortion afforded to practitioners through PMB at cost regulations. However, the ability to have variations in tariffs in subsequent bilateral negotiations will enable and encourage stakeholders to innovate in order to differentiate themselves from competitors.[748] Therefore, we recommend that non-PMB reference tariffs and maximum PMB tariffs can vary in subsequent bilateral negotiations provided that these negotiations result in value-based contracts which clearly benefit scheme members.

20. We have responded to the stakeholder requests for additional information relating to the role of the arbitrator.[749] The functions, responsibilities, technical skills and how the arbitrator is practically appointed have been expanded upon in the conclusion of this section (see paragraph 36 onwards).

21. There are two notable departure points from the recommendations of the PFR. The first is that facilities are no longer recommended to be part of the multilateral negotiation forum (see the section ***Tariff Setting Between Funders and Facilities*** for more details on this change).

22. The second is that references to practitioners within this section now refer to all healthcare practitioners, including pathologists and radiologists. Previously, for the purposes of tariff negotiations, we had sought to differentiate practitioners based on whether or not they could be considered corporate entities. However, on reflection such a delineation was considered to not only to be artificial but inherently problematic in categorising professionals who are licensed and regulated by one entity (the Health Professions Council of South Africa (HPCSA)) differently. Whether a practice is corporatized or not is merely a commercial arrangement and is not even necessarily permanent. Pricing of healthcare services is also at the core of medical ethics and there can be no justification for setting some practitioners apart from the rest, let alone corporatized pathologists from other pathologists, i.e. those in solo practice. Depending on the metrics chosen, one might consider a group general practice, practitioner association, or multi-disciplinary team to be as 'corporatized' as any pathology service and would justifiably expect to be exempt from the multilateral forum. We have therefore concluded that commercial arrangements cannot be considered ahead of the globally standardised professional classification. The fluid nature a commercial classification would create problems for the HPCSA in its mandate to regulate health professionals.

23. Allowances for practitioner entities to exclude themselves from the multilateral negotiation forum may result in unintended consequences, an unbalanced negotiation, and a failure for the process to achieve its intended goals. We recommend that all practitioners take part in the multilateral negotiation process. The SSRH will have the right to decide if some stakeholders may be excluded from the process. For example, medicine prices are determined through a separate (Single Exit Price (SEP)) process and the SSRH may decide that services that are not related to dispensing do not justify participation of pharmacies in the MLNF.[750]

24. In addition to these deviations from the provisional recommendations, we have included two additional points. First, in order to facilitate a fairer negotiation process, we recommend that the data used by parties to inform their position in the MLNF is to be shared by the negotiating parties. This anonymised data is to be shared ahead of time to allow for meaningful interrogation by all parties. The SSRH will determine the timing, format and logistics of submission and management of the data, but in all instances patient confidentiality will be paramount.

748 Discovery Health submission in response to the PFR dated 15 October 2018, paragraph 180.
749 See submissions to the PFR: Tiger Brands Medical Scheme dated 06 September 2018, p. 2, GEMAS dated 07 September 2018, p.4, Makoti dated 07 September 2018, p.4, Massmart Medical Plan dated 07 September 2018, p.3, BCIMA dated 07 September 2018, p.3, and Universal Administrators, dated 07 September 2018, paragraph 17.3
750 Such entities may include pharmacies and emergency services.

25. Second, a similar data sharing framework is to be devised by the SSRH to inform the process to be followed during the subsequent bilateral negotiations between parties. This is to ensure a balanced and fair negotiation process where both parties are placed on an equal footing in terms of the information available. We are determined that information asymmetry should not be a source of competitive advantage.

Conclusion on Funder and Practitioner Tariff determination

26. We recommend the following procedures for funder and practitioner tariff negotiations:

27. A multilateral forum will be constituted by representatives of practitioners, funders, government and civil society. The stakeholders will prepare individual proposals and present them simultaneously within the forum. Stakeholders will then negotiate FFS tariffs within a multilateral negotiating forum accommodated and governed by the SSRH.

28. The anonymised underlying data used to prepare these proposals are to be provided to the opposing parties ahead of time.

29. The tariff negotiations will be governed by a negotiation framework developed by the SSRH which will be duly mandated by law to organise, lead and govern the multilateral forum, and to issue guidelines for the negotiations, specifying rules and condition for the negotiations process, including the information sharing regime.

30. The information sharing regime should have regard to the Commission's published guidelines, noting that it is perfectly legitimate for regulators to collect and process the information from market participants. However, concern arises when the industry participants themselves collect and process the information without oversight.

31. The terms of reference will set the conditions against which the outcomes of the multilateral negotiations will be assessed. The conditions will, ex ante, specify the outcomes that will be deemed compatible with the public interest and public policy objectives, including the NHI. Conditions may include the maximum average tariff increase, the maximum acceptable increase in expenditure, or even expenditure per speciality. It may also include metrics such as acceptable levels of utilisation and admission growth, a trade-off between tariffs and volumes, and specific commitments to quality or outcomes improvements.

32. In addition to the information provided by stakeholders, the SSRH may call for additional relevant information from stakeholders or other parties in support of the tariff negotiation process. The legal framework within which it calls for and shares information will be consistent with competition law principles and the public interest.

33. The FFS tariffs for PMBs will be binding with no balance billing allowed. Other FFS tariffs will be considered reference prices. Both PMB and non-PMB tariffs can vary following subsequent bilateral negotiations provided they comply with the bilateral framework set out by the SSRH. In other words, they must include additional risk, quality, and outcomes metrics. These contracts must be submitted to the SSRH for approval.

34. Once the stakeholders reach agreement, the outcomes of negotiations will be submitted to the SSRH. The SSRH will validate and publish these outcomes.

35. Final PMB and reference tariffs must be published by the SSRH, the CMS, and funders. Service providers must do the same at each site of patient contact (e.g. consulting rooms and hospital reception areas) for relevant tariffs and in a manner that is accessible to consumers.

36. If stakeholders cannot reach agreement, or if the SSRH rules that the tariffs do not conform to the legal framework, the matter will be referred to an arbitrator for final determination. The determination of the arbitrator will be binding on all parties.

37. The arbitration will be submitted by agreement of the parties and governed by the Arbitration Act.[751] There are instances where a sole arbitrator may be suitable, while in other circumstances more than one arbitrator may be appropriate to resolve the dispute.

38. Before arbitration is needed, stakeholders must reach agreement on who will arbitrate, failure to do so will result in the SSRH selecting appropriate arbitrators. The chosen arbitrator/s may be registered or unregistered. It is essential to appoint suitably qualified arbitrators with relevant expertise. Organisations such as the Arbitration Foundation of Southern Africa (AFSA) or the Association of Arbitrators South Africa (AASA) may be used to appoint suitable arbitrators. These organisations also provide useful guidelines on rules and procedures for conduct of arbitration to ensure a fair resolution

751 Act 42 of 1965

of the dispute. The arbitration process for appointing an arbitrator as well as the powers of the arbitrator should be clearly outlined in the arbitration agreement.[752]

39. The SSRH will have a limited role in the arbitration process. It is the duty of the arbitrator to be independent of the parties, to be unbiased and to adhere to due process, rules and the applicable law in reaching a reasoned decision. The SSRH is however entitled to present relevant documents which will accompany those presented by the non-agreeing parties to the arbitrator to consider in the hearing.

40. No new information would be allowed to be presented at the arbitration stage.

41. The dispute to be arbitrated should be properly defined in the arbitration agreement. It can also be agreed where the arbitration is to be held, the procedures and rules to be followed, the determination and assessment of costs associated with the arbitration,[753] the confidentiality of proceedings, and any other relevant terms.

42. The conduct of the arbitration should be facilitated in a fair, expeditious and cost-effective manner to avoid lengthy and unnecessary delays.

Bilateral negotiations

43. ARM bilateral negotiations between providers and funders are wholly supported by the HMI. All stakeholders should strive to migrate from FFS to alternative, performance-based contracts with meaningful risk transfer to mitigate against over-utilisation of resources. This ideal can only be achieved through bilateral negotiations.

44. Terms of reference and overarching guidelines for the funder and practitioner bilateral negotiations will be established and published by the SSRH. Information sharing between parties will form part of these guidelines.

45. Bilateral contracts will be submitted to the SSRH and the CMS which will have the authority not to approve contracts which do not progressively incorporate, where appropriate, additional metrics such as risk, quality, and outcomes.

46. The submission of bilateral contracts to the SSRH will be confidential, the aim of which is to ensure that they include some element of risk transfer, value metrics related to quality and outcomes, and that they do not fall foul of competition law. The presentation of the contracts is necessitated by the fact that these contracts will be private to the contracting parties.

47. A data sharing framework is to be devised by the SSRH to inform the process to be followed during bilateral negotiations. This is to ensure a balanced and fair negotiation process where both parties are placed on an equal footing in terms of the information available. The HMI is determined that information asymmetry at that level should not be a source of competitive advantage but rather the use and technical analysis of the data should be the basis of any advantage.

48. We note that FFS is the main driver of volume and cost inflation and must be eradicated as far as possible. Ideally FFS is phased out within 5 years however, we are cognisant of the fact that ARMs and risk transfer may not be appropriate for all conditions.

Interim measure

49. The HMI is cognisant that the proposals put forward will take time to implement. Given the urgency and importance of pricing recommendations in the private sector, the HMI proposes an interim measure for immediate implementation.

50. The interim measure will leverage the powers granted to the Minister to make regulations regarding the publishing of guideline tariffs.[754] Further, it will leverage the capacity and knowledge of the CMS with regards pricing behaviour and use of existing regulation which enables the CMS to collect and disseminate information relating to prices, utilisation, and costs of health services.[755] [756]

752 This includes agreement on who the arbitrator is to be, how he or she will be appointed, or which organisation will appoint the arbitrator.
753 The parties involved in the arbitration have to bear the cost of the arbitration, an award as to who is liable for the costs will form part of the arbitrator's powers.
754 See BHF and WHO submissions in response to the PFR, pages 23 and 5 respectively
755 See CMS response to the PFR, page 88 where they note relevant experience emanating from: *"…the technical work leading the publications of NHRPL, supporting HPCSA ethical tariff guideline processes, 2010 engagements around Pricing Determination Framework, our regulatory work around the guideline for contribution increases, cost assumptions analysis and an expenditure analysis on benefits paid by medical schemes as well as recent work on quality health outcomes."*
756 See CMS submission in response to the PFR, page 90, specifically the reference to the Medical Schemes Act no. 131 of 1998, Chapter 3, Section 7(e), and the Medical Scheme Amendment Bill, section 8a (1)

51. The HMI recommends the following interim measure to provide some level of certainty on practitioner tariffs:

51.1 The Minister to regulate the CMS, as provided for in Section 90(1) of the National Health Act, to create and manage a negotiating environment for funders and practitioners which closely resembles the one recommended by the panel when the SSRH has been established. The CMS, in consultation with competition authorities and stakeholder representatives, is to set the terms of reference for the desired negotiation outcomes.

51.2 The framework for this interim measure will, as far as possible, be consistent with that of the proposed multilateral forum. The stakeholders will prepare individual proposals and present them simultaneously within the forum. Stakeholders will then negotiate FFS tariffs under the auspices of the CMS.

51.3 The anonymised underlying data used to prepare these proposals are to be provided to participating parties ahead of time.

51.4 The CMS is to publish the outcome of the negotiations and highlight that the tariffs are guidelines and are not mandatory.[757]

51.5 There will be an independent arbitration mechanism to ensure buy-in of all stakeholders. This arbitration mechanism will be the same process used in the multilateral negotiating forum and will carry over to the permanent multilateral negotiation forum when it is implemented. The panel does not anticipate that there will be many cases referred for arbitration at this stage, mainly because the reference tariffs will only serve as guidelines; and,

51.6 Practitioners and funders are free to continue to engage in bilateral tariff negotiations with outcomes being confidentially reported to the CMS.

52. The CMS will have no direct role in tariff determination between funders and facilities as these will continue to be settled through bilateral negotiations as it happens currently.

53. However, facilities will still be required to maintain "scheme rates" or "base rates" that would apply in the unlikely event that there have not been any bilateral negotiations for whatever reason.

54. The panel is firmly of the view that the CMS, a regulator for funders, should not be the permanent custodian of the negotiating forum as it will have a perceived bias towards the stakeholders which fund its operations. The CMS acknowledges that this responsibility should reside with an independent statutory pricing authority. [758]

TARIFF SETTING BETWEEN FUNDERS AND FACILITIES

Introduction

55. Since the intervention by the competition authorities to prohibit collective bargaining in 2003, funder and facility negotiations have taken place bilaterally, between individual hospitals or hospital groups and medical schemes or their administrators. The negotiations generally revolve around a single inflation figure which is applied across the various hospital tariff lines.

56. The negotiating process is fairly standardised. The Tribunal in the Netcare/CHG decision described the negotiation process as follows:

"Despite the end of central negotiations between hospitals and funders its culture still prevails. Negotiations occur once a year at the same time as they used to. Because hospitals have so many line items negotiations over tariffs appear to revolve more around the general than the specific. What happens in practice is that there is first a discussion on what medical inflation for that year is and once established, a negotiation of what increase will be on the previous year's tariff for that group."[759]

57. While we believe that the current bilateral negotiation process that occurs between funders and facilities may be the most appropriate mechanism for facility tariff determination, more needs be done to shift the focus from FFS towards meaningful risk-sharing and contracting on value-based metrics. Our recommendations to foster competition (standardised benefit package), create outcomes measurements (OMRO), improve funder bargaining strength (administrator collective negotiations), and

757 Under the existing legislation, and prior to the changes that will be made once the SSRH is constituted, only guideline tariffs for both PMBs and non-PMBs are currently legal. See Section 90(1)(v) of the NHA, "…the process of determination and publication by the Director General of one or more reference price lists…" (emphasis our own)
758 See CMS submission in response to the PFR, dated 07 September 2018, page 87
759 See non-confidential decision in case number 68LMAug06, paragraph 60.

oversight by the SSRH will help to ensure the outcome of this process remains competitive and in the best interest of consumers.

Findings on Funder and Facility tariff setting

58. We have found that the negotiation process between funders and hospitals generally takes one of three forms:

58.1 **No negotiation:** either schemes or hospital groups inform the other party of the proposed tariff increase (usually a percentage increase of the base tariff) and this is accepted and applied;

58.2 **Limited engagement:** hospital groups inform schemes of the proposed increase and a short negotiation process follows, often via email;

58.3 **Extensive negotiation:** hospital groups and schemes engage in a protracted negotiation process of face-to-face meetings, either directly between the hospital groups and the scheme, or between hospital groups and administrators, typically between large schemes / administrators and hospital groups.

59. We consider the facilities market to be highly concentrated with the three large hospital groups, and more recently the NHN, accounting for the bulk of the market. Smaller independent facilities that are not part of the NHN, including Clinix Group and Joint Medical Health (JMH), account for the remainder of the market.

60. We believe that the funders' market is also concentrated, with a few large players and a number of smaller players and that this market has been consolidating for some time.

61. In 2014 there were 29 negotiators representing 85 schemes. Of the 29 negotiators, two negotiators, Discovery Health and GEMS, represented 54% of beneficiaries. If the next three biggest negotiators, Medscheme, Metropolitan, and Bonitas, were included, the market share of the top five negotiators increased to 69% of beneficiaries.[760] The latest CMS figures show that, for 2017, the two largest negotiators DH and GEMS, represented 59% of the market. Including Medscheme, Bonitas, and MMI, the five largest negotiators represented 83% of the market.[761]

62. Within this market context, analysis undertaken by the HMI, and corroborated through submissions from stakeholders, indicates that while there are a number of factors driving tariff negotiations, the main drivers are:

62.1 the relative size of the negotiators;

62.2 the ability for funders to channel patients; and,

62.3 to a lesser extent, evidence of ARMs.

63. Our findings with regard to each of these points are considered in more detail below.

Size of negotiators

64. Our own analysis confirms submissions by the facility groups which show that larger funders achieve lower prices. Stakeholders generally agree that size matters in negotiations.[762] [763] [764] [765] [766] However, this finding is largely driven by the two largest negotiators – DH and GEMS – who are clear market leaders in terms of size relative to any other funder.[767] [768] The evidence demonstrates that these two negotiators have a degree of countervailing power in negotiations relative to schemes below a particular membership threshold.[769] Over time, this has translated into relatively lower tariffs for GEMS and Discovery Health, both of which accept that they benefit from scale during negotiations.[770] [771]

65. Some hospital groups have indicated that when bargaining with DH, they are in a relatively poor position given the substantial amount of revenue at risk should negotiations fail. This is even higher for specific hospitals, some of which may derive over half of their revenue from DH members.

760 CMS annual report annexures 2014/15.
761 CMS annual report annexures 2017/18.
762 BHF submission in response to the PFR dated 07 September 2018, p.5.
763 CompCare submission in response to the PFR dated 07 September 2018, p.2.
764 Discovery Health presentation at the Health Market Inquiry Seminar: Session 3 of 9 April 2019.
765 GEMAS submission in response to the PFR dated 07 September 2018, p.1.
766 PPO Serve presentation at the seminar organised by HMI, 9 -12 April 2019.
767 Annexure A – RBB Response to the HMI's Provisional Findings – Effectiveness of Competition p.13.
768 Netcare Compass Lexecon Bargaining Report dated 30 October 2014, paragraph 1.6 *"Beyond Discovery Health and GEMS however we do not find a significant role for the size of the negotiator (whether medical scheme or administrator) in determining the prices paid by medical schemes to Netcare."*
769 While submissions by LHC indicate that these two negotiators are able to *'impose onerous conditions on LHC"* they maintain that size on its own does not determine bargaining strength and therefore smaller negotiators are not at a disadvantage. See: RBB Note on Bargaining Power dated 19 April 2018, p.5.
770 GEMAS submission in response to the PFR dated 07 September 2018p.1.
771 Discovery Health presentation at the Health Market Inquiry Seminar: Session 3 of 9 April 2019.

However DH disputes this argument, noting that during national negotiations facility groups leverage total (national) market share to counter the scheme's power to exclude one or more of its hospitals (where appropriate) from participating in certain scheme/option networks.[772] DH submits that whilst it has to contract at the national level as it has a national footprint, at times it encounters difficulties at the regional level as facility groups apply resistance, exerting their power.[773]

66. The degree to which analytics and negotiating ability are able to impact tariff increases, means that the larger negotiators are likely to have greater access to information and more resources to bring to this exercise.

67. Anecdotal evidence suggests both smaller schemes and smaller facilities are at a disadvantage during negotiations. For example, Mediclinic Kathu was sold to the Lenmed group (part of NHN) in March 2015 and has since received lower tariffs from schemes. Equally, one of the largest facility groups acknowledged that it places more effort in negotiating with larger schemes and the smaller schemes are given a price without negotiation.

68. However, evidence also reveals a wide range and dispersion of tariffs achieved across smaller schemes, which illustrates that factors other than size play a role in tariff determination. Hospital groups submit that smaller schemes can and do exercise buyer power in network negotiations.[774] [775] [776] Netcare has argued that the report does not systematically consider documentary evidence that funders other than DH and GEMS have exercised significant bargaining power over Netcare. [777]

69. Netcare and LHC submit that the inquiry has not considered that facilities are substitutes from the perspective of funders but that schemes are not substitutes from the perspective of facilities and that this gives funders inherent countervailing power.[778] [779] As Netcare explains, whereas funders have numerous options to substitute among hospitals groups, hospitals risk losing significant volumes and large share of revenues if they fail to contract with the largest funders.[780] According to LHC, a failure to enter into an agreement with a funder irrespective of the size will translate into a loss in patient volumes, which any private hospital group would seek to avoid.[781]

70. We do not agree with this contention by Netcare and LHC. While theoretically this argument may be true in an environment with low facility concentration, in the South African market where the three hospital groups account for 90% of admissions, larger funders do not view any facility group as substitutable. Even in regional areas where one facility group may be excluded by a funder, DH has indicated that the excluded hospital group will respond by recouping lost revenue from the funder at the national level where the facility group cannot be excluded from negotiations.

The ability to channel patients

71. The ability of funders to channel patients through, for example, provider network options, worsens the outside option available to hospital groups during negotiations as they face a credible threat that patients will be channelled to rival hospitals. Stakeholders agree that networks are an important tool in negotiations.[782] [783] [784] However, this advantage is predicated on the assumption that funders are able to set up a viable network which excludes a particular hospital or hospital group.[785] [786] [787] In some areas this is simply not possible as there is only a single facility.

72. Hospital groups disagree with the contention that areas which only have a single hospital, i.e.

772 Discovery Health post-seminar submission to the HMI, dated 26 April 2019 p.2.
773 Discovery Health post-seminar submission to the HMI, dated 26 April 2019 p.2.
774 Life Healthcare post-seminar submission to the HMI, dated 26 April 2019 p.4.
775 Annexure A – RBB Response to the PHMI's Provisional Findings – Effectiveness of Competition dated 15 October 2018, p.3
776 Mediclinic presentation at the seminar organised by HMI, 9 -12 April 2019.
777 Netcare submission in response to the PFR, dated 15 October 2018, p.3.
778 Netcare post-seminar submission to the HMI titled HMI Seminars: Response Paper on Behalf of Netcare Limited, dated 26 April 2019 p.26.
779 LHC presentation at the seminar organised by HMI, 9 -12 April 2019.
780 Netcare presentation at the seminar organised by HMI, 9 -12 April 2019.
781 Annexure A – RBB Response to the PHMI's Provisional Findings – Effectiveness of Competition dated 15 October 2018 p.13.
782 Life Healthcare post-seminar submission to the HMI, 26 April 2019 p.4.
783 Netcare presentation at the seminar organised by HMI, 9 -12 April 2019.
784 Netcare post-seminar submission to the HMI titled HMI Seminars: Response Paper on Behalf of Netcare Limited, 26 April 2019 pp.25-32.
785 Medscheme presentation at the seminar organised by HMI, 9 -12 April 2019.
786 Discovery Health presentation at the seminar organised by HMI, 9 -12 April 2019.
787 Transcript of the seminar organised by HMI, 9 -12 April 2019.

solus facilities, have a material impact on network negotiations as they are too small and account for a relatively small proportion of national admissions.[788] [789] However, Mediclinic does acknowledge that if there is only one hospital in a local region, no network can exclude this hospital.[790] Large groups can also exert pressure on funders to not exclude a particular hospital by threatening to increase the base price across the entire network if particular hospitals are excluded from a network.[791]

73. Hospital submissions indicate that the other large funder, GEMS, has an additional source of bargaining power in that its members have high switching costs.[792] GEMS members receive government subsidies which they would forfeit should they switch to an alternative scheme. This means that GEMS can more effectively use co-payments to induce members to avoid non-contracted hospitals without significant losses in membership.

74. Medscheme and the larger hospital groups argue that the NHN has become a strong contender for anchor status on networks.[793] [794] [795] [796] However, both the CMS and DH caution against comparing the NHN to the big three hospital groups since they have limited bargaining power,[797] a limited national footprint, and the independent hospitals within the network are competitors.[798]

75. We agree that caution must be taken when comparing the NHN to the other hospital groups as they have a fundamentally different business model. For example, the NHN exemption does not allow for co-ordinated quality initiatives or scale advantages, in the form of cost efficiencies, centralised procurement, innovative risk adjustment models, or general innovation and technological improvements. Instead, the exemption has imposed conditions on the NHN relating to global fee arrangements, submitting information to the Commission, and sets out strict conditions for membership which are not a requirement for the facility groups.[799] Therefore, a comparison with the big three hospital groups is often inappropriate.

76. Our analysis shows that network options have resulted in lower tariffs. Non-network options almost always received a higher average tariff, with the lowest tariffs attributable to networks where the hospital group has a number of hospitals in the network. More notably, analysis shows that some smaller schemes, which had not outsourced negotiations to administrators, were still able to achieve low tariffs through successful implementation of network arrangements with the respective hospital groups.

77. However, these smaller schemes may be outliers which have a particular advantage, such as having members concentrated in a particular region or around a particular facility. Whether these smaller schemes would continue to enjoy favourable tariffs if they were to grow their membership base, and, therefore, compete with the larger schemes, is not clear.

Evidence of ARMs

78. The movement from FFS to ARMs is potentially beneficial for funders, as it provides a level of certainty in costs, and for facilities, since the funder would have to compensate for the risk transfer. In addition, ARM arrangements incentivise the hospitals to be sensitive to costs as, unlike FFS arrangements, hospital revenues do not necessarily increase with additional services rendered. ARMs are not without issues however, such as the potential for under-servicing and reduced granularity on patient cost information.

79. Evidence received by the inquiry and analysis undertaken by NMG (previously Willis Towers Watson) indicates that the ARMs currently in the market are not effective at reducing scheme costs and have a limited bearing on tariff negotiations.[800] We note that there is no consensus among

788 Life Healthcare post-seminar submission to the HMI, dated 26 April 2019 p.5. According to Life Healthcare, across all private hospital groups, solus facilities account for only 5% of admissions implying that instances in which funders may not have alternative private hospitals account for only a small proportion of admissions.
789 Mediclinic presentation at the seminar organised by HMI, 9 -12 April 2019.
790 Mediclinic presentation at the seminar organised by HMI, 9 -12 April 2019.
791 Discovery Health post-seminar submission to the HMI dated 26 April 2019 p.2.
792 Life Healthcare submission to the Statement of Issues dated 31 October 2014, p.33.
793 Medscheme presentation at the seminar organised by HMI, 9 -12 April 2019.
794 Netcare presentation at the seminar organised by HMI, 9 -12 April 2019.
795 LHC presentation at the seminar organised by HMI, 9 -12 April 2019.
796 Mediclinic presentation at the seminar organised by HMI, 9 -12 April 2019.
797 CMS post-seminar submission to the HMI, dated 2 May 2019. Page 2.
798 Discovery Health post-seminar submission to the HMI, 26 April 2019 p.3.
799 See NHN exemption notice, available online at: http://www.compcom.co.za/wp-content/uploads/2018/01/NATIONAL-HOSPITAL-NETWORK-GRANTED-CONDITIONAL-EXEMPTION.pdf
800 See: WTW Report on Analysis of Medical Schemes claims data – a focus on facilities, dated 15 December 2017, table 67

stakeholders, particularly large hospital groups, that the current uptake of ARMs is low. [801] The discrepancy is likely exacerbated by what is meant by the term ARM since while a number of procedures may have ARM prices, they are often paid at non-ARM rates given numerous "carve-outs" included in these agreements.[802] Further, the definition of what constitutes an ARM is varied with some, for example, per diems, having very limited actual risk transfer.

80. Anecdotal evidence suggests that, other than for some of the larger funders, ARMs are typically initiated by the facility groups and the line-item cost information that would allow funders to evaluate these arrangements is often not made available. The lack of transparency in these arrangements and the substantial carve-outs in the current South African context have meant that funders have chosen to revert to FFS arrangements and the market continues to be deprived of the full benefit of ARMs.

81. DH is notable in that it has been able to initiate ARMs with the facility groups, maintaining a shadow FFS arrangement to ensure that it still receives line-item cost data. This FFS cost data allows it to accurately benchmark its ARMs. Submissions from the other large funder, GEMS, has highlighted its willingness to initiate ARMs with providers.

82. Although submissions have indicated an increased uptake of ARMs and their contribution to negotiations,[803] the available evidence is that the market continues to be largely characterised by FFS models. Furthermore, where ARMs are initiated by the facility groups, it does not seem clear from the evidence provided whether there is substantial risk transfer or indeed whether funders are receiving value for these contracts.

Conclusion

83. Our analysis shows that the larger funders exert some degree of countervailing power against the large hospital groups relative to other funders. Smaller funders have been seen to use networks to improve their bargaining position. However, given the clear benefits from networks and ARMs for the consumer, it is concerning that networks and ARMs have not been implemented to a greater extent. More must happen in order to significantly improve efficiency and force hospitals to readjust operations and investment plans to target efficiency.

84. Funder submissions have hinted at difficulties in leveraging localised bargaining power to translate into real benefits as these regional dynamics play out in the national negotiations with the facility groups. Funders have pointed out that where they are able to achieve regional cost savings by excluding a particular hospital from its network, the facility group can recover the loss in other areas through a national tariff increase.[804] The ability of the big hospital groups to compensate for regional losses nationally, or elsewhere in their national network, signals the possession of market power at the national level.

Review of the Recommendations of the PFR

85. The three large hospital groups rejected the recommendation of a multilateral negotiation as a precursor to bilateral negotiations.[805] The NHN and Clinix supported the recommendation.[806] From the perspective of funders, DH believes that bilateral negotiations should remain the main contract negotiation modus operandi between funders and corporate providers (facilities and pathologists) for both FFS and ARMs,[807] while Polmed recommend a tariff regulation regime where an industry price regulator, such as the NDoH, will ensure that service providers (hospitals) compete on service and efficiencies.[808]

86. The hospital groups cite the evidence that prices are increasing at CPI, despite hospital costs increasing at levels higher than CPI, and the inquiry's findings on profitability as indications that the current bilateral negotiations do not result in excessive prices. [809]

801 LHC presentation at the seminar organised by HMI, 9 -12 April 2019.
802 Carve-outs are conditions or terms which specify when a treatment covered by an ARM reverts to a FFS arrangement
803 See Life Healthcare Group submission on Tariff Determination dated 03 November 2017, paragraphs 3.3.4.5 – 3.3.4.7 and Discovery Health/Discovery Health Medical Scheme– combined submission on Tariff Determination dated 20 October 2017, page 8.
804 Discovery Health post-seminar submission to the HMI, dated 26 April 2019, p.2.
805 LHC submission in response to the PFR dated 15 October 2018, pages 13 and 14, Netcare submission in response to the PFR dated 15 October 2018 p.130-136 and Mediclinic submission in response to the PFR dated 15 October 2015 p.14.
806 NHN submission in response to the PFR dated 07 September 2018 page 10 and Clinix submission in response to the PFR dated 07 September 2018 p.3-4.
807 Discovery Health submission in response to the PFR dated 15 October 2018, paragraph 186.
808 Polmed submission in response to the PFR dated 07 September 2018, p.4-5.
809 See LHC submission in response to the PFR dated 15 October 2018, paragraphs 4.5.4.4.1 to 4.5.4.4.4, and Mediclinic submission in response to the PFR dated 15 October 2018 paragraphs 6.3 and 6.6.3.4.

87. Concerns were raised regarding the potential for unintended consequences if prices are not left to the market. For example, if prices are based on the costs associated with larger hospital groups, they may be set too low relative to new entrants and would prevent entry.[810] This risk may also be exacerbated as there is limited scope for these new entrants to immediately win patient volumes through new or innovative ARMs.[811]

88. The hospital groups have also been clear in their position that any price regulation would be inappropriate. LHC believes that our concerns can be addressed through less intrusive means.[812] Netcare believes that there is no rational or reasonable basis for recommending a price control regime in relation to the facilities[813], and that our proposal to negotiate for each possible line item every year would not be possible.[814] Current bilateral negotiations are often protracted, and the inclusion of government and civil society would make it extremely unlikely, or near impossible, that all parties would be able to reach consensus on an annual basis.

Conclusion on Funder and Facility tariff setting

89. After considering stakeholder submissions, we have reached the following conclusions.

90.1 Both the facilities market and the funders' market are highly concentrated and dominated by a few large players.

90.2 Size is an important consideration in negotiations, though it is not the only factor, as there is evidence of smaller schemes being able to negotiate effectively.

90.3 Where DSP networks have been successfully implemented by funders they have clearly been seen to result in lower prices. This ability has been constrained by:

90.3.1 Local market power of solus facilities. While the hospital groups argue that solus facilities account for a relatively small proportion of national admissions and are unlikely to convey material bargaining power to hospital groups during national negotiations, the fact remains that solus hospitals represent instances where funders have no outside options.

90.3.2 The national bargaining dynamic confers power on the larger hospital groups as they are able to mitigate regional revenue loss through national negotiations. As confirmed by funders, there are repercussions for excluding larger facilities from participating in certain schemes or networks as the big three hospital groups are able to compensate for the loss of revenue at the national level.

90.4 There is evidence of an uptake of ARMs, but the market continues to be dominated by FFS models. Existing ARMs often have no substantial risk transfer and whether funders are receiving value for these contracts is often unclear. We believe that while not necessarily a market failure per se, the slow uptake of ARMs and an over-subscription to FFS reimbursement relative to international standards is a clear indication that the current market structure is not conducive to effective competition or innovation. We note that hospitals in the current environment are hindered in ARM contracting as they are not able to influence doctor behaviour which can have an impact on hospital costs. But we also note that hospitals have invested in infrastructure that facilitate doctor-initiated high cost care.

90. The funder / facility tariff recommendations which we have put forward seek to create a single, baseline FFS tariff structure for facility services, to provide a level playing field for smaller funders and facilities, and to encourage competition on metrics other than FFS tariffs. This recommendation would have accomplished our goal of ensuring that every hospital service had a collectively negotiated FFS price and would have created price certainty and increased transparency.

91. However, following a review of the submissions by stakeholders, we are of the view that the multilateral tariff negotiation recommendation for facilities would not be the most appropriate recommendation. Where the report has identified concerns in the funder / facility negotiations, these can be adequately dealt with through less interventionist measures.

92. Unlike the practitioner market which largely does not engage in bilateral negotiations, funders and facilities would be expected to engage in the multilateral forum in addition to the bilateral negotiations that currently occur. Absent stakeholder consensus, we do not believe that the

810 Netcare submission in response to the PFR, dated 15 October 2018, paragraph 269.3.
811 LHC submission in response to the PFR dated 15 October 2018, paragraph 4.5.4.4.11.
812 LHC submission in response to the PFR dated 15 October 2018, paragraph 4.5.3.2.
813 Netcare submission in response to the PFR, dated 15 October 2018, paragraph 266.5.
814 Netcare submission in response to the PFR, dated 15 October 2018, paragraph 267.4

additional costs associated with the imposition of the multilateral forum will outweigh the benefits, particularly in light of the issues raised, and the existence of alternative interventions.

93. The first issue is whether the multilateral forum would result in the intended outcomes envisaged, particularly as some stakeholders may not be adequately incentivised to negotiate in good faith. Submissions from the larger funders and facility groups have indicated that ARMs are a substantial and growing proportion of their claims. Other players, which may have a lower proportion of ARMs, would be more reliant on the FFS tariffs determined by the multilateral forum.

94. In a situation where the largest funders and largest facilities have the majority of their claims being covered by bilateral ARMs, it would risk their involvement in the multilateral forum becoming irrelevant, and it would open the possibility for the forum to be subverted as these players would have no incentive to bargain for FFS tariffs which would be relevant only for their rivals.

95. In terms of creating a level playing field, we believe that the exemption granted to the NHN has, to some extent, been successful in bringing together smaller facilities to achieve scale in negotiations. However, we note that in all other respects NHN is not a hospital group, in that individual facilities remain strategically and operationally independent.

96. In terms of the smaller funders, collective negotiations for administrators (see the section ***Administrator Collective Negotiations on Behalf of Medical Schemes*** below) will increase the scale, and therefore negotiating position, for a number of smaller schemes.

97. We acknowledge that there may be some smaller facilities, not part of the NHN, and some smaller schemes which choose to remain self-administered which may have benefitted from multilateral tariff negotiations. However, we maintain that the costs and unintended consequences inherent in this proposal are likely to outweigh the potential benefits.

98. In terms of transparency, we recommend that facilities publish comprehensive price lists on their websites and at facility locations for the base tariffs applicable for non-insured patients.

99. This approach does have some drawbacks. Notably that the negotiations will not be overseen by the SSRH, and civil society will not be able to participate, and pro-consumer input which would add value in ensuring outcomes would be removed from the negotiations. However, these roles are largely covered within the context of the remaining recommendations which aim to facilitate a greater linkage between administrator, scheme, and member incentives. Successful implementation of these recommendations should result in negotiations having a greater consumer focus.

100. We believe that the other recommendations outlined in this report will contribute to these negotiations being more relevant for consumers, for example,

101.1 outcomes measurement;

101.2 HPCSA rules changes;

101.3 collective administrator negotiations;

101.4 standardised base benefit packages; and

101.5 performance linked principal officer and trustee remuneration.

101. Therefore, we recommend that the current bilateral negotiations between funders and facilities continue. Further, we recommend that after a period of three years, bilateral negotiations are to focus exclusively on ARM contracting. We believe that the shorter timeframe, relative to the five years for practitioner negotiations, is appropriate given the greater sophistication of these stakeholders and the stated position by facilities that ARMs already constitute a significant proportion of claims.

102. To ensure a progressive movement towards ARMs which include meaningful risk transfer, quality metrics, and pro-competitive outcomes, these bilateral arrangements must be submitted for review by funders to the CMS and by facilities to the SSRH. Should contracts be found wanting in terms of these metrics, the SSRH in consultation with the CMS, will have the authority to intervene in any bilateral arrangement. Despite the contracts being identical, both parties must submit to their respective regulator to ensure accurate records are kept.

103. We acknowledge that a failure to conclude bilateral negotiations, or having bilateral arrangements be invalidated by either the CMS or SSRH, will cause a vacuum once again. To address this problem, we recommend that all funders must establish comprehensive scheme rates for all facility services which can be relied upon should bilateral negotiations fail.

PROVIDER NETWORKS

Introduction

104. Provider networks refer to a multitude of contractual arrangements and can include contracted general practitioners, specialists, facilities, or practically any type of provider of healthcare services. These arrangements benefit the designated provider either through higher tariffs or lower tariffs in combination with greater volumes of patients (through channelling and exclusivity). The benefits for the funder may include price certainty, discounted tariffs (if tariff reductions in response to greater volumes form part of the arrangement), increased competition amongst providers, lower costs (if providers are selected on efficiencies), and adoption of best practice protocols.

105. Provider networks generally bring competitive benefits to stakeholders which can be passed on to patients, but closed networks may also have unintended anti-competitive effects from the exclusion of efficient competitors and/or from increasing barriers to entry. However, provider exclusion is a fundamental part of networks; this must be balanced against the reduction in patients' freedom of choice.

106. The reduction in choice also partially addresses two issues commonly identified in healthcare: patient information asymmetry and the principal agent problem. Networks shift responsibility to the funder for where and what treatment is provided. Information asymmetry is mitigated as funders operate on a greater level of information parity vis-à-vis providers and the principal agent problem is removed as the funders are directly responsible for the payment of patient treatment and incentivised to seek cost-effective high-quality treatment.

107. Savings on network options allow funders to offer these plans at a discount. By leveraging this financial incentive, schemes can effectively channel patient volumes to receive treatment where they have determined providers to be the most effective and affordable. This initial benefit also has a knock-on effect as it creates pressure for providers to compete to be the most effective and affordable, resulting in substantial cost savings, and for quality and patient outcomes to become a regular part of the tendering process for network contracts.

108. We believe that provider networks have a net positive impact on both competition and access to affordable care and should continue to be an option in the sector's drive to provide quality care based on value.

Findings on Provider Networks

109. In our preliminary findings, we concluded that there is a lack of effective competition in the private healthcare market. However, this failing is not due to the lack of providers as, particularly in large urban areas, there are a multitude of hospitals or specialists to choose from when receiving treatment. Rather, the breakdown in competition occurs because schemes have little-to-no incentive to compete for good networks, and to publicize the benefit of those networks to their members. Competition breaks down also because:

110.1 patients are often unable to determine the quality of treatment received;

110.2 without a measure of quality, they are unable to determine whether the price of the treatment they are paying for is appropriate; and

110.3 private healthcare patients do not pay directly for the costs associated with treatment and, therefore, they have no incentive to switch when faced with high prices.

110. These factors serve to prevent effective competition from occurring amongst providers of healthcare, but they may be addressed through the implementation of provider networks. Schemes, with access to data and medical knowledge, do not suffer from the same problems faced by patients when receiving treatment.

111. Members who sign up for network options benefit from lower premiums relative to schemes' standard options but incur a cost of having to use a smaller selection of contracted providers or face significant co-payments. By signing up for a network option, members effectively signal to the funder a willingness to be channelled. At present this channelling is undertaken to save costs. However, funders should do more to include additional value-based metrics and educate consumers about the benefits.

112. Successfully establishing provider networks can create certainty on costs and can cap PMB expenditure. Facility networks serve to increase funder bargaining power by significantly worsening the hospital groups' outside option during negotiations. The network is a strong commitment device on behalf of the funder to indicate a willingness and ability to effectively channel patients and increases the opportunity cost of any hospital or provider which fails to join the network. However, this advantage is predicated on the assumption that funders have

an outside option which includes setting up a viable network with other available specialist practitioners or excluding a particular hospital or hospital group.

113. The data and submissions demonstrate that funders' effective use of facility network agreements typically results in lower tariffs. Analysis of the GEMS efficiency discount options further highlight the potential for networks to foster competition amongst facilities and thereby result in savings.[815] Supporting evidence was provided in 2017 when Bonitas failed to reach a favourable agreement with Life Healthcare facilities. Bonitas subsequently excluded these facilities from its network by publicly announcing that members would incur a 30% co-payment at 14 Life Healthcare hospitals. Shortly thereafter, Life reconsidered its stance and announced that the hospital group would waive these co-payments.

114. Aside from pure price considerations, networks also allow schemes to select the most efficient hospitals to be included in their networks, reducing costs and encouraging inefficient hospitals to improve. Similarly, schemes can ensure practitioner efficiency by mandating contracted-in practitioners to follow standard, international best-practice, clinical protocols. Statistical outliers in terms of negative patient outcomes (repeat cases, unnecessary treatment, and long length of stay) can be monitored and poor performing providers removed from the network, ensuring patients on network options receive treatment that is of a consistently high quality.

115. Submissions by hospital groups indicate that the use of networks by funders has driven competition among hospital groups and resulted in substantial discounts being offered to funders for inclusion in networks. Hospital groups are generally unwilling to be excluded from networks and have substantiated their claims that exclusion from a network results in lost patient volumes and revenues. Further submissions indicate networks can be an effective tool for smaller schemes to exercise countervailing power during negotiations against the larger hospital groups.

116. On the other hand, we have found that funders have struggled to implement practitioner networks in an environment where specialists can be reimbursed for PMBs at cost. Channelling is further hindered by patients having a greater loyalty to their doctors relative to any hospital facility. Where practitioner networks have been implemented, rather than receiving discounted tariffs for increased volumes, practitioners often need to be reimbursed at a higher tariff than the scheme rate in order to entice practitioners to join and/or to adhere to protocols. The additional costs involved in enticing practitioners to join the networks have meant benefits are often only realised in the long-term, raising barriers to implementation. These barriers have prevented successful practitioner networks from being more prevalent in the market.

Review of PFR Recommendations

117. The report recognises two types of networks: open networks, where any provider willing to meet the funder's published criteria can participate, and closed networks, which are selective and amenable to contracting based on value because the contracting parties need to enter into upfront agreement on fees, quality monitoring and reporting.

118. Given the different characteristics of the practitioner and facility markets, recommendations aimed at ensuring that competitive and value-based networks are implemented effectively, need to be considered separately.

Practitioner Networks

119. For practitioners, the multilateral tariff negotiation which results in capped PMB tariffs should assist in removing one of the identified barriers to effective practitioner network implementation.

120. In terms of practitioner networks, we recommend that networks which are based purely on FFS considerations must be open to any willing practitioner. We support this option as we have been convinced by (especially) restricted schemes that costly tender processes are not always necessary and can be uneconomic for smaller schemes. This is certainly most relevant for primary care networks, including pharmacies. Therefore, we recommend that open networks must be available as an option for funders who find the administration-intensive closed network to be uneconomical.

121. We are aware that this type of network will not necessarily guarantee increased patient volumes for network practitioners. Funders are unlikely to secure deep discounts from open network

815 GEMS submission in response to the PFR dated 07 September, Appendix 1 Emerald Value Option Update_Report_3 September 2018_V1_Final.

providers where increased patient volumes are not guaranteed. We anticipate that the limited benefits of open networks will be less attractive to industry players and selective contracting based on value will be preferred.

122. Open networks will benefit consumers, especially those living in rural and peri-urban areas, in terms of access to care.

123. Open network practitioners will have the option to opt-out of the network provided that they adhere to a predetermined notice period. We propose a three-month notice period, not more than six months. Likewise, funders should observe a preferably equal notice period if they wish to alter the open network terms. Price-only adjustments to the network terms would be subject to a shorter notice period. Network participation terms must state upfront how patients and provider payments will be managed during any transition period where providers are leaving or joining a network.

124. Given open networks are unlikely to result in foreclosure concerns, we do not prescribe any contract duration provided the notice periods as recommended above are recognised.

125. Funders and practitioners may enter into closed networks but only if these are based on value, with relevant (for example, utilisation, quality, and access) metrics being an integral part of the contracts. It is anticipated that our recommendation of a common dataset for negotiating parties will enable progressively increasing risk-transfer arrangements which will be monitored by the SSRH.

126. In both open and closed network arrangements, the selection criteria must be transparent and available to any service provider that enquires.[816] Where practitioners have been excluded (in closed networks), reasons must be communicated to them so that improvements can be made.

127. Closed networks should make use of a transparent process with clear terms of reference and rules for participation.[817] The results of this process must be lodged with the SSRH.

128. We note the concern that two years may be an insufficient period to allow for closed practitioner networks to be fully developed in order to derive all the potential benefits.[818] The purpose of the proposed time limit is twofold. First, to ensure funders continually test network conditions and prices against the market, and second, to ensure there is an opportunity for non-network practitioners and new entrants to join closed networks or DSPs. In terms of testing the market, we believe the greater competition amongst funders which will result from other recommendations (standardised benefits, governance) will incentivise funders to test the market regularly.

129. In terms of allowing access to practitioners who may have improved over time, where networks are open to any willing practitioner there would be less of a requirement for an imposed time-limit. Where networks are closed, we recognise that additional time may be needed and, therefore, recommend a time limit of three years. [819]After three years, the closed network should be re-initiated via a transparent process and be open to all providers who intend submitting proposals.

Facility Networks

130. For facilities, we recommend only closed, value-based networks (DSPs) where provider networks are contemplated. The fewer number of negotiating partners engaged in bilateral negotiations in the first instance make open networks difficult to justify.

131. Several stakeholders do not support open published tenders for facility DSPs.[820] They indicate that the tender process is complex and costly and does not necessarily yield better results than bilateral negotiations and argue that funders should be able to use whichever process they see fit.

132. Stakeholders indicate that a requirement which forces funders to publish the results of tenders will undermine the competitiveness of the market and lead to all prices ultimately converging at a higher level than where the results of competitive tenders or other processes remain confidential.

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816 PASA submission in response to the PFR undated, p.2, Medscheme submission in response to the PFR dated 06 September 2018, p.17 and MMI submission in response to the PFR dated 18 October 2018, p.3.

817 This is in alignment with the intention to declare elements of DSPs undesirable business practices, see CMS Judgement on Appeal of Independent Community Pharmacy Association vs Registrar of Medical Schemes and Council for Medical Schemes 12/07/2016 and CMS Circular 39 of 2017.

818 LHC submission in response to the PFR dated 15 October 2018, p.58, NHN page 12, Discovery Health submission in response to the PFR dated 15 October 2018, p.38, and CompCare submission in response to the PFR dated 07 September 2018, p.5.

819 LHC submission in response to the PFR dated 15 October 2018 p.58 and Western Cape Government submission in response to the PFR dated 21 September 2018 p.19.

820 Discovery Health submission in response to the PFR dated 15 October 2018, p.38.

133. Our recommendation is aimed at improving transparency in these network arrangements, but we are cognisant that publishing sensitive information may have anti-competitive outcomes. We recommend that all relevant information is lodged with the SSRH but only non-sensitive information relating to the winning bid should be published. The SSRH will determine the relevant information which is required and should be published but could include the names of successful network partners, the duration of the contract, the services contracted for, and quality metrics.

134. The other terms relevant to closed practitioner networks will also apply to the closed facility networks, namely, a three-year maximum duration, open and transparent processes, making available the selection criteria to any inquiries, and providing reasons for non-acceptance, the arrangements must progressively incorporate value metrics, and outcomes are to be submitted to the SSRH.

135. We recognise that some network arrangements may be initiated by practitioners and facilities (separately or in partnership) and may be proposed to funders suitable to them. We support this practice as it is likely to drive competition, innovation and local contracting. While provider-initiated networks may be exempt from an open process at inception, requirements that they must be pro-competition, value-based, last no longer than three years, and must be reported to the SSRH, remain.

Competition Concerns

136. Competition concerns arise from network arrangements due to the exclusivity which is an inherent requirement in closed networks. The primary concern is that exclusive contracts increase the risk of input or customer foreclosure and increase barriers to entry because exclusivity that prevents a new or existing competitor from gaining sufficient customers (or inputs) to reach a minimum viable scale can have a foreclosing effect.

137. A simple example of an anti-competitive outcome would be where an efficient practitioner is excluded from the dominant funder's network in a particular area and, without sufficient patients, is forced to exit the market. Similarly, if the beneficiaries in an area all belong to a single network and a new practitioner is unable to join the network, they would be unable to enter the market.

138. To assess whether vertical restraints such as these exclusive network arrangements are likely to be anticompetitive, authorities typically take the following approach:

138.1 an assessment of whether there is dominance or market power by either party in the agreement;

138.2 whether the agreement will result in foreclosure of current market participants or potential entrants and whether this will result in consumer harm; and

138.3 an assessment and balancing of any pro-competitive justification for the agreement against the anti-competitive harm.

139. Our recommendations for closed network duration and the requirement for networks to be implemented through a transparent and competitive tender process will go some way to address these potential anti-competitive concerns. Further, the oversight role played by the SSRH with respect to network arrangements will take into consideration the potential for these to result in anti-competitive outcomes.

140. The Competition Authorities must also play a role to monitor anti-competitive effects arising from networks, particularly where a large player demands exclusivity as a network provider. Such exclusivity, particularly in an area where the large player is necessary for sufficient network coverage, will prevent a funder from creating a network consisting of competing providers and may foreclose smaller providers.

Conclusion on Network Recommendations

141. In conclusion, we recommend the following:

142. In terms of practitioner networks:

142.1 Networks based purely on FFS considerations must be open to any willing practitioner;

142.2 Practitioners should have the option to opt-in or opt-out of open networks provided they adhere to a predetermined notice period. The HMI proposes a three-month notice period but not more than six;

142.3 Funders should be able to alter the network terms provided they give a preferably similar notice period, with a shorter notice period allowed for annual tariff adjustments;

142.4 Network participation terms must state upfront how patients and provider payments will be managed during a transition wherein a patient undergoes treatment under a network practitioner who subsequently leaves the

network before the patient has been discharged from his/her care;

142.5 Selective contracting on network arrangements are allowed only where networks include additional value-based metrics. Restrictive networks must be established through a transparent process and submitted to the SSRH for confirmation;

142.6 DSP arrangements and selection criteria must be transparent to patients and providers and be made available to any service provider that enquires it. Reasons for exclusion for unsuccessful bidders must also be made available; and

142.7 Closed networks are re-initiated via a new process after three years. Open networks, as outlined above, are unlikely to result in foreclosure concerns and therefore can be evergreen arrangements.

143. In terms of facility networks:

143.1 only closed network arrangements are recommended, but they must be established through a competitive and transparent process;

143.2 DSP arrangements and selection criteria must be transparent and available to any service provider that enquires, and reasons for exclusion must also be made available;

143.3 these agreements will be lodged with the SSRH who will publish relevant, non-confidential, information; and

143.4 closed networks are re-initiated via a new process after three years.

144. Facility and practitioner networks result in price certainty for the funder, provider, and consumer. There will be no balance billing allowed on any network arrangements. Further, funders will not be allowed to advertise or list providers as being 'network providers' if fees are not fully covered by the benefit package.

145. The SSRH will have oversight of these arrangements to ensure that over time they progressively include more outcomes and value-based metrics while ensuring no potential anti-competitive outcomes arise.

ADMINISTRATOR COLLECTIVE NEGOTIATIONS ON BEHALF OF MEDICAL SCHEMES

Introduction

146. We have sought to address the concerns raised by stakeholders with regard to collective negotiations by administrators.

147. Specifically, stakeholders have requested clarity on whether administrators are at risk of contravening the Competition Act should they engage in collective tariff negotiations on behalf of multiple schemes under administration. We understand that the lack of clarity on this issue has led to an uneven playing field amongst administrators. Those administrators which have elected to engage in collective negotiations on behalf of their client schemes are able to leverage greater size during negotiations vis-à-vis those administrators which have taken a more cautious approach to negotiate individually.

148. While it is not clear what the effect these different approaches have had on tariff outcomes, it is important to note that our analysis of tariff bargaining shows that size is important for the two largest schemes DHMS and GEMS. In practice it seems unlikely that the same administrator negotiating team which negotiates on behalf of multiple schemes against the same provider, sometimes even on the same day, does not leverage some element of repeated interactions during these negotiations, mainly because the administration team is responsible for analyses of all data for its schemes, including competing open schemes where applicable.

149. The lack of clear guidance on this issue has led to an uneven competitive environment amongst administrators. To provide clarity on this issue, in this section we set out what is legally allowed.

Case precedent

150. This question has previously been considered by the Competition Commission when Afrocentric Health Limited (Afrocentric) and Mr Dewald Dempers filed a complaint against Discovery Health (DH) and Discovery Health Medical Scheme (DHMS).

151. In the complaint, it was alleged that DH engages in collective bargaining on behalf of medical schemes under its administration with hospital groups during tariff negotiations. It was further alleged that DH uses DHMS's power in the open medical scheme market to negotiate identical tariffs for all the medical schemes under

administration. It was alleged that this practice amounts to collusive conduct in contravention of section 4(1)(a) and 4(1)(b) of the Competition Act.

152. Upon investigation of the matter, the Commission decided not to refer the matter to the Competition Tribunal on the basis that DH does not operate in the same line of business as the medical schemes it administers and, therefore, cannot be found to have engaged in collusive conduct.[821] The Commission's decision to non-refer was also premised on the understanding that arrangements between medical schemes and administrators would be probed by the Health Inquiry.

153. Despite Afrocentric self-referring the matter to the Tribunal, the question was not settled as the Tribunal ruled in Discovery Health's favour, on a technicality and not on the merits of the case.[822]

154. In its reply to Afrocentric's referral affidavit, DH presents three main arguments to support its contention that its behaviour is not anti-competitive. First, it was argued that the schemes in question do not compete with each other, since only one (Discovery Health Medical Scheme) is an open scheme and the rest are restricted schemes. DH argues that restricted schemes cannot compete with open schemes or with one another for members, since their members do not have a choice of which medical scheme to choose and cannot switch schemes.

155. The second argument was that the tariffs negotiated by DH on behalf of its schemes do not impact the tariffs that other non-DH schemes can negotiate since the negotiations between hospitals and schemes are not a zero-sum game. In other words, if a funder negotiates a favourable tariff with a hospital group, this does not preclude other funders from doing the same.

156. Finally, DH argued that size is not the primary factor in determining tariff outcomes, and that tariffs are actually predominantly determined by the skill and level of sophistication of the negotiator. DH also argued that if it were to negotiate for each scheme independently it would be artificial, since in any case the same people would negotiate on both sides for the different schemes. It would also be extremely time consuming.

The view of the HMI

157. To the extent that the uneven playing field benefits DH, it may lead to a reduction in the level of competition in the administrator market (and between schemes) over time as more schemes switch to DH. This argument is predicated on size being an important factor in negotiations and lacking the ability to negotiate collectively will render other negotiators (either administrators or schemes) unable to negotiate competitive tariffs. Size (in terms of number of beneficiaries) matters and this creates a positive feedback loop wherein DH growth results in lower relative tariffs and further growth.[823]

158. We have determined that open and restricted schemes primarily compete in separate markets while acknowledging that some competition for the same consumers may occasionally take place but, in general, we consider these to be two separate markets.[824] Within the restricted scheme market, we believe that these schemes, by their very nature, do not compete with each other.[825] One approach to competition law would indicate that an administrator would not be contravening the act when negotiating on behalf of multiple restricted schemes and, at most, a single open scheme.

159. In order to see how the impact of such a decision may affect the market it is informative to consider the current administrator and scheme landscape. Based on CMS data for 2017/2018, the breakdown of open and closed schemes under administration is presented in Table 7.1 below:

821 Section 4(1) of the Competition Act specifically refers to parties in a horizontal relationship. An administrator's relationship with medical schemes would be considered a vertical relationship.
822 Tribunal case number: CRP003Apr15/EXC266May15.
823 This effect is likely to be mitigated to the extent that tariffs are not the only administrator value proposition as other considerations, e.g. fees, will play a role when schemes are selecting between administrators.
824 PFR dated 05 July 2018, paragraph 12 p.78.
825 PFR dated 05 July 2018, paragraph 18 p.455.

Table 7.1: Comparison of number of schemes and proportion of beneficiaries of open and closed schemes under administration, by administrator for 2017

	Number of schemes		Proportion of beneficiaries	
Administrator	Open	Closed	Open	Closed
Agility Health (Pty) Ltd	2	0	100%	0%
Discovery Health (Pty) Ltd	1	18	81%	19%
Medscheme Holdings (Pty) Ltd	4	10	57%	43%
Metropolitan Health Corporate (Pty) Ltd*	0	1	0%	100%
MMI Health (Pty) Ltd*	1	12	58%	42%
Private Health Administrators (Pty) Ltd	1	1	90%	10%
Professional Provident Society Healthcare Administrators (Pty) Ltd	1	1	51%	49%
Providence Healthcare Risk Managers (Pty) Ltd*	2	3	27%	73%
Sanlam Health Administrators (Pty) Ltd	0	1	0%	100%
Sechaba Medical Solutions (Pty) Ltd	1	0	100%	0%
Thebe Ya Bophelo Healthcare Administrators (Pty) Ltd	1	0	100%	0%
Universal Healthcare Administrators (Pty) Ltd	2	4	40%	60%
V Med Administrators (Pty) Ltd	0	1	0%	100%

Source: CMS annual report annexures, 2017/2018

Excludes 6 open and 8 closed self-administrated schemes

** Note that Metropolitan Health Corporate, MMI Health, and Providence Healthcare Risk Managers are all technically under the same corporate umbrella although it is unclear whether they have a single negotiating team*

Table 7.2: Comparison of beneficiaries where multiple open schemes are administered by a single administrator

Administrator	Largest open scheme	Beneficiaries	Other Open Schemes	Beneficiaries
Agility Health (Pty) Ltd	Resolution Health	28 839	Spectramed	22 777
Medscheme Holdings	Bonitas Medical Fund	731 494	Fedhealth	143 511
			Hosmed	67 020
			LMS*	0
Providence Healthcare Risk Managers (Pty) Ltd	Medimed Medical Scheme	15 072	Suremed	2 600
Universal Healthcare Administrators (Pty) Ltd	CompCare Wellness	24 080	Makoti	4 937

Source: CMS annual report annexures, 2017/2018

** LMS Medical Fund amalgamated with Bonitas Medical Fund in October 2016*

160. The table clearly shows that in the current environment, DH leverages a significant part (81%) of its total volume during negotiations for its restricted schemes from its single open scheme. If other administrators were to adopt a similar strategy, this would benefit the administrators of multiple schemes which have a single open scheme under administration, namely MMI Health (58% of total beneficiaries are in its open scheme), Private Health Administrators (90%), and Professional Provident Society Healthcare Administrators (51%).

161. The administrators with multiple open schemes under administration, Agility Health (2 open schemes), Medscheme Holdings (4), Providence Healthcare Risk Managers (2),[826] and Universal Healthcare (2), would benefit from being able to negotiate collectively on behalf of the multiple closed schemes under administration. However, as open schemes are considered to be competing in the same market, negotiations for these open schemes would have to occur separately for each individual scheme.

162. A potential outcome of this proposal would be for these administrators to group together all restricted schemes along with only a single open scheme, the largest one possible. Any additional open schemes would need to be negotiated for individually. This may result in the exclusion of any remaining, likely smaller, open schemes.

163. In the current environment, the following small schemes are likely to be excluded from collective negotiations:

164. We understand that Bonitas Medical Fund does not rely on its administrator, Medscheme, for tariff negotiations and instead negotiates on its own. However, whether this arrangement will continue should Medscheme be in a position to negotiate collectively is unclear as combining the volumes from Medscheme's 10 restricted schemes will improve Bonitas' bargaining position.

165. The outcome for the remaining smaller open schemes, those not included in the collective negotiations, would not be materially different from the current situation. Administrators currently negotiate individually for these schemes and would presumably continue to do so going forward. While it may be the case that the stronger overall collective bargaining position of the administrator may have positive spill-over effects for these smaller schemes, administrators would have to guard against any perceived contravention of price fixing regulations.

Conclusion

166. We are not convinced that separate negotiations supported by the same administrator analytics team are as independent as has been suggested. Nevertheless, our view is that administrators negotiating on behalf of multiple restricted schemes and a single open scheme would not contravene the Competition Act.

167. Clarity on this position is likely to improve funder bargaining power which will benefit competition in the administrator market and may result in lower tariffs. The small open schemes which may be excluded from the collective negotiations do not constitute a significant proportion of the market and are unlikely to be substantially impacted relative to the status quo.

168. To the extent that administrator collective negotiations may result in lower scheme tariffs, self-administered open schemes, negotiating independently, will face greater price competition. However, as we recommend practitioner prices should be collectively negotiated across the industry, this greater price competition will be mainly in respect of facility tariffs, and where administrators are able to negotiate lower practitioner tariffs in subsequent bilateral negotiations.

169. Acknowledging that exceptions do exist, restricted schemes do not compete with other restricted schemes, restricted schemes do not compete with open schemes, and open schemes do compete with other open schemes. Therefore, it is our view that administrators may collectively negotiate for multiple restricted schemes and at most a single open scheme.

826 See Table 4 above, should Metropolitan Health Corporate, MMI Health, and Providence Healthcare Risk Managers be considered as a single entity for the purposes of negotiations, they would have 3 open schemes under administration.

Chapter 8
Healthcare Data, Quality and Outcomes

INTRODUCTION

1. The prevalence of imperfect and asymmetric information in the healthcare sector is widely accepted. Information problems on benefit options, the pricing and cost of provider services, and on the quality and effectiveness of provider services affect patients, practitioners, hospitals and funders in many ways.

2. A detailed discussion of information problems in healthcare was included in a report entitled *"Towards an understanding of imperfect and asymmetric information in private healthcare"* previously published by the HMI. This chapter focuses solely on information relating to the quality and outcomes of provider services.

3. Many stakeholders have acknowledged the importance of high-quality information, and, in particular, of outcomes measurement and to address the lack of information on the quality provided throughout the healthcare system. In the Revised Statement of Issues (RSoI), we stated that value-based competition requires the availability of cost and standardised outcomes data to enable competition to operate effectively.

4. Quality of healthcare measurement and reporting requires defining quality indicators, collecting data, auditing the data, performing necessary risk-adjustment of the data, measuring quality using the indicators, and disseminating the results to providers and the general public. Broad facets of quality that can be measured are structure and process variables (e.g. nurse qualifications, or the percentage of people receiving preventive services), standardised outcome measures (clinical information on procedure, medications, severity, combined with patients' reports on quality of life, pain, and functions after intervention) and patient experience information relating to aspects such as doctors' communication and the accessibility of hospitals.

5. Patient-reported outcomes measures (PROMs) are a critical component of assessing whether clinicians are improving the health of patients. For example, patients might be asked to assess their general health, ability to complete various activities, mood, level of fatigue, and pain. In coming years, patient-reported measures are expected to play a more prominent role in assessing performance and determining the comparative effectiveness of different treatments, in part because of a growing emphasis on patient-centered care and value-based payment approaches.

6. We have a firm preference for patient-oriented outcome measurement and reporting. Information on outcomes that really matter to patients, can serve as a critical driver of value-based competition, and improved quality in healthcare by making standardised, risk-adjusted and robust outcome information available to practitioners and hospitals for clinical improvements and to the general public. No doubt providers are intrinsically motivated to provide good quality care. However, as international experience has shown, transparency as to outcomes and efficiency will incentivise providers to invest in and adopt processes that improve the value of the healthcare provided. Competition matters, and providers are less likely to attract patients based on proximity, qualifications, word-of-mouth, or organisational affiliation.

7. Additionally, comparable information on the quality of provider services enables practitioners to refer patients to appropriate high-quality specialists and hospitals which will intensify

competition on quality in the market. The same is true for funders. We have observed that, contracting of doctors and facilities largely takes place with no, or almost no data-based knowledge of, or reference to the quality and clinical outcomes of these providers. Crucially, access to information on standardised and risk-adjusted outcomes enables practitioners to benchmark themselves against their peers, which is vital for any internal improvement of treatment practices and outcomes.

8. Health outcomes data would also enable facilities to benchmark themselves against their peers which, as with practitioners, provides an essential basis for the improvement of clinical pathways, organisation and outcomes of treatment. It allows more informed and objective engagement when facilities and funders negotiate contracts. Also, it will enable hospitals to engage practitioners more meaningfully on issues relating to quality.

9. Several critical success factors have been identified:

9.1 *Clinician engagement:* broad and active participation of the clinical community is essential to the success of an outcome measurement and reporting system. Outcome measurement is more effective when clinicians are actively involved in defining indicators, collecting and interpreting data as well as in leading clinical improvement efforts. Therefore, any efforts aimed at creating an outcome measurement and reporting system must win the support and active involvement of the clinical community. Doctors must be the drivers of any outcome definition, registration, measurement, reporting and improvement system.

9.2 *Patient's perspective*: the most critical objective of healthcare is to improve patients' health. Therefore, as international experience shows, outcome measurement must be done from the patients' perspective, including patient-driven registration of symptoms, quality of life and functional status both pre- and post-intervention.

9.3 *National infrastructure:* effective systems require common standards for tracking diagnoses and treatments at a patient level, and an appropriate legal framework to support the quality measurement and reporting system. IT platforms used by providers should be compatible with those used by the organisation that collects quality data. Also, national government should provide strategic direction to the institutionalisation of quality measurement and reporting and should seek to make it part of public discourse.

9.4 *Comprehensive, high-quality data:* it is critical to ensure that data collected is reliable and comparable, which requires a combination of both choosing the right variables and having an adequate number of observations. Common standards for coding must be established and followed by all providers, and case mix adjustment mechanisms need to be agreed.

9.5 *Health outcomes-based contracts:* when outcomes are a primary basis for contracting between providers and funders, value-based competition is stimulated and can be rewarded. This is strengthened when consumers choose providers based on outcomes data and GPs base their referral decisions on outcomes of hospitals and specialists.

10. We believe that to solve the current lack of relevant information on the quality of services provided in the South African healthcare system, outcomes measures are the most desirable measure of quality that stakeholders should aim to use. Outcomes are measured at the level of the individual patient and seek to determine the impact of care received on the health status of the patient.[827] Outcomes are what ultimately matter to patients, and are an objective means to assess effectiveness of care. When combined with cost data, they enable measurement of value which is the essential indicator for comparing providers.

11. We recognise that it may take some time to put into place robust outcomes measures in the sector, and thus acknowledge that there is some value to be derived from using process[828] and structural[829] measures although investing in them may delay the ultimate goal of being able to measure outcomes. If new systems are to be put in place, then it would be both reasonable and efficient to invest in the final parameter. Further, experience from the International Consortium for Health Outcomes Measurement (ICHOM) partnership indicates that it typically takes a year for a pilot program to become operational

827 Health Systems Improvement (2004). 'Measuring Healthcare Quality: an Overview of Quality Measures'.
828 Process measures seek to determine the extent to which providers follow best practice when offering their services. They are generally linked to procedures or treatments that are known to improve health status.
829 Structure refers to the attributes of the settings in which healthcare occurs. It includes attributes such as number and qualifications of practitioners, equipment, administrative systems, and the internal organisation of medical facilities.

using one (or more) of the 28 freely available, tested ICHOM standard outcomes measurement methods. Setup involves establishing steering groups, collaborating partner hospitals and clinicians, the training of hospital staff, implementation of a feedback program and the roll-out of the program. The transitory stage need not take too long for a set of preliminary programs to become effective.

Findings

12. We have reported extensively on our findings on the absence of the availability of appropriate information on the quality of healthcare services provided in South Africa. In the context of the NHI, all health facilities will be required to comply with national norms and standards for quality. When the NHI becomes operational, only health facilities that meet approved standards will be certified by the Office of Health Standards Compliance (OHSC) to render services and to be eligible for accreditation and contracting through the NHI Fund. [830]

13. Providers will be required to submit regularly specified information which will be used to monitor health outcomes which will be required to be eligible for contracting with the NHI Fund. Providers will be assessed against indicators of clinical care, health outcomes and clinical governance and not merely on the perceived quality of services.[831]

14. Section 74(1) of the National Health Act requires the National Department of Health (NDoH) to facilitate and coordinate the establishment, implementation and maintenance of health information systems. The development of a well-functioning nationally comparative information system will contribute towards the success of quality measurement and reporting initiatives and help to reduce the fragmentation of information in the healthcare system. However, it will not solve the problem of the lack of information if the data is not verified, if it does not compel providers to make available such information, and if providers are not incentivised to act on the outcomes they achieve.

15. The OHSC and the Council for Medical Schemes (CMS) have statutory mandates which include the collection and dissemination of healthcare information. The OHSC is a statutory body created by the National Health Amendment Act (NHAA) of 2013. Its primary function is to *"inspect and certify health establishments as compliant or non-compliant with prescribed norms and standards or, where appropriate and necessary, withdraw such certification"*.[832] The NHAA 2013 also established the Health Ombudsman which is located within the OHSC. The main function of the Health Ombudsman is to *"on receipt of a written or verbal complaint relating to norms and standards, or on his or her own initiative, consider, investigate and dispose of the complaint in a fair, economical and expeditious manner"*.[833]

16. The OHSC quality domains are mostly structural. They do not focus on patient outcomes. For example, the six priority areas for measurement are waiting times, cleanliness, values and attitudes, availability of medicines, patient safety, and infection prevention[834]. The OHSC is allowed, but not compelled, to collect information relating to prescribed norms and standards of healthcare,[835] and is mandated to publish information relating to prescribed norms and standards of healthcare or health outcomes.[836]

17. The role of the OHSC is that of an *inspectorate,* guaranteeing the adherence of providers to minimum norms and standards of care by on-site inspections and by certification of providers that comply with the prescribed norms and standards. Its role is therefore not that of an institution that facilitates provider benchmarking and analysis of registered outcomes in feedback loops between providers and a central analytical professional centre. Nor does it collect and disseminate standardised information on patient outcomes relevant for patient choice, and for contracting between funders and providers.

18. The CMS is required to "*make recommendations to the Minister on criteria for the measurement of quality and outcomes of the relevant health services provided for by medical schemes, and such other services as the Council may from time to time determine*",[837] and to "*collect and disseminate*

830 Section 38 of the National Health Insurance Bill, 21 June 2018 version.
831 Section 38 of the National Health Insurance Bill, 21 June 2018 version.
832 Section 79 (b) of the NHAA.
833 Section 81A of the NHAA.
834 Office of Health Standards Compliance, 2015/2016 Annual Inspection Report.
835 Ibid
836 Ibid
837 Section 7 (c) of the Medical Scheme Act No. 131 of 1998

information about private healthcare"[838]. These provisions can be interpreted as granting the CMS powers to recommend indicators that can be used to measure the quality of healthcare. The MSA also empowers the CMS to collect and disseminate information about the private healthcare sector.

19. The policies and legislation discussed have objectives for quality measurement and reporting and can be interpreted as relevant to outcomes measurement. However, we have found that none of the relevant institutions have embarked on systematic outcomes measurement as envisaged. It is also notable that the current framework has shortfalls, for instance, none of the laws provide for the mandatory collection and provision of data on healthcare outcomes by providers, nor have they been translated into actions at a national level to monitor, benchmark and disseminate information on outcomes. The question arises whether these are the correct institutions for the purposes of outcomes measurement and reporting as they do not take into account the principles expounded above that have led to the success of PROMS.

20. The Inquiry engaged stakeholders on quality measurement and reporting through submissions and public hearings and through the conduct of consumer and doctor surveys. It issued a discussion document on the measurement and reporting of health outcomes.[839] Stakeholders responded both through written submissions and in discussions in a follow-up seminar which was hosted by the Inquiry on 22 September 2017.

21. All three large private hospital groups (Netcare, Mediclinic, and Life Healthcare) undertake various forms of quality measurement. Their results are not shared with the general public but are used internally and shared with doctors and medical schemes. An exception to this is Mediclinic's patient experience survey which is made public at a facility level through a publicly accessible website.[840]

22. We have noted that there are some organisations involved in various forms of quality measurement in South Africa. We provided examples from the Independent Practitioners Association Foundation (IPAF), Health Quality Assessment (HQA), Discovery Health, and Lancet Global Health Commission in the PFR. However, the results cannot be compared because they do not use the same indicators to measure quality. Their findings are generally not shared with the public. In the case of hospitals, the results are internally shared with doctors, and some also privately shared with medical schemes.

23. Even if the results were to be made available to the general public, there is still a problem of credibility and comparability since the healthcare quality data that is collated is neither standardised nor risk-adjusted, nor scientifically verified and it is not prepared by an independent and trusted organisation. There is, therefore, no shared understanding amongst providers of how outcomes should be measured and how differences in outcomes can be understood.

24. Without sufficient buy-in by practitioners and by hospitals on outcome measurement and reporting standards, and without enabling legislation, unilateral collection and publication of quality data will always cause disputes and contestation limiting any impact on quality, on the empowerment of patients and on competition in general.

Recommendations

25. We recommend:

25.1 the establishment of an outcomes measurement and reporting system which should be practitioner driven and implemented in two stages, starting with a voluntary phase with a limited scope of registries, to be followed by a phase in which data reporting by practitioners is legally mandated;

25.2 the development of a legal framework which will mandate the reporting of outcome related data to the Outcome Measurement and Reporting Organisation (OMRO);

25.3 the establishment of a new and independent, non-for-profit collaborative organisation (OMRO) through which practitioners and facilities will gain access to scientifically robust comparative outcome information.

25.4 OMRO will collaborate with existing condition-specific registries, and stimulate new initiatives;

25.5 OMRO should be funded using a hybrid model which is expected to combine levies, government funding, and voluntary funding.

838 Section 7 (e) of the Medical Scheme Act No. 131 of 1998.
839 Health Market Inquiry's document titled "Health outcome measurement and reporting: Improving the cost and effectiveness of clinical care in a competitive private healthcare sector in South Africa", dated 28 August 2017.
840 Mediclinic. 2017. Patient Experience Survey Results. [ONLINE] Available at: http://patientexperience.mediclinicinfohub.co.za/. [Accessed 20 June 2017].

Patient centred and Practitioner Driven

26. We wish to emphasise how essential it is that outcome measures are based on the highest professional and scientific standards, designed and fully supported by practitioners. Equally important, outcome measures must be patient-centred, reflecting what really matters to patients.

27. Our view is that outcome indicators are the most useful and powerful indicators over and above structural, process and patient experience indicators. We are cognisant of the costs related to collecting data, and hence recommend that outcomes measures should be prioritised over other indicators. Most stakeholders fully support the principle of outcomes measurement in their submissions.

Independent body

28. We have noted the concerns raised in the submissions about the creation of another 'regulator' to conduct the outcomes measurement and reporting function. We seek to clarify here what is envisaged. We wish to emphasise that we do not envisage the setting up of a 'regulator' for outcomes measurement and reporting. We are proposing a provider-led, independent private body to coordinate the function of generating meaningful outcome information for the providers – both practitioners and hospitals - to improve clinical processes, and for patients to use in making choices.

29. We do not intend that the OMRO should regulate the conduct of market participants. This function will remain the mandate of the CMS for the demand side, and of the to be introduced Supply-Side Regulator of Health (SSRH) for the supply side. The OMRO will be responsible for data collection, for conducting the necessary research and processing of the information collected, for providing professional feedback to providers that will enable them to improve outcomes and clinical procedures. Ultimately, after an appropriate transitional period required to guarantee sufficiently robust information it will be shared with funders and be published. The mandate to collect relevant data and information will then depend on the regulatory powers and policy direction of the statutory SSRH which will ensure the coordination of the activities of OMRO with other regulators and with government.

30. The independent body should be seen in the context of the two-phased approach to implementation that we recommend. The organisation can be established through the formation of a non-profit company or association, akin to existing structures such as Health Quality Assessment (HQA) or the Independent Practitioners Association Foundation (IPAF), with representation from relevant stakeholders in the first phase. In this first phase, participation and cooperation from providers with the OMRO will be voluntary. It may take some time for the SSRH to be adequately instituted by law, and this is likely to take place in the second phase of implementation.

31. The independence of the organisation needs to be set out in its memorandum of incorporation and in any other founding documents. The primary reason for independence is to insulate the day-to-day operations of the entity from political and commercial influences. Independence increases trust in the body by doctors and other providers, and ultimately by funders, government, regulators and members of the public. The OMRO must, however, not operate in isolation; it needs the full cooperation and involvement of public and private practitioners and other relevant stakeholders. It must be fully transparent and accountable to these structures for its overall performance.[841] In the second phase, as it will depend on the legal powers of the SSRH, it will also be accountable to the SSRH, and through the SSRH to other regulators and to government for its role in providing relevant and dependable information.

32. Organisational autonomy is imperative. Financial independence means that the level of funding should not wholly depend directly on one specific market player or one government. Management independence means that the executive and staff of the OMRO must have autonomy over internal administration and should be protected from dismissal without due cause. Its strategic direction must come from doctors in cooperation with patients' representatives.

Functions of the OMRO

33. The OMRO will be responsible for identifying conditions that will be prioritised for outcome measurement and reporting though these may change over time. It will also be responsible for creating outcome indicators that will be used to measure health outcomes. It should work with clinical registries and providers to collect clinical outcomes data from providers. It should work with registries, professional medical societies, funders, government, civil society and hospitals,

841 For instance, the OMRO must publish and present to Parliament an annual report on its performance.

and advocate for measurement of outcomes by providers.

34. The OMRO should provide expert support (including clinical, epidemiological, methodological, logistical, technical and legal expertise) to providers through its central management structure. It should also provide primary implementation support by helping to reduce the administrative burden of data collection. The OMRO should play a role in ensuring data accuracy and the maintenance of patient confidentiality. It should pre-define the data format for submission, ensure that it is standardised across all providers, and provide that the data is de-identified. The OMRO may, however, benefit significantly from international experience, which generally is made available free of charge.[842]

35. Once the data have been collected, the OMRO should risk-adjust the data, perform any relevant analysis, and report outcome information and analytics to providers. The OMRO should identify problems with data and registrations, variations in outcomes, and the reasons for it and work with participating doctors and facilities in efforts to improve data and outcomes. As soon as the system and the data are robust, and the derived outcome information is reliable, it will then also need to be shared with the public and with funders. Evidence from abroad suggests that the building of trust in the robustness of the data and the sharing of outcome information per provider with stakeholders may take years of hard work. It is essential not to undermine the trust of participants by prematurely publishing flawed information.

The New Body vs Existing Structures

36. Some stakeholders have questioned the establishment of a new organisation. While noting these concerns we believe that while existing structures and organisations can be leveraged, they would need to be reconstituted to establish the outcomes measurement and reporting system. Thus, a new body would still be required, even were an existing structure to be used as the base.

37. We have considered each of the suggested existing structures proposed by some of the stakeholders to take on this function to determine which of these structures would be the most appropriate to establish the OMRO, as set out below.

37.1 We considered the proposal that this function could be taken on by the CMS as it is mandated (for instance, in terms of section 7(c) of the Medical Schemes Act) to engage in quality and outcomes measurement. We concluded that the CMS is not the appropriate body because, as already stated, outcomes measurement should be driven by the practitioners and is a function of the supply-side of the market. We note that the Medical Schemes Act does not regulate providers; it is limited to regulating funders. Therefore, these provisions cannot be used to enforce the collection and dissemination of health quality data from providers. It was submitted that minor amendments to the MSA would enable the CMS to collect and analyse outcomes data from providers and disseminate the results to the public. We believe that it would be inappropriate to conflate demand and supply-side regulation in this manner. The CMS should, however, require funders to incorporate healthcare outcomes when contracting with providers

37.2 The OHSC was suggested by some as the preferred existing structure to host the OMRO function. We do not believe that would be appropriate as its function is that of an inspectorate focused more on structural and process indicators. In this regard, the work of the OHSC and the OMRO will be distinct but complementary. The positioning of both organisations is different. OHCS is a public authority, an inspectorate overseeing and regulating the industry, mainly on healthcare safety issues. OMRO will be a privately incorporated organisation, by and for doctors, helping them to improve healthcare outcomes, with the active participation of facilities, funders and patients. Private organisations like the Dutch Institute for Clinical Auditing (DICA) and the International Consortium for Health Outcomes Measurement (ICHOM) in the United States are natural partners.

37.3 The vast majority of stakeholders dismissed the proposal that the function should be taken on by the NDoH because of the need for this function to be strictly independent in its strategy and operations, both from government and from direct commercial interests.

37.4 With regard to the proposals that the HPCSA should be used to fulfil this function, the HMI is of the view that this would equally be inappropriate.

842 www.ichom.org.

37.5 Proposals were also made for the function to be taken on by discipline-specific associations, by existing registries and academics, and by the HQA. We believe that the HQA has existing technical capacity for quality measurements although the system that HQA currently uses is not the measurement of health outcomes from clinical registries. It would, therefore, have to transform and to develop new systems, including methods to gather data from patients. The existing registries and the future ones will form the backbone of the OMRO organisation. Registries and participating doctors are an integral part of similar structures like DICA and ICHOM abroad. OMRO itself, as a central organisation will require multi-stakeholder participation with academic, healthcare-specific knowledge in its staff and participation of representatives from the various parts of the sector. It is recommended that OMRO draw upon the ways in which HQA created a partnership with funders, to build its own partnership with practitioners and associations. There is a clear benefit from creating health outcomes data: it will enable value-based purchasing for both the state and funders alike, who possess the capacity for co-funding.

38. If an existing structure were to be used as the platform to build the voluntary predecessor to the OMRO organisation and functionality, it would need to be reconstituted to give practitioners a prominent role in the process. For instance, as it functions now, HQA is primarily based on claims data from participating funders and financed by them. That formula is different from that anticipated as a first phase voluntary operational structure for OMRO, in which registries and doctors are the drivers not funders. If HQA were to serve as the launching platform for the first phase of OMRO, the organisational structure would need to be adapted to enable a separate clinical data-based structure, and a governance structure with appropriate representation of practitioners and patient organisations, as well as funders and academics.

39. After reviewing submissions to our PFR, we further explored with the HQA, if it would be willing and able to be the custodian body for the OMRO in the initial stages. HQA confirmed a willingness to serve as the initial OMRO platform as contemplated in our preliminary recommendations. In its submission, HQA stated that it understands that confidentiality of clinical data and an environment in which practitioners can feel safe to share and discuss results, prior to possible public dissimination are crucial factors for this initiative to succeed. This would require amendments to both its governance structures and processes.

40. OMRO will also require a robust national IT system to enable information gathering and sharing. We have been informed that a recent initiative in this regard, the CareConnect Health Information Exchange (HIE), would be well placed to perform this role.[843] The HIE was under development at the time of the drafting this report, however it is our understanding that it could take on the role as a conduit for the collection/dissemination of information from/to service providers. We, therefore, recommend that more detailed discussions should take place with the HQA and CareConnect to determine the initial phase of the OMRO.

Mandatory Reporting

41. Mandatory reporting is important since one of the factors for the success of an outcomes measurement and reporting system is comprehensive data.[844] Under a voluntary reporting system, there is no guarantee that the data collected will be comprehensive. Under-reporting would undermine the credibility of reported outcomes data.

42. Many industry stakeholders, both practitioners and facilities, who responded to the recommendations, support the mandatory provision of outcomes data. Some stakeholders have expressed concerns about both the administrative burden and the costs of compulsory participation. We believe that these costs should be kept at a minimum.

43. We propose a system that is empathically based on the determination and voluntary participation of doctors but recommend the mandatory provision of outcomes data by providers to the OMRO in the second phase. To give effect to the mandatory provision of data, the OMRO would be delegated authority through the legislated powers of the regulator (SSRH) to allow it to collect outcomes data from providers. Our proposal is that the SSRH would be the enforcing

843 CareConnect HIE is a non-profit organisation set up by the 6 large corporate entities in private healthcare, Discovery Health, Life Healthcare, Medscheme, Mediclinic, MMI Health and Netcare, who recognise that securely providing health information sharing services will improve patient and member outcomes, quality, safety and efficiency, and prove cost beneficial.

844 International Consortium for Health Outcomes Measurement (2016). 'Building National Outcomes Registries in the Netherlands: the Dutch Institute for Clinical Research'. Footnote reference required giving the location of this discussion

regulator. This process can align with other compliance requirements. [845]

44. Voluntary participation is always more effective than forced participation so mandatory legal provisions should serve as a 'last resort'. Since legislation takes some years to be promulgated this may happen automatically.

Consistency with the NHI

45. Both the NHI and the NDP refer to the need for quality improvement and measurement efforts that apply to the entire healthcare system. The future NHI Fund will procure services from both public and private facilities. Therefore, it is necessary that all facilities be subjected to comparable outcome standards and registration and reporting requirements.

46. One of the central concepts to be introduced by the NHI is "strategic purchasing", an essential dimension of which will be cost-effectiveness or value for money[846] which will require information on health outcomes and the costs of services. Outcomes measurement and reporting are thus expected to be essential to the NHI Fund in its role as a strategic purchaser.

47. The NHI will use treatment guidelines to guide the delivery of healthcare services. These guidelines will be based on available evidence about the most cost-effective interventions.[847] Cost-effective interventions are ones that result in the highest outcomes per cost or those that minimise the cost of a given outcome. Information on health outcomes are essential to determine the most cost-effective interventions.

48. Outcomes have been shown to improve when providers compare their performance relative to peers. The NHI Fund should incorporate outcomes-based metrics when contracting with providers, and its contracting should reward providers with better outcomes. We believe that OMRO is not only consistent with, but also essential to the operation of the NHI.

Staged implementation

49. We have recommended a two-stage approach to setting up an OMRO. A statutory body like the proposed SSRH requires legislation which takes time to develop and pass. Even after the law has been established, there can be a long lag before a statutory body starts operating. Measurement and reporting should not wait for the legal framework to be finalised. The outcomes measurement and reporting system should, therefore, be introduced in a staged manner. It should begin with voluntary participation, starting with a few already existing registries of condition-specific outcomes to gain experience with the formula. This more limited and voluntary system will build the required trust among practitioners and purchasers. It will be followed by mandatory provisions in later years once the legal structure has been established. In Sweden, mandatory provision was called for by doctors themselves after observing that a small minority of doctors stayed outside of the voluntary structure, endangering the success of the system.

50. The staged process should have a first phase and a second phase:

50.1 In the first phase (within 2 – 3 years from the implementation of the recommendations), the voluntary body – which could be based on the HQA/CareConect platforms - should set up organisational governance structures, identify specific conditions for outcome measurement and reporting, set up condition specific outcome monitoring working groups and work with existing stakeholders around initial funding. Existing registries are an obvious starting point. Also, internationally freely available, tested and widely used metrics must be considered. For each condition in the initial stage, the voluntary body must produce outcome indicators to measure the performance of participating providers. For each condition, the process must involve clinicians with expertise in that condition, patient representation and, if possible, a specialist medical association.

50.2 There are international organisations such as ICHOM and the Agency for Healthcare Research and Quality (AHRQ) that develop outcome indicators which can be adapted for use in South Africa. ICHOM and AHRQ can assist with possible adaptation and implementation.

50.3 In this first phase, indicators that have been agreed upon through the voluntary process can be tested in a sample of hospitals from each facility group and from independent providers. Results and experiences from the voluntary process should be used as input towards the second phase. They can also be used internally

845 See sections: ***Establishment of an Independent Supply-Side Regulator for Healthcare (SSRH) and Motivation for a new Independent SSRH.***
846 National Department of Health (2017). National Health Insurance for South Africa.
847 National Department of Health (2017). National Health Insurance for South Africa.

by providers to promote the adoption of best practices.

50.4 In the second phase, the legal framework should have been finalised, and the statutory SSRH, including its OMRO platform, should start operating on the basis of experience in the first phase. Participation will now be mandatory. Outcomes should gradually be included in reimbursement contracts between purchasers and providers. Importantly, during this second phase, information on patient-related outcome measures from participating doctors and facilities should become available for the general public, enabling the consumer (patient and beneficiary alike) for the first time to choose providers of healthcare services based on relevant clinical empirical facts.

The nature of the information shared

51. In the first phase of implementation, there may be data shortcomings and analyses based on insufficient data. Information derived from these data must be used to improve the system. These data may be shared with participating professional stakeholders, but to ensure accuracy and to build the trust of practitioners and consumers alike only mature reliable data must be published. International experience suggests that this process will take some years.

52. In this first phase, each provider may receive its data together with a national average. Each provider may also receive anonymised results of other providers, particularly the top performing ones. Information as to what informs variations in the outcome should be provided to assist individual providers to benchmark their performance against the average and top performing providers in the country. This will also inform the organisation where data and analyses need to be improved. The sharing of results initially with practitioners and facilities, therefore, will help assess if the system is working effectively. If there are critical areas of concern, these should be resolved within the initial period.

53. In the second phase, OMRO will share relevant outcome results with the public and with funders, to enable informed choices by patients and to improve performance-based contracting by funders. Ultimately this will contribute to developing value-based competition in the system. Reporting must adhere to standard conventions of protection of personal information, confidentiality and competition.

Funding

54. The OMRO, after the initial voluntary stage, will require a source of funding that is stable, reliable and sustainable. We have considered four possible funding models: government funding, levies, voluntary funding and a hybrid funding model.

55. Stakeholders were divided about the funding models that we have recommended. There is some support for a form of hybrid funding where all relevant stakeholders, including providers and funders, take responsibility for the financing of the system. However, a concern was raised that if levy funding is to be relied upon primarily, it may affect scheme affordability as it would increase non-healthcare expenditure and that cost this would be passed on to members of schemes.

56. After considering stakeholder's submissions to the PFR, we believe that the most appropriate funding model remains a hybrid model in which all relevant stakeholders play a role while funding should be received from both the national government and market participants to ensure buy-in and accountability in the process such funding should not come with any conditions that might affect the credibility of the OMRO, nor should it add to the unaffordability of healthcare coverage.

Summary of Recommendations

57. One of the key competition challenges that we have identified is the absence of reliable and available information on health outcomes in the private healthcare sector. Such information would allow patients to compare and select providers and would improve the ability of healthcare funders to compare costs and quality on value for money when contracting with providers. Further, case mix adjusted outcome information would enable providers to peer review, compare and adjust clinical performance.

58. The lack of outcomes information seriously impairs competition between providers. It limits consumer choice and prevents value-based contracting with funders. South Africa needs a radical improvement in the availability of reliable, comparable and meaningful information on healthcare outcomes, both in terms of private and public healthcare services. Such information will contribute to the successful implementation of NHI and will place the country in line with international good practice.

59. There are several key requirements to put in place reliable outcomes measurement system:

defining the quality of outcomes indicators, collecting standardised data through a central IT-platform, auditing the data, performing necessary risk-adjustment of the data, measuring how treatments improved patient health, and disseminating the results to providers, and, ultimately, to the general public and the funding sector. Fortunately, the process does not have to start de novo as there are international exemplars to inform this process.

60. We recommend that the primary objective, in the initial period, should be to build capacity to measure and report on patient-centred outcome indicators. Other facets of quality such as structure, process, and patient experience indicators, can be combined or added, if deemed necessary.

61. A nationwide system of measuring and reporting patient-centred outcomes information would address our main findings that:

61.1 there is no information available to the public in South Africa to select practitioners and facilities on the basis of past results, to judge the appropriateness of treatments, and to compare the quality of providers that funders contract;

61.2 funders generally lack sufficient outcome information to contract with providers on the basis of value for money;

61.3 the individual provider model of care operational in South Africa results in fragmented knowledge about the health status of a patient making health outcome difficult to ascertain;

61.4 lack of information constrains GPs in assisting patients to select the best possible treatment in terms of costs and expected outcomes;

61.5 the NHI and OHSC, which carry a nationwide responsibility for the quality of care provided, also generally lack basic information on the outcomes of care, both public and private.

62. Implementing a national system of outcome measurement cannot take a top-down approach. It requires the broad and active participation of the entire clinical community. International experience has shown that, in particular, the engagement of clinicians and patient representative groups are critical success factors in developing useful and effective outcome registries.

63. The participation of patients and their representatives will be essential to ensure that the system reports on metrics that matter for patients and that improve patients' health outcomes and the value for money that beneficiaries receive from their health insurance.

64. We recommend that the outcomes measurement reporting system be implemented in two phases.

65. The *first phase* should be one in which participation by practitioners and facilities is voluntary, and in which a coordinating platform is set up to assist doctors, registries and facilities to analyse and exchange health outcome information. This requires the establishment of a new and independent, not-for-profit collaborative Outcome Measurement and Reporting Organisation (OMRO). Through OMRO, practitioners and facilities will gain access to robust comparative outcome information which will allow them to understand differences in outcomes and improve clinical processes. OMRO will collaborate with existing condition-specific registries in South Africa and stimulate new initiatives. This first phase should be completed within 2 – 3 years from the publication of the HMI's final recommendations. The active participation of doctors and facilities is critical. OMRO should define standards for South Africa and could draw from existing registries and freely available and tested indicators. Funders, patients' representative organisations and representatives of relevant medical sciences must also be encouraged to participate in this first voluntary phase.

66. Several 'hosts' or 'custodians' for this first phase have been discussed with stakeholders. It has become clear that the most appropriate organisations for taking this initiative forward are the Healthcare Quality Assessment organisation that has been operational in South Africa for more than 10 years, in combination with the IT and information exchange platform, CareConnect, that is currently in the process of being developed. Providers and funders should take responsibility for financing this first phase of voluntary participation. Initiatives for co-funding formulas in the Netherlands and in Scandinavia may serve as a model.

67. We propose that the data collected in the first phase be released only to participating providers in individual feedback cycles aimed at improving the outcomes measurement and reporting system. Results and experiences from this first phase should then be used as an input towards developing OMRO in the second phase.

68. The second phase will involve a mandatory registration and reporting system. The mandatory participation in OMRO will be based on the legal powers of the statutory SSRH organisation and its mandate. The National Department of Health,

in consultation with relevant stakeholders, must take the lead in drafting the enabling legislation for the registration and reporting of relevant data to OMRO. OMRO itself, being a private organisation, will depend on the enforcement powers of the SSRH. The NDoH, in collaboration with the industry should aim for OMRO to be fully functional within 3 - 4 years of the conclusion of this inquiry.

69. During the second phase, the involvement of national government will be critical both in finding a sustainable funding mechanism for OMRO, and in establishing the legal mandate for the SSRH to support OMRO. Information collected in the second phase must serve to empower the consumer to choose the best provider, treatment, scheme and plan. Through the empowerment of the consumer, competition between providers and funders will be enhanced.

70. During our engagements with stakeholders, it became clear that OMRO is supported by all participating stakeholders. However, it was also made very clear that support for OMRO depend on trustworthiness, credibility and independence. It must be strictly operationally independent from government and from the private sector for it to have credibility amongst providers, patients and funders. It was clear that the majority of respondents would prefer a new and dedicated organisation, and not one of the existing quasi-governmental organisation or regulators.

71. OMRO, as a private organisation, should have board members reflecting the interests of doctors, patients, facilities and funders, and may also contain representatives of government, academia and regulating institutions. It is emphasized that the OMRO itself is not a regulator; it must be organisationally separate from government, private or public providers, and regulatory institutions.

72. The preferred funding model for the OMRO is a hybrid model with levies from schemes, complemented by contributions from providers, from national government and voluntary funding. The exact mechanics of how the funding model would work should be determined by the stakeholders, in consultation with the DoH and the National Treasury. What is essential is that the funding model should guarantee organisational independence and continuity of resources.

Chapter 9
Recommendations

INTRODUCTION

1. We have concluded that the private healthcare market is subject to distortions which adversely affect competition. We find that the facilities market is highly concentrated, and there is a lack of vigorous competition or innovation amongst the largest facility groups. Competition in the funder market, to the extent that it exists, takes place on metrics which do not place the end-consumer at the forefront. The practitioner market, which is hampered by obsolete HPCSA regulations, is characterised by both unilateral and coordinated conduct which does not necessarily benefit the patient.

2. Overall the private healthcare market is characterised by high, and increasing, expenditure, and by excessive utilisation of health resources without any discernible or credible corresponding measure of improved health outcomes.

3. We have, therefore, made recommendations in line with section 43C(1) of the Competition Act, which states that upon completion of a market inquiry the Commission must publish a report of the inquiry *"with or without recommendations, which may include…recommendations for new or amended policy, legislation or regulations; and recommendations to other regulatory authorities in respect of competition matters."*

4. Our recommendations focus on the key interventions necessary to correct competitive distortions, improve access to, and increase the affordability of private healthcare. The interventions which we recommend should be viewed as an integrated whole; and market failures may persist if a partial approach to the implementation of the recommendations is adopted.

5. In addition to promoting competition to the benefit of the consumers, and the long-term sustainability of the market, these recommendations are fully consistent with, and, in most cases, contribute to the underlying premises and objectives of the NHI policy which is to realise access to affordable and quality health services for all. The recommendations are thus made in the context of broader policy considerations, since irrespective of the final formulation and timing of the NHI, having a cost effective, competitive and appropriately regulated supply of private healthcare services, will support the development of the NHI.

6. A graphic presentation of the proposed recommendations, including the relevant institutions and functions, is provided in ***Annexure 9.1: Recommendations Infographic.***

Principles Considered In Designing the Recommendations

7. Our recommendations have been shaped by stakeholders' submissions, by information obtained from stakeholder engagements, and by our own research and analyses of data and information collected.

8. Submissions in response to our provisional recommendations highlighted areas of ambiguity, insufficient detail, issues of proportionality, and an imbalance between the supply side and demand side interventions. Stakeholders also suggested remedies that we had not considered. The final recommendations remove ambiguity, provide greater detail, and, where required, have been reconsidered and modified to take into account stakeholder submissions.

9. Our recommendations should be viewed as an integrated whole. In some cases, we

have proposed an explicit sequence for implementation. Overall, we have highlighted interdependencies and caution against piecemeal implementation.

10. In determining these recommendations, we considered well-accepted jurisprudential principles arising from Tribunal and Competition Appeal Court decisions. Whilst noting that these principles are derived from enforcement action cases, we believe that these principles are relevant.

11. One principle, extracted from the South African jurisprudence, is that of "appropriateness", referred to in Section 49D(1) of the Competition Act.[848]

12. In Competition Commission v SAA and others the Tribunal stated that "appropriate" simply means "suitable": [849]

    "…it is suitable in the sense that it is an agreement that suits the contending interests of the Commission, as the proxy of the public interest, and the respondent, and in that sense, can be said to be appropriate as between themselves".[850]

13. Simply put, there must be a fit between the recommendations made and the harm they wish to address.

14. Further, we have drawn lessons from the criteria used by the UK CMA. In particular, how comprehensively the possible remedy options (individually or as a package) address the adverse effects on competition, whether there are resulting detrimental effects on customers, and whether recommendations are reasonable and practicable.

Recommendations for Providers of Healthcare Services

15. Within this section we deal with recommendations for providers, which includes both facilities and practitioners. These have been combined given the overlap in providers' joint clinical operations and thus regulatory imperatives. We illustrate how one regulatory body would deal effectively with a number of different quality, value, and competition concerns across a range of stakeholders.

16. Our recommendations emphasise the importance of creating a competitive and cost-effective supply side within a coordinated regulatory framework that can also contract with the NHI Fund and other structures of a unified health system. All healthcare purchasers, including the NHI, will require providers to be properly regulated in order to achieve affordable access to quality care. Any single buyer system, like the NHI Fund, on its own, that is without complementary supply-side regulation, cannot succeed. In a mature and long-standing single purchasing system like the NHS in the United Kingdom, all public and private providers that provide care paid for by the NHS are regulated by Monitor,[851] the independent supply side regulator (now part of NHS Development) as well as by the Competition and Markets Authority, the competition enforcement agency.[852] We advocate that early implementation of these recommendations would pave the way for a more responsive and sustainable healthcare system both prior to and after the establishment of the NHI Fund.

17. The recommendation for the establishment of an independent supply-side healthcare regulatory authority (the SSRH) received support from industry stakeholders, specifically its proposed four core functions. Stakeholders agree that the supply side is largely unregulated and acknowledge the need for effective oversight to stimulate competition. [853]

18. However, some stakeholders raised concerns about overburdening the health system with many regulators and restricting pro-market solutions. Others, although agreeing with certain

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848 Section 49D(1) states: If, during, on or after completion of the investigation of a complaint, the Competition Commission and the respondent agree on the terms of an appropriate order, the Competition Tribunal, without hearing any evidence, may confirm that agreement as a consent order in terms of section 58(1)(b).

849 Case Number: 83/CR/Oct04.

850 At paragraph 47.

851 Monitor collaborates extensively with the Competition Authorities. Monitor's main tool for carrying out its functions is the NHS provider license, which contains obligations for providers of NHS services.

852 In addition to assessing NHS trusts for foundation trust status and ensuring that foundation trusts are well led, in terms of quality and finances, Monitor's other duties include:
- setting prices for NHS-funded care;
- enabling integrated care;
- safeguarding patient choice and prevent anti-competitive behavior which is against the interests of patients.

See: https://www.gov.uk/government/organisations/monitor

853 Refer to submissions in response to the PFR from BHF p. 18; GEMS p. 4; Medscheme p. 14; Intercare p. 3; Clinix p. 4; NHN p. 8; SAMA p. 68,

proposals for the SSRH, raise the issue of duplication of functions and argued that the functions we propose for the SSRH fall within the mandate of a number of existing entities.[854] The World Health Organisation (WHO) submitted that there should be caution in establishing new agencies and bodies to make-up for the weaknesses of existing agencies. It suggested that better outcomes would be achieved if the focus was on sustained financial investments and capacity building and strengthening both the governance and the accountability of existing agencies.[855]

19. We took note of these concerns and explored alternatives in detail but we remain convinced that the establishment of the SSRH is in the best interests of the health system, especially on a long-term view of the planned system changes. The four most compelling reasons for an integrated supply side regulator are:

19.1. enhancement of the mandate and relocation of the Office of Health Standards Compliance (OHSC) within the SSRH would mean that the net change in the number of regulators is zero;

19.2. any other option would require the same degree of investment in legislative changes, funding and governance;

19.3. a new regulator created by dedicated statute would be best placed to provide the necessary independence and minimise the risk of a single point of failure for both public and private sectors; and

19.4. there is one competent custodian of health, namely the Minister of Health, guided by the Constitution, and operating in the context of checks and balances.

20. Recognising the caution on the administrative burden of additional regulators, we have also advanced a less desirable alternative approach that will require the split of some of the main functions to different entities, i.e. the National Department of Health, the OHSC and the Council for Medical Schemes. Nevertheless, this alternative approach would still require regulatory reform and investment.

21. In recognition of the fact that some failures are too urgent to wait for the wholesale implementation of our recommendations, we have made interim proposals to address them, and note that they apply whichever regulatory option is implemented.

22. We have identified four essential areas of supply-side regulation that are critical but missing in the private healthcare sector. We make remedial recommendations and subsequently provide an overview of the institutional and implementation structure of the SSRH. Thereafter, we provide guidance on an alternative but in our view less desirable solution.

Critical Missing Elements in the Current Regulatory Framework

23. The supply side of private healthcare markets suffers from several structural, behavioural and regulatory imperfections that harm competition and undermine access to healthcare.

24. The supply side has generally operated within a fragmented, poorly enforced regulatory system with weak oversight.

25. The regulatory bodies have failed to implement the existing provisions of the National Health Act in a coherent manner. Specifically, this failure refers to provisions relating to price determination, a centralised licensing system, the setting up of a unified national health information system and the measurement of quality of healthcare services. As is evident, these provisions are predominantly related to the supply side.

26. Supply-side regulatory measures aim to provide guidance to, or add incentives and disincentives, to influence the behaviour of healthcare service providers. The existing regulatory framework is lacking or fails in four critical areas:

26.1. healthcare capacity planning and related information to guide rational and need-based investments in facilities and human resources for health;

26.2. economic value assessments of new healthcare technology and interventions;

26.3. implementation of appropriate pricing mechanisms where the market fails; and

26.4. reliable information on the quality and outcomes of healthcare services.

Establishment of an Independent Supply-Side Regulator for Healthcare (SSRH)

27. In our PFR, we made several recommendations that seek to address the regulatory gaps that impede competition on the supplier side of the private sector, the main one being the

854 Life Healthcare Group submission in response to PFR, pp.136 -139. 15 October 2018.
855 WHO submission in response to PFR, p.4. 21 September 2018.

establishment of an independent supply-side healthcare regulatory authority referred to as the SSRH. [856]

28. In the PFR, we recommended that the SSRH be established through the current ministerial functions under the National Health Act (NHA),[857] to oversee and manage functions related to: healthcare capacity planning (facility licensing and practice code numbering service); economic value assessments; health services monitoring; and mechanisms for payment of providers which included procedure codes and provider networks.[858] We argued that locating these functions within a single supply-side regulator would ensure operational coherence and provide data for rational policy development.

29. Some stakeholders argued that it would not be possible to establish the SSRH under the current provisions of the NHA, and that the powers attributed to the Minister under the NHA would not extend to the functions of the SSRH and would therefore necessitate legislative amendment. Moreover, it was argued that a body not created by statute, but by ministerial power, would not be properly independent. [859]

30. We envisage that the SSRH will be established through the NHA in light of the wide-ranging powers it attributes to the Minister. The Minister's powers in terms of the NHA are dealt with in detail in the section ***Minister's Powers in terms of the National Health Act below.***

Motivation for a New Independent SSRH

31. We noted in the PFR many serious supply side challenges relating to the conduct and structure of the providers of healthcare. These challenges are responsible for continuing high and rising prices of healthcare services and cannot be fixed by reorganising the funding side of healthcare alone, be it schemes and administrators or through the introduction of the NHI fund. The existing legal and regulatory framework for the supply side is incomplete, highly fragmented and poorly enforced, with little synergy and co-operation between the various regulatory bodies mandated to oversee providers.

32. The provincial departments of Health (PDOHs), the Office of Health Standards Compliance (OHSC), the South African Health Products Regulatory Authority (SAHPRA), the Health Professionals Council of SA (HPCSA) and the Council for Medical Schemes (CMS) all play a critical role and, if supported by effective and efficient supply side regulatory oversight, duplication of services where their roles overlap could be avoided. The regulators would also have a clearer sight of industry challenges and solutions necessary to achieve better outcomes and access to services. These are critical factors for the success of the NHI.

33. We emphasize the need for the SSRH to be an independent and transparent public entity, in line with international practice where there is a clear shift towards regulatory independence in the healthcare sector. Independence is important, particularly in a market where there are concerns of regulatory capture, regulatory failure, and lack of stewardship. Independence has been critical to the success of Thailand's National Health Security Office (NHSO), the autonomous purchasing agency, separate from the Ministry of Public Health, established to manage the Thai National Health Security Fund, and the provision of universal care to Thai citizens. The same can be said of the success of The National Institute for Health and Care Excellence (NICE) in the UK which provides national guidance and advice to improve health and social care.

34. The SSRH should have its own board appointed by the Minister, following a transparent public nomination process. The board should have autonomy to appoint its Chair, Chief Executive Officer and other executives, who will in turn be accountable for the appointment of all other appropriately qualified members of staff. We recommend that work to set up the SSRH begins immediately with the objective of getting the regulatory body being functional within five years.

35. The SSRH should have financial autonomy and its strategy and key performance indicators must be independently determined by the board.

Minister's Powers in terms of the National Health Act

36. In terms of section 3 of the NHA, the Minister is empowered as follows:

"(1) The Minister must, within the limits of available resources –

(a) Endeavour to protect, promote, improve and maintain the health of the population;

856 PFR, 5 July 2018, p463.
857 Act No. 61 of 2003.
858 PFR, 5 July 2018, p473, figure 10.1.
859 Netcare presentation at the seminar organised by HMI, 12 April 2019, slide 25.

(b) Promote the inclusion of health services in the socio-economic development plan of the Republic;

(c) Determine the policies and measures necessary to protect, promote, improve and maintain the health and wellbeing of the population;

(d) Ensure the provision of such essential health services, which must at least include primary healthcare services, to the population of the Republic as may be prescribed after consultation with the National Health Council; and

(e) Equitably prioritise the health services that the State can provide."

37. In addition, section 90(1) of the NHA empowers the Minister to make regulations regarding:

"(f) co-operation and interaction between private healthcare providers and private health establishments on the one hand and public healthcare providers and public health establishments on the other;

[…]

(u) the processes and procedures to be implemented by the Director-General in order to obtain prescribed information from stakeholders relating to health financing, the pricing of health services, business practices within or involving health establishments, health agencies, health workers and healthcare providers, and the formats and extent of publication of various types of information in the public interest and for the purpose of improving access to and the effective and efficient utilisation of health services".

38. With the above provisions in mind, it is arguable that section 3, read with section 90(1)(f), may be wide enough to permit the Minister to establish the SSRH with minimal amendment to the NHA. This view is premised on the notion that the establishment of the SSRH lies at the heart of facilitating cooperation between all actors in the private and public sectors with a view to ensuring the equitable provision of health services.

39. However, despite the above, it is necessary to ensure the express independence of the proposed SSRH, which could be established either through a simple set of regulations, or preferably through a new piece of legislation.

Public Finance Management Act – Schedule 3A Entity

40. In terms of section 1 of the PFMA, a national public entity is defined as:

(a) "a national government business enterprise; or

(b) a board, commission, company, corporation, fund or other entity (other than a national government business enterprise) which is –

(i) established in terms of national legislation;

(ii) fully or substantially funded either from the National Revenue Fund,

or by way of a tax, levy or other money imposed in terms of national

legislation; and

(iii) accountable to parliament".

41. Sections 47 and 48 of the PFMA provide for the listing of a public entity (once established) in either Schedule 2 or 3, with the proviso that the Minister of Finance may not include, in Schedule 3, *"any public institution which functions outside the sphere of national or provincial government".*[860]

42. Once an entity is listed in Schedule 3, the Minister of Finance must classify the said entity as either a national government business enterprise, provincial government business enterprise, national public entity or provincial public entity.25 Lastly, once established, section 49 stipulates that every public entity must have an accounting authority for the purposes of the PFMA.

43. We believe that the PFMA provides guidance as to the administrative processes to be complied to establish the SSRH. We propose that the establishment of the SSRH occurs through a Schedule 3A public entity, in terms of the PFMA. The entity will be a stand-alone special purpose public agency, with the mandate to fulfil a specific economic or social responsibility of government.

Funding Model

44. We propose initial financial support from Government to map out the feasibility and the implementation guide for the establishment of the SSRH. Once established, the entity could be funded by a levy on regulated stakeholders. The Levies Act exists and can be amended to allow for collection and allocation to the SSRH. Consideration could be given to establishing a consolidated health regulators levies Act to fund the various private health sector regulators.

45. Penalty fees for non-compliance, similar to fines collected by the competition authorities and CMS, would assist in revenue generation, which could be channelled back through the fiscus to the institution.

860 Section 47(4)(b).

Timelines to implementation

46. Significant consultations have revealed broad support for the proposed functions of the SSRH. Time to implementation can thus be shorter than if the policy process was being established from scratch. We estimate that it will take approximately five (5) years to implement the necessary legislative amendments if the process is prioritised by the Department of Health.

FUNCTIONS OF THE SUPPLY SIDE REGULATOR

Healthcare Capacity Planning

47. Healthcare capacity planning, for the purposes of this report, includes the assessment of available capacity, planning for future healthcare needs and demands, the licensing of facilities and the issuing of practice code numbers to providers to enable them to submit claims and be paid for services provided to medical scheme members and the NHI Fund. We recommend interventions in two areas: developing a coordinated facility licensing framework to replace the existing fragmented and incomplete system, and implementing a new practice code numbering system, relocating the service to a regulator instead of an industry player.

Facility Licensing

48. One of the main recommendations of the PFR was that to address unequal access to healthcare, a standardised, centralised licensing regime should be implemented by provincial departments, consistent with the principle of universal health coverage in line with the objectives of the NHI.[861] The majority of stakeholders, including the Department of Health and provincial authorities, supported a centralised licensing framework, and highlighted the need to address urgently the fragmented nature of the current framework.

49. Crucial elements of an improved licensing framework include, inter alia, assessment and projections of market need per specialty, per means of delivery (in-patient, out-patient, day-care), assessment of competitive impact, and assessment of clinical impact. The issuing of practice numbers and facility type classifications should form part of this process to enable effective monitoring. This central system should apply to both public and private facilities while taking into account local dynamics.

50. The SSRH, working with PDOHs, is ultimately the most suitable body to implement the facility licensing and related processes. When an application for a licence is under consideration, we recommend that the SSRH should work with the relevant PDOH as an integral participant throughout phases I and II of the licensing process, e.g. the Mpumalanga DOH should be part of the assessment and finalisation for a Mbombela licence application.

51. Through its licensing unit, the SSRH will lead the process of assessing and issuing licences for health establishments. The SSRH will chair the licensing body, provide secretarial services and will have some of its full-time staff participate as technical experts.

52. Representatives of the National Department of Health, PDOHs (to alternate based on the application under consideration), CMS, OHSC, HPCSA, the Competition Commission, Statistics South Africa (StatsSA) and COGTA will be permanent members of the licensing committee. The Competition Commission's role is essential in providing guidance with respect to local concentration as well as mergers and acquisitions trends. StatsSA will provide guidance on national, provincial, and local population and income distribution trends.

53. We are proposing a sufficiently resourced facility licensing unit with a range of high-level expertise. It would be uneconomical to have such a body replicated across all nine provinces and would reintroduce the risk of inconsistencies in processes and decisions. We are, however, mindful of the important role of the provinces and trust this joint approach will address many of the challenges we have identified in the current process.

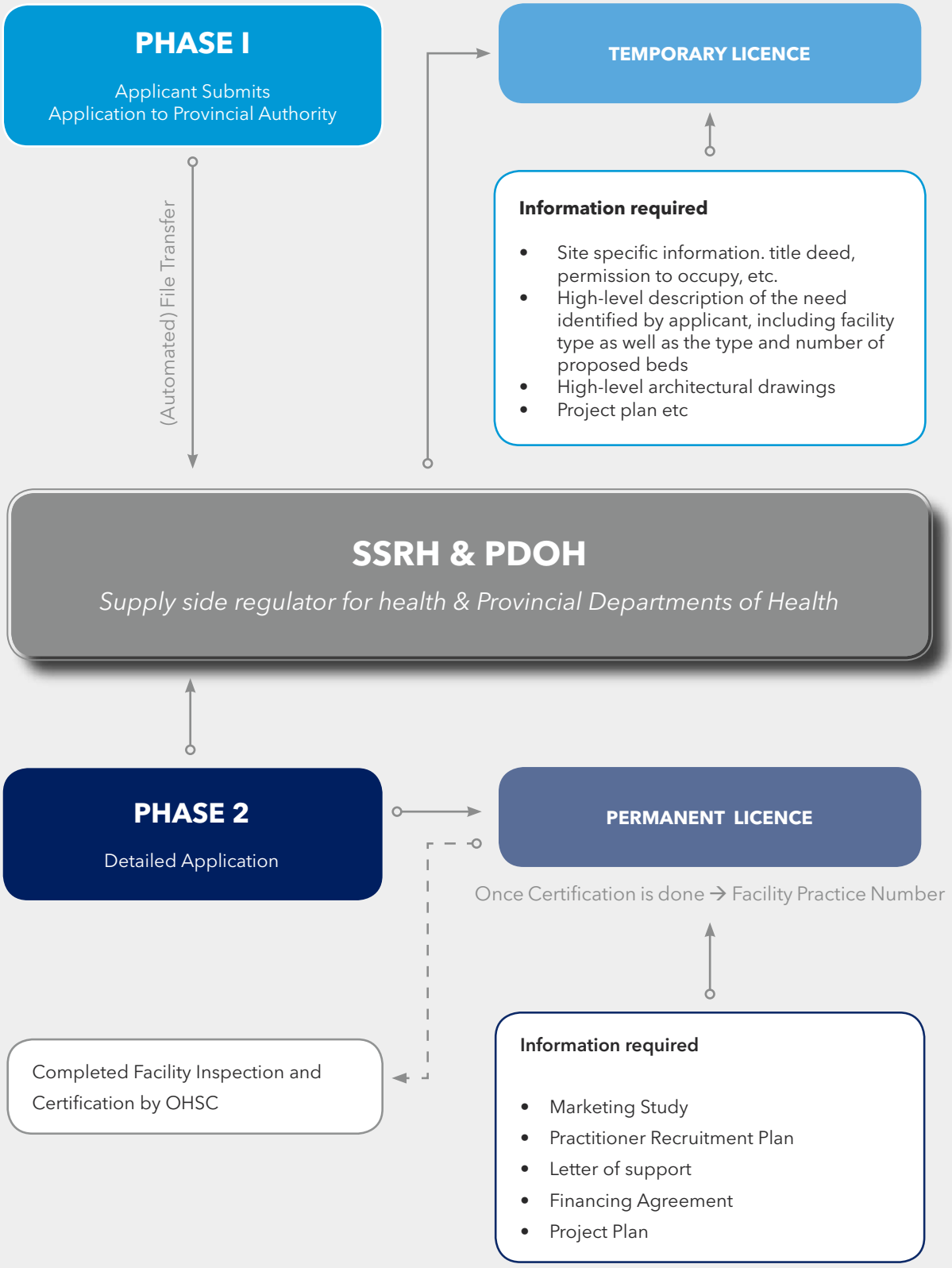
54. Private facility licensing will follow a two-phased process.

54.1. Phase I will determine the exact geographic location of the proposed site and, at a high level, the capacity of the applicant to succeed in the execution of the project. Location is the first step in determining need, and the SSRH licensing unit could very well terminate the process at this phase without issuing a temporary licence and proceeding to Phase II.

54.2. Phase II will verify whether a need for the facility and a viable market in that particular area exist. The capacity of the applicant to succeed will be considered in more detail during this phase of the application.

861 We have learned that a centralised licensing regime is also being considered internally by the NDoH, although we have not established the status of this process.

Figure 9.1: Proposed Licensing Process



55. Phase I starts with the applicant submitting an application to the relevant Provincial Department of Health (PDOH) which will confirm the completeness of documents and immediately forward the application to the SSRH via an automated process.

56. The SSRH licensing unit (incorporating the relevant PDOH) will commence Phase I within a reasonably short period. We recommend that applications must include at least the following information:

56.1. a specific site identified by officially recognised documents, e.g. title deed, permission to occupy, etc., and where applicants do not already own the site, proof that they have secured the right to acquire the site should the application succeed, which is essential for any useful needs assessment, and which should reduce the issuing of licences to parties who have no control over the property;

56.2. a high-level description of the need identified by applicant, including facility type as well as the type and number of proposed beds;

56.3. high-level architectural drawings;

56.4. a project plan;

56.5. other relevant information.

57. An application that does not meet need and other criteria should be declined at this stage. If the SSRH finds the Phase I application satisfactory, a temporary licence should be issued with copies filed by the SSRH and the relevant PDoH. We propose that the temporary licence be valid for no longer than two years.

58. The temporary licence is intended to eradicate some of the problems already identified, which include:

58.1. the PDOHs being uncertain of the number of licences in issue in any given year;

58.2. the practice of licences changing hands for money in a manner that is not transparent to regulators and which inadvertently subverts the ideal of industry transformation from an ownership perspective;

58.3. licences end up in the hands of prospective stakeholders who have no capacity to develop and commission facilities; and

58.4. The number of these licences in issue makes it impossible for competition and health authorities to determine accurately barriers to entry.

59. Before the expiry of the temporary licence, the applicant should return all necessary documents for consideration as the Phase II part of the licensing process.

60. Examples of documents that should be required for Phase II include:

60.1. a comprehensive market study, highlighting local demographics, the business case for the facility and how this relates to innovation and value-based care;

60.2. a practitioner recruitment plan;

60.3. letters of support from funders whose members make up at least 50% of the local insured population, e.g., medical schemes, business (mining houses), and government agencies (NHI Fund);

60.4. a provisional financing agreement from reputable financiers; and

60.5. a comprehensive project plan with construction timelines.

61. If the SSRH Licensing Unit is satisfied that the applicant meets its criteria, it may then issue a permanent licence for construction to commence. The unit should be empowered to revoke licences where there is no satisfactory progress after a licence has been issued.

62. When the construction of the facility has been completed (within the agreed timeframe), the SSRH will refer the facility to the OHSC for inspection and certification. If the OHSC elects to outsource this function, it will nonetheless remain accountable as the only authority empowered to play this role.

63. Once the OHSC has approved the facility as satisfactory and meets the required standards, it will issue a certificate which the applicant will submit to the SSRH PCNS unit to acquire a practice code number necessary for payment for clinical services rendered.

64. The details listed above should be regarded as guidelines to developing the recommended framework, but we are convinced that the two-phase process is essential and will remedy most of existing market problems.

65. The licensing framework should be based on a comprehensive national plan that takes capacity in both the private and public sectors into account. New licences should be issued in line with the national plan and should have regard to diversity of ownership of facilities, should consider whether the supply of beds and

practitioners bears reasonable relation to the population served, and should prioritise pro-competitive effects and innovative models of care. The national plan should be developed in a consultative manner with relevant stakeholder representation led by the Department of Health.

Role of the Provincial Departments of Health in Monitoring and Reporting

66. Regular monitoring by PDoHs, and inspection and reporting will be embedded in the licensing framework to ensure that minimum standards are met and that a reliable database of supply side services is established. Licensed establishments will, at a minimum, provide the following information to provincial departments of health on an annual basis:

66.1. The number of operational beds, operating theatres, intensive and high care units, specialized beds, e.g. cardiac and paediatric surgery;

66.2. bed allocation by type and changes to bed allocation, by type, over the previous calendar year;

66.3. ownership of the group/establishment and any planned acquisitions that have been notified but not yet assessed by the competition authorities;

66.4. occupancy rates by unit and/or bed types;

66.5. the names of practitioners who work from or have admission privileges to the facility by discipline; and

66.6. documentary proof of approval for RWOPS for public sector practitioners who work from or have practice privileges at private facilities.

67. PDOHs should report quarterly to the SSRH on the data and information collected from health establishments. Reporting should follow a standardised format to be determined by the SSRH with automatic updates to a national database accessible to NDoH and all PDoHs and be available in the public domain. Each province should also publish official annual reports, the structure of which will be determined in collaboration with the NDOH and the SSRH. These data will fill a gap identified by the Competition Tribunal merger hearings and will promote competition.

68. The renewal of a facility's licence will dependent on the facility meeting its annual reporting requirements, among other regulatory requirements. Initially, penalties (to be determined by the SSRH) may be levied on facilities that do not comply, but continuous infringements should lead to revocation of a facility's licence. This is an example where adequate stewardship by provincial and national government is essential to hold the private sector appropriately accountable. The licensing regulations should be amended to allow for these punitive measures.

Concentration in the facilities market

69. In the PFR, we raised concerns with the high market concentration in the facilities market and with the failure to address it of the current licensing system. We considered several options, including divestiture and imposing a moratorium on issuing licences to the three large hospital groups, Netcare, Life and Mediclinic. Under a moratorium these hospital groups would not be granted licences for new facilities, nor licences or permission to increase the number of beds within existing facilities until such time as their national market share, represented by number of beds, is no more than 20%. The moratorium would remain in place until new entry or growth in the private sector achieved a better competitive balance.

70. We have considered stakeholders' extensive submissions to this proposal. Stakeholders argued that it would have a material impact on the existing and future business of the three largest hospital groups as well as on the overall operation of the private healthcare system.[862] It was further argued that the measures were neither appropriate nor proportionate,[863] as the market is not highly concentrated and is rather gradually deconcentrating.[864] It was argued that we had not found sufficient evidence of the exercise of market power by the three large hospital groups to warrant drastic remedies such as divestiture or a licensing moratorium and that the 20% market share cap was arbitrary and lacked economic or any other foundation. [865] [866]

71. Whilst we argue in Chapter 4 that we are not convinced by the arguments of a rapidly deconcentrating market, we have reconsidered this recommendation and believe that our

862 Netcare Submission in response to the PFR,15 October 2018, p.109.
863 Ibid.
864 Ibid, Mediclinic Submissions to the PFR, 15 October 2018, p.6.
865 Mediclinic Submissions to the PFR, 15 October 2018, p.6.
866 Netcare Submission to the HMI's PFR by Compass Lexecon, 30 October 2014, pp.44-49; Netcare Submission in response to the PFR,15 October 2018, p.109, Mediclinic Submissions to the PFR, 15 October 2018, p.6.

interventions should rather lean towards the least restrictive approaches to competition. We agree that these recommendations may raise questions of proportionality and that less intrusive means are possible. For example, we believe that implementing a stricter needs-based centralised licensing system that takes into account competition and market concentration can address the observed concentration levels, provided it is fully and urgently implemented.

72. To further address concentration, we recommend that the appropriate regulator(s) - in our view, both the Competition Commission, the SSRH and the PDOHs – develop a set of criteria for assessing local concentration. The assessment framework should specify the maximum allowable level of concentration of private hospitals at the local level. These concentration levels may vary according to local conditions, i.e. available public hospital capacity and insured population capacity and strategic NHI purchasing.

73. We believe that the OHSC's mandate, which extends to quality inspections and the accreditation of private facilities, should remain. Practice numbering codes will only be issued to facilities and practices that have been certificated by the OHSC. Close collaboration between the SSRH and the OHSC will be required. We anticipate that over time the OHSC would become an integral part of the SSRH.

74. To further address the sale of hospital licences, which we believe materially affects competition and transformation in the sector, we recommend that the sale of licences be jointly notified to competition authorities, the SSRH and the PDoHs. The competition authorities should assess the effect of any sale on competition and the public interest. Given the current concentration in the market, all transactions must be notified.

Practice Code Numbering

75. We recommend that the practice code numbering service, which is currently managed by the Board of Healthcare Funders, be assigned to the SSRH licensing unit (see Figure 9 1). We note that the BHF is currently reviewing the PCNS. However, this process should ultimately be handed over to the SSRH as a regulator and should not be managed by an industry participant.

76. The purpose of the PCNS is to allocate practice numbers to providers for the purpose of claiming for services rendered to patients from relevant funders, e.g. medical schemes, the Compensation Fund and, in future, the NHI Fund.

77. Practice numbering and coding systems should be uniform, nationally coordinated and must be in the public domain. If, and where, current proprietary systems are preferred, appropriate financial compensation must be negotiated with the relevant custodians.

78. Specific to facilities, practice code numbers must be allocated to both public and private facilities to support strategic public purchasing from private providers within the NHI framework, and, vice versa, to support, for example, inclusion of public hospitals in private funders' provider networks.

79. We do not recommend that public hospitals should go through the licensing process described above, but certification by the OHSC remains a necessary prerequisite for maintenance of acceptable standards and allocation of practice code numbers for all providers of service.

80. We further recommend that the allocation of practice numbers be extended to facilities for General Practitioners and others where surgical and other high-risk medical procedures are performed. Such facilities could include specialists' rooms if procedures (not just consultations) are performed therein, for example, gastroscopies.

81. We recommend that the OHSC drafts guidelines to clarify which practitioner facilities will in future need certification as a prerequisite for allocation of practice code numbers. We recognise that certification and inspection cannot necessarily be immediate deliverables but the process to devise criteria should start within a year, even though inspections and enforcement could be delayed until the OHSC capacity allows.

82. Drafting and early publicising criteria early would help practitioners to plan and to prepare for contracting with the NHI Fund, as provided for in the NHA (See section ***Minister's Powers in terms of the National Health Act*** above). To be clear, the panel is not recommending that practitioner facilities be subjected to a licensing process, but it is requiring that all GP and other facilities where high risk procedures are undertaken be certified as a condition for being issued with practice code numbers.

83. The requirement for GP facilities to be certified has to be seen in the context in which the panel supports care-coordination with the GPs reverting to their original role as likely practitioners of first contact for private patients. The panel would be reluctant to channel patients to facilities whose safety is not verified.

84. The PCNS for public and private facilities will require close collaboration between the OHSC and the SSRH's Licensing and PCNS units.

85. To be able to document the human resources of all health professionals operating in the private health sector, the SSRH should maintain an "intelligent" practitioner code numbering system. The system should collect data on current working address, area of speciality, full/part-time status, and concurrent employment in the public sector.

86. Practice numbers should be unique and be issued to each practitioner for life to avoid confusion and to facilitate monitoring of practitioner profiles. Practice numbers should only be changed in specified circumstances, such as when a former GP qualifies and starts practising as a specialist. The old GP number must not be reallocated to another practitioner.

87. Group and multi-disciplinary practices must have their own practice numbers, separate from those of the practitioners within the practice. Claims submitted by group practices should include both the group and individual practitioners' practice numbers. Funders should only pay claims that reflect both numbers and claims information must contain both numbers. This is essential to ensure that individual and group practice profiles can be analysed without confusion. Public sector practitioners allowed to do private practice work will use their practice number when doing locum work.

88. The issuing of practice code numbers to practitioners requires close collaboration with regulators for all health professionals (HPCSA, SAPC, AHPSA, SANC, etc.) who must verify the registration of each applicant. Practitioners should be issued with an individual, unique practice number to be used for payment, irrespective whether the payer is a public or private sector purchaser.

89. Practice code numbers for all providers must be renewed on an annual basis subject to them meeting conditions set by the regulator (the SSRH). For practitioners, we recommend a number of additional conditions.

89.1. The applicant must submit an annual return containing information on the practitioner's discipline, employment, and an up-to-date address indicating the practice location. Where the provider practices in more than one location, they may provide the address where they spend most of their practice time.

89.2. As already described in the section P***ractice Code Numbering System (PCNS) as a method to measure supply*** above, practitioners' premises must be registered and will be allocated a facility practice number separate from that of the practitioner.[867] The facility practice number where care was provided must be captured in all claims to funders, with defined exceptions, e.g. roadside emergency. Proof of location of premises should be a core requirement for practice number renewal for both practitioner and premises. This is essential to enable routine and random inspections by the OHSC, to reduce the scourge of "ghost" practices and practitioners as well as to minimise claims fraud. Cleaning up of databases of practice locations is a necessary step in improving resource planning and to support growth of meaningful provider networks to service both private and public sector consumers.

89.3. Practitioners who work from facilities not owned or leased by themselves, e.g. anaesthesiologists, will be required to submit supporting documentation from management of the relevant facilities.

89.4. Practitioners employed in the public sector who also work in the private sector will be required to produce a certificate from the provincial health authority indicating that the practitioner has approval to do remunerative work outside the public sector. And,

89.5. Practice numbers will only be issued if providers comply with all relevant reporting functions of outcomes registries relevant to their area of work.

90. To be clear, practitioner facilities/premises will be issued a practice code number by the SSRH licensing unit after certification by the OHSC, while regulatory bodies like the HPCSA will remain responsible for the certification of qualified practitioners.

91. Given the enormity of the task of extending licensing to practitioner facilities, e.g. doctors' rooms, the OHSC may outsource some of its proposed functions but will remain accountable for all work undertaken by its service providers.

92. Ultimately when OMRO becomes functional, reporting on health outcomes will be included in the criteria for renewal of practice numbers.[868]

867 We note that it may take time for every practice location to be licensed and this condition will be applied mindful of this possibility.
868 Note the requirement is to report only. It is not dependent on the actual rating received.

Interim Solution for Facility Licensing and Practice Code Numbering

93. We recognise that it will take several years for the SSRH to become fully operational. Therefore, we propose an interim solution to ensure that a coordinated national licensing framework guided, by national policy objectives, is developed without delay.

94. We recommend that the Minister of Health uses existing provisions of the NHA to appoint a facility licensing working group led by the National Department of Health. Other members of the working group should include representatives of PDoHs, CMS, OHSC, HPCSA, the Competition Commission, Statistics South Africa (StatsSA), COGTA and independent consultants.

95. The working group should engage meaningfully with private sector stakeholders to develop a licensing framework that will be applied as already described under the section referring to ***Healthcare Capacity Planning***. Industry stakeholders should at the very least include HASA, NHN, BHF, HFA and the SAMA.

96. Owing to the very urgent need to address licensing failures, the working group should be given no more than three months to finalise the framework which can then be implemented once all the operational considerations have been completed, e.g. configuration of necessary IT systems. Once the task of the working group has been completed, the Minister should dissolve the working group.

97. After the working group has completed its work, but prior to the establishment of the SSRH, we propose the functions of the latter's Licensing Unit be allocated on the following basis (see the section ***Healthcare Capacity Planning*** above for the complete proposed process):

97.1. The Minister to appoint a committee to evaluate applications as intended for the SSRH Licensing Unit. Members of the (now dissolved) working group may or may not be appointed to serve on this body, but we advise that the same mix of skills be retained. This committee would be responsible for those functions ultimately intended for the SSRH Licensing Unit, i.e.:

97.1.1. to receive applications from relevant PDoHs;

97.1.2. to work with relevant PDOHs to undertake Phase I screening;

97.1.3. to approve and issue temporary licences;

97.1.4. to work with relevant PDOHs to assess Phase II applications; and

97.1.5. to approve and issue permanent licences.

97.2. The task of inspecting and certifying a completed facility should be the responsibility of the OHSC. The panel acknowledges the heavy workload of the OHSC but strongly recommends that the OHSC must be accountable for inspection and certification from the start of the new licensing process. If the proposed timelines cannot be met, consideration should be given to outsourcing the function to a suitable accreditation organisation in the short term.

97.3. The task of issuing practice code numbers after facilities have been certified by the OHSC, or outsource partner, should be managed by the BHF until this function can be transferred to the SSRH as recommended. Alternatively, the BHF can continue to work with its accreditation partner(s) to inspect the facilities and issue practice numbers.

98. This interim process is defined for licences for private facilities and certification of public and private hospital and day hospital facilities as a prerequisite for issuance of practice code numbers by the BHF. The panel is not proposing any interim solution for practitioner facilities/ premises.

99. Practitioners will continue with certification by relevant regulators and apply for practice code numbers from the BHF as is the case currently.

100. We believe that this interim process could be converted to the permanent alternative process if the option NOT to establish the SSRH is preferred by authorities. However, the following processes would still need to be implemented:

100.1. conversion of the NDOH licensing committee to a permanent legal structure;

100.2. the CMS with a new mandate to regulate both the funder and provider sides would be required to manage the PCNS in the long term; and

100.3. the PDOHs would be responsible for monitoring and reporting as proposed above.

ECONOMIC VALUE ASSESSMENTS

101. A critical tool of supply-side regulation is a system of assessing the cost effectiveness of health technology and interventions across the entire health system. We have not been provided with evidence of publicly available cost-effective standards of care and treatment protocols being used across the healthcare sector. The absence

of this information makes it difficult to assess the appropriateness of certain courses of treatment and to evaluate quality of care and value for money.

102. To inform practice and to curb waste on procedures, equipment and medicines that are not beneficial, and may not be cost effective, the SSRH should have a Health Technology Assessment function (HTA) to produce guidelines for both the private and public sector, though these may differ. It should be noted that guidance on how HTA is performed elsewhere should guide South African practice if only to avoid reinventing the wheel and to ensure the early establishment of an effective HTA unit. Consideration should be given to examples from the Philippines and Thailand who incrementally developed their own capacity for HTA by working in partnership with relevant bodies internationally. The practice of contracting specific HTA assessments to academic institutions should also be explored.

103. Specifically, standards of care, evidence-based treatment protocols and processes for conducting health technology assessments to assess the impact, efficacy and costs of medical technology, medicines and devices relative to clinical outcomes, must be developed. The process of developing HTAs, pharmaco-economic and standards of care evaluations should be based on standard accepted approaches. Where appropriate, collaboration with representatives of patients, academia, regulators such as SAHPRA and CMS, and national and international experts should be ensured.

104. All findings, positive or negative, of the economic value assessments should be published to stimulate competition, to mitigate information asymmetry, and to inform decisions about strategic purchasing by the public and private sectors. Funders, including the NHI, should be able to base their decision to reimburse providers on evidence-based and cost-effective treatment guidelines. The findings should also inform the market and should be central to the CMS in their definition and review of the standardised basic package.

105. There is recognition of the need for a system for economic value assessment. We note that the DOH has commenced the process of setting up such as system, and that it is a critical feature in the latest published NHI Bill. While we are not prescriptive on where this function should reside, we recommend that should be a collaborative effort between government, the proposed SSRH, industry stakeholders and academia, and must serve both public and private sectors.

106. As important as the Economic Value Assessment is, we do not propose an interim solution.

National Health Information Dataset – Data requirements for oversight of the healthcare market

107. Health information is essential for health system policy development, implementation, governance and regulation, health research, human resource development, health education and training, and service delivery and financing. Ideally, there should be a single data repository to collect timely and reliable information for both the public and private sectors.

108. Our recommendations require data for a range of reasons:

108.1. to provide a current list of facilities and their physical location, beds, bed types, and occupancy rates;

108.2. to provide a current list of providers (various practitioners) and their physical location and area of specialisation;

108.3. aggregated scheme membership demographic data to run the Risk Adjustment Mechanism;

108.4. OMRO will require data to undertake risk adjustment to assess and report on outcomes;

108.5. to assess the value of ARMs the CMS will require data to allow for risk adjustment and is likely to (initially at least) to conduct case studies to assess specific ARMs and to link these to health outcomes; and

108.6. research to inform policy, to be undertaken by the CMS or the SSRH or specific contracted-out research, to assess the overall functioning of the healthcare market, which will require detailed event level data similar to that collected by the course of the inquiry, to describe changes in cost and utilisation.

109. We recommend below, a new universal coding system which will provide comparable disease data.

110. To facilitate the rational and efficient collection of data we recommend that a national health data repository is created. It should be managed by a neutral body and must comply with POPI and be appropriately protected and managed.

111. We note that an opportunity exists to 'leap-frog' directly into a state-of-the-art repository taking advantage of technological developments and big data capacity which means there are no/few technical or storage limits that limit how big or complicated this repository can be. Further, there is technical know-how and human capacity and

experience that can be exploited to set this up. These come from the experience in the "shadow REF mechanism" previously run by the CMS and the data repository that we have assembled. Schemes already have experience of reporting to the shadow REF and significant advances to make that system more sophisticated and sensitive have already occurred. This can be revived.

112. Similarly, medical schemes already have experience of reporting data to the Inquiry which will stand both schemes and the data repository in good stead in setting up the required more detailed event level repository. The original list of variables developed for the Inquiry reporting process can be the starting point to develop, in consultation, a final set of variables that are routinely reported.

113. Consultation with those involved in the shadow REF process indicated that routine reporting (they suggest on a monthly basis) can be introduced into the standard operating procedures of schemes and that this makes the process more efficient for schemes and will produce up-to-date current data for the Risk adjustment mechanism (RAM) to allow for the proposed within-year risk adjustment to take place.

114. Detailed event level data will not be exploited on a monthly basis. However, a longitudinal data set to undertake the required research on the health market to assess if policy interventions are working and to make required adjustments, is required. Again, advice indicates that if this reporting is built into the routine reporting undertaken by schemes (rather than the once-off reporting as required by the HMI process) it will impact minimally on their usual functions. A once-off investment in the building of a report is required which can then be run every month. Similarly, the data repository will have to clean increments of data and build the data warehouse over a period, taking advantage of the learning gained during the HMI data process. If this is undertaken monthly it will not result in the time delays seen during the HMI process. It can then be accessed when needed and will provide an outstanding resource to monitor and evaluate policy interventions, including providing useful research outputs for the NHI.

115. These data will be linked with the proposed central beneficiary file under the auspices of the NHI.

116. The following policy and legal considerations should apply:

116.1. Unique individual identification number could be used, however should be

116.1.1. a unique identifier that tracks a person;

116.1.2. deidentified;

116.1.3. legally acceptable and reflect people in the healthcare system;

116.1.4. contain critical fields, including age and gender;

116.1.5. service all the datasets.

116.2. Include risk adjustment information

116.3. Standard definition for chronic disease

116.4. Uniform tariff coding system.

117. The proposed data repository will enable collection of the necessary data for the above functions. A specification for reporting on health information is presented in ***Annexure 9.1: Data Specification Template.***

HEALTH SERVICES PRICING

Recommendations on funder / practitioner tariff negotiations

118. For funder / practitioner tariff negotiations we recommend a multilateral negotiation forum (MLNF) under the auspices of the SSRH. The outcome of these negotiations will be a national maximum FFS tariff for PMB conditions and a reference tariff for non-PMB conditions. A distinction from pre-2003 negotiations, which were found to contravene the Competition Act, is that the SSRH will create the framework under which negotiations occur and it will be mandated to assess outcomes against several stated objectives, including public interest and policy considerations. This process will replace the tariff vacuum with competitively priced services while maintaining the space for subsequent bilateral negotiations to occur between practitioners and funders.

119. References to practitioners include all healthcare practitioners, including pathologists and radiologists. Previously for the purposes of tariff negotiations, we had sought to differentiate practitioners based on whether they could be considered corporate entities. However, on reflection such a delineation was considered not only to be artificial but inherently problematic in categorising professionals who are licensed and regulated by one entity (the HPCSA)

differently. Whether a practice is corporatized or not is merely a commercial arrangement and is not even necessarily permanent. Pricing of healthcare services is also at the core of medical ethics, and there can be no justification for setting some practitioners apart from the rest, let alone corporatized pathologists from sole practice pathologists. Depending on the metrics chosen, one might consider a group general practice, practitioner association, or multi-disciplinary team to be as 'corporatized' as any pathology service. We have, therefore, concluded that commercial arrangements cannot be considered ahead of the globally standardised professional classification. The fluid nature of a commercial classification would create problems for the HPCSA in its mandate to regulate health professionals.

120. For funders and practitioners, we recommend the following actions.

120.1. The MLNF will consist of representatives of providers, funders, government and civil society. Stakeholders will prepare individual proposals and present them simultaneously within the forum. Stakeholders will then negotiate FFS tariffs within a multilateral negotiating forum accommodated and governed by the SSRH.

120.2. The anonymised underlying data used to prepare these proposals are to be provided to the opposing parties ahead of time.

120.3. The tariff negotiations will be governed by a framework developed by the SSRH which will be duly mandated by law to organise, lead and govern the MLNF. The SSRH will issue guidelines for the negotiations, specifying rules and conditions for the negotiations process, including the information sharing regime.

120.4. The information sharing regime should have regard to the Commission's published guidelines, noting that it is perfectly legitimate for regulators to collect and process the information from market participants.

121. The terms of reference will set the conditions against which the outcomes of the multilateral negotiations will be assessed. The conditions will, ex ante, specify the outcomes that will be deemed compatible with the public interest and public policy objectives, including the NHI. Conditions may include the maximum average tariff increase, the maximum acceptable increase in expenditure, or even expenditure per speciality. It may also include metrics such as acceptable levels of utilisation and admission growth, a trade-off between tariffs and volumes, and specific commitments to quality or outcomes improvements.

122. In addition to the information provided by stakeholders, the SSRH may call for additional relevant information from stakeholders or other parties in support of the tariff negotiation process. The legal framework within which it calls for and shares information will be consistent with competition law principles and the public interest.

123. The FFS tariffs for PMBs will be binding with no balance billing allowed. Other FFS tariffs will be considered reference prices. Both PMB and non-PMB tariffs can vary following subsequent bilateral negotiations, provided that they comply with the bilateral framework set out by the SSRH. They must include additional risk, quality, and outcomes metrics. These contracts must be submitted to the SSRH for approval – see ***Bilateral Negotiations*** section below.

124. Once the stakeholders reach agreement, the outcomes of negotiations will be submitted to the SSRH which will validate and publish these outcomes.

125. If stakeholders cannot reach agreement, or if the SSRH rules that the tariffs do not conform to the legal framework, the matter will be referred to an arbitrator whose determination will be binding on all parties.

126. Final PMB and reference tariffs must be published by the SSRH, the CMS, and funders. Service providers must do the same at each site of patient contact (e.g. consulting rooms and hospital reception areas) for relevant tariffs and in a manner that is accessible to consumers.

127. The arbitration will be submitted by agreement of the parties and governed by the Arbitration Act.[869] There are instances where a sole arbitrator may be suitable, while in other circumstances more than one arbitrator may be necessary to resolve the dispute.

128. Before arbitration, stakeholders must reach agreement on who will arbitrate, failure to do so will result in the SSRH selecting appropriate arbitrators. The chosen arbitrator/s may be registered or unregistered, but it will be essential to appoint suitably qualified arbitrators with

869 Act 42 of 1965.

relevant expertise. Organisations such as the Arbitration Foundation of Southern Africa (AFSA) or the Association of Arbitrators South Africa (AASA) may be used to appoint suitable arbitrators. These organisations also provide useful guidelines on rules and procedures for the conduct of any arbitration to ensure a fair resolution of the dispute. The process for appointing an arbitrator,[870] as well as the powers of the arbitrator, should be clearly outlined in the arbitration agreement.

129. The SSRH will have a limited role in the arbitration process. It is the duty of the arbitrator to be independent of the parties, to be unbiased and to adhere to due process, rules and the applicable law in reaching a reasoned decision. The SSRH will be entitled to present relevant documents which will accompany those presented by the non-agreeing parties to the arbitrator.

130. No new information would be allowed to be presented at the arbitration stage.

131. The dispute to be arbitrated should be properly defined in the arbitration agreement. It can also be agreed where the arbitration is to be held, the procedures and rules to be followed, the determination and assessment of costs associated with the arbitration,[871] as well as the confidentiality of proceedings.

132. The conduct of the arbitration should be facilitated in a fair, expeditious and cost-effective manner to avoid lengthy and unnecessary delays.

Bilateral Negotiations

133. The HMI envisages that funder and practitioner FFS bilateral arrangements will be phased out as soon as possible. Bilaterally negotiated FFS tariffs will be replaced by the implementation of the interim, and then permanent, multilateral negotiating forum, which will apply to as many service delivery modes as rational. These FFS tariffs will subsequently be replaced with bilaterally negotiated ARMs which incorporate quality measurements and meaningful risk transfer. We note that FFS is the main driver of volume and cost inflation and must be eradicated as far as possible. However, we are cognisant of the fact that ARMs and risk transfer may not be appropriate for all conditions.

134. We support bilateral negotiations between providers and funders. All stakeholders should strive to migrate from FFS to alternative, performance-based contracts with meaningful risk transfer to mitigate against over-utilisation of resources. This ideal can only be achieved through bilateral negotiations.

135. Terms of reference and overarching guidelines for the funder and practitioner bilateral negotiations should be established and published by the SSRH. Information sharing between parties will form part of these guidelines.

136. Bilateral contracts will be submitted to the SSRH and the CMS which will have the authority not to approve contracts which do not progressively incorporate, where appropriate, additional metrics such as risk, quality, and outcomes.

137. The submission of bilateral contracts to the SSRH will be confidential, to ensure that they include some element of risk transfer, value metrics related to quality and outcomes, and that they do not fall foul of competition law. The presentation of the contracts is necessitated by the fact that these contracts will be private to the contracting parties.

138. A data sharing framework should be devised by the SSRH to inform the process to be followed during bilateral negotiations to ensure that both parties are placed on an equal footing in terms of the information available. Information asymmetry should not be a source of competitive advantage but rather the use and technical analysis of the data should be the basis of any advantage.

Recommendations on funder / facility tariff negotiations

139. Both the facilities market and the funders' market are highly concentrated, enabling funders and facility groups to engage in bilateral negotiations. Given the existence of relatively competitive negotiations (compared to the complete lack of negotiations between funders and practitioners) we believe that the imposition of a multilateral negotiation forum for funders and facilities would not be the most appropriate recommendation. Where we have identified concerns in the funder / facility negotiations, these can be adequately dealt with through less interventionist measures.

870 This includes agreement on who the arbitrator is to be, how he or she will be appointed, or which organisation will appoint the arbitrator.

871 The parties involved in the arbitration have to bear the cost of the arbitration, an award as to who is liable for the costs will form part of the arbitrator's powers.

140. We recommend that the current bilateral negotiations between funders and facilities continue but that after a period of three years these negotiations should focus exclusively on ARM contracting. Any carve-outs, which stipulate when an ARM treatment reverts to an FFS model, should be well justified and criteria determined in advance.

141. To ensure a progressive movement towards ARMs, which include meaningful risk transfer, quality metrics, and competitive outcomes these bilateral arrangements must be submitted for review by funders to the CMS, and by facilities to the SSRH, which will have the authority to negate any bilateral arrangement not meeting these criteria.

142. We acknowledge that a failure to conclude bilateral negotiations, having bilateral arrangements invalidated by either the CMS or SSRH, or where members receive services from providers who are not part of their schemes' DSPs, e.g. in emergencies, or who do not live within reasonable distance from the nearest DSP, may result in an undesirable tariff vacuum. To address this potential vacuum, we recommend that all facilities and funders continue to establish scheme rates which can be relied upon should bilateral negotiations not materialise for whatever reason.

Preferred Provider Networks

143. We believe that provider networks generally bring competitive benefits to stakeholders which can be passed on to consumers but in some circumstances, they may have unintended anti-competitive effects. The exclusionary nature of networks can in some instances result in the exclusion of efficient competitors and raise the barriers to entry. This exclusion is a fundamental part of networks, but it also results in a reduction in patients' freedom of choice.

144. Therefore, in terms of practitioner networks, we make the following recommendations:

144.1. networks based purely on FFS considerations must be open to any willing practitioner;

144.2. practitioners should have the option to opt-in or opt-out of open networks provided they adhere to a predetermined notice period of between three and six months;

144.3. funders should be able to alter the network terms provided that they give a preferably similar notice period, with a shorter notice period allowed for annual tariff adjustments;

144.4. network participation terms must state how patients and provider payments will be managed during a transition wherein a patient undergoes treatment under a network practitioner who subsequently leaves the network before the patient has been discharged from his/her care;

144.5. selective contracting on network arrangements should be allowed only where networks include additional value-based metrics, and restrictive networks must be established through a transparent process and submitted to the SSRH for confirmation;

144.6. DSP arrangements and selection criteria must be transparent to patients and providers, and be made available to any service provider on request, and reasons for exclusion for unsuccessful bidders must also be made available; and

144.7. while closed networks must be re-initiated via a new process after three years, open networks, as outlined above, are unlikely to result in foreclosure concerns and, therefore, can be evergreen arrangements.

145. For facility networks, we recommend that:

145.1. only closed network must be established through a competitive and transparent process;

145.2. DSP arrangements and selection criteria must be transparent and available to any service provider, with the reasons for exclusion also made available;

145.3. these agreements should be lodged with the SSRH who will publish relevant, non-confidential, information; and

145.4. to prevent extended foreclosure of existing or potential practitioners, closed networks must be re-initiated via a new process after three years.

146. Facility and practitioner networks result in price certainty for the funder, provider, and consumer. No balance billing should be allowed on any network arrangements.

147. Further, funders will not be allowed to advertise or list providers as being "network providers" if fees are not fully covered by the benefit package.

148. The SSRH will have oversight of both the facility and practitioner arrangements. This will ensure that over time they progressively include more outcomes and value-based metrics while

ensuring no potential anti-competitive outcomes arise.

149. To encourage innovation, facilities and practitioners are encouraged to initiate their own networks with preferred, selected or all funders that are suitable to them. These networks must also be in line with competition considerations.

150. Our recommendations on network duration, the requirement for networks to be implemented through a transparent and competitive tender process, and the oversight role played by the SSRH with respect to network arrangements will lessen the potential for networks to result in anti-competitive outcomes.

Administrator Collective Negotiations on Behalf of Medical Schemes

151. Stakeholders have requested clarity on whether administrators are at risk of contravening the Competition Act should they engage in collective tariff negotiations on behalf of multiple schemes under administration. We understand that the lack of clarity on this issue has led to an uneven playing field amongst administrators. Those administrators which have elected to engage in collective negotiations on behalf of their client schemes are able to leverage greater size during negotiations vis-à-vis those administrators which have taken a more cautious approach.

152. While acknowledging that exceptions do exist, we believe that restricted schemes do not compete with other restricted schemes, that restricted schemes do not compete with open schemes, but that open schemes do compete with other open schemes.

153. Therefore, it is our view that administrators may collectively negotiate for multiple restricted schemes and, at most, a single open scheme.

Provider Payment Models and Coding Systems

154. FFS models of remuneration currently dominate the industry. Funders and patients bear the entire financial risk, which clearly is undesirable from a competition perspective and is not sustainable in the longer term.

155. We have found that ARMs have not been widely adopted and, that where adopted, the format was such that not much effect on utilization and the transfer of risks have occurred.[872]

156. It is important that the sector adopts alternative payment models that promote financial risk sharing and contain costs while preserving or increasing access to quality care.

157. Our position echoes that of the National Commission on Physician Payment Reform in the USA which, in 2013, stated, "Our nation cannot control runaway medical spending without fundamentally changing how physicians are paid". They found that FFS was inherently inefficient and generates 'problematic' financial incentives. Accordingly, it recommended a phased transition from 'price-only' FFS to reimbursement models that reward physicians and facilities for value and quality.

158. While we strongly support a transition from FFS to alternative reimbursement models, we are not in a position to prescribe how this should happen. There will always be a place for FFS, for example in trauma care. The Inquiry wishes to encourage a variety of alternative forms of practice and methods of payment and stakeholders to engage in effective ARMs with real risk-sharing and a commitment to providing better value for money.

159. However, we are also aware that merely urging providers and funders to implement ARMs is not enough. We have therefore made various recommendations to develop avenues that should encourage a move away from fee for service. These recommendations include: a change to scheme governance to align scheme interests more closely with members; schemes reporting on what they have done to promote value-based contracting, to address supply-induced demand and to contain non-healthcare expenditure; a review of the HPCSA ethical rules to allow for multidisciplinary practices and global fees; and the encouragement of geographically based new entrants into the market.

160. We have concluded that there is less of a tariff vacuum in terms of funder and facility negotiations and, therefore, recommend that the current bilateral negotiations continue. However, to push the market towards greater transparency and the greater adoption of ARMs, we recommend that these agreements should be submitted to the CMS and SSRH for approval. These regulatory bodies will have the responsibility to ensure that, after three years, all facility agreements focus exclusively on ARM contracting.

161. Given the number and complexity of practitioner tariffs, we recommend that the move towards ARMs be achieved within five years.

872 See: WTW Report on Analysis of Medical Schemes claims data – a focus on facilities, 15 December 2017.

Coding systems

162. We recommend that coding systems across the sector be standardised to facilitate the meaningful sharing of information. This is particularly important in relation to the monitoring of quality of care, provider payment, the maintenance of coding systems in line with evolving developments in medical care, the introduction of new technology, and to prevent unilateral manipulation of codes to adjust tariffs.

163. Coding systems are integral to the adoption of provider payment systems. They are essential to a well-functioning healthcare system, and potentially affect all stakeholders' financial and clinical interests, albeit in different ways. A coding system, therefore, is essentially a public good.

164. We recommend, therefore, that management of coding systems should be one of the SSRH's important, ongoing functions. The SSRH will co-ordinate the process by engaging stakeholders in executing its research function. Since this is a highly specialized area, the SSRH should have the mandate to outsource certain parts of its work to independent experts as necessary.

165. The SSRH should ensure that skilled professionals, including scholars, are engaged in code and RVU setting and review. To fast track code review and RVU setting, the SSRH should consider working with academic institutions with an appropriate mix of clinical, actuarial, and economic professionals in defining and reviewing codes and RVUs. Academic institutions, as centres of clinical teaching and research, are uniquely positioned to advise on complexity of procedures within and between consulting and surgical disciplines which is important for determining RVUs. The panel believes that as experts, academic institutions would be best placed to lay the foundation in "resetting" the RVUs without influence from active industry players. However, the SSRH, as a public institution, must remain accountable for the final output and integrity of the process.

166. The SSRH should be responsible for the adoption and standardization of actual alphanumeric codes, descriptors and relative value units. We recommend that requests for new codes or the modification of existing ones should be submitted to the SSRH coding unit for consideration and final determination. Rules for introducing new codes, or the modification of existing ones, should be the responsibility of the SSRH coding unit, and be developed by an interdisciplinary team in consultation with stakeholders and published.

167. Presently, the healthcare sector uses Current Procedural Terminology (CPT) codes. It is our understanding that SAMA is the custodian of these codes owing to its longstanding arrangement with the American Medical Association. SAMA has submitted that it should remain the custodian of the coding system. We do not agree that coding should be the exclusive property of only one group of stakeholders. Standardisation of coding systems, including DRGs, can promote competition and must be in the public domain. However, if the sector decides that the CPT system remains the preferred one, SAMA may need to be compensated fairly for its existing intellectual property rights. Our recommendation will ensure that the system is rational, that degree of complexity is standardised across disciplines, and is not subject to unilateral manipulation by any one party.

INTERIM MEASURE: HEALTH SERVICES PRICING

168. We are is cognisant that our proposals will take time to implement. However, in view of the urgency and importance of pricing recommendations in the private sector, we propose an interim measure for immediate implementation.

169. The interim measure will leverage the powers granted to the Minister to make regulations regarding the publishing of guideline tariffs[873]. Further, it will leverage the capacity and knowledge of the CMS of pricing behaviour and the use of existing regulations which enable the CMS to collect and disseminate information on prices, utilisation, and costs of health services.[874] [875]

170. We recommend the following interim measures to provide some level of certainty on practitioner tariffs.

873 See BHF and WHO submissions in response to the PFR, pp. 5 and 23 respectively.

874 See CMS response to the PFR, p.88 where they note relevant experience emanating from: *"…the technical work leading the publications of NHRPL, supporting HPCSA ethical tariff guideline processes, 2010 engagements around Pricing Determination Framework, our regulatory work around the guideline for contribution increases, cost assumptions analysis and an expenditure analysis on benefits paid by medical schemes as well as recent work on quality health outcomes."*

875 See CMS submission in response to the PFR, p.90, specifically the reference to the Medical Schemes Act no. 131 of 1998, Chapter 3, Section 7(e), and the Medical Scheme Amendment Bill, section 8a (1).

170.1. The Minister should regulate the CMS, as provided for in Section 90(1) of the National Health Act, to create and manage a negotiating environment for funders and practitioners which closely resembles the one recommended by the panel when the SSRH has been established, as outlined above. The CMS, in consultation with competition authorities and stakeholder representatives, is to set the terms of reference for the desired negotiation outcomes.

170.2. The framework for this interim measure will, as far as possible, be consistent with that of the proposed multilateral forum in which stakeholders will prepare individual proposals and present them simultaneously, and then negotiate FFS tariffs under the auspices of the CMS.

170.3. The anonymised underlying data used to prepare these proposals are to be provided in advance to participating parties ahead of time.

170.4. The CMS is to publish the outcome of the negotiations and highlight that the tariffs are guidelines and are not mandatory.[876]

170.5. There will be an independent arbitration mechanism to ensure buy-in of all stakeholders. This arbitration mechanism will be the same process that is outlined above and will carry over to the permanent multilateral negotiation forum. We do not anticipate that there will be many cases referred for arbitration at this stage, since the reference tariffs will only serve as guidelines.

170.6. Practitioners and funders should be free to continue to engage in bilateral tariff negotiations with outcomes being confidentially reported to the CMS.

171. The CMS will have no direct role in tariff determination between funders and facilities which will continue to be settled through bilateral negotiations.

172. However, facilities will still be required to maintain "scheme rates" or "base rates" that would apply in the unlikely event that there have not been any bilateral negotiations, for whatever reason.

173. We are firmly of the view that the CMS, a regulator for funders, should not be the permanent custodian of the negotiating forum as it may have a perceived bias towards the stakeholders which fund its operations. The CMS acknowledges that this responsibility should reside with an independent statutory pricing authority.[877]

Alternative Health Services Pricing

174. As already stated, we recommend the SSRH health services pricing unit as the most suitable independent entity to manage tariff determination. If the SSRH is not the preferred option, the panel proposes the following procedures.

174.1. The CMS should assume the role of the SSRH health services pricing unit and manage all the relevant functions:

174.1.1. overseeing the operations of the MLNF in determination of reference tariffs for practitioners;

174.1.2. receiving and keeping documented outcomes of bilateral negotiations, as well as provider networks between funders and practitioners, and funders and facilities;

174.1.3. overseeing referral of matters to the arbitrator when necessary and publishing finalised reference tariffs.

175. We believe that the CMS as under current legislation and its mandate would not be the ideal regulator to manage the pricing of services indefinitely. As a result, there will need to be an amendment to the CMS mandate to enable it to be a fair and properly resourced regulator of both the funding and delivery sides.

876 Under the existing legislation, and prior to the changes that will be made once the SSRH is constituted, only guideline tariffs for both PMBs and non-PMBs are currently legal. See Section 90(1)(v) of the NHA, *"…the process of determination and publication by the Director General of one or more reference price lists…"* (emphasis our own).

877 See CMS submission in response to the PFR p.87.

SUMMARY OF SUPPLY SIDE FRAMEWORK

Recommendation	HMI Preference	Alternative	Interim Solution (Year 2020)
1. Health Capacity Planning	**SSRH Licensing / PCNS Unit**	**NDoH and PDOHs to implement national framework**	**NDoH and PDOHs to implement national framework developed by Licensing Working Group (to be appointed immediately)**
Facility licensing For private hospitals	• PDOH to receive application and immediately transfer file to the Central SSRH system (automated) • Phase I assessment by SSRH Licensing Unit (and relevant PDOH) • SSRH issues temporary licence to applicant • Phase II assessment by PDOH Licensing Unit (and relevant PDOH) • SSRH issues permanent licence to applicant • When facility is complete, applicant notifies PDOH and SSRH refers application to OHSC • OHSC to inspect and certify facility • SSRH to verify licence and OHSC certificate to issue practice code number • Applicant to commence business in private and public sectors	• PDOH to receive application and immediately transfer file to the Central NDOH system (automated) • Phase I assessment by NDOH Licensing Unit (and relevant PDOH) • NDOH Unit issues temporary licence to applicant • Phase II assessment by NDOH Licensing Unit (and relevant PDOH) • NDOH Licensing Unit issues permanent licence to applicant • When facility is complete, applicant notifies PDOH and NDOH refers application to OHSC • OHSC to inspect and certify facility • CMS PCNS unit to verify licence and OHSC certificate to issue practice code number • Applicant to commence business in private and public sectors	• PDoH to receive application and immediately transfer file to the Central NDOH system (automated) • Phase I assessment by NDOH Licensing Unit (and relevant PDOH) • NDOH Unit issues temporary licence to applicant • Phase II assessment by NDOH Licensing Unit (and relevant PDOH) • NDOH Unit issues permanent licence to applicant • When facility is complete, applicant submits application for accreditation to the BHF • BHF and accreditation partner inspect facility • BHF PCNS unit verifies licence and own inspection report to issues practice code number • Applicant to commence business in private and public sectors
Public hospitals	• Not required to apply for licence • OHSC to inspect and certify completed facility • SSRH to verify OHSC certificate to issue Practice Code number to public hospital to commence business in private and public sectors	• Not required to apply for licence • OHSC to inspect and certify completed facility • CMS PCNS unit to verify OHSC certificate to issue Practice Code number to public hospital to commence business in private and public sectors	• Not required to apply for licence • OHSC to inspect and certify completed facility • BHF PCNS unit verifies OHSC certificate (with or without accreditation partner) to issue Practice Code number to public hospital to commence business in private sector
GP and other (high-risk procedure) facilities	• No licence requirement • OHSC to inspect and certify practice facility • SSRH PCNS Unit to verify OHSC certificate and issue practice code number to applicant • Applicant accredited to work in private and public sectors	• No licence requirement • OHSC to inspect and certify practice facility • CMS PCNS Unit to verify OHSC certificate and issue practice code number to applicant • Applicant accredited to work in private and public sectors	• Interim solution not required

Recommendation	HMI Preference	Alternative	Interim Solution (Year 2020)
2. Economic value assessments	**EVA unit of the SSRH**	**CMS under new mandate / Act to oversee funder and providers**	• **Interim solution not required**
3. National Health Information dataset / info	**Health Monitoring Unit of the SSRH**	**CMS under new mandate / Act to oversee funder and providers**	• **Interim solution not required**
	• Maintenance of national health information dataset • Coding research, consultation, approval and implementation • Policy research • OMRO collaboration	• Maintenance of national information dataset • Coding research, consultation, approval and implementation • Policy research • OMRO collaboration	
4. Health services Pricing	**Pricing Unit of the SSRH**	**CMS under new mandate / Act to oversee funders and providers**	**CMS to oversee tariff determination – for guideline RPL**
4.1 Practitioners	• Multilateral Negotiating Forum (MLNF) overseen by the SSRH • Bilateral negotiations, outcomes reported to SSRH • Arbitration	• CMS Supplier unit oversees MLNF exactly as per SSRH model • Bilateral negotiations, outcomes reported to CMS • Arbitration	• CMS oversees MLNF exactly as per SSRH model • Bilateral negotiations, outcomes reported to CMS • Arbitration
4.2 Facilities	• Bilateral negotiations, outcomes reported to SSRH • Maintain "scheme rates"	• Bilateral negotiations – outcomes reported to CMS • Maintain "scheme rates"	• Bilateral negotiations – outcomes reported to CMS • Maintain "scheme rates"
4.3 Provider networks for practitioners	• FFS networks: open, evergreen • Value-based contracts: Closed » Transparency » 3-year max	• FFS networks: open, evergreen • Value-based contracts: Closed » Transparency » 3-year max	• FFS networks: open, evergreen • Value-based contracts: Closed » Transparency » 3-year max
4.4 Provider Networks for facilities	• Closed networks » Transparency » 3-year max	• Closed networks » Transparency » 3-year max	• Closed networks » Transparency » 3-year max

Outcomes Measurement and Reporting

176. One of the key competition challenges which we have identified is the absence of reliable information on health outcomes in the private healthcare sector. Such information would allow patients to compare and to select care and providers. It would also improve the ability of healthcare funders to compare costs and quality on value for money when contracting with providers. Further, case mix adjusted outcome information would enable providers to peer review, compare and adjust clinical performance.

177. The lack of outcomes information seriously impairs competition, limits consumer's choice and prevents value-based contracting with funders. There is need for radical improvement in the availability of reliable, comparable and meaningful information on healthcare outcomes, in both the private and public healthcare sectors to assist the successful implementation of NHI and to place the country in line with international developments.

178. There are several key requirements for putting in place a reliable outcomes measurement system. These requirements include defining the quality of outcomes indicators, collecting standardised data through a central IT-platform, auditing the data, performing necessary risk-adjustment of the data, measuring how treatments improved patient health, disseminating the results to providers, and ultimately to the general public and the funding sector. Fortunately, the process does not have to start from scratch as there are international exemplars to inform this process.

179. We recommend that the primary objective, in the initial period, should be to build the capacity to measure and report on patient-centred outcome indicators. Other facets of quality such as structure, process, and patient experience indicators, can be combined or added if deemed necessary.

180. A nationwide system of measuring and reporting patient-centred outcomes information will address our main findings that:

180.1. there is no information available to the public to select practitioners and facilities on the basis of past results, to judge the appropriateness of treatments, and to compare the quality of providers that funders contract;

180.2. funders lack sufficient outcome information to contract with providers on the basis of value for money;

180.3. the individual provider model of care results in fragmented knowledge about the health status of a patient making health outcomes difficult to ascertain;

180.4. GPs lack the information to assist clients and patients to select the best possible treatment in terms of costs and expected outcomes; and

180.5. the NHI and OHSC, who carry a nationwide responsibility for the quality of care provided, also generally lack basic information on outcomes of care – both public and private.

181. Implementing a national system of outcome measurement cannot take a top-down approach but requires the broad and active participation of the entire clinical community. International experience has shown that the engagement of clinicians and patient representative groups are critical success factors in developing useful and effective outcome registries.

182. The participation of patients and their representatives is paramount to ensure that the system reports on metrics that matter for patients and that improve patients' health outcomes and the value for money that beneficiaries receive from their health insurance.

183. We recommend that the outcomes measurement reporting system should be implemented in a two staged process.

184. The first phase should be one in which participation by practitioners and facilities is voluntary, and in which a coordinating platform is set up to assist doctors, registries and facilities to analyse and exchange health outcome information. This platform will require the establishment of a new and independent, not-for-profit collaborative Outcome Measurement and Reporting Organisation (OMRO). Through OMRO, practitioners and facilities will gain access to robust comparative outcome information which will allow them to understand differences in outcomes and improve clinical processes. OMRO will collaborate with existing condition-specific registries and stimulate new initiatives. This first phase should be completed within 2 – 3 years from the publication of our final recommendations. The active participation of doctors and facilities will be critical. OMRO should define national standards and could draw upon existing registries and freely available and tested indicators (such as ICHOM's). Funders, patients' representative organisations and representatives of the medical science community must also be encouraged to participate in this first voluntary phase.

185. Several "hosts" or "custodians" for this first phase have been discussed with stakeholders. It has become clear that the most appropriate organisations for taking this initiative forward are the Healthcare Quality Assessment (HQA) organisation that has been operational in South Africa for more than 10 years, in combination with the IT and information exchange platform, CareConnect, that is currently in the process of being developed. Providers and funders should take responsibility for financing this first phase of voluntary participation. Initiatives for co-funding formulas developed in the Netherlands and Scandinavia may serve as a model.

186. We propose that the data collected in the first phase should be released only to participating providers in individual feedback cycles aimed at improving the outcomes measurement and reporting system. Results and experiences from this first phase should then be used to assist the development of the second phase of the OMRO in the second phase.

187. The second phase, will involve mandatory registration and reporting, based on the legal powers of the statutory SSRH organisation and its mandate. The National Department of Health, in consultation with relevant stakeholders, should take the lead in drafting the enabling legislation for the registration and reporting of relevant data to the OMRO. As a private organisation, the OMRO will depend on the enforcement powers of the SSRH. The NDoH, in collaboration with the industry should aim for the OMRO to be fully functional within 3 - 4 years of the conclusion of this inquiry.

188. During the second phase, Government's involvement will be critical, in finding a sustainable funding mechanism for the OMRO, and in establishing the legal mandate for the SSRH to support the OMRO. Information collected in the second phase must serve to empower the consumer to choose the provider, treatment, scheme and plan. Through this empowerment of the consumer, competition between providers and funders will be enhanced.

189. During our engagements with stakeholders, it became clear that the OMRO is supported by all participating stakeholders in the Inquiry. However, it was also made very clear that support for the OMRO will depend upon its trustworthiness, credibility and independence. It must be strictly operationally independent from government and from the private sector for it to have credibility amongst providers, patients and funders. The majority of respondents indicated a preference for a new and dedicated organisation, rather than relying on one of the existing quasi-governmental organisation or regulators.

190. The OMRO, as a private organisation, should have board members reflecting the interests of doctors, patients, facilities and funders, and may comprise representatives of government, higher education and regulating institutions. It is emphasized that the OMRO itself will not be a regulator.; it must be organisationally separate from government, private or public providers and regulatory institutions.

191. The preferred funding model for the OMRO is a hybrid one with levies from schemes, complemented by contributions from providers, from government and from voluntary funding. The exact mechanics of how the funding model would work should be determined by the stakeholders, in consultation with the DoH and the National Treasury. What is essential is that the funding model should guarantee organisational independence and continuity of resources.

Recommendations to address over-servicing and SID

192. We have identified over-servicing and SID as a feature in the private facilities market that may undermine competition, and consequently harm consumers. We, therefore, recommend to the CMS to include metrics of SID in its published reports. The CMS need not conduct the analysis themselves but must publish information on what schemes/administrators are doing to cut back on supply induced demand.

193. To facilitate effective management of SID, and to improve the availability of data more generally, we recommend the continued collection of anonymised data as produced for the Inquiry. The CMS must, in collaboration with stakeholders, define the format in which data should be submitted but the experience gained through the HMI process should not be lost and data similar enough to that already collated should be collected on an annual basis so that research undertaken by the CMS can assess the impact of our recommendations on SID and over-utilisation. These data should be stored by the data repository described in the section ***National Health Information Dataset – Data requirements for oversight of the healthcare market*** above. The CMS must also specify penalties for non-compliance and rules for the secure storage and access to the data.

Recommendations to increase synergies between public and private facilities

194. We have found that there are a number of local markets where limited public sector capacity can be augmented by existing private bed capacity. We recommend that strategic purchasing of available private capacity to supplement capacity in the public sector need not wait for the NHI. Government could, and should, contract with the private sector where it needs capacity.

195. We, nevertheless, recognise systemic implementation problems in strategic purchasing of healthcare services have arisen internationally[878], and that such problems could arise as a result of the market power that currently exists in hospital sector and some practitioner markets.

196. Sufficient technical and procurement expertise, and a corresponding regulatory framework to govern the procurement process, will, therefore, be critical to the effectiveness of strategic purchasing.

197. We, therefore, recommend that a strict set of regulations be established by the National Treasury and the national Department of Health, to encompass mechanisms of risk sharing, accountability, monitoring and transparency.

878 Strategic Purchasing in Practice: Comparing Ten European Countries _Katarzyna Klasaa, Scott L. Greera, Ewout van Ginneken (2018). Health Policy 122 (2018) 457–472.

Supply Side Recommendations Specific to Practitioners

Functioning of practitioner associations

198. We found that practitioner associations are at risk of anticompetitive behaviour. We have set out detailed guidelines in the PFR.[879]

199. Associations are required to separate their academic functions from their business functions. Each entity must be registered appropriately so that they have a legal identity with formal founding documents, constitutions, terms of reference and memoranda of incorporation, which will determine the body whose laws, regulations and rules by which each entity should abide. For example, a private company will be registered as for profit or non-profit with the CIPC and be subject to the Companies Act with all the attendant requirements by which the organisation must abide. The same would apply to those that are registered as voluntary associations.

200. This approach would enable professional associations (e.g. Ophthalmological or Orthopaedic Society) to provide "academic support" with a clear mandate to promote ethical, high quality practice to practitioners in the private and public sectors. [880]

201. "Business support" must be provided through appropriately registered entities that would be best placed to provide services in line with their legal identity (e.g. Pty Ltd with directors and shareholders as appropriate). [881] [882]

202. It is beyond the scope of the Inquiry to determine the legal form that these organisations should assume, but practitioner associations must review the legal form of their associations to avoid contravention of the competition and other relevant laws when engaging in procurement, tariff negotiations, network development, and other activities on behalf of their stakeholders.

203. We differentiate professional and/or voluntary associations from single or multidisciplinary group practices which are legal entities of another type (e.g. incorporated partnerships or private companies) and which, when pooling and redistributing income among partners, are legally able to coordinate their actions.

204. We recommend that the Competition Commission, through its advocacy arm, issue clear guidance for practitioner associations on what kind of activities are, and are not, acceptable from a competition point of view.

Review of Ethical Rules of the Health Professions Council of South Africa

205. Changes to HPCSA ethical rules is required to promote innovation in models of care to allow for multidisciplinary group practices and alternative care models so that fee-for-service ceases to be the dominant payment mechanism. We have had significant correspondence and consultation with the HPCSA and details of the most pro-competitive possible approach to existing ethical rules are provided in detail in ***Chapter 6: Competition Analysis For Practitioners.***

The medical curriculum and the Health Professions Council of South Africa

206. We propose that it should become mandatory that curriculums for all health practitioners at both undergraduate and postgraduate level include training to ensure graduates are aware of the cost implications of their decisions, able to assess and to use HTA findings and best practice guidelines; and aware of how health system financing models impact on individual health decisions and ethics.

Recommendations Already Described and How they Pertain to Practitioners

207. We have put forward our interrelated recommendations to achieve systemic change to improve the context within which practitioners operate, and to create a shift towards a more competitive environment. We set out, in brief, below the recommendations as they affect practitioners and refer to the relevant sections of the report.

Pricing

208. A multi-lateral negotiating forum under the

879 See PFR, 5 July 2018, Annexure 7, p 364

880 Such academically oriented groupings may play a role in activities recommended by the HMI such as OMRO, HTA, development of medicines formularies, practice guidelines/treatment protocols and ensuring uniformity of clinical practice between practitioners in private and public sectors.

881 These entities may be involved in the proposed SSRH only as far as determining the codes, descriptors and relative value units.

882 The extent to which this type of organisation is resourced to do its work internally or on an outsource basis to a third party (e.g. Healthman) would be up to its governing and executive structures. How such entities are allowed to operate would depend largely on the legal form that they assume on formal registration.

auspices of a supply-side regulator will set maximum price for PMBs and reference prices for non-PMBs.[883]

Practice Code Numbering System and Practitioners' facility certification

209. To document the human resources of health professionals operating in the private health sector, the SSRH will maintain an "intelligent" health professional' numbering system. Data will be collected on current working addresses, areas of speciality, full/part-time status, and concurrent employment in the public sector. This single national practice number will be required in order to bill for services rendered to patients. It will be renewed annually at which point updated information must be provided. Practice codes will be withheld if practitioners do not update their personal information. See the section Role of the Provincial Departments of Health in Monitoring and Reporting in this chapter

210. To ensure quality and safety, private sector premises from which practitioners operate will require an OHSC certificate which will be implemented as soon as the OHSC possesses the functional capability. An up-to-date certificate will have to be displayed in all premises from which practitioners operate.

211. Coding of products (medicines and devices), diagnoses (ICD / ICPC), procedures (CPT, etc.) and DRGs.

212. Coding and setting of RVUs for the entire health sector will be undertaken by a dedicated unit within the SSRH to ensure that the system is rational, and, for example, the degree of complexity is standardised across disciplines. The coding unit in the SSRH will ensure that the right mix of skilled professionals are engaged in code and RVU setting and review. See the section ***Provider Payment Models and Coding Systems*** in this chapter.

213. Practice numbering and coding systems will be uniform, national, and publicly owned. If and where current proprietary systems are chosen, fair financial compensation arrangements will be ensured.

Outcomes reporting

214. Practitioners and their patients will be invited to report on health outcomes. This process will be practitioner led and voluntary in first instance. It will develop incrementally with new outcomes being reportable as the system develops. Once tested, reliable and established, reporting on selected health outcomes will become mandatory. See the section ***Coding systems*** in this chapter. We recommend that reporting by practitioners of both practitioner information and patient outcomes should be linked to the issuing of Practice Code Numbers.

215. The linking of reporting requirements to the issuing of practice numbers is deliberate. Because PCNS numbers are required for billing purposes, an incentive is created for practitioners to comply. With immediate effect, keeping working addresses, areas of speciality up to date will be required for the issuing and annual renewal of the practice code numbers. Practitioners will be encouraged to participate actively in outcomes reporting. In the second phase of the OMRO, it will be mandatory to report on relevant outcomes. Renewal of practice numbers will be withheld if health professionals do not provide outcomes information[884]. The overall purpose of this system is to promote quality care and to build a data base of healthcare practitioners and primary care facilities.

Health technology assessment

216. Guidelines on the effectiveness and cost effectiveness of healthcare interventions will assist both practitioners and patients in decision making. See the section ***Interim Solution for Facility Licensing and Practice Code Numbering*** in this chapter.

Recommendations to the Competition Authorities

217. We recommend a stricter approach to "creeping mergers" in the facility sector, and hence that amendments to the Competition Act and the prescribed guidelines. We believe that there is scope for the authorities to use public interest provisions to enable a broader approach to assess competition dynamics in healthcare markets.

218. The authorities should develop guidelines for information sharing in healthcare markets which will enable collective bargaining and for co-operation amongst competitors and information sharing for publishing and measurement of health outcomes. In particular, we have proposed specific guidelines for practitioner associations to avoid risk of potentially anticompetitive behaviour. The various functions of the SSRH

883 See paragraphs 118 - 132 in this chapter.
884 Note the requirement is to report only. It is not dependent on the actual rating received.

such the forum to establish reference pricing and set prices for what is currently known as PMBs, will provide certainty and guidance and will obviate the need for associations to perform some of their current functions which we judge to be anticompetitive.

219. The competition authorities should through their advocacy arm set out clear guidance for practitioner associations on what kind of activities are, and are not, acceptable from a competition point of view.

220. We have collected an anonymised large data set (545GB) which contains healthcare transactional data and is probably the most comprehensive likely the most comprehensive data set ever assembled for the private healthcare industry. Significant time and public resources were invested in creating this data set. While much work has been undertaken using these data, there is still more that can be done. Using these data to their maximum would represent a very good return on investment and will allow more in-depth work yielding new knowledge. We believe that it is in the public interest to allow interested parties access to this data set solely for academic research. We, therefore, recommend that our dataset should be made available for research and academic purposes. Further, this data set could form the basis for developing the National Health Information Dataset recommended in the section ***National Health Information Dataset – Data requirements for oversight of the healthcare market*** above.

221. Lastly, some of the conditions placed on the NHN Exemption are onerous and may hamper their ability to compete with the larger groups who do not face similar conditions. The Commission has imposed a condition requiring NHN members who do not meet the legislative criteria to be classified as either small businesses (SMME) or firms owned by historically disadvantaged persons (HDP) and to transform their ownership structures within a period of 24 months in order to meet the legislative criteria as stipulated for firms owned or controlled by historically disadvantaged persons. Whilst we appreciate the Commission's efforts to ensure that the NHN complies with the legislative criteria, the current environment where the NHN is still struggling to make strides to compete with the large firms in a highly concentrated market, leads us to recommend that the Competition Commission reconsider these conditions and propose less restrictive conditions.

RECOMMENDATIONS FOR FUNDERS

Standardised Benefit Package

222. We strongly believe that the introduction of a single, stand-alone, comprehensive standardised, obligatory base benefit package will increase transparency, allow consumers readily to compare options, and, along with a risk-adjustment mechanism, foster a greater degree of competition on metrics such as innovation and quality care.

223. To achieve these goals, we recommend:

223.1. one standardised benefit package that must be offered by all schemes (the obligatory 'base benefit option');

223.2. every person joining a scheme must purchase the base option;

223.3. the base option should cover catastrophic expenditure as well as some level of out-of-hospital and primary care;

223.4. schemes can offer supplementary benefit packages, but these can only be sold to those who have bought the base benefit option;

223.5. risk rating will be allowed on supplementary benefit packages (SBPs) provided that base cover is comprehensive;[885]

223.6. supplementary benefit packages should be easily comparable across schemes, conforming to rules set by the CMS as the appropriate regulatory body.

224. A standardised, identical base package, for everyone with private healthcare insurance will greatly enhance transparency in the market and will contribute to a highly needed empowerment of the beneficiaries of healthcare coverage.

225. The CMS will determine which services are to be included in the comprehensive package. The benefits should be designed in such a manner that they create an unavoidable liability for schemes, forcing schemes to compete on managing costs and achieving efficiencies.

226. The comprehensive, standardised, obligatory base benefit package will cover catastrophic expenditure and must include provisions for primary and preventative care as well as in-hospital and out-of-hospital care. Also, a specific list of items (medicines and devices) that must always be covered where there is an appropriate

885 This caution is required as the base cover is yet to be defined.

diagnosis must be included. A list of diseases together with appropriate treatments must be provided.

227. A negative list of those conditions not covered by the package must be provided.

228. Where the treatment of conditions is prescribed, these will be considered the minimum requirements schemes must provide to members, thereby creating scope for schemes to compete to offer better quality treatment. However, where schemes seek to expand coverage of conditions not covered by the base benefit option, this must be achieved through supplementary packages to avoid a situation where multiple schemes expand coverage on the base option to varying degrees and the market once again becomes incomparable.

229. The base benefit package must be reviewed by the CMS every two years. This will ensure that additional conditions and treatments are slowly added, and coverage is uniformly expanded as and when efficiency makes additional care affordable and as technology advances.

230. The introduction of the base package must be accompanied by a system of risk adjustment (see below) which will remove schemes' incentives to compete on risk factors such as age and will instead encourage schemes to compete on value for money and innovative models of care.

231. Schemes will be able to offer an unlimited number of risk-rated supplementary benefit packages (SBPs).[886] These packages can expand coverage for care not included in the base package. Risk rating will be allowed on SBPs provided that the base cover is comprehensive.[887]

232. SBPs can be customised geographically to allow schemes to compete locally, for example, where a regional disease burden may be significantly different to the national average, or where a unique opportunity exists to trial an innovative ARM before a national roll-out.

233. We recommend that the CMS develop a standardised framework for how funders may present SBPs to improve transparency and to assist consumers in comparing products, coverage, and value.

234. In addition to regional SBPs, we also recommend that the entry of geographically based medical schemes offering the base benefit package should be allowed. Such new entrants could take into account variations in population, disease burden, and delivery of care models. These schemes could potentially offer the standardised base package based on alternative reimbursement contracts with local providers to specifically address their unique demographic and risk profiles. Smaller, niche schemes should be agile and innovative, driving competition at the local level.

235. Regionally based entrants would initially only have a few members exposing the scheme to demographic and claims risk. To limit for these risks, we propose temporary reinsurance for new medical schemes along with the implementation of the RAM.

236. We support the demarcation regulations that came into effect on 1 April 2017 together with the amendment of the definition of a medical scheme business. The Demarcation Regulations allow insurers to continue to provide gap cover and hospital cash plans ('HCPs'), subject to strict underwriting and marketing conditions. The Regulations contain important provisions relating to risk-rating, risk adjustment based on claims experience, waiting periods and open enrolment. For example, an insurer cannot refuse to enter into a contract with a policyholder, unless the policyholder has committed an act of fraud.[888] The intention was to embed a requirement similar to the open enrolment principle contained in the MSA.[889] The relevant product lines must be underwritten on a group basis and there may not be discrimination between policyholders.[890] Our view is that the comprehensive standardised, obligatory base benefit package, along with supplementary cover, will remove the need for gap cover.

Review of Prescribed Minimum Benefits

237. The introduction of a single, stand-alone, standardised, obligatory "base" benefit package will replace the current Prescribed Minimum Benefits but will retain the same philosophy, that these are the minimum conditions/services that must be covered and paid for in full by medical schemes.

886 The standardised benefit option along with supplementary cover will remove the need for gap cover
887 This caution is required as the base cover is yet to be defined.
888 Regulation 7.3(3).
889 See https://www.fsb.co.za/NewsLibrary/2017%2005%2018%20DEMARCATION%20REGULATIONS%20FAQ%20v2.pdf accessed on 4 May 2018.
890 Regulation 7.3 (2)-(4).

238. The services covered by this package must be revised to make provision for out-of-hospital treatment and cost-effective care determined by best-practice treatment guidelines. By providing for out-of-hospital care, the base benefit package will remove the current incentive to admit patients to hospital, often at higher cost.

239. In addition to expanding the comprehensive package to include primary and preventative care, the base benefit option must include care coordination in the form of primary care provider and primary care provider-to-specialist referral.

240. The services provided for in the base package will be expanded as cost savings allow for greater depth and breadth of care.

241. As already provided for in PMB legislation, this base benefit package must be reviewed and updated at least every 2 years.

242. We believe that a simpler, less ambiguous design of the benefit package will help members to understand their cover. Replacing the PMB regulations with the base benefit package will obviate the requirement for schemes to provide additional PMB information to consumers.

243. We recommend that treatment plans and formularies (Health Economic Value Assessments) should be developed for all services covered by the base benefit option. There are several international examples on which the CMS can draw to develop these protocols as well as engaging with local universities.

Medical Scheme Governance

244. To improve governance and to align schemes' interests with those of consumers, we propose that the remuneration packages of executives, principal officers and trustees be linked more explicitly to the performance of schemes.

245. The CMS' proposed remuneration framework that seeks to cap trustees and principal officer remuneration, and align remuneration with performance, should be implemented. The remuneration framework should take into account indicators of improvements in the scheme's performance which must be linked to the performance of individual trustees.

246. These guidelines should take into account the long-term performance of the schemes to prevent trustees from taking decisions that show immediate benefits, but potentially cause long-term harm.

247. To foster a greater degree of competition amongst administrators, various performance metrics such as non-healthcare costs, the value of PPNs, DSPs, and ARMs, claims payment ratios and proportion of comprehensive standardised, obligatory base benefit package from risk versus those paid from savings, are to be published annually so that each administrator can be compared to a national average. These metrics must be comparable and will provide scheme trustees with an indication of administrator performance. The determination of appropriate metrics and the publication of relative performance results should be the responsibility of the CMS.

248. We believe that by recording and openly comparing performance metrics, administrators will have an incentive to act in the best interest of consumers and scheme trustees will be able to assess value for money to the scheme and change administrators where necessary.

249. We acknowledge that reporting by administrators / MCOs and the CMS should be done in such a way that it does not hamper competition by revealing commercially sensitive information or information which may facilitate collusion. Here, the CMS' non-healthcare expenditure project will assist in determining a standardized comparator for non-healthcare expenses across schemes.

250. Schemes must encourage greater member participation in Annual General Meetings (AGM). The following steps are recommended:

250.1. members must be notified of the scheme AGM in a timely manner and the AGM must be held at a time convenient for members (e.g. after office hours or on weekends);

250.2. AGMs make use of technology to facilitate participation of members who are not able to join in person; and

250.3. the CMS review its criteria for the election of trustees such that sufficient time and appropriate information is available to members to consider and choose trustees, and, that electronic elections of trustees becomes possible to avoid abuse of proxy votes. Elections of trustees must be conducted over an extended period and completed and audited prior to the confirmation of the election results at the AGM.

251. We note the contradiction in our recommendation regarding AGMs and the MSAB (Chapter 11A Governance). However, we believe that a review of the election process to encourage and facilitate greater participation and transparency

in the election of trustees is in the best interests of members and schemes. Mandatory elections for trustees at the AGM, as proposed by the MSAB, will entrench the inefficiencies of the current system.

252. The CMS's contact number must be included on the medical scheme card, to allow members to have direct access to the CMS.

253. We recommend regulating and mandating a set of core competencies for trustees and principal officers before they can be eligible to manage a scheme. This process is similar to that being proposed within the pension fund industry and similar reasoning can be applied across both industries.

254. In order to close the governance gap and ensure that trustees do not abdicate their responsibilities, we recommend recognizing the reality that administrators, just like trustees, occupy a relationship of trust vis-a-vis medical scheme members and that, therefore, administrators' fiduciary responsibility to consumers should be clearly spelt out.

255. We suggest the following wording to be included in the MSA:

255.1 "*where a board has appointed an administrator, the administrator shall have a fiduciary responsibility towards the medical scheme and its members";* and

255.2 "*any administrator, who contravenes this Act, for which no penalty has been prescribed, shall be liable to administrative financial penalty to be imposed by the Registrar".*

256. As administrators already claim to be behaving as if they have a fiduciary duty imposed on them through service level agreements with schemes, this recommendation should not result in any significant additional costs. However, it will provide trustees with an additional tool to enforce good governance and will open the door for members to hold administrators directly to account. Patients will have the option to approach the CMS for any perceived breach of these duties, a much more affordable option than the rather costly litigation process.

Brokers

257. Brokers play an important role in advising members but their interests should be aligned more closely to those of applicants/members. We, therefore, recommend that the broker system become an active opt-in system.

258. Members will be required, on an annual basis, to declare if they wish to use the services of a broker. For those that do, the scheme will facilitate the payment to the broker. Members who chose not to use the services of a broker will pay proportionally lower scheme membership fees.

259. The scheme/administrator and CMS should notify all members annually of the services that brokers provide and that they can opt out of the system.

260. Medical schemes must report broker fees separately to the CMS from distribution and other marketing fees, and the CMS should publish broker fees separately in its annual report.

261. We have previously considered several further recommendations to address concerns in the broker market. However, following a review of submissions, these recommendations were considered superfluous to the active opt-in recommendation.

Risk Adjustment Mechanism and Income Cross-subsidisation

262. Alongside the standardisation of benefits, a risk adjustment mechanism (RAM) must be implemented. A RAM will make financial adjustments across schemes to mitigate the risk-profile related effects on scheme costs. This will remove the current incentive for schemes to compete on low level competitive factors such as attracting a younger population.

263. Risk adjustment would be of little use if it were not applied to a standard basket of benefits. In the absence of a standard package, it would be impossible to measure the risk across schemes fairly. Therefore, we propose that a risk adjustment mechanism be implemented for the base benefit package to be offered by all schemes.

264. We recommend that the proposed RAM be initially facilitated by the CMS but will migrate to a separate authority established with full independence from the executive to avoid a conflict of interest with the CMS' regulatory role.

265. The RAM would require schemes to pay money into a risk adjustment fund on the basis of their respective risk. Low-risk schemes would pay money into the risk adjustment fund while high-risk schemes would receive risk adjustment subsidies from the fund.

266. Based on previous work undertaken during the shadow Risk Equalisation Fund process, it was

determined that approximately 80% of variation in risk can be attributed to age and gender factors alone. As age is correlated to income, the implementation of a RAM would mean healthy, younger, low-income individuals would be subsidising higher-income groups. This is an outcome which goes against the social solidarity principles of health insurance. To avoid this outcome, the low-to-high income subsidisation effect of RAM needs to be mitigated as far as possible by an offsetting income related cross-subsidization.

267. To address the needs of low-income scheme members, it is recommended that the current tax credit regime be reconstituted to take the form of a contribution subsidy. It is crucial to integrate both risk and income adjusted subsidy. Countries adopt different models of administering both risk and income adjusted subsidy. In some countries tax authorities administer the income subsidy and the risk adjusted contributions are administered by an institution responsible for the risk adjustment fund. In other countries both risk and income adjusted subsidy are integrated. We recommend that the CMS determine an appropriate and feasible model for the South African context. For the RAM to operate efficiently, the following measures must be in place:

267.1. all medical schemes, both open and restricted, must, by law, be required to belong to the RAM;

267.2. legislation will need to be changed to allow the administrator of the RAM to develop a database of all insured beneficiaries and the relevant demographic information to determine the prospective risk status of each beneficiary;

267.3. similar information on members' income needs to be obtained, stored securely, and subject to suitable confidentiality provisions;

267.4. a set of mandatory minimum benefits that all insurers must offer (the "base package) must be defined and implemented;

267.5. the administrator of the RAM (the CMS at the initial stage) must establish technical capability to provide within-financial-year financial transfers between schemes and the central fund based on the extent to which schemes' inherent risk profile vary from the average for the industry,

267.6. the technical capability to provide income cross-subsidisation to off-set the inherent low-to-high income substitution of the risk-adjustment must be established; and

267.7. the administrator of the RAM must have legislated structural independence from any party with a commercial interest in the risk adjustment outcomes which may include other regulators, national government, medical schemes and related parties, and healthcare providers.

268. One of the first and key tasks of the administrator of RAM will be to develop relationships and memorandums of agreement with key stakeholders such as SARS, the Treasury, the National Department of Health, administrators and medical schemes, and the financial sector.

Anti-Selection Measures

269. To address anti-selection, we recommend that the CMS reviews the existing tools available to funders, namely waiting periods and late joiner fees, with a view of strengthening them.

270. We affirm that non-risk benefits (such as medical savings accounts) should not attract any waiting periods as schemes do not bear any risk for any claims paid from non-risk benefits.

271. In principle, we agree that mandatory membership will address anti-selection. However, before mandatory cover is introduced, the industry needs to show clear indications of closer alignment to consumer interests and better cost containment, which must be expressed in three conditions:

271.1. inflation corrected contributions stabilise or decrease;

271.2. more than 50% of beneficiaries are covered by plans which make use of preferred provider networks and these contracts must include performance-based remuneration; and

271.3. the OMRO is operational and more than 25% of hospital outcomes are measurable and available to the public and to schemes.

272. We recommend that mandatory scheme membership, when introduced, should start with the highest income bands and progressively include additional income groups as more of our recommendations are successfully implemented and the cost of joining a scheme decreases.

273. This approach has several attractive features. The highest income bands will be most able to afford the increased monthly expenditure. Assuming these members are of average health, their

inclusion should improve the overall risk pool and help to reduce premiums and make scheme membership more attractive to lower income bands.

274. The inclusion of successive income bands should be contingent on stakeholders implementing our recommendations. This will provide an incentive for stakeholders to remove the market inefficiencies that we have identified. Through these actions medical cover should become more affordable and will result in members voluntarily entering the scheme market and the phased implementation of mandatory membership will impact fewer individuals.

Annexures

ANNEXURE 4.1:

Strategic and Effective Purchasing by the Public Sector

Overview

1. We have assessed the distribution of health facilities and hospital beds in various provinces in the section ***Distribution of facilities and hospital beds.*** Facilities are also subject to the regulatory authority of the Office of Health Standards Compliance (OHSC) which was created by the National Health Amendment Act of 2013 and the Competition Act insofar as it relates to competition issues, i.e. merger transactions, enforcement and exemption investigations and market inquiries. The facilities market is indirectly governed by the regulatory authority of the Health Professions Council of South Africa (HPCSA), which is mandated to oversee the conduct of healthcare practitioners and their relationships with hospitals. In our assessment we identified indications of overcapacity in the private healthcare sector. We have received several submissions that in KwaZulu Natal and in some other provinces, medical schemes and administrators have experienced an oversupply of hospital beds. Some of the funders have taken active steps to manage increasing capacity and excessive utilisation locally and are reluctant to reimburse new or intended new facilities in these markets.

2. We believe that overcapacity in the private facilities market can be used strategically by the public sector through strategic purchasing and contracting. The UK NHS serves as an example where the NHS has contracted with the private sector for maternity and neonatal services through a competitive bidding process.[891] Strategic purchasing is designed to improve the performance of the health system and promote progress towards universal health coverage. It is consistent with NHI and it may also help to reduce overcapacity in certain provinces.

3. We observe that the failure by the public sector to contract with the private sector might largely be due to budgetary constraints. Over the years, the national government has not allocated budget to enable purchasing and contracting with the private sector. If the public sector effectively contracts with the private sector to purchase available capacity, it could stimulate competition in the private sector and also improve healthcare access. This recommendation is aligned to the national health insurance (NHI) plan which is modelled around strategic purchasing. Using the NHI Fund, NHI will also contract with certified and accredited private providers at higher levels of care based on need.[892]

4. Stakeholders, including the hospital groups and funders, overall support the recommendation of strategic purchasing of excess capacity from

891 NDoH (2017). Safer Maternity Care: The National Maternity Safety Strategy - Progress and Next Steps. Accessed from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/662969/Safer_maternity_care_-_progress_and_next steps.pdf

892 NDoH (2017) White Paper on National Health Insurance for South Africa. Accessed from http://www.health.gov.za/index.php/nhi?download=2257:white-paper-nhi-2017 on 25 June 2019.

the private sector.[893] [894] [895] [896] [897] [898] [899] [900] [901] For instance, Discovery Health, argues that there is an opportunity to expand immediate access to cover this, alleviating pressure on the public health system.[902] LHC argues that facilitating collaboration between the ailing public sector and the private sector, in order to address the lack of access to healthcare services in the public sector is an appropriate intervention. SAMA argues that to improve efficiencies and access to healthcare, it is imperative that national government utilises excess capacity and under-utilised private sector beds, through universal coverage policies.[903] The Health Funders Association (HFA) believes that this recommendation is a component of the NHI policy and that there will be further benefits if ARMs are encouraged to adopt this model.[904]

5. We also find that internationally, the strategic purchasing of healthcare services is recommended by the World Health Organization and the World Bank.[905] [906] [907] Further, several countries have increased efforts to use various forms of strategic purchasing to achieve universal health coverage.[908]

6. International evidence suggests that there are, nevertheless, systemic problems in implementing strategic purchasing of healthcare services.[909] The process is often complex, with no guaranteed win-win solution for both the purchaser and the providers and requires experience and technical ability by the purchaser to negotiate and contract effectively. It may ultimately drain state resources if not managed correctly.

7. To enable effective strategic purchasing, purchasers must adopt an active role and incorporate issues such as population needs, quality, evidence, efficiency, and a concern for equity and population health.[910] We also find in the international literature that effective and accountable purchasers and providers are integral to strategic purchasing. Other key components of an effective strategic purchasing system include strong governmental stewardship and the capacity to monitor and audit contracted stakeholders.[911] The regulation and monitoring of purchasers and providers is considered critical but the process is considered difficult to enact. The international evidence demonstrates that only a few countries with strong regulatory frameworks have been able to achieve the defined monitoring mechanisms.[912] [913] [914] [915] [916] [917]

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893 HMI Seminar Transcript dated 10th April, session 2, p.6.
894 Discovery Health post-seminar submission to the HMI, 26 April 2019.
895 Mediclinic Seminar Presentation by Econex, 12 April 2019.
896 Mediclinic Submission in response to the PFR,15 October 2018, para 8.1.1.
897 LHC Post-seminar Submission to the Health Market Inquiry Seminars (9-12 April 2019), 26 April 2019, pp. 30-31.
898 CMS Submission in response to the PFR titled CMS Position Document on Competition and Regulatory Issues within the South African Private Healthcare Industry, 7 September 2018.
899 HFA Submission in response to the PFR ,7 September 2018.
900 SAMA Submission in response to the PFR, 1 October 2018, p.21.
901 Section 27 Submission in response to the PFR,1 October 2018.
902 Discovery Health Post Seminar Submission. 26 April 2019.
903 SAMA Submission in response to the PFR, 1 October 2018, p.21.
904 HFA Submission in response to the PFR ,7 September 2018.
905 Honda, Ayako; (2014) What is strategic purchasing for health? Other. RESYST. DOI: Accessed on 5 September 2019 at https://doi.org/10.17037/PUBS.02760470.
906 Preker AS, Bank W. Public Ends, Private Means: Strategic Purchasing of Health Services: World Bank; 2007.
907 World Health Organisation. The World Health Report 2000: Health Systems: Improving Performance. World Health Organization; 2000, 2000/1, p.215.
908 Honda, Ayako; (2014) What is strategic purchasing for health? Other. RESYST. DOI: Accessed on 5 September 2019 at https://doi.org/10.17037/PUBS.02760470.
909 Strategic Purchasing in Practice: Comparing Ten European Countries _Katarzyna Klasaa, Scott L. Greera, Ewout van Ginneken (2018). Health Policy 122 (2018) pp.457–472.
910 Greer S, Wismar M, Figueras J. Strengthening Health System Governance: Better Policies, Stronger Performance 2015; European Observatory on Health Systems and Policies, p.272.
911 van Ginneken E. Governing competitive insurance market reform: case studies from the Netherlands and Switzerland. In: Greer SL, Wismar M, Figueras. J, editors. Strengthening Health Systems Governance: Better policies, stronger performance. Maidenhead/Brussels: Open University Press/European Observatory on Health Systems and Policies; 2016, pp.129–42.
912 Greer S, Wismar M, Figueras J. Strengthening Health System Governance: Better Policies, Stronger Performance 2015; European Observatory on Health Systems and Policies, p.272.
913 Chevreul K, Berg Brigham K, Durand-Zaleski I, Hernandez-Quevedo C. France: health system review. Health Systems in Transition 2015;17(3):1–218, xvii.
914 Kroneman M, Boerma W, van den Berg M, Groenewegen P, de Jong J. Van ginneken E. Netherlands: health system review. Health Systems in Transition2016;18(2):1–240.
915 Cylus J, Richardson E, Findley L, Longley M, O'Neill C, Steel D. United Kingdom:health system review. Health Systems in Transition 2015;17(5):1–126.?
916 Boyle S. United Kingdom (England): health system review. Health Systems inTransition 2011;13(1):1–483, xix-xx.
917 Busse R, Blumel M. Germany: health system review. Health Systems in Transition 2014;16(2):1–296? p.xxi.

8. The identity of purchasers varies across countries. An effective purchaser should have the ability to carry out its primary function autonomously and should remain free from political interference.[918] Purchaser organizations are public in some countries, private in others, or there is a combination of both.[919] Key purchasers can also be regional or provincial governments or national governments.[920] [921] Some form of accountability to patients should also be organised through mechanisms such as strong governance and/or having consumers represented in purchasing and governance boards of purchaser organizations.[922]

9. While the need for strategic purchasing and contracting is emphasised in the international literature, we are cognisant that it may be undermined by the market power that currently exists in the hospital sector and in some practitioner markets. Sufficient technical and procurement expertise and a corresponding strong regulatory framework to govern the procurement process, will determine the effectiveness of strategic purchasing.

10. Despite these challenges in South Africa, we recommend strategic purchasing of available capacity from private facilities. We believe that strategic purchasing through competitive bids for healthcare services provides scope to achieve universal health coverage by utilising idle overcapacity in the private sector and may contribute to addressing excessive utilisation occurring in the private sector.[923] It could also be used to stimulate price competition between the private and the public sectors and to promote innovative entry and small players such as the NHN and independents. Our recommendation to introduce central licensing that considers need assessment and market capacity, ARMs, global fees and team-based risk sharing contracts, provides a tool which could enable value-based purchasing.

11. Lastly, we draw lessons from the successful implementation of strategic purchasing by the national government in the pharmaceutical industry which has resulted in significantly lower prices. The price advantages in the pharmaceutical industry were possible due to the economies of scale achieved as a result of pooling the entire country's pharmaceutical procurement into one central mechanism administered by the National Treasury[924]

12. We conclude that the strategic purchasing of excess capacity from the private sector is a key component of a unified healthcare system both to improve access and to stimulate competition. We recommend that a strict set of regulations be established by the National Treasury and the National Department of Health, to encompass mechanisms of risk sharing, accountability, monitoring and transparency.

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918 Strategic Purchasing in Practice: Comparing Ten European Countries _Katarzyna Klasaa, Scott L. Greera, Ewout van Ginneken (2018). Health Policy 122 (2018) pp.457–472.

919 Strategic Purchasing in Practice: Comparing Ten European Countries _Katarzyna Klasaa, Scott L. Greera, Ewout van Ginneken (2018). Health Policy 122 (2018) pp.457–472.

920 Adolph C, Greer SL, Massard da Fonseca E. Allocation of authority in European health policy. Social Science & Medicine 2012;75(9):1595–603.

921 Olejaz M, Juul Nielsen A, Rudkjobing A, Okkels Birk H, Krasnik A, Hernandez-Quevedo C. Denmark health system review. Health Systems in Transition2012;14(2):1–192, i-xxii.

922 Strategic Purchasing in Practice: Comparing Ten European Countries _Katarzyna Klasaa, Scott L. Greera, Ewout van Ginneken (2018). Health Policy 122 (2018) pp.457–472.

923 Honda, Ayako; (2014) What is strategic purchasing for health? Other. RESYST. DOI: Accessed on 5 September 2019 at https://doi.org/10.17037/PUBS.02760470

924 Berger, J. et al. 2010. "Challenges and Opportunities for Improvement of Medicines Procurement in South Africa's Public Sector – March 2010". Accessed from: http://ipasa.co.za/Downloads/Policy%20and%20Reports%20%20Medicines/procurement/Medicines%20Procrement%20Task%20Team%20Report-%20Final%2029%2004%202010.pdf on 26 June 2019.

ANNEXURE 4.2:

Hospital Database Methodology

Purpose

13. This annex sets out the methodology used to construct a database of private hospital beds from 2000 to 2017. This dataset was also used for overall industry trends in the facilities market.

Data Sources

14. The data used to compile the dataset came from multiple sources.

15. These sources include:

    15.1 the Hospital Association of South Africa (HASA) publications for the periods 1999 to 2010;

    15.2 data provided by the hospital groups reflecting bed numbers in 2014;

    15.3 a HASA data file representing membership as at March 2016;

    15.4 data provided separately in 2016 by Netcare, Mediclinic, Life and the National Hospital Network (NHN) data;

    15.5 data on billing start dates for new hospitals for the period from 2009 based on claims data provided by Discovery Health (Pty) Ltd;

    15.6 data provided by RiskCape providing hospital locations by enumerator area (used to update location data);

    15.7 data from Medpages and our independent research;

    15.8 data submitted by provincial departments of health (in Gauteng, Western Cape, Kwazulu Natal, Limpopo, the Free State and Mpumalanga).

Data Challenges

16. The data provided from the HASA publications (2000 to 2010) were used as the principal source for establishing the database. HASA offered a substantial amount of bed data by bed type over this period. However, the data was inconsistently recorded resulting in many apparent inconsistencies including:

    16.1 bed type categorisations were not continued consistently (e.g. sometimes neonatal ICUs were classified as specialised ICUs with categorisations changing arbitrarily over the period) and bed data was missing in some years;

    16.2 data for the year 2000 presented problems as missing data could indicate either that a hospital did not exist or merely that data was not provided;

    16.3 hospitals changed their names due to changes in ownership which resulted in data entries ending under one name and beginning under a new name.

17. The additional datasets used to estimate the data for the period from 2011 also present many difficulties:

    17.1 no bed data breakdowns were available for the period 2011 to 2015;

    17.2 over the period 2011 to 2015 only total beds per hospital were available for one year only, 2014;

    17.3 the data for 2016 was only available for some and not all hospitals identified, and was broken down by bed type, it sometimes differed materially from the last available detailed breakdown for 2010 as well as the overall beds per hospital for 2014;

    17.4 the data provided in 2017 was essentially the latest data available to the hospital groups and differed significantly from 2016, 2014 and 2010 data;

    17.5 the NHN data for 2017 provided additional hospitals that were not included in any of the HASA data – but only provided total beds and no breakdown of distribution.

18. It is important to note that the Health Market Inquiry (HMI) requested this data in an electronic format from the hospital groups for the period 2000 to the present since it was stated that no such database existed. It was necessary to generate a consistent database taking into account all available, although imperfect, data.

Methodology

19. The following process was adopted to develop the most accurate representation of the data over the period 2000 to 2017.

19.1 The 1999 HASA data was used to validate the 2000 HASA data. This procedure clarified whether missing data from hospitals was because they did not exist. Significant deviations in the bed numbers between the two years was also flagged for further review using data from later years.

19.2 Bed breakdowns and hospital bed totals were compared across all years. Inconsistencies in trends, such as anomalous changes in bed categories, were adjusted to what appeared to be the most consistently entered data through time.

19.3 The visual consistency check (see Table 4.11) allowed for the following consistency checks:

19.3.1 comparisons over the period 2000 to 2010;

19.3.2 comparisons of adjusted data with unadjusted data;

19.3.3 overall total comparisons of the 2010 and 2016 data with the 2014 total;

19.3.4 comparisons with a 2017 breakdown, where available; and

19.3.5 comparisons with a 2017 overall total, where only the total was available.

20. Hospitals that changed names and owners over the period were categorised according to their practice number. All hospitals were therefore compared as a single hospital over time regardless of ownership or name changes.

21. The following approach was followed to generate the time series information.

21.1 Where bed information was consistent for long periods, gaps in data were adjusted to the most recently available consistent data.

21.2 The period 2011 to 2015 was estimated by the following procedures:

21.2.1 consistency was matched between three sets of relatively complete data: the 2010 data by bed type, the 2016 data by bed type and the 2014 total beds per hospital;

21.2.2 the closest match consistent with all three data sets was used to fill in the missing data;

21.2.3 to achieve the most consistent breakdown of beds over the entire period;

21.2.4 inconsistencies were always resolved in favour of the longest series of supplied data, including adjustments required to the 2017 data;

21.2.5 inconsistences were, as far as possible, resolved in such a way that the overall totals for the main sub-categories of beds were "protected".

The main sub-categories were: overall in-patient beds excluding ICU and HC (which includes medical, surgical, maternity, oncology and orthopaedic beds); overall ICU beds (which includes all types of ICU bed and HC beds); psychiatric beds; day beds; and other beds.

21.3 Additional data supplied by NHN was used to supplement bed information provided from the HASA datasets. The new hospital data did not include bed breakdowns. The following approach was, therefore, used to adjust the database:

21.3.1 the 2017 data was treated as applicable unchanged to all the years that the hospital had been in existence;

21.3.2 where a hospital was categorised as a general hospital, a rough breakdown of beds was used based on the general structure of known hospitals in the database; and

21.3.3 hospital categorised as "day" "psychiatric" had all beds added to those categories.

21.4 The location data was based on the following approach:

21.4.1 Hospital data provided by enumerator area from the Riskcape database was read into the time series database using practice code numbers. Missing data was based on enumerator area names developed using the actual addresses of hospitals. Where no database contained location information, the information was obtained directly from hospital websites through internet research.

21.5 Any information that could not be obtained from the various databases were resolved through reviews of hospital websites.

Market Definition: Facility Data Set

22. The market definition and concentration analyses rely on a data set of private healthcare facilities, developed from the information collated from

various sources. Currently, South Africa lacks a central data set, either nationally or provincially, of licenced facilities (including types) and numbers of beds, area of distribution, and the extent of use by market participants. Further, there is no uniform categorisation of the types of facilities and beds. The difficulty for the Inquiry in securing accurate information in its data set was acknowledged by multiple stakeholders in the licensing seminar held and in Tribunal proceedings in the merger between Netcare and Akeso group.[925] [926] [927] [928] [929] [930] However, certain stakeholders suggested that there is a database existent with the provincial departments of health responsible for granting facility licenses[931]. However, to date none of the provincial departments have been able to provide us with a complete and accurate facility information database. Some information was, however, received from provincial governments in Gauteng, Western Cape, Kwazulu Natal, Limpopo, Free State and Mpumalanga.

23. Facility information, including the geographic location, was submitted by some private facilities in line with our request for information.[932] It was supplemented with data from other sources, including the National Hospital Network (NHN) database, Medpages, the Hospital Association of South Africa (HASA) published annual reports, medical schemes claims data information, as well as from independent Internet research.

24. The data set of private healthcare facilities included the "multi-disciplinary" acute facilities (generally referred to as hospitals) which provide a combination of in-hospital and out-of-hospital services, sub-acute facilities, medical centres, day facilities (including day hospitals), public-private partnership (PPP) facilities, mining facilities and specialist facilities such as eye, psychiatric, oncology and urology facilities.

25. For the purposes of the market definition and concentration analysis, we focused on the multi-disciplinary acute facilities and day facilities which provide primarily "in-hospital" care. These facilities are classified the "057" (Private Hospitals-Multi Sub-Discipline ('A' - Status)) and "058" (Private Hospitals ('B' - Status)), while the day facilities are "077" (Approved Day Clinics/ Hospitals) as per the Board of Healthcare Funders' (BHF) Practice Code Numbering System (PCNS).

26. The focus on "057", "058" and "077" facilities was adopted since both private acute facilities and day facilities provide a range of in-hospital healthcare services within certain geographic areas and, therefore, compete with one another.

27. There are 195 facilities classified as private hospitals and day facilities ("057", "058" and "077" facilities) relevant for the market definition analysis out of the data set of 409 private health facilities.[933] This accounts for approximately 48% of the total private healthcare facilities. Out of the 195 private healthcare facilities that provide a range of in-hospital healthcare services, 181 (approximately 93%) were multi-disciplinary private acute facilities and 14 (approximately 7%) were stand-alone day facilities. This distribution is also not significantly different from the dataset used by the facility groups when conducting their market definition analyses.

28. The other facilities such as medical centres, specialist and mining facilities were excluded from the analysis, as they are not in real competition with the multidisciplinary acute or day facilities. For example, specialist facilities are characterised by highly complex medical offerings which may not be available at a normal acute facility, whereas mining facilities generally offer services on a different model and the disease burden largely

925 Discovery Health. Submission, 21 February 2018 in response to the HMI's "Proposed Regulatory interventions for Licensing of Health Facilities Document", pp.2-4.
926 Mediclinic. Submission, 21 February 2018 in response to the HMI's "Proposed Regulatory interventions for Licensing of Health Facilities Document", p.6.
927 South African Society of Physiotherapy. Submission, 21 February 2018 in response to the HMI's "Proposed Regulatory interventions for Licensing of Health Facilities Document", p.7.
928 Netcare & Akeso Group Merger Case No: LM017Apr17 "Hearing Transcript 26th February 2018", pp.103-104.
929 Western Cape DoH. Submission in response to the HMI's "Proposed Regulatory interventions for Licensing of Health Facilities Document", dated 26 February 2018, Accessed on 5 September 2019, from http://www.compcom.co.za/wp-content/uploads/2018/02/Department-of-Health-Western-Cape-1.pdf, p.5.
930 Free State DoH. Submission in response to the HMI's "Proposed Regulatory interventions for Licensing of Health Facilities Document".http://www.compcom.co.za/wp-content/uploads/2018/02/Free-State-Province-presentation-February-2018-Licensing.pdf. February 2018.
931 Netcare submission, 28 February 2018, in response to the HMI's "Proposed Regulatory interventions for Licensing of Health Facilities Document", pp.19-20.
932 HMI Information Request, 17 March 2015.
933 The facilities in the HMI data set were categorised by network and industry affiliation, ownership type and facility type. The dataset also included information on the total number of registered beds, facility practice numbers, facility geocode, i.e. address and, district municipality, post code area, and GPS coordinates as available.

differs. This may suggest that these types of facilities may not necessarily compete. Facilities also owned by the South African facility groups that operate in other countries such as Lesotho, Namibia and Swaziland were excluded from the facility master list.

29. The facilities used in the market definition analysis were geo-mapped against patient information derived from the admissions and claims data (2010 -2014) to establish catchment areas in line with the methodology that we published. The admissions data was sourced primarily from the three hospital groups. However, given resource constraints, smaller groups were unable to provide the admissions data, or alternatively the submitted data was of poor quality, and thus not usable. We could not have excluded the smaller hospitals in the analysis, as this would have biased the analysis. We supplemented the data with the claims data obtained from the medical schemes[934], which was converted to reflect admissions. Nevertheless, we acknowledge the deficiencies in this information, not least as the spatial information is imperfect due to un-updated scheme address records.

30. We further noted that certain facilities have entered the market after the 2010 – 2014 period. It was not possible to geo-map these entrants who were thus excluded for the market definition analysis. Further, where there was change of ownership, or an acquisition of a specific facility, this was reflected under the acquiring facility or facility group name in the market definition analysis list.

31. Discovery Health claims data listing facilities from which claims were received based on the unique practice numbers and linked names for which there are recent start dates to identify new claimants, did not give bed numbers. We note that this dataset included some facilities where the name of the facility changed although not a new hospital. Where there were some names that did not make sense, this was rectified through internet searches, and if there was no way to find the facility, it was excluded. It should be noted that in this dataset start dates differed from start dates for the same hospital provided by NHN. In that case, the NHN start dates were used.

32. We used (static) total registered beds submitted and verified by the three main hospital groups to calculate the market shares for the facilities. However, for the total registered beds for the National Hospital Network (NHN) members, and other independent facility groups, we were only able to verify the total registered beds as far as the data was available using the database from the NHN.

33. Our approach is reasonably consistent with that followed by certain facility groups for the market definition analysis. For example, Netcare employed a method of using "full hospitals"[935] and where patients tend to stay overnight for its market definition analysis[936], whilst Life Healthcare considered several different competitor private hospital operators present in local areas centred upon each of LHC's 24-hour facilities, which were taken to be broadly equivalent to hospitals with inpatient facilities.[937]

34. Overall, Netcare and LHC adopted what one could equally refer to as a conservative approach to the market definition analysis. They similarly excluded other types of facilities, specialist and day facilities as potential competitive constraints to their facilities.[938] [939] In contrast, we considered day facilities providing inpatient care to be a competitive threat to the "acute facilities" in our market definition analysis.

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934 This included data in the analysis datasets which have been described in the Report on Analysis of Medical Schemes Claims Data – Descriptive Statistics, which were built using the detailed claims and membership data which was requested by the HMI from medical schemes and their administrators. For this analysis, data from Liberty Medical Scheme was excluded as its address information was totally unusable.

935 Netcare's definition of full hospitals is a residual; from the list of all private healthcare facilities received from Netcare. Netcare eliminated day clinics, rehabilitation and step-down facilities, and specialised facilities such as eye clinics, psychiatric facilities, oncology centres, etc. (Confidential).

936 Netcare. "Market Definition and Relevant Markets: Assessment of Competitive Alternatives" dated 30 October 2014, pg. 28. Prepared by Compass Lexecon.

937 Life Healthcare. Private Healthcare Market Inquiry: Local Market Assessment,18 March 2016, p.2. Prepared by RBB Economics.

938 Ibid.

939 Netcare. "Market Definition and Relevant Markets: Assessment of Competitive Alternatives" 30 October 2014, p.31,prepared by Compass Lexecon.

Table 4.11: Table used to provide a visual consistency check over the period 2000 to 2017

Tzaneen	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2014	2017
Total	0	0	0	0	64	64	64	64	64	65	72	82	93	129	129	129	129	134	129	134
	Results accoring to bed type																		2016	2017
Medical	-	-	-	-	18	18	18	18	18	16	2-	23	25	35	35	35	35	35	35	35
Surgical	-	-	-	-	18	18	18	18	18	2-	2-	23	25	35	35	35	35	35	35	35
Maternity	-	-	-	-	12	12	12	12	12	12	15	17	19	28	28	28	28	28	28	28
ICU	-	-	-	-	3	3	3	3	3	3	3	5	8	10	10	10	10	10	3	10
ICU Neonatal	-	-	-	-	1	1	1	1	1	1	1	1	1	1	1	1	1	6	1	6
ICU Specialised	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0
High Care	-	-	-	-	-	-	-	-	-	-	-	-	-	3	3	3	3	3	3	0
Paediatric	-	-	-	-	12	12	12	12	12	13	13	14	14	17	17	17	17	17	17	17
Psychiatric	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0
Day	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0
Orthopaedic	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0
Oncology	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0
Other	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	3
																			122	134

ANNEXURE 9.1:

Recommendations Infographic

REGULATION OF THE SUPPLY SIDE

Supply side regulator for health

Health Services Pricing Unit

Review contracts to ensure they are value-based contracting

Must include:
- Risk sharing arrangements
- Encompass a value (price and quality) component
- Comply with the Competition Act

Health Services Monitoring Unit

Maintenance of the National Health Information Datatset

Assessment of health technology and interventions for cost effectiveness

SAHPRA
South African Health Products Regulatory Authority

PDoH
Provincial Departments of Health

Health Services Planning unit:
- Licensing Unit
- PCNS unit

Rational allocation & distribution of health resources - deal with inappropriate supply and inequity

HPCSA
Health Professionals Council of South Africa

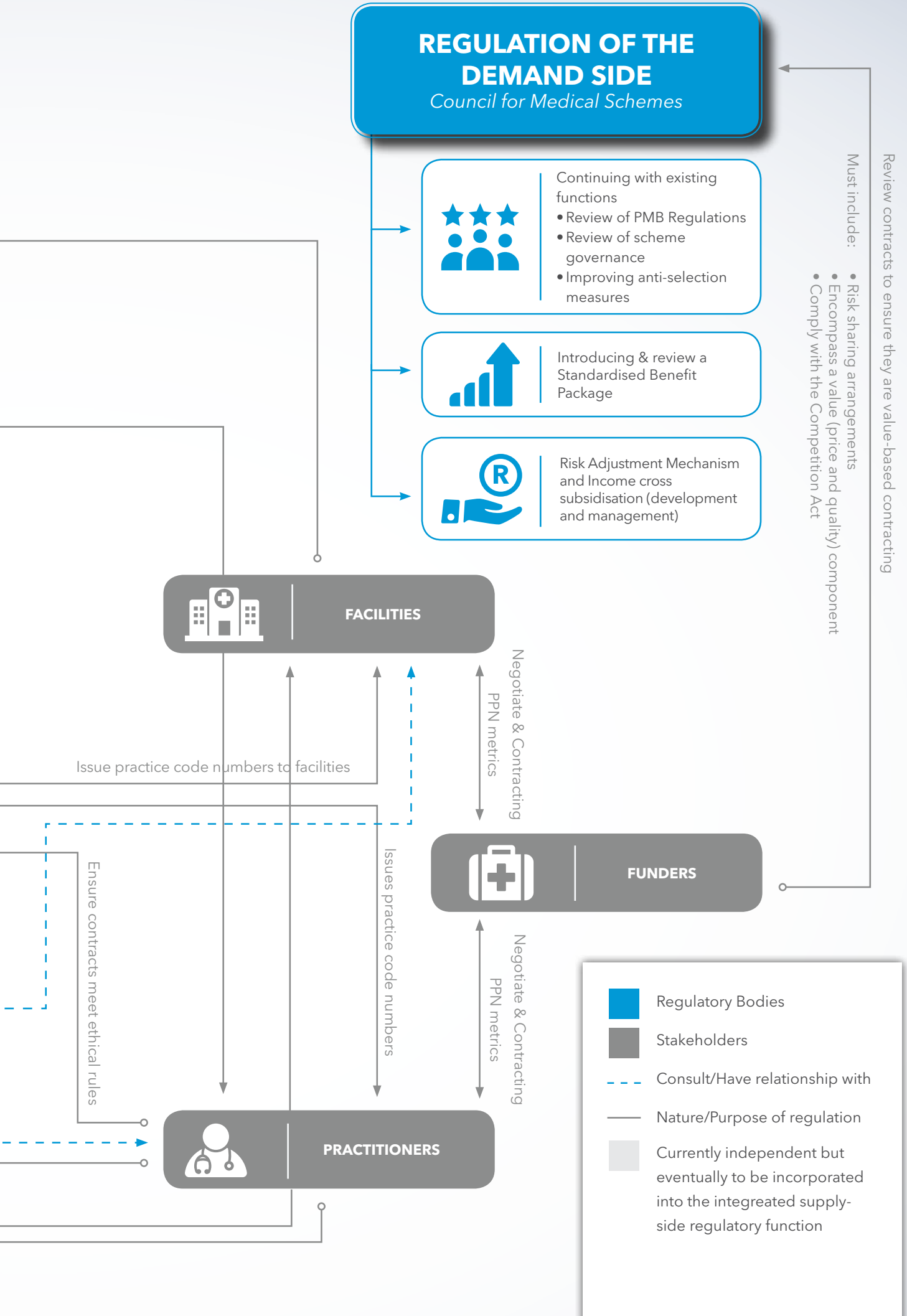
OMRO
Outcome Measurement and Reporting Organisation

Inspections and certification

OHSC
Office of Health Standards Compliance

Rational allocation & distribution of health resources - deal with inappropriate supply and inequity

Run tarriff negotiating forum


REGULATION OF THE DEMAND SIDE
Council for Medical Schemes
Continuing with existing functions
• Review of PMB Regulations
• Review of scheme governance
• Improving anti-selection measures
Introducing & review a Standardised Benefit Package
Risk Adjustment Mechanism and Income cross subsidisation (development and management)
Review contracts to ensure they are value-based contracting
Must include:
• Risk sharing arrangements
• Encompass a value (price and quality) component
• Comply with the Competition Act
FACILITIES
Negotiate & Contracting PPN metrics
Issue practice code numbers to facilities
FUNDERS
Ensure contracts meet ethical rules
Issues practice code numbers
Negotiate & Contracting PPN metrics
PRACTITIONERS
Regulatory Bodies
Stakeholders
Consult/Have relationship with
Nature/Purpose of regulation
Currently independent but eventually to be incorporated into the integreated supply-side regulatory function

ANNEXURE 9.2:

Data Specification Template

Please provide each of the files listed below (Provider, Claim, Beneficiary, Main member & Scheme) for your medical scheme.

File details

- ASCII 8 format
- -Column delimiter (hexadecimal): 7C ("|")
- Record delimiter (hexadecimal): 0A (line feed)
- First line to include the column description
- Provide the same number of columns in the same sequence as listed below
- Providers to include any provider that has billed the scheme in the period 1 January 2010 to 31 December 2014
- Claims to include all claim records paid or reversed having service from dates from 1 January 2010 to 31 December 2014
- Beneficiaries to include all lives that were members of the scheme for any period from 1 January 2010
- Main members to include all principal members of the scheme for any period from 1 January 2010

Column No	Column Desc	Example	Comment
PROVIDER			
1	Practice number	6072704	
2	Practice type (i.e. specialty)	60	
3	Practitioner postal code	2500	
4	Group or single practice identifier	S	
5	Participant in network arrangement (Y/N)	N	
6	Description of network 1	DSP	
7	Description of network 2		
8	Description of network 3		
CLAIM			
1	FamilyNo ref number	12345	References FamilyNo + DepNo in Beneficiary file
2	DependentNo	1	
3	PlanCode	A1	References Code in Scheme File
4	Practice Number	6072704	References Code in Provider File
5	Practice Type (i.e. specialty)	60	
6	Service from Date (start of service / admission date)	20150401	YYYYMMDD format
7	Service to Date (end of service / discharge date)	20150401	YYYYMMDD format
8	In hospital flag	N	Range is Y or N
9	ICD10 Code 1 (Diagnosis)	I10.1	
10	ICD10 Code 2 (Diagnosis)	I10.1	
11	ICD10 Code 3 (Diagnosis)	I10.1	
12	Tariff Code	0190	Include leading zeros where applicable
13	Tariff Code Modifier	091	Include leading zeros where applicable
14	Tariff Code Unit	Each	
15	Tariff Code Quantity	1	
16	Tariff Code Type	Standard	Range is Standard or In-house
17	NAPPI Code	704121	Napp6 format
18	NAPPI Quantity	10	
19	Claimed Amount	60.42	Reversed claim with leading "-" sign
20	Paid Amount (from insured)	55.00	Reversed claim with leading "-" sign
21	Paid Amount (from savings)	55.00	Reversed claim with leading "-" sign
22	PMB Flag	N	Range is DTP, CDL or N
23	RuleCode	12345	Numeric or Alpha-numeric
24	In-houseCode	12345	Numeric or Alpha-numeric

Column No	Column Desc	Example	Comment
BENEFICIARY			
1	FamilyNo ref number	12345	
2	DependentNo	1	
3	Date of Birth ref number	12345	
4	Gender	M	Range is M or F
5	Scheme Registration Date 1	20100201	Scheme not Plan registration date
6	Scheme Resignation Date 1	20120630	First resignation date after registration (if applicable)
7	Scheme Registration Date 2	20100201	Second registration date (if applicable)
8	SCHEME RESIGNATION DATE 2	20120630	Second resignation date (if applicable)
9	SCHEME REGISTRATION DATE 3	20100201	Third registration date (if applicable)
10	SCHEME RESIGNATION DATE 3	20120630	Third resignation date (if applicable)
11	RSA IDENTITY NUMBER REF NUMBER	12345	
13	BENEFICIARY TYPE	Adult	Range is Adult or Child
8	Description of network 3		
MAIN MEMBER			
1	FamilyNo ref number	12345	
2	Address 1 ref number	12345	Latest address
3	Address 2 ref number		Previous address
4	Address 3 ref number		Earlier address
5	Address 1 effective date	20100201	Date from which latest address applies
6	Address 2 effective date		Date from which previous address applies
7	Address 3 effective date		Date from which earlier address applies
8	PlanCode 1	A1	Latest Plan Code
9	PlanCode 2		Previous Plan Code
10	PlanCode 3		Earlier Plan Code
11	PlanCode 4		Earlier Plan code
12	PlanCode 5		Earlier Plan Code
13	PlanCode 1 effective date	20100201	Date from which latest Plan Code applies
14	PlanCode 2 effective date		Date from which previous Plan Code applies
15	PlanCode 3 effective date		Date from which Plan Code 3 applies
16	PlanCode 4 effective date		Date from which Plan Code 4 applies
17	PlanCode 5 effective date		Date from which Plan Code 5 applies

Column No	Column Desc	Example	Comment
MAIN MEMBER			
18	Income band 1	Band A	Latest income band
19	Income band 2		Previous income band
20	Income band 3		Earlier income band
21	Income band 4		
22	Income band 5		
23	Income band 1 effective date	20100201	Date from which latest Income Band applies
24	Income band 2 effective date		Date from which previous Income Band applies
25	Income band 3 effective date		Date from which earlier Income Band applies
26	Income band 4 effective date		Date from which Income Band 4 applies
27	Income band 5 effective date		Date from which Income Band 5 applies
SCHEME TABLE			
1	PlanCode	A1	
2	Scheme Name	GEMS	
3	Plan name	Emerald	
RULECODE TABLE			
1	RuleCode	1234	Numeric or Alpha-numeric
2	RuleCode description		
IN-HOUSECODE TABLE			
1	In-houseCode	990001	Latest Plan Code
2	In-houseCode description		Previous Plan Code
RSA IDENTITY NUMBER TABLE*			
1	RSA Identity Number ref number	12345	Earlier Plan code
2	RSA Identify Number	6001015011089	Earlier Plan Code
FAMILYNO TABLE*			
1	FamilyNo ref number	12345	
2	Family No		
ADDRESS TABLE*			
1	Address ref number	12345	
2	Street number	10	
3	Street Name	High Street	
4	Post Code	2500	
DATE OF BIRTH TABLE*			
1	Date of Birth ref number	12345	
2	Date of Birth		

** Tables containing personal data that will be de-identified*

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