



**Life Healthcare Group's
Response to Stakeholder Submissions:
Competition Commission Inquiry
into Private Healthcare**

03 April 2015

NON-CONFIDENTIAL

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Executive Summary

LHC addresses eight key themes in its second written submission to the Private Healthcare Market Inquiry Panel (“**the Panel**”), in response to recurring allegations made in various stakeholder submissions published by the Panel on 5 February 2015. The eight themes are Market Power; Medical Schemes’ Bargaining Power; Profitability; Pricing; Price Regulation; Formularies; Quality, and Regulatory Aspects (doctor incentives and employment).

Market Power

Although many stakeholders claim that the private hospital market is concentrated and as a result, is marked by severely restricted competition, LHC’s analysis does not support this contention. (See accompanying Profitability Report prepared by RBB Economics.)

Medical Schemes’ Bargaining Power

LHC submits that claims that private hospitals have unconstrained market power and can price as they please are also not borne out by supporting evidence. Indeed, the abundant evidence of bargaining power exercised by medical schemes and administrators illustrates quite the opposite – that medical schemes and administrators exercise significant countervailing power. This power is particularly well-illustrated by the use of designated service provider (“**DSP**”) arrangements which have proved to be a highly effective bargaining tool for medical schemes and administrators. (See in particular paragraph 4.3 of this Submission.) Consequently, hospitals have no option but to actively compete in order to acquire DSP status by trading discounted pricing for patient volumes, and to compete on a variety of grounds including quality and service offerings.

Profitability

LHC submits that the competitive environment within which it operates, which is driven by very powerful funders, does not allow for excessive profit taking. LHC’s profitability study (which accompanies this Submission) attests to this fact, and illustrates that LHC’s returns are not at an excessive level but are rather consistent with its participation in a competitive market.

Pricing

LHC’s effort to provide a more competitive offering includes various cost-savings mechanisms. As explained in detail in LHC’s First Submission, these include alternative reimbursement methods

(“**ARMs**”) and pharmaceutical formularies. ARMs are aimed at cost containment through various initiatives for example, managing the utilisation of drugs and equipment and encouraging the use of more cost-effective but qualitatively equivalent drugs and equipment. Significantly, it is Discovery Health that attests to the effectiveness of ARMs – which is illustrated by the fact that, in 2014, ARMs covered 70% of total Discovery Health Medical Scheme admissions and 65% of total hospital expenditure.¹

Price Regulation

Price regulation is generally seen in industries where multiple competitors do not exist. The underlying rationale in such cases is that a firm may be able to price at monopoly or near-monopoly levels absent price regulation, and there is no scope for market forces to resolve this concern over time. LHC submits that such industries are clearly different from the private healthcare industry, where multiple competitors do exist at many key levels of the supply chain. As such, the conditions for price regulation do not present in the private healthcare industry, and there is every reason to expect competition to give rise to efficient outcomes.

Formularies

LHC is committed to the provision of cost effective quality care and a critical component of its cost management initiatives includes the pharmaceutical formulary process, which seeks to manage utilisation of ethicals and surgicals through leveraging formularies.

As indicated in the First Submission, LHC’s formularies are compiled through a rigorous evaluation process to ensure that selected products are not only cost effective but also of high quality. In addition, LHC strives to contain the cost of drugs and surgicals through rigorous price negotiations with suppliers. LHC views its efforts with respect to price negotiations for drugs in particular as having a positive impact not only for its patients, but the industry more broadly as a result of the single exit prices achieved

Quality

As the Panel will have noted, it is has been alleged that the quality of care at private hospitals has deteriorated and that there is no monitoring and evaluation of the quality of healthcare services. LHC refutes this allegation and requests that the Panel call for the underlying data in support of this

¹ Discovery Health Medical Scheme Administrator at page xiv.

contention.

Quality is a deeply rooted core value and a key business strategy for LHC. Each LHC hospital measures its quality across a number of key quality indicators which are detailed below. These scores are reviewed and audited and LHC's quality measures have trended in a way that illustrates continuous improvement. LHC continues to fulfil its aim of ensuring world-class care at its facilities.

Regulatory Issues

An important next step towards enhancing the cost-effectiveness of the sector, relative to the quality outcomes, is for hospital groups to have a greater ability to co-ordinate the care provided within their facilities while still preserving the autonomy of healthcare professionals to make clinical decisions. On this basis, LHC seeks to selectively employ doctors, but is prevented from doing so by the current regulatory framework. As previously submitted LHC sees doctor employment as a significant contributor to spurring innovation in the sector and thereby driving down healthcare costs, in addition to enabling better co-ordinated and quality care.

LHC reiterates the fact that it does not enter into arrangements with doctors that result in perverse incentives and refutes any adverse allegations made against LHC in this regard. As the Panel will recognise after considering LHC's submissions, LHC's relationships with doctors are transparent and fair. LHC does not believe that these allegations are supported by any empirical evidence.

Conclusion

As the Panel will recognise through the detailed input of this submission, various allegations have been made against private hospitals which do not accurately reflect how LHC in fact operates in this market. LHC has attempted to highlight these inaccuracies for the Panel and trusts that this Submission proves useful in the Panel's assessment of the market and the formulation of recommendations.

Overview of the Key Allegations and LHC's Response

The below table summarises the position of LHC on the key themes addressed in this submission.

Theme	Submissions Made	LHC Response
Market Power		
Concentration	The private hospital market is dominated by the three large hospital groups and is marked by severely restricted competition.	LHC's analysis does not support this claim since LHC returns are consistent with its participation in a competitive market.
Competition between Hospitals	There is a lack of true competition between private hospitals.	LHC refutes this allegation. Private hospitals compete regularly for staff, specialists and patients via funder networks. Each hospital group has annual individual negotiations with the healthcare funders and there is thus regular ongoing price competition between private hospital groups through their engagements with healthcare funders.
Bargaining Power of Medical Schemes		
Bargaining Power of Medical Schemes	The ability of medical schemes to negotiate reasonable prices with private hospital groups is severely limited.	There is abundant evidence of bargaining power exercised by medical schemes and administrators, in particular through DSP arrangements, illustrating significant countervailing power.
Profitability		
Profitability	Private hospital groups make excessive profits.	LHC's profitability study indicates that LHC's

		returns are not excessive but consistent with its participation in a competitive market.
Pricing		
Pricing Post 2004	The abolition of collective bargaining led to a spike in the price of private healthcare.	There is no empirical support for this allegation.
Double dipping	After SEP was introduced in 2004 and later the removal of rebates on materials and devices, hospitals simply added 5% and then 6% to their tariffs to maintain profits.	LHC refutes this allegation. Double dipping in fact refers to adjustments made for different margin elements made by hospital groups.
Pricing Models: ARM and FFS	ARMs make it easier to hide the costs of service delivery and reduce transparency in pricing.	ARMs are well understood by the medical schemes who reimburse LHC based on these models. These broad statements regarding the transparency of ARMs are merely uninformed.
Price Regulation	Some form of price regulation of the health care market is necessary.	The conditions for price regulation are not present in the private healthcare market which is characterised multiple competitors at many key levels of the supply chain. As such, there is every reason to expect competition to give rise to efficient outcomes.
Formularies at LHC Hospitals		
	Hospitals compel doctors to use medicines and equipment that may not be in the best interests of the patients	LHC's formularies are compiled through a rigorous evaluation process to ensure both cost containment but high quality of products – in consultation with doctors.
Quality at LHC Hospitals		

	Quality of care at private hospitals has deteriorated and there is no monitoring and evaluation of the quality of healthcare services.	LHC refutes this allegation. LHC has implemented comprehensive quality measures at all its hospitals and its 2014 quality performance indicates continuous improvement.
Regulatory Aspects		
Employment of Medical Practitioners and Conflicts of Interest	Doctor employment will compromise the independence of treating doctors.	LHC seeks to employ doctors as appropriate, to drive down treatment costs by co-ordinating patient care and eliminating inefficient use of resources, while preserving doctor autonomy.
PMB Allegations that Hospitals Drive up costs	Hospitals over-service and charge more for PMB conditions while as compared to non-PMB conditions since funders are required to cover the full cost for PMBs.	LHC rejects this allegation. Rates agreed with medical schemes and funder authorisation methods apply regardless of whether the treatment involved is a PMB or non-PMB.
Specific Allegations		
Access to Specialist Nursing Care	LHC limits access to specialist nursing care at its hospitals.	LHC denies that it deliberately limits access to specialist nursing care. LHC's staffing decisions are aimed at managing staff efficiently without compromising patient care.
Emalahleni allegation re: Langamed Ambulance	LHC has arrangement with Langamed to allocate patients preferentially to Life Cosmos hospital to the disadvantage of Emalahleni Hospital.	LHC denies that there is any preferential arrangement with Langamed.

1. Introduction

- 1.1 On 5 February 2015, the Panel for the Market Inquiry into Private Healthcare (“the Panel”) published the submissions made by industry stakeholders and other interested parties in response to the Panel’s Call for Submissions;² and issued Supplementary Guideline No. 1 on the Inquiry’s follow-up process (“the Guideline”).
- 1.2 The Guideline requested responses to the published submissions from existing participants in the Inquiry and other parties. In particular, the Guideline required that i) the responses must correct inaccurate or misleading information and methodologies and ii) affected parties must respond where specifically adverse allegations have been made.
- 1.3 This submission is made by Life Healthcare Group (“LHC”) in response to the Guideline.
- 1.4 In considering the most appropriate method of responding to the stakeholder submissions, LHC has identified key themes in relation to private hospitals that recur in a number of the submissions. LHC responds to submissions made by certain stakeholders under the banner of these key themes, which provide the necessary context for the submissions and allows LHC to provide a holistic response. To a limited extent, LHC addressed specific allegations made by certain stakeholders.
- 1.5 The key themes identified are:
- 1.5.1 Market Power
 - 1.5.2 Bargaining Power of Medical Schemes
 - 1.5.3 Profitability
 - 1.5.4 Pricing
 - 1.5.5 Price Regulation
 - 1.5.6 Formularies
 - 1.5.7 Quality
 - 1.5.8 Regulatory Aspects

² The Call for Submissions was made on 1 August 2014 and invited all those who wish to participate in this Inquiry to make submissions on the issues identified in the Statement of Issues, read with the Terms of Reference.

- 1.6 Many of the allegations against private hospitals that have emerged from the stakeholder submissions have been addressed in LHC's First Submission. As such, LHC's First Submission must be read together with this Submission.
- 1.7 LHC notes that many of the submissions make sweeping statements that are not supported by the necessary evidentiary analysis. As we understand, the Panel does not intend to rely on such bare assertions but aims to test the veracity of these statements in the course of the Inquiry.
- 1.8 This submission does not deal with each and every allegation made against LHC but focuses on the key themes, identified above, which LHC considers to be central to the Inquiry. This approach should not be interpreted to mean that LHC concedes the correctness of any allegation not specifically addressed.

2. **Private Healthcare is Not a Public Good and Section 27 Obligations**

Private healthcare is not a public good

- 2.1 The BHF takes the view that, healthcare, including private healthcare, is a public good on the basis that it meets the following conditions – consumers have limited discretion when choosing suppliers as a consequence of high concentration and/or other factors that limit choice; information asymmetry regarding products and services; little or no bargaining power on the part of consumers; and provider selection primarily takes place based on trust and locality as opposed to competition between hospital operators.
- 2.2 It is submitted that BHF's conditions for determining whether the provision of private healthcare is a public good are incorrect. As a matter of economics, a public good is one which is non-rivalrous and non-excludable, meaning that consumption of it by one individual does not reduce its availability to other individuals and that no individual can be effectively excluded once the good is supplied.
- 2.3 In the case of private healthcare, this is clearly not the case since there is a limited supply of beds, specialists and medicines, and hence consumption by one individual reduces the availability of the good to others, making it rivalrous. Further, by virtue of the fact that consumption of private healthcare requires payment to a provider or medical scheme certain individuals can be excluded.

- 2.4 In support of its more general position that there is market failure in the supply of private healthcare in South Africa, the BHF provides a number of reasons, which we briefly discuss below.
- 2.5 First, the BHF alleges that, unlike commodities, expenditure on health care only involves a small element of discretion on the part of the patient, particularly in the case of medical emergencies, and therefore consumers are not particularly responsive to quality or price. However, this claim ignores the important role played by (i) medical schemes/administrators in responding to price or quality through negotiations with private hospitals on behalf of their members, and (ii) the role played by GPs (i.e. trained medical professionals with knowledge of local hospitals and consultants) in referring patients to particular hospitals/specialists on the basis of price or quality.
- 2.6 Second, the BHF states that parties to private healthcare transactions rarely have equal bargaining power, and that in particular medical schemes have limited countervailing bargaining power to negotiate low prices for their members. This is claimed to be a result of consolidation of the private hospital industry. However, it is administrators, as opposed to medical schemes, that generally negotiate with private hospitals. The administrator industry is concentrated, with the three major administrators alone representing nearly 80% of all medical scheme beneficiaries by volume.
- 2.7 The significant number of patients that each of these large administrators represent suggests that they possess a significant amount of countervailing buyer power in their negotiations with private hospitals. Administrators/schemes possess a range of mechanisms through which to discipline a private hospital operator in the event that one attempted to raise prices above competitive levels. These include threats to exclude a hospital operator from DSP arrangements.
- 2.8 Moreover, even if one party to a transaction has extremely limited bargaining power, this does not provide any reason whatsoever to believe that a competitive process will be ineffective or incapable of yielding efficient outcomes or that price regulation is required to achieve such outcomes. There are myriad industries where sellers and buyers do not possess equal bargaining strength but where it is nevertheless widely accepted that competition can work effectively.

- 2.9 Third, the BHF submits that the assumption that competition in the healthcare sector exerts downward pressure on prices is misguided, as the laws of supply and demand do not apply in the same way as other markets. This is made on the basis of Roemer's observations in 1959, that there is a positive correlation between the number of hospital beds per person and the rate of hospital days used per person (and thus in turn private healthcare costs). BHF concludes that as a result "an increase in service provider numbers does not therefore mean increased competition as one might ordinarily expect".
- 2.10 However, the BHF's use of the number of hospital beds per person as a proxy for the intensity of competition is misguided. In particular, while an expansion in supply (i.e. the number of beds offered) may amount to increased competition, this will only be the case if demand stays constant, and is not increasing at the same time.³ In this regard, while the BHF refers only to Roemer's observations, which are based on the US private healthcare industry, it is well accepted that in the South African context demand has not remained constant over time. Indeed, the relationship between bed numbers per person and rate of hospital days per person is complicated, and one cannot make inferences about the functioning of competition in the healthcare sector based upon a cursory examination of two variables. Indeed, other factors beyond the supply of beds per person will determine the number of bed days used per person, such as disease burden.
- 2.11 Moreover, competition in the supply of private healthcare takes place over a large number of different dimensions, with the number of beds provided being but one of these. The BHF has thus failed to take into account how hospitals compete, and what factors may be expected to shape such competition (such as the number of competing firms' face in any given locality).
- 2.12 Fourth, the BHF highlights several sources of information asymmetry that it considers limits the ability of patients to make informed choices, including the lack of any form of benchmark prices, technical price schedule or reference price list, as well as the general lack of transparency in pricing and quality of care. This ignores the important role played by (i) medical schemes/administrators in responding to price or quality

³ The BHF effectively claims that in healthcare industries in general, it has been observed that as the number of beds per person increases (i.e. as supply increases), there is an associated bed day increase per person (i.e. demand increases). This observation is therefore a statistical correlation and not a description of causality.

through negotiations with private hospitals on behalf of their members; and (ii) the role played by GPs in referring patients to particular hospitals/specialists on the basis of price or quality.

- 2.13 Moreover, even if a lack of transparency were to exist due to a lack of benchmark prices or quality measures, and even if this adversely distorted competitive outcomes, this would not provide a compelling reason for the replacement of a competitive process with price regulation as proposed by the BHF. Indeed, there are far less invasive measures that can be implemented in an attempt to improve the quality and quantity of information available directly.

Section 27 Obligations

- 2.14 LHC notes that some of the stakeholder submissions suggest that Section 27 of the Constitution – which provides for the right to have access to healthcare services and that the State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right – constitutes authority for the State to take measures which will translate into the State, in effect, requiring the private healthcare industry to significantly compromise its own interests in order to assist with alleviating the public health burden faced by the State.⁴

- 2.15 LHC agrees with the Panel’s comment in the Final Statement of Issues that access to healthcare services is a constitutional right and that this right also informs the competition assessment that it must undertake.⁵ LHC also fully appreciates the role of the State in fostering the realisation of this right. LHC fulfils its constitutional mandate to provide access to healthcare services by providing emergency care to any person who requires treatment, regardless of whether they are a scheme funded patient or not and by virtue of the arrangement it has entered into with the State through Life Esidimeni. Specifically, LHC, through its wholly-owned subsidiary Life Esidimeni delivers healthcare services to State patients under contract to provincial Departments of Health and Social Development and has been providing this service for over five decades.

- 2.16 In LHC’s view, however, Section 27 of the Constitution does not require private

⁴ Section 27’s Submission at page 13 – “As the obligation to realise the right to access to healthcare services rests “primarily” – although not exclusively – on the state, the states’ role in ensuring it is realised through the private healthcare sector is a fitting starting point.”

⁵ Final Statement of Issues at paragraph 19.

healthcare providers to adopt the burden of ensuring general access to healthcare services nor does it permit the State to impose this burden on private healthcare providers. As such, LHC does not accept that the realisation of this right requires the State to take measures that will compromise other constitutional rights afforded to private healthcare stakeholders, such as the rights to property and freedom of trade.⁶

2.17 LHC has expressed on many occasions, its support for well-functioning private public partnerships with the State and remains committed to having this engagement with government.

2.18 Further, this Inquiry is a competition law inquiry being conducted under the auspices of the Competition Act and as such, it is the competition assessment that is central to the Panel's work. The Panel itself acknowledged this when it noted in the Statement of Issues that "*this [healthcare] right must inform the competition assessment that it must undertake*".

2.19 Furthermore, LHC's view is that the Panel's mandate, as expressed in the Final Statement of Issues, does consider the public healthcare sector, – but within a particular (competition) framework, when it states that "*[w]hilst the [Competition] Act, and accordingly the Terms of Reference, do not permit the Panel to inquire into the public healthcare sector, the Panel nevertheless considers it important to consider how the public sector affects competition and access in the private health sector.*"⁷

3. **Market Power**

3.1 Concentration

LHC is of the view that very few, if any, of its hospitals are located in areas where it faces little or no effective competition, and even in these areas, it does not possess the ability to exert any material degree of local market power. This is because the competitive constraints that hospital operators face at a national level are sufficiently strong to curtail any ability to exert local market power

⁶ Section 27 Submission at page 13 – "*Moreover, the duty to protect requires the state to regulate for purposes which extend far beyond making healthcare 'affordable'. The state is required to 'regulate domestic health service delivery in a manner that enables equitable access to healthcare services and ensures the availability, accessibility, acceptability and quality of health care'.*"

⁷ Final Statement of Issues at paragraph 49.

3.2 Competition Between Hospitals

3.2.1 BHF alleges that “[t]here is a lack of true competition between private hospitals due in part to their significant consolidation in recent years” and that an increase in service provider numbers does not necessarily mean increased competition.⁸

3.2.2 LHC submits that this allegation is simply untrue. Private hospitals compete on a regular basis and this can be seen in the various responses by hospital operators. As per LHC’s First Submission, hospitals compete for staff, specialist support and patients via funder networks.

3.2.3 KwaZulu-Natal is a market that has experienced many new entrants in the past few years – Hillcrest Hospital, eThekweni Heart Hospital and the new Gateway hospital. As illustrated in the First Submission, LHC has lost many doctors who have moved their practices to these competing facilities. In addition to these moves, LHC’s KZN hospitals have all been impacted by staff attrition, where key employees have moved to these competitors. **[CONFIDENTIAL]**.

3.2.4 As a consequence of the impact of new entrants, LHC has had to ensure that its facilities remain attractive to doctors and patients and has undertaken various upgrades at its facilities to ensure that the demands of the various constituents are met. These include upgrades to doctors’ suites, wards, reception areas, parking and coffee shops after entry by Hillcrest and eThekweni hospitals.

3.2.5 In addition, LHC has had to explore new service offerings in a bid to remain a provider of choice despite new entrants. Examples of this include the introduction of electrophysiology studies at Life Entabeni and a vascular laboratory at Life Westville, both in 2014. Another example of this competition in the market is the introduction of rehabilitation services by Hillcrest hospital – in an effort to compete with Life Entabeni’s offering.

3.2.6 As explained in LHC’s First Submission, each decision to make a capital

⁸ BHF Submission at pages 34 and 63.

investment, including the purchase of new technology, is carefully considered and must first be informed by a compelling business case. As such, while LHC actively competes with other private hospitals, in terms of its service offering, as described above, it does not simply acquire new technology without justification in an effort to create demand. Considering the examples cited above, in each case a comprehensive investment case, underpinned by demonstrable need, was presented to the relevant internal approval bodies in line with LHC's policies regarding capital expenditure.

4. Bargaining Power of Medical Schemes

4.1 There are a number of allegations made in the stakeholder submissions that hospital groups are dominant and restrict competition, and that the ability of medical schemes to negotiate reasonable prices is limited given the scarcity and demand of private hospital services.⁹ Some schemes also allege that medical schemes are price takers.¹⁰

4.2 As indicated in LHC's First Submission,¹¹ negotiations between schemes and LHC are a robust and informed process. **[CONFIDENTIAL]**.

4.3 LHC's experience is that there have been many instances where smaller schemes have used their market power in negotiations with LHC. Any scheme, regardless of its size, has the ability to exercise market power by threatening to move its volume of patients. No matter how small the volume, this translates into market share that LHC would not want to lose. **[CONFIDENTIAL]**:

4.3.1 **[CONFIDENTIAL]**;

⁹ "Private hospital groups have become more powerful as they have consolidated, leading to greatly diminished bargaining power on the part of smaller medical schemes to negotiate good prices for their members." BHF at page 25.

¹⁰ See submissions made by Medscheme, Profmed and BHF. "The hospital market is dominated by three large groups, namely, Netcare, Mediclinic and Life Healthcare. Upon inspection of the hospital group's geographical distribution across South Africa, it is evident that it is difficult to eliminate any one of the largest hospital groups from a national network, as each major hospital group has a regional dominance in at least one province with little alternatives." Medscheme at page 92.

"The private hospital market in SA is an oligopoly, with Netcare, Life Healthcare, Mediclinic and NHN dominating the market. This severely restricts competition and the ability of medical schemes to negotiate reasonable prices with medical schemes....Schemes are in essence 'price-takers' with respect to these hospitals." Profmed at page 34-5.

"Even if the purchaser is a large medical scheme, providers still retain a significant degree of bargaining power due to the scarcity of, and demand for, the services they provide and as a result of the nature of those services ... In South Africa there is regional distribution of large provider groupings such as private hospitals which can have the effect that in any particular region a medical scheme is effectively negotiating with only two of the big three groups if one could call a price taker a negotiator. The size of a medical scheme does not seem to have an impact on cost increases for private hospital care." BHF at page 20.

¹¹ See LHC's First Submission at paragraph 8.2.

4.3.2 [CONFIDENTIAL];

4.3.3 [CONFIDENTIAL];

4.3.4 [CONFIDENTIAL]; and

4.3.5 [CONFIDENTIAL].

4.4 Moreover, the loss of DSP designation at a given facility may significantly impact the practice of a specialist, who is based at that particular facility. In a context where hospitals compete for specialists, this exerts even further pressure on LHC to ensure that its hospitals are included in DSPs, thereby providing schemes that leverage DSP networks with an additional element of bargaining power.

4.5 As is evidenced above, there are many instances where schemes exercise market power by removing LHC off a DSP list and moving this volume to a competitor. In this way DSP exclusions serve as a real threat to LHC during negotiations. [CONFIDENTIAL].

4.6 The countervailing power exercised through DSP arrangements is acknowledged by Discovery Health Medical Scheme – *“Provider networks have led to significant savings for Discovery Health Medical Scheme and its member ...Provider networks have disciplined the provision of healthcare services by providers and reduced the fees charged.”*¹²

4.7 While the submissions the BHF, Bestmed and Medscheme suggest hospital groups are in a strong position when negotiating with medical schemes/administrators as a consequence of possessing local market power in particular areas, this is simply not the case for LHC.¹³ As noted above, there are few areas where LHC does not face competition from other hospitals, and these areas are not material in the context of LHC’s overall business. Accordingly, these areas do not play a central role in shaping negotiations between LHC and schemes/administrators.

4.8 In fact, while the BHF appears to cite the lower tariffs charged by NHN hospitals

¹² Discovery Health Medical Scheme at page 63 and 64.

¹³ Board of Healthcare Funders, paragraphs 5.22 and 6.1; Bestmed, paragraph 77.2; Medscheme, page 86.

(notwithstanding that the table presented in the BHF submission does not support this proposition) as evidence of the negotiating power that the three large groups obtain from instances of regional dominance, the truth is that a much greater proportion of the NHN estate is located in areas where its hospitals face little or no competition than is the case for LHC's hospitals.

5. Profitability

- 5.1 Profitability analysis is typically used by competition authorities to infer whether a firm (or a group of firms) is earning excess returns, which are defined as profits above the level which would prevail in a competitive market equilibrium (i.e. "normal returns"). The intuition is that in markets where competition is able to function effectively, excess returns that a particular firm or firms may be able to earn in the short run will be competed away by rivals in the medium to long term. Thus, where excess returns are observed on a sustained basis, this may reflect a lack of effective competition.
- 5.2 Under the textbook model of perfect competition, competition between firms leads to prices being competed down to marginal cost, and as such no returns over marginal costs are observed. However, given that the vast majority of real world industries feature fixed costs, a competitive outcome is considered, more generally, to be one where prices are set to cover both variable and fixed costs over the medium to long term. This should also include a reasonable margin to cover the cost to the firm of having to reward the providers of its capital.
- 5.3 To this end, LHC has requested that RBB Economics conduct an assessment of the profitability of LHC's South African hospital operations. In order to do so, RBB has calculated LHC's return on capital employed ("**ROCE**"), which is a commonly used measure of profitability in competition investigations, and was used in the UK CMA's private healthcare market investigation. An advantage of ROCE is that it can be compared to a proxy for normal returns, typically taken to be the firm's or industry's weighted average cost of capital ("**WACC**"). RBB cites this reason, as well as to ensure consistency with the UK's approach in its recent private healthcare investigation, for adopting a ROCE measure of profitability.
- 5.4 RBB also notes that when comparing ROCE against WACC it is common to allow for the existence of a certain differential between the two before concluding that a firm or an industry is earning excess returns. This primarily reflects two issues.

- 5.5 First, hindsight or “survivorship” biases create a risk that efficient firms are incorrectly implicated for earning “excessive” returns, an issue that is well-acknowledged by competition authorities as being important in profitability assessments. Specifically, by only observing the profitability of those firms that have survived, a regulator will necessarily only be assessing those firms which were successful, and so the sample of firms analysed will not be balanced. As a result a degree of caution is required when interpreting the results of firm or industry profitability, and in particular there should be no presumption that returns should equal the cost of capital. Indeed, if this bias is not recognised by an authority there is a risk that a false conclusion of excess returns will be reached.
- 5.6 Second, a key difficulty in profitability assessments is the risk of measurement error. For example, in terms of the WACC, there is clear uncertainty over the true values of the risk free rate and the equity risk premium. Similarly, when measuring capital employed there can be substantial measurement uncertainty, for example concerning the quantification of intangible assets, economically useful lives of assets, and replacement costs of assets.
- 5.7 RBB’s analysis, in which capital employed is valued using the current cost accounting approach and then compared to industry WACC indicates that LHC is not earning returns of a level that indicate that such returns are excessive, even on the basis of a conservative approach. Rather, LHC’s returns are consistent with its participation in a competitive market.
- 5.8 **[CONFIDENTIAL].**

6. **Private Hospital Pricing**

6.1 Pricing Post 2004

- 6.1.1 It is alleged in various stakeholder submissions, including the BHF¹⁴, Cosatu and the National Department of Health (“DOH”), that the abolition of collective bargaining led to a spike in the price of healthcare. LHC notes that evidentiary analysis proving a spike in price as a result of the abolishment of

¹⁴ BHF at page 34.

collective bargaining has not been presented to support this allegation. LHC urges the Panel to further interrogate these stakeholders' submissions by requesting the underlying data supporting these conclusions.

6.2 BHF's allegation of "double-dipping"

- 6.2.1 The BHF alleges that, following the introduction of SEP in 2004 and later removal of rebates on materials and devices, hospitals simply added 5% and then 6% to their tariffs in order to maintain profits; and that this amounted to a double dip because hospitals had previously been allowed to charge higher prices in exchange for moving to NAP in 1999.¹⁵
- 6.2.2 As detailed in LHC's First Submission, prior to the introduction of SEP in 2004, margin was made by hospitals charging FFS on stock items utilised. This margin significantly cross-subsidised the tariffs being charged at the time for ward, theatre and equipment.
- 6.2.3 Prior to 1999, this margin was made up of 2 components, i) the mark up off the supplier's list price, and ii) the difference between the supplier's list price and the true cost of stock purchased – this difference was paid back to the hospital group through a rebate system.
- 6.2.4 During the price negotiations between RAMS and HASA for 1999, it was agreed to partially address this cross-subsidisation through the removal of the mark-up of supplier list prices, but retain the discount that hospital groups were negotiating with suppliers below the supplier's list prices.
- 6.2.5 This margin – the difference between the supplier list prices and the cost price to hospitals – was the subject of negotiated adjustments made to tariff in future years in response to SEP legislation in the case of drugs, and in response to funder requests in the case of surgicals.
- 6.2.6 Thus, the BHF allegation of "double dipping" by hospitals is refuted, as the exercises that BHF refers to as double dipping were actually adjustments made for different margin elements made by hospital groups.

¹⁵ "(In 1998 RAMS agreed that private hospitals could be given a higher increase to go the Net Acquisition Price (NAP) route for medicine, materials and devices").

6.2.7 These transfers were done in a transparent and open manner and all stakeholders were aware of the decision to transfer the margins.

6.3 Pricing models: FFS vs ARMs

6.3.1 As explained by LHC in its First Submission, the major problem within the FFS structure is the lack of incentives for hospital groups to contain costs.¹⁶ LHC regards the FFS system as unsustainable and implemented ARMs in order to change the incentives from growing margin purely from increased utilisation to a system where margin increasing opportunities became available through cost containment (**[CONFIDENTIAL]**).

6.3.2 This shift toward the utilisation of ARMs is not unique to South Africa. There are international examples, including Medicare in the US, where there has been a concerted shift from FFS payment toward alternative reimbursement models that incentivise higher value care.¹⁷ In addition, the World Health Organisation has consistently recognised that FFS payments in some instances lead to longer periods of inpatient care and, hence, higher costs than are medically necessary.¹⁸

6.3.3 Certain stakeholders have alleged that ARMs are not transparent and are set up to hide information.¹⁹ LHC is not certain why these statements have been made, as the alternative reimbursement model is well understood by the medical schemes who reimburse LHC based on the agreed models. **[CONFIDENTIAL]**. **[CONFIDENTIAL]**. We are therefore of the view that these broad statements regarding the transparency of ARMs are merely uninformed.

6.3.4 LHC reiterates its view that the FFS structures are unsustainable and regards ARMs as promoting sustainability through an incentive to contain costs. Significantly (and contrary to the submissions about non-transparency),

¹⁶ See paragraph 7.4.1.

¹⁷ Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value, <http://www.hhs.gov/news/press/2015pres/01/20150126a.html>, 26 January 2015.

¹⁸ World Health Organisation, *The World Health Report: Health Systems Financing, The path to universal coverage* (2010.).

¹⁹ BHF at page 35 – “Alternative reimbursement methods make it easier to hide the costs of service delivery relative to the profits in such models and reduce transparency in pricing by building in the current inefficient prices and reducing the availability of treatment details necessary to interrogate pricing.”

Discovery Health (Medical Scheme Administrator) strongly supports the use of ARMs – a position which it records in its submission – “*DH relies on its data analytic capacity, and a range of clinical adjustment tools and assets to manage hospital costs within the context of alternative reimbursement mechanisms, hospital network plans....In 2014, ARMs cover 70% of total DHMS admissions and 65% of total hospital expenditure.*”²⁰

7. Price Regulation

7.1.1 A number of stakeholder submissions have called for some form of price regulation in the private healthcare market.²¹

7.1.2 From an economic perspective a case for intervention in a market exists when there is clear evidence of market failure. General examples of market failure are those where a product will be under- or over-supplied in a marketplace compared to what is optimal from society’s perspective. The classic example of such a product is a public good, for example national defence, which a marketplace would under-supply due to its properties of being both non-excludable and non-rival. Put differently, a public good would be under-supplied because the price mechanism which underpins the functioning of a competitive marketplace would not operate correctly since the good in question is non-excludable and non-rivalrous.

7.1.3 However, it simply does not follow that the identification of a market failure means that price regulation is required in order to correct for it. On the contrary, the general nature of many market failures means that price regulation would at best not address the underlying cause of the market failure (for example in the case of public goods), and would potentially do more harm than good.

7.1.4 Price regulation is generally seen in industries where multiple competitors do not exist, such as industries which tend towards ‘natural monopoly’ due to the

²⁰ Discovery Health Medical Scheme Administrator at page xiv.

²¹These include the BHF, the DOH and Section 27. “*It has been demonstrated internationally that because health care is a public good some form of price regulation and other regulatory control of the health care market is necessary.*” BHF at page 3.

“*In the absence of price regulation, these problems result in inflated medical costs, unaffordable premiums and subsequent contractions of benefit scope.*” DOH at page 11.

“*We note that the current absence of an effective framework for price regulation has the effect of compromising patient’s rights to high quality, affordable healthcare services,...*” Section 27 at pages 3 and 8.

presence of substantial economies of scale. As a result, utilities industries often face price regulation, with the regulated price designed to replicate the price that might have prevailed were it possible to achieve a competitive outcome. The underlying rationale in such cases is that in utilities industries where (multiple) competitors do not exist, a firm may be able to price at monopoly or near-monopoly levels absent price regulation, and there is no scope for market forces to allay this concern over time.

7.1.5 However, such industries are clearly different from the private healthcare industry, where multiple competitors do exist at many key levels of the supply chain, and thus there is every reason to expect competition to give rise to efficient outcomes (subject to the removal of any other features that might inhibit competition).

7.1.6 Moreover, there are potentially a number of significant problems with the application of price regulation to industries in general, which may be particularly acute in the private healthcare industry.

7.1.7 First, it is logical that any regulated price must enable operators to earn a sufficient return to recover costs, including costs of capital. However, in this regard, absent detailed information on firms' respective cost bases and complex analyses of these data (which can entail a degree of subjectivity in any case and are often extremely costly to undertake), there can be a very significant risk of prices being set at inappropriate levels. In this situation, 'government failure' replaces 'market failure'.

7.1.8 Second, private healthcare is a dynamic sector featuring regular changes in the number and quality of products, and healthcare providers do not offer a homogenous product (unlike water supply or electricity supply for example). These features would make price based regulation particularly challenging due to the large information requirements for efficient regulation.

7.1.9 Third, price regulation in general can create incentives for suppliers to reduce or degrade the quality of service. This is because suppliers can reduce costs, and increase their profits for a given level of revenue, by offering a lower quality of services to customers, while ensuring they meet any price-based regulation.

- 7.1.10 Fourth, price caps in particular can also lower incentives for investment by firms. For example, uncertainty as to whether a regulated firm will be able to recover efficiently its incurred costs, including a return on capital, associated with any investments made when prices are re-set can weaken incentives for investment.
- 7.1.11 Finally, price cap regulation can reduce allocative efficiency by not allowing cost changes to be quickly reflected in price changes.
- 7.1.12 LHC therefore submits that the stakeholders proposing price regulation have failed to establish that the conditions for price regulation apply to the South African private healthcare industry, and notes that invasive regulation of this sort would risk leaving end consumers substantially worse off.

8. Formulary

- 8.1 The South African Private Practitioner’s Forum (“**SAPPF**”) alleges that hospitals compel doctors to use medicines and equipment that may not be in the best interests of the patients.²² This is echoed by the South African Medical Association which alleges that private hospitals enforce the use of certain products agreed with the schemes and oblige doctors to use these products irrespective of their own clinical judgment.²³
- 8.2 **[CONFIDENTIAL].**
- 8.3 **[CONFIDENTIAL]**
- 8.4 **[CONFIDENTIAL].**
- 8.5 **[CONFIDENTIAL].**
- 8.6 **[CONFIDENTIAL].**
- 8.7 **[CONFIDENTIAL].**

²² SAPPF Submission at page 86 to 88.

²³ SAMA Submission at Page 39.

8.8 [CONFIDENTIAL],²⁴ [CONFIDENTIAL].²⁵

8.9 There is no incentive for LHC to include more expensive ethicals in its formulary as LHC makes no margin and charges no dispensing fee on drugs supplied under the formulary.

9. Quality

9.1 There have been many submissions that have alleged that the quality of care at private hospitals has deteriorated and that there is no monitoring and evaluation of the quality of healthcare services.²⁶

9.2 Please refer to Paragraph 3 of LHC's First Submission which deals comprehensively with LHC's quality measures and monitoring mechanisms. As mentioned in the First Submission, LHC's vision is to be a world class provider of quality healthcare for all. Indeed, quality is one of LHC's deeply rooted core values and a key business strategy.

9.3 As explained in the First Submission, LHC measures quality performance against certain key metrics at each hospital. A detailed description of each metric is specified below:

Indicator	Brief description
Patient Experience (PXM)	
PXM – overall experience (inpatient)	The post discharge survey incorporates a number of questions asked of discharged in-hospital patients using an electronic feedback system (email/USSD). The post discharge survey questions cover certain touch points. For the overall experience indicator it is the overriding view from the patient of their overall hospital stay/experience

²⁴ [CONFIDENTIAL].

²⁵ [CONFIDENTIAL].

²⁶ See submissions by BHF, Profmed and SAMA.

"The private health sector likes to puff about how the quality of its healthcare services is so high as a way of justifying the high prices but this is questionable since here is no ongoing scientific monitoring and evaluation of the quality of healthcare services in the private healthcare service." BHF at page 10.

"There is not a rational relationship between the quality of services supplied by hospitals and prices charged for these services. For example, although the quality of nursing care has deteriorated, prices nevertheless increase year-on-year in excess of consumer inflation". Profmed at page 38.

PXM – recommend (inpatient)	For the recommend indicator it is the probability of the patient referring friends or family to that specific hospital
PXM – overall experience (EU)	The post discharge survey incorporates a number of questions asked of discharged emergency unit patients using an electronic feedback system (email/USSD). The post discharge survey questions cover certain touch-points. For the overall experience indicator it is the overriding view from the patient of their emergency unit visit/experience
PXM – recommend (EU)	For the recommend indicator it is the probability of the patient referring friends or family to that emergency unit
Positive comments	Positive feedback received from patients whilst in-hospital and provided to us on a manual comment card
Patient Health and Safety	
Total Incident Rate	Includes medication, falling, procedure related, behaviour, death due to unnatural causes, burns, other patient incidents and patient absconded
Medication Incident Rate	Includes pharmacy dispensing, nursing administration and issuing incidents and also other medication incidents - patient related and administration by doctor/paramedic
Falling Incident Rate	Includes nursing, patient, equipment, environmental and therapy related falls and nursing related slips
Procedure Related Incident Rate	Includes equipment not accounted for or found, rehabilitation equipment failure, incorrect use of rehabilitation equipment, incorrect diagnosis/ treatment resulting in complications, doctors' orders not followed (excluding medication related incidents), incorrect or no identification, developed pressure ulcers, developed/acquired wounds, lesions, marks, etc. (excluding pressure ulcers), procedures not followed resulting in complications or major risk to the patient, venous thromboembolism (VTE) cases developed in hospital, patient documentation incorrect or incomplete, patient complication or patient compromised related to procedure or equipment, wrong site, wrong surgery, foreign object left in patient and IV therapy related
Medication Bundle Compliance (MBC)	
MBC – Legal Medication Prescription	Measuring compliance of the following elements: Prescription complies with legal requirements, telephonic prescription – RN and witness signed, time of order and doctor signed within 24 hours. Medication from home – all medications recorded RN and witness signed. Doctor reviewed home medication and prescribed/ signed for

	medication to be continued
MBC – Complete Medication Administration	Measuring compliance of the following elements: Medication calculation correct and double check was done, correct medication according to prescription, administered to the correct patient, pre-med as well as other medication administered to the right times and frequency and medication was given via the correct route
MBC – Recording of medication administration	Measuring compliance of the following elements: Recorded on the medication chart, nursing notes signed and dated. Sample signature up to date and in place, schedule 5 & 6 drugs only – prescription written in words and numbers, correct and complete checks and entry made in drug book
MBC – Effects/ Side Effects of Medication monitored and recorded	Measuring compliance of the following elements: Patient informed of possible side effects of medication given and recorded. Analgesia – pre-administered and 30 minutes post administration pain score recorded. Nebulization: Assessment of patient before and after administration and recorded. Record patient response to medication given. Side effects after administration of medication actioned and recorded.
MBC – Average %	The average of the following 4 bundles: Legal medication administration, complete medication administration, recording of medication administered, effect/ side effects of medication monitored and recorded.
Employee Health and Safety	
Total Incident Rate	Includes falling, mobility (sprains/ strains), needle sticks/ sharps (body fluid/ blood), cut/ puncture (no body fluids), foreign object, stacking and storage, occupational health – infection related (COVID accepted cases), occupational health other, burns, assault, motor vehicle related accident, equipment related injury, injuries other, exposure to body fluid, attitude, behaviour, LOH classification, ethics and other.
Falling Incident Rate	Includes dry floor, wet floor, uneven floor surface e.g. paving, stairs, out of chair, during patient handling/ unbalanced, trip over, alleged fall, incorrect shoes/ footwear, not placing/ lack of “wet floor” signage, not complying with “wet floor” signage, using a cell phone, unsafe practice – surgeon/ doctor and other.
Needle-stick Incident Rate	Includes handling/ passing device after use, scalpel or theatre sharps handling, recapping patient Insulin, recapping other e.g. Clexane, unsafe disposal,

	containers overfilled/ unsafe, unsafe practice, neutral zone not utilized, incorrect placement of container, container not available, restless/ aggressive patient and other.
Mobility Incident Rate	Includes struck by/ struck against, caught between, lifting/ moving patient(s), lifting/ moving objects, handling/ push and pull object
Other Incidents	
Other Incident Rate	Includes the following categories – customer/ visitor/ relative, member of multi-disciplinary team, property, environment and supplier/ service provider incidents.
Infection Prevention	
VAP Bundle Compliance	Measuring compliance of the following elements: The head of the bed is elevated 30-40°, sedation vacation – patient has been assessed daily for readiness to extubate, peptic ulcer prophylaxis is given, DVT prophylaxis is given/ foot pumps are used and mouth care is done at least 6 hourly using chlorhexidine mouth wash.
SSI Bundle Compliance	Measuring compliance of the following elements: If hair is removed, it is only done with clippers or depilatory cream, there is proof of antibiotic/s given on the peri-operative document and blood glucose maintained between 4 – 10 throughout the ICU/HC stay.
CLABSI Bundle Compliance	Measuring compliance of the following elements: Hand washing procedure was followed, maximal barrier precautions were used by the doctor as per checklist, 2% Chlorhexidine in alcohol skin prep is done and allowed to dry before insertion, central line is sited in the subclavian or jugular vein, a daily review is done of the need to keep the line (CVP), the line is properly secured e.g. with a special dressing/ device or stitched and the dressing is visibly clean and intact.
CAUTI Bundle Compliance	Measuring compliance of the following elements: A sterile catheter pack was used to insert the catheter, the catheter is properly secured to avoid pulling, catheter (perineal) care is done at least twice daily and after bowel movement using hibiscrub and water/ chlorhexidine and cetrimide. A disposable cloth/ cotton wool or gauze may be used (bar soap or face cloths are not used). A daily review is done of the need to keep catheter insitu.
HAI Infection Rate	Combines the VAP, SSI, CLABSI, CAUTI and other

	infections acquired in the hospital/ healthcare facility.
VAP Infection Rate	Ventilator associated pneumonia acquired whilst patient is intubated or 24 hours after extubation (according to CDC guidelines)
SSI Infection Rate	Surgical site infections acquired up to 30 days after surgery or within 12 months if prosthesis was used (according to CDC guidelines)
CLABSI Infection Rate	Central line associated bloodstream infections acquired whilst central line is insitu and 24 hours after removal (according to CDC guidelines)
CAUTI Infection Rate	Catheter associated urinary tract infections acquired whilst patient is catheterized and 24 hours after removal (according to CDC guidelines)
Cardiac Excellence (Cathlabs)	
Aspirin on Arrival	Administer anti-platelet drug to prevent blood clot formation within 30 minutes from arrival e.g. aspirin, Disprin, Ecotrin, Plavix, Integrilin <i>*except when contra-indicated</i>
Aspirin on Discharge	Anti-platelet drug is prescribed for home use (TTO) e.g. aspirin, Disprin, Ecotrin, Plavix, Integrilin <i>*except when contra-indicated</i>
Beta Blockers in 24 Hours	Administer Beta Blocker to lower/ control blood pressure within 24 hours e.g. Atenolol, Ten-Bloka, Inderal <i>*except when contra-indicated</i>
Beta Blockers on Discharge	Beta Blocker is prescribed for home use (TTO) e.g. Atenolol, Ten-Bloka, Inderal <i>*except when contra-indicated</i>
PCI < 90 minutes	Percutaneous coronary intervention e.g. angioplasty or stenting of the coronary arteries within 90 minutes from admitted with AMI
Thrombolytic in 30 minutes	Thrombolytic therapy commenced within 30 minutes, to dissolve blood clots, restoring blood flow. This excludes Heparin. <i>*except when contra-indicated</i>
AMI Mortality Rate	AMI patients admitted to our hospitals and passed away during their hospital stay
Statin on discharge	This refers to Statin prescribed for home use (TTO) to reduce cholesterol levels e.g. Lipitor, Lescol, Lovacool

Smoking Cessation on discharge	Patient has been educated on the risk of smoking and provided with supportive documentation.
Cardiac Excellence (Feeder Hospitals)	
Aspirin on Arrival	Administer anti-platelet drug to prevent blood clot formation within 30 minutes from arrival e.g. aspirin, Disprin, Ecotrin, Plavix, Integrilin <i>*except when contra-indicated</i>
Beta Blockers in 24 Hours	Administer Beta Blocker to lower/ control blood pressure within 24 hours e.g. Atenolol, Ten-Bloka, Inderal <i>*except when contra-indicated</i>
Thrombolytic in 30 minutes	Thrombolytic therapy commenced within 30 minutes, to dissolve blood clots, restoring blood flow. This excludes Heparin. <i>*except when contra-indicated</i>
Patient Documentation Audit (PDA)	
PDA %	Patient documentation audit includes evaluation of the following 9 elements – patient assessment, legal, medical prescription and doctors' clinical progress notes, nursing care programme, progress monitoring, infection prevention, safe patient environment and immediate ward environment, legal compliance, case management and nursing responsibility for accurate charting.
PDA ratio per admission	To measure whether the amount of patient documentation audits performed is in line with the admissions – in order to make the score reliable and a true reflection.
Sustainability Measures	
Refrigerant Gasses	Monitoring refrigerant gasses e.g. R134A, R22, R404A, R407C, R410A and R507 with the aim of managing the impact resulting from using these gasses and phasing out harmful gasses starting with R22
HCRW Kg/ PPD	Monitoring the amount of health care risk waste generated by hospital - including pharmaceutical waste, anatomical waste, sharps, cytotoxic, infectious non-anatomical waste and radioactive waste
Electricity/ KWH	Monitor the amount of electricity used through use the metering system with the aim of understanding and reducing the usage
Water/ KL	Monitor the water usage with the aim of reducing the water usage

- 9.4 LHC's group scorecard process and outcomes measures are reviewed yearly and new measures are added to the scorecard, where appropriate. Each year a target score is agreed for each metric and this feeds into the group business plan, hospital business plans, and department business plans. Hospitals then review their performance on a monthly basis using their hospital specific scorecards and trends are identified. These trends are discussed at quarterly quality review meetings and actions agreed to address any negative trends and to improve performance. Hospital performance against the agreed targets is audited yearly through the internal quality audit process.
- 9.5 As can be seen from the 2014 group scorecard (attached as **Annexure 9**) these quality measures have trended in a way that illustrates continuous improvement and is in line with LHC's commitment to providing world class care at its facilities.
- 9.6 LHC requested that its expert economists, RBB Economics, extend its local concentration analysis to cover non-price aspects of competition. In particular, LHC requested that RBB examine whether competitive outcomes in the form of healthcare quality indicators are worse in local areas where a LHC hospital faces fewer local competitors. RBB has focused upon three families of indicators, namely indicators of infection prevention, indicators of cardiac excellence (which RBB understands is a widely used indicator in the relevant literature), and indicators of infection rates.
- 9.7 The results of RBB's analysis are that there is no systematic relationship between quality of care and local concentration, and in particular that there is no statistically significant difference between the quality scores of those hospitals facing one or fewer rival hospitals and those hospitals facing two or more rival hospitals.

10. **Regulatory**

10.1 Employment of medical practitioners and conflicts of interest

- 10.1.1 Please refer to Paragraph 16 of LHC's First Submission. In LHC's view, the highly fragmented nature of inpatient services in the South African context, where doctors and allied health professionals all operate as independent practitioners, has significant implications for both the cost and the quality of

care provided. Therefore, an important next step towards enhancing the cost-effectiveness of the sector, relative to the quality outcomes, is for hospital groups to have a greater ability to co-ordinate the care provided within their facilities while still preserving the autonomy of healthcare professionals to make clinical decisions.

10.1.2 As explained in the First Submission, LHC does not seek to employ all doctors, but rather to employ certain categories of healthcare professionals in an effort to provide patients with a more integrated delivery platform that lends itself to better co-ordination of care with the resultant cost and quality benefits.

10.1.3 It is widely recognised that business structure regulations may have a negative impact if they inhibit providers from developing new services or cost-efficient business models.²⁷ This is echoed by the many international jurisdictions that allow doctor employment by various corporate entities in an effort to reduce costs, create efficiencies and enhance innovation in the market.²⁸

10.1.4 Any employment model for healthcare professionals would necessarily be designed to solve for the provision of appropriate, quality care in a cost-effective fashion, with no incentive to over-service or under-service, particularly in light of the alternative reimbursement models now prevalent in the market.

10.2 Adverse allegations regarding hospitals' relationships with specialists

Perverse incentives for specialists and doctor shareholdings

10.2.1 It has been alleged by certain stakeholders that relationships between hospitals and doctors create *perverse incentives*²⁹ and *suspicious practices*.³⁰

²⁷ European Commission, *Report on Competition in Professional Services*, 9 February 2004.

²⁸ Federal Trade Commission, *Roundtable on Competition in Professional Services – United States (Working Party No. 2 on Competition and Regulation)* (1999); Commission of the European Communities *Report on Competition in Professional Services* (2004).

²⁹ Profmed alleges that “[t]he relationship between hospitals and medical specialists is inherently conflicted and perverse as hospitals need to ensure, by offering a variety of incentives ... that specialists support them and drive utilisation...”. At page 38. See also page 44 and 45 of Cape Medical Plan’s submission “Suspicious Practices” which raises the issue of doctor incentives.

³⁰ See Cape Medical Submission at pages 44 and 45.

Metropolitan Health also raises allegations of perverse incentive based on what it calls a “*crude analysis*” that it conducted which shows the costs experienced in two hospitals with significant shareholding by specialists.³¹

10.2.2 LHC denies these statements and requests that empirical evidence is provided to illustrate that these practices occur at LHC hospitals. As the Panel would have noted from LHC’s First Submission, LHC has provided a comprehensive discussion of its arrangements with specialists, none of which indicate any of these practices alleged by these stakeholders.

10.2.3 As regards shareholdings, as per LHC’s First Submission, LHC’s shareholding scheme is transparent and contains certain measures aimed at preventing perversity. To propose that doctors drive utilisation based on their shareholding in a hospital is simplistic and does not recognise the lack of ability on the part of doctor shareholders to materially influence their own returns. We refer the Panel to Figure 15 in LHC’s First Submission which contains a theoretical example showing the income generated by an orthopaedic surgeon through professional fees and through a dividend from shareholding.

Inappropriate use of new technology to attract specialists

10.2.4 Metropolitan Health has proposed that hospitals compete for specialists who control admissions to hospitals – by creating excess capacity through investment in beds and equipment.³²

10.2.5 LHC refutes this allegation. For a hospital group to simply respond to doctors’ requests for further expansion where there is no investment case is not financially viable. As indicated to the Panel in LHC’s First Submission,³³ all decisions by LHC to purchase new technology or expand a facility are made on the basis of a robust investment case, which must demonstrate the need for the requested investment.

³¹ “*Metropolitan has done a crude analysis of the costs experienced in two hospitals with significant shareholding by specialists ... The results indicate that there may be unwanted changes in therapeutic behaviour by doctors and that costs are higher in doctor-owned hospitals ... A more comprehensive analysis is however required to show conclusively whether doctor-ownership results in poorer outcomes at higher costs.*” At page 11.

³² See Metropolitan’s submission at page 11.

³³ See paragraph 9.7.2 of LHC’s Submission.

10.3 PMBs and over utilisation

10.3.1 There have been various allegations made that hospitals over-service and charge more for PMB conditions than they do for non-PMB conditions – because medicals schemes are compelled to cover the full cost of the PMBs.³⁴

10.3.2 LHC rejects this allegation. LHC agrees on particular rates with different schemes and these rates apply regardless of whether the treatment involves a PMB or a non-PMB condition. In addition, the complete funder authorisation process is applicable for PMB conditions in exactly the same manner as it applies to non-PMB conditions, that is, the same authorisation protocols and managed care processes apply.

11. Specific Allegations

11.1 The Society of Private Nurse Practitioners of SA (“**SPNPSA**”)

11.1.1 The SPNPSA has made various allegations against private hospitals (including LHC specifically)³⁵ relating to:

11.1.1.1 Policies in place in private hospitals which restrict the ability of private midwives to perform their services in a hospital setting;

11.1.1.2 The reduction of specialist nursing positions at hospitals in an effort to reduce costs and allowing medical practitioners to perform some of these functions;

11.1.1.3 Policies which discourage an employed nurses’ ability to take instructions from a private nurse practitioner and instead seek authorisation from a medical practitioner.

Allegation reading policies that restrict midwife access

³⁴ See BHF and Profmed submissions. Profmed, at page 35, alleges that “*hospital costs are influenced by the “guaranteed payment” for PMBs by medical schemes*. BHF, at page 27, notes that medical schemes have no option but to pay whatever the hospital charges for in the case of a PMB and that this contributes to the imbalance of power between medical schemes and private hospitals.

³⁵ See SPNPSA submission at page 6.

11.1.2 LHC does in fact have private midwives who practice at some LHC hospitals. The reasons as to why these arrangements are not more common place relates to the scarcity of private midwives in South Africa (only approximately 140 midwives registered with the SPNPSA). This, coupled with the fact that there are some anomalies with professional indemnity insurance for private midwives,³⁶ has meant these services are not consistently available at LHC's national network of hospitals.

11.1.3 **[CONFIDENTIAL]**³⁷.

Allegations relating to the reduction of specialist nursing positions

11.1.4 LHC refutes this allegation and is of the view that these statements are anecdotal and do not properly present the situation with regard to these nursing specialities.

11.1.5 To clarify the position, uncomplicated wound care is provided by all LHC's registered and enrolled nurses. With regard to advanced wound care certain LHC hospitals offer wound care clinics and the registered nurses who perform services there are in the employ of LHC.

11.1.6 Stoma therapy is an advanced nursing skill which is managed by the nurses at LHC hospitals. Any advanced stoma needs are referred to a specialist where appropriate.

Allegations relating to instructions from private nurse practitioners

11.1.7 LHC refutes this allegation and is of the view that these statements ignore the regulatory requirements relating to the prescription of care or treatment of a patient. Currently a private nurse practitioner can participate in the agreement of a comprehensive nursing care plan for a patient in a LHC hospital (for example the management of wound drainage apparatus or stoma care).

³⁶ Currently most private midwives only have cover through DENOSA which provides a limit of up to R1 million rand. In a context where insurance claims in the OBGYN space are so severe, LHC must ensure its patients are adequately protected.

³⁷ **[CONFIDENTIAL]**.

- 11.1.8 Where instructions are sought from medical practitioners, this would be in the context of the prescription of care that only medical practitioners have the ability to approve. To ignore such requirements has legal indemnity consequences to which LHC will not expose patients.
- 11.2 Emalahleni Private Hospital Complaint Re: Langamed Ambulance Service
- 11.2.1 LHC notes the allegations contained in the Emalahleni Private Hospital submission that there is an arrangement with Langamed to allocate patients preferentially to Life Cosmos hospital and records that it has no prior knowledge of this specific incident that was alleged to have taken place.
- 11.2.2 Indeed, LHC categorically denies that there is any arrangement with Langamed to allocate patients preferentially to Life Cosmos hospital.
- 11.2.3 LHC is only aware of an incident with a patient of Dr Rauf. This patient was erroneously dropped off at Life Cosmos Hospital as a result of an incorrect instruction to Langamed regarding the drop off location and not because of an arrangement for preferential allocation. Once the error was discovered, the doctor was contacted and the patient transferred to the correct facility on the same day.
- 11.2.4 Regarding the relationship between LHC and Langamed ambulance service, Life Cosmos sponsors Langamed at R15 000 per month for a co-branded paramedic response vehicle. Attached is an invoice showing an example of this payment marked **Annexure 10**. The vehicle is co-branded with an Anglo American logo and a LHC logo. The decision to sponsor this service was made in order to ensure that there was a rapid response vehicle available for the mines. There is no formal agreement in place with Langamed.
- 11.2.5 In addition to this sponsorship, Life Cosmos also assists Langamed with staff refreshments, disposing some of Langamed's medical waste and with fresh linen in circumstances where the response vehicle needs to attend to another case and is unable to return its base before doing so.

12. Concluding Remarks

- 12.1 The stakeholder submissions clearly illustrate that there are a number of significant players in the private healthcare market whose conduct plays a crucial role in the delivery of private healthcare. It is also evident from the submissions that the complexities of the private healthcare market are nuanced and have far reaching implications.
- 12.2 We trust that LHC has assisted the Panel in considering some of the key issues that have been raised by the various stakeholders and we re-iterate our commitment to the Inquiry process.