PRESENTATION OF THE HMI PROVISIONAL REPORT

I. Introduction

1. Today we are announcing the publication of the Provisional Findings and Preliminary Recommendations of the Health Market Inquiry which are contained in our provisional report. This announcement will of course be incomplete without highlighting our key provisional findings and preliminary recommendations.

2. But perhaps to put our provisional report in context, let me refer briefly to the background to the investigation, remind you of our mandate, describe the process we followed in carrying out our mandate and refer to some of the challenges that we encountered in the process. It is necessary to refer to these challenges because they underscore some of our preliminary recommendations.

II. Background

3. The Competition Commission initiated the HMI after observing increases in prices and expenditure in the private healthcare sector which had reached "levels which only a minority of South Africans can afford".[1] This observation prompted the Commission to inquire into, and evaluate, explanations for observed increase in price and expenditure in the private healthcare sector.

4. The Commission wanted the inquiry to establish whether there are any factors that prevent distort or restrict competition in the private healthcare sector and to establish information that will "provide a factual basis upon which the Commission can make

[1] ToR paragraph 3 page 80.

evidence-based recommendations that serve to promote competition in the interest of a more affordable, accessible, innovative and good quality private healthcare" [Id]

5. Against this background, the Commission appointed a Panel of independent experts to conduct the Health Market Inquiry into the state of competition in the private healthcare sector. The Panel's mandate is set out in the Terms of Reference for the Inquiry published in the Government Gazette on 29 November 2013.

6. It is important to understand that the focus of our investigation is the private healthcare sector and not the public sector. While the inquiry has provided us with a window through which to see what is happening in the public sector, this report does not deal with the public healthcare sector. An inquiry into the cause of the poor quality of healthcare services in the public sector is a question for another day.

7. This inquiry focuses primarily on understanding the factors that prevent, distort and lessen competition in the private healthcare sector. The Terms of Reference required us to establish a factual basis for recommendations that support the achievement of accessible, affordable, high quality and innovative private healthcare in South Africa. The question of how to improve access to affordable and good quality healthcare has therefore been approached primarily through a competition lens while noting that the crucial issue of equitable and fair access to good quality healthcare services does not rest entirely on competition.

8. A comprehensive commission of inquiry into the state of healthcare in both the public and private sectors may be more appropriate to evaluate the general state of healthcare services in South Africa in order to give effect to the constitutional right of access to healthcare services and goods guaranteed in section 27 of the Constitution.

III. The mandate of the HMI

9. The statutory question that we are required to answer is whether there are features in the private healthcare markets for services and goods which harm competition or have a potential to harm competition. These features can take the form of structure or conduct, or both, of participants in the private healthcare sector as well as poorly designed and implemented legislation, improper governance and poor regulatory oversight.

10. In answering this question, we had to comply with the principles of procedural fairness and transparency which is a constitutional requirement. This required us to provide stakeholders sufficient time to engage with, review and consider the information and analyses conducted by the Inquiry that may adversely affect them.

11. It was in the light of these principles that the HMI published various reports and offered the stakeholders the opportunity to comment on these reports and granted them access to the underlying data used in compiling the reports. Indeed, the very publication of the provisional report and inviting comments on it, is a fulfilment of the requirement of fairness.

IV. The Process of Inquiry

12. Broadly speaking the inquiry process progressed through four phases, namely, the Establishment phase; Evidence Gathering; Analysis of Information and Data; and the Release of the Provisional Findings and Preliminary Recommendations Report.

13. The Establishment Phase involved setting up the platform for the inquiry process and initial engagements with stakeholders. This included the publication of foundational documents for the conduct of the inquiry, such as the Statement of Issues setting out

issues that were the focus of our initial investigation; and the Guidelines for the Conduct of the Inquiry

14. The Evidence Gathering phase had four constituent parts:
    a. conducting background research
    b. receiving written submissions from stakeholders,
    c. requesting and receiving data from 175 stakeholders, including requests for financial data as well as detailed claims data for the period 2010 to 2014 from 80 medical schemes; and
    d. holding Public hearings and seminars on selected topics

15. The call for written submissions generated more than 15 000 pages of written submissions which largely consisted of technical data and information on various healthcare markets. Before these written submissions could be published for comment by other stakeholders, we had to consider several claims to confidentiality which were raised by a number of stakeholders. This was a time consuming but essential process.

16. The third phase of the Inquiry entailed the analysis of the data and information collected. It ran concurrently with the second phase. Various models and base analytical processes were run to determine, among other things, expenditure and costs trends, profitability and market power. The results from all the analytical work, including the input of the technical team and panel members, formed part of comprehensive technical reports on each set of service providers, including Descriptive Statistics Report, Attribution Analysis Report, Prescribed Minimum Benefit Analysis Report and Associated Projects and Various Case Studies.

17. The fourth phase brings us here today, with the publication of the provisional report. But the road to this phase has been punctuated by some challenges.

V. The challenges

18. One of our greatest challenge was in the area of the identification of data sources, collection of data and the processing of information and data. And the importance of data for our investigation cannot be gainsaid.

19. The Terms of Reference, for instance, require the HMI to inquire into factors that drive the observed increases in private healthcare expenditure and prices, to evaluate various explanations for such increases and to identify competitive dynamics at play. Data is essential in determining trends in expenditure, costs, and profitability as well as the explanations for the observed increases, in particular, whether these increases are due to the exercise of market power or some other anti-competitive conduct.

20. The first challenge we faced is that there is no central and uniform data and information storage system pertaining to private healthcare in South Africa. The only sources of data are medical schemes, practitioners, hospital groups and public data sources, including regulatory bodies. These stakeholders collect data and information for their own use, with limited criteria and requirements for reporting in the sector.

21. Secondly, we experienced significantly long and sometimes cynical delays in the submission of data by stakeholders. This prolonged the process of data collection and included a number of engagements with lawyers representing various stakeholders.

22. Thirdly, processing, collating and storage of data presented its own challenges. We had to satisfy ourselves on the integrity and quality of data. In addition, we had to ensure that data submitted were correct in terms of category and time series, that it

was submitted in correct format, and that it was accurate and complete. In some cases, data had to be sent back to the submitting stakeholder in order to correct data sets or present data in the correct format. The integrity of data is crucial to the accuracy of any analysis.

23. Fourthly, one of the issues of concern pertaining to data, was the need to preserve confidentiality in respect of the data collected. The data contained personal patient information which could not be disclosed. We had to develop a De-Identification tool that would ensure the removal of personal identifiers in all data sets in our possession. This process allowed stakeholders to provide us with data pertaining to patient information and addresses in a format that ensured that patients' personal identities and residential addresses would not be identifiable while keeping each individual patients' records distinct for analytical purposes. This was also a very time-consuming exercise.

24. The delay encountered in collecting, collating and storing data was exacerbated by the complexity of processing data into a format that can be used for analysis and the sheer volume of data that had to be processed. We collected over 545 GB of data. This process involved data being compiled in a uniform format from very diverse systems. Making data compatible and then organising it into data sets and warehousing these data sets has been an enormous task.

25. Quite apart from this, certain Stakeholders requested access to the underlying data of all the analytical reports published by the HMI over the duration of the Inquiry. In response, the HMI had three separate Data Room periods to facilitate fair opportunity for stakeholders to comment on the analytical reports. Such access to underlying confidential information was restricted to external advisers of stakeholders who wished to review the data and workings of the HMI. The HMI has therefore made

significant efforts to ensure that stakeholders were given adequate opportunity to conduct the relevant verifications of analytical reports in the Data Room, whilst also ensuring it complied with the commitments made to data providers.

26. We believe that the challenges encountered in context of data collection and processing underscore the urgent need to develop a comprehensive national health information system which will require stakeholders to provide information relating to health financing, the pricing of healthcare services, business practices involving hospitals and health care providers, and the publication of various types of information in the public interest and for the purpose of improving access to healthcare and the effective and efficient utilisation of health services, as envisaged by the National Health Act.[2]

27. The significance of data in this market inquiry is amply demonstrated by the fact that the integrity of the data we used, the methodologies used to analyse the data as well as our application of these methodologies, are heavily contested by the stakeholders.

28. Before highlighting our key provisional findings and preliminary recommendations, I wish to make a few general remarks.

VI KEY FINDINGS

29. Firstly, the South African private healthcare sector comprises a complex set of interrelated stakeholders that interact in markets that are not transparent and so not easily understood.

[2] Section 74(1) read with section 90(1)(t) and (u).

30. Secondly, the South African private healthcare sector is part of a two-tier national health system with a dual problem. The cost of private healthcare is high and rising while public healthcare services are affordable, but generally of poor quality. The public health sector does not pose a significant competitive constraint to the private sector for patients or for service providers. The public sector is not a big purchaser of services from the private sector and so, unlike in some other countries, public sector tariffs do not influence what is charged in the private sector. Due to the poor quality of facilities in the public sector, private patients are barely inclined to use the public sector even if it is much cheaper.

31. Thirdly, by and large, the market is characterised by high and rising costs of healthcare and medical scheme cover, highly concentrated funders' and facilities' markets, disempowered and uninformed consumers, a general absence of value-based purchasing, ineffective constraints on rising volumes of care, practitioners that are subject to little regulation and failures of accountability at many levels.

32. Finally, the evolution of the market to its current form is a consequence of a changing regulation environment which saw periods of deregulation in the late 1980s and then partial re-regulation which has led to the status quo. The end result is that facilities are not regulated beyond the requirement of a licence to operate and practitioners are licensed to practise by the Health Profession Council of South Africa but little more. The funder (demand) side of the market is characterised by significantly more regulation including open enrolment, community rating and a prohibition of risk rating. However, the funders' regulatory regime is incomplete.

33. The overall incomplete regulatory regime can largely be attributed to a failure in implementation on the part of regulators and inadequate stewardship by the Department of Health over the years. We say this because some of the

recommendations we have considered are already provided for in current legislation but have not been implemented.

34. I will address the key findings in four broad areas. First, I will present the key findings on expenditure and supply-induced demand. The findings of supply-induced demand have not been published before and will thus be new to stakeholders. Thereafter, I will set out the key findings pertaining to funders which includes medical schemes, administrators and brokers, then to hospitals, and; finally, medical practitioners.

(a) Expenditure and supply-induced demand

35. In its terms of reference for the Inquiry, the Commission cited high and rising prices and expenditure as one of the key reasons for the initiation of this Inquiry. One of the first tasks of the Panel was thus to understand the factors that drive expenditure in the private healthcare sector.

36. The analysis of the industry claims data provided the HMI with an opportunity to quantitatively describe expenditure trends in the private healthcare sector. The data allowed the inquiry to identify what proportion of the claims costs can be explained by factors that are known to influence expenditure, such as age, gender, disease profile and the severity of the medical condition the person is being treated for (also known as the "case mix"). In our model, these are called the "explained factors". After identifying the "explained factors", an "unexplained" portion of expenditure remains. Bearing in mind that we have done our utmost to identify all factors reasonably expected to drive healthcare expenditure, the portion that remains unexplained cannot easily be attributed to the illness or demographic features of the population.

37. The claims analysis shows that the Commission's initial concern with affordability and escalation of healthcare expenditure is well founded. The Inquiry collected claims data for the period 2010 to 2014. Over this period, the average expenditure per

private medical scheme member increased by 9.2% per annum. After adjusting for factors such as inflation, age, members' plan type, gender, disease profile and membership movement, the unexplained (or residual) increase in spending per member was still greater than 2% per annum in real terms. To put this in context, 2% of spending amounts to around R3 billion in 2014 terms, that is R330 per beneficiary per annum that could not be explained by factors rationally expected to drive expenditure.

38. Most of this unexplained increase in claims cost can be attributed to in-hospital rather than out-of-hospital care, indicating a relative shift in claims costs towards hospital-based care that cannot be entirely attributed to the proxies for risk analysed by the HMI.

39. The unexplained portion of in-hospital claims cost were also materially higher than out-of-hospital care. Unexplained factors accounted for 32% of in-hospital claims cost for open schemes (these are schemes that provide for open enrolment and thus accept all applicants as members) and 27% for restricted schemes (the rules of restricted schemes circumscribe who may become a member of the scheme, for example based on employment).

40. In comparison, for out-of-hospital care only 16% of claims costs were unexplained for open schemes and 2% for restricted schemes. The high proportion of unexplained claims cost increases for in-hospital care is concerning and our findings suggest that this is, in part, due to high utilisation (that is, a higher number of admissions) and increases in cost per admission.

41. We conducted further detailed analysis of the claims cost focusing on practitioners, facilities and funders. These reports were published on 15 December 2017 and stakeholders have engaged with them extensively.

42. Given our findings of high unexplained increases in claims costs, the HMI more closely evaluated the effect of increased utilisation and the possible presence of supplier-induced demand in the private healthcare sector. The data suggest that there is indeed strong evidence of supplier-induced demand.

43. Supply-induced demand is the phenomenon by which increasing access stimulates additional use of the service that would not have otherwise occurred. So if there are more beds available they can be used and in health care they will be. Or the offer of more or another investigation or more treatment to "make sure" or "just to be careful or exclude anything else" than is strictly needed, then it will be used. If you can go to specialists rather than a GP or nurse, then you will.

44. In healthcare markets, the doctor decides what treatment a patient should receive. Patients do not know what care they need and are not able to critically assess the doctor's advice. Patients are also insensitive to the cost of treatment because these costs are borne by a third party, such as the medical scheme. Their decisions are not influenced by prices as they would be in normal markets.

45. In perfect conditions, the doctor would only prescribe treatment that is absolutely medically necessary. If this relationship breaks down and the doctor recommends or encourages a patient to consume more care than is required for their medical problem, this is called supplier-induced demand. This happens, for example if a doctor orders more tests than are absolutely necessary; conducts a caesarean

section when it is not absolutely necessary to do so, admits patients to hospitals when their condition can be treated out of hospital, or admits them to an ICU when general ward admission would be appropriate.

46. In short, utilisation rates are worrying. The absolute age-adjusted hospital admission rates in South Africa were higher than all but two of the 17 OECD countries compared against. The HMI also evaluated utilisation for seven discretionary procedures. For six of the seven procedures studied, South African utilisation rates were higher than average. For four of these, namely cataract surgery, arthroplasty, tonsillectomy and caesarean sections, South African private sector utilisation was higher than all other countries in the sample.

47. South Africa's age-adjusted ICU admission rates in the private sector were also higher than all eight countries for which we had data. This is a startling finding 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. If the South African private ICU admission rate per head of population were reduced to half of its current level; that is, to between the rates of Belgium and the USA, and half of the costs associated with these avoided ICU admissions were reinvested in better ward-based care, we would still save approximately R2.7b annually which amounts to just over 2% of private healthcare spending overall for the period studied.

48. The HMI found that for all hospital admissions (including both PMB and non-PMB admissions) and in nine out of 11 specialties examined, there was a significant positive correlation between risk of admission and having more doctors or hospital beds in that geography. Similarly, there was a significant positive correlation between the risk of admission to ICU and the number of ICU beds in a geography. This

observation, when combined with the fact that ICU admission rates are high by international standards, suggests that utilisation is at least partly driven by supply of doctors and facilities, rather than patient need.

49. The utilisation analysis also found evidence of adverse selection. Members who had recently joined a medical scheme were more likely to be admitted to hospital, other factors being equal, than members who had been members of a scheme for more than two years.

50. To the best of our knowledge, this is the first time that a comprehensive analysis of supply-induced demand has been done publicly. The findings are concerning. We are particularly interested in hearing from stakeholders how this can be curtailed.

(b) The state of competition in funder markets

51. Overall, our observation on the funders market is that there are few incentives to ensure that scheme employees, trustees and principal officers act in the best interest of consumers and hold administrators to account. In the current model, administrators have far more analytical capacity and 'know how' than schemes, and administrators seem to make decisions on behalf of schemes, even on key issues of strategy. The 'separation' between not-for-profit schemes and for-profit administrators, often seems artificial, particularly in the case of large open schemes. As a result, administrators face insufficient pressure from schemes to deliver better value for money or to lower non-healthcare related costs.

52. Competition in the funders market is neither as vigorous nor as effective as it could, or should, be. In both the administration and open scheme markets, one large player (Discovery Health in administration and Discovery Health Medical Scheme in open

schemes) leads the market, especially in terms of growth, innovation and profitability. Other players largely follow its lead.

53. The most important findings from our profitability analysis in the funders market is that competition is simply not as vigorous as it should be and in fact appears to be almost absent. The analysis, conducted over a ten-year period from 2006 – 2015, shows that one player, Discovery Health, recorded sustained high profits over the entire period and much higher than its competitors, Metropolitan and Medscheme. Under normal competitive market conditions such a situation would see incumbents or new entrants into the market disciplining as it were a highly profitable firm. Making a profit as a first entrant is what is often seen, sustaining over years and maintaining difference between the most profitable firm and its competitors is what leads us to conclude that the market is not competitive.

54. We also have some concerns about the nature of competition amongst funders, where it is occurring. There is limited competition between schemes on factors aimed at improving affordability and value-for-money of medical scheme cover. There is also limited evidence of schemes entering into effective alternative reimbursement models to contain expenditure and encourage value-based contracting. Instead, schemes compete primarily on risk factors, such as attracting a younger and healthier population relative to peers.

55. In addition, we have found that there are failures in regulation, governance and adverse incentives associated with the current market structure that contribute to the lack of competition on value and prices and that limit innovation.

(c) Practitioners' market

56. Healthcare practitioners are central decision-makers in the use of healthcare services. Consumers are usually unable to judge what care they need and rely primarily on the guidance of their healthcare provider in this regard. Practitioners therefore have the ability to drive nearly all healthcare expenditure by virtue of the agency role they play.

57. To understand how practitioners, affect competition, we evaluated the market power of practitioners, the incentives they face that may drive expenditure and utilisation; including the effect of fee-for-service reimbursement on driving expenditure, and regulations that limit innovative team-based care and competition.

58. There is obviously very little competition between practitioners across various specialties. The primary competition analysis focused on competition within areas of specialisation and the vertical relationships between practitioners and facilities.

59. We found that the practitioner market is still quite atomistic with most medical practitioners working as individuals in their own private practice and charging on a fee-for-service basis. Practitioners are not forming multidisciplinary group practices or developing team-based models of care that can deliver greater value at lower cost. This is partly due to regulatory constraints, which are addressed in the recommendations. Practitioners are also not compelled to report on outcomes or the quality of services provided. This makes it difficult to track their performance and benchmark outcomes against others or against best practice, and to engage in value-based contracts that may be more beneficial to patients.

60. We are also concerned that practitioner associations, which often represent competing practitioners, have a chilling effect on competition and, in some case, engage in horizontally restrictive practices.

(c) Hospital market

61. The private hospital market is highly concentrated. At a national level, the three largest hospital groups have a market share of approximately 90% based on hospital admissions and more than 83% based on registered beds. In the majority of local markets, concentration levels are alarmingly high according to several recognised metrics commonly used to screen for concentrated markets. One of the challenges of this, from a competition perspective, is that it affords the big-three hospital groups "must-have" status in bargaining for contracts with funders which reduces funders' countervailing power. The Inquiry makes recommendations about how to address this high level of concentration.

62. In terms of the nature of competition in the hospital market, we note that most of the hospitals in South Africa are large acute-based facilities and although there has been increasing entry by day hospitals in recent years, the hospital market seems to lack dynamism, with new entrants following similar models to the three large hospital groups; Netcare, Mediclinic, and Life Healthcare.

63. The relationship between facilities and practitioners is crucial to understanding competitive dynamics in the facilities market. Hospitals do not compete directly for patients, but rather compete for practitioners who refer patients to hospitals. The HMI identified various incentives and arrangements between facilities and practitioners designed to attract practitioners to their hospitals and to maintain or increase admission rates.

64. We now turn to our preliminary recommendations. I will not provide a comprehensive exposition of all preliminary recommendations but will focus on the main recommendations and those related to contested matters.

VI. Preliminary recommendations

65. As we have identified a number of features that harm competition, we are required to make recommendations on how this harm may be remedied. Our preliminary recommendations are intended to address harm to competition. And these preliminary recommendations should form the basis of engagement on how best to address harm to competition that we have identified in our provisional findings.

66. We have not previously engaged stakeholders on our approach to the determination of appropriate remedial action. We consider it desirable therefore to set out our framework for the determination of an appropriate remedy.

67. In the considering an appropriate remedy, we are required to recommend measures that are aimed at addressing harm to competition. An appropriate remedy is one that is effective in achieving this aim. It is a remedy that is practical and that is capable of effective implementation, monitoring and compliance. In addition, an appropriate remedy must be proportionate to the harm that is being addressed. Proportionality requires that the remedy should be the least burdensome and must not be disproportionate to the harm it seeks to remedy.

68. The preliminary recommendations we have made must be viewed as a package. We have identified multiple and interrelated failures that have an adverse effect on competition. The interventions we have proposed are similarly closely interrelated and market failures may persist if a partial approach to the implementation of the

recommendations is adopted. In considering these recommendations, we would urge stakeholders to have regard to the links between recommendations as well as the sequence of implementation, where specified.

(a) Preliminary recommendations with respect to Funders

69. The preliminary recommendations related to funders market are aimed at improving transparency, ensuring that schemes act more concertedly in the interest of schemes members in holding administrators to account, and ensuring that schemes act to reduce supplier-induced demand and curtail excessive utilisation.

70. Preliminary recommendations include the following:

    a. Medical scheme options must be simplified by introducing a base benefit option that covers catastrophic expenditure as well as out-of-hospital preventative and primary care. The base benefit option should be standardised across schemes so that it is easy to compare and will be obligatory – all medical scheme members must purchase the base benefit option.

    b. We recommend that a risk adjustment mechanism be implemented with respect to the base benefit package. This will remove schemes' incentive to compete on demographic risk factors such as age, and will instead encourage schemes to compete on factors such value for money and innovative models of care.

    c. Various recommendations have been made to improve the governance of schemes and to ensure that schemes act in the interest of members in holding administrators to account. These include ensuring that the remuneration of Trustees and Principal Officers' remuneration is explicitly linked to objective performance-based criteria, that minimum education and training standards be put in place for trustees and Principal Officers, and that schemes actively

encourage member participation in Annual General Meetings. This could take place, for example, by increasing the quorum for properly constituted AGMs and making use of mobile and other platforms to facilitate remote participation by members.

d. We recommend that the period of election of scheme trustees be extended to give as many members as possible an opportunity to vote. To this end, electronic voting must be considered and voting must be completed and audited prior to the Annual General Meetings. At the AGM, the final result will be confirmed by the auditors and officially recorded.

(b) Preliminary recommendations with respect to providers (supply-side recommendations)

71. The Inquiry's primary concern in the hospital market is the high level of national and local concentration in hospital markets.

72. The National Health Act 2003, makes provision for Certificates of Need (CON) to replace hospital licences. Some of the factors that must be considered before issuing a Certificate of Need include:

    a. "the need to ensure consistency of health services development in terms of national, provincial and municipal planning"[3],

    b. "the need to promote an equitable distribution and rationalisation of health services and healthcare resources, and the need to correct inequities based on racial, gender, economic and geographical factors"[4].

[3] Section 36(3)(a)
[4] Section36(3)(b)

73. If this process was implemented and these principles properly applied, the new licensing framework could promote innovative entry and competition to the benefit of consumers.

74. These provisions of the National Health Act are yet to be implemented. We urge the Department of Health to implement these provisions without delay.

75. The inquiry has considered a number of alternative options on how to address the high level of concentration, including divestiture, and imposing a moratorium on issuing licences to the three large hospital groups, namely, Netcare, Life and MediClinic. Such recommendations raise a number of questions such as the proportionality, their effectiveness and whether there are less intrusive means of achieving the objective of greater competition. We invite stakeholders to make submissions in this regard.

76. More broadly, the Inquiry has found that the current regulatory measures on the supply side of the healthcare market are limited and fragmented compared with other countries where there is often a single, dedicated supply-side regulator. In South Africa, the supply side has generally been left to operate within a fragmented, poorly enforced regulatory system, with weak oversight. The existing regulatory system does not go far enough in terms of achieving optimal healthcare outcomes and appropriate access to quality healthcare services. For this reason, the inquiry makes comprehensive recommendations for additional supply-side regulation in four areas:

    a. healthcare capacity planning,
    b. conducting economic value assessments,
    c. implementation of appropriate payment mechanisms, and
    d. outcome measurement, registration, and reporting.

77. For effective and efficient regulatory oversight of the supply-side of the healthcare market, the Inquiry recommends the establishment of a dedicated healthcare regulatory authority, referred to here as the Supply Side Regulator of Healthcare (SSRH).

78. We now present the recommendations under each of the four areas for additional supply-side regulation.

(c) Healthcare capacity planning

79. We recommend that the current fragmented licensing framework be replaced with a national licensing framework for all health establishments. More effective monitoring, inspection and reporting will be embedded in the licensing framework to support the development of a comprehensive and reliable database of healthcare facilities.

80. We recommend that practice code numbering, which is currently managed by the Board of Healthcare Funders, be assigned to the Supply Side regulator for Health and that comprehensive annual reporting is built into the practice code numbering system to build a comprehensive national database of practitioners.

(d) Economic value assessments

81. The inquiry could not find good evidence of publically available cost-effective standards of care and treatment protocols being used in the healthcare sector. We recommend that standards of care, evidence-based treatment protocols and processes for conducting health technology assessments be developed.

(e) Health services monitoring

82. There is currently no standard mechanism for measuring the performance of providers. In line with requirements for greater transparency and more objective

benchmarking, a standard system should be developed to monitor the quality and outcomes of healthcare services.

(f) Health Services Pricing

83. One of the most frequent complaints made to the Inquiry is that there is currently a "tariff vacuum" in the private healthcare sector that makes it very difficult for schemes and members to estimate and compare the costs of care amongst providers.

84. The Inquiry has two proposals to remedy the "tariff vacuum":
    a. A regulatory solution where the Supply Side Regulator will set tariffs after extensive consultation with stakeholders in a public forum, or
    b. A multilateral price-setting mechanism where stakeholders conduct tariff negotiations and reach agreement under a negotiation framework determined by the Supply Side Regulator.

85. In both cases, failure to reach agreement and/or fundamental disagreements with the outcomes of the process will be resolved through a compulsory arbitration mechanism.

86. Regardless of the eventual form of the price-setting mechanism, the Inquiry recommends that tariffs for PMBs should be binding and that tariffs for non-PMB conditions will have the status of reference tariffs.

87. Bilateral negotiations between funders and providers, not just corporate providers like hospitals and pathologists, are wholly supported by the HMI. The HMI sees bilateral negotiations as essential if wider adoption of meaningful risk transfer through performance-based contracts is to be attained.

88. The Inquiry also proposes that a broad group of stakeholders be involved in the price-setting forum. Representatives of providers, funders, government and civil society should all participate in the process.

(g) Preliminary recommendations with respect to Practitioners

89. The HMI recommends that coding systems across the sector be standardised to facilitate meaningful sharing of information. The codes should be managed by a public entity. We recommend that the Supply Side Regulator for Health be responsible for the adoption and standardization of alphanumeric codes, descriptors and relative value units. Applications for new codes or modification of existing ones must be submitted to the Regulator for review and final determination.

90. The HMI has found that provider networks such as Designated Service Provider Networks or Preferred Provider Arrangements are generally positive for consumers, as they reduce costs and do not unreasonably restrict choice. There are, however, concerns about the potential exclusionary effect of networks. The HMI thus recommends that there be greater transparency in the selection of 'designated' providers to be on scheme networks. In particular, the HMI recommends that DSP partners should be appointed after an open tender process, with the results of the tender lodged with the Supply Side Regulator for Health. DSP contracts should not be longer than two years.

91. Lastly, the HMI has found that some of the HPCSA's Ethical Rules have an adverse effect on competition and recommends that these be reviewed. The rules, as currently interpreted, make it difficult for multi-disciplinary practices and partnerships to be set up and for effective alternative reimbursement models to be developed. The rules should be reviewed with the aim of creating an environment that allows

practitioners to adopt new and innovative models that may lead to better outcomes for patients.

VII. Conclusion:

92. These provisional findings represent our observations on the evidence collected and reviewed thus far and, with a few exceptions, they are a product of extensive engagement with stakeholders on some of the profoundly difficult issues of economic models and competitive assessment which underlie our findings.

93. There are still fundamental differences between the HMI and stakeholders on some of the issues covered by the report including the reliability of the data used, the methodologies used, our application of those methodologies as well as the preliminary conclusions drawn from our analysis. These differences are reflected in the report.

94. The provisional report provides stakeholders the opportunity to see how their comments have been dealt with in the provisional report and, if their concerns still persist, these will be dealt with during the comment stage on the provisional report which allows further opportunity for engagement on these differences. The provisional report provides a basis for further engagement with stakeholders on these issues.

VIII. The way forward

95. The provisional report is now available on the website of the Competition Commission.

96. Stakeholders have until **Friday 7 September 2018** to provide comments on the provisional findings and proposed recommendations. We would urge stakeholders to engage constructively with the provisional report and provide detailed submissions in respect of our provisional findings and our proposed recommendations. Submissions should be substantiated, as far as possible, with evidence.

97. The panel will consider all comments and if necessary, revise the report with the view to publishing the final report and recommendations by 30 November 2018.

98. We wish to thank the stakeholders for their participation in the inquiry over the past four years. We trust that the spirit of cooperation that has by and large characterised the inquiry thus far, will continue over the next few months as we work together in the interest of a more competitive, innovative, and accessible private healthcare sector.

99. I would like to thank my colleagues on the Panel and the technical team for working tirelessly to ensure that these provisional findings and preliminary conclusions are published today. And above all, on a personal note I would like to thank them for educating me on the intricacies of competition economics and health economics. And finally, I need to record the Panel's appreciation of the support that we have received from the Commission from time to time. And I am sure I speak on behalf of my colleagues on the Panel if I say we thank the Commission for entrusting this important task on us.

Justice Sandile Ngcobo

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5 July 2018