Life Healthcare Group Submission
Health Market Inquiry Seminars (9-12 April 2019)
Facilities and Funder Concentration and Supplier Induced Demand

1. Introduction:

1.1 LHC welcomed the opportunity to participate in the stakeholder seminars hosted by the Health Market Inquiry (HMI) between 9 and 12 April 2019, as these seminars provided an opportunity to interrogate stakeholders’ concerns relating to concentration, and market power in the facilities and funder markets, as well as the concerns around increasing utilisation of healthcare services, in an effort to arrive at effective and proportionate remedies.

1.2 In considering the appropriateness of the remedies proposed by the Provisional Findings and Recommendations Report (the PF), it is once again instructive to refer to the Terms of Reference (ToR) for this market inquiry. The ToR indicate that the Commission initiated an inquiry into the private healthcare sector because it had reason to believe that “there were features of the sector that prevent, distort or restrict competition” and that it sought to “establish a factual base upon which it could make evidence–based recommendations” that would serve to promote competition.

1.3 In the PF, the HMI concluded that the South African private healthcare market suffers from multiple market failures. In relation to the private hospital market, the HMI found that – the market is highly concentrated; direct competition between hospitals is limited; there is no evidence that schemes exert sufficient buyer power on the hospital groups; and that the high and rising costs of care is due, in part, to a combination of overcapacity and over-investment in technology and supplier induced demand (SID). However, as LHC noted in its response to the PF, the analyses conducted by the HMI’s own experts did not support these findings.

1.4 This lack of evidentiary support for the HMI’s provisional concentration and SID findings was clearly reflected in the discussions at the recent seminars and in the HMI’s own updated concentration analysis, set out in the note published on 2 April 2019, which supports a moderately concentrated (as opposed to highly concentrated) hospital market and noted that it had not been able to establish a clear link between concentration and adverse outcomes in the facilities’ market. In these circumstances, LHC submits that a careful reconsideration of some of

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1 Notice 1166 of 2013.
the remedies, in particular divestiture of hospitals, licence moratoriums, and collective bargaining proposed by the HMI in the Provisional Findings is warranted.

1.5 This reconsideration is necessary not only due to the inadequate evidentiary support, but also in order to ensure that any remedies ultimately put forward in the final report are commensurate with the competition harms actually identified and evidenced by the HMI.

1.6 As regards commensurate remedies, LHC submits that the remedies in the final report should be proportionate to the harm identified, and should accordingly not exceed what is necessary\(^2\) to achieve the intended objectives of the HMI\(^3\), based on the harm identified. The remedies should also be suitable in the sense that they must be objectively capable of satisfying their stated purpose.

1.7 This is in line with the HMI’s own acknowledgement that the principle of appropriateness\(^4\) must apply to the remedies that it has proposed - “the remedy must be measured against the harm it wishes to address, the effect on the stakeholders involved and the purpose it wishes to achieve.”

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\(^2\) The remedies should also adhere to the necessity principle, which requires that the measure is permissible only if no less restrictive suitable measure is available to achieve the objective. Remedy Design and Application in South Africa: The Fourth Annual Competition Commission, Competition Tribunal and Mandela Institute Conference on Competition Law, Economics and Policy in South Africa, 2010 Laurie Binge and Johann van Eeden citing Sullivan, E. T. (2003): Antitrust Remedies in the US and EU: Advancing a Standard of Proportionality. University of Minnesota Law School.

\(^3\) Proportionality in the strict sense requires that the seriousness of the intervention and the gravity of the reasons justifying it are in adequate proportion to each other. See reference in footnote 2.

2. Commentary on areas of consensus and discord

2.1 Facilities market concentration

2.1.1 Level of concentration

2.1.1.1 It is important to note that the HMI’s updated concentration analysis, as presented in the HMI’s note responding to stakeholder submissions on its facilities’ concentration analysis dated 2 April 2019, no longer supports a finding that the facilities’ market is “highly concentrated” on the basis of the criteria set out in the PF.

2.1.1.2 In particular, the HMI’s updated concentration analysis shows that the bed-based Herfindahl-Hirschman Index (“HHI”) for the private healthcare facilities’ market declined from 2,446 in 2010 to 2,421 in 2017. This implies that, in each of the 8 years considered by the HMI in its most recently published concentration analysis; concentration in the facilities’ market consistently fell below the HHI threshold of 2,500 set out in the PF for finding the market to be “highly concentrated”. Rather, based on the HMI’s pre-defined concentration thresholds, the available evidence appears to support a finding that the facilities market is only “moderately concentrated”.

2.1.1.3 Apart from the HMI’s most recent analysis, Medscheme’s own analyses of market concentration and market shares indicates a moderately concentrated market when acute and day hospitals are considered together and indicates that the market remains moderately concentrated when only acute hospital are considered.

2.2 Concentration and market power

Consensus

2.2.1 There is consensus that concentration is not problematic in and of itself, and that concentration is not a direct or conclusive indicator of market power. There is also consensus that there can be legitimate reasons for high levels of concentration in certain markets, and that effective competition and high levels of concentration can coexist in such markets.

2.2.2 Importantly, there is no reliable evidence or analysis that links the level of concentration in the facilities market to facilities having market power, or any anti-competitive or inefficient outcomes.

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6 Medscheme presentation – Facilities market concentration and remedies by Dr Jenni Noble, 9 April 2019.
2.2.3 The analyses conducted by the HMI do not establish a link between the level of concentration in the facilities market, either at the local or national level, and ineffective competition or market power on the part of the facilities. This is confirmed by several of the HMI’s own findings.

2.2.3.1 The HMI concludes that the level of private hospital group profits are not excessive, which means, by definition, hospital profitability is not, in and of itself, a concern.\(^7\)

2.2.3.2 Tariffs have, on average, increased in line with CPI, which indicates that facilities are not able to implement price/tariff increases that are above increases in their costs.\(^8\) There appears to be consensus that, given that tariffs are not above competitive levels, bilateral negotiations between the hospital groups and funders are broadly effective.

2.2.3.3 Funders enjoy countervailing power and are able to exercise countervailing power through the use of networks and other mechanisms. This indicates that facilities are constrained from charging prices that are above competitive levels.\(^9\) There also appears to be a consensus that funders have an inherent degree of countervailing power due to the fact that funders are not substitutes from the perspective of facilities, while, in contrast, facilities are considerably more substitutable from the perspective of funders. This is true not only in the case of DSPs, but also more generally. Although Discovery and GEMS are shown to possess the greatest countervailing power, the existence of countervailing power is not limited to just these funders - in fact there is evidence of a number for smaller schemes being able to negotiate effectively.\(^10\)

2.2.4 Accordingly, there appears to be a general consensus that the HMI’s analysis does not provide robust evidence that facilities possess the kind of market power that would justify highly invasive intervention.

\textit{No consensus}

2.2.5 Bilateral tariff negotiations

2.2.5.1 There does not appear to be consensus regarding whether bilateral negotiations involving smaller hospitals and/or funders are effective and efficient. However, it is important to note that it is not the size of each negotiating party, in and of itself, that determines relative bargaining power, but rather each party’s respective outside options. Irrespective

\(^7\) Health Market Inquiry, Provisional Findings and Recommendations Report, page 251, paragraph 459.
\(^8\) Health Market Inquiry, Provisional Findings and Recommendations Report, page 223, paragraph 305.
of their size, funders can be expected to exert countervailing power during negotiations with private hospital groups because a failure to enter into an agreement with a funder would translate into a loss in patient volumes, which any private hospital group would want to avoid.

2.2.5.2 Therefore, there is no a priori reason to expect that negotiations involving smaller schemes would not be effective for the purposes of tariff determination. This is consistent with the fact that the HMI’s own analysis shows that, aside from Discovery Health and GEMS, there is no clear relationship between funder size and the average tariff achieved by funders through bilateral negotiations with hospital groups.\textsuperscript{11} Moreover, even compared to Discovery and GEMS, there are funders that were able to negotiate low tariffs, based on the HMI’s analysis. [CONFIDENTIAL] Therefore, the available evidence appears to suggest that bilateral negotiations involving smaller schemes are effective for the purposes of tariff determination. LHC is not aware of any scheme with which it does not have a tariff in place.

2.2.6 Solus Facilities

2.2.6.1 In addition, there does not appear to be any consensus on whether solus facilities possess “must have” status in negotiations with funders. However, across all private hospital groups solus facilities account for only 5% of admissions.\textsuperscript{12} This implies that instances in which funders may not have alternative private hospitals (i.e. credible outside options) account for only a small proportion of admissions.

2.2.6.2 Accordingly, even if, hypothetically, a failure to conclude an agreement with a private hospital group resulted in patients residing in those areas in which there are no local alternatives to that group’s hospital switching away from a particular scheme, it is highly unlikely that the loss of these members would have a material adverse effect on that scheme (or its administrator). It would therefore be highly counterintuitive to expect these solus facilities to convey material bargaining power to private hospital groups in their national level network negotiations with funders.

2.2.6.3 It is also important to note that where no agreement is reached between a funder and a hospital, the funder is able to exercise other powers such as paying the patient directly for hospital services rather than reimbursing the hospital, with the result that the hospital has to take on the administrative burden and collection risk of obtaining payment from the patient. Where there is no agreement, the scheme can also impose co-payments and

\textsuperscript{11} PHMI, Technical Bargaining Annexure, paragraphs 15-18.
\textsuperscript{12} RBB, Response to the PHM’s Provisional Findings: Facilities Concentration Analysis, 15 October 2018, page 21 and Table 2.
specific managed care protocols that increase hospital administration costs. These create a strong incentive for “solus” hospitals to contract with schemes even though the rest of the groups hospitals in the network have been excluded from a schemes’ network arrangements

2.3 Remedies

2.3.1 Divestiture, moratorium on licensing

2.3.1.1 There appears to be consensus that there is a lack of evidence to justify remedies of forced divestiture and/or a moratorium on the granting of new licenses in respect of the major hospital groups, and that, such remedies would also be associated with significant unintended, adverse consequences.

2.3.1.2 These recommendations are economically unsustainable, impractical and will not result in increased competition in the private hospital market.

2.3.2 Divestiture:

2.3.2.1 It should be emphasised that any divestiture remedy would likely be associated with a number of unintended consequences, which should be taken into account when assessing the effectiveness and proportionality of such a remedy. Most notably, divestiture based on a national market share cap would likely provide a significant disincentive for hospital groups to compete vigorously in order to gain market share, and would also likely act as a disincentive for hospital groups to establish new hospitals in areas where they currently do not have a presence (thereby enhancing competition in these areas). Similarly, a divestiture remedy targeted at specific hospitals located in concentrated local markets (e.g. solus hospitals) would simply result in the transfer of local market power (should such market power exist) from the seller to the acquirer, and would therefore not be effective at remedying any concerns relating to market power at the local level.

2.3.2.2 It should also be noted that a divestiture remedy would likely be associated with a loss of efficiency, both in relation to the divested hospitals and the hospitals remaining under the ownership of the hospital groups. This is because divestiture would result in a loss of economies of scale, with divested hospitals not being able to spread certain shared fixed costs over multiple hospitals and hospital groups having fewer hospitals over which to spread shared fixed costs. This would also result in a reduction/loss of procurement efficiencies as hospital groups would not be able to leverage the same volumes in return for lower prices. This may ultimately harm consumers in the form of higher prices.
Likewise, a divestiture remedy may ultimately result in a reduced uptake of alternate reimbursement mechanisms (ARMs) by hospitals. This is because following the implementation of a divestiture remedy hospitals groups will have a less diverse portfolio of hospitals over which to spread risk, and will likely have a reduced incentive to take on additional risk as a result (i.e. will become more risk averse). Since ARMs effectively involve the transfer of utilisation risk from funders to hospitals, hospital groups would therefore be likely to have a lessened appetite for greater uptake of ARMs following any divestiture remedy.

It should also be appreciated that there have, in any case, been a number of new entrants into the private hospital market in the last three years. This suggests that there may be more proportionate and effective means than divestiture to address any residual concerns that the HMI may hold relating to concentration in the facilities market (such as remedies that have effect of lowering barriers to entry, or that improve potential new entrants’ ability to effectively assess where new entry may be warranted).

In this regard, the experience of the UK Competition and Markets Authority (CMA) in its private healthcare market investigation is instructive.

First, it is notable that the CMA used concentration only as an initial filter to identify hospitals that warranted a more extensive competitive constraints assessment. The CMA then conducted an in-depth analysis of the strength of the competitive constraints acting on hospitals, and also assessed whether there was a link between concentration and market outcomes such as quality and range of services, prices, bargaining strength, and profitability. The CMA noted that “[o]ut of 140 hospitals […] that were identified as hospitals of potential concern by the [concentration] filters, following our local assessments; we have identified 70 hospitals that the evidence indicates are subject to insufficient competitive constraints”. In other words, consideration of direct evidence in addition to concentration resulted in a 50% reduction in the number of hospitals found by the CMA to be subject to ineffective competition.

Second, following an in-depth assessment of the likely costs and benefits associated with divestiture, in its provisional decision on remedies the CMA recommended divestiture in the case of only 9 of the 70 hospitals that the CMA had found to be subject to insufficient competitive constraints. Moreover, following further consideration of the effectiveness
and proportionality, the CMA ultimately concluded that divestiture would not be a proportionate remedy in respect of any of the hospitals found to be subject to insufficient competitive constraints.16 In other words, consideration of both the effectiveness and the proportionality resulted in the CMA finding divestiture inappropriate in relation to all of the hospitals identified as subject to ineffective competition. This was the case despite the profitability of these hospitals being significantly higher, unlike in the present circumstances.

2.3.2.8 Finally, the HMI should also note that there are likely to be a number of practical difficulties associated with designing and implementing any divestiture remedy. These include, for example, how to go about identifying which hospitals should be divested, how to determine a fair price for those hospitals, and identifying appropriate and willing buyers for those hospitals.

2.3.3 Moratorium:

2.3.3.1 In the absence of any established link between the level of concentration and ineffective competition or market power in the private hospital market, there is no basis for a moratorium on hospital licenses.

2.3.3.2 A license moratorium which prevents the big three hospital groups from increasing the number of beds in existing facilities does not solve for any potential interim increase in demand for hospital services and is dependent on new entry occurring. Such entry is uncertain and is dependent on it being economically feasible. In this instance, the overflow would lead to patients travelling longer distances in order to access hospital services, as the existing hospitals will not have the capacity to service them and would not be able to add more beds in order to service them. Where new entry never occurs, this increase in demand for hospital services will remain unmet.

2.3.3.3 In this regard, it is notable that a remedy that effectively imposes a moratorium on the granting new licenses to the major hospital groups may have the unintended consequence of reducing new entry into concentrated local markets, and in particular into local markets that are currently served by solus facilities. This is because the major hospital groups are, by virtue of their relative efficiency, often best placed to invest in new facilities – particularly in local markets with relatively low demand for private healthcare services.

Moreover, it should be noted that neither economic theory nor the HMI’s analysis provides any indication that hospitals (or firms in general) are able to exercise market power when their market share exceeds a certain threshold. In turn, this means that specifying any market share threshold above which a moratorium on new licenses would be imposed would be arbitrary.

2.3.4 Licensing regime and CoN

2.3.4.1 There is consensus for a standardised, national licensing regime.

2.3.4.2 When considering the appropriateness of the certificate of need, it is important to note that the current licensing regime already makes provision for an assessment of need. Applicants are currently requested by the provincial authority to demonstrate the demand in the area and to provide bed to population ratios. In LHC’s view, there is no obvious need for a separate and more complicated CoN regime. Instead, LHC submits that the existing needs assessment can be conducted with greater effectiveness on the part of the provincial authorities.

2.3.4.3 Importantly, funders should not be required to provide support for a new license, as there is a direct conflict of interest if funders have a veto power over new hospital builds or extensions (as funders have a strong incentive not to support any additional beds).

2.3.4.4 LHC submits that provision needs to be made for the distinction between public hospitals and private hospitals when considering the granting of licensees to private hospitals. This is in line with the HMI’s conclusion that public hospitals do not compete with private hospitals.
2.4 Multilateral negotiations

2.4.1 There does not appear to be consensus regarding whether multilateral tariff negotiations are necessary and/or would be effective.

2.4.2 It is worth noting though that the three hospital groups and Discovery have submitted that bilateral negotiations between the hospital groups and funders should continue. Specifically, Discovery indicated that the bilateral negotiation process should continue for corporate providers and that “[c]ollective bargaining will undermine competition and favour providers, thus harming schemes and members”.

2.4.3 As a starting point, it should be noted that the fact that the tariffs have on average increased at levels approximating CPI, would suggest that the tariffs are not excessive. This is corroborated by the HMI’s profitability analysis, which concludes that profits are not excessive. In the circumstances, the HMI appears to support the current bilateral negotiations between funders and hospital groups. Moreover, the HMI has not presented any analysis to show that hospitals are not effectively constrained by funders during tariff negotiations. As explained in previous submissions and as illustrated at the recent seminars, the private hospital market is subject to vigorous competition and strong countervailing power from the funders, which results in a rigorous tariff negotiation process.

2.4.4 There is thus no need for price intervention as price competition in the private hospital market is robust, given the countervailing power of the funders. The strength of competition for the provision of private hospital services is evidenced by, amongst others, the increasing prevalence of networks and the increasing discounts granted by the hospital groups in favour of the schemes. In this regard, we note the presentation from GEMS about the Emerald value option which has proven to be effective in reducing cost per admission (by 20.6%) due to efficiencies and discounts.

2.4.5 Market driven pricing for hospital services is a more effective means of establishing fair and competitive pricing and will lead to efficient outcomes. Price intervention, on the other hand, creates a significant risk of inherent inefficiencies.

2.4.6 Accordingly, the HMI’s concerns regarding the current tariff negotiation process does not appear to be that negotiated prices are too high, but rather appears to be related to the perception that bilateral negotiations have given rise to a “tariff vacuum”. Specifically, LHC understands that the HMI is concerned that the current negotiation process means that there

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17 Discovery Presentation Workshop 2: Funders’ market concentration and countervailing power dated 10 April 2019.
18 GEMS presentation – Market Concentration and Countervailing Power dated 10 April 2019, p 25
are no tariffs negotiated between some funders and providers, and that negotiated tariffs may not exist in respect of certain services.

2.4.7 In this regard, it should be noted that this concern is not likely to arise in respect of funders and the major hospital groups. In particular, LHC has not experienced any tariff vacuum and currently negotiates with all funders.

2.4.8 Accordingly, there would not appear to be any clear benefit associated with requiring hospital groups to participate in multilateral negotiations in addition to engaging in bilateral negotiations with funders.

2.4.9 Indeed, requiring hospital groups to participate in multilateral negotiations would, if anything, introduce further costs to the tariff determination process. In particular, the HMI’s proposed remedies are envisaged to require stakeholders to prepare detailed proposals, together with supporting data and analysis, relating to a large number of individual healthcare services when participating in the multilateral negotiations. Such a process is likely to be both time consuming and costly for all stakeholders involved. Moreover, these costs would be incurred in addition to those currently incurred in bilateral negotiations, since the HMI envisages that stakeholders would continue to engage in bilateral negotiations following participation in the multilateral negotiations.

2.4.10 Moreover, the HMI’s proposed remedies relating to multilateral tariff negotiation would likely be associated with a number of unintended consequences, particularly in relation to binding tariffs for PMBs.

2.4.10.1 Reduced price competition –

2.4.10.1.1 Price regulation that sets a fixed and binding tariff for PMBs will prohibit any price competition - even in circumstances where suppliers may want to offer a lower price. In short, the binding tariff for PMBs disincentives price competition entirely.

2.4.10.1.2 It is LHC’s fundamental view that leaving the market to determine the price leads to the most efficient price. If it had been the case that price increases were as a result of cost increases faced by hospital groups, the market would have experienced higher price increases than have been sustained over the past few years, through a competitive price setting process. The lower price increases over the past few years is evidenced by the reduction in hospital margins, illustrating that price increases have been below cost increases.
2.4.10.1.3 The current regime of bilateral negotiations compels purchasers to be as efficient as possible, with schemes exercising significant downward pressure on price. This was confirmed by Discovery in its presentation at the Funders Concentration Seminar, where it acknowledged that – “administrators face strong incentives to actively manage cost and quality of healthcare services”.¹⁹

2.4.10.2 Perverse incentives

Distinguishing between the two baskets (PMB and non-PMB) will likely create perverse incentives to extract higher revenues from the non-PMB basket. This, LHC submits, runs counter to what the HMI is trying to solve for.

2.4.11 Regulating FFS tariffs will not address the HMI’s concern that SID is driving increases in expenditure through increases in utilisation, as the level of the FFS tariff itself will not reduce the incentive to over service patients. That incentive remains regardless of the level of the tariff. The current proposal to regulate prices does not propose sufficient controls for managing utilisation. Accordingly, the binding tariff for PMBs will not have a positive impact on healthcare expenditure.

2.4.12 Accordingly, LHC suggests that, rather than introducing a further step in the tariff negotiation process, the HMI should consider whether regulation relating to the current bilateral negotiation process can be adapted to efficiently deal with its concerns relating to a tariff vacuum. More specifically, LHC suggests that the HMI recommends remedies that are targeted at the particular stakeholders in respect of which concerns regarding a tariff vacuum are most apparent (for example, practitioners), so as to avoid introducing unnecessary cost into an otherwise effective and efficient tariff determination process.

¹⁹ Discovery presentation – Workshop 2 : Funders’ Market Concentration and Countervailing Power 10 April 2019
3. Funders market concentration

3.1 Level of concentration

3.1.1 There appears to be consensus that the funders’ market is highly concentrated, and that the market is becoming increasingly concentrated over time.

3.1.2 There is however no consensus regarding the introduction of regional-based schemes.

3.1.3 It is not clear that introducing regionally-based schemes would necessarily promote competition (as compared to national schemes). This would depend on the scheme in question and the type of network arrangement, and could vary over time as market conditions change. In theory therefore, regionally-based schemes could promote competition. Since the impact of regional schemes on competition is ambiguous at the level of theory, it would only be warranted if the HMI has conducted a detailed empirical analysis.

3.1.4 The HMI concluded that open and restricted medical schemes primarily compete in separate product markets and that in general would treat these two as separate markets. If we accept (as LHC does), that open and closed schemes largely do not compete with each other, it is difficult to see how the HMI’s recommendation to encourage small new entrants to enter as regional schemes (which, in effect, will have to be restricted on the basis of region), will lead to increased competition.

3.1.5 A critical component of a medical scheme’s composition is its ability to spread risk by having members that represent a balanced risk profile (that is, having both sick and healthy members). With a regional scheme, there is a significant risk that the population in that specific area may be prone to certain chronic conditions. In that case, the scheme would not be able to spread its risk and as a consequence, members would pay higher premiums and the scheme’s sustainability may ultimately be at risk. The HMI has acknowledged that demographic and claims risk is likely to be an obstacle for new regionally-based schemes.

3.1.6 This proposal is not viable, as this would in effect concentrate the risk for schemes and would affect the sustainability of the schemes in the long term.

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20 Health Market Inquiry, Provisional Findings and Recommendations Report, page 459, paragraph 34.
22 See paragraph 3.4.2 of LHC’s response to the HMI’s provisional report dated 15 October 2018.
3.2 Effectiveness of competition

It is notable that no consensus appeared to be reached regarding the effectiveness of competition or existence of market power in the funders’ market. It appears that this is largely due to the fact that only limited analysis and results have been presented by the HMI in this regard. For example, the publication of the results from a comprehensive profitability and/or pricing analysis for funders would provide useful insights into the effectiveness of competition in the market, and would allow stakeholders to engage more fully with the proposed remedies directed at the funders’ market.

3.3 Bargaining power

3.3.1 There appears to be consensus that funders are able to leverage the inclusion/exclusion of hospitals from DSP networks in negotiations with hospital groups, which gives funders significant countervailing bargaining power in those negotiations.

3.3.2 As the HMI’s own results have revealed, where there is a difference between non-network tariffs between schemes that offer a network option and those that do not, “it is schemes that have a network option as part of their offering which receive relatively lower tariffs for their non-network options compared with schemes that do not offer a network option.”

3.3.3 There also appear to be consensus that funders have been able to exclude hospital groups that possess solus facilities from DSP networks in the past (which we would contend suggests that such groups do not possess solus hospitals with true “must have” status).

3.3.4 This is evident from the fact that there are some schemes in respect of which LHC, Netcare and Mediclinic have not been selected as a DSP provider anywhere in the country. Recent decisions by schemes to implement networks that exclude one or more of the major hospital groups is evidence that contradicts the HMI’s contention that schemes are constrained by this so-called “must-have” status of the major hospital networks.

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24 Netcare/ Compass Lexecon presentation – Facilities’ Market Concentration and Remedies 9 April 2019, Slide 12
4. **Excessive utilisation and supplier induced demand**

4.1 **Increasing utilisation is the primary cause of rising healthcare costs.**

There is consensus that the increase in expenditure is attributed largely to increased utilisation and, not increases in tariffs – with utilisation being driven by the significant deterioration of the underlying disease burden of the insured population.

4.2 **Demand and supply-side contributions to rising utilisation**

There also appears to be consensus that increasing utilisation is the result of both demand- and supply-side factors. However, there does not appear to be consensus regarding the relative significance of these two categories of factors in driving increased utilisation. It is important to note though that, Discovery gave more weight to demand side factors (in particular anti-selection) as the utilisation driver.  

4.3 **Extent and source of SID**

4.3.1 There appears to be a general consensus that some degree of SID exists, yet there does not appear to be consensus regarding the extent of that SID, or its main driver(s).

4.3.2 Nevertheless, the HMI itself appears to have acknowledged in the Provisional Report that it is primarily practitioners that directly induce demand, which it states that “practitioners have some discretion around whether to treat and are being paid based on the number of interventions they undertake. This gives them both the ability and incentive for potential manipulation of patients’ demand for health services through SID”.  

Similarly, the HMI notes that “practitioners are directly involved in the clinical diagnosis and the final decision to admit the patient”.  

4.3.3 It is also important to take into account the context within which this limited SID occurs and the level of this SID. A certain amount of SID may occur as a result of the manner in which medical scheme benefits are structured, to exclude primary care, with the result that doctors could feel a moral obligation to provide access to healthcare inappropriately. Indeed, the PF note that “[d]uring public hearings, certain practitioners have conceded that they admit patients for in-hospital care when it is not strictly necessary to do so, due to the structure of medical scheme benefits and fragmentation of care.”

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25 Discovery Presentation - Workshop 3: Key cost drivers – 12 April 2019 by Roseanne Harris.
26 Health Market Inquiry, Provisional Findings and Recommendations Report, page 245, paragraph 429.2.
4.3.4 Another issue that doctors try to solve for is ensuring that a patient receives comprehensive care, as opposed to the most cost-effective care, commonly known as defensive medicine. A further contributing factor to a doctor’s decision in providing care is the threat of medical malpractice claims.

4.4 The role of hospitals in SID

4.4.1 Consensus was reached that there are a number of potential sources of increasing utilisation of healthcare services. These included significant demand-side as well as a range of supply-side factors.

4.4.2 In light of this, it is critical that, when designing remedies to address increasing utilisation, the HMI first seeks to robustly identify the extent to which each of these factors is responsible for increasing utilisation. Given that many of these factors are closely related to one another, the HMI should also strive to isolate the specific impact arising from each factor. Otherwise, remedies will inevitably be ineffective and costly.

4.4.3 In this regard, there does not appear to be consensus regarding whether practitioners alone are responsible for SID, or whether hospitals are able to induce demand for healthcare services indirectly (as opposed to merely benefitting from practitioner-induced SID). This is largely a result of the fact that, although there is an agreement that the HMI’s analysis of SID is subject to material shortcomings, there is does not appear to be agreement on the extent to which the HMI’s analysis can still be relied upon to support various findings by the HMI.

4.4.4 It is therefore useful to consider what the HMI’s evidence is able to tell us about the sources of increasing utilisation, and the extent to which these may be related to the effectiveness of competition.

4.4.5 First, consistent with the existing literature, the HMI’s regression analysis shows a much stronger correlation between admissions and the local supply of doctors than it does between admissions and local hospital bed capacity. This provides some indication that the role of hospitals in driving increasing utilisation may be relatively limited.

4.4.6 Second, notwithstanding the shortcomings of the model, the small observed correlation between local hospital bed capacity and admissions has a number of potential explanations in addition to SID on the part of hospitals. While the correlation could, in theory, be due to local competition between hospitals to attract practitioners (as hypothesised by the HMI in the PF), it may equally be the result of inefficient hospital expansion and entry. The correlation could also be explained by reverse causality (i.e. that hospitals tend to expand capacity in areas in which demand for healthcare services, and therefore admissions, are likely to be
or the fact that a significant proportion of beneficiaries do not have any beds in their municipality and also have a lower (but positive) probability of being admitted to hospital (thereby inducing a positive correlation that may not exist in practice).

However, there does appear to be consensus that the additional evidence presented by the HMI (namely, its analysis of the relationship between levels of unexplained admissions and expenditure increases and the degree of local concentration) does not support a conclusion that the correlation between local bed capacity and admissions is the result of local competition between hospitals.

**Doctor Shareholding**

While LHC accepts that doctor shareholding in its hospitals may be perceived as a means of incentivising doctors to admit patients, LHC submits that this is a very simplistic interpretation that does not take into account the extent of the income actually generated by the shareholding. The additional income that a doctor can derive from dividends is significantly less (almost 300 times less) than the income they can generate from their professional fees. The primary purpose of the shareholding arrangement is to increase engagement between doctors and management on quality and service issues; ensure doctors have a real interest in the reputation of the hospital; and align doctors' interests to deliver high quality, cost effective and efficient healthcare.

LHC emphasises that it does not have the ability to admit patients. Decisions with respect to a patient admission, the appropriate level of care and the treatment modalities are made by the treating doctors who are independent practitioners.

**Concentration and SID**

There appears to be consensus that, even at the level of principle, the linkage, if any, between local concentration and SID is unclear, and ambiguous in terms of direction. Indeed, the HMI’s own expert, Doctor Soderlund expressly conceded during his presentation that he had not drawn a link between SID and local concentration.

Indeed, if the HMI were correct, in that SID is less prevalent in more concentrated markets - with facilities in concentrated regions typically exhibiting below expected admission rates and lower claim increases over time, relative to those in less concentrated markets, this result,
and its policy implications, would be directly at odds with any concerns over local concentration and facility market power.31

4.5.3 Therefore, if there were to continue to exist a degree of correlation between local hospital bed capacity and admissions in the HMI’s model once its shortcomings have been corrected for, the most plausible explanation for it would be inefficient capacity expansion on the part of hospitals.

4.5.4 In this regard, there does not appear to be consensus on how (if) national market power gives rise to SID on the part of hospitals. However, no clear mechanism that exists for how national market power may allow facilities to expand capacity inefficiently. Moreover, evidence on new licences issued suggests that capacity expansion is not being primarily driven by the large hospital groups (and, therefore, inefficient capacity expansion does not appear to have any empirical link to potential market power).

4.5.5 To the extent that increased utilisation is in part a result of inefficient hospital capacity expansion, it is, therefore, useful to consider the causes of such expansion. For example, imperfect information and inadequate data may mean that hospitals are unable to evaluate properly the level of residual demand (i.e. demand that is not being met by existing hospital capacity) in a given local market. Hospitals may also be expanding capacity in order to meet an expected increase in demand for their services in the future (for example, due to the expected implementation of NHI).

4.6 Remedies

4.6.1 Demand-side

4.6.1.1 Managed Care Organisations (“MCO”)  

There appears to be consensus that funders are able to curtail SID, at least in part, through managed care Interventions. MCO’s have a primary function to perform in controlling for SID. The effect of managed care interventions on LHC was demonstrated during the SID seminar by the declining group occupancy rate over the period 2016-2018.32 In addition, GEMS, in its presentation on SID provided evidence of declining admission rates and psychologist consultation rates following interventions to proactively address providers suspected of SID and other abusive practices at the end of 2016.33

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32 LHC presentation – SID seminar, Matthew prior dated 12 April 2019.
33 GEMS presentation – Supplier Induced Demand dated April 2019, slide 11 - 14
4.6.1.2 **Primary care benefit design**

There also appears to be consensus that funders would be able to reduce utilisation by extending benefits to include cover for primary care. However, there does not appear to be consensus as to whether/why funders have not implemented these measures more extensively.

4.6.1.3 **Mandatory membership and risk equalisation mechanism**

There appears to be consensus in favour of various remedies designed to address the demand-side causes of increased utilisation, including the introduction of mandatory membership and a risk-adjustment mechanism for medical aid premiums.

Mandatory membership would alleviate this increasing cost burden by ensuring that healthy younger members are incorporated into the medical schemes, while reducing relative utilisation, which would lead to a reduction in medical scheme premiums.

In the absence of a sustainable risk pool comprising of healthy and sick members, schemes are compelled to raise funding through premiums. Mandatory membership would solve for the increasing cost of medical scheme premiums and would also decrease the healthcare burden on the public sector.

4.6.2 **Supply-side**

4.6.2.1 **Review of HPCSA ethical rules**

4.6.2.1.1 There appears to be consensus in favour of remedies to amend the HSPCA ethical rules, particularly in respect of those rules relating to the adoption of integrated care models.

4.6.2.1.2 This is the one key measure that can be implemented in order to facilitate the transition from FFS to ARMs for practitioners. This involves a review and amendment of the HPCSA ethical rules to allow for multidisciplinary practices, fee sharing, employment of practitioners, and global fees, in line with the HMI’s own proposal.

4.6.2.2 **Move towards ARMs**

There also appears to be consensus that the FFS model is unsustainable and that remedies should encourage greater adoption of ARMs.

4.6.2.3 **Publication of data on quality performance indicators**
4.6.2.4 There is consensus amongst stakeholders that there should be a phased introduction of a standard mechanism for measuring the performance and outcomes of practitioners and facilities. As LHC explained at the SID seminar, it currently publishes individual hospital quality information as well as patient experience scores. However, there was not consensus as to which body should undertake the quality monitoring function.

4.6.2.5 Licensing regime

4.6.2.5.1 There is consensus for a standardised, national licensing regime that must be implemented by provincial departments, as well as a robust and transparent reporting and monitoring system to be administered by the NDoH.

4.6.2.5.2 When considering the appropriateness of the certificate of need, it is important to note that the current licensing regime already makes provision for and undertakes an assessment of need. Applicants are currently requested by the provincial authorities to demonstrate the demand in the area and requests to provide for bed to population ratios. In LHC’s view, there is no obvious need for a separate and more complicated CoN regime. Instead, LHC submits that the existing needs assessment can be conducted with greater effectiveness on the part of the provincial authorities.

4.6.2.5.3 As proposed by LHC during the seminar, one means of dealing with excess capacity in the private sector is to encourage public facilities to purchase excess capacity from private facilities, and to introduce a sustainable “state rate” for state patients treated in private facilities.

4.6.2.6 A standardised licensing regime and a state rate would address any residual concerns that the HMI might have relating to existing overcapacity and inefficient capacity expansion (which may be linked to excessive utilisation and/or SID).

4.6.2.7 Shareholding agreements

4.6.2.7.1 It is not clear if there is consensus regarding the introduction of restrictions on doctor shareholding arrangements, similar to those set out by the CMA

4.6.2.7.2 LHC notes the HMI’s view that “some of the contractual relationships between practitioners and facilities may facilitate SID in the private facilities market”. LHC submits that doctor shareholding do not lead to doctors over-servicing in order to drive the profit of the hospital. [CONFIDENTIAL]

4.6.2.7.3 In this regard, we refer to the GEMS presentation on SID which noted variations in the utilisation of healthcare services by region and in particular observed that KZN admission rates are 18% higher than the national rate.\(^\text{35}\) (Please refer to LHC’s first submission for a detailed explanation of the doctors’ shareholding model employed by LHC and the limited extent of the doctor income actually generated from the shareholding model.\(^\text{36}\))

4.6.2.7.4 In this regard, the findings reached by the Competition Markets Authority (CMA) in the UK’s private healthcare market investigation may provide useful guidance to the HMI in formulating any remedies designed to limit any potential competitive harm arising from doctor shareholdings in hospitals. Indeed, the CMA ultimately concluded that the small-scale equity participation schemes between private hospital operators and clinicians practicing at or referring patients to the hospitals concerned should be allowed, but subject to certain conditions. These conditions included that:

- the equity stake must be paid for by the clinician upfront and at fair market value;

- where a company which owns, directly or indirectly, one or more hospitals is involved (i.e. the equity participation is a stake in a hospital in which a private hospital operator also has a stake), then the equity stake of any individual clinician with practicing rights at, or the ability to commission tests at, the facility concerned should be limited to 5%;

- the acquisition of an equity stake must not be linked to any requirement on the clinician, express or implied, to refer patients to the private hospital or to conduct a minimum percentage of his private practice at that hospital, or to practice at that hospital for a minimum period, or to commit to providing a given level of throughput in the case of a specialized piece of equipment;

- any dividends or profit shares distributed to a shareholder must be strictly pro rata to that shareholder’s stake in the entity; and

- the equity stake must not be associated with any ‘non-compete’ restrictions.\(^\text{37}\)

4.6.2.7.5 LHC submits that any requirement to refer a minimum percentage of a doctors’ practice at a hospital should not raise SID concerns. As such, while the CMA guidance is very useful, the restriction on this requirement should not be adopted. Requiring a

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35 GEMS presentation – Supplier Induced Demand dated April 2019 Slide 7 and 8
36 LHC’s First Submission to the Health Market Inquiry, dated 31 October 2014, paragraph 14.3.3.
37 Final report, paragraph 11.461.
doctor to conduct a minimum percentage of his practice at a hospital is not a stipulation that the doctor should drive a level of volume to that hospital. It is important to distinguish between an absolute number/volume of patients imposed on a doctor (which LHC categorically does not support) and requiring a doctor to conduct a proportion of his practice at that hospital (whatever the size of that practice may be). In relation to the latter, there is no volume requirement and thus this would not contribute to SID.
5. **Summary of areas of consensus and discord**

5.1 **Facilities Market Concentration**

<table>
<thead>
<tr>
<th>Findings/Remedies</th>
<th>Theme</th>
<th>Consensus</th>
<th>Discord / No consensus</th>
<th>Not discussed sufficiently</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Findings</strong></td>
<td>Concentration and market power</td>
<td>Concentration cannot be taken as evidence of market power or competitive harm in and of itself. There are also legitimate reasons for high levels of concentration in certain markets, and competition can be effective in markets with high levels of concentration.</td>
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<tr>
<td><strong>Concentration threshold</strong></td>
<td>The facilities market is not “highly concentrated”.</td>
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<tr>
<td><strong>Indicators of market power</strong></td>
<td>No evidentiary link between the concentration and any theories of harm, implying that there is no robust evidence of market power on the part of the major hospital groups</td>
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<tr>
<td><strong>Profitability</strong></td>
<td>No excessive profits on the part of the three major hospital groups, which indicates that tariffs are not excessive. [CONFIDENTIAL]</td>
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<tr>
<td><strong>Bargaining Power</strong></td>
<td>Bilateral negotiations between the major hospital groups and major funders are effective, given that tariffs are not above competitive levels.</td>
<td>Hospitals possess a “must have status” during network selection</td>
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<tr>
<td><strong>Remedies</strong></td>
<td>Proportionality of remedies</td>
<td>Lack of evidence exists to justify divestiture and/or moratorium on granting of new licences</td>
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<tr>
<td><strong>Proposed remedies</strong></td>
<td>Tariff determination</td>
<td>Bilateral negotiations between major hospital groups and major funders are effective (given that tariffs are not excessive) and are efficient</td>
<td>Bilateral negotiations involving smaller hospitals, smaller schemes, and practitioners are effective.</td>
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<tr>
<td>Licensing regime</td>
<td></td>
<td>Any facility concentration concerns can be addressed with standardising an</td>
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<td></td>
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<tr>
<td>Findings/Remedies</td>
<td>Theme</td>
<td>Consensus</td>
<td>Discord / No consensus</td>
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<td></td>
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<td>efficient and effective licensing regime</td>
<td></td>
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<tr>
<td>Private rates</td>
<td></td>
<td></td>
<td></td>
<td>If the HMI wants to fill the “tariff vacuum” for the uninsured market then it will be solved by the publication of rates for private patients. This point was raised by LHC during its presentation but was not discussed further.</td>
</tr>
<tr>
<td>Publication of quality data</td>
<td>Remedies to improve the collection and collation of (standardised) capacity, quality and outcomes data</td>
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<tr>
<td>Certificate of Need</td>
<td></td>
<td></td>
<td>Introduction of the CoN</td>
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<tr>
<td>Multilateral Negotiations</td>
<td>Multilateral negotiations are necessary or effective</td>
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</tbody>
</table>
## 5.2 Funders Market Concentration

<table>
<thead>
<tr>
<th>Findings/Remedies</th>
<th>Theme</th>
<th>Consensus</th>
<th>Discord / No consensus</th>
<th>Not discussed sufficiently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Findings</td>
<td>Anti-selection</td>
<td>There is evidence that points to the existence of anti-selection in the funder market.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funders profitability</td>
<td>Scheme and administrators market is highly concentrated, and there has been no material new entry in recent years.</td>
<td>The level of funders’ profitability -largely because no similar profitability analysis to that conducted for the hospital groups has been published by the HMI.</td>
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<tr>
<td>Funders market concentration</td>
<td>Funders are not substitutes from the perspective of facilities (given facilities generally do not face capacity constraints), while facilities are more substitutable from the perspective of funders, and this gives funders an inherent degree of countervailing bargaining power.</td>
<td>Whether solus hospitals grant the major hospital groups “must have” status in negotiations with funders.</td>
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</tr>
<tr>
<td>Bargaining power</td>
<td>Funders are able to leverage inclusion of hospitals on DSP networks in negotiations with hospital groups. There are also a number of other mechanisms available to funders to leverage better terms in negotiations with private hospital groups to channel patients away from a specific hospital.</td>
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</tbody>
</table>

### Proposed remedies

<table>
<thead>
<tr>
<th>Remedies</th>
<th>Mandatory membership coupled with Risk Equalisation</th>
<th>Introduction of standardised benefit options.</th>
<th>Timing of introduction of mandatory membership and risk equalisation.</th>
<th>Number of benefit options.</th>
</tr>
</thead>
<tbody>
<tr>
<td>This will partially address concerns regarding increasing utilisation, stabilise the risk pools, and improve affordability.</td>
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<tr>
<td>Timing of introduction of mandatory membership and risk equalisation.</td>
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<tr>
<td>Number of benefit options.</td>
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<tr>
<td>Regional contracting</td>
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<td></td>
<td>Concerns about the sustainability of the existing medical schemes through the removal of “good risk” into smaller pools that do not have the necessary risk pool to provide appropriate protection for members.</td>
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</tbody>
</table>


### 5.4 Excessive utilisation and SID

<table>
<thead>
<tr>
<th>Findings/Remedies</th>
<th>Theme</th>
<th>Consensus</th>
<th>Discord / No consensus</th>
<th>Not discussed sufficiently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Findings</td>
<td>Source of increasing utilisation</td>
<td>Increase in costs is principally attributable to increases in utilisation and not increases in tariffs.</td>
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<tr>
<td></td>
<td>Demand- and Supply-side contributing factors:</td>
<td>Consensus that increasing utilisation is the result of both demand- and supply-side factors. Demand-side factors outweigh supply side factors.</td>
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</tr>
<tr>
<td></td>
<td>Source of SID</td>
<td>There is consensus that only practitioners (and not facilities) are able to drive SID.</td>
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<tr>
<td></td>
<td>Extent of SID</td>
<td></td>
<td>There is no consensus regarding the extent of SID that exists.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Analysis of SID</td>
<td>There is consensus that there are material shortcomings in relation to the HMI’s analysis of the extent and sources of SID.</td>
<td>There does not appear to be consensus regarding the probative value of the HMI’s analysis of SID in light of the shortcomings identified.</td>
<td></td>
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<tr>
<td></td>
<td>SID and local concentration link</td>
<td>There is consensus that HMI’s hypothesis linking concentration in the facilities’ market and SID is counterintuitive and lacks empirical support.</td>
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<tr>
<td></td>
<td>Market power and SID</td>
<td></td>
<td>There is no consensus on whether market power gives rise to SID on part of the hospitals.</td>
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</tbody>
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<table>
<thead>
<tr>
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<th>Discord / No consensus</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Funders ability to curtail SID</td>
<td>There is consensus that funders are able to limit unnecessary utilisation through, for example, the introduction of managed care protocols and the extension of benefits to include cover for primary care. There was also consensus that funders are able to disincentivise new hospital entry/expansion in local markets with excess capacity.</td>
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<tr>
<td>Excess capacity</td>
<td>There is some level of excess capacity in the market.</td>
<td>There does not appear to be consensus regarding the reasons for inefficient capacity expansion by hospitals.</td>
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</table>

**Proposed Remedies**

<p>| Remedies | Consensus | |
|----------|-----------|------------------------|---------------------------|
| Mandatory membership with risk equalisation | Consensus that mandatory membership with risk equalisation will address demand-side causes of increased utilisation. | | |
| HPCSA ethical rules | There is consensus that the HPCSA ethical rules should be reviewed in order to promote team based care models. | No consensus regarding the employment of doctors. | |
| Primary care benefits | Incorporate primary care benefits into mandatory benefits. | | |
| Doctor Shareholding | No clear consensus regarding the introduction of restrictions on doctor shareholding agreements, similar to CMA. | | |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>ARMGs</td>
<td></td>
<td>It is important to drive the transition from FFS to ARMGs in order to facilitate value base contracting and move away from the FFS model that has the incentive to drive utilisation. This includes the mandatory publication of data on quality performance which will promote VBC.</td>
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<tr>
<td>Licensing regime</td>
<td>A need to improve the current licensing regime.</td>
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<tr>
<td>State rate</td>
<td></td>
<td>The creation of a sustainable state rate in order to encourage public facilities to purchase excess capacity for uninsured patients was raised by LHC but not discussed.</td>
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</tbody>
</table>
6. Conclusion

6.1 LHC urges the HMI to take the opportunity to make recommendations that contribute to the sustainability of the private healthcare sector, so as to allow this sector to continue relieving the burden on the public sector and to continue meeting the challenges of providing healthcare to both the private and public sectors – in furtherance of the constitutional right of access to healthcare services in terms of section 27 (1) of the Constitution.

6.2 Section 27 (2) of the Constitution provides that the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the right of access to healthcare services. In circumstances where the public healthcare sector in South Africa is in a state of crisis and is unable to meet the current healthcare demand, LHC submits that it is incumbent on the State to take appropriate measures that leverage the private sector to assist with meeting the healthcare needs of the South African population.

6.3 For these measures to translate into meaningful access to healthcare services for public sector patients, it is imperative that the private healthcare sector is functional, sustainable and able to service both the private and the public sector.

6.4 In the South African context, measures which may undermine the sustainability of the private healthcare sector, such as divestiture and license moratoriums are to be guarded against – as they will ultimately be to the detriment of both public and private sectors. A dysfunctional private healthcare sector will only serve to increase the burden on the already strained public sector. In addition, on the HMI’s own independent evidence, there is no basis on which to intervene by means of hospital divestitures, license moratoriums or price interventions.

6.5 Given the public sector’s challenges and the role that the private sector must play in alleviating those challenges, the primary focus of the remedies proposed by the HMI should be to address the shortcomings in the current regulatory framework in order to enable a sustainable private healthcare sector.

6.6 Together with the other remedies supported by LHC (as above), LHC submits that an appropriate intervention would be to facilitate collaboration between the ailing public sector and the private sector, in order to address the lack of access to healthcare services in the public sector. LHC’s submissions are fully aligned with the HMI’s PFs, which has recommended the “strategic purchasing” of available private capacity to supplement capacity in the public sector”. As the
HMI has pointed out, “government could, and should, already contract with the private sector where it needs capacity.”[1]