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Life Healthcare Group

Response to
Health Market Inquiry
Provisional Findings and Recommendations Report
15 October 2018

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Glossary of terms

AMA – American Medical Association	SAMA – South African Medical Association	ICHI - International Classification of Health Interventions
	HAI – Hospital Acquired Infection	SARS – South Africa Revenue Services
ARM – Alternative Reimbursement Model	MCO – Managed Care Organisation	PO – Principal Officer
CoN – Certificate of Need	BHF – Board of Healthcare Funders	CPI – Consumer Price Index
HMI – Health Market Inquiry	AHPCSA - Allied Health Professions Council of South Africa	FFS – Fee For Service
LHC – Life Healthcare Group	SSRH - Supply-Side Regulator for Healthcare	NHA – National Health Act
MSA – Medical Schemes Act	REF – Risk Equalisation Fund	HPCSA – Health Professions Council of South Africa
NHI – National Health Insurance	PDoH – Provincial Department of Health	MJ4L – Major Joints for Life
NHLS – National Health Laboratory Services	PPP – Public Private Partnership	PROMs – Patient Reported Outcome Measures
NHN – National Hospital Network	RFP – Request For Proposal	CPT – Current Procedural Terminology
NHRPL – National Health Reference Price List	RAMS – Representative Association of Medical Schemes	GEMS – Government Employee Medical Scheme
PCNS – Practice Code Numbering System	EBM – Evidence Based Medicine	VBC – Value- Based -Contracting
RAM – Risk Adjustment Mechanism	LCBO – Low Cost benefit Options	HTA – Health Technology Assessment
SID – Supplier Induced Demand	OHSC – Office of Health Standards and Compliance	HASA – Hospital Association of South Africa
SoI – Statement of Issues	NDoH – National Department of Health	BoT – Build-operate and transfer model
TASS - Therapeutic Assessment Scoring System	ICU – Intensive Care Unit	OMRO – Outcome Measurement and Reporting Organisation
ToR – Terms of Reference	CMS – Council for Medical Schemes	DSP – Designated Service Provider
UHC – Universal Healthcare Coverage	PMB – Prescribed Minimum Benefit	ICD - International Classification of Diseases
WHO – World Health Organisation	MIT – Master Industry Table	

1. Executive Summary

Introduction

1.1 As a significant stakeholder in the South African private healthcare sector, LHC is invested in ensuring that quality cost-effective healthcare is delivered in a sustainable manner. LHC welcomed the opportunity to participate in the market inquiry, as the inquiry provided an opportunity to ventilate the challenges facing the healthcare sector and to consider appropriate solutions. LHC has accordingly engaged with the Commission, with the objective of contributing meaningfully to the issues considered in the inquiry.

1.2 LHC acknowledges the significant effort invested by the Commission and the HMI team in producing the Provisional Report. While LHC does not agree with all of the Provisional Findings (as detailed below), there are a number of findings and recommendations that LHC does support:

1.2.1 LHC agrees with the HMI that there is no reliable outcomes measurement and reporting system in place and supports the recommendation for a standardised system to be administered by an independent body. This standardisation is necessary, as the various healthcare providers currently use different methods and criteria, making meaningful comparisons very difficult.

1.2.2 LHC fully supports the HMI advocating for "*a thoroughgoing review of all ethical rules with a view to their impact on competition*."[1] In particular, LHC agrees that the rules should be rephrased to be more enabling in nature, in relation to encouraging group practices, not prohibiting global fees and allowing conditional employment of doctors. The suggested changes to these rules will greatly assist hospitals in providing more cost effective and better quality care. This will promote the development of" *innovative models of care and funding.*"[2]

1.2.3 LHC supports the inclusion of cover for primary and preventative care in the proposed base benefit package. This package must however take affordability into account - in this regard, it is important for the HMI to bear in mind that the objective of insurance cover is to provide for catastrophic expenses and to solve for financial risk protection sought by consumers.

1.2.4 While LHC does not agree with the HMI that the excess capacity in the private sector is linked to inappropriate utilisation, LHC does agree that spare capacity in the private sector should be made available to under-serviced areas in the public sector. LHC also supports the HMI's recommendation that "…*available private capacity to supplement capacity in the public sector*

1 Health Market Inquiry, Provisional Findings and Recommendations Report, page 359, paragraph 286.
2 Health Market Inquiry, Provisional Findings and Recommendations Report, page 358, paragraph 278.

need not wait for the NHI."[3] Indeed, LHC is already an active participant in a number of public-private- partnerships entered into with the state, and looks forward to contributing in a sustainable way to meeting the government policy objective of Universal Health Coverage. In this regard, LHC is currently tendering to provide hospital services to the public sector in order to alleviate patient backlogs at state facilities.

1.3 LHC's concerns about the findings and recommendations are summarised below.

Supply-side concerns

1.4 In considering the veracity of the Provisional Report, it is necessary to refer to the Terms of Reference (ToR) for this market inquiry. The ToR indicate that[4] 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.

1.5 In the Provisional Report, the HMI concludes that the South African private healthcare market suffers from multiple market failures.[5] In relation to the private hospital market, the HMI finds 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; the high and rising costs of care is due to overcapacity and over-investment in technology and supplier induced demand. However, the analyses conducted by the HMI's experts do not support these findings nor do they support the ultimate conclusion of market failure. For this reason, LHC submits that a number of the recommendations put forward by the HMI are not appropriately evidence-based.

1.6 Specifically, the HMI's evidence is deficient in the following respects:

1.6.1 **Concentration Analysis** – Although the HMI concludes that the private hospital sector is highly concentrated and that, as a consequence, private hospital groups are able to exercise market power, the Provisional Findings have failed to conclusively show any systematic link between market concentration and market power and/or ineffective competition.[6] In addition, the concentration calculations are based on outdated data, and updated information indicates that the HMI's thresholds for identifying highly concentrated markets would no longer be met at a national level. There are also likely to be a number of local markets that no longer meet this threshold.

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3 Health Market Inquiry, Provisional Findings and Recommendations Report, page 478, paragraph 174.
4 Notice 1166 of 2013.
5 Health Market Inquiry, Provisional Findings and Recommendations Report, page 454, paragraph 1.
6 RBB Economics, Response to the PHMI's Provisional Findings: Facilities Concentration Analysis, 15 October 2018, page 20, paragraph 5 marked Annexure C.

1.6.2 As regards market power, it is important to note that the HMI's **profitability analysis** finds that the levels of private hospital group's profits are not excessive and that the HMI's **bargaining power analysis** finds that larger funders exert countervailing power against the hospital groups. This in turn indicates that facilities are constrained from charging prices above competitive levels. Accordingly, by the HMI's own admission in many instances, the evidence arising from the analyses of profitability and bargaining power does not support a link between market concentration and market power on the part of the hospital groups.

1.6.3 **Expenditure Analysis** – The HMI's analysis of claims costs does not provide any reliable basis to conclude that observed recent increases in claims costs have been as a consequence of market power or supplier induced demand. In particular, there are a large number of significant methodological flaws in the HMI's cost attribution analysis, which render the results unreliable, and accordingly do not provide a robust basis to conclude that significant unexplained costs exist. Significantly, the use of the narrow disease burden underestimates the extent of the increasing disease burden within the medical scheme population.

1.6.4 Further, the HMI takes the position that healthcare prices are inherently inefficient and derived from an anti-competitive collusive base; it does not provide any evidence to support this allegation. As such, the HMI also does not provide the assessment of historical prices required in order to show that the pre-2004 prices were above competitive levels. Again, the HMI itself notes that "*there is no empirical evidence that the coordinated approach to tariff setting prior to 2004 resulted in higher than competitive tariffs*".[7] As such, the HMI's assessment of historical prices is speculative. Notably, the HMI concludes that annual tariff increases have largely been in line with CPI.

1.6.5 Finally, as regards in-hospital expenditure patterns, the HMI's allegation that the hospital groups suffer from inefficiencies, which give rise to higher cost per admission than other hospitals, is directly contradicted by its own analysis – which shows that the hospital groups are more efficient if the more important aspect of case mix is controlled for.

1.6.6 **Supplier-Induced Demand (SID) Analysis** – Although the HMI concludes that SID may be one of the causes of increased utilisation in healthcare, the HMI's analysis does not support the conclusion that facilities play any role in SID. The SID analysis, even if taken at face value, shows a very weak relationship between the number of beds and admissions; and for the majority of specialties, there is no significant positive relationship between the supply of doctors and discretionary admissions. Moreover, there is no evidence of any positive relationship when certain flaws with the HMI's analysis are corrected. The SID analysis also does not reliably demonstrate a

[7] Health Market Inquiry, Provisional Findings and Recommendations Report, page 236, paragraph 367.

systematic relationship between the level of local concentration and the level of unexplained expenditure increases (that the HMI hypothesizes is as a consequence of SID).

1.7 In these circumstances, LHC submits that the HMI's analyses do not, in fact, support a finding that there is ineffective competition between hospitals/hospital groups, or that the conduct of hospitals results in SID or market failure more generally.

1.8 LHC further submits that the Provisional Report does not present a balanced reading of the evidence that HMI's own experts have put forward.

1.9 LHC also submits that the HMI has failed to consider a number of key pieces of evidence put forward by stakeholders. In this regard, we refer to reports prepared by LHC's expert economists during the course of the inquiry.[8]

1.10 Given the evidentiary deficiencies, LHC submits that many of the HMI's recommendations in relation to private healthcare facilities are not warranted.[9]

1.11 What the HMI's findings in respect of the hospital market actually show, is that the market is functioning competitively. There may be some overcapacity due to increased investment that occurred when there was significant increase in insured lives, which resulted primarily from the extensive time lag between the decision to invest in facilities and the time that the facilities come on-stream. The expected continued growth in lives has not occurred. This very situation has led to robust competition between hospitals, [CONFIDENTIAL]

1.12 In the current competitive context, LHC submits that the HMI's proposed remedies are misconceived. The proposals regarding licence moratoriums and divestitures are solving for market circumstances that do not exist. [CONFIDENTIAL] Even if these market circumstances did exist, the proposed remedies would not be appropriate, as they would not enhance competition. If implemented, these measures have the potential to severely disincentivise investment by the major hospital groups. The imposition of licence moratoriums and divestiture in the present circumstances will remove [CONFIDENTIAL]. Accordingly, while the HMI's proposed measures may result in a less concentrated market, they will also result in a market where competition is less effective and where market outcomes are worse.

[8] RBB Economics , Comments on the Commission's proposed methodology for assessing market power of health facilities ,
25 January 2016; RBB Economics, private Health Market Inquiry: Local Market Assessment, 18 March 2016.

[9] Refer to Annexure 10 which deals with concerns about the data room.

Private hospital market developments 2015-2017

DSP Networks

1.13 While LHC acknowledges the lifespan of the inquiry, it submits that the Provisional Findings do not sufficiently take into account the current market circumstances. Over this time, the hospital market has experienced significant changes and has become increasingly competitive. In particular, LHC highlights the increasing use of DSP networks as a significant dynamic. This factor is not given sufficient weight in the Provisional Findings, as the HMI takes the position that "*[p]rovider networks and/or DSPs are a promising tool to introduce competition among hospital groups, but are neutralised by dominance of hospital groups at a local level*….".[10] This conclusion is particularly inaccurate, given that the "must-have" hospitals account for only a very small share of admissions.[11] This is evident from the fact that there are [CONFIDENTIAL]. The growing use of DSP networks must also be viewed against the background of an already consolidated medical scheme administrator market and stagnant medical scheme membership, along with recent decisions by schemes to implement networks that exclude one or more of the major hospital groups. The evidence contradicts the contention by the HMI that schemes are constrained by this co-called "must-have" status of the major hospital networks.

New entrants and expansions

1.14 The HMI's concentration analysis fails to take into account the significant new entry and expansions by NHN and independent hospitals in the private hospital market in the last 3 years. In fact, the number of beds attributable to this new entry and expansion is more than the three hospital groups' combined new beds for the period of 2014/15 to 2017/18. As such, the HMI's concentration analysis overestimates the market share attributable to the three hospital groups, and as a result draws incorrect conclusions regarding the levels of concentration that currently exist in the market.

Price regulation and the certificate of need

1.15 LHC does not support the recommendation for price regulation or the requirement for a Certificate of Need (CoN). Robust competition will control for costs more effectively than regulation would. This is amply evidenced by [CONFIDENTIAL].

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10 Health Market Inquiry, Provisional Findings and Recommendations Report, page 11, paragraph 49.
11 RBB Economics , Response to the PHMI's Provisional Findings: Facilities Concentration Analysis, 15 October 2018, page 21, paragraph 5.3 marked Annexure C.

HPCSA Ethical Rules

1.16 In LHC's view, there is 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.

1.17 LHC does not seek to employ all doctors. Rather, it is seeking to have the right to employ doctors and for the doctors to have the right to be employed, so that these doctors can concentrate on their clinical duties rather than being concerned with the business side of their activities. In addition, having the ability to employ doctors will give private hospitals the ability to drive cost effectiveness of care, quality of care, innovation in delivery models and efficient utilisation of limited resources.

Funder concerns

Mandatory membership

1.18 The HMI appears to have disregarded the significant negative consequences of the current incomplete regulatory framework – in that it has not seen fit to recommend mandatory membership. In taking this position, the HMI has ignored the significance of the deteriorating risk profile of medical scheme members, which is the primary reason for the "high and rising" cost increases. 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.

Proposed remedies

1.19 In the final Statement Of Issues (SOI)[12], the HMI acknowledged that "*the private healthcare sector comprises a number of inter-related markets and divides these markets into three broad categories, namely; the financing of healthcare*[13] *, the providers of healthcare services (including facilities*[14] *and practitioners*[15] *) and consumables*". In the Provisional Report, the HMI found that – the administrator market is highly concentrated, with Discovery Health and Medscheme accounting for 76.1% of the market and each holding more than 35% market share (suggesting dominance); there were high market shares for some administrators and high concentration levels for the medical scheme

[12] Dated 1 August 2015, accessible on: http://www.compcom.co.za/wp-content/uploads/2015/05/Final-Statement-of- Issues-01082014.pdf , last accessed 11 October 2018

[13] Healthcare financing refers collectively to Medical Schemes, Medical Scheme Administrators, Managed Care Organisations and Healthcare Insurers.

[14] Healthcare facilities include hospitals, day clinics, sub-acute, specialised care centres and other similar facilities where healthcare services are provided.

[15] Practitioner refers to any person, including a student, who is registered with the Health Professions Council of South Africa (HPCSA) in a profession registrable in terms of the Health Professions Act 56 of 1974, including specialists, general practitioners etc.; as well as certain allied professions registered with the Allied Health Professions Council of South Africa (AHPCSA).

administrator market as a whole; and significant entry had not occurred in the medical scheme administrator market in over a decade. [16] The HMI has similarly concluded that the private hospital market is marked by high concentration levels and market power.

1.20 Despite the acknowledgement of the inter-relatedness of the private healthcare market and the adverse findings regarding the medical scheme market in the Provisional Report, the HMI has not proposed any structural recommendations to address concentration (such as divestiture, restrictions on growth and capping of market shares) – as it has done for the private hospital services market. The reason for this disparity in the recommendations is not evident in the Provisional Findings. Given the similarity of the anti-competitive conclusions reached by the HMI in respect of the funder and supply-side segments of the private healthcare market, LHC submits that the remedies proposed for the medical scheme market, as compared to the private hospital market, raises questions about the completeness of the remedies proposed and the fairness of these remedies.

Supply-Side Regulator for Healthcare (SSRH)

1.21 LHC acknowledges that there is a need for the development of cost effective standards of care, treatment protocols, health services monitoring, and oversight and management of healthcare capacity planning. However, LHC submits that the functions proposed by the HMI for the SSRH fall within the mandate of a number of existing entities, and as such, there is limited need for a new regulator to perform these functions. LHC further submits that this duplication of functions should be avoided in light of the significant funding that will be required for the establishment and operation of this new regulator. Instead, existing regulators should be appropriately evaluated and perform the functions for which they are responsible.

Conclusion

1.22 LHC agrees with the HMI that an evidence based approach is required for the market inquiry. This is in line with the Competition Act, which contemplates that where there is no evidence or insufficient evidence to prove an anticompetitive outcome, a finding of substantial, lessening and prevention of competition is not justifiable. We would therefore urge the HMI to make findings and recommendations that align with the evidence. As noted above, LHC submits that there is a lack of robust evidence to support the HMI's findings and recommendations. For this reason, LHC submits that the HMI should reconsider a number of its recommendations, in particular, as regards price regulation, licence moratoriums, divestiture, and measures to introduce a complete regulatory regime that ensures the sustainability of the private healthcare industry.

[16] Health Market Inquiry, Provisional Findings and Recommendations Report, page 133, paragraph 340.

2. Summary of LHC's position on the recommendations

HMI's Recommendation	LHC's View
Funder recommendations	
Improve scheme governance	LHC fully supports the recommendations to strengthen scheme governance.
Administrators must report publicly on the value and outcomes of all ARMs on an annual basis	LHC supports schemes being required to report on the value of ARMs, subject to measures being put in place to prevent disclosure of competitively sensitive information.
CMS to produce a biennial report on the value of managed care services	LHC supports the publication of a biennial report by the CMS subject to, measures being put in place to prevent disclosure of competitively sensitive information.
Introduction of regionally based schemes	LHC does not support the introduction of regionally-based schemes as they are likely to impact 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.
Tax credit to be administered by RAM and not SARS	LHC does not support the RAM administering the tax credit regime on the basis that SARS is best placed to perform this function by virtue of its access to necessary information and its existing experience and expertise.
All schemes must-have an obligatory base benefit package	LHC supports this recommendation subject to considerations of affordability.
Supplementary cover with risk rating	LHC supports the provision of supplementary cover but does not support any form of risk rating as this undermines principles of social solidarity.
PMBs: • revised every 3 years, • be expanded to include primary and preventative care • tariffs to be published by SSRH, CMS and funders • upfront additional cost implications to be shared with patient • treatment plans and formularies not binding on schemes • CMS to publish a biennual report on the value of managed care services, detailing the risks and benefits shared and how savings are passed onto members	LHC supports the inclusion of primary and preventative care in a revised PMB package but has reservations about the affordability of such a package. LHC is of the view that the primary purpose of the PMB's should be to protect members from financial risk that can occur through catastrophic expenditure. LHC supports the publication of a biennual report as it will introduce a much needed system of transparency subject to measures being put in place to prevent disclosure of competitively sensitive information.
CMS to publish biennial report on value of MCOs detailing risks/benefits shared and use of savings generated	LHC supports this initiative, subject to measures being put in place to prevent disclosure of competitively sensitive information.
Although the HMI supports the principle of mandatory membership, it does not believe it should be implemented within the current flawed system	The HMI has fundamentally misconceived the role of mandatory membership in the regulatory framework and it has failed to properly consider the incomplete nature of the existing regulatory framework.

HMI's Recommendation	LHC's View
Brokers play and important role in advising members – the broker system must be change to an active opt-in system	LHC agrees that brokers play an important role and also supports the opt-in broker system recommended by the HMI, allowing members to exercise a choice as to whether they want to have a broker or not.
Supply-side Recommendations	
Establishment of SSRH	LHC is concerned about the potential cost implications inherent in the recommendation of an SSRH, and submits that existing agencies and bodies should perform the duties that they have been allocated rather than having a new body established. LHC acknowledges that there is a need for the development of cost effective standards of care, treatment protocols, health services monitoring, and oversight and management of healthcare capacity planning. However, LHC submits that the functions proposed by the HMI for the SSRH fall within the mandate of a number of existing entities, and as such, there is no need for a new regulator to perform these functions. LHC does not support the requirement for a CoN. In principle, LHC does not support price regulation of the hospitals by the SSRH – or by any other regulator.
Healthcare capacity planning	
Licensing Framework	LHC supports a standardised licensing regime that must be implemented by provincial departments and, a robust and transparent reporting and monitoring system administered by the NDoH. There is no need for the SSRH to administer the reporting and monitoring system.
CoN	LHC does not support the requirement for a CoN. Robust competition will solve for supply better than regulation would.
Sale of licences to be jointly notified to competition authorities, SSRH and PDoH	LHC supports the following: PDoH to monitor transfer of uncommissioned licences. Competition Authorities to assess sale of commissioned licences and facilities.
OHSC's mandate to remain for quality accreditation	LHC supports the recommendation that the OHSC continues to undertake accreditation.
Practice code numbers: • managed by SSRH , not BHF, housed in licensing unit • Allocated to both public and private facilities	LHC does not agree that the control of the practice code numbers should be allocated to a new entity.
Healthcare Services Pricing	
Health Services Pricing • FFS a reflection of market failure • Proposal 1: Regulated pricing managed by SSRH • Proposal 2: Multilateral tariff negotiation managed by SSRH	The HMI has not presented any evidence to support its conclusion that FFS tariffs reflect market failure. The presence of FFS is not in and of itself, evidence of market failure – there must be a causal link between market failure and the FFS tariff system. LHC also notes that some schemes prefer the FFS tariff system. LHC does not support price regulation for private hospital services. The HMI's recommendation for price regulation is not

HMI's Recommendation	LHC's View
• Arbitration process for deadlocks	consistent with its finding that "*tariff increases to funders have, on average, increased at levels within the CPI index*.[17]"
Practitioner payment models HMI supports transition from FFS to ARMs	LHC supports the HMI's finding that it is important for the sector to adopt ARMs – this is equally relevant to healthcare facilities and healthcare practitioners. A key measure to facilitate the adoption of ARMs by hospitals is the employment of doctors.
Coding Systems	
Practitioner coding systems where a standardised system is recommended by SSRH SSRH responsible for adoption and standardization of actual alphanumeric codes, descriptors and relative value units	LHC supports the HMI's position that the coding system across the private sector be standardised but submits that standardisation of coding system should occur across both the public and private sectors and must make provision for pharmaceutical products and medical devices. In addition, the coding systems must be easily accessible and affordable.
Provider networks	
Provider networks have positive impact on competition and to continue Any provider who matches network FFS prices set up by any medical scheme should be allowed to provide services to same population Arrangements to promote local funder/provider contracting Open tender process recommended with contract no longer than 2 years	LHC supports the HMI's view that provider networks are pro-competitive and that these networks should continue to be used to drive value-based contracting. LHC does not support the HMI's concern about the potential exclusionary nature of provider networks. [CONFIDENTIAL] Removing this exclusionary element will defeat the purpose of a network. LHC submits that the duration of the network arrangement should ideally be negotiated between the parties and that the proposed two year duration is inadequate to achieve efficient outcomes.
Concentration: • Divestiture • Moratorium on licences • SSRH and PDoH to develop criteria to assess local concentration	The HMI's findings of a highly concentrated market is based on outdated data, and fails to present any 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. The recommendations for divestiture and licence moratoriums are not warranted, are economically unsustainable and impractical. LHC suggests that a standard, transparent licensing regime should be implemented and does not warrant the introduction of a new regulator, with the concomitant cost that it will incur.
Outcome Measurement and Reporting	
Economic value assessments Standards of care, evidence based treatment protocols and processes for conducting HTA's recommended	LHC does not support the SSRH for the purposes of assessing standards of care and treatment protocols. This function is best performed by the medical schemes – the medical schemes currently perform this function.
Outcome measurement and reporting system	LHC does not support the recommendation that the OMRO be responsible for the measurement and reporting of healthcare outcomes. LHC submits that the OHSC is best placed to

[17] Health Market Inquiry, Provisional Findings and Recommendations Report, page 223, paragraph 305.

HMI's Recommendation	LHC's View
• 1st phase voluntary (3-4 years) where published data only released to participating providers • 2nd phase OMRO to oversee process to be operational within 6 years of publication of report where it is mandatory Collaborative body to oversee process, hybrid funding model recommended	undertake this function and that the existing mandate of the OHSC should be expanded to accommodate outcomes measurement and reporting. This would be preferable to the introduction of a new regulator with the concomitant cost that would be incurred.
Supplier Induced Demand	
Over-servicing and SID	The HMI has not provided robust evidence and analysis to support its allegation of SID.
Synergies between public and private facilities	
Increase synergies between public and private facilities	LHC fully supports public private partnerships, as its own history in this regard illustrates.
HPCSA ethical rules	
Review HPCSA ethical rules	LHC supports the HMI's recommendations that the HPCSA ethical rules should be reviewed in order to allow for inter alia the use of global fees, group practices and doctor employment.

LHC RESPONSE TO THE HMI'S RECOMMENDATIONS

3. FUNDERS

3.1 Scheme Governance

3.1.1 LHC supports the HMI's recommendation that medical scheme governance be strengthened[18], including in relation to: the remuneration packages of trustees and principal officer being linked to performance of the scheme; performance measurement in relation to non-healthcare and other costs; the publication of administrators' comparative performance on various metrics; encouraging member participation in annual general meetings; and the development of core competencies for trustees.

3.1.2 LHC believes that these measures are in the best interest of members; as they are intended to hold the trustees and Principal Officer (PO) accountable by introducing a number of performance-based metrics, aimed at securing greater value for members. The recommendation on core competencies will result in a standard being set for trustees, and in turn, these standards will ensure that trustees have the appropriate expertise and will therefore be better equipped to fulfill their roles. These measures will also promote transparency in the industry and will allow members to compare performance.

3.2 ARM Reporting

3.2.1 LHC supports the recommendation that administrators report publicly on the value and outcomes of all ARMs[19], PPNs and DSP arrangements they have entered into. However, LHC submits that this information should be reported on an industry-aggregated basis, to avoid any competitively sensitive information in relation to specific providers being disclosed. As such, a scheme should report a global figure for its spend on individual plans and the savings generated for each plan. However, these savings may not be further disaggregated so as to identify the specific service providers.

3.3 Managed Care Organisations (MCOs)

LHC supports the HMI's recommendation for CMS to produce a biennial report on the value of managed care services.[20] This will introduce transparency into the managed care services industry, and will enable members to interrogate the value they receive from Managed Care Organisations and whether the cost savings generated by the Managed Care Organisations are in fact passed

[18] Health Market Inquiry, Provisional Findings and Recommendations Report, page 458, paragraph 32 - 32.6.
[19] Health Market Inquiry, Provisional Findings and Recommendations Report, page 457, paragraph 31.4.
[20] Health Market Inquiry, Provisional Findings and Recommendations Report, page 459, paragraph 33.6.

onto the schemes. However, LHC cautions that any information published in the biennial report must not disclose competitively sensitive information in respect of the providers.

3.4 Introduction of Regionally – Based Schemes

3.4.1 It is not clear that introducing regionally-based schemes would necessarily promote competition (as compared to national schemes). [21] 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. However, the HMI has not provided any evidentiary analysis to support its recommendation to facilitate the entry of regionally based schemes in order to promote competition.

3.4.2 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.[22] 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, will lead to increased competition. We note that the HMI does not elaborate how regional schemes would work in practice. A regional scheme, with agreed tariffs in a specific region, will have to choose between two options – a regional open scheme which allows any member in the country to join and a restricted medical scheme which only allows members within a specific region to join. In the case of an open regional scheme, the challenge would be when the scheme has to accept members outside of the region and these members are allowed to use any private healthcare provider because they are too far from a designated service provider. This would entirely defeat the purpose of a regional scheme, which by its very nature, contemplates the use of service providers in a particular region. If the regional scheme restricted membership to the specified region, it would then have to be registered as a restricted medical scheme. In such a case, it is unclear how the scheme would facilitate competition in the open scheme market. In a market where restricted schemes and open schemes do not compete, the introduction of any number of regional restricted schemes would not solve for the concentration problem that the HMI has identified.

3.4.3 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

[21] Health Market Inquiry, Provisional Findings and Recommendations Report, page 459, paragraph 34.
[22] Health Market Inquiry, Provisional Findings and Recommendations Report, page 78, paragraph 12.

be an obstacle for new regionally-based schemes. To mitigate this, the HMI proposes reinsurance for small new entrants.[23]

3.4.4 The converse situation of regional schemes attracting low risk members away from an existing scheme would damage the existing schemes risk profile. The risk equalisation mechanism would have to be introduced simultaneously in order mitigate against this risk.

3.4.5 LHC submits that 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.

3.5 Tax Credits

3.5.1 LHC is of the view that the tax credit regime should remain the responsibility of the South African revenue Services (SARS) [24] for the following reasons:

3.5.1.1 A medical scheme does not have information on the income earned by the majority of its members. This information will only be available to a scheme in income rated options. As such, schemes would have to source their member's income information. The typical source used to verify a member's income would be an IRP5 certificate or recent bank statements. A number of members are retired and are therefore unable to provide such information. Schemes requesting bank statements may not receive information regarding all bank accounts. There is therefore considerable opportunity for members to understate their income;

3.5.1.2 SARS currently has a global view of income earned. This includes rental income, investments that produce income and trust income; and

3.5.1.3 To avoid duplication of work it would therefore be necessary for SARS to share information with RAM.

3.5.2 In addition, LHC submits that a risk based adjustment mechanism is essential in the existing market, and that this work has been extensively led by the CMS which is perfectly placed to administer such a mechanism. Please refer to the expert report prepared by Cadiant Partners, titled *HMI's Draft Findings and Recommendations, prepared for Life Healthcare Group, 15 October 2018* marked Annexure G.

3.6 Introduction of Obligatory Base Benefit

3.6.1 LHC supports the introduction of a stand-alone, standardised, obligatory base benefit package that all schemes must be required to offer.[25] In addition, LHC agrees that the base benefit

[23] Health Market Inquiry, Provisional Findings and Recommendations Report, page 459, paragraph 34.
[24] Health Market Inquiry, Provisional Findings and Recommendations Report, page 460, paragraph 43.
[25] Health Market Inquiry, Provisional Findings and Recommendations Report, page 457, paragraph 31.1.

package must also include catastrophic cover as a critical component of that package and that primary and preventative care cover should also be included.

3.6.2 Although LHC appreciates that the HMI is seeking to expand the scope of medical cover for medical scheme members, the HMI contends that affordability is a key metric in this debate. In this regard, the proposed base benefit package may have the unintended consequence of existing medical scheme members exiting the scheme, as a result of not being able to afford the package.

3.6.3 LHC submits that the HMI must consider Low Cost Benefit Options (LCBO) that should be made available outside the base benefit package. We note that the CMS has previously conducted an investigation into LCBOs. Please see attached Annexure 1 and 2, Low Income Medical Scheme Publications, issued by the Council for Medical Schemes.

3.6.4 LHC supports a system of risk adjustment[26] in order to compensate between low risk and high risk schemes. We note the HMI's recommendation that the proposed risk adjustment mechanism be initially facilitated by CMS and to later be migrated to a separate independent authority. As regards the authority that will ultimately administer the risk adjustment mechanism, LHC submits that this authority must be properly established with appropriate governance measures and must be independent (as the HMI has itself acknowledged).

3.7 Supplementary Cover

3.7.1 LHC supports the recommendation that the CMS ought to develop standards and requirements for all supplementary cover options[27], in order to improve transparency and assist consumers in making product comparisons. However, LHC seeks to understand the HMI's rationale for recommending risk rating[28] for supplementary cover. LHC's view is that schemes should not be permitted to risk rate members for supplementary cover, as this undermines the principles of social solidarity.

3.7.2 With reference to the HMI's comments on supplementary benefits, LHC submits that there is a lack of clarity as to how comprehensive the base benefit package should be. This is illustrated by the HMI indicating that risk rating will be allowed on supplementary benefit packages where that base cover is comprehensive; but that risk rating will not be allowed where the base benefit cover is so limited that supplementary cover becomes a "must-have". [29]

3.7.3 Where base benefit cover is so limited that supplementary cover becomes a "must-have", LHC submits that this defeats the purpose of the base benefit cover. LHC accordingly submits that the

[26] Health Market Inquiry, Provisional Findings and Recommendations Report, page 457, paragraph 31.2.
[27] Health Market Inquiry, Provisional Findings and Recommendations Report, page 457, paragraph 31.3.
[28] Health Market Inquiry, Provisional Findings and Recommendations Report, page 460, paragraph 47.2.
[29] Health Market Inquiry, Provisional Findings and Recommendations Report, page 460, paragraph 47.2.

base benefit package ought to be comprehensive. Where this is not the case and supplementary cover has to be provided, this is contrary to the HMI's intention that the base benefit package should be easily comparable across schemes - as it creates the opportunity for schemes to create different categories of base benefit packages.

3.7.4 This lack of clarity introduces significant uncertainty for all stakeholders, as schemes will most likely deviate from the intended uniform package.

3.8 Prescribed Minimum Benefits (PMBs)

3.8.1 In principle, LHC supports the inclusion of primary care and preventative care[30] in a revised PMB package. However, LHC has serious reservations regarding the affordability of such a package and would caution against a package that would compromise the scheme's sustainability. The HMI must therefore consider low cost benefit options, which the Council for Medical schemes has itself been considering. Please refer to Annexure 1 and 2 for the Low Income Medical Scheme Publications, issued by the Council for Medical Schemes.

3.8.2 LHC understands and supports the rationale underlying the recommendation for members to be made aware of the cost implications[31]. However, this recommendation may be problematic under certain circumstances:

3.8.2.1 Where the physical condition of the patient does not permit i.e. if a patient is unconscious, it will simply not be possible to have that discussion; and

3.8.2.2 Where the predictability of care is not possible i.e. patients may suffer complications or have chronic conditions that impact their treatment plans.

3.8.3 In this regard, where good faith provision has been made by the hospital and other providers to ensure necessary treatment, the schemes should be obliged to pay the claim.

3.8.4 It is not clear to LHC what the HMI intends by stating that treatment plans and formularies should not be binding on schemes.[32]Treatment plans and protocols are necessary cost levers .As such, they must be binding on the schemes. In the absence of this obligation, the treatment plans and formularies will serve no real purpose, as the schemes are not likely to adhere to them. However, where the doctor chooses to treat outside of the formulary /treatment plan for good clinical reasons, which is ultimately his/her clinical decision to make, the schemes must be liable to pay the claim.

3.8.5 In addition, it is essential that binding treatment plans and formularies are transparent to providers.

30 Health Market Inquiry, Provisional Findings and Recommendations Report, page 459, paragraph 33.2.
31 Health Market Inquiry, Provisional Findings and Recommendations Report, page 461, paragraph 49.3.
32 Health Market Inquiry, Provisional Findings and Recommendations Report, page 461, paragraph 50.

3.8.6 LHC agrees with the HMI that the development and review of formularies and treatment plans will likely be a resource-intensive process and that it ought to be managed in an inclusive, comprehensive and reputable manner.[33] What is important is that the treatment plans and formularies must be cost-effective and must not be designed to the detriment of patients i.e. these treatment plans and formularies must balance between affordability and quality of care.

3.9 Anti-Selection

3.9.1 The HMI has taken the view that: "*…mandatory membership would simply add more beneficiaries into a system with high and rising costs, significant SID, limited competition and no incentives to create value for members.*" [34]

3.9.2 Mandatory membership is intended to solve for anti-selection by members. Anti-selection occurs when beneficiaries join a medical scheme only when they need expensive medical care, and depending on their health status, would either leave when the scheme has paid for their treatment or remain on the scheme and continue incurring high expenditure.

3.9.3 Anti-selection is problematic as it results in the "premium death spiral" [35], where younger healthier people choose not to be part of a medical scheme and fewer people are left in the risk pool to fund the scheme. This pushes up the premium, which in turn acts as a disincentive for younger and healthier people to join the scheme, consistently worsening the risk profile of the scheme.

3.9.4 Mandatory membership is, therefore, not intended to manage utilisation (SID), competition or incentives to create value for members. Mandatory membership is intended to solve for the cost of medical scheme premiums, by ensuring that a stable population is covered in the risk pool and that not only the sick seek insurance cover. The current remedies proposed by the HMI to address this anti-selection issue will simply increase costs for older members, as it is suggested that younger members be granted a discount in order to encourage their entry into the system. This would simply mean that older members would have to compensate for this discount.

3.9.5 Estimates of the impact of mandatory cover are between a 15% and 20% drop in the cost of care and an increase in cover of between 5 million and 6.2 million citizens, depending on the income level used to determine mandatory membership.[36]

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33 Health Market Inquiry, Provisional Findings and Recommendations Report, page 461, paragraph 50.
34 Health Market Inquiry, Provisional Findings and Recommendations Report, page 461, paragraph 53.
35 The South African Private Healthcare Sector: Role and Contribution to the economy. Available on: https://econex.co.za/wp-content/uploads/2016/09/Econex_private_health_sector_study_12122013-1.pdf , last accessed 27 September 2018.
36 The role of risk equalization in moving from voluntary private health insurance to mandatory coverage: the experience in South Africa, Heather Mcleod and Pieter Grobler, 2009. Note that the reduction in costs referred to was quantified on PMBs.

3.9.6 As regards "*SID*", we note that the HMI has not provided robust evidence to support this allegation, for the reasons set out in the report prepared by RBB Economics titled *Response to the PHMI's Provisional Findings: Supplier Induced Demand, 15 October 2018 marked Annexure B*.

3.9.7 In addition, the aspect of the HMI's assessment of SID at the procedure level is problematic since the level of discretion that doctors have in respect of certain the procedures analysed by the HMI is likely to be limited[37] (due to the risks associated with not treating a patient that displays symptoms that are typically treated by such procedures). In particular,

3.9.7.1 cholecystectomy procedures treat the cause of chronic and agonising abdominal pain, which often affects women;

3.9.7.2 tonsillectomy procedures treat one of the leading causes of Upper Airways Obstruction in repeated throat infections children, which, if untreated, can lead to secondary complications that may affect the heart;

3.9.7.3 major joint arthroplasty treats arthritis of major joints which is the leading cause of chronic debilitating pain in patients above 65 years of age;

3.9.7.4 inguinal hernia repair procedures, while not an emergency procedure, can lead to life threatening strangulation if not performed;

3.9.7.5 cataract surgery treats one of the leading causes of blindness in South Africa and is necessary to restore someone's vision; and

3.9.7.6 coronary artery bypass grafting for coronary ischemia is a life-saving complex surgery for patients with Ischaemic Heart Disease.

3.9.8 Increased utilisation has to be addressed by managing the conduct of healthcare providers. The HMI has itself acknowledged this when it recommended that the CMS include metrics of SID in its published reports and that it must publish information on what schemes or administrators are doing to cut back on SID.[38] Denying mandatory membership does not solve for SID.

3.9.9 As regards "*high and rising costs*", the HMI has misdirected its inquiry. LHC submits that the rising costs are due to a deterioration of risk profile and which in turn have led to increased utilisation. Mandatory membership would alleviate this 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.

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37 Health Market Inquiry, Provisional Findings and Recommendations Report, page 377, paragraph 8.
38 Health Market Inquiry, Provisional Findings and Recommendations Report, page 478, paragraph 172.

3.9.10 As regards "*limited competition*" and " *no incentive to create value for members*" , LHC notes that, competition between healthcare providers is facilitated by, *inter alia*, the bargaining power exercised by medical schemes, the use of DSPs and Value Based Contracting (VBC). As detailed in this submission, the private hospital market is subject to [CONFIDENTIAL]. Funders are best placed to speak about their incentives to create value for their members.

3.9.11 The HMI has not properly considered the incomplete nature of the regulatory framework and the severe impact that this has had on the private healthcare sector. As LHC has previously submitted, the Medical Schemes Act (MSA) Amendment of 2000 that introduced guaranteed benefits, open enrolment and community rating was only part of a broader reform agenda towards universal coverage. As the HMI is aware, the government suspended this reform agenda without introducing any of the measures that were critical to ensure the sustainability of schemes, including measures such as the Risk Equalisation Fund (REF), mandatory cover and risk based solvency.

3.10 Brokers

3.10.1 LHC agrees that brokers play an important advisory role to members.[39]

3.10.2 LHC also supports the recommendation that schemes transparently reflect broker fees in the premium.[40] This breakdown of the premium must clearly indicate the allocation of any commission and any other associated services provided by the scheme, such as loyalty programmes. This breakdown would properly inform the members as to the interests held by each service provider.

3.10.3 LHC supports the opt-in broker system[41] recommended by the HMI. This will allow members to exercise a choice as to whether they want to have a broker or not, as opposed to having a broker automatically assigned on an annual basis. LHC submits that the annual declaration required by the member must be facilitated by the scheme. In other words, the scheme must contact the member and confirm that the member wishes to use a broker. This may appear to be an onerous requirement. There are however, cost effective measures that the schemes can adopt to engage with members. This would include a general mass communication to members on an annual basis, by means of an email and an sms, which provides an opt-in and an opt-out option. LHC also supports the recommendation that members should have the freedom to deal with a licenced broker of their choice.[42]

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39 Health Market Inquiry, Provisional Findings and Recommendations Report, page 461, paragraph 54.
40 Health Market Inquiry, Provisional Findings and Recommendations Report, page 462, paragraph 54.4.
41 Health Market Inquiry, Provisional Findings and Recommendations Report, page 461, paragraph 54.1.
42 Health Market Inquiry, Provisional Findings and Recommendations Report, page 462, paragraph 54.2.

3.10.4 Finally LHC notes that the opt-in system may impact the sustainability of the broker profession, especially having regard to the existing low levels of mandated broker fees.

4. **Supply–Side**

4.1 Establishment of the SSRH

4.1.1 LHC acknowledges that there is a need for the development of cost effective standards of care, treatment protocols, health services monitoring, oversight and management of healthcare capacity planning. However, LHC submits that these functions fall within the mandate of a number of existing entities, and as such, there is a limited need for a new regulator to perform these functions. LHC submits that the following entities can carry out the functions as set out below:

4.1.1.1 Development of cost effective standards of care and treatment protocols - as is currently the case, medical schemes should drive cost effectiveness as they are best placed to undertake this function;

4.1.1.2 Health services monitoring – Office of Health Standards and Compliance(OHSC); and

4.1.1.3 Healthcare capacity planning – National and Provincial Department of Health.

4.1.2 LHC further submits that this duplication of functions should be avoided, particularly in light of the significant funding that will be required for the establishment and operation of this new regulator. We note that the Provisional Report does not indicate how the SSRH is going to be funded and who will bear the burden of this cost.

4.1.3 LHC emphasizes that it does not support the requirement for a CoN and regulated pricing, as these are not functions that LHC believes should be assigned to the SSRH or any other regulator for that matter.

4.2 Health capacity planning

4.2.1 *Licensing Framework*

4.2.1.1 LHC agrees with the HMI that the current licensing regime under Regulation 158, followed by 7 of the 9 provinces, has been disparately applied. There has been no uniformity in the nature of the criteria applied, the interpretation of how the criteria are to be applied or the applicable time frames for considering an application.[43] The lack of a coherent, consistent and rational licensing system under Regulation 158 has proved very challenging.

4.2.1.2 LHC therefore supports 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.[44] LHC submits that the NDoH is best placed to

[43] Health Market Inquiry, Provisional Findings and Recommendations Report, page 462, paragraph 56.2.
[44] Health Market Inquiry, Provisional Findings and Recommendations Report, page 464, paragraph 70.

undertake the responsibility for the administration of the reporting and monitoring system given the fact that it issues the licences. In the circumstances, LHC submits that it would not be appropriate for the SSRH to perform this function.

4.2.1.3 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. In the circumstances, the proposed comprehensive national plan that is intended to take into account both the public and private sectors, must include a consideration of the distinction between the sectors. However, were the NHI to come into effect, this distinction would likely no longer be relevant, as there would be competition between the sectors for these patients.

4.2.1.4 LHC agrees that the development of the national plan ought to be undertaken in a consultative manner with relevant stakeholder representation facilitated by the DoH.[45] This consultative process would only be required when the NHI regime is realised. Until the NHI regime is properly and fully realised, in that the private and public sectors are comparable, license applications for private facilities should not be prejudiced by the existence of public sector capacity.

4.2.1.5 In principle, LHC agrees that the licensing framework should include regular monitoring, inspection and reporting requirements. While LHC largely agrees with the minimum reporting requirements proposed by the HMI , we make the following comments:

4.2.1.5.1 While we agree that ownership of the establishment must be provided, we do not see what purpose is served by reporting to the PDoH any planned acquisitions that have been notified to the competition authorities, as the competition assessment falls within the jurisdiction of the competition authorities.[46]

4.2.1.5.2 We agree that licensed establishments must provide the name of practitioners who work from or have admission privileges to their facilities, categorised by discipline. LHC further submits that the practitioners should include allied healthcare professionals. This will ensure good clinical practices in terms of accounting for practitioner conduct and patients being sufficiently informed about the practitioners that treat them.

4.2.1.6 LHC has no objection to the data and information collected from the health establishments being published on a national database that is accessible to the NDoH and PDoH. However, some of this information may be confidential and competitively sensitive and should therefore not be available in the public domain. In the circumstances, the national database should have two platforms, a confidential platform that is only accessible to the NDoH and PDoH and

[45] Health Market Inquiry, Provisional Findings and Recommendations Report, page 464, paragraph 69.
[46] Health Market Inquiry, Provisional Findings and Recommendations Report, page 464, paragraph 70.3.

a public platform that is generally accessible and that has been sanitised for confidential and competitively sensitive information. [47]

4.2.1.7 In principle, LHC agrees with the licence renewal mechanism being proposed. However, LHC submits that, in accordance with the current system, a detailed report of the shortcomings in a facility must be provided by the licensing officials and appropriate timelines must be agreed to between the facilities managers and the licensing officials. These timelines must be agreed to in consultation with the hospital manager, in order to ensure that there is no disconnect between the expectations of the licensing officials and the ability of the hospital manager to resolve the concerns identified. This is particularly relevant to older hospital buildings. As regards penalties, the first penalty should only be imposed after a facility has failed to correct the concerns identified. This is in line with current practice.[48]

4.2.1.8 As LHC understands the two phase licensing framework being proposed, the first and second phase will apply to greenfield operations while only phase two will apply to existing facilities.[49] LHC has no objection to the provisions of phase one. However, as regards phase two, LHC does not agree that letters of support from local funders should be a licensing requirement.[50] There is a direct conflict of interest if funders have a veto power over new hospital builds or extensions. As the HMI will appreciate, funders have a strong incentive not to support additional beds, be it in a new hospital or as part of an extension. LHC also submits that it is not appropriate for the licensing regime to have a requirement stipulating the inclusion of new and innovative models of value-based-care[51]. It is not appropriate for innovation to be prescribed, as innovation by its very nature does not align with rigid rules. Innovative models of value-based-care are more appropriately placed within the domain of the funders who have the necessary expertise and experience to engage with facilities. Finally, as regards the request for a comprehensive project plan for construction with detailed timelines[52], LHC submits that provision should be made for overruns, subject to valid reasons being provided.

47 Health Market Inquiry, Provisional Findings and Recommendations Report, page 464, paragraph 71.
48 Health Market Inquiry, Provisional Findings and Recommendations Report, page 465, paragraph 72.
49 Health Market Inquiry, Provisional Findings and Recommendations Report, page 465, paragraph 73 and 74.
50 Health Market Inquiry, Provisional Findings and Recommendations Report, page 465, paragraph 74.2.
51 Health Market Inquiry, Provisional Findings and Recommendations Report, page 465, paragraph 74.1.
52 Health Market Inquiry, Provisional Findings and Recommendations Report, page 465, paragraph 74.7.

4.2.2 *Facility licensing - Certificate Of Need (CoN)*

4.2.2.1 LHC is of the opinion that the considerable regulatory and logistical factors necessary to successfully implement CoN are underestimated by the HMI, given the number of health establishments and the various providers of health services to which this regime applies.

4.2.2.2 The current hospital licensing regime is governed by Regulations 158 and 187 (R158 and R187) depending on the province. The application of R158 is highly problematic, as each province has adopted its own interpretation of the regulations and attends to the administrative procedures and requirements differently. This has created disparity and uncertainty. In addition, provincial administrators have, on occasion, developed internal policy documents governing the process and adjudication of applications. These documents, which have not been made available for comment, are not freely available in the public domain and are applied inconsistently. All of this operates to create a highly disorganised licensing system. Such a system and its results are not remedied by the introduction of the CoN.

4.2.2.3 LHC is a member of the Hospital Association of South Africa (HASA). The HASA in its submission to the DoH in 2014, made the following relevant comments[53]:

4.2.2.3.1 CoN provisions will contribute to making medicine a less attractive career option.

The necessity and rationale for the provisions on CoN in the National Health Act (NHA) is questionable for a number of reasons. HASA has reason to believe that the South African CoN concept originated from the United States (US) since no other country in the world appears to have CoN legislation. Other countries, such as Dubai, Switzerland, the United Kingdom, Australia and Italy do have licensing procedures for hospitals but these are not the same in scope or extent as the CoN provisions in South African law and the laws of the various American States. The US introduced a certificate of need system in the 1970s and HASA believes that it is important to understand the US experience with the certificate of need concept. Please see below lessons learnt from the US experience:

4.2.2.3.2 Certificate of need adversely affects access to health care services

The premise that placing regulatory burdens, such as CoN, on the creation of new medical facilities will increase availability of medical services to communities is inherently contradictory. By forcing potential medical professionals to go through an application process, CoN both delays and discourages the development of new facilities in outlying

[53] Hospital Association of South Africa comments on Certificate of Need.

areas. Furthermore, CoN laws do not provide any additional incentives to medical providers to locate in areas where they cannot raise the revenue to sustain their business.[54]

It has been observed that CoN reduces the overall quality of care by inhibiting the availability of higher-quality forms of health care delivery. Even absent political pressure, a government body is inherently unable to strike the proper balance between access and safety for millions of patients across billions of encounters with medical personnel. Such an authority would inevitably restrict access to care and block innovations that make healthcare better, cheaper, and safer.[55]

4.2.2.3.3 Certificate of need is not effective in controlling health care costs

In the USA, a core intention of the CoN was to manage healthcare costs. There have been numerous academic studies regarding the effects of the CoN on the cost of healthcare. Virtually no studies have shown that the CoN lowers costs.[56] One study performed by Conover and Sloan in 1998 found that "*mature certificate of need programs resulted in a slight (2 percent) reduction in bed supply but higher costs per day and per admission, along with higher hospital profits.*"[57]

In 2004 the US Federal Trade Commission and the Department of Justice both claimed that CoN programs actually contribute to rising prices because they inhibit competitive markets, which should otherwise be operating to control the costs of care and guarantee quality and access to treatment and services.

4.2.2.3.4 Certificate of need hampers the introduction of new health technologies

CoN provisions have been subject to wide criticism. It is argued that CoN programs operate to reduce price competition between facilities, and raise the barriers of entry to potential new competitors into the market.[58]

The principle of competition relies on the fact that there is a certain degree of excess capacity within a market. The CoN system attempts to eliminate that excess capacity from the system. As such, it is in direct opposition to competition principles where ideally, supply should not exactly match demand but should be slightly greater. If supply exactly matched

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54 Valone P, Certificate of Need: Access Denied, 19 September 2011, available at http://www.nccivitas.org/2011/certificate-of-need-access-denied/

55 Cato Handbook for Policymakers 7th ed http://object.cato.org/sites/cato.org/files/serials/files/cato-handbook-policymakers/2009/9/hb111-15.pdf.

56 Kavanagh K.T., The Certificate of Need: An Outdated Concept in Need of Re-Examination http://www.healthwatchusa.org/publications/2009-Certificate_of_Need-Final-4.pdf.

57 Conover, C.J., & Sloan, F.A. (1998). Does removing certificate-of-need regulations lead to a surge in health care spending, Journal of Health Politics, Policy and Law, 23, 455-81.

58 US Federal Trade Commission and the Department of Justice, Competition in Healthcare and Certificates of Need, 2008, available at http://www.justice.gov/atr/public/comments/233821.htm.

demand there would be no competition because the providers will all be operating at capacity and will act as residual monopolists knowing that they cannot lose volumes to rivals. In real terms such equilibrium is not only unfeasible, it is undesirable because it stifles innovation and exploration of new and more efficient ways of achieving access to healthcare services.[59]

4.2.2.3.5 Certificate of need does not improve the distribution of healthcare services

There is no evidence that the certificate of need programme increases access to care. The proponents believed that CoN had only added to health costs by bureaucratizing the planning process and obstructing the development of integrated delivery systems.

HASA is of the view that the CoN provisions of the National Health Act were ill-conceived from the inception as they were based upon an already floundering American concept that has since been proven to be largely unsuccessful in its land of origin, which is the reason why these provisions of the National Health Act had never been brought into effect.

4.2.2.3.6 It is against this backdrop that the DOH should reflect on the long-term consequences of any potential regulations introduced in the context of CoN.

4.2.2.3.7 Finally, as LHC has previously submitted, the licensing regulations are inappropriate as the state should not be involved in determining the need for a private hospital, as this is tantamount to regulating competition. The establishment of private hospitals should be determined by market forces which are better placed to regulate need in the private sector.

4.2.3 *Facility Licensing - Sale of licences*

4.2.3.1 As regards the HMI's proposal that the sale of hospital licences be notified to the competition authorities, the SSRH and the PDoH [60], LHC believes that there is an important distinction to be made between uncommissioned hospital licences and commissioned hospital licences, that is, licences to which a developed facility attaches. In respect of hospital licences that have not been commissioned, we believe that the PDoH is best placed to consider the transfer of the license, and that neither the SSRH nor the competition authorities should have any jurisdiction over the transfer of these licenses. LHC submits that an uncommissioned licence is not part of a business. As such, the competition authorities are likely to consider this a "bare asset" and thus not likely to require notification of the transfer of such a license.

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[59] Caudill S.B., Ford J.M, Kaserman, D.L. Certificate of Need Regulation and the Diffusion of Innovations: A Random Co-Efficient Model, Journal Of Applied Econometrics, Vol. 10, 73-78 (1995).

[60] Health Market Inquiry, Provisional Findings and Recommendations Report, page 466, paragraph 83.

4.2.3.2 Section 12(1)(a) of the Competition Act provides that a transaction constitutes a merger when "*one or more firms directly or indirectly acquire or establish direct or indirect control over the whole or part of the business of another firm*". When considering the meaning of this provision in *Competition Commission / Edgars Consolidated Stores Ltd / Retail Apparel Group (Pty) Ltd* Case No.: 95/FN/Dec02, the Tribunal took the position that, "[t]*he mere acquisition of an asset, assuming it otherwise falls within the thresholds … does not constitute a merger. What the Act clearly sets out, as a limiting feature, is that which is taken control of is a "business" or "part of a business".*[61] As to when the acquisition of an asset constitutes a merger, the Tribunal noted further that "*.. when the acquisition of an asset constitutes the acquisition of a business or part of a business is a question of fact that must be examined in the context of the whole transaction. Is the acquiring firm by acquiring the asset, acquiring something more than a bare asset that would enhance its competitive position? One example would be where the purchase of an asset enables the acquiring firm to increase its market share or pre-empt a rival from increasing its.*[62]"

4.2.3.3 An uncommissioned licence may or may not ultimately be commissioned to develop a hospital facility. In this regard, the HMI itself makes reference to "*idle and uncommissioned licences*"[63] and notes that "[a]*fter obtaining the required licences, potential entrants struggle to get the projects off the ground primarily due to a lack of capital, often until the licence expires*."[64] LHC submits that an uncommissioned licence is a bare asset, as it, *inter alia*, has no market share attributable to it i.e. the licence on its own has no beds attributable to it – this only occurs when the facility is developed.

4.2.3.4 In relation to hospital licences that have been commissioned, the competition authorities already have a merger regime in place. This merger assessment regime subjects all notifiable transactions to a stringent review by the competition authorities and includes both an assessment of the competition and public interest aspects of a transaction. The competition authorities are therefore best placed to assess any such transactions, especially since this recommendation is aimed at addressing the issue of market concentration.[65]

4.2.3.5 The HMI contends that a number of un-commissioned licenses were acquired by the three hospital groups and that these transactions were only notified to the licensing authorities after the fact.[66] LHC has never acquired an un-commissioned licence and in the circumstances, this

61 Paragraph 22.
62 Paragraph 24.
63 Health Market Inquiry, Provisional Findings and Recommendations Report, page 201, paragraph 191.
64 Health Market Inquiry, Provisional Findings and Recommendations Report, page 253, paragraph 470.
65 Health Market Inquiry, Provisional Findings and Recommendations Report, page 462, paragraph 56.3.
66 Health Market Inquiry, Provisional Findings and Recommendations Report, page 201, paragraph 191.

contention does not apply to LHC. LHC respectfully requests that the HMI substantiates its claim in relation to it.

4.2.4 *Facility Licensing - Mandate of the OHSC*

4.2.4.1 LHC agrees with the HMI that licenses should only be issued to facilities and practices that have been certificated by the OHSC.

4.2.4.2 In performing its certification function, the OHSC should be cognisant of older facilities that were built under different specifications in terms of the hospital building requirements at the time. These facilities may not meet current hospital building requirements and in these circumstances, the OHSC must make provision for any upgrades that might be required and must allow sufficient time for this to happen. These facilities should therefore not be prejudiced in relation to license renewals.

4.2.5 Practice code numbering system

4.2.5.1 LHC does not agree with the HMI's proposal that the SSRH takes over the assignment of practice code numbers from the Board of Healthcare Funders (BHF).[67] The HMI recommends that the SSRH take on the function of administering the Practice Code Numbering System (PCNS),[68] on the basis that practice code numbers will in future have to be allocated to both public and private facilities, to support strategic public purchasing from private providers in the National Health Insurance framework and to support the inclusion of public hospitals in private funders provider networks. However, it is not apparent why, even in the context of the NHI; the BHF cannot continue to be responsible for the PCNS.

4.2.5.2 The PCNS was developed over a long period of time, commencing in the 1960s, initially under the supervision of the Statutory Organisation of Medical Schemes (later Bestmed medical scheme). In 1978, the Statutory Organisation of Medical Schemes and the Representative Association of Medical Schemes (RAMS) entered into an agreement regarding the future administration of the PCNS via the RAMS, in terms of which RAMS would be responsible for the continued issuing of practice numbers. The RAM was ultimately succeeded by the BHF, which took over the PCNS function. LHC's understanding is that this was allocated to BHF through a tender process.

4.2.5.3 Since its inception, the PCNS has grown significantly and the BHF has expended extensive time, effort and money to develop and maintain the PCNS. The court[69] has previously found that the PCNS is an original work and that the BHF and its predecessor are the authors of that work,

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67 Health Market Inquiry, Provisional Findings and Recommendations Report, page 466, paragraph 84.
68 Health Market Inquiry, Provisional Findings and Recommendations Report, page 466, paragraph 84.
69 Board of Healthcare Funders, v Discovery Health Medical Scheme and others, (2012) ZAGPPHC 65.

and that it is therefore protected by the Copyright Act. The court also found that, despite the fact that the PCNS had been developed under the direction of the state, and its content was determined by the regulations to the Medical Schemes Act, copyright did not vest in the state. Even though the BHF had to develop the PCNS in compliance with the regulations to the Medical Schemes Act, it had done so under its own control.

4.2.5.4 In LHC's experience, the PCNS is effectively managed by the BHF, and there is thus no reason for this function to be moved to any other entity. Even with the NHI coming into effect, the administration of the PCNS can continue to be undertaken by the BHF. Given that the BHF has been developing and managing this system since 1978, it has the required experience and expertise regarding the PCNS. In the circumstances, LHC submits that BHF is well placed to administrate the PCNS. This will avoid unnecessary costs being incurred to set up a unit within the SSRH to perform a function that is already being adequately performed by the BHF. As noted above, in principle, LHC does not support the establishment of the SSRH.

4.2.5.5 In relation to practitioners, LHC does have concerns about how the practice code numbers are issued. First, the proposed practice code numbering system does not make any provision for any changes in a practitioner's status, namely, where a practitioner goes from full-time to part-time practice or vice versa. [70] In this circumstance, LHC proposes that the practitioners be required to report on an annual basis as to whether they are practicing full-time or part-time. Second, LHC submits that practitioners should provide address information in respect of all facilities at which they practice and not only the facility at which they spend most of their time. [71] The practitioner should also provide an estimate of the amount of time spent at each of the facilities. This will ensure that the BHF has a complete view of how a practitioner allocates his time between facilities.

4.2.5.6 Doctor licensing – OHSC mandate

4.2.5.6.1 While LHC agrees that the task of extending licensing to primary care is an enormous one, and agrees that the OHSC should be permitted to outsource its functions,[72] LHC notes that the licensing regime must be applied on a consistent basis. By outsourcing these functions, the OHSC must guard against the risk that the healthcare standards will not be uniformly applied.

70 Health Market Inquiry, Provisional Findings and Recommendations Report, page 466, paragraph 87.
71 Health Market Inquiry, Provisional Findings and Recommendations Report, page 466, paragraph 90.2.
72 Health Market Inquiry, Provisional Findings and Recommendations Report, page 467, paragraph 93.

4.3 *Economic Value Assessments*

4.3.1 Although LHC agrees with the HMI that there are no publicly available cost-effective standards of care and treatment protocols[73] in South Africa, medical schemes have been applying international care and treatment protocols that take cost-effectiveness into account. As far as LHC is aware, each scheme/administrator that has adopted international standards of care and treatment protocols in order to manage costs, has done so independently of other schemes. As such, there is no uniform standard applied by each scheme. This, however, does not detract from the fact that schemes use Evidence Based Medicine (EBM) in managing care in a cost-effective manner.

4.3.2 AS LHC understands, the medical schemes undertake the following process when referencing to international standards of care and treatment protocols :

4.3.2.1 The clinical quality of international published literature is assessed in order to determine robustness of the studies undertaken;

4.3.2.2 They have regard to the practice of international funders in relation to the treatments being considered; and

4.3.2.3 Subject to the clinical quality evaluation passing muster, the scheme then undertakes a health economic evaluation. This assessment takes into account a number of factors including cost-effective analysis, cost-benefit analysis, budget impact analysis, cost minimisation analysis as well as the incidence and prevalence of the particular disease from a South African context. This composite assessment is then used to inform the schemes funding decisions in respect of treatments, medical devices, and care pathways amongst others.

4.3.2.4 As far as LHC understands, schemes have units that are dedicated to undertaking the assessments described above. In the circumstances therefore, LHC does not support the creation of an independent body that will assess standards of care and treatment protocols. Schemes are adequately performing this function and currently develop protocols and treatment plans following a consultative process. The creation of cost effective protocols and treatment plans is also a mechanism that schemes use to compete with each other.

4.3.3 This approach, which is evidence-based, sets the platform for value-based-contracting. The implementation of cost effective standards of care and treatment protocols allows schemes to assess and compare outcomes by healthcare providers. This in turn allows the scheme to select the healthcare providers with the best outcomes, and for the healthcare providers to better assess the circumstances in which they can take risk on quality outcomes. This risk sharing is what value-

[73] Health Market Inquiry, Provisional Findings and Recommendations Report, page 467, paragraph 94.

based-contracting contemplates. LHC has existing contracts that incorporate elements of value-based-contracting, and expects these to grow in scope.

4.4 *Health Services Monitoring*

4.4.1 LHC supports the phased introduction of a standard mechanism for measuring the performance and outcomes of practitioners and facilities.[74]

4.4.2 However, LHC does not support the establishment of a monitoring body in the form of the OMRO, but proposes rather that the mandate of the OHSC be expanded to perform this function. This will avoid a waste of resources and will facilitate a more efficient monitoring process. Please refer to the section 4.10. of this submission titled *Outcomes Measurement and Reporting System* for a detailed commentary regarding the OMRO.

4.5 *Health Services Pricing*

4.5.1 *FFS a reflection of market failure*

4.5.1.1 According to the HMI, FFS tariffs should be regulated because "*regardless of how they are negotiated,* [they] *are a reflection of market failure within the private healthcare system*", as the prices do not, in the HMI's view, "*consider quality of care or try to reduce SID*".[75] The HMI also concludes that FFS contracts will remain a significant feature of the market for the foreseeable future and that, for this reason direct intervention is required.[76]

4.5.1.2 LHC submits that there is simply no basis to conclude that the existence and the extent of FFS tariffs reflects market failure, for the following reasons:

4.5.1.2.1 The HMI has not presented any evidence for concluding that FFS tariffs reflect market failure;

4.5.1.2.2 The presence of FFS tariffs, in and of itself, is not evidence of market failure. In order to sustain an argument of market failure, the HMI must show a causal link between market failure and FFS;

4.5.1.2.3 As LHC indicated in its first submission to the HMI, it considered the FFS system to be unsustainable and for this reason, started implementing ARMs in the late 1990s. This was done well before ARMs were being considered by the industry and has accounted for

74 Health Market Inquiry, Provisional Findings and Recommendations Report, page 467, paragraph 99.
75 Health Market Inquiry, Provisional Findings and Recommendations Report, page 468, paragraph 103.
76 Health Market Inquiry, Provisional Findings and Recommendations Report, page 468, paragraph 104.

[CONFIDENTIAL] of LHC's revenue being generated from ARMs.[77] LHC's major concern with the FFS structure was the lack of incentives to contain costs. Under FFS, there is an incentive to utilise increasingly expensive consumable items as higher margins can be achieved on more expensive items. However, under ARM, pricing is less fragmented and there is less scope to simply pass on the particular cost items to schemes;

4.5.1.2.4 While LHC continues to hold the view that ARMs are more efficient, it is not LHC's position that the existence of FFS is indicative of a market failure. The primary reason for LHC's view is that there is a robust bargaining process that has been in existence between schemes and healthcare providers. This robust bargaining process has ensured that hospital groups actively compete for medical scheme business. [CONFIDENTIAL]. This indicates that the current bilateral negotiations are effective and that the existence for FFS does not indicate that tariff negotiations are not functioning effectively.

4.5.1.2.5 The HMI also alleges that FFS prices do not consider quality of care nor do they consider or try to reduce supplier-induced demand. LHC suggests that quality metrics can be introduced into a FFS system or an ARM system. At LHC, quality of care is taken into account regardless of the pricing system. As noted above, [CONFIDENTIAL] of LHC's revenue is generated from ARMs - the quality of care measures that are in place are the same for LHC's ARM tariffs and limited existing FFS tariffs in LHC's business. As such, LHC's internal quality care measures are applied consistently regardless of the payment system. In addition, the HMI has not provided any evidence to show that quality of care does not play a role in FFS negotiations.

4.5.2 Alleged anti-competitive base price prior to 2004

4.5.2.1 The HMI alleges that:

4.5.2.1.1 The "*tariff setting pre-2004 implies that tariffs for private hospitals were determined in an anticompetitive way*"[78], in that the prices were set by competitors acting in a coordinated manner.

4.5.2.1.2 "*The post-2004 tariff setting, based mainly on inflationary increases on the determined National Health Reference Price (NHRPL) schedules, had some containing effect on price increases in that tariff adjustments were based on inflation increases….*"[79], and that "[a]*lthough there is no empirical evidence that the coordinated approach to tariff setting*

77 LHC's first submission to the HMI, paragraph 7.4.
78 Health Market Inquiry, Provisional Findings and Recommendations Report, page 235, paragraph 365.1.
79 Health Market Inquiry, Provisional Findings and Recommendations Report, page 235, paragraph 365.2.

prior to 2004 resulted in higher than competitive tariffs, reasonable inferences can be drawn."[80]

4.5.2.1.3 *"The pricing models adopted after the end of the anticompetitive bargaining period did not correct the base price and hospital tariffs remain linked to a collusive price."*[81]

4.5.2.2 LHC disputes the HMI's view that the base price was collusive and anticompetitive. While on a literal reading of the Competition Act, the base price could be argued to be collusive, LHC submits that the manner in which the base price was determined does not fall within the traditional prohibitions against collusive conduct. Contrary to the HMI's view, the bargaining forum created a balance of power as between the healthcare providers and funders and gave the funders the ability to constrain prices. This was both in relation to the base tariff and the subsequent increases.

4.5.2.3 The zero-based costing model which was used to arrive at the base price was designed taking into account the actual cost of a 160 bed hospital at the time. RAMS, as the BHF was known at the time, exercised equal input and approval on the zero-based costing model. This was not an exercise undertaken by the hospitals alone as the model could not be adopted without RAM approval.

4.5.2.4 As regards, the subsequent tariff increases, RAMS exercised a significant constraint on the level of the price increases. One of the key tools that RAMS utilised was the ability to direct that payments be made to member instead of the provider. The provider would then have to undertake the administrative burden and costs associated with securing that payment from the member.

4.5.2.5 Between the period of the implementation of the zero based costing model and the prohibition of the collective bargaining in 2004, the annual increases were negotiated rigorously between medical scheme and hospital group representatives and were not in any way excessive.

4.5.2.6 On the basis on the submissions above, LHC submits that there is no requirement for the correction of the base price – as a robust costing model was used to arrive at the base price and subsequent increases were in line with CPI.

4.5.3 *Principles used to inform the recommendation for price regulation*

4.5.3.1 LHC does not understand the correlation between the principles underlying the pricing recommendations, and the recommendations themselves.

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80 Health Market Inquiry, Provisional Findings and Recommendations Report, page 236, paragraph 367.
81 Health Market Inquiry, Provisional Findings and Recommendations Report, page 235, paragraph 362.

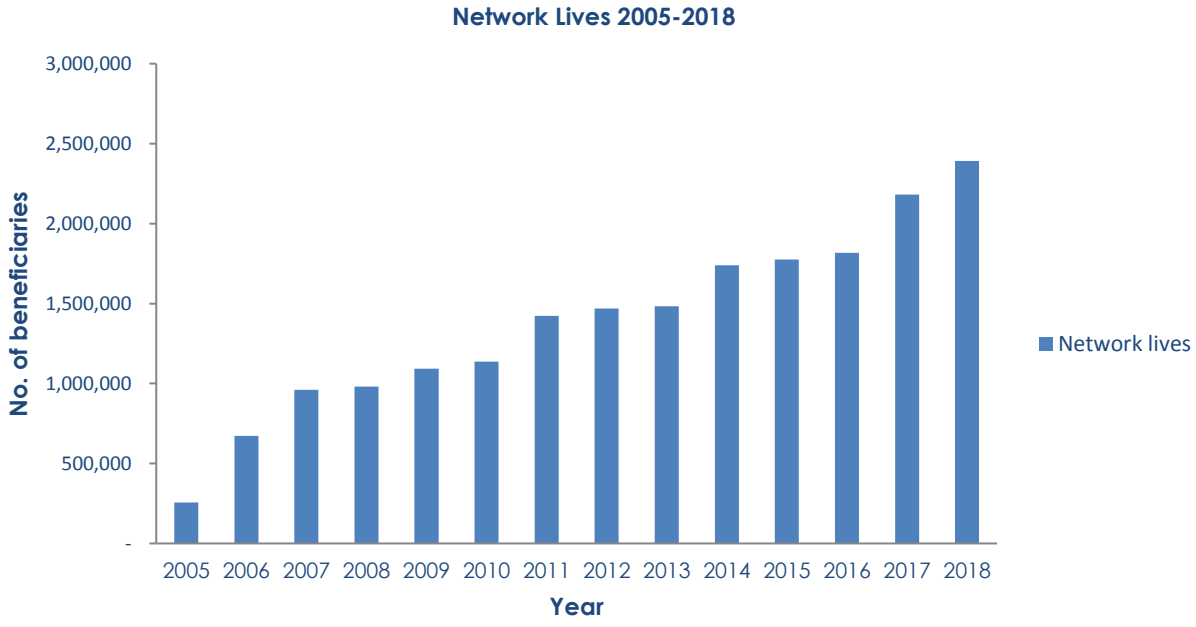
4.5.3.2 In LHC's view, these principles can be achieved independent of price regulation - the recommendations will not achieve the underlying principles.

4.5.3.3 Affordability and access to healthcare [82]

4.5.3.3.1 LHC submits that, in the South African private healthcare market, the best method of ensuring improved affordability and access to healthcare is competition between suppliers, within a sustainable legislated environment.

4.5.3.3.2 The proposed recommendation of setting a regulated price will stifle price competition, as it is likely to create the incentive to price up to the regulated price, as opposed to competing below that price.

4.5.3.3.3 Currently, hospitals compete vigorously [CONFIDENTIAL]. As the HMI is aware from the countervailing power submission made by LHC on 19 April 2018, [CONFIDENTIAL]. It is also worth noting that there has been a substantial increase in the number of network lives, that is, the number of members that belong to specific networks constituted by the medical schemes. Please see graph below which depicts the growth in the network lives from 2005 until 2018.



4.5.3.3.4 It is also important to note that certain schemes have [CONFIDENTIAL]. 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*

[82] Health Market Inquiry, Provisional Findings and Recommendations Report, page 468, paragraph 105.1.

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."[83]

4.5.3.3.5 We also refer the HMI to the LHC submission on the Countervailing Power dated 19 April 2018. This submission demonstrated the countervailing power exercised by the schemes and the [CONFIDENTIAL].

4.5.3.3.6 As the HMI will have observed from LHC's countervailing power submission, [CONFIDENTIAL]. The anticipated growth in networks must also be viewed against the stagnant number of lives in the insured market.

4.5.3.3.7 It is also important to note that schemes are able to offer lower premiums to their members [CONFIDENTIAL]. The schemes are best placed to advise [CONFIDENTIAL], translate into savings for their members. Against this background, LHC submits that the proposal to regulate prices is not required, and as noted above is unlikely to increase affordability.

4.5.3.4 Price uncertainty [84]

4.5.3.4.1 LHC does not agree with the HMI's contention that there is complete price uncertainty in relation to the price of hospital services, as the multiyear pricing agreements entered into with medical schemes contain detailed pricing information. Prices for hospital services are fixed during negotiations with medical schemes, and a member is able to acquire the pricing information in terms of an uncomplicated admission. There may however be certain instances where providing pricing information may not be feasible:

4.5.3.4.1.1 The physical condition of the patient - if a patient is unconscious it will simply not be possible to have that discussion; and

4.5.3.4.1.2 Predictability of care – The predictability of care is not always possible i.e. patients may suffer complications or have chronic conditions that impact their treatment plans.

4.5.3.5 Fixed tariffs for PMBs[85]

[CONFIDENTIAL]

4.5.3.6 Standardised coding systems [86]

While LHC supports the need for a standardised coding system, this coding system can be developed independently and is not dependent on the existence of regulated pricing.

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83 Health Market Inquiry, Provisional Findings and Recommendations Report, page 222, paragraph 297.
84 Health Market Inquiry, Provisional Findings and Recommendations Report, page 468, paragraph 105.2.
85 Health Market Inquiry, Provisional Findings and Recommendations Report, page 468, paragraph 105.3.
86 Health Market Inquiry, Provisional Findings and Recommendations Report, page 468, paragraph 105.4.

4.5.3.7 Innovative models of funding and delivery [87]

The development of innovative models is not dependent on regulated pricing. As previously emphasised by LHC and various stakeholders, innovation in healthcare is being stifled by rigid HPCSA rules. For example, rules that do not permit employment or fee sharing. Indeed, the HMI has itself acknowledged this point.[88]

4.5.3.8 Competition amongst service providers [89]

LHC wishes to highlight that there is already fierce competition between competing hospitals. In this regard, we refer the HMI to LHC's countervailing power submission. Price regulation will stifle price competition, incentives to innovate where the cost to innovate cannot be recovered, and will remove any incentive to reduce existing costs, as the fixed tariff will simply increase by reference to suppliers' costs each year.

4.5.4 *HMI's proposals – regulated pricing*

4.5.4.1 The HMI has rightly taken the view that the principle of appropriateness[90] 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*." LHC submits that the price regulation recommendations are not appropriate, as they seek to remedy harm in relation to the pricing of hospital services in circumstances where that harm does not in fact exist. As LHC understands, the HMI is seeking to implement price regulation in order to achieve the principles articulated immediately above. As explained above, the principles are capable of implementation independently of price regulation. For this reason alone, the price regulation remedy is not appropriate.

4.5.4.2 The HMI makes two proposals in relation to price regulation[91]:

4.5.4.2.1 The determination of FFS tariffs to be determined by the SSRH; and

4.5.4.2.2 Multilateral tariff negotiations where the tariff is determined multilaterally by stakeholders.

4.5.4.3 Under both alternatives, the tariffs for PMB procedures would be binding, while other FFS tariffs would be considered reference prices. In both proposals, the HMI recommends the continuation of bilateral negotiations. As LHC understands, bilateral negotiations in respect of

87 Health Market Inquiry, Provisional Findings and Recommendations Report, page 468, paragraph 105.5.
88 Health Market Inquiry, Provisional Findings and Recommendations Report, page 7, paragraph 14.
89 Health Market Inquiry, Provisional Findings and Recommendations Report, page 468, paragraph 105.6.
90 Health Market Inquiry, Provisional Findings and Recommendations Report, page 455, paragraph 11.
91 Health Market Inquiry, Provisional Findings and Recommendations Report, page 469, paragraph 110-122.

PMBs will be limited to non-price factors, while bilateral negotiations in respect of non-PMBs may include negotiations in relation to the reference price and non-price factors.

4.5.4.4 In principle, LHC does not support a system of price regulation for the provision of hospital services. Consequently, LHC also does not support the SSRH functioning as a price regulator. In the circumstances, LHC does not support either of the two regulated pricing proposals put forward by the HMI. The reasons for LHC's position are set out below.

4.5.4.4.1 The HMI has found that the tariffs have on average increased at levels approximating CPI[92], despite hospital costs increasing at levels greater than CPI.

4.5.4.4.2 As regards increasing hospital costs, LHC notes with disappointment that the HMI has neglected to undertake an assessment of hospital costs, particular the escalating cost of nursing salaries.

4.5.4.4.3 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 has provided no evidence that the current bilateral negotiations has resulted in inefficient or excessive FFS tariffs. Moreover, the HMI has not presented any analysis to show that hospitals are not effectively constrained by funders during tariff negotiations. As repeatedly explained in this submission, the private hospital market is subject to vigorous competition and strong countervailing power from the medical schemes, which results in a rigorous tariff negotiation process.

Please refer to the report prepared by RBB Economics titled *Response to the PHMI's Provisional Findings: Bargaining Power, 15 October 2018 marked Annexure D*.

4.5.4.4.4 There is thus no need for price regulation as price competition in the private hospital market is robust, given the countervailing power of the medical schemes. The strength of competition for the provision of private hospital services is evidenced by, amongst others, [CONFIDENTIAL] in favour of the schemes. [CONFIDENTIAL].

4.5.4.4.5 LHC submits that 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 for inherent inefficiencies.

4.5.4.4.6 As regards competitive pricing, LHC submits that price regulation that sets a fixed and binding tariff for PMBs will prohibit any price competition - even in circumstances where

92 Health Market Inquiry, Provisional Findings and Recommendations Report, page 223, paragraph 305.

suppliers may want to offer a lower price. In short, the binding tariff for PMBs disincentives price competition entirely.

4.5.4.4.7 To be clear, [CONFIDENTIAL]. 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.

4.5.4.4.8 Another likely consequence of regulated pricing, is that it will lead to inefficiencies as suppliers will have no incentive to contain costs or to manage costs down. This is because the proposed regulation will be based on supplier's costs and will not reward a supplier whose costs are lower. The current regime of bilateral negotiations compels suppliers to be as efficient as possible, as schemes exercise significant downward pressure on price. This drive for efficiencies in turn compels suppliers to be innovative. In circumstances where an innovation incurs costs that cannot be recovered under the proposed regulated system, suppliers will simply not undertake that innovation. This will have a stifling effect on innovation in the hospital services market, as it will discourage facilities from introducing new and improved treatments, this will ultimately be to the detriment of the patient.

4.5.4.4.9 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.

4.5.4.4.10 Contrary to what the HMI is trying to achieve regarding the quality of healthcare services, the price regulation proposal for binding PMB tariffs may create the incentive to reduce the quality of services in order to achieve cost reductions.

4.5.4.4.11 The regulation of FFS tariffs may discourage new entry of independent hospitals, particularly if funders continue to resist the move towards ARMs. This risk arises since smaller hospitals typically face higher costs than larger groups, and hence may be unable to recover costs, if the FFS tariffs are capped at levels that are close to the costs of larger groups. This risk may also be exacerbated due to there being limited scope for these new entrants to win patient volumes through new or innovative ARMs. Notably, this principle was affirmed by the UK's Competition and Markets Authority Private healthcare market investigation.[93]

[93] Specifically, the CMA stated that price control "…*would also discourage new entry in sectors subject to a capping regime, unless the potential new entrant could be certain that its entry would result in the removal of price caps*." (CMA, Private healthcare remittal final report, 2016, page 320).

4.5.4.4.12 There are also challenges that will arise from the proposed price regulation process:

4.5.4.4.12.1 The sharing of costing information could facilitate collusive behaviour across a broader range of tariffs (i.e. per diem and fixed fees);

4.5.4.4.12.2 The proposed forums will result in longer and more costly negotiations for all stakeholders, with there being a subsequent risk of these costs being passed on to consumers;

4.5.4.4.12.3 It is unlikely that there would be consensus amongst stakeholders on the determined tariff, meaning that the decision would fall to the arbitrator, where the appropriateness of the price would be a function of how effective and informed the arbitrator is.

4.6 *Concentration analysis*

4.6.1 The HMI identifies the highly concentrated structure of the facilities market as an imperfection that harms competition and undermines access to healthcare.[94] However, the HMI fails to present any reliable evidence or analysis that links the level of concentration in the facilities market to any anti-competitive or inefficient outcomes.

4.6.2 In fact, the HMI acknowledges that "*prevalent high concentration levels both at the national level and in the majority of local markets is not a definitive conclusion of market power*." [95] It is for this reason that the HMI has itself acknowledged that further analyses including "*bargaining and tariff determination, relationships between practitioners and facilities, expenditure analysis ,utilisation , profitability analysis and analysis on barriers to entry and exit*"[96] is required to assess the full state of competition in the market. In other words, these analyses are required in order to examine whether the concentration levels have resulted in anticompetitive outcomes.

4.6.3 While the HMI has acknowledged the need for these analyses and has undertaken these analyses, the problem is that the analyses do not establish a link between the level of concentration in the facilities market and ineffective competition or market power on the part of the facilities. There are two reasons for this failure to establish a link. First, the results of the analyses do not provide any evidence of market power on the part of the facilities. Second, in those instances where the results, if taken at face value, suggest that facilities enjoy some market power, the analyses are simply not reliable.

94 Health Market Inquiry, Provisional Findings and Recommendations Report, page 462, paragraph 56.1.
95 Health Market Inquiry, Provisional Findings and Recommendations Report, page 198, paragraph 182.
96 Health Market Inquiry, Provisional Findings and Recommendations Report, page 198, paragraph 183.

4.6.4 In the case of the failure to illustrate a link between concentration and market power, the HMI nevertheless makes a number of findings that are inconsistent with facilities being able to exercise market power. In particular:

4.6.4.1 The HMI concludes that the level of private hospital group profits are not in themselves a concern, as profitability appears to be within tolerable levels.[97]

4.6.4.2 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; and[98]

4.6.4.3 Larger funders, such as Discovery Health and GEMS, enjoy countervailing power and funders are more generally able to exercise countervailing power through the use of networks, which indicates that facilities are constrained from charging prices that are above competitive levels.[99] There is evidence of a number for smaller schemes being able to negotiate effectively.[100]

4.6.4.4 In the case of the results produced by HMI's analysis, which at face value, suggest that facilities have some market power, as is discussed in the attached reports prepared by RBB Economics, there are fundamental shortcomings in the HMI's bargaining power, expenditure/attribution and supplier induced demand (SID) analyses, which render the results unreliable.

4.6.5 Bargaining power

4.6.5.1 Although the HMI finds that "*countervailing power exerted by funders on facilities is limited*"[101] and that instances of local concentration will "*negatively affect funders' ability to negotiate competitive network prices*" the HMI do not present any analysis to show:

4.6.5.1.1 That concentration (either at a local or national level) has a material impact on tariff negotiations and affords facilities with superior bargaining power, relative to funders;

4.6.5.1.1.1 That, outside of Discovery Health and GEMS, there is a relationship between scheme size and tariffs; or

4.6.5.1.1.2 That the tariffs that funders have been able to negotiate are in any way excessive.[102] Please refer to the report prepared by RBB Economics, titled *Response to the PHMI's Provisional findings: Bargaining Power, 15 October 2018* marked Annexure D.

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97 Health Market Inquiry, Provisional Findings and Recommendations Report, page 251, paragraph 459.
98 Health Market Inquiry, Provisional Findings and Recommendations Report, page 223, paragraph 305.
99 Health Market Inquiry, Provisional Findings and Recommendations Report, page 223, paragraph 307.
100 Health Market Inquiry, Provisional Findings and Recommendations Report, page 223, paragraph 307.1.
101 Health Market Inquiry, Provisional Findings and Recommendations Report, page 223, paragraph 309.
102 Health Market Inquiry, Provisional Findings and Recommendations Report, page 223, paragraphs 307.2

4.6.6 Expenditure

We note that the HMI finds that the increase in expenditure is attributed largely to increased utilisation and, to a lesser extent, increases in price, a view echoed by LHC. LHC differs from the HMI in its understanding of what is driving this increase in utilisation. LHC is of the view that the underlying disease burden of the insured population has deteriorated significantly, continues to deteriorate, and drives this utilisation. LHC is of the view that the methodology employed by the HMI in its attribution analysis is fundamentally deficient, which renders its results entirely unreliable;[103] Please refer to the report prepared by RBB Economics, titled *Response to the PHMI's Provisional Findings: Expenditure Analysis, 15 October 2018* marked Annexure F, and to the report prepared by Cadiant Partners titled *HMI's Draft Findings and Recommendations, prepared for Life Healthcare Group, 15 October 2018* marked Annexure G.

4.6.7 SID

The HMI's analysis of the relationship between the level of local concentration and the prevalence of SID suggests 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.[104] This is obviously clearly counterintuitive. Please refer to the report prepared by RBB Economics, titled *Response to the PHMI's Provisional Findings: Supplier Induced Demand, 15 October 2018* marked Annexure B.

4.6.8 HMI's recommendation to address concentration

4.6.8.1 As a consequence of concluding that the private hospital market is highly concentrated, the HMI has proposed restraining the existing hospital groups by means of divestiture and licence moratoriums – these measures are intended to encourage new entry and reduce concentration.

4.6.8.2 As explained above, it is insufficient for the HMI to propose recommendations simply on the basis of illustrating a concentrated hospital market. LHC submits that in addition to showing concentration, the HMI is also required to show the anti-competitive effects of that concentration. As detailed above, the HMI has simply failed to do so.

4.6.8.3 In addition, the HMI has not taken sufficient account of the existing highly competitive nature of the private hospital market, and that there have been a number of new entrants over the past three years.[105] Please refer to the report prepared by RBB Economics on titled: *Response*

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and 309.

103 Health Market Inquiry, Provisional Findings and Recommendations Report, page 240, paragraph 393.

104 Health Market Inquiry, Provisional Findings and Recommendations Report, page 239, Tables 6.13 and 6.14.

105 Health Market Inquiry, Provisional Findings and Recommendations Report, page 169, paragraph 17 The

to the PHMI's Provisional Findings: Facilities Concentration Analysis, 15 October 2018 marked Annexure C, which details the new entry.[106] The available evidence on new entrants suggests that national concentration in the private hospital market falls below the HMI's threshold for what constitutes "*high concentration*". The HMI relies on high concentration levels for many of its recommended interventions – on the basis of the more recent data; LHC submits that the justification for divestiture, licence moratoriums and market share limitations no longer exist.[107]

4.6.8.4 In the circumstances, these recommendations are economically unsustainable, impractical and will not result in increased competition in the private hospital market.

4.6.9 Divestiture

4.6.9.1 The HMI raises divestiture as an option to address the national level of concentration. However, the HMI notes that "*divestiture raises a number of questions such as proportionality, effectiveness and whether it is the less intrusive means*".[108] While not expanded on, what the HMI presumably means is that it is necessary to consider:

4.6.9.1.1 Whether divestiture would be a proportionate remedy to the issues that have been identified;

4.6.9.1.2 Whether there may be less intrusive means of reducing the level of national concentration, or otherwise addressing the perceived issues arising from the level of concentration; and

4.6.9.1.3 Whether reducing the level of national concentration would ultimately be effective in remedying the issues that have been identified.

4.6.9.2 From the outset, it should be emphasised that forcing a private hospital group to divest one or more of its facilities would have a serious impact on that hospital group. It would also act as a disincentive for hospital groups to compete vigorously in order to gain market share in the future or establish new hospitals in areas where they previously did not have a presence (thereby enhancing competition in these areas), since they may be concerned that if they gain market share they may be required to make divestments.

HMI has found that. "……*the proportion of market share accounted for by the NHN and other independent hospitals and day clinics not affiliated to NHN has reduced significantly over time*." As noted in this report this finding is flawed as the HMI's analysis has not taken into account the significant number of new entrants over the last three years.

106 Page 11, paragraph 3.4.

107 RBB Economics , Response to the PHMI's Provisional Findings: Facilities Concentration Analysis, 15 October 2018 ,page 2-3, paragraph 1.

108 Health Market Inquiry, Provisional Findings and Recommendations Report, page 465, paragraph 79.

4.6.9.3 Divestiture should therefore only be considered if there is clear and robust evidence that competition is currently highly ineffective and that forcing a hospital group to divest one or more of its facilities would materially improve competitive outcomes. Careful consideration should also be given to the potential impact of such forced divestiture on longer-term incentives, and the harm that would arise from this effect.

4.6.9.4 However, in the current context and as discussed above, the HMI provides no robust evidence that competition is either ineffective or that forced divestiture would materially enhance competition. In the circumstances, divestiture is simply not warranted. As such, even if there were evidence of competition being so ineffective that divestiture might be a relevant consideration:

4.6.9.4.1 The HMI has not linked concentration levels to any anti-competitive outcomes, there is no identification of which specific facilities would be the most appropriate candidates for divestiture, nor any analysis to demonstrate how such divestiture would improve competitive outcomes; and

4.6.9.4.2 Any divestiture of individual facilities would likely be expected to reduce levels of local concentration, which according to the HMI would be likely to result in SID - given that the HMI finds that SID is more prevalent in less concentrated markets, as a consequence of the increased competition to attract practitioners, on which facilities rely for admissions.[109]

4.6.9.4.3 In the UK Health Market Inquiry, the Competition Commission (now the CMA), initially recommended the divestiture of certain hospitals. These divestitures were recommended on the basis of the Commission identifying high barriers to entry and expansion for private hospitals and weak competitive constraints on private hospitals in many local markets. Ultimately, the Commission revised its opinion and withdrew its recommendation of divestment, following a challenge by the affected hospital group. The decision to withdraw was made after the Commission considered new evidence and, despite a finding that there was an adverse effect on competition in the market for private healthcare services in Central London, and that hospital groups prices were higher than would be expected in a well-functioning market, the CMA concluded that divestiture would be disproportionate, as there was uncertainty as to the likely impact of the divestiture and there the real prospect of new entry.

4.6.9.4.4 LHC submits that divestiture is not a proportionate remedy as there have been a number of new entrants into the private hospital market in the last three years and as the likely impact of any divestiture is entirely uncertain.

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[109] Health Market Inquiry, Provisional Findings and Recommendations Report, page 238, paragraphs 384 and 385.

4.6.10 Moratorium on hospital licences

4.6.10.1 The HMI is also considering imposing a moratorium on licences for the three hospital groups. The moratorium would operate such that the hospital groups would not be granted new licences or approval to increase the number of beds within existing facilities until the national market share for each group is no more than 20%. This proposal raises several fundamental problems.

4.6.10.2 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 license moratorium as noted above.

4.6.10.3 The 20% threshold appears to be entirely arbitrary and is not justified by any analysis. Notably, if this were to mirror local markets then it would imply that four competitors would be required in each area in order for competition to be effective, a threshold which is implausibly high and for which there is simply no empirical support.[110]

4.6.10.4 To the extent that the HMI has concerns over there being only one hospital in certain localities (or indeed only two competing hospitals), the moratorium would prevent the large hospital groups from entering or expanding in those local markets. However, given their industry knowledge, access to capital and existing head office operations, it is the large hospital groups that are most likely to be able to successfully and efficiently enter into a new local market and act as an effective competitive constraint on the incumbent facility.

4.6.10.5 The HMI expenditure analysis, indicates that the three large hospital groups have lower costs per admission than the NHN hospitals (after controlling for identifiable demand side differences), suggesting that the three large groups are more efficient - in these circumstances a moratorium would likely prevent entry and expansion by the most efficient suppliers .[111]

4.6.10.6 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.

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110 RBB Economics Report – Response to the PHMI's Provisional Findings: Facilities Concentration Analysis, 15 October 2018, marked Annexure C, page 16, paragraph 4.4.

111 Expenditure Analysis Report 4: Facility Analysis, page 39

4.6.11 Supply side regulator to assess local concentration

4.6.11.1 In addition to the divestiture and license moratorium proposals, the HMI also recommends that both, the SSRH and the PDoHs, develop a set of criteria for assessing local concentration[112].The assessment framework is required to specify the maximum allowable level of concentration in each area, with the sale or transfer of hospital licenses requiring notification with the regulator.

4.6.11.2 The assessment of concentration falls squarely within the competition law framework. The competition authorities, who have been specifically tasked with administering the Competition Act, are best placed to make this assessment where there is a change in control of a facility. Such an assessment would involve a comprehensive consideration of the impact of the transaction on competition in the relevant market and would not only consider the change in concentration.

4.6.11.3 In practice, defining the appropriate level of concentration is a complex task, requiring numerous and detailed analyses in order to determine the level at which competition would no longer be effective. Given the Competition Commission's expertise in this area, it is best placed to make such an assessment, within the context of the existing competition legislation. Given the existing competition framework, it is inappropriate for the SSRH and the PDoHs to make any assessment about market concentration.

4.6.12 The potential impact of the proposed divestiture and license moratorium on new entrants

4.6.12.1 LHC is of the view that the two proposed recommendations aimed at facilitating new entry is misconceived and are not likely to encourage such entry. We take this view for the reasons set out below:

4.6.12.1.1 New entrants need to be able to enter and compete effectively on a sustainable basis. In this regard, it is critical for a new entrant to have sufficient economies of scale to allow that entrant to operate on a sustainable basis and to secure contracts with the medical schemes. As regards the scale and scope of entry, a new entrant would have to invest in a hospital with at least a 100 beds in order to achieve a sustainable return on investment. As such, it would not be possible for new entrants to enter on a more limited basis as they would not be able to recover the cost of their investment.

4.6.12.1.2 It is important to note that a new entrant cannot enter simply in order to meet a marginal increase in demand, as that kind of limited entry is not sustainable. In those circumstances, where demand only exists for marginal supply, a sustainable new entrant would result in an oversupply of beds, as there was not in the first instance sufficient demand for that many beds. In that case, there is a significant risk that the new entrant may ultimately exit the

[112] Health Market Inquiry, Provisional Findings and Recommendations Report, page 465, paragraph 81.

market due to a lack of demand. In the case of marginal demand, the more appropriate solution would be for the existing hospitals to add the required number of beds. However, the proposed remedy of license moratoriums would make this impossible.

4.6.12.1.3 Refusing to grant the hospital groups new licenses or ordering them to divest some of their existing facilities, does not assist with the challenge that will be faced by the new entrant. The ability to enter and compete on a sustainable basis, is dependent on the new entrants overcoming a number of barriers, including the structural barriers identified by the HMI, such as funding and regulatory barriers. It is also important to know the behavioural barriers, in particular, recognition and contracting by medical schemes, is a factor that is not within the control of the existing hospital groups.

4.6.13 LHC's proposal in respect of new entrants

4.6.13.1 The HMI's proposals in respect of divestiture and license moratoriums aim to restrict the businesses of the three hospital groups in order to support new entrants.

4.6.13.2 LHC takes issue, not with the HMI promoting new entry, but with the fact that the HMI sees the divestiture and license moratoriums as the means by which to promote such entry. In other words, the HMI sees the stifling of the three hospital groups businesses as only means of facilitating entry into the market. With respect, LHC views these proposals as destructive of competition and innovation. In short, these proposals are not economically sustainable because they will in effect constrain the investment decisions of the hospital groups to such an extent that the groups will not be able to make any investment decisions. In LHC's view there are more constructive and effective ways to facilitate new entrants, as set out below:

4.6.13.2.1 Funding

Licence moratoriums and divestiture by the three hospital groups will not solve the funding barriers faced by new entrants. As the HMI has noted, "*access to capital and funding was identified as a major stumbling block*"[113]. For this reason, LHC submits that consideration should be given to the establishment of funding arrangements specifically tailored to meet the needs of new entrants. For example, the Growthpoint Healthcare Fund, which is part of Growthpoint, invests exclusively in healthcare assets in South Africa. These assets are occupied by licensed operators of hospitals, clinics, pharmacies and laboratories. As we understand, this fund owns the property to which the healthcare asset attaches and is able provide funding for the building of a new hospital by a third party operator (new entrants). In March 2017, the Growthpoint CEO Norbert Sasse, indicated that a second tier of hospital groups was emerging, which

[113] Health Market Inquiry, Provisional Findings and Recommendations Report, page 253, paragraph 470.

included Busamed, Lenmed and Mellowmed and that these groups did not have the capital to build a new hospital and the healthcare fund could provide this capital.[114] [115]LHC submits that new entrants could also be funded by institutions such as the Industrial Development Corporation.

4.6.13.2.2 Private medical colleges

Given the shortage of healthcare practitioners, LHC proposes that the establishment of private medical colleges, fully accredited by the relevant state institutions be permitted, in order to train more practitioners. These practitioners would be subject to community service for the state and to all other requirements currently imposed by the state on practitioners that train at state universities.

4.6.13.2.3 Nurses

Given the existing shortage of nurses and that the three big hospital groups have already taken measures to alleviate the shortage by running private nursing colleges, LHC submits that the NDoH should take further measures to train more nurses.

4.7 *Practitioner Payment Models*

4.7.1 LHC agrees with the HMI that, "[i]*t is important that the sector adopts alternative reimbursement payment models that promote financial risk sharing and contain costs and volumes , while preserving or increasing quality of care.*"[116]

4.7.2 As LHC has submitted on various occasions to the HMI, LHC's approach has been to adopt and implement ARMs as far as possible - indeed [CONFIDENTIAL] of LHC's revenue is currently generated from ARMs. However, we acknowledge that ARMs have not been implemented by practitioners on any significant scale.

4.7.3 In LHC's view, there is 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

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114 Growthpoint in new strategy by Roy Cokayne, 8 March 2017. Available on: https://www.iol.co.za/business-report/companies/growthpoint-in-new-strategy-8092658, last accessed 7 October 2018.

115 Growthpoint launches SA's fist healthcare – focused property company by Alistair Anderson, 14 June 2018. Available on : https://www.businesslive.co.za/bd/companies/property/2018-06-14-growthpoint-launches-sas-first-healthcare-focused-property-company/ , last accessed 7 October 2018.

116 Health Market Inquiry, Provisional Findings and Recommendations Report, page 474, paragraph 143.

global fees, in line with the HMI's own proposal. With regard to the employment of doctors, please refer to the detailed submission made in *LHC's First Submission* dated 31 October 2014.[117]

4.8 *Coding Systems*

4.8.1 LHC agrees with the HMI that coding systems across the private sector should be standardized.[118] However, LHC submits that the standardisation of coding systems should happen across the public and the private sector and must make provision for pharmaceutical products and medical devices. This would ensure alignment between practitioners, facilities, funders, pharmaceutical and medical device companies in both the private and public sectors. [119]

4.8.2 LHC does not agree that the SSRH should be responsible for coding systems. Instead, LHC submits that the NDoH should undertake this function. In so doing, the NDoH should be able to outsource some of its work to independent experts, for example, academics. However, the independence of those experts is a critical factor. These experts should not work for an organisation in the private healthcare sector nor should they receive any kind of funding for their work from the private sector. If this were to be the case, the independence of the expert would be compromised.

4.8.3 The technical multidisciplinary team that the HMI recommends[120] for the coding unit, must comprise of individuals who have diverse industry experience. This should include experience at funders, practitioners, facilities, pharmaceutical and medical device industry as well as academics. This is in line with the HMI's position that coding should not be the exclusive property of one group of stakeholders. [121]

4.8.4 There are various challenges with the current coding system that should be highlighted. First, the Current Procedural Terminology (CPT)codes is an expensive tool because licences are issued on a per user basis and licences are required to be renewed annually. For example, in an organisation such as LHC, the AMA does not allow LHC to use one license for the organisation as a whole. Instead, LHC is required to pay an annual fee for every person within LHC that accesses the coding platform. For this reason, LHC has been forced to limit the number of people that can administer the CPT codes at its facilities. The HMI's proposal that SAMA be compensated for its Intellectual Property rights, if the sector decides that the CPT system is the preferred one, is not a workable solution.

4.8.5 Given the manner in which this license is issued, affordability is a challenge, especially for small scale providers. For this reason, LHC submits that consideration must be given to adoption of a coding system that is available in the public domain or a coding system that charges affordable

117 LHC's first submission, paragraph 16.2.
118 Health Market Inquiry, Provisional Findings and Recommendations Report, page 474, paragraph 147.
119 This is especially relevant in anticipation of NHI.
120 Health Market Inquiry, Provisional Findings and Recommendations Report, page 475, paragraph 150.
121 Health Market Inquiry, Provisional Findings and Recommendations Report, page 475, paragraph 151.

licensing fees. LHC submits that the International Classification of Health Interventions (ICHI) system of classifying procedure codes, which is being developed by the WHO, would be an appropriate system to consider adopting. LHC submits that ICHI is an appropriate system for the following reasons:

4.8.5.1 ICHI covers interventions carried out by a broad range of providers across the full scope of health systems, including acute care, primary care, rehabilitation, assistance with functioning, prevention and public health;

4.8.5.2 ICHI was designed with low level of complexity for countries seeking a straightforward classification for national use, while also serving as a basis for international comparisons; and

4.8.5.3 ICHI will be freely available for adoption by Member States."[122]

4.8.5.4 We note though that this system is not yet ready for operational application.

4.8.6 Master Industry Table:

4.8.6.1 It is important to record that the public and private sector are both currently involved in the collation of the Master Industry Table (MIT),[123] which involved the updating of ICD 10 coding. "*The MIT is considered the healthcare industry standard for ICD-10 codes and contains all the ICD-10 codes to be used in South Africa*"[124]. The work done on this project is valuable and should be taken into account.

4.9 *Provider Networks*

4.9.1 As LHC advised the HMI in its first submission, LHC is the leading hospital provider to medical aid funds for DSP networks. This is primarily due to the fact that LHC adopted a cost containment strategy which led to LHC being regarded as the most cost-effective of the major hospital groups and thus the natural choice as a hospital group for DSP arrangements. LHC was also at the forefront of the implementation of ARMs and, as a legacy of that innovation, as well as LHC's on-going cost containment strategy, it continues to enjoy extensive coverage on a number of medical aid scheme's DSP networks.[125]

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122 World Health organisation , International Classification of Health Interventions, available on http://www.who.int/classifications/ichi/en/ , last accessed 26 September 2018.

123 The MIT is considered the healthcare industry standard for ICD-10 codes and contains all the ICD-10 codes to be used in South Africa.

124 South African ICD -10 technical users Guide, available on file:///C:/Users/ranigaa/Downloads/icd-10_technical_mzuserguide%20(1).pdf , last accessed 26 September 2018.

125 Life Healthcare Group's first Submission to the panel in the Competition Commission Inquiry into private healthcare, dated 31 October 2014, page 45, and paragraph 8.6.4.

4.9.2 Based on LHC's history in relation to provider networks, it supports the HMI's view that provider networks are pro-competitive[126] and these networks should continue to be used as a lever to drive value-based-contracting.

4.9.3 However, LHC has reservations about the HMI's concerns regarding provider networks, specifically as to" *the potential exclusionary nature of networks and a reduction in consumer choice*."[127] While LHC understands that the HMI appreciates the need for some reduction in consumer choice, provided that there is reasonable patient access to service providers, LHC is of the view that the HMI does not fully appreciate that the potential exclusionary nature of networks is a fundamental principle. [CONFIDENTIAL]. Removing the exclusionary nature of a DSP would defeat the purpose of the DSP and would have the effect of removing any incentive for a hospital to provide a discount. This incentive system is equally applicable to FFS arrangements as well as ARMs.

4.9.4 Although the HMI raises concerns that certain facilities may have been excluded from network arrangements[128], the HMI does not elaborate further. These concerns presumably stem from the concern that funders may be less willing to enter into network arrangements with NHN hospitals or independent hospitals because they may offer more limited coverage, either geographic or in terms of the range of specialists that operate at the facility, and that by missing out on network arrangements these facilities miss out on significant volumes. However, LHC is advised by its experts that there is no evidence in support of this concern. This is dealt with in the confidential version of the RBB Economics report titled *Response to the PHMI's Provisional Findings: Bargaining Power, 15 October 2018 marked Annexure D – to which LHC does not have access*.

4.9.5 Moreover, even if it were found that NHN and independent hospitals had not been placed onto as many networks as the three large hospital groups, it would have to be demonstrated that this was not simply on the basis of being less efficient, and thus unable to match the discounts offered by the three major hospital groups via an effective competitive process. However, the HMI's expenditure analysis indicates that the three large hospital groups do, in fact, have lower costs per admission than the NHN hospitals (after controlling to identifiable demand side differences).[129] [130] For clarity, this suggests that the big three are more efficient than the NHN hospitals, so if they were to have a greater share of network admissions it would be justifiable on the basis of them being more efficient.

4.9.6 We set out below LHC's comments in relation to the specific recommendations made by the HMI.

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126 Health Market Inquiry, Provisional Findings and Recommendations Report, page 475, paragraph 152.
127 Health Market Inquiry, Provisional Findings and Recommendations Report, page 475, paragraph 155.
128 Health Market Inquiry, Provisional Findings and Recommendations Report, page 475, paragraph 155.
129 Expenditure Analysis Report 4: Facility Analysis, page 39.
130 While the analysis suggests that the cost per admission at other independent facilities is, on average, lower than the cost per admission at Netcare, it is shown to be higher than the cost per admission at Life and Mediclinic.

4.9.6.1 Transparency of network agreements

While LHC agrees that health outcomes and the location of practitioners and facilities should be made publicly available, LHC does not agree that pricing arrangements should be disclosed.[131] As the HMI will appreciate, pricing information is competitively sensitive information and allowing competitors to view each other's pricing arrangements may ultimately stifle competition as facilities may use the information to arrive at benchmark prices, as opposed to actively competing on price.

4.9.6.2 Charging lower than negotiated DSP fees

The proposal by the HMI that service providers should be allowed to charge fees that are lower than the fees negotiated[132] by their network managers is financially unsustainable. When a hospital group proposes a significant discount, it does so on the basis that it will be able to charge the prices that are agreed for the DSP network. The discounts are calculated following a comprehensive budgeting process which considers the level of the discount that a hospital group is able to afford and the level at which a discount is financially unsustainable. Discounts that are offered to the schemes are therefore carefully considered and have a direct link to the prices that are agreed to for the DSP. The ability to charge lower than negotiated fees will disincentivise service providers from offering significant discounts and will consequently serve to undermine the DSP negotiation process as a whole.

4.9.6.3 Matching network FFS prices

As noted above, there is no distinction between the FFS pricing structure and the ARM pricing structure in the creation of a DSP. Regardless of whether a scheme decides to enter into FFS or ARM arrangements for a particular DSP, the scheme would still need to limit the number of service providers in order to incentivise those service providers to offer significant discounts in return for patient volumes. Allowing any provider who was not originally selected for the DSP to match[133] network FFS providers and to service that scheme population, will completely undermine the basis (trading price for volume) on which the DSP was constituted. In circumstances where a Request For Proposal (RFP) was issued and a tender process was followed, and the scheme subsequently entered into a contract with the successful service providers, that scheme would be in breach of those contracts, if it allowed non-network providers (including unsuccessful bids) to match prices after the fact and to service the same scheme population. This will render the tender process unreliable and will discourage service

131 Health Market Inquiry, Provisional Findings and Recommendations Report, page 475, paragraph 155.1.
132 Health Market Inquiry, Provisional Findings and Recommendations Report, page 475, paragraph 155.3.
133 Health Market Inquiry, Provisional Findings and Recommendations Report, page 475, paragraph 155.6.

providers from responding to the RFPs, as there would ultimately be no benefit from acquiring a DSP status. The HMI's proposal will ultimately render DSPs ineffective for FFS prices.

4.9.6.4 We note that the HMI sanctions selective contracting in respect of ARM agreements, in contrast to its approach to FFS network agreements. In LHC's view this distinction is misconceived, as funders regularly consider both FFS and ARM proposals for the same DSP network and their decision to select a service provider is ultimately based on the overall efficiency of the provider and not on the pricing structure (ARM or FFS) proposed.

4.9.6.5 Integrated service delivery

For network arrangements to progressively reduce fragmented delivery[134], the HPCSA ethical rules must be amended to allow for global fees and fee sharing - as the HMI itself has recommended.

4.9.6.6 Local funder/provider contracting

4.9.6.6.1 As LHC understands, the HMI's proposal that DSP arrangements must promote local contracting is not prescriptive[135], that is, funders and providers retain the option to enter into local or national contracting. This discretion will allow funders and providers to maximise efficiencies and cost savings that may be realised by different arrangements and will avoid the risk of creating distortions that may ultimately harm competition. It is worth noting that holding a single national level negotiation with a hospital group is materially more efficient than holding negotiations for each individual facility. Therefore, disallowing or discouraging national level negotiations will likely increase costs and, in turn, reduce the benefits from provider network arrangements.

4.9.6.6.2 There is no evidence that current network negotiations do, in fact, result in the exclusion of local independent facilities. In particular, while negotiations with the major hospital groups take place nationally, we understand that funders do take local market factors into consideration when selecting network partners and that funders are prepared to divide their national network amongst multiple hospital groups. For example, not all LHC hospitals are included in certain network arrangements; despite the fact that they are nationally negotiated (e.g. the Bonitas network, where only certain LHC hospitals form part of its network). Evidence regarding the success of the NHN is also at odds with the HMI's suggestion.

4.9.6.6.3 National negotiations in respect of provider networks are premised on volume discounts. Local contracting simply doesn't offer the same volume opportunities as national

134 Health Market Inquiry, Provisional Findings and Recommendations Report, page 475, paragraph 155.7.
135 Health Market Inquiry, Provisional Findings and Recommendations Report, page 475, paragraph 155.9.

contracting and may result in lower discounts being offered and consequently higher tariffs for hospital services – in circumstances where a national contract would achieve lower tariffs for all members including the members in that local area.

4.9.6.7 Poorly accessible network providers

LHC agrees that no penalties must be levied on consumers for emergencies and poorly accessible network providers.[136] However, there must be clearly defined criteria in respect of what constitutes a poorly accessible network provider.

4.9.6.8 Publication of DSP tender results

While LHC agrees that DSP partners should be appointed following an open tender process[137], LHC submits that there is a distinction to be made as regards the results of the process, the identity of the successful parties and the content of the winning proposal. LHC has no objection to the identity of the winning parties being made public. However, LHC submits that the content of all tender proposals is confidential and should not be for public consumption. The content of the proposals is competitively sensitive and must thus be handled with extreme caution.

4.9.6.9 Duration of DSP contract arrangements

LHC disagrees with the proposed two year limit for DSP contracts and submits that the duration of the contract should be determined bilaterally between the provider and the funder. This is particularly appropriate given that the HMI has concluded that network agreements convey countervailing power upon funders. It is therefore illogical that funders would not be able to convey a duration that is efficient (given the costs associated with changing a network provider).

In LHC's extensive experience, the proposed two year limit[138] is inadequate as it does not take into account the amount of time required for a DSP service provider to implement systems and processes to achieve efficient outcomes. One component of achieving these efficiencies is encouraging doctors to follow certain care pathways in order to manage costs. Doctors are often very reluctant to follow these recommended pathways. For this reason, if a time limit were to be imposed, LHC submits that a three year duration would be more appropriate for a DSP contract. LHC does not believe that a three year duration will make it that much more difficult for new entrants to compete for DSP contracts.

136 Health Market Inquiry, Provisional Findings and Recommendations Report, page 475, paragraph 155.10.
137 Health Market Inquiry, Provisional Findings and Recommendations Report, page 476, paragraph 156.1.
138 Health Market Inquiry, Provisional Findings and Recommendations Report, page 476, paragraph 156.3.

4.10 *Outcomes Measurement and Reporting System*

4.10.1 LHC agrees that there is no reliable outcomes measurement system in place[139] in South Africa. However, it is important to note that many healthcare providers are presently engaged with quality monitoring. LHC itself has a comprehensive internal quality monitoring system. Please refer to the submissions on LHC's Quality Management System in its first submission.[140]

4.10.2 Despite the existing quality monitoring systems that are in place in the industry, there has to date been no standardised quality measurement and reporting system, as providers use different methods and criteria. This has the result that outcomes for different providers cannot be compared. In addition to the lack of a standardised system, there is no single reporting platform for all providers - although there are various individual reporting platforms.

4.10.3 LHC has considered the HMI's recommendation that an independent statutory body called the Outcomes Measurement and Reporting Organization (OMRO) should be created to measure and report on healthcare outcomes. In LHC's view, while there is a need for an independent, appropriately structured statutory body that has comprehensive stakeholder representation, this body should be the Office of Health Standards Compliance (OHSC) and not the OMRO. Given that the existing mandate of the OHSC encompasses quality inspections and accreditation, the outcomes measurement reporting system, which essentially targets quality measures, is more appropriately viewed as an extension of the OHSC's mandate.

4.10.4 The measurement of quality has three pillars - structure, process and outcome. The OHSC's current mandate solves for structure and processes. What is lacking, is the quality outcomes component. Given the three quality pillars, LHC submits that the OHSC is the most appropriate body to undertake management and administration of the outcomes measurement and reporting system. Having the OHSC carry out the functions under the three quality pillars will allow the OHSC to act as a powerful centralised unit. This centralisation will enable the measurement and reporting of structure, process and outcomes for both the public and private healthcare sectors. This would greatly assist with any future policy changes, in particular the implementation of the National Health Insurance. As we have previously emphasized, the independence of the OHSC is critical.

4.10.5 A useful example of a quality organization that has dual functions is the Care Quality Commission in the United Kingdom. [141]

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139 Health Market Inquiry, Provisional Findings and Recommendations Report, page 476, paragraph 159.

140 Life Healthcare Group's First Submission to the Panel in the Competition Commission Inquiry into private healthcare, page 14, paragraph 3.

141 An example of such an entity with multiple quality functions is the Care Quality Commission in the United Kingdom.

4.10.6 Staged Implementation

4.10.6.1 In light of future policy changes, it is imperative that both the public and private sectors participate in the establishment of the outcomes measurements reporting system. In an NHI era, quality of care would need to be monitored for both public and private facilities. Examples where public quality reporting cuts across both tiers are Australia, Abu Dhabi, Singapore and Switzerland. For this reason, the proposed framework should consider the changing policy landscape.

4.10.6.2 LHC supports the two stage process for establishing the outcomes measurement and reporting system[142] and makes the comments set out below.

4.10.7 Mandatory participation

The first phase should be mandatory and not voluntary[143] – participation from all stakeholders is critical for the outcomes measurement and reporting system to have credibility. Data from all service providers is required in order to create a comprehensive and complete measurement and reporting system.

4.10.8 Representation

Public health representatives should be required to participate in phase one in order to represent public hospitals - it is too late in the process for public health representatives to only be involved in phase two.

4.10.9 Independent oversight by the OHSC

Representatives from the OHSC should participate in phase one in order to maintain the integrity of the process and to balance the different interests that will be put forward by stakeholders.

4.10.10 Mandatory funding

Given that the outcomes measurement and reporting system is intended to cater for all public and private providers and will assist the funders to assess providers and to undertake value-based-contracting, it follows that funding of the system should be undertaken by all stakeholders. LHC acknowledges that the funding requirements will differ depending on the stakeholder. Contributions should also be made by the public healthcare sector given the need for their involvement. As such, LHC proposes a hybrid funding model for phase one.

[142] Health Market Inquiry, Provisional Findings and Recommendations Report, page 477, paragraph 164.
[143] Health Market Inquiry, Provisional Findings and Recommendations Report, page 477, paragraph 164.1.

4.10.11 Phase one data

Where participation is mandatory, the data collected can be released to all providers. LHC fully supports the release of this data in individual feedback cycles, not only because it will improve the outcomes measurement and reporting system, but also because it will allow providers to put in place the systems required in anticipation of the new outcomes measurement and reporting system.

4.10.12 Implementation period

The proposed outcomes measurement and reporting system will be able to leverage off the existing work done by various stakeholders and, as such the proposed time frame of six years for a fully functional system should be adequate.

4.10.13 Stakeholder representation

As noted above, LHC's view is that the OHSC must undertake the function proposed for the OMRO. The subcommittee within the OHSC that undertakes the management of the outcomes measurement and reporting system must include the representatives suggested by the HMI, and in particular, must cater for both public and private facility representation.

4.10.14 Composition of the subcommittee

In order to ensure the independence of the members of the subcommittee that manage the measurement and outcomes reporting unit within the OHSC, the Minister should not have a veto power in respect of appointments to this subcommittee. LHC submits that it would be more appropriate for the public nomination process to be followed by an interview process, conducted by a panel of stakeholders, and that these stakeholders should reach consensus on the persons that should be appointed to the subcommittee.

4.10.15 *Publication of Life Healthcare Quality Results*

4.10.15.1 LHC supports the call for transparency in reporting quality and clinical outcomes. This reporting has three components - patient experience, Patient Reported Outcome Measures (PROMS) and clinical outcome measures. In 2017, LHC commenced its first phase of reporting and published patient experience results on its website. This information is available to anyone who accesses the website and is categorised into national, regional and hospital level reporting. The LHC Quality data is loaded onto the website as patient surveys are completed and importantly, patients can view individual hospital results. [144]

[144] The Discovery Health Patient Survey of 2017 ranked LHC hospitals amongst the top 20 hospitals in the country. [CONFIDENTIAL] The 20 LHC hospitals that achieved the highest scores in the survey account for approximately [CONFIDENTIAL] of LHC hospitals.

4.10.15.2 [CONFIDENTIAL]

4.10.15.3 LHC supports the proposed health outcomes and measurement reporting system, as this will promote the quality of patient care and can be used to hold providers accountable for patient outcomes.

4.10.16 International Guidelines for Quality Reporting

We refer to LHC's submission titled *Health Outcome Measurement and Reporting, dated 18 September 2017*, which sets out a number of international systems that can be used as a starting point for the health measurement and outcomes reporting system and can be adapted for the South African context.

4.11 *Allegations of Over-servicing and Supplier Induced Demand (SID)*

4.11.1 The HMI concludes that "SID might be one of the causes of increased utilisation of healthcare in the private facilities market in South Africa."[145]

4.11.2 As LHC understands, the HMI makes the following allegations as to how supplier induced demand manifests itself. The first is that "*the observed increase in bed capacity over time further coincides with this increasing utilisation, thus suggesting that excess capacity is driving use, and a possibility of Supplier Induced Demand (SID).*"[146] The second is that "*Contracts between practitioners and facilities may increase inappropriate utilisation*."[147] The third is that care is increasingly provided at inappropriate levels[148], with the result that a number of admissions where intensive care or high care fees have been claimed have been gradually increasing over time[149]. The HMI also notes that the pronounced increase in ICU beds between 2014 and 2017 suggests a significantly sicker population which is not evident from its analysis.[150]

4.11.3 LHC case studies - Increased beds do not lead to supplier induced demand

4.11.3.1 In LHC's experience, it has not been able to simply induce demand whenever it builds a new hospital. By way of example, [CONFIDENTIAL].

4.11.3.2 [CONFIDENTIAL]

4.11.3.3 [CONFIDENTIAL]

145 Health Market Inquiry, Provisional Findings and Recommendations Report, page 245, paragraph 429.
146 Health Market Inquiry, Provisional Findings and Recommendations Report, page 234, paragraph 359.
147 Health Market Inquiry, Provisional Findings and Recommendations Report, page 245, paragraph 429.2.
148 Health Market Inquiry, Provisional Findings and Recommendations Report, page 231, paragraph 340.
149 Health Market Inquiry, Provisional Findings and Recommendations Report, page 231, paragraph 338.
150 Health Market Inquiry, Provisional Findings and Recommendations Report, page 231, paragraph 340.

4.11.3.4 Contracts between practitioners and facilities

4.11.3.4.1 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. LHC has never previously and does not currently incentivise doctors to admit patients.

4.11.3.4.2 The HMI itself appears to acknowledge that it is primarily practitioners that directly induce demand, when it states that "*practitioners have some discretion round 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*". [151] Similarly, the HMI notes that "*practitioners are directly involved in the clinical diagnosis and the final decision to admit the patient*".[152]

4.11.3.4.3 While it is fair for the HMI to conclude that there is "some" SID, it is important to take into account the context within which this limited SID occurs and the level of this SID. As regards the context, limited 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. The Provisional Findings 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*."[153]

4.11.3.4.4 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.

4.11.3.4.5 A further contributing factor to a doctor's decision in providing care is the threat of medical malpractice claims.

4.11.3.4.6 As regards the level of the SID, LHC submits that the HMI's analysis is inflated and that the use of the narrow disease burden is inappropriate. Please refer to the expert reports prepared by Cadiant Partners, titled *HMI's Draft Findings and Recommendations, prepared for Life Healthcare Group, 15 October 2018 marked* Annexure G, which illustrate that the percentage of the unexplained increase is significantly lower. LHC submits that the expansion of medical scheme benefits to primary care/out-of-hospital benefits would go a long way to decreasing the limited SID that is present in the system. LHC also submits that managed care organisations have a primary function to perform in controlling for SID. In

151 Health Market Inquiry, Provisional Findings and Recommendations Report, page 245, paragraph 429.2.
152 Health Market Inquiry, Provisional Findings and Recommendations Report, page 240, paragraph 397.
153 Health Market Inquiry, Provisional Findings and Recommendations Report, page 225, paragraph 318.3.

this regard, LHC highlights that since 2016, numerous managed care interventions have been implemented by GEMS, Discovery, Bonitas, Fedhealth and other schemes to manage utilisation. As such, healthcare providers' decisions are increasingly being scrutinised by funders. Examples of these interventions are detailed in Annexures 3.1 to 3.11.

4.11.3.4.7 Notwithstanding LHC's comments above regarding SID, LHC submits that the analysis undertaken by the HMI to illustrate SID, does not provide any robust support for the existence of SID in South Africa or, for the HMI's conclusion that South Africa tends to over-service. Please see the report prepared by RBB Economics, Titled "Response to PHMI's Provisional Findings: Supplier *Induced Demand, 15 October 2015* marked Annexure B" for a detailed exposition in this regard.

4.11.3.4.8 LHC notes the HMI's view that "*some of the contractual relationships between practitioners and facilities may facilitate SID in the private facilities market*".[154] LHC submits that doctor shareholding do not lead to doctors over-servicing in order to drive the profit of the hospital. This is evidenced in this submission by [CONFIDENTIAL]. 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.[155]

4.11.3.5 LHC case studies – ICU admissions policed by LHC Therapeutic Assessment Scoring System (TASS)

LHC categorically refutes the HMI's allegation that "*there is a relatively high tendency to admit patients in ICU wards when it is not necessary*."[156] LHC follows a policy called [CONFIDENTIAL] and using that assessment to ensure that the patient is billed for the appropriate level of care. This assessment is conducted by the critical care nursing staff and serves to: [CONFIDENTIAL]. Please refer to LHC's policy document in this regard, titled [CONFIDENTIAL].

4.11.3.6 CMS oversees monitoring of SID

4.11.3.6.1 The proposals made by the HMI in order to address the alleged over servicing are inadequate. In the first proposal, the HMI recommends that the CMS stipulate the metrics of SID and that it must publish information on what administrators are doing to cut back on SID, but then states that the CMS need not conduct the analysis itself. It appears then that the CMS will not interrogate whether the schemes' efforts to cut back on SID align with the metrics of SID that the CMS will provide. In other words, there will be no assessment of how effective the scheme have been in controlling for the alleged existence of SID. [157]

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154 Health Market Inquiry, Provisional Findings and Recommendations Report, page 245, paragraph 429.2.
155 LHC's First Submission to the Health Market Inquiry, dated 31 October 2014, paragraph 14.3.3.
156 Health Market Inquiry, Provisional Findings and Recommendations Report, page 232, paragraph 341.
157 Health Market Inquiry, Provisional Findings and Recommendations Report, page 478, paragraph 172.

4.11.3.6.2 In the second proposal, the HMI proposes that the CMS must collect anonymised scheme data but does not make any provision for analysis of that data.[158] In the circumstances, it is not clear what purpose the collection of the anonymised data will ultimately serve.

4.11.3.6.3 We agree with the HMI that the CMS should undertake any proposed analysis of SID as it is an independent body.

4.12 Increasing Synergies between Public and Private Facilities

4.12.1 LHC fully supports the HMI's recommendation aimed at increasing synergies between public and private facilities. As the HMI is aware from LHC's first submission, LHC has historically been involved in a number of public private partnerships, for example Life Esidimeni[159], Life Occupational Health, Life Isivavana and through some of its work at the Life College of learning and its partnership with the College of Medicine.

4.12.2 LHC's public private partnerships are based on a number of different models: build-operate-transfer, renovate and operate, co-location, commissioning and outsourcing. All of these models are relevant and their utilisation is dependent on the need identified in the public health sector.

4.12.3 Build-operate and transfer model (BOT)

4.12.3.1 The BOT model is utilised where the public sector hospitals are not functional and there is a need for a new hospital or a replacement hospital in a particular area. In this case, LHC will build, operate and manage the hospital over an extended period, typically 15 to 20 years, and will transfer ownership of the hospital to the state after the agreed period. The contract usually includes the option of the state buying the facility at any time during the contract, at an agreed amount to cover the capital cost incurred with reference to the remaining period of the contract. LHC operates the hospital in return for an agreed tariff that makes provision for the recovery of LHC's capital costs.

4.12.3.2 An example of such a facility is [CONFIDENTIAL]. In this model, the private and state sector both contributed doctors, including community service doctors when possible. [CONFIDENTIAL].

4.12.3.3 [CONFIDENTIAL].

[158] Health Market Inquiry, Provisional Findings and Recommendations Report, page 478, paragraph 173.
[159] As recorded in LHC's first submission, Life Esidimeni has been delivering healthcare services to state patients for over five decades and is the largest and oldest PPP in South Africa.

4.12.4 Co-location model

4.12.4.1 In the co-location model, a private ward is operated by a private company in a public hospital. An example of a co-location model is [CONFIDENTIAL].

4.12.4.2 [CONFIDENTIAL].

4.12.4.3 [CONFIDENTIAL].

4.12.4.4 Another example of the co-location model, is [CONFIDENTIAL].

4.12.5 Concession model

A concession involves the right to use land and property for a specified purpose and in this instance, is granted by the state. Typically with the concession model, the government has a facility which is underutilised or has spare capacity and a private company is allowed to use it as it sees fit for the provision of private healthcare services. The private entity pays a rental to the state for the space utilised. [CONFIDENTIAL].

4.12.6 Commissioning Model

A Commissioning model, in this instance, involves a situation where the hospital infrastructure has been built by the state but is commissioned, equipped and operated by a private healthcare company. [CONFIDENTIAL].

4.12.7 Outsourcing Model

4.12.7.1 With the outsourcing model, a service is provided to public sector patients by a private company on either a long term or short term basis, usually on the premises of the private company. Both models solve for constrained capacity on the part of the state.

4.12.7.2 The long-term outsourcing model services the needs of patients who need care on an on-going basis. In LHC's experience, these include drug rehabilitation, chronic mental health, frail care, chronic care of children with severe physical and intellectual impairment, tuberculosis (in-patient and Multi Drug Resistant TB) and prisoners.

4.12.7.3 The short-term outsourcing model is aimed at servicing an overflow of patients from the public sector and solves for short-term capacity constraints on the part of the state. For example, the state has issued a tender for the purposes of outsourcing cataract procedures to private service providers, in circumstances where the state is unable to cope with the volume of patients.

4.12.7.4 Other short term outsourcing arrangements include [CONFIDENTIAL].

4.12.8 Renovate and operate Model

The renovate and operate model contemplates the existence of an existing public healthcare facility which is not operational and which requires significant investment in order to provide hospital services. [CONFIDENTIAL].

4.12.9 LHC observations regarding the PPP models

[CONFIDENTIAL]	[CONFIDENTIAL]	[CONFIDENTIAL]
[CONFIDENTIAL]	[CONFIDENTIAL]	[CONFIDENTIAL]
[CONFIDENTIAL]	[CONFIDENTIAL]	[CONFIDENTIAL]
[CONFIDENTIAL]	[CONFIDENTIAL]	[CONFIDENTIAL]
[CONFIDENTIAL]	[CONFIDENTIAL]	[CONFIDENTIAL]
[CONFIDENTIAL]	[CONFIDENTIAL]	[CONFIDENTIAL]

4.12.10 Other LHC observations

4.12.10.1 Alignment between the state and the private partner

There must be alignment between the state and the private partner in respect of the need for the PPP, the objectives of the PPP, the manner in which those objectives will be achieved, the roles and the obligations of state and the private partner and funding of the PPP and related payment arrangements. The state should set clear criteria, standards and outcome measures that the private provider is obliged to adhere to and to deliver as efficiently as possible. By way of example, [CONFIDENTIAL].

4.12.10.2 Managing healthcare resources

Given the shortage of healthcare professionals in the country, it is critical that PPP arrangements are properly staffed in order to ensure their viability. It is important to have doctors who have good management skills and who are able to lead by example in terms of diligence and clinical competence. [CONFIDENTIAL].

4.12.10.3 Capacity planning

Capacity planning is critical as there must be sufficient capacity to service the needs of a particular community, taking into account the size of that community and the specific healthcare needs of that population. [CONFIDENTIAL].

4.12.10.4 Decision making

In order for the PPP to function efficiently, it is necessary for the hospital manager to be sufficiently empowered to make critical decisions. This will expedite decision-making and thereby enhance service delivery. By way of example - 1) during water shortages the hospital

manager must be able to easily authorise purchases of water from private tankers; 2) when critical pharmacy stock runs out, the hospital manager must be able to authorise purchases.

4.12.10.5 Hospital board members

Hospitals in PPP arrangements must have stakeholder representation in their governance structures similar to equivalent public hospitals, in particular, as regards community representation.

4.12.10.6 Community liaison

The PPP's which provide hospital services to public patients, must have a community liaison officer. The liaison officer must perform community outreaches in order to educate the community about the services provided by the PPP and that they have access to these healthcare services at state cost.

4.12.10.7 Payment delays

[CONFIDENTIAL]. This may prove highly problematic where the private company does not have sufficient financial resources to carry months of unpaid accounts.

4.12.10.8 In conclusion, LHC agrees with the HMI that limited public sector capacity can be augmented by private bed capacity and that such state contracts do not need to wait for the NHI to occur. This is amply illustrated by the Life Healthcare partnerships described above.

4.13 *Review of HPCSA Ethical Rules*

4.13.1 LHC appreciates that the HMI has taken on board stakeholders concerns about the HPCSA ethical rules and that the HMI has made recommendations that align with many of the proposals made by stakeholders. LHC agrees with the HMI's recommendation in respect of rule 7(4) and (5)[160] as well as rule 8 and 8A[161].

4.13.2 Rule 18

4.13.2.1 In essence, Rule 18 of the HPCSA Rules holds that professionals shall only accept employment from employers approved by the HPCSA.

4.13.2.2 In terms of the HPCSA's interpretation document[162] rule 2.2.2 only recognises the public sector, universities and training institutions and all HPCSA registered persons as "*employers*." Any other

[160] Health Market Inquiry, Provisional Findings and Recommendations Report, page 478, paragraph 176.1.
[161] Health Market Inquiry, Provisional Findings and Recommendations Report, page 478, paragraph 176.2.
[162] Health Professionals Council of South Africa: Policy document on Undesirable Business Practices, As at 22

category of persons or institutions must make application to the HPCSA, explaining why it wishes to employ HPCSA professionals. For this reason, private hospitals are required to apply to the HPCSA should they wish to employ doctors.

4.13.2.3 As previously submitted, LHC does not seek to employ all doctors. Rather, it is seeking to have the right to employ doctors and for the doctors to have the right to be employed, so that these doctors can concentrate on their clinical duties rather than being concerned with the business side of their activities. In addition, having the ability to employ doctors will give private hospitals the ability to drive cost effectiveness of care, quality of care, innovation in delivery models and efficient utilisation of limited resources.

4.13.2.4 LHC notes, that where doctors are employed, a private hospital will be able to manage the doctor's workload to avoid a situation where the doctor takes on too much work and has poor care outcomes or suffers from burnout. The hospital can also ensure that a doctor's patients are cared for when the doctor is off duty, by allocating those patients appropriately to other doctors.

4.13.2.5 The HPCSA has encouraged its members to act as independent contractors or service providers rather than full time employees for clinical services required by a corporate entity. In this regard, the HPCSA cautioned that healthcare practitioners must always act in the best interests of their patients and they should not enter into any arrangements that may result in the clinical quality of care being compromised.[163] The HMI has itself indicated that it believes "*The inquiry believes that the concern with professional autonomy over-occupies the HPCSA*."[164] LHC emphasises that it does not seek to compromise the clinical decisions and the independence of treating doctors, or to incentivise under-servicing or over-servicing of patients. In as much as the HPCSA is concerned with improving quality of care and clinical outcomes, LHC is equally as concerned. Employing doctors would allow LHC to have significantly better oversight in this regard and the ability to manage quality of care. Were LHC to employ doctors, it would put in place stringent measures to guard against the concerns raised.

4.13.2.6 These measures would include the following:

4.13.2.6.1 [CONFIDENTIAL].

4.13.2.6.2 [CONFIDENTIAL].

September 2005. Accessible on: http://www.hpcsa.co.za/downloads/conduct_ethics/undesirable_business_practices.pdf, last accessed 14 October 2018.

163 HPCSA bulletin, November 2014.

164 Health Market Inquiry, Provisional Findings and Recommendations Report, page 358, paragraph 281.

4.13.2.6.3 [CONFIDENTIAL]

4.13.2.7 LHC conducted an internal study of the international experience with doctor employment. Please refer to Annexure 5, which details this international experience and draws on experiences of a number of countries including Kenya, India, the United Kingdom, Australia and the United States. The international experience illustrates that there are both advantages and disadvantages with regard to the employment of doctors in private hospitals. [CONFIDENTIAL]. In the circumstances, the motivation for the employment of medical officers is to improve access, availability, enhanced quality and better outcomes for the patient, in addition to achieving more cost effective medical care.

4.13.2.8 The HMI has requested proposals for employment of specified categories of doctors in the private sector that would be a net positive for the sector as a whole.[165] Please see below a detailed motivation for the various categories of practitioners that LHC seeks to employ in its hospitals.

[CONFIDENTIAL].

[CONFIDENTIAL].

[CONFIDENTIAL].

[CONFIDENTIAL].

[CONFIDENTIAL].

4.13.2.9 [CONFIDENTIAL].

[CONFIDENTIAL].

[CONFIDENTIAL].

[CONFIDENTIAL].

4.13.3 *Rule 23A*

4.13.3.1 LHC has no objection to more effective monitoring of the practitioner's interest in a facility[166] and therefore supports the monitoring measures proposed. In respect of these reporting measures, while practitioners should be required to declare their interests to the HPCSA, the publication of this information on a website and at the relevant hospitals should be limited to the fact of the shareholding. The name of the doctor and the name of the hospital at which he/she has a shareholding should be published, but no more information than that. Any other

[165] Health Market Inquiry, Provisional Findings and Recommendations Report, page 479, paragraph 176.3.
[166] Health Market Inquiry, Provisional Findings and Recommendations Report, page 479, paragraph 176.4.

information is commercially sensitive and should not be for public consumption and is not required to solve for the public interest.

4.13.3.2 Information declared to patient

LHC supports the HMI's proposals which are aimed at transparency and making patients aware of financial interests which a doctor may have, and that is linked to the patient's care. As such, LHC agrees that practitioners should upfront inform patients if their rates are higher than funder approved rates and that patients should give written consent to these rates. As noted above, LHC has no objection to the doctor disclosing the fact of their shareholding at a particular facility. It is important for a patient to know where a doctor uses products from companies in which he/she holds financial interests.[167] These proposals are viable during elective admissions but may not be possible to follow where the patient is admitted in an emergency situation.

5. Additional comments

5.1 Hospital Innovation

5.1.1 The provisional report highlights a lack of innovation in the hospital environment: A consequence is that the market is characterized by an absence of effective direct competition between the three big hospital groups. "*Except for limited pressure from DHMS (and DH) and lately GEMS, we have not seen evidence that other schemes and administrators exert sufficient buyer power on the hospital groups. The three big hospitals groups can continue in the knowledge that significant challenge is unlikely and this is probably the main reason the industry is not seeing innovation throughout the sector*."[168]

"*On the whole, entry and expansion in the facility market has been 'more of the same' with innovation to bring about meaningful efficiencies in the sector lacking*"[169]

5.1.2 LHC disputes the HMI's contention regarding the lack of innovation in the hospital environment, and it disputes that only Discovery Health and GEMS exercise countervailing power. Life Healthcare has implemented several initiatives and programs, with the focus on improvement and efficiency to ensure better quality and clinical outcomes. We set out a description of each of these initiatives below.

5.1.3 [CONFIDENTIAL].

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[167] Health Market Inquiry, Provisional Findings and Recommendations Report, page 479, paragraph 176.5.
[168] Health Market Inquiry, Provisional Findings and Recommendations Report, page 11, paragraph 51 and 52.
[169] Health Market Inquiry, Provisional Findings and Recommendations Report, page 269, paragraph 553.

5.1.4 [CONFIDENTIAL].

5.1.5 [CONFIDENTIAL].

5.1.6 [CONFIDENTIAL].

5.1.7 [CONFIDENTIAL].

5.1.8 [CONFIDENTIAL].

5.1.9 [CONFIDENTIAL].

5.1.10 [CONFIDENTIAL].

5.2 Alleged illegal dumping of patients

5.2.1 The HMI has made the following observation - "*Possible unethical dumping of patients by medical schemes to the public sector for non-PMB conditions. The illegal dumping can occur where patients have exhausted their medical benefits and patients then default to the public sector, because the scheme would not pay for the services required*."[170]

5.2.2 In circumstances where the patient is stabilised and the patient can be transferred to a public facility, it is not clear to LHC why the HMI takes the view that a private hospital is obliged to continue servicing a patient whose medical scheme benefits have been exhausted for non-PMB conditions, and where that patient is unable to independently fund his/her continued treatment. The underlying premise for receiving care at a private hospital is that the patient must be able to pay for that care. In circumstances where the patient is unable to do so, there is no legal obligation on the private hospital to service that patient except in case of emergencies. In relation to emergencies, LHC has clearly defined guidelines which it implements diligently in order to ensure that emergency patients are appropriately cared for, and that they are not transferred unless they are stabilised and the doctor in charge has authorised the transfer.

5.2.3 LHC notes that patients are fully informed of their financial obligations when they are admitted to a LHC facility. Specifically, a patient is required to sign a letter which includes provisions regarding liability for payment and disclaimer of liability. These provisions are marked for the patients attention and the hospital admissions staff are required to ensure that the clauses are read and understood by the patients. The patient is required to initial these particular clauses to acknowledge that they have been read and understood. While LHC appreciates the sentiment attaching to a patient being moved from a private facility to a public facility, it submits that it is not feasible for a private hospital to treat patients who are unable to pay for their care on an

[170] Health Market Inquiry, Provisional Findings and Recommendations Report, page 273, paragraph 576.2.

indefinite basis. Provided that LHC has complied with its obligation in terms of Section 27 of the Constitution, the ethical rules of the Health Professionals Council of South Africa, and Section 5 of the National Health Bill, LHC submits that it is not illegal to move a patient from its facility to a public facility. Please refer to LHC's policy in relation to emergency unit procedures and admissions procedures marked [CONFIDENTIAL], respectively. In the circumstances, LHC fails to understand why the HMI views the transfer of patients from private to public facilities for non-PMB conditions as illegal.

5.3 History of price determination – Rebates of surgicals and consumables

5.3.1 The HMI makes the following allegations in relation to the history of price determination in private healthcare:

5.3.1.1 "*The coordinated or collusive approach to tariff setting pre-2004 implies that tariffs for private hospitals were determined in an anticompetitive way*." [171]

5.3.1.2 Although the post-2004 tariff setting had some containing effect on price increases in that tariff adjustments were based on inflation, there are two problems – 1) "*the base tariff was not competitively determined*"; and 2) "*the subsequent tariff regimes did not correct the anticompetitive price base as market players had largely applied inflation to the increases.*"[172]

5.3.1.3 The transfer of the margin on surgicals and consumables into hospital ward and theatre tariffs "*appears to reflect market power and is therefore anti-competitive*." [173]

5.3.2 On the back of these criticisms, the HMI then concedes that "*there is no empirical evidence that the coordinated approach to tariff setting prior to 2004 resulted in higher than competitive tariffs*". [174] Despite this concession, the HMI then concludes that reasonable interferences can be drawn that the prices were higher than competitive tariffs – in short, from the fact that HASA, BHF and SAMA entered into settlement agreements in which they agreed that the collective tariff determination amounted to price fixing in contravention of the Act.

5.3.3 The HMI's interpretation of the pricing history in the private healthcare market is problematic for a number of reasons. The most obvious reason is that these criticisms are not based on any empirical evidence and hence amount to no more than assumptions on the part of the HMI. Given that the HMI is querying prices, the appropriate approach would have been to collate and undertake an assessment of relevant pricing data in order to make the required comparison with present day

171 Health Market Inquiry, Provisional Findings and Recommendations Report, page 235, paragraph 365.1.
172 Health Market Inquiry, Provisional Findings and Recommendations Report, page 235, paragraph 365.2.
173 Health Market Inquiry, Provisional Findings and Recommendations Report, page 235, paragraph 366.
174 Health Market Inquiry, Provisional Findings and Recommendations Report, page 235, paragraph 367.

prices. It is not clear whether the HMI tried and failed to gather this evidence because it was not available, or whether the HMI elected not to collect and analyse this information.

5.3.4 First, as regards the collusive tariff setting pre-2004, and the settlement agreements entered into by HASA, BHF and SAMA; the HMI ignores one fundamental factor, namely, that the coordinated price setting did not only involve competitors, as is ordinarily the case, but included both competitors and their customers (the Board of Healthcare Funders (BHF) / the medical schemes). Despite the coordinated approach to tariff setting, it is not logical that the schemes would have simply colluded with the hospital groups to maintain prices at anti-competitive levels. The schemes have always represented opposing interests and have an obligation to act in the best interests of their members and to manage down the cost of healthcare. Contrary to the HMI's assessment, LHC's experience was that the schemes actively utilised the threat of paying members directly in order to secure better price increases – this was the primary bargaining tool in the hands of the schemes at the time.

5.3.5 Second, as regards the base tariff, which the HMI contends was not determined competitively; HMI does not provide the basis on which it makes this finding or the evidence on which it relies to conclude that there was no balance of power between the schemes in determining the base price. As far as LHC is aware, the schemes actively participated in the setting of the base prices. We refer to the detailed pricing discussion in section 4.5 of this submission.

5.3.6 Thirdly, as regards transfer of the margin, the HMI provides no evidence to support its conclusion that this reflected market power on the part of the hospital groups and was therefore anti-competitive.

5.4 Investment in technology

5.4.1.1 The HMI alleges that a key problem underlying high and rising costs of care and medical scheme contributions is over-investment in technology. [175]

5.4.1.2 LHC strong disputes this allegation. All decisions by LHC to purchase new technology are carefully considered and must pass a stringent business case test before being approved. LHC has a range of internal approval processes for different purchases.

5.4.1.3 [CONFIDENTIAL].

5.4.1.4 [CONFIDENTIAL].

[175] Health Market Inquiry, Provisional Findings and Recommendations Report, page 12, paragraph 59.

5.4.1.5 It is important to note that medical schemes act as a constraint on all consumable and new equipment purchases in that they will not simply approve payment. An example of this includes having benefit caps for prostheses.

5.5 Funder Remedies [176]

5.5.1 In the final Statement Of Issues (SOI)[177], the HMI acknowledged that "*the private healthcare sector comprises a number of inter-related markets and divides these markets into three broad categories, namely; the financing of healthcare*[178]*, the providers of healthcare services (including facilities*[179] *and practitioners*[180] *) and consumables*". The HMI also noted that it is required to "*conduct an analysis of the inter-relationships of various markets in the private healthcare sector*", including "*the nature of competition within and between these markets, and the ways in which competition can be promoted*". On the basis of this approach, it was to be expected that the HMI would adopt a balanced approach in proposing remedies for the various markets, in order to address for the inter-related nature of the private healthcare market.

5.5.2 In the Provisional Report, the HMI found that – the administrator market is highly concentrated with two administrators, Discovery Health and Medscheme accounting for 76.1% of the market[181]; as with the medical schemes market, there were high market shares for some administrators and high concentration levels for the medical scheme administrator market as a whole[182]; and there has not been any sustainable and significant entry in the medical scheme administrator market in over a decade[183]. The HMI also confirms that both Discovery Health and Medscheme may be dominant administrators[184] and noted that the "*observed levels of profits for Discovery Health point to a degree of market power on the downstream market*"[185].

5.5.3 Similarly, the HMI has concluded that the facilities market is characterised by high levels of concentration[186] and that the hospital groups exercise market power.[187] We note though that the

176 Health Market Inquiry, Provisional Findings and Recommendations Report , page 133, paragraph 340.
177 Dated 1 August 2015, accessible on: http://www.compcom.co.za/wp-content/uploads/2015/05/Final- Statement-of-Issues-01082014.pdf, last accessed 11 October 2018
178 Healthcare financing refers collectively to Medical Schemes, Medical Scheme Administrators, Managed Care Organisations and Healthcare Insurers.
179 Healthcare facilities include hospitals, day clinics, sub-acute, specialised care centres and other similar facilities where healthcare services are provided.
180 Practitioner refers to any person, including a student, who is registered with the Health Professions Council of South Africa (HPCSA) in a profession registrable in terms of the Health Professions Act 56 of 1974, including specialists, general practitioners etc.; as well as certain allied professions registered with the Allied Health Professions Council of South Africa (AHPCSA).
181 Health Market Inquiry, Provisional Findings and Recommendations Report, page 133, paragraph 340.
182 Health Market Inquiry, Provisional Findings and Recommendations Report, page 136, paragraph 344.
183 Health Market Inquiry, Provisional Findings and Recommendations Report, page 136, paragraph 345.
184 Health Market Inquiry, Provisional Findings and Recommendations Report, page 133, paragraph 340.
185 Health Market Inquiry, Provisional Findings and Recommendations Report, page 146, paragraph 401.
186 Health Market Inquiry, Provisional Findings and Recommendations Report, page 197, paragraph 171.
187 Health Market Inquiry, Provisional Findings and Recommendations Report, page 198, paragraph 179.

private hospital markets do not suffer from the same lack of new entry as the medical schemes market. In this regard, the HMI has noted that "*while barriers to entry exist in the private hospital market, they are not insurmountable" and that "entry and expansion at varying levels of the facilities market, has happened.*"[188]

5.5.4 Given the similarities of the findings in relation to the medical schemes market and the private hospital market and the acknowledgement that these markets are inter-related, it would be expected that the remedies proposed would share some similarity. Despite the adverse findings in respect of medical schemes market, the HMI has not proposed any structural remedies to address the concerns raised regarding concentration, market power and lack of new entry – as it has done for the private hospital services market.

5.5.5 The reason for this disparity in the recommendations is not evident in the Provisional Findings. LHC submits that the remedies proposed for medical scheme market, as compared to the private hospital market, are incomplete and raise questions of fairness. In this regard, LHC notes that Section 20 (1) (b) of the Competition Act requires the commission to be impartial and to "*perform its functions without fear, favor or prejudice*."

6. Conclusion

6.1 In making this submission, LHC has been cognisant of the health policy reforms being considered by the State, in particular, Universal Healthcare Coverage (UHC). LHC fully supports the principle of UHC and believes that the private healthcare system and the public healthcare system can operate in a complementary manner and that the strengths of each system can be harnessed to create synergies between the two sectors. In doing so, viable operating, purchasing and subsidisation models can be built to support the attainment of a universal health system. We refer to the examples of [CONFIDENTIAL], described above, which demonstrate the synergies possible when the private sector and public sector collaborate to share resources.

6.2 In the context of the NHI, public and private sector providers will compete for contracts on an equal footing and will both be required to meet the same accreditation, service level and pricing considerations. This will encourage competition between public and private sector healthcare providers. In the NHI landscape, the HMI's current concentration assessment is not likely to hold, as public facilities have not been considered in the HMI's assessment.[189] As LHC understands, the State is committed to ensuring the implementation of UHC and is actively taking steps to realise this imperative. In the circumstances, LHC submits that any proposed remedies by the HMI must take into

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188 Health Market Inquiry, Provisional Findings and Recommendations Report, page 269, paragraph 551.

189 Health Market Inquiry, Provisional Findings and Recommendations Report, page 175, paragraph 56. "*In the current situation and for the purposes of this market inquiry, the HMI will not consider public healthcare facilities generally to be a reasonable alternative to the services of private facilities in South Africa*."

account the health policy reforms and their impact on the private healthcare sector. The HMI must ensure that it proposes measures that ultimately enhance the private sectors' ability to participate in the realisation of UHC.