COMPETITION COMMISSION OF SOUTH AFRICA

TERMS OF REFERENCE FOR MARKET INQUIRY INTO THE PRIVATE HEALTHCARE SECTOR

(Market Inquiry Commencement Date: 06 January 2014)

Notice is hereby given that the Competition Commission ("Commission") will conduct a market inquiry into the private healthcare sector ("healthcare inquiry") in terms of Chapter 4A of the Competition Act, 89 of 1998 (as amended) ("Competition Act"). The terms of reference for the healthcare inquiry, set out below, indicates the scope of the healthcare inquiry as well as the time within which it is expected to be completed.

This notice is published in terms of section 43B(2) of the Competition Act.

Members of the public are invited to provide information to the healthcare inquiry in accordance with guidelines for participation to be determined by the Commission. These guidelines will be made available on the Commission's website at www.compcom.co.za before the date of commencement of the inquiry.

Copies of the terms of reference are also available at the Competition Commission offices at the DTI Campus, Mulayo (Block C), 77 Meintjies Street, Sunnyside, Pretoria; or on the Commission's healthcare inquiry website at www.healthinquiry.co.za.

TERMS OF REFERENCE FOR THE MARKET INQUIRY INTO PRIVATE HEALTHCARE

1. LEGAL BASIS FOR THE MARKET INQUIRY

The Competition Commission ("the Commission") will conduct a market inquiry into the private healthcare sector in terms of Chapter 4A of the Competition Act, 89 of 1998 (as amended) ("the Act") and in keeping with the purpose and functions of the Commission set out in section 2 and section 21 of the Act respectively[a].

Section 21 of the Act calls on the Commission to, *inter alia*, "implement measures to increase market transparency" and "advise, and receive advice from, any regulatory authority". In order to fulfil these functions, and in line with the purpose of the Act, Chapter 4A of the Act enables the Commission to conduct market inquiries in respect of the "general state of competition in a market for particular goods or services, without necessarily referring to the conduct or activities of any particular named

[a] Chapter 4A of the Act, which introduces the powers to conduct market inquiries came into effect on 01 April 2013.

firm"[b]. A market inquiry is thus a general investigation into the state, nature and form of competition in a market, rather than a narrow investigation of specific conduct by any particular firm.

The Commission is initiating an inquiry into the private healthcare sector because it has reason to believe that there are features of the sector that prevent, distort or restrict competition.[c] The Commission further believes that conducting this inquiry will assist in understanding how it may promote competition in the healthcare sector, in furtherance of the purpose of the Act.[d]

One of the prerequisites to commence a market inquiry is that the Commission must develop and publish Terms of Reference ("ToR") for the market inquiry. These terms of reference must include, "at a minimum, a statement of the scope of the inquiry and the time within which it is expected to be completed"[e]. In accordance with these provisions, this ToR sets out the scope of the market inquiry, as well as the expected timelines for the inquiry.

Although the ToR delimits the scope of the market inquiry as currently envisaged, additional and related matters not identified herein may arise during the conduct of the inquiry. If the Commission believes that the ToR should be amended in any way, either through the addition of new matters or exclusion of matters currently identified herein, the ToR may be amended in terms of section 43B(5) of the Act.

2. THE PRIVATE HEALTHCARE SECTOR

This inquiry will examine the private healthcare sector, which encompasses numerous interrelated markets. In this document, "private healthcare sector" refers to that portion of healthcare services that are funded by private patients themselves, either through medical schemes, insurance or through out-

[b] Section 43A of the Act.
[c] According to section 43B (1)(i) of the Act, the Commission may initiate a market inquiry if it has reason to believe that any feature or combination of features of a market for any goods and services prevents, distorts or restricts competition within the market.
[d] The purpose of the Act, as set out in section 2, is to "promote and maintain competition in the Republic in order –
(a) to promote the efficiency, adaptability and development of the economy;
(b) to provide consumers with competitive prices and product choices;
(c) to promote employment and advance the social and economic welfare of South Africans;
(d) to expand opportunities for South African participation in world markets and recognize the role of foreign competition in the Republic;
(e) to ensure that small and medium-sized enterprises have an equitable opportunity to participate in the economy; and
(f) to promote a greater spread of ownership, in particular to increase the ownership stakes of historically disadvantaged persons."
[e] Section 43B(2) and section 43B(4) of the Act.

of-pocket payments.[f] The private healthcare sector is distinguished from the public healthcare sector, which is funded predominantly by public funds and is operated by the state.

Due to the many interrelated aspects of the various markets that comprise the private healthcare sector, competition in one market affects that in another. This implies that one can only fully understand the nature and dynamics of competition and associated matters such as cost, pricing and demand, by evaluating the dynamics within and relationship between the various markets that comprise the private healthcare sector. The achievement of the inquiry's objectives thus requires the consideration of a range of markets, including healthcare financing and suppliers of healthcare goods and services.

For purposes of analysing competition, these markets can be more narrowly defined through a detailed evaluation of the relevant product/service and geographic markets, taking into account supply- and demand-side substitution. The use of the term "market" in this ToR is thus best viewed as a preliminary hypothesis that will be refined during the course of the inquiry as more information becomes available.

The ambit of the inquiry is defined in more detail in section 5 of this ToR. The remainder of this section provides some background on healthcare markets in general, as well as cursory highlights of the South African healthcare sector. It also sets out considerations of the South African healthcare sector that are relevant to this inquiry.[g]

2.1. Healthcare in South Africa

The South African healthcare sector is characterised by many challenges related to uneven distribution of coverage and access to funding, poor infrastructure and human resource constraints. These challenges are particularly pertinent in the public sector:

- In 2012, 42.5 million[1] South Africans were dependent on the public sector for the provision of healthcare services, whilst 8.7 million[2] were serviced by the private sector.[h]
- In 2011/2012, the per capita expenditure on healthcare in the private sector was R13 800, whilst per capita expenditure in the public healthcare sector was R2 880.[3]

[f] Private payments are often subsidised by employers and by tax rebates.
[g] These terms of reference clarify why the Commission believes there are features of the interrelated markets in the healthcare sector that prevent, distort, or restrict competition. The Commission believes that it is both fair and prudent to provide this rationale, but emphasises that it will refine and sharpen its understanding of the general state of competition in these interrelated healthcare markets during the course of the inquiry.
[h] Numbers are rounded to the nearest decimal place.

- In 2011/2012, private sector funding equated to 48.6% (R120.8 billion) of total healthcare expenditure and covered 17% of the population, whilst public sector funding equated to 49.3% (R122.4 billion) of the total healthcare expenditure and covered 83% of the population. The remaining 2.1% of healthcare expenditure in 2011/2012 (R5.3 billion) could be attributed to donor and NGO spend.[4]
- According to the latest available information, the number of beds in the public sector was equivalent to about 2.1 per 1 000 of the population, whilst in the private sector the ratio was 3.5 per 1 000 of the population[5].

South Africans are also facing what is referred to as a "quadruple burden of disease": The first burden is the HIV/AIDS pandemic; the second is that of injury, both accidental and non-accidental; the third consists of infectious diseases such as tuberculosis, diarrhoea and pneumonia, and the fourth is the growing prevalence of lifestyle diseases[i] related to relative affluence.

Similar to the challenges faced by many other developing countries, South Africa thus has to come to grips with diseases of poverty and affluence simultaneously.

2.1.1. The South African Private Healthcare sector

As stated above, the private healthcare sector is made up of several interrelated markets involving the financing of healthcare, healthcare goods (such as medical devices and pharmaceutical products) and healthcare services provided by hospitals, practitioners and other intermediaries/agents.

2.1.2 Financing of healthcare/Financing mechanisms

Financing mechanisms refer to the institutional framework that exists to support risk pooling (i.e. insurance) and the purchase of healthcare goods and services. This framework principally includes health insurance entities such as medical schemes and private insurance companies, supported by administration and managed care companies. Direct purchases of healthcare goods and services also constitute a form of personal healthcare financing.

At the end of 2012 there were 92 registered medical schemes in South Africa, of which 25 were open schemes and 67 were restricted (closed) schemes. Only 30 medical schemes had more than 30,000 beneficiaries[6]. Closed medical schemes are restricted to a defined population, usually the employees

[i] Lifestyle diseases also fall into the category of non-communicable diseases.

of a company or industry. Open medical schemes are open to anyone that can afford the contributions.

The Board of Healthcare Funders ("BHF") is an industry body representing more than 85% of the medical schemes in South Africa[j]. Medical schemes and administrators are subject to oversight by the Council for Medical Schemes ("CMS").

Medical schemes are responsible for the bulk of private healthcare expenditure. It is estimated that medical schemes contributed R98.1 billion (~81.2%) to total private healthcare expenditure in 2012 and provided coverage to 8.7 million beneficiaries[7]. The next largest contributor to private healthcare expenditure was out-of-pocket contributions, estimated at R18.2 billion (~15.1%) in 2012. Private insurance and employers were responsible for a further R4.6 billion (~3.8%) of private healthcare expenditure.[k8]

Medical schemes are required to comply with the Medical Schemes Act, 131 of 1998, designed to achieve the following:

- *Open enrolment;* whereby all open membership schemes must accept all applicants;
- *Community rating;* whereby schemes are not permitted to determine contribution rates based on the health status of beneficiaries; and
- *Mandated minimum benefits;* whereby schemes must cover certain medical conditions fully, either directly or through a Designated Service Provider ("DSP").[l]

Medical schemes are predominantly administered on an outsourced basis. A fair degree of consolidation has occurred over the past 15 years: at the end of 2012, three administrators controlled 78.2% of the total market based on the number of beneficiaries.[9]

Managed care companies can be closely affiliated with administrators (a subsidiary of the same holding company) or even part of the same company. In only a few instances are they more closely affiliated with healthcare providers. In 2012, expenditure on managed care companies accredited by the Council for Medical Schemes in terms of the Medical Schemes Act, totalled R2.3 billion compared to R6.5 billion for third-party administration[10]. Outsourced managed care and administration services

[j] Note that although BHF represents 85% of schemes, this does not translate to the same proportion of beneficiaries. For example, the largest open medical scheme, Discovery Health Medical Scheme is not listed as a member of BHF according to the BHF website. Date Last Accessed: 14 May 2013.
[k] Numbers may not add to exact figure due to rounding.
[l] A DSP may also be referred to as a "contracted health service provider".

therefore totalled R8.8 billion in 2012, representing 7.5% of medical scheme Gross Contribution Income ("GCI").

Managed care intermediaries represent that part of the healthcare funding framework responsible for the development of innovative contracts with healthcare service suppliers. Although there has been growth in the business provided to these intermediaries, the sector-wide impact on private healthcare costs is not clear.

2.1.3 Suppliers of healthcare goods and services

Suppliers of healthcare goods and services include (1) healthcare professionals; (2) health facilities such as hospitals and clinics; (3) retail medicine distributors, such as pharmacies and dispensaries; (4) product manufacturers for medical consumables, medical devices, and medicines; and (5) logistics service suppliers for the distribution of medical products to health facilities and retail outlets.

According to the Department of Health, there were 27 784 medical practitioners (including specialists) working in the public and private sector in South Africa in 2010.[11] Primary care providers (GPs, dentists, and specialists) operate independently. They play a vital role in directing patients along the healthcare pathway. In theory, primary care providers act as "gatekeepers" responsible for making referrals to specialists, ordering medical tests and prescribing medication.

The three largest private hospital groups by number of beds are Netcare Limited, Life Healthcare Limited and Mediclinic Southern Africa Proprietary Limited, accounting for approximately 87.8%[12m] of private hospital beds. A further 12.2% of private hospital beds are provided by smaller independent players.

The South African medical devices, pharmaceuticals and consumables industries consist of smaller local and larger multinational companies that can be classified into importers, retailers, wholesalers, manufacturers and exporters. Pharmaceutical products can include ethical medicines, generic medicines, over-the-counter drugs and biologicals. Hospital medical equipment and supplies comprises various devices, tools, instruments and medical consumables used in hospitals and healthcare institutions.

While South Africa relies largely on imports to meet the country's demand for medicines, devices and consumables, there are some South African providers that service the local market. Activities in the

[m] This number is based on publicly available information, but is contested. The actual numbers and market shares will be reviewed during the inquiry.

pharmaceutical, devices and consumables industry include the manufacture, distribution, wholesale and retail sale of products.

2.1.4 Agents

Agents include all market participants that provide advice to consumers on the purchasing of insurance and healthcare goods and services. This principally includes financial advisors or brokers and medical doctors (general practitioners and specialists).

3. RATIONALE FOR A MARKET INQUIRY

Access to health care services is enshrined in the Constitution of the Republic of South Africa as a fundamental human right.[n] Section 27(2) imposes an obligation on the state to take reasonable measures to achieve the progressive realisation of this right. Private healthcare provision takes place within the context of this constitutional commitment to the provision of universal healthcare services to all people in South Africa.

The latest CMS annual report indicates that 8.7 million South Africans were serviced by the private healthcare sector during 2012.[13] The 2012 General Household Survey indicates that users of private healthcare facilities were largely satisfied with the service they receive in the private sector.[o14]

However, prices in the private healthcare sector are at levels which only a minority of South Africans can afford, evidenced by the (small) share of the population with access to private healthcare. Various concerns have indeed been raised about the functioning of private healthcare markets in South Africa as a result of the fact that healthcare expenditure and prices across key segments are rising above headline inflation. These increases in prices and expenditure frame the Commission's inquiry into the sector.

Various explanations have been put forward to explain the above-inflation increases in prices in private healthcare. These explanations range from information asymmetries and distorted incentives inherent in healthcare markets, though varying degrees of market power at different levels of the value chain, to changes in utilisation. Given the large number of possible explanations for these increases, there is a need for an inquiry into the factors that drive the observed increases in private

[n] Section 27(a) of the Constitution states that "everyone has the right to have access to health care services, including reproductive healthcare"
[o] According to the 2012 General Household Survey, 92.2% of users of private healthcare facilities were very satisfied with private facilities while only 57.3% of individuals were very satisfied with public healthcare facilities.

healthcare expenditure and prices in South Africa. The market inquiry into private healthcare will evaluate the various explanations for cost, price and expenditure increases in the private healthcare sector and will identify competitive dynamics at play. Through this analysis, the inquiry aims to identify all factors that prevent, distort or restrict competition, including any evidence of market failure, regulatory failure or competition concerns. This will provide a factual basis upon which the Commission can make evidence-based recommendations that serve to promote competition in the interest of a more affordable, accessible, innovative and good quality private healthcare.

The following sections contain an overview of initial observations on the private healthcare sector in South Africa. Note that all statements contained herein are subject to review during the inquiry.

3.1. Structural features of the healthcare sector

The healthcare sector typically involves a wide range of funding mechanisms, prioritisation and rationing mechanisms, role-players, stakeholder interests, and government regulations. The delivery of healthcare is facilitated by agency relationships,[p] especially those between patient and doctor and patient and medical funder.[q]

The private healthcare sector is prone to various forms of market failure affecting both the purchasing and supply of health services. [15] This sector is characterized by many areas of imperfect information, specifically asymmetric information. In many cases, the consumer (patient) is not price sensitive, as the service (medical treatment) is either paid for by a medical scheme or by government.[16] In these instances, competition based on price is less relevant and quality becomes the significant competitive factor.[17]

The consumer (patient) is also in a unique position, as the services purchased are not traditional economic goods, but often an emotional and necessary purchase of which he or she has very little knowledge. Due to the complexity of healthcare products or services, consumers are often advised by agents, in the form of doctors and brokers, on what they should buy. This further diminishes the relationship between costs, household budget constraints, and consumer preferences. The intermediation of agents in the purchasing decisions of consumers makes health markets vulnerable

[p] An “agency relationship” refers to a situation wherein one party (the agent) acts on behalf of another party (often referred to as the “principal”). In an agency relationship, the principal expects the agent to act in their best interest, but the agent has limited influence and understanding to evaluate whether this is the case.
[q] In these examples, the patient is the principal and the medical professional (doctor) and payer (medical scheme) act on his/her behalf as agents of the patient.

to conflicts of interest, particularly where the interests of consumers do not converge with those of agents.

The functioning of these relationships and the nature of the incentives in the medical value chain, will determine the eventual price, quality and outcomes that patients experience.

3.2 Regulation in the healthcare sector

Given the complexity of the healthcare sector, the role of agents, and the asymmetries of information that exist, different views exist with regards to the level of intervention and regulation that is desirable in healthcare.

The purpose of regulation is often to achieve a number of goals that cannot be accomplished by the private market operating on its own, for example ensuring coverage for vulnerable groups based on their income and health status. The specific instruments used vary by country.

Many countries have a "mixed" healthcare system, including publicly-delivered services, social insurance funds, and regulated private markets. Industrialized countries are less pluralistic in nature and tend to favour one or other predominant approach to financing and delivering healthcare. Although there are no model ("best practice") systems, regulatory regimes do fall into families. For instance, regulated private markets, such as those of the Netherlands and Germany, achieve solidarity and certain macro-level cost-containment goals through non-market mechanisms. Public schemes, such as those of the United Kingdom, are able to internalize solidarity goals by having a single fund, and manage costs through explicit contracting. The specific configuration of instruments required to achieve a sustainable health system will, however, depend on local circumstances.

In South Africa, factors such as the country's disease profile, income levels, healthcare infrastructure and demographic profile add additional layers of complexity and will influence policy decisions. However, many of the recognised international health market imperfections are evident in the South African private health sector and inform the need for this inquiry.

3.3 Expenditure increases in the private healthcare sector

Expenditure increases have been raised as a concern in the private healthcare sector in South Africa. Various views have been expressed as to the reasons for these trends[18]. This inquiry will investigate the extent of increases in cost, prices, and expenditure and how these increases relate to competition.

A preliminary view of expenditure increases is presented below; using claims data collected from medical schemes over the period 2003 – 2012 (inclusive). The data suggests that two categories; hospitals and specialists, accounted for 60% of all claims expenditure. These categories contributed to expenditure increases in the following ways:[19]

Hospitals, which constitute 36.7% of all claims expenditure (in 2012):

- Real per capita expenditure increase from 2003 to 2012: 40.7%
- Real expenditure increase from 2003 to 2012: R16.4 billion

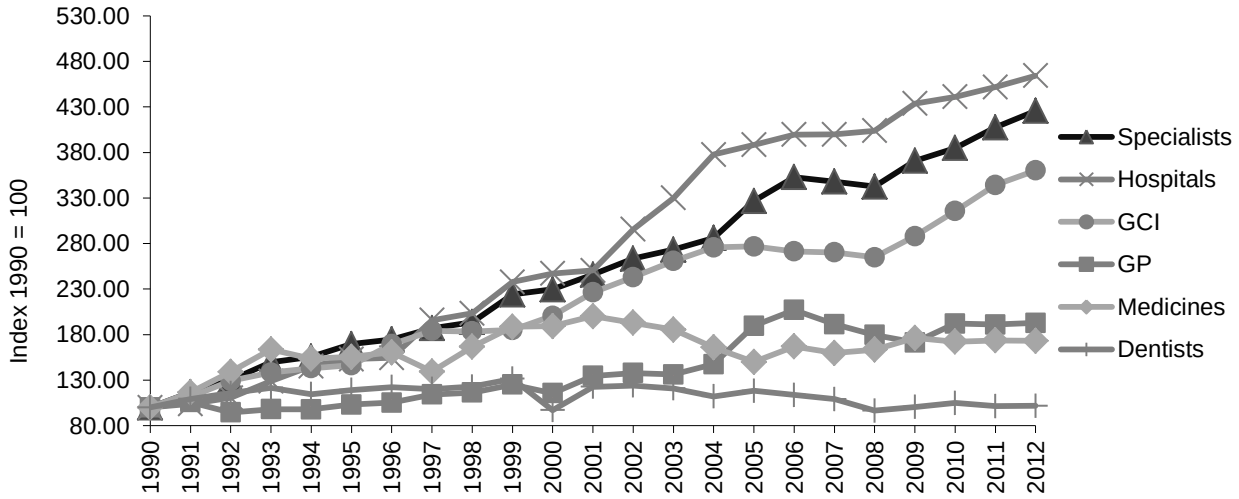
Specialists, which constitute 23.3% of all claims expenditure (in 2012):

- Real per capita expenditure increase from 2003 to 2012: 55.7%
- Real expenditure increase from 2003 to 2012: R11.7 billion

These indicative trends suggest that private healthcare expenditure is increasing. Numerous factors may explain these increases, including utilisation, type of disease, benefit design, and the interaction between the regulatory environment and the sector. The veracity of this data and the underlying drivers of increased expenditure must be evaluated during the inquiry.

Trends in medical scheme claims and Gross Contribution Income (GCI) per medical scheme beneficiary also indicate an upward trend:

Figure 1: Claims expenditure per beneficiary per annum from 1990 to 2012 for hospitals, specialists and the rest compared to Gross Contribution Income (index = 100 in 1990)



Source: Council for Medical Schemes: Annual Reports from 1991 to present

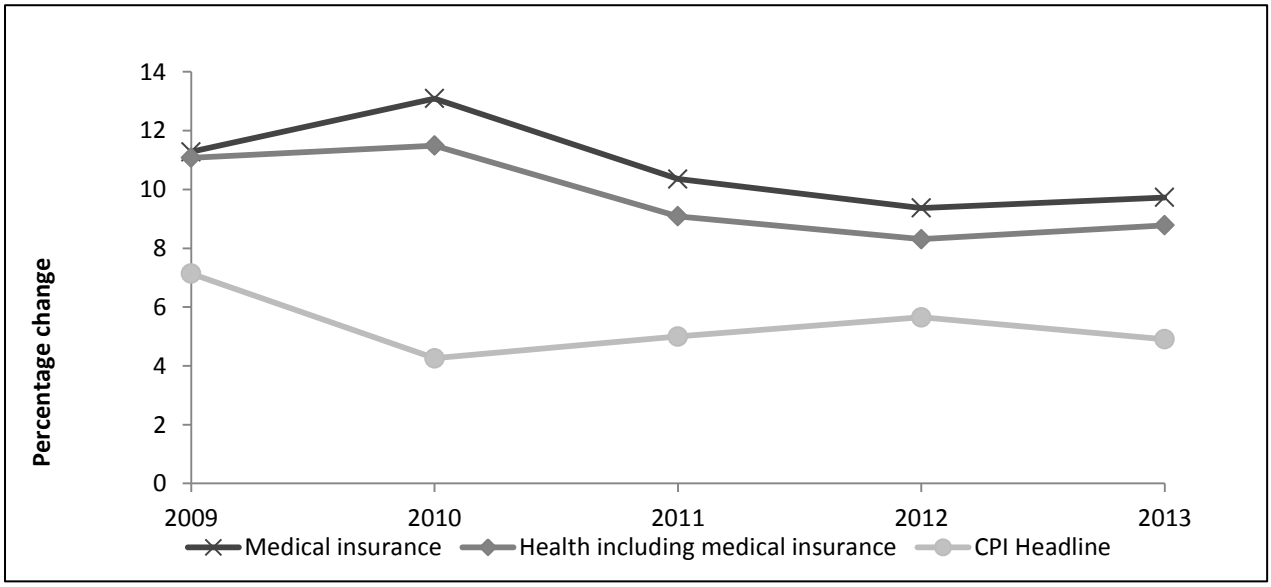
Despite the substantial real increases experienced in hospital and specialist claims, trends in medical schemes' GCI, which reflects contribution changes charged to medical scheme members, indicates that all of these increases were probably not passed on to members. Instead, schemes could have compensated by reducing other benefits or paying the difference from other sources such as reserves. The potential reasons for these trends will have to be investigated as part of this inquiry.

Finally, we consider the experience of households in South Africa with respect to healthcare prices. According to Statistics South Africa, the price increases that households have experienced in their healthcare prices (including medical insurance), as measured by the Consumer Price Index (CPI), exceeded headline CPI inflation by an annual average of 4.3 percentage points between 2009 and 2013 year to date. This indicates that prices for healthcare services experienced by consumers have been rising at a faster rate than average consumer prices in the economy[20].

Medical insurance inflation as measured for households, has also exceeded headline CPI inflation by an average of 5.4 percentage points per annum between 2009 and 2013 year to date. As a result, the share of medical insurance paid by households as a share of their total expenditure has increased from 3.4% in 2005/06 to 7.2% in 2010/11[21].

These indicative trends suggest that healthcare prices paid by households are increasing. The data and the underlying drivers of increased expenditure will be evaluated during the inquiry.

Figure 2: Headline CPI vs health and medical insurance inflation (index = 100 in 2012)



Source: Statistics South Africa CPI data from 2008 to present

3.4 Consolidation in key markets

In addition to the changes in prices and expenditures within the private healthcare sector, there has also been consolidation in a number of key markets:

- Hospital groups: 3 groups share 87.8% of the total number of beds in the national private hospital market[r];
- Administrators: 3 entities represent 78.2% of the total number of beneficiaries of medical schemes on a national basis; and
- Medical schemes: 3 schemes cover 55.5% of all beneficiaries of medical schemes[22].

Concerns have been expressed around the levels of concentration within the South African private healthcare sector. [23] This potentially stems from a series of mergers within the industry.[24] The nature and effects of consolidation that has already taken place, as well as the likely consequences if it continues; will also have to be evaluated during the inquiry.

4. PURPOSE AND OBJECTIVES OF THE MARKET INQUIRY

The **purpose** of the market inquiry is:

- To conduct an analysis of the interrelationship between various markets in the private healthcare sector, including examining the contractual relationships and interactions between and within the health service providers, the contribution of these dynamics to total private expenditure on healthcare, the nature of competition within and between these markets, and ways in which competition can be promoted;
- To assess the impact of Commission's interventions in private healthcare through enforcement action and merger regulation; including any impact this has had on prices, bargaining mechanisms, consolidation and competition in the healthcare sector;
- To inquire into the nature of price determination in the private healthcare sector in South Africa; and
- To establish a factual basis for recommendations that support the achievement of accessible, affordable, high quality, and innovative private healthcare in South Africa.

[r] This number is based on publicly available information, but is contested. The actual numbers and market shares will be reviewed during the inquiry.

The main **objectives** of the market inquiry are to:

- Evaluate the nature of price determination in private healthcare with reference to:
  - the extent of competition between different categories of providers and funders;
  - the extent of countervailing bargaining power between different providers and funders; and
  - the level and structure of prices of key services, including an assessment of profitability and costs;
- Evaluate and determine what factors have led to observed increases in private healthcare prices and expenditure in South Africa;
- Evaluate how consumers access and assess information about private healthcare providers, and how they exercise choice;
- Conduct a regulatory impact assessment that reviews the current regulatory framework and identify gaps that might exist. Examples include the interpretation of Prescribed Minimum Benefits ("PMBs"), the introduction of a risk equalization fund etc.;
- Make recommendations on appropriate policy and regulatory mechanisms that would support the goal of achieving accessible, affordable, innovative and quality private healthcare; and
- Make recommendations with regard to the role of competition policy and competition law in achieving pro-competitive outcomes in healthcare, given the possibly distinctive nature of the market.

5. SUBJECT MATTER OF THE INQUIRY

The market inquiry will probe the private healthcare sector holistically to determine the factors that restrict, prevent or distotrt competition and underlie increases in private healthcare prices and expenditure in South Africa. Decisions on the subject matter of the inquiry were informed by the Commission's preliminary research, consideration of stakeholder comments on the draft ToR, the main categories of private healthcare expenditure, and consideration of areas of the inquiry that would make the greatest impact within the Commission's limited resources. The Commission has delineated the current scope of the inquiry as best it can on the basis of the information available to it at this stage. The scope set out below provides an indication of the questions that will be asked, based on the Commission's preliminary theories of harm. These statements in no way imply that any conclusions have been reached; they will all be evaluated and tested during the inquiry.

The current scope of the inquiry includes the following:

5.1. Healthcare financing

The demand for health insurance	• The market for health insurance[s] products, including medical schemes and long- and short-term insurance
	• Product marketing to consumers and the associated effect on competition
	• The impact of information asymmetries on consumer choice, including the impact of brokers (as intermediaries in the purchase of health insurance)
	• The relationship between health insurance product-design and the purchase of health goods and services
The demand and supply of support services to health insurers	• The impact of intermediary services[t] on the services that medical schemes provide to consumers
	• The impact of the 'not-for-profit' status of medical schemes in schemes' relationship with support services and any consequential impacts on related healthcare markets
	• The role of risk transfer arrangements (reinsurance, alternative reimbursement arrangements and parallel insurance) in benefit design and any other effect on healthcare goods and services
The purchasing of health goods and services by insurers	• Health insurance products and the markets for healthcare goods and services
	• The relationship between consumer choice and the available range of purchasing arrangements for healthcare goods and services

[s] This is a functional definition of health insurance that refers to any form of risk transfer or risk pooling arrangement related to healthcare.
[t] Refers to all outsourcing arrangements and services that medical schemes make use of to operationalise the scheme, which would, *inter alia*, include administrators, managed care companies, payroll services, broker services, switching services, etc.

Integrity of the regulatory framework	• The extent to which the regulatory framework achieves the adequate functioning of the market for health insurance
	• The influence of the regulatory framework on health insurers and private health insurance, to respond to the demand for health goods and services

5.2. Healthcare services

Health professionals	• The role of the doctor (general practitioner and specialist) as an agent of the patient
	• The role of gatekeepers in the management of demand for health services
	• The nature of competition in the market for health professionals, in terms of both price and quality
	• The determination of tariffs and fees charged to health insurers and to households making out-of-pocket purchases
	• The inter-relationship between prices (fees and tariffs) and service volumes
	• Contracting regimes and their relationship to competition
	• Review of how price determination takes place and consider its implications for both the expenditure and quality of health services
	• Inter-relationships between the public and private systems and any implications for competition and cost
	• The implications that a market for salaried health professional (GPs and specialists) will have on provider competition
Hospital-based services	• The role of the hospital in influencing the demand for healthcare goods and services

	• The relationship between hospital-based services and healthcare purchasers
	• The nature and extent of competition between suppliers of hospital-based services
	• The extent and impact of markets for substitutes (day hospitals, outpatient services, clinics, sub-acute facilities) on acute in-patient hospital services
	• The relationship between hospitals and services such as emergency transport, pathology, radiology, medicines, consumables, and medical devices and the role of these services as systemic cost drivers
	• The relationship between hospitals and doctors (GPs and specialists) and the role of doctors (GPs and specialists) as a systemic cost driver
	• The relationship between hospitals and nurse practitioners, including the role of nurse agencies and the public sector
	• The determination of tariffs and fees charged to medical schemes and for out-of-pocket purchases
	• The inter-relationship between prices (fees and tariffs) and service volumes
	• The influence of changes in technology on costs and expenditure
	• The influence of factors such as population morbidity and demographic profiles on costs and demand volumes
	• The influence of market concentration on the costs and quality of hospital-based care
	• The factors required to drive competition based on service cost and quality

	• Alternative reimbursement arrangements and the extent to which they drive competition for hospital services
	• Contracts between medical scheme intermediaries[u] and hospital groups outside of any contract with a medical scheme
	• The hospital licensing process and its influence on the market for hospital services
Non-hospital-based services and healthcare products	• The relationship between pharmaceutical manufacturers, logistics services, health professionals, hospitals and hospital groups, doctors, and retail pharmacy as a systemic cost driver
	• Medical devices and consumables as a systemic cost driver
	• The pricing and demand for new technology entering the health market involving, *inter-alia,* medicines, equipment, and pathology and their role as systemic cost drivers
	• The influence of Government's tender processes on product prices in the private health sector
Integrity of the regulatory framework	• The influence of regulatory frameworks on the effective functioning of the private health market with specific emphasis on: • Social protection legislation incorporated into the Medical Schemes Act No.131 of 1998 • The ethical rules applicable to health professionals • The application of a reference tariff schedule to determine when over-charging by health professionals occurs

[u] Intermediaries include third party administrators and managed care companies.

6. THE PROPOSED MARKET INQUIRY PROCESS

The Commission will evaluate the subject matter of the inquiry through an inquisitorial process of public hearings and a review of secondary material, obtained via information requests, consultations and summons, as required. All interested and affected parties are also invited to submit information relevant to the inquiry in accordance with the guidelines for participation to be determined by the Commission. Guidelines for participation in the inquiry will be made available on the Commission's website.

A panel comprising three to five experts will preside over the hearings, review submissions, examine evidence and oversee the drafting of the inquiry report and recommendations. The panel of experts will report to the Competition Commissioner.

A team of researchers and analysts will support the panel. This team will assume primary responsibility for producing position papers, reviewing submissions and briefing the panel prior to the public hearings. The support team will also assist the panel with hearings and with drafting the inquiry report.

The participants in the market inquiry process will include firms, industry associations, government departments, public entities, patient groups, civil-society based organisations, patients, and any other stakeholders that may be able to provide information relevant to the market inquiry. Members of the public will be invited to participate in the inquiry during the information gathering phase of the inquiry, as well as during the public hearings and are encouraged to participate fully in the inquiry process.

The Commission is committed to the principles of fairness, transparency, and integrity and will conduct the inquiry in accordance with these principles. It is the Commission's view that the benefit of a market inquiry is that it lends itself to greater transparency than an investigation of a prohibited practice. The Commission will thus take all reasonable steps to ensure that all interested parties understand the Commission's thinking on the subject matter of the inquiry as it develops. To give effect to the Commission's commitment to transparency, the Commission will also release "issues statements" or interim reports throughout the market inquiry for public consideration and comment. The Commission will allow stakeholders fair and reasonable opportunity to provide input into the inquiry process.

6.1. Commencement and completion of the Market Inquiry

The market inquiry will commence on 06 January 2014. The final market inquiry report, which may include recommendations, will be completed by 30 November 2015.[v] Further details regarding the administrative phases of the market inquiry, along with guidelines for participation in the market inquiry will be made available on the Commission's website.

[v] Note that, in terms of section 43B(5) of the Competition Act, the Commission may amend the time within the market inquiry is expected to be completed by further notice in the Government Gazette.

Notes

[1] Health Systems Trust, http://www.hst.org.za/content/health-indicators, date last accessed 7 October 2013.
[2] Council for Medical Schemes, Annual report 2012/2013 Annexures, Annexure E.
[3] National Treasury 2012 Budget Review, Statistics South Africa General Household Survey 2010/2011, Health Systems Trust, *(Note* 1 *above)*.
[4] National Treasury, 2012 Budget Review p.82.
[5] Health Systems Trust, *(Note* 1 *above)* date accessed 7 October 2013; data derived from General Household Survey published by Statistics South Africa.
[6] Council for Medical Schemes, Annual Report 2012/2013 p.226.
[7] Council for Medical Schemes, *(Note 6 above)*, p.228.
[8] National Treasury, *(Note 4 above)*, p.82.
[9] Council for Medical Schemes, (*Note 6 above*) *p.273.*
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