



competition commission  
south africa

# HEALTH MARKET INQUIRY

## EXECUTIVE SUMMARY

September 2019



# Executive Summary

1. In our review of the South African private healthcare market we found that it is characterised by high and rising costs of healthcare and medical scheme cover, and significant overutilization without stakeholders having been able to demonstrate associated improvements in health outcomes.
2. We have identified features that alone or in combination, prevent, restrict or distort competition. The market is characterised by highly concentrated funders and facilities markets, disempowered and uninformed consumers, a general absence of value-based purchasing, practitioners who are subject to little regulation and failures of accountability at many levels.
3. We are concluding our work at a time when South Africa is embarking on a journey to establish a National Health Insurance Fund (NHI), a means to achieve universal health coverage. Based on the latest version of the NHI Bill, Gazetted on 26/7/2019 (Gazette no. 42598), it is envisioned that the NHI will create: a unified health system by improving equity in financing; reduce fragmentation in funding pools; and by making healthcare delivery more affordable and accessible, eliminate out-of-pocket payments when individuals need to access healthcare services; and ensure that all South Africans<sup>1</sup> have access to comprehensive quality healthcare services.
4. Full implementation of the NHI is some years away, with the Fund scheduled to be operational by 2026 at the earliest. The private sector will continue to operate in the interim and also after 2026. We have taken this into account in the implementation of our recommendations which will provide a better environment in which a fully implemented NHI can function. Nonetheless, we have always had regard to the mandate reflected in the TOR: to primarily focus on issues that affect the private sector.
5. We have found there has been inadequate stewardship of the private sector with failures that include the Department of Health not using existing legislated powers to manage the private healthcare market, failing to ensure regular reviews as required by law, and failing to hold regulators sufficiently accountable. As a consequence, the private sector is neither efficient nor competitive.
6. A more competitive private healthcare market will translate into lower costs and prices, more value-for-money for consumers and should promote innovation in the delivery and funding of healthcare. As the state becomes a purchaser of services (from the private sector as indicated by the NHI Bill), it will be able to enter a market where interventions like the establishment of a supply side regulator, a standardised single obligatory benefit package, risk adjustment mechanism,

<sup>1</sup> All South Africans, permanent residents and other registered users as defined in Chapter 2 of the NHI Bill will be covered by the fund.



and a system to increase transparency on health outcomes have already led to greater competition and efficiency.

7. Competition should occur on price, cost and quality, not on risk avoidance. The risk adjustment mechanism is a regulatory component designed to eliminate fragmented risk pools but, more importantly, it is an essential market mechanism to ensure that purchasing in the market becomes more effective, by forcing funders to compete on value and, therefore, stimulate competition between and the efficiency of providers. The resultant competitive environment will benefit the NHI. The proposed RAM includes income cross subsidisation an important move towards greater equity and it will build technical capacity in running health funds. We are aware that the RAM is contested but we reiterate that it is a vital regulatory component to eliminate risk rating. It will create a single risk pool ready for integration with the NHI Fund in due course as appropriate.

#### Facilities

8. Three hospital groups; Netcare, Mediclinic and Life, dominate the facilities market. In 2016, their market shares based on beds (and admissions) were 31% (33%); 26.8% (28.6%); and 25.3% (28.5%) respectively. A fringe of independent hospitals, mostly part of the National Hospital Network (NHN), exerts some competitive constraint in part due to an exemption from the Competition Act enabling them to negotiate with funders collectively. The market shares for NHN and independent hospitals in 2016 based on beds (and admissions) were 13.6% (7.7%) and 2.3% (2.2%) respectively. Using the compound annual growth rate (CAGR,) the NHN registered a market share growth of 4.7% for all registered beds between 2010 and 2018 and a growth of 3.9% in acute beds.
9. Concentration in the facilities market occurs at both the national level, where contracting with funders takes place, and at the local level, where funders contract with hospitals to form DSP networks. The majority (approximately 60%) of local facility markets are highly concentrated. National concentration levels

are higher than the threshold for markets defined as “highly concentrated”, even against the most conservative (US) enforcement standards. Even using stakeholders’ own estimates, national markets are highly concentrated against benchmarks proposed by the International Competition Network.

10. The level of concentration in facilities markets raises two concerns. First, concentrated markets are more vulnerable to collusion, both formal (cartels) and informal, and collusion in these highly complex healthcare markets is very hard to detect. Secondly, local level concentration limits the extent to which funders can employ DSP networks to effectively discipline hospital groups.
11. We have found that the three large hospital groups, both individually and collectively, are able to secure steady and significant profits year on year. The hospital groups make it very hard for newcomers and fringe-players to grow and to compete on merit. The three groups are able to distort and prevent competition by binding the best medical specialists to their hospitals with lucrative inducement programs, with associated exclusionary effects on innovative newcomers. There are few, if any, DSPs which do not include at least two of the big three hospital groups - they dominate DSP arrangements relative to other hospitals. Further, the three largest groups all but dictate year-on-year price and costs increases for funders. They facilitate and benefit from excessive utilization of healthcare services, without the need to contain costs, and they continue to invest in new capacity beyond justifiable clinical need without being disciplined by competitive forces.
12. Additionally, facilities operate without any scrutiny of the quality of their services and the clinical outcomes that they deliver because there are no standardised publicly shared measures of quality and healthcare outcomes to compare one against the other. It is impossible for patients, funders or practitioners to exercise choice based on value (quality and price).

13. We, therefore, find that competition has largely failed in the facilities market. The market is highly concentrated - both nationally and locally - and incumbent facilities are not forced to innovate or to compete vigorously. This failure is exacerbated by the fact that neither the public hospital system nor individual independent facilities exert an effective competitive constraint on the large facility groups. Public hospitals are not able to compete with private hospitals, since they do not consistently provide the quality of care required to compete against the large hospital groups.

14. Independent hospitals’ ability to compete is hampered by a number of factors, including limited bargaining power in tariff and network negotiations, a lack of information to implement effective performance-based reimbursement contracts (ARMs), and an inability to attract specialists to their facilities. They, therefore, do not provide significant competitive constraints. This is not likely to change significantly without a change in the regulatory environment designed to promote a more competitive market.

15. Independent hospitals have received some regulatory assistance from the temporary exemption granted by the Competition Commission (most recently with strict conditions not currently applied to the big three groups) enabling the NHN network to negotiate tariffs and conditions collectively. In all other respects, NHN is not a hospital group since individual facilities remain strategically and operationally independent and compete with each other. Nonetheless, the Competition Commission’s exemption has led to a marginal improvement in competition and a slight decrease in overall market concentration. As highlighted above, the NHN registered a Compound Annual Growth Rate of only 4.7% between 2010 and 2018 based on total registered beds.

16. However, more action is needed. Competition and competitive bargaining pressures from funders has to be increased significantly. Facilities’ market concentration must be reduced. The Competition Commission’s review of “creeping mergers” has, to date, not

been effective enough in reducing high levels of concentration. We note that the recent amendments to the Competition Amendment Act may improve this situation.

17. Most importantly, regulatory oversight must be improved. The supply side of the market is largely unregulated, with negative consequences for competition and for the consumer. We recommend that regulation of the supply-side of the market is essential and ideally administered through a new regulatory authority that we have called a supply-side regulator for health (SSRH). We have considered with great care the establishment of this regulator and have made a proposal where the net number of regulators will not change. We further consider it to be a positive contribution to the private and public sector. The United Kingdom National Health Service has shown that even a mature single public purchaser system requires regulatory oversight of suppliers by an industry-specific regulator. Moreover, those suppliers are, and need to be, subject to competition laws and to enforcement action by competition authorities.

18. One prominent responsibility of the new regulator will be the formulation of a new needs-based system of licensing which will be more rational, effective, inclusive, and can be oriented to promote innovation. Importantly, licensing will be applied consistently across all provinces with the aim of balancing capacity across the country by reducing or redirecting overcapacity and overinvestment to areas with lower capacity which could contribute to curbing excessive utilization. This new system of licensing, which is consistent with the NHA, will be guided by national policy and implemented by the supply-side regulator in close collaboration with provincial departments of health which will have further responsibilities for ongoing monitoring of performance of the system at local level and reporting obligations to the supply side regulator for health and the National Department of Health.

## Practitioners

19. In all healthcare markets, healthcare professionals are central to the consumption of healthcare services. They have more, and often untransferable, knowledge about disease diagnosis and treatment and must advise patients on what care is needed. They also order investigations, refer to other providers and, in the case of medical doctors, admit patients to hospital and other care centres.
20. In order to make the inquiry feasible, we focused on GPs and Specialists (collectively called practitioners) as they directly and indirectly contribute the most to expenditure when compared to other health professionals and are the main decision-makers about healthcare consumption.
21. There are 1.75 private practitioners per 1000 insured population. General practitioners (GPs) are distributed relatively evenly across the insured population at just under one per thousand. Specialists are more concentrated in provincial capitals and metropolitan areas, and in some areas, there are no specialists at all. We have found that the purported scarcity of practitioners does not explain market outcomes, rather it is how healthcare professionals operate in response to incentives in the market that has greater impact.
22. We found no reliable up-to-date data base documenting the number and location of practitioners, and we have made a recommendation to remedy this failure through an adaptation of the existing practice code numbering system.
23. Barriers to entry for practitioners were found to be justified when related to registration and training standards to protect the public. Other barriers were found surmountable, given that over the five-year period studied almost 1000 new practitioners entered the market. Practically all entry that took place followed conventional models. Innovative business models, however, were almost absent and were reported to be obstructed by funders, and by some practitioner associations and limited by the rules of the Health Professional Council of South Africa.
24. The 2004 Competition Commission prohibition on collective negotiating created what has been called a price vacuum and what is charged is either what the market can tolerate or, when patients cannot afford co-payment, practitioners (in the main general practitioners) accept scheme rates. The pricing vacuum has extended to relevant parties avoiding meetings where potentially competition sensitive information could be exchanged, including meetings that would review clinical codes, leading to an out-of-date coding (and related payment) system and unilateral code changes.
25. The private healthcare market is characterised mainly by stand-alone single practices or, in some disciplines, single-speciality group-practices but multidisciplinary teams are not a feature of the market. This absence limits up and down referral leading to an irrational use of care where specialists are performing functions that other practitioners may do without any loss of quality.
26. There is no standardised method to measure and to report on quality and health outcomes in the practitioner markets. The public is uninformed and cannot compare outcomes across interventions and practitioners. Practitioners too cannot benchmark their own practice nor judge on objective criteria to whom to refer. Funders too cannot contract on value for money.
27. We found that practitioners can influence to their own benefit how networks are remunerated or can avoid joining a network and can afford to ignore tenders.
28. Practitioners are often members of professional associations which perform a number of functions to ensure professional development and business support. The format of these associations is a concern and needs to change. These associations have been seen to provide quasi-collusive forums where advice on charging, coding and participation in networks are shared leading to co-ordinated behaviour on the part of individual practitioners.

29. Overall, we are of the view that many practitioners and their associations either are not aware of, or otherwise deliberately ignore, restrictions placed on all private sector players with regard to horizontal cooperation. The evidence that we have examined indicates that some market participants behave anti-competitively to the detriment of consumers.
30. We have found that utilisation rates (that is hospital admission rates, level of care (admissions to High Care and Intensive Care Units) and length of stay) were higher than can be explained by the burden of disease of the population being cared for. We found that excessive utilisation was a significant driver of healthcare costs.
31. Over servicing, or using higher levels of care than required, is not necessarily better care. It leads to a waste of resources and may even be disadvantageous to patients' health. It pushes up the cost of care and, if it is high enough, it will make it unaffordable and threaten the sustainability of the healthcare market.
32. We have also found that when holding all other factors constant, where there is a greater number of practitioners (in particular specialists with the exception of obstetricians) more admissions to hospitals occur. Thus, we have concluded that there is evidence of supply-induced demand.
33. Incentives in the market promote overutilization. In particular fee-for-service means that the more services practitioners provide, the greater their income, which creates a perverse incentive for profit maximising individuals or groups. Mandatory cover of prescribed minimum benefits, payable at cost, creates an opportunity for practitioners to determine their own degree of intervention and rates which must be paid for in full by funders. Benefit design, in particular almost guaranteed payment of most costs associated with hospitalisation and decreasing cover for out-of-hospital care, has encouraged the admission of patients

to hospital to ensure payment is guaranteed which benefits both patients and practitioners in the short term.

34. Current regulation of practitioners through the Health Professionals Council, in particular on fee-sharing, multidisciplinary group practices,<sup>2</sup> and employment of doctors, has significantly inhibited the evolution of innovative and integrated models of care that practitioners provide in other jurisdictions. What is increasingly becoming the standard of care internationally – multidisciplinary group practice with a range of reimbursement models – is undeveloped and discouraged at worst, or made difficult at best, by fear of sanction (warranted or not) by the HPCSA.

## Funders

35. Funders compete in an environment which is characterised by an incomplete regulatory framework, so distorting the parameters of competition. Our recommendations are designed to complete the regulatory framework, and to create a market environment conducive to effective competition on pro-consumer metrics.
36. The social solidarity principles of open enrolment (schemes must accept all applicants) and community rating (schemes must charge a contribution price for a particular plan which is identical for all members no matter age, sex or pre-existing conditions) were always meant to be implemented alongside a risk-adjustment mechanism (schemes with above average risk-profiles are balanced through funds received from schemes with below average risk-profiles) and mandatory membership. Absent a RAM, and having to pay PMBs at cost, has meant schemes' costs, and, therefore, member premiums, are highly correlated to the overall risk-profile of their members, which has resulted in schemes competing on the risk-profile of their members, for example by designing benefit options to attract younger and healthier members. This competition on benefit design

<sup>2</sup> Multidisciplinary group practices refer here to a group of healthcare practitioners of different disciplines, each providing specific services (e.g. medical and allied professionals) to the patient. It should be differentiated from group practices which refers to a group of healthcare practitioners providing health services (e.g. in the same discipline). Income from the practice is pooled and redistributed to the members of the group according to a prearranged plan.



is at the expense of competition on metrics which improve consumer welfare, such as procurement of value-for-money healthcare services, increasing benefits, adopting innovations, improving service quality, and/or directly competing on premiums.

37. A consequence of this competition on benefit design has been the proliferation of generally incomparable benefit options. The inability of consumers to easily compare options across funders has meant that consumers do not readily switch schemes in response to better offers from rivals. Absent this disciplining effect arising from consumers, schemes have no pressure to compete on pro-consumer metrics and to offer better products. This is exacerbated by the principal officers and trustees of schemes having remuneration policies which are not linked to beneficiary-centred performance metrics. Principal officers and trustees receive their full compensation irrespective of scheme performance.
38. These factors clearly do not foster an environment conducive to competition on metrics which would result in positive consumer welfare outcomes.
39. On the supply side, prescribed minimum benefit (PMB) regulations, while having had a positive impact in ensuring a minimum level of coverage for members, have had unintended effects on competition. Regulation 8 of the Medical Schemes Act specifies that PMBs must be paid in full without deductibles or co-payments which has shifted market power towards practitioners who are able unilaterally to set prices for PMBs which funders must then reimburse in full.
40. Further, the focus of PMB provisions on catastrophic cover to the exclusion of primary healthcare, has promoted hospital-centric care. In the face of rising costs and declining membership growth, funders have attempted to offer the lowest-cost, lowest-benefit plans possible. As schemes are mandated to cover the catastrophic conditions included in the PMB regulations, funders have created bare-minimum hospital-plans. Instead of saving money, this approach has had the unintended

consequence of raising costs as members are hospitalised unnecessarily in order to have treatment paid for.

41. Under open enrolment and community rating but where participation is optional, consumers can engage in anti-selective behaviour. Consumers have an information advantage over funders concerning expected health expenses (e.g. when deciding to become pregnant or being diagnosed with a chronic illness). Using this advantage, and the regulatory environment, consumers may opt to forego joining a medical scheme until it becomes necessary or they may adjust their level of coverage in response to their anticipated need. This behaviour can result in an individual member's claims outweighing their contribution, necessitating higher premiums for all members.
42. We believe that anti-selection exists and is already entrenched in premiums charged by funders. However, we do not believe that anti-selection has continued to be a factor that contributes to the increasing costs and premiums. We acknowledge the concern but note that tools to mitigate anti-selection, (waiting periods and late joiner fees), exist and that their impact has, as yet, not been fully evaluated.
43. In principle, we agree that mandatory membership will address anti-selection. However, before mandatory cover is introduced, the industry needs to show clear indications of closer alignment to consumer interests and better cost containment. We have not recommended mandatory membership at this point but believe that at a future date it would be appropriate.
44. We are of the view that the broker market is operating sub-optimally. Most members do not derive value from brokers and there is no incentive, such as an opt-in system, to align brokers' interests with those of scheme members.
45. We have found that the high barriers to entry in the administrator market has meant there has been little-to-no entry for several years, despite some incumbent administrators

earning very high profits while assuming limited risk relative to either the funders or providers. Discovery Health has, over a sustained period, earned profits that are a multiple of those of its main competitors with no sign of effective challenge from incumbents or new firms. The existing administrators do not seem to impose a significant competitive constraint on Discovery Health.

46. The principal officers and trustees of schemes could be more active in ensuring that beneficiary interests are protected. There is often a very close relationship between administrators and the schemes they administer. While the interests of administrators and members of schemes are not always misaligned, there is nevertheless a need to strengthen the role played by the boards of trustees and principal officers to ensure the member is always put first. Therefore, we recommend that the board members and principal officers should be sufficiently trained and incentivised to ensure that they are receiving appropriate value for money and quality from both administrators and healthcare providers.

#### Recommendations

47. Based upon our findings, we recommend a set of interrelated interventions designed to promote systemic change to improve the context within which facilities, funders, and practitioners operate, and create a shift towards a pro-competitive environment. These recommendations must be seen as a package. Market failures may persist if a partial approach to the implementation of our recommendations is adopted.
48. We recommend that the Competition Commission review their approach to creeping mergers to address high levels of concentration through effective merger review and that they provide guidance to practitioner associations about what constitutes pro-competitive conduct and have suggested a method to evaluate the functioning of associations.
49. For effective and efficient regulatory oversight of the supply-side of the healthcare market,

we recommend the establishment of a dedicated healthcare regulatory authority, referred to here as the Supply Side Regulator for Healthcare (SSRH). The role of the SSRH will include regulation of suppliers of healthcare services, which includes health facilities and practitioners. The SSRH will have four main functions: healthcare facility planning (which includes licensing); economic value assessments; health services monitoring; and health services pricing.

50. The SSRH will have the following duties:
  - 50.1. Be responsible for capacity planning and issuing of facility licences following national guidelines which will be developed by a technical team. Licences will be issued after facilities have OHSC approval. Licensing will be undertaken in conjunction with Provincial Departments of Health who will collect, collate and publish facility data which will include bed data, occupancy rates, and quality measures. We have recommended new mechanisms and timelines for applying for licences and that licences to develop a new facility should not be evergreen.
  - 50.2. Set up a multilateral negotiating forum for all practitioners to set a maximum price for PMBs and reference prices for non-PMBs which will ensure PMB prices for practitioner services balance market forces and that the regulations do not artificially shift market power to either participant with an arbitration mechanism to break deadlocks.
  - 50.3. Maintain an "intelligent" health professionals' numbering system linked to required annual reporting of current working address, area of speciality, full/part-time status and requirements to report on health outcomes.
  - 50.4. Run a committee to set and regularly review codes, which will include meaningful consultation with relevant practitioners and funders.
  - 50.5. Set up committees or other processes as part of the research function to advise on best practice for particular medical

conditions. The SSRH will provide support to enable this research but it will contract out this work if practitioner associations do not fill this information gap with credible evidence-based guidelines.

50.6. Conduct or contract out health technology assessments to guide cost-effective practice.

50.7. Liaise with the proposed Outcomes Measurement and Reporting Organisation to ensure that practitioners report on health outcomes and use these data for HTA assessments where appropriate.

51. We have recommended the following interventions to promote competitive contracting and a move away from fee-for-service contracts:

51.1. Practitioners who do not want to engage in fee-for-service contracts will be encouraged to enter into bilateral negotiations with funders. In this case practitioners will not be bound by the MLNF tariffs as long as the bilateral contracts include a value component, include risk transfer, and are not in contravention of the Competition Act. Both funders and practitioners will be required to submit these contracts to the CMS and the SSRH (respectively) for approval.

51.2. Bilateral negotiations between facilities and funders will continue and facilities will not participate in the MLNF. Facility-funder contracts will have to demonstrate that they include risk transfer, include a value component, and are not in contravention of the Competition Act. Both funders and practitioners will be required to submit these contracts to the Council for Medical Schemes (CMS) and the Supply Side Regulator for Health (SSRH) (respectively) for approval. Within three years the bilateral negotiations between funders and facilities are to focus exclusively on ARM contracting. Contracts between funders and facilities will be approved by the CMS and the SSRH. The submissions to the CMS and SSRH will be confidential.

51.3. Fee for service practitioner networks will be open to any willing provider and will be evergreen, subject to a 3-6-months' notice period by providers seeking to leave a network, or when funders seek to change terms of network. In any eventuality, patients must be protected during these transition periods.

51.4. Value-based contracts with practitioners and facilities may be closed networks because upfront negotiation of contract terms is essential. However, they must also be transparent and be limited to 3 years before new contracts must be initiated.

52. We recommend the creation of an Outcomes Monitoring and Reporting Organisation (OMRO) as a platform for providers, patients and all other stakeholders in the provision of healthcare to generate patient-centred and scientifically robust information on outcomes of healthcare. The OMRO will be an independent, private organisation in which key actors such as providers (doctors and hospitals) and patients co-operate to generate relevant and standardised outcome information for two purposes: to provide practitioners and hospitals with relevant outcome information and ways to improve clinical quality, and, secondly, to provide patients and funders with relevant choice information on health outcomes.

53. In the first phase of its development, participation of providers in the OMRO will be voluntary, but in the second phase, reporting of outcome data by providers will be a condition of receiving a practice number.

54. Separation of the academic and business functions of practitioner associations and formalisation of their role as a registered organisation or juristic person must be introduced.

55. Changes are needed to HPCSA ethical rules to promote innovation in models of care to allow for multidisciplinary group practices and alternative care models so that fee-for-service ceases to be the dominant payment mechanism

56. We have proposed guidelines for Associations to ensure that they are not at risk of potentially anti-competitive behaviour. Further, the various functions of the SSRH such as the forum to establish reference pricing and to set prices for what is currently known as a PMB, and coding and related functions, will provide certainty and guidance which will obviate the need for associations to perform some of their current functions which are anti-competitive.

57. We propose that the HPCSA makes mandatory that curriculums for all health practitioners at both undergraduate and postgraduate level include training to ensure that graduates are aware of the cost implications of their decisions, are able to assess and use HTA findings, and best practice guidelines, and are aware of how health system financing models impact on individual health decisions and on ethics.

58. To increase comparability between schemes and to increase competition in the funders market, we recommend, the introduction of a single, comprehensive, standardised base benefit option, which must be offered by all schemes. It will enable consumers to compare products, reward those funders which are able to innovate to offer lower prices and/or higher quality, and, thereby, both discipline and reward the market.

59. We recommend the introduction of a risk-adjustment mechanism linked to the single, comprehensive, standardised base benefit option to remove any incentive by schemes to compete on risk. Schemes should compete on metrics designed to attract new members, irrespective of their age, health, or risk profile. Regionally-based medical schemes should be allowed through a temporary reinsurance facility to mitigate their exposure to demographic and claims risk.

60. We recommend that scheme Boards of Trustees and Principal Officers should be sufficiently trained and incentivised to ensure that schemes receive value for money from both administrators and healthcare providers, subject to performance-based remuneration.

61. We recommend an active opt-in system for brokers.



# REGULATION OF THE SUPPLY SIDE

Supply side regulator for health

# REGULATION OF THE DEMAND SIDE

Council for Medical Schemes

**Health Services Pricing Unit**

Review contracts to ensure they are value-based contracting

- Must include:
- Risk sharing arrangements
  - Encompass a value (price and quality) component
  - Comply with the Competition Act

**Health Services Monitoring Unit**

Maintenance of the National Health Information Dataset

**Assessment of health technology and interventions for cost effectiveness**

**SAHPRA**  
South African Health Products Regulatory Authority

**PDoH**  
Provincial Departments of Health

**Health Services Planning unit:**

- Licensing Unit
- PCNS unit

Rational allocation & distribution of health resources - deal with inappropriate supply and inequity

**HPCSA**  
Health Professionals Council of South Africa

**OMRO**  
Outcome Measurement and Reporting Organisation

**OHSC**  
Office of Health Standards Compliance

Inspections and certification

**FACILITIES**

Issue practice code numbers to facilities

**FUNDERS**

Negotiate & Contracting PPN metrics

**PRACTITIONERS**

Ensure contracts meet ethical rules

Issues practice code numbers

Negotiate & Contracting PPN metrics

Rational allocation & distribution of health resources - deal with inappropriate supply and inequity

Continuing with existing functions

- Review of PMB Regulations
- Review of scheme governance
- Improving anti-selection measures

Introducing & review a Standardised Benefit Package

Risk Adjustment Mechanism and Income cross subsidisation (development and management)

- Review contracts to ensure they are value-based contracting
- Must include:
- Risk sharing arrangements
  - Encompass a value (price and quality) component
  - Comply with the Competition Act

Run tariff negotiating forum

**Legend:**

- Regulatory Bodies
- Stakeholders
- - - Consult/Have relationship with
- Nature/Purpose of regulation
- Currently independent but eventually to be incorporated into the integrated supply-side regulatory function





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