REVIEW

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# The Health Market Inquiry and its potential contribution to improving health systems functioning in South Africa


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The HMI found that private health care in South Africa is characterised by high and rising costs in a predominantly fee-for-service market, with little innovation, and that large profit-making players were not challenged by new entry into the market or disciplined by losing custom.

In 2014, the Competition Commission of South Africa instituted a market inquiry into the South African private health sector in order to ascertain whether there were features or a combination of features preventing, distorting or restricting competition. Adjustments were made to the provisional report of the Health Market Inquiry (HMI) based on stakeholder input, and the final report was released in 2019.

The HMI found that private health care in South Africa is characterised by high and rising costs in a predominantly fee-for-service market, with little innovation, and that large profit-making players were not challenged by new entry into the market or disciplined by losing custom. Increasing health care consumption, over and above that which can be explained by disease burden and acuity, were found to be driving increased hospital admission rates and rising costs.

The findings of the HMI were reported in three categories: facilities, practitioners and funders, each of which is described below. The focus of the chapter is on selected system-wide recommendations relevant to more equitable health-systems development in South Africa.


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## Introduction

Market inquiries are a general investigation into the state, nature and form of competition in a market; they explore the incentives operating in that market, how those incentives drive market behaviour, and whether the market benefits consumers or not. In a health market that benefits consumers there is effective competition in the market based on price, quality and health outcomes. While there is much debate around whether health care should be a commodity and whether economic market analyses can be applied to healthcare provision, health care is nonetheless sold in the private sector and private beneficiaries are estimated to consume approximately 40% of healthcare benefits annually,[1] while representing only 15.5% of the population.[2]

In 2014, the Competition Commission of South Africa instituted a market inquiry in terms of section 43B(1)(i) of the Competition Act[3] to investigate whether there were features or a combination of features preventing, distorting or restricting competition in the private health sector.[4] The resultant Health Market Inquiry (HMI) released two reports, with the findings described at length in the provisional and final reports.[5,6]

The HMI process involved significant engagement with stakeholders, and there was agreement across the board that intervention of some kind is required. Multiple market failures were found, requiring government intervention to ensure that consumers are protected.

## Summary of the HMI findings

The HMI found that private health care in South Africa is characterised by high and rising costs in a predominantly fee-for-service market, with little innovation, and that large profit-making players were not challenged by new entry into the market, or disciplined by losing custom. Rising costs, in particular in the hospital market, were found to be driven by increasing hospital admissions. The practitioner market was found to be over-serviced, and in both markets, factors other than disease burden and acuity were found to be influencing levels of utilisation.

The findings of the HMI were reported in three categories: facilities, practitioners and funders, each of which is described below.[a]

### Facilities market

The HMI found that the facilities market was dominated by Netcare, Mediclinic and Life Healthcare, which collectively own 83.1% of the hospital beds in the private sector and accounted for 86.9% of admissions from 2010 to 2014, with each group individually accounting for about one-third of the market.

The HMI noted that the dominant hospital groups did not seem inclined to compete vigorously with each other; used their market share to negotiate better per-day rates with purchasers (schemes and administrators); and recorded consistent year-on-year profits. The three big companies are also able to dominate the market by offering doctors, who have admission rights over patients, attractive packages to practise in their facilities, thus indirectly influencing admission rates. The implication of this is that larger hospitals out-compete small hospitals by attracting doctors who then admit patients into their facilities.

### Practitioners

No accurate database exists on the number of practitioners active in the private sector. Using claims data, the HMI found that there are 1.75 private practitioners per 1 000 insured population. While general practitioners (GPs) are evenly distributed across the insured population (just under one per 1 000), specialists are concentrated in provincial capitals and metropolitan areas. Most doctors work in solo practices, except for single-discipline group practices such as radiologists, some anaesthetists, and corporate pathology groups. Multidisciplinary groups that allow for up- and down-referral are notable by their absence. This kind of organised care is not well supported by funders and some practitioner associations and is limited by the current Health Professions Council of South Africa (HPCSA) ethical rules. Fee-for-service is almost ubiquitous. Following on the ruling by the Competition Commission that collective bargaining between funders and practitioners was anti-competitive, and the failure of the National Department of Health (NDoH) to establish a workable reference pricing system, there has been what has been described as a "price (reference) vacuum".[6] Practitioners have indicated that the prohibition on collective bargaining has meant that they cannot meet without risk of sanction. Nonetheless, they co-ordinate how they use and define codes, which are the basis for charging. Coding is also out of date, and unilateral code changes have taken place. A competition analysis of practitioner associations suggested that they engage in quasi-collusive behaviour. Practitioners either do not know about or flout the law regarding co-operation between private sector players.

Using detailed medical scheme claims data from 2010 to 2014, it was found that hospital admission rates increased by 1.99% per year. The HMI compared the total days of hospital stay per person per year in South Africa with available Organization for Economic Co-operation and Development (OECD) datasets, covering 17 high-income countries. The citizens in the comparator countries had universal coverage through publicly funded national health or insurance schemes and thus were expected to have similar or greater access to care compared with the insured population in South Africa. Not only

a Facilities: This included private hospitals only. Practitioners: The analysis was restricted to doctors, both general practitioners and specialists, while recognising that the term 'practitioners' includes other health professionals such as physiotherapists, dentists, etc. Funders: This included not-for-profit medical schemes, for-profit healthcare administrators, and managed care organisations.

have South African age-standardised rates of admission risen over time, but they are higher than those in most of the OECD countries for which complete data were available, as shown in Figure 1.

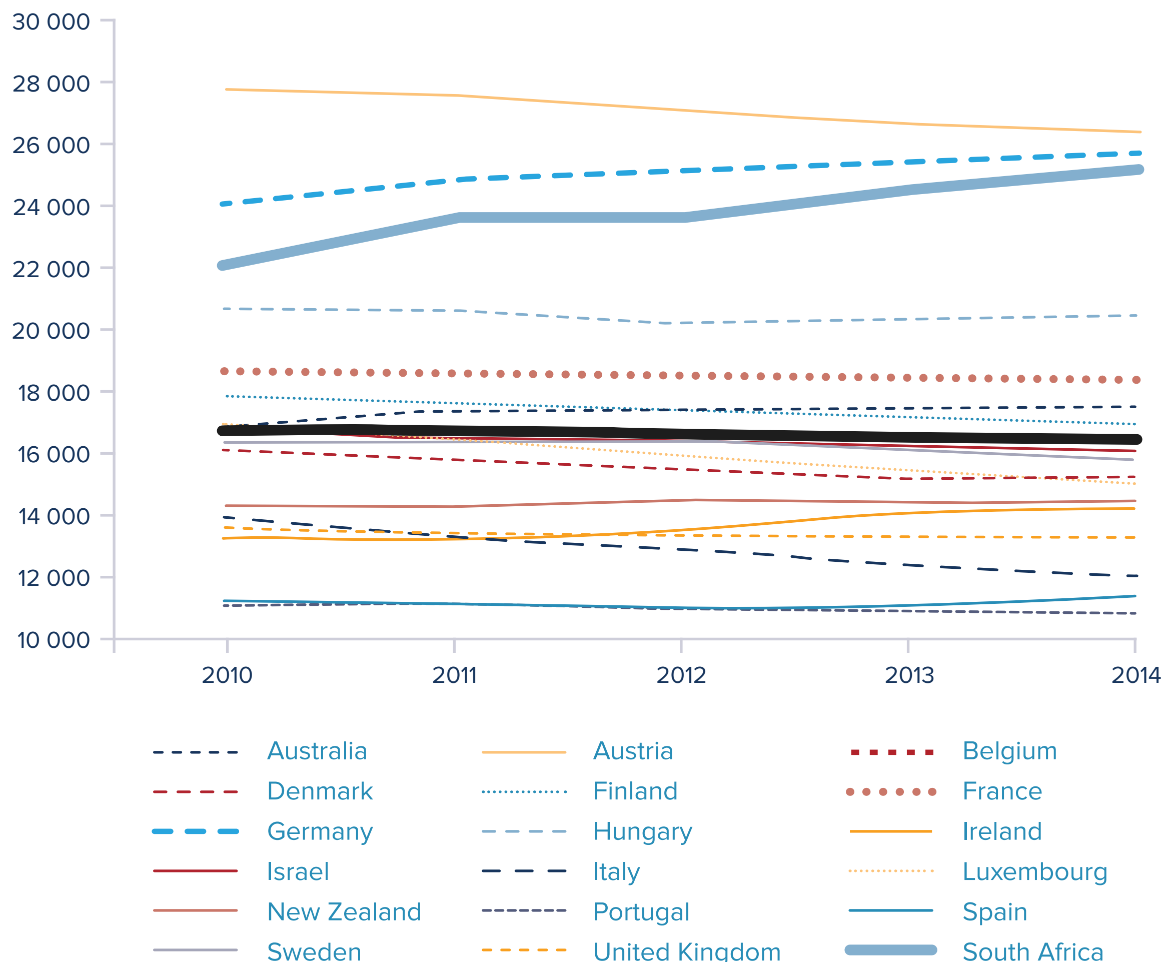
The HMI also investigated the relationship between the concentration of specialists and the number of hospital admissions; in general, it found that the higher the concentration of specialists, the higher the admission rates. This is a phenomenon known as supply-induced demand and is common in many, if not all, healthcare markets.

Age-standardised intensive care unit (ICU) admission rates in South Africa were found to be higher than in all eight countries for which there were comparable data. If the ICU admission rate per head of population was reduced to half its current level, and if half of the costs associated with these avoided ICU admissions were reinvested in better ward-based care, approximately R2.7 billion would still be saved annually – just over 2% of private healthcare spending overall for the period studied. The HMI also found that there was a positive correlation between the risk of admission, and the existence of more ICU beds.

## Funders

The funder market, schemes, administrators and managed care organisations, also respond to the incentives framing its operations. Incentives include that no-one may be refused membership of a medical scheme if they can pay the costs (open enrolment), and that they have to be charged the same fee as others joining that option (community rating), which cannot be based on health status. They can be charged a late-joiner penalty if they have not been a member of a medical scheme for a number of years. If joiners have not been beneficiaries of a scheme before, they may be subject to a waiting period (of some months) for pre-existing conditions. This is to make up for the loss that schemes experience if people join only when they are sick and know that they will need care (referred to as anti-selection). This approach is to ensure social solidarity, i.e. the healthy cross-subsidise the sick.

Figure 1: Age-standardised hospital admission rates for the South African private sector and a subset of 17 OECD countries, 2010 - 2014




Source: Health Market Inquiry, 2019.[6]
OECD = Organization for Economic Co-operation and Development.

In almost all jurisdictions with open enrolment and community rating, scheme funds are reallocated to standardise the risks. Thus, a scheme that has people in it who are more ill than the average would receive a net income from other schemes. Governments aim to equalise the risk between schemes by creating a risk-sharing mechanism in order to reduce the incentive for schemes to compete for members on a risk basis. In summary, a virtual fund is formed, pooling all income from all schemes; money is then paid into schemes where risk is on average higher than in other schemes.[7]

Although South Africa has explored this policy option, it has not been implemented. There is evidence that South African funders have competed to get younger, and thus healthier, people to join their schemes. They have also created a large number of benefit options so that members are forced to risk rate themselves; less healthy people choose higher-cost schemes. Schemes and administrators have claimed that they do this to increase choice and meet the market's diverse needs; however, the HMI was not in agreement with them. The HMI found that funders have not negotiated vigorously with the supply side of the market. Hospitals are very concentrated and practitioners (in particular specialists) can, to a large extent, set their own income, in particular when it comes to the ruling that prescribed minimum benefits (PMBs) must be reimbursed in full. Rather, funders have either passed on extra costs to their members, and/or have limited the range of services that are reimbursed. The HMI concluded that a risk-adjustment mechanism is essential to address this problem. The HMI has also recommended a single identical base benefit package that every scheme has to offer and all medical scheme members have to buy.

The HMI found that there was insufficient transparency in the private healthcare market, and that consumers cannot understand what they are buying; as such they are unable to compare what one scheme/option is offering against another. This is compounded by the high number of options available. To address this problem, the HMI has recommended that every scheme offer one base benefit package that everyone has to purchase. In this way, members can compare between schemes, and this mechanism will force funders to negotiate vigorously with suppliers.

Another policy option that often accompanies open enrolment, community rating and risk equalisation is mandatory membership. The HMI supported this idea, in principle, but recommended that it only be introduced once the other incentives such as fee-for-service, a new tariff regimen, the single base package forcing changes on the supply side, and transparency on value had taken effect and changed the behaviour of market players. Once the market was able to demonstrate its ability to move towards pro-consumer competitiveness, mandatory membership could be considered. This is an incentive to the market to improve its competitiveness.

The Inquiry found that while one-on-one tariff negotiations between funders and hospitals are practical, there is a need to change from a fee-for-service basis to alternative payment models that include real risk transfer.

Networks are a mechanism whereby a medical scheme negotiates with a hospital group for the group's hospitals to be part of the recognised scheme network. Those hospitals charge a known rate for members of that scheme and do not charge the scheme member a co-payment. These networks have shown some limited benefit and need to be encouraged further. However, negotiations between funders and practitioners are not practical; there are too many practitioners, and a new system is required that is consistent with competition law and that will not result in a stalemate or extended legal challenge.

One of the fundamental requirements of an efficient market is that purchasers receive value, which is a combination of cost and quality. In South Africa, there is little publicly accessible information on quality, and no information on health outcomes. Patients do not know whether the intervention prescribed is on average associated with improved health outcomes, whether their doctor or the hospital that the doctor is admitting them to is of higher or lower quality than another, and whether one doctor gets better outcomes than another. Even doctors themselves cannot know if they achieve better outcomes than their peers.

The excessive utilisation driving healthcare costs in South Africa could theoretically be justified if it was resulting in very significant positive health outcomes at an acceptable cost, but there is no way to assess this. The HMI noted this as an important and urgent gap to fill.

## Recommendations

The section below details some of the system-wide recommendations of the HMI which are relevant to the development of equitable health systems.

### Demand-side regulation

The HMI recommended that the functions of the Council for Medical Schemes (CMS), which already exists as a demand-side regulator, be extended, and that the CMS review of PMB regulations (to ensure that these include primary care functions and that they are provided out-of-hospital when appropriate) should continue. Defining the new base benefit package in consultation with stakeholders, which all schemes must offer, was also an important task recommended for the CMS. This intervention will dovetail with work required to define a basic package for the NHI.

### New tariff negotiation regimen

A new tariff negotiation regimen has been recommended, which requires that the CMS review and approve funder-hospital and funder-practitioner contracts. This is to ensure that three conditions are met in bilateral contracts: that they are negotiated on the basis of value (that is price and quality); that they include risk transfer components; and that they are in line with competition law. The recommendation indicates that hospital-funder contracts change to value-based contracts within a two-year period. In the case of practitioners, it is expected that this may take longer to achieve. This is a major lever to move the market towards alternative reimbursement models.

The HMI has recommended that the CMS re-establish its risk-adjustment capacity and set in place the processes required to set up a risk-adjustment mechanism (RAM), which includes income cross-subsidisation. Fundamentally this involves the administrator of RAM (the CMS in the initial stage) developing relationships and memorandums of agreement with key stakeholders such as the South African Revenue Service (SARS), National Treasury, the NDoH, administrators and medical schemes, and the financial sector to integrate both risk and income in the subsidy. The shadow Risk Equalisation Fund process showed that approximately 80% of variation in risk can be attributed to age and gender alone. As age is correlated with income, implementation of a RAM would mean healthy, younger, low-income individuals would be subsidising higher-income groups. To avoid this, the HMI recommended that the current tax credit regimen be reconstituted to take the form of a subsidy. All medical schemes, both open and restricted, must by law be required to belong to the RAM. Legislation will need to be changed to allow the administrator of the RAM to develop a database of all insured beneficiaries and the relevant demographic information to determine the prospective risk status of each beneficiary. Similarly, information on members' income needs to be obtained, stored securely, and subject to suitable confidentiality provisions.

An operational RAM will remove the incentive for schemes to compete on risk and this will be further entrenched by the single comparable base-benefit package. This will drive competition on the supply side of the market, which will force greater efficiency.

## Supply-side regulation

### Negotiation of prices and contracts

The HMI has identified a number of inadequacies on the supply-side of the market. To tackle the fundamental problem of tariffs, the HMI has recommended that a multi-lateral negotiating forum (MLNF) be set up that sets the terms of and oversees tariff negotiations between practitioners and funders. The benefit of this will be that because it is set up under the auspices of the Competition Act, parties will have to share information beforehand. This will reduce the information asymmetry that currently exists in practitioner-funder price determination. It will also set in place a new deadlock-breaking mechanism whereby an independent arbitrator will determine the price if no agreement is reached. As it will not be permissible to present new information to the arbitrator, this will encourage parties to come to the negotiation with their best offer, and avoid court delays. The forum will set a maximum price for PMBs, which will reduce the space that practitioners have to set the degree of intervention and thus their related income in the current 'payment-in-full' scenario. Government would benefit by participating in this process as some conditions will always require a fee-for-service option. It will introduce government to a form of negotiation that it has as yet not had to participate in.

This funder-practitioner negotiation system proposed by the HMI also sees a place for bilateral negotiations between funders and collectives of practitioners who want to negotiate using an alternative (i.e. not a fee-for-service) method of payment, such as a capitation system, using a multidisciplinary team. This leaves room for innovation in the market.

### Licensing as an effective regulatory tool

Licensing of hospitals is currently the only direct form of regulation of the hospital sector, and the HMI found it to be irrational, inconsistent, and insensitive to competition issues. Licensing has not taken into account the population needs of the area where the hospital services are being proposed; the effect of the proposed hospital on supply-induced demand; the impact that hospital provision may have on meeting needs beyond the private sector as public purchasing becomes a possibility; and the impact on utilisation of the type of beds approved (e.g. ICU beds and acute-hospital versus day-hospital beds).

The HMI also identified a missed opportunity in the licensing system, namely to link annual licence renewal to reporting requirements that are essential to manage the health sector. The HMI recommended that reporting should include quality indicators, occupancy rates, bed types, and listing of service providers (including if any service provider is also simultaneously employed in the public sector).

The HMI's licensing proposals are detailed and stipulate who should be on the licensing committee, and how licensing should be approached in a two-phase process to prevent issuing of evergreen licenses that are never realised or that are sold on; the proposals are also mindful of the role of the Office of Health Standards Compliance (OHSC) in accrediting hospitals, and the role of provinces in oversight. Licensing is currently separate from OHSC approval, and the OHSC indicated to the inquiry that private hospitals were not cooperative. Including OHSC certification as a prerequisite for annual licence renewal would create an incentive for private hospitals (and private providers who operate from their own premises) to comply. The HMI therefore proposed that continued licensing be conditional on annual reporting, and that this be a lever used to ensure compliance of private hospitals with regulatory requirements. The HMI

also considered the skills and resources required to run a rational and efficient licencing regimen and envisaged quite broad membership, with specific roles ascribed to each member.[6] Duplicating this function in each province is wasteful, and in all likelihood not possible. Therefore, a single national body is proposed, with representation from the province where the licence is being applied for. This will ensure a well-resourced licensing system and take provincial concerns into account. This integrated approach of public and private players and regulators will set the basis for rational decision-making across the entire health system and move the systems closer towards the unity ultimately envisaged. The current approach has been inconsistent, but evidence presented to the HMI also indicated that provinces were unable or unwilling to oversee the private sector. Provinces were reported to be resistant to demanding, collating or reporting on private hospitals. Ignoring the private sector in this way makes specialist entry into the private sector too easy, to the detriment of the public sector, ignores mechanisms for managing abuse of remuneration of work outside of the public sector (RWOPS), and allows unmanaged proliferation of hospital beds, which exacerbates the nursing shortage, in particular with regard to ICU nurses.[8,9]

### The practice code numbering system

The entire reimbursement system in the private sector relies on practice codes. This, too, presents an important opportunity to promote quality and to have a method of describing the physical health resources in the country. The HMI has recommended that both doctors' surgeries/rooms as well as hospitals be given a practice code number conditional on achieving OHSC certification. As providers will not be able to be reimbursed without such a number, this will be useful as a lever to promote compliance. It will also allow the NHI Fund, once it begins to purchase, to know where both GP and hospital resources are located and have some reassurance of minimum quality standards being met.

Individual private practitioners (including but also beyond GPs and specialists) must have a practice code to bill; thus, this can be a lever to induce reporting, which any health system needs in order to plan and protect the public. This requires that the current Practice Code Numbering System (PCNS) for individual providers (as opposed to their premises) be revamped into an intelligent number system with annual reporting by practitioners so that physical location, area of speciality, full/part-time status, and concurrent employment in the public sector can be codified. The HMI recommended extending this requirement to both public and private providers so that all providers are inducted into a system where obligatory reporting on outcomes is routine. This will provide a national practitioner resource picture for the country, and the PCNS would become a public good in the public domain, overseen by a public entity. It will also require close collaboration with all statutory health profession council regulators to ensure that each applicant is compliant with the requirements of his or her professional body in order to practise.

### Coding of healthcare interventions

The HMI found that the current billing system, where interventions are converted into codes, was out of date and subject to manipulation, and that investment and national standardisation of codes are required. The HMI has recommended that this be undertaken by rational and disinterested parties.[6] This is a public good and should be identical across the public and private sectors. It therefore makes sense that it is managed by a trusted body that consults appropriately in setting up and renewing codes. Existing mechanisms to do this in either the public or private sector can be brought together under a supply-side regulator.

## Value-based purchasing

The only way to assess if an intervention is worthwhile is to assess whether it improves health outcomes, to know the costs, and to make an assessment as to affordability. Two component parts contribute to this. One is health technology assessment (HTA), a term that embraces more than just single interventions or technologies, but also includes assessment of whether different modes of delivery (for example) are more cost-effective. This is a missing element in our healthcare system, both public and private, and the HMI has recommended that it be established and add value across both sectors. The HMI is cognisant that the safety and registration of products is the ambit of the South African Health Products Regulatory Authority (SAPHRA), which can provide the HTA system with information as required. The HTA function can be homed in a supply-side regulator for healthcare (SSRH) that serves both the public and private sectors.

The other component is outcomes monitoring. This is different from satisfaction surveys or process measures. Outcomes monitoring can indicate if an intervention improves patient wellbeing. It is important, in particular but not exclusively from a competition point of view, in order to purchase on the basis of value. Outcomes measurement can improve the sensitivity of HTA. It also allows healthcare providers to benchmark themselves against their peers, and makes rational planning possible. Again, this is an essential missing component in both the private and public healthcare sectors. But different from all the other interventions listed thus far, experience has shown that this is best embraced outside of a regulatory environment.[10] The HMI made a detailed recommendation (in Chapter 8 of the final Report)[6] that a practitioner-led, patient-oriented system be instituted, initially on a voluntary basis, but ultimately as a reporting requirement to entitle practitioners to receive a practice number.

## A supply-side regulator

There is no doubt that supply-side regulation is required. While there is consensus that regulation is required, the notion of a new regulator is not universally supported. The HMI considered this in great detail and concluded that to give coherence to the system, a SSRH is essential. This structure will house and coordinate the multiple

regulatory functions essential to improving the efficiency and effectiveness of the private health market. As already noted, aspects of its work are relevant to the public sector, in particular systems to ensure quality and health outcomes reporting, and having up-to-date accurate information on the location and number of providers (both individuals and types of beds) benefits health-service planning at a national level. The SSRH will also provide skills and expertise and some requirements that are valuable to the public sector and that can support value-based purchasing. The oversight of contracts is the most obvious example. In rationalising the supply-side of the market, the HMI took note of the OHSC and its intended role in both the public and private sectors, as well as the existing efforts of the NDoH in setting up HTA capacity. These two functions, namely quality control and rational resource use, are important to the public and private sectors. Thus the HMI does not envisage an increase in the total number of regulators, as the OHSC, with some extended functions, will be part of the SSRH. Rather, the HMI recommends that existing supply regulatory efforts already underway be incorporated within a single body. This coincides with the cost-saving measures indicated in the 2019 mid-term budget policy as the SSRH would consolidate and merge entities; however, it also contradicts the mid-term budget policy as the HMI proposes an extension of regulatory functions.[11] Nonetheless, the regulatory absences identified by the HMI, if implemented, would increase pro-consumer competition in the market, and the same mid-term budget policy noted the relationship between competition and growth.

The HMI argues that the establishment of the SSRH is in the best interests of the health system overall, especially taking into account the long-term view of the possible system changes. The HMI has argued that enhancement of the mandate and relocation of the OHSC within the SSRH would mean that there is no net change in the number of regulators. Incorporation of the OHSC into the SSRH would also give the OHSC the independence that was envisaged for it. Moreover, it would provide a home for the HTA functions already envisaged by the NDoH, and within the SSRH this function can and should serve both the public and private sectors. Importantly, the proposed HMI regulator will achieve two additional things. Firstly, by making this both a public- and private-sector function there is an opportunity to fund this function in part through a levy. Secondly, the governance structure proposed by the HMI will ensure independence from vested interests, both public and private.

Furthermore, to achieve the supply-side regulation, which almost all stakeholders agree is urgently required, through any other mechanisms is likely to require as many legislative changes and incur similar investments without the same coherence. A single regulator will avoid duplicate investment in funding, administration, management and governance. An independent SSRH will enjoy greater credibility and enhance decisions on purchasing that are made for the NHI Fund and for the private sector. This new regulator, set up within the governance format proposed by the HMI,[6] will likely minimise risk and build trust.

## Additional recommendations

The HMI has made additional recommendations, including to the HPCSA about their ethical rules, and through them to health-practitioner training institutions and to the Competition Commission, as well as detailed recommendations on the nature of contracting in the private healthcare market. This chapter has highlighted those recommendations that are system-wide and relevant to more equitable health systems development in South Africa.

## Linking the HMI recommendations with the NHI Bill

Full implementation of the NHI is scheduled for 2026. This is ambitious, government has indicated that it is not immediately affordable,[11] and the Act may face legal challenge. Government's responsibility is to oversee the entire health sector. The HMI has identified, among other things, that inadequate or inappropriate regulation of the private sector has allowed it to develop uncompetitively to the detriment of consumers. The inefficient private sector draws resources, in particular human resources, to the detriment of the public sector. Attention must be given to furthering the ambitions of the NHI Bill, and a number of recommendations from the HMI promote this.

The missing regulatory functions described above are relevant to both the public and private sectors. Setting them up now in light of the HMI recommendations, and using the governance and funding processes recommended, will create institutional capacity for both sectors. The CMS and SSRH contract-oversight mechanisms to ensure that contracts (public-private or private-private) are value based, and that they include risk transfer and are compliant with the Competition Act, will shift the negotiating terrain to one of value purchasing, and could provide a method to ensure that contracts are not skewed by vested interests, public or private. This would provide some guarantee for both private and public healthcare users that contracts are delivering value, and will built trust. At the point that the NHI Fund begins to procure healthcare services they will engage with private providers who are more comfortable with value-based purchasing, but the brunt of forcing that change will be borne by the private sector.

Similarly, setting up the HTA functions, the new licensing regimen, and developing a national procedure coding and practice number system is urgent and of benefit to both

sectors. Locating these in an independent supply-side regulator is desirable as it could be co-funded by a levy system and provide a governance model that engenders trust. The single base-benefit package must have a transparent logic that drives prioritisation; the same is true of the NHI package, and having a single approach to prioritisation gives credibility to both systems and begins to align them.

Protection of the Competition Act provides advantages. Without it, even if government were to set prices, providers (hospitals and practitioners) can collude legally. Obligatory sharing of information, in particular on occupancy rates as one example, is important information for both parties to know when negotiating hospital rates.

While the RAM appears to contradict the single fund, in the interim it presents many opportunities. Beyond its competition function, it allows for income cross-subsidisation. The active and willing participation of the private sector in the shadow risk equalisation process indicates that a RAM is possible and that the skills in running it can be reassembled and extended. Even it if is managed as a separate entity, over a period of five years the RAM may well be in a position to transfer funds in a transparent and managed way, on a risk-adjustment basis, into a national fund that purchases on behalf of public-sector users. This may present a more efficient and acceptable method of pooling funds and ensuring cross-subsidisation.

## Conclusion

The HMI recommendations are not in opposition to realisation of the ambitions of the NHI Fund. Adopting the HMI recommendations can build a range of institutional and individual capacities to manage healthcare provision in South Africa. The funding mechanism and governance proposed deal with some of the governance concerns that are central to the current critique of the NHI Bill. In addition, oversight of contracts between purchasers and providers is a strength (be they public-private or private-private contracts). The HMI recommendations also provide an opportunity to build national capacity for a more rational healthcare system in South Africa by using both public and private funding. The uncontrolled and irrational (not aligned with population health needs) growth of the private market is an obstacle to achieving the aims of the NHI Fund.

## Conflict of interest

Three authors (LN, NB, and SF) were panel members on the Health Market Inquiry, and one (MR) was a member of the HMI technical team and the Inquiry Director.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