

## DECLARATION

This serves to declare that the title 'The Challenges of Standardisation of Pricing in Private Healthcare in South Africa'

Is my own original work and where other sources or works of other authors have been used, I have acknowledged the use of such sources by highlighting within text or at the back of my document in the Reference list.

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Thanks to our senior, Dr William Oosthuizen who tutored us with perseverance and good temper till the end.

Dr Jimmy Mmathate Selesho

# **The Challenges of Standardization of Pricing in Private Healthcare in South Africa**

## **Abstract**

The aim of the study is to analyse the challenges faced by different stakeholders in the standardisation of prices in private healthcare in South Africa. The definition of pricing is discussed, and the pricing models used by both the public service and the private healthcare sector are explored and compared. Different legislation applicable to healthcare is analysed, including the envisaged National Health Insurance. The study looks at how medical schemes have found a way of controlling pricing through legal concepts designed by the government, concepts such as the Designated Service Providers and Managed Care Protocols.

Future plans aimed at reaching consensus in the setting of prices is also discussed, including the government's Discussion Document: The Determination of Pricing in the Private Sector.

The study also looks at how the courts have become the role players in the arguments about the pricing of private healthcare. Each chapter is set on its own topic that deals with a specific section of the topic. There is an introduction to each chapter, ending with a relevant conclusion at the end. Where Abbreviations were used, the abbreviation is usually preceded by the full meaning of the letters in order to reduce the size of the document.

## **Limitations**

The subject has limited literature sources, information is scattered and collected in bits and pieces, private sector organisations lack unity in matters of pricing, maybe because of competition laws.

Health and medical case law facts are so sequential such that quoting end up looking too verbatim. Omissions of other facts is very difficult as the cases are usually based on a sequence of events. Chapter 5 has been especially challenging since much of the information is based on a document yet to be implemented by the government, the private sector is still quiet about matters of pricing at the moment

Division of the subject into chapters has been very challenging, with some of the subsections overlapping.

## KEY TERMS

- ❖ Balanced Billing
- ❖ Charge
- ❖ Coding
- ❖ Co-morbidity
- ❖ Competition
- ❖ Consultation
- ❖ Consultation
- ❖ Co-payment
- ❖ Cost
- ❖ Gap cover
- ❖ Healthcare service provider
- ❖ Healthcare user
- ❖ Out-of-pocket payment
- ❖ Price
- ❖ Purchaser
- ❖ Seller
- ❖ Stakeholders
- ❖ Transparency

## **INTRODUCTION AND GENERAL CHAPTER OVERVIEW**

The study is divided into five chapters, with each chapter having its own introduction and conclusion.

Chapter 1 deals with pricing and the applicable concepts and models in both the public and private sector. The study however, focusses on the private sector, mention of the public sector is mainly comparative.

Chapter 2 deals with coding and classification of healthcare conditions and the importance of using codes to describe healthcare conditions. The chapter also looks at the legal challenges posed to the billing and pricing codes.

Chapter 3 looks at how medical schemes use some of the legal concepts within regulations of healthcare legislation to control pricing, and how some of the concepts like the Designated Service Providers are challenged by private healthcare organisations on ethical grounds.

Chapter 4 looks at the legislation that can be explored for the purpose of setting prices, and also the legal challenges that have been met by the government in its objective of trying to regulate pricing in private healthcare. The two main legal challenges discussed are the ones concerning the Reference Price List and the Single-Exit price.

Chapter 5 deals with the future plans aimed at negotiating or regulating pricing in private healthcare. The government's Discussion Document : Determination of pricing in private healthcare is discussed, although the documents is still a mere plan which lacks any legal impetus at the moment.

All chapters end with a conclusion that is related to each individual chapter

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## CHAPTER 1

### **What is Pricing in Healthcare?**

#### **1. Introduction**

The pricing of healthcare services is very important to the allocation of appropriate budget and resources by the funders of healthcare.

Section 2 of this chapter looks at the pricing concepts and definitions that are or can be applicable in healthcare. Legal and illegal billing methods are explained together with the applicable legislation.

Section 3 discusses the factors that influence pricing decisions in healthcare, factors that include, but not limited to the following:

- The nature and characteristics of the health condition;
- The nature and characteristics of the healthcare user;
- The nature and characteristics of the healthcare service provider;
- The duration of the service;
- The place where the examination and treatment takes place;
- The time on which the service is carried out;
- The method and the instruments used to carry out the service; and
- The seller-purchaser perceptual differences.

Section 4 compares the two different pricing models applied in the public and the private health sector. The section discusses the constitutional obligations of the two sectors of healthcare to the South African nation. The classification of patients in the public service is summarised, using text from government sources. The private sector has two main divisions of healthcare users, cash-paying users and medical scheme members, however the main focus is on the medical scheme sector regulated by the Medical Schemes Act No. 131 of 1998.

A short summary of the coming National Health Insurance (NHI) is also included, with special emphasis on the medical schemes and their future in South Africa, and how the NHI is structured to change and regulate pricing for both public and private healthcare in South Africa.

Section 5 summarise the possibility and outcomes of capping prices in private healthcare. The concept of capping is not popular in South African healthcare literature.

Section 6 is a summary conclusion of the chapter.

#### **2. Pricing concepts.**

Pricing in healthcare is very difficult to set and implement, usually it can only be stated as an estimate. For example when a patient is admitted to hospital, the pricing on admission to a normal ward and that to the intensive care unit are very different, and at admission it may not be known where they will end. In South Africa at present, medical schemes seem to be controlling the price of healthcare in the private sector, especially through designated service provider contracts, whereas other service providers like

private hospitals and specialist practitioners charge extra fees called co-payments to healthcare users to cover for the short-fall of the price paid by medical schemes. Under normal circumstances, the seller usually controls the price, but it is not so in private healthcare. The healthcare user is often confused by what is being charged in private healthcare, how much is charged and who must pay what in the charge.

Preker and others describe four core policy questions relevant to resource allocation and purchasing decisions in healthcare.<sup>1</sup>

1. For whom to buy?
2. What to buy, in which form, and what to exclude?
3. What price to pay and how to pay (prices and incentive regime)?
4. From whom to buy, at what price, and how much (factor and product markets)?

As healthcare users face increased exposure to increasing healthcare costs, an urgent need for a meaningful and transparent price information becomes necessary. To the healthcare user, the healthcare provider, the healthcare funder and the employer, the words charge, cost and price might have different perceptual meanings.<sup>2</sup>

In order to simplify the analysis, it is better to define and explain some of the applicable terms and concepts in this chapter.

**Charge:** the rand amount a provider sets for services rendered before any negotiable discounts. The charge can be different from the amount paid.<sup>3</sup>

**Cost:** the definition of cost varies by the party incurring the expense:

- ✚ To the healthcare user, cost is the amount payable out of pocket for healthcare services.
- ✚ To the provider, cost is the expense (direct and indirect) incurred to deliver healthcare services to healthcare users.
- ✚ To the insurer or medical scheme, cost is the amount payable to the provider (or reimbursable to the user) for services rendered.
- ✚ To the employer, cost is the expense related to providing healthcare benefits (premiums or claims paid).<sup>4</sup>

**Price:** the total amount a provider expects to be paid by payers and healthcare users for healthcare services provided.

**Consultation:** in the healthcare industry, a consultation is the process of seeking advice or help from a healthcare service provider regarding the nature of a medical condition, injury or state of poor health, what it is, how it can be treated and what the treatment implications are.<sup>5</sup>

**Co-payment:** the amount a healthcare user pays as the difference between what the healthcare user has charged and what the medical scheme has paid or is prepared to

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<sup>1</sup> Waters H and Hussey P, Pricing Health Services for Purchasers: A Review of Methods and Experiences, September 2004, HNP/ World Bank, 1.

<sup>2</sup> Report from the HFMA Price Transparency Task Force: Price Transparency in Health Care, 2014, HFMA, 1.

<sup>3</sup> Supra (n2) 1.

<sup>4</sup> Supra (n2) 1.

<sup>5</sup> Author's own submission.

pay. There are insurance companies that have seen an opportunity in this concept by providing covers they call gap or short-fall covers.

**Gap cover or short fall payment:** these are payments made by short-term insurance companies registered under the **Short-Term Insurance Act 53 of 1998**. It is the amount that remains after a medical scheme registered under the **Medical Schemes Act No. 131 of 1998** has paid a service provider. Gap cover policies are only sold to medical scheme members, and there have been proposals to have them capped at less than R3000 per day.

**Balanced Billing:** it occurs when a service provider sends two identical accounts to the healthcare user and the healthcare funder, informing them of any short fall amount not paid by the funder.

**Split-billing:** occurs when a service provider sends two different accounts to the healthcare user and the healthcare funder with different amounts. Split-billing is illegal in terms of **section 53(1)(b)** of the **Health Professions Act 56 of 1974**. According to these law, healthcare service providers are required to inform the healthcare user about the cost implication of the services before even the services start. Also according to the **Medical Schemes Act 131 of 1998**, a healthcare provider is required to reflect the full cost and nature of the service rendered on all accounts and is not permitted to charge a healthcare user any amount without that amount being reflected on the statement sent to the medical scheme. This implies that healthcare providers need to make pricing of healthcare services very transparent.<sup>6</sup>

Price transparency should empower healthcare users and purchasers to make meaningful price comparisons prior to receiving care. The biggest challenge to healthcare users regarding pricing in healthcare, is that they may not have the time to make price comparisons among healthcare service providers while in the diseased state, and other factors like literacy levels can hamper the attempt to compare pricing.

Standardised pricing eliminates the need for healthcare users to shop around comparing prices, and also removes the need for co-payments. However, standardization of pricing is uncompetitive behaviour according to section 4 of the **Competition Act 89 of 1998**.

Different service providers charge different fees, and different healthcare funders pay different amounts to similar services. After the Competition Commission ruled against unified pricing as uncompetitive,<sup>7</sup> healthcare funders have taken advantage of the ruling by starting to determine their own prices which are negatively affecting the sustainability of private healthcare, especially at general practitioner level.

Healthcare pricing is influenced by a lot of different factors.

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<sup>6</sup> Balanced-billing versus Split-billing, SAMA 2017, 1-2.

<sup>7</sup> {Council for Medical Schemes and Another v South African Medical Association and Others [2015] ZACAC 6 (11 December 2015)}.

### **3. Factors that affect pricing in healthcare.**

#### **3.1. The nature and characteristics of the health\_condition.**

A human body is made up of different systems functioning together to maintain life, and each of these systems is affected differently by any unhealthy condition. For example, the diagnosis, treatment and care of hypertension and diabetes mellitus are very different in approach and handling in all respects. Recovery from these two conditions differs in duration, type of treatment used and type of conservative and lifestyle modification advice given. Conservative and lifestyle advice meaning things like the influence of diet, exercise and other life style issues like smoking and alcohol consumption. Co-morbid issues also have different outcomes in both conditions.

#### **3.2. The nature and characteristics of the healthcare\_user.**

Characteristics like age, body size, race, cultural background, lifestyle, employment and the presence of other co-morbid conditions have an implication on the type of treatment to be used on any individual.

#### **3.3. The nature and characteristics of the healthcare service provider.**

Factors like the level and type of professional qualifications of the healthcare provider, experience, the type of practice and where the provider practices all have an impact on the pricing of healthcare services which such individuals provide. For example a specialist physician would charge different fees to a general practitioner, and the same specialist would charge different fees in a normal ward than in an intensive care setting.

#### **3.4. The duration of the service.**

Some healthcare professionals like clinical psychologists charge their services based on time spent with the healthcare user. Another example is that between a normal ward in a hospital, and a theatre which charges hourly rates for any procedures performed therein.

#### **3.5 The place where the examination and treatment takes place.**

Similar procedures can have different fees charged in the provision of healthcare services, depending on the place where the services are performed, for example a circumcision procedure may charge about R900 in a general practice, while the same procedure may charge up to R4000 in a private hospital set-up.

#### **3.6 The time on which the service is carried out**

The norm in the working environment in South Africa is the 40 hour per week duration, which most companies and government start at 8am to 5pm. Any work done outside this bracket is considered overtime. Private hospitals charge overtime rates to medical schemes for any work done outside the 40 hour bracket. Medical schemes tend to prefer only emergency consultations being done after hours.

### **3.7 The method and the instruments used to carry out the service**

The type of instruments used for specific procedures have an impact on pricing, for example, a laparotomy done by the open abdomen approach and one done by laparoscopy carry different price tags. The examination of a pregnant woman with sonography carries a different price than the one done without sonography.

### **3.8 Seller-purchaser perceptual differences**

Opposing views of the healthcare provider versus those of the funder and the healthcare user have different price implications. Often the funder and the user see the pricing by the provider as unreasonably high, while the provider see the pricing as lower than what is charged.

All the above factors affect pricing decisions and need to be taken into consideration when pricing of healthcare services is planned or standardised.

## **4 Pricing models**

There are quite huge differences in the pricing models used by the National Department of Health (NDOH), as the public service, and that of the private health healthcare sector. It is mainly because the NDOH structured its pricing regulations on its constitutional responsibility as envisaged by **section 27 of the Constitution of South Africa** which states that:

27(1). Everyone has the right to have access to-

(a) Healthcare services, including reproductive healthcare

(2). The state must take reasonable legislative and other measures, within its available resources to achieve the progressive realisation of these rights.

(3). No one may be refused emergency medical treatment.

Although consideration is given to the above sections of the Constitution in the private sector, only section 27 (3) places a legal duty on the sector. The private healthcare sector is a business model based on the sale of services for some profit, and the move to have a unified pricing model is always hampered by the Competition Commission through section (3) of the Competition Act.

### **4.1 Public healthcare services**

As stated above, pricing in the public sector is influenced by the Constitution. The Department of Health is obliged by section 27 of the Constitution to provide healthcare services to everyone in the Republic of South Africa.

In the public service patients are classified into three main groups for the purposes of service fee determination.<sup>8</sup>

a. Full paying patients

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<sup>8</sup> Explanations of the Current Policy regarding Classification of patients, Department of Health, 14 June 2002, 1.

b. Subsidised patients

c. Free services.

### **A. Full paying patients**

This category of patients includes but is not limited to externally funded patients, patients being treated by their private practitioner and certain categories of non-South African citizens. They are liable for the full fees of the Uniform Patient Fee Schedule (UPFS).

### **B. Subsidised patients**

These are patients who do not fall in the category of full paying patients. Subsidised patients are categorised further based on their ability to pay for health services into four categories: H0, H1, H2 and H3. The fees payable by subsidised patients are expressed as a percentage of the fees payable by full paying patients as determined by the latest edition of the Uniform Patient Fee Schedule (UPFS).

The classification of dependants is determined by the classification of their guardians or parents. Subsidised patients are divided into two main groups:

#### **a. Patients qualifying for full subsidisation (H0).**

Patients in this group receive all services free of charge. Patients must provide proof that they have no income in order to be classified into this group. Patients can only qualify for full subsidisation if they are referred to hospital from primary healthcare services.

This is not the default classification for a patient attending a public hospital. Unless proof of status is produced a patient is classified as H1 to H3 depending on income. The default classification for a person without income is therefore H1.

#### **b. Patients qualifying for partial subsidisation ( H1, H2 and H3)**

This is the default group for subsidised patients and the level of subsidisation depends on the assessment of income (frequently called the means test). The income cut-off point between H1 and H2 patients is set at the 80<sup>th</sup> income percentile as determined by Statistics South Africa. This means that 80% of employed individuals earn less than the cut-off amount per annum. Currently this amount is a yearly income of R36 000 for a single person. The cut-off between H2 and H3 is set at the 90<sup>th</sup> percentile, namely R72 000 per annum. Patient earning above this amount will pay full UPFS fees. This is to encourage those individuals to take out medical aid.

Notes:

1. The H1 inpatient fee is expressed as a percentage of 7 days of the UPFS General Ward Inpatient fee to approximate the average length of stay of inpatients in this category. Although the fee calculation is based on 7 days, for H1 patients this fee will be applicable for each 30 days of inpatient stay or part thereof. No differentiation is made on the basis of bed type.

There exist certain circumstances under which patients will receive services free of charge independently of their classification as full paying or subsidised patients. These circumstances have a statutory basis and apply only to the episode of care directly related to the circumstances under which the patient has qualified for free services. Table 5 below summarises the circumstances under which patients will qualify for free services.<sup>9</sup>

### **C. Free services**

1. Pregnant Women and children under the age of 6 years, including non-citizens of South Africa.
2. Primary health care services.
3. Termination of Pregnancy as by the provisions of the Choice on Termination of Pregnancy Act 92 of 1996.
4. Services rendered in terms of the Criminal Procedure Act 51 of 1977.
5. Children committed to a children's home, foster care or industrial school as by the provisions of the Child Care Act 74 of 1993.
6. Persons with mental disorders as described by the Mental Health Act 18 of 1973.
7. Infectious, formidable and/or notifiable Diseases.
8. Other exempt conditions like malnutrition, pellagra or other services determined by a province.
9. Organ donations and related services.

#### **4.2 National Health Insurance (NHI)**

The National Department of Health has formulated a policy document called the National Health Insurance (NHI) which seeks to unify all healthcare funding into one pool. According to the document, the main financial objectives of the policy is intended to manage the following:<sup>10</sup>

- The costly private health sector;
- Escalating costs of medical schemes;
- Benefit design of medical schemes;
- Prescribed minimum benefits;
- Fee-for-service environment;
- Inequitable healthcare financing;
- Fragmentation of funding pools;
- Out-of-pocket payments; and
- Weak purchasing and financing system that punish the poor.

Summarily, the NHI is a healthcare pricing strategy by the government in order to avoid interference by the Competition Commission. According to the document, the government is going to create a purchaser-provider environment where the NDOH is going to purchase healthcare services from private healthcare providers at a fee. The providers would have to be accredited by the Office of Healthcare Standard Compliance through the Certificate of

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<sup>9</sup> Supra (n8) 4.

<sup>10</sup> National Health Insurance Policy: Towards Universal Health Coverage, Department of Health, 28 June 2017, 14.

Need before being given the business of healthcare. All providers shall abide by specific treatment protocols and guidelines promulgated by the government. There shall be one fixed payment for services at primary level of care.<sup>11</sup>

#### 4.2.1 The future of Medical Schemes in the NHI

According to section 308 of the NHI policy document, once the NHI is implemented, the role of medical schemes will change to complementary plans to fill the gaps in the service coverage of the NHI. In order to achieve this, the government has drafted the Medical Schemes Amendment Bill. The Bill seeks to amend the Medical Schemes Act 131 of 1998 in order to align with the NHI. The proposed amendments to the Bill are the following:

- Abolishing of co-payments as designed by medical schemes;
- Control of reserve funds of medical schemes;
- Abolishing of brokers within the medical scheme environment;
- Abolishing of prescribed minimum benefits by replacing them with comprehensive service benefits;
- Abolishing of unequal and unfair benefit options by medical schemes;
- Introduction of fines for any organisation carrying out the business of medical schemes while not registered under the Medical Schemes Act;
- Creation of a central beneficiary and provider registry by the Registrar of the Council of Medical Schemes;
- To introduce an income cross-subsidization model into healthcare;
- To compel medical schemes to pay-back savings if a member uses a designated service provider according to the rules of the scheme;
- Cancellation of waiting periods for new members joining a scheme; and
- To introduce governance requirements that would set minimum education and expertise standards for the Boards of Trustees and CEOs of medical schemes.<sup>12</sup>

The NHI is still on pilot studies and its implementation and proper funding models are yet to be announced.

### 4.3 Private healthcare services

The pricing model applied in private healthcare is very different to that applied in the public serve. There are no free services and no subsidisation in private healthcare. Currently, medical schemes pay different rates for similar healthcare services, and this is partly because of **section 4 of the Competition Act 89 Of 1998** which restricts collusive setting of prices

The following table illustrates the rates paid by different medical schemes versus the rates calculated by Healthman<sup>13</sup>. It can be clearly seen that each scheme pays its own rates.

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<sup>11</sup> Supra (n10) 54.

<sup>12</sup> The Medical Schemes Amendment Bill, HPCSA E-Bulletin 1-2

<sup>13</sup> Healthman's General Practitioner's Costing Guide 2018, HealthMan 1-6.

TABLE 1: **Medical scheme rates versus Health man tariffs** (Adapted from Healthman)

Medical Scheme	Service	Scheme rates		Healthman rates	
		RCF	BASE RATE	RCF	TARIFF
1.Bankmed	Consultation 0190	23.2	348.1	34.4	517.1
2.Bestmed	Consultation 0190	24.1	361.6	34.4	517.1
3.Discovery Health	Consultation 0190	24.2	363.3	34.4	517.1
4.Gems	Consultation 0190	24.1	361.5	34.4	517.1
5.KeyHealth	Consultation 0190	24.6	369.8	34.4	517.1
6.Medihelp	Consultation 0190	24.6	368.8	34.4	517.1
7.ProfMed	Consultation 0190	24.3	364	34.4	517.1
8.Bankmed	Drainage of abscess 0255	13.2	263.8	34.5	689.4
9.Bestmed	Drainage of abscess 0255	13.4	268.9	34.5	689.4
10.Discovery Health	Drainage of abscess 0255	12.9	256.2	34.5	689.4
11.Gems	Drainage of abscess 0255	12.5	250.3	34.5	689.4
12.KeyHealth	Drainage of abscess 0255	13.6	272.4	34.5	689.4
13.Medihelp	Drainage of abscess 0255	13.5	271.6	34.5	689.4
14.ProfMed	Drainage of abscess 0255	12.7	253.6	34.5	689.4

Factors of the perceptual differences between the funders of private healthcare and the providers of services can be deduced from the above table. Price estimates by Healthman, which is an independent private entity, appears much higher than most scheme tariffs, or the schemes' tariffs are much lower.

According to the South African Medical Association (SAMA), significant focus is placed on practice cost studies in South Africa in an attempt to develop reasonable tariff guidelines for services in the private sector. SAMA further states that where practice cost studies are used to calculate tariff guidelines, the tariffs often are based on the stratification of averages across different professions and specialities than not. The averages also include extrapolated costs for healthcare services over different geographical locations where the average income of patients varies greatly.<sup>14</sup> By practical observation, healthcare pricing differs according to arear of services concerning cash paying patients, rural service providers tends to be cheaper than providers in affluent arears. This further emphasizes the fact that the pricing of healthcare also depends on the place where the service is provided.

South Africa has no unified pricing model for private healthcare, due to fragmentation of provider organisations, and the restrictions imposed by the Competition Act.

<sup>14</sup> The true cost of delivering sustainable healthcare services in the private sector – the practice calculator, SAMA 3.

SAMA states that practices have direct and indirect costs which affect pricing, and that the healthcare provider has to be aware of the income potential of the patients in his or her area, including the type of healthcare services delivered, whether essential or luxurious. This statement introduces a need for proper community-based income analytical strategies which shall be difficult to implement. What makes the costing of healthcare services more delicate is that the services should be offered at a cost that makes it possible for patients in a given area to have access to the services.

SAMA states that a pricing model based on the application of averages to calculate tariffs could be used effectively in an active market within a developed country but poses significant challenges when applied to a developing country. The following conditions within the South African healthcare industry represent significant challenges for an average-based-tariff model:<sup>15</sup>

- The forces of supply and demand costing are not active in the South African healthcare industry, as healthcare professionals are not truly awarded the opportunity to set the prices of supply when entering into supplier contracts with medical schemes;
- Principles are most often designed for developed countries, and not for developing countries and are based on the assumptions that:
  - (a) The cost to deliver procedures over a country are purely based on speciality and can be quantified and averaged to deliver a pure Rand Conversion Factor;
  - (b) The demographics of a country and the household income of patients do not have a significant impact on the setting of tariffs and
  - (c) The vast majority of the population earns comparable salaries (South Africa has a very high unemployment rate).

According to SAMA, the tariff model used by medical schemes is based on the claims risk profile, which is based on the number of claims processed during prior periods, the risk of re-occurrence of the number of claims during current periods as well as available funds. This accordingly resulted in medical schemes offering healthcare providers with tariffs which medical schemes could afford, without the providers being able to assess whether they deliver sustainable healthcare services at the offered prices.

In conclusion, SAMA states that a fair value is not below the cost to deliver the service, and where tariffs are offered to healthcare providers that result in a loss, additional fees should be recovered from the patients to support a sustainable business.<sup>16</sup>

The challenge of matching the pricing of private healthcare services with the costs incurred by service providers and the profits they could derive from the funders remains complex and difficult to solve.

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<sup>15</sup> Supra (n14) 3.

<sup>16</sup> Supra (n14) 3.

## **5 Can private healthcare pricing be capped?**

Capping of prices can look good on the surface, but it has the potential of affecting quality, innovation and development in health research. Capping, if only directed at the healthcare services and not production and sale of healthcare equipment, can render healthcare service provision unsustainable. An example is the single-exit pricing of medicines where pricing is capped only to control the profits of the buyers and not the pricing of the producers. Ironically, medicines are not necessarily cheaper, it only means that they are sold at lesser profits, it is more like putting a stone in half-filled glass of water to raise the level to the brim, it is some form of illusion.

### **Conclusion.**

Pricing of healthcare services remains the biggest challenge to all stakeholders in private healthcare. Like in any other sphere of purchaser versus seller, pricing perceptions shall always exist, to the purchaser, prices may seem high and seemingly unaffordable, while to the seller, the same prices may seem low and threatening to the sustainability of their businesses. Unified pricing is also hampered by the Competition Act which forbids collusion in the setting of prices in all sectors of business, not only in healthcare. Unless the Competition Act is amended, pricing in private healthcare shall always be fragmented until the National Health Insurance is implemented.

## CHAPTER 2

### Coding and Classification of Healthcare Conditions and Medicines

#### 1. Introduction

This is probably the shortest chapter in the document. The chapter analysis the use of coding in healthcare.

Section 2 looks at the importance and the necessity of coding and classification in healthcare, and the objective of concealing patient data.

Section 3 discusses the various coding and classification methods applied in healthcare. The three commonly used coding methods are discussed, the International Classification of Disease (ICD), as diagnostic codes, the Current Procedural Terminology (CPT) as procedural codes, and the National Pharmaceutical Product Interphase (NAPPI) codes for medicines and related substances.<sup>17</sup>

Section 4 discusses Billing and Pricing codes. The National Health Reference Price List (NHRPL) and the Reference Price List are also discussed, how they are applied and mention how the legal challenges led to their withdrawal, the NHRPL by the Competition Commission, while the RPL was struck by the judgement of Ebersohn AJ in the **Hospital Association of South Africa v Minister of Health and Another**.<sup>18</sup>

Section 4 concludes the chapter on coding and classification of healthcare conditions.

#### 2. The need for coding and classification of healthcare conditions

Whilst there is no statutory body that governs the setting of prices in healthcare, there is a general consensus that a coding structure is needed for the following reasons:

- There is a need to provide a standardised coding and tariff structure
- There is a need to generate an understanding of actual costs of healthcare as well as the nature of the services offered.
- Whilst a reference price list purports to be non-binding, it de facto determines the levels of scheme reimbursements and a description of services delivered
- New medical technology in terms of procedures and clinical practice is continually being developed and needs to be incorporated and reflected in healthcare professional billing and tariff structures. Without appropriate billing codes, these new procedures and techniques cannot find their way into serving patients.<sup>19</sup>

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<sup>17</sup> Ferrera M, Investigations into a Procedural Coding System, February 2017, BHF/ Deloitte 6.

<sup>18</sup> Hospital Association of South Africa Ltd v Minister of Health and Another, ER24 EMS (Proprietary) Limited and Another v Minister of Health and Another, South African Private Practitioner's Forum and Others v Director-General of Health and Others (37377/09, 37505/09, 21352/09) [2010] ZAGPPHC 69, 2010 (BCLR 1047 (GNP), [2011] 1 ALL SA 47 (GNP) (28 July 2010)

<sup>19</sup> Venter C, Principles and Guidelines for Establishing and Maintaining an Effective Medical Coding System in South Africa, Annexure E, 19 March 2013, Healthman 1.

Medical conditions are confidentiality issues protected by the Protection of Personal Information Act, of which access is governed by the Promotion of Access to Personal Information Act, and most of the time, information is captured into electronic filing systems, and medical coding is then applied where medical conditions are stored in alphanumeric codes. This probably helps to conceal sensitive diagnostic and treatment information about patients against any other non-medical personnel.

### **3. Coding and classification of PMB conditions**

In South Africa the commonly used codes are:

- Diagnostic coding as the International Classification of Diseases, or ICD codes,
- Procedural coding as the Current Procedural Terminology or CPT codes, and
- Medicine classification coding as the National Pharmaceutical Product Index codes or the NAPPI codes for medicines.

ICD codes are diagnostic codes that create a uniform vocabulary for describing the causes of injury, illness and death. The ICD codes were established by the World Health Organisation in the late 1940s. It has been updated several times since its inception.<sup>20</sup> The current purpose of the ICD is to promote international comparability in the collection, classification, processing, and presentation of health statistics, including both morbidity and mortality. In practice, the ICD has become the international standard diagnostic classification for all general epidemiological and many health management purposes.<sup>21</sup> Through repeated revisions of the ICD codes, it was realised that the great expansion in the use of ICD necessitated a thorough rethinking of its structure and an effort to devise a stable and flexible classification which should not require any fundamental revision for many years. Consequently, the alphanumeric coding scheme replaced the numeric one. The ICD is updated every ten years. The ICD is the coding standard for South Africa as accepted by the National Department of Health and the Council for Medical Schemes.<sup>22</sup>

Next is the Current Procedural Terminology (CPT) codes which are copyrights of the American Medical Association and are currently used for surgical procedures in South Africa. CPT was introduced to South Africa in 1996. The South African Medical Association was licensed by AMA to modify and customise the CPT, hence it became known as the Complete Current Procedural Coding for South Africa. CPT is used largely in the private sector for the purposes of data collection and analysis and to a lesser extent for reimbursement within contractual agreements between funders and providers of healthcare.<sup>23</sup>

NAPPI codes are primarily used for the classification and identification of medicines. A NAPPI code is a unique identifier for a given product (medicine or surgical products). Medikredit is responsible for the management and maintenance of the NAPPI file subject to the authority of the NAPPI Advisory Board (NAB). NAPPI codes are available for free, the 9

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<sup>20</sup> Why we code: Everything you need to get started in medical billing and coding, MB&CC 1.

<sup>21</sup> Supra (n17) 7.

<sup>22</sup> Supra (n17) 8.

<sup>23</sup> Venter C, Principles and Guidelines for Establishing and Maintaining an Effective Medical Coding System in South Africa, Annexure E, 19 March 2013, Healthman 7.

digit NAPPI code is available on the Medikredit website. Medikredit ensures the accuracy of the pricing data of the codes by running weekly comparisons against various other price files available in the industry highlighting discrepancies to the individuals where investigation is required.<sup>24</sup>

#### **4. Billing and pricing codes**

NAPPI coding allows the provider to identify which brand he/she is dispensing, the dispensed pack and the manufacturer. NAPPI codes can be linked to ICD codes, and this linking can allow both providers and funders to identify the exact product claimed for and the condition being treated. In this way, funding and pricing decisions are easily implemented. NAPPI codes are however not used in the public sector.

The NHRPL are billing and pricing codes that have contentious issues at the moment, although most funders and providers still use them as a guide for billing purposes. The NHRPL is a product of the Council for Medical Schemes. The NHRPL was intended to serve as a baseline against which medical schemes can individually determine benefit levels and healthcare providers can individually determine fees charged to patients. It is especially intended to serve as a basis for negotiation between individual funders and individual healthcare providers with a view to facilitating agreements which will minimise balanced-billing against members of medical schemes. The NHRPL is not legally binding, providers and schemes may still determine their own fee structures.<sup>25</sup>

The National Department of Health then published the Reference Price list (RPL) which was a modification of the NHRPL. The RPL contained four distinct elements:

1. Coding structure, which includes the code number and the terminology or nomenclature that is associated with a specific number or concept. The NHRPL did not contain all codes.
2. The relative value (RVU) of each concept, which is prescribed to be based on the average time taken to perform the healthcare intervention associated with the concept.
3. The Rand Conversion Factor (RCF) which represents an average cost per minute and is calculated by taking into account the cost of the resources required to perform a healthcare intervention, including the professional income of the healthcare provider. The reference price of each item in a schedule is calculated by multiplying the RVU of each concept by the RCF. The RCF is scientifically determined and not chosen arbitrarily. The NHRPL could not be used as it contained no costing data.
4. The costing spreadsheet through which the relative value units, the RCF and the reference price is calculated. The total duration of all interventions that are estimated to be performed by a healthcare has to balance back to that healthcare provider's standard volume of time. Similarly, the total estimated revenue has to balance back to the total input costs, including the professional remuneration of the

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<sup>24</sup> Ferreira M, Investigation into a Procedural Coding System for South Africa, February 2007, Deloitte/ BHF 19.

<sup>25</sup> Venter C, NHRPL, 2006, Annexure C, 31 March 2013, Healthman 5.

healthcare provider and a return on investment. The NHRPL had no costing spreadsheet.<sup>26</sup>

To constitute a complete RPL, all these specific requirements must be met.<sup>27</sup>

The RPL unfortunately could not stand the test of time as on 28 July 2010, acting Judge Ebersohn, in *The Hospital Association of South Africa v Minister of Health and Another*, ruled that the RPL was null and void. Ebersohn JA set aside the RPL 2009 and its regulations declaring them to be invalid. Since then South Africa had no uniform pricing references that is binding.

The items or concepts within a coding structure must comply again with the following requirements:

- Comprehensive. The list should provide all the recognised interventions that are offered by the healthcare provider group to which it is applicable.
- Consistent. There should be no duplication or overlap between items in a list.
- Systematic. The list should reflect basic organising concepts used by provider groups, such as anatomical regions or treatment modalities.<sup>28</sup>

Besides being used for filling patient information electronically, codes helps to make more accurate diagnosis and help in enhanced treatment protocols:

- Ensuring accuracy in medical coding is crucial to administering proper healthcare. Medical coding not only ensures a systematic and standardized manner in which third parties claim payment, the critical data that medical coding generates can be harnessed for further use.
- The information contained in medical coding data in the form of medical codes is a precise indicator of a patient's medical history. This information can be used for further planning by health insurers.
- By feeding public health departments and policy makers with medical coding information, it helps in proper allocation of resources for handling epidemics and other communicable diseases. This leads to improved outlook of the general population and reduces wasting in fund allocation.<sup>29</sup>

Coding and Classification systems, whether in the private or public domain, with or without a copyright, should meet several goals. They should:

- Ensure that the system is efficient to all kinds of users
- Ensure that the codes within the system interact smoothly with one another
- Be reasonably priced, both to obtain and to maintain, to assure access to all users

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<sup>26</sup> Supra (n25) 5.

<sup>27</sup> Venter C, Principles and Guidelines for Establishing and Maintaining an Effective Medical Coding System in South Africa, Annexure E, 19 March 2013, Healthman 5.

<sup>28</sup> Supra (n27) 6.

<sup>29</sup> 26. Mentor Health: A Brief Understanding of the Uses of Medical Coding. <http://www.mentorhealth.com/control/medical-coding>. Accessed 24/09/2018, 1.

- Be maintained in a way that allows for input from all users to assure that any modifications or clarifications respond to the needs of all users.

It would seem that these goals might be easier to reach if classification and coding systems were in the public domain.

## **Conclusion**

In South Africa, there has not been any serious legal challenges to the three basic coding methods used, the ICD, the CPT\$ and the NAPPI codes. Arguments have always been about the value of the codes and not on the codes themselves. The only coding and billing method challenged and nullified by the courts is the Reference Price List (RPL) as shall be seen in Chapter 4, where the government was challenged on the implementation of the RPL.

Coding and Classification systems should be universal as far as possible:

- so that the public and private sector could be able to compare statistics and analysis;  
and
- to ease payment to the public service should a medical scheme member opt to use a public facility for any reason.

A single coding system would allow the transfer of chronic medical history very easy to transfer between the systems. However, the Rand value of the codes shall remain a challenge unless the Competition Act is amended, or the National Health Insurance is implemented.

## CHAPTER 3

### Medical Schemes and the Control of Pricing and Financial Risk.

#### 1. Introduction

This chapter deals with base of what is priced in private healthcare, the Prescribed Minimum Benefits as promulgated by the Medical Schemes Act. The chapter looks at how medical schemes use different sections of the Act to control pricing, amid the vacuum created by the Competition Commission by declaring the Reference Price List introduced by the Council for Medical Schemes as null and void.

Section 2 deals with the Prescribed Minimum Benefits, herein referred to as PMBs. The section deals the PMBs, the exclusions on PMBs, the legal challenges to the PMBs, the guidelines for the reviews on the PMBs and the proposals for further additional PMBs.

Section 3 looks at Designated Service Providers promulgated by the Medical Schemes Act, how medical schemes use them to control pricing and risk associated with PMB. The section also look at how DSP contracts affects patients as consumers, the co-payments as punitive measures for members using non-DSPs, and the ethical challenges submitted by the South African Medical Association to the Council for Medical Schemes alleging a list of ethical breaches by medical schemes in their use of DSP contracts.

Section 4 analyses the Managed Care Protocols as promulgated by the Medical Schemes Act and as applied by medical schemes as a price and financial risk control strategy. Alternative means for healthcare users is mentioned where Managed Care Protocols do not apply.

Section 5 discusses the use of Formularies, lists of medicines to be dispensed by contracted DSPs for members of specific medical schemes. Sections of the Medicines and Related Substances Act which regulates formularies are also discussed.

Section 5 discusses the controversial subject, Peer Reviews. Peer Reviews are controversial because healthcare providers seldom know who the peers the peers are with whom they are compared, there are guidelines and treatment protocols.

Section 7 concludes the chapter.

#### 2. Prescribed Minimum Benefits

The baseline of the pricing of healthcare services are the Prescribed Minimum Benefits (PMBs). PMBs are a set of defined benefits to ensure that all medical scheme members have access to certain minimum health services, regardless of the benefit option they have selected. The aim is to provide people with continuous care to improve their health and well-being and to make healthcare more affordable.

PMBs are featured in Annexure A of the Regulations of the Medical Schemes Act, in terms of which medical schemes have to cover the costs related to the diagnosis, treatment and care of:

- ❖ Any emergency medical condition (Sec 27(3) of the Constitution),
- ❖ A limited set of 270 medical conditions (as defined in the Diagnosis Treatment Pairs),
- ❖ And 25 chronic conditions (defined in the Chronic Disease List).

Section 29(1) of the Act specifies matters for which rules shall provide. Subsection (o) stipulates that medical schemes must fund the minimum benefits that are prescribed by the Minister of Health. Subsection (p) says that no limits may be applied in paying for these services and that the minimum services provided and paid for by medical schemes may not be less than the services that is offered in public hospitals. Regulation 8 further stipulates that any benefit option offered by a medical scheme must pay in full for the diagnosis, treatment and care of the PMBs. No co-payments may be charged and no deductibles can be applied.

The regulations of the Medical Schemes Act provide for specific principles that medical schemes may use to manage financial risks associated with PMBS. These principles include:

- ❖ Designated service providers
- ❖ Managed care protocols
- ❖ Formularies

When deciding whether a condition is a PMB, the healthcare provider should only look at the ‘symptoms and not at any other factors, such as how the injury or condition was acquired. Once a diagnosis is made, the appropriate treatment and care is decided upon as well as where the patient should receive the treatment, at a hospital, as an out-patient or at the primary healthcare provider’s rooms.

A Diagnosis Treatment Pair links a specific diagnosis to a treatment plan and therefore broadly indicates how each of the 270 PMB conditions should be treated. The treatment and care of PMB conditions should be based on healthcare that has been proven to work best, taking affordability into consideration.<sup>30</sup>

## 2.1. Exclusions on PMB conditions

Medical schemes often have a list of conditions, such as cosmetic surgery under which a member has no cover. This is an example of an exclusion. Exclusions, however do not apply to PMB Conditions. For example, if one contracts sepsis following cosmetic surgery, the medical scheme would have to pay for the treatment of the sepsis.

In the Council for Medical Schemes v Genesis Medical Scheme,<sup>31</sup> Leach LE ruled that a medical scheme is obliged to pay for all PMBs.

The ruling followed a previous ruling by the Western Cape Division of the High Court, which ruled that Genesis Medical Scheme was not obliged to pay for three orthopaedic prosthesis used in the treatment of one Miss Roxanne Joubert. The Appeal Committee of the Council

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<sup>30</sup> 30. Council for Medical Schemes. What are PMBs.

[https://www.medicalschemes.com/medical\\_schemes\\_pmb/](https://www.medicalschemes.com/medical_schemes_pmb/) Accessed 10/07/2018, 1.

<sup>31</sup> (The Council for Medical Schemes v Genesis Medical Scheme (20518/2014) [2015] ZASCA 161; 2016 (1) SA 429 (SCA); [2016] 1 ALL SA 15 (SCA) (16 November 2015)

for Medical Schemes initially made a ruling in favour of Miss Joubert, and it is this ruling that the matter was taken to the Western Cape High Court. Miss Joubert was injured in a quad bike accident and suffered a tibial fracture, and was treated at a private hospital on three occasions where three prostheses were used. The High Court ruled against the Appeal Committee's ruling that Genesis Medical Scheme was obliged to pay for all the cost of the three procedures. The Council for Medical Schemes then took the ruling on appeal.

*The legal officer of the Registrar of Medical Schemes had stated that Miss Joubert's condition was a PMB the treatment of which under s29 (1) (p) of the Act and Regulation 8 promulgated under the Act is defined as a reduction/relocation and that as the treatment had been for a PMB condition it was irrelevant whether the scheme rules made provision for funding of the device in question.*

*Genesis did not agree, in an email response they alleged that:*

- (a) The term relocation used in the regulations is unfamiliar in medical circles-an allegation that the Registrar investigated and established was not correct (in the Registrar's subsequent ruling it is stated the term relocation is widely used in the treatment of fractures and is very well known terminology').*
- (b) The external fixators had been incorrectly coded by the hospitals and that it was not liable for the costs thereof under its rules*
- (c) If a member elects to have her PMB condition treated at a public rather than a private hospital, Genesis would pay for the treatment prescribed in the Act.*

Genesis went on to argue that the previous use of two fixators worth R60 000 was wasteful, and that the third one that cost R75 000 was similar to the last two. The logical answer was that the fixators were used to prevent amputation of the limb, let alone the physical and mental grief it would have on the patient. Dr Bernstein, the treating surgeon explained that the three fixators had different properties and served different purposes. The Registrar was of the opinion that Genesis was liable for all three fixator treatment as the fracture of the tibia was a PMB condition. In a turn of events, Genesis agreed that the injury and its treatment were justifiable as the injury was a PMB, but they contended that they would only pay if the treatment was done at a public hospital. Genesis then appealed the ruling of the Registrar to the Appeals Committee. The Appeals Committee issued another ruling indicating that Genesis was liable for all treatment expenses. Genesis appealed again, under section 50(3) of the Act, and stated that under its rules, it is not obliged to pay for a PMB other than at a public hospital. The Appeal Committee dismissed the appeal, but issued the following ruling:

Genesis is required to compensate the member for the costs incurred for the diagnosis, treatment and care of a PMB condition to the level of a public hospital for all three fixators.

Genesis then took the matter to the High Court, which made the following ruling:

- (a) That the ruling of the Appeal Committee against which Genesis had appealed to the board had related solely to the third fixator and not the first two;

- (b) That absent a cross-appeal, the Appeal Committee had no statutory power to exercise jurisdiction in respect of the first two prostheses and, for that reason, the ruling of the Appeal Board insofar related to those prosthesis could not stand;
- (c) That the rules of Genesis did not allow for payment of the cost of an external fixator such as the third prosthesis where same was obtained from a hospital other than a public or state hospital, and that the Appeal Board erred in reaching the contrary conclusion;
- (d) That accordingly, the decision of the Appeal Board relating to Genesis' liability for the external prosthesis fitted to Roxanne (Miss Joubert) could not stand;
- (e) That for similar reasons the counter application could not succeed, and that both the Council and the Registrar had misconstrued their relief and ought rather to have employed s31 of the Act ( which inter alia, empowers the Registrar to order a medical scheme to amend its rules should they be applied in a manner inconsistent with the Act), or s51 thereof (which empowers the Registrar to apply to court for relief in the interest of beneficiaries to obtain relief including an order that the rules be amended).

The court made a ruling that Genesis was not obliged to pay for the cost of the treatment with the prostheses.

In dealing with the primary issue of whether Genesis rules are such, and fall to be applied that Genesis is not liable to compensate a member for the cost of an external fixator fitted in a private hospital, Leach LE of the Supreme Court of Appeal mentioned the following statutory provisions:

Under s20 of the Act, a medical scheme may not carry on the business of a medical scheme unless it is registered under s24. Section 29 provides that the Registrar shall not register a medical scheme, and that no medical scheme may carry on business unless its rules make provision for a number of specific matters. In particular ss29 (1) (o) and (p) provide that the rules must make provision for:

(o) The scope and level of minimum benefits that are to be available to the beneficiaries as may be prescribed.

(p) No limitation shall apply to the reimbursement of any relevant health service obtained by a member from a public hospital where this service complies with the general scope and level as contemplated in paragraph (o) and may not be different from the entitlement in terms of the service available to a public hospital patient.

The minimum benefits referred to in s29 (1) (o) are those prescribed in Regulations 7 and 8 promulgated in terms of s67 of the Act by the Minister. Regulation 8 provides that:

- (1) Subject to the provisions of this regulation, any benefit option that is offered by a medical scheme must pay in full, without co-payment or the use of deductibles, the diagnosis, the treatment and care costs of the prescribed minimum benefit conditions.

- (2) Subject to s29(1)(p) of the Act, the rules of a medical scheme may, in respect of any benefit option, provide that-
- (a) The diagnosis, treatment and care of a prescribed minimum benefit condition will only be paid in full by the medical scheme if those services are obtained from a designated service provider in respect of that condition, and
  - (b) A co-payment or deductible, the quantum of which is specified in the rules of the medical scheme, may be imposed on a member if that member or his or her dependant obtains such service from a provider other than a designated service provider, provided that no co-payment or deductible is payable by a member if the service was involuntarily obtained from a provider other than a designated service provider.

From the deliberations of the case, Genesis does not seem to have chosen the public or state hospital as its DSP, no DSP contract was presented to the court. It was revealed in the proceedings that Genesis was at loggerheads with the Council for Medical Schemes, opposing the directive to appoint DSPs. The judge ruled that for Genesis to regard the public or the state as its DSP is very misleading and unacceptable.

The fracture that Roxanne Joubert suffered is a PMB condition described by code 900H, and according to the proceedings, Genesis accepted this. The judge upheld the appeal in favour of the Council for Medical Schemes with costs.

This case illustrates one of the debates about PMBs, DSPs and pricing issues in healthcare. Although much of the deliberations were not about pricing, Genesis highlighted the price when they argued that the third prosthesis was very similar but more expensive than the other two. DSP contracts in some instances may not have a positive impact on price reduction, they can only serve to limit co-payments. In terms of primary healthcare however, DSP prices are set by the medical schemes, where the joining contractors are obliged to accept a pre-determined price.

According to the Medical Schemes Act, PMB conditions are subject to review every two years to address issues relating to:<sup>32</sup>

1. Inconsistencies or flaws in current regulations;
2. The cost effectiveness of healthcare technologies or interventions;
3. Consistencies with developments in health policy;
4. The impact on medical scheme viability and its affordability on members.

## **2.2. Guidelines for the review of PMB conditions**

The guiding principles for the review of PMBs is as follows:

- ❖ The current health situation of the country
- ❖ The needs of the country
- ❖ Internationally agreed instruments
- ❖ Clinical and cost effectiveness of interventions

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<sup>32</sup> CMScript, Council for Medical Schemes, Issue 8 of 2014, 1.

- ❖ Efficiency
- ❖ Affordability of interventions

### 2.3. Proposals for new PMB conditions

The proposal for the new PMB conditions covers the following aspects of health:

- Preventative services (vaccinations)
- Maternal and neonatal services
- Child health services
- Mental health services
- Diagnostic laboratory services
- Diagnostic imaging services
- Pharmaceutical services
- Emergency medical services
- Palliative services

These additional services implies that pricing in healthcare is yet to change further. Presently, medical schemes do not cover vaccination, which is provided by the public service, and most medical schemes avoid payments for the treatment of epidemics like pulmonary tuberculosis. Healthcare users in need of such services are usually referred to the public sector, creating overload of the already sick system. Prophylactic treatment for HIV is also not covered by most medical schemes, especially where the reason is social. And in the private healthcare sector, HIV-suspect needle-prick injuries are treated as injury on duty and never covered by the respective medical scheme.

### 3. Designated Service Providers (DSP)

A designated service provider is a healthcare service provider (medical practitioner, pharmacist, hospital, etc.) that is a medical scheme's first choice when its members require diagnosis, treatment or care of a prescribed minimum condition.<sup>33</sup> DSPs are promulgated under Regulation 8 of the Medical Schemes Act 131 of 1998. Regulation 8(2) indicates that if a member uses a DSP of his or her medical scheme, the medical scheme must pay the price of the services provided by the respective DSP in full. However, if a member chooses to use a non-DSP, the member may be liable for co-payment.

On the other hand, DSP contracts interferes with the healthcare user's freedom of choice. The Consumer Protection Act enforces the consumer's right to freedom of choice, which is also entrenched in section 18 of the Constitution of the Republic. In the context of a member of a medical scheme, such a member should not be prevented from consulting with a medical professional of his or her choice. Prevention, in this sense, takes into account that if a scheme refuses to pay for or towards the costs of such consultation, they are, in

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<sup>33</sup> Supra (n32) 2.

effect, preventing the member from consulting the practitioner concerned.<sup>34</sup> In this regard, section 13 of the Act stipulates:

13 (1). A supplier must not require, as a condition of offering to supply or supplying any goods or services, or as a condition of entering into an agreement or transaction, that the consumer must-

- (b) Enter into an additional agreement or transaction with the same supplier or a designated third party; or
- (c) Agree to purchase any particular goods or services from a designated third party, unless the supplier-
  - (i) Can show that the convenience to the consumer in having those goods or services outweighs the limitation of the consumer's right to choice;
  - (ii) Can show that the bundling of those goods or services results in economic benefit for consumers; or
  - (iii) Offers bundled goods or services separately and at individual prices.

Frequently, medical schemes offer plans to the lower-income population bracket, in terms of which scheme members' medical consultations shall be paid for directly by the scheme on the express condition that the member consults with only those clinicians on a pre-selected list of preferred service providers as provided by the scheme. It would appear that such a scheme contravenes section 13(1) of the Act on account that such practices cannot be justified by 'the convenience of the consumer in having those...services bundled outweighing the limitation of the consumer's right to choice, or the bundling of those...services resulting in economic benefit for consumers' (section 13(1) (c) (iii) does not apply)<sup>35</sup>

Members of medical schemes are often charged co-payments for using non-designated service providers, and this does not look like an incentive, it looks punitive, because an additional payment is imposed on the members.

DSP arrangements removes a significant portion of the healthcare users' autonomy from the spectrum of patient rights in exchange for an arrangement in terms whereof the selected providers charge the medical scheme lower rates in exchange for more pairs of feet being herded through their doors. It could be submitted in this regard that autonomy can only be removed from a patient, especially a member who for any reason cannot understand the significance and purport of such removal, in circumstances of emergency, and then only to the extent that such emergency dictates.<sup>36</sup>

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<sup>34</sup> Snoyman H. An Ethical and Legal Analysis of South African Medical Schemes: An examination of the legal and ethical relationship between medical scheme and member. 2013. Lambert Academic Publishing 77.

<sup>35</sup> Supra (n34) 77.

<sup>36</sup> Supra (n34) 78.

Snoyman further argues that this practice of medical schemes is 'unconscionable', in terms of the Act on two bases, namely:

- (i) The quality of healthcare providers differ according to experience and expertise. To deny a member the opportunity to consult with a clinician of sufficient skill, as may be required in a given circumstances seems entirely 'unfair and unjust', and
- (ii) Particularly in a medical context, severe prejudice could be suffered by a member who may have to travel significant distances to consult with a scheme-approved clinician when a more expensive yet unapproved clinician may be geographically more convenient.

The manner in which DSPs contribute to saving funds for members remain controversial, DSPs seem only to be punishment for healthcare providers who do not want to join the networks. It shall be seen in the next section of the SAMA submissions that some providers are even denied the role of being DSPs.

Medical schemes have to ensure that beneficiaries of their plans have easy access to their DSP. If there is no DSP within reasonable distance of the member or beneficiary, that member or beneficiary can use the nearest service provider without incurring co-payment charges. In the case of an emergency, users can go to any service provider and will not pay any co-payments, the scheme is obliged to pay as if it were at a DSP. When a DSP is unable to treat a member, the scheme remains liable for all the cost associated with the PMB at a non-DSP provider.

Regulation 8(3) specifies three instances when using a non-DSP is involuntary and no co-payment may be charged:

- When the service is not available from a DSP or the service cannot be provided without unreasonable delay. Unreasonable is not defined in the act, and it is not mentioned who is to rule whether a waiting is not reasonable.
- In an emergency or urgency situation where immediate medical or surgical intervention is required under the circumstances which reasonably precludes the member from obtaining it from a DSP.
- There is no DSP within reasonable proximity of the member or beneficiary's place of work or residence. That is if the distance to a DSP is not fair and reasonable.

It is the responsibility of members to ascertain and familiarise themselves with the DSPs appointed for them. Medical schemes often draft DSP contracts with pre-determined pricing of services, so in some way DSPs are price control measures as even the Act mention DSP as other means of financial risk control which medical schemes can apply. According to Pearmain D, Regulation 8 is intended to assist medical schemes to contain costs associated with the prescribed minimum benefits for which schemes are liable for paying in full.<sup>37</sup>

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<sup>37</sup> Pearmain D. The law of Medical Schemes in South Africa. 2016. Juta 7-5.

Most healthcare funders do not pay for the costs associated with any emergency service, be it a DSP or non-DSP, funders only pay a normal fee whilst such services are exhaustive, time consuming, stressful, and are associated with costly materials.

### **3.1. Legal and ethical challenges to the DSPs**

SAMA has prepared a document where the designated service provider concept by healthcare funders is debated and opposed.<sup>38</sup> The submission is an invitation to interested parties to make written presentations concerning the intended declaration of certain practices by medical schemes in selecting designated healthcare providers and imposing excessive co-payments on members as irregular and undesirable practises by the medical schemes in terms of section 7 of the Financial Institutions (Protection of Funds) Act, read with section 7 of the Medical Schemes Act.

Section 7 of the Financial Institutions Act states thus:

7. (1) The registrar may, by notice in the Gazette, declare a specific practice or method of conducting business an irregular or undesirable practice or an undesirable method of conducting business for a specific or categories of financial institutions or for all such institutions.

The SAMA document is primarily against the method used by medical schemes to select DSPs, and the imposing of excessive co-payments on members of medical schemes who chooses not to use DSPs. DSPs are third party contracts that infringes on the rights of freedom of choice of healthcare users.

SAMA made the following submissions:

- SAMA is in support of the intention to declare the following business practices irregular and undesirable:
  - (a) The selection by medical schemes of a provider or group of providers as DSPs without engaging in a fair, equitable, transparent, competitive and cost-effective process.
  - (b) Imposing a co-payment in terms of Regulation 8(2) (b) that exceeds the quantum of the difference between what is charged by the scheme DSPs and what is charged by a service provider other than a DSP.

The following sections are adapted from the SAMA document mentioned above:

SAMA has taken several written comments from its membership of medical practitioners when compiling these submissions. These speak to the specifics of challenges of general and specialist practitioner with particular schemes and particular arrangements.

In addition to DSP arrangements, many medical schemes also have networks of DSP general and specialist practitioners which they appoint on a contractual basis as part of managed

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<sup>38</sup> Submission to: The Council for Medical Schemes In respect of Department of Health Notice 435 of 2017 and CMS Circular 39 of 2017, dated 30 June 2017, SAMA 1-3.

healthcare processes. These do not necessarily pertain to the treatment of prescribed minimum benefits, although many arrangements overlap.

#### **4. Managed Healthcare Protocols**

Managed healthcare organisations are promulgated in terms of Regulation 15A of the MSA. These groups are formed to ensure that appropriate interventions aimed at improving the efficiency and effectiveness of healthcare are implemented. The main objective of managed healthcare protocols is cost control, price control and affordability.<sup>39</sup>

Techniques employed in managed care protocols include:

- Preauthorisation before procedures are performed by healthcare users
- Application of recommended treatment protocols including a list of pathological and radiological tests
- Use of recommended medicine formularies.

Most medical schemes control the number of consultations per year. It is recommended that all managed care protocols must be developed on evidence-based medicine, taking into account considerations of cost-effectiveness and affordability. This implies that even if there is scientific evidence for the efficacy of a specific treatment, it may not be cost-effective, affordable and appropriate to prescribe in the South African environment.<sup>40</sup> Unfortunately this gives medical schemes an escape route of denying to pay for effective therapies like cancer treatments, where there is sufficient scientific evidence of efficacy concerning a medicine.

If a member voluntarily chooses to use a different treatment protocol, the scheme may charge a co-payment (e.g. a member who chooses to deliver a baby by an elective caesarean whilst a normal vaginal delivery is not absolutely contraindicated). Sometimes it may be clinically necessary to have more consultations and other interventions to manage a member's condition than is stipulated in the treatment protocols of the scheme. In such instances exceptions do apply. Regulation 15H(c) highlight certain exceptions:

15H. if managed care entails the use of a protocol-

- (c) Provision must be made for appropriate exceptions where a protocol has been ineffective or causes or would cause harm to a beneficiary, without penalty to that beneficiary.

Any member of any medical scheme has a right to request the medical scheme to provide with treatment protocols that applies to the member's disease condition. Regulation 15H (b) stipulates that the medical scheme must provide such protocol to healthcare providers, beneficiaries and members of the public upon request. In practice most members are not familiar with such requests or protocols, and only rely on the information they get from healthcare providers.

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<sup>39</sup> CMScrip, Issue 8 of 2014, Council for Medical Schemes 3.

<sup>40</sup> Supra (n39) 4.

## 5. Formularies

A formulary is a restricted list of medicines compiled by a medical scheme for the treatment of specific medical conditions without a co-payment being charged. Formularies, just like treatment protocols, must be developed on the basis of evidence-based medicine, taking into account considerations of both cost effectiveness and affordability. Even when a drug has scientific evidence for efficacy, it may not necessarily be considered cost effective, affordable or appropriate in the South African environment. This part of the regulations is unfortunately prone to abuse by healthcare funders whilst trying to practice cost containment. Members have a right to request a list of formularies from their schemes, Regulation 15I (b) stipulates that a medical scheme must provide such formulary to the healthcare providers, beneficiaries and members of the public upon request.<sup>41</sup> Formulary lists are long and tedious, and are thus time-consuming.

Although the regulations allow medical schemes to implement formularies for their members and their DSPs, there are instances where these principles cannot be enforced. Regulation 15I(c) state as follows:

15I. if managed healthcare entails the use of a formulary or restricted list of drugs-

- (d) Provision must be made for appropriate substitution of drugs where a formulary drug has been ineffective or causes or would cause adverse reactions in a beneficiary, without penalty to that beneficiary.

Formularies are subjects of indirect price control by the government through Regulation 8 of the Medicines and Related Substances Act 101 of 1965. This is done through the single-exit price concept where medicine pricing is capped at a percentage price, where profits are controlled. Under these regulations, the Minister also controls the annual increment on medicine pricing. This shall be discussed in Chapter 4.

## 6. Peer Reviews

Peer Reviews are clinical evaluation methods used by medical schemes to assess performance of individual healthcare providers regarding the diagnosis and treatment of their members. Peer reviews are said to be composed of healthcare providers at the same level of skill as the provider under assessment. Peer Reviews are controversial in that the healthcare providers are not informed about the composition of peer review committees, the treatment protocols to be followed and who their peers are. The following seems to be what is evaluated by peer review committees:

- The number of consultations the healthcare provider sees his/her patients over a set duration determined by the respective medical scheme;
- The medicines used whether they are from the formulary or out of the formulary list designed by the medical scheme;
- The number of procedures performed by the healthcare professional;

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<sup>41</sup> Supra (n39) 5.

- The frequency of referring for other services like specialists, pathological and radiological services.

There is no literature about peer reviews and each healthcare provider gets a monthly communication from each medical schemes, stating whether the provider is downgraded or upgraded to receive performance incentives. Providers are paid different fees for services by a medical scheme regardless of whether the provider is a DSP or non-DSP. Once the evaluation picks up some discrepancies regarding the use of member funds, the provider is downgraded and the fees paid for services are consequently reduced.

It is not known whether the evaluation committee has all the necessary skill and equipment to be compared fairly with the provider evaluate, this is only known by each medical scheme and its chosen evaluation committee.

Primarily, peer reviews are price control strategies used by medical schemes in addition to DSPs, managed care and medicine formularies.

## **Conclusion**

The implementation of the legislation enforcing the payments of the Prescribed Minimum Conditions has benefitted both the healthcare user and the providers of healthcare. What remains is the addition of other evidence-based services like vaccination, where the bulk of such services is still provided by the government through its health budget. Medical schemes do not pay for most of these services at present.

The primary objectives of the addition of Designated Service Providers (DSP) in Regulation 8 of the Medical Schemes Act was to control the risk of price escalation in private healthcare, but this has led to abuse of the legislation by paying uneconomical prices to the private healthcare providers. These low prices are incorporated into the DSP contracts offered to providers, together with co-payments incurred by healthcare users who voluntarily opt to use non-DSP providers. It makes no logic not to include all providers in a particular locality as DSPs, where one price shall be paid for all, and with no co-payment charged to the users of the services. Other challenges like having a provider being a DSP, while the hospital where the provider operates is not, should be resolved by accrediting all providers in one locality to be DSPs. The response to the SAMA Document on DSPs has not yet been done by the Council for Medical Schemes when this research article was prepared.

Managed care protocols should be made less procedural in terms of authorisation of services. A practical example is where a medical scheme requires pre-authorisation to suture a wound, and is 13h00 on a Saturday. Most medical schemes do not open their offices over weekends, and they give only 24hrs for a provider to pre-authorise. When Monday comes, the authorisation has already expired and the patient must pay out-of-pocket. This need to be resolved.

Formularies must not only be based on cheaper pricing, but on the efficacy of the drug.

Peer review committees must be known and their protocols must be made available to healthcare providers. As at present, peer reviews operates like spying agencies, they are not

used to prevent overcharging of services by providers, they are used to punish providers who are suspected of overcharging.

## CHAPTER 4

### The Authority to Set Prices in Private Healthcare

#### 1. Introduction

This chapter deals mainly with the authority to set prices in private healthcare, with the main focus being the government.

Section 2 deals with the legislation that can be used to empower the government to regulate pricing in private healthcare. The section looks at the availability of any provisions in the South African legislation which can empower the government to regulate pricing in private healthcare.

Section 3 deals with other legislation in private healthcare, looking at the patients as consumers under the Consumer Protection Act, and the application of the Competition Act in price regulation.

Section 4 deals directly with the legal challenges that led to the demise of the Reference Price List, it covers the legal proceedings of the court challenge.

Section 5 deals with the legal challenges to the Single-Exit price and the court proceedings.

The last section is the conclusion of the chapter.

#### 2. The government's legal role

South African legislation does not state who controls pricing and coding of services in private healthcare, it only gives guidelines that points to the Minister of health as the one who should guide policy development in healthcare. At present, providers can charge what they like, and funders can reimburse what they like too. Whilst the Competition Act forbids collusion in setting up pricing in private healthcare, the National Health Act does empower the minister to give policy directives in healthcare, which may include directives on pricing.

Section 3(l) of the National Health Act of 2003 state thus:

The minister must, within the limits of available resources-

- (a) Endeavour to protect, promote, improve and maintain the health of the population;
- (b) .....
- (c) Determine the policies and measures necessary to protect , promote, improve and maintain the health and well-being of the population;

Whether the Minister has a right to dictate prices in private healthcare is not mentioned in the Act, it remains a debatable issue.

In terms of Section 7 of the Medical Schemes Act 131 of 1998, the Health Minister also has powers to allocate a function to the Council in addition to existing and equally relevant functions:

7. The functions of the Council shall be to-

- (a) Protect the interests of the beneficiaries at all times;
- (b) Control and co-ordinate the functioning of medical schemes in a manner that is complementary with the national health policy
- (e) Collect and disseminate information about private healthcare;
- (g) Advise the Minister on any matter concerning medical schemes, and;
- (h) Perform any other functions conferred on the Council by the Minister or this Act.

In trying to play these roles, the National Department of Health, together with the Council for Medical Schemes, came up with a draft of the “ Discussion Document: The Determination of Health Prices in the Private Sector.” This document comes after the Council for Medical Schemes failed in its bid to enforce the now defunct Reference Price List, which was a mirror image of the National Health Price Reference List of 2010.

The Discussion Document follows a meeting held on 18 October 2010, between the DOH and stakeholders to stimulate further debates of pricing in private healthcare.

According to the DOH in its ‘Discussion Document: The Determination of Healthcare Prices in the Private Sector, since the evolution of medical schemes within the South African context, fee-for-service tariffs have been predominantly negotiated on a centralised bases. The reasons are:

- The focus of medical schemes have always been on the reimbursement of medical expenses incurred by a beneficiary.
- As a third party payer, the medical scheme can face an infinite liability if it does not establish reimbursement prices which limit the level of reimbursement.
- As reimbursement prices form the predominant income of many providers, prices are typically subject to negotiations between schemes and affected service providers.<sup>42</sup>

The centralised negotiations were always characterised by some degree of acrimony. It was then decided that the Representative Association of Medical Schemes (RAMS) would negotiate tariffs that would be gazetted each year. This persisted till 1994 when the Medical Schemes Act was amended. RAMS, which later became the Board of Healthcare funders, shifted from negotiating the actual set of prices to negotiating reference pricing.

The South African Medical Association began publishing its own reference list, which was higher in prices than what RAMS had published. This gave birth to the concept of balanced billing to users whose medical schemes paid less than the SAMA prices.

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<sup>42</sup> Discussion Document: The Determination of Health Prices in the Private Sector, Version 1.00, 28 October 2010, Depart of Health and the Council for Medical Schemes 10-12

The Hospital Association of South Africa (HASA) then applied to the competition authorities to set its own prices which was granted.

In 2004, the Competition Commission ruled that the centralised reference tariffs used by the BHF(formerly RAMS), HASA and SAMA were a restricted practice as they were set in a collusive manner according to Sec 4 of the Competition Act.<sup>43</sup>

The ruling by the Competition Commission introduced a new set of logistical and competition problems for the setting of prices:

- Medical schemes were theoretically required to negotiate with each individual service provider for pricing.
- Hospitals have consolidated into three main groups, Mediclinic, Lifehealthcare and Netcare, which generated a negotiation imbalance. This has created a problem of competition in pricing among private hospitals.

The structuring of the background of the document seem biased against healthcare providers in favour of medical schemes.

In order to mitigate the logistical problems created by the ruling of the Commission, the CMS established the National Health Reference Price List (NHRPL). The CMS was able to do this because it had no commercial gain as the NHRPL fell outside the jurisdiction of the Competition Act.

However, medical service providers with market power like the three hospital groups were able to deviate from the NHRPL, since the list was not derived by negotiation but by cost-analysis.

Medical schemes were then forced to condone balanced-billing practices because failure to do so would leave many of their members without cover. Some healthcare providers still charge co-payments to cover the balanced billing.

The NHRPL was ultimately handed over to the Department of Health which became known as the Reference Price List, which became useless because of its conflicting roles. The central problem of the RPL was that it allowed providers to collude in setting prices and this was against section 4 of the Competition Act.<sup>44</sup>

### **3. Legislation and pricing in private healthcare.**

Since the Competition Commission has ruled that unified agreement on pricing is un-competitive behaviour, medical schemes have become the unilateral controllers of pricing at the expense of providers, especially at primary care level through the use of DSP contracts.

Private healthcare has become one of those business sectors where the seller does not set the price for his goods. Medical schemes have come up with 'take it or leave it' designated

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<sup>43</sup> Supra (n42) 11-12.

<sup>44</sup> Supra(n42) 12

service provider and capitation contracts where prices are already set. Specialists and bigger hospitals on the other hand, are using the lack of standardised pricing by charging high co-payments to the users. The healthcare users, as consumers protected by the Consumer Protection Act, feel the effect of these discrepancies. When remuneration for services becomes too low, the quality of the service offered may as well depreciate, and this is against the spirit of the **Consumer Protection Act 68 of 2008**.

In terms of the **Consumer Protection Act**, the users of healthcare services have a right to demand quality healthcare. It requires among other factors.<sup>45</sup>

- That services must be performed timeously
- Consumers to be given timely notice of a delay in the performance of the services
- Services to be performed in a manner and quality that could be generally expected

If these standards are not met, the healthcare user as a consumer can opt to:

- (a) Accept the pit falls
- (b) Reject the service and
- (c) Cancel the consultation agreement without penalty.

The relationship between medical schemes and providers is a third party contract, where the provider enters into an agreement with the user, but the medical scheme becoming the payer of the service. This implies that even though providers are not registered as credit providers in terms of the provisions of the National Credit Act, they are creditors by virtue of the payment arrangements they have with the users and their funders. The fact that a healthcare user leaves the premises of a healthcare provider without having paid by cash or debit card means the relationship between the two is a credit relationship.

Uniform pricing in healthcare shall not be achievable unless Section 4 of the Competition Act 89 of 1998 is amended. The Act states as follows:

4. Restrictive horizontal practices prohibited
  - (2) An agreement between, or concerted practice by, firms, or a decision by an association of firms, is prohibited if it is between parties in a horizontal relationship and if-
    - (a) It has the effect of substantially preventing, or lessening competition in a market, unless a party to the agreement, concerted practice, or decision can prove that any technological, efficiency or other pro-competitive gain resulting from it outweighs that effect; or
    - (b) It involves any of the following restrictive horizontal practices:
      - (i) Directly or indirectly fixing a purchase or selling or selling price or any other trading condition;
      - (ii) Dividing markets by allocating customers, suppliers, territories, or specific types of goods or services; or

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<sup>45</sup> Moodley K. Medical ethics, law and human rights: A South African perspective. 2017. Van Schaik Publishers 64.

- (iii) Collusive tendering.
- (3) An agreement to engage in a restrictive horizontal practice referred to in subsection (1)(b) is presumed to exist between two or more firms if-
  - (a) Any one of those firms owns a significant interest in the other, or they have at least one director or substantial shareholder in common; and
  - (b) Any combination of those firms engages in that restrictive horizontal practice.

It is this section that prohibits the setting of prices by any two or more providers or group of providers which may include but not limited to the following, Independent Provider Associations (IPA), South African Medical Association (SAMA), South African Private Practitioner's Forum (SAPPF) or any other. The only workable possibility for the organisations that are discussing pricing is perhaps to decide on a price range, to set up a minimum and a maximum fee that service providers in different categories can charge for services, where an individual provider would choose to charge a minimum or a maximum fee. Whether fixing a price range shall be seen as price-fixing is debatable, but a range of different prices seem competitive enough.

These challenges of the Competition Act led to the formation of an independent coding authority, the South African Classification of Healthcare Interventions (SACHI). SACHI's objectives as defined in its memorandum of incorporation are as follows:

- ❖ To be an independent, multi-stakeholder, non-profit organisation, free of any political or other interference;
- ❖ To assist and manage processes related to the implementation of procedural codes by healthcare providers in Southern Africa;
- ❖ To recommend revisions, updates or modifications to IPAs, SAMA, SAPPF and other healthcare professional societies in respect of the codes, descriptors, rules and guidelines in the use of the codes;
- ❖ To collect and analyse coding data
- ❖ To develop Relative Value Units to be assigned to new or revised codes, to ensure the fair and accurate valuation for all healthcare providers and allied discipline service providers in Southern Africa;
- ❖ To set and regulate SACHI membership fees for all participating medical associations and disciplines;
- ❖ The company shall promote and carry out public benefit activities, envisioned in the 9<sup>th</sup> Schedule to the Income Tax Act, in the Republic of South Africa.<sup>46</sup>

It remains to be seen how SACHI is going to be constituted. If it is going to be formed by any individuals or organisations that are directly involved in the practice of healthcare, the Competition Commission may very likely view it as uncompetitive behaviour masked in another form.

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<sup>46</sup> Private Practice Review, January 2017, Healthman 6.

#### 4. The Legal challenges to the Reference Price List

The RPL failed to achieve satisfactory outcomes on the final prices, as the costing analysis occurred without considering the budget constraints of the medical schemes and their members, and the costs of running private practices as businesses by the providers. Schemes would consequently object to the publication of benchmarks that would immediately translate into high fees. Providers on the other hand, objected to going through costly benchmarking exercises that ultimately would not lead to adjustments of the RPL to sustain or suit profits.

In another blow to the RPL, Judge Ebersohn PZ, in the **Hospital Association of South Africa Ltd v Minister of Health and Another**<sup>47</sup>, ruled that the RPL regulations were null and void. The judge made the following order:

1. *The promulgation by the Minister of Health on 23 July 2007, under GN 681, and purportedly in terms of the powers afforded her by Section 90(1) of the National Health Act 61 of 2003 of The Regulations Relating to the Obtainment of information and the Process of Determination and Publication of Reference Price List is hereby reviewed and declared invalid and is set aside together with the Regulations.*
2. *In consequence of the order in paragraph 1 hereof, all acts and on the part of the Director-General of the Department of Health, purportedly in terms of the regulations –including the promulgation of guidelines and methodologies, notices and invitations, and the publication of any one or more national reference price lists- is hereby declared to be invalid and null and void and of no force and effect with retro-active effect.*
3. *The Minister and the Director-General, the one paying the other to be absolved, are ordered to pay the cost of the three applications.*

The applicants (the Hospital Association of South Africa, ER 24 EMS, South African Private Practitioners Forum) presented a well-structured argument by finding many loopholes in the Regulations relating to the RPL. They presented that;

*[143]. in paragraph 3.6 of the guidelines the Director-General recorded the following:*

*“It is acknowledged that the costing methodology described in this document is not suitable for all healthcare disciplines or service environments. This is particularly applicable to facilities such as hospitals, pathology laboratories and emergency services. If an intended costing methodology deviates substantially from the methodology documented here, then the methodology must be properly documented and submitted for approval to its use in costing studies for the RPL.”*

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<sup>47</sup> Hospital Association of South Africa Ltd v Minister of Health and Another, ER24 EMS Ltd and Another v Minister of Health and Another, South African Private Practitioners Forum and Others v Director-General of Health and Others (37377/09, 37505/09, 21352/09) [2010] ZAGPPHC 69; 2010 (10) BCLR 1047 (GNP); [2011] 1 All SA 47(GNP) (28 July 2010)

In simple analysis of the case, it could be seen that the DOH came to court in a poorly prepared manner, they seemed to believe that by mere presentation of an ambition to control pricing in healthcare in a way to protect consumers from the rising costs, they had an upper hand, perhaps by the maxim of 'for the interest and benefit of the public' which they did not present to the court. The formulation of a Reference price list remains a challenge in private healthcare. To private healthcare providers, the Competition Commission is a challenge, to the government it is simply a lack of proper policy directives and preparedness which is a problem.

After the RPL was declared primarily unlawful by the court, pricing in private healthcare took another turn, healthcare providers, especially specialists and private hospitals, started charging own prices above what medical schemes pay, and this leaves healthcare users with short-falls that must be paid either from out-of-pocket or by gap cover insurances. Medical schemes then responded to the market by setting their own prices, and introducing the Designated Service Provider (DSP) and capitation contracts that seem to worsen the quality of care than uplifting it. DSP contracts are more focussed on money-saving than on the provision of good quality healthcare.

This system failed among many providers because the providers could not cope with the user demands, and most users were misinformed about the value of the money paid to their allocated service providers. What the author has picked up in the relationship between cheaper options medical schemes and their members is that the truth about the real cost of healthcare is withheld from these members, and most members believe that what is deducted from their salaries as a monthly premium by their medical scheme, is totally transferred to the allocated service provider as a profit, and this exposes service providers to unnecessary arguments, where the service provider spends more time explaining what the medical scheme was supposed to have explained ( Authors Observations)

DSPs and Capitation deals do not come cheap to service providers, at least by time and stationary. The information manual of Gems Beryl and Sapphire options comes as an email with an average of 144 pages, reading 144 pages of a cheap medical scheme option can be strenuous. These type of options come with other losses like having to preauthorise even for small procedures like draining an abscess. The telephone bill and the time spent on these cheaper options is worrisome. Most of these options do not cover all pathology tests for economic reasons, and they provide a list of their own and forbids healthcare providers from using the original list provided by the pathology laboratory. The pathology request list is then sent to the allocated service provider as one page, where the service provider must incur losses of printing or photocopying the page. Even the 144 pages of information for the allocated service provider comes as an email, where the provider must incur printing losses.

## 5. Legal challenges to the single-exit price.

The Single Exit Price (SEP) was introduced by the government in 2004. The intention was to abolish discounts and levies applied on the sales of medicine and to make the pricing of medicines more transparent and affordable.

Using the Medicines and Related Substances Act No. 101 of 1965, the government was able to enforce the control of pricing of medicines by the formulation of new regulations. However, the control, in the form of the Single-Exit Price, only targets those who buy and sell medicines, and not those who manufacture it. Patented drugs are still more expensive than generic drugs even where the efficacy is the same. Pharmacists and dispensing medical practitioners are the ones feeling the effects of patented prices. Most pharmacist though charge co-payments to make up the difference which a scheme has not paid.

The government was perhaps supposed to approach manufacturing companies to see if pricing could not be reduced at the production level, to check why any two companies charge different prices for the same drug, one calling it patented, while one calling it generic. However, this might bring in conflicts with the Competition Commissioner as it would suggest collusion and price fixing which would amount to uncompetitive behaviour.

The single exit price, like any other pricing concept attempted by the government, did not go unchallenged by part of the private healthcare sector.

In the Minister of Health and Another v New Clicks South Africa (Pty) Ltd and others<sup>48</sup>, Chaskalson CJ of the Constitutional Court upheld in part the appeal by the Minister of Health and the Pricing Committee against a ruling by the Supreme Court of Appeal which ruled that the regulations regarding the single exit price were invalid.

The Constitutional Court judgement follows two contradicting judgements by the High Court and the Supreme Court of Appeal. The litigation cases arose from the regulations made to the Medicines and Related Substances Act to give effect to the pricing system for the sale of medicines by the Minister of Health on the recommendation of the Pricing Committee. The validity of the regulations were challenged.

*[5] In May 2004 two applications challenging the regulations on various grounds were instituted in the High Court by, New Clicks in one case, and the Pharmaceutical Society of South Africa in the other. The challenges included an attack on the functioning of the Pricing Committee, the procedures used by the Pricing Committee and the substance of the regulations promulgated by the Minister on the Pricing Committee's recommendation. The two matters were consolidated and heard by a bench of three judges. A majority dismissed the challenges while a minority judgement held that the regulations should be set aside on various grounds. The Applicants sought leave to appeal and on 20 September the appeal was heard and judgement was reserved.*

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<sup>48</sup> Minister of Health and Another v New Clicks South Africa (Pty) Ltd and others (CCT 59/2004) [2005] ZACC 14; 2006 (2) SA 311 (CC); 2006 (1) BCLR (CC) (30 September 2005

*While there was a delay in delivering judgement on the application for leave to appeal, the applicants decided to approach the Supreme Court of Appeal directly. The SCA set the matter for argument on 30 November and 1 December. Counsel for the Minister contended that the SCA had no jurisdiction to hear the appeal, as no decision had yet been given on the Pharmacies' (New Clicks and the Pharmaceutical Society) application for leave to appeal, and asked for argument on the issue of jurisdiction to be separated from argument from arguments on the other issues raised in the application. But the SCA directed that both arguments be heard at a single sitting. On 3 December the High Court delivered judgement refusing leave to appeal. On 20 December, the SCA ruled that it had jurisdiction to hear the matter and held that the regulations were invalid. The Minister and the Pricing Committee then took the matter to the Constitutional Court.<sup>49</sup>*

*[11] The Minister and the Pricing Committee argued that the SCA had not had jurisdiction to hear the appeal on the merits and that the appeal should succeed on that alone. They further contended that the Minister had complied with the terms of the Medicines and Related Substances Act when making the regulations. The Pharmacies, on the other hand argued that the SCA had jurisdiction to hear the appeal and that both in terms of the process followed and in regard to their substance, the regulations had failed to comply with the requirements of the Act. More particularly, they argued, that the fee the pharmacies were allowed to charge was not appropriate as required by the Act.<sup>50</sup>*

The CC held that the Act did permit the regulations to **provide for price control** in the manner in which the Minister and the Pricing Committee applied them. On the question of the appropriateness of Regulations 10 and 11 giving a dispensing fee, six members of the court held that they did not, while five held that the dispensing fee was appropriate. However, they also held that the regulations were not appropriate in so far as rural and courier pharmacies were concerned.

The Constitutional Court held unanimously that the challenge to the regulations should fail, and that the Supreme Court of Appeal was accordingly wrong in setting aside the regulations as a whole. However, the court considered a wide range of challenges to individual regulations. Considering whether because of the defects in Regulations 10 and 11, the entire regulations should fail, the court applied the conventional test of severance laid down in *Johannesburg City Council v Chesterfield House (Pty) Ltd*

*“Where it is possible to separate the good from the bad in a Statute and the good is not dependent on the bad, then that part of the Statute which is good must be given effect to, provided that what remains carries out the main object of the Statute.”<sup>51</sup>*

Regulations 10, 11 and 13 were remitted to the Pricing Committee for review.

The Minister of Health was ordered to pay half the costs of the respondents.

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<sup>49</sup> Supra (n48).

<sup>50</sup> Supra (n48)

<sup>51</sup> Supra (n48) para 15

The Constitutional Court judgement further strengthened the Department of Health's will to control pricing in private healthcare. The Minister of Health gained his authority to amend the annual pricing of medicines in the private sector.

In the **Government Gazette No. 41762, Issue 9 of 9 July 2018**, the Minister of Health made the following annual amendment to Regulation 10 of the Act:

Amendment of Regulation 10 (this followed the Constitutional Court Judgement)

The following regulation is hereby substituted for regulation 10 of the regulations,

10. (1) the appropriate dispensing fee, exclusive of VAT, as contemplated in section 22G of the Act to be charged by pharmacists, must:

(a) Where the single exit price of a medicine or scheduled substance is less than one hundred and nine rand and fifty seven cents (R109.57), the dispensing fee shall not exceed R13.15 plus 46% of the single exit price in respect of that medicine or scheduled substance;

(b) where the single exit price of a medicine or scheduled substance is greater than or equal to one hundred and nine rand seven cents (R109.57) but less than two hundred and ninety two rand and twenty six cents (R292.26), the dispensing fee shall not exceed R25.20 plus 33% of the single exit price in respect of that medicine or scheduled substance;

(c) where the single exit price of a medicine or scheduled substance is greater than or equal two hundred and ninety two rand and twenty six cents (R292.26) but less than one thousand and twenty two rand ninety four cents (R1022.94), the dispensing fee shall not exceed R77.00 plus 15% of the single exit price in respect of that medicine or scheduled substance;

(d) Where the single exit price of a medicine or scheduled substance is greater than or equal to one thousand and twenty two rand ninety four cents (R1022.94), the dispensing fee shall not exceed R178.00 plus 5% of the single exit price in respect of that medicine or scheduled substance.

(2) The provisions of regulation 10 must be reviewed annually by the Minister after taking into account-

- a. The need to ensure the availability and affordability of quality medicines and scheduled substances in the Republic;
- b. Annual inflation rates published by Statistics South Africa;
- c. Information supplied by pharmacists in accordance with guidelines determined by the Minister from time to time by Notice in the Gazette; and
- d. Any other information the Minister may deem necessary to consider.

(3) A pharmacist dispensing a medicine must-

(a) By means of a clearly displayed notice in the pharmacy, inform members of the public of the maximum fee structure used by such pharmacist to determine the dispensing fee; and

(b) Provide an invoice in respect of the sale of each medicine that clearly indicates the-

- (i) Dispensing fee charged; and
- (ii) The single exit price.

The above is part of the amended pricing regulations recommended for review by the Constitutional Court. When adjusting the annual single exit price, the Minister must apply the following guidelines stated under Regulation 8.

As far as the pricing of medicines is concerned, the government seems to have gained an upper hand in controlling the prices as compared to the pricing of consultation services.

According to Nicola Brink, the Executive director of the Self-Medication Manufacturers Association of South Africa (SMASA), medicine prices dropped by 22% after the introduction of the Single Exit Price<sup>52</sup>. According to Brink, the following benefits are offered by the Single Exit Price:

- Patients can know what they expect to pay to the pharmacist when they are given a prescription,
- Patients can know the maximum amount payable for the medicines,
- Overcharging is avoided,
- The choice of generics is broadened.

SEP information about medicines can always be found at [www.mrp.gov.za](http://www.mrp.gov.za).

### **Conclusion**

The court challenges to the Single-Exit price of medicines were mainly procedural, the objective of regulating pricing was upheld by the court. What is needed are cost studies to see whether the business of selling medicines is sustainable under the circumstances. As said earlier, the government has mainly targeted the buyers and dispensers of medicines for pricing control, pricing among the producers was not really affected. There are still big differences between the price of patented medicines and that of generic medicines.

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<sup>52</sup> Chowles T. How Medicine Prices are regulated in South Africa. <https://ehealthnews.co.za/medicines-prices-regulated-south-africa/>. Accessed 05/10/2018, 1.

## CHAPTER 5

### **Proposals for Negotiated Prices.**

#### **1. Introduction.**

The high court judgement by Judge Ebersohn, in the *Hospital Association of South Africa v Minister of Health and Another*,<sup>53</sup> nullifying the reference price list (RPL) regulations, has the results that there will not be an RPL to establish tariffs.

The current tariff structure is in need of being updated, and has resulted in uncoordinated changes to the tariff structure, which will be exacerbated in future.

This creates uncertainty with providers, members, and schemes on whether charges will be paid by medical schemes or not, resulting in members frequently not being covered for services provided using “new” tariff codes.

The CMS has engaged in discussions with various stakeholders to explore a process of determining tariffs through a multilateral tariff negotiation process with the aim of establishing a medical scheme tariffs for 2011. The purpose of this process is not to replace the RPL, but to arrive at a negotiated tariff. The Council for Medical Schemes and the Department of Health (DOH) have prepared a Discussion Document.<sup>54</sup>

The purpose of this document is to present a proposal on a tariff negotiation process, and will be circulated to affected stakeholders before the negotiation process starts.

#### **2. Proposed guidelines for the regulation of pricing in private healthcare.**

Presently, there is no authority or statutory body that controls pricing, and or formulated any regulations that control pricing of private healthcare services in South Africa, as far as consultation and procedural services are concerned. We have read how the government is controlling medicine pricing through amendments to the Medicines and Related Substances Act in previous sections. There is a need for an independent, non-political, non-profit and non-governmental organisation that will be registered under Section 21 of the Companies Act 61 Of 1973. In this regard, the South African Private Practitioners Forum has facilitated the establishment of an NPO that is called the South African Classification of Healthcare Interventions. Health man reports that several stakeholders have agreed to the formation of such an institution.<sup>55</sup>

The DOH in its document, the ‘Discussion Document: The Determination of Health Prices in the Private Sector’, made some few suggestions to the policy frame work for the discussion of pricing of healthcare services. The policy framework requires a coordinated approach by a number of structures to:

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<sup>53</sup> Supra (n47)

<sup>54</sup> Discussion Document: The Determination of Health Prices in the Private Sector. Version 1. 28 October 2010, Department of Health and the Council for Medical Schemes (DOH/CMS).

<sup>55</sup> Venter C, Principles and Guidelines for Establishing and Maintaining an Effective Medical Coding System in South Africa , Annexure E, 19 March 2013, Healthman

- ✚ Engage in consultations with the stakeholders;
- ✚ Guide interventions in a pre-legislative phase; and
- ✚ Support the development of and implementation of legislation.

According to the document, there is a provision for collective bargaining in terms of the Competition Act, which also restricts collusion.<sup>56</sup> The Act state this in terms of Section 3:

- (1) This Act applies to all economic activity within, the Republic, except-
  - (a) Collective bargaining within the meaning of section 23 of the Constitution, and the Labour Relations Act 66 of 1995;
  - (b) A collective agreement as defined in section 213 of the Labour Relations Act, 1995;
  - (c) .....
  - (d) ....;
  - (e) Concerted conduct designed to achieve a non-commercial, socio-economic objective or similar purpose.

Section 23 of the Constitution only deals with matters of labour relations and it clearly states that every trade union, employer’s organisation and employer has the right to engage in collective bargaining. It seems like only Sec (1) (e) may be applicable to the discussion of pricing, but how a discussion of pricing could be deemed non-commercial is a matter of interpretation.

It would seem that the objective of such a discussion panel would be for the ‘interest of the public’ and the Competition Tribunal would be silent.

Since the formation of the SACHI, the private sector has not come up with any discussion document about pricing in healthcare.

In its Discussion Document, the DOH states that the non-commercial socio-economic purpose of both the interim and final framework is consequently confirmed by the following:

- ✚ The private healthcare suffers from a number of systemic market deficiencies which, if not addressed through interventions such as these orchestrated by public authorities, would undermine access to healthcare in South Africa.
- ✚ The policy document envisaged here is coordinated and implemented by public authorities that serve no private commercial purpose, and operate under the direction of the Minister.<sup>57</sup>

There are many difficulties in trying to set-up prices in private healthcare because of many information asymmetries and market power imbalances, like the power gap between smaller and bigger hospitals, and that between primary practitioners and specialists. Often specialists and private hospitals get a bigger share of the market by controlling their own pricing. According to the DOH, many countries with sophisticated private healthcare sectors

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<sup>56</sup> Supra (n54) 23.

<sup>57</sup> Supra (n54) 23.

intervene in one way or another to manage systemic cost increases. As health costs invariably involve a combination of price and volume changes, interventions mainly focus both on managing price changes and mitigating perverse incentives by providers and patients that unnecessarily drive up demand (volume).<sup>58</sup>

In most cases, prices in private healthcare are not formally negotiated, each supplier sets his or her own price. This is competitive behaviour within the provisions of the Competition Act, but can have a negative impact on the consumers when the price gets high.

According to the document, unilateral pricing only works in markets facing normal competitive behaviour where the consumer has substantial discretion to avoid the purchase if over-priced. Private healthcare in South Africa does have enough competition, the issue may be the distribution of services, and NOT necessarily that competition is abnormal.

### **3. The proposed policy framework for price determination.**

The DOH, together with the Council for Medical Schemes in their Discussion Document, formulated a strategic framework that would bring the medical schemes, the government and the healthcare providers at one table to discuss the pricing and affordability of private healthcare services. How the medical schemes and the providers would come in a non-collusive manner remains a challenge. Another challenge is the acceptance of the invitation, which hopefully shall be welcomed by all parties. Acceptance or denial of the invitation has no legal consequences.<sup>59</sup>

#### **3.1. Strategies for the implementation of the proposals.**

In order to expedite resolution to the strategic challenges outlined above, a provisional policy framework has been developed for implementation both on an interim basis, and ultimately by way of legislation. It is however recognised that the interim framework will prove viable only with the consent of both medical schemes and providers. Achieving this consent within a voluntary framework may prove difficult, but will also be a test of the overall commitment of all parties to a fair process.<sup>60</sup>The policy framework envisages:

- The establishment of a process by which private health system prices can be negotiated collectively by all affected parties, through their representatives.
- The structuring of the process to:
  - Require completion of negotiations within discrete time periods;
  - Allow for the fair resolution of disputes by way of arbitration, which should also be completed within discrete time periods;
  - Ensure that no party can unfairly leverage off the process to serve a private commercial purpose.

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<sup>58</sup> Supra (n54) 14.

<sup>59</sup> Supra (n54) 15.

<sup>60</sup> Supra (n54) 16

- The ultimate production of the following outputs which shall be contained in a schedule published by the Council on an interim basis, and ultimately in terms of a legislated framework:
  - An agreed medical scheme tariff schedule;
  - An agreed provider price schedule;
  - An agreed code structure for prices;
  - Agreed billing rules and conduct of medical schemes in reimbursing providers;
  - An agreed general price change; and
  - An agreement on conduct in relation to balance billing.

### **3.2 The proposed process to arrive at negotiated tariffs**

According to the Discussion Document, the proposals for the process shall be circulated to concerned parties before the process starts.<sup>61</sup> The objectives of the process are the following:

- To focus on multilateral tariff negotiations to determine a non-balance-billing tariff fee structure. Failure to reach agreement on this shall be referred for arbitration;
- To set up a time frame for the process;
- To discuss logistics and governance of the process. The Council for Medical Schemes shall provide facilities for the process. A steering committee is suggested to comprise the following, the Health Professions Council of South Africa, the Nursing Council, the Competition Commission, and the Council for Medical Schemes;
- To formulate the constitution of the negotiating parties; and
- To formulate the mandate required for participation.<sup>62</sup>

There is no private organisation from the private sector that is listed in the steering committee, which is a probable cause of stand-offs before the process starts. The Council for Medical Schemes and the Department of Health may have done this to avoid contravening section 4 of the Competition Act.<sup>63</sup>

### **3.3 Failure to reach agreements at the negotiation process**

According to the document, once the negotiators fail to reach an agreement, the process shall be referred for arbitration within the provisions of section 33 of the Arbitration Act no. 33.<sup>64</sup> The specific arbitration institution is not mentioned by the document.

According to the document, each party shall bear its own arbitration costs in respect of submissions and presentations made to the arbitration panel.

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<sup>61</sup> Supra (n54) 28.

<sup>62</sup> Supra (n54) 28-33.

<sup>63</sup> Competition Act No. 89 of 1998

<sup>64</sup> Supra (n54) 35

## Conclusion

The process to reach a unified standard of pricing for private healthcare services is still riddled with uncertainties. Suggested negotiation processes are still about the methods to be agreed upon for the negotiation process, and not about the negotiation of the price itself. The formation of the steering committee is still a likely source of prolonged debate, as it would appear more unilateral concerning the government side. Another challenge is section 4 of the Competition Act. It remains to be seen whether the private practice organisations that would constitute the group that would go for negotiations would not constitute a firm or association of firms that is restricted by the Act to collude pricing. The presence of the government institutions may help to dilute section 4 of the Act by the application of section 3(1) (e) which states that:

3(1) This Act applies to all economic activity within or having an effect within, the Republic, except-

- (e) Concerted conduct designed to achieve a non-commercial socio-economic activity objective or similar purpose.

It is not known whether the private sector would use the South African Classification of Healthcare Interventions as the representative organisation should the process start.

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