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SECTION27 SUBMISSION TO THE PANEL OF THE MARKET INQUIRY INTO THE PRIVATE HEALTH SECTOR

31 OCTOBER 2014

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EXECUTIVE SUMMARY

1. SECTION27 is a public interest law centre that seeks to influence and use the law to protect, promote and advance human rights. One of our priority areas is the right of access to health care services as guaranteed by section 27 of the Constitution of the Republic of South Africa. As an organisation that acts in the public interest, we are concerned about equitable access to health care services in the private sector, particularly, pricing and the drivers of the high cost of health care in the private health care sector.

2. As our submission bears out, the inequities within what is supposed to be a single, unified South African health system, the inadequate and incomplete regulatory environments and inefficient underperforming regulators, place the health, wellbeing and sometimes even lives of users of the private health care system at risk.

STRUCTURE OF THE SUBMISSION

3. First, we discuss the importance of an evidence-based analysis of the merits of price regulation within in the health care sector. We note that the current absence of an effective framework for price regulation has the effect of compromising patient's rights to high quality, affordable health care services, despite the positive duties on the state to progressively increase access to health care services.

4. Second, we identify the harmful effects of the failure of the Professional Boards to fulfil their obligation to publish fee norms, noting that this regulatory gap effects patients' ability to exercise their right to complain about overcharging by health professionals.

5. Third, we investigate the extent to which the Council for Medical Schemes (CMS) has been effective in implementing existing regulations on Prescribed Minimum Benefits (PMBs) and preventing what appears to be widespread non-compliance with the coverage that all medical scheme members are entitled to by law, without any co-payments. As our patient testimonials, annexed to this submission, strongly indicate there are serious physical, emotional, psychological and financial harms caused by this non-compliance.

6. Our submission therefore grounds itself on an understanding of the centrality of the constitutional right to access to health care services to the Health Inquiry Panel's investigation into the private health care sector.

SUMMARY OF RECOMMENDATIONS

7. SECTION27 makes the following recommendations:

Price regulation

8. Based on international experience and the submissions on the 2010 proposed process to regulate prices, SECTION27 makes the following recommendations:
    8.1. A thorough, evidence-based, investigation by the Panel into potential price regulation in the private health care sector;
    8.2. An approach to price regulation as a means of fulfilling the state's duty to protect the rights of users of the private health care sector;
    8.3. Any recommended process for price setting should be transparent and independent and should include meaningful participation by relevant stakeholders;
    8.4. The determination and definition of the roles of existing statutory bodies (in particular the CMS, HPCSA and the Competition Commission) in the process of price regulation to prevent interventions which disrupt effective price regulation.

Council for Medical Schemes

9. SECTION27 encourages the Panel to make recommendations to assist and equip the CMS to fulfil the crucial function of ensuring compliance with PMBs. In particular, an assessment of the CMS's existing capacity to fulfil this function, including: access to human and financial resources; medical scheme members knowledge of and accessibility to its complaints procedures and mechanisms; ability to enforce compliance with their decisions; and political independence.

Health Professions Council

10. SECTION27 urges the HPCSA to urgently complete the ethical tariff process started in 2012. This is an important step in achieving greater equality in accessing health care services for health care users in the private health care sector in accordance with the Bill of Rights.

General recommendations

11. The Panel's recommendations should aim to achieve more equitable access to health care services. The panel must consider whether any proposed intervention will have the effect of diminishing access to health care services, and, if it does, reject such a proposal.

12. SECTION27 recommends that the Panel and the Commission complete all-important investigation into the private health care sector as expediently as possible. The process of initiating the Health Inquiry and implementing its beginning phases have already been subject to unnecessary delays as a result of litigation initiated by a significant stakeholder in the inquiry.[1] Though it essential that the entire inquiry process complies with proper, fair process within the bounds of the law, SECTION27 notes that further delays in the inquiry process would allow existing rights violations to continue. As our patient testimonials indicate, these violations result in significant, avoidable human suffering.[2]

13. For this reason, and to avoid the complications and delays involved in the implementation of the recommendations made by the Panel in terms of the banking inquiry,[3] SECTION27 recommends that the Panel should propose a process to be followed in the assessment and implementation of its recommendations.

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[1] *Netcare Hospitals (Pty) Ltd v KPMG Services (Pty) Ltd and Another (47505/2013) [2014] ZAGPJHC 186 (22*
[2] Refer to patient testimonials at annexure A of this submission.
[3] See for example, M Griffiths and W Gumbie, "Probing the value of market inquiries from the perspective of the Banking Enquiry" (2014) available at http://www.compcom.co.za/assets/Uploads/events/Eighth-Annual-Conference/Parallel-2A/Banking-Enquiry-Griffiths-Gumbie.pdf.

I INTRODUCTION

1. SECTION27 is a public interest law centre that seeks to influence and use the law to protect, promote and advance human rights. One of our priority areas is the right of access to health care services as guaranteed by section 27 of the Constitution. As an organisation that acts in the public interest, we are concerned about equitable access to health care services in the private sector, particularly, pricing and the drivers of the high cost of health care in the South African private health care sector. We are also concerned about the impact that the high cost of health care has on the quality of health care services accessed by users of the private health care sector.

The importance of a patient-focused Health Inquiry

2. SECTION27 recommits to supporting the Competition Commission ("Commission") and the Health Inquiry Panel ("Panel") in conducting a thorough, transparent, participatory, patient-focused inquiry.[4] In order to assist with this process, as a public interest organisation, our submission draws attention to the impact that private sector regulations have on the users of the private health care system. This submission is therefore grounded in our interaction with clients and members of the public who use the private health care system as a means of accessing their constitutional right to access to health care services.

3. We agree that given the various explanations put forward for the costs, prices and expenditure increases in the private health care market, a market inquiry is an

[4] See SECTION27's submissions on to the Commission and Panel thus far: Section27 (2014), - Submission on the Draft Statement of Issues for the Market Inquiry into the Private Health Care Sector, 30 June 2014 [SECTION27 Submissions: Draft Statement of Issues]; Section27 (2014), - Submission on the Draft Guidelines for Participation for the Market Inquiry into the Private Health Care Sector, 30 June 2014 [SECTION27 Submissions: Draft Guidelines for Participation]; Section27 (2013); and - Submission on the Draft Terms of Reference for Market Inquiry into the Private Health care Sector, 24 June 2013 [SECTION27 Submissions: Draft Terms of Reference].

appropriate mechanism to establish the facts upon which the Panel can make evidence-based recommendations that serve to promote competition that is grounded in enhancing affordable, accessible, innovative and good quality private health care in South Africa.[5]

4. As the Competition Commission frankly acknowledged in its Terms of Reference, South Africa's private health care sector faces many challenges. The market inquiry into the private health care sector ("Health Inquiry") is intended to investigate these challenges and assist in determining and understanding their causes and making recommendations, which will contribute to remedying them. Unlike other markets for goods and services, market outcomes in the private health care sector affect people's health and wellbeing in a direct way.

5. As our submission bears out, the inequities within what is supposed to be a single, unified South African health system, the inadequate and incomplete regulatory environments and inefficient underperforming regulators, place the health, wellbeing and sometimes even lives of users of the private health care system at risk.

6. With this in mind, our submission to the Panel aims to support its investigation into the private health care sector by pinpointing some of the weaknesses in the regulatory environment which SECTION27 has encountered in our work and the impact that these weaknesses have on those who are often referred to as "consumers" or "users" of the private health care system in competition analysis: people. We do so by integrating anonymous patient testimonials and real life examples throughout our submission and intend doing so during the public hearings. These are just a few examples to highlight the experience of patients in the private health system.

[5] *Terms of Reference for Market Inquiry into the Private Health care Sector* Government Gazette Notice 1166 of 2013 at 80-5. [Terms of Reference]. On the appropriateness of a market inquiry mechanism to perform this function, see Timothy Fish Hodgson, "Public interest, the Constitution and the Health care Inquiry: preventing patients from becoming the victims of market failure" [Hodgson] (2014) Competition Commission of South Africa: Eighth Annual Conference on Competition Law, Economics & Policy part I and II, available at http://www.compcom.co.za/assets/Uploads/events/Eighth-Annual-Conference/Parallel-2A/Public-interest-the-Constitution-and-the-Private-Health care-Inquiry-preventing-patients-from-becoming-the-victims-of-market-failure.pdf at 18-21.

7. Our submission begins by painting the constitutional context, which differentiates health care markets from other "ordinary" markets for goods and services, and the private health care sector in South Africa from private health care sectors elsewhere in the world. This constitutional context, we note, informs the competition analysis which the Panel will undertake. We suggest that a rights-based approach to the Panel's investigations will best ensure that the Panel's analysis remains people-focused and capable of alleviating inequality within our health system and improving the quality of health care available in both the private and public sectors. In so doing, we seek to provide the Panel with some assistance in navigating the complex competition law analysis, which it is mandated to perform, and has committed to conducting through a constitutional lens.[6]

8. Using these tools, which we submit are of more general application throughout the entire Health Inquiry process, we concretise our approach by analysing three key regulatory issues within the private health care sector and the human impact which they have on a day-to-day basis on those who access their constitutional right to access health care services through the private sector.

9. First, we discuss the importance of an evidence-based analysis of the merits of price regulation within in the health care sector. We note that the current absence of an effective framework for price regulation has the effect of compromising patient's rights to high quality, affordable health care services, despite the positive duties on the state to progressively increase access to health care services. Not only may this absence of price regulation contribute to the high and increasing prices prevalent in the health care sector, but it may also lead to uncertainty for patients when they access health care services in the private sector.

[6] Terms of Reference at 80; Competition Commission of South Africa, *Statement of Issues* (2014), [Statement of Issues] at para 19 ("The Panel appreciates that access to health care services is a constitutional right and that this right also informs the competition assessment it must undertake").

10. Second, we identify the harmful effects of the failure of the Professional Boards to fulfil their obligation to publish fee norms, noting that this regulatory gap affects patients' ability to exercise their right to complain about overcharging by health professionals. This regulatory gap creates a void in determining overcharging and may prejudice patients and may damage the all-important relationship of trust between patients and health professionals.

11. Third, we investigate the extent to which the Council for Medical Schemes (CMS) has been effective in implementing existing regulations on Prescribed Minimum Benefits (PMBs) and preventing what appears to be widespread non-compliance with the coverage that all medical scheme members are entitled to by law, without any co-payments. As our patient testimonials, annexed to this submission, strongly indicate there are serious physical, emotional, psychological and financial harms caused by this non-compliance. Patients in desperate need of cancer treatment, hip replacements and chronic HIV medication, for example, have their health and wellbeing compromised by medical schemes and the CMS's failure to effectively implement the regulatory scheme governing PMBs.

12. The power of patient testimonials and examples of human impact captured in this submission extends beyond their usefulness in highlighting specific instances in which regulatory weaknesses result in harm to patients. They illustrate the risks and harm, which many of the 8.7 million people, with medical aid cover, who access their health care services through the private health care sector, are exposed to on daily basis. Importantly, it is not only medical scheme members that access the private health system. In 2012, out of pocket expenditure was estimated at R18.2bn (approximately 15.1%), which was the next largest contributor to private health care expenditure after medical schemes and before private insurance.[7] According to a recent survey, "rural

[7] Terms of Reference for the Market Inquiry into the private health care sector, p. 78

informal residents were more likely to pay for inpatient services out of pocket than their counterparts".[8]

13. The Constitution of the Republic of South Africa, 1996 ("Constitution") seeks to shield everyone in South Africa against these risks, harms and dangers. It does so by entrenching access to health care services as a fundamental human right.

14. Our submission therefore grounds itself on an understanding of the centrality of the constitutional right to access to health care services to the Health Inquiry Panel's investigation into the private health care sector. The importance of this right in this context, has been acknowledged by the Competition Commission in its Terms of Reference,[9] the Panel in its Statement of Issues[10] and various stakeholders with public interest mandates in their submissions to the Panel, including the National Department of Health,[11] The Congress of South African Trade Unions[12] and SECTION27[13]. Indeed, the High Court has described the Health Inquiry in its entirety as a "constitutional measure" taken in order to comply with the state's obligation to "promote and fulfil that right of access to health care".[14]

15. This submission builds upon our submission to the Commission on the Draft Terms of Reference;[15] our submission to the Panel on the Draft Statement of Issues[16]; and

[8] Human Sciences Research Council, "South African National Health and Nutrition Examination Survey" (2013) at 299 accessible at http://www.hsrc.ac.za/uploads/pageNews/72/SANHANES-launch%20edition%20(online%20version).pdf.

[9] Terms of Reference at 80.
[10] Statement of Issues at para 19.
[11] National Department of Health, *National Department of Health: Response to Draft Statement of Issues* (2014) at 1.
[12] Congress of South African Trade Unions, *COSATU Submission on the Statement of Issue and Guidelines for Participation in the Competition Commission's Health Inquiry*, 30 June 2014 at 2.
[13] SECTION27 Submission: Draft Statement of Issues at p 1-8.
[14] *Netcare Hospitals (Pty) Ltd v KPMG Services (Pty) Ltd and Another (47505/2013) [2014] ZAGPJHC 186 (22 August 2014)* at para 28.
[15] SECTION27 Submissions: Draft Terms of Reference.
[16] SECTION27 Submissions: Draft Statement of Issues.

Guidelines for Participation[17]; and our presentation at the Competition Commission's Policy Conference earlier this year.[18] It accordingly is best read in the context of these submissions and presentation.

A Single, Unified Health care System Aim At Realising The Right To Access Health Care Services

16. The Constitution affords everyone the right to have access to health care services.[19] Interpreted generously, purposively, and in light of the history and context of the existing South African health care system,[20] this broadly phrased right is applicable to all avenues through which people in South Africa access health care services: the health care system as a whole including both the public and private health care sectors. Simply put, people do not relinquish their constitutional rights when they buy health care services through the private health care sector. Nor should their choice to access health care services in the private sector make them participants in a separate health system, subject to separate constitutional standards, artificially separated from those applicable to the public health system.

17. This interpretation of the right to access to health care services is confirmed by the National Health Act, which, "recognising the socio-economic injustices, imbalances and inequities of health services of the past", and in an attempt to realise the right to access to health care services seeks to "*unite the various elements of the national health system* in a common goal to actively promote and improve *the national health system*" of South Africa and "promote a spirit of co-operation and shared responsibility among public and private health professionals and providers".[21] This statement, which reveals Parliament's legitimate interpretation of the constitutional right to access to health care services,

[17] SECTION27 Submissions: Draft Guidelines for Participation.
[18] Hodgson above n 2.
[19] Constitution, s 27.
[20] L du Plessis, *Interpretation* in S Woolman et al (eds) *Constitutional Law of South Africa* 2ed Vol 2 at 32-167-32-169); *Investigating Directorate: Serious Economic Offences and Others v Hyundai Motor Distributors (Pty) Ltd and Others In re: Hyundai Motor Distributors (Pty) Ltd and Others v Smit NO and Others* [2000] ZACC 12; 2001 (1) SA 545 (CC) [Hyundai] at 21-6.
[21] National Health Act 61 of 2003, Preamble. Emphasis added.

infuses and animates South Africa's one, unified health system aimed at providing equitable and quality access to health care for all.

18. Although the Panel's focus will rightly be on the private health care system, it is necessary that it understands this sector as part of a unified whole aimed at realising the right to access to health care services. Users of the private health care system are entitled to the full protection of their constitutional rights. All analysis of regulation of the private health care sector and indeed all action taken by regulators, legislators, members of the executive and market participants should be approached from this constitutionally-informed perspective. The constitutional right to access to health care services is therefore at the centre of Health Inquiry. Though this much has already been recognised by the Commission and the Panel, it is worth emphasising given the stances taken by some stakeholders in the sector in their submissions to the Panel and their interaction with the media.[22]

19. In the following section we identify and expand upon three major ways in which the right to access to health care services is understood in the context of a unified health care system, applies to the private health care sector and the Health Inquiry's investigation. First, we detail the obligation of state institutions to protect the right to access to health care services of users of the private health care sector through regulation. Second, we describe the need to investigate the different markets and market participants in the sector with cognisance of market participants own constitutional obligations in terms of the right to access to health care services. Third, we discuss the relevance of the right to the Panel's competition analysis and

[22] For example, see Mediclinic, *Market Inquiry into the Private Health care Sector: Draft Statement of Issues* (2014) at 17 (claiming that the constitutional obligation in terms of the right to access to health care services lies solely on the state); Life Health care *Comments on Statement of Issues and Guidelines for Participation in the Market Inquiry into the Private Health care Sector* (2014) at p 1 (denying the Constitution's direct relevance to the market inquiry process). See also for example, Chis Charter, "Health Market Probe Could Surprise" (2014) Business Day, available at http://www.bdlive.co.za/opinion/2014/06/06/health-market-probe-could-surprise (suggesting that the rights focus of the inquiry is, inappropriately, "geared towards suit an agenda aimed at engineering the private sector to serve the state's delivery objectives") and Jason Urbach, "Letter: Inquiry a Red Herring" (2014) Business Day, available at http://www.bdlive.co.za/opinion/letters/2014/08/28/letter-inquiry-a-red-herring (describing the Health Inquiry as a "red herring" and scoffing at a rights-based approach as "legitimate justification" for it to proceed).

competition law and policy more broadly. Throughout we refer the Panel to literature, which may be of assistance in developing a theory of how, when and why the right to access to health services must impact on its decision-making.

II APPLICATIONS OF THE RIGHT TO ACCESS TO HEALTH CARE SERVICES DURING THE HEALTH INQUIRY

20. Section 27 of the Constitution places an obligation on the state, acting through all of its organs, branches and spheres, to take "reasonable legislative and other measures" in order to ensure the "progressive realisation" of the right to have access to health care services.[23] As the obligation to realise the right to access to health care services appropriately rests "primarily" – though not exclusively – on the state, the state's role in ensuring it is realised through the private health care sector is a fitting starting point.[24]

The right to access to health care services and the state's duty to regulate health care markets

21. The Constitutional Court has confirmed that, consistently with the duty to protect the right to access to health care services in terms of international law[25] and section 7(2) of the Constitution,[26] "government is entitled to adopt, as part of its policy to provide access to health care, measures designed to make [health care services] more affordable than they presently are".[27] Moreover, the duty to protect requires the state to regulate for purposes which extend far beyond making health care "affordable". The state is required to "regulate domestic health service delivery in a manner that enables equitable access to health care services and ensures the availability, accessibility,

[23] Constitution, s 27.
[24] M Pieterse, *Can Rights Cure?* (Pretoria: *Pretoria University Law Press*, 2014) [Pieterse] at 128.
[25] Committee on Economic, Social and Cultural Right, General Comment No.14. "The right to the highest attainable standard of health" [General Comment 14].
[26] Constitution, s 7(2).
[27] *Minister of Health and Another v New Clicks South Africa (Pty) Ltd and Others* (CCT 59/2004) [2005] ZACC 14 at para 32.

acceptability and quality of health care."[28] This interpretation of the right to access to health care services is also consistent with the Constitution's founding values: a commitment to the achievement of equality[29] for all health users and a respect for the inherent human dignity of patients,[30] at what is often a particularly vulnerable time when they interact with health care system, private or public.

22. Furthermore, this interpretation is consistent with General Comment 14 of the Committee on Economic, Social and Cultural Rights which requires that when payment for health care services takes place it must be affordable:[31]

> "Payment for health care services, as well as services related to the underlying determinants of health has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups".[32]

23. Building on this clear statement, The United Nations Special Rapporteur on Health has acknowledged the importance of the regulation of corporate entities providing health care services, arguing that globalisation has had a significant impact on access to health care services globally due to transnational corporations' global power and reach and, particularly because:

> "not all States have a robust regulatory mechanism, owing either to their poor negotiating power or because they are unwilling to hold domestic corporations accountable for harms caused, obligations should also be conferred on domestic corporations."[33]

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[28] Pieterse at 127.
[29] Constitution, s 1 (a).
[30] Ibid.
[31] See *Government of the Republic of South Africa and Others v Grootboom and Others* (CCT11/00) [2000] ZACC 19; 2001 (1) SA 46 [Grootboom] at para 45 (highlighting the importance of the General Comments in "plumbing the meaning" of the Constitution).
[32] General Comment 14 at para 12(b).
[33] Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. 11 August 2014. United Nations General Assembly A/69/299.

24. Understanding any and all regulation of the private health care sector as a component of the duty to protect the right to access to health care services is therefore of paramount importance to the Panel's investigation of the private health care sector. The Panel will have the opportunity at the end of the inquiry to make recommendations to the legislature, the executive and regulatory authorities. Despite the fact that the Panel's primary focus is a health rights informed competition assessment, it must ensure that these recommendations are ultimately consistent with state entities' obligations to fulfil the duty to protect. To do otherwise would be to risk recommending unconstitutional action. As Pieterse concludes, the constitutionality of reform and regulatory measures in the health care sector turn on whether their overall aim – the achievement of "more equitable access to health care services" is achieved.[34] The recommendation of measures that "have the effect of actually diminishing access to care, will be unlikely to pass constitutional muster".[35]

25. Furthermore, as organs of state, empowered and bound by the Constitution and other legislation, both the Panel and the Commission are themselves bound to respect, protect, promote and fulfil the right to access to health care services throughout the proceedings and in the aftermath of the Health Inquiry. Therefore, though neither the Panel, nor the Commission are regulators, we submit that the duty to protect the right to access to health care services requires both to exercise their powers in a manner that will assist regulators in realising the right to access to health care services.

26. Steps taken towards the realisation of the right to access to health care services generally, and the fulfilment of the duty to protect in particular, are constitutionally required to be reasonable and effective.[36] Whether these steps take the form of legislation, regulations, policies or official recommendations of the Panel and

[34] Pieterse at 139.
[35] Ibid.
[36] Grootboom at para 39-44*; Glenister v President of the Republic of South Africa and Others* (CCT 48/10) [2011] ZACC 6; 2011 (3) SA 347 (CC) ; 2011 (7) BCLR 651 (CC) (17 March 2011) at para 189 ("Implicit in section 7(2) is the requirement that the steps the state takes to respect, protect, promote and fulfil constitutional rights must be reasonable and effective").

Commission that may lead to legislation, regulation or policy reform, this requires that the action of the relevant organ of state must be:

26.1. conceived of with an appropriate understanding of constitutional and statutory obligations.[37]

26.2. both conceived of and implemented reasonably;[38]

26.3. comprehensive and coherent;[39]

26.4. balanced and flexible;[40]

26.5. transparent, accessible and made known to the public;[41]

26.6. co-ordinated in accordance with the principles of co-operate governance, each relevant sphere and branch of government and all relevant regulators accepting appropriate responsibility for the implementation and design or measures taken to fulfil the duty to protect the right to access to health care services;[42]

26.7. capable of equipping institutions responsible for implementing health policy and programmes and protecting the public interest;[43]

26.8. able to assist in making the right to access to health care services more accessible to a larger number and wider range of people as time progresses, with a primary focus on urgently attending to the needs of those facing the most intolerable challenges to the right to access to health care services;[44] and

26.9. able to make appropriate financial and human resources available to the relevant government departments and regulators to ensure that all recommendations, regulations, policies and legislation are capable of reasonable and effective implementation.[45]

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[37] *City of Johannesburg Metropolitan Municipality v Blue Moonlight Properties 39 (Pty) Ltd and Others* [2011] ZACC 33 at para 74.
[38] Grootboom at para 40-43.
[39] Id para 39 and 40.
[40] Grootboom para 68, 78 and 95.
[41] *Minister of Health and Others v Treatment Action Campaign and Others (No 2*) (CCT8/02) [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002) at para 123.
[42] Grootboom at paras 40 and 60.
[43] Id at para 43.
[44] Id at para 45.
[45] Id para 30.

27. SECTION27 submits that in the context of the Health Inquiry it is necessary to emphasise the capacity of regulators to carry out their respective mandates in realising rights is an important part of the analysis. According to *Grootboom*, both the content and implementation of measures adopted to advance socio-economic rights must be balanced and inclusive. The court held in the context of the right to have access to adequate housing:

> "In determining whether a set of measures is reasonable, it will be necessary to consider housing problems in their social, economic and historical context and to consider the *capacity of institutions responsible for implementing the* programme".[46]

28. Furthermore, the requirements for reasonable, constitutionally compliant, action are relevant throughout the processes of the Panel and the Commission, given that, as Matojane J has held, that the Health Inquiry in its entirety – and all of its component parts – is a "constitutional measure" in terms of the right to access to health care services.[47] The importance of these requirements, and in particular the necessity for properly conceived of budgeting, costing and spending for the right to access to health care services in the particular context of regulators will emerge below in our analysis of regulators such as the Council for Medical Schemes and the Health Professionals Council. While we focus on these two regulators, other regulators such as the South African Nursing Council, Pharmacy Council and the Medicines Control Council, are in a similar position. The constitutional obligation placed on regulators such as the CMS and HPCSA to cost, budget and spend reasonably and effectively in order to realise the right to access to health care services cannot be overstated. The Public Protector in a presentation to Parliament has recently emphasised the necessity for adequate budgeting.[48] A press release of the Public Protector's office notes that "repeating the

[46] Grootboom at para 43.
[47] *Netcare* above note 9 at para 28.
[48] Public Protector, "Public Protector Thuli Madonsela calls for funding proportional to workload" (22 October 2014) available at http://www.gov.za/public-protector-thuli-madonsela-calls-funding-proportional-workload; Legal Brief, "Madonsela considers ConCourt option on funding" (24 October 2014) available at http://www.legalbrief.co.za/article.php?story=20141024095806240; Thabo Mokone, "Madonsela: No funds, no public protector", Timeslive (23 October 2014) available at http://www.timeslive.co.za/thetimes/2014/10/23/madonsela-no-funds-no-public-protector.

calls she has consistently made over the years, Public Protector Madonsela implored Parliament to seriously revisit the funding of her office",[49] because without adequate funding it could not fulfill its mandate. Madonsela has also been reported to note that if an appropriate budget is not secured then it may be necessary to "approach the Constitutional Court" to ensure the Public Protector's ability to operate effectively.[50]

29. Finally, the Panel will have to consider not only the duty on the state entities to progressively realise the right to access to health care services, but also the nature and extent of the constitutional obligations of private parties, including market participants such as medical aid schemes and their administrators, health care professionals, pharmaceutical companies and private hospitals, among others. It is important to recognise the interplay between the state's duty to regulate the private health care sector and the nature and extent of private parties' obligations in respect of the right to access to health care services:[51]

    29.1. In a state with a unified health care system in which 8.7 million people access health care services through the private sector, the obligations of private and public sectors – and those operating within these sectors – cannot be hermetically separated. The private and public systems must form part of a coherent whole to avoid distortionary effects of the one on the other to the detriment of the users of the health care system.

    29.2. The Constitution requires courts to delve into development of the common law to give effect to rights in the Bill of Rights only "to the extent that legislation does not give effect to that right".[52] It therefore appears to show a sensible preference that the legislature and executive take up the primary

[49] Public Protector, "Public Protector Thuli Madonsela calls for funding proportional to workload" (22 October 2014) available at http://www.gov.za/public-protector-thuli-madonsela-calls-funding-proportional-workload.
[50] Legal Brief, "Madonsela considers ConCourt option on funding" (24 October 2014) available at http://www.legalbrief.co.za/article.php?story=20141024095806240
[51] S Liebenberg, "The application of socio-economic rights to private law" TSAR (2008) 3 at 471. (Describing this interaction between the state's duty to protect and constitutional obligations placed on private parties as "an important nexus … to protect the socio-economic rights of more vulnerable members of society against powerful private actors").
[52] Constitution, S 8(3)(b); Pieterse at 147.

responsibility for the elucidation of the constitutional obligations of private parties.

30. Pieterse therefore concludes that "[o]verall, it is clear that the Constitution allows for legislative and judicial elaboration of a network of private obligations flowing from socio-economic rights".[53] SECTION27 supports this approach and submits that it is therefore crucial that the recommendations made by the Panel – an expert, dedicated entity legislatively empowered to make recommendations to the legislature and the executive and required to table its report in Parliament – considers and proposes regulatory changes which are cognisant of and assist in detailing the nature and extent of the constitutional obligations of market participants in the private health care sector. We now turn to a brief discussion on the private obligations imposed by the Constitution on private parties in respect of the right to access to health care services.

The constitutional obligations of market participants in private health care markets in respect of the right to access to health care services

31. Unlike many other Constitutions, the South African Constitution places constitutional obligations in terms of the rights in the Bill of Rights on both the state and private parties. It does so deliberately, so as to commit our society as a whole, through justiciable legal duties, to the project of transformation it sets out.[54] Friedman therefore correctly observes that:

> "The Constitution thus confronts South Africa's tragic past not only idealistically, but also realistically: it recognises that the pervasive injustices of apartheid not only have to be eliminated from public life, *but also have to be rooted out of the private sphere*."[55]

[53] Pieterse 149. See also Liebenberg at 471.
[54] N, Friedman "The South African Common Law And The Constitution: Revisiting Horizontality" (2014) 30 *SAJHR* at 67.
[55] Ibid, emphasis added.

32. We submit that the socio-economic rights entrenched in the Constitution, including the right to have access to health care services, have a crucial role to play in this transformation, which the late Chief Justice Langa described as requiring a "social and economic revolution".[56] The right to access to health care services is therefore precisely the type of right, which, due to its very nature, the existence of a large private health care sector, and its purpose within the Constitution's broader project of transformation, ought to place constitutional obligations on private as well public entities.[57] Pieterse notes that there appears to be broad consensus that the right to access to health care services will, to some extent at least, place obligations on private parties.[58]

33. The question is therefore not *whether*, but *when* and *to what extent* market participants in private health care markets carry constitutional obligations. Health care providers, medical schemes administrators, hospitals and other participants in private health care markets elect to participate in a market for health care services and products.[59] These services and products are, as the Panel has recognised,[60] not ordinary commodities – they are also allocated to everyone as constitutional rights. Though, unlike the state, market participants are not inherently obliged to participate in the realisation of the right to access to health care services, in choosing to operate in these markets, most on a for-profit basis, participants in the private health care sector accept not only moral obligations but also the constitutional obligations attendant to realisation of the right to access to health care services.[61]

34. The Panel will have to grapple on a case by cases basis with the extent of the constitutional obligations of specific market participants in specific instances. However, we submit that several general observations can be made about these "horizontal" constitutional obligations.

[56] P Langa "Transformative Constitutionalism" Stell LR (2006) 3 351.
[57] SECTION27 Submissions: Draft Statement of Issues at para 7-9.
[58] Pieterse at 144-49.
[59] Pieterse at 144-49.
[60] Statement of Issues at para 19.
[61] Hodgson above note 2 at 19-21.

35. First, we submit that the more necessarily vulnerable a user of the health care system is in his or her interaction with a market participant, the stronger the participant's constitutional obligation is. This is supported by Liebenberg's interpretation of the Constitutional Court's judgment in *Khumalo v Holomisa*, which she suggests indicates that the extent of a constitutional obligation on a private party "should depend on the power of the private party concerned to undermine the interests and values protected by the particular right".[62]

36. Second, we submit that, at a minimum, the constitutional obligations placed on private participants in terms of the right to access to health care services include both "negative" and "positive" elements, including:

    36.1. A "negative constitutional obligation not to impair" a user of the health care systems right to access to health care services. In *Juma Masjid*, albeit in the context of a different socio-economic right, the Constitutional Court indicated that this would require a private party to act reasonably in ensuring such impairment does not take place.[63]

    36.2. A positive obligation to support the state's efforts to progressively realise the right to access to health care services in the private sector, which includes:

        36.2.1. The duty to comply fully with the regulations which regulate the markets in which a market participant operates, actively placing users of the sectors right to access to health care services at the core of all decisions.

        36.2.2. The duty to provide state entities, such as the Panel and the Commission, with information they require to regulate the private sector. The High Court has confirmed that stakeholders in the inquiry such as hospital group Netcare are "obliged by law to disclose any

[62] Liebenberg at 470.

[63] *Governing Body of the Juma Musjid Primary School & Others v Essay N.O. and Others (CCT 29/10) [2011] ZACC 13; 2011 (8) BCLR 761 (CC) (11 April 2011)* at para 54-6.

information that is relevant to the market inquiry *voluntarily and in a candid manner*."[64]

36.2.3. The duty to assist in good faith with the expeditious implementation of recommendations made by the Panel and subsequent action taken by the executive or the legislature in terms of such recommendations.

37. Though private companies and health care professionals are fully entitled to operate in and profit from operating in the private health care sector in South Africa, this is subject to the adherence to strict monitoring, appropriate regulation and compliance with their own constitutional obligations in terms of the right to access to health care services.[65] In addition to being legally binding conditions for their participation in these markets, these strict standards affirm the dignity of those market participants, particularly medical professionals who hold strong ethical and moral duties to their patients. As Friedman notes, more generally, enforcing constitutional obligations against private parties "reaffirms the human dignity of those who bear such duties as much as it does those who benefit from their performance."[66]

Competition law analysis through the lens of the right to access to health care services

38. The Constitution is not only relevant to broad health care regulation but also central to competition analysis itself. In the context of legislation regulating the manufacture, sale and possession of medicines that the Constitutional Court noted "there is only one system of law. It is shaped by the Constitution which is the supreme law, and all law … derives its force from the Constitution and is subject to constitutional control."[67] Competition law, and therefore competition analysis and assessment are no exception. The Panel in its Statement of Issues acknowledges this, stating that the right to access to health care services "informs the competition assessment that it must undertake".[68]

[64] Netcare at para 110. Emphasis added.
[65] SECTION27 submissions: Draft Statement of Issues.
[66] Friedman at 67.
[67] *Pharmaceutical Manufacturers Association of South Africa and Another: In re Ex Parte President of the Republic of South Africa and Others* [2000] ZACC 1; 2000 (2) SA 674 at para 44.
[68] Statement of Issues at para 19.

39. The Commission's Terms of Reference indicate that the Health Inquiry was initiated in part in order to fulfil the purposes of the Competition Act.[69] These purposes include broad public interest goals including the advancement of the "social and economic welfare of South Africans",[70] which, according to the constitutional principles of statutory interpretation, *must* be considered in the interpretation of the Act itself and the Commission's role in enforcing it.[71] As the Constitutional Court has acknowledged the Act "deliberately sets out both efficiency and equity based goals".[72] Indeed the Act itself is purposed more generally at "addressing the apartheid legacy" and "correct[ing] market outcomes" as part of the process of economic reform and transformation.[73] The Competition Tribunal has acknowledged that the historical and present context of existing markets should be considered in the assessment of competition.[74] The private health care sector is a prime example of a market in which this kind of contextual approach to markets is crucial. It is beyond dispute that injustices, imbalances and inequities within the South African health care system were "generated by apartheid".[75]

40. According to Heywood, the shape of the health system is determined by and evolved under successive colonial governments, the Union and finally under apartheid. For 300 years health care services had been planned and provided primarily to serve the white minority. Whilst there was an important medical tradition established through mission hospitals and by a small number of maverick white health professionals, as a matter of

[69] Terms of Reference at p 74.
[70] Competition Act 89 of 1998, s 2(c).
[71] Hyundai at para 21-6, see also Hodgson at 6-13 for a full discussion on the purposes of the Competition Act in the context of the Health Inquiry.
[72] *Competition Commission v Yara South Africa (Pty) Ltd and Others* (CCT 81/11) [2012] ZACC 14; 2012 (9) BCLR 923 (CC) (26 June 2012) at para 49.
[73] G Makhaya & S Roberts "Expectations and outcomes: considering competition and corporate power in South Africa under democracy" (2013) *Review of African Political Economy* Vol 40 (138) 556.
[74] *Competition Commission vs Sasol Chemical Industries Ltd and Safripol (Pty) Ltd* Case No: 011502 [*Sasol*], (executive summary available at http://www.comptrib.co.za/cases/complaint/retrieve_case/1722) at paras 89 and 119.
[75] A Hassim, J Berger & M Heywood (eds), *Health & Democracy*: *A guide to human rights health law and policy in post-apartheid South Africa* (Cape Town:*Siber*Ink, 2007) at 167.

policy the health of black people was only a consideration if it affected the labour supply or if infection posed a risk to public health for white people.[76]

41. SECTION27 therefore submits these equity-based and broader public interest goals of the Act take on still greater importance when the markets that are subject to scrutiny are markets in which the products and services traded are constitutionally entrenched rights.[77] We therefore submit that the right to access to health care services ought to pervade and inform the Panel's competition assessment throughout: the Panel's competition assessments themselves should therefore be focused both at ensuring efficient health care markets and at ensuring equitable and high quality health care markets, which produce equitable and high quality health outcomes for their users.

42. Furthermore, we submit that the general importance of a right to access to health care services focused approach to competition assessment in private health care markets is even more pronounced in the context of the Commission's power to initiate market inquiries in general and the context of the Health Inquiry in particular.[78] The Health Inquiry provides an opportunity and a platform for nuanced, wide-ranging far-reaching, development oriented policy analysis which may, for various reasons, be less appropriate for the Commission to conduct when performing its other core functions in terms of the Act.[79] The Commission's powers to contribute to economic reform and transformation through its complaints and referral processes have been inhibited over the years by court rulings.[80] In some markets in the private health care sectors its attempts to do so through merger control have been equally unsuccessful.[81]

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[76] See, M Heywood "The Broken Thread: primary health care, Social Justice and the Dignity of the Health Worker", available at http://wiser.wits.ac.za/system/files/documents/Heywood%20Public%20Positions.pdf) quoting H Coovadia et al, The Health and Health System of South Africa: historical routes of the current public health challenges, *The Lancet*, Vol 374, September 5 2009.
[77] Hodgson at 3-6.
[78] Ibid at 13-21.
[79] Competition Act, s 21. Hodgson at 13-18.
[80] See for example *Woodlands Dairy (Pty) Ltd and Another v Competition Commission* (2010 (6) SA 108 (SCA); [2011] 3 All SA 192 (SCA)) [2010] ZASCA 104; 105/2010 (13 September 2010) at para 20; and See *South African Breweries and Others v Competition Commission* (134/CR/DEC07) [2011] ZACT 73 (16 September 2011) at PART B.
[81] G Robb, "Creeping mergers – should we be concerned? A case study of hospital mergers in South Africa" (2013) Competition Commission 7th Annual Conference.

43. SECTION27 therefore submits that the nature of market inquiries as non-adversarial, broad, truth-seeking and disseminating exercises makes market inquiries the most appropriate and effective vehicle through which the Commission and the competition law regime can contribute towards achieving more equitable health care markets that produce better health outcomes. The Panel has dedicated resources, pre-existing expertise, wide information gathering powers and access to all relevant stakeholders placing it in a perfect position to make policy sensitive, structural and regulatory recommendations.

44. SECTION27 has made detailed arguments on the impact of the Constitution on competition law and assessment in the particular context of the Health Inquiry.[82]

<u>The role of other rights in the Health Inquiry: Freedom of Trade and Occupation, Dignity, Equality and related rights</u>

45. Rights intersect, interact with and inform one another and are therefore indivisible.[83] There are various rights of users of the private health care sector other than the right to access to health care services, which are critically impacted on a daily basis in accessing their health care services, including the rights to life,[84] privacy,[85] freedom and security of person[86] and human dignity.[87] As the patient testimonials show, the rights of vulnerable persons such as the elderly and children are also particularly implicated and impacted on by inefficiencies within the private health care sector.[88] Children's rights to health care services are specifically entrenched as a separate right in the Constitution and the best interests of children are of paramount importance in any situation in which children are affected.[89] The right to freedom and security of the person is relevant to reproductive

[82] Hodgson above note 2.
[83] *National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others* (CCT11/98) [1998] ZACC 15; 1999 (1) SA 6 at para 112.
[84] Constitution, s 11.
[85] Constitution, s 14.
[86] Constitution, s 12.
[87] Constitution, s 10.
[88] See for example, Annexures to this Submission marked: A2 and A9.
[89] Constitution, s 28. See in particular s 28 (2) and s 28(1)(c).

health,[90] an issue particularly important for women. The Panel should throughout its processes remain cognisant of the web of intersecting constitutional rights that may be relevant to any given investigation, assessment or recommendation it undertakes.

46. In particular, SECTION27 submits that the Panel should be conscious throughout that its recommendations will impact on human beings who "must be treated with care and concern",[91] particularly in the circumstances which pertain to their health and in interactions with health providers and medical schemes. In these circumstances, where people are often poorly informed and desperate as a result of ailing health, users of health care services may become vulnerable as a result of information asymmetries and unequal bargaining power.[92]

47. In addition, on a systemic level, the rights to equality and dignity are crucially relevant to the Panel's assessments and recommendations: they highlight that the Constitution is not neutral to the outcomes of a given market structure, particularly in the context of a market for health care services. The constitutional right to "equal protection and benefit of the law"[93] and its core value "the achievement of equality"[94] require the Panel to adopt an approach to its mandate and competition assessments which, as highlighted above, favours an equitable health care market, perhaps even at the expense of competing aims such as markets efficiency.[95] Similarly, the right to have one's dignity respected and protected[96] and the corresponding constitutional value of human dignity,[97] require the panel to adopt a patient-focused inquiry which favours market outcomes that provide quality access to health care services.

[90] S 12 of the Constitution.
[91] Grootboom at para 44.
[92] Terms of Reference at 81.
[93] Constitution, s 9.
[94] Constitution, s 1(a).
[95] National Health Act, Preamble read with Competition Act, s 2.
[96] Constitution, s 10.
[97] Constitution, s 1.

48. Finally, we note that the Panel acknowledges, for the first time, the relevance of the recognition of freedom of trade and occupation in its Statement of Issues.[98] As a constitutionally entrenched right,[99] the right to freedom of trade and occupation is no doubt relevant to any attempted regulation of a trade or occupation, indeed in the context of the regulation of health care professionals, the Constitutional Court has said that the Constitution "embraces both the right to choose a profession and the right to practice the chosen profession".[100]

49. Despite this protection Ngcobo J, writing for a unanimous Court, continued to note that this right also contemplates appropriate regulation of professions, which, "if anything … should enhance [medical practitioners] dignity in the eyes of the public that they serve".[101] The Court therefore emphasised that the state's obligation to make medicines affordable was sufficiently compelling that it would ordinarily justify even price control measures which curtail to some extent the freedom of trade and occupation of health professional seeking to dispense medicines.[102]

50. Though limitations on the freedom of professionals to choose and practice their professions should not lightly be undertaken, in the context of the health care professionals, the public interest in such regulation will therefore often justify such an encroachment.

51. SECTION27 therefore respectfully agrees with this finding of the Constitutional Court and its conclusion that "provided it is in the public interest and not arbitrary or capricious, regulation of a vocational activity for the protection both of persons involved in it and the of the community at large affected by it, is to be both expected and

[98] Statement of Issues at para 15. The freedom of trade and occupation was not alluded to as a rationale for inquiry in either the Commission's Terms of Reference or the Panel's Draft Statement of Issues, which preceded the issuing of its Final Statement of Issues.
[99] Constitution, s 22.
[100] *Affordable Medicines Trust and Others v Minister of Health and Another* (CCT27/04) [2005] ZACC 3; 2006 (3) SA 247 (CC); 2005 (6) BCLR 529 (CC) (11 March 2005) [Affordable Medicines] at para 66.
[101] Ibid at para 104.
[102] Pieterse at 131; Affordable Medicines at para 14-18.

welcomed."[103] This, in our submission, is likely to be the case with many attempts to regulate professionals working in both the public and private health care sectors.

III PRICING OF HEALTH CARE SERVICES

52. Regulation of the private health care sector in accordance with the duty to protect the right to access to health care services is the subject of much debate within the sector and amongst regulators. While controversial, price regulation will have to be considered by the Panel during the Health Inquiry.

53. SECTION27 feels that the prevailing concerns about price regulation in the private health care sector should not deter the Panel from engaging in a rational, evidence-based, comparative investigation as to the merits of various existing and potential forms of price regulation. As we have discussed above a rights-based approach to the private health care sector and competition law make it clear that certain health care market outcomes are constitutionally preferred.

54. In addition, South African competition law itself contemplates the possibility of direct competition law interventions to curb excessive prices. The Act prohibits dominant firms from leveraging market power to "charge an excessive price to the detriment of consumers".[104] This provision, must, in the context of the markets for health care products and services, as we have argued above, be interpreted through the lens of the right to access to health care services and the public interest provisions of the Act. SECTION27 submits that it may well be that prices tolerated in ordinary markets are considered excessive for competition purposes in the context of markets within the private health care sector as a result of the state and market participants' constitutional obligations in terms of the right to access to health care services.

[103] Affordable Medicines at para 60.
[104] Competition Act, Section 8(a).

55. The Competition Tribunal has recently adopted a similarly contextual, purposive approach to the excessive pricing provision. In *Competition Commission of South Africa v Sasol Chemical Industries Limited*, the Tribunal, in coming to the conclusion that Sasol had engaged in excessive pricing in contravention of the Competition Act considered the "particular and very significant historical state support" and the absence of "risk taking and innovation" on Sasol as relevant to assessing its position of dominance.[105] Crucially, the nature of Sasol's advantage was found to be not only monetary, but in "creating" Sasol's dominance which "has endured in the current market(s)".[106]

56. SECTION27 submits that this is a useful approach to the interpretation of the excessive pricing provision, which also requires nuanced application in markets such as those within the private health care sector. Information asymmetries and unequal bargaining power are characteristics of health care markets throughout the world. A constitutionally entrenched right to access to health care services may require more interventionist, context-sensitive approaches to both price regulation and competition law analysis.

57. SECTION27 therefore submits that an analysis of current price-setting forms both part of the Panel's constitutional mandate in terms of the right to access to health care services as well as its competition law mandate in terms of at very least the excessive pricing provision.

58. SECTION27 therefore reaffirms[107] its support for both the Commission, in its Terms of Reference[108] and the Panel, in the Statement of Issues[109] in their observations that high and increasing prices for which there are presently competing explanations and insufficient rational explanation are at the core of the rationale for and focus of the inquiry.

[105] Sasol at paras 89 and 119.
[106] Sasol at para 108.
[107] SECTION27 Submissions: Terms of Reference; SECTION27 Submissions: Draft Statement of Issues and SECTION27 Submissions: Guidelines for Participation.
[108] Terms of Reference at 80.
[109] Statement of Issues at para 16.

59. What follows is an attempt to detail the context in which price regulation should be considered and to place before the Panel recommendations based on both South African experiences and attempts to engage on the regulation of prices within the private health care sector and some comparative examples.

Why pricing matters

60. Across health care markets and health systems, prices for health care goods and services are a matter of concern. In contrast to most other markets, the conditions at which payers purchase goods and services for their own health not only determine health care costs in general but they also impact on the overall fairness of the health care system. If prices are unaffordable to the majority of society, then they necessarily lead to an inequitable distribution of health care services within society.[110]

61. There is a long and established literature arguing that health care is far from being a classic, ordinary, market for general goods and services. Health care is characterised by patients that have imperfect information. Providers have the information and thus exercise a disproportional influence on decisions about patient's options.[111] Patients tend to rely on health care providers, especially General Practitioners, to help them navigate the health care system. Medical practitioners have the ability to recommend services, which, in turn, determine their own reimbursement. Insurers, such as Medical Schemes, are interested in providers of health care services economising on the use of services in order to reduce their expenditure. This combination of information asymmetry and diverging motivations has often justified a greater degree of price regulation in health as governments seek to ensure socially optimal levels of service delivery, and promote efficiency in the system.[112]

62. The issue of pricing and cost of health care services in the South African private health care sector is one that has been fraught with debate and discussion over the past 10

[110] See above paras 19 and 43-9.
[111] Blomqvist, A "The doctor as double agent: Information, asymmetry, health insurance, and medical care" (1991) *Journal of Health Economics,* vol.10.
[112] Ellis, R. P. and T.G. McGuire "Supply-Side and Demand-Side Cost Sharing in Health Care" (1993) *J. Econ. Perspectives,*volume 7(4), p. 135-51.

years. This primarily follows on the ruling made by the Competition Commission that prohibited groups of providers and groups of medical schemes from setting tariffs. The rulings have been criticised by funders and providers alike, which combined with the lack of a suitable alternative bargaining forum or mechanism for price determination, have become an obstacle to the efficient functioning of the private health care market.

63. In addition to the lack of a mechanism for price negotiation, there is currently no price transparency provided to patients at the point of selection of a health care practitioner (e.g. on referral by a doctor to a specialist). Most specialists are selected by doctors (GPs) but in the absence of price and quality transparency the patient is often left with no choice or simply follows her doctor's recommendation. As a result there is currently no real competition between doctors on quality or price. In addition, the HPCSA restricts promotional activities by practitioners on the basis that it may mislead consumers and induce excessive use of services.

64. From a patient perspective the lack of any price setting mechanism has meant that there may be a divergence between the prices reimbursed by medical schemes and those charged by providers. Consequently, each health care service provider can set his or her own fee. Whereas, medical schemes individually publish the amount they are willing to reimburse at. The resulting gap has to be funded by the patient out of pocket. The fact that a large gap cover insurance industry (which covers this difference between reimbursement and provider charges) has grown in recent years suggests that the affordability of these gaps is a serious issue for patients.

65. Gap cover products are short-term insurance products designed to provide a benefit to cover the difference between what a policy holder's medical scheme pays and what the health care provider charges. Cover relates mainly to specialist fees for in-hospital procedures and benefits are paid to the policyholder. In 2012, it was estimated that there were up to 250,000 gap cover policies in effect.[113]

[113] Finmark Trust & Lighthouse Actuarial Consulting, 2012. Review of the South African Market for Hospital Cash Plan Insurance. September 2012, at 27

66. South Africa's challenges in health are substantial. Against a backdrop of significant inequality and poverty, South Africa is facing limitations on revenues and challenges with delivery capacity in the public sector. It also has fewer doctors and nurses compared to countries such as Australia, Canada, the US and European countries.[114] These factors, among several others, have contributed to the emergence of a large private health care sector with a disproportionate share of medical specialists. Access to private service providers is largely determined by the ability to pay with the most common means of financing access to private health care services being medical schemes.

67. Accounting for 42% of total health spending, the medical scheme industry in South Africa is more economically significant than in any OECD country.[115] The high level of spending on medical schemes is particularly remarkable given how small a share of the population it covers. Approximately 16% of the population (8.7 million people) are enrolled in a medical scheme.[116]

68. The major beneficiaries of the high level of spending on medical schemes are private hospitals and medical specialists. Though private hospitals account for only 26% of the country's total hospital bed capacity, they engage 55% of doctors.[117] According to the Council for Medical Schemes, expenditure on specialists amounted to 24.5% and private hospitals to 35.3% of total expenditure in the last financial year.[118]

69. The high proportion of spending on private sector facilities and their major role in engaging doctors mean that prices set in the private sector can have an enormous impact across the entire health care system. It affects the affordability of medical scheme coverage, limits access to private care to those who can afford it and sets norms for doctors' wages that may constrain the public sector's expansion efforts.

[114] Kumar, A.; Lagasnerie, G.; Maiorano, F. and Forti, A. (2014), - Pricing and Competition in Specialist and Medical Services, An Overview for South Africa, OECD Report, May 2014.
[115] OECD, Pricing and Competition in Specialist Medical Services (May 2014).
[116] Council for Medical Schemes Annual Report 2013/2014 at page 146.
[117] Health Systems Trust (2010), *Health Indicators*, http://www.hst.org.za/content/health-indicators (Last accessed: 22 April 2014).
[118] Council for Medical Schemes Annual Report 2013/2014 at p 150.

Competition and Health Regulators

70. As is discussed above, health regulators are charged with protecting public health and the public interest. The objectives of regulators vary and include ensuring quality, value for money, accountability of providers and funders and social goals such as equality. Every regulator has specific objectives but ultimately, health regulators in South Africa have an obligation to ensure improved access to health care services and must ensure that the private sector operates in a manner consistent with human rights principles.

71. Moreover, competition law applies to the health care sector and to the firms that participate in it. The competition authorities have considered a range of issues in the private health care market, including the excessive pricing of ARVs, exemption applications and the rulings against negotiated prices in respect of Board of Health care Funders (BHF) and South African Medical Association (SAMA).

72. A good example of the importance of the competition authorities' interventions in vindicating the right to affordable health care services is the Hazel Tau Case. Ms Tau was in need urgent access to ARVs at time at which the cost of ARVs per month was R4500. This was beyond the amount the average South African could afford. Without this treatment, there was a real prospect that she and others would die. Ms Tau herself says in retrospect that the Commission was literally her only hope at the time.[119]

73. A combination of advocacy efforts of the Treatment Action Campaign and SECTION27 and investigations and findings of the Competition Commission resulted in a far-reaching settlement with pharmaceutical companies, the net effect of which is that today the same ARV medication is available at less than R100 per month. The Competition Commission in its 15th year review notes that the result of these efforts was that "with affordability no longer an obstacle, many people were able to access treatment" and

[119] Competition Commission, "Affordability and Accessibility of A.R.T in South Africa" (2014) in *15 Years of Competition – A People's Account* at 13-15 available at http://www.compcom.co.za/assets/Publications/15-Years-of-Competition-Enforcement.pdf

that "almost 12 years after the Hazel Tau case, and the misery of HIV and AIDS in South Africa, the country's success on ART is a good story to tell".[120] SECTION27 submits that the Commission's human rights, patient-focussed approach to investigations within the private health care sector played a major part in ensuring this victory.

74. On the other hand, the Competition Commission has been criticised for its other decisions that have had a negative impact on pricing of health services. The first complaint considered SAMA's annual publication of tariffs for the pricing of the provision of medical services.[121] The second complaint was in respect of the BHF's annual publication of benchmark tariffs for health care services.[122]

75. Following the Commission's investigation, the Competition Tribunal ordered by consent that the collectively determined price lists compiled by industry participants violated section 4(1)(b)(i) of the Competition Act and that BHF and SAMA would cease the conduct. The conduct was found to fall into the category of prohibited agreements or concerted practices by firms in a horizontal relationship that result either directly or indirectly in the fixing of a purchasing or selling price.

76. This was deemed to be anti-competitive because the parties that were meant to be in competition with one another were agreeing on prices for the health services they provided or funded. The SAMA and BHF decisions ended negotiations on tariffs. The decisions prevented any discussion on the fixing of a purchasing or selling price and have been interpreted to include preliminary talks between the respective stakeholders to discuss any proposals on regulation of pricing.

77. The Panel should interrogate the impact of the Commission's decisions in the escalating costs of health care services in the sector and make recommendations that will help to address the consequences.

[120] Ibid.
[121] *Competition Commission v SAMA* case no 23/CR/Apr04, 26 April 2004.
[122] *Competition Commission v BHF* case no 07/CR/Feb05, 3 March 2005.

78. Some countries have a specialised competition framework particular to the health sector in light of the particular nature of health care services as a right or public good rather than an ordinary commodity. This entails legislation that empowers collective negotiations between providers and purchasers to set prices to help meet public health objectives. We would like to draw the Panel's attention to the following examples:

78.1. **France**: the Social Security Code allows for negotiations between medical associations and the National Union of Health Funds.[123]

78.2. **Switzerland**: the Federal Act on Health Insurance allows negotiations between medical associations and insurers associations.[124] The Federal Act on Cartels and Other Restraints on Competition excludes the "statutory provisions that do not allow for competition in a market for certain goods or services," which includes provisions that establish an official market or price system.[125]

78.3. **Turkey**: in respect of minimum fees and price setting by medical associations, the competition authority decided that a medical association that set two different price schedules – one for purchases by the social security institutions and one for individual purchasers – was contrary to competition law.[126]

78.4. **Australia**: the Australian Competition and Consumer Commission has allowed collective bargaining among small private hospitals for a fixed period of five years and subject to a range of conditions, including limiting the size of the bargaining group. [127]

78.5. **The Netherlands**: the Authority for Consumers and Markets has issued guidelines on agreements and negotiations between health insurers and health providers. Principles for these agreements include the following:[128]

78.5.1. The agreement must contribute to improved efficiency of production or distribution, or to technical or economic innovation;

78.5.2. Efficiencies resulting from the agreement should benefit consumers;

[123] Article L. 162-5, Code de la Securité Sociale.
[124] Article 42 and following of the Federal Health Act.
[125] Article 3 of the Federal Act on Cartels and Other Restraints of Competition.
[126] OECD, Pricing and Competition in Specialist Medical Services (May 2014) at page 31.
[127] Available from Australian Competition and Consumer Commission website http://registers.accc.gov.au/content/index.phtml/itemId/1036396/fromItemId/401858.
[128] OECD, Pricing and Competition in Specialist Medical Services (May 2014) at page 31.

78.5.3. Restrictions must be proportionate to the objective to be achieved;

78.5.4. Agreement should not entirely eliminate competition in the market.

The history of pricing in South Africa

79. The South African government over the last 15 years has taken some steps to attempt to regulate the price of medicine and the price of health care services. The Medicines and Related Substances Control Amendment Act, 101 of 1965 and regulations provide for regulation of medicine prices. However, the regulatory framework is incomplete, exposing users of the private health care sector to the risk high and increasing prices and low quality health outcomes. In 2014, the Department of Health released draft regulations for transparent pricing (international methodology) for public comment.[129] The rationale for the draft regulations is a concern about the cost of medicines and the need to ensure that people in South Africa get value for money and do not pay higher prices than their counterparts in other countries.

80. Though the current regulatory framework and draft proposals purport to serve the purpose of reasonably limiting prices, what we have seen is that whilst there has been an attempt to regulate the price of medicines there has been no attempt or only failed attempts to regulate the price of private health care services more generally. To date none of the proposed price setting mechanisms for private health care services have been implemented successfully and processes that have once been started have stalled. The 2010 proposed process was the last attempt by the state to regulate prices. The most recent attempt was the 2012 HPCSA proposed process on the determination of fee norms for health care professionals. Both are explored in more detail below.

81. Price setting in the private health care sector in South Africa after 1990 has a somewhat turbulent history. Prior to 1994 the Representative Association of Medical Schemes (RAMS), later the BHF, negotiated a set of statutory tariffs, which were Gazetted on an annual basis in terms of the Medical Schemes Act, 43 of 1975. These tariffs provided the fixed rate at which medical schemes would reimburse providers.

[129] Government Gazette 37625 Government R354.

82. In 1994 amendments to the Medical Schemes Act were made. RAMS then shifted from negotiating reimbursement prices for all medical schemes to negotiating reference prices. Medical schemes would then use these price points as a reference in negotiations with their providers. SAMA also began to publish their own reference price list "Benchmark Guide to Fees for Medical Services", which applied to medical practitioners (both GPs and specialists). These were set higher than the RAMS prices and were used by courts and the HPCSA to determine cases of overcharging.[130] As such, where doctors charged the SAMA rates and were reimbursed at a lower rate, patients were required to pay the difference. The Hospital Association of South Africa similarly published a recommended tariff schedule that dealt with hospital tariffs.

83. As discussed above, the 2004 Competition Commission ruling found that centralised reference price lists amounted to price-setting and were collusive. The practice was therefore outlawed and punitive fines were administered on the various associations including the BHF[131], the Hospital Association of South Africa (HASA)[132] and SAMA.

84. Following on this ruling each scheme needed to negotiate prices with each provider separately. While this was feasible in the case of large hospital groups, it was infeasible in the case of individual health care providers. As such, there was still a need for some form of list price. Following the Competition Commission rulings there were four separate attempts at publishing lists (or methods to arrive upon a list).

The National Health Reference Price List (NHRPL)

85. The NHRPL was established by the Council of Medical Schemes in the wake of Competition Commission decisions that prohibited collective bargaining to set prices. The NHRPL was a cost-based price that sought to be a form of reference price that

[130] *Competition Commission v SAMA* case no 23/CR/Apr04, 26 April 2004.
[131] Competition Tribunal, 07/CR/Feb05, In the matter between the Competition Commission and the Board of Health care Funders.
[132] Competition Tribunal 24/CR/Apr04, In the matter between the Competition Commission and the Hospital Association of South Africa.

would provide a basis for bargaining (as it was impractical for every medical scheme to bargain with every provider). It also aimed to be a resource for understanding health care costs and therefore inform policy. The CMS published the NHRPL in 2004, 2005 and 2006. The NHRPL was not a recommended price for doctors, nor a recommended reimbursement level for medical schemes but was rather a model that aimed to provide a basis for individual price setting. The NHRPL documentation[133] notes the following:

85.1. Providers should be able to plug in their own costs and profitability expectation into the NHRPL model to develop their own estimate of costs.

85.2. Medical schemes should determine reimbursement based on their own affordability, but that the NHRPL would provide a measure of transparency on provider costs.

85.3. Prices determined are national averages and may differ geographically.

The Department of Health Reference Pricelist (DoH RPL)

86. In 2006, the Department of Health (DoH) took over the publication of a reference price list. They aimed to publish RPL for 2007. This differed from the NHRPL as it aimed to be a definitive price list from which variation was not possible. Again in 2009 the DoH attempted to publish a RPL. The RPL 2007-2009 were set aside by the High Court as a result of legal action from most provider groupings[134]. The Court found that the process prior to the publication of Regulations Relating to the Obtainment of Information and the Process of Determination and Publication of Reference Price List, promulgated on 23 July 2007 was flawed. This was primarily on the basis that the DoH did not publish the regulations after consultation with the National Health Forum as is required by s 90(1) of the National Health Act and therefore contravened Promotion of Administrative Justice Act 3 of 2000 (PAJA). As a result of this both the 2008 and 2009 RPLs were also set aside. Secondly the ruling stated that s 90(1)(u) and (v) of the NHA were designed and intended to achieve discrete and distinct purposes and as such reliance on s 90(1)(u) to publish regulations that relate to s 90(1)(v) was not valid.

[133] Council for Medical Schemes, Circular 8 of 2005, Paragraph 34, Page 6
[134] *HASA v Minister of Health*, Case No. 37377/09, Date: 28/07/2010.

87. In addition, Ebersohn J noted that the reference price lists were intended to be a "reflection of actual prices of services rendered, procedures performed and items utilised." Other issues raised included the manner in which the regulations specify who could make submissions. Specifically, only professional associations and regulatory bodies were able to make submissions (no individuals or companies). Furthermore, sample sizes were specified for each discipline in a manner that excluded any submissions that represented less than 95% of the population, which led many stakeholder submissions to be rejected. Once the RPL was overturned, there was effectively no form of price list available for use by the private sector.

The 2010 proposed process for regulating prices

88. In October 2010, the Department of Health in conjunction with the Council for Medical Schemes published a discussion document, which included a draft framework for the price determination in the private health care sector. The purpose of the policy process was to address the void in the regulatory framework following the HASA judgment in 2010 setting aside the RPL. There was a view that urgent action was needed to address the void as well as to curtail excesses in the private health care sector.

89. The discussion documents proposed the establishment of two parallel pricing mechanisms: A consultative process to establish a health care pricing authority that was envisaged to be fully operable by November 2013 and a voluntary interim process to negotiate tariffs while the consultative process to establish a pricing authority continued.[135] The key feature of the price determination authority was a negotiation-based system within discrete time periods with arbitration to resolve disputes.

90. The purpose of the first parallel process was to establish a health care pricing authority via multilateral negotiations with stakeholders, beginning with the release of the draft

[135] Department of Health (2010) - The Determination of Health Prices in the Private Sector, Discussion Document, Version 1.00, 28 October 2010.

discussion document on the determination of health prices in the private sector. The purpose of the interim pricing mechanism was to arrive at negotiated health care tariffs, including PMBs and other services; general increases; billing rules and code structures.

91. Comments were solicited from the public. The response to the draft discussion document gave a good indication of the views of the many stakeholders in the private health care sector. Most were willing to participate in the process but only on the condition that it is a lawful process. Criticism of the mechanism centred on the arbitration process. In particular there was a strong opposition to the design, which allowed arbitrators to choose between competing submissions but not to choose any variation that took components of each submission. Furthermore, there was concern over the fact that there would be no recourse to courts. There has been no feedback from the Department of Health as to whether it is proceeding with the 2010 process or whether a different process is contemplated.

92. Today we are confronted with an environment in South Africa where the cost of health care service is unregulated. South Africa would benefit from greater transparency about what health care services actually cost. In addition, government should have access to that information in order to allow it to put in place a system that allows reasonable regulation of prices and service provision to the benefit of all people. This is certainly true in the context of National Health Insurance, which is the government's plan to achieve universal access to health care services. In order to address the financing problems, the cost of private health care certainly has to be addressed.

International experience

93. It is generally accepted across different countries that governments or public authorities play a proactive role in fostering the setting of prices in order to reach policy objectives. Research suggests that setting prices encourages providers to compete for quality, helps

share financial risks between insurers and the provider; and can proactively prevent escalation in prices of health care services in highly concentrated markets.[136]

94. Price regulation is used to control the costs of health care. There exists a considerable economic literature on the heterogeneity of production costs across providers, and the asymmetric information between health care providers and their regulators.[137] Building on this is a substantial literature that suggests competition for quality amongst providers is more likely to occur when prices are fixed. When prices are fixed, providers have to compete on other parameters than prices. Provided there are quality standards, price signals provide an incentive to improve efficiency and can encourage competition on quality.

95. Gaynor has suggested that the expected impact of competition in hospital markets depends on how prices are determined.[138] In markets with price competition, where hospitals can set their own prices, increasing the number of competitors could improve or harm clinical quality depending on the ability of patients to assess both quality and price. As hospital quality is often difficult to measure and observe, competition on prices and quality in the hospital sector may lead to reductions in prices and quality if consumers are more able to observe price than quality. In markets where prices are fixed by a regulator, as long as the reimbursement rate is higher than hospitals' marginal costs, increased competition should improve hospital quality.[139]

96. Fixed prices are further used in order to avoid the impact of perverse market consolidation in the hospital sector where increases in prices in some regions could

[136] OECD, Pricing and Competition in Specialist Medical Services (May 2014) at page 15ff.
[137] See for example: Newhouse, J.P. (1996), —Reimbursing Health Plans and Health Providers: Efficiency in Production Versus Selection Author(s) , *Journal of Economic Literature,* volume 34(3), pp. 1236-1263.
[138] Gaynor, M. (2012), Reform, competition, and policy in hospital markets, Roundtable on Competition in hospital services, DAF/COMP(2012)9.
[139] Gaynor, M. (2012), Reform, competition, and policy in hospital markets, Roundtable on Competition in hospital services, DAF/COMP(2012)9.

create inequalities in the cost of care. The overwhelming finding in the literature is that consolidation leads to higher prices.[140]

Price regulation: recommendations

97. The main concerns about the pricing of service providers emerge because the market participants within the private health care sector have power. Negotiations between medical schemes, private hospitals and medical practitioners determine how a large section of the country's funds for health are spent, and sets norms which will likely impact on the public sector's ability to compete for medical personnel. Though we have argued that market participants within the sector carry constitutional obligations in terms of the right to access to health care services, the state and regulators within the private health care sector have a crucial role to play in the public interest to ensure that pricing mechanisms produce affordable prices and quality health outcomes.

98. International experience shows that prices impact on all activities within a health system and that they constitute an important instrument for optimising service delivery. Some form of price setting currently takes place in the payment of specialists and for hospital services across most countries, although this is often not a transparent process. International experience also shows that the economic rationale for setting prices is to control costs, foster competition on quality and mitigate against excessive financial claims. For these reasons, governments have often been more open to allowing for the setting of price norms or regulating prices in health care markets than in other parts of the economy.

[140] See Dranove, D. and M.A. Satterthwaite (2000) "The industrial organization of health care markets", in Culyer, A. and Newhouse, J., (eds.), *Handbook of Health Economics*, pp. 1094-1139. Gaynor, M. and W. B. Vogt (2000) "Antitrust and competition in health care markets" in Culyer, A. and Newhouse, J., editors, *Handbook of Health Economics*, pp. 1405-1487; Vogt, W.B. and R. Town (2006), —How has hospital consolidation affected the price and quality of hospital care?; *Research Synthesis Report No.9, Robert Wood Johnson Foundation.;* Gaynor, M. and R.J. Town (2011), —*Competition in Health Care Markets"*, NBER Working Paper.

99. The experience of other countries demonstrates that price schedules can be useful public goods. They can be used by the public sector to better link payments or budgets with activity. They can create a basis on which the public sector can draw on private services, and can be used by private insurers to scale prices to reflect their commercial objectives. Above all, pricing benchmarks provide certainty to doctors and patients. Given the extent of distrust between key health care actors in South Africa today, better pricing could improve the environment in which policy development occurs going forward and contribute significantly towards the fulfilment of the state's obligation to take reasonable and effective regulatory steps to protect users of the private health care sector's right to access to health care services.

IV NON-COMPLIANCE WITH MEDICAL SCHEMES LEGAL FRAMEWORK

The purpose of the Medical Schemes Act

100. Like all other health care legislation, the Medical Schemes Act should be understood as a measure taken by Parliament to progressively realise the right to access to health care services, in accordance with the state's obligation in terms of the duty to protect this right and by means of private sector regulation. This is particularly so, as is the case with the Medical Schemes Act, where an explicit, detailed, purpose is not spelled out in the Act.[141] The provisions of the Medical Schemes Act must be interpreted through the lens of this purpose.

101. In addition, obligations placed on market participants such as medical aid administrators, should be interrogated as legislative attempts to articulate the constitutional obligations of market participants, in addition to regulators, with regard to the right to access to health care services. We submit that this is particularly

[141] The application chapter of the Act, Chapter 2, affirms the supremacy of the Constitution and indicates that the Act is purposed at being the primary governing legislation for Medical Schemes, but does not spell out an explicit purpose. See also the CMS Annual Report 2012/13 at p 28 ("Section27 of the Constitution places the obligation on the state to make reasonable legislation to progressively realise access to health care. The Medical Schemes Act 131 of 1998 represents such legislation…").

necessary when it comes to one of the Act's core protection mechanisms: the requirement that every medical scheme make provision for what the Regulations to the Act refer to as "Prescribed Minimum Benefits" (PMBs).

102. As will emerge below, the protections provided by PMBs are vital. They ensure that extremely vulnerable patients have access to lifesaving treatments for conditions such as HIV, tuberculosis, heart conditions, cancers, important and necessary surgical operations and emergency medical treatment. All in all 270 conditions and 25 chronic illnesses constitute PMBs.[142] As the CMS has noted all people "regardless of whether they are serviced by the public or private health care sector, deserve good quality care."[143] When medical schemes fail to meet their obligations to pay in full, without co-payments, for the diagnosis, care and treatment of PMB conditions they expose their members to the risk and reality of aggravated illness, placing users under significant physical, financial, emotional and psychological strain and deteriorating health. SECTION27 submits short-payment and non-payment for claims relating to PMBs therefore amount to serious violations of the right to access to health care services.

The purpose of Prescribed Minimum Benefits

103. Section 20 of the Act indicates that no person may carry out the business of a medical scheme without being registered in terms of the Act.[144] The Act's guardian, the Council for Medical Schemes, is not permitted to register any medical scheme, unless, amongst other things the scheme in question complies with the provisions of the Act[145] and such registration "is not contrary to the public interest".[146]

104. The public interest in respecting, protecting, promoting and fulfilling the right to access to health care services is then manifested explicitly in Chapter 5 of the Act, which

[142] Regulations to the Medical Schemes Act 131 of 1998, Annexure to Regulations [Regulations to Medical Schemes Act]. CMS Annual Report 2013/14 at page 35.
[143] CMS Annual Report 2013/14 at page 31.
[144] Medical Schemes Act 131 of 1998, s 20.
[145] Ibid, s 24 (2)(b).
[146] Ibid, s 24 (2)(f).

spells out the requirements for the "rules of medical schemes". It states that no medical scheme can be registered or carry on any business unless it makes provision in its rules for "minimum benefits available to members".[147] It is worth repeating that medical schemes cannot either lawfully be registered or continue to operate unless they provide members with cover for PMBs. The CMS itself has described the PMBs as a "unique"[148] "fundamental provision" and "arguably the most striking feature of the Act".[149]

105. These PMBs are those conditions for which medical schemes "must pay in full, without co-payment or the use of deductibles", for diagnosis, treatment and care.[150] Annexure A to the Regulations, then goes further specifying in detail the conditions covered in terms of section 29(1)(o) of the Act and Regulation 8.[151] Consolidating the legislative purpose of ensuring broad coverage and significant protection to medical scheme members, PMBs are "diagnosis-driven", rendering how the condition was contracted "irrelevant".[152] Further confirming the executives' commitment to achieving this purpose, many of the conditions covered by PMBs are "serious, often life threatening", and the "most expensive" conditions.[153] The CMS notes that PMBs are necessary to deal with "unforeseen and catastrophic health events".[154]

106. Though neither s 29(1)(o) nor Regulation 8 state an explicit purpose, one thing that is clear is that the PMBs ensure consistency in health care rights protection, and therefore access to a basic "minimum" level of health care services regardless of whether these services are procured through the public or private sector. This is evidenced by the plain wording of the Medical Schemes Act[155] and the Regulation's brief explanatory note which details the objectives of specifying a detailed of list of PMB conditions alongside the regulations.[156]

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[147] Ibid, s 29(1)(o).
[148] CMS Annual Report 2012/13 at p47.
[149] CMS Annual Report 2013/14 at p 35.
[150] Regulations to Medical Schemes Act, Regulation 8.
[151] Ibid, Annexure A.
[152] CMS Annual Report 2012/13 at p47.
[153] CMS Annual Report 2012/13 at p47.
[154] CMS Annual Report 2012/13 at p 48.
[155] Medical Schemes Act 131 of 1998, s 29 (p).
[156] Regulations to the Medical Schemes Act, Annexure A (i)-(ii).

107. Put simply, the PMBs are Parliament (speaking through the Medical Schemes Act) and the executive's (speaking through Regulations passed in terms of the Medical Schemes Act) attempt to:

107.1. Ensure medical schemes are required to provide minimum benefits to ensure a constant level of cover for users no matter whether they choose to use the private or public sector to access health services;[157]

107.2. Protect medical scheme members from exposure to "serious illness and consequent risk" in the event that their benefits are depleted;[158]

107.3. Protect medical scheme members from financial disaster in the event of a health care crisis, thereby providing them with social security;[159]

107.4. "Encourage efficiency in the allocation of Private and Public health care resources" by ensuring that users of the private health care sector do not drain limited public sector resources in the event of depleted benefits.[160]

108. This understanding of the purposes and functions of the PMBs is consistent with the National Health Act's vision of one "unite[d] … national health system" which displays a "spirit of co-operation and shared responsibility".[161] It requires medical schemes to share in the constitutional responsibility for the realisation of the rights of its users and is clear example of legislative initiative in detailing the constitutional obligations of market participants within the private health care sector.

[157] CMS 2013/14 Annual Report at 41.
[158] Regulations to the Medical Schemes Act, Annexure A (i).
[159] CMS Annual Report 2013/14 at 31.
[160] Regulations to Medical Schemes Act, Annexure A to Regulations at (i).
[161] National Health Act, Preamble.

PMBs in practice

109. Given the clear importance of the PMBs within the private health care sector as a means of protecting the health care rights of medical scheme members, it is crucial that medical schemes operate in a manner which makes it easy for members to access treatment for PMBs without burdensome administrative processes or any out of pocket expenses.[162] Medical schemes are statutorily and constitutionally obliged to ensure that this occurs.

110. Yet many medical schemes resist the payment in full of PMBs. The is evidenced by what the Council for Medical Schemes in its 2013-14 Annual Report described as "glaring non-compliance" with regulations on PMBs.[163] A year before, in its 2012-13 Annual Report, the CMS stated this position even more firmly decrying the fact that "PMBs remained under constant attack" without any rational basis.[164] It describes these attacks as "vociferous and unrelenting".[165]

111. Despite the clarity provided by the PMBs being listed in the Annexure to the Regulations, stressing that medical schemes are required to "pay in full, without co-payment or deductibles", for at least the last five years the majority of valid complaints to the Council for Medical Schemes have been about "non-payment" or "short payment" of PMBs by medical schemes.[166] So, for example, of 4651 valid complaints in the 2012-13 reporting period 2411 related to non-payment or short payment of PMBs.[167] Similarly, 2736 of 5008 valid complaints in 2013-14 related to non-payment and short payment.[168] This has rightly led the CMS to conclude that: "most complaints

[162] Regulation 8 clearly requires medical schemes to "pay in full" any costs that would accrue for "diagnosis, treatment and care", without any copayment.
[163] Council for Medical Schemes 2012/13 Annual Report at p 75.
[164] Council for Medical Schemes 2012/13 Annual Report at p 48.
[165] Council for Medical Schemes 2012/13 Annual Report at p 48.
[166] Council for Medical Schemes Report at 76 (confirming that this is a "trend"); Council for Medical Schemes Annual Report 2013/14 at 50-3 and also at 35 indicating "most complaints that the CMS receives from members are related to schemes refusing to pay for PMB conditions as prescribed by law".
[167] Council for Medical Schemes Report at 73-75.
[168] Similarly 2736 of 5008 valid complaints in 2013-14 related to non-payment and short payment.

that the CMS receives from members are related to schemes refusing to pay for PMB conditions prescribed by law".[169]

112. Going still further to avoid compliance with the legal requirement to pay out on PMBs, in 2011, a collective of medical schemes, the Board of Health care Funders (BHF), went as far as initiating litigation in the High Court, arguing that despite the fact that regulations require payment in full without co-payments for PMB conditions, that "pay in full" did not in fact mean pay in full but rather "pay in full according to the rules of the medical scheme and not 'pay in full as per invoice'".[170] The interests of health care users – the members of BHF's own members and clients who rely on them for access to the health care services – and the protection of their right to access to health care services was conspicuously absent on the papers in the BHF's attempt to convince the High Court to imagine away the plain language, context and purpose of the Act and its Regulations, in order for it to be construed in the interests medical scheme administrators profits.

113. This is particularly alarming if the CMS's assessment, that medical schemes industry remains financially stable is accurate.[171] The financial stability of medical schemes is crucial to the protection of the rights of medical scheme members. Given existing debates between the CMS and medical schemes about the level of solvency that ought to be legally required for medical schemes,[172] SECTION27 submits that the Panel should consider the solvency and financial stability of medical schemes and the role of the CMS in monitoring solvency and financial stability in its investigations.[173]

114. Given the low awareness that many medical scheme members have of their rights to full payment for PMB conditions and still less of their rights to complain to the Council for Medical Schemes, it is likely that these complaints underestimate the extent to

[169] CMS Annual Report 2013/14 at 35.
[170] *Board of Health Care Funders of the Southern Africa (Association Incorporated Under Section 21 of the Companies Act, 61 of 1973) and Another v Council for Medical Schemes and Others* (70018/10) [2011] ZAGPPHC 206 (7 November 2011) case at para 23. This application was dismissed for procedural reasons and the Court ultimately made no authoritative pronouncement on the meaning of the Regulation 8 or the importance of the PMBs.
[171] CMS Annual Report 2013/14 at 31 and 45-7; CMS Annual Report 2012/13 at 65-6.
[172] Regulations to Medical Schemes Act, Regulation 9.
[173] Ibid.

which there is non-compliance with PMBs. This suspicion is fortified by SECTION27's own experiences in receiving complaints from users of the private health care system who have been denied full payment for PMB conditions and approached SECTION27 for assistance. Ultimately, as the patient testimonials in the next section show, it is members of medical schemes who, as patients at extremely vulnerable times in their lives, bear the brunt of non-compliance with PMB regulations.

Patient testimonials relating to non-compliance with PMBs

115. The following anonymous testimonials are examples from clients of SECTION27 and other PMB-related problems experienced by medical scheme members brought to the attention of SECTION27 and partners organisations. Examples of a similar nature, noting complaint adjudications made by the CMS and The Appeals Committee are detailed in the CMS's annual reports.[174] The full details of these and other testimonials are attached in Annexure A to this submission.

Patient ES: non-payment of PMB condition – HIV

116. ES is a single mother and a teacher employed at a school in Mamelodi, Pretoria. She lives with and supports her children. ES and her daughter are members of Genesis Medical Scheme ("Genesis") since March 1998. Her cover is under the "private comprehensive" plan option, the most comprehensive option offered by Genesis. She pays a contribution of R1 965 every month for this cover.

117. ES is HIV positive. In August 2011, she started taking Atripla, a fixed-dosed combination antiretroviral. At that time, her doctor contacted Genesis to authorise payment, and was told that her medication would be paid for through her medical savings account. Regulation 10(6) provides specifically that "the funds in a member's medical saving account shall not be used to pay for the costs of a prescribed minimum benefit".[175] Compounding this problem, once ES's medical savings were exhausted, she has to pay for her medication out of her own pocket.

[174] See for example, CMS Annual Report 2013/14 at 55-56.
[175] Ibid, Regulation 10(6).

118. Genesis is aware of this and maintains that because it has not designated a private service provider, the cost of the medication would only be covered if obtained through the public sector. This is the approach Genesis takes in relation to all PMB conditions.

119. ES is required to refill her prescription once a month. Her busy job and parental responsibilities prevent her from regularly enduring long queues at public health care facilities during their limited hours of operation in order to access her antiretrovirals. ES therefore purchases her medication every month from Dischem, a private sector pharmacy. Each month she attempts to claim payment through Genesis, but, unless there are funds in her medical savings account, her claim is rejected. She therefore currently pays approximately R500 every month out of her own pocket for her medication, even though Genesis should cover this in full.

120. The importance of taking Atripla regularly should not be underestimated. Defaulting on antiretroviral treatment can result to drug resistance with potentially dire consequences. ES therefore never interrupts her treatment. However, the additional R500 per month places serious financial strain on ES, who sometimes is forced to go without food for herself and her family so that she is able to afford her medication. This is very stressful for a mother in ES's positions because of her numerous financial responsibilities.

121. SECTION27 made a complaint on behalf of ES to the Council for Medical Schemes (CMS). The CMS ruled in favour of ES. Genesis appealed to the appeal body of the CMS. This appeal has now been put on hold pending a decision of the Western Cape High Court in a matter involving Genesis concerning similar legal issues.[176]

Patient P: short payment and non-payment of PMBs – hip replacement

122. P is 65-year-old woman who lives in Mpumalanga. She fell out of a stationary truck in May 2013 and discovered in December 2013 that her hip was broken. She is member of Transmed Medical Fund and has been since 1982. Transmed was one of the ten most

[176] CMS 2013/14 Annual Report, page 58 / Genesis v Joubert (Case no 19503/2012).

complained about restricted medical schemes in 2013.[177] She requires a left hip replacement. P has previously had a total hip replacement for her right hip. She is currently in severe pain and paying for her painkillers out of pocket. She has had to borrow a wheelchair and is, for the most part, immobile. Transmed has designated a state hospital in Nelspruit as the designated service provider for P. This is the approach taken for PMB and non-PMB conditions for all members.

123. P has, in attempt to vindicate her rights, approached a State Hospital in Nelspruit. However, because of a shortage of orthopaedic surgeons in the province, she is number 401 on the waiting list to receive a hip replacement. There are only four orthopaedic surgeons in Mpumalanga and only one situated at the State Hospital where P is on the waiting list. This unfortunate situation illustrates the existing lack of capacity in the public sector, and highlights the reasons why the PMBs are precisely purposed at alleviating this burden. This unfortunate situation illustrates how inadequate it is for medical schemes to designate a State Hospital as a primary DSP and limit access to other providers. In the meantime, P has to endure constant pain and immobility.

124. The "fracture of a hip" is a PMB condition.[178] In addition an "open fracture/disclocation of bones or joints" is a PMB condition.[179] Though both of these conditions appear to cover hip replacements, Transmed appears to have interpreted these PMBs narrowly, disregarding the interests and healthcare rights of P and similarly placed members, with the cumulative effect of providing coverage only for the hip replacement prosthesis and not the necessary surgery for P's hip to actually be replaced. However, even on the plain wording of these to PMBs read together, it is difficult to see the logic of Transmed's interpretation.

125. Making matters worse, Transmed limits payment for the prosthesis to R 41 000 for a prosthetic despite it costing R 51 189.42. Not only does Transmed exclude crucial parts of P's treatment and care for her PMB conditions, it also refuses to "pay in full" for those

[177] CMS 2013/14 Annual Report, page 54.
[178] Regulations to Medical Schemes Act, Annexure A.
[179] Ibid.

aspects of this treatment and care it accepts are correctly covered. As we have submitted, medical schemes, when interpreting the PMB conditions are constitutionally required to do so broadly, taking cognisance of the interest of their members right to health and the purposes of the PMBs.

126. Far from providing P of assurance and comfort that her medical scheme should provide, Transmed's neglect of P's right to full coverage for PMB conditions, is exactly the type of brazen and glaring non-compliance with the PMBs noted by the Council for Medical Schemes and experienced by medical scheme members throughout the country.

127. P remains in need of a hip replacement and remains immobile and in significant pain. P's pain should not be prolonged and exacerbated by a misinterpretation by her medical scheme of a regulation meant to protect her under these exact circumstances. As an elderly woman, P had relied on payment of substantial medical scheme premiums for her good health and peace of mind. Transmed's misinterpretation therefore harms her physical and psychological well-being. Her only option to remedy this situation is to pay out of pocket for that to which she is legally entitled.

Ensuring Compliance with PMBs

The constitutional obligations of Medical Schemes

128. The CMS's mandate to oversee the operation of medical schemes does not excuse minimal, reluctant and delayed compliance by medical schemes with their obligation to pay in full for PMBs, as evidenced by the glut of complaints received by the CMS with regard to PMB non-compliance and the patient testimonials provided by SECTION27 within this submission. SECTION27 submits that it is a cause for concern that the CMS describes the behaviour of certain schemes as "glaring non-compliance", and crucial legal requirements of the Act as "constantly under attack". On the other hand, medical schemes are constitutionally and statutorily obliged to take into account the interests

and rights of their members in accessing PMBs, free from debilitating out of pocket co-payments. SECTION27 urges the Panel in its recommendations to take account of the importance of medical schemes' statutory and constitutional obligations.

Strengthening the Council for Medical Schemes

129. The Council for Medical Schemes is established by the Medical Schemes Act,[180] and arms it with broad powers, empowering it to oversee and coordinate the functions of medical schemes[181] in order to "protect the interest of members".[182] The Act also specifically allows the CMS to investigate complaints and settle disputes between medical scheme members[183] and suspend or cancel the registration of medical schemes.[184] Despite these extensive powers and its important constitutional and legislative mandate, in the CMS's own assessment, medical schemes continue to flout crucial provision of the Medical Schemes Act including cover for PMB conditions.[185]

130. Moreover, the CMS is also mandated to take urgent steps to end non-compliance with PMBs in terms of its role as guardian of the Act. Furthermore, as organs of state, both the CMS and the National Department of Health are constitutionally mandated to ensure that "peoples needs are responded to"[186] particularly when they are channelled through appropriate statutory mechanisms such as the CMS's complaints process.

131. SECTION27 therefore encourages the Panel to make recommendations to assist and equip the CMS to fulfil the crucial function of ensuring compliance with PMBs. In particular, an assessment of the CMS's existing capacity to fulfil this function, including: access to human and financial resources; medical scheme members knowledge of and accessibility to its complaints procedures and mechanisms; ability to enforce compliance with their decisions; and political independence. In addition, we urge the CMS to use the

[180] Medical Schemes Act 131 of 1998, s 3.
[181] Ibid, s 7(b).
[182] Ibid, s 7 (a).
[183] Ibid, s 7(d).
[184] Ibid, s 8(f).
[185] Council for Medical Schemes Annual Report cited above.
[186] Constitution, s 195 (1)(e).

platform of the Health Inquiry to fulfil its statutory advocacy function to "collect and disseminate information about private health care".[187]

132. Although the CMS itself and medical schemes are better placed to put information in front of the Panel about the effectiveness of the CMS in performing the function of overseeing the availability of full and easy cover of PMBs to medical scheme members, SECTION27 notes the following:

132.1. **Independence:** Members of the CMS may be appointed by the Minister of Health "for such a period as the Minister may deem necessary",[188] but may not be appointed for terms which exceed six years in total,[189] and the Minister alone appoints the chairperson of the CMS.[190] The variability of the length of appointment of members raises concerns about the independence of CMS members. It is of further concern that the Act limits the reports' ambits to the "Council's activities" and does not explicitly mandate the CMS to conduct a focused analysis of the compliance of medical schemes with the provisions of the Act.

132.2. **Institutional Capacity:** It is possible that some of the CMS's inability to curb abuses of the Medical Schemes Act, including non-compliance with PMBs is as a result of insufficient institutional capacity and a lack of financial and human resources. As part of the state's constitutional obligation for realising the right to have access to health care services, it must ensure that critical functions such as the oversight and supervision of medical schemes are carried out appropriately. SECTION27 submits that the Panel consider whether sufficient resources are made available to the CMS to allow it to perform its functions effectively. Note that the CMS currently underspends

[187] Medical Schemes Act 131 0f 1998, s 8(e).
[188] Ibid, s 4(2).
[189] Ibid, s 4(6).
[190] Ibid, s 4(3).

its budget in variety of crucial units and offices while overspending in others.[191]

132.3. **Enforcement Powers:** the CMS has the power to suspend or deregister medical schemes.[192] Furthermore, the Registrar of the CMS has the powers to "at any time instruct an inspector to carry out an inspection of the affairs" of a medical scheme[193] and insist that medical schemes produce any documents "necessary to obtain any information relating to the medical scheme required in connection with the administration of the Act".[194] These are broad powers of investigation. However, the CMS has no power to impose fines on medical schemes.[195] SECTION27 submits that the Panel should consider and make recommendations about the impact of the CMS's lack of clear enforcement powers, the existing power's lack of specificity and its failure to use these existing powers despite widespread non-compliance with the Act.

133. The CMS itself has recently noted that it is "necessary" to strengthen the Medical Schemes Act, including specifically provisions relating to PMBs.[196] The Regulations provide that the Department of Health, in consultation with other stakeholders including crucially the CMS and "consumer representatives", review the "impact, effectiveness and appropriateness" of PMB provisions "at least every two years".[197]

[191] CMS Annual Report 2013/14. Underspent: Strategy Office R1.05 million (p 67); Complaints Adjudication Unit R170 000 (p68); Research and Monitoring Unit R772 000 (p81); Stakeholder Relations Unit R614000 (p85). Overspent: Accreditation Unit R 319 000 (p79). CMS Annual Report 2012/13. Underspent: Strategy Office R 35 000 in 2012/13 and R 4.09 million in 2011/12 (p94); Complaints Adjudication Unit R 35 000 in 2012/13 and R 243 000 in 2011/12 (p104); Research and Monitoring Unit R 12 000 in 2012/13 (p123); Stakeholder Relations Unit R217 000 (p 128); Accreditation Unit R 273 000 in 2012/13 and R 142 000 in 2011/12 (p143). Overspent: Research and Monitoring Unit R484 000 in 2011/12 (p123); Stakeholder Relations Unit R 220 000 in 2011/12 (p128).

[192] Although the Regulations do provide for the conditions for suspension or withdrawal of accreditation of brokers, administrators and managed health care.

[193] Financial Institutions Act No 80 of 1998 s 3(1) read with section 1's definition of "registrar" in the specific context of the Medical Schemes Act. See also s 44 (1) of the Medical Schemes Act.

[194] Medical Schemes Act s 44(1)-(2).

[195] Contrast with the powers of the UK Financial Conduct Authority set out in the Financial Services and Markets Act 2000, s 167(1).

[196] CMS Annual Report 2013/14 at 35.

[197] Regulations, Annexure A, Explanatory Note.

134. The CMS's most recent Annual Report indicates that draft regulations reviewing PMBs were submitted to the Department of Health in 2010 and their publication was anticipated in 2012/13.[198] The CMS also notes an undertaking to "review the definition of various PMBs" but no timeframes are provided.

V HPCSA ETHICAL TARIFFS

The purpose of the Act

135. The Health Professions Act, 56 of 1974 establishes the HPCSA and professional boards. The Act empowers the HPCSA to regulate various aspects of health professionals' practice and conduct. The HPCSA regulates the conduct of health professionals in both the public and private sectors. Health professionals or practitioners are defined means any person, including a student, registered with the HPCSA in a profession registrable in terms of the Health Professions Act. The HPCSA is responsible for the registration of professionals, holding professionals to a standard of care and ethical conduct as well as the accreditation of training programmes and facilities.

136. The HPCSA is empowered to provide this framework by publishing ethical tariffs in terms of the Health Professionals Act of 1974, discussed in further detail below. For this, a tariff is necessary to provide certainty on the part of the provider and patient as to what level of pricing is too high and at which point disciplinary action for overcharging is applicable.

137. In terms of section 3 of the Act, the objects and functions of the HPCSA envision a broad public interest role for the Health Professions Council. These functions are required to be interpreted in the context of the right to access to health care services and are examples of regulation of health professions in accordance with the state's duty to protect this right, and regulate the health care profession in the public interest:

[198] CMS Annual Report 2013/14 at 35.

137.1. To assist in the promotion of the health of the South African population;

137.2. To support universal norms and values, especially democracy, transparency, equity, accessibility and community involvement;

137.3. To serve and protect the public in matters involving the rendering of health services by health professionals;

137.4. To be transparent and accountable to the public in achieving its objectives;

137.5. To maintain professional and ethical standards within the health profession;

137.6. To investigate complaints in order to protect the interest of the public;

137.7. To ensure that health professionals respect the dignity, bodily and psychological integrity and equality rights of patients and take appropriate disciplinary action against those who breach this obligation.

138. Threading through these provisions is the firm understanding, consistent with the right to access to health care services, that there is an obligation on the HPCSA, individual health professionals and the Professional Boards which the Act contemplates as representing health care professionals, to protect the interests of the public as well as the integrity of the profession as a whole. These obligations are, in addition to ethical and moral duties, as discussed above, Parliament's expressions of the HPCSA, the Professional Boards' and health professionals' varying constitutional obligations in terms of the right to access to health care services.

<u>The purpose of overcharging provisions</u>

139. Section 53 of the Act deals with "fees charged by registered persons". It aims to protect consumers and has several components:

139.1. First, informed consent is required for charges above the "usual fee". Section 53(1) requires health professionals to disclose to patients the fee that will be charged prior to rendering a service, if (1) they are requested or (2) the fee exceeds what is usually charged for such services. The "usually charged" fee is interpreted to be the ethical tariff.

139.2. Second , patients are allowed to query invoices. Section 53(3)(a) provides that a patient can query an invoice with the professional board, which then must determine what a practitioner should charge for the service. The practitioner must be given an opportunity to make representations before a professional board makes a final decision.

139.3. Third, where overcharging is found, a health professional is subject to penalties. Overcharging may be considered unprofessional conduct (once all the circumstances, as well as the area of practice are considered). This is defined by the Act as improper or disgraceful or dishonourable or unworthy conduct. Health professionals found guilty of such conduct are subject to penalties such as reprimand, caution, suspension for a period of time, removal from the register, compulsory service or a fine.[199]

140. In order to assist in this process, a professional board is empowered by section 53(d) to publish an ethical tariff:

> "a professional board may from time to time determine and publish the fees used by the professional board as norm for the determination of amounts contemplated in paragraph (a)".[200]

141. As such, in terms of the Act, the fee determined by the professional board can be used as a basis to adjudicate complaints from the public against a practitioner regarding the fees charged for a service.

142. Since the Act explicitly designates Professional Boards the power to determine fee norms, and as without such norms the section undermines the patient's rights as set out in section 53, it is not sufficient for health professionals to use medical scheme rates or rates that they commonly or routinely charged – as a matter of fact – as this reference point. We submit, therefore, that despite the fact that the Act indicates that Professional Boards 'may' determine fee norms, that in the context of the section read

[199] HPSCA Act 56 of 1974, s 42.
[200] Ibid, s 53(d).

as a whole they 'must' do so to prevent the operation of the entire section read as a whole from being undermined. In other words, the Professional Boards have a positive obligation to determine fee norms.

143. A legal interpretation of overcharging can be gleaned from the courts' interpretations of the previous legislation that governed the health profession,[201] as well as the courts' approach to overcharging in the context of the legal profession.

144. The courts have considered the meaning of excessive charging of fees in relation to the legislation preceding the current Health Professions Act,[202] which provides some guidance about how to interpret the current Act. The old Act prohibited "excessive or extortionate charges for services rendered".[203] In *McLoughlin v South African Medical and Dental Council*, the court found that the provision that prohibited overcharging did not provide enough guidance to health practitioners. The court then provided the following guidance to assist the board in deciding whether excessive fees were charged under the old Act:

144.1. whether the patient agreed to a fee in advance;

144.2. whether he or she agreed to the fee freely and with full understanding of the fee; and

144.3. whether the patient knew that he or she was not obliged to use the services and could go elsewhere.[204]

145. In addition to the specific prohibition against excessive or extortionate fees, the old Act also required practitioners to advise a patient of the fee upon request, or "when such fee exceeds that usually charged for the services for the professional service before rendering such service".[205] Any practitioner found to have charged excessively was guilty

[201] Medical, Dental and Pharmacy Act, 13 of 1928.
[202] *McLoughlin v South African Medical and Dental Council* 1947 SA (2) 377 (WLD).
[203] Medical, Dental and Pharmacy Act 13 of 1928, s 80(1).
[204] *McLoughlin v South African Medical and Dental Council* 1947 SA (2) 377 (WLD) at page 403-407.
[205] Ibid.

of improper or disgraceful conduct and subject to removal from the roll of practitioners.[206]

146. The court held that a health professional could not avoid an allegation of overcharging simply by agreeing on a fee with a patient in advance. In other words, the fee itself had to be objectively reasonable. While the current Act does not refer to "excessive or extortionate" fees, it still prohibits overcharging.

147. The Professional Boards are empowered to provide this framework by publishing fee norms, which provides certainty on the part of the health care professional and patient as to what level of pricing is too high and at what point disciplinary action for overcharging may be triggered.

148. In 2012, the Medical and Dental Professions Board published "tariff guidelines" with the purpose of guiding professionals on fees. The tariffs added an inflator to what was published by the Council for Medical Schemes in 2006. The industry objected to the failure of the Board to consult the profession and to the approach, which was characterised as unscientific and arbitrary.

149. In October 2013, Medical and Dental Professions Board embarked on a process of determining tariffs for purposes of adjudication in terms of Section 53(3)(d) of the Health Professions Act of South Africa but the process was inexplicitly stalled. SECTION27 made similar submissions to the Health Professions Council, emphasising the importance of the implementation of fee norms to a health rights, patient-focussed approach to the Act's mandate and the Council's functions.[207] We submit that given the centrality of the ethical tariff mechanism to the protection of health care users right to affordable, quality health care, the HPCSA Act not only empowers Professional Boards, but also obliges them to publish fee norms.[208] The proposed process was well received but the implementation of the new process is behind schedule. By March 2014, the

[206] Ibid.
[207] SECTION27 Submission on the HPCSA Proposed Process for Fee Norm Determination (18 November 2013). On file with author.
[208] Ibid.

norms should have been gazetted and available for comment. However, no new information has been shared with stakeholders since October 2013. Questions have been raised about why the process has stalled, but no clear answers are forthcoming from the HPCSA.

150. The Medical and Dental Board resolved the process of determining tariff guidelines to review. According to the latest annual report, new project plans were developed and the timelines for finalising and publishing new Tariff Guidelines have been "set for a later stage".[209] It is does not specify a time line for the fulfilment of the requirement in terms of the Act to publish fee norms. The Psychology Board "resolved to regard the issue of guideline tariffs as a priority for the Board, but decided to defer the matter until the process had been mapped to avoid litigation".[210] Given that the tariff process has been identified, the failure to take meaningful steps to implement brings into question the ability of the regulator to carry out their mandate to protect the public interest and amounts to a violation of its constitutional obligations in terms of the right to access to health care services.

151. The processes aimed at regulating prices for health care services, and that have stalled or been abandoned by organs of state, are crucial constitutional steps. Such steps must be pursued and completed transparently and on an evidence-based basis and should be carried out without undue delay.[211]

152. Patients indicate that they often do not understand their medical aid cover, the brochures are too complicated and don't know where to turn when they have been overcharged. In a survey conducted by the Mail & Guardian in 2013, 63% of respondents responded that a doctor or dentist had overcharged them.[212]

[209] HPCSA Annual Report 2012/2013 at page 53.
[210] HPCSA Annual Report 2012/2013 at page 67.
[211] Section 237 of the Constitution requires that "all constitutional obligations must be performed diligently and without delay".
[212] Thalia Holmes " Contested Doctors Tariffs on Hold", Mail & Guardian, 28 March 2014, accessible at http://mg.co.za/article/2014-03-27-contested-doctors-tariffs-on-hold.

Ensuring compliance with health professions legal framework

153. The professional boards that regulate the health professions can only investigate the conduct of practitioners after receiving specific complaints. They are empowered by the Act to initiate an inquiry into "any complaint, charge or allegation of unprofessional conduct" made against a health care professional.[213] There is no provision in the HPA allowing the boards to launch investigations on their own initiative.

154. In New Zealand, for example, the regulatory authorities lack the power to launch inquiries on their own initiative. However, by virtue of section 8 of the Health and Disability Commissioner Act 1994 (HDCA), New Zealand has established a Health and Disability Commissioner. The Commissioner prepares a Code of Health and Disability Services Consumers' Rights. Section 40 (1) of the HDCA gives the Commissioner the power to investigate any action of a health care provider if the action is, or appears to the Commissioner to be, in breach of the Code. This allows the Commissioner to launch investigations on his or her own initiative without having to wait for specific complaints.

155. In Australia, the regulators have the power to launch investigations on their own initiative. Section 160 (1) of the National Law Act 2009 allows national boards to investigate a registered health professional because the board for any other reason believes that the way the practitioner practices or conducts him or herself may be unsatisfactory. The boards are therefore free to investigate the conduct of practitioners whenever they have concerns about professional conduct.

156. The panel should consider whether the HPCSA should be given powers to begin investigations into the conduct of health professionals or any other matter relevant to the profession on their own initiative as the regulators in Australia and New Zealand do. Given that the HPCSA underspent its R11.3 million budget for disciplinary matters by R8.56 million, this may be a useful allocation of resources to ensure a maximum use of

[213] S 41 of the Health Professions Act, 1974.

public resources in the public interest.[214] Indeed, as we have argued above appropriate costing, budgeting and use of budgets is a component of the constitutional requirement that the HPCSA, as organ of state, take reasonable measures to realise the right to access to health care services.[215]

Recommendations

157. The HPCSA concedes in its 2012/2013 annual report that the "unavailability of Tariff Guidelines continues to pose challenges on adjudication of complaints relating to overcharging".[216] Given that the Terms of Reference identifies 'the application of a reference tariff schedule to determine when over-charging by health professionals occurs' as an area for investigation,[217] we suggest that the Panel consider recommending the urgent completion of the ethical tariff process started by the HPCSA in 2012. This is an important step in achieving greater equality in accessing health care services for health care users in the private health care sector in accordance with the right to access to health care services.

158. We also encourage the Panel to consider recommending a mandatory display of patient rights in all facilities in which patients access health care services.

VI SUMMARY OF RECOMMENDATIONS

Price regulation

159. Based on international experience and the submissions on the 2010 proposed process to regulate prices, SECTION27 supports the following conclusions:

159.1. A thorough, evidence-based, investigation by the Panel into potential price regulation in the private health care sector;

159.2. An approach to price regulation as a means of fulfilling the state's duty to protect the rights of users of the private health care sector;

[214] HPCSA 2013 Annual Report at page 111.
[215] See above at paras 24-6.
[216] HPCSA Annual Report 2012/2013 at page 7.
[217] Terms of Reference for the market inquiry into the private health care sector at page 90.

159.3. Any recommended process for price setting should be transparent and independent and should include meaningful participation by relevant stakeholders;

159.4. The determination and definition of the roles of existing statutory bodies (in particular the CMS, HPCSA and the Competition Commission) in the process of price regulation to prevent interventions which disrupt effective price regulation.

160. Regardless of which approach to the regulation of prices is adopted, careful attention will have to be placed on a dispute resolution mechanism in any form of negotiation or stakeholder participation in discussions about pricing mechanisms.

Council for Medical Schemes

161. SECTION27 urges the panel in its recommendations to take account of the importance of medical schemes' statutory and constitutional obligations.

162. SECTION27 therefore encourages the Panel to make recommendations to assist and equip the CMS to fulfil the crucial function of ensuring compliance with PMBs. In particular, an assessment of the CMS's existing capacity to fulfil this function, including: access to human and financial resources; medical scheme members knowledge of and accessibility to its complaints procedures and mechanisms; ability to enforce compliance with their decisions; and political independence.

163. CMS should use the platform of the Health Inquiry to fulfil its statutory advocacy function to "collect and disseminate information about private health care".

Health Professions Council

164. SECTION27 urges the HPCSA to urgently complete the ethical tariff process started by the HPCSA in 2012. This is an important step in achieving greater equality in accessing

health care services for health care users in the private health care sector in accordance with the Bill of Rights.

165. We also encourage the Panel to consider recommending a mandatory display of patient rights in all facilities in which patients access health care services.

General recommendations

166. The Panel's recommendations should aim to achieve more equitable access to health care services. The panel must consider whether any proposed intervention will have the effect of diminishing access to health care services, and, if it does, reject such a proposal.

167. SECTION27 recommends that the Panel and the Commission complete all-important investigation into the private healthcare sector as expediently as possible. The process of initiating the Health Inquiry and implementing its beginning phases have already been subject to unnecessary delays as a result of litigation initiated by a significant stakeholder in the inquiry.[218] Though it essential that the entire inquiry process complies with proper, fair process within the bounds of the law, SECTION27 notes that further delays in the inquiry process would allow existing rights violations to continue. As our patient testimonials indicate, these violations result in significant, avoidable human suffering.[219]

168. For this reason, and to avoid the complications and delays involved in the implementation of the recommendations made by the Panel in terms of the Banking Inquiry,[220] SECTION27 recommends that the Panel should propose a process to be

[218] *Netcare Hospitals (Pty) Ltd v KPMG Services (Pty) Ltd and Another (47505/2013) [2014] ZAGPJHC 186 (22 August 2014).*
[219] Refer to patient testimonials at annexure A of this submission.
[220] See for example, M Griffiths and W Gumbie, "Probing the value of market inquiries from the perspective of the Banking Enquiry" (2014) available at http://www.compcom.co.za/assets/Uploads/events/Eighth-Annual-Conference/Parallel-2A/Banking-Enquiry-Griffiths-Gumbie.pdf.

followed in the assessment and implementation of its recommendations. We strongly suggest that these recommendations include:

168.1. A proposal for the creation of a structure which includes all relevant government departments, regulators, industry and civil society stakeholders to oversee the process of taking the Panel's recommendations forward after its report is finalised and published;

168.2. An indication of the most urgent recommendations that require more immediate attention in order to protect the rights of users of the private health care system;

168.3. A proposed timeline for setting up the structure and carrying out the envisaged process for implementing the Panel's recommendations; and

168.4. Proposed measures that both the Competition Commission and other stakeholders must take in order to ensure that users of the private health care sector understand their rights and the impact of the outcomes of the Health Inquiry process on those rights.

VII CONCLUSION

169. We hereby notify the Panel that we intend making oral submissions during the public hearings. We remain available to the Panel and the Competition Commission to answer any questions or participate in consultations.

170. SECTION27 thanks the Panel for the opportunity to make this submission.

ENDS

Annexure A: Patient Testimonials (A1-9)

In this annexure, SECTION27, provides a range of patient testimonials (A1-9) drawing attention to the experience the users of the private health care system in order to assist the Panel and Commission. SECTION27 will continue documenting patient testimonials throughout the health inquiry process and intends presenting these before the Panel during the public hearings.

A1: Mr E's struggle - Prescribed minimum benefit (PMB) non-payment

Background to Mr E's surgery

Mr E, a member of Bonitas Medical Fund ('Bonitas'), lives in South Africa, a country in which everyone has a constitutionally entrenched right to have access to health care services. He and 17% of the population access this right through the private health care sector by paying monthly contributions to a medical aid scheme.

Like many South Africans, he is HIV positive. He has been on antiretroviral treatment since the early 2000s. As better drugs became available, his drug regime changed several times and he developed a painful side effect – antiretroviral-related lipodystrophy – which causes fatty growths to develop on the back and neck. As a result, Mr E experienced various health problems that affected his daily quality of life and well-being, including extreme headaches, back pain and impaired sleep.

Seeking approval from Bonitas

At this stage Mr E's physician determined that the lipodystrophy was significantly affecting his health. The surgical removal of the accumulated fat around his neck was recommended. Bonitas, however, declined Mr E's application for the approval of the surgical procedure even though he was entitled to the cover in terms of his benefit option.

Mr E, a year later, experienced an episode of loss of consciousness, which was determined to be related to the lipodystrophy. Once again his physician recommended surgery to further prevent serious health problems. Despite receiving this further medical motivation, Bonitas again denied authorisation for the surgery on the basis that the treatment sought was cosmetic surgery and not covered under his benefit option.

Distraught, Mr E paid for the surgery from his savings, even though he could not afford it. He approached SECTION27 and it helped him to recover his money from the scheme at the scheme rate because the procedure should have been classified as a prescribed minimum benefit (PMB) condition and paid in full by the scheme. The PMB treatment relevant to Mr E's condition as defined in Annexure A of the Regulations to the Medical Schemes Act 1998 include 'medical and surgical management' relating to skin conditions and treatment for

'HIV-infection'.

Bonitas' categorisation of the surgery as cosmetic had no basis in Medicine and the refusal to authorise the surgery had no basis in law. Bonitas should have duly considered all the relevant facts, motivations and medical opinions at the time of application for authorisation.

The PMB framework

To ensure that the users of the private health care system are protected in the health care market, the Medical Schemes Act provides for prescribed minimum benefits (PMBs), which detail the treatment every medical scheme is required to pay in full, regardless of the member's plan.

This means that, when unanticipated serious illnesses occur, members do not have to pay for the diagnosis or treatment of PMBs from their pockets or their medical savings accounts, which are meant to cover day-to-day health care expenses. The minimum benefits prescribed include 270 conditions and 25 chronic illnesses such as HIV, tuberculosis, pregnancy, heart conditions and emergency medical treatment. But the protection provided by the minimum benefits has often evaded people like Mr E.

Financial hardship, debt and despair

Many other people have experienced financial hardship, debt and despair, or have even gone without the health care they need, because their schemes do not pay their claims despite being under a clear legal and constitutional obligation to do so. A medical scheme that does not cover the full cost for PMB conditions is in contravention of the law.

Last year, 2 411 of the 2 717 complaints to the Council for Medical Schemes (CMS) were about PMBs. Those, like Mr E, whose claims are unlawfully refused by medical schemes, must make difficult choices in order to access the health care they need and believed they had protected themselves against.

A2: Hip replacements and prescribed minimum benefits

P's plight – how she fractured her hip

P is 65 and lives in Mpumalanga. She fell out of a truck in May 2013 and discovered in December 2013 that her hip was broken. She is member of Transmed Medical Fund and has been since 1982. Transmed was one of the ten most complained about restricted medical schemes in 2013. She requires a left hip replacement. P has previously had a total hip replacement for her right hip. She is currently in severe pain and paying for her painkillers out of pocket. She has had to borrow a wheelchair and is, for the most part, immobile.

Transmed's coverage of a hip replacement

P thought she had the ultimate peace of mind as a member of a medical aid. As it turns out, this was not to be. P is on Transmed's State Plus Own Choice. 'Fracture of hip' is a prescribed minimum benefit (PMB) condition. The Regulations to the Medical Schemes Act in Annexure A provide a long list of conditions identified as 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. However, P's benefit option stipulates that a State Hospital is designated as the primary Designated Service Provider (DSP). Only in limited circumstances can P use another hospital as a secondary Designated Service Provider (DSP) according to access criteria stipulated by the medical aid.

Although fracture of the hip is a PMB, her medical aid only covers R 41 000 for the prosthesis which has been quoted at R 51 189.42, but have refused to pay for surgery required to install the prosthesis. The cost of the surgery itself is R 110 889.42 at Life Health Care Cosmos Hospital. The shortfall in medical aid coverage would be unaffordable for any medical aid member, especially an elderly woman with no fixed income per month.

The problem with a State Hospital as a primary DSP

P has approached the State Hospital in Nelspruit. However, because of a shortage of orthopaedic surgeons in the province, she is number 401 on the waiting list to receive a hip replacement. There are only four orthopaedic surgeons in Mpumalanga and only one situated at the State Hospital where P is on the waiting list. This unfortunate situation illustrates how inadequate it is for medical schemes to designate a State Hospital as a

primary DSP and limit access to other providers. In the meantime, P has to endure constant pain and immobility.

The PMB framework and hip replacements

The PMB regulations set out the following: for the diagnosis of 'fracture of hip', the treatment is either 'reduction' or 'hip replacement'. It does not refer specifically to hip replacement surgery. There is, however, a further PMB category referring to the diagnosis of 'open fractures/dislocation of bones or joints' and the treatment of 'reduction/relocation' and 'medical and surgical management'.

It would appear that Transmed has interpreted the PMB as only covering the hip replacement (prosthesis) and not the necessary surgery. Even so, Transmed limits payment to R 41 000 for a prosthetic which in reality costs R 51 189.42. This is problematic because PMBs require *"100% of diagnosis, treatment and care"* to be covered. Hip replacement surgery is surely part of the treatment.

Furthermore, Transmed has included *'hospitalisation'* as one of the *'major medical benefits'*. '*Hospitalisation*' will only be regarded as a *'major medical benefit'* if it is classified as a PMB. Fracture of the hip is regarded as a PMB condition and inevitably P would require replacement surgery in addition to a prosthesis.

Further highlighting the shortfalls in Transmed's coverage is the fact that they have introduced an additional benefit called 'New Joint Replacement Benefit' on the SATS Pensioners benefit option. This new benefit covers admission in hospital, an orthopaedic surgeon, anaesthetist, prosthesis and physiotherapist for PMB and non-PMB conditions. Although this is a positive development, it still ignores that there is a legal obligation to cover PMB conditions fully whether a member has this new benefit or not irrespective of their benefit option.

P's pain should not be prolonged and exacerbated by a misinterpretation by her medical aid of a regulation meant to protect her under these specific circumstances which is not consistent with P's right of access to health care services.

A3: ES v Genesis

Background

ES is a female teacher and employed at a school in Mamelodi, Pretoria. She lives with and supports her children. ES and her daughter are members of Genesis Medical Scheme ("Genesis") since March 1998. Her cover is under the "private comprehensive" plan option, which is the most comprehensive option offered by Genesis. She pays a contribution of R1 965 every month for this cover.

In 2005 ES was diagnosed with HIV and started to take Atripla in August 2011. She had a CD4 count of 300 at the time of a check-up on 13 January 2012. At the time that ES started to take Atripla, her doctor contacted Genesis to authorise payment, and was told that her medication would be paid for through her medical savings account. Once these funds were exhausted, she would have to get her medication through a public health care facility or pay for it out of her own pocket. This is the approach Genesis takes in relation to all PMB conditions.

The reason for this was that Genesis had not designated a service provider in the private sector. Genesis has stated that because they had not designated a private service provider, the cost of the medication would only be covered if obtained through the public sector.

Paying out-of-pocket for a PMB

ES is required to refill her prescription once a month. Although she lives close to public health care facilities in Mamelodi and Mamelodi West, it is difficult for her to get medication from these facilities. One of the major reasons for this is that her job is very demanding, and therefore does not have time to queue on a monthly basis to get her medication.

ES therefore has to get her medication every month from Dischem, a private pharmacy, in Silver Lakes. They try to put the payment through her medical aid every month, but, unless there are funds in her medical savings account, it is always rejected.

ES is paying approximately R500 every month out of her own pocket for her medication, even though this should be covered in full by Genesis. The importance of taking Atripla

regularly should not be underestimated. However, although she is adamant on never interrupting her treatment, she has to sometimes have to go without food for herself and her family so that she is able to afford her medication. This is very stressful for a mother in ES' position because she doubts whether she is able to support her children. ES continues to pay her premiums for her medical aid cover every month, and has never missed a payment.

Genesis' contravention of the law

Genesis' attitude towards the payment of PMB conditions is a denial of her right of access to health care services and a breach of the General Regulations ('the Regulations') to the Medical Schemes Act.

HIV is one of the 27 chronic illnesses included in the PMBs list in Annexure A to the Regulations. Regulation 8(1) states that *'any benefit option that is offered by a medical scheme must pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions.'* Regulation 10(6) provides specifically that *'the funds in a member's medical saving account shall not be used to pay for the costs of a prescribed minimum benefit.'*

Genesis appears to be in breach of the Medical Schemes Act and Regulations in so far as they relate to PMBs and a denial of ES' right of access to health care as guaranteed by section 27 of the Constitution.

SECTION27 made a complaint on behalf of ES to the Council for Medical Schemes (CMS). The CMS ruled in favour of ES. Genesis appealed to the appeal body of the CMS. This appeal has now been put on hold pending a decision of the Western Cape High Court in matter against Genesis involving the exact same legal issues.

A4: M v Discovery Health

Hospitalisation of M

M is on the KeyCare Plus option with Discovery Health. On 4 May 2011, M fell ill and consulted a medical doctor for the treatment of flu-like symptoms. On 6 May 2011 she fell ill again and went for medical treatment to another doctor. She was then admitted to the Life Brenthurst Clinic on 6 May 2011 for respiratory problems. Discovery confirmed authorisation for M's hospitalisation and a CT sinus scan but did not pay the R 515.00 for the scan instead expecting a part payment of R 200.00 from M. The CT scan detected that M required an operation to drain pus from her sinuses.

Discovery had indicated that it will not cover the costs for the medical procedure required as it was excluded from Key Care Plus according to its rules. Life Brenthurst Clinic stated that they would refer M to a public hospital for the medical procedure.

The dispute with Discovery Health

SECTION27 made a complaint to Discovery in terms of its rules. There was a factual dispute as to whether the diagnosis and treatment fell into the general scheme exclusion or not for Key Care Plus members - functional nasal surgery v functional sinus surgery. The primary goal of functional nasal surgery is to create open and even passageways on both sides of the nose. Functional sinus surgery is the mainstay surgical treatment for sinusitis.

Discovery Health's dispute committee held that Discovery properly relied on its rules in refusing to pay for the surgery. Discovery correctly stated that scheme exclusions do not imply that a procedure is not medically necessary. It means that it is simply part of the benefit design and pricing of the plan.

The dispute committee stated that M's sole reliance on the Key Care Plus Member Guide 2011 when contracting with Discovery was dangerous. In its member guide, Discovery only excludes 'functional nasal surgery' and not 'functional sinus surgery'. The dispute committee ruled that the rules of Discovery Health formed the basis of the contractual relationship with M and not the member guide which M relied on. However, the dispute committee believed that on the face of it, Discovery may not have complied with section 30(2) of the Medical Schemes Act 1998 (MSA). This section states that every member on admission to a

medical scheme should be furnished with a summary of the rules specifying the member's rights and obligations. The member guide clearly did not provide a full picture of M's benefits and therefore rights. The dispute committee could not deal with this aspect as this type of non-compliance must be addressed by the Council for Medical Schemes.

Conclusion

M's story illustrates the information asymmetry that exists between medical aid members (including at the point of taking up membership), medical schemes and providers of health care services. It further highlights the need for medical schemes to continuously inform members of their rights (including coverage).

A5: Refusal to pay for oncology related treatment and procedures

Background

L was a member of Medshield medical scheme as her husband's dependent. They were on a benefit option called Core Plus. They have now moved to Discovery Health. L required six sessions of therapy with Herceptin for the treatment of breast cancer. Medshield did not authorise the use of Herceptin as they stated it would exhaust her oncology benefits. This was not the only refusal to pay for oncology-related treatment. L had to pay out of pocket for a prosthesis (breast implant) which was later reimbursed. The test to determine whether she needed chemotherapy was not paid for. She had to pay out of pocket for this too, an amount of R3500. Medshield did not approve alternative tests either.

She did not formally complain at the time, but did liaise tirelessly with various divisions within Medshield. On her new medical aid with Discovery Health, L has not asked for approval of treatment with Herceptin as it is now apparent that she is allergic to chemotherapy.

Medshield's oncology benefits and consistency with the Prescribed Minimum Benefit (PMB) framework

On the Core Plus option, Medshield provides for the following oncology benefits: treatment for the active treatment period, radiology and pathology and post active treatment. The conditions placed on this benefit are that they are subject to prior authorisation and use of designated service providers in a network. Once the benefit limit is exhausted, the PMB level of care applies to all PMB conditions. Treatment for long-term chronic conditions that may develop as a result of chemotherapy and radiotherapy is not included in this benefit. Another benefit is that of oncology medicine. This benefit is also subject to prior authorisation and access from a designated service provider. There is a limit of R200 000 per family.

Medical schemes are required to pay 100% of diagnosis, treatment and care of a PMB condition. Treatable cancer of the breast is a PMB condition. The treatment includes medical and surgical management - chemotherapy and radiation therapy.

Medshield refused to pay for a test (or its alternative) to determine whether Lorraine

required chemotherapy or not. This would fall under diagnosis. In this instance, Medshield appears to have erred given that one of their oncology benefits explicitly includes coverage of PMBs at the PMB level of care.

Medshield's refusal to pay for Herceptin on the basis that it would exhaust her oncology benefits seems to be inconsistent with the PMB framework. Limiting oncology medicine to R 200 000 per family is wholly inadequate to ensure PMB conditions like breast cancer are covered.

A6: Non-payment of a crucial drug for metastatic breast cancer

The patient

M is a 50 year-old single mother from Somerset West suffering from metastatic breast cancer. She was diagnosed three years ago. M comes from a family with a history of cancer. Her mother had cancer as well as her cousins. Her fear of dying has been her biggest challenge. M and her condition has taken its toll on her sons.

M's condition and prevalence in South Africa

Metastatic breast cancer is also classified as Stage 4 breast cancer which means that the cancer has spread to other parts of the body. This usually includes the lungs, liver, bones or brain. Symptoms are wide ranging depending on where the cancer has spread.

These include: severe, progressive pain, swelling, bones that are more easily fractured or broken, persistent, progressively worsening headache or pressure to the head, vision disturbances and behavioral or personality changes.

An estimated 8 000 South African women are diagnosed with breast cancer every year. Statistics predict about 1 600 (20%) die. Many of these women may develop metastatic breast cancer.

M has been prescribed Tamoxifin for three years. It is used to prevent the growth of cancer cells which may cause cancer of the uterus, strokes, and blood clots in the lungs. These conditions are serious and are potentially fatal.

Non-payment of a crucial breast cancer drug

M had to fight to get Herceptin, a crucial drug for treating breast cancer as part of her therapy. Only when she went to the press, her medical aid authorised the payment of Herceptin. The average survival is 24.4 months when treated with Herceptin as part of a first-line regimen.

'Treatable' 'cancer of the breast' is a prescribed minimum benefit condition (PMB). The treatment includes 'medical and surgical management' – 'chemotherapy and radiation therapy'. Every medical scheme is required to pay in full for a PMB condition regardless of

the member's plan. Furthermore, because of the advanced nature of metastatic breast cancer, it is very surprising that medical schemes refuse to pay for a drug which would curtail the rapid spread of the cancer resulting in other cancers of the body (which may be PMB conditions in their own right).

Members in M's position should not be put through the emotional trauma of fighting with their medical schemes where there is a clear violation of the PMB regulations and a clear medical need for a particular drug.

A7: Lack of private health services in rural areas

The unfortunate position of private health cancer patients in rural areas

R is 48 living in Calvinia. She suffers from breast cancer and requires chemotherapy and radiation on a regular basis. Calvinia is situated in the Northern Cape several hundred kilometres from Cape Town where she was referred for treatment. R is one of many private cancer patients in her region having to travel long distances for treatment.

R is on her husband's medical aid. Because of this she cannot access many state services. R does not have the money to pay for transport from Calvinia to Cape Town and accommodation. Furthermore, even though 'treatable cancer of breast' is a prescribed minimum benefit condition (PMB) where the medical aid has to pay for treatment in full, they only cover some treatment and not others. These two factors result in huge expenses for R which she cannot afford to pay for. Patients accessing health care at state hospitals in Bloemfontein and Kimberley have to be transported in ambulances over 800 km taking about 8 hours.

The effects on treating PMB conditions

An estimated 8 000 South African women are diagnosed with breast cancer every year. Statistics predict about 1 600 (20%) die. If not detected early, or treatment adequately thereafter, the consequences can be dire. As a PMB condition, even if medical schemes pay in full (which they are required to do), patients in R's position have very little comfort. This shows how a lack of private health services in a given locality can thwart the benefits of having medical aid cover.

A9: The limitations of medical aid benefits

Introduction

G is the principal member of the Government Employees Medical Scheme (GEMS) on the Emerald option. His daughter is a dependent member on his medical aid. G's story reveals the limitations of medical aid benefits.

Putting a capped amount on a benefit per family per year

G's daughter was struggling with the eyesight in her one eye. He took his daughter to an optometrist. The optometrist referred his daughter to an opthalmologist because her apparent condition was not within the scope of his practice. G was required to pay a levy for the services of the opthalmologist in spite of his medical aid cover.

The Emerald option includes specialist consultations with the 'Day-to-Day block benefit' which includes 'Specialist Services'. It is limited to R3 506 per beneficiary and R7 013 per family per year. Under the sub-benefit of 'Specialist Services', there is 'reimbursement at 200% of Scheme Rate for cataract procedures performed by ophthalmologists in their room'.

Ostensibly, this type of benefit seems comprehensive. What limits it, however, is the cap on the benefit amount per family per year which is almost always less than the total sum of the limit per beneficiary.

The overlap of in- and out-of-hospital benefits

G has had problems of his own. He fractured three teeth and requires dental procedures including tooth extraction, bridging and exploration. GEMS is not paying for these because his dental benefits have already been exhausted. As part of G's out-of-hospital benefits, dental services are included. In total, the dental services benefit is R 5 784 per beneficiary per year. However, the breakdown and structure of this benefit makes it a very limited benefit. The out-of-hospital dental services benefit is combined with an in-hospital dentistry sub-limit of R3 918 per beneficiary per year. Conservative and restorative dentistry is limited to only R1 866 per beneficiary per year.

These two instances reveal the limitations of medical aid benefits due to two type of structuring of benefits:

1. A cap on the benefit amount of a family per year which almost always is less than the total sum of the benefit amount per beneficiary; and
2. The overlap of certain in- and out-of-hospitals benefits which easily result in the exhaustion of those benefits.