JOINT PRESS CONFERENCE BETWEEN THE MINISTER OF HEALTH, DR AARON MOTSOALEDI AND THE MINISTER OF TRADE, INDUSTRY AND COMPETITION (DTIC), MR PARKS TAU ON THE IMPLEMENTATION OF THE RECOMMENDATIONS OF THE HEALTH MARKET INQUIRY(HMI)

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Programme Director

My Colleague Minister of Trade, Industry and Competition, Mr Parks Tau

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The Commissioner of the Competition Commission, Ms Doris Tshepe

The Registrar and CEO of the Council for Medical Schemes, Dr Musa Gumede

Members of the Media

Ladies and Gentlemen

Good morning

In our country, it is generally agreed that the cost of Private Health Care is now beyond the reach of most South African. We would be right to assert that it has become an uncontrollable expen. Needless to say, this affects every aspect of South African life. It definitely affects the medical Price Inflation (MPI), which eventually influences the Consumer Price Index (CPI).

Even before that, it affects Medical Aid Premiums which become a big factor in salary negotiations between employer and employee, particularly between the Government and State employees.

Many blame the State for having done nothing to put this runaway costs under control. The blame often arises when the debate on the National Health Insurance (NHI) starts getting hot, with a lot of finger-pointing.

However, the history of tariff-setting in our country indicates otherwise, as we shall indicate below.

BACKGROUND

History of Tariff setting in South Africa

Let us start this history by stating that Private Health Care was never structurally planned and no Act of Parliament was ever passed to establish it. It just evolved on its own as time went on. Only later was a Statute passed in this regard but this Statute controlled only one aspect of Private Health - i.e the financing of health but not the provisioning of health care. An Act of Parliament, the Medical Schemes Act, was passed in 1967 and amended in 1998 (Act No. 131 of 1998) to establish the Council for Medical Schemes (CMS), whose CEO is here today.

No Act was ever passed to regulate the health care providers, i.e those who provide everyday healthcare services to patients.

As a consequence, tariff setting was not a structured process, thus leading to many different tariffs, which varied over time.

A structure called RAMS (Representative Association of Medical Schemes) was set up out of necessity by Medical Schemes. They had a responsibility of negotiating service tariffs.

In 1994 the process was then amended through amendments to the Medical Schemes Act (1967). RAMS now negotiated 'guideline prices', with provider organisations. The guide prices referred to as ‘Recommended Scale of Benefits for Medical Practitioners’ aimed to assist medical schemes with embarking on their own price negotiations with providers.

The then Medical Association of South Africa (MASA), now South African Medical Association (SAMA) introduced the ‘Doctors’ Billing Manual’ which competed with the RAMS prices, with fees that exceeded the RAMS guideline prices. Schemes decided to pay whatever amount the considered appropriate. Patients were then left to pay the difference between the reimbursed amount and the price charged. (last published in 2003)

At the same time Hospital Association of South Africa (HASA), representing private hospitals, received permission from the competition authorities to publish a ‘Benchmark Guide to Fees for Medical Services’.

In 2004, a Competition Commission found that there was a collusion in the way in which prices were agreed upon, and passed a ruling prohibiting any collective negotiation of prices.

The commission was of the view that fee guidelines, including the scale of benefits, used by the Board of Healthcare Funders (BHF), the fee guideline of the Hospital Association of South Africa (HASA) and the South African Medical Association's (SAMA) Tariff Book, respectively are fixing the prices of medical aid reimbursements, hospitals and doctors. Practitioners should set their own tariffs rather than the use of centralised tariff setting process where there is no real competitive process between scheme administrators and providers in the tariff setting process. As such they contravene the Competition Act and were illegal.

The Competition Commissions then avert that the effect of the 'guidelines' is that the practitioners, who are competitors and therefore are 'firms' [under the Act], do not compete on price for their services. To the extent that they do, they use the guidelines as a basis. This amounts to indirectly fixing a price," the commission explained.

The consequence of the ruling required medical schemes/patients to have to negotiate tariffs with individual doctors and other healthcare providers, a practice that would be impossible given the obvious power and knowledge imbalance between a patient and his or her doctor.

This left a deep lacuna in tariff setting. The address the lacuna, in 2004, the National Health Reference Price List (NHRPL), based on an agreed

list of services and standardised coding environment, was established, based on BHF tariff guide adjusted for CPI. Medical schemes could use the NHRPL to calculate their own reimbursement levels based on membership and affordability, usually a percentage of the NHRPL tariff. The set reimbursement level unfortunately had no connection to the billed price charged by providers – who continued to charge higher prices.

This resulted in members being billed for the 'balance' between the NHRPL/reimbursement level and the billed prices. In the absence of penalties for exceeding the NHRPL the health provider groups were in a position of market power and faced no incentives to curb their fees.

In December 2006, the NDoH published regulations relating to the process of determining RPL for comments, in terms of section 90(1)(u) and (v) of the National Health Act and in July 2007 the Minister promulgated the Regulations. Based on these regulations the Director General of Health (in 2008) invited for submissions from all stakeholders contemplated in Section 90(1)(v). This regulation served to invite private hospitals, medical practitioners and medical schemes to submit information regarding the cost of running health services.

There were several disagreements with the submissions made by the private healthcare sector. These relate to the following:

- Incorrect cost data submitted by practitioners – identified during verification exercise.
- Disagreement regarding acceptable bed occupancy rates.

- Disagreement regarding property valuation – replacement value. The healthcare providers insisted on factoring the cost of their property in the setting of the prices to patients, but insisted on the replacement value and not the initial cost of putting up the building.
- Providers unwilling to consent to verification process
- Private hospitals unwilling to share detailed information regarding cost information
- Non-representative sample size in the cost survey

This resulted in a legal challenge by HASA, SAMA and others against the RPL in 2009. The North Gauteng Division of the High Court (28 July 2010) ruled that the underlying regulations for determining the RPL were found to be invalid, due to the absence of consultations between the Minister of Health and the National Health Council. In other words, the case against the State setting regulated tariffs, was won on the basis of procedural technicality but not on the substance or merit of it.

The HPCSA also attempted to regulate the tariffs of practitioners. The HPCSA is empowered in terms of section 53 (3)(d) of the Health Professions Act to determine and publish normative fees In 2012 HPCSA attempted to issue ‘Guideline Tariffs’’ for the determination of fee norms by the medical and dental professional board using the CMS's NHRPL 2006 rates inflated by 46.66%.

- Various stakeholders objected to the proposal alleging that they had not been consulted and that the basis on which the prices were decided was arbitrary, flawed and possibly anticompetitive.

- The South African Private Practitioners Forum, which represents specialists, threatened to take the Health Professions Council of South Africa to court.

The Minister of Health then appointed a task team from the CMS, HPCSA, NDOH and legal experts to develop a framework for negotiation of tariffs in the private healthcare sector. The task team published a discussion document in 2010 on a framework for price negotiations and invited interested parties to participate in a voluntary price negotiation process.

The specialist groups and private hospitals were not willing to participate in the voluntary process. Hence this once more left a void in the price regulatory mechanisms, which of course led to an untenable situation. As can be seen, the history of price setting was riddled with disagreements, long-winded and tortures processes, infused with lots of legal challenges.

Course of Action by the Department of Health

With this state of affairs, the Department of Health approached the Competition Commission in a desperate bid to stem the already run-away prices. The request was for the Commission to reverse the 2006 ruling so that a RAMS-like structure could be set up to regulate prices.

The Competition Commission was not amenable to this proposal because they were worried about the price collusion experienced up to 2006.

The Birth of Health Market Inquiry (HMI)

After a series of discussions between the Department of Health and the Competition Commission, the Commission decided to then set up a Health Market Inquiry (HMI) to conduct a market-wide investigation into the price-setting, and competition in the whole Private Sector.

The HMI was chaired by former Chief Justice, Sandile Ngcobo. He was assisted by four other Commissioners from the Academia and from the field of healthcare.

The HMI was conducted in terms of Chapter 4A of the Competition Act, 1998 (Act No. 89 of 1998). It was run for a period of five (5) years between 2014 and 2019.

This period overlapped with the National Health Insurance (NHI) White Paper (December 2015 and June 2017), but before the Parliament debate on the Bill, its own five (5) years between 2018 and 2023.

While the Report and Recommendations of the HMI predate the NHI legislative process, the link between the HMI Recommendations and the NHI Act must be appreciated to ensure uniformity in approach and policy coherence.

High-level HMI Findings

In summary, the HMI found that the Private Health Care Market is subject to distortions which adversely affect competition, and is characterized by:

- High and increasing expenditure
- Excessive utilisation of health resources but,
- Without any discernible or credible corresponding measure of improved health outcomes.

Three (3) parts of the Sector were evaluated, namely:

- Facilities market
- Funder market
- Practitioner market

Findings

- **Facilities market:** Highly concentrated and lacking rigorous competition or innovation amongst the largest facility groups
- **Funder market:** Not placing the end consumer at the forefront
- **Practitioner market:** Hampered by obsolete HPCSA regulations and characterised by both unilateral and coordinated conduct which does not necessarily benefit the patient.

The HMI recommends that the establishment of various regulatory agencies:

(i) Independent Supply-side Regulator for Healthcare (SSRH):

Its functions will include Healthcare capacity planning, facility licensing and Practice code numbering.

The proposal is to establish SSRH as a new schedule 3A Public Entity

(ii) Licensing of establishments:

HMI noted that licensing of private hospitals is haphazard and uncoordinated. Prior to 1993, licensing was administered centrally by the National Department of Health (NDOH), under Section 44 of the Health Act of 1977. This changed when the Interim Constitution, 1993 (Act No. 200 of 1993) devolved the licensing process to provincial governments.

The HMI recommended a National licensing Unit under SSRH.

(iii) National Health Information Dataset:

There should be a single data repository to collect timely and reliable information for both the Public and Private Sectors

Funder/Practitioner and Funder/facility tariff negotiations

The HMI recommended that Private Sector prices should be negotiated. The negotiation should be carried out by establishment of a Multilateral Negotiation Forum (MLNF) which should be established under the auspices of SSRH.

The MLNF should consist of representatives from:

- Providers
- Funders
- Government
- Civil society

After these stakeholders reach an agreement, the outcomes must be sent to the SSRH for validation and publishing.

The HMI noted that fee-for-service (FFS), which means cash payment for every service received, is the main driver of volume and cost inflation.

The HMI hence recommended that FFS as a payment mechanism for health services must be eradicated as far as possible, to be replaced by a progressive movement towards alternative reimbursement mechanisms.

The Gazetting of draft block exemptions regulations by the Minister of Trade, Industry and Competition

The Department of Health has been working with the Competition Commission since January 2024, even prior to the President assenting to the NHI Act.

The aim of the engagement was to design a legal mechanism by which fees and tariffs can be determined collectively.

The Competition Commission has received several applications by different stakeholders in the Private Sector, requesting individualised exemptions from the Competition Act so that they can regulate prices within funders.

The Competition Commission after sector wide consultations, decided not to exempt individual groupings but rather to pursue a block exemptions using mechanisms that closely resemble the recommendations of the HMI.

An agreement was reached between the NDOH and the Competition Commission in late 2024. This led to the Minister of Trade, Industry and Competition publishing block exemption regulations on the 14th February 2025.

This exemption is in terms of Section 10 of the Competition Act and hence falls within the purview of the Minister.

Outcomes Measurement and Reporting (OMRO)

The HMI lamented the absence of reliable information on health outcomes of the Private Health Care Sector. Hence it recommended the establishment of a new and independent not-for-profit collaborative outcome measurement and Reporting Organisation (OMRO) which would define national standards.

The NDOH agrees entirely that healthcare outcomes are the reason for delivering healthcare services. The Private Health Sector voluntarily collects and analyses data but is reluctant to share, allegedly owing to commercial competition interest. Health legislation has mandated this function to the Office of Health Standards Compliance (OHSC).

Practice Code Numbering System and Practitioner Facility Certification

Presently, the Practice Code Numbering System (PCNS), which is the only gateway through which Medical Aids can pay for provider services, is controlled by the Board of Health Funders (BHF) which is a Private voluntary association of some medical schemes and their administrators.

The HMI recommends that this function be located in the Supply-Side Regulator of Health (SSRH)

Health Technology Assessment (HTA)

The HMI recommends that the SSRH should have a Health Technology Assessment function.

Standardised Benefit Package

The HMI recommends a single, stand-alone, comprehensive standardised, obligatory base benefit package for all medical schemes.

The NDOH agrees with the recommendation. However, it is very complex so it is proposed that it should initially be voluntary and be built progressively to be obligatory.

The proposal under discussion with the Council for Medical Schemes (CMS) is that the base cover of such a standard package should be comprehensive Primary Health Care.

Health Professions Council of South Africa (HPCSA) Ethical Rules

The HMI recommends that changes be made to HPCSA ethical rules to promote innovation in models of care that allow for the multidisciplinary group practices and alternative care models so that fee-for-service ceases to be the dominant payment mechanisms.

The HPCSA is busy with this change of ethical rules and other matters as envisaged in the White Paper on NHI, the recently assented to NHI Act.

In summary the actions are underway:

- Healthcare Capacity Planning will be firmly located within the NDOH, including licensing of establishments.

- The National Health Information Dataset is incorporated in the NHI digital architecture and there is collaboration with a wide range of private stakeholders.

- Funder/practitioner & funder/facility tariff negotiations will commence with the block exemption regulations where tariffs and fees set will be in respect of both Prescribed Minimum Benefits (PMBs) and non-Prescribed Minimum Benefits (non-PMBs) in the healthcare sector.

- Fee-for-service (FFS) will be systematically eradicated as far as possible with progressive movement towards alternative reimbursement mechanisms (ARMs) such as capitation and DRGs.

- Outcomes Measurement and Reporting will be executed as a function of the Office of Health Standards Compliance.

- Under the NHI the NHI Fund will replace the need for practice numbers where every establishment will have a unique Master Health facility List (MHFL) identity and individual professional providers working in establishments will use unique provider identities linked to their professional registration numbers.

- Health Technology Assessment (HTA) has commenced with the establishment of the Technical Working Group, soon to be upgraded to a Ministerial Advisory Committee.

- The Standardised Benefit Package is under discussion with the Council for Medical Schemes and a range of practitioners.

- Health Professions Council of South Africa (HPCSA) has already amended many ethical rules

Conclusion

It must be noted that the HMI recommends the establishment of a series of totally new 3A entities. Unfortunately, the National Treasury has made it clear that they discourage so many 3A entities and are actually in the process of de-establishing some of those which already exist. Afterall the NHI itself will be established as a 3A entity and hence a large number of these structures will fall under the umbrella of this 3A entity.

It is for these reasons that we are implementing some of the recommendations of HMI as a temporary stop-gap measure which will be progressively upgraded to the levels envisaged. We are doing this because naturally the phased-in implementation of NHI is going to take longer and we need the interim to relieve the pressure which people experience when seeking healthcare services.

We thank you