SECTION27 Submission on the Proposed Amendment to Regulation 8 of the Regulations made in terms of the Medical Schemes Act

Background

1. On 14 July 2015, the Minister of Health published for public comment a draft amendment to the regulations to the Medical Schemes Act ("Act"). The draft amendment is published in terms of section 67 of the Act. SECTION27 welcomes the opportunity to make these submissions.

2. The proposed amendment elicited much public debate about what the amendment would mean for access to health care services and, from the perspective of providers, what it means for the sustainability of the private sector practices.

3. SECTION27, Treatment Action Campaign, South African Depression & Anxiety Organisation and People Living with Cancer expressed concern about the amendment for patient rights. SECTION27 represents three patient support organisations in the case before the Western Cape High Court: Genesis Medical Scheme v Minister of Health (Case No. 15268). The three organisations were admitted as *amici curiae* (friends of the court) in a court order dated 29 July 2015. The amici will introduce legal argument about the role of regulation 8 in realising the right to access health care services, and the consequences on patients' access to health care services should it be struck down by the High Court as is sought by Genesis Medical Scheme.[1]

4. The structure of the submission is as follows:
    - 4.1. Constitutional and international law obligations;
    - 4.2. Current Regulatory framework;
    - 4.3. Rationale for the proposed amendment;
    - 4.4. Consequences of the proposed amendment;
    - 4.5. The amendment is unreasonable.

[1] The Council for Medical Schemes, South African Private Practitioners Forum, Hospital Association of South

Constitutional and international law obligations

5. Ours is a constitutional democracy. All law must be consistent with the Constitution and any law inconsistent with it is invalid. Furthermore, all obligations imposed by the Constitution must be fulfilled. The Constitution commits us all to a transformation project at the centre of which are the founding values of equality and dignity.

6. Section 27 of the Constitution places an obligation on the State to take "reasonable legislative and other measures" to ensure the "progressive realisation" of the right to have access to health care services. The Act is such a legislative measure. The purpose of the Act is, in part, to "to make provision for the registration and control of certain activities of medical schemes; **to protect the interests of members of medical schemes**". (our emphasis).

7. The State's obligations under section 27 are further underpinned by section 7(2) of the Constitution, which include the following obligations:

    7.1. the obligation to "respect" which requires the State to refrain from interfering directly or indirectly with the enjoyment of health care rights;

    7.2. the obligation to "protect" which requires the State to take measures that prevent third parties from interfering with health care rights; and

    7.3. the obligation to "fulfil" which requires the State to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realisation of the right.

8. The Constitutional Court has confirmed that, "government is entitled to adopt, as part of its policy to provide access to health care, measures designed to make medicines more affordable than they presently are".[2] 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, acceptability and quality of health care".[3] The obligation to take legislative and other measures includes measures to prevent rights infringements by third parties. The Constitution also recognises the horizontal application of the rights in the Bill of Rights to private parties.

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[2] *Minister of Health and Another v New Clicks South Africa (Pty) Ltd and Others* (CCT 59/2004) [2005] ZACC 14 at para 32.

[3] Pieterse at 127.

9. In addition, international law recognises the right to health as a fundamental human right. Article 12 of the International Covenant on Economic, Social and Rights, requires states to respect, protect and fulfil the right to health.

10. The right has been elaborated upon and interpreted by the Committee on Economic, Social and Cultural Rights in General Comment no. 14 of 11 August 2000 ("General Comment 14"), which has a bearing on Regulation 8 in the following respects:

    10.1. The obligation to progressively realise the right of access to health care services requires that the State to adopt measures that are 'deliberate, concrete and targeted towards the full realisation of the right'.[4]

    10.2. The duty to progressively realise the right also means that the State has a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realisation of health rights.[5] Further, there is a strong presumption that retrogressive measures taken in relation to health care rights are not permissible and if they are taken the State bears an extremely high burden of proof to justify them.[6]

11. The Constitutional Court has cited General Comment 14: 'retrogressive measures…would require the most careful consideration and would need to be fully justified with reference to the totality of the rights provided for in the Covenant and in the context of the full set of the maximum available resources".[7]

12. In this constitutional context, it is highly concerning that rather than contributing to the progressive realisation of the right to access health care services, the amendment constitutes a retrogressive measure. This is because it introduces potential barriers to access whereas the current regulation promotes access to health care services for patients by guaranteeing cover for prescribed minimum benefits. The regulation does not lead to an overall improvement in access to benefits for medical scheme members and potentially violates their rights to access health care services. Such measures must be appropriately justified and be evidence-based. The State will face a high burden of proof and 'careful

[4] General Comment No 14 at para 30.
[5] Ibid at para 31.
[6] Ibid at para 32.
[7] *Government of South Africa v Grootboom* 2001 (1) SA 46 at para 45.

consideration' of whether it is fully justified with reference to the totality of rights, if challenged in court. It is unlikely it will withstand such scrutiny.

Current Regulatory framework

13. The Explanatory Note to Annexure A of the Regulations[8] made in terms of the Act sets out the objectives of 'specifying a set of Prescribed Minimum Benefits' as:

    13.1. To avoid incidents where individuals lose their medical scheme cover in the event of serious illness and the consequent risk of unfunded utilisation of public hospitals; and

    13.2. To encourage improved efficiency in the allocation of Private and Public health care resources.

14. The Regulations provide certainty as to the cover available to every beneficiary of medical schemes. Patients who require diagnosis, treatment and care for conditions including HIV/AIDS, tuberculosis, various forms of cancer and mental illness, are covered for the full invoice for such services. Also included are treatment costs related common chronic illnesses hypertension, diabetes, asthma, epilepsy and multiple sclerosis, rheumatoid arthritis.

15. Importantly, **emergency medical treatment** must be paid in full by all schemes regardless of the plan a member is on and regardless of the facility at which they seek emergency medical treatment.

16. Medical schemes retain, however, the ability to manage their risk in a number of ways in terms of the Act and Regulations, including:

    16.1. Designating service providers (DSP) and requiring members to obtain services from DSPs;

    16.2. Imposing co-payments on members who voluntarily use a non-designated service provider;

    16.3. Use of medication formularies to limit cover to specific medicines;

    16.4. Waiting periods e.g. 90-day general waiting period before accessing any benefits; and

[8] General Regulations published under the Government Notice R1262 in Government Gazette 20556 of 20 October 1999.

16.5. Penalties to limit abuse by members.

17. Thus, the current legislative regime protects both members and schemes.

18. **The regulatory gap appears to be the lack of regulation of fees for the rendering of health services by health professionals**. There is no doubt that this gap must be addressed, however the proposed amendment shifts the risk to patients without addressing the cost of fees for health care services. This is far too burdensome for individuals and may lead to financial distress for medical scheme members. For this reason as well, it is unlikely to be consistent with the Constitution.

Consequences of the proposed amendment

19. Other than stating that the proposed amendment is made in terms of section 67 of the Act, and that the Minister intends to publish it after consultation with the Council for Medical Schemes, the gazette does not contain any explanation for the amendment or what it is intended to achieve. When asked by members of the media about the reason for the amendment, the Department of Health stated:

- "the aim of the draft regulations was to protect medical schemes from open-ended liability for prescribed minimum benefit conditions claims." (Business Day, 20 July)
- "In the current context, we are trying to fix an immediate problem faced by schemes." (Business Day, 21 July)

20. According to a Business Day article of 20 July 2015, the Department further '**conceded that patients might face co-payments**.' (our emphasis)

21. It is clear from the above statements that the purpose of the amendment is to promote the interests of the medical schemes industry and to address a problem experienced by schemes. It appears further that the problem it seeks to address involves overcharging by health care professionals and the resultant medical scheme exposure to high costs of services provided by the health professionals in the private sector. If this were indeed the motivation for the proposed amendment, the proper means of addressing it would be to address those issues directly. A retrogressive measure to limit access to PMBs is not a suitable or permissible measure to address overcharging by health professionals.

22. The amendment retains regulation 8(1), which provides as follows:

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

23. The above is made subject to the rest of the Regulations. Regulation 8(2) allows medical schemes to manage their risk by, inter alia, requiring members to obtain health services from designated services providers, failing which, a co-payment or deductible may be imposed on the member. Under the current Regulation, schemes must pay in full for health services, unless a member voluntarily uses a non-DSP.

24. In addition to the above, the amendment would enable schemes to:

24.1. Pay for PMB-related health services rendered by a health care professional in accordance with the 2006 National Health Reference Price List published by the Council for Medical Schemes and adjusted by the consumer price index (CPI).

24.2. Negotiate with health service providers for a tariff for which no co-payment or deductible is payable by a member.

25. The latter provision is already the practice of medical schemes, in keeping with their ability to manage their liability and therefore does not add anything to the current position.

26. The former provision will drastically change the current position. Data indicates "prices for healthcare services experienced by consumers have been rising at a faster rate than average consumer prices in the economy".[9] Schemes will be able to change their rules to determine payment for any health service obtained by a member, including those obtained from a designated service provider, in terms of a tariff, which is likely to be lesser than the actual amount charged by the service provider. This will result in co-payments for patients because providers are not required to charge the proposed tariff rate.

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[9] Terms of Reference for Market Inquiry: Private Healthcare Sector, No. 37062, 29 November 2013 at page 84.

27. On 29 July 2015, the General Manager: Stakeholder Relations for the Council for Medical Schemes released a public statement indicating the Council's views on the proposed amendment. The Council stated that the regulation creates a dispensation only for the voluntary use of a non-DSP, in which a tariff equivalent to the 2006 NHRPL plus inflator is applicable. In other words, the suggestion is that PMBs obtained from a DSP will continue to be covered in full on invoice, but voluntary use of a non-DSP will be subject to the proposed new tariff (with beneficiaries paying the balance).

28. However, the Department of Health's proposed amendment makes no such distinction. According to the wording of the amendment, the 2006 NHRPL plus the inflator would be applicable to all PMBs not just those obtained voluntarily from a non-DSP.

The proposed amendment to regulation 8 is unreasonable

29. The proposed amendment is a 'legislative or other measure' in terms of section 27 of the Constitution. It must therefore meet the objective of section 27, which is to advance the right to access health care services and should not take away or limit such access.

30. The proposed amendment is unreasonable in that it may take away existing entitlements and it may 'have an unnecessarily onerous impact on affected persons'.[10] It may require out of pocket expenditure for PMB conditions, chronic illnesses and emergency medical treatment. In this sense, the proposed amendment undermines the important purposes of the Act, which include to 'protect the interests of medical scheme members'.

31. The proposed amendment to regulation 8 is disproportionately onerous to patients, who often have to navigate the health system at a vulnerable time in their lives. They do not have the power to choose service providers or negotiate fees. The patients who are currently able to access treatment through their medical schemes will face co-payment if the cost of treatment is higher than the tariff set by the proposed regulation. The regulation does not apply directly to health professionals but to medical schemes. In other words, the health professionals will not be compelled to charge at a rate equivalent to the proposed tariff. The use of the 2006 NHRPL has been criticised by stakeholders as an outdated and unrealistic benchmark for current prices. Patients will therefore be left with unknown and potentially high costs, which they will have to pay out of pocket. SECTION27 has assisted patients who face steep co-payments and out of pocket expenses for

[10] See *Ehrlich v Minister of Correctional Services* 2009 (2) SA 373 at para 42.

conditions that are PMBs. Some will not be able to afford co-payments and will be forced to forgo treatment altogether as a result.

32. Some will certainly be able to access services in the public sector. However, this places a (often unfunded) burden on the public sector and does not offer a sustainable solution for users or the State.

33. An additional, perhaps unintended, consequence of the amendment is the probable growth of health 'gap cover' insurance to cover the shortfall. This type of insurance is currently not regulated as the demarcation proposals intended to regulate health insurance are still pending under the rubric of treasury regulations. In other words, beneficiaries will have to pay the cost of additional insurance because of the very real possibility of large co-payments.

34. Moreover, timing of the publication is relevant to the reasonableness of the proposed amendment. The following are important processes relevant to the proposed amendment that are currently underway:

    34.1. The Competition Commission's market inquiry into the private health sector seeks to uncover the cost drivers in the sector.

    34.2. Health Professionals Council of South Africa (HPCSA) process for the development of ethical tariffs.

Health Inquiry into the Private Sector

35. In January 2014, the Competition Commission launched an inquiry into the private health sector.

36. Part of the rationale for the market inquiry is an indication "that prices for healthcare services experienced by consumers have been rising at a faster rate than average consumer prices in the economy".[11] The Health Inquiry "will investigate the extent of increases in cost, prices, and expenditure and how these increases related to competition".[12]

37. Other issues that are the subject of the market inquiry are:

[11] Ibid at page 84.
[12] Ibid at page 82.

37.1. The important role of medical scheme administrators in negotiating tariffs and reimbursement mechanisms with providers of health care services.[13]

37.2. Whether there are any concerns with possible coordination in tariff setting.[14]

37.3. The healthcare funder's ability to compare cost and quality when contracting providers.[15]

38. The scope of the Health inquiry also includes the integrity of the regulatory framework as it pertains to the conduct of health funders' response to the demand for health goods and services.[16] The integrity of the regulatory framework also encompasses "the application of a reference tariff schedule to determine when over-charging by health professionals occurs." The "determination of tariffs and fees charged to health insurers" and a "review of how price determination takes place" are also part of the scope of the market inquiry.[17]

39. The market inquiry's recommendations may include the reform of policy and regulatory mechanisms that would support the goal of achieving accessible, affordable, innovative and quality private healthcare.[18]

The Health Professions Council of South Africa – Determination of Fee Norms and Guideline Tariffs

40. 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 to the 2006 NHRPL. The industry objected to the failure of the Medical and Dental Board to consult the profession and to the approach, which was characterised as unscientific and arbitrary.

41. Subsequently in 2013, the 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

[13] Competition Commission's Statement of Issues, 2014 at page 10.
[14] Ibid at page 13.
[15] Ibid at page 20.
[16] Terms of Reference n9 at page 88.
[17] Ibid at page 88.
[18] Ibid at page 86.

Professions Act of South Africa but after several consultations, the process inexplicably stalled.

42. The HPCSA conceded in its 2012/2013 annual report that the "unavailability of Tariff Guidelines continues to pose challenges on adjudication of complaints relating to overcharging".[19] In its 2013/2014 annual report, the HPCSA again committed to determining tariff guidelines for the purposes of determining overcharging by medical practitioners. The HPCSA resolved that the Tariff Committee should proceed with the project on activities as detailed in the 2014 project plan.[20]

43. While the process has stalled, it is an important one and should be completed in order to address a key gap in the regulatory framework for delivery of health care services.

Conclusion

44. SECTION27 is of the view that the proposed amendments to regulation 8 are unreasonable and not justified in light of the constitutional duty to progressively realise the rights in the Bill of Rights and ensure the protection of patients. This measure is potentially detrimental to the right of users to access health care services. Under the circumstances, the proposed Regulations are potentially premature and not adequately informed by current policy and evidence gathering processes. We recommend that the regulation be withdrawn in its current form and the Department of Health consult with the industry stakeholders and users of the health system with the purpose of finding a solution to the problem of overcharging of providers, if that is indeed the case.

45. SECTION27 remains available to the Department to answer any questions and participate in any consultations.

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[19] HPCSA Annual Report 2012/2013 at page 7.
[20] Ibid at page 34.