SUBMISSION

On

"Designated Service Providers (DSPs): Based on an Analysis of Stakeholder Submissions. A Discussion Document & Working Paper. April 2026"

("DSP document")

By South African Society of Cardiovascular Intervention (SASCI)

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To: dsp@medicalschemes.co.za

1. Introduction

We welcome the opportunity to comment on the Council for Medical Schemes' (CMS) discussion document and working paper on Designated Service Providers (DSPs), published April 2026 ("the Discussion Document"). We write as a stakeholder in the healthcare sector, specifically as a group seeing numerous Chronic Disease List (CDL), DTP PMBs, and also many emergency conditions.

SASCI is in a unique position to highlight how DSP- and other network pathways affect real-world patient pathways including, but not limited to, treatment delays, outcomes and the overall efficiency of specialist cardiovascular care. The heart of our submission is encapsulated in section 4, on the meaning of the concepts of "availability" (capability/ability and capacity) and "circumstances" that go beyond location/geography.

We support the CMS's stated objective of developing DSP guidelines through balanced, evidence-based stakeholder engagement. However, we wish to raise specific concerns arising from the fact that the Discussion Document's analysis and preliminary guidelines were developed exclusively from pharmacy-sector and general practitioner submissions. We submit that several of the framework's underlying assumptions do not transfer easily to independent practitioners in a highly specialized field (cardiology), and we set out below why that is the case.

Although, as we explain below, DSPs are, legally speaking limited to service providers (healthcare professionals, such as cardiologists), our comments regard the term as

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denoting all forms of contracted-, preferred-, appointed-, network-, "participating providers" and/or selected providers. This, of course brings the managed care chapter of the Medical Schemes regulations, at play, at least for "participating providers". But it also leaves a large number of current provider-arrangements outside of the regulatory ambit.

There is, therefore, a significant legislative gap in terms of healthcare participating in arrangements, with no definitions or legal rules relating to the above listed types of provider arrangements, with "participating providers" (regulation 15 and 15E) and DSPs (regulation 8), not containing subjected to similar protections to patients in terms of co-payments, circumstances and locations.

It is noted that a large part of the report is based on principles in sociology and economy. Although it is appreciated that the CMS wanted to be open and transparent about the process followed and its outcomes, these pages are difficult to read and comment on, whereas the essence of the matter, namely proposed guidelines, and possible legislative *lacunae*, should have been the focus of such a document. The stakeholder analysis is perhaps more suited for an internal CMS document.

2. About SASCI

SASCI, the South African Society of Cardiovascular Intervention, is affiliated to the SA Heart Association. SASCI represents Cardiologists and Allied health care practioners with a special interest in structural - and cardiovascular intervention. The society, a registered not for profit entity, acts in an advisory capacity to funders, industry, members and government on subject matters relating to interventional cardiology. The society's principal objective is to further the education of cardiologists and allied professionals still in training and to create continuous professional development opportunities for those already in practice.

3. DSPs only applicable to PMBs and PMB-related conditions (Reg 8)

The document is not clear as to whether only DSPs in this narrow sense are implied and whether stakeholder comments were limited to those, or whether it pertains to participating providers, preferred providers or other contracted- or associated- or direct and/or indirect managed care arrangements.

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DSPs, legally, only refer to service providers servicing patients with PMB conditions. It is defined in the regulations as:

"a health care provider or group of providers selected by the medical scheme concerned as the preferred provider or providers to provide to its members diagnosis, treatment and care in respect of one or more prescribed minimum benefit conditions"

Of course, very relevant in this regard is the fact that PMBs include the effects or implications, or even adverse events, that flow from a PMB, or the treatment of a PMB.

Regulations 8(2) and 8(3) relates to DSPs, clearly limiting the scope thereof to the PMBs. It also clearly only applies to healthcare providers (and the services and goods they would supply as part of their services):

(2) Subject to section 29 (1) (p) of the Act, the rules of a medical scheme may, in respect of any benefit option, provide that—

(a) the diagnosis, treatment and care costs of a prescribed minimum benefit condition will only be paid in full by the medical scheme if those services are obtained from a designated service provider in respect of that condition; and

(b) a co-payment or deductible, the quantum of which is specified in the rules of the medical scheme, may be imposed on a member if that member or his or her dependant obtains such services from a provider other than a designated service provider, provided that no co-payment or deductible is payable by a member if the service was involuntarily obtained from a provider other than a designated service provider.

4. Regulation 8(3): exemptions to DSPs and prohibition on co-payment: specific applications to cardiology

Regulation 8 reads as follows:

(3) For the purposes of subregulation (2) (b), a beneficiary will be deemed to have involuntarily obtained a service from a provider other than a designated service provider, if—

(a) the service was not available from the designated service provider or would not be provided without unreasonable delay;

(b) immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circumstances or at locations which reasonably

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precluded the beneficiary from obtaining such treatment from a designated service provider; or

(c) there was no designated service provider within reasonable proximity to the beneficiary's ordinary place of business or personal residence.

Some key features that are evident from the above legal framework, are:

- It does not provide for the **non-payment of a non-DSP**:

This, however, often occurs and even where patients / clients are willing to co-pay, they are disincentivized or discouraged from doing so.

- It does not only refer to location, sub-regulation (3)(b) also refers to the "**circumstances**":

This should include circumstances whether provider has been seeing patient over numerous years, know the patient's history and would be the most efficient way of ensuring appropriateness of care, and one would not have to repeat diagnostics or other investigations. Other examples include care rendered to the elderly, who may not be able to travel independently, or consideration of a patient treatment history, and continuity of care – where more than one visit is required in order to address a PMB condition, it would make little sense for a patient to start that journey at one provider, and then have to move to one, or more, as DSPs appointments are made or changed over time.

- It also refers to **availability**, (sub-regulation 3(a)):

This means that the DSP must be appropriately qualified, trained and experienced in terms of the providers and/or personnel (i.e. **ability, capability and capacity**), must have the appropriate equipment or medical devices, etc. See, for example, the 17 December 2021-ruling in *Dr CA Joseph v Fedhealth*.[1] This would of course also apply to circumstances where the hospital is a DSP, and the healthcare professional not, but where the hospital does not have the necessary equipment and staff (see discussion below on discordant DSPs).

There are special considerations relating to time-sensitive cardiovascular care, which highlights **capability versus geography**. Furthermore, a provider who is limiting their practice largely to, for example, interventional cardiology, or emergency services, must be considered. Although other cardiologists may be considered, if TAVI is the appropriate treatment, the provider would have to be trained and proficient in TAVI, and be able implant the specific TAVI (not all providers are able to use all type of implants), i.e.

[1] https://www.medicalschemes.co.za/wpfd_file/dr-ca-joseph-vs-fedhealth-medical-scheme/

capability. Not every hospital has a cardiac catheterisation laboratory. Not every catheterisation laboratory is PCI (percutaneous coronary intervention)-**capable**. Not every hospital provides a 24/7 interventional cardiology service, on-site cardiac surgery, electrophysiology, structural heart interventions or advanced heart failure services such as ECMO, LVAD or cardiac transplantation.

A hospital should therefore not be regarded as an appropriate DSP purely because it is geographically close. It must also be capable of providing **the level of care** that the patient's condition is reasonably likely to require. For many cardiovascular conditions, particularly PMBs, the initial admission is only the start of the patient's episode of care. **The ability to provide definitive treatment without avoidable delay should therefore form part of the assessment of "availability"**.

This becomes particularly relevant in **acute coronary syndromes, cardiogenic shock, complete heart block, life-threatening arrhythmias, acute decompensated heart failure and other cardiovascular emergencies**. Patients are often directed to hospitals based primarily on network arrangements or cost, only for the cardiologist or physician to determine that coronary angiography, PCI or another specialised intervention is required. The patient then requires transfer to another facility, often with additional authorisation, motivation and transport arrangements before definitive treatment can proceed. Whilst each of these individual steps may be reasonable, the cumulative effect may be a clinically significant delay in definitive care.

These legislated aspects, namely:

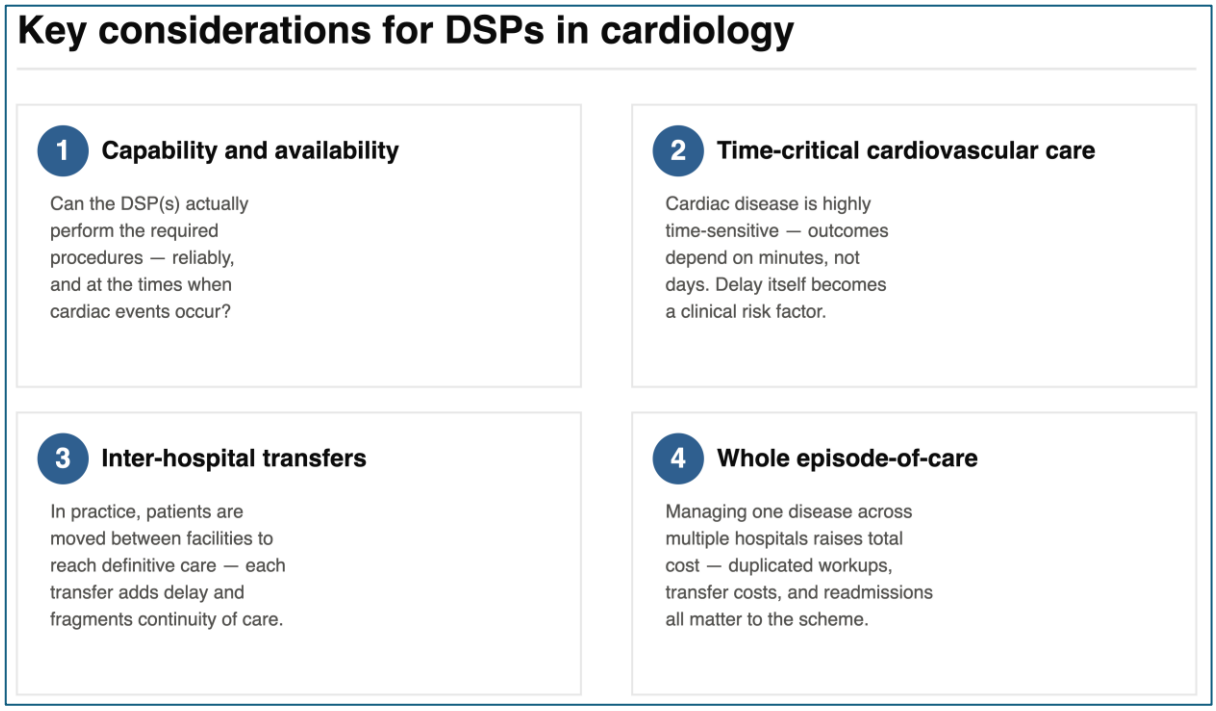
- Ability and
- Capability (as part of availability); and
- Circumstances

Relating to DSPs (or other networks) are virtually absent from the discussion document, or conflated with location (see for example, 4.6 page 69).

5. The question of costs, fees and savings

The Discussion Document refers to DSPs and non-DSPs being paid the same. That analysis makes little sense, as the objective of DSPs would be to create savings and have predictable professional and facility fees. However, allowing the non-DSP to match the DSPs, would be a perfectly acceptable, and pro-competitive response. This is,

unfortunately, not the case. Despite a non-DSP matching DSP fees, schemes would still impose a penalty co-payment. This makes no sense and violates the fairness principle.



The question of whether the apparent saving from directing the initial admission to a lower-cost facility truly represents a saving over the entire episode of care? **Inter-hospital transfers, duplicate investigations, prolonged hospitalisation and delays** to definitive treatment may ultimately increase both healthcare costs and patient risk. It may therefore be more appropriate to evaluate network design based on the cost and efficiency of the complete episode of care, rather than the cost of the initial admission in isolation.

The Guidelines should address this matter, and a cost-saving DSP or network must indeed be that, not merely cost-shifting, or cost-postponing.

6. Pre-occupation with location / distance

In practice, and it also seems to be the case with the Discussion Document and in the submissions on which it is based, that DSPs are seen a geographic only.

This manifests in the document in the narration relating to requiring a national footprint, e.g. the preference of some stakeholders for not having “sub-national” contracts. This obviously is impossible for most practitioners, who are in solus, or smaller practices,

with limited geographical reach. Competition law also prohibits entities not within the same legal entity to jointly tender, or even to form networks, in order to tender for contracts.

This also speaks to the necessity to have different guidelines for different types of providers, and different scenarios.

7. Participating providers and managed care (reg 15E)

The document raises stakeholder submissions relating to the transparency and fairness in the appointment of providers. These criteria are found in regulation 15E(2), and relates to managed care, and not DSPs.

Regulation 15E is the second of two legislated mechanisms for medical schemes relating to provider selection: Participating Providers.

> *A "participating health care provider" means a health care provider who, by means of a contract directly between that provider and a medical scheme in terms of regulation 15A, or pursuant to an arrangement with a managed health care organisation which has contracted with a medical scheme in terms of regulation 15A, undertakes to provide a relevant health service to the beneficiaries of the medical scheme concerned*

Administrators, networks and managed care are not specifically addressed in the document, which appears to be largely focused on pharmacy and medical practice (doctors), and its unique challenges in relation to generic substitution and, specifically, the ICPA's challenges on penalty co-payments as undesirable business practices for medical schemes.

The following remains unclear, both in terms of legislative framework (unlike DSPs), and the absence of this being addressed in the DSP document:

- What the legal framework is around an administrator for only one specific field of care, that includes a network of which all or those aspects of the care being rendered, are being controlled?

- Whether the "networks" operating in terms of administrative contracts, or managed care contracts are deemed to be participation providers?

- Whether such administrators and managed care entities require approval prior to offering such networks to the professionals at stake?

8. Burden of proof in DSP cases

Another important matter is that the CMS, in rulings before it, appears to place the onus on the member to prove that "the treatment was required to be done in circumstance or at locations which reasonably precluded the use of a DSP".[2] Whereas it is understood that the patient must show the existence of specific circumstances, in all likelihood in conjunction with their provider, the existence of other DSPs, who are suitably qualified, equipped, available and within reasonable proximity of the patient, would have to rest on the patient.

9. Discordant healthcare practitioner vs facility DSP

Hospitals often sign agreements with medical schemes that cover all types of care, in all settings, at an agreed fee level or rate. It also often ensures that, where so-called "never events" occur, or in cases of negligence, the hospital takes full financial accountability. These agreements invariably cover all conditions and all fields, whether PMBs, or no-PMBs.

Our comments above (at point 4) on the ability, capability and capacity of hospitals to provide the necessary levels of care required for cardiology, are pertinent here as well.

Doctors have no control over a hospital's commercial decisions (e.g. to become a DSP or not), or that of the scheme to not appoint a hospital as a DSP. A doctor cannot simply up and move to a new hospital, setting up a new practice each time when a scheme moves hospital-DSPs. Doctors are also not allowed to admit patients where they are not allowed so-called "admission privileges, in other words, if a hospital loses its DSP status, the doctor cannot simply see the patient in, for example, a cathlab in a DSP hospital (provided such hospital would, in such an example, have a cathlab!).

[2] Z v LA Health (ruling of April 2023).

10. Tenders as a mechanism to contract DSPs

The clear preference for tenders raises two fundamental issues:

- Competition law compliance, in provider groups setting up their own networks; and
- Ability of micro, small and medium enterprises to participate, as such entities would never have a national footprint.

SASCI submits that a tender process for individual specialist DSP contracts would be impractical and, in effect, impossible to implement. Tenders only work for large, national entities, such as hospital groups. It is recommended that the CMS considers the differences between the types of service providers, and set guidelines that also enables small, independent and localized providers to become DSPs.

11. Contact details

SASCI can be contacted at and would appreciate the opportunity to engage with the CMS on this important matter:

George Nel
george@medsoc.co.za