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To: The Minister of Trade, Industry and Competition, Minister Tau
For the attention of: Dr Ivan Galodikwe
By email IGalodikwe@thedtic.gov.za

Dr. Ivan Galodikwe,

The Competition Commission's Health Market Inquiry and the Proposed Block Exemption Framework for Tariff Determination from a Private Interventional Cardiologists' perspective

Introduction:

The recently proposed interim block exemption for tariff determination, allowing for collective negotiations within the healthcare sector, appears at first glance to be a laudable step toward improved transparency and structure. However, from a practical, clinician-based perspective, its success hinges on the quality and insightfulness of its implementation.

Multilateral tariff-setting may sound ideal in principle, but the success of such a system rest heavily on clinical insight, real-world healthcare economics, and an understanding of global best practices. There is a legitimate concern that this process may be prematurely centralised, bypassing meaningful engagement with specialists and clinicians whose livelihoods and patient outcomes are directly tied to these tariffs. An oversimplified approach, driven by non-clinical agents with limited knowledge of the ecosystem, risks rendering the process unworkable and unsustainable.

The Competition Commission's Health Market Inquiry (HMI) has made a noteworthy effort to identify structural challenges in tariff setting across South Africa's healthcare sector. However, the recommendations arising from the HMI, particularly the promotion of a structured, multilateral tariff determination framework underpinned by a block exemption, require critical evaluation. Price determination in healthcare is a complex, multi-variable exercise grounded in the financial, operational, and regulatory realities of managing a sustainable private medical enterprise.

South Africa's private healthcare providers operate within an inflationary economic climate where capital expenditure for equipment, personnel, training, infrastructure, and compliance is significant. Despite these rising input costs, many tariff schedules have remained relatively static for years. The notion that a perceived "vacuum" in tariff regulation has created unchecked or excessive pricing is misleading. In reality, providers have absorbed considerable financial pressures, often without the benefit of inflation-adjusted increases. These businesses not only deliver essential clinical services, but also support a broad workforce, invest in technology, contribute to training and academic advancement, and sustain a meaningful portion of the tax base.

The process of collective bargaining proposed in the HMI—especially in a fragmented market where a 'lack of bilateral negotiations' have historically prevailed—is far more complex than suggested. Even under the current model, where tariffs may appear

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unregulated, the entry of most healthcare products into the market occurs at prices that are already discounted or subsidized at the source. The perception of a tariff vacuum is therefore driven more by a lack of technical insight than by a systemic failure.

Oversight and commentary in this domain often stem from non-specialists lacking a granular understanding of procedural complexity, technological evolution, and coding precision. This disconnect results in superficial generalisations about cost inflation, while failing to appreciate the investment behind research and development, especially in specialised fields like cardiology, interventional radiology, and endovascular surgery.

The South African Society of Cardiology (SASCI), along with other professional bodies, has taken an active role in assessing the appropriateness of new technologies entering the market and in guiding tariff allocation. These efforts have been aligned with strict local and international coding frameworks. Professional societies apply nuanced, evidence-based decisions to align procedural coding and remuneration with actual resource consumption, time, expertise, and clinical risk. These specialist-driven processes are essential to accurate tariff representation and cannot be easily replicated through a centralised economic framework alone.

Standardising tariffs in such a technically variable field is fraught with challenges. Devices, implants, and interventional therapies differ significantly across platforms, manufacturers, and techniques. Proper standardisation overseen by a centralised Tariff Governing Body requires a, technically proficient entity that integrates clinical expertise with clinicians at the helm, an understating of health economics pertaining to the realities of ‘life’ of the private and public sectors, and international benchmarking. Without this depth, essential detail is inevitably lost in translation—leading to oversimplified tariffs that do not reflect clinical complexity, real-world variability, or sustainability. This discrepancy may lead to contraction of the skills base needed to deliver services in the long-run.

Furthermore, the proposed block exemption appears to be predicated on a purist economic model that underestimates the realities of private healthcare practice. These are not abstract economic units; they are practices employing real people, running physical infrastructure, and delivering real-time care under demanding conditions. Deviating from this operational reality to focus solely on affordability or economic theory without accounting for viability is not only short-sighted—it is potentially detrimental.

The promulgation of the National Health Insurance (NHI) Act signals an ambitious restructuring of the sector. However, until the NHI is fully implemented, policy reforms such as the proposed block exemption must incorporate a more realistic understanding of how clinical services are delivered and financed. The risk of undervaluing the professional inputs, procedural sophistication, and capital intensity involved in private healthcare is considerable.

While structured tariff determination may be desirable, it must be embedded within a professionally governed, clinically informed, and economically realistic process. I would like to provide additional commentary and recommendations in response to the broader framework in the next following paragraphs from the perspective of a *real* practising cardiologist.

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The reality

Capital expenditure (CAPEX) within cardiology, and most specialist disciplines, is significant. In a single private cardiology practice, the operational demands are steep: two echocardiography machines may cost more than R1-1.5 million each; treadmills used for stress testing can cost up to R250,000 per unit; four computers at R15,000 each; and an ongoing IT maintenance cost of R2,000–3,000 monthly. Rentals in private medical environments can exceed R20,000 per month. Monthly consumables, such as ECG electrodes (many other items) and diagnostic tools, amount to R10,000-20,000 or more/month, and cleaning services and administrative consumables add to the fixed overheads. **When aggregated, running costs may well exceed R300,000 per month**—before any personal income is realised by the specialist. Not to mention tax in the highest bracket and VAT payments every 2 months requiring high volumes of liquidity. VAT can run anywhere between R 100,000 to R 400,000 every 2 months.

In addition to this, salary obligations must be considered. **A practice manager, technologists, and administrative staff** (many of whom support families, travel long distances to work, and have limited support structures) must be paid monthly, often ranging between R100,000 to R150,000 collectively.

The **costs of regulatory compliance**—HPCSA fees, indemnity cover, CPD requirements, practice licensing and audit compliance—add significantly to the non-negotiable overhead. Cardiologists, for example, may pay up to R50,000 annually in professional indemnity cover alone.

While collective bargaining over tariffs, codes, and standards is commendable, it must not be sanitised into a one-size-fits-all framework. Procedural and device complexity, specialist skill, and practice overheads must be reflected in the final tariffs. A centralised Tariff Governing Body (TGB), if detached from clinical and economic realities, risks doing more harm than good.

The South African Society of Cardiology (SASCI) and South African Heart Association (SA Heart association) must be embedded within this process to ensure appropriate representation. These bodies already have substantial experience with coding protocols, technology assessment, and tariff benchmarking, and should not be peripheral to the discussion—they should be pivotal.

Furthermore, healthcare professionals are also tax contributors, job creators, and community employers. Many small-to-medium-sized practices, especially those in cardiology, operate at narrow margins despite public perception. The NHI framework must acknowledge and integrate these dynamics if it hopes to be truly transformative.

It is also imperative that the framework not compromise clinical independence or the autonomy of practitioners. Central to a sustainable and ethical healthcare system is the assurance that treatment guidelines, coding structures, and formularies—both medical and device-related—remain clinician-led, grounded in evidence, and responsive to data, outcomes, and real-world practice. Medical decision-making must not be subordinated to

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centralised administrative interpretation, particularly when innovation, safety, and efficacy are at stake.

I would like to end my submission with 4 comments and recommendations:

1. A standardised tariff model, while administratively attractive, risks oversimplifying the economic and clinical diversity of specialised practices. High-CAPEX disciplines such as cardiology are underpinned by significant infrastructural investments as discussed above and should be factored into tariff discussions.

2. Autonomy, independence, and evidence-based practice must remain the cornerstone of healthcare delivery, tariff regulation, and system reform. Tariffs should reflect not only economic models, but should be constructed with professional oversight, a deep understanding of the medical expertise involved, and acknowledging the risk, and cost structure that underpin specialist care in SA.

3. While the block exemption and proposed tariff reforms are a necessary evolution in healthcare financing, they must be grounded in real-world data, transparent dialogue, and inclusive participation. Practices of all sizes should be encouraged to submit operational data and similar narratives to ensure that policymakers fully grasp the complexity and cost of delivering high-level, patient-centred care.

4. The South African Society of Interventional Cardiology and similar bodies should lead this advocacy on behalf of cardiologists, ensuring that the voice of the specialist remains central—not peripheral—to tariff reform.

I hope that my sentiments are met with positive dialogue and progressive, constructive reforms.

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