SASCI
South African Society of Cardiovascular Intervention

SUBMISSION ON BEHALF OF SASCI Private Practice Committee

ON THE MEDICAL SCHEMES AMENDMENT BILL, 2018

21 SEPTEMBER 2018

1. About SASCI

South African Society of Cardiovascular Intervention (SASCI) is an organisation of physicians; scientists and allied professionals with the purpose to advance the development of cardiology and coronary revascularisation and to provide minimally invasive; image guided diagnosis and treatment of cardiac medical conditions. It also acts in an advisory capacity to funders; industry; members and the government on matters relating to interventional cardiology. The latter is a branch of cardiology that deals specifically with catheter-based treatment of heart diseases and includes procedures such as angioplasty and Trans Aortic Valve Implantation (TAVI). SASCI feels that our submission is important to act in the best interest of our patients.

SASCI is affiliated as a Special Interest Group with the SA Heart Association and developed this submission with support from another SA Heart Special Interest Group CASSA (Cardiac Arrythmia Society of Southern Africa).

This submission has been prepared by the Private Practice Committee (PPC) of SASCI with input from private practice cardiologists from CASSA. For this submission SASCI must been viewed to mean SASCI PPC.

2. Introduction

We organize our submission below in order of priority for cardiologists, and in particular cardiologists in the field of interventional cardiology. SASCI is more than willing to engage further on any matter it raises in its submission.

We strongly believe that the recommendations of the Health Market Inquiry (HMI), whose report was issued on 5 July 2018 be fully canvassed before this draft law is finalized. Two important areas for consolidation are proposals on a price negotiation mechanism and the standardization benefits around the existing PMBs. The draft law, the Medical Schemes Amendment Bill ("MSAB") does not consider the HMI proposals at all, and proposes legislative amendments that will stop the above necessary reforms in their tracks.

3. Cost-capped comprehensive benefits

Section 32I makes a fundamental change in the nature of medical schemes benefits. The PMBs, as it stands, is responsive to the cardiovascular burden of disease facing South Africa. Cardiovascular disease is the leading cause of death in South Africa after HIV/Aids.[1]

Although SASCI acknowledges that there are concerns around the interpretation and implementation of the PMBs, such concerns do not warrant the PMBs being abolished. Doing so would undermine the road toward universal health coverage: the HMI has definitely shown that the PMBs are not a cost-driver, and that it is a vital element in preventing patients from falling into financial difficulties when faced with care required for serious and catastrophic events.

The removal of a diagnosis-based system of mandatory benefits is therefore detrimental to medical scheme patients. It directs the limited resources of medical schemes to cover every conceivable condition (presumably up to a volume limited and definitely with a price/cost cap), with no linkages to burden of disease, the objectives of social security or any recommendations made by stakeholders during the PMB Review process.

There are no definitions provided on what is meant by "service benefits" nor of what is meant by "comprehensive".

There is also no indication what is meant by "payment in full" of "the cost" of "any relevant health services" per se, or when associated with "such conditions". There is no indication what "costs" mean. For example, does it mean that services, currently denoted by the use of RPL codes and NAPPI codes will be paid at whatever is charged for such codes? Or does not mean that there would be a cost per procedure, all inclusive of services (healthcare professional, hospital, etc.) as well as medicines and devices used? Or will the services and NAPPI codes be limited, namely that only certain codes could be charged?

The prohibition on co-payments, as worded in section 32I would also be problematic. Not all co-payments are punitive or prohibitive. If the published service benefit, for example, refers to a patient requiring the care of an interventional cardiologist, and requires stenting, but such is limited to only a certain number of stents, or a certain type of stent, this prohibition on a co-pay mean that the patient would not be able to self-fund a larger number of stents, or to co-pay to access another type of stent. Such a co-payment is necessary of the patient to exercise a choice and/or to access care beyond what is prescribed by the Council and the Minister in terms of section 32I.

SASCI supports the recommendations by the HMI in relation to the standardisation of benefits (as "core" and "supplementary"), the addition of some primary care benefits, and the clarification that PMB care can be

[1] Msemburi W, Pillay-van Wyk V, Dorrington RE, Neethling I, Nannan N, Groenewald P, Laubscher R, Joubert J, Matzopoulos R, Nicol E, Notilana B, Prinsloo M, Sithole N, Somdyala N and Bradshaw D. *Second national burden of disease study for South Africa: Cause-of-death profile for South Africa, 1997 2010*. Cape Town: South African Medical Research Council, 2014. ISBN: 978-1-920618-34-6.

provided out of hospital. This is an approach that will align with the constitutional imperative of "progressive realization" of healthcare and social security rights. It does not leave the current system susceptible to unknown definitions, timelines and determinations, not been done in law (and only by "notice").

Most importantly, the HMI approach ensures that the existing rights of patients are kept intact, and will prevent instances where patients may be forced to use the public sector with no funding, once the volume of their "service benefits" run out.

SASCI therefore objects, in the interests of the patients in both the public and private sectors, against a wholesale change to the fundamentals that underpin the current PMBs. The unintended consequences will be severe and not address the needs of the population to cardiovascular healthcare benefits.

SASCI also supports the collective negotiation model so as to keep tabs on the fees of specialists and the reimbursement levels of medical schemes, as recommended by the HMI. This cannot be achieved by unilateral action by the CMS through cost-capping of "service benefits". To ensure this, the CMS and National Department of Health would, however, have to support the profession in obtaining exemption from the Competition Act, so as to make this a reality.

SASCI also notes that section 32I leave it unclear as to what will happen with "risk" and "savings" pool benefits, and, within "risk", between non-PMB risk-pooled benefits and PMB-risk-pooled benefits. It further notes that the section in the Act, namely section 29(1)(9), that authorize the PMBs to be prescribed in law, have not been proposed to be amended. It is unclear how, from a policy perspective, the PMBs will be reconciled with the "comprehensive service benefits".

4. EDO's and DSPs (discounts for using DSPs)

SASCI in principle supports efforts to reduce the premiums (contributions) of medical scheme members. However, the quid pro quo for these reduced premiums are set out in section 32G is that beneficiaries would agree to only visit DSPs. There are two concerns in this regard:

- A part of cardiology is always emergencies or suspected emergencies. Beneficiaries cannot be expected to find a DSP in such circumstances and should not be penalized by higher contributions for behavior that is not within their control.
- The HMI recommended that DSPs be set on value and outcomes, and not only on price. It also stated that, if only based on price, all providers willing to match that price should be reimbursed. SASCI believes that these principles should apply to section 32G as well.

5. The implied issue of tariffs

Two definitions refer to tariffs paid by schemes, and fees charged by providers. These definitions however only refer to the duty of Boards of Trustees to public scheme tariffs, inclusive of negotiated provider fees.

Although not explicitly stated, it does appear that the CMS may want to use information on fees, costs, etc. it gathers under sections 7(e), 7A(c), 32J(1)(b)(iii), 32J(1)(c)(iii) and 32J(2) to effect market adjustments on the pricing and cost of private healthcare in the interim, and share that with the NHI Fund, presumable, to inform decisions as to in particular inform the reimbursement models and quantum of specialists in the NHI.

Although the CMS would, in principle, be entitled, in the interest of the beneficiaries it protects and the schemes it regulates, to informed pertaining to *claims and reimbursement* levels as it relates to *medical schemes*, the mandate provided to the CMS in the above sections far exceed the overall statutory mandate of the CMS.

Section 7(e) in particular gives the CMS the power to access any "information" about "any aspect" of "private healthcare", including information about "price, utilisation and cost". This means that the CMS could, potentially, as any provider to provide information on its pricing, as well as the costs that underpin a service being rendered (e.g. input costs).

The purpose(s) for which these information disclosure requirements are set, are not clear at all. The sections also constitute limitations of rights of individuals and businesses, such limitations must be fair, reasonable and in line with the provisions of constitutional legislation such as the Promotion of Access to Information Act, 2000 and the Protection of Personal Information Act, 2013.

As Reference Price List process,[2] undertaken in terms of the National Health Act, 2003 and which was struck down (in spite of fairly detailed empowering provisions, not in existence in the MSAB) have shown:

- State entities does not have the right to, by notices and the likes, require the submission of information subject to conditions set in such notices. In the RPL case the regulations were supplemented by notices that were found to not constitute law. Limitations of rights must be done by law, and administrative action of entities in the executive branch of the state must be clearly permitted by law, and not by notices issued by itself.
- The information can only be used for clearly identified purposes, as set by the law (e.g. in the RPL case the information was not used to set benchmarks for reimbursement levels and for professional fees, it was used to set fees and govern increases in fees).

6. The Patient and Provider Registers

[2] *HASA v Minister of Health and another* (case no. 37377/09); *ER24 and another v Minister of Health and another* (case no: 37505/09); *South African Priva Practitioners Forum and others v Director-general of Health and others* (case no 21352/09), North-Gauteng Division of the High Court of South Africa, ruling 28 July 2010.

Although a standardized, national health information system is sorely needed, and is authorized under the National Health Act's as of yet unimplemented sections 74, 75, 76 and section 90(1)(t), the MSAB appear to create two registers to collect information.

Section 19A(1) authorize the categories of information to be provided to "be prescribed", but prohibits the information from including the name or any identifiable information or the persons "health status". However, according to section 19A(2) the purpose is to "identify" and "assess" risks to better manage . It is unclear how, without knowing a person's health status, risks could be identified / assessed. It is also unclear how this would be any different to the anonymized information currently provided by schemes to the CMS and which is used to produce the CMS's annual report.

How it would be a "Beneficiary Register" without containing scheme membership numbers, etc. is not clear – it would simply be a collation of certain information, and not a true register.

Section 32J then authorizes the Provider Register. It seems that this is what is currently called the PCNS – practice code numbering system. However, it does appear to have the potential to be used for other purposes that being paid by a scheme, as the "any other additional information or particulars" may be required of practitioners, not by law, but merely by notice in the Gazette. This stipulation (section 32J(b)(iii) is overbroad and violate the principle confirmed by the High Court in the RPL case.

This MSAB misclassifies (section 32J(b)(i) and (ii)) healthcare professionals as always being "natural" persons, and entities such as hospitals always being "non-natural" (presumably this means juristic-) persons. Many cardiologists practice in juristic entities, such as incorporated companies. It is also not clear why the CMS would require information on "field of practice" (the meaning thereof being unclear) and the "interest" of that practitioner (meaning thereof also being unclear). It is submitted that only information that are registered and registrable at the HPCSA, SANC, SAPC, etc. be required.

Through section 32j(2), the CMS will be able to allocate total medical scheme income per practitioner (per practice number). Why they would require this information at this level of detail, and not aggregated, is not stipulated, and this power also appears overbroad an unjustified.

7. Rulings of the CMS Appeal Board to be final and binding

SASCI welcomes the amendments to tighten the CMS complaints and appeals processes. It further proposes:

- The addition of an empowering provision in section 49 to prescribe, in regulations:
    - the details around such complaints and appeals in terms of timelines and records or submissions required;

  - timelines in relation to complaints, the respondents' replies thereto and the timelines within which rulings must be made;
- A clear indication in the Act that the rulings of the Appeal Board-
  - is final, and binding; and
  - non-compliance with, and/or non-implementation of a ruling constitutes a breach of the Act and the legal principles such ruling seeks to protect;
- An expedited process in cases where, due to the specific condition and/or care required, time is of the essence at both complaints (section 47) and appeal (section 49) levels.

SASCI and its members, and their patients, have real-life evidence on how the failure to abide by the Final Appeal Board ruling in relation to TAVI, also by the CMS itself, has led to patients being severely compromised. This ruling is simply being ignored, even by the scheme against which it was made, and is now required to have been started afresh as various complaints at the CMS. This is a waste of resources, and a gross violation of the right of patients to have the same benefit and protection of the law.

8. CONCLUSION

SASCI PPC makes this submission in the interest of the patient and will be happy to further engage on any matter.

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