SASCI

South African Society of Cardiovascular Intervention

SUBMISSION BY SASCI

ON THE APPLICATION FOR EXEMPTION FROM THE COMPETITION ACT BY THE BOARD OF HEALTHCARE FUNDERS (BHF): Case No: 2021Dec0045

30 June 2022

1. About SASCI

SASCI, the South African Society of Cardiovascular Intervention has been participating in competition law engagements since the Health Market Inquiry (HMI) processes that started in 2015 and ended in 2019. SASCI was an active participant in those processes.

SASCI is affiliated to SA Heart Association and represents cardiologists with a special interest in cardiovascular intervention. The society, a registered not for profit entity, also acts in an advisory capacity to funders, industry, members and government on subject matters relating to interventional cardiology.

SASCI has partnered with medical schemes in specific projects relating to specific cardiology interventions and offer a peer guidance service to assist members in practicing cardiology.

2. About the funding of interventional cardiology

In spite of the fact that many heart conditions are PMBs, SASCI's members are battling to ensure funding in full for their professional fees, as it attested to in its written and verbal submissions to the HMI.[1] SASCI's research survey, which it believes, if replicated today, would show similar results, found:

- The majority of its members were setting their fees with reference to scheme reimbursement, schemes are therefore not price takers;
- Members signed up to designated service provider agreements, as they felt they had no choice;
- There are significant burdens imposed by schemes before a practitioner can use complex technology or prescribe novel or expensive therapies, with schemes reported to be successful in preventing such prescriptions in about 50% of cases where motivated for.

[1] SASCI letter to the HMI, 2015; SASCI HMI Survey Report, 2016; SASCI Reply to HMI Request, 2016; Submission by SASCI on the series of Willis Towers Watson Reports, 2018; SASCI Tariff Determination submission, 2017; etc.

SASCI therefore cannot find any substantiation for the statement in paragraph 4.2 of the exemption application of "runaway prices" as it pertains to its members and the services the members render to medical scheme beneficiaries.

SASCI fears that the collective / collusive action of the BHF means that it wants the Competition Commission to sanction a system that would exacerbate the limitation of rights of patients, who are beneficiaries of medical schemes. Given recent case law[2] that competition law has to be interpreted in line with the Constitution of the RSA and specifically the Bill of Rights, the aspect must be considered by the Commission when evaluating the exemption application, i.e. will this exemption lead to an enhanced realisation of healthcare rights, or further dimmish it to the level of the lowest option of the financially smallest medical scheme in the BHF stable. One should also bear in mind that access to healthcare is not only about affordability, it is also about availability. If the collective action (collusion) of the BHF leads to cardiology services, and products not being available (as providers are not able to sustain viable practices at such price levels), the right of access to healthcare would be violated.

It is clear that medical schemes are successful in managing the cost of healthcare, in particular that of specialists, medical devices and medicines, for which there are various tools in regulations 8(4), and the whole of chapter 5 of the Regulations to the Medical Schemes Act, on managed care. Schemes seem to be able to effectively implement these techniques, perhaps too effective in that patients may be denied appropriate care as a result.

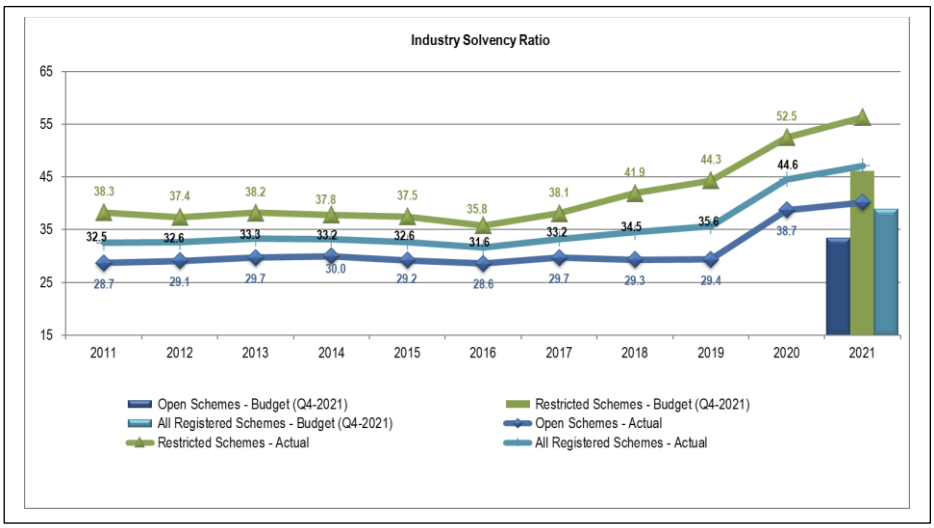
The CMS's Research Note 1 of 2022[3] explains how schemes do not cover PMBs in full and shift those risks to patients in the form of co-payments or out of pocket payments. This report estimates the value of these non-payments at R470m.

The BHF in paragraph 4.5 of its exemption application states that "smaller medical aid schemes" do not have the "necessary bargaining power". BHF however represent some very large, powerful medical schemes, such as Fedhealth and Bonitas. Apart from the fact that smaller schemes should be amalgamating, the BHF's solution would simply authorise a "race to the bottom". It also includes powerful restricted schemes, such as GEMS and Polmed, and employment-related schemes, where changes in benefits will also be of labour law importance, such as Tiger Brands and WoolTru.

[2] http://www.saflii.org/za/cases/ZACC/2021/35.html.

[3] https://www.medicalschemes.co.za/research-note-1-2022-funding-of-healthcare-services-by-medical-schemes/.

The CMS during a presentation[4] to Principal Officers in May 2022 on scheme solvency and financial wellbeing, showed that scheme solvency for close schemes sit at over 55%, and open schemes at around 40%. This is far in excess of the statutory requirement of 20%.



The notion that schemes have to collude in order to better manage the PMBs, and/or to ensure its financial sustainability, is therefore misplaced.

3. The exemption application, the HMI recommendations and health policy imperatives

Exemption should not be seen as a remedy to the lack of government to address aspects on health reform that is within its power to address.

These include, amongst others:

- the review of the PMBs;
- the implementation of the HMI recommendations such as a Supply-Side Regulator for Health;
- the implementation of low-cost benefit options;
- the implementation of risk adjustment mechanism (e.g. risk equalisation fund);
- the avoidance of the necessary consolidation of medical schemes, which is SASCI's understanding include some of the members of the BHF.

Should BHF succeed in its application, there would no impetus for it to support such sector-transformational objectives. This would, however, leave other stakeholders in the cold, and exacerbate the power imbalances created not only by administrators and schemes versus healthcare professionals. It will effectively abdicate healthcare policy in the medical schemes arena, to the collusive determinations as a sector of the market. SASCI's biggest concern is that, if driven by case by case exemption applications by stakeholders, there will be no policy coherence and no alignment with health legislation – as that is not the remit of the Commission.

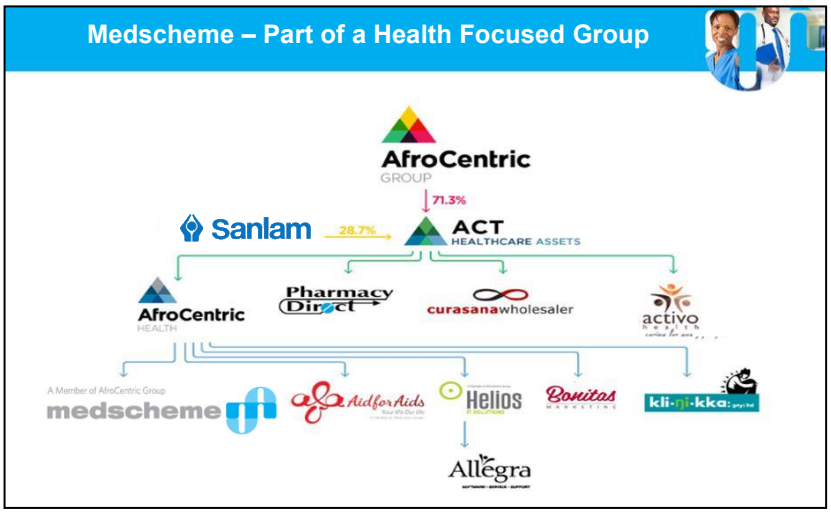
[4] https://www.medicalschemes.co.za/publications/#2009-3658-wpfd-po-forum-ct-17-may-2022.

4. Unpacking the elements of the exemption application

4.1. About the members of the BHF

Paragraph 3 of the exemption application as published, refers to the BHF members as medical schemes. This is, however, not true. The BHF includes two of the three largest medical schemes administrators as well (Medscheme and the Metropolitan Health Group). This means that its application would not only allow for horizontal, but also for vertical collusion.

The HMI expressed concern as to the structure of Medscheme, which is, as an administrator, also vertically integrated with device and medicines supply chains. The figure from Medscheme's presentation to the HMI on this, is copied herein.



The impact of the BHF application therefore far exceed just schemes collectively negotiating and setting prices, benefits and coding.

4.2. Avoiding regulatory control by approaching the

Apart from the general regulatory issues addressed above, the BHF exemption application states that it is making this application because of the "strict-rules-based and inflexible regulatory approaches" of the CMS and the failure to ensure regular reviews of the PMBs (paragraphs 4.3 and 4.4 of the exemption application). It however is an irrational approach – if the problem is with the CMS, the medical schemes legislation or the regulatory approach of the CMS, this has to be addressed by means of the correct forums. To turn to the Competition Commission to solve regulatory challenges that can be solved at the correct place, i.e., at the CMS and the Ministry of Health.

It will be a problematic precedent, should the Competition Commission allow stakeholders in the health sector to solve their regulatory issues at the Competition Commission.

A further implication of this exemption would be that aspects of regulatory control, such as the PMBs and its funding in accordance with regulation 8 and chapter 5 of the Medical Scheme Regulations, will be collectively avoided until challenged. As the mechanisms are now implemented, post the *Cotty* case,[5] all medical schemes in the BHF stable would be able to avoid implementing, for example, appropriate care interventions for heart valve stenosis until challenged at the CMS Appeal Board level or, in court for many years.

4.3. Publication of a Scale of benefits

The National Health Act (section 90(1)(authorise the National Department of Health to publish reference price lists. By granting an exemption on this front, the BHF would effectively be usurping a power of government, it being sanctioned by the Competition Commission. Such a list would not, as purported, apply to providers as well as consumers, as they would not be part of this exemption, and would not be able to be held to this guidance.

It seems unclear on what basis this "scale of benefits" would be set, and how that would relate to a "reference price list". Under the current medical schemes system "benefits" are different to "tariffs" or "prices reimbursed". A benefit would be, for example, the full funding of a PMB condition in accordance with formularies and protocols compliant with the legal framework. "Prices" or tariffs would refer to, for example, the price a scheme is setting as payment for a cardiologist consultation, or for a heart valve. At present these are negotiated with suppliers, and, for providers, are negotiated with hospital groups or managed by means of Designated Service Provider agreements.

SASCI see no argument from BHF as to why these mechanisms are not working, which would warrant a deviation from the existing system.

And, of course, the issue of scales of benefit relates intrinsically to the coding system. Unless there is agreement on how professional activities are coded, and how for example new treatments and techniques are translated into codes, any subsequent process of setting fees or tariffs will also fail. Without the systemic changes recommended by the HMI, and even where collective bargaining is possible for provider groups (see comment below), the absence of a consensus-mechanism on coding will lead to a repeat of the negotiation stale-mates that were a significant feature of the late 1990's and early 2000's.

4.4. Collective negotiations

Allowing only the scheme-side of the medical scheme tariffs or pricing to be collectively negotiated, whilst stakeholders such as SASCI is prohibited from engaging in collective bargaining, would create a negotiation imbalance.

[5] http://www.saflii.org/za/cases/ZAGPPHC/2021/68.html.

The BHF exemption application erroneously states that it would be possible to "negotiate collectively" with "healthcare providers" or "their representative associations". It is for this very reason that the HMI proposed a collective bargaining model under the auspices of a statutory structure, where all stakeholders would be able to negotiate on an equal footing. What BHF proposes would mean it do not have to play by competition law rules, but others, including the individuals that make up SASCI, must do so.

4.5. Collective Health Technology Assessment (HTA)

The CMS invited comment on a collective HTA systems in May 2022. It remains unclear how the BHF sees its proposal relate to the CMS proposals, and the recent proposals by the National Department of health, on health technology assessment.

A legislative barrier to such collective action exists in the medical schemes legislation, as regulations 15D, 15H, 15I, etc. refers to the scheme undertaking cost effectiveness analyses bearing in mind its own levels of affordability. If is therefore not possible to embark on this system without negating and contravening the legislative prescripts in relation to cost-effectiveness and affordability analyses. Each scheme option must in any event be sustainable. In order to reach this, it would mean that the BHF's levels of affordability for an HTA would have to be set, yet again, at the lowest possible level of its scheme with the lowest affordability levels.

It is also unclear on what basis, as set out in paragraph 5.3, the BHF believes HTA will "bring prices down". HTA amounts to an assessment of "value for money" and is not a price-setting mechanism. It should be a factor in reimbursement, but not the only factor and definitely not a mechanism for setting of prices. It may, indeed, be used as a justification for higher levels of reimbursement, or greater adoption of higher-cost technologies.

4.6. Collective submissions, "freely" made on prices, quality, trade practices, a standard benefit package, coding and health outcomes

The BHF seems to believe that it is severely constrained in undertaking the above submissions. However, the BHF is already collectively involved in negotiations on the review of the PMBs, the pricing of a primary healthcare package, and specifically the medicines component thereof, etc. They are also, with the HFA and other entities, collectively sharing information relating to billing and coding as part of its forensic "fraud, waste and abuse" initiatives, which leads to the total exclusion of funding for practitioners who find themselves at the receiving end of this collective action.

If BHF believes these activities are not permitted, why are they currently engaging in them?

5. Conclusion

SASCI remains convinced that the medical scheme members of the BHF is, largely, not part of an industry in decline. Where there are challenges, there are able remedies in law and policy to address those. SASCI is also of the view that this exemption will exacerbate bargaining inequalities in the sector, and possibly lead to even higher increases in the split of reimbursement between the main categories of medical scheme expenditure (hospitals, specialists and medicines), as hospital negotiators would be better placed to serve as a countervailing power to the BHF. Cardiologists would not be in such a position. Lastly, we see no efficiency gains, and only see an increase risk to the rights of patients to receive appropriate care, progressively, as the Constitution demands.

SASCI remains available to assist the Commission in this important matter and to provide further information. Please do contact the SASCI Office on 083 458 5954 and sasci@sasci.co.za