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SECTION27 SUBMISSION ON THE PROVISIONAL REPORT OF THE HEALTH MARKET INQUIRY

1 OCTOBER 2018

1st floor, South Point Corner, 87 De Korte Street, Braamfontein, 2001. PO Box 32361, Braamfontein, 2017. T +27 (0)11 356 4100 f +27 (0)11 339 4311 info@section27.org.za

Introduction

1. SECTION27 is a public interest law centre that seeks to influence, develop and use the law to protect, promote and advance human rights. Our name is drawn from section 27 of the Constitution which enshrines everyone's right of access to health care services, food, water and social security.

2. As an organisation that acts in the public interest, we are concerned about equitable access to health care services in the private sector, particularly, pricing and the drivers of the high cost of health care in the private health care sector. We recognise the importance of understanding the complexities in the private sector as part of the constitutional obligation to attain universal health coverage. We are also keenly aware of the significant dysfunction and the need for reforms in the public sector. In this regard, it is important to note the recent publication of the National Health Insurance Bill, 2018, which was released for public comment shortly before the release of the provisional report of the HMI. SECTION27, together with its partner, the Treatment Action Campaign, submitted comments in respect of the NHI Bill, Medical Schemes Amendment Bill, and National Quality Improvement Plan. We have attached our submission as Annexure A for the Panel's interest.

3. We commend the HMI for addressing the need for better public / private integration, including strategic purchasing by the state from private facilities.[1] We also agree with the recommendations around the licensing of hospitals, including that "[t]he licensing framework should be based on a comprehensive national plan that takes capacity in both the private and public sectors into account."[2] These will all be important steps towards the full integration of health services envisaged by NHI. As we have stated in our NHI submission, we believe the public and private health systems require a great deal of institution strengthening. There is widespread dysfunction in the public sector and the recommendations of the HMI will have to be considered in that light given the

[1] Provisional report at page 209-210
[2] Provisional report at page 464, para 69

need for more integration. Although, we support introducing new regulators such as the supply side regulator, we are also cognisant that adding more regulatory bodies to a system of dysfunctional institutions may further alienate the envisaged outcomes.

4. The HMI's provisional report is the outcome of an unprecedented four and a half year investigation into the private health care sector. The investigation was launched partly in the context of numerous failed attempts to regulate the cost of private health care in South Africa. Some of these are outlined in the provisional report. We believe the entire health system, and the entire health system reform, would benefit from the type of evidence based analysis seen in the HMI's provisional report.

Background

5. SECTION27 has robustly engaged with the Health Market Inquiry and has publically supported the inquiry since its inception in 2014. We have done so through making public statements, producing publications, engaging the media, and in participating in various stages of the inquiry. As we do in much of our advocacy and policy work, we have approached the HMI with a clear agenda to promote the right of access to health care services and to reduce inequality. We have done so, often in collaboration with civil society partners, specifically, by making written and oral submissions to the Panel throughout the HMI, including in respect of the following:

    5.1. Draft Terms of Reference[3];
    5.2. Draft Statement of Issues[4];
    5.3. Draft Guidelines for Participation[5];
    5.4. General submission to the Panel.[6]

[3] 24 June 2013
[4] 30 June 2014
[5] 30 June 2014
[6] 31 October 2014

6. We note that as part of our general submission, we produced a booklet on the right to health care services and the private sector, entitled "The Heart of Private Healthcare: A Patient Story Handbook." The booklet presents stories of patients that struggled to access health services and links those struggles to the systemic problems we observed in the private health system. The publication was widely circulated. Early on, once the terms of reference were released, SECTION27 was the first to publish a fact sheet to guide the public on the nature, scope, and great public importance of the inquiry.[7] We believed it was important to demystify what was a brand new legal mechanism, and a technical subject matter involving powerful stakeholders. As we still believe that to be so, we make a recommendation in this regard later in this submission.

7. In addition, SECTION27 together with its partners, made oral submissions to the Panel during the public hearings held in Pretoria in 2016. SECTION27 brought together the Treatment Action Campaign, Rural Health Advocacy Project, South African Depression & Anxiety Group, and several of our clients. Our aim was to make oral submissions to the Panel to ensure that the Panel heard directly from users of the health care system as well as those who advocate for the rights of users. These were important voices that highlighted to the Panel the nature of the struggle for access to health care, the issues people face in trying to realise their rights, and as well as the gaps in the regulatory framework. As a result, all of these difficulties are much better understood as a result of the Panel's work.

8. Lastly, on 31 August 2018, SECTION27 convened a range of civil society organisations to interrogate the provisional findings and recommendations of the HMI, including health unions, one Chapter 9 institution, a professional association for doctors, patient advocacy groups, academics, private and public sector doctors and activists. All agreed on the critical importance of the HMI and its provisional report for the reform of health care in South Africa. Some of the outcomes included actions for civil society in the coming period, including to:

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[7] SECTION27 Fact Sheet "Competition Commission Inquiry into the Private Healthcare Sector" http://section27.org.za/wp-content/uploads/2016/11/Final-Fact-sheet-PDF-1.pdf

8.1. Highlight how the NHI Bill and HMI Report are not mutually exclusive and find a solution to synergise these two properly.

8.2. Highlight health professionals' excellent work to rebuild the morale of the health workers.

8.3. Encourage group practices that include community health workers, pharmacist assistants and clinical associates.

8.4. Work to ensure civil society participation in all the health reform processes currently underway.

Private Constitutional obligations

9. We submit that the failure to properly regulate has resulted in the sustained violation of the right of access to health care services for many users of the private health sector.[8] Millions of people who use the private health sector (including those who use the sector for only particular services such as GP visits, but ordinarily use the public sector) have, for many years, been negatively impacted by this failure. Lack of appropriate regulation has placed an unaccounted for burden on the public health sector when medical scheme members run out of benefits and fall back on the public health sector. The failure to regulate has profound consequences for health.

10. In our view the final report would benefit from a more deliberate framing within the constitutional right of access to health care services, children's unqualified rights to basic health care services, and other rights that have a direct bearing on health. This is entirely appropriate despite that this is an inquiry into the market using competition law and economics. The Terms of Reference of the HMI promised the Commission would "**make evidence-based recommendations that serve to promote competition in the interest of more affordable, accessible, innovative and good quality private health care in South Africa**." As such, we submit that the findings and recommendations of

[8] See SECTION27 publication "the Heart of Private Healthcare: a patent story handbook" http://section27.org.za/wp-content/uploads/2016/11/Section27_Story-booklet_Web-FINAL-1.pdf

HMI *must* be viewed through the lens of the Constitution. Accordingly, we further submit that this needs to be better reflected in the final report.

11. We also submit that the language referring to the Constitutional imperative be strengthened to frame the state's positive obligations to protect, promote, and fulfil the right. This framing is essential to set the tone for implementation of the final recommendations, especially by state actors such as the regulators of the private health sector. In this regard, we must take cognisance again of the current draft NHI Bill and Medical Schemes Amendment Bill and what appears to be significant political pressure to pass legislation in time for the general elections set for 2019. In our joint submission on the NHI Bill and Medical Schemes Amendment Bill, we have raised the significant danger of rushing the law-making process in the context of both a failing public health system and the pending evidence from the HMI. We believe this evidence would only strengthen the state's ability to put in place rational and evidence-based regulations that protect, promote, and fulfil the right to access health care services. Thus, framing the state's positive obligations will help to provide the impetus needed to implement such regulation.

12. We also note that the Provisional Report does not sufficiently grapple with the constitutional obligations on the market participants, such as the funders and providers. We submit that this omission should be corrected in the final report of the HMI. This issue was specifically canvassed and debated during the public hearings in 2016. According to our record of the proceedings, the Panel engaged with the stakeholders about the private sector obligations and there was debate about the extent to which the stakeholders are duty bearers. We provide extracts from our daily reports of the public hearings below and attach the full summaries as Annexure B:

    12.1. "Mediclinic acknowledged that the "Constitution is at the centre of the Inquiry" and that Mediclinic could potentially "be held responsible for negatively infringing on the right to healthcare services" of patients."[9]

[9] http://section27.org.za/2016/03/hmi-quizzes-life-and-mediclinic-on-price-and-quality/

12.2. Though beginning its submission by acknowledging that "we know that with healthcare the SA Constitution is primary", the Board of Healthcare Funders ("BHF") immediately proceeded to describe medical schemes as a "financing vehicle for health services" and emphasized "the business of medical schemes is not health." This submission follows on a worrying trend thus far from some private sector market participants of paying lip-service to the constitutional right to health and then denying any responsibility to ensure that it is made a reality.[10]

12.3. "Justice Ngcobo made a statement regarding the intersection of private interests and public policy and the role of the state to regulate both the public and private sector to ensure the right to healthcare services is realised. However, Norton was adamant that while inequality in South Africa needs to be addressed the mandate and scope of an Inquiry by the Competition Commission is limited to the Competition Act and should be looked at squarely from a competition lens. This was peculiar because the Inquiry has been conducted in a human rights language and framed in a constitutional context because the subject of the Inquiry is a constitutional right."

12.4. "The discussion then shifted to the constitutional obligations of the private sector players, which Dr Jonny Broomberg of Discovery Health characterised as limited to supporting the state in meeting its constitutional obligations in respect of the right to health. The Judge was not satisfied with the answer and asked whether the private sector stakeholders were not subject to the constitutional right, which is fundamental to the Constitution and is sometimes a matter of life and death. Dr Ayanda Ntsaluba, also of Discovery Health, stepped in to say that section 27 of the Constitution reflects the pact entered into by all the stakeholders, and that achieving the objectives involved the state but that the private sector had a role in helping to attain the objectives of the Constitution".[11]

13. The above commentary illustrates the need for a firm statement from the HMI Panel on the constitutional obligations of private actors in its final report.

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[10] http://section27.org.za/2016/03/panel-deepens-probe-into-private-healthcare/

[11] http://section27.org.za/2016/03/hmi-interrogates-health-insurers/

14. In our respectful view, the provisional report does not go far enough. At paragraph 25-27, the report states in part:

> "25. The obligation imposed by the constitutional right of access to healthcare therefore emphasises the need to:
> 25.1 empower the private healthcare sector to provide healthcare services and goods to enhance access to healthcare services;
> 25.2 regulate private healthcare services;
> 25.3 ensure that consumers have access to quality healthcare services;
> 25.4 ensure that consumers have access to information concerning healthcare matters so as to make informed choices on the treatment they require.
> 26. What is implicit, if not explicit in the obligations imposed by section 27(2), is the need for the regulatory framework to facilitate access to private healthcare services by promoting competition in the private sector to ensure that consumers have access to competitive services and prices from which to select.
> . . .
> 27. The obligation imposed by section 27(2) is echoed in the Competition Act which declares as one of its objects "to provide for markets in which consumers have access to and can freely select, the quality of goods and services they desire" and sets out as one of its purposes "to provide consumers with competitive prices and product choices." It is in this sense that the constitutional right of access to healthcare services and competition law and policy converge. Understanding this convergence is important in assessing the impact of the regulatory framework on competition.

15. We submit that the constitutional obligation on private actors includes negative obligations to not violate rights and positive obligations. SECTION27's earlier submissions on this point are worth repeating here:

16. "We submit that, at a minimum, the constitutional obligations placed on private participants in terms of the right to access to health care services include both "negative" and "positive" elements, including:

16.1. A "negative constitutional obligation not to impair" a user of the system's right to access to health care services. In *Juma Masjid*, albeit in the context of a different socio-economic right, the Constitutional Court indicated this would require a private party to act reasonably in ensuring such impairment does not take place.[12]

16.2. A positive obligation to support the state's efforts to progressively realise the right to access to health care services in the private sector, which includes:

16.2.1. The duty to comply fully with the regulations, which regulate the markets in which a market participant operates, actively placing users of the sectors right to access to health care services at the core of all decisions.

16.2.2. The duty to provide state entities, such as the Panel and the Commission, with information they require to regulate the private sector. The High Court has confirmed that stakeholders in the inquiry, such as the hospital group Netcare, are "obliged by law to disclose any information that is relevant to the market inquiry *voluntarily and in a candid manner*."[13]

16.2.3. The duty to assist in good faith with the expeditious implementation of recommendations made by the Panel and subsequent action taken by the executive or the legislature in terms of such recommendations."[14]"

17. We recommend that, in light of the above, the Panel includes strong language about the constitutional obligations of market participants in its final report. We believe this will provide essential context within which to implement the recommendations of the

[12] *Governing Body of the Juma Musjid Primary School & Others v Essay N.O. and Others (CCT 29/10) [2011] ZACC 13; 2011 (8) BCLR 761 (CC) (11 April 2011)* at para 54-6
[13] Netcare v Competition Commission at para 110. Emphasis added.
[14] SECTION27 general submission (31 October 2014) at paragraph 36.

Panel. As such, these recommendations will require buy-in by the state actors, the private actors, as well as the public.

Comment on the Provisional Report Recommendations

18. In this submission, we consider the vast report and its recommendations in the context of the right to access health care services. At the outset, we state that the recommendations of the Panel appear to be well-reasoned and well-founded in the evidence, analysis, and findings presented in the provisional report. We support evidence based policy making and therefore, support the recommendations made by the Panel. We note, however, that it will be important to consider the implications of the recommendations on existing regulatory institutions and avoid unnecessary overlap, while also encouraging collaboration, sharing of information and resources, and aligning of objectives.

19. We briefly consider select recommendations:

    19.1. Providers: Supply Side Regulator; Outcomes Measurement and Reporting Organisation; pricing.

    19.2. Funders: Base benefit option; risk equalisation fund; brokers; governance of schemes and administrators.

Providers

Supply Side Regulator

20. In light of the longstanding and significant gaps in the regulation of price and quality of health services in the private sector, we agree that a new independent regulator is the appropriate response. We also agree that its independence is vital to its ability to achieve its objectives and gain the confidence of the public and, importantly, the market stakeholders. This will require, inter alia, budgetary and management control, security

of tenure of the heads of the regulator, an independent board, and accountability to Parliament. Mechanisms for cooperation and collaboration with the Office of Health Standards Compliance, National Public Health Institute of South Africa (as it relates to quality of health services), the Council for Medical Schemes, and other relevant regulators should be built into the legislative framework.

Outcomes Measurement and Reporting Organisation (OMRO)

21. We agree with the recommendation to establish an OMRO to address the gap in health outcomes reporting and monitoring. This will have an overall positive effect on public health if the information gathered is shared with relevant government departments and institutions and the public in a manner that protects the privacy of individual healthcare users and healthcare workers. This would include, for example, the National Institute for Communicable Diseases, which conducts, inter alia, public health surveillance. We believe this body should operate across the public and private health sectors.

Pricing

22. This is the crux. The HMI cannot conclude its work without coming to a firm view on the nature and scope of a pricing mechanism for health services. While we do not comment on the two proposals because we do not have the expertise to opine on the most appropriate mechanism, we do agree with the principles for such a mechanism. These include in particular, ensuring greater access to quality health services by improving affordability of health services; ensuring there cannot be excessive pricing of health products or services; reducing price uncertainty; introducing fixed tariffs for PMBs; introducing a standardised coding system to facilitate monitoring, analysing and publication of expenditure and health outcomes; and promoting innovation in funding and delivery of health services.

23. The dispute resolution function is critical and is likely to make or break the system. Given the private health sector is particularly litigious, it is important to ensure price setting is not routinely determined by the courts.

Funders

Base benefit option & PMBs

24. SECTION27 has defended the prescribed minimum benefits from attack on many occasions, not because they are perfect, but because they are a key part of the realisation of the right of access to health care services.[15] The same would be true in respect of the proposed base benefit option. We commend the HMI on making recommendations to retain and expand the protections of PMBs, specifically:

    24.1. That tariffs for PMBs are made binding[16]

    24.2. That the PMB package be extended to include "primary and preventative care"[17]

25. We support the recommendation that a base benefit option should be standardised across all medical schemes to enable members to compare and choose a scheme and a benefit option on the basis of quality and value.

26. We also recommend that the HMI expressly includes all emergency medical treatment as is currently the case with PMBs. This aligns with the constitutionally guaranteed right not to be denied emergency medical treatment in terms of section 27(3) of the Constitution. The current position on emergency medical treatment in the private sector

[15] See for example SECTION27 submission on the draft amendment to Regulation 8 of the Medical schemes Act, in which we opposed the amendment on the grounds that it was retrogressive of the right to health and unconstitutional; Genesis Medical Scheme v Minister of Health in re: MediClinic Southern Africa & Others in re: Treatment Action Campaign & Others (15268/14) 4 All SA 302 in which SECTION27 acted on behalf of the Treatment Action Campaign, the South African Depression & Anxiety Group and People Living with Cancer, in which we defended the regulation making powers of the Minister. Check citation and link to submission

[16] Provisional Report at page 469-470.

[17] Provisional Report at page 457.

is undesirable because there is no clear understanding of what the obligations are on private health providers. Therefore, we believe the HMI provides an opportunity to settle the matter, or at least to put in place a process to develop a code of conduct on emergency medical treatment which would govern the conduct of all stakeholders involved in delivering emergency medical services, and funding those services and others in the value chain. We recommend that the HMI does so in its final report.

27. Finally, we suggest that the recommendation to review PMBs at least every three years must be implemented immediately given that this is already a legal requirement but PMBs are only now under review.

Risk equalisation fund

28. We support the establishment of a risk equalisation fund for the reasons outlined in the HMI's provisional report.

Brokers

29. The provisional report recommends that the broker system is made an active opt-in system so that the interests of brokers and scheme members are more aligned. These are one of the hidden costs to members for non-health services, which are significant and growing. Civil society organisations consulted by SECTION27 agree that brokers are an unacceptable drain on member's resources and do not provide a service proportional to the cost. These organisations argue that brokers should be eliminated altogether as, even with a shift to align with members as suggested by the HMI, brokers do not provide value for money. This will be even more true if the HMI's other recommendations on more transparency in medical schemes; better accountability by Trustees; and other measures aimed to break the information asymmetry between users and providers are carried out. These recommendations are particularly important. If brokers are to remain as an interim measure, we agree that members who opt-out should have lower premiums.

Governance of medical schemes and administrators

30. These recommendations address the core issues of disempowerment in the HMI process expressed by medical scheme members. We welcome the findings and the comprehensive analysis of the serious failings in the governance of medical schemes and administrators. Specifically, the clear link to the ability of members to achieve their rights and to hold their schemes accountable for what appears from the provisional report to be largely a neglected duty to prioritise the needs of members. We agree with the recommendation that savings made by an administrator, for example, through managed care or fraud control, are passed on to members. We would like to see workable mechanisms included in the final report's recommendations. In our view, this should be a legal requirement on medical schemes in accordance with the number one function of medical schemes to "protect the interests of the beneficiaries at all times".[18]

Post the final report

31. In our general submission dated 31 October 2014, we anticipated that the Panel would propose extensive recommendations for the reform of the private health sector. We therefore, requested that some consideration be given to the implementation of the Panel's recommendations. The reason for this request is the disjuncture we often see between recommendations or policy and their implementation. South African policy making tends to be carried out without sufficiently thinking out the implementation process. This leads, repeatedly, to unanticipated consequences[19] and lack of implementation. While we recognise that the HMI Panel is not responsible for implementation of its recommendations, the Panel has the opportunity to break this cycle of recommendation without implementation.

[18] Section 7(a) of the Medical Schemes Act 131 of 1998.

[19] Ditlopo, P., Blaauw, D., Bidwell, P., & Thomas, S. (2011). Analyzing the implementation of the rural allowance in hospitals in North West Province, South Africa. *Journal of Public Health Policy*, *32*(1), S80-S93; Lehmann, U., & Gilson, L. (2012). Actor interfaces and practices of power in a community health worker programme: a South African study of unintended policy outcomes. *Health policy and planning*, *28*(4), 358-366.

32. In this regard we recommend that:

32.1. The final report is accompanied by summaries and explanations of the findings and recommendations to enable the public to understand them.

32.2. The HMI Panel seeks a commitment from the relevant government stakeholders, including the National Department of Health and the provincial health departments; the Council for Medical Schemes; and the Health Professions Council of South Africa, to undertake implementation plans and to streamline these plans as much as possible.

32.3. The HMI Panel seeks the commitment of the stakeholders that were the subject of the inquiry, including the medical schemes; hospital groups; pathology services; and health professionals, to constructively participate in the reforms that most directly affect them. For example, request that providers participate in the pricing structures recommended by the HMI.

32.4. The HMI Panel requests that the CMS does a costing of the increased responsibilities of the CMS and determine the probable additional budget needed to undertake the new duties and responsibilities.

32.5. All stakeholders commit to openness and transparency in their dealings with regulators and the public in implementing the reforms.

32.6. A structure be created to include- all relevant government departments, regulators, industry and civil society stakeholders, to oversee the process of taking the Panel's recommendations forward after its final report is published together with timelines for the establishment of this structure.

32.7. The HMI Panel gives an indication of the most urgent recommendations that require more immediate attention to protect the rights of private health care system users, together with timelines as has been done in respect of the Supply Side Regulator and OMRO.

32.8. The HMI Panel establishes a path for transition to full implementation of its recommendations.

33. While we appreciate that the Panel's work must come to an end, we advocated in our 2014 submission for some mechanism of oversight over the implementation of its recommendations. We again make that suggestion. We appreciate that this will require significant resources, however, we believe real buy-in and public understanding of the report, its findings, and recommendations, are important in order to advocate and monitor their implementation.

Conclusion

34. We thank the Panel for the opportunity to make this submission and for the extension granted to SECTION27.

35. We again express our support for the entire process. We commend the Panel for conducting the proceedings with openness, transparency, responsiveness and accountability and for treating the contributions of civil society organisations and affected individuals with dignity.

36. SECTION27 consulted the following organisations in drafting this submission:

    36.1. Ba Phakamise
    36.2. CANSA
    36.3. Can-Sir
    36.4. Corruption Watch
    36.5. HOSPERSA
    36.6. OUTA
    36.7. Peoples Health Movement
    36.8. Rural Health Advocacy Project
    36.9. South African Depression and Anxiety Group
    36.10. South African Federation for Mental Health
    36.11. South African HIV Clinicians Society
    36.12. South African Human Rights Commission
    36.13. South African Medical Association
    36.14. Faculty of the University of the Witwatersrand
    36.15. Treatment Action Campaign

37. For further information, please contact Umunyana Rugege, Deputy Director, SECTION27 at rugege@section27.org.za or 011 356 4100.

ANNEXURE A – JOINT SUBMISSION OF SECTION27 AND THE TREATMENT ACTION CAMPAIGN ON THE NATIONAL HEALTH INSURANCE BILL, 2018

ANNEXURE B – SECTION27 SUMMARIES OF THE PUBLIC HEARINGS HELD BY THE HEALTH MARKET INQUIRY PANEL