# To change, or not to change...

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I can think of more than one cliché dealing with the concept of change. I'm sure you can as well. I'm supposed to deal with developments in healthcare legislation, but that is like trying to explain why the chicken crossed the road and, no doubt, your versions will be better than mine. So, I decided to write about change.

Fundamentally, we're dealing with massive sweeping changes to healthcare legislation: the Medical Schemes Act[1], the National Health Act[2], the Medicines Act[3] and numerous sets of regulations and policy documents.

## WHY CHANGE?

Change is apparently necessary to afford more people access to healthcare, pursuant to government's obligations in terms of Section 27 of the Constitution[4]. How is this access to be achieved? Through legislative acts, requirements, obligations, controls, regulation and other peremptory measures. Therefore, we have changes to current healthcare legislation, which has already been amended – bear in mind, however, that previous amendments apparently fell short of the constitutional directives of institutions such as the Constitutional Court.

"Access" is a word that is bandied about like the word "change". No one really knows what it means in pragmatic or practical terms, or even as it is used in Section 27 of the

Constitution[4]. However, what it does mean, when viewed in the context of legislative amendments, is "let more people in" – into ICUs, emergency rooms, theatres, wards and clinics – at a lower price. Therefore, "access" means two things – cheap and available.

## THE POLITICS OF ACCESS

How does "access" translate into or from proposed legislative amendments? I cannot, with the space provided to me and the pervasive extent of the amendments to three pieces of legislation, go into detail in respect of all of the proposed amendments. This literature deals with that I believe to be the ideology underlying the amendments to each of the acts that I have mentioned.

## THE MEDICINES ACT

Medicines are already regulated[5] by pricing regulations introduced, after much redistribution of wealth to lawyers, in 2005. Accordingly, the theory is that medicines do not contribute any longer to healthcare inflation. However, what the Medicines Act failed to do, was regulate the billions of rands worth of complementary medicines, foodstuffs and cosmetics that make medicinal claims in SA.

Therefore, taking one's allopathic branded medicine under price regulation does not reduce the economic burden for those South Africans relying, not on allopathic branded medicines, but also on complementary medicines, vitamins and herbs to heal themselves. The clear focus of amendments to the Medicines Act, therefore, is to widen the scope of its application in order to control more effectively the price of complementary medicines, foodstuffs and cosmetics that make medicinal claims. To this end, Section 18A of the Medicines Act – which prohibits discounts, rebates and incentive schemes in respect of the supply of medicines – will apply to all products, not just medicines, thus removing the perversities that make these products expensive[5].

## THE NATIONAL HEALTH ACT

The introduction of pricing control for the

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stakeholders referred to in Sections 90(1)(u) and (v) of the National Health Act (NHA) – previously known as the private hospital sector[6]. These amendments introduce mandatory negotiations and prices, which will be applicable to healthcare establishments, as defined in the NHA, and health services – traditionally provided by private hospitals, rehabilitation clinics, psychiatric hospitals and specialist and general medical practitioners.

It is unequivocal that the Department of Health views current costing models, implemented by the private hospital sector, as too expensive and consequently as posing a significant threat to the economic viability of medical schemes and "access" as a whole. In addition, since the private hospitals will apparently not submit to agreed reductions, the only alternative means is direct regulation. Simply put, private hospitals do not promote "access" to healthcare. They do not realise this right in the hands of individual South Africans across all income bands and are holding the entire healthcare system to ransom by sheer economic muscle. Consequently, the only recourse is, like with medicines and scheduled substances, proper regulation by "the Facilitator" – the proverbial iron fist in the velvet glove[6].

In terms of the amendments now proposed to the NHA – bearing in mind, it's the second draft – the Facilitator will call everyone together, facilitate a debate about what costs should be, decide what the costs are and enact them into law as the be-all and end-all of those costs as debated. This debate will be governed by the rules determined by the department. The powers of the facilitator to solicit comment from everybody who is interested, and anybody he or she is interested in, will also be outlined in due course.

The point of the negotiations is to agree a maximum price "using the Reference Price List (RPL) as a source of reference". This system is to be used not to determine an RPL but rather a set of maximum prices. The RPL is determined in terms of Sections 90(1)(u) and (v) of the NHA – it is a distinct legal process. Amended Chapter 10A of the NHA thus only applies to "healthcare providers, health establishments and medical schemes". Bargaining must occur to determine maximum prices in respect of Prescribed Minimum Benefits (PMBs) and "prices that do not relate to PMBs". Only when disputes that relate to the determination of PMBs and negotiations amongst "the parties" fail, will the matter be referred to arbitration for determination[6].

## THE MEDICAL SCHEMES ACT

The introduction of the Risk Equalisation Fund (REF) and "basic benefits" into the Medical Schemes Act (MSA) will, fundamentally, introduce among others a new Chapter 3A to introduce the REF. Risk equalisation is defined to mean "the system of financial transfer to ensure the sharing of expected costs of providing benefits contemplated in Section 19B". The benefits referred to in Section 19B are those referred to in the current Section 67(1)(g) of the MSA. The formula for risk equalisation will be prescribed in consultation with the Minister of Finance. However, this formula shall, "as far as reasonably possible, result in the *expected* cost to a medical scheme, per beneficiary, of providing the risk equalised benefits, being equivalent to the average expected cost per beneficiary among all medical schemes, assuming a reasonable level of efficiency in the delivery of those benefits[5]".

The finer details will be published as regulations pursuant to the amended MSA. A new chapter, 5B, introduces community rating in certain controlled circumstances, which are designed to be based on the results of a medical scheme's expected average costs of providing basic benefits taking into the scheme's REF projections. Discounts on contributions will also be allowed in certain circumstances. These circumstances are based upon the existence of efficiencies that are present by virtue of the choice by a member of certain service providers and the discount is disclosed in the rules of the scheme[5].

The introduction of Section 32J is designed to decline a basic and supplementary benefits package. In terms of new Section 32J(1) basic benefits are those prescribed in terms of Section 67(1)(5) of the MSA and "any additional benefits which the medical scheme offers in respect of services rendered to a beneficiary while that beneficiary is an inpatient in a hospital". There are a number of additional amendments to the MSA, but those affect primarily governance, the

admission of beneficiaries and the contents of the rules of a medical scheme[5].

## CONCLUSION

### Where does this leave "change"?

Well, I've understated the *overall* effect of the amendments – it's about as much of a change as the French Revolution was a peace rally. The proposals and amendments indicate a paradigm shift in healthcare and its regulation in SA. In its collectivity, the amendments to these three acts give content to the word "access". Accordingly, "access" does not only mean cheap and available.

### The challenges are mighty

The stakes are high and the effects should not be underestimated. To get this right – healthcare as a constitutional right – much debate must be held. Robust debate is imperative. It does not matter if it takes place in parliament, in camera, or in court. Health is a privilege, but healthcare is a complex system of give and take, rights and obligations and both public and private interests.

### Who is killing our healthcare?

A snapshot of the healthcare debate in the United States, in Regina Herzlinger's *Who Killed Health Care*? may be a prudent way to conclude:

"To cure our healthcare problem, we need innovators and laws that sweep away the obstacles. Incremental changes to our laws without a clear vision of what we are trying to attain got us into this mess. For example, Richard Nixon's ad hoc stabs at healthcare public policy entangled us with managed care and congressional management of the care for kidney disease. Incremental changes to our laws will not solve the problem. We need vision and boldness, not politics as usual.

"A consumer-driven healthcare system can keep the Jack Morgans hale and hearty, without breaking the back of our economy or the spirit of our doctors. When you control the money in the healthcare system, the institutions that helped to kill Jack Morgan will either change their behaviour, or find themselves replaced by new, entrepreneurial, consumer-driven ones.

"Consumer-driven insurers will design consumer-friendly insurance policies that give you the benefits, coverage, and doctors you want at a price you are willing to pay. If you want managed care, OK – but if you want another kind of policy, you will have access to that too.

"Consumer-friendly hospitals will take part in integrated teams that give you everything you need for your disease or disability. They will abandon their quest to dominate the healthcare delivery system. Consumer-friendly employers will direct their HR staff to give you back the part of your salary that they used to buy your health insurance, and then they will help you choose from the many new varieties of policies that become available.

"The US Congress will pass laws that enable you to buy your health insurance with tax-free income, help to create information about the quality and prices of medical care providers, and transfer money to the poor so they can shop for health insurance like all other Americans. Senators and representatives will stop practising medicine and setting prices. They will get out of the way, and let the doctors do the doctoring and us to do the shopping.

"Lastly, the academics will research how to make this consumer-driven market work better, just like the Nobel prize-winning economists who help to uncover inefficiencies in the financial markets and devise ways to correct them[7]."

## REFERENCES


1 Medical Schemes Act, 1998

2 National Health Act, 2003

3 Medicines Act, 2003

4 The Constitution of the Republic of South Africa, 1996

5 Medical Schemes Act Amendment Bill 2008, Government Gazette No. 31114 of 2 June 2008

6 National Health Amendment Bill 2008. Government Gazette No. 31114 of 2 June 2008

7 Herzlinger, Regina. *Who Killed Health Care?*: America's $2 Trillion Medical Problem – and the Consumer-Driven Cure (New York: McGraw-Hill, 2007)