UNIVERSAL HEALTHCARE ACCESS COALITION

MTIC REGULATIONS ON BLOCK EXEMPTIONS

Healthcare access in South Africa

– an evaluation of the Minister of Trade Industry and Competition's block exemption for tariffs determination in the healthcare sector released for public comment on 14 February 2025

March 2025

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UNIVERSAL HEALTHCARE ACCESS COALITION

The Universal Healthcare Access Coalition (UHAC) is comprised of national organisations in the healthcare sector representing a substantial proportion of healthcare professionals in the health system.

The purpose of this coalition is to establish a public space to convene strategic conversations on health system reform.

The promise of an integrated, sustainable and responsive healthcare system is a democratic dividend to which South Africa and her people are entitled.

There has, however, been little by way of effective public or private sector healthcare reform for almost two decades, contributing to a weakening trend in the health systems' performance.

As a response to this policy vacuum, the reform framework outlined in this report was developed through a process convened by the UHAC.

It offers a considered response to the unmet imperative for productive health systems reform with the aim of enhancing universal access to healthcare consistent with section 27 of the Bill of Rights.

While this report has been developed at the initiative of the UHAC, it has been made available to interested stakeholders outside of the coalition with an invitation to both comment on and co-develop a constructive health system reform framework for South Africa.

It is anticipated that this process will continue indefinitely as a space for the difficult conversations that tend to be avoided by both government and stakeholders.

PURPOSE

On 14 February 2025 the Minister of Trade Industry and Competition (MTIC) Mr. Mpho Parks Tau gazetted a block exemption to the Competition Act No. 89 of 1998 to collective conduct in the following areas:[1]

- "*the collective determination of healthcare services tariffs*";
- "*the collective determination of standardised diagnosis, procedure, medical device and treatment codes*"; and
- "*the collective determination of quality measurements/metrics, medicines formularies and treatment protocols/guidelines*".

Given this, the UHAC seeks to evaluate the 2025 Government Gazette on tariff determination in the healthcare sector. This evaluation builds upon UHAC's previous analyses of private sector governance requirements.

[1] Minister of Trade Industry and Competition (2025, p. 1).

MOTIVATION

The Minister positioned this block exemption as a crucial step toward healthcare pricing reform, aiming to enhance affordability, competition, and regulatory oversight while addressing long-standing inefficiencies in South Africa's healthcare market.

When announcing the 2025 draft interim block exemption for tariffs determination in the healthcare sector, the Minister of Trade, Industry, and Competition, Mr. Mpho Parks Tau, highlighted several factors that motivated this intervention.

Healthcare Affordability and Pricing Transparency

The current lack of a structured tariff determination process has led to pricing inconsistencies, making healthcare unaffordable for many South Africans.

The exemption aims to introduce a standardised, transparent framework for tariff setting in both Prescribed Minimum Benefits (PMBs) and non-PMBs.

Competition and Market Dysfunction

The absence of a collective tariff-setting mechanism has created a fragmented negotiation system, often favouring dominant market players.

The proposed Multilateral Negotiating Forum (MLNF) seeks to "improve competition" by facilitating fair price negotiations among all healthcare stakeholders.

Legal Justification for the Block Exemption

The Competition Act (No. 89 of 1998) generally prohibits collaborative price-setting, but exemptions can be granted in cases that serve the public interest.[2]

This exemption is framed as a temporary regulatory intervention to address market failures in the healthcare sector.

[2] Importantly, the exemption addresses "agreements" or "practices", not entities or structures.

Historical Context: The Need for Reform

Since 2003, there has been a regulatory vacuum in tariff determination, leading to bilateral price negotiations between healthcare providers and funders.

The Health Market Inquiry (HMI) findings emphasised the need for a structured, multilateral approach to pricing in healthcare.

Balancing Cost Control with Quality Healthcare

The proposal allows for the collective determination of healthcare service tariffs, standardised coding, and treatment protocols to ensure cost-effectiveness while maintaining quality standards.

The Minister referred to measures that would prevent overutilisation and unnecessary cost escalations in the healthcare system. This related to the setting of standard clinical guidelines and treatment protocols.

Alignment with Broader Health Policy Goals

The exemption supports the government's long-term health reform agenda by ensuring that tariff negotiations align with broader national healthcare objectives.

The Minister emphasised the importance of multi-stakeholder engagement to ensure the framework is fair, effective, and sustainable.

Public Consultation and Implementation

The public is invited to submit comments within 30 business days, ensuring stakeholder participation in refining the final regulations.

The exemption will be valid for three years, with a review mechanism to assess its effectiveness before potential renewal.

HISTORICAL CONTEXT

Period to 1994[3]

As in many countries, fee-for-service reimbursement by health insurers lends itself to centralised price and tariff negotiations. This is to facilitate the payment for large volumes of claims happening on a daily basis.

Historically (prior to 1994), tariffs were determined centrally in South Africa, with the Representative Association of Medical Schemes RAMS[4] by way of central negotiations with providers. This led to a system of opting in an out – whereby medical practitioners who accepted the tariffs could claim directly from medical scheme and those who did not had to claim through the member.

Just before the elections in 1994, this system was abolished by the National Party government as part of a strategy to substantially deregulate medical scheme coverage in South Africa. While this deregulation was reversed in 1998 (Republic of South Africa, 1998), the central determination of fee-for-service prices was left to informal negotiations between the representative associations for medical schemes[5], doctors[6] and hospital groups[7].

Period from 1994 to 2004

The informal negotiations were imperfect and only led to the establishment of various reference price schedules – published for each of the associations. The one for medical schemes merely established the reimbursement prices that schemes would pay. The

[3] See for instance (CMS, 2008; National Department of Health, 2002)

[4] RAMS had the delegated authority to set these tariffs. This authority was withdrawn in 1994 just prior to the first democratic elections.

[5] Initially RAMS – but later the Board of Healthcare Funders (BHF).

[6] Initially the Medical Association of South Africa (MASA) – but later the South African Medical Association (SAMA).

[7] The Hospital Association of South Africa (HASA).

provider tariff schedules were typically set at a surcharge to the medical scheme reference price list, with patients having to pay the difference – through balance billing.

The negotiations did allow for the standardisation of coding – even if it did not address systematic challenges in price setting.

In 2000 the prescribed minimum (PMB) benefit framework came into effect, requiring that medical schemes reimburse the specific disease treatment pairs (DTPs) in full – without balance billing, co-payment or reimbursement from a medical savings account.

In theory, this set the scene for schemes and providers to come to agreements on the pricing of PMB benefits. However, in 2004 the Competition Commission abolished the central negotiations, which were coordinated by the Board of Healthcare Funders (BHF), substantially complicating the determination of pricing for PMBs as well as non-PMB benefits.

Period from 2004 to 2006

To maintain some order in the system, the Council for Medical Schemes (CMS) established an interim process to at least allow for the standardisation of codes and the tariffs that schemes would use to reimburse benefits.

This was referred to as the National Health Reference Price List (NHRPL) – which largely continued the BHF process – but under the administration of the regulator.

There was no formal statutory framework for the process, and it was carried out as a “research process” of the CMS – which is one of its statutory functions. The modality was approved by the Competition Commission without a formal exemption.

The idea was for this process to be interim while a more permanent statutory framework was developed. Two tariff schedules were published through this process.

Period from 2007 to 2010

Instead of moving toward a statutory framework, the National Department of Health (NDOH) took over the process in 2007 ostensibly to continue with this approach on an indefinite basis. This was referred to as the Reference Price List or RPL process.

However, due to procedural weaknesses in the capabilities of the NDOH, no tariff schedule ever materialised. This process was ultimately placed before the courts by various healthcare provider associations, where the Minister of Health (MOH) in 2010 was found to have exceeded their authority by seeking to establish reference prices.[8]

The 2010 Proposal

Given the resulting institutional gap, in 2010, the then MOH (which is also the current Minister) released a discussion document[9] on the establishment of another "interim" process to set tariffs.

The interim nature of the process was to pilot a framework that could then be implemented formally through legislation and the establishment of appropriate public structures.

Whereas the RPL process attempted to centrally determine tariffs by the NDOH, after consultation with affected parties, the proposed new framework sought to establish a multilateral negotiating forum. In this approach, prices would not be established centrally but independently negotiated by the stakeholders themselves.

As it was the intention to establish final provider tariffs on an annual basis, and not just scheme reimbursement tariffs, it was recognised that the various parties may not converge on a final position timeously. Not only could the process logjam, but any final tariff schedule

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[8] The Reference Price List (RPL) was invalidated by the North Gauteng High Court in the case of Hospital Association of South Africa Ltd v Minister of Health and Others (Case No. 37377/09) on July 28, 2010 (North Gauteng High, 2010). The court found that the Minister of Health had failed to consult with the National Health Council before promulgating the regulations, as required by Section 90(1) of the National Health Act 61 of 2003. Additionally, the court held that the Minister had improperly delegated the power to develop the methodology for determining the RPL to the Director-General, which was beyond the scope of the Minister's authority. Consequently, the regulations and all actions taken under them, including the publication of the RPL, were declared invalid and set aside.

[9] National Department of Health (2010)

determined by the NDOH would face inevitable legal challenges – as the NDOH and the MOH had no legal authority to make such determinations.

It was, therefore, proposed that a deal-breaking mechanism would be introduced that would avoid legal challenge by allowing the parties themselves to agree on an expedited process to reach a final determination that would avoid deadlock and consequential price collusion opportunities.

It was recognised that where a process has deadlocked, the parties to the negotiation have effectively participated in a form of coordinated conduct which would allow them to take advantage of their shared knowledge to informally set the prices as they see fit – imposing them on both schemes and patients using their resulting market power. To avoid this result, the negotiation process would need to formally conclude.

The rules of participation therefore required everyone to accept arbitration as a mandatory mechanism to resolve disputes.

The proposed panel was required to have no conflicts of interest and have appropriate expertise. The panel process would operate as follows:

- Each party submits a complete tariff proposal, including medical scheme tariffs, provider fees, and no-balance-billing tariffs.

- These submissions would need to include full motivations and justifications and make use of information already included in the negotiation phase.

- The panel must select the most reasonable proposal from the competing submissions.

- The panel cannot modify proposals or suggest a compromise—it must choose one side's full proposal (pendulum arbitration).

    - The arbitration decision must:

        - be final and binding on all parties;

        - be delivered within 14 days; and
        - include a written explanation within 28 days.
- No appeals are allowed against the arbitration decision.
    - A party may apply to the courts for a review under Section 33 of the Arbitration Act (42 of 1965), but only on grounds of:
        - Misconduct by arbitrators;
        - Gross procedural irregularities; and
        - Exceeding jurisdiction.
    - The arbitration ruling remains in force unless overturned by the courts.

The 2010 framework sought to pilot (in 2011) a fair and expedient resolution of tariff disputes by removing incentives for negotiation deadlocks while preventing collusive behaviour. The pendulum arbitration model was designed to force parties to submit reasonable proposals from the outset, reducing manipulation of the process.

However, the MOH at the time (also the current one) failed to pursue the process, and it was abandoned without explanation.

Health Market Inquiry in 2019

The HMI never regarded price regulation as the central pre-requisite to contain costs in the private health system. Instead, addressing the competition issues in the health system required a multifaceted approach, of which price regulation through a multilateral negotiating approach, as envisaged in the 2010 discussion document, was regarded as one component.

The reason for the multifaceted approach is that costs within the private health system are a function of two factors - price and demand.

Given the fee-for-service system, which cannot be done away with in the foreseeable future, fixing prices will have little impact on cost if the incentives to drive up demand by providers cannot be addressed.

Unlike in conventional markets for goods, insured markets distort demand relationships, as households become price insensitive. Given this, providers can either increase prices excessively and/or increase the demand for their services through the way they offer their services.

This is referred to as supplier-induced demand (SID) – which the HMI identified as an issue. Fixing prices alone are insufficient to manage overall costs – which are ultimately transferred to consumers through medical scheme contribution increases.

> "*We assessed the likelihood that excessive utilisation and supplier induced demand (SID) exist in the private facilities market. We do not necessarily draw a distinction between facilities and practitioners in the analysis of SID and excessive utilisation as both facilities and practitioners are required for SID to occur. We have examined holistically the entire system*." (HMI, 2019, p. 95)

> "*The issues raised by the stakeholders have not altered our position. We conclude that SID may be one of the causes of increased utilisation of healthcare in the private facilities market*." (HMI, 2019, p. 97)

To address the inter-related features of the private healthcare system that result in unjustified cost increases, the HMI proposed a framework of institutional interventions, which it regarded as necessary for government to implement holistically to have any effect.

First, the HMI noted that the market failures in the private health system can be attributed to the failure of government to exercise proper stewardship.

> "*We have found there has been inadequate stewardship of the private sector with failures that include the Department of Health not using existing legislated powers to manage the private healthcare market, failing to ensure regular reviews as required*

by law, and failing to hold regulators sufficiently accountable. As a consequence, the private sector is neither efficient nor competitive." (HMI, 2019, p. 30)

Second, the HMI offered recommendations as a holistic package and not as a piecemeal set of interventions that can be cherry-picked.

"*Our recommendations focus on the key interventions necessary to correct competitive distortions, improve access to, and increase the affordability of private healthcare. The interventions which we recommend should be viewed as an integrated whole; and market failures may persist if a partial approach to the implementation of the recommendations is adopted*." (HMI, 2019, p. 210)

Third, the inter-related set of recommendations included systemic interventions aimed at both the funder and provider sides of the health system. These included inter alia, the establishment of a risk equalisation system, mandatory minimum benefits, a supply-side regulator and an information regulator. Included in the set of measures was a system to establish a multilateral negotiating forum (MLNF) as originally considered in 2010.

Whereas the holistic set of interventions would compel the market to compete on cost (price and demand) and value (quality-related features), the MLNF would focus narrowly on prices applicable to fee-for-service reimbursement.

However, the broader intention of the complete framework was to drive contracting away from pure fee-for-service over time. On its own, however, the MLNF would never be able to address the complex issues of cost and quality purchasing within the private health system.

Multilateral Negotiating Forum (MLNF) Proposed by the HMI

The HMI recommended the establishment of an MLNF to be administered by a new regulator – the Supply-Side Regulator of Health (SSRH). It, however, narrowed the focus of the MLNF, relative to the 2010 proposals, to healthcare practitioners only.

"We emphasize the need for the SSRH to be an independent and transparent public entity, in line with international practice where there is a clear shift towards regulatory

*independence in the healthcare sector. Independence is important, particularly in a market where there are concerns of regulatory capture, regulatory failure, and lack of stewardshi*p." (HMI, 2019, p. 213)

The SSRH would be funded by industry levies as is the case with the CMS.

For funder / practitioner tariff negotiations we recommend a multilateral negotiation forum (MLNF) under the auspices of the SSRH. The outcome of these negotiations will be a national maximum FFS tariff for PMB conditions and a reference tariff for non-PMB conditions. A distinction from pre-2003 negotiations, which were found to contravene the Competition Act, is that the SSRH will create the framework under which negotiations occur and it will be mandated to assess outcomes against several stated objectives, including public interest and policy considerations. This process will replace the tariff vacuum with competitively priced services while maintaining the space for subsequent bilateral negotiations to occur between practitioners and funders." (HMI, 2019, p. 223)

The envisaged approach is outlined as follows (HMI, 2019, pp. 223-225):

- The Multilateral Negotiating Forum (MLNF) will comprise representatives from providers, funders, government, and civil society.
- Each stakeholder will prepare and present tariff proposals simultaneously, using anonymised underlying data shared in advance.
- Negotiations will be conducted within a structured framework governed by the Supply-Side Regulator for Health (SSRH), which will issue guidelines, rules, and an information-sharing regime in line with competition law and public interest principles.

Tariff Outcomes and Arbitration:

- Fee-for-service (FFS) tariffs for Prescribed Minimum Benefits (PMBs) will be binding, with no balance billing allowed, while non-PMB tariffs will serve as reference prices.

- Agreements reached in the MLNF will be validated and published by the SSRH.
- If no agreement is reached, or if the SSRH deems tariffs non-compliant, the matter will be referred to binding arbitration.

Arbitration Process:

- Arbitration will be governed by the Arbitration Act, with either a sole arbitrator or multiple arbitrators, depending on the nature of the dispute.
- Stakeholders must agree on an arbitrator; if they fail, the SSRH will appoint one. Suitable arbitrators may be sourced from the Arbitration Foundation of Southern Africa (AFSA) or the Association of Arbitrators South Africa (AASA).
- The SSRH will not interfere in arbitration but may submit relevant documents.
- No new information may be introduced during arbitration.
- The arbitration agreement must define the dispute, procedures, rules, cost assessment, and confidentiality measures.
- Arbitration must be fair, efficient, and cost-effective, avoiding unnecessary delays.

This structured approach ensures transparency, compliance, and enforceability, fostering fair tariff negotiations in the private healthcare sector.

BLOCK EXEMPTION FROM THE COMPETITION ACT

Purpose

The 2025 Government Gazette outlines a MLNF for tariff determination in the healthcare sector, aiming to enhance pricing transparency, affordability, and competition. The framework is offered in terms of an exemption to the Competition Act in terms of section 10(10).

Tariffs Governing Body

It is proposed that a Tariffs Governing Body (TGB) is established to oversee the multilateral tariff determination process in the healthcare sector.

Governance and Structure

The MLNF will consist of representatives from government, healthcare providers, funders, civil society, and patient advocacy groups – all appointed by the MOH.

The TGB, chaired by a senior NDOH official, will oversee the MLNF.

The CMS will validate and store tariff proposals and cost data.

MLNF

The Multilateral Negotiating Forum (MLNF) is ‘responsible’ for the following five functions:

Function A: Setting maximum tariffs

- The MLNF will work together to set the highest allowed prices for healthcare services covered under Prescribed Minimum Benefits (PMBs) and non-PMBs.

Function B: Recommending standardised medical codes

- If the NDOH Coding Committee has not yet developed certain codes, the MLNF will suggest standardised codes for use in the healthcare system.

Function C: Recommending quality standards and treatment guidelines

- The MLNF will propose quality measurement standards to the Office of Health Standards Compliance (OHSC).

- It will also suggest approved medication lists (formularies) and treatment guidelines to the NDOH.

Function D: Providing evidence for Health Technology Assessments (HTAs)

- If the NDOH HTA Committee has not developed certain Health Technology Assessments (HTAs), the MLNF will gather relevant international or local evidence to assist the committee in making informed decisions.

Function E: Agreeing on the Tariff Determination Process

- The MLNF will decide on the process that should be followed when determining tariffs to ensure fairness and consistency.

Tariff Determination Process

Stakeholders will submit anonymised data and prepare tariff proposals before negotiations.

The MLNF will collectively determine tariffs for Prescribed Minimum Benefits (PMBs) and non-PMBs.

PMB tariffs will be binding with no balance billing. Non-PMB tariffs will also be determined.

The TGB will validate tariffs through cost-price assessments before publication.

If MLNF members are unable to make a determination on tariffs or deviate from the determined tariffs, the TGB shall have the authority to make a final determination of the tariffs and may request claim line data, cost structures or other data relevant to confirming the veracity of proposed tariffs.

Compliance and Monitoring

Bilateral negotiations may occur only for prices that are lower than those set through the MLNF process.

The CMS will monitor compliance and submit quarterly reports to the Competition Commission and the Department of Trade, Industry, and Competition (DTIC).

CRITICAL REVIEW OF THE BLOCK EXEMPTION

Legal and Regulatory Concerns

The block exemption, in the form of regulations, seeks to establish what, on the face of it, amounts to a structured policy framework that falls outside of the authority of the MTIC.

There is no part of the Competition Act that enables the establishment of a health-related policy framework for the setting of tariffs, or any other matter referred to in the Gazette.

An exemption provision in legislation is a legal mechanism that allows certain practices and/or agreements to be excluded from specific statutory restrictions or prohibitions under defined conditions.[10]

The purpose of such provisions is to balance regulatory objectives with practical considerations, ensuring that the law achieves its intended goals without creating unintended barriers or inefficiencies.

This block exemption does not appear to be a standard application of an exemption provision.

Instead, this exemption seeks to introduce wide-reaching regulatory control over pricing and market conduct, making it closer to price regulation than would be expected from a traditional competition exemption.

Typically, this would only be possible if supported by explicit enabling provisions in the principal Act.

Certain of the functions to be included in the MLNF negotiations are also inappropriate for such a forum.

[10] Competition Act exemptions are about negotiations between competitors and suppliers / funders to reach an agreement. Not about setting (“determining”) tariffs or maximums.

These include: recommending quality standards and treatment guidelines; and providing evidence for Health Technology Assessments or implementing the outcomes of HTA processes or codes set by the Coding Committee. These functions should belong in an independent technical authority responsible for performing such assessments and should not be determined by way of negotiation.

The exemption therefore purports to allocate the authority to the MOH, the NDOH and the CMS to perform functions and establish structures by way of regulations that are not provided for in health-related legislation – from which they normally derive their authority to act.

It is quite likely that this is unlawful.

It, furthermore, blurs the line between regulatory oversight and direct market intervention, raising legal, economic, and competition policy concerns.

Governance and Institutional Oversight

The exemption allocates the authority to the MOH to select the participants in the MLNF. No criteria for selection are provided, leaving participation to be determined at the full discretion of the MOH. This appears to allow the MOH to exclude and include stakeholders on arbitrary grounds.

The TGB is effectively appointed by the MOH via the Head of Department. This results in a body that is appointed by a political office-bearer and is therefore not structurally independent. Conflicts of interest operating through political parties will then be able to influence key decisions and have sight of confidential information.

According to the Gazette, decisions by the MLNF are taken by ‘consensus’. However, there is no indication of what is meant by consensus. For instance, how is a consensus to be objectively determined? Is any dispute an absence of consensus? Who makes the decision as to what is a consensus if it is not a consensus of all the parties? What level of dissensus requires arbitration?

The MLNF is apparently free to determine the process to be followed to determine the tariffs. However, the process to be followed if the parties do reach agreement on the process is not indicated. While disputes in the determination of tariffs are to be submitted for a final determination, the Gazette makes no provision regarding disputes relating to tariff determination process.

No provision is made for how compliance with the 'process' is to be "enforced" and in terms of which legal framework will they be enforced.

The 'requirement' to submit data and supporting evidence to the CMS is unclear. This appears to contradict the requirement that the MLNF determine the process of negotiations. Furthermore, the process appears to envisage that information sharing will be intermediated by the CMS, instead of directly between the parties.

It is unclear why specific reference is made to calls by either the CMS or the TGB for cost structures and claim line date – when it would be up to the stakeholders to motivate their tariff proposals. It is fairly clear that medical schemes are likely to motivate their arguments with claims-related data, while providers will motivate using cost structures, both without the need for intermediation.

Stakeholder Participation

Given the absence of a clear statutory framework, participation by stakeholders in the MLNF is entirely voluntary. It can be assumed that stakeholders that choose not to participate will continue to set tariffs as they do now. The status of any 'negotiated' tariff schedule via the MLNF, even in relation to PMBs, is therefore uncertain.

Effectiveness in Addressing Market Failures

Aside from questions of legality, this framework is unlikely to have any impact on costs in the private sector and could even exacerbate them.

- First, participation is voluntary – and any resulting tariff schedule will only be one set of schedules amongst others operating in the system.

- Second, price determination accounts for only a small part of the rise in healthcare costs, with demand factors more important. For these to be addressed, the rest of the HMI recommendations must be implemented.

- Third, the MLNF is designated to address only a small part of the prices and tariffs set in the private healthcare system. Excluded are all health facilities – where most healthcare costs are generated.[11]

- Fourth, health facility costs, by which is meant price multiplied by demand, are principally driven by medical practitioners. In the unlikely event that this framework fixes the tariffs affecting medical practitioners, they could make up revenue by increasing the demand for hospital-based services – for which they also derive revenue. It is for this reason that partial approaches are counterproductive.

- Fifth, given the shallow nature of the framework, no incentives will result that drive strategic bilateral contracting that include the market features of price, demand and quality.

- Sixth, the separation of medical practitioner tariff setting from hospital tariffs ensures that contracts that integrate the two are less likely.

Dispute Resolution and Arbitration Process

The TGB plays a key role in the dispute resolution process. Given the arbitrary nature of the appointment of members of the MLNF, it is not hard to envisage scenarios where disputes are manufactured such that they are subject to the discretionary decision-making of the TGB, which is itself subject to arbitrary appointments.

The TGB is not an independent structure and to the extent that it makes any determination that matters, its decisions are challengeable in the courts as occurred with the RPL. It should

[11] This is irrational. For example, a billing code associated with an ECG machine, for example, will be subject to this if owned by a doctor. However, if owned by a hospital, will lie outside of this. This could therefore lead to an increase of hospital admission to access device utilisation.

be noted that the 2010 revised construct addressed this risk by restricting the role of the arbiters to ‘pendulum arbitration’.

Given the untidy design of the arbitration approach, which includes an option for the TGB to call for more information with a discretion to make decisions that vary from those of the stakeholders, the scope for dispute, legal challenge and delay is large – as occurred with the RPL process.

Aside from questions of legality, there is no clarity how anyone participating in any part of the process will be bound by any decision made in the process.

Comparison with Previous Pricing Models

The 2010 consultation document attempted to establish a framework that would work outside of a legislated process. It addressed issues of MLNF selection, the voluntariness of the process, and the binding force of final determinations. It also attempted to avoid the pitfalls of the RPL process that got struck down by the courts.

Whereas the revised 2010 approach was also interim, this was because it was a pilot to determine a solid legal framework. It appeared to recognise that such an informal framework was not sufficiently stable to last for longer than a single year (2011).

The value of the HMI is that it was able to consider holistic reforms, within which it could locate the tariff setting framework. The HMI connected the supervision of the process to the proposed supply side regulator. The Gazette allocates this function largely to the TGB, which, aside from being structurally conflicted, is unlikely to ever achieve the minimum capability requirements required.

FINDINGS ON THE BLOCK EXEMPTION FOR TARIFF DETERMINATION

Legal and Regulatory Concerns

The block exemption extends beyond the standard use of exemption provisions by introducing regulatory controls without a clear legislative foundation.

There is no provision in the Competition Act that enables the establishment of a health-related policy framework for setting tariffs under an exemption.

The exemption grants regulatory powers to the MOH, NDOH, and CMS, despite these entities not having explicit legal authority to establish such structures under existing health legislation and despite the MTIC having no authority to establish structures within the health sector.

The absence of a statutory basis makes the exemption susceptible to legal challenge.

Governance and Institutional Oversight

The MOH holds full discretion over MLNF participant selection, with no clear criteria for inclusion, allowing for potential arbitrary exclusion of stakeholders. All these instances of full discretion potentially mount to an unauthorised delegation of legislative power.

The TGB allows for appointments based on political affiliation, lacking structural independence, which could lead to conflicts of interest and undue influence.

Decision-making within the MLNF lacks clarity, particularly regarding what constitutes consensus and how disputes over process will be resolved.

Enforcement of compliance with the tariff-setting process is unclear, with no defined legal framework for ensuring adherence to procedural requirements.

Inappropriate Functions Assigned to the MLNF

Certain functions included in MLNF negotiations are inappropriate for a tariff-setting forum, including:

- Recommending quality standards and treatment guidelines; and
- Providing evidence for Health Technology Assessments.

These technical functions should be handled by independent expert bodies with specialised knowledge and methodological rigour, rather than being subject to negotiation by industry stakeholders.

Placing these functions within the MLNF risks politicising critical healthcare assessments, reducing objectivity, scientific integrity, and regulatory independence.

Effectiveness in Addressing Market Failures

Voluntary participation undermines the exemption's effectiveness, as stakeholders can opt out and continue setting tariffs independently.

Price determination is only a minor factor in healthcare cost increases, while demand-side factors and systemic inefficiencies remain unaddressed.

The exemption excludes hospital tariffs, which is a major driver of healthcare costs, limiting its impact.

The risk of cost-shifting by medical practitioners and other providers who could treat patients in hospitals, could increase overall healthcare spending instead of reducing it. Healthcare professionals who are employed by hospitals, as per the HPCSA's ethical rule 18 permissions, will then also be excluded from the process.

The framework does not incentivise strategic bilateral contracting, nor does it facilitate any alternative reimbursement and service delivery models, thereby failing to integrate price, demand, and quality into purchasing decisions by medical schemes.

Dispute Resolution and Arbitration Process

The TGB plays a decisive role in arbitration, despite not being an independent structure, making disputes vulnerable to legal challenge.

The arbitration process lacks clarity, particularly regarding the role of the TGB in calling for additional information and overriding stakeholder decisions.

The design allows for extensive legal disputes and delays, similar to those seen in the RPL process.

There is no clear mechanism binding participants to arbitration outcomes[12], increasing the risk of non-compliance, misuse of the information gleaned in the negotiations, and further litigation.

Comparison with Previous Pricing Models

The 2010 framework attempted to establish a voluntary and legally sound model, recognising that a non-legislative structure could not be sustained long-term.

The HMI's recommendations placed tariff setting under an independent supply-side regulator, ensuring greater transparency and institutional capacity than the TGB-based model in the exemption.

Unlike the HMI's holistic approach, the exemption focuses only on tariff negotiations, neglecting broader healthcare reforms necessary to control costs effectively.

Conclusion

The block exemption for tariff determination is not a viable short-, medium- or long-term solution due to legal vulnerabilities, governance weaknesses, and limited effectiveness in addressing market failures.

[12] These were expressly addressed in the 2010 proposals and the HMI. Ultimately, to have any value, the MLNF must establish a uniform binding set of codes and tariffs applicable to all fee-for-service contracts.

The lack of a clear legislative mandate, structural independence, and enforcement mechanisms makes it highly susceptible to legal challenges and policy inefficiencies.

A more comprehensive, legally grounded, and independently regulated framework is necessary to ensure transparent, fair, and sustainable healthcare pricing.

RECOMMENDATIONS

The Block Exemption Process Should Be Abandoned

The block exemption appears fundamentally flawed and may not be remedied through revisions or modifications. Its legal, governance, and structural weaknesses are too significant to be corrected within the proposed framework.

The exemption does not have a clear legislative basis under the Competition Act or any health-related legislation, making it vulnerable to immediate legal challenge and regulatory uncertainty.

Certain of the functions allocated to the MLNF are inappropriate for a negotiating arrangement and have clearly not been though through.

The TGB and MLNF structures are not independent, allowing for political interference, conflicts of interest, and arbitrary decision-making. Seen together, these undermine the integrity of the proposed tariff-setting process.

Given its voluntary nature, the exemption is incapable of achieving meaningful cost regulation, as major stakeholders can opt out, leading to fragmented and ineffective pricing structures.

Immediate Action to Implement the Health Market Inquiry Recommendations

The HMI provided a detailed, evidence-based roadmap for addressing healthcare pricing and market distortions, yet more than four years have passed with no substantive implementation.

Government has had ample time to develop a structured, lawful, and independent tariff-setting framework, but has instead pursued an ineffective and legally questionable block exemption process.

The current MOH was responsible for the proposed 2010 interim tariff-setting framework but halted the process without justification, wasting valuable time that could have been used to build a legitimate regulatory system. This could have been done without waiting for the HMI.

A formal, legislative process should now be urgently initiated to holistically implement the HMI's recommendations, including:

- Establishing the SSRH, an independent regulatory authority to oversee tariff-setting and prevent anti-competitive pricing.
- Developing a structured MLNF within the SSRH, ensuring transparent, fair, and binding price negotiations.
- Incorporating hospital and facility pricing into the framework, addressing the largest contributors to healthcare cost inflation.
- Implementing HMI-recommended market reforms, such as the risk equalisation mechanism together with an enhanced mandatory minimum benefits framework.

Reinforcing Accountability and Policy Coherence

Government must publicly justify why the HMI recommendations have not been implemented despite their broad stakeholder support and clear legal foundation.

The Minister and relevant departments should commit to a binding timeline for implementing the HMI reforms, ensuring proper legislative processes rather than pursuing legally questionable exemptions.

The Competition Commission, CMS, and National Treasury should play a greater oversight role, ensuring that any tariff-setting mechanism is economically sound, competition-compliant, and legally enforceable.

CONCLUSION

Given its legal and structural shortcomings, the block exemption process is unlikely to achieve its intended objectives and should be reconsidered in favour of a more comprehensive legislative framework.

Government must take responsibility for the years of inaction and immediately initiate a proper legislative and regulatory process to implement the HMI recommendations in full.

The time for short-term, piecemeal interventions has passed and South Africa requires a coherent, legally grounded, and independently regulated healthcare pricing framework that aligns with global best practices and competition law principles.

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