HEALTH MARKET SEMINAR ON TARIFF DETERMINATION

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RECONCILING THE IRRECONCILABLE

- The conundrum that has always thwarted previous attempts at determination of a fair private sector tariff:
- How to reconcile two competing requirements:
  - A tariff that adequately and fairly compensates practitioners with a return on the investment that has been made in
    - Training
    - Skills & Experience
    - Establishment of a practice
  - The need to ensure affordability of the service to consumers in the TARGET market.
  - *Too much attention paid by the authorities to the latter in the past*

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SIX IMMUTABLE PRINCIPLES

- The Tariff must be cost based
- The 2006 NHRPL does not reflect costs and therefore cannot be used
- CPI is an inappropriate measure for interim inflation adjustments
- A dispersion factor needs to be included
- A ‘legitimate cost defence’ is required
- There is a need for the tariff to provide a ‘safe harbour’ for practitioners for billing purposes

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The Tariff must be cost based

- The tariff should act as a norm for use in the process of determining whether patients had been overcharged.
- In the absence of a sound consideration of medical practitioner costs the tariff could be set too low, or too high.
- A tariff guide therefore should be linked to the median cost estimate-akin to the methodology used for the determination the 2007 NHRPL.

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The 2006 NHRPL does not reflect costs and cannot be used

- In 2005 the CMS invited submissions relating to the 2007 NHRPL.
- The guidelines stated that the cost of the medical service should be explicitly stated and this cost should form the basis of the Reference Price List (RPL).
- Six disciplines made submissions and their NHRPL tariffs were increased by an average of 35%.
- Following the DOH assuming responsibility a draft schedule for 2007 was published, challenged and ultimately abandoned. A 4.9% increase was awarded.

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THE 2006 NHRPL'S LACK OF A COST BASIS RENDER IT WHOLLY INAPPROPRIATE AS A BASIS FOR A FUTURE TARIFF

- The 2006 NHRPL was based on the 2004 NHRPL
- The 2004 NHRPL was not cost reflective
- The coding structure of the RPL has remained largely unchanged since 2004 and does not provide for time based consultations.
- The 2008 and 2009 RPL were published by the DOH with an inflationary increase of 5.4% and 10.75 respectively.
- The 2009 was subsequently declared illegal and set aside by the North Gauteng High Court in 2010

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CPI is an inappropriate measure for interim inflation adjustments

- A key objective underpinning inflationary adjustments to a tariff is ensuring that the tariffs allow practitioners to cover their increasing costs whilst earning a reasonable return.
- CPI is a price measure not a cost measure
- The overall health weighting of the CPI index is 1.39%
- On average medical inflation exceeds consumer inflation internationally by between 2 to 4 %
- CPI does not track the drivers of healthcare costs and only partially tracks the drivers of healthcare prices

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A dispersion factor needs to be included

- The median cost estimate cannot by itself be the guideline
- The median cost estimate will by design exceed the costs of half of practitioners whilst understating the costs of the other half.
- Running costs of practices differ:
  - Material costs
  - Standard and special equipment
  - Rentals, location, number of practitioners,
  - Indirect labour costs
  - Fees charged ; Experience and skills, contracts (DSP), patient needs

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Using standard deviations (SD)to define an appropriate dispersion factor

- For a normal distribution, one standard deviation (SD) represents 68.2% of the sample population, two SD represent 95.4% of the sample population.
- To generate a fee a Rand Conversion Factor (RCF) needs to be multiplied by a Relative Value Unit (RVU)
- The RCF is the basis on which a SD is calculated per field of medicine
- It s proposed that one SD above the mean be adopted to establish the upper limit of the fee to be charged. This would cover 84.2% of practitioners

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A ‘legitimate cost’ defence is required

- One SD above the median costs estimate would still be below the legitimate costs of15.8% of practitioners.
- Where tariffs above the guideline represents legitimate costs they should be allowed
- Exceptional circumstances warranting an additional fee:
  - *Super specialisation*
  - *Emergency services*
  - *Special patient driven needs*
    - *Co-morbidities*
    - *Complex procedures*

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The need for a ‘safe harbour’ for billing purposes

- The tariff needs to provide medical practitioners with an indication of a cost level at or below which no action for overcharging would be taken by the Medical and Dental Board
- The Guideline tariff should constitute a:

SAFE HARBOUR INDICATOR

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Medical services as a credence good

- Credence good: A good or service of which the quality and quantity required cannot be evaluated by consumers before consumption nor thereafter
- This asymmetric information may lead to many opportunistic (moral hazard) problems such as under and over-servicing
- International evidence supports the use of flexible non-binding reference price lists to overcome information asymmetries and empower consumers

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Price caps will further exacerbate the shortage of specialists

- The price at which quantity supplied equals quantity demanded reflects the equilibrium price
- Legislating a fixed maximum price below the equilibrium price (a price cap) may result in specialists reducing their services or exiting the market
- A price ceiling may encourage consumers to increase demand for specialist services. Since the market was in equilibrium before introduction of the cap the quantity supplied will be less than the quantity provided leading to a shortage of specialist services

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Establishment of an independent tariff authority

- The SAPPF in its submission to the HMI recommended the establishment of an independent tariff authority (SACHI) to establish and maintain the tariff with a legal status comparable to the CMS and HPCSA
- It should comprise of a permanent secretariat funded by stakeholder organisations and the fiscus with representation from all stakeholders.
- It should be free from political interference

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To summarise

- Establishment of a cost based flexible reference price list (RPL) with the following features:
  - Incorporation of a dispersion factor based on one standard deviation above the median costs of procedures
  - A ‘legitimate costs’ defence
  - The provision of a ‘safe harbour’ for billing purposes
  - Avoidance of price caps that could aggravate the existing shortage of specialists
- The establishment of a permanent, representative, independent, stakeholder and tax funded, tariff authority, to develop and maintain the tariff RPL

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Appeal to HMI Committee

- Opportunity for the HMI to strike a blow for common sense and a sustainable private sector
- What South Africa deserves is a tariff and coding system that is morally defendable, socially acceptable and economically sustainable.
- SAPPF will support a legally constituted, transparent and independent negotiation process aimed at the achievement of fair and reasonable tariffs.
- I would like to acknowledge the invaluable contributions from both Genesis Analytics (Pty) Ltd and ECONEX in the preparation of this presentation.

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