Annexure "B2"

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National Department of Health
Pharmaceutical Economic Evaluations
Director: Dr. Anban Pillay

Dear Dr Pillay,

Submission to Pricing Committee – Billing of Anaesthetic Gases in Private Hospitals

Thank you for the invitation to submit comments on the proposal by the Society of Anaesthetists ("Society").

It has recently come to Netcare's attention that the Department of Health is of the view that the per minute formulation of charging for anaesthetic gases is inconsistent with the medicine pricing regulations.

The current billing mechanism for anaesthetic gases in private hospitals is on a per minute basis. This is a perpetuation of the method determined in 1991 when the zero-based costing exercise was completed and agreed between the respective predecessor organizations of the current BHF and HASA. Furthermore, the billing of gases on a per minute basis is consistent with the most recent NHRPL documents published by the Department of Health.

Although we do not share the Department of Health's concern that the per minute formulation of charging for anaesthetic gases may be inconsistent with the medicine pricing regulations, Netcare is more than willing to consider alternative pricing mechanisms which would assuage any concern which the Department of Health may have.

Detailed Response to the proposal by the Society of Anaesthesiologists

1. Netcare is not contesting the scientific merits of the model at this time as further analysis by independent experts is required before this is possible. We look forward to a constructive engagement with you in due course in this regard. At this stage, we would draw the following questions to your attention in relation to some of the base assumptions underlying the proposal of the Society.

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Reg. No. 1996/008242/06

2. The apparent assumption by the Society that the entire industry has Low Flow machines and that all anaesthetists use Low Flow machines (and operate them at Low Flow rates) is fundamentally flawed.

3. It appears that the number of Low Flow machines operated in the private sector is less than 50% of total anaesthetic machines operated by private hospitals. Netcare has possibly the highest ratio of Low Flow to total anaesthetic machines in its facilities.

4. The Society's Low Flow model ("model") would have a very detrimental effect on hospital groups and independent hospitals that have a low proportion of Low Flow machines. It would, essentially mean that these entities would be compelled to supply the volatiles below acquisition cost.

5. The model also does not take account of the specific situation of Day Clinics, which have shorter theatre [time] cases. The model is based on an assumption of an average theatre time (which is not disclosed) and thus under-reimburses shorter theatre cases. In a number of situations, the application of the model would result in a severe under recovery in respect of anaesthetic gases.

6. We note that the assumption that a rate of 1.0 MAC is used when administering anaesthesia is on the low side. We await confirmation from an independent expert but initial indications are that most anaesthetists are running at approximately 1.3 to 1.5 MAC.

7. It is important to note that the price of the delivery system included in the current theatre time fee was based on a 1991 model and thus solely on high flow anaesthetic equipment.

    a. Low Flow machines were first introduced in the late 1990's. These machines were a step change in technology and substantially more expensive than the High Flow machines they replaced.
    b. The theatre time fee was not re-negotiated with medical schemes and accordingly the equipment cost weighting of the theatre time fee continues to only include High Flow machines. The statement in the Society's letter that "*[t]he cost of the anaesthetic delivery system should have been calculated into the theatre time fee of Rand/minute*" should be read in this light.
    c. It was unnecessary to include the higher cost of the Low Flow machines in the theatre time fee as the charge for the anaesthetic gas was itself time-based and could accommodate this cost.
    d. As a result, a reduction in the fee in respect of the provision of the anaesthetic gas, would of necessity require a re-evaluation of the theatre minute fee in the light of the higher capital cost of the Low Flow machines.

8. The Society's proposed model makes no allowance or suggestions for how Anaesthesia administered by High Flow should be calculated or reimbursed.

    a. High Flow anaesthesia is administered:
        - when the equipment for Low Flow is not available;
        - and when the practitioner administering the anaesthesia does not opt to practice Low Flow or is not qualified to do so.

9. The assumption in the model that there is, on average 7 minutes of non-anaesthetic time per theatre case is also open to question:

    a. We question the scientific basis by which the Society arrived at this number of minutes.
    b. In 1994/95 during discussions and negotiations between HASA and the BHF/RAMS this very matter was tabled; in this agreement it was calculated that the "non anaesthetic" time was 4 minutes.
        i. In order to simplify the charging this downtime was catered for and calculated into the agreed per minute fee. If there is scientific reason tabled to increase this to 7 minutes then a similar exercise is needed.
        ii. Netcare wishes to bring to your attention that in 2006 we had 238 theatre cases where the total theatre time was 5 minutes or less. There were 2639 cases between 6 and 10 minutes.
        iii. When the cases in ii above were pointed out to the Society they indicated that only cases greater than 15 minutes should be reduced by 7 minutes.
        iv. One needs then to simply point out two issues: firstly, that a case of 15 minutes would thus be reimbursed more than a case of 21 minutes; and secondly, the model does not adequately cater for the large number of operations where the total theatre time is less than, or only slightly more, that the allocated 7 minutes of non-anaesthetic time.
        v. The amount of the non-anaesthetic time that is to be applied should be carefully considered and should be clearly reflected in any formula that is ultimately determined.
    c. The complexity in implementing a system which treats the measurement of anaesthetic time differently to the theatre time and the related complexity for the various parties' IT systems indicate that it is a far better approach to price in the non-anaesthetic time when agreeing the charge per minute.

10. The assumption that "*altering the remuneration model of volatile anaesthesia will encourage the anaesthesiologist to practice low flow anaesthesia and for the hospital to insist that low flow anaesthesia is actually used*" is unsound.

    a. It should be questioned how changing the remuneration model for the hospital could influence an independent practitioner who would be practicing "best medicine".
    b. How can it be suggested that a hospital dictate on clinical matters to an anaesthesiologist who is responsible for all clinical decisions regarding the patient?
    c. In any event, the purpose of a model is to calculate, insofar as possible, the amount of the anaesthetic gas actually administered (and therefore the single exit price that should be charged), and not to interfere with the medical care offered to a patient by a particular health care institution (or the capital expenditure required to deliver that care).

11. In many cases Low Flow machines are used at "high flow rates", this is a decision purely in the hands of the independent practitioner and is dependent on his/her training, skill level and clinical decision making related to the patient. The model should be able to take account of variations in the flow rate on low flow rate machines.

Capital Requirement

12. The anticipated capital cost of upgrading all anaesthetic machines to Low Flow to facilitate compliance with this proposed model is substantial.

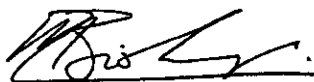
    a. To highlight the capital cost of converting to Low Flow, we use a Netcare example: if Netcare were to replace all anaesthetic machines (both Low Flow and High Flow) at current market values to the suggested Low Flow it would cost R157,500,000 (R157 million). If one extrapolates this to the industry it would cost approximately R600,000,000 (R600 million). If the existing market penetration is approximately 50% then the capital cost to the total private industry to comply with this proposed Low Flow model is R300,000,000 (R300 million).
    b. Notwithstanding the fact that Netcare has a majority of Low Flow machines, these older machines would still require additional investment in digital measuring devices. It is our estimate that to be able to measure actual volume of gas used in all theatres across the Netcare group will cost approximately of R82,207,000 (R82.2 million).
    c. This expenditure would be for no added quality or value to the patient.

Conclusion

13. Given the short time period since the invitation for comments on the Society's proposed formula, the comments set out above are confined to identifying certain key difficulties with the Society's proposed model. Netcare would welcome the opportunity to engage further with the Department of Health in relation to the proposed formula, in due course. To this end, we suggest that, once the Department has considered the matter, it should publish a more detailed draft methodology for comment. This would enable Netcare (and other interested parties) to provide more specific input on the detail of the methodology proposed by the Department.

We trust that this will meet with your approval.

Sincerely



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