



## PROPOSED HEALTH PRICE REGULATIONS STIR UP HORNET'S NEST



Dr Kgosi Letlape, SAMA chairperson.

Picture: Chris Bateman.

The draft bill proposing a national 'facilitator' for health pricing, a tribunal to make rulings and 'inspectors' with draconian data search and seizure powers, is 'unrealistic and unconstitutional' and has 80% of specialists ready to pack it in.

South African Medical Association Chairman, Dr Kgosi Letlape, last month labelled the bill thus while a snap survey of 2 144 general practitioners and specialists indicated that 1 627 of them would leave local medical practice if it became law. Specialist groupings and the Hospital Association of South Africa (HASA) predicted respectively the 'collapse' of private health care and that the bill would aggravate the

situation and ultimately punish the very people it intended to serve – patients.

The bill gives the minister of health unprecedented powers to regulate prices of private health care services, including hospitals' prices and doctors'

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professional fees. It follows years of finger-pointing between doctors and medical schemes over soaring health care prices and hotly disputed and various half-baked tariff regulation mechanisms.

The government removed a potentially far-reaching exemption for doctors and specialists, which seemed to acknowledge fears of a skills flight, at the eleventh hour. The survey had 66% of doctors considering emigration, 16% remaining in the country but leaving full-time clinical practice and 0.72% joining the public service. Conducted by an independent IT company, the appraisal was predominantly of doctors in full-time private practice (83%), with 14% of respondents in part-time private practice. Specialists formed 84% of respondents and GPs 5%.

### Converse outcome predicted

George Dempster, MD of the survey company, said any implementation of the amendment to the National Health Act would have 'a far-reaching and possibly fatal impact on private practice, and compromise the ability of the health department to progressively increase access to health care for all South Africans'.

Netcare, SA's biggest private hospital group, warned of 'terrible unintended consequences', including skills flight, if the health department ignored industry concerns. Netcare CEO Richard Friedland said the government's approach stood in stark contrast to that of the UK, which intervened only to maintain patient safety and good governance, leaving the private sector to set its own prices. 'We need a regulator of outcomes, so we don't see babies dying in hospitals, and people are held accountable,' he said.

Letlape cited a gross failure by a monolithic health care industry to grasp a golden opportunity to open up the



market, offered by the Competition Commission ruling 4 years ago. He challenged lawmakers to state which tariff would be 'facilitated'. If it was to be the National Health Reference Price List (NHRPL) then 'how can you agree to have someone facilitating a historical thumb suck?' he asked incredulously.

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When the Council for Medical Schemes (CMS) was faced with incorporating practice cost studies (which SAMA spent millions on expertly compiling) it merely passed the NHRPL onto the national health department. Unless the CMS suddenly claimed to be empowered by law to create a statutory tariff and declared itself exempt from the Competition Commission, it had acted well beyond its powers.

### **NHRPL costing studies**

Studies conducted by independent health care consultancy HealthMan indicate that the current NHRPL tariffs will have to increase by at least 170% for procedures and by 120% for specialist consulting codes to reflect the cost of running a private practice. For GPs a further increase of at least 25% will be required. The results of these studies (of 1 296 specialist and GP practices) were presented to the DoH on 20 May this year and were 'consistent' with SAMA submissions exactly a year earlier. Both showed that the HPCSA erred in not adjusting the HPCSA ethical tariffs in 2007 and 2008.

### **Doctors' input costs ignored**

Letlape said setting delivery prices via ministerial decree (the envisaged tribunal has the Minister of Health as final arbitrator) could cause financial ruin, especially for those at the top of the specialisation spectrum, where equipment costs were highest.

SAMA would 'have a fighting chance' if it could wean doctors off their dependence on, and addiction to, medical aid schemes.

'Doctors are addicted to payments from medical aids, so not having a tariff feeds that addiction – the addiction of economic dependence. We have to see the industry for what it is: privatised, not private. It's medical aid-dependent, legally dependent on the Medical Schemes Act – so you can't say that an independent service provider dependent on a statutory law to feed them is a market place!'

Letlape puzzled as to how the proposed law could work if it remained silent on a legitimate tariff-setting committee. 'Which tariff will they facilitate? Discovery, SAMA, the NHRPL... and on what basis? They are simply creating a mechanism to violate other laws.'

Asked about the threat of losing doctors, Letlape said he refused 'to use scare tactics' and held no brief for people who were not committed to South Africa. 'The truth of the matter is that doctors have been leaving private practice long before this. I'd be a hypocrite to say everything is hunky-dory and that it's only this bill that makes them want to leave. The issue is the Amendment bill. Let's deal with the merits and demerits of that – we shouldn't confuse the two,' he added.

The only people to benefit from the new bill would be lawyers, as doctor groups challenged the unconstitutional 'inspectorate' provisions which he

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described as 'straight-out violations of doctor and patient information'.

### **Health Scorpions?**

'To create another kind of Health Scorpions because of the mess in health is frankly objectionable. What will they be looking for? If it's about what the doctor has charged, then the patient has a receipt.'

Dr Chris Archer said that SAMA's private practice committee, of which he is a member, had worked out an average costs figure for each medical discipline. Using a 'complex' process in which service providers arrived at prices based on the NHRPL and costs of the service with a salary component thrown in before dividing this figure by the number of minutes in a year, they had arrived at a rand-per-minute rate.

They discovered that more than half of each discipline would find costs higher than the formula that allowed for them to make a return on their practice. If one added into this mix medical aids negotiating prices down in the proposed forum, specialists would be the first to crumble financially, resulting in a 'general dumbing down of expertise'.

### **Cheaper for the patient – if they can find a doctor!**

If one looked at how prices were set world-wide in any service industry, suppliers of goods and services set the fees and then competed for market share. While it was a 'laudable objective' to make prices affordable, affordability was a two-edged sword; it had to be affordable to the supplier as well.

Alarming figures of pharmacists quitting their industry were already emerging as new and as-yet incomplete regulations constraining drug pricing were promulgated. 'This survey is telling us that if you can't make a living out of practising your profession, you simply stop – that's the danger.'

With an estimated 21 million people accessing private services through straight cash payments or via medical



aids, the private health care industry only had room left for 'probably another million who are insured'. (Below this level the cost of insurance becomes too high for the average South African.)

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That starkly illustrated the need for low-cost medical schemes serving an additional 10 - 12 million people who were employed but uninsured. 'Everyone is trying to find mechanisms for unlocking value in that market and clearly a fee-for-service model will not work there – we have to look for alternative reimbursement models (ARMs).'

Another unintended consequence of the new price-fixing bill was that it virtually ruled out any chance of an ARM working. This was because it would outlaw service providers taking on some of the financial risk in exchange for a potentially better fee. This would stifle innovation in the market place.

Archer put the current confusion and disarray in the health care market place down to 'a clash of ideologies'. 'One side believes in the power of the market and the other believes in central regulation of national health by stealth.'

## **Goodwill being eroded**

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The response by doctors was not wilful but 'an inevitable consequence of very poor legislation, really lousy laws'. 'I think we've been brow-beaten into accepting what medical aids will pay and that leads to all sorts of noise,' Archer added.

HASA CEO, Advocate Kurt Worrall-Clare, described the bill as 'vague and lacking clarity', while infringing on the constitutional rights to property, freedom of trade, occupation and profession. It had been drafted in response to CMS 'misinformation', which incorrectly inferred that the rise in hospital expenditure was due to higher tariffs. The average real hospital price increases from 1998 to 2006 was just 1.7% above inflation.

The pricing reality was that the impact of road accidents and a greater incidence of diabetes, cardiovascular disease and HIV/AIDS had led to greater hospital utilisation.

As to the bill's provisions, 'even common criminals are afforded the dignity of a warrant... but these regulations give the tribunal, facilitator and inspectors unfettered and arbitrary powers'.

The process by which schedules of fees were to be determined were 'clumsy and unworkable', while the system would cost over R100 million to fully implement.

Other health care access initiatives such as national health insurance and a review of the Prescribed Minimum Benefits promised far greater long-term benefits, he said.

Board of Healthcare Funders (BHF) spokesperson Heidi Kruger responded that the latest (06/07) Registrar's Report for the CMS had medical aid claims outweighing contributions by R2.1 billion.

'Luckily most schemes have quite a high solvency rate but with an ageing membership stagnant at 7 million for the past decade, it's an unsustainable scenario.'

***The government's approach stood in stark contrast to that of the UK, which intervened only to maintain patient safety and good governance, leaving the private sector to set its own prices.***

She described the bill as an 'opportunity for transparency and consistency in terms of coding and various schedules out there. I think they (doctors) are reading much more into it than is there. The details are still to be worked out and there's no clear relationship between the bargaining chamber and the NHRPL in the bill.'

Medical schemes were under 'huge pressure' to keep contributions to CPIX while the bill would finally enable 'fair and reasonable' fees for relevant health services.

**Chris Bateman**