

The development of medical tariffs in South Africa

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It would appear that tariffs for medical care will forever be a cause of dispute. Although our patients are by and large pleased to have our services available for them when needed, they would much rather not be in such need, and resent paying for what needs to be done (rather like my approach to the legal fraternity). On the other hand, I think it was our revered medical forefather, Hippocrates, who stated that 'treatment without payment is not treatment'.

19th century tariffs

In his *A History of Medicine in South Africa* E H Burrows

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describes how various medical tariffs were determined in the Cape Colony during the 19th century.

As Head of the Colonial Medical Department Dr James Barry negotiated a tariff with the local medical practitioners, which was published in 1823. A new departure for those days was that no distinction was made between surgeons and physicians. Another tariff, negotiated by the practitioners in the Cape who had formed a 'vigorous South African Medical Society' later replaced Dr Barry's tariff.

In later years a tariff published in the Transvaal Republic allowed great latitude in permissible charges, a situation that was to change quite radically in the 1960s.

20th century tariffs

During the 1930s various large employers negotiated a preferential tariff (on a fee-per-service basis) for their employees with the then Medical Association of South Africa (MASA). The Association determined the content of the tariff and set the level of the fees. This tariff was based on a 30% reduction on the fees charged for private patients. Part of this



agreement was that the tariff would apply only to a certain proportion of those employees earning above a predetermined level. This later led to a lot of friction when the Medical Association became aware of the fact that many of the 'top brass' of a number of companies were availing themselves of this preferential tariff.

The Medical Schemes Act of 1967

After lengthy and acrimonious negotiations between the Minister of Health, the Medical Association and the Dental Association, an Act of Parliament was passed in 1967, 'To provide for certain measures for the control and promotion of medical schemes; for the purpose to establish a Central Council for Medical Schemes, and to provide for matters incidental thereto'. This was generally referred to as the Medical Schemes Act.

This Act differentiated between 'medical aid schemes' and 'medical benefit schemes', the former in essence catering for a 'fee-for-service' system, and the latter for contractual, periodic remuneration on a per capita basis for services rendered to members of the schemes, e.g. the Mines Benefit Society and the South African Railways Medical Benefit Scheme. These latter were not affected by this Act.

The Representative Association of Medical Schemes (RAMS) and the Medical and Dental Associations were recognised in the Act as being bodies with an interest in determining a tariff, and as such could make representations to the remuneration commissions which were established in terms of this Act.

Definitions xxi and xxii of the Act referred to a 'schedule of relative values' for services rendered to members of schemes, and a 'tariff of fees'. The tariff and its contents were to be determined by a 'Remuneration Commission'. The Act made no mention of the basis on which a tariff was to be determined by the Remuneration Commission, nor did successive commissions given any indication as to what their guidelines were to be, which omission led to much confusion and acrimony. This lack of an acceptable, agreed-upon basis for negotiation, which has persisted to the present, has bedevilled all negotiations, be it with the remuneration commissions, RAMS or with whomsoever we were to negotiate.

During the early 1960s a monumental task was performed, mainly by Professor Julius Bremer and Mr Jack Wolfowitz, in establishing the so-called Standard Tariff of Fees. Until very recently all our tariffs were to a greater or lesser extent based on their work. Rightly or wrongly, the basis of their approach was to attempt to set a tariff that would enable medical practitioners, working in whatever discipline, to earn a similar amount of money during their working lives. This so-called Standard Tariff was the tariff presented to the First Remuneration Commission as a basis for negotiation. However,

the determination of a Tariff of Fees by successive remuneration commissions was far below a level regarded as reasonable and acceptable to the medical and dental professions. In addition, the list of procedures as presented to the commissions was amended, resulting in gross distortions of the relativity of the fees allocated to the various procedures. I believe that the cumulative effect of all this was to lead to many of the problems currently facing our profession.

Initially two remuneration commissions sat to determine the structure and monetary level of the Medical Aid Tariff. The latter of these two met in 1974. Both the Medical Association and the Dental Association were grossly dissatisfied with the findings of these commissions. (Between the sittings of the First and Fourth Remuneration Commissions, two sittings were held to deal with technical matters, with no effect on the tariff as a whole.) These commissions and all subsequent commissions sat under the chairmanship of the late Mr Justice R Erasmus. The Medical Association was allowed to nominate one representative on the commissions. On one occasion our representative wished to submit a minority report, which was vetoed by the chairman, with the result that our representative refused to sign the report. In terms of the Act, practitioners could 'contract in' or 'contract out' of the system. If contracted in they would be paid directly by medical schemes for services rendered to their members, at the level set in the tariff. If contracted out medical aid schemes were forbidden to pay the practitioner directly, irrespective of what was charged.

The Act was later changed, giving the respective professions the task of determining a list of procedures with relative unit values for all procedures, the Remuneration Commission then to attach a monetary value to the units. The same monetary value was to apply to all items in the tariff. Whereas previous tariff lists were based on specialist listings, the new tariff proposed by the Medical Association attempted to unify the listings under anatomical headings, thus avoiding numerous duplications and anomalies that appeared in previous tariffs (for instance a sigmoidoscopy performed by a physician had a different monetary value to one done by a surgeon).

Having drawn up this tariff list, MASA decided in good faith that it would be to everyone's advantage were they and RAMS to agree on the economic approach to be made to the Commission, which was to meet in 1977. To this end a meeting with RAMS was held (in the Southern Transvaal Branch's office in Johannesburg). To our very pleasant surprise we left the meeting with, as we thought, an agreement that we would arrange for our economic adviser, Professor J Lombard of Pretoria University, and their adviser, Professor Botha of the University of the Witwatersrand to get together and work out a common economic approach to the Commission. Alas, we were too naïve and it was not to be. As the time for the sitting of the Commission approached, we were to discover that they had reneged on the agreement reached, offering the totally spurious



argument that the Commission would take exception to our usurping one of its functions, and we were forced once again to make our representations to the Commission on an adversarial basis. Understandably, this soured our relations with the medical aid representatives for years to come. MASA's approach in 1977 was that for practical reasons the findings of the 1974 Fourth Remuneration Commission would be used as a benchmark from which to proceed, even though we did not and could not in any way accept the previous determinations as being just or reasonable. At no stage during our representations to the Commission, or those of RAMS, did the members of the Commission query this approach.

Working from that benchmark, MASA presented the proposed tariff as described above to the Fifth Remuneration Commission, which was charged by law with finally determining the monetary value to be attached to the units as proposed by MASA. To our dismay and (and, so we were very reliably informed) that of the advocate representing RAMS, the Commission decided, without any debate with us, that the previous (1974) tariff had been too high. They therefore reduced the monetary value of the units in the tariff and adjusted the new tariff accordingly. The result was absolutely disastrous. It led to a total distortion of the relative values, the monetary value of the whole tariff being reduced uniformly. The result was that, *inter alia*, the value for anaesthetics was reduced by a considerable amount (I think by something like 20%), and that after 4 years of inflation!

Following this debacle, the Medical and Dental Associations negotiated to have the function of determining a tariff taken from the Remuneration Commission. The function was transferred to a very unwilling South African Medical and Dental Council (SAMDC), whose Tariff Committee attempted, perhaps unwisely, to rectify the perceived inequities resulting from the activities of the remuneration commissions in one fell swoop. This led to the then Minister of Health, in his total lack of wisdom, having the Act changed once more, giving him the task of approving or altering the tariff as proposed by the SAMDC's Tariff Committee. As was to be expected, this too had disastrous results.

Subsequently RAMS gained even more recognition in the Act. 'Consultation' was interpreted by them as meaning, 'have a chat and then do what we wish', which it would seem may be what is now facing the profession once again.

In 1978 I was afforded the opportunity to visit the offices of the Ontario Medical Association, whose 'Ontario Tariff' was at

that time held up to us as a model of how things should be. However, on enquiring how they managed to obtain unanimity among the various disciplines, I was informed that war broke out each year when the tariff had to be adjusted.

Can we learn anything from what has happened before?

Two generations of medical and dental practitioners in this country have practised in a system in which an ever-increasing proportion of their patients are dependent on some form of medical insurance to enable them to meet the cost of medical care. Private practice as we know it in this country today could not survive without medical aids or other forms of medical insurance in whatever guise, which fact greatly reduces the profession's bargaining power, while affording the medical insurance inordinate leverage in negotiations.

Whereas the initial idea of medical aid societies was that they would enable their members to afford private medical care, after the advent of the Medical Schemes Act, which gave statutory recognition to the Representative Association of Medical Schemes, the medical aid movement, in the guise of protecting the public, took it upon itself to interfere with both the contents as well as the level of tariffs, with what I have always believed to be a spurious claim, viz. that they were acting in the best interests of the patients!

At all times we must remember that we practitioners, as well as all others involved in health care, are eating from the same 'cake', which is always smaller than we would wish, resulting in so much squabbling among the profession as to how that cake should be divided.

To quote rather loosely from an address given by Professor Uwe Reinhardt of one of the Ivy League universities, to the World Medical Association meeting in Singapore: 'There is no answer as to how many doctors a country needs, other than to say that it depends on how much that country is prepared and/or able to pay for their services'.

May we hope that the present generation of medical practitioners will have the gumption to stand up be counted when faced with challenges to the independence of the profession, in contrast to what happened during the late 1970s at which time our members failed the Medical Association dismally when called upon to confront the government of the day over the right to 'contract out' under the terms of the Medical Schemes Act.

1. Burrows EE. *History of Medicine in South Africa Up To the End of the Nineteenth Century*. Cape Town: AA Balkema, 1958.