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Unit 16, Northcliff Office Park, 203 Beyers Naude Drive
Northcliff, Johannesburg, 2115, South Africa
Tel: (+27)(11) 340 9000, Fax: (+27)(11) 782 0270
Email: healthman@healthman.co.za
PO Box 2127, Cresta, Johannesburg, 2118,
South Africa
Registration No.: 1996/14778/07
VAT Reg.# 4190163982

ANNEXURE C

NHRPL 2006

1. INTRODUCTION

In this annexure we examine "The Appropriateness of using the 2006 National Health Reference Price List ('the NHRPL") determined by the Council for Medical Schemes ("CMS") as a basis for the guideline tariffs and, if not appropriate, a proposal regarding an appropriate basis that the Board and its Committee should use for the determination of the guideline tariff".

There are various types of reference prices:

1.1 A Reference price to determine reimbursement of medical schemes. Circulars 8 & 69 of 2005 were quite clear that it was not the intention of the CMS to publish a NHRPL that becomes the reimbursement rates of medical schemes. In section 6 of this document we will show that medical schemes have the ability to set their own scheme tariffs and have done so successfully since 2004. These tariffs are based on scheme and member affordability.

1.2 Ethical tariffs to determine disciplinary actions. The setting of ethical tariffs is dealt with in Annexure A of the SAPPF submission and is not repeated in this document.

1.3 A reference price list that is cost based and aimed at full transparency. This type of reference price list would provide a guideline to all stakeholders in the healthcare system as to what the average cost and tariffs of medical services are and they can then in turn then use this information to compare and a gain a better understanding of tariffs in the market and of medical benefits and the pricing thereof as provided by medical schemes.

The balance of this document focuses on the development of the 2006 NHRPL and why it is not appropriate for use by the Health Professions Council of South Africa ("HPCSA") to determine a guideline tariff.

2. BACKGROUND TO THE PUBLICATION OF THE 2006 NHRPL

2.1. The NHRPL was established by the CMS in 2004 following the Competition Commission's ("CC") decision in 2003 to prohibit collective bargaining and the setting of tariffs by the Hospital Association of South Africa (HASA), Board of Healthcare Funders ("BHF"), South African Medical Association ("SAMA") and various other professional societies. The CC found that the recommended tariffs of

various professional societies and industry bodies were a product of horizontal and vertical collusion between interested commercial parties.

2.2. Not only was the collective process of developing these tariff structures collusive and anti-competitive, but it also did not necessarily bear any relationship to actual costs experienced. Per Circular 8 the tariffs were "The result of a historical accident rather than a sensible understanding of the relationship between price and costs".

2.3. BHF published its last Recommended Scale of Benefits for Medical Practitioners in 2003. SAMA published its last Benchmark Guide to Fees for Medical Services in 2003. SAMA published a Doctors Billing Manual for the years 2005 to 2009. This publication was in hard copy and included NHRPL and COID tariffs. In 2010 to 2013 SAMA merely released a summarised electronic version of the DBM. These publications are further dealt with in Annexure E of the SAPPF submission.

2.4. The NHRPL was conceptualised to fulfil two major objectives:

2.4.1. The first is an administrative function. It is not practical for multiple Healthcare Professionals ("HCPs") and multiple funders to individually negotiate tariffs. There was a need for a standardised coding and tariff structure with a reference price against which decisions on prices charged or paid can be made independently by each medical scheme and each HCP, or as a product of negotiations between funders and HCPs.

2.4.2. The second objective of the NHRPL was to generate an understanding of the actual costs of healthcare services. Decisions on pricing needs to be taken on a scientific basis with reference to an understanding of real costs.

2.5. The NHRPL was therefore intended to be the product of research into costs in the healthcare environment, the findings of which would allow for more sensible decisions to be taken from a business perspective and to assist with policy planning. The NHRPL was never intended to be a recommended tariff for HCPs, nor a recommended reimbursement for medical schemes. CMS Circular 8 of 2005 made it clear that:

2.5.1. HCPs should be able to insert their own costs and profit expectations into the NHRPL model to develop their own estimates of costs and tariffs.

2.5.2. Medical Schemes should develop their own reimbursement levels based on their budgets and member affordability. The NHRPL would provide a measure of transparency of HCPs' costs.

2.5.3. Costs and tariffs determined would be national averages and could differ on a regional basis. Being averages it is a theoretically at a 50% level. This aspect has been examined in Annexure A of the SAPPF submission.

2.6. The 2004 and 2005 NHRPLs published by the CMS included limited changes to coding as submitted by various stakeholders but did not yet include any cost based submissions as a Cost Based Methodology had not yet been developed. These NHRPLs were in essence the 2003 BHF Tariff Guide adjusted by CPI and some coding changes.

3. PUBLICATION OF 2006 NHRPL

3.1 The CMS published Circular 8 of 2005 on 14th March 2005: National Health Reference Price 2006: Invitations for Submissions. Some of the principles of Circular 8 are discussed in paragraph 2 above.

3.2 Circular 8 included a costing methodology. The methodology and other technical issues were discussed at an industry stakeholder meeting held on 25th February 2005. The CMS invited further input into the model and processes to be followed. These were included in Circular 69 of 2005 which expanded on the model and invited submissions for NHRPL 2007.

3.3 The CMS acknowledged that the task ahead was "mammoth, requiring a major investment by HCP groups and that all would not be achieved in a big bang approach." It however stated that there would be benefits in terms of appropriate adjustments to the NHRPL. It was also clear that the CMS intended to phase in the impact of NHRPL over a number of years.

3.4 The deadline for submissions was 30th June 2005 and it was made clear that any submissions after 30th June 2005 with a financial implication would only be considered for the NHRPL 2007. The time allowed within which to make submissions for NHRPL 2006 was too tight and only 2 specialist societies were in a position to do so, being Psychiatry and Anaesthetics. Other specialist societies commenced with the research and planned to make submissions for NHRPL 2007. A number of allied groups made submissions for NHRPL 2006.

3.5 The CMS published Circular 42 of 2005 on 2nd September 2005. It dealt with NHRPL 2006 version 2006.02. Paragraph 12 of the circular lists the financial impact of cost submissions on NHRPL 2006, the impact where no submissions were made or the impact where only coding changes were made. These include amongst other :

3.5.1	Anaesthesiology (excl. consults and clinical procedures)	20.00%
3.5.2	General Medical Practice (no costing submissions, only codes)	10.85%
3.5.3	Psychiatry (costing submission done)	30.35%
3.5.4	Specialists (codes only, no costing submissions done)	6.26%
3.5.5	Physiotherapy (costing submission done)	38.83%
3.5.6	Occupational Therapy (costing submission done)	30.04%
3.5.7	Audiology & Speech Therapy (costing submission done)	85.55%

With the exception of 3.5.1 and 3.5.2, costing submissions were done by HealthMan. It should also be noted that the CMS made a VAT error in its publication of the costing submissions and consequently a further 14% adjustment was required. This would have been corrected in NHRPL 2007. The Psychiatry

impact would therefore have been 44.35%. Items 3.5.5 to 3.5.7 would also have required a further 14% adjustment.

It should be noted that Psychiatry carries probably the lowest overhead cost component of specialist medical practice, yet required at least a 44.35% NHRPL adjustment. It would be expected that other consulting and surgical disciplines with much higher overhead expenditure structures would have received NHRPL adjustments in excess of 44.35%.

3.6 Paragraphs 8, 9 & 10 of Circular 42 deals with Time Based Tiered Consultations. Whilst the CMS previously argued for a decay factor to be built into tiered consultations it now acknowledged that this would not be consistent with the NHRPL costing methodology and published the Psychiatry consultation and psychotherapy time based codes without any time decay. This was also applied to the time based codes of the allied groups mentioned in 3.5 above.

3.7 The CMS published Circular 66 of 2005 on 17th November 2005. The Circular deals with the costing models of the submissions in paragraph 3.5 above. Comments in the circular are:

3.7.1 Para 5: This is not an opportunity to open up debate around underlying costs behind NHRPL values, but rather to demonstrate the essential value of the NHRPL which is to create a transparent reference pricing system.

3.7.2 Para 6: By making component costs explicit, it is intended to create the conditions for more meaningful negotiations about benefits and pricing between funders and HCPs, and for rational decisions to be taken by funders on benefit levels and by providers on pricing.

3.7.3 Para 7: Instead of negotiations taking place at the level of what an appropriate inflator should be on the Rand Conversion Factor ("RCF") from one year to the next, negotiations can now take place at the level of, for example what an appropriate professional remuneration should be for a particular discipline, what the actual costs of standard or specialist equipment should be, etc..

3.7.4 Refinements to the models were included in circular 69 of 2005.

3.8 With the exception of Psychiatry and Anaesthetics the NHRPL 2006 does not include any costing data of General Medical Practice, Consulting or Surgical Disciplines. It is therefore inappropriate to use it as the basis for guideline tariffs.

3.9 The CMS published Circular 69 of 2005 on 21st December 2005. The circular included an updated costing methodology and costing models and invited costing submissions for NHRPL 2007. The deadline for these submissions was 31st May 2006. Various submissions, including consulting and surgical submissions were made, but the process ground to a halt when the National Department of Health ("NDOH") assumed control of the process. NHRPL 2007 & 2008 were published with only inflators to NHRPL 2006.

3.10 On the 23rd July the NDOH published Regulations as required by the National Health Act, 2003. New costing studies were commissioned and submitted to NDOH. Following various failures by the NDOH in publishing a cost based Reference Price List ("RPL") legal action followed and the RPL was set aside by the High Court.

4. SUMMARY OF THE JUDGEMENT OF THE HIGH COURT ON 28TH JULY 2010 IN RESPECT OF THE REFERENCE PRICE LIST PUBLISHED BY NDOH

4.1 On 28th July 2010 Acting Judge Ebersohn of the North Gauteng High Court handed down judgment in ***The Hospital Association of South Africa v Minister of Health and Another, ER 24 EMS (Pty) Ltd and Another v The Minister of Health and Another, South African Private Practitioners Forum and Others v The Director-General of Health*** Case No. 37377/09.

4.2 In this application the SAPPF and 22 other associations of healthcare professionals challenged the manner in which the Director-General of Health determined the RPL 2009 which was published on 24th December 2008.

4.3 Ebersohn AJ made a number of noteworthy findings and statements in relation to the RPL 2009 and the process leading to the RPL 2009:

4.3.1 A perusal of the submissions submitted on behalf of SAPPF and these associations indicates that they "*were prepared on the basis of extensive research, including a comprehensive costing study which involved considerable person hours and significant costs to the applicants".*

4.3.2 The publication of the RPL 2009 is having" *a damaging impact on private healthcare service providers and on healthcare consumers".* The court acknowledged two key " damaging impacts " felt by the healthcare industry:

4.3.2.1 Despite its stated purpose of creating a mere guideline for the determination of fees and levels of reimbursement, the RPL in many instances effectively determines the levels at which medical schemes reimburse for healthcare services and the amount that service providers are able to charge for their services. The judge went on to state that " *the fact that the RPL 2009 tariffs were unreasonably low meant that healthcare providers would continue to struggle to cover their costs (let alone make a reasonable return on investment)…"*

4.3.2.2 The gap between the real cost of healthcare services and the RPL and the RPL rates meant either (a) the medical schemes do not use the RPL to determine their benefits or (b) if the RPL rates are used, consumers would be required to make co-payments. In either event, the RPL would fail to act as an "*effective guideline"* to healthcare pricing and would be a "monumental *waste of resource*".

4.4 Ebersohn JA set aside the RPL 2009 and the regulations declaring them to be invalid. A cost order was granted and subsequently paid to SAPPF by NDOH.

4.5 RPL 2009 is based on NHRPL 2006 with an inflator adjustment and NHRPL 2006 could end up with a similar legal challenge.

5. ADDITIONAL FACTORS RESULTING FROM REVIEWING NHRPL 2006

We have not carried out a detailed review of the contents of NHRPL 2006, but need to emphasize some of its fundamental flaws and errors.

5.1 NHRPL 2006 is not cost based, except for the disciplines mentioned in paragraph 3 above. A cost based NHRPL was one of the main principles of NHRPL.

5.2 NHRPL 2006 does not take into account variations in scope of practice, experience and different fields of specialization. NHRPL remunerates all consulting and surgical disciplines at the same level. In addition the same RCF is used for General Practitioners as for Specialists.

5.3 The RCF used for Clinical Procedures is discounted by approximately 38% when compared to the RCF used for Consulting Services. This application has no logic to it and will not be consistent with a cost based tariff. It should also be noted that in the case of Psychiatry the RCFs for consultations and procedures are the same, which is the correct application of a cost basis.

5.4 The NHRPL 2006 does no longer represent the full scope of specialist practice in South Africa, as it excludes approximately 1000 codes, descriptors, rules, changes in interpretation, deletions, etc. This is confusing to practitioners, patients and funders.

5.5 In many disciplines the NHRPL 2006 does not include latest technologies, or new technology that has already been used in patient care in recent years. This compromises not only patient care, but also the funding thereof.

5.6 NHRPL 2006 does not incorporate Time Based Tiered Consultations, except for Psychiatry. Refer to discussion under paragraph 3.6.

5.7 NHRPL 2006 uses a consultation coding structure and reimbursement level that has no logic to it and is not cost based. As an example, an ENT Surgeon will only be remunerated for 17 minutes, a Gynaecologist for 18 minutes, a Paediatrician for 27 minutes and a Neurosurgeon for 27 minutes. There is no structure to bill for either longer or shorter consultations. This inevitably leads to patient co-payments.

5.8 NHRPL 2006 which has been based on CPI adjustments since 2003 does not take into account for changes in Malpractice Insurance which has increased at levels well in excess of CPI. Refer to discussion in paragraph 7. The same argument would also apply to the rapidly increasing prices of capital

equipment. As an example, there have been massive increases in the costs of Ultrasound and Mammography equipment, yet no changes were made to the unit values since 2002.

5.9 NHRPL 2006 and SAMA DBM include Radiology sections that have not been updated for at least 10 years. Specialist Radiology is dealt with separately.

5.10 NHRPL 2006 does not include an evaluation of a fair remuneration for practitioner, nor a return on investment .

6. SUMMARISED RAND CONVERSION FACTORS (RCFs) – SCHEME RATES 2013

6.1 Whilst the NHRPL 2006 and various billing manuals and tariff schedules comprise thousands of line items it is essentially managed by the application of a RCF to various groupings of fee items. A summary that will cover Consulting, Surgical and General Practitioner services is set out below. We have included three schemes for illustrative purposes. The application of the various RCFs to the tariff item and Relative Value Unit (RVU) results in a set of Scheme Rates.

Code		DISCOVERY 2013	GEMS 2013	PROFMED 2013
10	Consultative Services	R 16.742	R 16.243	R 16.298
11	Psychiatry	R 18.876	R 19.373	R 19.438
12	Consultative Services *(Paediatrics & Paediatric Cardiology)*	R 16.742	R 16.243	R 16.298
20	Clinical Procedures	R 9.801	R 10.059	R 10.093
30	Anaesthesiologists	R 61.683	R 63.142	R 63.349
130	GP Consultative Services	R 19.466	R 18.083	R 18.272
60	Ultrasound	R 9.343	R 9.589	R 9.621

6.2 Medical Schemes have to a large extent stuck to the NHRPL 2006 RCFs and adjusted it by CPI. The GEMS and PROFMED RCFs are slightly higher as they allowed small increases above CPI in one or 2 years. Discovery in general applies CPI as at the end of August of a year. These RCFs do not represent the actual costs of running private practice nor are there any discussions about it with HCPs. Discovery Health applies inconsistent RCF's to consultative services. The rate reflected under Code 10 is for consulting groups. For surgical groups it is R 17.829 (Discovery).

6.3 If medical schemes consistently applied these RCFs to its reimbursement strategies and benefit design patients would invariably be faced with co-payments. This problem would be compounded in the case of reimbursement for Prescribed Minimum Benefits ("PMBs").

6.4 Medical schemes however offer benefit options that vary from the scheme rate and are usually at percentages of 150%, 200% and 300% of scheme rate.

6.5 This does however not resolve co-payments for scheme members that are on scheme rate options. Schemes have accordingly started to enter into varying payment arrangements with HCPs across the medical spectrum. In the specialist environment these payment arrangements vary between 130% and 217%.

6.6 If the NHRPL 2006 plus a CPI inflator is used, it will be at approximately the Discovery RCF Rate. It will therefore be lower than the majority of medical scheme rates as Discovery is at the lowest RCF and it will also be at levels well below all payment arrangements. All such services rendered will therefore require patient consent and will have no real value.

7. MEDICAL MALPRACTICE INSURANCE

The widening gap between the RVU and RCF for procedures and the malpractice insurance premium for obstetrics

7.1. The current MPS premium for obstetricians has increased almost exponentially year on year and currently stands at R240 000.00 p.a. with commercial insurers now even higher. In 2000 the MPS premium was R24 380, an increase of 884% in 13 years, an average increase of 68% per annum. During the same time the RCF for procedures increased from R4.72 to R8.94, an increase of 88.55%.

7.2. There has been some improvement in the RVU's for obstetrics during this time. In 1999 the RVUs both for Normal Vaginal Deliveries ("NVDs") and Caesarean Sections ("C/S's") stood at 259 units. In 2000 the units split; NVD's being allocated 274 units and C/S's remaining at 259 units for elective procedures but with an additional 12 units/ ½ hour for emergency caesarean sections.

7.3. In 2001 there was a further adjustment with NVD's increasing to 282 and C/S's to 267. This was the one and only unit increase granted specifically to compensate for the accelerated rate of increase in malpractice insurance premiums. There have been no further adjustments for eleven years.

7.4. To alleviate the imbalance that has crept in over the intervening 11 years it is calculated that an additional 80 RVU units will be required to ensure that obstetricians are appropriately compensated for the impact created by this increase in malpractice insurance premiums.

7.5. As a temporary measure it is proposed that these additional 80 units be allocated to a special obstetric levy. It is however acknowledged that other disciplines (including gynaecologists who do not do obstetrics) are also facing an increasing problem albeit at a

slightly slower rate of acceleration in their malpractice insurance rates, and a more definitive solution (one that unlocks malpractice insurance from the general medical cpix), must be agreed with the industry.

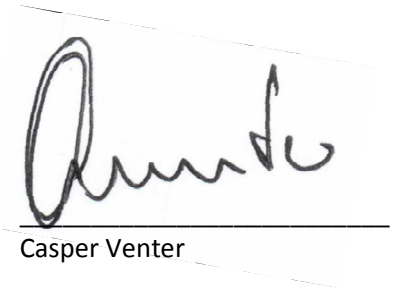
8. CONCLUSION

8.1 It is clear that the NHRPL process that was initiated by the CMS was with the objective to publish a scientifically researched cost based tariff schedule that could be used by practitioners to individually set their own tariffs, by funders to negotiate tariffs and set benefits for its members and for patients to have access to a transparent and accurately costed set of healthcare prices that would enable them to better understand the prices charged by healthcare practitioners and the benefits set by their medical schemes.

8.2 For all the reasons stated above and the various appendices attached to the SAPPF submission this did not happen and the NHRPL 2006 with CPI indices applied thereto can under no circumstances be used to set guideline tariffs.

8.3 The only way forward is to start the process from ground zero, develop a pricing methodology as set out in Annexure B to the SAPPF submission, do the extended research and submissions and to publish the results for review, comment and a future inclusion within a NHRPL.

8.4 The only other alternative is the development of a “Model Virtual Practice” per discipline. We have not explored this possibility in this submission, but will investigate it in the coming months.



Casper Venter

Managing Director
HealthMan
31th March 2013