

**BOARD of
HEALTHCARE
FUNDERS
of SOUTHERN AFRICA**

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**Comments on the Regulations Relating to The Obtainance of
Information and the Processes of Determination and Publication
of Reference Price Lists (Government Gazette, No. 29443, 01 Dec
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The Board of Healthcare Funders of Southern Africa (BHF)

The Board of Healthcare Funders of Southern Africa (BHF) became a Section 21 company in February 2001. It is the recognised body in the medical scheme industry representing 95% of registered medical schemes throughout South Africa, Namibia, Zimbabwe, Botswana as well as Lesotho.

Our comments are two-fold: the first set deals with health service remuneration in general and the second set addresses the published regulations specifically.

General comments on health service remuneration

BHF supports the goal of universal access to healthcare services through the optimal use of all the resources at the country's disposal

1. While the price for services charged by practitioners is important, patient choice of health service provider is often based on accessibility, reputation, preference for the type of service rendered or referral by a healthcare practitioner to another specific health practitioner, rather than those supplying services at the lowest price. Competitive forces, therefore, have no material effect on price and/or reduction thereof. In healthcare competition is not determined solely by price alone. There are other factors such as perceived quality, accessibility, availability and, to a lesser extent, clinical outcome.
2. Reference pricing does not work in the current market. This pattern is evident by observing the charging behaviour of health service providers, particularly private hospitals and specialists, over the past few years.

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Attempts therefore need to be made to ensure greater levels of compliance for the overall benefit of the health system. The National Health Act and the Health Charter process attempts to address this very issue. There needs to be a strong political will to ensure that all stakeholders in the health system – funders and providers alike – work together to ensure that the broader goals of accessibility, affordability, quality, acceptability and sustainability are achieved. The NHRPL – in principle – has the potential to act as the very catalyst that can assist the State in the Stewardship role advocated for by the World Health Organisation (WHO, 2000) both to improve South Africa’s poor health system ranking and to bolster South Africa’s attempts to achieve the Millennium Development Goals. Both these objectives are in line with the Government’s broader objective to tackle poverty and inequality.

3. Absence of a standardised price list for health services recently created uncertainty and led to confusion amongst many providers, who are uncertain of the level to charge their medical aid members and to be assured of direct payment from medical aid schemes, which resulted in them seeking guidance from various representative organisations, including the BHF call centre. Anecdotally there has been the emergence of split-billing with providers charging additional co-payments to patients without reflecting this on the bill sent to the medical aid – a practice that is illegal. Even if this co-payment was to be reflected on the invoice it represents an additional cost to the patient – a cost that is regressive and burdens households. It is important to achieve stability and certainty for health service providers, medical aids and patients through the re-introduction of a **standardised price list** for health services.
4. Standardised remuneration for essential healthcare services and basic benefit should be pursued with the same regulatory vigour as health benefit determination. It is recommended that Section 90 (1) of the National Health Act make provision for a regulated fee structure for the current Prescribed Minimum Benefits and the eventual Basic Benefit envisioned for the country. This would go a long way in reducing healthcare costs which will result in improved affordability of medical aid schemes. Not only will this ensure enhanced access to the

current environment. Such a move will provide more certainty vis-à-vis the development and implementation of low-income medical schemes (LIMS). The current uncertainty in the market undermines any attempt to introduce LIMS.

5. Reference pricing, however, could apply to non prescribed health benefits.
6. Precedent for a prescribed fee for health services has been set in the COID Act.
7. It is recommended that provision should be made in the Medical Schemes Act to prescribe a fee schedule for the procurement of Prescribed Minimum Benefit services by medical aid members. The National Department of Health is currently amending the Medical Schemes Act.
8. In the interim, and in the absence of a regulated fee for basic benefits and while the Competition Commissioner rulings stand, we urge the Minister to secure from the Minister of Trade and Industry an exemption for all medical aid schemes from the provisions of the Competition Act. Medical Aid schemes are non-profit organisations purchasing healthcare on behalf of its members. Medical Aid schemes are mutual societies geared towards protecting its members, not towards the market logic of profit. This exemption coupled with political will to protect the population (from regressive co-payments for instance) will allow funders and organisations representing funders to protect members while legislation and Regulations are amended.
9. Fee determination, reference or otherwise, must be standardised for all providers of health services. It is therefore important not only to align methodologies to determine the remuneration but also to align all the Health Professional bodies HPCSA, Nursing Council, Allied Health Council, Pharmacy Council and the like for this purpose.

Specific comments on the Draft Regulations

Regulation 2

The word "may" must be altered to "must". The Director-General should not be given a discretion as to whether or not to embark on the information gathering exercise. Reference prices lists have to be reviewed every year even if in the final analysis, although it is unlikely, the conclusion is reached that no amendments are necessary for the year ahead.

This is especially important if the reference price list published by the Director-General in terms of the regulations is to be *the* private health sector benchmark as opposed to other reference price lists that may be published from time to time by bodies such as the HPCSA.

The need to do the information gathering exercise every year exists not only because the reference price list should be reviewed annually but also because it is necessary to-

1. monitor the impact of the regulations on the private health sector;
2. detect undesirable business practices that may arise in response to the reference price list;
3. cater for developments in medical science and health technology which may need to be included in the following year's reference price list;
4. detect unintended consequences of the reference price list within the sector;
5. establish the manner in which the sector is interpreting and applying the reference price list;
6. build on the previous year's experience and data in developing the next year's reference price list.

It is not necessary to mention each of the different stakeholders in regulation 2 by way of a list unless it is the intention that the Director-General may publish separate notices in the Gazette for each different stakeholder grouping relating to the information that is required of them.

It is submitted that methodologically and practically speaking it may be preferable for the Director-General to publish a single notice requesting information from interested parties and thereafter interrogate the information supplied or follow up on the request with regard to the specifics by way of correspondence with the stakeholder concerned.

The wording of section 2 should therefore read as follows –

Request for Information

1. The Director-General must annually by notice in the Gazette request interested parties to provide in writing such information as is necessary for the development and publication of a national health reference price list to be used for the purposes contemplated in section 90(1)(v) of the Act.
2. The Director-General may, at his discretion, hear representations from an interested party in order to further interrogate or clarify the information submitted in response to the notice contemplated in regulation 2(1) or any other information that has been submitted to him by any other person.
3. The Director-General may request members of an advisory committee appointed by the Minister in terms of section 91(1) of the Act to be present at the representations contemplated in sub-regulation (2) in order to hear the representations and to give advice and make comment thereon to the Director-General.
4. The Director-General may enter into correspondence with a party who submits the information contemplated in sub-regulation (1) in order to obtain further information, or to obtain clarity on or verification of information submitted by that party or any other person.

In the draft Regulations there is no provision for mandatory submission and the penalty for non submission is a zero increase. This may entrench unsubstantiated high fees in the existing NHRPL. Provision must be made for downward adjustment where these are found to exist, for instance through relative value unit (RVU) comparisons for particular codes.

Regulation 3

It is noted that the language used in regulation 3 is not entirely consistent with that of the Act. It should use the same terminology as is used in the Act itself for the sake of clarity. There are also some items of information which could be added to the list in order to break down some of the current obstacles to transparent pricing of health services for the benefit of

consumers. These are italicised below. They may be controversial but if the national reference price list is to be meaningful then it should reflect a realistic fee in respect of each health service that it describes excluding direct or indirect cross subsidisation –

1. of richer schemes by poorer schemes or *vice versa*,
2. of one health establishment by another health establishment;
3. of health services to foreign nationals by South African medical schemes or South African citizens and permanent residents or *vice versa*;
4. of non medical scheme patients by medical scheme patients or *vice versa*;
5. of health establishments by medical schemes or *vice versa*;
6. of the public health sector by the private health sector or *vice versa*.

Some of the wording in regulation 3 is not clear and some suggestions have therefore also been included in the draft below to improve on clarity.

Regulation 3(1) would in the light of the foregoing, have to be amended to read as follows –

Information to be submitted by stakeholders

1. The information contemplated in regulation 2(1) may, at the discretion of the Director-General, include but not limited to –
 - a. overhead costs of a health establishment;
 - b. activity times for health services rendered within a health establishment, including surgical and medical procedures;
 - c. *the costs of health technology including capital, maintenance and operational costs associated therewith*;
 - d. the cost of labour within a health establishment *and the professional fees charged by health care providers working at a health establishment*;
 - e. the price *of individual items used in the rendering of health services*;
 - f. the cost of medicines, scheduled substances and medical devices *purchased by a health establishment or used by a health establishment*; [*Note: Inefficient stock control systems can lead to unnecessary purchases which add to the cost of health service delivery which is why it is important to see the difference between what is purchased and what is actually used by each health establishment. Also, one health establishment may do the*

purchasing for a number of other health establishments in which case it is important to establish which health establishments are actually using the goods and how they are charged out to users. Remember that pharmacies also satisfy the definition of "health establishment" under the National Health Act. Whilst the price of medicines is now regulated, the price of medical devices, surgical devices etc is not and health establishments can charge what they like for these items].

- g. the cost of maintenance of the premises of a health establishment;
- h. the cost of consumables used in the delivery of health services by health care providers and health establishments;
- i. the cost of security services necessary for the safety and security of users of a health establishment;
- j. the costs of foodstuffs for users;
- k. the cost of services or products used to ensure the safety of users;
- l. the cost of public liability insurance taken out by a health establishment *as contemplated in section 46 of the Act*;
- m. details of persons or institutions providing health services and other services at or to a health establishment;
- n. scales of fees payable by a medical scheme to a health establishment;
- o. *levels of bed occupancy of health establishments*;
- p. the details of billing rules and guidelines where applicable;
- q. *non-confidential information on users treated at health establishments including the number of users that are not South African citizens or permanent residents and the number of users who fund health services out of their own pockets or from funders other than medical schemes including the fees paid by each category of funder and the total amounts received annually from them by health establishments or health care providers*;
- r. *the details of the professional income of health care providers or the income of health establishments from sources other than medical schemes*;
- s. *the details of agreements between medical schemes and health care providers or health establishments as the case may be including scales of fees, penalties and bonuses payable, and the nature of the services to be provided in terms of the agreement*;
- t. *information and data submitted by medical schemes to the office of the Council for Medical Schemes*

With regard to subregulation (2) it is submitted that the words "that relates to health care providers" be deleted and that the word "including" is inserted between the words "any person" and "a professional association". It is further submitted that the words "a consumer representative organisation, stakeholder representative organisation, statutory council, trade union, academic institution, non-governmental organisation organ of state" are also inserted.

With regard to subregulation (3)(a) it is recommended to insert "coding and" between "standard" and "nomenclature".

With regard to subregulation (3)(b) it is recommended to delete "an agreed" and replace it with "a". Furthermore, it is recommended to insert "recommended by the advisory committee appointed by the Minister in terms of section 91(1) of the Act" between "methodology" and "to".

Regulation 4

Regulation 4 must make provision for the Director General to accredit the independent consultant. This will provide clarity apropos who will verify the independence and how it will be verified.

It must be clear that the cost of submitting data and information is to be borne by the entity submitting the information requirements.

It is recommended to add a subsection 2 to Regulation 4.

Costing evaluations must include comments on and explanations for adjustments related to but not limited to -

- a) Sample size, unit and level of analysis
- b) Non response bias
- c) Time estimations per provider group
- d) Management of data e.g. missing data, and data errors
- e) Determination/estimation of efficiency factor
- f) Determination/estimation of output and/or outcome measures
- g) Explanation for all assumptions made in the modelling
- h) Quality of cost input data – for instance health technology, medical consumables, medical devices, building infrastructure
- i) Utilisation data [to estimate cost per case and to evaluate impact of proposals; differs by speciality and/or geographic region]

Regulation 5

Cost based methodology, referred to in subregulation (2)(a) may entrench existing inefficiency in the cost of service delivery.

- a) All cost inputs must be evaluated for appropriateness, for instance, the marketing cost is not relevant to the provision of a certain health service (code) but related to increasing the frequency of delivering the marketed service.
- b) Cost based methodology determination of fees should be based on an optimal number of patients that can be seen by providers or occupancy rather than current average number of patients seen or bed occupancy.
- c) Submitted data must be independently audited to prevent distortions and over-estimations. Guidelines for this process may need to be established.

Health funders are "interested parties" as referred to in Regulation 2. Provision must be made for these entities to provide relevant information that may influence reference price determination. To that end we recommend:

Add subregulation (2)(d) "ability of the public to pay"

Add subregulation (2)(e) "obligation of medical schemes in terms of the Medical Schemes Act".

Regulation 6

With regard to subregulation (6)(c), it must be consistent with subregulation (3)(b) of Regulation 3. It is recommended to delete "an agreed" and replace it with "a". Insert "recommended by the advisory committee appointed by the Minister in terms of section 91(1) of the Act" between "methodology" and "for determining".

It must be noted that there are significant differences of opinion on the cost based methodology published in Circulars by the office of the Council for Medical Schemes:

- a) Time as determined in the existing methodology is an under-estimate of the time spent (five hours of work time on Saturday is not included as input time) leading to above average estimation of cost per minute, and an underestimate of utilisation of services. The effect of which is compounded and results in an unintended inflated price, additional

revenue for the provider and additional burden on funding costs and member contribution.

- b) Time and motion studies are required to avoid distortions. While this is desirable it is not necessarily feasible. There are huge ethical concerns and given the nature of healthcare and research in healthcare it might not be possible to obtain informed consent from provider and patient alike.

There needs to be some level of estimation through the triangulation of a combination of provider interviews, survey, focus group and secondary evidence to reach a reasonable estimation of time spent per case/consult/procedure – there are a range of services with varying times and it seems as though the onus is on those with vested interests to provide the necessary data. Because the NHRPL process is such a key one it will be important for many aspects such as the ‘provider time’, ‘efficiency factor’, and ‘acceptable profit/surplus level’ to be determined by research conducted objectively by a strong-willed State – a State keen on strengthening the health system overall. It cannot be left to those parties with vested interests to provide key pieces of data that ultimately distort the cost valuations towards the exacerbation of current unsustainable cost trends.

Notwithstanding the comments made above related to cost based methodology, the pricing currently is regressive in that lower-income members spend disproportionate shares of household income when paying co-payments or fees that are the same as those paid by higher income medical scheme members. With uncertainty and with providers charging fees higher than what the medical schemes can afford to sustain, the ultimate loser is the medical scheme member. Given that medical aid contributions on its own represents a fairly substantial share of household income already, additional financial costs incurred by the members undermine households’ financial position and crowd-out medical aid membership to the detriment of the public sector in that the numbers of public-sector dependants are thus increased placing a heavier burden on the fiscus.

Affordability and a value based determination or willingness to pay considerations may keep prices in check as evidenced through the Recommended Scales of Benefit review processes (RSOB).

While this process may not have been perfect, the RSOB review assured stability in the environment and protected the system from potentially negative impacts.

Regulation 7

We recommend deleting the word "verification" from subregulation 2 and add "investigation, comment" between the words "for" and "and advice". To read-
"..., for investigation, comment and advice,"

Regulation 9

It is recommended to add "and its respective billing guide" after "Reference Price List" and add "with its respective billing guide" between "lists" and "in the Gazette".

Regulation 9(3) is unnecessary in view of the provisions of the Copyright Act and provided that the National Department of Health does not simply publish the billing guides etc as submitted by interested parties as part of the NHRPL. The Copyright Act provides for copyright to subsist with government when published in the Government Gazette, and therefore "public domain".

With regard to regulation 9(3) it is noted that this is apparently the only place where mention is made of "National Health Reference Price Lists" in the proposed regulations. Elsewhere, mention is made only of "Reference Price Lists". The regulations should use consistent terminology throughout.