Into the Void

CONSIDERATIONS IN ADDRESSING THE ABSENCE OF A FRAMEWORK FOR HEALTH PRICE DETERMINATION IN SOUTH AFRICA

A brief history…

Collective Bargaining

- Prices negotiated and published by different regulators and interested groups
- Flawed?

Competition Commission 2003 process

- Price determination left to market forces
- Flawed?

Price Determination Vacuum

- NHRPL and Practice Cost Studies
- Removal of "ethical" tariff
- Flawed?

The Mandate of the HPCSA

- Section 53 of the Health Professions Act
- The Act makes provision for the establishment of a norm (for the purposes of assessing <u>overcharging</u> by practitioners)
- The norm will have financial implications for health professionals, funders and the general public
- This means that the process followed needs to be fair, rational and lawful

Messes vs. Problems

- “(We) are not confronted with problems that are independent of each other, but with dynamic situations that consist of complex systems of changing problems that interact with each other. I call such situations messes. Problems are abstractions extracted from messes by analysis; they are to messes as atoms are to tables and chairs.” (Ackoff, 1981)

The Process of Establishing a Norm

- HPCSA initially published a norm of 2006 NHRPL + CPI adjustment

- Complex process
- High levels of mistrust
- Conflicting stakeholder perspectives

- Common understanding of the objectives?
- Uncertainty over the consequences of action

Summary of submissions received

- Submissions from 69 individuals/entities

Categories	Examples of submissions made
Medical practitioners	Large number of individual submissions from practitioners (including dentists, GPs and pyschologists) as well as groups
Professional bodies	SAMA, SADA, Surgicom, SAPPF, RSSA, OSSA
Civil society/consumer groups	Helen Suzman Foundation, National Consumer Commission, Section27
Government	Western Cape DoH
Funders/Administrators/MHC	Medscheme, Medihelp, VeriRad, Liberty, Discovery, Interdent
Individual consumers/patients	
Other	Competition Commission

Broadly…

- Many of the submissions were thorough and well prepared
- Clear that a large amount of work has gone into their preparation
- The highly emotive nature of the situation is evident
- Comments extend beyond the publication of a guideline for overcharging
- There are areas of clear consensus and agreement
- And other areas where there is a clear divergence of views

Wide Range of Issues Raised

Policy

- Right of access to healthcare, sustainability of the healthcare system, balancing of affordability with practitioner rights
- Problems for all stakeholders arising from current vacuum (balance billing, PMBs, admin complexity, uncertainty)

Process

- Transparency, stakeholder involvement, fair and rational process
- Link between coding process and price determination
- Link between guideline prices for overcharging and reimbursement rates

Pricing

- Strong support for a scientific basis – for example, practice costing studies , benchmarking against public sector salaries with allowance for overheads and ROI
- Idea of using the median plus a dispersion factor
- Strong refuting of 2006 NHRPL and CPI as an inflator from all quarters

Areas of Agreement

Current Vacuum

- Problematic for all stakeholders
- Admin complexity, lack of pricing certainty
- Opportunity to develop a better process

2006 NHRPL

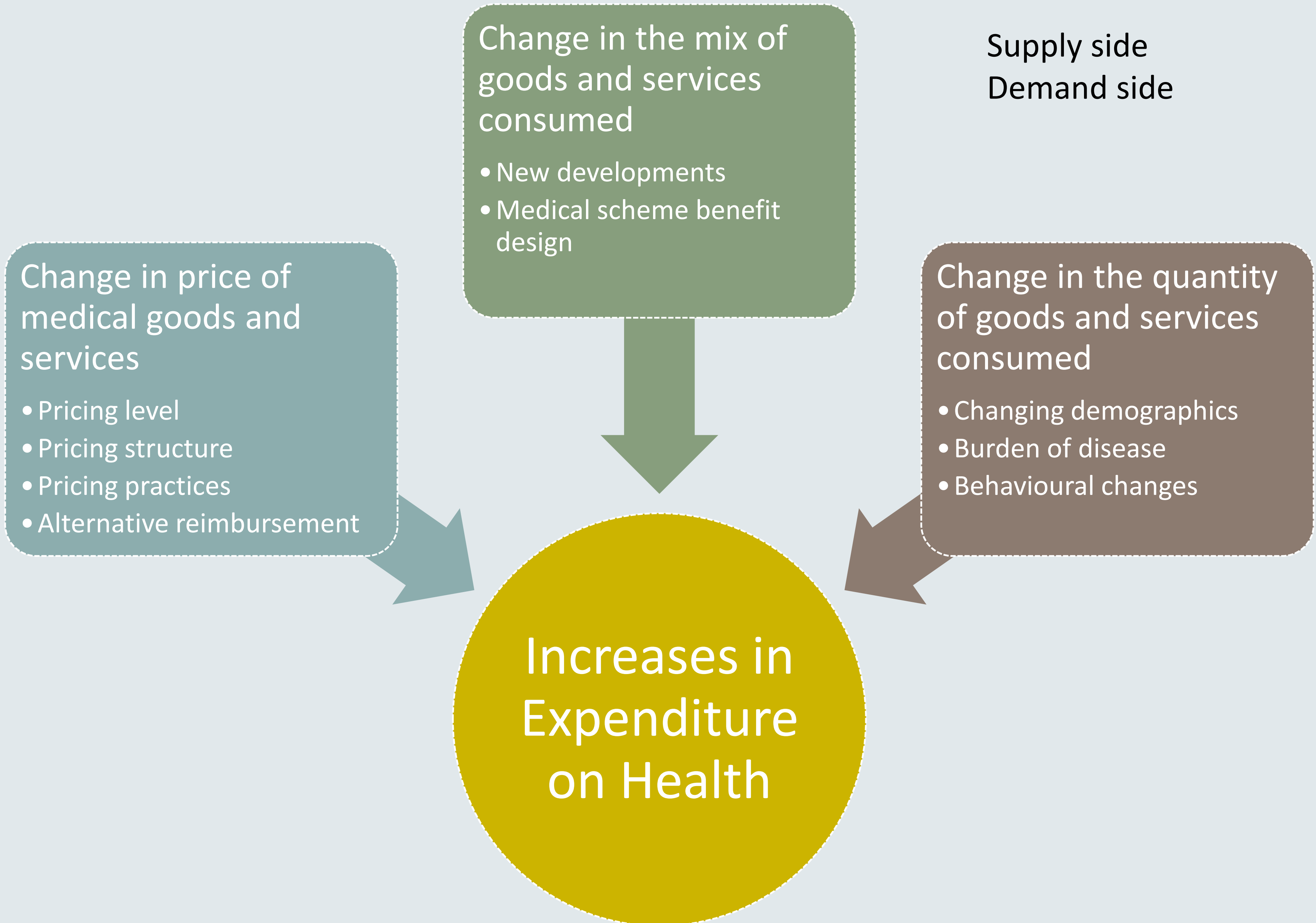
- Outdated codes
- Not based on practice costing i.e. does not reflect actual relativities between activities
- Different purpose (reimbursement not guideline for overcharging)

Coding

- Need for system that is comprehensive, consistent and systematic
- Complete billing guide to ensure correct use of codes

CPI

- Relates to general price levels
- reflects the consumption patterns of households and the prices incurred by households
- Does not reflect actual inputs/cost drivers


Change in the mix of goods and services consumed
• New developments
• Medical scheme benefit design
Supply side
Demand side
Change in price of medical goods and services
• Pricing level
• Pricing structure
• Pricing practices
• Alternative reimbursement
Change in the quantity of goods and services consumed
• Changing demographics
• Burden of disease
• Behavioural changes
Increases in Expenditure on Health

Protecting practitioners

- Right to earn a fair living
- Recognition of scarce skills
- Sustainability of private medical practice
  - Private/public balance
  - Attractiveness to new entrants
  - Emigration

Consumer perspective

- Fair and reasonable fee
- Affordability

- Transparency
- Awareness of prices

- Informed consent
  - Practicalities: where provider does not have direct contact with the patient e.g. pathology labs
  - Informed consent insufficient on its own

Purpose of the guideline tariff

- Used in the process of determining overcharging
  - Used in complaints
  - Concept of a safe harbour for practitioners
- Different purpose to a reimbursement tariff
- Balancing practitioner freedom to charge different prices with issues of balance billing, split billing and price certainty
- Concern that in the vacuum any guideline published will become the reimbursement tariff
  - From two perspectives: too high or too low
- Inter-relationship between guideline tariff and reimbursement tariff
  - Duplication of effort
  - Administrative simplicity

Over-charging

- Anything above the published guideline?
- Should other factors be taken into account?
- Proposal of “enumerated and identified exceptional circumstances”
  - Experience
  - Super-specialisation
  - Patient-driven factors
    - Co-morbidity
    - Complexity
  - Emergency services

Broad support for a RBRVS approach

- The National Health Reference Price List is an example of a Resource Based Relative Value Scale (RBRVS) system.
- Done by determining a relative cost for procedures performed by providers, which is then multiplied by a fixed conversion factor (McMahon Jr, 1990).
- Requires decisions on the following elements:
  - Coding structure
  - Calculation of RVUs for each element (time, responsibility)
  - Calculation of an appropriate RCF
  - How to balance back the RVUs * RCF with total duration and total input costs

Coding

- Comprehensive, consistent, systematic
  - Inclusion of codes for new procedures
  - Unbundling of codes
  - Excision of codes for obsolete procedures
  - Internal consistency, consistency between specialities
- Usage of codes: up coding, down coding, padding, code farming
- Solutions to current imperfect situation
  - Independent body
  - International coding systems
  - Correcting current imperfect practice
  - Time frames?

Practice cost studies

- Purpose?
  - RCF
  - RVUs (alternative is to reference against CPT4®
- Advantages
  - Satisfy the interests of practitioners
  - Protect the rights of practitioners
  - Legally defensible (if done correctly!)
  - Reasonable
  - Rational
- Concerns
  - Entrenching any existing inefficiencies
  - Expensive and time consuming to conduct
  - Highly dependent on sampling methodology

Methodological issues

- Sampling?
- Cover the costs of running a medical practice
  - Enable a reasonable return on investment
  - Take into account the diversity of medical practitioners
  - Take into account differing circumstances
- Needs to allow for various components of costs:
  - Direct labour costs, direct material costs, allocated overhead costs, rate of return
- Where in the distribution do you pitch the guideline tariff?

Inflator for updating the guideline tariff

- Why?
  - Costly to recalculate guideline tariffs from first principles
  - Adjust appropriately for changes in input costs
- Creation of an appropriate methodology and index
  - Choice of formula
  - Choice of base period
  - Choice of items for basket
  - Frequency of updating weights

What about an approach based on charging norms?

- The professional board needs to be able to determine when a professional has over-charged with respect to the following:
  - An out-of-pocket charge to any patient, which may involve
    - The excess over-and-above an amount a medical scheme is in general prepared to reimburse
    - The out-of-pocket amount invoiced to a patient without medical scheme cover
  - An amount charged to a patient covered by a medical scheme where a medical scheme is by law required to cover the cost in full (i.e. a prescribed minimum benefit)

Two options have arisen from the consultation process thus far…

- **Option 1**: Administrative norm determination process
  - Expert Committee decides based on
    - Information and evidence submitted
    - Technical review
    - Appropriate consultation with all affected parties
- **Option 2**: Negotiated norm determination process
  - Consensus-based decision is made involving all affected parties and based on
    - Information and evidence submitted
    - Technical review
  - Failing which (i.e. where no consensus is reached after a reasonable time period), an impartial expert Committee decides based on the information supplied by the parties to the negotiation process

The Swamp

- "In the swampy lowland, messy, confusing problems defy technical solution. The irony of the situation is that the problems of the high ground tend to be relatively unimportant to individuals or society at large, however great their technical interest may be, while in the swamp lie the problems of greatest human concern." (Schon, 1987)