'ETHICAL' TARIFFS TO BE SCRAPPED BY MAY – HPCSA

Chairperson of the General Practitioners Private Practice Committee, Trevor Terblanche. Picture: Chris Bateman

The assertion by the Health Professions Council of South Africa (HPCSA) that ethical tariffs 'will be scrapped' and replaced by a new National Health Reference Price List (NHRPL) by the end of April or May is 'premature, unilateral and uninformed – not to mention impractical'.

These are the combined views of Trevor Terblanche, Chairperson of the General Practitioners Private Practice Committee (GPPPC), and his Specialist Private Practice Committee (SPPC) counterpart, Mzukisi Grootboom.

The move, if implemented, would effectively seal the vice grip the funding industry has established over doctors, and replace the 'willing buyer, willing seller' principle with an arbitrary rock-bottom pricing benchmark.

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 last year and were 'consistent' with SAMA submissions exactly a year earlier. Both claim to show that the HPCSA erred in not adjusting the HPCSA ethical tariffs in 2007 and 2008.

Terblanche said that for the HPCSA to replace the ethical tariff (three times the NHRPL) with the NHRPL when the benchmark Reference Price List (RPL) had yet to be finalised (verification of the cost studies still underway) 'simply boggles the mind'.

Grootboom said the DoH itself acknowledged that the 2004-published RPL was 'illegal' and had agreed to a process of verifying the highly detailed and expensive South African Medical Association (SAMA) cost studies.

'Premature'

Terblanche said this would take 'at least another 2 - 3 months' before being subject to a process of publication and comment (he was speaking on 30 January). Grootboom said that the HPCSA, 'bowing to pressure from the DoH and funders', had already decided in December last year to scrap the ethical rate and was now seemingly hell-bent on a PR exercise to legitimise its intentions.

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The duo were reacting to HPCSA Registrar Advocate Boyce Mkhize's press conference at the end of January in which he outlined intended tariff principles, re-asserted the HPCSA's intentions and set a time line, claiming 'industry-wide consultations'.

Mkhize indicated there would be more consultations before the arbitrary new deadline and was at pains to emphasise that scrapping the ethical tariffs was 'in no way a means to short-change practitioners'.

Terblanche said Mkhize's press conference was 'merely restating their position of last November, in fact pre-empting the discussion that should rightly be held at the Medical and Dental Professions Board (MDPB), and after the new HPCSA board is constituted'.

Mkhize said that in terms of Section 53 of the Health Professions Act of 1974, the HPCSA, as a regulatory body, would retain its authority to determine whether a practitioner had overcharged a patient or not.

HPCSA's billing 'guiding principles'

In reaching this 'determination', the HPCSA would use a number of 'guiding principles'. These were that:

- A practitioner should charge a non-insured patient the NHRPL rate, except where the patient provided written informed consent for a billing higher than this rate. Any charge above the NHRPL rate without a patient's written consent would be deemed to be overcharging.
- A practitioner could also charge a private-paying insured patient a rate payable by the patient's medical scheme if the rate was higher than the NHRPL rate. However, any rate higher than the relevant medical scheme rate would be deemed to be overcharging, except where the patient had given written informed consent.

- For the purposes of establishing whether the patient had provided informed consent, the practitioner 'must tell the patient the prevailing NHRPL or medical scheme rate for whatever procedure the patient presents for,' said Mkhize.

The practitioner would also need to indicate the difference between the rates as well as the amount the patient may have to pay in addition to the stipulated rate. Both doctor group spokespersons denied that they were properly consulted on what Mkhize was now presenting as a 'virtual *fait accompli*'.

Ignoring history endangers health care delivery

Both said the HPCSA was also ignoring the history of medical aid fee structures that led to the DoH (in spite of agreeing that an RPL should reflect the basic cost of rendering a service) entrenching BHF rates as an RPL in 2004.

Grootboom said that in the 1970s and 80s, when medical aids were first introduced, SAMA agreed with funders that they would charge a lower fee – provided they were guaranteed payment after rendering the service. This enabled medical aids to garner more members at more affordable rates and gave doctors an assured income. Doctors' fees were negotiated annually and then gazetted. However, in a seismic shift, the section of the Medical Schemes Act guaranteeing payment was removed, 'pulling the ground' from under doctors and leaving an ever-widening gap between the medical aid fee and the costs of rendering the service.

To aggravate matters there was no tariff increase that year and, until 2008, only 'below inflation' annual increases, making the proposed NHRPL tariff ridiculously low, especially for specialists requiring high overheads to retain professional standards.

Grootboom emphasised: 'In our view even the so-called ethical fee does not reflect the cost incurred by providers.' He said ethical tariffs were bedevilled by the very use of the word 'ethical' given the varying costs between different practices and their locations.

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Terblanche illustrated the difficulties created in the public mind via the tariff nomenclature used to describe the preferred 'ethical' cost ceiling: 'It implies that if you exceed it you are being unethical … in other words you are criminalising the behaviour of thousands of doctors, who according to the Competitions Commission and our national Constitution, have a right to set their own fees'.

Mkhize appeared not to understand the essence of what the RPL represented, i.e. that it was merely one of several benchmarks. Doctors had an ethical duty to look at the circumstances of every patient and hence to arrive at 'a mutual value exchange'.

Grootboom said his group acknowledged that there had to be 'some sort of guideline', but putting a ceiling on prices while substantive differences in demographics and geography existed gave rise to 'all sorts of anomalies'.

The SPPC encouraged an active role in the peer review committees of various specialist groups in determining whether a fee amounted to overcharging or not.

It agreed with the HPCSA that doctors should discuss their fees and costs with patients, who must agree to the fee prior to the service being rendered. 'For example, in a hip replacement, support the patient to contact the anaesthetist to get his costs, phone the medical aid, see what they cover and then get them to come back to you and see how much they can afford – they must be happy before you go ahead.' This would drastically reduce the number of disgruntled patients writing to the HPCSA about 'overcharging'.

Grootboom accused Mkhize of 'trying to legitimise an illegal process'.

HPCSA interfering with 'free economic activity'

Terblanche said the HPCSA was 'overstepping its mandate' (to 'protect the public, consumers of health care services and provide guidance on educational, professional and ethical issues to practitioners') by determining what fees a doctor should charge.

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He qualified this by adding: 'I understand that we've been sitting with a situation where some of our profession used the pricing model to perhaps charge what many regard as a very high fee. But that doesn't make it unethical.' He said that policing wilfully incorrect billing or abuse of codes was more appropriate to the HPCSA's mandate. SAMA was 'quite willing' to play the role of peer facilitator when it came to inappropriate and incorrect billing and to help with advice through its specialist and GP groups.

Asked what would happen if the new tariffs were forced through, Terblanche said the profession needed to 'be clear in terms of what its rights are', so it could 'examine its options', but he stopped short of threatening court action. The mere fact that the HPCSA had admitted it did not have the capacity to come up with an ethical price list by itself begged the question of how it would enforce new regulations 'when myriads of complaints start to come in about overcharging'. South Africa had 'bigger issues to deal with than this – we must get together and make a decision that makes the most

sense for as many South Africans as possible,' he said.

Former SAMA chairman, Kgosi Letlape, cited his frustrations at attempting to lobby for a more equitable health dispensation (relying on a universal health tax instead of 'iniquitous' medical aids), as a primary reason for resigning in January.

The latest HPCSA move follows last year's draft bill proposing an amendment to the National Health Act, creating a national 'facilitator' for health pricing, a tribunal to make rulings and 'inspectors' with draconian data search and seizure powers.

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A survey found that if passed, this bill would have 'far-reaching and possibly fatal impact on private practice, compromising the ability of the health department to progressively increase access to health care for all South Africans'.

Chris Bateman