EDITORIAL

Are we under attack?

With the precarious global and local financial situation, health care costs are justifiably being interrogated as to efficiencies and affordability. The USA, a champion of private-based care, is finding health spend in the order of 16% of GDP unsustainable. Attempts to define 'appropriate use criteria' are occurring. This will define which procedures, and for what indications, will be funded. This may not be too different from our local Prescribed Minimum Benefit policies. More aggressive strategies such as 'recovery audit contractors' are being employed to recover funds from service providers where 'fudging' of codes may be occurring. This is also occurring locally, with Discovery claiming R250 million's worth of fraud in the media recently.

The local aggressive processes, both the official enquiry into health costs and the relentless media barrage of 'over-charging' and 'over-servicing' are creating disquiet among all stakeholders.

As orthopaedic surgeons we may be forgiven for feeling a little paranoid that 'they' are against us.

There are constant media reports with statements short on facts making a response difficult. Much of this sentiment is driven by government statements. Is this a calculated effort to drive us to NHI? Clearly specialists will not currently contract to NHI at the low rates that the state is likely to offer. These negative statements resound in all the media with the few sensible, balanced statements limited in exposure to the general public.

The funders continue to increase our administrative load, frustrating efforts to earn a living. The legal fraternity add to this cost by driving litigation with increasing frequency due to a contingency-based service where the patient can 'have a go' with no downside risk. Their efforts to earn a living after losing the Road Accident Fund (RAF) pot of gold is threatening ours with rampantly increasing indemnity costs, which in turn feeds the cost spiral.

The controversial RWOP practices are under threat. Although abused by a few, this system allows retention of skilled staff in the state service and our teaching units. Efforts to destabilise academic departments by forcing teachers to resign for financial reasons will only destroy the future of orthopaedic surgery in SA with lower quality training. Although the Occupational Specific Dispensation (OSD) was meant to address state salaries, the reality remains that provincial government cannot afford the appropriate post structures. This prevents any form of career progression in the state with highly skilled heads of units earning at basic levels. Controlled RWOPs allow these surgeons to earn appropriately without leaving academic practice.

Many of our problems are self-perpetuated. Naivety is a problem. For some reason, doctors seem to think that if they gain the required medical skills and work hard, they will be successful. They fight against administration and business principles. The conflict of earning versus the socialistic principles of medicine aggravates the issue with accusations and divisions between us.

The first step is for surgeons to acknowledge the importance of the financial aspects of surgery from the cost of personal practice to the total cost of surgery to the patient. We need to ensure that the patient is receiving quality care at the best price by minimising unnecessary consumables and use of over-priced prostheses. We are only shooting ourselves in the foot when we allow the implant suppliers to bill at exorbitant levels when alternatives are available. We are the patients' advocate.

Each surgeon should be aware of his cost of practice. He should base his Rand Unit Value (RUV) on this cost and a reasonable workload. The current short-term survival strategy of many is to use a low RUV (based on NRPL) and simply increase volume. This is unsustainable for many reasons.

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Not only will the surgeon work himself to death, but to generate the volume, surgical indications may be 'softened' from evidence-based indications. This increases litigation risk and destroys our credibility as a profession. In addition, our fee is usually in the order of 8% of the total cost to the funder. Therefore driving volume to increase surgeon's earnings has a huge impact on total cost to the funder, which responds with indiscriminate obstruction and downward pressure of fees.

Unfortunately funders also fail to recognise this relationship and encourage volume by limiting reimbursement to NRPL levels which are inadequate for a surgeon to survive on. I have previously had this conversation with funders. It is difficult for them due to the two diverse strategies employed by surgeons. These are aggressive coding at a low RUV versus more appropriate coding at cost-based (higher) RUV. Clearly, if an increased reimbursement per unit is not met with less aggressive coding, funders are in for a hiding.

I recently presented data (SASS June 2013) following a survey on coding behaviour in spine surgery. There was a very wide standard deviation of 392 (with a median of 1 174) in the number of units charged for a lumbar decompression and interbody fusion. The RUV ranged from R10.05 to R30. This indicates the range of practice and difficultly in moving forward. This was despite a very similar direct cost base of R80 000 per month.

We are not going to change sentiment in the short term, so what can we do? We need to make sure our house is in order professionally. This means appropriate surgery both in terms of indications and choice of procedure. We need to be proud of our practice and invoice appropriately based on our costs. If uniformly and fairly practised, funders will increase reimbursement or lose their patients to those who pay appropriate rates as no one likes a shortfall. There will always be the surgeon who disagrees but he will have to work a lot more to survive, and thus offer a poorer service at higher risk in the end.

This principle runs true for those involved in RWOP practices. To avoid the ire from colleagues, employers and the public, RWOP surgeons must comply with the policy. The rules are clear – just poorly enforced. The answer is not blanket banning but local enforcement. Staff should be audited; not only on time, but service and academic outputs. One only needs to look at local society abstracts to realise the deficits in our local academic outputs. This is unacceptable.

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As individuals we can ensure that there is a future for orthopaedic surgery in South Africa by employing the above principles, and as a group, our societies can engage with other role-players to explain it.

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