



**SECTION27 SUBMISSION IN RESPONSE TO THE HEALTH
PROFESSIONS COUNCIL'S CALL FOR SUBMISSIONS ON
GUIDELINE TARIFFS FOR MEDICAL AND DENTAL SERVICES**

21 February 2013

By Sha'ista Goga, Umunyana Rugege and Adila Hassim

1. Introduction

SECTION27 is a public interest law centre that uses the law to advance human rights. As a law clinic, SECTION27 conducts research, advocacy and litigation to change socio-economic conditions that undermine access to fundamental rights including healthcare services. As an organisation that acts in the public interest, we are concerned about pricing in the private healthcare sector in South Africa.

As such, we welcome the opportunity to engage with the Health Professional Council of South Africa ("HPCSA") on the proposed tariffs. This submission is structured as follows:

1. First, we discuss the role of regulation in healthcare and make the argument that healthcare is not an ordinary product market and requires forms of regulation.
2. Secondly, we discuss the legal framework within which the HPCSA operates in relation to pricing.
3. Thirdly, we comment on the proposed tariff structure.
4. In addition, in the attached appendix we discuss some of the more technical concerns relating to the use of the 2006 NHRPL and CPI as an inflator.

2. The role of regulation in healthcare

Healthcare is of substantial importance both to individuals and to the country. Economic theory posits a direct link between healthcare outcomes and labour productivity as well as economic growth. However, healthcare also has a very direct impact on the well-being of individuals. Furthermore, healthcare is characterised as a merit good, as its benefits extend beyond the individual to the wider society. There is universal acceptance that health is a human right, and is reaffirmed in international conventions, and in the South African Constitution and national laws.

Given the importance of healthcare it is essential that healthcare systems function effectively. However, due to the nature of healthcare itself, it cannot be treated as a competitive economic market. This is because, unlike other commodity markets, the market for healthcare is replete with various distortions, which prevent it from functioning effectively. These include the following:

1. *The nature of demand:* Demand for healthcare by any individual is both unpredictable and irregular. However, when an episode of ill-health occurs it often has a direct impact on an individual in terms of their person, risk of death and impairment and loss or reduction of earnings.
2. *Product uncertainty:* In addition to the need for healthcare being unpredictable there is considerable uncertainty regarding treatment itself. While a patient may know that they require healthcare services, patients do not know specifically what treatment is required, their options in terms of different treatment paths or whether their doctor is providing them with the best options. In addition, in selecting their practitioner there is no way to differentiate between varying levels of competence or the quality of care. Ultimately, the patient relationship with a physician is a relationship of trust. This is unlike other commodity markets in which quality and price trade-offs can be made more readily and in which trial is often possible
3. *The nature of supply:* The nature of supply also differs from ordinary markets. In normal markets supply of a product is driven by the returns derivable. If there is high demand for a product it stimulates new entry, which works to bring prices down. In healthcare markets due to the importance of healthcare and the need to ensure quality and trust, there are very strict licensing and regulatory barriers to new entry. Only fully trained health professionals can enter the market and as such supply is limited. In addition, there are also different behavioural norms for healthcare as compared to other markets. In healthcare there are ethical restrictions and boundaries on the part of providers. Self-interest is not the norm and exploitation on the basis of demand or need is not considered acceptable.

Given these important differences between healthcare and other products or commodities it follows that regulation is important. This is accepted by the health profession as well as members of the public. As a result, tools to reduce the impact of the different distortions on the market are the norm. These include various regulatory tools under the auspices of the

HPCSA such as registration of professionals, holding professionals to a standard of care and ethical conduct as well as the accreditation of training programmes and facilities.

However at present there is insufficient regulation to safeguard patients and practitioners in terms of pricing. While self-interest is not an accepted norm it is not clear that self-regulation is insufficient to overcome informational asymmetries that a patient has which prevent him or her from fully engaging on price. Ultimately what is required is a regulatory framework that reduces these asymmetries and allows patients to make more informed decisions and to have recourse where they believe that unethical behaviour such as overcharging is occurring.

The HPCSA is empowered to provide this framework by publishing ethical tariffs in terms of the Health Professions Act of 1974, discussed in further detail below. For this, a tariff is necessary to provide certainty on the part of the provider and patient as to what level of pricing is too high and at which point disciplinary action for overcharging is applicable.

SECTION27 strongly supports the institution of an ethical tariff by the HPCSA. However, we believe that for the tariff to have the desired effect, there needs to be substantial and inter-disciplinary input towards the design and achieving the correct price point.

3. The Legal Framework

Both the South African Constitution and various international treaties treat access to healthcare as a human right. Section 27 of the Constitution enshrines the right of access to healthcare services in the Bill of Rights and imposes a positive obligation on the state to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the right to health.

The Health Professions Act, 1974 ("the Act") establishes the HPCSA and professional boards. The Act empowers the HPSCA to regulate various aspects of health professional's practice and conduct.

The HPCSA is an organ of state in terms of section 239 of the Constitution, due to its role as an institution that exercises a public power or performs a public function in terms of any legislation. The HPCSA regulates the conduct of health professionals in both the public and private sectors.

Section 3 of the Act sets out the objects and functions of the HPCSA, including¹:

- s3(c) to determine strategic policy in accordance with national health policy as determined by the Minister, and to make decisions about finance, education, training, registration, ethics and professional conduct, disciplinary procedure, scope of the professions, interprofessional matters and maintenance of professional competence;
- s3(j) to serve and protect the public in matters involving the rendering of health services by health professions;
- s3(k) to exercise its powers and discharge its responsibilities in the best interest of the public and in accordance with national health policy determined by the Minister;
- s3(l) to be transparent and accountable to the public in achieving its objectives and when performing its functions and exercising its powers;
- s3(m) to uphold and maintain professional and ethical standards within the health professions;
- s3(n) to ensure investigation of complaints concerning health professionals and take appropriate disciplinary action against those who contravene the Act in order to protect the interests of the public; and
- s3(o) to ensure that health professionals respect the dignity, bodily and psychological integrity and equality rights of patients and take appropriate disciplinary action against those who breach this obligation.

Underlying the above provisions is the notion that there is an obligation on both the HPCSA and individual health professionals to protect the interests of the public as well as the integrity of the profession as a whole.

Section 53 of the Act deals with "fees charged by registered persons". It has several components.

First, informed consent is required for charges above the "usual fee". Section 53(1) requires health professionals to disclose to patients the fee that will be charged prior to rendering a service, if (1) they are requested or (2) the fee exceeds what is usually charged for such services. The "usually charged" fee is interpreted to be the ethical tariff.

¹ Some sections are paraphrased. Please see section 3 of the Health Professions Act for complete wording of the provisions.

Secondly, patients are allowed to query invoices. Section 53(3)(a) provides that a patient can query an invoice with the professional board, which then must determine what a practitioner should charge for the service. The practitioner must be given an opportunity to make representations before a professional board makes a final decision.

In order to assist in this process, a professional board is empowered by section 53(d) to publish an ethical tariff:

“a professional board may from time to time determine and publish the fees used by the professional board as norm for the determination of amounts contemplated in paragraph (a)”.

As such, in terms of the Act, the fee determined by the professional board can be used as a basis to adjudicate complaints from the public against a practitioner regarding the fees charged for a service.

Thirdly, where overcharging is found, a health professional is subject to penalties. Overcharging may be considered unprofessional conduct (once all the circumstances, as well as the area of practice are considered). This is defined by the Act as improper or disgraceful or dishonourable or unworthy conduct. Health professionals found guilty of such conduct are subject to penalties such as reprimand, caution, suspension for a period of time, removal from the register, compulsory service or a fine (in terms of section 42).

A legal interpretation of overcharging can be gleaned from the courts interpretation of the previous legislation that governed the health profession,² as well as the courts' approach to overcharging in the context of the legal profession.

The courts have considered the meaning of excessive charging of fees in relation to the legislation preceding the current Health Professions Act,³ which provides some guidance about how to interpret the current Act. The old Act prohibited “excessive or extortionate charges for services rendered”.⁴ In *McLoughlin v South African Medical and Dental Council*, the court found that the provision that prohibited overcharging did not provide enough guidance to health practitioners. The court then provided the following guidance to assist the board in deciding whether excessive fees were charged under the old Act:

- whether the patient agreed to a fee in advance;

² Medical, Dental and Pharmacy Act, 13 of 1928.

³ *McLoughlin v South African Medical and Dental Council* 1947 SA (2) 377 (WLD).

⁴ Section 80(1) of Act 13 of 1928.

- whether he or she agreed to the fee freely and with full understanding of the fee; and
- whether the patient knew that he or she was not obliged to use the services and could go elsewhere.⁵

In addition to the specific prohibition against excessive or extortionate fees, the old Act also required practitioners to advise a patient of the fee upon request, or ‘when such fee exceeds that usually charged for the services for the professional service before rendering such service’. Any practitioner found to have charged excessively was guilty of improper or disgraceful conduct and subject to removal from the roll of practitioners.

The court held that a health professional could not avoid an allegation of overcharging simply by agreeing on a fee with a patient in advance. In other words, the fee itself had to be objectively reasonable.

While the current Act does not refer to “excessive or extortionate” fees, it still prohibits overcharging.

The Constitutional Court has recently had the opportunity to consider the issue of overcharging in the legal profession.⁶ The court held that the proper approach was to look at the total reasonable remuneration (including charges for items such as photocopying and transport) for the work done in the relevant case.⁷ It is useful to repeat what the Constitution Court said in relation to the public interest nature of the service that legal professionals provide, because it directly correlates to medical services that health professionals provide to the public. In other words, private practitioners still provide services in the interests of the public and public health because of the nature of the services they provide. The fact that access to health care services is constitutionally guaranteed also supports this view. The Constitutional Court stated the following:

“We feel obliged to express our disquiet at how counsel’s fees have burgeoned in recent years. To say that they have skyrocketed is no lose metaphor. No matter the complexity of the issues, we can find no justification, in a country where disparities are gross and poverty is rife, to countenance appellate advocates charging hundreds of thousands of

⁵ *McLoughlin v South African Medical and Dental Council* 1947 SA (2) 377 (WLD) at page 405-406.

⁶ *Camps Bay Ratepayers and Residents Association v Municipality of the City of Cape Town* CCT 76/12 (CC).

⁷ *Camps Bay Ratepayers and Residents Association v Municipality of the City of Cape Town* CCT 76/12 (CC) at paragraph 9.

rands to argue an appeal”.⁸

“No doubt skilled professional work deserves reasonable remuneration, and no doubt many clients are willing to pay market rates to secure the best services. But in our country the legal profession owes a duty of diffidence in charging fees that goes beyond what the market can bear. Many counsel who appear before us are accomplished and hard-working. Many take cases pro bono, and some in addition make allowance for indigent clients in setting their fees. We recognise this and value it. But those beneficent practices should find a place even where clients can pay, as here. It is with these considerations in mind that we fix the fees as we have”.⁹

In the health profession, given the seriousness of unprofessional conduct, the sanctions which result from it, and the impact of such conduct on patients, it is essential that any regulatory tool functions effectively and in an easy to assess and transparent manner.

4. Comment on type of reference price chosen

There are various types of reference prices that have been instituted in South Africa at different points in time. These can be broken down largely into the three following categories:

1. *A reference price list to determine reimbursement:* This is the type of reference price list that was predominantly used in the past. These lists (such as the RAMS or NHRPL) were predominantly used as a point of negotiation between reimbursers and providers and were also used as a point for determining pricing.
2. *Ethical prices to determine disciplinary measures:* These are published as a guide to the acceptable level of prices. Historically the HPCSA has published ethical prices as a ceiling or cap.
3. *A reference price list aimed at transparency and patient advocacy:* This type of reference list would provide a guideline to patients and contain some form of prices

⁸ At paragraph 10.

⁹ At paragraph 11.

(average prices or recommended prices) to allow them a better understanding of how the tariffs being charged compares to the recommended level.

At present, in terms of Section 53(d) of the Act, the HPCSA is empowered to determine and publish a price list for the purpose of assessing whether a price charged is excessive, which could lead to disciplinary action. The most recent proposal by the HPCSA sought to do this by form of a benchmark. The idea is that providers would have to get informed consent from patients for any price in excess of that listed.

There is, however, still no explicit ceiling on prices if informed consent is garnered.

We have serious concerns related to the efficacy of such a price list in practice. The reference list will have a positive impact in the event that it has a direct effect on pricing behaviour by doctors. Our concern is that this may not go far enough in providing the type of guidance required by patients and practitioners.

1. *Informed consent and higher prices could become the norm with no real choices for patients:* Our concern is that if the price list is does not bear a reasonable relation to prices charged, the result will be that most practitioners would price above the reference price list. If this occurs, informed consent for pricing above tariff rates will simply become the norm. In this situation there is still no real choice for patients. Informed consent, while important is insufficient to provide a patient with true bargaining power while they are in a position of vulnerability. It is likely that a patient when faced with an informed consent form (possibly provided at a reception desk as a formality before consulting a doctor) will not be sufficiently empowered to decline treatment on this basis as a result of the importance of healthcare to their personal wellbeing (as mentioned previously). The fact that some of the recommended prices on the basis of the 2006 NHRPL inflated by CPI are less than the amounts currently used by medical schemes for reimbursement suggests that current pricing is likely to be higher than the price list in certain situations. This raises a concern that informed consent for pricing above the list will simply become a norm with no real downward price pressure on those that are charging co-payments and high prices.
2. *This structure does not provide guidance as to when a charge is unethical:* This is an important issue for practitioners as well as patients. There is some line that has

to be drawn as to when a price is ethical or not ethical. In the event that the HPCSA does not specify it in their guidelines, they will still have to make that determination on a case-by-case basis. However, the uncertainty over where that line is likely to make disciplinary proceedings more complex. In addition, there is far too much room for debate and neither healthcare providers nor patients are provided with clear and understandable guidelines.

3. *Current price lists (such as the NHRPL which has been suggested as a benchmark) does not cover the full scope of practice:* It is our understanding that the NHRPL does not cover the full scope of practice. As such, it is not clear how the HPCSA will deal with overcharging as it relates to practises that are not coded. As it is likely that newer codes relate to newer forms of treatment, which are often using new technology and can be expensive, this is a serious cause for concern.

As such, while we welcome a form of benchmark prices that form a basis for patient advocacy and increased transparency we are concerned that the HPCSA needs to fully utilise its powers to determine a cap on ethical prices, which is a ceiling on prices in order to make a tangible difference to patients. Section 8 of the Constitution provides for the horizontal application of the Constitution, which means that the right to health (section 27) may apply to practitioners providing health services, given the nature of the right and the nature of the duty to provide access to health care services. While this has not been tested in relation to the provision of health services by health practitioners, it is exactly this kind of private conduct which concerns a public service which could fall within ambit of section 8. In other words, it is arguable that there is a constitutional duty on private providers to make sure that their health services are accessible to the public.

APPENDIX: DISCUSSION OF THE 2006 NHRPL AND INFLATOR

The HPCSA has suggested a guideline tariff made up of two components.

- a) The baseline tariffs which are based on the 2006 NHRPL.
- b) The inflator, which is based on CPI.

This section discusses core issues related to these two components of the tariff. As the baseline NHRPL is intricately linked to costing studies these are also discussed.

Background to the NHRPL

The NHRPL was established by the Council of Medical Schemes in the wake of Competition Commission decisions that prohibited collective bargaining to set prices. The NHRPL sought to be a form of reference price that would allow a basis for bargaining (as it was impractical for every medical scheme to bargain with every provider). It also aimed to be a resource for understanding healthcare costs and therefore inform policy.

The NHRPL was not a recommended price for doctors, nor a recommended reimbursement level for medical schemes. The NHRPL documentation (paragraph 34 of page 6 of Circular 8 of 2005) notes the following:

1. Providers should be able to plug in their own costs and profitability expectation into the NHRPL model to develop their own estimate of costs.
2. Medical schemes should determine reimbursement based on their own affordability, but that the NHRPL would provide a measure of transparency on provider costs.
3. Prices determined are national averages and may differ geographically.

The NHRPL guidelines determine price based on the cost of provision of an item. This is made up of direct labour and materials as well as an allocation of overall costs, plus a return on investment.

1. *Direct labour*: Annual professional remuneration is estimated based on a comparison with the public sector or other equivalently qualified professionals. This

is divided by the available time worked to calculate remuneration per minute. The cost of the procedure is calculated in minutes.¹⁰

2. *Allocated costs*: These are calculated by taking total costs and dividing over the year and multiplying by the time to get a procedure cost.¹¹
3. *Return on investment*: This is actually a markup on operating costs and not a conventional ROI (which is a return on capital expenses).¹²

It therefore relies on two types of information, zero-based information and survey information.

1. Zero-based information includes information that is set based on comparisons such as the cost of equipment or the remuneration of professionals.
2. Survey data regarding costs is used to determine costs of various other factors such as rental etc.

Our two key concerns regarding the 2006 NHRPL are firstly, its applicability for use as an ethical tariff. Secondly we have concerns over whether it is sufficiently current to be meaningful.

These concerns are based on the following.

1. The fact that by its nature the NHRPL inflated by CPI is best placed to be a reference price (or the “usual” price) and not a cap.
2. The fact that cost-based studies may have inherent bias which make the results difficult to correctly interpret.
3. That the inflator used may not be appropriate.

Underlying this is the real concern that if the price level is not determined in an accurate and fair manner it will not be used and may be subject to legal action. This will result in increased uncertainty for patients and will slow down the movement to a fairer and more transparent pricing system.

¹⁰ This time accounts for sick and annual leave and also incorporates a productivity factor based on time studies.

¹¹ This does not include sick leave and annual leave which the professional one does.

¹² This is a markup on overheads based on bankers acceptance and a risk provision.

Drawbacks of the 2006 NHRPL

Price regulation on the basis of costs is often done in regulated industries that are of importance to the country at large (such as telecoms and energy markets). However, in general these markets are made up of a few large providers. In contrast, healthcare providers are generally numerous and geographically dispersed. This generally creates several issues in utilising cost data.

Since the NHRPL represents the average costs of provision across the country it follows that in a normally distributed population half of the practitioners will have costs above, and half would have costs below those used to develop the NHRPL. Some reasons for variation in costs include the following:

1. *Location of practice:* Practices can be based in a range of locations ranging from home practices that incur little or no rental to practices that are based in high rental office blocks or shopping centres. Rentals also differ based solely on geography and rentals in metropolitan areas are generally higher than those in peri-urban or rural areas.
2. *Salaries:* A key component of practice costs are salaries of employees. These generally differ based on the type of skill and experience and employees hired as well as the geographical location.
3. *Equipment:* Given changes in technology over time and variation in equipment available, there is a natural variation in costs due to the type of equipment purchased by a practice. This may be particularly important for particular specialties. For example, while two obstetricians may both have ultrasound machines, one may have a second-hand and basic machine that provides basic information while another may be more complex and provide more advanced information.

Deviation is therefore likely on the basis of differing geographic costs. While this makes it appropriate as a benchmark it would require case-based knowledge to adjust for geographic and practice-specific differences if it is to be used as a basis for ethical tariffs. Our concern is that this would make the determination of overcharging by the professional boards on a case-by-case basis extremely time-consuming and difficult as the board will in

effect have to make a determination of each practitioners deviation from normal costs and to determine whether their price deviation is therefore reasonable.

Our sense is that while such an exercise can be done, if the current proposal is put forward it would be best to create a template (similar to the NHRPL template), to serve as a tool to allow the board to make these determinations by inputting the specifics of a provider. This template should be developed in conjunction with pricing and health experts. However, a quicker and fairly effective way to avoid this would simply be to determine a cap on fees over which providers are subject to disciplinary action unless the provider can prove that there are extenuating circumstances. This cap would need to be set at a level that does not capture the bulk of providers, but captures those that are charging excessively. While there is little scientific basis for the 300% rule that was instituted in the past, this type of rule (or some variation) may be useful as an interim measure in providing an absolute ceiling on prices charged.

Remuneration

The NHRPL has two measures, which provide a practitioner with remuneration. One is a salary and the second is a return on investment. These can be done using a zero-based method based on public sector salaries, for example. However, this is often problematic due to the range of experience levels etc.

There is generally severe contestation over the correct level to be used. An alternate method is by utilising financial accounts of practices. The drawback of this method is that it is circular and could therefore entrench overpricing (if practices are very profitable due to high prices) or entrench undercompensation (if practitioners are taking home lower salaries due to underpricing).

In addition, the NHRPL does not use a return on investment, in the standard sense but rather uses a margin on costs. This does not have a scientific basis and should be remedied going forward.

Sampling issues related to bias

Reference prices determined by cost studies often face challenges due to the representivity of the data collected. Most cost studies are voluntary. As a result the sample

collected could be biased towards those most motivated to respond for calls for information. For example, one possible bias could be towards those that have lower volumes and are therefore quieter so have more time to respond, or to those that feel strongly that the fee is too low (whereas those that are happy with the fee may be less inclined to respond).

This is especially problematic if cost studies are used as a fixed fee rather than a benchmark as responses from a higher number of high cost practices is likely to bias the ultimate figure.

In order to correctly construct such as study it would be important to get statistical advice and to create a random stratified sample. Those selected should be required to participate to ensure that the average price determined is reflective of average costs and is not distorted by self-selection.

The 2006 NHRPL

It can be argued that the 2006 NHRPL is inaccurate. Even at that stage not all prices were developed fully on the basis of costs, but only where sufficient information was received. As such, some procedures were adjusted on an inflationary basis at that stage so would reflect 2004 prices. Given changes in both the scope of practice and cost drivers in the last 6-8 years it would make more sense to develop a more realistic price list than to utilise a fairly dated one.

Concerns over inflator used

While CPI is commonly used for inflationary adjustments it is not clear whether it is entirely applicable when used to adjust cost-based prices as it may reflect a different composition of goods. It could therefore adjust prices inaccurately. In addition, where an industry has different cost-drivers from the economy at large (for example, a higher dependence on imported goods), these differences may make the use of CPI inappropriate.

Going forward the best way to adjust prices would be to get a representative basket of costs from the key cost drivers and to get a statistician (perhaps from Statistics South Africa) to create a basket that is representative of medical costs.