Excuse me, there is an 'elephant in the room'

To the Editor: With the HPCSA calling for submissions from interested parties to assist in drawing up an ethical tariff that may be charged by practitioners, much thought, discussion and effort has

gone into the concept of a new coding and billing structure. Much insightful and informed input has long been given to this process by the South African Private Practitioners Forum (SAPPF). An 'ethical tariff' cannot be established unless the tariff upon which this is based is itself reasonable, fair and ethical.

Clearly, there are glaring deficiencies in the existing coding and billing structure that do not allow for the addition of codes applicable to new procedures. Equally importantly, intertwined with a coding structure, is the billing structure. Each code has a unit value and each unit a Rand value, so determining the fees that practitioners may charge for a particular procedure. By law, the fees charged by practitioners must be cost-based, a situation that definitely does not prevail at present. A cost-based tariff implies that the fee for each and every procedure and service is based on the costs of performing such a procedure, or delivering such a service. These costs then reflect the complexity of the procedure, the training required to perform the procedure, and the physical costs involved. The tariff is to be based also on a return on the financial investment in each practice entity. This concept is rational, reasonable and fair.

But there is an 'elephant in the room' that refers to a situation which is glaringly obvious, but apparently not acknowledged, and a reality that is either missed or dismissed. This reality is the huge discrepancy in the existing rates of remuneration for different groups of medical practitioner that are still determined by the National Health Reference Price List (NHRPL). This is a reality, moreover, that seems to have been accepted and worked with by both medical practitioners and funders.

How can it be that one sector of the profession is remunerated at a higher rate than others? How can it be that, for instance, an anaesthetist's fee is calculated according to the time taken to complete a surgical procedure, while the surgeon's fee is set at a fixed amount for the procedure, regardless of the degree of difficulty and the surgeon's time in undertaking, firstly, the procedure and, secondly, necessary postoperative in-hospital, and post-discharge, management? The clinical input of the surgeon is clearly so much greater than that of the anaesthetist. The time-based fee charged by anaesthetists frequently results in it being more than the surgeon's fee. This is but one of many discrepancies inherent in the present system.

Clinicians, in addition, bear the cost of running consulting rooms, writing letters to referring doctors, and much else. Other discrepancies include the inadequate remuneration for consultative services, and the lack of a 'tiered' system of charging for consultations. There are many other billing practices inherent in the NHRPL that would not withstand logical scrutiny.

The question arises as to how this system came about in the first place. The first coding system was drawn up, presumably by members of the medical association and possibly by funders, in the 1940s! This was a much simpler age, lending itself to a simpler system; e.g. surgical procedures were divided into three basic groups, viz. minor, moderate and major, with a fee applicable to each of these categories. Interestingly, the anaesthetic fee was calculated as a percentage of the surgical fee.

Subsequently, as a result of the workings of successive members of various committees, there has been a gradual change from this simple system, with a measure of inter-disciplinary relativity, into the present unfair and, in the strict sense of the word, unethical system with its inherent discrepancies. Discrepancies have arisen because representatives of the various disciplines on the private practice committee have always lobbied for their own interests, frequently to the detriment of others. There appears to have been little concern for the overall fee structure, and this has resulted in the distorted fee structure that is used. The situation is an indictment of the process and of the members of the medical profession involved. It is truly surprising that this situation has prevailed for so long; equally surprising is the fact that healthcare funders, with their (supposedly) deep financial insights, have made no mention of this situation at all.

Now, when a cost-based tariff is introduced, interdisciplinary relativity will be re-established. As healthcare funding is limited, this may necessitate an increase in the rate of remuneration in some instances and a decrease in others. It is difficult to imagine members of any sector of the medical profession agreeing to a reduction in their fees.

The drawing up of a cost-based tariff will be a difficult and complex task, requiring the input of the medical profession, economists and politicians. It will truly require the wisdom of Solomon to eject the 'elephant' from the room.

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S Afr Med J 2013;103(6):354-355. DOI:10.7196/SAMJ.6992