SADA
THE SOUTH AFRICAN DENTAL ASSOCIATION

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Attention General Manager: Professional Boards
The Registrar
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P O Box 205
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2013/hcpsa/tariffs/ms/pg
21 February 2013

Per e-mail: BhekiM@hpcsa.co.za

Dear **Dr J B Mbhele**

SUPPLEMENTARY COMMENTS ON PROPOSED PROCESS TO DETERMINE GUIDELINE TARIFFS FOR MEDICAL AND DENTAL PRACTITIONERS

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1 We refer to our submission dated 20 February 2013 in the above matter duly acknowledged by you by letter sent by e-mail of same date.

2 We would like to supplement our initial submission referred to above and request that it be referred to the Tariff Committee. We would also request that the Committee be informed to consider both submissions.

3 We advise that approximately 50% of enquiries from service providers, medical schemes/third party funders and patient that come to attention of the Association are complaints or questions about fees and how the fees are to be applied or funded. Remarkably few of these complaints concern dissatisfaction with the actual level or amount of fees charged by practitioners or relate to alleged "overcharging". Much more commonly, such complaints involve patients alleging that they have not been made sufficiently aware of certain charges on their accounts or the total costs of treatment, or perhaps that they had not properly understood what the charges related to. This speaks to the issue of valid consent and the ability of patients to make properly informed decisions about healthcare options presented to them, but not the actual fees charged by practitioners.

4 In the United Kingdom between 1951 and 2006, the state-run National Health Service (NHS) operated a system whereby both the fees paid to dentists, and also the contribution to those total fees that patients were required by law to make, were fixed by Government and reviewed

annually. In some parts of the United Kingdom (namely, Scotland and Northern Ireland) a similar system persists today, but in England and Wales where the majority of UK dental treatment is delivered, the system of controlling gross fees centrally by means of the equivalent of a tariff was abandoned in 2006. An independent review commissioned by Government and published in 1993 (the Bloomfield Report) drew attention to the undesirability of having a single fee scale applicable to every practitioner, in every practice across the country.

5 We would argue that any form of tariffs that is to be applied on a national basis that does not take into consideration or reflect the differing overheads and costs of delivering services which can vary significantly between areas and locations is flawed.

6 Any attempts to introduce tariffs could therefore adversely affect the viability and sustainability of some dental practices and this could influence or force practitioners to increase their output/productivity at the expenses of quality and the time that they are able to spend with individual patients. This in turn may have an impact on the quality of care provided.

7 We state that where practitioners have little or no control over some cost areas impacting upon their practices (such as the cost of acquiring and maintaining premises, staff salaries and other such location-specific costs), and their total fees are also "capped" and determined by third parties because of an externally imposed tariff, their only remedy if the profitability of their private business is to be preserved at a viable and sustainable level, is to compromise on the quality of laboratory support, equipment, and materials used in the provision of dental care and treatment. Other important areas such as staff training might also be compromised and all of this has the potential to have a direct effect upon patient safety.

8 A tariff also act as a strong disincentive for the best and most capable practitioners to undertake further postgraduate training and the achievement of higher qualifications because having incurred the substantial additional cost of this advanced postgraduate training, they would be prevented from recovering this cost through their fees in subsequent years. Indeed, they would be competing at a distinct financial disadvantage against other less highly qualified professional colleagues who had not invested in such training, and were not therefore having to service the financial legacy of having undertaken it. This may ultimately deny the South African public access to these most skilled and highly trained professionals because they may elect to practise outside South Africa as the only means at their disposal for recovering the additional costs that they had incurred.

9 A tariff would also have the perverse effect of protecting the worst practices while constraining the growth and development of the best practices. This would act directly against the free operation of the market and the public interest.

10 Any reduction in the quality of care provided, for any of the above reasons, may lead to an increase in claims and to increased settlement costs which will have a detrimental impact on professional indemnity subscriptions for healthcare professionals in South Africa and only serve, in turn, to drive up total costs of providing care to the South African population.

11 The proposed introduction of tariffs for dental practitioners, while no doubt intended to operate in the public interest, would in fact have quite the opposite effect in reality. The greater need is not for price control in isolation, but for a better and more transparent flow of information about the charges themselves, what they relate to and how different treatment alternatives compare not only in terms of their cost, but also in terms of their relative benefits, limitations and risks.

12 It is well recognised throughout the world that choice is desirable in healthcare provision, as a reflection of respect for patient autonomy. Members of the public cannot exercise free choice when seeking healthcare, without adequate information. Cost is a legitimate part of that choice process and variations in cost make it more likely that patients will, to their ultimate benefit, seek more information from their healthcare providers before agreeing to undertake treatment.

Yours faithfully

Maretha Smith
Chief Executive Officer: South African Dental Association

cc Mr N Kirby and Ms A Ngidi, per e-mail: nkirby@werksmans.com and angidi@werksmans.com