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Attention General Manager: Professional Boards
The Registrar
Health Professions Council of South Africa
P O Box 205
Pretoria, 0001

2013/hpcsa/ms/pg
20 February 2013

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

Dear **General Manager: Professional Boards**

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

PREAMBLE

1. We refer to the above Proposed Guideline Tariffs (Board Notice 198) published on 7 December 2012 (Gazette Number 35931) inviting comments and representations on the terms of reference and the process which the Medical and Dental Professions Board ("Board") intends to embark on to determine and publish a new tariff ("guideline tariffs" or "ethical tariffs") in respect of fees for medical practitioners and dentists and dental specialists ("dental practitioners").

2. The South African Dental Association (SADA) is a national professional body representing the vast majority of registered dental practitioners engaged in clinical practice both in the private and public sectors in South Africa.

3. The SADA leadership has been in extensive discussions with its member base in all regions in terms of the proposed guideline tariffs and this submission is the consolidated view of the SADA membership. Please note that the contents of any independent submission by a SADA member do not necessarily represent the views of SADA and its members as a collective.

4. We hereby formally withdraw our previous submissions to the Board and/or the Tariff Committee and request that our submission/s made in response to Board Notice 152 dated 14 September 2012 not be considered in the light of the Board Notice 198 dated 7 December 2012 referred to above.

5. Once again, we wish to raise our concerns and objection to the initial time periods that were unilaterally imposed in the notice on 7 December 2012, being a period when many dental practitioners in private practice, who are materially and adversely affected by the proposals, are away from their practices, and also to the limited time afforded to make submissions by the notice.

SADA POSITION ON MANDATE OF THE HPCSA

1. We reiterate our position that the determination of any guideline, norm or such similar tariff (referred to collectively herein as "the tariffs"), in terms of section 53(3)(d) of the Health Professions Act No.56 of 1974, as amended ("the HPA") is a Board competency and that the HPCSA has no role to play in this process.

2. Any costs incurred in the determination of the tariffs must be borne by the Board and/or HPCSA and should not be borne by dental practitioners registered with the HPCSA.

3. We furthermore reiterate our position that the tariffs to be determined by the Board cannot be a reimbursement tariff and thus cannot dictate to dental practitioners what to charge for services rendered by them. In addition, any attempt to define an ethical tariff based on a particular fee level set in the 2006 National Health Reference Price List ("NHRPL") is ultra vires the HPA, is unreasonable and thus unlawful:

    3.1 Although the HPCSA, through its representatives, confirmed that the tariffs will not be a reimbursement tariff, it is foreseen that, in the absence of any other price lists (reference or otherwise) in the marketplace for health care services, such tariffs will become the level at which medical schemes and funders will converge to reimburse for services rendered to their members and at which service providers will be expected to charge for their services.

    3.2 As such, we are concerned that the tariffs will *de facto* determine reimbursement levels and fees in the healthcare industry to the prejudice of sustainability of dental practices and, ultimately, to the prejudice of the public at large who are dependent on access to dental services.

    3.3 Any tariff determined on the basis of the 2006 NHRPL will not bear any relation to the actual costs of providing health care services by dental practitioners.

4. The mandate of the HPCSA concerns the regulation of ethical behaviour, and not tariffs *per se*. As such, any consideration by the HPCSA of tariffs should be aimed at addressing dental practitioners' behaviour with respect to how fees are charged, rather than the actual level of fees. In this context, it is our considered view that:

    4.1 Practitioners may be found to be charging unethical amounts, even when charging below the "Ethical Tariff" set by the Board, conversely, charges above the tariffs will not necessarily be unethical.

    4.2 A practitioner who is charging below the tariffs may still be acting unethically with respect to the tariffs, for example when overservicing (i.e. performing unnecessary services for a fee), padding accounts (i.e. adding charges for services not rendered)- or scheduling repeat visits that are not indicated.

Any 'ethical tariff' should be about moral behaviour with respect to fees and coding rather than a set fee or 'ceiling' or even a fee level.

1. The definition of regulation is the ***"setting up rules or standards by which a given market or any of its agents must abide in order to correct a failure or undesirable situation in the interests of a social benefit"*.**

2. As such, regulation should therefore only be implemented when the expected market benefits outweigh the costs of intervention.

3. Regulation is often inefficient, because:

3.1 regulated prices may not reflect the costs of services, thereby adversely affecting sustainability of services and, ultimately, affecting access to such services;

3.2 in a regulated environment, there are no incentives on individuals to enhance efficiency in delivery of services, thus having a negative impact on overall costs of services;

3.3 regulation imposes excessive administrative overheads, indirect costs and general mistrust in the trading environment.

4. The allegation generally cited in favour of tariff regulation, is that providers are abusing the current non-regulated environment to overcharge patients for services. To this effect, we wish to state that the predominant organisation for indemnity insurance in the dental profession, Dental Protection Limited (DPL), has confirmed that they do not receive complaints referred to the HPCSA that relate to "overcharging". Instead, the complaints relate to members of the public not having been made aware of certain charges to be effected on their accounts. This speaks to the issue of informed consent - not the actual charges - and SADA's position remains that informed consent is mandatory in respect of all procedures and fees charged in the dental profession. This position will empower patients and serve to regulate practitioner behaviour, as opposed to fees.

5. Furthermore, it is argued by the HPCSA that patients are vulnerable when it comes to fees charged, as they are mostly not in a position to have an informed discussion about the reasonability of medical fees. We wish to state that this is not the case in dentistry, where an informed discussion between practitioner and patient is possible in every instance except emergency situations where the patient is unable to respond..

6. Finally, there is concern by the HPCSA that, in the current prescribed minimum benefit (PMB) environment, practitioners effectively are provided with a "blank cheque facility", which medical schemes are required to pay. In this respect, we wish to draw attention to the fact that dentistry falls largely outside the PMB environment.

COMPETITIVE CONCERNS

1. In 2004 the Competition Commission ("the Commission") was alerted to practices of industry bodies collectively recommending and publishing health tariffs. Consequently, the Commission initiated an investigation against some stakeholders with regard to their conduct. In particular, the Commission was concerned that the recommended and published tariffs and collective actions by these stakeholders and their member constituted contravention of section 4(1)(b) of the Competition Act No. 89 of 1998 ("the Competition Act"), in that it amounted to an agreement between or concerted practice by firms, or a decision by an association of firms, that involved directly or indirectly fixing a purchase or selling price or any other trading condition.

2. The Commission has in the past made it clear that tariff discussions amongst providers and other sellers and purchasers in the health care sector, should be avoided, which includes direct participation or indirect participation in surveys concerning projected future changes to or quantification of costs for services. In addition, they must avoid discussing these subjects with competitors. Avoidance is also critical if the survey or discussion relates to the current or future prices of specific or identified competitors.

3. Thus, in establishing any final framework for the determination of the tariffs, due consideration must be taken of the provisions of the Competition Act, which prohibits collusive practices and anticompetitive conduct in general.

4. While the Board may have obtained an advisory opinion from the Commission approving its proposed course of action, in relation to any process finally determined by the Board, an exemption or approval from the Commission is a non-negotiable pre-requisite to any

participation by SADA and its members in the process. Without this exemption the inability of an entire constituency to discuss pricing will remain a fatal flaw in any process finally determined by the Board. This must be addressed urgently when the terms of reference are finalised for determining the compilation of the tariffs.

5. Even if no actual price-fixing agreements result, exchanges of competitively sensitive information amongst competitors still can be deemed unlawful under rule-of-reason analysis if their effect is to raise or stabilise prices (or lower or stabilise wages or the price of some other input).

6. There is no basis to accept that the process now contemplated by the notice will not present us with an immediate prospect of contravening previous rulings of the Commission, or acting contrary to advisory opinions already obtained by us from the Commission.

7. In the absence of exemption from the Commission or confirmation by the Commission to the effect that SADA and its members who are dental practitioners are granted unconditional exemption in terms of section 10(1)(b) of the Competition Act from the provisions of section 4 (1) and section 4(2) of the Competition Act for a period that is required to enable SADA and its members to participate in surveys and engage in discussions concerning current and future projected payments for services and exchange of competitively sensitive information. SADA, on behalf of its members, will not be able to make proper and meaningful representations on the tariffs.

8. We also wish to record that continued and flagrant disregard for the competition issues raised by SADA through our attorneys is still a cause of great discomfort to us. The notice, like earlier notices, is unclear about what public participation process is even possible in the absence of approval from the Commission of any process for determining the tariffs. Failure to take due cogniscance of the inherent limitation of our rights and those of our members renders the process susceptible to a constitutional challenge. The challenge will not be of our own making but rather of the refusal by the Board and/or the HPCSA to take into account the bases on which we are unable to participate meaningfully or at all in the process that the Board intends on following.

IMPORTANT CONSIDERATIONS IN THE DETERMINATION OF THE TARIFFS

In the rare number of instances where it may be necessary to have predetermined tariffs in dentistry, as result of patient vulnerability or prescribed minimum benefits, the following must be taken into account:

1. The reasonability and appropriateness of such tariffs is critical and requires:

    1.1 A rigorous approach that takes into consideration all the costs and activities involved in the procedure/service, as well as other expenditure and profit requirements faced by dental practitioners. The process has to allow for these components accurately and fairly within the related tariff.

    1.2 Modelling of the costs of procedures in as much detail as possible to determine the charging structure that would be appropriate for the proposed service. This involves detailed analysis of each activity associated with the service that generates costs.

    1.3 In order to reflect the operational and capital intensive nature of the dental business model, the determination of costs should be based on the actual cost experience of an "average representative practice", while still allowing for activity based model components depending on the location and sophistication of individual practices. The choice of model is very important and research (and international benchmarking) should be conducted into the applicability of models such as the Capital Asset Pricing

Model (CAPM), the Economic Margin (EM) method, and the cashflow return on investment (CFROI) model.

2. The information that would be required by the Board and that the Board would have to obtain includes, but is not limited to, the following:-
   (a) activity times for health services rendered within a dental practice including surgical and dental procedures, which means the time required to complete the actual procedure or service;
   (b) overhead costs, i.e the costs incurred in rendering a set of items included in the ethical tariffs;
   (c) labour costs, i.e the costs of labour that can be traced to the provision of an item listed in the ethical tariff;
   (d) professional fees;
   (e) cost of medicines, Scheduled substances and medical devices;
   (f) cost of maintenance of dental premises;
   (g) cost of consumables used in the delivery of health services;
   (h) security costs;
   (i) cost of services or products used to ensure patient safety;
   (j) cost of insurance related to the provision of health services;
   (k) details of persons or institutions providing services to or at the practice;
   (l) different scales of benefits payable by medical schemes to the dental practice;
   (m) occupancy rates, which is the utilised capacity of a facility or equipment divided by the available capacity during the period under consideration;
   (n) any other non-confidential information relating to running of a dental practice;
   (o) income and expenditure;
   (p) professions billing guidelines and rules, where these exist;
   (q) waste management costs;
   (r) details of any agreements with third parties such a designated service provider or preferred provider agreements;
   (s) continuing professional development; *and*
   (t) any other costs that are ordinarily incurred in a dental practice.

3. The information that is obtained from dental practitioners, as service providers, must also indicate costs parameters that are different in respect of different specialists groups in dentistry. It must provide explanations for adjustments or assumptions made in cost evaluations.

4. The tariffs must include an explanation of the application of appropriate processes to calculate:-
   (a) pricing, i.e. the methodology for the determination of reference prices for items;
   (b) procedures for addition, deletion or change of items; *and*
   (c) calculation of responsibility values. Responsibility value means the increased responsibility for providing a service relative to a standard service for providers and is calculated by taking into account experience and knowledge, judgement and mental effort, skull and physical effort as well as risk and stress to the patient.

5. In determining the tariffs, the Board must at least take into account the following – bearing in mind that there are numerous variables as between dental practices country-wide that will influence the information requested and received:-
   (a) the need for private dental practices to have a return on investment;
   (b) the need for dental practitioners as health care providers to earn an income; and
   (c) the need for certainty, sustainability, affordability and stability within the medical schemes environment and among private sector consumers.

6. Any tariffs must provide for variations in quality of service, health outcomes and practice costs – all of which vary dramatically across the country. Practice costs vary from group to group, specialist to specialist and geographically, so attempting to set a single 'ceiling' tariff would be unreasonable and arbitrary.

7. The tariffs must also take into account a practitioner's experience, the complexity of the procedure and his or her overheads and practice costs and not only the patient's medical plan or whether or not the fund must pay in full.

8. The tariffs must be based on what is fair and just when applied with regard to patient's right to autonomy, freedom of choice and quality health care. The tariffs must honour the dentist patient relationship without third party interference.

9. Taking into account what is set out above, the Board will either have to make a budget and resources available to collect the information that is needed or the Board will have to mandate SADA to perform such a function. In so far as SADA is mandated by the Board to perform such a function, then SADA would have to exempt from the Competition Act or receive an indemnification from the Board or the HPCSA in respect of any liability for any contravention of the Competition Act.

APPROPRIATENESS OF 2006 NHRPL

1. The use of the NHRPL as either a base list of tariffs or for the purposes of benchmarking, requires a thorough understanding of the background and development of the tariff since publication and the methodology behind these tariffs.

2. The NHRPL was first published in 2004 by the Council for Medical Schemes to assist schemes to set benefit levels in cases where they were unable to negotiate rates directly with providers. The costing model used benchmark values and standardised assumptions and was not intended as a recommendation of the prices to be charged by providers as this would depend on provider-specific conditions such a s productivity and expenditure levels.

3. It is our understanding is that the 2006 NHRPL simply adopted the BHF scale of benefits, which the BHF determined on behalf of medical schemes. In making this determination BHF did not take into account any information from SADA or its members or any other interested and affected party regarding actual costs of providing services by dental practitioners.

4. In fact, the introductory paragraph to the 2006 NHRPL makes it clear it was a baseline and not a set of tariffs: *"[t]he following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well".*

5. The 2006 NHRPL was always intended to be an interim measure until the government was ready to take on the function of determining tariffs under provisions section 90(1)(v) of the National Health Act No. 61 of 2003.

6. In 2007, the National Department of Health ("the NDOH") took over the compilation of the tariffs and published referency price list ("RPL") schedules allegedly based on the NHRPL. More recently, in July 2010, the NDOH RPL was reviewed, declared invalid and set aside by the High Court of South Africa. This was due to issues with the data used and the methology followed in the determination of these tariffs.

7. Up until 2007, the HPCSA annually requested the SADA National Schedule of Recommended Fees and Guidelines and subsequently SADA Codes and Terminologies all of which formed the basis of the HPCSA Ethical Tariffs for dental practitioners.

8. In fact, on 28 November 2005, the Tariff Committee of the Medical and Dental Professions Board, with Dr A W Barday as chairperson, announced in a letter that after consultation with SADA, the South African Medical Association, the Board of Healthcare Funders of Southern Africa ("the BHF") and the Council for Medical Schemes, the proposed professional fees for medical practitioners and dentists, prepared by the Tariff Committee, were approved by the Finance, Investment and Tariff Committee of the HPCSA.

9. In compiling the abovementioned tariffs the existing researched coding structures were used in the determination and development of the standardised system. The codes, descriptors and relative value units were identical to those determined and published by SADA. A copy of the letter dated 28 November 2005 is annexed marked "A".

10. Therefore, the use of the 2006 NHRPL as base would require a thorough assessment of the manner in which these tariffs were determined and the data upon which it is based to ensure that it is unbiased, accounts for all the costs involved and appropriately allocates these cost components.

11. Thereafter, the appropriate inflation factors will need to be used to inflate the tariffs to 2013. This exercise is not as simple as merely using Consumer Price Inflation (CPI) each year, as medical inflation has far outstripped CPI over the years. In essence, different inflation factors will need to be applied to each cost component depending on the nature of each cost. For example, consultation fees of dental practitioners may increase by salary inflation, equipment could increase by CPI or medical inflation, and some cost components may require increases in line with the increase in hospital tariffs each year.

12. Ultimately, an appropriate inflation factor is required for each cost component and this factor may not be widely published and may need to be calculated taking into consideration the multiple factors that impact inflation, such as new technology, changes in exchange rates, and new processes/procedures.

13. In addition, the NHRPL will need to be updated for new codes that are not on the list. Using the 2006 NHRPL as the basis for determining the tariffs will ignore all technological innovation in dentistry since 2006.

14. The 2006 NHRPL ignores new and amended codes or codes that have been deleted to reflect new technology, procedures and materials used by dental practitioners. In determining appropriate codes and descriptors, SADA has invested substantial intellectual property rights in the compilation of a coding list with proper descriptors and guidelines. These procedures codes and terminologies make provision for new methods of rendering dental services including new technology used in providing these services. It also eliminates old and redundant codes and descriptors.

15. The 2006 NHRPL has not kept pace with new coding structures and refinements to existing codes and procedures required within and by the dental profession and the use of the 2006 NHRPL as a basis for guideline tariff will simply perpetuate the defects in this process, is without foundation, is unreasonable and entirely irrational.

16. In short, until 2006, recommended fees, coding and terminologies of professional associations like SADA were used for determination of tariffs by the HPCSA. Accordingly, there is no rational or reasonable basis why the 2006 NHRPL should now be used as the basis for the determination of the tariffs.

17. The 2006 RPL does not indicate, and there is no basis to accept that it does, that it takes into account the costs of either operating a dental practice, including, but not limited to, capital

expenditure, employee costs, rentals, return on investment and profit, nor the monetary value of what a dentist should be earning based on his or her particular levels of training, expertise, experience, education and geographical location.

ABILITY AND CAPACITY OF THE HPCSA TO DETERMINE THE TARIFFS

1. In the process of determining the tariffs, the Board would have to obtain at least the information referred to above and information relating to health financing, the pricing of health services, the overall costs of business practices within or involving dental practices, health workers or health care providers.

2. The HPCSA tariff was discontinued in 2009. According to the media statement of 26 November 2008, the HPCSA took a decision to scrap its ethical tariffs used by dental practitioners as a ceiling for patient accounts. The reasons given by the HPCSA Business Practice Committee for the discontinuation of the HPCSA Ethical Tariff determination for 2009 were, amongst others, that the HPCSA did not have the capacity and expertise to make an annual tariff determination.

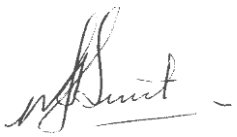
3. We question the Board's capacity and expertise to manage the process for the compilation of the tariffs. We are of the view that the Board does not possess the requisite capacity to process the vast volumes of information, which are obviously required to be produced by numerous disciplines for the purposes of determining a reasonable tariff for each and every speciality and disciplines currently registerable as a profession in terms of the HPA.

CONCLUSION

It is incumbent upon the Board to consider carefully the appropriateness of determining tariffs for use in dental practices, taking into account economic considerations, sustainability of services and quality of services.

In the limited instances where dental tariffs could be regulated, it is incumbent on the Board to produce an effective, reasonable and lawful ethical tariff which set rates at an appropriate, reasonable level that is grounded in the reality of the costs of operating dental practices.

Yours faithfully



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