DISCUSSION DOCUMENT

THE DETERMINATION OF HEALTH PRICES IN THE PRIVATE SECTOR

Version 1.00

28 October 2010

Department of Health

CMS
COUNCIL FOR MEDICAL SCHEMES

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1 Background and purpose of this document

At a meeting held by the Director General for Health (DG) with stakeholders in the private healthcare environment on 18 October 2010, the DG indicated that a discussion document will be released by 1 November 2010. The purpose of this document is to stimulate debate and to elicit participation in this policy development process.

The draft policy framework for price determination in the private healthcare system is presented in Annexure A (page 7). Note that this document deals with two parallel but distinct processes. The first process is consultative in nature and seeks to arrive at the establishment of a healthcare price determination authority. It is clear from the details presented in section 2 below that it would take at least three years before such a proposed authority could be operational.

The second process aims to establish voluntary interim tariff negotiations led by a public authority. This process will commence after delineated exemption from certain provisions of the Competition Act has been obtained. Section 3 (page 5) of this document provide more details on interim negotiations, while the proposed interim negotiation process is presented in Annexure B (page25).

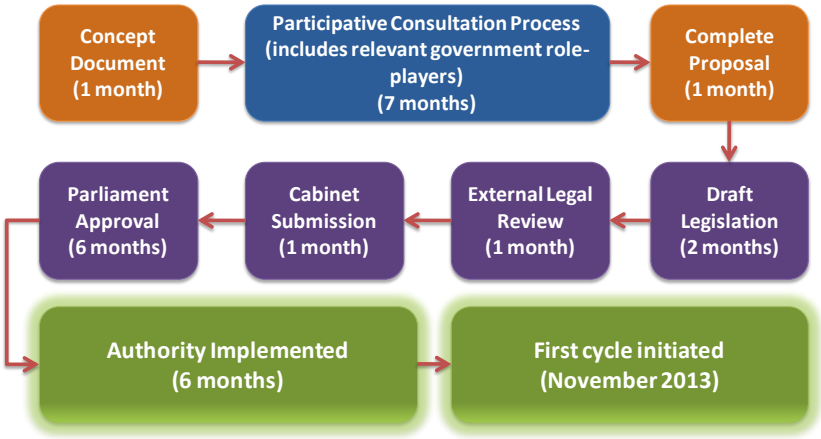
Section 4 (page 6) presents the governance structure overseeing the consultative process and provides more details on the roles of the respective participants.

Finally, section 5 (page 6) invites stakeholders to participate in the process.

2 Consultative process to establish a healthcare pricing authority

Figure 1 (page 4) shows that the first phase of the policy development and implementation process has started with the release of this draft discussion document.

Figure 1: Estimated duration of the price-determination-policy development and implementation



Subsequent to the consideration of comments on this document, a consultative workshop will be held early in 2011, when a response to the stakeholder comments will be presented and further work, which may include the establishment of consultative working groups, will be organised.

Figure 2 (page 5) shows that the envisaged pricing authority could be a commission that should function independently to ensure that the trust of all stakeholders could be achieved. The figure also identifies four potential functions of the authority. The first is to manage a negotiation chamber where relevant healthcare prices could be negotiated on an annual basis.

The figure shows that provision should be made for an arbitration mechanism to ensure that prices are determined timeously. The figure proposes a compliance or enforcement function, as well as research function which could perform technical analysis of prices. This function may incorporate the RPL function as well as the current medicine pricing committee, and may have the express function of providing advice to the Minister in respect of healthcare costs. The research arm might also consider alternate remuneration mechanisms.

Figure 2: Key features of the envisaged health price determination authority

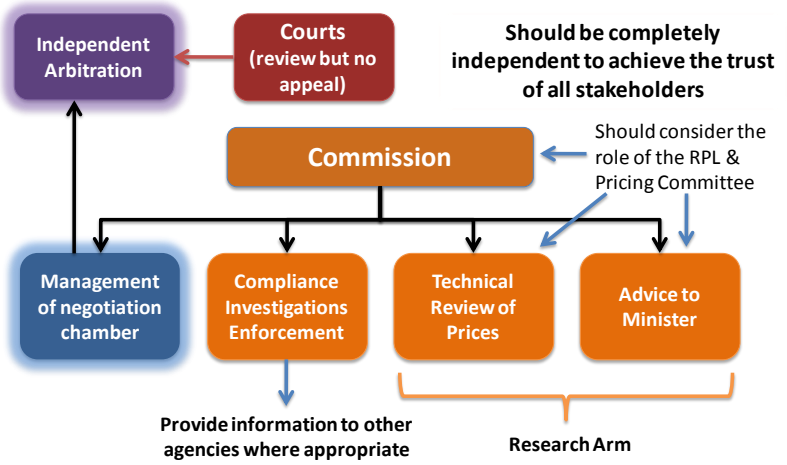
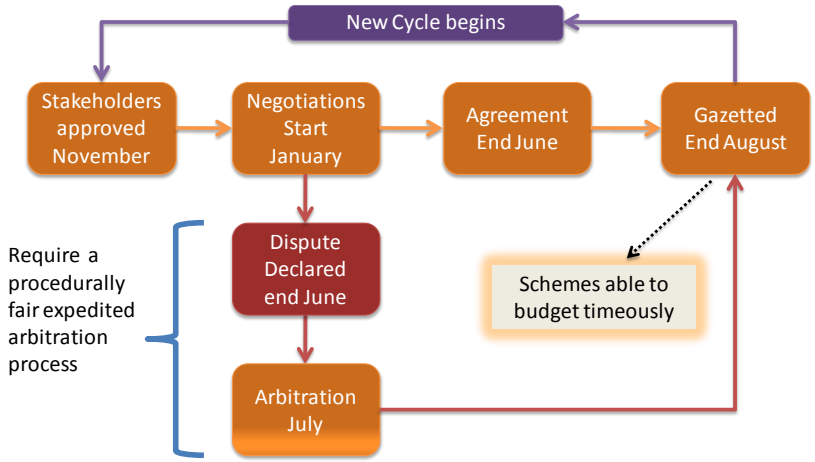


Figure 3 (page 5) demonstrates a proposed negotiation cycle which should commence in November each year, and must be concluded by August to enable schemes adequate time to consider the impact of price changes before they submit their proposed contribution levels to the CMS. More details on the proposed arbitration process are presented in Annexure B (Section 6, page 35), while the potential subject of the negotiations is presented in the same Annexure (Section 5, page 33).

Naturally, experience gained from the implementation of the interim process (detailed in Annexure B, page 25), will inform the final process adopted by the envisaged statutory authority.

Figure 3: Proposed negotiation cycle for adoption by the envisaged statutory pricing authority



3 Interim process to negotiate tariffs while the consultative process on the establishment of a pricing authority continues

Section 2 above shows that the proposed statutory pricing authority will potentially only commence operations in 2013, with the first negotiated tariffs being implemented only in 2014. Due to the

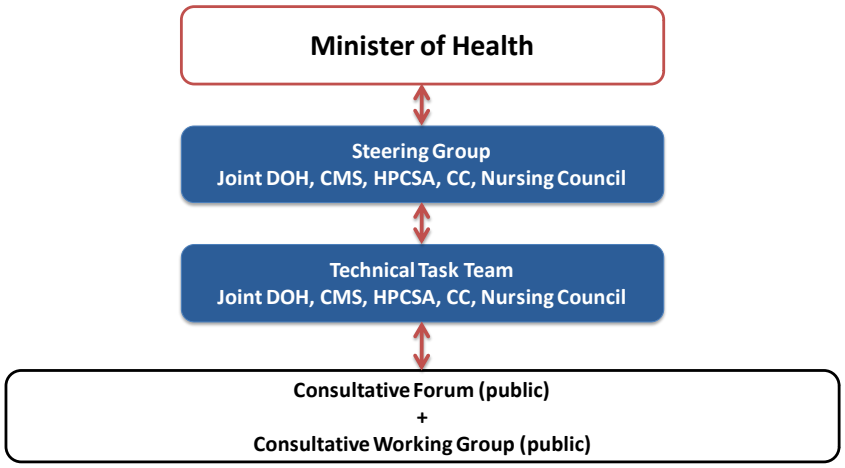
uncertainty created by the removal of the RPL, an alternate solution is sought to operate while the consultative process on the statutory pricing authority continues.

Annexure B (page 25) constitutes a proposed interim tariff negotiation process, which could be concluded within four months after clearly delineated exemption from the Competition Act has been obtained. Note that this would have to be a voluntary process whereby parties agree to abide by the outcome of the negotiation or arbitration process. The document warns that partial participation and withdrawal before completion may constitute collusive activity in contravention of the Competition Act.

4 Governance of the policy development process

The structure presented in Figure 4 shows that the process is led by the Minister of Health, who has the authority to make policy. The project will be overseen by a steering group with representatives from statutory organisations. A technical task team with officials from the respective organs of state will also be established. The consultative process will include the creation of a consultative forum and may include the establishment of consultative working groups.

Figure 4: Proposed governance of the price determination policy development process



5 Invitation to comment

Stakeholders are invited to comment on this draft discussion document before 15 December 2010. Innovative suggestions on improving this first draft are highly appreciated.

Annexure A: Draft policy framework

DRAFT POLICY FRAMEWORK FOR PRICE DETERMINATION IN THE PRIVATE HEALTH SYSTEM

1 NOVEMBER 2010

CONTENTS

LIST OF ABBREVIATIONS

BHF	-	Board of Health Funders (formerly RAMS)
Council	-	Council for Medical Schemes
Commission	-	Competition Commission
ffs	-	fee for service
HASA	-	Hospital Association of South Africa
NHRPL	-	National Health Reference Price List
PMBs	-	Prescribed minimum benefits, as prescribed in terms of the Medical Schemes Act
RPL	-	Reference Price List
RAMS	-	Representative Association of Medical Schemes
SAMA	-	South African Medical Association

1. PURPOSE

1.1. This report provides a draft policy framework for achieving stability in the determination of prices in the South African health private health system. Incorporated in this framework is a strategic position on the policy going forward as well as an approach to realising the strategy.

1.2. The policy framework seeks to achieve price stability through the establishment of an enabling mechanism for the *rational* and *fair* determination of final prices used by suppliers of health services for billing patients and medical schemes and the tariffs used by schemes as a basis for determining their levels of reimbursement.

2. BACKGROUND

2.1. Since the evolution of medical schemes within the South African context fee-for-service (ffs) tariffs have been predominantly negotiated on a centralised basis. The reasons for this are:

- Medical schemes have traditionally focused on the reimbursement of medical expenses incurred by a beneficiary. Given this, members/beneficiaries choose their own medical service provider. In such circumstances the relationship between the scheme and the medical service provider is indirect and the tariff does not result from mutually-beneficial negotiations and arrangements.
- However, as a third-party payer (i.e. the medical scheme) will face an infinite liability if it does not establish "reimbursement prices" which limit the level of reimbursements. These may not always be the same as the prices that are actually charged by service providers.
- In practice however reimbursement prices (scheme tariffs) form the predominant income source for many health care service providers as many beneficiaries are unable to pay for health services reliably at point-of-service. Given this, reimbursement prices are typically subject to negotiation between medical schemes and affected service providers.

- The quid-pro-quo for reaching a settlement in such negotiations has often been that the reimbursement price either equals or closely approximates the actual price charged. If there were to be a significant divergence between the prices charged and the reimbursement price, the rationale for risk pooling (insurance) would be diminished, particularly in relation to catastrophic health conditions.

2.2. The centralised negotiations were however characterised by an unsurprising degree of acrimony. Ultimately a decision was made that the Representative Association of Medical Schemes (RAMS) would negotiate a set of statutory ffs tariffs which would be published in the Gazette each year. This arrangement persisted until 1994 when it was abolished in amendments to regulations of the then Medical Schemes Act.

2.3. As a direct consequence of this change RAMS shifted from negotiating an actual set of ffs prices to "negotiating" reference prices. Medical schemes were consequently expected to negotiate their own prices separately but could use the reference prices as a guide.

2.4. At the same time the body that is now known as the South African Medical Association (SAMA) began publishing a competing reference price schedule that applied to GPs and specialists. This tariff schedule resulted in fees that were higher than the RAMS reference prices. Doctors often used the SAMA schedule as a basis for balance-billing (charging prices in excess of scheme tariffs) patients.

2.5. The Hospital Association of South Africa (HASA) applied for and received permission from the competition authorities at the time to set its own "reference price". However, this schedule did not ultimately result in a difference with the RAMS schedule as the two associations de-facto negotiated common reference prices to which all parties adhered.

2.6. In 2004, the Competition Commission (Commission) declared that the centralised reference tariff schedules produced variously by the Board of Health Funders (BHF – formerly RAMS), HASA and SAMA were a restricted practice as they were set in a collusive manner with anti-competitive outcomes.

2.7. However, the decision by the Commission created significant logistical and competition problems for the price-setting process:

- Medical schemes were theoretically required to negotiate general reimbursement prices with every single medical service provider. Assuming the logistical problem of negotiating the fees could be overcome, this would result in a situation where every doctor would be quoting different consultation fees and different procedure fees for every option in every scheme.
- Hospitals had consolidated into three major groups, which generated a negotiation imbalance with the less concentrated medical schemes and administrators. This placed the hospital groups in an oligopoly position which has largely eliminated any possibility of price competition.

2.8. To mitigate the logistical problem, the Council therefore established an interim reference tariff schedule, the National Health Reference Price List (NHRPL). The Council was able to do this as it derived no commercial gain from establishing the tariff schedule and therefore fell outside the jurisdiction of the Competition Act (see below).

2.9. The NHRPL was however only able to achieve a limited set of objectives. As a reference price schedule the values were not determined by negotiation but, instead, by cost analysis. In reality, however, medical service providers with market power deviated from the NHRPL when it suited them without any market penalty. This included the three main hospital groups that have sufficient market power to impose their increases on medical schemes, and specialists who balance bill patients, sometimes by as much as 300% of the NHRPL.

2.10. In the case of specialists, medical schemes were forced to condone the balance-billing practices as not to do so would leave many beneficiaries without adequate cover. In addition they needed to fund prescribed minimum benefits (PMBs) fully as required by the Medical Schemes Act.

2.11. The NHRPL process was ultimately handed over to the Department, and became referred to as the Reference Price List (RPL), which fairly quickly

became hamstrung by the conflicting roles that it was expected to play by key stakeholders. On the one hand schemes used it as a benchmark for their tariffs, while on the other hand providers saw it as cost-based system of administered prices. However, the central problem is that it permitted providers, with permission, to collude in the setting of prices, and the determination of code structures that would ultimately be charged as balance-billed amounts to patients rather than schemes.

2.12. The RPL process ultimately could not achieve a satisfactory outcome on final prices, as the costing analyses occurred without consideration of the budget constraints of medical schemes and medical scheme members. Schemes would consequently strongly object to the publication of benchmarks that would immediately translate into higher fees. Providers, on the other hand, objected to going through costly benchmarking exercises that ultimately did not lead to adjustments in the RPL. Problematically, however, permitting providers to sit together in the RPL process effectively allowed them to determine prices collusively in the market even where the RPL process failed to complete.

3. UNDERSTANDING THE PROBLEM

3.1. Price setting in the health sector is fraught with difficulties due to the many information asymmetries and market power imbalances. Given this, most countries with sophisticated private health sectors intervene in one way or another to manage system cost increases. As health costs invariably involve a combination of price and volume changes, interventions focus both on managing price changes and mitigating perverse incentives by providers and patients that unnecessarily drive up demand (volume).

3.2. Many of the prices charged in the market are also not formally negotiated, and merely set unilaterally by suppliers of health goods and services. In conventional markets unilaterally determined prices that are excessive will be penalised through reduced demand leading reduced profits. Within health care markets, where demand is sustained by insurance, excessive prices are not penalised and unilaterally determined prices will result in the achievement of super-normal profits.

3.3. Unilateral pricing essentially only works in markets facing normal competitive conditions where the consumer has substantial discretion to avoid the purchase if over-priced. Importantly, the prices are sensitive to household budget constraints, even though the relationship is indirect. Within healthcare markets, given that demand is sustained regardless of the price, the relationship to medical scheme and household budget constraints is broken, and needs to be re-constituted.

3.4. Achieving balance therefore requires that a direct link be established between scheme and household budget constraints and supplier prices. This can only be achieved by requiring that all prices for private health goods and services be pre-negotiated, even where they are paid for on an out-of-pocket basis. However, as bilateral negotiations are not always practical or feasible, a framework has to be established for negotiations that are not bilateral. These can only be collective or multi-lateral in nature and all affected parties need to reasonably participate in the process.

3.5. However, just as unilateral price determinations in a market "distorted" by insurance can prejudice final purchasers, there is some risk that providers

could be unfairly penalised where colluding purchasers are in a position to "monopsony" price, i.e. excessively drive prices down. Such an outcome is recognised as undesirable and needs to be avoided by ensuring that the process is fair to all parties.

3.6. Aside from prices, there is a need to agree on technical issues relating to code structures and billing rules. As these have material affects on costs and behavioural incentives they also need to be properly and fairly negotiated.

4. STRATEGIC POLICY FRAMEWORK

4.1. In order to expedite resolution to the strategic challenges outlined above, a provisional policy framework has been developed for implementation both on an interim basis, and ultimately by way of legislation. It is however recognised that the interim framework will prove viable only with the consent of both medical schemes and providers. Achieving this consent within a voluntary framework may prove difficult, but will also be a test of the overall commitment of all parties to a fair process.

4.2. The policy framework envisages:

- The establishment of a process by which private health system prices can be negotiated collectively by all affected parties, through their representatives.
- The structuring of the process to:
  - Require completion of negotiations within discrete time periods;
  - Allow for the fair resolution of disputes by way of arbitration, which should also be completed within discrete time periods;
  - Ensure that no party can unfairly leverage off the process to serve a private commercial purpose.
- The ultimate production of the following outputs which shall be contained in a schedule published by the Council on an interim basis, and ultimately in terms of a legislated framework:
  - An agreed medical scheme tariff schedule;
  - An agreed provider price schedule;
  - An agreed code structure for prices;
  - Agreed billing rules and conduct of medical schemes in reimbursing providers;
  - An agreed general price change; and
  - An agreement on conduct in relation to balance billing.

4.3. Although the various private sector stakeholders will technically be colluding in this process, it is not seen as anti-competitive by the Minister or the Department. Instead this framework is seen as an important mechanism to achieve rational and sustainable prices and costs. As the process is fully sanctioned by the Minister and Department, and administered by the Council, it falls outside the domain of the Competition Act.

4.4. However, in order for parties to the process to be properly exempted from the Competition Act they would only be protected to the extent that they abide by the rules of the process, which should be consistent with the objectives of the policy framework.

4.5. An important design element of the negotiation process will involve the implementation of a mandatory dispute resolution mechanism by way of arbitration. This is seen as necessary to avoid the risk that the negotiations could rupture each cycle. Were negotiations to break down in this way, providers would have been permitted to sit together and discuss prices and price structures to the point of the breakdown, *de-facto* permitting collusion against final consumers as the final bid provider prices could now be implemented without further discussion or technical work. Were this to be permitted providers would have an incentive to negotiate, but not to reach agreement.

4.6. However, dispute resolution mechanisms could also be subject to tedious determinations and appeals. To achieve an expedited result it is proposed that an independent arbitrator be used who is permitted only to make a choice between competing bids within a limited time period, which would be no longer than a month. Importantly, the parties would only be permitted to present evidence to the arbitrator that had already been submitted to the negotiation process. In other words the parties would need to rely on arguments *already made*, and would be prohibited from developing new arguments purely for the arbitrator.

4.7. This dispute resolution mechanism is therefore seen as an important pro-competitive element which:

- Encourages parties to reach agreement without arbitration; and

- Encourages parties to rationally motivate their bids with hard evidence during negotiations, as any inconsistency in argument and evidence would increase the risk of a failure of their bid.

4.8. An important further outcome of the process would be that structural changes in prices can occur more frequently by way of direct negotiation, allowing for relative price changes in fee-for-service tariffs and prices that could not occur any other way. These structural changes would need to be evidence-based as they will be tested in open and transparent negotiations.

4.9. The multi-lateral negotiations would however in no way undermine normal bilateral negotiations conducted in a proper manner compliant with the Competition Act.

5. SHORT- AND MEDIUM-TERM TERM STRATEGY

5.1. The proposed framework for multi-lateral negotiations appears fine in concept, but may need refinement or alteration in practice. For this reason it is proposed that the industry test this approach on a voluntary basis as a prelude to a statutory framework. Flaws in the system, in particular any systemic unfairness against any party, could then be identified.

5.2. It is therefore envisaged that this interim process, conducted on a voluntary basis, operate for the 2011 and 2012 financial years, noting of course that very little of substance may be possible for 2011. It is however anticipated that the full legislated framework would be in place for the 2013 financial year.

5.3. It is envisaged that the interim process be implemented in terms of an exemption from the Competition Act. Prior to obtaining the exemption it is anticipated that discussions will begin between industry role-players on the detailed design of the interim process.

6. LONG-TERM STRATEGY

6.1. As already noted, it is planned that a comprehensive legislative framework, would be in place for 2013, which would require that legislation be considered for Parliament in 2011. Even if successfully passed in 2011, there

would be no time for the new framework to be in operation for 2012, thus necessitating the continuation of the interim process. However, the final framework should be able to operate during 2012 and help set prices for 2013.

7. AUTHORITY FOR THE PROCESS

7.1. To achieve the stated purpose of the policy framework requires a coordinated approach by a number of government and statutory structures to:

- Engage in consultations with stakeholders;
- Guide interventions in a pre-legislative phase; and
- Support the development and implementation of legislation.

7.2. Given that certain of the interventions need to occur during a pre-legislative phase, it is important to clarify from where the process derives its authority. In particular this relates to the prominent position required of the Council for Medical Schemes (Council) acting in support of the policy framework and process, particularly during the pre-legislative phase.

7.3. The Minister of Health (Minister) derives an authority to determine health policy through section **3(I) of the National Health Act of 2003**.

"*The Minister must, within the limits of available resources-*

(a) endeavour to protect, promote, improve and maintain the health of the population;

(c) determine the policies and measures necessary to protect, promote, improve and maintain the health and well-being of the population";

7.4. In terms of **section 7** of the *Medical Schemes Act, No.131 of 1998*, the Minister also has powers to allocate a function to the Council in addition to existing and equally relevant functions:

"*7. The functions of the Council shall be to—*

"(a) protect the interests of the beneficiaries at all times;"

"(b) control and co-ordinate the functioning of medical schemes in a manner that is complementary with the national health policy;"

"(e) collect and disseminate information about private health care;"

"(g) advise the Minister on any matter concerning medical schemes;" and

"(h) perform any other functions conferred on the Council by the Minister or by this Act."

7.5. To achieve the objectives of this process, and to expedite the setting up of a rational price-setting framework, it is envisaged that the Minister establishes a steering group consisting of various regulatory authorities to drive the initiatives outlined in this policy framework. In this regard the steering group will oversee the following:

- Implement interim measures and processes to stabilise price determination mechanisms in the private health system with the cooperation of private sector health stakeholders.
- In collaboration with the Department of Health (Department), supported by the Council for Medical Schemes, finalise a complete policy framework, which shall include the development of legislation, for the management and determination of prices in the private health system, through:
  - The establishment of a regulator for private health prices which:
    - Coordinates and manages multi-lateral price negotiations;
    - Enforces or supports the enforcement of compliance with all legislation relating to price determination in the private health system;
    - Determines benchmarks; and
    - Manages disputes arising from negotiations.
  - Full engagement with all stakeholders and role-players with a view to maximising consensus on the way forward, which stakeholders and role-players must as far as possible include:
    - Medical schemes;
    - Medical schemes intermediaries;
    - Health professionals;
    - Private and public hospitals;
    - Provincial health departments;
    - Consumer representatives;

- Manufacturers of medicines and medical products;
- Pharmacists;
- The Health Professions Council;
- The Pharmacy Council;
- The Medicines Control Council;
- The Nursing Council;
- The Competition Commission;
- The Pricing Committee; and
- National Treasury.

8. LEGAL CONSIDERATIONS

8.1. In establishing this policy framework, due consideration has been taken of the **Competition Act** which prohibits collusive practices and anti-competitive conduct in general. The policy framework outlined here has however been designed to achieve *pro-competitive outcomes* that favour the common good, particularly insofar as they *promote access to health services by protecting their affordability*.

8.2. In this respect it is well known that public health services are under severe pressure and the private sector needs to support the national imperative of universal health coverage. An objective that would be in peril if the imperfect market for health services, distorted by the need for health insurance, was permitted to operate without a correcting hand.

8.3. The **Competition Act** makes provision for collective action of this nature where it serves to achieve "*a non-commercial socio-economic objective or similar purpose*" (*section 3(1)(e)*).

> *"3. Application of Act*
> *(1) This Act applies to all economic activity within, or having an effect within, the Republic, except –*
>
> *(a) collective bargaining within the meaning of section 23 of the Constitution, and the Labour Relations Act, 1995 (Act No. 66 of 1995);*
>
> *(b) a collective agreement, as defined in section 213 of the Labour Relations Act, 1995; and*
>
> *(c) . . .*
> *Paragraph (c) was deleted by section 2 (a) of The Competition Second Amendment Act, 2000.*
>
> *(d) . . .*
> *Paragraph (d) was deleted by section 2 (a) of The Competition Second Amendment Act, 2000.*
>
> *(e) concerted conduct designed to achieve a non-commercial socio-economic objective or similar purpose."*

8.4. The non-commercial socioeconomic purpose of both the interim and final framework is consequently confirmed by the following:

- The private market for health care suffers from a number of systemic market deficiencies which, if not addressed through interventions such as these orchestrated by public authorities, will undermine access to health care in South Africa.
- The policy framework envisaged here is coordinated and implemented by public authorities that serve no private commercial purpose, and operate under the direction of the Minister.

8.5. The policy framework, therefore, in both its interim and final forms are not in conflict with the Competition Act.

9. PROCESS GOVERNANCE

9.1. The implementation of this policy framework has been assigned by the Minister to a steering group, who will oversee the process administered by the Department with the support of the Council which. The steering group

will manage the interim phase of this process, and advise on the ultimate approach. The details of this process, and the specific details outlining its governance as a project, will be provided in a separate report to be distributed by the steering group.

10. CONCLUDING REMARKS

10.1. In conclusion therefore, it is hoped that, despite its voluntary nature, all parties operating within the private health system cooperate to make this process a success. Ultimately it is to the advantage of all commercial actors in the private health system to protect its sustainability. This process therefore seeks to provide an opportunity for this to be achieved with the substantive participation, and hopefully consensus, of all affected parties in the interests of maximising universal access to healthcare in this country.

Annexure B: Draft Interim tariff negotiation process

Proposed voluntary process to establish healthcare tariffs under exemption from the Competition Act

1 November 2010

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Proposed process to arrive at negotiated healthcare tariffs

In my conception, however, there are only problems to confront and decisions to make. There is nothing to govern.

JODY FREEMAN[1]

1 Introduction

The recent high court judgement, nullifying the reference price list (RPL) regulations, has the result that there will not be an RPL to establish 2011 tariffs.

The current tariff structure is in need of being updated, and has resulted in uncoordinated changes to the tariff structure, which will be exacerbated in future.

This creates uncertainty with providers, members, and schemes on whether charges will be paid by medical schemes or not, resulting in members frequently not being covered for services provided using "new" tariff codes.

The CMS has engaged in discussions with various stakeholders to explore a process of determining tariffs through a multilateral tariff negotiation process with the aim of establishing a medical scheme tariff for 2011. The purpose of this process is not to replace the RPL, but to arrive at a negotiated tariff.

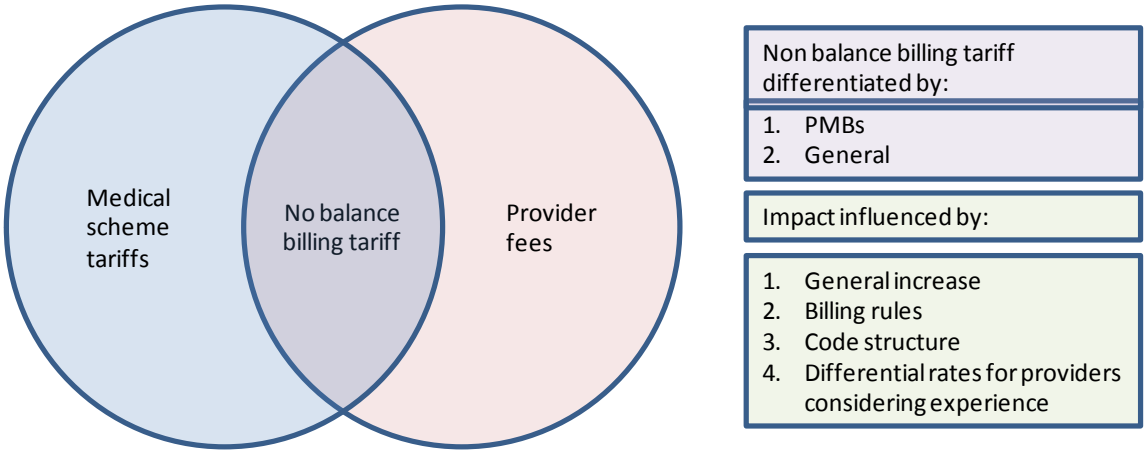
The purpose of this document is to present a proposal on a tariff negotiation process, and will be circulated to affected stakeholders before the negotiation process starts (See **Table 2**, page 30).

2 Focus of multilateral tariff negotiations

The focus of the process is to determine a non balance billing tariff fee and structure, medical scheme tariffs, and provider fees, through a process of multilateral negotiations. Figure 5 shows that this will specifically consider payment for PMBs versus other services, and would consider a general increase, billing rules, code structures and may include differential rates for providers based on their level of experience. Failure to reach agreement on these tariffs will result in an arbitration process, which will be binding on all parties.

[1] **The private role in public governance**. Jody Freeman. New York University Law Review, Volume 75, Number 3, June 2000

Figure 5: Objectives of, and key elements in multilateral tariff negotiations



Definitions of the terms used in Figure 5 appear in Table 1.

Table 1: Deliverables of the multilateral tariff negotiation process

Deliverable	*Definition*
1. Provider fees	• The final schedule of fees, which providers may charge, as agreed to by the negotiating parties • This may make provision for differential fees in accordance with qualifications, and experience • Discussion will be held with the HPCSA to make this the ethical tariff, and providers may not charge more than this rate unless they obtain informed consent from patients to do so
2. Medical scheme tariffs	• The final schedule of fees, which schemes will pay for, as agreed to by the negotiating parties
3. Allowable balance billing	• This is the difference between the provider fees and the medical scheme tariffs
4. No balance billing tariff: a. General b. PMBs	• This is the final schedule of fees arrived at through negotiation or arbitration, which must be paid for by schemes and for which providers may not balance Bill, unless there is an explicit agreement between the provider and the patient and the patient is informed that he/she will be responsible for the balance bill • This no balance billing tariff may differ between tariffs for PMBs and other benefits
5. General increase	• This is a percentage increase based on the existing rates, excluding changes to specific areas
6. Code structure	• The detailed description of procedures, and will be based on the RPL structure • New codes must be considered in the negotiation process
7. Billing rules	• This applies to the application of the modifiers, the use of duplicate codes, and others, and will be based on the RPL, with specific consideration to the latest SAMA billing manual
8. Differential rates (seniority)	• The purpose is to remunerate senior providers at a higher rate than junior providers • A process must be developed to ascertain seniority level

3 Time scale of project

Table 2: Activities in the determining of negotiated tariffs for 2011

Period	*Activities*
Month 1	• Meetings with affected stakeholders to finalise process , clarify uncompetitive conduct, obtain mandates for negotiations, appoint lead negotiators, nominate persons to serve on the arbitration panel, and to submit initial tariff proposals
Month 2	• Negotiations at discipline level • Submissions of consolidated tariff schedules • Acceptance of negotiated fees, or submission for arbitration
Month 3	• Arbitration finalised and final schedule published • Written reasons for decision within fourteen days
Month 4	• Last date for application to the courts for the review of the decision by the arbitration panel

At the conclusion of the project, the steering group will incorporate lessons learnt from this process into the consultative process on the development of a statutory pricing authority.

4 Logistic matters for consideration and governance of the process

4.1 Role of the CMS

4.1.1 Governance of the process: Tariff negotiation steering committee

A steering committee governs this process, and should consist of representatives from the HPCSA, the DoH, the Nursing Council, the Competition Commission, and representatives of the CMS who would include the Registrar of Medical Schemes, the Chief Financial Officer, the Head: Legal Services, the Head: BMU, the Head: Research and Monitoring, the Specialist: REF& & SPU, and the Advisor to the registrar.

The purpose of this committee is to guide the work of the Chairperson of the negotiation chamber, and to make resources available to support this process.

4.1.2 Chairperson of the negotiation chamber

The CMS must assign a chairperson from its staff for the negotiation chamber, who must also manage the project and ensure that deadlines are met. The chairperson should have a thorough understanding of the tariff structures and the dynamics of the respective groups.

4.1.3 Secretariat

The secretariat, which will assist the chairperson of the negotiation chamber on a project basis, must be appointed by the CMS and should constitute of an administrative person, a legally qualified individual, and an individual with a qualification in finances.

4.1.4 Logistics and other support

The CMS will provide boardroom facilities, printing, photocopying, faxing, and other support facilities.

4.1.5 Establishment of an arbitration panel

The CMS must appoint and fund an arbitration panel. Negotiating parties must submit proposals for individuals that are suitable candidates to serve on the arbitration panel to the CMS. The chairperson of the panel must have a good technical understanding of the tariff structure, and have a full understanding of the dynamics in this environment. Two additional members with technical and legal knowledge of the subject matter must be appointed to support the arbitration chairperson.

Members of the arbitration panel may not have any interest in the outcome of the negotiations or the arbitration process.

4.2 Constitution of negotiating parties

The mandates required for participation are discussed in section 4.3 (page 33).

4.2.1 Lead negotiators

The providers and funders must each appoint two lead negotiators who are mandated to agree to items for inclusion / exclusion on the full chamber (c.f. paragraph 5.1, page 33).

4.2.2 Groupings of health care providers

Considering the large number of groupings and the limited available time, it is proposed that a single session be held with all of these groupings and the funders, where a general tariff increase is negotiated.

Table 3: Health care provider groupings

Groupings for which tariffs exist (Excluding medical practitioners)		
Ambulance Services	Medical Technology	Psychology
Biokinetics	Mental Health Institutions	Psychometry
Chiropractors	Occupational and Art Therapy	Psychometry and Registered Counselors
Clinical Technologists	Optometrists	Radiography
Dental Practitioners	Orthoptists	Radiology
Dental Therapy	Osteopathy	Registered Nurses in Private Practice and Nurse agencies
Dieticians	Physical Rehabilitation Hospitals	Social Workers
Genetic Counselors	Physiotherapy	Speech Therapists and Audiologists
Hearing Aid Acousticians	Phytotherapy	Sub Acute Facilities
Homoeopaths	Podiatry	Tissue Transportation
Hospices	Private Hospitals	Unattached Operating Theatre Units

4.2.3 Medical practitioners

Due to the diverse nature of health care services rendered by medical practitioners, it is proposed that they are grouped together in 10 groups (10 individuals), as indicated in **Table 4**.

Table 4: Proposed grouping of medical practitioner disciplines for tariff negotiations

Discipline group	*Proposed number of delegates*
1. Radiology (Including Nuclear Medicine, Radiation Oncology	1
2. General Practitioners	1
3. Anaesthesiology	1
4. Obstetrics and Gynaecology	1
5. Medicine (Specialist Physician), (Including Pulmonology, Gastroenterology, Neurology, Cardiology, Physical Medicine, Rheumatology,)	1
6. Psychiatry	1
7. Medical Oncology	1
8. Paediatrics (Including Pulmonology, Gastroenterology, Neurology, Cardiology)	1
9. Surgery (Including Otorhinolaryngology, Ophthalmology, Plastic and Reconstructive Surgery, Urology, Cardiothoracic Surgery, Neurosurgery, Orthopaedics)	1
10. Pathology (Clinical and Anatomical)	1

4.2.4 Private hospital groups

Provider negotiators should include representatives from private hospitals, hospices, and unattached operating theatre units. A maximum of 10 negotiators is allowed.

4.2.5 Public hospitals

Provider negotiators should include representatives from public hospitals. A maximum of 10 negotiators is allowed.

4.2.6 Funders

In order to balance the numbers and expertise, a maximum of 10 negotiators is allowed.

4.3 Mandate required for participation

4.3.1 Basis for exemption from Competition Act 89 of 1998

Completion of the entire negotiation process and acceptance of its outcome would be required to qualify for exemption from the competition Act. Should any participant not complete the full process, collusion / concerted efforts by any party preceding this point would constitute a contravention of the competition Act.

Note that collusion by parties who do not fully participate in this process may be a contravention of the Competition Act.

4.3.2 Complete mandate given to negotiators

All parties agreeing to participation must submit a formal agreement indicating that they are fully mandated to negotiate on behalf of their grouping and that the outcome of the negotiations is binding on all parties. This mandate, which appears in draft format in Annexure C (page 37), explicitly states that full negotiation powers is assigned to the representatives, and that the mandators agree to fully abide by the outcome of the negotiation or arbitration process.

A formal process will be set up where the formal mandate given to representatives is submitted to the CMS prior to the commencement of negotiations.

5 The negotiation process

5.1 Agreement on items that will be negotiated

Due to the limited time available, negotiators must agree on the high priority items that need to be addressed in 2011. This must include a general tariff increase, and specific items that may be raised by any party.

Given the time constraints for 2011, the chairperson of the negotiation chamber, with the assistance of the steering committee, and in collaboration with the lead negotiators, must determine the final items for negotiation. The following items must be considered for 2011:

- General increase
- Medical scheme tariffs
- Provider tariffs (including all hospital services, professional services and procedures)
- All relative values used to arrive at a tariff whether scheme or provider
- Tariffs applicable to PMBs
- Billing rules
- Information to be supplied on accounts to patients and medical schemes
- Permissible levels of balance billing on tariffs

5.2 Submission of position documents

After the items for negotiation have been agreed to, all parties must submit their proposed tariffs / documentation in this respect.

5.3 Detailed negotiations with provider sub-groups

The secretariat must distribute all documentation pertaining to subgroups and arrange meetings.

5.4 Preparation and submission of consolidated tariff lists to negotiation chamber

Wherever agreements have been reached at the subgroup levels, these must be submitted to the chamber as a consolidated document, and separate documents pertaining to items that could not be resolved must be submitted to the full chamber.

5.5 Agreement on non balance billing tariff or submission to arbitration

When full agreement is reached on all items, a non balance billing tariff and the medical schemes tariffs must be published by the CMS. It is suggested that the HPCSA publish the provider tariffs. Where parties fail to agree, the parties must make submissions to the arbitration process as detailed below.

6 The arbitration process

6.1 Submission of documentation for arbitration

Three sets of tariff schedules (medical scheme tariffs, non-balance billing tariffs, and provider tariffs), along with full motivations, must be submitted by the parties for consideration by the arbitration panel.

The structure of the submissions to the arbitration panel must be agreed to by the parties. Each submission must consist of a complete tariff structure, with billing rules and fee levels, which could potentially be selected by the arbitration panel as the final set of tariffs.

To assist the arbitration panel, the submissions must clearly identify areas where agreement has been reached, and highlight areas of the tariff schedule where agreement was not reached.

6.2 Arbitration costs

Each party shall bear its own costs in respect of submissions and presentations made to the arbitration panel. The panel does not have the power to make a costs order.

6.3 Consideration of submissions to the arbitration panel

To prevent the framework from indirectly permitting collusion by parties, the process may not conclude without a result.

In order to allow for speedy resolution of any failure to reach agreement, final contract arbitration (also known as pendulum arbitration)[2] must be applied.

6.3.1 Factors for consideration by the arbitration panel

a. Only the submissions referred to in paragraph 6.1 may be considered
b. The arbitration panel may not amend any of the proposals in any manner, and may select only the most reasonable proposal
c. The duty of the panel is to support the public interest position, and it may consider the affordability of the proposals, bearing in mind that providers may exit the market, resulting in the public not having access to services in the event of prices being too low.

6.3.2 Opportunity for presentations

The arbitration panel may grant parties the opportunity to make oral submissions in favour of written proposals.

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[2] "*Pendulum Arbitration refers to a determination in industrial disputes where an arbitrator has to resolve a claim between a trade union and management by making a determination of which of the two sides has the more reasonable position. The arbitrator must choose only between the two options, and cannot split the difference or select an alternative position. It was initiated in Chile in 1979 and has proved to be a very effective mechanism.*" (http://en.wikipedia.org/wiki/Arbitration, Accessed 26 August 2010)

6.4 Pronouncement of decision and furnishing of reasons

A determination by the arbitration panel is final and binding on all parties, with parties participating in the process consenting to this condition from the outset. No appeal will lie against any decision of the arbitration panel, and any referral to the courts will be limited to the extent of the provisions contained in section 33 of the Arbitration Act. The panel shall make its decision available within 14 days, and shall provide written reasons for such findings within 28 days.

The publication of these findings is required to be in accordance with the specifications contained in paragraph 5.5 (page 34). Upon publication, the findings will become the enforceable tariffs.

7 Considerations in respect of role-players not participating

Parties choosing not to participate will remain subject to the Competition Act and accordingly be obliged to hold bilateral negotiations. Where no bilateral contract is entered into, parties may use the non-balance billing tariff schedule provided that these are not unilaterally amended and that these amendments do not constitute any contravention of the Competition Act.

Annexure C: Special power of attorney given to negotiators in the health tariff negotiation process

Personal details

1. I, (**full names)** ……..

   with ID number, (**ID Number**) ……., of

   (**work address**) ……. employed

   by (**Employer**) …… will participate

   in the (**provider / funder**) …… delegation.

2. I am duly appointed by the parties in **Table 5** (page 39) of this mandate (where the number of parties appointing me exceeds 10, a separate list must be appended as Annexure E on page 43).

Full mandate

3. I declare that the parties on whose behalf I have been mandated, (in paragraph 13) have granted me full authority to participate in this process on their behalf, and that they have agreed to abide by the outcome of this negotiation and its processes as fully set out hereunder.

Agreement with the process

4. I, together with the parties that have mandated me, accept the negotiation and arbitration process, as outlined in the document titled "**Proposed process to establish healthcare tariffs for 2011, Draft 1.06 of 7 October 2010"**
5. I am authorised to agree to changes in the process outlined above, where such changes have been duly considered by the negotiating parties and where the chairperson of the negotiation chamber has accepted these changes as reasonable.
6. On agreement of any aspect in the negotiation chamber, such agreement shall be binding on the parties on whose behalf I have been mandated.

Acceptance of the outcome of an arbitration process as binding and review by the court

7. The arbitration panel shall resolve any dispute referred to it by making a determination on which of the sides to the dispute has presented the most reasonable position.
8. I, along with the parties that have mandated me, agree that we will fully abide by the tariff schedule and other items if the negotiations are not concluded and an arbitration panel has made a final pronouncement. We accept that the arbitration process is binding on all parties.

9. Any party not satisfied by any decision of the arbitration panel, shall be entitled to apply for review and setting aside of such decision by the arbitration panel in any court having jurisdiction, and such review application shall be brought within the ambit and the grounds provided for in section 33 of the Arbitration Act (see Annexure D) .
10. In the event that a party applies for the review of a decision by the arbitration panel, the decision of the arbitration panel shall be of full force and effect until the decision has been overturned by the court.

Implication of premature withdrawal from the negotiation process and the Competition Act

11. I, together with the parties that have mandated me, undertake and agree not to withdraw from this negotiation and arbitration process, and we are aware that withdrawal from this process before its final conclusion might constitute a contravention of the Competition Act.
12. I, and the parties that have mandated me, are aware that any concerted efforts to agree to fees or tariffs by any group outside of this process, may constitute a contravention of the Competition Act.

Organisations mandating me to participate on their behalf

13. Organisations that have mandated me to negotiate on their behalf are listed in **Table 5** (page 39), and are fully appraised of the extent of the mandate given to me and in terms of their signatures hereunder, bind and commit themselves to the express terms, spirit and purport of this mandate and to the negotiation and arbitration procedure set out in this mandate.

Table 5: Schedule of organisations / groupings / individuals giving special power of attorney to negotiators (should the number of parties appointing the negotiator exceed 10, a separate list must be appended as Annexure E, page 43)

Full names and surname	*Employer*	*Work address*	*Representing (Provider organisation, Association or scheme)*	*Signature of the person appointing the individual in paragraph 1, (page 37)*	*Date*	*Place*	*Witness name*	*Witness signature*
1.								
2.								
3.								
4.								
5.								

Full names and surname	*Employer*	*Work address*	*Representing (Provider organisation, Association or scheme)*	*Signature of the person appointing the individual in paragraph 1, (page 37)*	*Date*	*Place*	*Witness name*	*Witness signature*
6.								
7.								
8.								
9.								
10.								

Negotiator receiving special power of attorney:

Signed: ……

Full names: ……

Date: ……

Place: ……

Witness 1:

Signed: ……

Full names: ……

Witness 2:

Signed: ……

Full names: ……

Annexure D: Section 33 of the Arbitration Act 42 of 1965

33 Setting aside of award

(1) Where—

(a) any member of an arbitration tribunal has misconducted himself in relation to his duties as arbitrator or umpire; or

(b) an arbitration tribunal has committed any gross irregularity in the conduct of the arbitration proceedings or has exceeded its powers; or

(c) an award has been improperly obtained,

the court may, on the application of any party to the reference after due notice to the other party or parties, make an order setting the award aside.

(2) An application pursuant to this section shall be made within six weeks after the publication of the award to the parties: Provided that when the setting aside of the award is requested on the grounds of corruption, such application shall be made within six weeks after the discovery of the corruption and in any case not later than three years after the date on which the award was so published.

(3) The court may, if it considers that the circumstances so require, stay enforcement of the award pending its decision.

(4) If the award is set aside the dispute shall, at the request of either party, be submitted to a new arbitration tribunal constituted in the manner directed by the court.

Annexure E: Additional parties appointing the negotiator referred to in paragraph 1 (page 37) of Annexure C, not included in Table 5 (page 39)