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Introduction

The South African Medical Association ("SAMA") is the professional association for doctors in South Africa and welcomes the opportunity to make a submission in accordance with the provisions of Circulars 69 of 2005 and 1 of 2006 regarding the National Health Reference Price List (NHRPL) process for 2007.

SAMA reaffirms its support at measures aimed at making health care more accessible and affordable. This harmonizes the rights entrenched in section 27 of the Constitution of the Republic of South Africa. However, it must be ensured that, in progressively realizing the above rights, the public interest and patients' health must remain paramount, and, in support of this the sustainability of medical practice is fundamental.

From the onset, it should be noted that SAMA commissioned a firm of actuaries and consultants, namely, Fifth Quadrant to assist its two private practice committees, the General Practitioner Private Practice Committee and the Specialist Private Practice Committee, and the Private Practice Unit with the preparation of the SAMA submission in respect of the NHRPL process for 2007.

The Council for Medical Schemes deserves to be complimented on the development of the model that has been prescribed for the NHRPL process for 2007.. However, it could not have been expected that a single model would perfectly fit all the role-players in the process and suggestions have accordingly been made to the model where it was deemed to be appropriate. All concerned would probably be *ad idem* that the NHRPL process in its current format is in its infancy and it is likely that a number of further iterations will be required along the road to the desired model. With this in mind, certain issues have been highlighted and suggestions made toward further improvements of the process and further engagements on those issues and suggestions will be welcomed.

The basis for all the calculations that were made during the preparation of the submission that accompanies this report is the prescriptions encompassed in Circulars 69 of 2005 and 1 of 2006 of the Council for Medical Schemes, as well as the model spreadsheet that accompanied Circular 1 of 2006. To the extent that it was possible, the formulae in the said spreadsheet were retained and where changes were believed to be justified a consistent approach was followed across all disciplines.

As was expected, the single biggest challenge in the NHRPL process thus far related to the collection and collation of sufficient data for us to develop enough confidence in the quality and the reliability of the submissions that are being made. This is especially true in light of the fact that the data that was provided with originated from different sources, and was collected against very stringent time frames and, in some instances, represents fairly small sample sizes. To this end, the raw data that was provided was subjected to robust statistical analyses and certain recommendations have been made as a result of these analyses.

Where sufficiently reliable data could not be sourced locally, data from international databases, notably the database of the Centres for Medicare and Medicaid Services (CMS) in the United States of America has been accessed. Although this approach proved not to be absolute, it allowed for a consistent approach and the application of the same formulae across all disciplines. Anomalies and oddities did inevitably arise, but these have been highlighted in the various submissions themselves and will have to be addressed through, we believe, a consensus seeking approach.

In terms of the minimum requirements outlined in Circular 69, each submission should be based on the following information:

1. The range of item codes and descriptors to which the submission pertains;
2. The responsibility values with regard to each item code and descriptor;
3. The relative utilisation of each item code and descriptor;
4. The overhead costs of the affected discipline/profession;
5. The cost of any specialised equipment that may be required or put to use;
6. The average duration of each procedure or service; and
7. The benchmarked professional income of the affected discipline or profession.

With the exception of specialised equipment data/information has been received pertaining to all of the above parameters and submissions have been prepared accordingly. Due to the variety and the complexity of the issues pertaining to the specialised equipment, it was our brief to exclude all specialised equipment from the submissions for 2007. These will and should be dealt with during a next round of submissions. However, the acquisition cost of the specialised equipment has been taken into account in the calculation of the provisions for bad debt as per the prescribed formulae.

Data received

Data was received from various sources and pertaining to a variety of disciplines:

Discipline	Data source
1. Anaesthesiologists	South African Society for Anaesthesiologists (SASA) survey
2. Cardio Thoracic surgeons	South African Society for Cardio Thoracic Surgeons (SASCTS) survey
3. Cardiologists	HealthMan
4. General practitioners	SAMA survey
5. Gynaecologists	HealthMan
6. Neurosurgeons	HealthMan
7. Ophthalmologists	HealthMan
8. Orthopaedics	HealthMan
9. Otorhinolaryngologists	HealthMan
10. Paediatricians	HealthMan
11. Physicians	HealthMan
12. Plastic and Reconstructive Surgeons	SAMA survey
13. Psychiatrists	HealthMan
14. Pulmonologists	HealthMan
15. Rheumatologists	HealthMan
16. Urologists	HealthMan
17. Vascular surgeons	SAMA survey

The data that was received varied significantly in terms of:

- Sample sizes;
- Quality; and
- Level of detail.

In order to accommodate these variations, some data cleansing had to be performed during the statistical analyses of the data. The detail of the data cleansing will be expanded on in the section on the statistical analyses, but it has at this juncture to be emphasised that no auditing of the data that was received was performed. Auditing of the data was not part of our brief and the results of the analyses that are reported on in this report are reflective of the data as we received it.

In addition to the data provided, the groups mentioned above have submitted varying degrees of structural changes to their coding systems. In some instances these changes were limited to isolated codes, while in other instances a complete changeover to a Current Procedural Terminology (CPT®) structure, or a hybrid of that structure, is being suggested. The details of these suggested changes will be addressed in the discussion pertaining to the relevant disciplines.

To the best of our knowledge, the relevant specialist societies as well as SAMA and its Specialist Private Practice Committee have sanctioned these suggested changes.

It is believed that there may be some issues pertaining to the intellectual property and copyright of the American Medical Association (AMA) insofar it concerns the use and the placing in the public domain of the CPT® system. These issues, if they are still in existence, have to be resolved between SAMA and the AMA and fall beyond the scope of this report, save to say that it has for the purposes of this report, been assumed that those issues either have been or will be resolved in time for the encompassing of the suggested changes in the NHRPL for 2007.

Variables

In order to calculate the cost associated with the provision of each service and performing of each procedure, a number of variables that contribute to these costs have to be taken into account. Circular 69 prescribes specific approaches to the calculation of each of the variables, in addition to the conversion of the costs to a cost per minute. The latter is based on certain standard volumes of available time and certain productivity factors. It allows for a multiplication of the cost of the variables with the average duration of the procedures and services in order to arrive at a NHRPL cost for every service and procedure.

Practice costs

In the case of medical practitioners these costs should represent the running costs (exclusive of value added tax) of a medical practice including the costs pertaining to the acquisition and maintenance of furniture, fittings and equipment, the staff salaries, provisions for bad debt and the professional income of the medical professional to whom the practice belongs.

Time factor

The time factor should represent the average time that a procedure or service takes. Circular 69 requires that these times be surveyed across a statistically representative sample of each procedure.

Responsibility factor

The fact that different procedures and services require different amounts of knowledge, skill and judgment and that there are different risks attached to certain procedures and/or services, relative to others, is acknowledged. Circular 69 requires that members of a discipline score each service and procedure that is provided or performed by a specific discipline.

The scoring is then indexed by determining a relative weighting according to the estimated time use profile for each service and procedure. This estimated time use profile is also determined through estimation by the members of a discipline.

Ultimately the responsibility factor is applied to the time factor, in order to “correct” the time factor for the responsibility associated with each service and/or procedure.

Labour

The labour component, in essence, represents the human resources that are associated with the rendering of services and procedures. These human resources can either be directly involved in the rendering of services and the performing of procedures or provide indirect support to those that are directly involved in the provision of services and/or the performing of procedures.

Direct labour

The direct labour component refers to the direct or “hands on” involvement in a service or procedure. In most instances this would involve the medical professional's time and he/she may or may not require the assistance of an assistant, such as a professional nurse, radiographer etc. The involvement of the latter should however be based on standard medical practice, as opposed to personal preference.

Indirect labour

The indirect labour component refers to the human resources that are required to support the normal functioning of a medical practice. Examples would include the receptionists, accounting staff and cleaning staff, all of whom are not directly involved in the clinical management of patients.

Utilisation statistics

The utilisation statistics refer to the frequency of occurrence of each service and procedure within each discipline. In terms of Circular 69 these frequencies should be calculated according to the estimated percentage of the available time spent on each of the services and procedures.

Methodology

Circular 69 prescribes specific methodologies to be used for the collection of data as well as the statistical analyses of that data.

Data collection

Data on the practice costs should be collected through surveys in a prescribed format of practices belonging to a specific discipline. Various role-players through electronic and/or manual media conducted these surveys and data was received from:

- The South African Medical Association;
- HealthMan (Pty) Ltd;
- The South African Society for Anaesthesiologists; and
- The South African Society for Cardio Thoracic Surgeons

As has been stated before, the auditing of the data that has been received fell beyond the scope of our brief and hence the data was assumed to be correct and the processing thereof performed accordingly.

Statistical analyses

Circular 69 prescribes a basic analysis methodology for the analysis of the practice cost data, through which an arithmetic mean should be determined, together with a calculation of the 95% confidence interval to that mean.

The objective of calculating the 95% confidence interval to the mean is to enable a “correction” of the mean for any uncertainties in terms of issues such as the size of the sample and variations in the data.

Model

Finally, Circular 69 prescribes a model which accompanied Circular 1 of 2006, into which the data and the variable that have been described had to be imported in order to calculate the NHRPL rates for the various services and procedures.

Issues encountered

During our analysis of the data and the submissions that were received, specific issues were encountered. The purpose of this section is to highlight those issues in general terms, while the issues that have been encountered in terms of the specific submissions that were received will be discussed in the sections dealing with the specific submissions.

Practice costs

The data that was received on the practice costs in many, but not all, cases represented relatively small sample sizes. In addition, large variances in the total costs were observed with no specific trends in terms of geographical location and/or practice sizes. Therefore, it was not possible to develop a logical stratification of the data, either according to practice size or geographical location and the data was analysed per discipline only, without taking into account any other possible causes of variation in the data.

The fact that the sample sizes were relatively small also made the mean very susceptible to outliers with very large confidence intervals. In some cases big differences between the median and the mean were observed. These issues will be addressed in more detail in the section that deals with the specific submissions that were received.

Time factor

The collection of surveyed data on the average duration of services and procedures turned out not to be feasible, mainly as a result of the costs that would be associated with following the procedures as prescribed in Circular 69. Furthermore, the time available for the finalisation of the submission to the NHRPL 2007 was insufficient to allow us to embark on a project of this magnitude, in addition to conducting practice cost studies.

Attempts were made to obtain data pertaining to theatre times and the average length of stay of patients from the private hospital groups through the Hospital Association of South Africa (HASA) as well as certain individual groups such as MediClinic. Unfortunately, it became evident that this data would not be suitable for use during the preparation of a submission in respect of the NHRPL for 2007:

- The level of accuracy of the CPT® coding applied by the hospital groups seemed to be inadequate;
- The data provided by the hospital groups represented so-called “clock time”, which does not necessarily correspond with the actual duration of a procedure; and
- It was not possible to obtain accurate average lengths of stay in intensive care units, high care units and general wards respectively per procedure.

Responsibility factor

The prescribed process for the determination of the responsibility factors for every service and procedure cannot be faulted, but to the extent that data was received on the responsibility factors that were determined according to the prescribed process, it did seem that the scores were consistently high within each discipline. This, to a very large extent defeated the object of establishing a relative responsibility value between the various services and procedures.

More importantly though, the prescribed methodology does not take into account the fact that within the medical profession many services and procedures are performed by more than one discipline in the profession. Therefore, it is possible that the same procedure can have different responsibility factors, depending on which discipline the person performing the procedure belongs to. It is not believed that this would be a sustainable situation and it is also not in line with international practices. Furthermore, it is our understanding that one of the fundamental principles behind the NHRPL process is that the NHRPL rates should as far as possible reflect

the cost of the rendering of specific services. If this is the case, it follows that the only basis by which the NHRPL rate for the same procedure can differ from one discipline to another should be the cost of performing that procedure, exclusive of the influence of a responsibility factor.

The CPT® system for example has over the years gone through a number of iterations, that were supported by research conducted by the Harvard University, in order to achieve a balance between the inter-disciplinary relationships and relativities between procedures.

Labour

The costs associated with the human resources required to render medical services have in Circular 69 been suggested to be benchmarked against the salaries that staff in a similar category would earn in the public sector. Given the purpose of the NHRPL, it is believed that this approach fundamentally makes sense, but, at the same time, it is believed that, in practical terms, it will not be possible to apply this principle throughout:

Direct labour

There are two direct labour components:

- The medical professional him-/herself. The expected professional income of the doctors in the practices is prescribed to be benchmarked against that of their peers in the public sector. This prompts questions on who their peers are and at what level those peers are employed. No official information on the answer to those questions could be obtained. It appears that the averages between levels 12 and 13 and 14 and 15 in the public sector have been used as the suggested benchmarks for general practitioners and specialists respectively.

If this is reasonable, clarity needs to be obtained regarding the extent to which the added or “fringe” benefits should be taken into account in the calculation of the benchmark professional income level.

- It also seems that the expected salaries of the health care assistants that are employed by the doctors are to be benchmarked against the salaries of similar categories of staff in the public sector. This is not believed to be a realistic approach, because it does not represent a true reflection of the cost of providing the services where the services of staff in these categories are required. The reality is that, in order to recruit and retain staff in these categories, significantly higher salaries than those in the public sector have to be offered. It is also common knowledge that the public sector is experiencing difficulties in the recruitment and retention of staff and it is submitted that one of the reasons for this is the salaries that are offered by the public sector.

Indirect labour

The issues that were identified insofar it concerns the support staff are similar to the ones that have been raised with regard to the direct labour components, except that it is unlikely that it will be possible to consistently apply public sector employment categories to staff that are employed in private practices. The duties performed by receptionists and accounting staff in private medical practices is in many respects unique and the salaries that are paid are to a large extent determined by market forces.

Utilisation statistics

The prescribed process for the determination of utilisation statistics through an estimation of time utilisation profiles proved to be very difficult, if not impossible, to apply practically. The main reason for this is the subjectivity that is associated with estimations of this nature.

Time and financial constraints do not allow for objective measurements of the time use profiles of the various services and procedures.

Suggested approaches

The purpose of this section is to describe the alternative approaches to the prescribed approaches that have been followed in order to address the issues that have been highlighted in the preceding section.

Practice costs

As it has been stated before and will be further highlighted in the section pertaining to the specific submissions that were received, the arithmetic mean seemed to be highly susceptible to outliers in the samples and the confidence intervals were in many cases excessively large.

The sample medians, however, consistently reflected a more reasonable midpoint estimate for practice costs than the mean or any other variants. The ranges in which the median fell also represented the area where most practice costs were prevalent. The formulae in the model spreadsheets have been amended accordingly in that the medians, rather than the means, were applied throughout.

The model spreadsheet, at least to an extent, allows for separate reporting of equipment and salary costs, which proved to be the correct approach. Once the provisions for salaries, equipment and bad debts were removed from the practice cost data, the degrees of fluctuation in the costs seemed to reduce quite significantly. In fact, a fair level of consistency was observed, to the extent that the data of certain groups could be merged and analysed together, rather than separately. This approach caused vast improvements in the confidence interval, but it is maintained that the median would provide a more accurate reflection of the average practice costs especially as it is less susceptible to outliers.

In calculating the median of all practice costs, excluding provisions for salaries, equipment and bad debt, a detailed completion of the "Overheads" page in the model spreadsheet becomes problematic, because the sum of the medians of each of the components will never add up to the median of the total costs. Hence the number of lines in the "Overheads" page has been reduced to reflect the median of the total costs plus the provisions for salaries, equipment cost and bad debts.

The detailed data that has been received and analysed has for practical reasons not been included in this report, but it can be made available on request.

Time factor

The difficulties that were experienced with the collection of time data proved to be one of the biggest challenges in the preparation of this report and submission to the NHRPL process. As has been explained earlier, it proved to be impossible to either collect local data or to use the local data that is available.

However, research that was conducted revealed that the time data that is being used by the Centre for Medicare and Medicaid Services in the United States of America in the determination of the Relative Value Units in the Resource Based relative Value Unit System (RBRVS) is in the public domain and can be downloaded from the Centre for Medicare and Medicaid website. The downloadable database contains times for pre-operative services, intra-operative services, as well as post-operative services. In most instances the sum of the times of these three categories of services equals the total time for the procedure. However, it was not consistently

the case, as in some instances some of the services are excluded and only the total time is reflected.

In addition, it seems that the total times are in many instances excessive, which is due to two main reasons:

- The way in which procedures are billed for in the Medicare and Medicaid environments differ from the South African environment in that total or global fees that include pre-, intra- and post-operative care are often raised; and
- The times that are reflected in the database are used for the development of indices in the RBRVS system, meaning that they are often relative, as opposed to absolute.

However, barring a few exceptions, which are all self-evident in the specific submissions, the intra-operative times seem to correspond well with South African practice. This is to be expected, because there are very little, if any, differences in the nature of procedures that are performed by doctors throughout the world. As a result it is recommended that the Medicare and Medicaid database be used as a point of departure for the determination of the duration of procedures. This is not only a cost-effective approach, but it will add to the overall credibility of the NHRPL, due to the ability to benchmark against internationally accepted standards.

Where intra-operative times are not available in the database, it is recommended that the total times are used, as it does, in general terms, seem that these times are reflective of South African practices for the affected procedures.

Therefore the recommended approach is that the intra-operative times in the Centre for Medicare and Medicaid Services time database is used to determine the duration of the procedures in the NHRPL, but with two exceptions:

- Where intra-operative times are not reflected in the database, the total times are used, and
- Where the time that is extracted from the database is obviously incorrect, manual adjustments, which could be either up or down, will be required, but such adjustments will have to be properly substantiated and the reasons recorded for future reference.

This recommended methodology has consistently been applied in all the submissions and model spreadsheets that are attached to this report. However, it has to be noted that the use of the intra-operative times do not account for in- or out-of-hospital post-operative care, including care in intensive and high care units. These should be included in the procedure times, due to the vast differences in the extent of the post-operative care that different procedures require no consistent formula could be developed for this purpose. Hence, it is suggested that a mutually acceptable approach be jointly developed between SAMA and the Council for Medical Schemes on this issue once the content of the submissions has been studied.

Furthermore, the times that have been imported into the model spreadsheets have been shown to be highly dependent on the accuracy of the crosswalks between the current SAMA structure and the CPT® structure. In order to obtain these crosswalks a combination of the SAMA crosswalk and the Medcodelink crosswalk as well as crosswalks that have been received for some of the individual disciplines have been used, but there may still be some inaccuracies that require amendment.

Responsibility factor

The “work” relative value unit in the Resource Based Relative Value System, comprises the following:

- The time required to perform a procedure;
- Technical skill and physical effort;
- Mental effort and judgement; and
- Psychological stress associated with the practitioner's concern about iatrogenic risk to the patient.

Therefore, it is submitted that the "work" relative value unit in the RBRVS is equivalent to the Responsibility Factor in the NHRPL model plus the time that it takes to perform a procedure. Since the time is a known factor from the Centre for Medicare and Medicaid Services database, the RBRVS equivalent of the Responsibility Factor can be calculated.

It is believed that this approach would add substantial credibility to the NHRPL process in that:

- It has been developed and is still being continuously improved by the Harvard University through a process that is as devoid of subjectivity as is probably possible;
- It takes into account the interdisciplinary relationships insofar it concerns procedures that are performed by more than one discipline; and
- It establishes a principle that can be used in the future.

This methodology has been applied to all of the submissions that accompany this report, but although the normalisation of the responsibility values has been applied according to the model spreadsheet, it is believed that the application of this methodology obviates the need for such normalisation.

Labour

As has been pointed out in a previous section of this report, certain issues have been encountered with the calculation of the costs associated with human resources:

Direct labour

As far as the doctors are concerned, consensus on the appropriate level in the public sector against which doctors in the private sector should be benchmarked, given the fact that they incur certain risks that their peers are not equally exposed to in establishing a private practice. These risks *inter alia* include:

- The increased risk of litigation;
- The investment risk associated with the capital and other expenditures that are required for the establishment of a practice;
- Risk of an incorrect location of a practice; and
- The exposure to macro and micro-economic fluctuations.

In addition, it would only be fair for the fringe benefits that the public sector employees enjoy to be included to the total professional income that is used as a benchmark for those that practice in the private sector.

Although the figures that have been provided in the model spreadsheet have essentially been retained, a draft model that can assist in the calculation of the total actual value of the public sector employees' salaries has been developed and can be made available. The level against which specialists and general practitioners should respectively be benchmarked is a subject for debate between the Council for Medical Schemes and the South African Medical Association and that falls beyond the scope of our brief.

Indirect labour

As has been indicated before, it is not believed that the salaries of the employees in the private practices can realistically be benchmarked against public sector salaries. Therefore, the salaries

that are reflected in the submissions are based on the average salaries that have been obtained through the practice cost surveys.

Utilisation statistics

Due to the fact that difficulties were experienced with the collection of accurate, reliable and objective time usage data for each procedure and service, it is suggested that the utilisation statistics rather be determined from actual claims data.

To this end, SAMA's consultants have got access to the claims data of approximately 1,2 million lives and the utilisation statistics in the submissions are based upon the claims experience in that patient pool. It is acknowledged that the statistics that have been obtained may not be a 100% reflection of the trends in the private health care industry as a whole, but the trends are unlikely to differ significantly. It should also be possible to simply update the utilisation statistics when further data with regard to the utilisation statistics can be obtained.

Process

Taking into account the issues that were encountered and the suggested methodology that has subsequently been developed the following steps have been followed in the development of model spreadsheets for each submission that was received:

1. Using a combination of the various crosswalks between the SAMA structure and the CPT® structure that are available, a mapping of each CPT® code to a SAMA code or *vice versa* was performed;
2. Where a CPT code was available the corresponding intra-operative time (or total time) was imported from the Centre for Medicare and Medicaid Services database;
3. Where there was no CPT® code available the default time value was made zero;
4. Where there was a CPT® code available a responsibility value that was derived from the RBRVS Work RVU and calculated to be between 1 and 2 was imported;
5. Where there was no CPT® code available the default responsibility value was made 1;
6. Where there was a SAMA code available the expected utilisation was determined according to a count in actual claims data of the corresponding code for a specific discipline;
7. The estimated time use profile was computed by expressing this account as a percentage of the total;
8. Where a SAMA code was not available the default estimate time use value was made zero;
9. The 2007 revenue was computed by multiplying the estimated utilisation (count of the codes from the claims data) with the calculated NHRPL 2007 value.

Although not optimal, it is believed that his process provides a sound basis for the further development of the NHRPL, but it has to be taken into account that:

1. Post-operative care is not accounted for;
2. Equipment costs, to the extent that they should be part of the procedure costs, are not accounted for;
3. There are certain anomalies in the Centre for Medicare and Medicaid Services database, which will inevitably be imported into the NHRPL and will need to be addressed on an individual basis; and
4. The outcome of the process is highly dependent upon the accuracy of the crosswalks.

Therefore, there are significant potentials for flaws and they are self-evident in the model spreadsheets, but for the sake of transparency the results have been left as is with the hope that an opportunity will be created to address them through a consensus seeking approach.

Specific submissions

Submissions pertaining to seventeen disciplines were received and analysed for the purposes of this report. A model spreadsheet has also been compiled for each of the seventeen disciplines and electronic copies will accompany this report.

The submissions have been imported into the model spreadsheets as they were received without adding or removing any codes. The checking of the relevance of codes to a specific discipline did not fall within the scope of our brief. Similarly the crosswalks were performed through a purely electronic process, meaning that manual checks on the accuracy were not performed in all instances.

The scope of this project also became such that there was insufficient time for the SAMA coding department to perform their customary rigorous accuracy checks. With the initial priority having been to establish certain principles and to complete the data analyses and population of the model spreadsheets, at least some refinements on the content of the coding structures are still to follow.

Anaesthesiologists

The South African Society for Anaesthesiologists (SASA) re-submitted their 2005 submission with updated practice cost studies. According to this submission it is proposed that the current SAMA structure for anaesthetics is completely replaced by the CPT® coding structure and the American Society for Anaesthesiologists (ASA) relative values.

The 2005 submission was supported, but could not be implemented as a result of:

- Certain outstanding copyright issues with the American Medical Association (AMA); and
- Uncertainty around the potential cost impact of the new structure in the funding industry.

The model spreadsheet for anaesthesiology contains all the relevant codes and the cost studies that have been performed, but is incomplete insofar it pertains to the calculation of the anaesthetic Rand conversion factor. This requires a complex model, which should, amongst others, include certain case mix adjustments in order to balance the total estimated income of anaesthetists back to the NHRPL benchmarked income for specialists.

Insufficient time was available for the development of this model, but it is believed that it would be opportune for Council to be part of the development of this model. Fifth Quadrant will also make resources available for this development process.

Cardio thoracic surgeons

The South African Society for Cardio Thoracic Surgeons (SASCTS) has submitted a virtually complete restructuring of their existing coding structure. The result of this restructured structure is a combination of the current SAMA structure and the CPT® structure, which is believed to address a number of shortfalls in the current SAMA structure.

The methodology that has been described earlier in this document has been applied to populate the model spreadsheet for the cardio thoracic surgeons.

Based upon the results of these calculations it became evident that the methodology that has been applied is likely to have a profound impact on certain procedures that performed by cardio thoracic surgeons on a regular basis. It is likely that the omission of the post-operative care from

the formulae are the cause of this effect, notably because a high percentage of the cardio thoracic surgeons' patients require post-operative care in intensive care units.

Although their submission is ready, a decision has been made to withhold the submission pertaining to procedures until such time that consensus has been reached on the approach to be followed with regard to procedure times. Therefore, the current submission only pertains to the consultation structure.

SASCTS supports the NHRPL process as it has been outlined in Circular 69 and is desirous to participate in the process, subject to the finding of a solution to the accounting for post-operative care.

Cardiologists

The South African Society for Cardiology has submitted a complete change from the current SAMA structure to the CPT® structure.

The CPT® structure has in the model spreadsheet for cardiology been populated according to the methodology described earlier in this document, but it should be noted that no provision for the use of specialised equipment has been made at this stage. As has been stated before, the specialised equipment component for all medical services will be dealt with in a future submission to the NHRPL.

At the time of this report the cost of standard equipment and specialised equipment was also not available. Therefore, it is believed that the values that are currently reflected in the model spreadsheet are an understatement of the actual cost of cardiology services.

General physicians

A combined submission that is based upon the patterns of utilisation of the current SAMA coding structure has been received for the following disciplines:

- General physicians
- Pulmonologists
- Rheumatologists

A model spreadsheet has been compiled according to this submission, but there is some concern about the size of the surveyed sample in relation to the total population of physicians. This aspect will be dealt with in the section on the specific analyses.

The time components in the model spreadsheet are also solely based upon information that has been received through the submission and the origin of this information has not been researched.

General practitioners

A comprehensive submission, based upon the patterns of utilisation of the existing SAMA codes has been received from SAMA on behalf of the General Practitioners.

A model spreadsheet has been populated based on this submission as well as the practice cost data that has been received.

Gynaecologists

The South African Society for Obstetricians and Gynaecologists (SASOG) has submitted a changeover from the current SAMA structure to a modified CPT® structure for obstetrics and gynaecology.

A model spreadsheet has been populated, using the methodology that has been described elsewhere in this document. However, the results have yielded some anomalies, particularly insofar it concerns the obstetric codes. These have been left as is for the purposes of this submission and the sake of transparency, but it is clear that further engagement between SAMA, SASOG and Council will be required in order to resolve these issues through consensus.

Neurosurgeons

The South African Society for Neurosurgeons has submitted a modified CPT® structure, which is to replace the current SAMA structure for neurosurgery.

A model spreadsheet has been compiled using the methodology described elsewhere in this report and the results seem to be acceptable with no major issues evident.

Ophthalmologists

The Ophthalmologic Society of South Africa (OSSA) has made a submission that is limited to their consultative services only and has therefore elected not to make a submission pertaining to their procedures. The reasons that have been cited largely evolve around uncertainties pertaining to the crosswalks between the SAMA structure for ophthalmology and the CPT® structure and the corresponding procedure times in the Centre for Medicare and Medicaid Services database.

A model spreadsheet has been compiled using the methodology described elsewhere in this document.

OSSA specifically requested us to note the fact that they support the practice cost study initiative and that they support it. However, they would like to engage on a phased implementation process, largely as a result of the uncertainties around the times in the Centre for Medicare and Medicaid Services database and the difficulties around the development of an accurate crosswalk between the SAMA and eh CPT® structures for ophthalmology.

The situation around ophthalmology is believed to be complex to the extent that it requires further analyses and data accumulation before a more comprehensive submission can be made. To this end, OSSA have undertaken to perform audited time and motion studies to accurately determine the time values of ophthalmologic procedures. The sample size in the practice cost studies is also inadequate and it needs to be increased as well as discrepancies addressed. OSSA have undertaken to have this information available for submission for the NHRPL 2008.

Orthopaedics

The Orthopaedic Association of South Africa has submitted a complete CPT® structure, which is to replace the current SAMA structure for orthopaedics *in toto*.

A model spreadsheet has been developed and populated using the same methodology that has been used for all of the other disciplines. The result is difficult to interpret due to the fact that the CPT® structure is significantly more detailed than the current SAMA structure and only a few crosswalks between the CPT® and the SAMA codes for orthopaedics exists.

We also have to express our concern on the large number of new orthopaedic codes that are being proposed and the impact that this may have on the industry at large, including practicing orthopaedic surgeons. However, this is a matter that needs to be resolved between SAMA, the Orthopaedic Association and Council.

Otorhinolaryngologists

The South African Society for Ear, Nose and Throat Surgeons has made a submission based on the current SAMA coding system for otorhinolaryngology with a few modifications to that system.

A model spreadsheet has been compiled using the same methodology that was used for all the other disciplines and the results seem to be fairly acceptable, with the exception of a few anomalies. These anomalies have been left as is for the purposes of this submission, but it is clear that further engagement on these will be required.

Paediatricians

The Paediatric Society of South Africa has made a submission based upon the current SAMA coding structure for paediatrics, together with a number of suggested amendments. These amendments include a new equipment code as well as adjustments to the intensive care unit codes.

A model spreadsheet has been compiled using the methodology that has been described elsewhere in this document, with the exception that the time factors that were applied are according to the submission that was received from the Paediatric Society. These times have been applied at face value and have not been audited, nor have we had access to raw data in this regard.

Plastic and Reconstructive surgeons

The South African Society for Plastic and reconstructive surgeons have submitted an amended structure that is based upon a combination of the current SAMA structure and the CPT® structure. This amended structure allows for a lot more detail than what is currently the case with the SAMA structure.

The amended structure has been used to compile a model spreadsheet using the same principles that have been applied to the other disciplines.

Due to a large number of new codes being introduced and some incomplete crosswalks between the current SAMA structure and the CPT® structure, the impact of the proposed structure is difficult to assess.

Psychiatrists

The South African Society for Psychiatrists has essentially submitted the current SAMA coding structure for psychiatry, with certain amendments. The main object of the amendments is to address the anomalies that arose during the NHRPL process for 2006.

A model spreadsheet has been compiled for the psychiatrists using the same principles, with the exception that the time components are based either on tiered systems, where applicable, or the expected duration of a service. The latter has been derived from practical experience in the psychiatric field and has already to a large extent been in effect since the beginning of 2006.

Pulmonologists

No definitive submission has been received from the Pulmonology Society of South Africa, but it has been suggested that their submission be combined with that of the general physicians.

Rheumatologists

No definitive submission has been received from the Rheumatology Society of South Africa, but it has been suggested that their submission be combined with that of the general physicians.

Urologists

A submission that is based on the current SAMA structure for urology has been received from the Urology Society of South Africa.

A model spreadsheet has been compiled according to the same principles that applied to the other disciplines. The results of the calculations seem to be reasonable, with the exception of a few anomalies that are not dissimilar to the ones that were encountered with the other disciplines.

Vascular surgeons

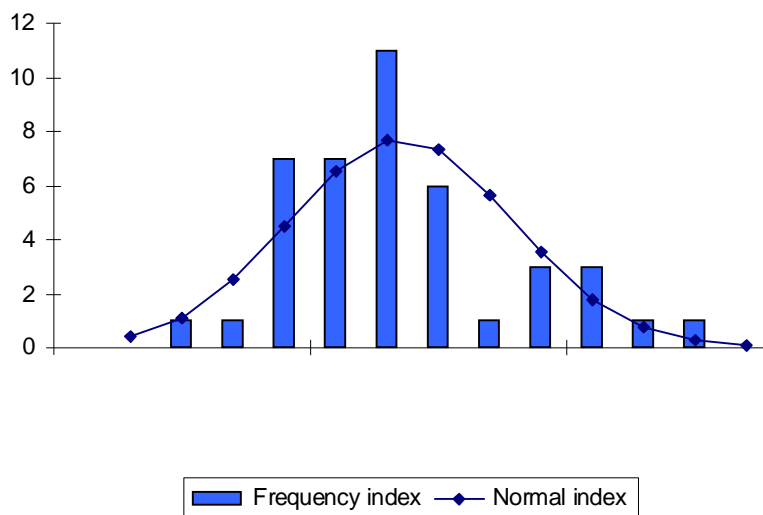
A submission for a completely new structure for vascular surgery that is based on a combination of the existing SAMA structure, the CPT® structure and the Radiological Society of South Africa (RSSA) structure has been submitted by the South African Society for Vascular Surgeons. The submitted structure also addresses the various issues that are currently in existence around the endovascular procedures.

A model spreadsheet has been populated using the same rules that have been applied to the other disciplines and the results of the calculations seem to be reasonable.

Analyses per group

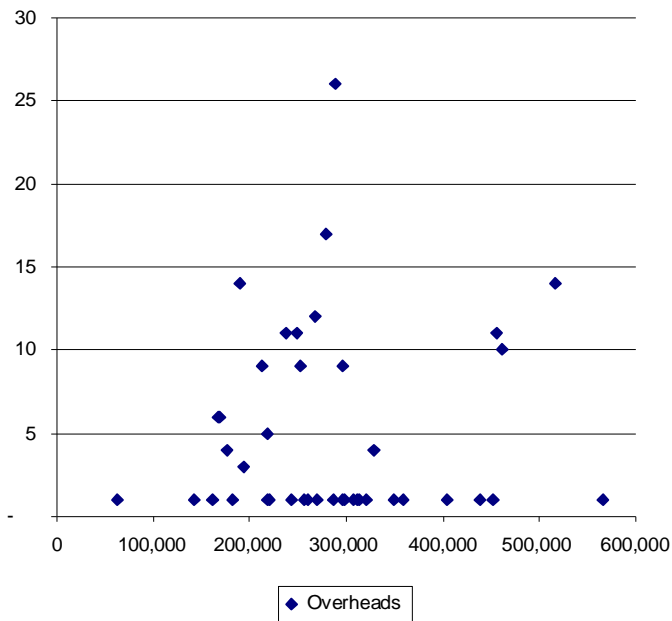
Anaesthesiologists

We were presented with the cost information for 42 practices. These costs were adjusted to reflect the costs per practitioner, but no further adjustments or checks were performed. We grouped the practice costs into ranges of R50 000 and calculated the number of practices that fall in each cost band. The result is represented in the following graph:



From the analyses performed, the mean (R280 000) and median (R274 000) are relatively close and although the median was lower than the mean it represented a closer resemblance to the costs of an average practice.

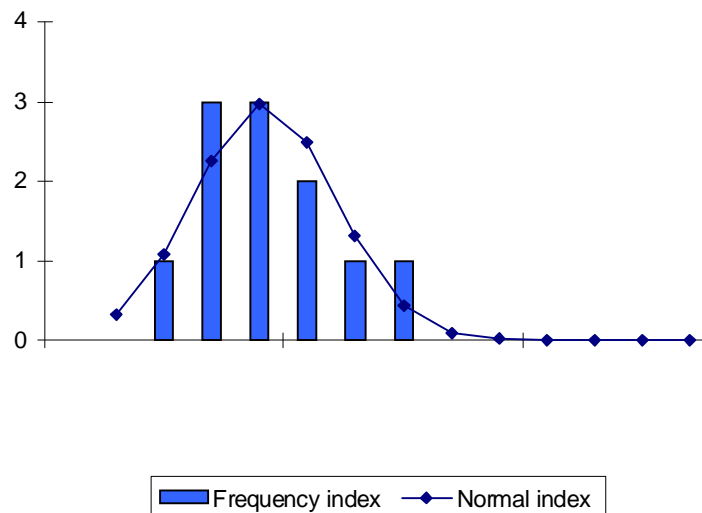
In addition, it was observed that the costs per practice are consistent regardless of the number of practitioners present at a specific practice. This is graphically reflected below:



The practice costs are highly concentrated between R250 000 and R350 000 and although the confidence interval (R32 555) is fairly large when compared to the mean, we believe that we can reasonably conclude that an appropriate approximation for the practice cost of an anaesthetist is the median of the costs of the sample per practitioner.

Cardio thoracic surgeons

We were presented with the cost information for 11 practices. The data was used as supplied. We grouped the practice costs into ranges of R200 000 and calculated the number of practices that fall in each cost band. The result is represented in the following graph:



From the analyse
The size of the

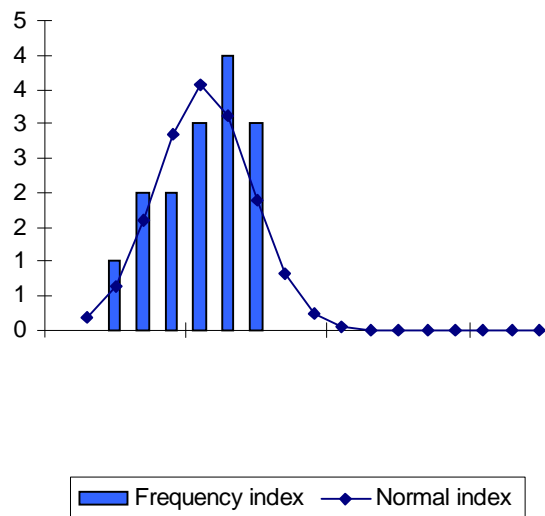
are relatively close.
ouped are very big.

However, a good fit to the normal distribution could be obtained but with a range of responses of R1 million it is difficult to recommend the statistics that are derived from this analysis.

As a result we have combined this data with the data for the other surgeons (detailed below) in order to get a sample that is less susceptible to outliers and represents a meaningful reflection of the population as a whole.

Cardiologists

We were presented with the cost information for 15 practices. The data was used as supplied. We grouped the practice costs into ranges of R80 000 and calculated the number of practices that fall in each cost band. The result is represented in the following graph:



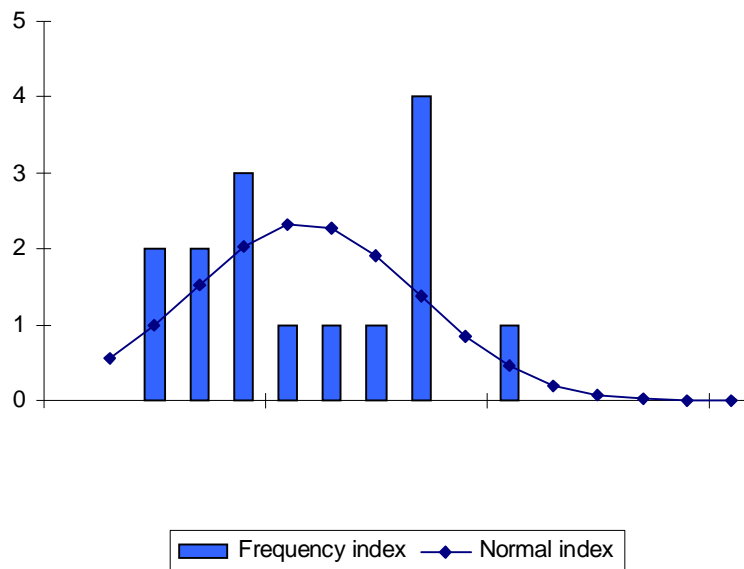
From the analyses performed, the mean (R369 000) and median (R377 000) are relatively close. As a result of the wide spread of the practice costs in the sample the cost bands used in the histogram are fairly sized. However we were able to fit a model to the data that enables us to reasonably be comfortable with the statistics derived.

We must however stress that the sample size as well as the population as a whole is very small and thus the analyses performed are highly influenced by the quality of the data provided. This is also relevant to the other analyses performed as part of the costing process.

The confidence interval was very wide as a result of the small sample size and the wide spread of respondents and as such we believe that the practice costs are again best modelled by the median of the sample. This provides an adequate mid-point estimate.

Physicians

We were presented with the cost information for 16 practices. The data was used as supplied. We grouped the practice costs into ranges of R60 000 and calculated the number of practices that fall in each cost band. The result is represented in the following graph:



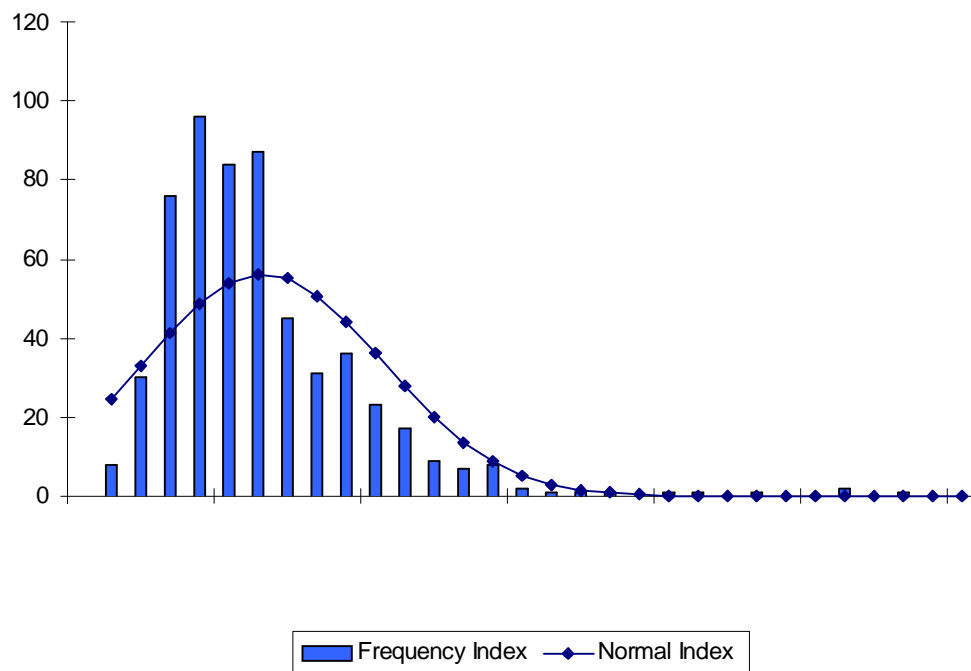
From the analyses performed and the graph above it is clear that the sample provided no real indication of a realistic cost estimate and although at first glance it appears that there is a clear preference for the cost band R480 000 to R540 000, we must point out that it only reflects one more respondent than that contained in the cost band R240 000 to R300 000.

In addition, the number of respondents in the sample is too low to reasonably be considered to represent population as a whole. The sample size was therefore found to be inadequate.

As a result we cannot make a reasonable recommendation to the group in terms of an estimate for practice costs.

General practitioners

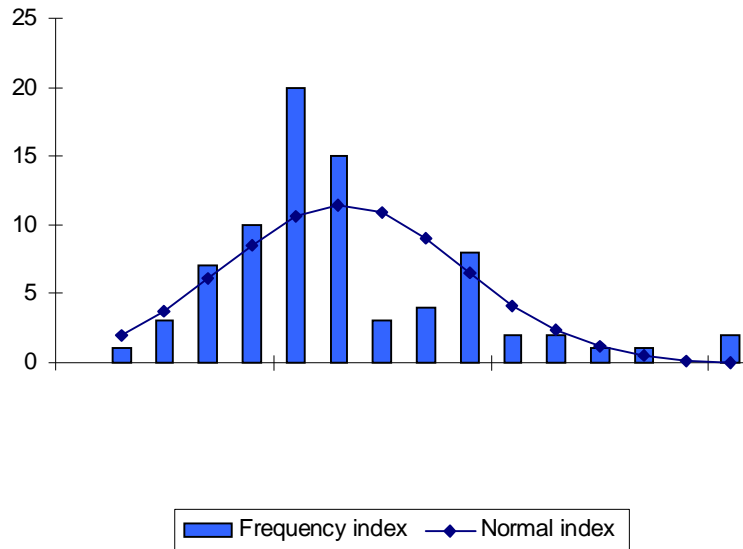
We were presented with the cost information for 569 practices. (This is the biggest single sample provided.) The data was used as supplied. We grouped the practice costs into ranges of R50 000 and calculated the number of practices that fall in each cost band. The result is represented in the following graph:



From the analyses performed, the difference between the mean (R284 000) and median (R242 500) is fairly large. The range of costs is also big (R2,2 million). It is however clear from the graph above that most practices fall into the cost band between R150 000 to R350 000 and it was possible to fit a model to the histogram. In addition, there is a clear indication that the distribution is very skewed (positively) again indicating that the mean and confidence intervals will be highly susceptible to the values in the tail. As such, we are confident that the lower median will be a reasonable estimate for the overall practice costs of general practitioners and that this is echoed by the high concentration of respondents in the smaller cost bands.

Gynaecologists

We were presented with the cost information for 81 practices. (This is the biggest single sample provided other than for the general practitioners.) The data was used as supplied. We grouped the practice costs into ranges of R75 000 and calculated the number of practices that fall in each cost band. The result is represented in the following graph:

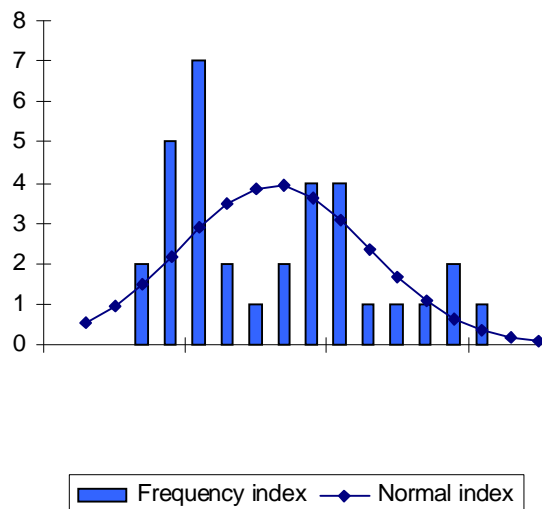


From the analyses performed, the difference between the mean (R420 000) and median (R370 000) is fairly large. In addition, we removed two outliers from the sample that were well above the costs for the rest of the sample.

Despite the relatively big sample and the removal of the two outliers the range of costs remains big (R1 million). It is however clear from the graph above that most practices fall into the cost bands R300 000 to R375 000. However, as a result of the wide spread of costs we have pooled the data for the gynaecologists with the data provided by other surgeons. This analysis is set out below and is the basis for the submissions made for the surgeons, including the gynaecologists.

Neurosurgeons

We were presented with the cost information for 35 practices. The data was used as supplied. We grouped the practice costs into ranges of R60 000 and calculated the number of practices that fall in each cost band. The result is represented in the following graph:

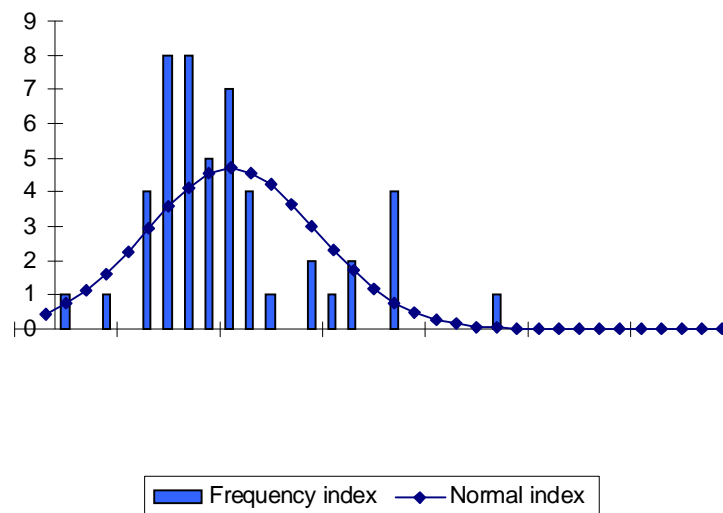


From the analyses performed, the difference between the mean (R428 000) and median (R390 000) is fairly large. In addition, the sample is small and the spread is big. It is however clear from the graph above that most practices fall into the cost band R240 000 to R300 000, but we do not believe that the sample size is adequate to make a reasonable recommendation to estimate practice costs. The model fitted does not allow for the high frequencies in the lower bands and as a result may be open to criticism, especially as the sample size is so small. As a result we combined the data for the neurosurgeons with the data supplied by other surgeons in order to provide a more meaningful analysis of the costs.

The result of the surgeons' pooled analysis is set out below and is the basis for the submissions made for all the surgical disciplines considered.

Ophthalmologists

We were presented with the cost information for 52 practices. The data was used as supplied. We grouped the practice costs into ranges of R40 000 and calculated the number of practices that fall in each cost band. The result is represented in the following graph:

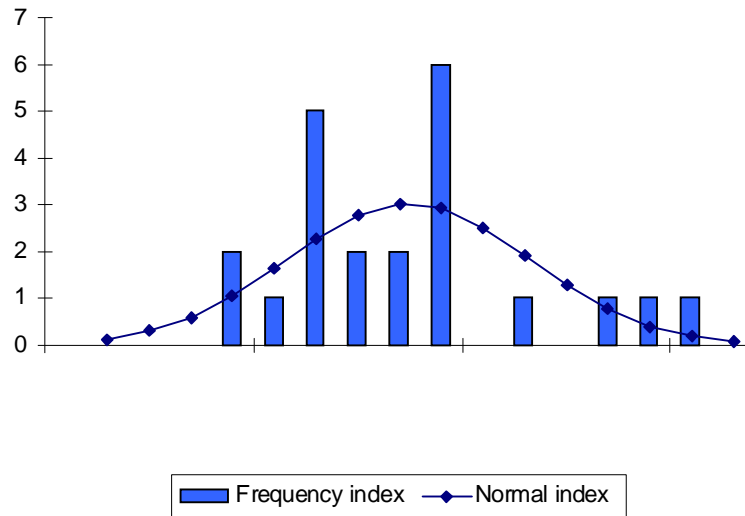


From the analyses performed, the difference between the mean (R382 000) and median (R349 400) is fairly large. In addition, we removed three outliers from the sample that were well above the costs for the rest of the sample. Despite the fairly sized sample (relative to the other samples provided) and the removal of the three outliers the range of costs remains large (R810 000). It is however clear from the graph above that most practices fall into the cost band R240 000 to R480 000. This is a very wide preference range and is indicative that one cannot rely on this data in isolation to recommend a cost estimate.

As a result we have pooled the data for the ophthalmologists with the data provided by other surgeons. This analysis is set out below and is the basis for the submissions made for the surgeons, including the ophthalmologists.

Orthopaedics

We were presented with the cost information for 24 practices. The data was used as supplied. We grouped the practice costs into ranges of R50 000 and calculated the number of practices that fall in each cost band. The result is represented in the following graph:

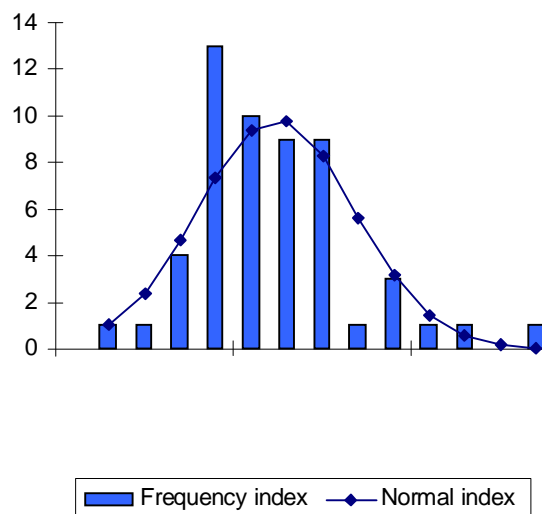


From the analyses performed, the difference between the mean (R385 000) and median (R365 000) is fairly small. We, however, removed two outliers from the sample that were well above the costs for the rest of the sample. There are two ranges where most practice costs were prevalent with the highest number of respondents falling into the range R450 000 to R500 000. The spread is fairly narrow with a small difference between the mean and the median. It is difficult to make a firm recommendation for this group, as the sample is very small.

However, should an estimate be sought for the practice costs the best representation of the group will be the median especially as it is less influenced by outliers than the confidence interval or the mean. As this group is positively skewed it serves to reason that the mean is dragged up by the higher values in the positive tail.

Otorhinolaryngologists

We were presented with the cost information for 56 practices. The data was used as supplied. We grouped the practice costs into ranges of R60 000 and calculated the number of practices that fall in each cost band. The result is represented in the following graph:



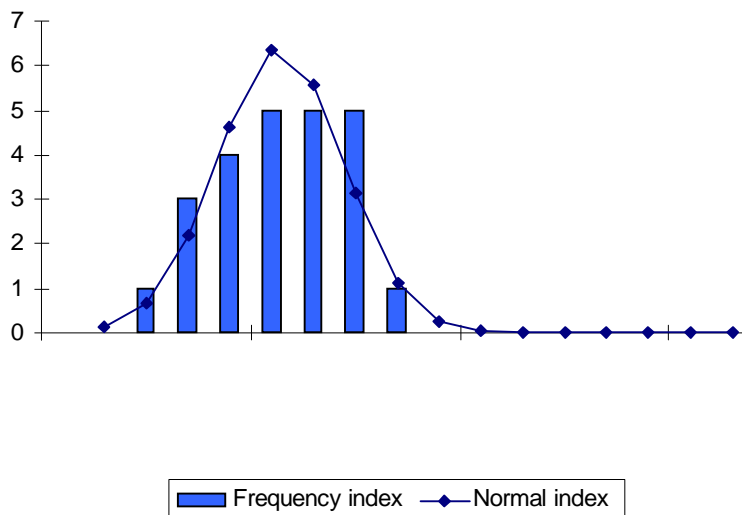
From the analyses performed, the mean (R311 000) and median (R291 000) are relatively close. The size of the sample was relatively big compared to other submissions received and a reasonable model could be fitted to the frequencies calculated. The median appears to have a closer resemblance to the costs of an average practice. In the process of defining a model for the costs, we had to remove two outliers from the data, which were well above any other observations in the sample.

The practice costs are highly concentrated between R180 000 and R300 000 and although the confidence interval (R34 049) is fairly large when compared to the mean, we believe that we can reasonably conclude that an appropriate approximation for the practice cost of an otorhinolaryngologist is the median of the costs of the sample per practitioner.

However, as a result of the size of the sample we have combined the data for the otorhinolaryngologist with other surgeons (detailed below) in order to get a sample that is less susceptible to outliers and represents a more meaningful reflection of the population as a whole.

Paediatricians

We were presented with the cost information for 28 practices. The data was used as supplied. We grouped the practice costs into ranges of R80 000 and calculated the number of practices that fall in each cost band. The result is represented in the following graph:



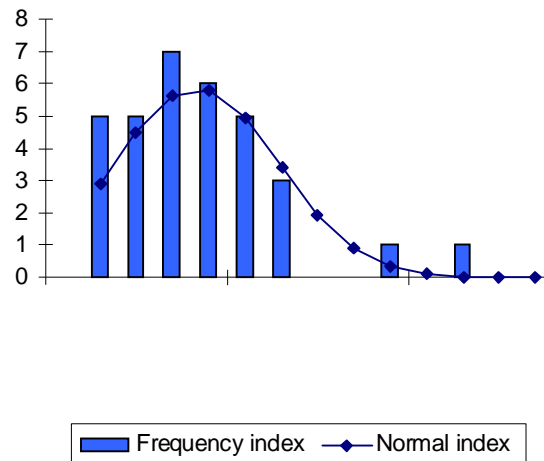
From the analyses performed, the difference between the mean (R377 000) and median (R389 000) is fairly small. We, however, removed three outliers from the sample that were well above the costs for the rest of the sample. This reduced the sample considerably but enabled us to find more meaningful picture of the data. In addition it reduced the range of responses and reduced the mean and median significantly. Consistent with this the distribution became negatively skewed whereas it was positively skewed with the inclusion of the outliers. It also became possible to fit a distribution to the histogram.

The sample is relatively small especially when compared to the population of paediatricians as a whole and therefore it is important that it is noted that there is still much uncertainty around the representation of the sample relative to the population as a whole. In addition the sample is highly influenced by outliers.

In order to remove some of the uncertainty our best estimate of the practice cost will be the median of the sample.

Plastic and reconstructive surgeons

We were presented with the cost information for 33 practices. The data was used as supplied. We grouped the practice costs into ranges of R140 000 and calculated the number of practices that fall in each cost band. The result is represented in the following graph:



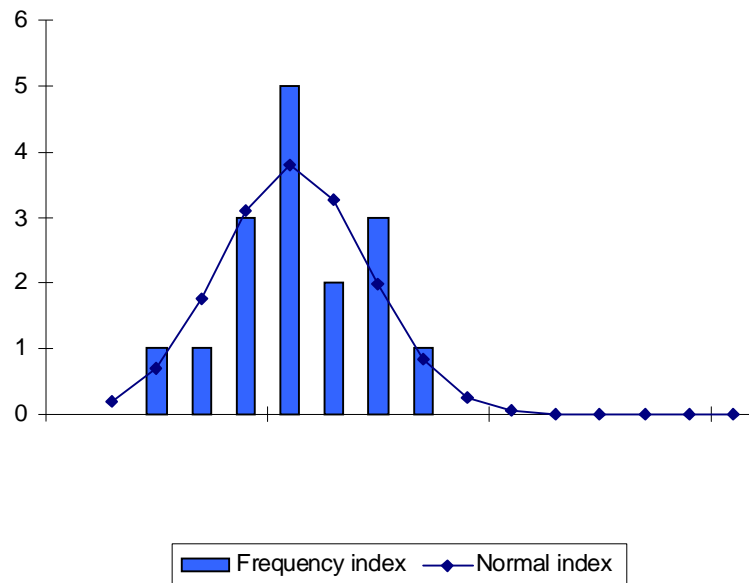
From the analyses performed, the difference between the mean (R443 000) and median (R375 000) is fairly large. In addition, the sample size is small and the range of costs is big (R1,4 million). It is however clear from the graph above that most practices fall into the cost band R280 000 to R420 000, but we do not believe that the sample size is adequate to make a reasonable recommendation to estimate practice costs. In addition, the size of each cost band had to increase above what we believe reasonable in order to accommodate the wide spread.

As a result we combined the data for the plastic and reconstructive surgeons with the data supplied by other surgeons in order to provide a more meaningful analysis of the costs.

The result of the surgeons' pooled analysis is set out below and is the basis for the submissions made for the surgical disciplines considered.

Psychiatrists

We were presented with the cost information for 17 practices. The data was used as supplied. We grouped the practice costs into ranges of R50 000 and calculated the number of practices that fall in each cost band. The result is represented in the following graph:



From the analyses performed, the difference between the mean (R229 000) and median (R220 000) is fairly small. We removed one outlier from the sample that was well above the reasonable costs observed in the remainder of the sample. It is important to note that the sample is relatively small especially when compared to the population of psychiatrists.

There is one range in particular where most practice costs were prevalent and this is also the range in which both the median and mean are situated. The confidence interval is fairly large as is the spread of responses. In order to accommodate both problems it is clear that the median will be the best estimate of practice costs for psychiatrists.

We attempted to combine the data for the psychiatrists with other consulting specialists, but were unable to find a meaningful correlation.

Pulmonologists

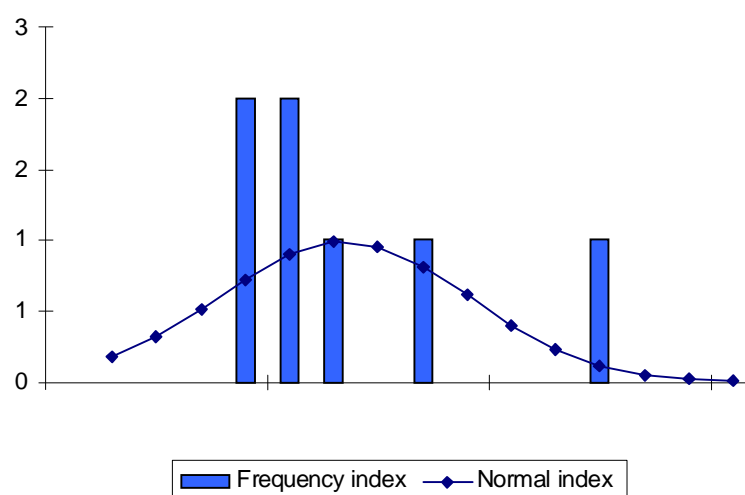
We were presented with the cost information for 2 practices and as a result did not analyse the data for the pulmonologists.

We attempted to combine the data for the pulmonologists with other consulting specialists, but were unable to find a meaningful correlation.

Rheumatologists

We were presented with the cost information for 7 practices. This is clearly a very small sample and on this basis alone would not be useable to provide a cost estimate for the rheumatologists.

However, we used the data as supplied to further ensure that the sample did not reflect a specific trend. We grouped the practice costs into ranges of R40 000 and calculated the number of practices that fall in each cost band. The result is represented in the following graph:



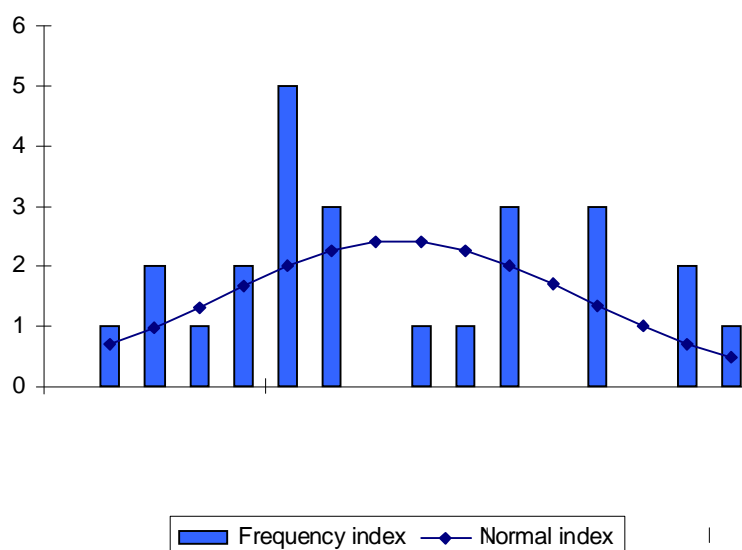
From the analyses performed, the difference between the mean (R230 000) and median (R165 000) is fairly large. There are two ranges where most practice costs were prevalent, but it is difficult to make a reasonable recommendation on the data provided as a result of the sample size and the lack of observable trends and descriptive statistics.

As a result we cannot make a reasonable recommendation to the group in terms of an estimate for practice costs.

We attempted to combine the data for the rheumatologists with other consulting specialists, but were unable to find a meaningful correlation.

Urologists

We were presented with the cost information for 25 practices. The data was used as supplied. We grouped the practice costs into ranges of R55 000 and calculated the number of practices that fall in each cost band. The result is represented in the following graph:

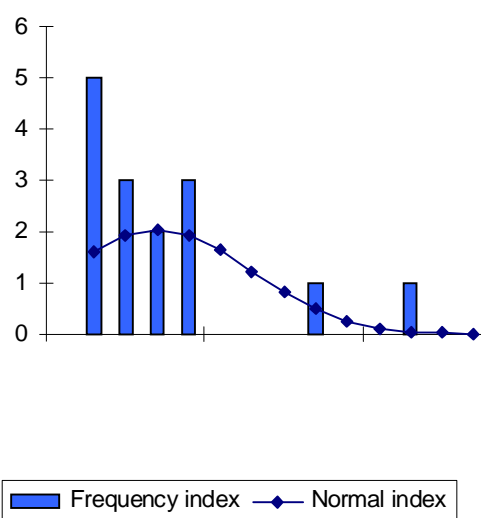


From the analyses performed, the difference between the mean (R387 000) and median (R290 000) is fairly large. The sample is relatively small and the range of responses was also very wide (R780 000). It is difficult to make a reasonable recommendation on the data provided as a result of the sample size and the lack of observable trends and descriptive statistics.

As a result we cannot make a reasonable recommendation to the group in terms of an estimate for practice costs.

Vascular surgeons

We were presented with the cost information for 15 practices. The data was used as supplied. We grouped the practice costs into ranges of R150 000 and calculated the number of practices that fall in each cost band. The result is represented in the following graph:



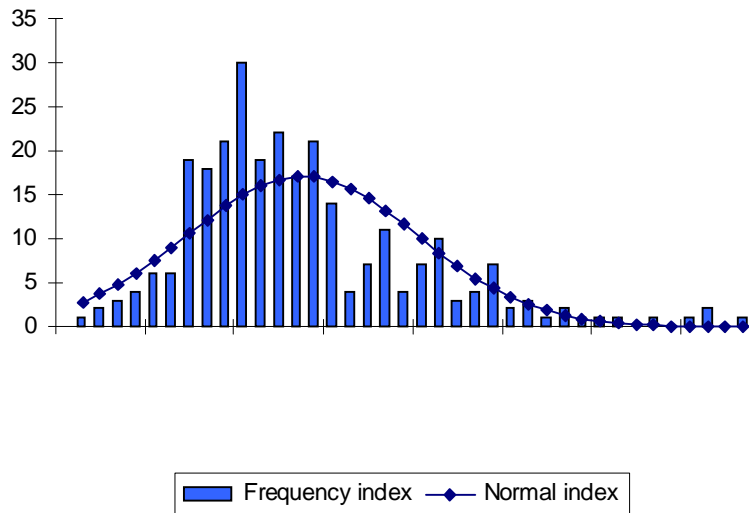
From the analyses performed, the difference between the mean (R481 000) and median (R366 500) is fairly large. In addition, the sample size is small and the range of costs is big. It is however clear from the graph above that most practices fall into the cost band between R100 000 and R250 000, but we do not believe that the sample size is adequate to make a reasonable recommendation to estimate practice costs. As a result we combined the data for the vascular surgeons with the data supplied by other surgeons in order to provide a more meaningful analysis of the costs.

The result of the surgeons' pooled analysis is set out below and is the basis for the submissions made for the surgical disciplines considered.

Surgeons (pooled)

We pooled the data provided by the neurosurgeons, otorhinolaryngologist, cardio thoracic surgeons, orthopaedics, ophthalmologists, urologists, and gynaecologists in order to obtain a meaningful sample for the surgeons as a whole. The aim of the pooled analysis (as also explained above) was to obtain a sample that is less susceptible to outliers and is a meaningful representation of the population as a whole. In this case we were able to observe 284 respondents.

The data was pooled and grouped in cost bands of R30 000. The number of practitioners in each cost band was calculated and a model fitted to the histogram. The following graph sets out the result of the analysis:



Firstly we observed that the costs were positively skewed with the median being smaller than the mean. We were able to group the costs into smaller bands of R30 000 each which increased our confidence in the data analysed. The difference between the mean (R384 305) and the median (R341 952) is fairly large, however, but this is as a result of a few individual respondents whose values are to the tail of the distribution as well as a large number of respondents in the cost band R300 000 to R360 000.

The confidence interval was a mere R22 433, which is within our reasonable expectations and increased our confidence further in the pooled data.

We believe that the data support a reasonable cost estimate for all surgeons included in the analysis and that the best estimate for costs in this case is the median of R341 952 per practitioner. This is echoed by the cost spread of the respondents and the high frequencies in the cost band R300 000 to R360 000. Using the median is also in line with the aim of the NHRPL, i.e. to represent a mid-point cost for practitioners.

Projected impact on National 2007

Health Reference Price List for

Judging by the initial results of the calculations in the model spreadsheets as they are presented in this submission, it seems that in many instances quite significant increases in the NHRPL rates may be required. However, much more analysing will be required before any opinion on either the overall impact or the impacts per discipline can be expressed. Furthermore, there are a significant number of areas that will need refinement before these final analyses can be performed.

The submissions that have been received are also likely to have impacts on the NHRPL that are not directly linked to the NHRPL rates:

- A significant number of new codes are being proposed, which not only holds implications for the medical scheme administration and related industries, but also for the SAMA coding structure in that the current four digit coding system will have to be changed to a five or a six digit system;
- New coding rules will have to be developed, which again holds implications for the medical scheme administration and related industries; and
- Despite the clarification that has been provided through Circular 9 of 2006 of the Council for Medical Schemes, the difficulty that will inevitably be experienced in assessing the impact of the new systems is likely to pose a number of challenges during the budgeting processes of the medical schemes.

It is strongly believed that these issues have to be taken into consideration and that intensive engagement between the various role players will be required. The suggested structures seem to represent substantial improvements on the existing structures and will provide a lot more detail in terms of information, but their implementation is likely to pose at least a few challenges.

A phased approach might therefore be a more prudent route to follow.

Relative Value Units

An issue that deserves specific mentioning is the way in which the Relative Value Units (RVU) of services and procedures are calculated in the model spreadsheet.

According to the prescribed formula, the computed value of a service or procedure is divided by an arbitrary amount of R15-00 in order to arrive at the RVU value. This implies that if more than one discipline each with its own cost structure performs the same procedure they will have different RVUs for the same procedure.

If our understanding is indeed correct, this approach is likely to have a number of unintended consequences:

- Most procedures will have numerous RVUs and will have to be published as such;
- General practitioners will have different RVUs to specialists for those procedures that they perform or services that they render;
- This will cause the primary objective of the RVU (i.e. maintaining inter-disciplinary relativities) to be lost;
- Schemes will have difficulty in applying a benefit factor for a specific discipline or a specific procedure or service in the presence of multiple RVUs;
- Similarly providers will have difficulty in calculating their fees;
- Most administration systems and practice management systems are designed to accommodate a single RVU per procedure with different Rand Conversion Factors (RCF) per discipline or network. (In fact, the year on year updates of these systems is achieved through the adjustment of the RCF);

- An inordinate amount of confusion between the various tariff systems, namely the NHRPL, the Compensation for Injury on Duty (COID), the Health Professions Council of South Africa and more likely than not the Road Accident Fund, will be caused (It will be much easier to accommodate these variances through a single RVU and varying RCFs for each service or procedure);
- A publication of the NHRPL will require at least 22 columns, which could render it impossible for SAMA to publish its Doctors' Billing Tables and Manual; and
- It will no longer be possible to publish multiple tariffs such as the NHRPL and COID in a single publication.

It is therefore recommended that an alternative formula for the calculation of the RVUs be developed in order to accommodate a single RVU. The complexity of this formula is by no means underestimated and further consultation with SAMA regarding this matter should be pursued.

The indirect cost to medical schemes of implementing a "multiple RVU system (e.g. due to the administrative complexity impacting on the administrative fees) should also be an important consideration when submissions are made to Council.

Conclusion

In conclusion, the Council for Medical Schemes deserves to be commended on the process that has been prescribed for the NHRPL for 2007 and beyond. The level of detail that is required is unprecedented and probably justifiably so.

However, many have probably underestimated the scope of the process, especially when it comes to the medical profession where there are so many variables that have to be taken into account. Time constraints have not allowed us to pay justice to the full complexity of the issues at hand and significant refinements are still required, but then the fee structure for medical services are still undergoing refining in many developed countries.

In terms of the NHRPL for 2007 there are still a number of issues that have to be resolved, before it can be finalised:

- The number of new codes that have been proposed;
- The SAMA numbering system;
- The new coding rules that have to be developed;
- The assessment of the financial impacts on the industry and agreeing on making the transition as smooth as possible;
- The resolving of the various issues around the time components;
- The resolving of the issues around the post-operative care;
- The clarification of the appropriate public sector salary scales together with the associated fringe benefits that should be used as benchmarks; and
- The clarification of the interpretation of the Relative Value Units.

Given all of these uncertainties it is recommended that this submission and report be used as a basis for further deliberations between the Council for Medical Schemes, the South African Medical Association and the relevant specialist societies, rather than a final submission.

Compiled by: -

The South African Medical Association

Date: 31 May 2006

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