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**To:**
**All medical schemes, administrators, health care provider organizations and other interested parties**

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## CIRCULAR 9 OF 2006

## NATIONAL HEALTH REFERENCE PRICE LIST: CLARITY OF INTENT

1. There appears to be a need to clarify certain misperceptions about the reference prices contained in the National Health Reference Price List (NHRPL).

### What is the NHRPL?

2. The NHRPL contains schedules of health service procedure codes, accompanied by units expressing the relative value of the procedures, and bearing a set of reference prices which are proportionate to the relative values of the procedure codes.

3. The standardized structure of the NHRPL facilitates billing processes in the industry by allowing funder and health care provider systems to "talk" to each other, while at the same time independently setting benefits and prices matching their own affordability constraints and cost structures.

4. The NHRPL is ultimately intended as, and is evolving into, a costing model utilizing benchmark values and standardised assumptions which can –

   4.1. be substituted at an individual practice level by actual cost, income and profit expectations and efficiency levels to generate a practice-specific set of item-level rand values which will be some percentage of the NHRPL (e.g. 85% NHRPL values or 110% NHRPL values);

   4.2. be varied by individual funders to better understand the relationship between benefit levels and their purchasing power; and/or

   4.3. form the basis of more meaningful negotiations between funders and providers – instead of negotiations being on the basis of an overall percentage increase on historically determined values, the costing model should allow pricing negotiations to take place at the level of items within a detailed breakdown of costs underpinning item values.

5. The NHRPL should therefore create the stimulus for greater levels of differentiation of benefit and pricing levels within the private health sector – and thereby promote competition among health care providers and between medical schemes.

**What the NHRPL is NOT (1)**

6. The NHRPL is not a recommendation of what prices should be charged by providers.

7. Even if the costing methodology underpinning the reference prices in the NHRPL, and the manner of collection of data, were flawless, they would still give rise to a set of *average* cost values.

8. In other words, the distribution of actual costs experienced by providers is such that for a portion of providers facing higher than average costs (or who work at lower than average productivity or efficiency levels), they may need to charge above NHRPL to achieve their target income and profit.

9. However, equally there will be a substantial portion of providers who would need to charge less than NHRPL to recover their actual costs and achieve their target income and profit levels. These are providers who are more productive than the average practitioner or who experience lower costs than the average.

10. Even those practitioners who experience higher than average costs could potentially undercut competitors by charging less than the NHRPL by increasing their productivity levels above the norm provided for in the NHRPL.

11. Given the distribution of actual costs and productivity levels above and below the NHRPL averages and norms, if all providers started to charge NHRPL as the normative minimum, this could result in overall pricing increases and substantial over-recovery of costs by a significant proportion of providers. It would also defeat the pro-competitive objective of the NHRPL.

12. The NHRPL should therefore be seen by providers for what it is – a standardised costing model which can be adapted to the specifics of individual practices to ensure greater rationality in pricing. It bears no recommendation whatsoever that the values contained therein are appropriately charged by individual providers.

**What the NHRPL is NOT (2)**

13. The NHRPL is not intended as a "medical aid tariff" and is certainly not a recommendation of a minimum level at which medical schemes should set their benefits.

14. The first reason for this is that it may not be desirable to link minimum reimbursement levels to average cost experience, as this may incentivise lower cost providers to increase prices disproportionately to their costs.

15. The second reason for this is that while the NHRPL costing process may in some instances give rise to NHRPL increases significantly above inflation, contribution levels simply cannot be permitted to increase at the same rate.

16. Current contribution levels among medical schemes already present an obstacle to membership growth among medical schemes, and above-inflationary increases of contribution levels are likely to cause a reduction in membership levels. This would negatively impact on access to health care, increase the burden on the State, and decrease the ability of health care providers in the private sector to be reimbursed for their services from medical schemes.

17. It should therefore be clear that if NHRPL reference prices for a discipline increase by 30% in a year, a medical scheme cannot simply increase its benefit levels by 30% without negatively impacting on affordability of the scheme or otherwise eating into reserves of the scheme and thereby jeopardizing overall scheme sustainability. And if schemes respond by increasing reimbursement levels by 30%, but lowering overall benefit ceilings, this will simply result in benefits to members being exhausted earlier in the year.

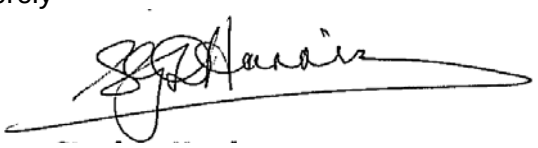
18. It is therefore imperative that medical schemes independently determine benefit levels in relation to the NHRPL based on medical scheme-specific considerations of affordability, as well as the best overall package of health goods that they can purchase for their members within those affordability constraints (which may well result in schemes quite legitimately and responsibly structuring some of their benefits below NHRPL levels).

19. Numerous considerations now come into the process of benefit level determination by schemes, including for example, affordability, responsiveness to member needs and preferences, and incentivisation of providers to offer quality health care while containing the likelihood of unnecessary upstream costs (which decrease the portion of the "pie" that medical schemes may allocate to those providers).

## Conclusion

20. For the reasons above, it is imperative that both medical schemes and health care providers make the paradigm shift from the historical "medical aid tariffs" to understanding the NHRPL for what it is: a costing model that facilitates meaningful negotiations and a more rational approach to the process of price-setting and benefit determination. For medical schemes to passively link benefits to the equivalent of 100% of NHRPL prices, or to be pressured into doing so, defeats this objective and may result in access to health care or the sustainability of medical schemes being compromised.

Sincerely



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