Private healthcare – too expensive?

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Only 20% of the South African population can afford to use private healthcare, yet the sector contains 80% of the country's doctors. Conversely, 80% of the population is stuck with 20% of the doctors – overworked, underpaid public servants who often lack the equipment or medicines to treat their patients properly. Besides being a great example of the so-called 'Pareto principle' (also known as the 80-20 rule), these simple facts also highlight the tremendous inequalities that exist in South African society. One imagines it is for reasons like this that the World Bank has consistently labelled South Africa one of the most unequal countries in the world.

The 80-20 distribution of South African healthcare is always going to be a contentious issue in a society that – at least on paper – values greater social equity, and has in fact attracted a great deal of attention from decision makers outside of the medical industry. The recent announcement of a formal Competition Commission inquiry into private healthcare costs is only the latest in a long line of red flags raised by regulatory and civil society bodies. In fact, the prime motivating factor for the country's National Health Insurance (NHI) scheme is the unequal distribution of medical services among the public. Ultimately, the question doctors must ask themselves is whether all this attention is warranted. In a nutshell, are private doctors greedy?

What is greed?

The exact definition of greed is unfortunately rather nebulous. This is both a blessing to people who are genuinely greedy, since it provides them with the defense 'What is greed?', and a curse to those who wish to regulate greed-driven enterprises. The recent price regulatory overtures by the Department of Health and the Competition Commission have defined the industry as greedy because it is unaffordable to the vast majority of citizens. According to acting Competition Commission chair Tembinkosi Bonakele, the goal of the commission's enquiry into private health is to find indications of "... price increases and expenditures that tend to be above inflation in the private healthcare sector".

So how do doctors determine their tariffs? Remarkably, it is often a rather straightforward process. Let us assume Patient A goes to Doctor B for a check-up that lasts an hour. Doctor B requires a guideline according to which he can bill Patient A. Prior to 2004, he would have had a choice between a guideline structure drawn up by the Board of Healthcare Funders (BHF) or one drawn up by SAMA. In 2004 a Competition Commission ruling created a single tariff structure called the National Health Reference Price List (NHRPL), which is now known simply as the RPL, so that is what Doctor B will be using as a baseline to determine his fee.

Doctor B will first have to determine how much the consultation has cost him. He has to pay his staff and pay his rent, for example, and both of these amounts can be fractured into an hourly rate. Then he has to calculate his take-home pay rate, which is entirely at his discretion, but has to be justifiable according to industry regulations. He then divides this amount, which is his practice cost (salary plus expenses), against the amount of hours he spent on the consultation (taking into account that doctors are calculated as having an average of 46 working weeks a year).

This is the amount a doctor will charge. Any additional costs are at the doctor's discretion, though medical aids can refuse to pay these. It is overcharging at this point that has arguably led to the public perception that doctors are greedy. Research by Discovery Health indicates that although 45% of specialists charged fees at NHRPL rates, an estimated 5% were charging over 300%. Keep in mind that specialist procedures are expensive by definition, so even a rate that is 100% of NHRPL will appear intimidating to the average patient.

However, according to Dr Meshack Mbokota chairman of SAMA's Specialist Private Practice Committee, the issue is more complex than a statistical overview of prices can suggest. "First of all, patients are only in a position to say that somebody is overcharging if there is a norm to compare their charges to," Dr Mbokota said, "and since the Competition Commission effectively ruled in 2004 that no one can fix the price of medical care anymore, there are no industry norms." According to Dr Mbokota, the fact that government is not regulating the healthcare industry has left patients and doctors with no frame of reference. "The notion that doctors are overcharging is therefore preposterous since there is no reference structure to measure their rates against."

Regulation

With the recent advent of the Competition Commission's new enquiry into public healthcare, the introduction of price regulation and guideline tariffs has again become a distinct possibility. According to Sha'ista Goga, an economist with Acacia Economics, there are very good reasons why this should be the case.

"The main reason why prices should be regulated," Goga said, "is because healthcare is not normal goods like food or clothing. It is a highly specialised field. The patient desperately needs to know the details of the care they are going to receive, but these are usually too complicated for them to understand. As a result, a situation arises that economists refer to as 'information asymmetry'. In instances like this, the government has a responsibility to ensure that patients are provided with guidelines that can redress this imbalance."

Umunyana Rugege of activist group Section 27 agrees: "There is a definite need for tariff guidelines, especially since after 2004 there has been a lack of transparency for patients. The South African Constitution treats access to healthcare as a human right. For private healthcare to be accessible to the public, it must first become a transparent process, and that is why tariff guidelines are a good idea." Rugege also pointed out that the industry is already regulated to an extent since technically the Health Professions Council of South Africa can determine guidelines on overcharging in terms of a provision in the Health Professions Act.

A complex issue

It must be kept in mind that six years of medical school costs roughly R1.4 million, leaving many doctors crippled by debt from the outset of their careers. The financial burden on doctors is therefore much higher than that experienced by the vast majority of professionals, and doctors increasingly have to contend with the growing threat of medical malpractice suits – a threat which has increased by an average of 500% over the last five years – which necessitates very expensive practice insurance coverage.

Goga concedes that price regulation is a complex task. "Certainly, no one should be in favour of lowering prices ridiculously, nor should doctors subsidise people who can't afford care." Practice costs are also extremely difficult to pin down, since a practice in Sandton, for example, will have much higher costs than a practice in Beaufort West, and as a result it is not helpful to determine averages between the two.

Werner Swanepoel of Medical Practice Consulting identifies a number of factors that complicate charging tariffs based on averages. "Since South African doctors cannot set the price of supply when they enter into contracts with medical schemes, the principles of supply and demand costing do not apply here. We are still a developing country and the vast majority of people in our country do not earn comparable salaries, since we have a 25.2% unemployment rate."

Fair value

Central to the question of whether or not doctors are overcharging is the concept of a 'fair value'. According to Swanepoel, the concept of a fair value derives from the Health Professions Act and implies that health professionals should behave with discretion when charging fees. "A fair value should not be below the cost to deliver a service and where tariffs are offered to healthcare professionals that result in a loss, additional fees should be recovered from the patient to support the business." At the same time, Swanepoel says, "Charging exorbitant mark-ups that do not reflect the level of skill or risk of the procedure does not constitute a fair value."

In South Africa, the average income of patients over large geographical areas can vary tremendously, further complicating any attempt to find average values that can regulate private healthcare prices. "You must remember that a private healthcare practice is a business," Swanepoel said. "It has direct and indirect costs. Healthcare professionals must be allowed the freedom to tailor their costs in such a way that it makes their services affordable to patients in their area of practice." Additionally, there are concerns that pricing on the basis of cost, which is being suggested by some regulators, effectively provides no incentives for efficiency. This particular complaint has been a recurring feature of the UK's National Health Service, one of the models that South Africa's NHI programme is trying to emulate.

According to Goga, these concerns about pricing according to cost are "... a prime reason why the debate must move beyond price towards a focus on efficiency and quality." The solution according to Swanepoel is quite simply for private doctors to start running their practices as businesses. Doctors need to be able to negotiate with medical schemes in a way that allows them to calculate a profit on the delivery of the procedure and should be in a position to refuse tariffs that are not viable. "Every private doctor needs to draw up a dynamic budget from actual financial data taken from their

practice. This will give them an accurate picture of the true cost of procedures in their area."

However, the fact remains that the general public takes a negative view of the cost of private healthcare. As long as this situation exists, regulations and guideline tariffs will be among the solutions offered by regulatory bodies and civil society, and doctors can best prepare for this by keeping their own house in order.

The South African Medical Association's Code of Conduct for doctors states:

- When determining professional fees, consider the financial position of the patient and discuss the financial implications of treatment options.
- Respect the rights of patients, including the right to informed consent, which includes discussion and information relating to their condition so as to assist informed decision-making.
- Ensure that undue pressure from third parties does not influence patient management.
- Patients enter into a contract with a doctor and not with their medical schemes. Patients remain responsible for payment of their doctor's account. Schemes usually settle accounts within 30 days after receipt of a claim.
- A doctor or his/her staff can give estimated costs for further treatment, but precise amounts can only be given after the actual service has been rendered.
- A doctor may not ask for an 'up front' payment before a service is rendered. This is only allowed in certain cases of cosmetic or corrective surgery where the patient has been informed about this arrangement beforehand. Some medical schemes require patients to pay a levy when visiting a doctor. This is not regarded as advanced payment.
- Patients are advised to negotiate fees with all the members of the surgical team when going for an operation. They should be made aware that all of the members of the team (surgeon, assistant anaesthesiologist, etc.) can charge medical scheme benefits individually.