The looming loss by radiologists of R100 million in profit on contrast medium and the South African Medical Association’s refusal to back technical moves to avoid it has led to the Radiological Association of South Africa leaving SAMA.

Imminent regulations creating a single exit price for drug manufacturers, effectively banning discounts plus increasing ‘corporatisation’ of radiology practices, are the major reason behind an RSSA bid to adjust the charging structures.

SAMA and the RSSA are in profound disagreement over how to respond to the legislation, which allegedly stands to reduce radiologists’ overall income by up to 40%. This disagreement contributed directly to last month’s unprecedented walk-out by a specialist group.

The RSSA wants to either increase the units allocated to procedure codes or have the contrast medium profit included in the new professional dispensing fee. SAMA however insists that this amounts to ‘hiding profits’, skews the price coding system (which operates on inter-disciplinary relative values), making it ‘unscientific’.

SAMA argues that demands such as the RSSA’s militate against the overall interests and credibility of the medical profession.

“We’re saying you cannot convert profit on a consumable into a professional fee,” said one well-placed SAMA negotiator who refused to be named for fear of ‘aggravating relations’.

Sources within radiology cited mark-ups (including discounts) on contrast medium of up to 234% and higher – with further drug company incentives such as free overseas trips.

Richard Tuft, President of the RSSA, confirmed that the annual contrast medium profit was R100 million but emphasised that this constituted 5% of the annual payout to radiology (R2 billion).

The SAMJ calculated that if all registered diagnostic radiologists in South Africa (564) are practising, this puts contrast medium profit at R177 304 per radiologist per year.

The legislation is aimed directly at making drugs affordable to more people and slashing the massive profits currently generated between the source and the end-consumer.
in 1997, but regulations were drawn up and time-framed this year.

From 2 May next year the pharmaceutical industry will be banned from offering discounts to registered health care professionals and pharmacists. Doctors will have to apply for dispensing licences (after completing a supplementary course in dispensing and being accredited by the Pharmacy Council).

‘We just wanted to increase our professional fee to keep our income the same,’ he stressed.

One well-respected lawyer in the field characterised reaction from the medical profession as ‘furious, irrational, ill-informed and blaming’. She said many dispensing doctors erroneously believed that the R25 per script proposed by pharmacists as a dispensing fee was proscriptive. The truth was that the dispensing fee would depend on how successful applicants were in their upcoming representations to the statutory pricing committee.

Nominations for this body of experts, drawn from legal, medical and pharmacological disciplines, were called for on 10 February this year.

The committee is obliged to hold hearings and uphold the rights and legitimate expectations of stakeholders, but had yet to be constituted at the time of going to press.

Tuft confirmed the deadlock with SAMA and said the ensuing pull-out of his society was ‘really about the way that we handle the profit on contrast medium’.

‘As significant part of radiologists’ income (40%) comes from that – we had an agreement with the BHF and funders to put it back into the item it was in by increasing the number of units into the procedure. We want to make it a zero sum exercise for the whole country,’ he added.

Tuft said this was ‘not dissimilar’ to the GPs ‘taking the profit out of dispensing and putting it into the professional fee’.

‘We just wanted to increase our professional fee to keep our income the same,’ he stressed.

Another issue the RSSA had put before SAMA’s Specialist Private Practice Committee (SPPC) was for an exchange rate modifier, because radiologists were ‘very dependent on importing equipment’.

The manufacturers of the contrast medium believe that they are equally entitled to part of the redistribution of the discount.’

Tuft said the RSSA had recommended that its members remain members of SAMA.

‘We’re not trying to smash the association, we just want to go our own way,’ he said.

Tuft said that the RSSA’s walk-out was ‘premature without having had us (SAMA) for an audience – I’m really concerned about a divided profession in these difficult times for health care in South Africa’.

Tuft retorted that every attempt had been made to engage SAMA and charged that RSSA proposals to Letlape, which included remaining in SAMA as a specialist group, had remained unacknowledged and that the board was selectively apprised of developments.

The BHF’s chief benefit and risk officer, Fiona Robertson, confirmed that the BHF had adopted a principle that any tariff schedules would be corrected in accordance with the new law and that rates agreed upon should be cost neutral.

‘Technically Tuft is correct, but the base has now been extended to a third
party – namely the manufacturers of the contrast medium who believe that they are equally entitled to part of the redistribution of the discount.’

This has made discussions just ‘a little bit more complicated’.

Tuft revealed that the RSSA had since agreed to give back 17% of their profit to the drug companies.

The BHF has also been in a standoff with SAMA who claim copyright and intellectual property rights over existing descriptor codes which the BHF wants to amend.

Robertson said she hoped that by August an agreed model would have been developed with all parties to address the issues and provide a new recommended billing structure for radiology into the future.

Pressed on what the new model would look like she said: ‘We’ll need to understand what percentage is contrast and what percentage is the professional fee, so we can break it down and adjust it in the years to come to accommodate for contrast’.

The new act was intended to ‘take the fat out of the system’.

Jan Talma, chairman of the SPPC, said his committee had an obligation to address all unitary values on the same principles. ‘We cannot defend a structure which has distortions. If a group can negotiate a good rand value for units, good for them, but our duty is to be transparent and fair to all groups – we need a defendable benchmark,’ he said.

He described the situation as ‘still very fluid’ and denied Tuft’s claim that his committee had rejected the RSSA’s suggestion of an exchange control modifier.

Meanwhile struggling GPs, especially those in rural and low-income urban areas where they cannot practise good medicine without dispensing drugs themselves, are fighting the impending legislation.

The National Convention on Dispensing (NCD) were granted a reprieve by the Pretoria High Court after challenging the readiness of the State to deal with their drug dispensing licence applications within a compulsory 12-month period.

They have applied to have the legislation declared null and void, arguing that at the very least, current State inefficiency could deny them the right to continue dispensing.

Judge Eberhardt Bertelsman declined the State’s request to refuse the NCD’s application and postponed the matter to 21 October this year for review.

‘Whether we dispense or not, GPs are underpaid – we get just 7% of the total payout and specialists get 23%, yet we outnumber them by three to one,’ he added.

Chris Bateman

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