# The Dilemma of Cost

## — who must save on Medical Expenses?*

— J J du Toit

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***Summary***

*A study, based on the 1987 records of the Midland Medical Plan, examines the financial position of the GP within the medical aid system to see what costs are bound up with his servicing*

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KEYWORDS: Costs and Cost Analysis; Direct Service Costs; Family Practice; Insurance, Health

### Curriculum vitae

Dr Johan Jakob du Toit graduated from the University of Cape Town in 1951. He practised as a General Practitioner in Port Elizabeth for 30 years; served on East Cape Branch (Cape Midlands) of South African Medical Association and was also President of that branch. He was vice-chairman of the National General Practitioners group for 10 years, and active in founding of Midland Medical Plan by medical practitioners in 1961. He served on the board of directors for 20 years and has been the Managing Director of the Plan for the past 7 years. Dr du Toit holds directorship on the Boards of 3 private hospitals in which MMP has investments as well as a directorship on the Board of a computer bookkeeping buro for medical practitioners which is an integral component of the Plan.

**Talk given at the 6th GP Congress, Cape Town 1988.*

This study is based entirely on the 1987 records of Midland Medical Plan, (an East Cape Medical Plan) with a majority (90%) membership in the Uitenhage/Port Elizabeth area.

The following should be taken into account before drawing conclusions from the statistics.

a) The servicing pattern is probably regional and might differ in other areas. My opinion is that the GP plays a slightly bigger role in medical care in the Eastern Province than in the rest of the country.

b) The Plan controls referrals more effectively than other medical aids. In cases of self-referral the specialist is paid a full fee but the difference is recovered from the member. Referrals are valid for 4 months only.

In contrast the fund is very representative in black and white membership of the total relative medical aid membership in South Africa. It is completely non-racial and has been serving black members for 25 years. It can be regarded as a microcosm of medical aids in South Africa.

Keep this in mind when evaluating the figures and the conclusions.

The catch phrase in the medical aid world today is "flexibility" and for this to be achieved the guaranteed payment under the Medical Schemes Act will have to go.

Employer groups are insisting upon savings and

the service by the GP is the natural target. It is seldom catastrophic in cost, fluctuating between reasonable limits and can in the main be afforded by the member as an unassisted payment.

To both the medical aid and the employer it appears very attractive to apply the legal yearly limit of R100 on this aspect of service allowing the member to contract mainly for catastrophic or hospital-serviced illnesses.

This study was undertaken to examine the financial position of the GP within the medical aid and to see what costs are bound up with his servicing.

*It is the GP as a script writer who causes the highest cost of all sections controlled by him*

The result of the study has really surprised me (as it will probably surprise you). My impression was largely formed by the high profile of technology at present and I thought that this type of servicing generated a fair percentage of cost. The study proved otherwise. I tried to establish the exact amount, per average month, per member paid to the GP and, in addition, the costs directly controlled by him.

I will not bring the breakdown to percentages but give the true figures in Rands and Cents.

Our members cost us R132,01 per month, on average. Average family size is 3,2 beneficiaries per member, thus a beneficiary costs R41,25 per month.

*Of all the scripts going to the chemist, 87% came from the GP*

Two categories of cost are completely separated from GP control and I take these out immediately.

*Administrative* costs run to R7,92 per member per month and

*Dental costs* amount to R12,41 per month. It is the residual R111,68 which we are going to discuss.

(*A small residual* caused by dental treatment, eg hospitals and anesthetists, could not be taken out but will not cause significant disturbance.)

By complete coincidence one out of every three beneficiaries attend the GP every month, (being equal to 1 beneficiary per family of 3 average, receiving treatment) and the cost per member per month thus equals the cost per beneficiary treated monthly.

From this the GP received per month: (Sept 87)

| | |
|---|---|
| 1. Consultations 1st and repeat | R16,23* |
| 2. Non-consulting room servicing | R1,60 |
| 3. Procedures | R1,63 |
| 4. Non-surgical hospital care | R0,60 |
| 5. Anaesthetics | R0,44 |
| 6. Material and injection costs | R0,85 |
| Total | R21,35 |

*Every 100 1st consultations per month produce 19 more in the same month and with all services included, an average beneficiary is seen 1,35 times per month. Consultations produce 76% of the GP's income with spin-offs from dispensing, materials, office procedures etc.

The specialist in the EP only manages R18,40 per member per month

| | |
|---|---|
| Procedures | R14,90 |
| Consultations | R3,50 |

*Surprisingly, it was not the technology-service which generated the high costs!*

Of these fees the GP's use of the diagnostic specialities, radiology and pathology, amounts to an astonishing 63% of total, ie another R8,95 per month. This figure is based on number of accounts and not on the total amounts on the accounts generated by specialist and GP and may be inaccurate.

We will not take other referrals to specialists into account although a high percentage of these and the resulting costs will be GP-controlled. This will probably offset the excess added from the diagnostic specialities.

Hospital costs amount to R18,96 per month with the GP in our area having a low share of treatment of the seriously ill but a high percentage of minor surgery — his patients costing, R5,85 per month, ie 30,8% of total hospital cost.

It is the GP as a script writer who causes the highest cost of all sections controlled by him.

## Dilemma of cost

Except for the cost of the dispensing doctor averaging R7,24 per member per month, 87% of scripts going to the chemist came from the GP. In September 1987 the GP accounted for 85% of the cost of pharmacy medicines and the specialist 15%. The GP's overall cost percentage if dispensing is included — is 89% of total.

Average script cost in October 1987 was R26,97 for the GP and R31,85 for a specialist.

The GP thus controlled a combined medicine cost of R47,38 per member per month.

We have a further section called "paramedical", running at 4% of total. Some of the costs here, like referral to psychologists, are almost totally GP-controlled, in others, like optometric benefits, or chiropractic services he has no role. I have made an arbitrative award of 25% of these costs as being under his control.

To add up — per member per month:

| | |
|---|---|
| GP-controlled medicine cost | R47,38 |
| GP servicing | R21,35 |
| GP share of hospital costs | R5,85 |
| Paramedical cost generated by GPs | R1,32 |
| Use of Diagnostic specialities by GPs | R8,95 |
| Total | R84,85 |

This R84,85 represents 64% of total cost and 76% of the medical costs.

In addition to his paltry R21,35 per month per member, he controls R63,50 directly, ie, 300% of his own income. An increase in the R21,35 will be very dependant on a saving somewhere in the R63,50, making this the target for saving with a resultant increase in the GP income. The GP will have to study this in a scientific way — present this to the medical aid movement and apply this knowledge. Tariff determination today does not allow for this type of response or "inset", to be presented by subgroups of the Medical Association, but why not change this?

To conclude, the study demonstrated that the GP controls a very major slice of medical aid costs. He is best placed to introduce the incentives to examine critically those medical practices dominated by habit which are the major cause of waste. The GP group should barter these incentives for higher fees for themselves but will have to go to the bargaining table as an informed group capable of making major cost saving proposals.

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