

13-14 MAY 2026 | SANDTON

Aligning Pricing, Performance and Protection

Dr Anban Pillay,
Deputy Director-General: Health Regulation & Compliance
National Department of Health

Outline

- Fair Pricing in Healthcare
- Global experience in regulating healthcare prices
- SA history on price determination and HMI recommendations
- 2010 Pricing proposal
- Strategic Purchasing

Fair Pricing

- As the high cost of healthcare puts increasing pressure on affordability, the need to identify **fair** prices has never been greater.
- Conventional supply-side and demand-side approaches for determining a fair price have been ineffective in healthcare since healthcare is an essential service that does not follow the usual dynamics in economics.
INELASTIC

What would then constitute a fair price:

- Reimburse the total input costs incurred to deliver the service
- Reimbursement of the health professional's labour
- Fair return on investment

Global experience with Healthcare pricing

- Controlling the growth of health care spending while maintaining or increasing access is a major policy priority.
- Generally, health care spending increases at rates higher than general inflation. This is a function of both volumes of care and prices.
- In this context, price setting and regulation serves as an instrument to control volumes of services and spending, maintain quality, and promote sustainability and efficiency.
- In recognition of its complexity and importance, many countries have established or designated specific entities to carry out price setting and regulation.

United Kingdom

- NHS Payment Scheme (NHSPS) - national tariff. Patient-level cost data submitted by NHS providers.
- NHS England determines baseline prices based on the average unit cost of treatments. National Cost Collection for the NHS database - 80 NHS trusts and 152 NHS foundation trusts
- Complexity Top-Ups – services and procedures that are more complex will have an add-on to the basic tariff
- Market Forces add on – some areas have higher input costs, such as rental, wages, etc
- Standard procedures have set prices. Non-standard/complex services are set at the local level through negotiation.
- Some 75 staff work in the pricing teams.

Japan

- Bureau of Medical Affairs - 84 staff biennial revision of the fee schedules and authorises negotiations between the Japanese Medical Association, hospital associations, and specialist groups.
- Negotiations informed by data from the health economic survey of facilities, and the national claims database.
- Negotiations involves 7 members from payer groups (including social health insurance, business, and labor), 7 members from provider groups, 6 members who represent public interests, and 10 specialists representing professional associations and industry.
- The government publishes online a report surveying patient satisfaction indicators nationally
- Prime Minister, sets the global revision rate in the biennial revision of fees after negotiation

Republic of Korea

- The Health Insurance Review and Assessment (HIRA) Committee analyses costs and provider behaviour related to pricing.
- HIRA negotiates fees with each health care provider association, including physicians, hospitals, and pharmacists.
- Price and volume data are collected regularly to inform this process. Regulated prices and quality measures are published online.
- The committee consists of 25 members, chaired by the Vice Minister of Health and Welfare. Eight members represent payers (including labour unions, employers, and civic associations), eight represent health care professional associations, and eight are experts and public agency representatives (independent experts).
- 50 full-time staff conduct negotiations with health care provider associations

Thailand

- The National Health Security Office (NHSO) is a state agency under the supervision of the Public Health Minister.
- A subcommittee on financing analyses the unit cost, utilisation rate, high-cost interventions, and all other benefit packages.
- The budget for the Universal Coverage Scheme is evaluated by all relevant actors, including the Ministry of Finance, the Bureau of Budget, technical experts, and health care provider representatives.
- 50 full-time staff conduct negotiations with health care provider associations

Lessons from the International Experience

- Responsibilities for price regulation are either established under the health ministry or entities with the legal authority to set payment rates.
- There is a clear independent process of data collection to analyse inputs costs associated with service delivery
- These costs are presented to service providers and funders and form the basis for negotiation.
- The technical task of researching the costs of efficiently delivering the service is separated from the process of negotiating payments with health care providers.
- Interested parties such as unions and civil society are part of the price negotiation forum.
- There is approval and confirmation of the final price through a publication process by the political head.
- Price setting could create incentives for providers to shift care to other settings that are not subject to price regulation

SA history of the price determination (1)

- In 2004, the Competition Commission (CC) declared that the centralised reference tariff schedules produced by the Board of Health Funders (BHF – formerly RAMS), HASA and SAMA were a restricted practice as they were set in a collusive manner with anticompetitive outcomes.
- This decision by the Commission created significant logistical and competition problems for the price-setting process and created a void in the market.
- To mitigate these problems, the CMS established an interim reference tariff schedule (National Health Reference Price List (NHRPL)). The NHRPL was however only able to achieve a limited set of objectives. as the reference price schedule was determined by cost analysis. There was no agreement between funders and suppliers about the tariff calculated nor was there a market penalty for non compliance.

SA history of the price determination (2)

- The NHRPL process was ultimately handed over to the NDOH, and was referred to as the Reference Price List (RPL) and faced several challenges. The NDOH used Section 90 (1) (u) and (v) to implement the RPL.
- On the one hand, schemes used it as a benchmark for their tariffs, while on the other hand, providers saw it as a cost-based system of administered prices. There was a successful legal challenge from providers.
- The additional problem was that it led to providers colluding on prices and codes.
- The RPL process could not achieve a satisfactory outcome on final prices, as the costing analyses occurred without consideration of the budget constraints of medical schemes. Schemes would consequently strongly object to the publication of benchmarks that would immediately translate into higher fees.
- Providers, on the other hand, objected to going through costly benchmarking exercises that ultimately did not lead to adjustments in the RPL.

Key HMI recommendations on Pricing

- Establish a Supply Side Regulator
- Set up a multilateral negotiating forum for all practitioners to set a maximum price for PMBs and a reference price for non-PMBs.
- **Interim measure for immediate implementation**
 - Minister to make regulations regarding guideline tariffs using 90(1) of NHA to establish a negotiating forum on tariffs with TORs.
 - Stakeholders negotiate FFS tariffs under the auspices of the CMS.
 - Cost data collected is shared with all parties in negotiation
 - Outcome of negotiation published – non-mandatory
 - Disputes referred to arbitration
 - Bilateral negotiation can occur outside of this process

2010 Proposal on a Multilateral Price Negotiation Forum

Pricing Proposal

1. In the 2010 document the NDOH had oversight of the Multilateral Negotiation Forum (MLNF) and ultimately approved the outcomes of negotiation.
2. The proposal involved the **CMS as the secretariat and technical team** to support the process.
3. The MLNF funded through **levies** which the CMS.
4. Providers must provide **detailed costing information**, which will be verified by the technical team at the CMS. The costing will inform the **negotiation** between parties and lead to the development of the **reference price**. This would be done on a voluntary process
5. **The process is concluded when both parties agree on a tariff for each service**. The NDOH/CMS role is to convene the parties and ensure that negotiation does not lead to collusive practices. The DG and Minister approve the tariff that is agreed upon by both parties if the tariff is based on a fair process.
6. **Where parties fail to reach an agreement, the Minister indicates a guide tariff.**

Health Services Pricing Proposal

- 90 (1) (u) the processes and procedures to be implemented by the Director- General in order to **obtain prescribed information from stakeholders relating to health financing, the pricing of health services, business practices within or involving health establishments**, health agencies, health workers and health care providers, and the formats and extent of publication of various types of information in the public interest and for the purpose of improving access to and the effective and efficient utilisation of health services;
- 90 (1) (v) the processes of **determination and publication by the Director- General of one or more reference price lists** for services rendered, procedures performed and consumables and disposable items utilised by categories of health establishments, health care providers or health workers in the private health sector which may be used -
 1. (i) by a **medical scheme as a reference to determine its own benefits**; and
 2. (ii) **by health establishments, health care providers or health workers in the private health sector as a reference to determine their own fees**, but which are not mandatory.

Strategic Purchasing

What do we mean by strategic purchasing in healthcare

1. There are two types of purchasing: **Passive and Strategic (active)**.
2. With passive purchasing, information/ evidence is NOT used to define either
 - the goods/service we want to purchase or
 - to select the providers who will deliver the services or
 - How the service providers will be contracted and paid to improve quality
3. Providers are paid using historical input-based budgets, with no explicit link to the delivery of priority services, or, at the other extreme, they use open-ended fee-for-service payment with no mechanism for expenditure management.
4. Strategic purchasing uses evidence and information about population health needs and health provider performance to make decisions about which health services should have priority for public funding (“what to buy”), which providers will provide these services (“from whom to buy”), and how and how much providers will be paid to deliver those services (“how to buy”).

Paying for Performance

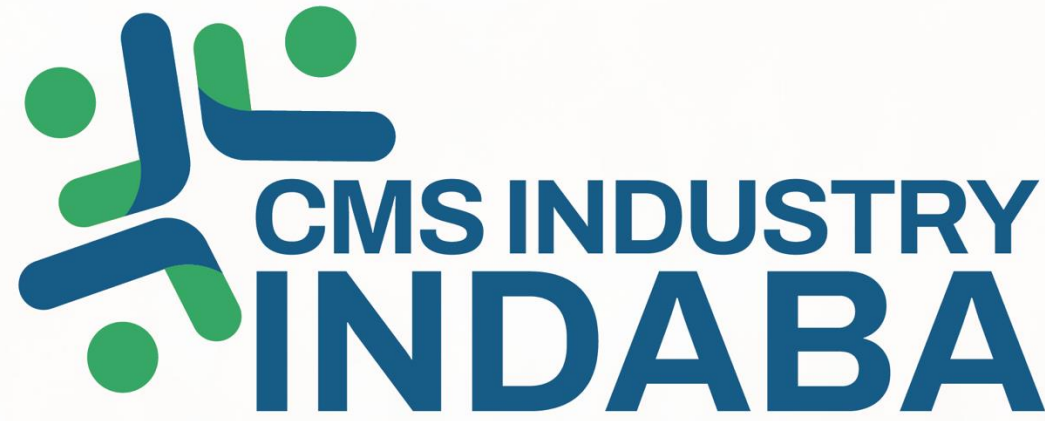
- Pay-for-performance (P4P): P4P, or also referred to as Performance / Results Based Financing (PBF or RBF) is one way of paying providers, but moreover, it can also act as a catalyst for health system reform.
- There is a need to shift to a multi-faceted intervention that:
 1. Move away from paying for input/procedure to paying for output;
 2. Invest in good data systems, and
 3. Make explicit choices on benefit prioritisation.
- Example – reimburse General Practitioners for reducing the HbA1c in high-risk diabetic patients.

Strategic Purchasing of Goods

- Prior to 2010, South Africa was purchasing ARVs at significantly higher prices than the global average price.
- This is despite South Africa having the highest HIV burden globally. One would have anticipated that we would be paying the lowest price.
- Strategic purchasing interventions, including:
 - Reference pricing
 - Exchange rate adjustment
 - Price negotiation
- We have reduced ARV costs by over 50% in a single tender using these interventions.

Future Consideration

- Pharmaceutical companies argue that they are unable to launch innovative medicines in South Africa and the obstacles include:
 - Single Exit Price
 - Medical Scheme's reluctance to include these products on the formulary
 - Low-volume market
- A pay-for-performance arrangement could be the solution.
- Possible Solution: The programme's enrolment criteria are based on defined clinical entry criteria. The CMS keeps a register of all scheme members with the medical condition eligible for the drug. There are agreed treatment milestones that must be met for the scheme to pay the company an agreed amount. This approach would resolve many of the current obstacles reported by the industry, clinicians and patients.



13-14 MAY 2026 | SANDTON

Thank you!

