B·H·F
SOUTHERN AFRICA

BHF SUBMISSION

HEALTH MARKET INQUIRY

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Contents

1. Introduction

The Board of Healthcare Funders (BHF) welcomes the release of the interim report by the Health Market Inquiry (HMI). The contents of the report confirm what BHF and other industry stakeholders have been saying for years prior to the Inquiry.

The recommendations in the report are in line with what the industry has been saying for many years. In fact , Judge Ngcobo notes that -
"a comprehensive commission of inquiry into the state of healthcare in both the public and private sectors may be more appropriate to evaluate the general state of healthcare services in South Africa in order to give effect to the constitutional right of access to healthcare services and goods guaranteed in section 27 of the Constitution".

Time is running out and given the length of time it took to complete the preliminary findings, one can only imagine how long the work of such a Commission of Inquiry would take while the pressing problems of affordability and adequate regulatory control of pricing and quality continue unabated.

BHF would like to warn against the view that competition, now that the Report has been released, might be regarded as the panacea for what ails the sector. The HMI's mandate, as clearly explained by Judge Ngcobo, is to answer the question whether there are features in the private health care markets for services and goods which harm competition or have potential to harm competition. In this paradigm competition is the object of the Inquiry. The Inquiry is the means to its end. There is thus a pervasive underlying assumption within all of the work of the HMI that competition is the solution. In BHF's view this detracts from the actual constitutional goal which should be the provision

and funding of health care goods and services at affordable prices i.e. the promotion of access by consumers to health care goods and service.

2. General Observations

We believe that competition will not solve majority of the challenges in the industry because competition in the private health sector does not work. For example, the sector's response to the Competition Commissioner's 2004 rulings prohibiting collective bargaining as anti-competitive. If this was true, and blossoming of competition in the private health sector subsequent to the rulings resulted in improved prices and access for consumers, the HMI would not be taking place.

Whilst the HMI Report is valuable and documents and highlights systemic challenges which need to be addressed outside of the realms of competition, it lacks implementable solutions for the health sector.

The consolidation of private hospital groups that is lamented by the HMI is the result of competition (not its absence) in the fragmented regulatory environment created by provincial licensing of private hospitals and the failure to implement a centralised national certificate of need licensing system.

The weaknesses in corporate governance amongst Boards of Trustees of medical schemes are at least partly attributable to the result of competition (not its absence) between administration companies as is the consolidation of such administrators. In the competition environment, at least in health care, the big fish always wins, and competition promotes the existence of big fish.

Medical schemes are fragmented and this has caused failure of the industry as highlighted in the HMI Report. Furthermore, medical schemes are so highly regulated that competition between them is diminished rather than to the existence of competition between them. That no new "regional schemes" have entered the market is indicative of the extremely high barriers to entry for new medical schemes as a result of the capital requirements and regulatory barriers on the funders.

BHF will use the findings in the Report to continue to lobby government on the subject of regulation especially of the supply side of the private health care industry and will encourage its membership to take on the initiatives identified by the HMI to improve accountability and the value of the service offering to its beneficiaries. BHF will explore better benefit design, coordinated care and encourage network arrangements as these are more cost-effective interventions as highlighted in the provisional report. BHF members will also work towards strategic purchasing as recommended by the HMI.

The supply-side recommendations are largely regulatory changes. It seems this is an admission by the HMI that healthcare markets are unable to be efficient on their own. This then needs to be remedies by regulation to restore the current imbalance between the highly regulated funding industry and the poorly regulated supply side.

The HMI rightly identifies greater challenges on the supply-side of health service provision due in no small part to regulatory failures. As a consequence of the inefficiencies identified, the HMI recommended that there be interim measures in place while the supply-side regulations are being implemented. However, there are limited details on how these interim measures will be put in place or who is responsible for these.

In our submission, we will include a section on the interim measures as well as a sequence of changes required for some of the proposed recommendations. In the same breath, reforms must be implemented in full, piecemeal approaches to reforms often lead to unintended consequences to the harm of the industry.

An additional problem that has not been fully addressed is the trust deficit that currently exists in the industry. This relates to some extent to the HMI finding that there has been inadequate stewardship by the NDoH. The strong vested interests, especially in for-profit entities that are in the environment make the navigation of any regulatory changes difficult. The lack of alignment of interests of stakeholders is perhaps the biggest risk faced by the industry.

The HMI report also notes the significant imbalance between market players. The report identifies certain medical schemes which can negotiate lower prices to the detriment of smaller market participants. The unintended consequence of the 2004 ruling of the Competition Commission preventing collective bargaining further entrenches the market power of these schemes. The unintended consequences of the HMI views are significant and should not be underestimated. The current environment allows such entities to thrive and the HMI notes that the benefits of economies of scale are not being passed on to the consumer.

The HMI view that collective bargaining cannot be reviewed benefits the entities that already have significant market power. The smaller hospitals through the Independent Hospital Network (IHN) are exempted from the prohibition on collective determination of tariffs, yet smaller schemes are not granted the same consideration when it comes to contract negotiation with providers. This situation works to the advantage of the supply-side which the HMI concedes is under regulated while medical

schemes are strictly regulated. There is no justifiable logic for this and it leads to entrenching the market power of the big schemes in the market, to the detriment of competition which might benefit consumers.

The lessons from the past should not be ignored as the HMI deliberates on the recommendations for the future. Firstly, reforms should not be implemented in part, yet the HMI highlights that it cannot recommend mandatory membership for people earning above a certain threshold. The HMI notes that this is because currently the industry is inefficient. This begs the question, why is the industry inefficient and the answer is that it is due to inadequate and in some cases inappropriate regulation. It is therefore not helpful to say that mandatory membership can only be introduced once the market is less flawed because one of the reasons it is flawed is the absence of mandatory membership in the current regulatory environment.

Incomplete regulatory and structural reforms in the private healthcare market are responsible for the many problems identified by the HMI yet the HMI itself shows reluctance for the completion of these reforms. While the HMI highlights regulatory and oversight failures on the part of the National Department of Health, it does not adequately acknowledge the extent of the imbalances in the market created by the existence of partial reform. The funder side is highly regulated, to the point of over-regulation in some cases, and yet is expected to conduct itself in a manner that requires a certain freedom of commercial spirit and enterprise. A highly regulated industry tends to default to the operational and strategic norms set by the regulator and there is active systemic discouragement of risk taking and innovation on the part of medical schemes except perhaps in the case of the very largest. Even they have had their battles with the regulator in order to introduce new ideas. BHF submits that the private health care market has stagnated in large part

due to the heavy regulation of funders combined with the inadequate regulation of the supply side. The extent of regulation of medical schemes tends coupled with the severe legal risk burden on boards of trustees discourages entrepreneurial spirit. One cannot have one's cake and eat it. If medical schemes are rigidly controlled by the Council for Medical Schemes, and BHF submits that they are, then competition between them is proportionately unlikely. In any event medical schemes, except for the large open schemes set up as cash cows by for-profit administrators, have never been regarded as business enterprises, either by the employers or other groupings that established them or by the trustees that govern them. As non-profit organisations their drive to compete is minimal because that has never been a part of their ethos. They were established as captive benefit organisations by employer and other groupings to serve the interests of their members. The notion that they are participants in a "market" has been superimposed by competition law and economics ideology and is incidental to their existence rather than central to it.

Another concern is setting conditions that entrench market power of bigger market participants. The proposed tariff determination process fails to level the playing field for all market participants. The rules under both proposals still offers significant benefits to the bigger market entities. It is important for the HMI to provide recommendations that offer equal opportunities for all market participants – the current view that focuses more on competition law rather than the healthcare will fall short of dealing with the challenges in the healthcare system. They may deliver on effective competition but fail the health citizen.

3. Medical Schemes

Any recommendations on the funder's side should be measured against the objective of efficient healthcare delivery, level playing field and competition should be on the right thing, such as quality of service. Recommendations that allow providers to compete on benefit design, for instance, bring about unintended consequences. Recommendations that require a large risk pool give unfair advantages to large open schemes as they already have membership volume and they can grow without limit. Restricted schemes are by their nature unable to grow in the same way, thus limiting their ability to negotiate on patient volume.

3.1 Imbalance between administrators and boards of trustees

The HMI report identifies inadequate / poor oversight by board of trustees in the management of scheme. Strongly related to this is the significant skills gap and capacity between the board of trustees and the administrators. The HMI rightly identifies this as a problem which often leads to sub-optimal health outcomes as well as cost-ineffective healthcare provision. The HMI provisional report, in some instances notes how boards may have handed over some of their responsibilities to administrators.

The recommendations do not address how these challenges identified can be addressed. It would be beneficial if the HMI provides the industry with concrete steps that deal with this challenge as it would significantly mitigate some of the problems identified. BHF has identified the following problems relating to the composition of Boards of Trustees -

(a) There is currently no minimum qualification, level of experience or skill that a person must have in order to be elected or appointed as a trustee. This often leads to the election or appointment of trustees who are poorly qualified for office, who

have the wrong agendas or who have scant understanding of the business of a medical scheme. In the case of some schemes, labour unions unduly and detrimentally influence, or even seek to dictate, the election of trustees who do not satisfy the "fit and proper" requirement of the Medical Schemes Act. The Act currently contains no proactive mechanisms to ensure that only trustees who are fit and proper can be elected to office. There is only a retrospective mechanism which allows the Council to remove trustees who are not fit and proper after they have been elected or appointed and have done something of sufficient significance to draw the Council's attention to their incompetence or unsuitability for office. This is usually well into their term of office and may be even into a second or third term of office. It occurs too often that within boards of trustees there are usually some who are merely "passengers" because they are so out of their depth that they cannot make a meaningful contribution to corporate governance of the scheme. It is often difficult for the remaining trustees to get rid of these passengers once their incompetence becomes apparent because there are no direct mechanisms for doing so and there are also politics at play within the scheme generally and the Board specifically that mitigate against such action by the other trustees.

(b) Scheme members seem to be generally disinterested in actively participating at scheme AGMs and tend to elect trustees almost by default. The Council for Medical Schemes and schemes themselves acknowledge this problem of apathy on the part of members and have tried to address it in a number of different ways over the years but without much success. It is all very well to say that AGMs must be structured to ensure membership

participation but scheme members do not exhibit the same interest in holding trustees accountable as shareholders of companies do with respect to company directors. It is BHF's view that member participation in scheme governance issues needs to be addressed in more innovative and proactive ways that require member participation in, for instance, rating the performance of individual trustees from time to time though the use of active surveys using social media and telephonic communication with members that is specially designed to provoke members into applying their minds to the work of specific trustees on the Board. The models for shareholder participation in the corporate governance of companies such as AGMs and other meetings do not work in the medical schemes environment because shareholders, unlike scheme members, are usually business people themselves, or are advised by stock brokers and other investment experts, and are much more inclined to be commercially driven than individual members of medical schemes. The fact is that medical schemes are not purely commercial entities and have a strong socio-economic objective, despite the Competition Commission's view that they do not fall within the purview of section 3(1)(e) of the Competition Act No 89 of 1998 (concerted conduct designed to achieve a non-commercial, socio-economic objective or similar purpose). Consequently, they do not fit comfortably within the standard economic, regulatory and commercial paradigms espoused by the Competition Commission.

(c) There are very powerful incentives for administrators to influence the election of trustees of large open schemes because these schemes have historically been established by administrators as cash cows for their for profit business. These

medical schemes were set up as a means to an end and were not the end itself. The end was a highly profitable medical scheme administration business. This is why there is often such close alignment of medical schemes governance with the interests of large administrators. The scheme and the administrator sit in such a close symbiotic relationship to each other in which the termination of the administration contract by the scheme would be nothing short of catastrophic for the administrator's business. In some cases, a change in administrators could also prove just as catastrophic for the scheme. Discovery Health's relationship with Discovery is the obvious example but there are others. Whilst it is understandable that medical schemes must have their own strong corporate governance structures distinct from their administrators and that there should be a strictly arms length relationship between them, the reality of the situation is that they are locked into a co-dependant existence and the HMI Report does not take sufficient cognisance of this unique feature of the industry. There is some justification for the argument that in certain contexts medical schemes and their administrators should be regarded as binary systems rather than discrete business entities. BHF believes that this conceptual approach would lead to more innovative solutions for the industry than trying to force a situation that simply does not match reality. Medical scheme administrators are in point of fact more knowledgeable than Board of Trustees about the medical schemes they administer, and it is with them that the real expertise with regard to medical schemes resides. As long as third party administrators exist, this will always be the case. The relationship between scheme and administrator from a

regulatory perspective therefore requires a different approach to that applied to normal businesses.

3.2 Benefit design and fragmentation

The HMI has highlighted the significant fragmentation in the medical schemes environment. This fragmentation exists in an environment where benefit design is very complex. The HMI provisional report notes that even brokers who are supposed to help beneficiaries with selecting benefit options do not understand the entire industry's benefit options. The HMI report identifies the difficulty beneficiaries have in selecting benefit options (they tend to be more focused on price rather than health needs or expected health outcomes).

In its recommendations the HMI does not make any firm recommendations to address these challenges identified. From a benefit design point of view, the HMI notes review of the Prescribed Minimum Benefits (PMBs) to include primary and preventative care. When the Risk Adjustment Mechanism (RAM) is discussed, there is a suggestion that there should be a common benefit which should be provided on all benefit options and then beneficiaries may purchase supplementary over. Furthermore, the risk adjustment will in all likelihood maintain the fragmented medical scheme risk pools.

It's not clear what the HMI is recommending from a benefit design perspective. From its recommendations it is unclear how fragmentation should be addressed. In some instances, the HMI recommends setting up regional schemes which could lead to further fragmentation within the industry. The Council for Medical schemes has recently started pursuing and agenda of consolidation of medical schemes which conflicts with the notion that more schemes should be added into the mix. There

seems to be a fundamental contradiction between the goals of competition which is to have a multitude of competing funders vying for members on the one hand and the goal of bigger and more efficient risk pools through the consolidation of schemes on the other.

The problem of complexity of benefit design has not been addressed adequately in the recommendations. It's important that beneficiaries can make better informed decisions when purchasing healthcare. If benefit design and fragmentation are not addressed adequality then some of the recommended changes may fail or further entrench the challenges such as benefit complexity and fragmentation.

Do medical savings accounts add to the complexity? By their nature they do not contribute to the principles of social solidarity that underpin the existence of medical schemes. HMI has avoided commentary on this aspect of benefit design.

3.3 Governance in Medical Schemes

The HMI report notes governance failures in schemes as well as the narrow focus of medical schemes on financial performance and less on the health of the beneficiaries. The BHF notes the HMI recommendation of linking trustee and principal officers' remuneration to performance. The HMI also recommended that the contracts of administrators be linked to specified performance matrices. The BHF agrees with these recommendations and further proposes that these initiatives be included as part of Annual General Meetings (AGM) deliberations. This will go a long way in improving governance as intended.

In the same vein, BHF recommends that the agenda items of the AGMs be expanded to include other important matrices to improve the trustees'

accountability on the health of the beneficiaries. The matrices that should be discussed at the AGM include reports on health outcomes and process indicators. BHF recommends that in addition to AGMs there should be mechanisms for direct communication between trustees and members on an ongoing basis and that members should be actively canvassed throughout the year by the scheme by means of telephonic surveys, questionnaires, social media surveys and other appropriate means on the performance of trustees based on information provided to the members by the scheme. Members cannot be forced to attend AGMs and human nature being what it is, they have repeatedly demonstrated reluctance to do so. This is a headache that schemes and their administrators, as well as the Council, have grappled with for years without much success. It is suggested that alternative, innovative, focussed and ongoing forms of communication with members are more aggressively pursued by schemes in order to secure member participation in the affairs of the scheme.

The HMI recommends that the schemes put in place measures to increase pressure on administrators to demonstrate the increase value that is added (paragraph 29 of chapter 10). The BHF notes that the schemes have limited control over this process. The HMI provisional report notes significant concentration in the medical schemes market and difficulty of some schemes leaving their administrators. The BHF believes this recommendation and responsibility for it implementation should be placed on the Council for Medical Schemes (CMS). The CMS, through the administrator accreditation process, can implement this recommendation by requiring administrators to provide the necessary information that can be used by scheme to assess their performance. BHF therefore recommends that the CMS reviews the accreditation criteria for medical schemes administrators to ensure that administrators have to at least conduct periodic assessments of their performance with regard to each

scheme they administer and provide such information to Boards of Trustees and scheme members.

3.4 The Risk Adjustment Mechanism

The RAM provides schemes with an opportunity to compete on providing quality services rather than the current scenario where schemes focus more on getting a better risk profile. Furthermore, the RAM enhances social solidarity.

There are some conditions on which such a mechanism should be put in place. The RAM in principle should provide a risk sharing mechanism which is based on:

a) Efficient services – risk equalisation should not reward schemes which do not actively purchase health services without regard for efficiency and outcomes.
b) Include income cross subsidies – income cross subsidisation is an important social solidarity principle and any risk transfer mechanism should also allow for income cross-subsidisation.
c) Standardised benefits package – a clearly set out benefits package should be the basis of the transfer of funds.
d) Consolidation of benefit options – the RAM should be applied across the single (common) benefit option. It is very complicated to equalise over the current fragmented risk pools. A RAM mechanism on the current environment will further entrench the fragmentation that currently exists.

Putting in place a RAM requires carefully considered sequencing of events and a set of conditions to be met. These must be considered given the direction the NDoH intends to follow with regards to healthcare.

The RAM must exist on its own without requiring subsidies from the state. The income cross-subsidies should be within the fund itself to avoid a situation where low income earners pay into the fund simply because they are healthier. At a functional level, the schemes should have one income-based contribution table for a standardised benefits package. The transfer of funds on RAM would be based on the net of the income cross subsidies and the risk as measured through the RAM process. The risk transfer amount must be based on an efficient price of health services and not the actual expenditure by schemes.

3.5 Mandatory membership

BHF notes with concern that the HMI agrees that mandatory membership is required for effective risk pooling, reducing anti-selection, but is unable to place it as a recommendation. The reasons sighted being the current inefficiencies in the healthcare system. Other than the indirect admission that the HMI believes its recommendations will be ineffective on fixing the current challenges, this is inconsistent with the recommendation on RAM.

The same conditions that are required for the risk adjustment mechanism apply to a mandatory membership environment. It should naturally follow that if RAM is possible under these conditions, then the mandatory membership will strengthen the environment.

BHF once again warns that piecemeal implementation of reforms is problematic. The HMI found that anti-selection is present in the environment. While we agree that the extent of anti-selection is not as bad as other cost push factors, it is not optimal to propose recommendations that ignore anti-selection and its impact. Reforms must be put in place which provide for an environment with optimal outcomes

not to ignore other inefficiencies just because they are not as bad as others.

It's not good policy to say once some of the problems are fixed we will reconsider mandatory membership. This HMI process has been taxing on the industry in terms of time and resources. Therefore, maximum benefit must be derived from this, rather than putting in place measures that will require another enquiry in the future for challenges already identified.

4. The healthcare providers

The provision of healthcare has been largely unregulated. Where state interventions exist such as facility licencing, these have been largely fragmented and ineffective. At the same time there are regulatory provisions in the National Health Act which have not been implemented. BHF welcomes the recommendations which focus on the regulation of supply-side interventions to improve healthcare delivery.

4.1 The Regulatory Requirements Recommended

The HMI recommendations for healthcare providers largely refer to regulatory changes or setting up new regulatory bodies. The HMI report notes the current regulatory failures in the private healthcare markets. The HMI provisional report also notes the insufficient actions and stewardship by the NDoH and at the same time the HMI wishes to place more responsibilities on the NDoH. There is therefore justifiable scepticism on how effectively and to what extent, if at all, the HMI's regulatory recommendations will be implemented by the government.

It is unclear to stakeholders if the recommendations are in line with the trajectory the government intends to take in terms of private healthcare reforms. If any of the recommendations are contrary to the planned healthcare trajectory then the current problems highlighted in the HMI report will persist.

Furthermore, regulatory changes take a long time to implement. Setting up new regulatory bodies may take even longer. The proliferation of regulatory agencies must be approached with caution because they add enormous expense to the system without necessarily reducing costs. Ultimately, it is the consumer who end up bearing the brunt of increase regulatory costs within the system. BHF submits that there is a need to put in place immediate measures to address the challenges identified in the HMI report. It's therefore important that the HMI considers making specific and constructive recommendations that can be implemented immediately in the short term. Given the regulatory failures of the past, it is important to consider possible practical measures that can at least contribute something to the mitigation of problems that ultimately require longer term regulatory solutions.

4.2 The Supper Supply Side Regulator (SSSR)

The BHF commends the HMI for recommending the setting up of the SSSR. This is a much-needed intervention as the providers of health services are largely unregulated. The proposed responsibilities of this regulator are wide and are critical for the effective provision of health services.

The proposed functions of the supply-side regulator include:

- Healthcare capacity planning such as licensing of facilities and professionals;

- Economic value assessment as well as health technology oversight;
- Implementation of payment mechanisms; and
- Outcomes measurement and reporting.

While the HMI recommends a review of the HPCSA rules, it's not clear who will exercise oversight of the relationships/contractual arrangements between the hospital groups and the healthcare professional providers. We recommend that the SSSR be tasked with this responsibility as well.

4.3 The Outcomes Measurement Regulator (OMRO)

The BHF understands the need for outcomes measurement and outcomes monitoring. The proposed mechanisms of having outcomes measurement are practical and are likely to have stakeholder buy-in and support.

We however are of the view that this function must permanently reside within an existing regulatory body, preferably the Office of Health Standards Compliance (OHSC). Whilst the OHSC may need additional capacity to fulfil this role, this option is still more cost effective than setting up a new regulatory body altogether.

Alternatively, the CMS may be mandated to measure outcomes. The National Health Act currently empowers the CMS to collect data from health institutions pursuant to its mandate. The CMS is currently measuring process indicators for medical scheme beneficiaries. The proposal to move the registration of providers in the interim to the CMS will further entrench the CMS ability to measure outcomes. The private healthcare industry in South Africa is relatively small with under 9 million lives. Having many regulators will overburden the industry from a cost perspective.

4.4 Regulated Price Setting

The tariff vacuum has been a major driver of healthcare inflation and it is a welcome recommendation to establish a tariff regime. Both processes recommended for determining tariffs are plausible and may work. The BHF prefers the second option, the Multilateral Tariff Negotiation Forum (MNF) where the SSSR would be facilitating the negotiations. This requires less technical capacity at the SSSR and its less prone to be viewed as being biased.

Caution must be exercised on the other features around the tariff setting process. The first and critical steps are a standardised PMB package and national standardised coding system. The tariffs would be based on these two components.

The proposed tariff system should also be viewed considering potential responses to the tariff system. The separation of tariff regimes between PMBs and non PMBs may influence provider decisions on diagnosis. As economic entities; they are inclined to choose a system that offers them the highest rewards. A tariff system that will eventually influence clinical coding decisions is not a good idea. To avoid this, a tariff/reimbursement system for both PMBs and non-PMBs must be implemented. The HMI proposal may be pro-competition but is not pro-health! It is not aligned to the Universal Healthcare Coverage policy adopted by SA. The BHF therefore strongly opposes the recommendations made by the HMI in this regard.

It is a welcome initiative to encourage innovation in the industry by allowing for platforms for strategic purchasing. The underlying currency for success of such payment mechanisms and bi-lateral negotiations is

patient volumes. In the absence of some form of collective bargaining for smaller schemes, this places the bigger schemes at an advantage. So as not to entrench the market power of the big schemes, it is important to exempt the smaller schemes to collectively bargain and negotiate with providers.

4.5 Health Professions Council South Africa (HPCSA)

The failures at HPCSA are well known by industry stakeholders. The HMI provisional report also highlights some of these shortcomings at the HPCSA. The recommendations that the HPCSA should review it rules while noble are unlikely to be successful. It's highly unlikely that the HPCSA will be able to review its own rule to the benefit of the patients given its inherent failures. In other jurisdictions, the idea of self-regulation by the health professions is being increasingly questioned by competition authorities due to findings that these institutions strive to preserve the status quo, stifle supply side innovation, are protective of the professions rather than the general public and prevent rather than promote competition between their members.

BHF recommends that the rules of the HPCSA be reviewed through a multi-stakeholder panel that includes key stakeholders such as other regulatory bodies, the NDoH, the funders and the hospital groups to mention a few. This will encourage wider view of related healthcare issues rather than be focused on views of a few stakeholders. The powers of the HPCSA and other statutory professional regulates to make rules that relate to the business conduct of professionals should be reviewed and possibly removed to another more objective regulatory body. The professional regulatory body's primary functions should be the monitoring and evaluation of professional education, the setting of educational and ethical standards and the certification if professionals

as competent to practice. Rules that interfere with the free association of different types of professionals, preventing group practices, the employment of professionals by non-professionals and that entrench current cost ineffective business models are outmoded and interfere with the capacity of the supply side to adapt to changing market requirements. The powers of the statutory professional councils to make such rules should be abolished by way of legislation.

It is important to highlight some of the observations noted in the HMI provisional report on supplier induced demand. The application of the prescriptive rules by the HPCSA are to a large extend to blame as this fails to address the relationships between the professional providers and the hospital groups. In the absence of rules that focus on patient outcomes, the proposed recommendations on tariffs will fall short of the objective of affordable healthcare as the issue of higher than necessary utilisation is not adequately addressed.

4.6 Materials and devices

The HMI has avoided making recommendations on the pricing of materials and devices notwithstanding its investigation in this area. We believe it is valuable for the HMI to provide details of their findings on this matter.

5. Interim measures

The following section details the interim measures that need to be implemented while awaiting all the recommendations to be put in place.

5.1 Tariffs

This is a much-needed intervention and cannot wait for the setting up of the SSSR. BHF propose that a tariff negotiation mechanism be implemented immediately. It is within the power of the Minister of Health in terms of section 90 of the National Health Act to make regulations on the processes of determination and publication by the Director-General of one or more reference price lists for services rendered, procedures performed, and consumable and disposable items utilised by categories of health establishments, health care providers or health workers in the private health sector which may be used-

(i) by a medical scheme as a reference to determine its own benefits; and

(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.

BHF advocates the urgent implementation of this section by the Minister of Health to create a mechanism for the development of such references price lists with input from stakeholders in the industry. The National Department of Health should be the hub around which the process of the development of such reference price lists revolves.

5.2 HPCSA

The HMI notes that some of the HPCSA rules should be reviewed, especially those that inhibit innovation and constrain the gatekeeping function of primary care practitioners. We propose that this be addressed immediately and overseen by the Minister of health or the NDoH.

5.3 Quality measures

The measurement of quality and reporting of such measures is vital. This should be the basis on which beneficiaries purchase healthcare. There are some efforts to measure and report on quality indicators by the Health Quality Assessment (HQA), though this is not available to the public. The CMS currently reports on quality through the annual report though these reports are based on process indicators only.

BHF recommends that the reports on quality be made available to the beneficiaries immediately. The CMS should encourage the schemes to include more outcome reporting and publish these for their beneficiaries to see. This will immediately force the boards of trustees to have a more health focus than financial focus in the management of the schemes.

All Medical Schemes must report on healthcare quality and outcomes at each AGM. Managed Care Organisations must publish their quality of care and outcomes performance to medical schemes, the public and the regulator.

5.4 Benefit design

Benefit complexity currently prevalent must be addressed immediately. The benefit offering for schemes need to be standardised to ensure beneficiaries and brokers understand more easily what the benefit offering is.

Other than removing complexity on benefit design for the benefit of beneficiaries, it is also a necessary step for the implementation of a risk equalisation fund. The standard benefits package that will be the basis of the RAM needs to be defined urgently. This does not have to be

designed to perfection, but a process of incremental steps should be followed to allow the package to be improved. This package needs to be offered through a single all benefit option and contribution for this benefit must be income based (standardised using the South African Revenue Service income bands for instance).

If required, the BHF is available to engage with the HMI on this response submission.