
# WESTERN CAPE DEPARTMENT OF HEALTH

# SUBMISSION TO THE COMPETITION COMMISSION ON THE HEALTH MARKET INQUIRY

**DUE DATE: 7 SEPTEMBER 2018 EXTENSION DATE: 1 OCTOBER 2018**

5th Floor, 8 Riebeek Street, Cape Town, 8001
Tel: +27 21 483 9356 Fax: +27 21 483 4990

Private Bag X2060, Cape Town, 8000
Michael.Manning@westerncape.gov.za

## INTRODUCTION

The Western Cape Department of Health (WCDoH) thanks the Competition Commission for the work done on the Health Market Inquiry (HMI) and find the insights contained in this report valuable in gaining a deeper understanding of the complexities which exist in the South African healthcare market. Furthermore, the WCDoH fully endorse the need for reforms within the current private healthcare market, with a view to creating a more inclusive and affordable environment.

The current healthcare market in South Africa face a number of intricate challenges. These include:

1. **High comparative expenditure** – The World Health Organization recommends an increasing % GDP spend for countries at comparable levels of development on healthcare. In South Africa it is evident that because of the increased burden of disease and other factors, public and private sector share a cumulative healthcare spend of 8.7% of GDP (2018).

2. **Imbalances in spending/population service ratio's** – in addition to the comparatively high spend which exists in healthcare expenditure, the market also reflects significant inequality in its service provision. While the expenditure split between public and private sectors are similar (just over 4% of GDP), the public sector covers approximately 84% of the population, while the private sector only covers 16%. This indicates that the private sector spends roughly 5 times more per capita on its consumers, in comparison to the public sector.

3. **Expensive private sector** – In many ways, the increased burden of disease in public sector places a premium on service provision in the private sector. The private healthcare which generally operates efficiently, if one removes the over servicing aspects, remains accessible, However, as a consequence of the economic and socio-economic status of South Africa, coupled with the rising costs of healthcare (largely as a result of oligopolistic hospital groups), private healthcare is only utilized by a minority, leaving the public sector to absorb the vast majority of the burden of care.

4. **Distribution of Practitioners** – Functioning of the healthcare market is also largely dependent on the availability of the necessary human resources. Given that only 1 in 10 dentists, 3 in 10 doctors and 1 in 10 pharmacists work in the public sector, this represents a huge inequality in the distribution of resources and puts additional strain on current practitioners in the public sector. Furthermore, the availability of practitioners is often concentrated in urban locations (in both sectors), putting rural and outlaying locations at risk of not being able to access required care when needed.

Owing to the above, it is widely recognized that there is a need to address the challenges facing both the public and private sectors. The WCDoH supports the need for reforms in the private healthcare market, specifically by increasing accessibility through the easing of barriers to entry for alternative funding models, implementing mechanisms to control cost-drivers and facilitating better value for consumers. Also, with significant developments made on the migration towards Universal Health Coverage, the WCDoH recommends that any proposals for changes in the healthcare market align with the objectives and functions of the UHC.

# SECTION 1

This section will directly address specific recommendations made in the HMI report. The Proposed Manner of Implementation, Proposed Entity Responsible for Implementation and Proposed Timelines are populated where applicable.

* The numbered points in this document correspond to those in the Health Market Inquiry for ease of reference when reading the responses.

| HMI Recommendation | Western Cape Department of Health Comments | Proposed Manner of Implementation | Proposed Entity Responsible for Implementation | Proposed Timelines |
|---|---|---|---|---|
| *17. Overall, the HMI finds that competition in the funders market is neither as vigorous nor as effective as it could, or should, be. This is true of both administration services and medical schemes.* | Agree, more so for administration schemes than medical schemes. The market is also restrictive in allowing for alternative funding models, which further limits competition. | | | |
| *18. In both the administration and open scheme markets, one large player (Discovery Health in administration and DHMS in open schemes) leads the market, especially in terms of growth, innovation and profitability. Other players largely follow its lead. Restricted schemes, by their very nature, do not compete with open schemes nor do restricted schemes compete with each other. The HMI found that there is limited competition between schemes on factors that increase the value of medical scheme cover (in terms of both cost and quality) and limited evidence of efforts to design and implement alternative reimbursement models to contain expenditure and encourage value-based contracting. The HMI believes that there are failures in regulation, governance and adverse incentives associated with the current market structure that contribute to this lack of* | Agree, there is a measure of competition between and open and restrictive schemes but not to the extent which would significant exert pressure on either to offer greater value or reduce costs. | | | |

| | | | | |
|---|---|---|---|---|
| *competition and innovation.* | | | | |
| *19. At the heart of the failure of funders to deliver better value to consumers lie multiple problems: a profound lack of transparency (including on scheme options and quality of outcomes), a lack of accountability of schemes to members, and a failure of governance that align scheme interests too closely with that of administrators. The lack of incentives operating at scheme level weakens schemes' resolve to hold administrators to account for delivering value to members. Health care costs and administration costs fees are increasing, and benefit packages cover less care.* | Agree, rising administration related costs are particularly problematic e.g. malpractice insurance premiums for clinical specialties (such as Gynaecology & Neurosurgery) are excessively exorbitant (in excess on R850 000 per year (2017) in some cases). The incidence of these costs often falls onto the consumers through higher premiums for benefit packages, as well as further depleting disposable income to pay for supplementary funding models (such as gap cover) and out-of-pocket payments. | | | |
| *20. The Inquiry has also found that all schemes have failed to adequately manage supply- induced demand. Given that supply-induced demand is known to exist in healthcare markets (and has been shown to exist in South Africa too), we would expect medical schemes to force their administrators to actively manage this in the interest of protecting scheme members' health and the financial sustainability of the scheme. The ability to effectively manage SID should also be a competitive differentiator for administrators. The widespread inability to manage and supply-induced demand suggests a lack of effective competition in the market for administration.* | Supply induced demand is particularly difficult to manage given that information asymmetries in this regard are always likely to exist. Drivers of SID such as over-servicing are tedious to pinpoint as they are easily masked by comprehensiveness in treatment protocols (considering the risks of malpractice claims).<br><br>Also, clinical practitioners are guilty of price discrimination where they are aware of the extent of coverage which consumers may have i.e. those with comprehensive plans and supplementary funding models (such as gap cover) are often billed more than those without gap cover and/or on less comprehensive benefit options. | A clear governance arrangement is needed | | |
| *21. With respect to the lack of transparency, consumers* | Agree, consumers often only become aware of | Comprehensive information packs for | CMS | 3-6 Months |

| | | | | |
|---|---|---|---|---|
| *simply do not know what they are purchasing and cannot hold funders accountable. There are too many plan options, very little understanding of what they cover, how the plans compare, and no measure of the value that consumers are receiving. In the absence of such information, consumers may simply choose what they can afford.* | what their treatment plans offer when they either require treatment or have already undergone treatment and are required to make co-payments due to the limitations of their options. | each benefit option available from Schemes and supplied to consumers once packages have been purchased. | | |
| *22. Ideally the trustees of schemes should be interceding on behalf of members to ensure that they receive value for money and that administrators are delivering the best possible value to scheme members. But, the governance of schemes is problematic.* | Agreed, trustees should be accessible to members and take grievances directly to administrators. | Be made an integral component of trustee duties.<br><br>Schemes should apply uniform rates to Trustee remuneration, issued from CMS via gazette; potentially include qualification criteria for Trustees | CMS | 3-6 Months |
| *23. There are few incentives to ensure that scheme employees, trustees and principal officers always act in the best interest of consumers. And even if they tried, administrators generally have far more analytical capacity and 'know how' than schemes and generally make decisions on behalf of schemes, even on key issues of strategy. The 'separation' between schemes and administrators often seems artificial, particularly in the case of large open schemes. This failure in governance is severe and is a major concern for the Inquiry.* | Agreed, it is tedious to attempt to manage the relationship between Administrators and the Schemes from a regulatory perspective, without intervening in operational aspects, however attempts can be made in this regard. | Regulatory intervention | CMS in consultation with relevant stakeholders | 12-15 Months |
| *24. A unique feature of the South African private market is that not-for-profit-schemes are administered by for-profit administrators. Our overall observation is that the interests of the for-profit administrators are dominant; scheme members and trustees are* | As per response in 29 | | | |

| | | | | |
|---|---|---|---|---|
| *too weak and or disempowered to force administrators to align to schemes members' interests.* | | | | |
| *25. The incentive alignment between restricted schemes and their members (from whom trustees are often appointed) is closer than that between open schemes and their disparate members. In closed schemes, particularly employer-based schemes, the cost of scheme administration influences the employer directly if they subsidise membership or indirectly if employees are dissatisfied with their health cover. We have found that closed schemes tend to have lower healthcare related costs, on average, than open schemes. For instance, non-healthcare expenditure for GEMS was amongst the lowest at 7.5% in 2015.* | As per response in 29 | | | |
| *26. However, even if restricted schemes exert some pressure on administrators, nonetheless administrators face insufficient pressure from schemes. Non-healthcare costs for the 10 largest schemes in South Africa range from 5% to 13.4% of gross contribution income compared to only 3% of GCI on average for OECD countries. Additionally, during annual negotiations it seems that trustees are generally satisfied with CPI-linked increases in member contributions year after year.* | As per response in 29 | | | |
| *27. We find no evidence that schemes demand information on the costs saved by administrators related to, for example, managed care or fraud control and whether the* | As per response in 29 | | | |

| | | | | |
|---|---|---|---|---|
| *related savings are passed on to scheme members.* | | | | |
| *28. The Inquiry has considered various options to address this failure in governance. We have decided that it is not practicable to recommend that administrators be converted to not-for-profit entities or that schemes be allowed to become for-profit entities in order to resolve the incentive constraint. We cannot trust that for-profit schemes will deliver better value for consumers given multiple information failures and adverse incentives shown to exist in the South African healthcare sector.* | As per response in 29 | | | |
| *29. Therefore, the panel recommends measures to strengthen governance to ensure that schemes place greater pressure on administrators to deliver value to members, that members place greater pressure on schemes to improve value for money, and measures that enable the regulator (the CMS) to exercise more effective oversight over funders.* | Agreed. giving the CMS greater oversight over funders can facilitate better value in the offerings. However, it must be approached with caution to avoid regulating to the extent which hampers competitiveness | Regulatory intervention with respect to governance | NDoH, CMS in consultation with relevant stakeholders | 12-15 Months |
| *30. The Inquiry would like to see an environment in which schemes promote alternative models of care that lower healthcare expenditure. This includes:* | Agreed. There is also a need to promote alternative funding models (such as primary health insurance) as opposed to attempting to place greater regulation on them (such as the 2017 Demarcation Regulations) and thereby reducing competitiveness in the industry. | Policy level which ease the barriers to entry for alternative models of care | NDoH, in consultation with regulatory bodies and relevant stakeholders | 12-18 Months |
| *30.1. multidisciplinary team-based care,* | Agree | | | |
| *30.2. investing in models of care where appropriate providers provide primary care,* | Agreed, as per comment on 30. | | | |
| *30.3. re-affirming/strengthening the* | Agree | | | |

| | | | | |
|---|---|---|---|---|
| *care co - ordinator role of GPs,* | | | | |
| *30.4. investing into innovation forms of care,* | Agree | | | |
| *30.5. employment of doctors in specific value-based quality-assured managed care service provision,5 and* | Agree | | | |
| *30.6. designing alternative reimbursement models that shift more of the risk of excess utilisation onto providers.* | Difficulties with respect the designing alternative reimbursement models are well documented | | | |
| *31. To improve transparency and promote competition we propose:* | Agree | | | |
| *31.1. The introduction of a stand-alone, standardised, obligatory 'base' benefit package that all schemes must offer. The package must include cover for catastrophic expenditure, i.e. the current Prescribed Minimum Benefits (including making provision for treating PMBs out of hospital) and; additionally, include, primary and preventative care. The base option would include a standard basket of goods and services and will thus be easily comparable across schemes.* | A "base" benefit package is supported on the premise that it would potentially reduce hospital admissions. It is expected however that in the "base" package would only become more cost effective once Schemes observe a decrease in admissions for PMB related cases and a subsequent cost-saving. | Consultation with relevant stakeholders required in this regard. | CMS with relevant stakeholders | 12-15 Months |
| *31.2. The introduction of the base package must be accompanied by a system of risk adjustment (see below), which will remove schemes' incentives to compete on risk factors such as age, and will instead encourage schemes to compete on value for money and innovative models of care.* | It must be taken into consideration that risk adjustments are not easily achieved given the complexities thereof. | Consultation with relevant stakeholders required in this regard. | CMS with relevant stakeholders | 12-15 Months |
| *31.3. Supplementary cover can be provided for care not included in the base package. We recommend that the CMS develop standards and requirements for all options for supplementary cover. This will improve* | Will CMS assume responsibility for regulating options and the review of PMB's?<br><br>CMS can develop standards & requirements for supplementary cover, | Standards for supplementary packages stipulated through regulations | CMS | 6-9 Months |

| | | | | |
|---|---|---|---|---|
| *transparency and assist consumers in comparing products, coverage and value across the industry.* | but should not be stringent, and be flexible enough to allow Schemes to be innovative in their offerings | | | |
| *31.4. That administrators must report publicly on the value and outcomes of all ARMs, PPNs and DSP arrangements they have entered into on an annual basis. These reports must be presented in a simple and accessible way, so that it allows consumers to see how much administrators have saved from these arrangements.* | Agree, any relevant reporting enhances overall transparency and provides insight into performance of the system and where improvements can be made | Regulatory to ensure administrators comply with requirements as stipulated | CMS | 3-6 Months |
| *32. To improve governance and align schemes' interests with those of consumers, we propose:* | | | | |
| *32.1. That the remuneration packages of employees of schemes, particularly that of trustees and Principal Officers, be linked more explicitly to the performance of schemes. Performance will be measured in terms of the value delivered to members. Presently, the remuneration of Principal Officers and Trustees is poorly connected to performance. We propose that the remuneration of Principal Officers and trustees be set at a minimal base level and that the rest of their package be linked to clearly-defined quantitative objectives of the scheme such as reductions in non-healthcare costs, administration costs etc.* | Schemes should apply uniform rates to Trustee remuneration (Which is capped), issued from CMS via gazette; Performance can be incentivized but also capped at certain level<br><br>Strict minimum qualification criteria for Trustees must also be included. | Regulatory to ensure administrators comply with requirements as stipulated | CMS | 3-6 Months |
| *32.2. That administrators' comparative performance on metrics such as non-healthcare costs; the value of PPNs, DSPs and ARMs, claims payment ratio, and the proportion of PMB and non- PMB claims paid from risk versus those paid from* | Agree, this supports greater transparency from administrators. | Regulatory to ensure administrators comply with requirements as stipulated | CMS | 3-6 Months |

| | | | | |
|---|---|---|---|---|
| *savings be published annually for each administrator compared to a national average. This publication should be produced by the CMS.* | | | | |
| *32.3. That schemes encourage member participation in its Annual General Meeting (AGM). This includes:* | Given the size of Schemes (even smaller Schemes), it is difficult to organize members in this regard. | The use of electronic platforms to create convenience for members and increase participation | Schemes with recommendations from the CMS | Immediately |
| *32.3.1. Modifying the requirements for attendance at the scheme AGMs to ensure adequate representation of members who are not employees, brokers, officers, consultants or contractors of the scheme or its administrator and do not have a material relationship with anyone contracted to or employed by the scheme to provide administrative, marketing, broker or managed care services. In other words, all conflicts of interest must be avoided.* | Agreed | Potentially made regulatory (if feasible) | CMS | Immediately |
| *32.3.2. That members must be notified of the scheme AGM in a timely manner and the AGM must be held at a time convenient for members (e.g. after office hours or on weekends).* | Members may be more reluctant to attend an AGM where it is held outside of business hours. May be more viable to consider an aggressive technological approach as recommended in 32.3.3 | The period for notification be made regulatory. Schemes may choose dates/times | CMS & Schemes | Immediately |
| *32.3.3. That AGMs make use of technology to facilitate participation of members who are not there in person.* | Agree | As per recommendation | Schemes | Immediately (at the next selection of trustees by Schemes) |
| *32.3.4. That the CMS review its criteria for election of trustees such that sufficient time and appropriate information is available to members to consider and choose trustees and that electronic election of trustees is possible to avoid abuse of proxy votes. Election of trustees must be conducted over an extended period and completed and audited* | Agreed, electronic election may be more accessible and thus reduce the number of proxy votes. Members must also be informed of what the role of trustees are and how they can assist in ensuring better value is given to members. Voting must be an open and public process. | Members are notified via mobile messaging that trustee information is available via e-mail or online Scheme portals. E-voting can also be done via these mechanisms. | Schemes with recommendations from CMS | Immediately (at the next selection of trustees by Schemes) |

| | | | | |
|---|---|---|---|---|
| *prior to the confirmation of the election results at the AGM.* | | | | |
| *32.4. The CMS's contact number must be included on the medical scheme card, to allow members to have direct access to the CMS.* | Agreed, CMS contact details are currently readily available; All calls or interactions logged with unique reference numbers to ensure an adequate audit trail. | As per recommendation | CMS | Immediately |
| *32.5. A set of core competencies for trustees also needs to be developed, taking into account the diversity of expertise required.* | Agreed, a set of minimum requirements must be developed for nomination as a trustee. This information must be sent to all members annually prior to the AGM.<br><br>Recommended Skills are:<br><br>Actuarial, Legal (Advocate level), Economist and/or Health Economist, CA (SA), ICT, Medical Practitioners, specifically GP's, nursing and specialties. Trustees should also have 10 or more years at Senior level | Not regulatory but made as a recommendation from CMS. Schemes may adjust as required | CMS | Immediately (at the next selection of trustees by Schemes) |
| *32.6. The CMS's proposed remuneration framework that seeks to cap Board of Trustees and Principal Officer Remuneration and align remuneration with performance should be implemented. The remuneration framework should take into account concrete indicators of improvements in the scheme's performance which must be linked to the performance of individual trustees.* | Agreed, issued from CMS via gazette. | As per recommendation | CMS | 1-3 Months |
| *32.7. That the broker system is an active opt- in system so that the interests of brokers and scheme members are more closely aligned. Members will be required, on an annual basis, to declare if they want to use the services of a broker. For those that do, the scheme* | Support a continued cap on broker fees.<br><br>Agreed, a monthly or annual fee (depended on usage) to be levied to ensure regular income stream for brokers and discourage the frequency in the | Regulatory with respect to the brokers operating with Medical Schemes | CMS | Immediately (with effect from the new year) |

| | | | | |
|---|---|---|---|---|
| *will facilitate the payment to the broker. Members who chose not to use the services of a broker will pay proportionally lower scheme membership fees.* | switching of schemes (where brokers are paid for new members) | | | |
| *33. To improve regulation and ensure that the basic obligatory package is appropriate, we recommend that:* | | | | |
| *33.1. The mandated cover for Prescribed Minimum Benefits must be revised to make provision for out-of-hospital and cost-effective care for PMBs. This will remove the current incentive to admit patients to hospital, often at higher cost, for PMB care.* | If increasing the scope of PMB to include out-of-hospital will reduce the cost of benefit options, then it is supported. Given that hospital admissions would be reduced, this would represent a saving and thus the cost of benefit options would be expected to be lower. | Regulatory bodies (SSRH) in consultation with relevant stakeholders, primarily Medical Schemes | SSRH & CMS | 12-15 Months |
| *33.2. The PMB package be expanded to include primary and preventative care.* | Agreed, primary and preventative (wellness) care will improve member health outcomes and reduce care required at secondary and tertiary levels. | Regulatory bodies (SSRH) in consultation with relevant stakeholders, primarily Medical Schemes | SSRH & CMS | 12-15 Months |
| *33.3. This revised PMB package should make hospital plans obsolete and will be replaced by the obligatory standard package.* | Hospital plans can still be in place for cases where emergency services are required. This improves accessibility and eases the burden of care on the state. | | | |
| *33.4. The services provided for in basic obligatory package can be extended over time as cost savings allow for greater depth or breadth of care.* | Unlikely that this would be viable considering the increasing burden of disease. Where there are cost savings, it may be plausible to consider reducing the premium (or increasing it at a rate lower than CPI) for the "base" package. The "base" package can be expanded by depth or breadth of care based on the review of the PMB's. Also, where there are cost savings, premiums for supplementary cover packages can be reduced (or increased | Regulatory bodies (SSRH) in consultation with relevant stakeholders, primarily Medical Schemes | SSRH & CMS | 12-18 Months |

| | | | | |
|---|---|---|---|---|
| | at a rate lower than CPI) thus making it more accessible. | | | |
| *33.5. That PMBs be reviewed regularly, as provided for in legislation.* | Agreed, annually if possible. Every two years is also acceptable if an annual review is not feasible | The newly formed SSRH submits proposal for comment; Responses are consolidated, a formal decision made | SSRH, with support from CMS and in consultation with relevant stakeholders in healthcare market | 1-3 Months |
| *33.6. That the Council for Medical Schemes produces a biennial report on the value of managed care services including the extent to which risks and benefits are shared between contracting parties and how savings are passed on to scheme members by lowered premiums or increased range of benefits* | Agreed, additional reporting tools are valuable in facilitating a greater degree of transparency. The report should also be comprehensive in terms of the CMS indicating (based on the results) whether they would be expecting a review of premiums or range of coverage by Schemes. | As per recommendation | CMS | Immediately |
| *34. To facilitate competition, we recommend facilitating the entry of regionally-based schemes. Innovation in the healthcare sector almost always starts small. New innovations will often be limited to particular services or geographies. However, schemes and administrators mostly have national membership and thus prefer national coverage. Facilitating the entry of regionally-based schemes may provoke different forms of competition in the market. However, if these regionally based entrants were to enter the current medical schemes environment, they would have to compete on risk selection, and thus face demographic risk and claims risk when beginning with only a few members. To mitigate this, the inquiry proposes reinsurance for small new entrants.* | Not supported, as indicated, new entrants into the market are likely to face significant risk and will struggle to compete with larger, established Schemes benefiting from economies of scale. Also, regionally based Schemes are likely to perpetuate geographic inequality in access to cover, given that Schemes would only see viability to compete in urban regions with higher per capita incomes and greater probability of choosing Scheme membership. Competitiveness can be fostered by facilitating alternative funding models (such as medical insurance) to compete directly with Schemes (particularly around designing low-cost options) | Easing the barriers to entry (regulatory) for alternative coverage models; allow for competition with Schemes (specifically in designing low-cost options).<br><br>The Medical Schemes Amendment Act should oversee the governance of the concerns | NDoH (Policy/Act level), in consultation with CMS | 3-6 Months |

35. Below, we provide more detail on these recommendations, where necessary.

# SECTION 2

This section will provide comment on selected recommendations which are discussed in more detail in the HMI report.

### ADDITIONAL/SUPPLEMENTARY BENEFITS

*47.3. Supplementary benefit packages should be easily comparable across schemes. This means that they will need to conform to rules set by the CMS as the appropriate regulatory body.*

RESPONSE: Agree, supplementary benefit packages should conform to specified rules, however Schemes need to be given a strong measure of flexibility to design innovative supplementary benefit packages, which will promote competitiveness.

### PRESCRIBED MINIMUM BENEFITS (PMBS)

*49. To facilitate scheme members' understanding of PMBs, including what they are entitled to and when additional (out-of-pocket) payments may arise, schemes must, at a minimum, provide the following information:*

*49.1. The ICD-10 checklist and plan formulary description for each PMB,*

*49.2. The list of DSPs for the treatment of PMBs, and*

*49.3. During the pre-authorization process, members should explicitly be told whether their choice of service provider or treatment course has additional cost implications and what alternatives are available.*

RESPONSE: Agreed, there is an onus on members to ensure that they have a comprehensive understanding of what their benefit option provide, however it is also the responsibility of the Scheme to ensure that this information is readily accessible and communicated to members in ways which are easily understood.

### ANTI-SELECTION MEASURES

*51. The SID analysis presented in Chapter 8 confirms that there is anti-selection in the market. What is not clear to the inquiry (nor is known to stakeholders) is whether the current legal provisions against adverse selection (waiting periods and late joiner penalties) offset the financial implications of anti-selection. Without this knowledge it is difficult to know whether additional steps must be taken to address anti-selection. Presently, one of the ways in which anti- selection is managed is that schemes are able to impose a late joiner penalty on an applicant who is 35 years or older when joining a medical scheme for the first time. The late joiner penalty is calculated on the basis of the applicant's age, the number of years since the applicant was a member of a medical scheme and the number of years that the applicant had no cover at all. The late joiner penalty discourages consumers from joining a scheme*

*later in life, when they are older and more likely to require care. We recommend that an incentive be put in place to encourage younger members to join schemes. This could take the form of a regulated discount on the medical scheme premium for new joiners younger than 35 to nudge younger members to join. The discount can be determined by the Minister of Health in consultation with the CMS.*

RESPONSE: Agreed, schemes should work towards attracting younger members, however careful considering needs to be given to the potential impact of the discount to ensure that it is not made too low or high. Attracting younger members into Schemes, coupled with greater intensity in the promotion of preventative care in benefit packages will also have significant positive effects on health outcomes over the long-run.

**SUPPLIERS OF HEALTHCARE SERVICES**

58. *For effective and efficient regulatory oversight of the supply-side of the healthcare market, the Inquiry recommends the establishment of a dedicated healthcare regulatory authority, referred to here as the Supply Side Regulator for Healthcare (SSRH). However, some of the recommendations proposed to deal with significant supply-side failures cannot wait for the establishment of a new regulatory authority. In these cases, interim proposals are made for existing regulatory or interim bodies to oversee the implementation of the recommendations.*

RESPONSE: Agree, there is a need for a greater degree of regulation in the supply of healthcare services (specifically in the private sector). An independent body (who works closely with the NDoH and other relevant stakeholders) should be constituted, with a diverse representation of stakeholders from public and private sectors, as well as academia. The intention here is build synergy between public and private sector, and to promote inclusiveness in decisions around regulation. The SSRH can assume responsibility for the provision of policy and regulatory frameworks at a national level, however PDoH's must retain mandate with respect to the implementation thereof. The role of the SSRH may also develop and become more crucial with the advent of the UHC.

**FACILITY LICENSING**

81. *To further address concentration, the inquiry recommends that the appropriate regulator(s) - in our view, both the SSRH and the PDOHs – develop a set of criteria for assessing local concentration. The assessment framework should specify the maximum allowable level of concentration of private hospitals at the local level. These concentration levels may vary according to local conditions, i.e. available public hospital capacity and insured population capacity.*

RESPONSE: Agreed, facility licensing must remain within the PDoH's with support from SSRH with respect to the development of regulatory framework and criteria. The criteria must however not create barriers to entry for new entrants to the market. In addition to this, the current burden of disease and estimated future health service needs per local conditions must also be taken into account.

## PRACTICE CODE NUMBERING

90.2. *Practitioners' premises must be registered and will be allocated a facility practice number separate from that of the practitioner. The facility practice number where care was provided must be captured in all claims to funders, with defined exceptions, e.g. roadside emergency. Proof of location of premises will be a core requirement for practice number renewal for both practitioner and premises. This is essential to enable routine and random inspections by the OHSC; to reduce the scourge of "ghost" practices and practitioners as well as to minimise claims fraud. Cleaning up of practice locations is a necessary step in improving resource planning and to support growth of meaningful provider networks to service both private and public-sector funders.*

RESPONSE: Agreed, there is a need to minimize fraudulent claims and practices. The OHSC should also be able to coordinate with PDoH's and utilize their databases to assist in this regard.

92. *To be clear, practice facilities/premises will be licensed by the SSRH licensing unit after certification by the OHSC, while regulatory entities like the HPCSA remain responsible for the certification of qualified practitioners. Practice numbers will only be issued to providers who have valid licences or certification from the relevant body.*

RESPONSE: The SSRH should only assume responsibility for registration but not licensing. Licensing should remain the responsibility of the PDoH's. A national policy and regulatory framework with norms and performance markers will be required, which can be the responsibility of the SSRH to develop.

## ECONOMIC VALUE ASSESSMENTS

94. *The Inquiry could not find good evidence of publicly available cost-effective standards of care and treatment protocols being used in the healthcare sector. This makes it difficult to assess the appropriateness of certain courses of treatment and to evaluate quality of care and value for money in the healthcare sector. The Inquiry recommends that this be remedied. Specifically, standards of care, evidence-based treatment protocols and processes for conducting health technology assessments to assess the impact, efficacy and costs of medical technology, medicines and devices relative to clinical outcomes must be developed.*

96. *Findings of the economic value assessments should be published to stimulate competition in the market, to mitigate information asymmetry, and to inform decisions about strategic purchasing by the public and private sectors.*

RESPONSE: The need for Economic and Outcome Value Assessments are viewed as a critical requirement and fully supported. Related practice guidelines in respect of these Assessments are also needed.

## HEALTH SERVICES MONITORING

100. *The Inquiry recommends that the requirement to measure quality and outcomes will eventually be legally enforceable, if necessary, by the SSRH in partnership with the proposed Outcomes Measurement and Reporting Organization, discussed in a separate section below. Given the importance of developing an outcomes registry, we also recommend a phased approach to implementation.*

RESPONSE: Enforcing a measure for quality and outcomes is fully supported, however the motivation for the establishment of an additional institution to oversee this process is unclear (unless it is determined that there are no current resources or capacity to undertake this function.

## HEALTH SERVICES PRICING

103. *As a result, fee-for-service prices are now largely determined bilaterally between individual providers and funders (either individual schemes or with administrators on behalf of all the schemes they administer), or between associations of providers and funders. Fee-for-service tariffs, regardless of how they are negotiated, are a reflection of market failure within the private healthcare system. These prices do not consider quality of care, nor do they consider or try to reduce supply-induced demand.*

RESPONSE: Agree, the pricing of private healthcare services is inefficient and, in many ways, foster supply-induced demand. Consumers of private healthcare largely bare the burden of these market failures through higher Scheme premiums, the need for supplementary funding models and out-of-pocket payments. There is also little to no accountability where providers compromise on the quality of care.

124. *The multilateral forum will be constituted of the same stakeholders as above; that is, providers, funders, government and civil society. Instead of presenting their tariff proposals to the regulator for tariff determination as in option 1 above; the stakeholders will prepare individual proposals and present them simultaneously within the forum. Stakeholders will then negotiate FFS tariffs within a multilateral negotiating forum accommodated and governed by the SSRH.*

RESPONSE: The tariff setting function is seen as one of the core functions of the SSRH. Of the two-proposed tariff setting models, a multilateral approach would be favoured. Will tariffs only be applicable to private sector or can these be made uniform and applied to the public sector as well?

## ESTABLISHMENT OF AN INDEPENDENT SUPPLY-SIDE REGULATOR FOR HEALTHCARE (SSRH)

137. *As indicated above, the Inquiry recommends that an independent supply-side regulator be established to oversee and manage functions related to healthcare capacity planning, economic value assessments, the determination and implementation of appropriate payment mechanisms (including the determination of fees via the MNF), and outcome measurement, registration, and reporting.*

*Locating these functions within a single supply-side regulator will ensure coherence in policy development and implementation.*

RESPONSE: The establishment of the SSRH is supported. It is also important for the SSRH to have at its human resources highly skilled in the fields of Actuarial Sciences, Accounting, Clinical Practice and Law. A National policy and regulatory framework is needed for the regulatory function. A benefit analysis be done to determine the most appropriate level to vest the various authorities in the value chain towards licensing and value chain governance.

138. *The SSRH can be established through the National Health Act which gives the Minister wide ranging powers. The SSRH should be an independent public entity, with its own executive and a board appointed by the Minister following a transparent, public nomination process. It is recommended that work to set up the SSRH begins immediately with the objective of getting to regulatory body functional within five years of publication of the final Inquiry report.*

139. *It is important to emphasise that the SSRH should be an independent public entity and that its independence be explicitly affirmed in its founding legislation. Other mechanisms that should be considered to ensure the independence of the institution include being clear on the role and functions; specifying that though the governing body is appointed by the Minister it should have sole powers to appoint its accounting officer and other senior staff members without interference; that it has financial autonomy, and that the long-term strategy, and key performance areas of the regulator be independently determined.*

RESPONSE: Given all the Public entities proposed by the NHI Bill, it should be noted that a further Public entity is likely to add administrative cost. The goals could be achieved with clear policy, regulatory framework and oversight by the unit with regulatory functions. Also, given the prevalence of fraudulent activities within public entities, strong governance and accountability mechanisms need to be put in place.

**PRACTITIONER PAYMENT MODELS**

145. *The HMI strongly supports a transition from FFS to alternative reimbursement models but is not in a position to prescribe how this should happen. There will always be a place for FFS in particular in trauma care. The Inquiry has hopes to encourage a variety of alternative forms of practice and methods of payment and would like to promote stakeholders to engage in effective ARMs with real risk-sharing and a commitment to providing better value for money.*

146. *However, the Inquiry is also aware that merely urging providers and funders to implement ARMs is not enough. Various recommendations we have made which include; a change scheme governance to align scheme interests more closely with members; the recommendation that schemes report on what they have done to promote value-based contracting, address supply-induced demand and contain*

*non-healthcare expenditure; the review of the HPCSA ethical rules to allow for multidisciplinary practices and global fees; the encouragement of geographic based new entrants into the market. These all provide avenues that should encourage a move away from fee for service.*

**CODING SYSTEMS**

147. *We recommend that coding systems across the sector be standardised to facilitate meaningful sharing of information. This is particularly important in relation to monitoring of quality of care, provider payment, maintenance of coding systems in line with evolving developments in medical care, introduction of new technology, and to prevent unilateral manipulation of codes to adjust tariffs.*

RESPONSE: Agree, there is a need for greater consistency in the use of coding systems, particularly to control the manipulation of codes to adjust tariffs. It is unclear whether this should again be a function of the SSRH. As previously mentioned, existing structures with the capacity to manage these processes should be used more effectively. It should not be the intention to overload the SSRH with multiple functions (at least in the short-medium term).

**PROVIDER NETWORKS**

155.1. *The structure of network agreements must promote transparency regarding pricing, health outcomes, and location of practitioners and facilities;*

155.2. *Reasonable patient access to service providers must be a key consideration in development of provider networks,*

155.7. *Network arrangements must progressively reduce fragmentation of service delivery and promote integrated delivery among clinicians, without introducing incentives for supplier induced demand.*

155.8. *Network arrangements must promote competition among health care product suppliers, i.e. avoid product exclusivity without selected network suppliers having been involved in competitive bidding;*

155.10. *No penalties must be levied on consumers for emergencies and poorly accessible network providers; and 155.11. No balance billing for services provided by approved network providers must be allowed.*

RESPONSE: Agreed, promoting the use of provider networks is supported. There is a greater measure of control in the use of provider networks, particularly with respect to controlling inconsistency in pricing. There is a need for a geographical balance in available providers to ensure that services are easily accessible to all members. Also, agreements on pricing for services must be explicit in ensuring that balance billing is not practiced by providers to any degree. The CMS or SSRH must develop mechanisms to monitor Scheme provider networks, to ensure the above practices are adhered to.

*156.1. DSP partners should only be appointed after an open tender process and results of the process must be lodged with the SSRH and published.*

*156.3. DSP contract arrangements should not be longer than two years. We make this recommendation to eliminate evergreen contracts while leaving the door open for new entrants to compete. Testing the market regularly in an open manner will have a positive effect on competition as well as expenditure in the long run.*

RESPONSE: The use of tender processes for the appointment of DSP partners is supported, given that it promotes transparency and competition. It is however not supported to propose that DSP agreements be no longer than 2 years. Allowing a period of 3-5 years would be better suited.

**OUTCOMES MEASUREMENT REPORTING SYSTEM**

*158. The lack of outcomes information seriously impairs competition and consumer choice in South Africa and also limits providers' ability to continually improve the service they provide. Radically improving the availability of information on quality of care will allow doctors to compare results and improve treatments. It will also provide funders the information they need to improve contracting.*

*159. There are several key requirements for putting a reliable outcomes measurement system in place. It requires defining quality indicators, collecting standardised data through a central IT-platform, auditing the data, performing necessary risk-adjustment of the data, measuring quality using the indicators and disseminating the results to providers and ultimately to the general public and funding sector. Fortunately, the process does not have to start from scratch as there are international exemplars to inform and kick-start this process.*

*160. 1The Inquiry recommends that the primary objective, in the initial period, should be to build capacity to measure and report on patient-centred outcome indicators. Other facets of quality such as structure, process, and patient experience indicators are less pressing and can be added at a later stage.*

RESPONSE: The need for tools to measure the quality of services in the private sector is fully supported, with a specific focus on patient-centred outcome indicators. In addition to this, there should be accountability mechanisms where services have not been efficiently rendered (consistently).

**OVER-SERVICING AND SID**

*172. We identified over-servicing and SID as a feature in the private facilities market that may undermine competition and consequently harm consumers. In this respect, the HMI recommends to the CMS to include metrics of SID in its published reports. The CMS need not conduct the analysis themselves but must publish information on what schemes/administrators are doing to cut back on supply induced demand.*

173. *To facilitate effective management of SID and to improve availability of data more generally, the Inquiry recommends the collection of anonymised data as was done for the HMI. The relevant regulatory authority (in this case, the CMS) must, in collaboration with stakeholders, define the format in which data should be submitted and how frequently it should be done. The CMS must also specify penalties for non- compliance and rules for secure storage and access to the data.*

RESPONSE: As previously indicated, it is agreed upon that SID and over-servicing undermine competition but also drive-up costs of healthcare through various channels i.e. increase scheme premiums, out-of-pocket payments, supplementary funding models etc. Given the complexities which exist in accurately identifying cases of SID and over-servicing, the approach of the HMI is supported. Furthermore, the imposition of penalties for non-compliance is also supported. The CMS can manage this process in the interim, with the SSRH assuming responsibility once constituted.

## SYNERGIES BETWEEN PUBLIC AND PRIVATE FACILITIES

174. *In Chapter 6 on Facilities, we have found that there are a number of local markets where limited public-sector capacity can be augmented by existing private bed capacity. It is not clear to the Inquiry why government has not already engaged in strategic purchasing in these markets. Nevertheless, the Inquiry recommends that strategic purchasing of available private capacity to supplement capacity in the public sector need not wait for the NHI. Government could, and should, already contract with the private sector where it needs capacity.*

RESPONSE: The notion of increased collaboration between public and private sector in the delivery of services is supported, however the WCDoH refutes the statement that government has not engaged in this market. Given the sensitivities involved with respect to the purchasing of private sector resources to deliver public services, there is a natural inclination of the public sector to approach this with caution. The WCDoH have however implemented a number of innovative, mutually beneficial models of collaboration between the public and private sectors for the delivery of public health services and continue to explore areas where this is considered feasible and within the prescripts of relevant legislation. It is also expected that with the development of NHI that the notion of contracting with the private sector for the delivery of public health services will be pursued more aggressively and with a greater degree of uniformity across PDoH's

## REVIEW OF REGULATORY ENVIRONMENT GOVERNING PRACTITIONERS

### REVIEW OF HPCSA ETHICAL RULES

175. *The HPCSA must undertake a review of its ethical rules with a view to:*

175.1. *Reviewing all rules from a competition perspective.*

175.2. *Re-phrasing rules to be more permissive or enabling in nature, including that:*

*175.3. Encouraging group practices;*

*175.4. Promoting the use of global fees.*

RESPONSE: Increasing the scope of the HPCSA to include aspects related to competition in supported. The WCDoH also notes additional concerns with respect to inconsistencies in the application of rules and guidelines by the HPCSA and encourages the need for reform in this regard. The WCDoH also supports the need for improvement in governance and monitoring mechanisms by the HPCSA, specifically the latest figures with respect to the number of practitioners active in both public and private sectors.