

# Health Outcomes Measurement and Reporting

Submissions review  
22 September 2017



**competition commission**  
south africa

# Outcome measurement as an end goal

## HMI's current position

- Need to strike a balance between cost and benefits of measurement
- HMI recognizes that outcomes depend on structure and processes
- But what ultimately matters to the consumer are outcomes
- And when combined with cost, they enable measurement of value (outcomes/cost)
- Given the need to minimize the compliance cost and to collect the most beneficial types of measures, the HMI is of the view that the system should focus on outcomes



# Outcome measurement as an end goal

## Stakeholders

- *Most stakeholders fully support the focus on outcomes measures, however:*
- Some stakeholders state that process measures are a good starting point, given the time it will take to implement outcome measures,
- Others emphasize that all three (structure, process and outcome) are useful
- Those process measures that have already been accepted by doctors and have been shown to improve results should be included



## New independent statutory body

- *There is full agreement that the OMRO should be independent for it to be trusted by all stakeholders. It is critical that providers trust the institution and results reported*
- However some stakeholders are not in support of establishing a new body
  - General idea is that we should build on existing structures to achieve QM&R as envisaged
  - Some argue that the structure and capacity required for ORMO exist inside the CMS – so they recommend CMS
  - Others argue for the OHSC and NDoH
  - Others argue for HQA, COHSASA, Health Commission



## Doctors' attitudes on outcomes reporting - survey

Reporting to providers N=695		Reporting outcomes to the public N=694	
Indifferent	<b>12.4</b>	Indifferent	<b>20.2</b>
Neither useful nor relevant	<b>5.0</b>	Somewhat opposed	<b>16.0</b>
I would be happy to participate	<b>77.3</b>	Very opposed	<b>8.9</b>
I would not want to participate	<b>5.3</b>	Somewhat supportive	<b>36.7</b>
		Very supportive	<b>18.3</b>

## Org. method for QM&R – doctor survey, N=692

	Societies	Colleges	HPCSA	OHSC	Univ.	New body
1	51.5	16.2	12.3	12.8	14.8	31.3
2	13.0	21.7	6.1	9.1	13.8	15.5
3	9.8	18.4	9.6	14.1	19.4	11.4
4	6.7	16.4	9.4	13.6	17.3	10.7
5	5.5	10.9	13.6	17.7	11.5	7.1
6	13.6	16.4	49.0	32.7	23.3	24.0
<b>Weighted score</b>	<b>2.4</b>	<b>3.3</b>	<b>4.5</b>	<b>4.1</b>	<b>3.7</b>	<b>3.2</b>



## Mandatory provision of data

- *Wide support for mandatory reporting to ensure sufficient participation*
- Poor response by practitioners to voluntary participation in the SANJR
- Voluntary system will result in different levels of participation and an unfair distribution of costs on providers
- There are some concerns relating to mandatory provision:
  - Mandatory collection of comprehensive outcomes data will impose cost (time and money) on practitioners
  - Administrative burden on practitioners will have to be carefully considered



## Public, private, NHI

- *Some submissions emphasized the need to align HMI recommendations to the NHI perspective*
- Given NHI ambitions and developments, all OMRO activities should equally apply to public and private facilities.
- Mandatory provision should apply to both public and private practitioners as NHI services will be procured by the NHI from both private and public practitioners
- Different implementation time lines may be needed



# Funding

- *Funding must be sustainable and linked to ‘independence’*
- Cost of operating a registry is argued to be very high – R10 mn per year for one registry
- HMI presented four options – Gov., levies, voluntary, hybrid
- Levies – is an important measure of independence.
- Government - through Parliament, rather than MoH
- Voluntary- less reliable
- Many stakeholders (e.g. CMS and LHC) are in support of a hybrid model
- Others (e.g. IPAF) suggest using a patient levy payable in both public and private sectors.

