Submission to the Health Market Inquiry (HMI) on areas of commonality and differences in relation to the HMI’s proposed findings and recommendations, following the April 2019 stakeholder seminars

26 April 2019
Contents

Contents .................................................................................................................................................. 2
Introduction ............................................................................................................................................. 3
Supply Induced Demand and Hospital Concentration ............................................................................ 3
Negotiations with Service Providers .................................................................................................... 5
Funders Concentration ........................................................................................................................... 6
Annexure 1: HHI analysis .................................................................................................................... 9
Annexure 2: ARMs in healthcare ......................................................................................................... 13
Introduction

This submission has been compiled in response to the request from the Health Market Inquiry (HMI) Panel to provide input following the workshops of 9, 10 and 12 April 2019. This submission should be read in conjunction with the previous Discovery Health (DH) submissions as well as the presentations made at the aforementioned workshops available at http://www.compmcom.co.za/seminar-presentations-2/.

This submission presents the following:

1. A brief synopsis of key points emanating from the discussions at the three HMI workshops mentioned above; and
2. Suggestions on a way forward, addressed in three themes:
   a. Supply Induced Demand and Hospital Concentration;
   b. Negotiations with service providers;
   c. Funder concentration

Supply Induced Demand (SID) and Hospital Concentration

1. HMI’s Supplier Induced Demand Analysis
   - We concur with the HMI’s findings that there is over-utilisation of hospital services in the industry. We have made submissions to the HMI to demonstrate that this over-utilisation is due to a combination of demand side and supply side factors.
   - Our analysis presented to the HMI, indicates that the HMI’s analysis on SID overstates the impact of supply side factors, and understates the effect of demand side factors on utilisation. We have demonstrated that the demographic deterioration due to anti-selection has been as significant a contributor to the excess escalations of contributions over inflation as the supply side factors.
   - The overall results of the HMI analysis on supplier-induced demand is consistent with DH’s experience. As our analysis demonstrates, we have also found a strong and statistically significant correlation between an increase in supply side factors and utilisation.
   - We note that hospital groups disagree that the number of hospital beds has a causation effect on utilisation. However, they have not offered any evidence providing a different explanation. Also, we have clearly shown how there is a “dose response” effect with increases in hospital beds. This means that even if causation is not proven, from a policy perspective it still makes sense to curb the proliferation of hospital beds in well-served regions.
   - We support the HMI’s response that using the “broad disease burden” definition in the model to assess the likelihood of a hospital admission is circular logic.

2. Growth in Hospital Beds
   - We have illustrated the incremental financial impact of the increase in hospital beds on utilisation, translating this impact into a financial cost for DHMS. Over a 10 year period (2008 to 2018), the cumulative financial impact of new hospitals on the Scheme was R3.3 billion (two-thirds of this, R1.98bn was over the last 3 years (2015-2017) and R763.2m in 2017 alone).
   - We agree that:
     o The majority of growth in the hospital market since 2015 has been driven by NHN thereby increasing NHN’s market share. However, as demonstrated in Annexure 1, the three corporate hospital groups continue to account for more than 85% of DH’s hospital expenditure.
     o Despite the growth of NHN, the three corporate hospital groups continue to enjoy bargaining advantages over NHN. Hospitals negotiating under the NHN umbrella are independent (and competing) and therefore cannot rely on cross-subsidies between hospitals.
3. Impact of Managed Care in Containing Over-utilisation
- DH has invested substantially in initiatives to manage the impact of supply and demand side factors on utilisation, for all our client schemes. The success and impact of these initiatives and savings realised by our client schemes has been reported in depth to the HMI, and have been externally audited and verified.
- Our submissions have demonstrated that these initiatives have proven to be highly effective with an (externally audited) ROI to DHMS on managed care fees now in excess of 200%. These savings from managed care result in direct benefits to the scheme members in terms of lower contributions and benefits that are more extensive. Had these initiatives not been in place, medical inflation would have been significantly higher. There were no submissions or evidence submitted by any role players indicating that these savings were not delivered.
- However, focused interventions that would result in better alignment of incentives to deliver quality care efficiently will significantly enhance affordability, provided that the regulatory framework allows such additional interventions.
- We note that there are several structural and regulatory features of the market that limit the effectiveness of managed care interventions, including:
  - The absence of a universal coding system and a collaborative system for regular coding updates;
  - The poor definition of PMBs as well as the requirement to pay PMBs in full; and
  - The HPCSA rules constraining the development and implementation of alternative reimbursement models (ARMs)

4. Proposed Remedies to Manage Utilisation Associated with Supply and Demand Side Factors
- We support the following proposed remedies:
  - A centralised hospital licensing processes, where hospital licenses are awarded following a scientific needs-based analysis. We note that the submissions by the hospital groups are in support of this recommendation.
  - The scope of such a licensing process should also include expansions of bed capacity in existing (licensed) facilities and any transactions in this regard.
  - Greater participation of public hospitals in the private sector, where hospitals can compete directly with private hospitals for medical scheme members. We further support Life Healthcare’s recommendation of the development of reference prices for private hospitals to treat public patients.
  - More effective mechanisms to prosecute those found guilty of committing fraud. There seems to be broad support for this proposal.
  - An environment that enables ARM contracting including
    - Relaxing of the HPCSA employment rules to allow for multi-disciplinary care.
    - Outcomes reporting on effective clinical indicators to enhance competition in the provider market via established entities (such as the HQA, OHSC etc.).
    - Patient-centred approach to relationships between hospitals and specialists to ensure doctors are supported in their professional ethical responsibilities.
- Remedies to manage demand side utilisation include:
  - Mandatory membership above defined income thresholds and/or other mechanisms that enable better protection against anti-selection, as mentioned in previous submissions. We strongly believe that the HMI should explicitly recommend this policy change, as it will be the most effective of any policy change in reducing the current rate of medical inflation and ensuring greater long term affordability; and
  - Clear PMB definitions with associated well-defined maximum tariffs for doctors and non-corporate providers.
Negotiations with Service Providers

1. Coding
   - We support an organised and collective negotiation process for the updating and maintenance of billing codes for individual health professionals as well other healthcare service providers, such as hospital and pathology groups.

2. Tariffs
   - Tariff negotiation between healthcare professionals and funders
     o We support the establishment of non-binding reference prices for non-PMBs (following an appropriate revision of the PMB definitions).
     o We also support the proposals for a maximum fee for service (FFS) tariff for PMB services, with no balance billing of consumers. However, this should not constrain in any way, the opportunity for bilateral arrangements. This is an important mechanism for patient protection.
   - Tariff negotiation between corporate providers (facilities and pathology) and funders
     o We support the recommendation that bilateral negotiations be the main contract negotiation modus operandi between funders and corporate providers (such as facilities and pathologists) for both FFS and ARM based agreements.
   - This approach will stimulate innovation in contracting, providing an incentive for providers to accelerate the development of effective ARMs.
   - It is important to note that there are a variety of ARM constructs (as per our submission of July 2016). There have been a number of further developments (within current market constraints) and these updates are presented in Annexure 2.

3. Healthcare Provider Networks
   - We do not support the proposal that DSP arrangements should be open to “any willing provider able to price match” as this will limit funders’ ability to selectively purchase quality healthcare services and to channel patient volumes to preferred providers in return for valuable contractual provisions that address both price and quality of care provided.
   - It is important to distinguish between corporate and individual providers when considering the DSP tender process. It is impractical and unreasonable to impose any requirement on medical schemes, to negotiate bilaterally with or to issue tender documents to more than 20,000 healthcare professionals.
   - The mandatory terms proposed for DSP contracts are inappropriate. This approach will reduce innovation and competition, impeding value to members and quality of care. We recommend that contract terms remain flexible at the discretion of contracting parties.

4. Alternative Reimbursement Models (ARMs)
   - We believe that the ability to transfer risk (partially or fully, where appropriate) from funders to providers in the form of ARMs is imperative to enhancing provider accountability and realising the goal of more efficient healthcare delivery.
   - We agree that mechanisms are required to ensure that the health practitioner’s clinical integrity is not compromised in any way when participating in ARM contracts.
Funders Concentration

1. Benefit Design
   - We support a process that aims to simplify benefit design to reduce consumer information asymmetry. However, standardisation should not come at the expense of innovation and competition, as this will reduce accessibility to care.
   - We recommend that a low income basic benefit package be considered where income verification is possible (i.e. for employees in formal employment) to promote affordability and that at least 2-3 package structures are contemplated to address diverse affordability and healthcare needs.
   - The base benefit package can replace the current PMB package, provided the revised benefit package is limited to covering necessary and effective care, and the cost of the package does not exceed current levels of PMB costs.
   - The base benefit package/s must be accompanied by mandatory membership and a risk adjustment mechanism to prevent anti-selection and enhance competition. The sequencing of these reforms must be carefully considered to prevent any unintended consequences on the industry (and the accessibility of cover).
   - Attention must also be given to the urgent need for the development of a Low Cost Benefit Option (LCBO) and how this process will impact on the concurrent PMB revision process. There is an opportunity to significantly expand immediate access to cover to alleviate the pressure in the public health system.
   - It is not appropriate for the regulator to limit the number or level of benefit options, given that this will come at a great cost to competition and will have a number of harmful effects on consumers, including either reduced benefits and/or higher premiums for likely millions of scheme members. Aside from the issue of consumers finding the number of options confusing, which we accept, no party submitting to the HMI has provided any real evidence of the harm arising from the fact that consumers have a range of benefit options to choose from. This provides substantial choice and benefit to consumers, and the gains in terms of reduced confusion must be balanced against the harms of reducing choice and forcing millions of scheme members into options that are not suited to their needs. The number of benefit options in the open medical scheme market has arisen out of the need to compete on price, and the need to give consumers the choice of restricted networks in return for lower premiums. Enforcing a reduction in the number of benefit options with inevitably result in forcing members to choose between higher contributions or lower benefits than what they currently have. We are preparing more evidence for submission in this regard.
   - We strongly support that brokers are best positioned to assist consumers with option comparability (taking into account specific client requirements) given that their conduct is governed under the FAIS Act.

2. Mandatory Medical Scheme Membership
   - As illustrated to the HMI by GEMS and DH, the effect of open-enrolment and community rating has led to rampant adverse selection across the industry. This adverse selection comes at a direct cost to members in the form of higher contributions, and happens despite significant managed care interventions and resultant cost savings. The submissions to the HMI that argue against these findings are not supported by the clear evidence provided by DH and GEMS.
   - There is also a high degree of churn where members are able to select against schemes to best suit their needs. The resultant instability in membership creates financial distress for the scheme, a cost that is borne by the loyal, long-standing members of the scheme.
   - We therefore firmly believe that mandatory membership is critical in this environment for the financial sustainability of schemes. As indicated to the HMI, we believe the impact of mandatory membership would reduce current contributions by a once off 17%-23%.
   - We expect this to be followed by an average 1.5% to 2.0% reduction in year on year claims inflation; given that demand side factors are largely attributable to anti-selective effects.

---

1 We have illustrated to the HMI that during the period 2010-2018 the average risk claims inflation for DHMS (plan mix adjusted) was 11.0% p.a. Of this, 2.8% p.a. was due to demand side effects.
As illustrated in the Figure 1 below, there is therefore a once off step-down effect in cost as well as a subsequent annual reduction in claims inflation associated with implementing mandatory membership. The figure illustrates that the gap of 17% in year 1 (2019) increases to a gap of as much as 30% by year 10 (2028).

Figure 1: Impact of mandatory membership on claims inflation

Figure 2 illustrates that there is a significant proportion of higher-earning households who do not have medical scheme coverage (over 20% for households with income in excess of R400 000 per annum) and are likely to have remained outside cover (as a rational decision) for anti-selective reasons since the regulatory framework permits them to only enter when cover is required. Mandatory membership above an income threshold would be more feasible as it accommodates affordability and could be incremental.

Figure 2: Medical Scheme coverage by income band

Source: Masters dissertation by Daniel Shapiro, University of the Witwatersrand
3. Funders’ Market Concentration
- We have presented extensive evidence that the medical scheme market is competitive. Almost 25% of DHMS members are making changes to their benefit options and/or medical scheme cover each year\(^2\).
- We do not agree with the funder concentration assessment presented by Netcare, noting our reservations regarding the use of HHI as any kind of absolute test and using the market share of administrators (given that tariff negotiation occurs at this level), the HHI is at 2,305\(^3\) for 2017. These calculations are included in Annexure 1.
- With regards to the HMI recommendation to introduce regional schemes to the market to enhance competition, we are concerned that this may create an uneven playing field resulting in adverse selection at local level, to the detriment of members of national schemes, regardless of their size. There has been very little detail provided on this proposal to date and so it is difficult for us to comment further other than to note the need for considering the consequences in detail before making the recommendations.

4. Governance of Medical Schemes
- We have demonstrated that DH’s business model is aligned with the interests of its client schemes. By delivering sustainable value to members, the scheme is able to attract more lives, hence creating a sustainable risk pool and increased affordability of cover.
- We do not object to the University of Fort Hare’s recommendations regarding the fiduciary duties of administrators. We currently conduct ourselves on this basis and therefore do not believe that these recommendations will have any effect on improving scheme governance other than to add to the cost burden of compliance reporting.
- The HMI has not presented evidence of systemic governance failure in medical schemes and it is our view that the role of the trustees in exercising their fiduciary role is taken seriously by the vast majority of trustees. We therefore believe that trustees are already acting with the aim of protection of members’ interests. It is important that any regulatory or other impediments to the exercise of these duties are prevented.

We appreciate the opportunity to submit this additional input as well as the opportunity to have presented at the workshops on the 9\(^{th}\), 10\(^{th}\) and 12\(^{th}\) of April 2019. We would be happy to expand on or provide more clarity on any of the points raised.

---

\(^2\) The difference in churn figures presented at the HMI Funders Workshop (10\(^{th}\) April 2019) is due to the exclusion of newborns in slide 16. Newborns were included in the figures on slide 3.

\(^3\) GEMS has been included independently, given that GEMS (rather than its administrator) performs their own tariff negotiation. It is not appropriate to separate open and restricted lives in this calculation.
Annexure 1: HHI analysis

1. Introduction
Concentration refers to the extent to which a small number of firms account for a large proportion of economic activity. Various measures have been suggested to measure concentration used to describe market structure and/or a prima facie indicator of market power or competition among firms.4

The Herfindahl-Hirschman Index (HHI) is a popular measure used to calculate market concentration. This measure is based on the total number and size of firms in the industry. It is computed as the sum of the squares of the market share of all firms in the market.5 As such, the index can range from zero to 10,000, where 10,000 would represent an industry with a monopoly.

The U.S. Department of Justice considers markets below 1500 to be un-concentrated; those between 1500 and 2500 to be moderately concentrated, whilst those above 2500 are classified as highly concentrated.6

Despite the mathematical and economic advantages of the HHI, the HHI as with all other concentration measures only provides a one dimensional view of the market, namely market structure. As Econex explains, the limitation of the HHI is the erroneous conflation of market power (market share) with consumer disutility. The theory relies on causality of market structure (the number and size of firms) with market conduct and market performance, where conduct refers to the behaviour of firms, whether competitive or anti-competitive, and performance includes profit levels, efficiency and economics of scale etc. However, as Econex concludes, regardless of these limitations, the HHI serves as a useful starting point in market structure analysis.7

2. Facilities HHI Analysis
The three listed hospital groups (Mediclinic, Life Healthcare and Netcare) have all illustrated the growth of NHN since 2010 and the impact of this growth on their market shares hence, bargaining power against funders. In particular, the number of NHN beds have doubled, increasing NHN’s market share from 16.0% in 2010 to 25.1% in 2017. This increase in market share of NHN has come at the cost of a reduction in the market share of the three listed hospital groups. The three listed hospital groups claim that this growth of NHN has created a “fourth hospital group”, giving NHN similar levels of bargaining power against funders.

NHN however do not agree that this increase in market share has led to an increase in their negotiation power, as unlike the three hospital groups, hospitals negotiating under the NHN umbrella are independent (and competing) and therefore cannot rely on cross-subsidies between hospitals to ensure the group reaches profit levels as a whole. This cross-subsidy advantage of the three hospital groups dilutes NHN’s bargaining power against funders.

Nonetheless, despite the growth of NHN (and treating it as a group), it has been presented there has been no significant change to the market concentration at a national level with the hospital HHI increasing slightly from 2,106 in 2010 to 2,179 in 2017. The hospital groups contend that this should not be of concern to the HMI given that HHI levels remain well below the levels of 2,500. These figures are illustrated in Table 1 below.

---

4 OECD, Glossary of Industrial Organisation Economics and Competition Law 
5 OECD, Glossary of Industrial Organisation Economics and Competition Law 
7 Econex, The use of concentration indices to measure competition in South Africa’s medical services markets, Occasional Note, April 2012
Table 1: Market share and HHI of hospital groups 2010 -2017

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>4,397</td>
<td>13.5%</td>
<td>181</td>
<td>3,535</td>
<td>8.7%</td>
<td>76</td>
</tr>
<tr>
<td>Life</td>
<td>7,360</td>
<td>22.5%</td>
<td>507</td>
<td>8,636</td>
<td>21.2%</td>
<td>451</td>
</tr>
<tr>
<td>Netcare</td>
<td>8,556</td>
<td>26.2%</td>
<td>685</td>
<td>10,088</td>
<td>24.8%</td>
<td>615</td>
</tr>
<tr>
<td>Mediclinic</td>
<td>7,126</td>
<td>21.8%</td>
<td>475</td>
<td>8,195</td>
<td>20.1%</td>
<td>406</td>
</tr>
<tr>
<td>NHN</td>
<td>5,245</td>
<td>16.0%</td>
<td>258</td>
<td>10,228</td>
<td>25.1%</td>
<td>632</td>
</tr>
<tr>
<td>Total</td>
<td>32,684</td>
<td>100%</td>
<td>2,106</td>
<td>40,682</td>
<td>100%</td>
<td>2,179</td>
</tr>
</tbody>
</table>

Source: Netcare Presentation to the HMI Facilities Workshop – 9th April 2019

However, despite the growth of NHN in bed numbers, this increase in the group’s market share is not evident in claiming patterns across DH administered schemes (DHMS and all in-house schemes). In fact, the trend in the distribution of admissions and claims by hospital network between 2015 and 2018 has been uniform across the period, with the three large hospital groups continuing to treat the large majority of DH patients. For example, in 2015, the three hospital groups accounted for 83.6% of total DH admissions. In 2018, despite the reported loss of market share of these three hospital groups, DH admissions at these hospitals reduced only marginally to 82.6%. In turn, admissions to NHN hospitals increased from 12.9% in 2015 to 14.3% in 2018. This is evident in Table 2 below.

Table 2: DH in-hospital admissions by hospital network 2015 -2018

<table>
<thead>
<tr>
<th>Hospital Network</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Netcare</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Healthcare</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mediclinic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinix</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>JMH</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Network</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>32,684</td>
<td>2,106</td>
<td>40,682</td>
<td>2,179</td>
</tr>
</tbody>
</table>

Similarly, Table 3 shows similar trends when these calculations are done using risk claims paid.

---

8 In-hospital admissions at 57/58 hospitals only
9 Risk claims for in-hospital admissions at 57/58 hospitals only
Table 3: DH risk claims paid by hospital network for in-hospital services 2015 - 2018

<table>
<thead>
<tr>
<th>Hospital network</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Netcare</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Healthcare</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mediclinic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinix</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>JMH</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Network</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Using the market share of actual distribution of admissions and claims paid by DH by hospital group to calculate the HHI, it is evident that the hospital market is highly concentrated, hovering around the 2,500 level on both measures.

This indicates that for DH, the hospital market is still highly concentrated with the three hospital groups still possessing significant market power. We also find that the HHI is slightly higher on claim amount which reflects the greater concentration of higher acuity beds.

Table 4: Hospital HHI indicators using admissions and risk claims paid of DH in-hospital patients 2015-2018

| Hospital HHI using admissions | 2,503 | 2,487 | 2,509 | 2,493 |
| Hospital HHI using claims paid | 2,631 | 2,615 | 2,625 | 2,608 |

We do note that these statistics are different to the HHI calculations presented by Medscheme\textsuperscript{10}. Medscheme contends that the hospital market is in fact not concentrated, based on their admission data. Medscheme calculates that the hospital HHI decreases from 2,128 in 2014 to 2,169 in 2018 using their admissions by hospital group. This is due to the increase in NHN admissions from 18% of admission in 2014 to 21% in 2018. As evident, these trends are markedly different from that observed by DH, likely due to the differences in the footprint of DH and Medscheme schemes, where Medscheme patients likely have greater access to NHN hospitals giving them better negotiation power over the three listed hospital groups.

3. Funders HHI analysis

Calculating the HHI for medical schemes using the average beneficiaries from 2017 from the CMS Annual 2017/18 Report shows that the funder market as a whole is moderately concentrated with an index of 1,529. However, as contended by the hospital groups, open schemes and restricted schemes do not directly compete and should therefore be considered as separate markets. This would result in HHI’s for open and restricted schemes of 3,422 and 2,375 respectively, suggesting that the open scheme market is highly concentrated due to the dominance of a few large schemes.

We however believe that a more objective measure of HHI would be to use administrator market shares given that tariff negotiations occur at the administrator level. For example, Discovery Health negotiates on behalf of DHMS and all restricted schemes under our administration collectively. Using this methodology, the HHI of administrators for

\textsuperscript{10} Medscheme presentation to the HMI facilities workshop – 9th April 2019
2017 is 2,305\textsuperscript{11}. Using this measure, it is evident that the funder market is in fact not highly concentrated, but experiences similar levels of concentration as the facilities market. This suggests that the funder and facility market is in fact evenly balanced, evidenced in the aggressive tariff negotiations that ensue each year between these stakeholders.

4. Concluding remarks
The purpose of this note is to address points made in the HMI seminars of 9-12 April 2019 rather than to suggest that these are measures that can be relied on. The work of the HMI has been extensive and so analysis has moved beyond using HHI which are more useful as a preliminary indication when approaching a market.

\textsuperscript{11} GEMS has been included independently, given that GEMS (not its administrator) performs their own tariff negotiation
Annexure 2: ARMs in healthcare

We refer to our submission made on 6 July 2016 to the HMI entitled “Discovery Health Submission to the Health Market Inquiry: Alternative Reimbursement Models”.

In this abovementioned submission we illustrated the different forms of alternative reimbursement models (“ARMs”) that DH has developed with various service providers including hospitals, GPs, specialists, pathologists, pharmacist and suppliers of surgicals and medical devices. From this submission, it is evident that ARM contracts are structured to recognise the specifics of each provider market and to maximise value for the patient, scheme and provider, within the regulatory and competitive constraints.

As such, there are a range of ARMs in place in the market, each unique in the contracting terms and the degree of risk transferred to the provider. For example, the Keycare capitation arrangement transfers a degree of utilisation risk to the provider, giving providers an incentive to manage utilisation. With fixed fee contracts (such as the heart transplant fixed fee or the organ transplant fixed fee) on the other hand, the utilisation risk is retained with the scheme and only the price risk is transferred to the provider.

The submission further highlights DH’s progress towards value based contracting, where most of the ARM contracts in place financially reward providers for better quality care. This alignment between funders and providers has therefore not just realised cost efficiencies for the schemes under our administration, but has improved patient experience and clinical outcomes.

Since 2016, DH has refined ARM contracts in place to include innovative value and quality metrics to enhance contracting efficiencies and improve data collection. For example, the Keycare capitation model was optimised to include stricter criteria for new GPs wishing to join the network. These criteria included prohibiting GPs from balance billing, and requiring all GPs to participate in a peer review process to monitor and evaluate clinical outcomes. These enhanced contracting terms has benefited members directly in terms of better financial protection and improved quality.

In addition, DH has implemented several new ARM contracts with specialists including:

- **Hip and Knee Arthroplasty Network**: We are working towards Centres of Arthroplasty Excellence, which aim to deliver the maximum value to patients funded by a value based ARM. The contracting and engagement process has resulted in over 90% of joint arthroplasty surgeries performed within the selected network facilities. Progress has been achieved through encouraging hospital networks to remain flexible in the reimbursement models available to the surgical teams. The current focus of the network is on sharing quality and outcomes data to further enhance care.

- **Obstetric Quality Network**: In 2018, a joint effort to improve obstetric care delivery through a shared value programme led by The South African Society of Obstetricians and Gynaecologists and the Gynaecology Management Group (SASOG-GMG), DHMS and DH was implemented. Through this initiative, DHMS, DH and SASOG-GMG commit to working together to enhance maternity care for the women of South Africa. The parties commit to implementing the initiative in a manner which will strengthen and sustain the profession of obstetrics – including through enhanced remuneration. A purpose-built, electronic maternity record based on SASOG-GMG and international guidelines supports the initiative. The record is made available on HealthID, which provides a platform for a move to electronic record keeping. Obstetricians can elect to initially complete a simple discharge summary and move to a more comprehensive clinical record as the practice becomes more proficient with the electronic interface. Take up of the network continues to grow in 2019 with support for doctors and scheme members via data sharing and enhanced care improving with the evolution of the program.

- **SASA fixed fee contract**: This is an arthroplasty initiative which allows for direct contracting at a fixed fee by a member of SASA with DH schemes for specified bundle of services - in this case provision of anaesthesiology
services for primary elective hip or knee replacement. The fee is agreed on between DH and healthcare practitioners, but the structure of the agreement is such that the SASA member is held accountable to provide a service that is in accordance with the HPCSA ethical rules and SASA best practice. While maintaining their clinical autonomy it specifically recognises the coordinated team based care benefits that impact cost effective care and positive patient outcomes. It also provides for the sharing of clinical outcomes data and peer review by SASA.