Summary of Recommendations for the Health Market Inquiry

Submission: 26 April 2019
1. Background
The Government Employees Medical Scheme (GEMS) unequivocally supports the realisation of an equitable, efficient and cost-effective healthcare system for all South Africans. More specifically, GEMS supports the introduction of universal healthcare and believes that the recommendations put forward by the Health Market Inquiry can and must contribute significantly towards this aim.

As requested, below is a brief synopsis of the recommendations which GEMS believes should be championed by the Health Market Inquiry. These recommendations are consistent with that which has been previously put forward by GEMS.

2. Summary of Recommendations
Key conclusions and recommendations are detailed below.

2.1. Supplier Induced Demand
GEMS believes that supplier induced demand (SID) exists in the South African context. Supplier induced demand is most evident in the context of hospitalisations but is not in anyway limited to hospitalisations. Supplier induced demand contributes to higher costs and poorer healthcare outcomes. In the context of scarce financial resources, this translates into reduced access to care.

Unexplained increases in the utilisation of healthcare services over time (in the absence of observable improved healthcare outcomes), variations in the utilisation of healthcare services by region and the correlation between supply-side capacity and utilisation are all indicative of supplier induced demand. The following remedial actions are recommended:

- Care coordination has been shown to reduce healthcare costs whilst simultaneously improving outcomes. The impact of care coordination is exemplified by the GEMS Emerald Value Option (EVO). Care coordination should be mandated across all medical scheme options. Care coordination should take the form of general practitioner nomination, general practitioner to specialist referrals and the channelling of members to efficient hospitals (and other providers).

- Hospital network participants should be selected via a transparent and open process. The maximum network term should be three years.

- Care coordination has reduced the cost of care (on a risk adjusted basis) by nearly 16%. Most notably, the admission rate has decreased by over 11% and the specialist visit rate by over 16%.

- Unwarranted increases in hospital capacity must be inhibited through the establishment of a more robust licensing regime. In particular, applications for additional beds should be assessed against objective and scientific criteria. Applications should only be granted where unmet demand can be clearly demonstrated. Facilities which fail to maintain adequate standards, should have their licenses withdrawn. The Department of Health (DoH) must be capacitated to adequately assess’ applications. This includes clinical, economic and actuarial
resources. Additionally, explicit consideration must be given to empowerment when considering licensing applications.

- Administrators and managed care organisations have been insufficiently incentivised to proactively manage supplier induced demand and other untoward drivers of claims experience. Schemes should be permitted to enter into risk sharing arrangements with administrators and managed care organisation whereby these entities can be held financially responsible for their ability to manage both the cost of care and healthcare outcomes.

- Schemes and healthcare providers should be encouraged to enter into progressive alternative reimbursement models which incentivise cost effective and high-quality care. Participation in alternative reimbursement models should not, however, be mandatory. This is in view of the complexity associated with alternative reimbursement models and the potential for unintended adverse consequences. By contrast, providers found guilty of gross fraud should be prevented from practicing.

2.2. Market concentration and countervailing powers

GEMS believes that significant reforms are need to better align member and funder incentives. Central to this is the creation of a basic benefit package underpinned by care coordination. Standardisation and simplification must extend beyond just benefit design. The following actions are recommended:

- A single basic benefit package should be established. The basic benefit package should underpin all options. Unlike Prescribed Minimum Benefits (PMBs), the basic benefit package should not be overly hospital-centric. The basic benefit package must include extensive primary care and preventative care benefits. These additional benefits can be funded through the savings which accrue from care coordination.

- The basic benefit package should be coupled with introduction of standardised independent provider profiling, simplified member communications and regimented administrative and managed care costs. Currently, healthcare providers are confounded by an array of often contradictory profiles whilst members are left bewildered by overly complex communications. Moreover, non-healthcare costs vary dramatically across schemes. The benefits derived from high administration and managed care costs are in some instances questionable.

- The basic benefit package must be associated with income equalisation and income rated contributions. Risk equalisation should also be applied (separately for open and closed schemes). Risk equalisation should not be applied in the absence of income equalisation.

- Designated service provider networks have the potential to significantly reduce the cost of care and to improve healthcare outcomes. An example of a successful and highly impactful designated service provider network is the GEMS hospital network as applied to the Emerald Value Option (EVO).
The degree to which providers compete based on their ability to deliver quality care is constrained by the lack of consensus as to what constitutes high quality care. Competition between providers, which can be leveraged to create more impactful designated service provider networks, could be enhanced through the development and maintenance of a standardised quality assessment framework. The Supply Side Regulator of Healthcare (SSRH) should undertake this task.

Designated service provider networks can be made more meaningful still by allowing healthcare providers (across disciplines) to contract collectively. Failing which designated service provider networks are inevitably constructed in a piecemeal fashion and be may somewhat disjointed. Currently, the ethical rules maintained by the HPCSA inhibits contracting across disciplines.

With the exception of corporatised healthcare providers such as hospital groups and pathology laboratories (where bilateral negotiations are common), there is no formal processes to determine fair tariffs. Schemes unilaterally determine the amounts which they are prepared to pay whilst healthcare providers unilaterally determine the amounts which they charge. Neither is necessarily informed by scientific or objective criteria. The disconnect between payments and claims lead to out of pocket expenditure for members and exorbitant obligations for funders in the context of Prescribed Minimum Benefits (PMBs) and Regulation 8 of the Medical Schemes Act.

GEMS supports the establishment of the Supply Side Regulator of Healthcare (SSRH) to independently establish fair tariffs structures and rate. Scheme and healthcare providers should be permitted to deviate from these mandated tariffs by mutual agreement. For example, higher tariffs may apply to incentive quality improvements whilst lower tariffs may apply in the context of additional volumes.

Finally, corporate governance in the industry, including the management of conflict of interest, should be improved. The King IV Code and Report is the appropriate standard and entities should be held to account in respect of applying the King VI principles and recommended business practices.