Commentary on the White Paper on National Health Insurance

5/31/2016

Contents

GEMS Commentary on the NHI White Paper published on 11 December 2015

1) Introduction

a) The establishment of GEMS followed a lengthy research process that was aimed at identifying and implementing a solution that would meet the criteria of equity in access to medical cover, affordability and value for money. As such, there is close alignment between the mandate of GEMS and the objectives of National Health Insurance as stated in the NHI White Paper.

b) Since the operationalisation of GEMS, the Scheme progressed steadily in respect of the implementation and refinement of the strategy, policies, governance structures and operational systems and processes, to enable the Scheme to fully meet its stated mandate. A strategic review saw the Scheme introduce a new Three-Year Strategic Plan in 2014 which represents a significant shift in focus as the Scheme embarked on a journey towards becoming an Activist Purchaser and Payer of Healthcare Services. The strategy is underpinned by contracting for outcomes and value with healthcare providers. Specifically, the Scheme seeks to:

   i) Place the emphasis on healthcare outcomes.

   ii) Increasingly focus on the management of overall population health.

   iii) Achieve healthcare delivery that is integrated and coordinated.

c) GEMS has grown to represent nearly 1.8 million beneficiaries. The Scheme's annual healthcare expenditure amounts to approximately R30 billion. Viewed differently, GEMS is responsible for approximately 20% of medical scheme healthcare funding and approximately 10% of total healthcare funding in South Africa.

d) The Scheme's development and learnings since establishment means that the Scheme is well positioned to support the establishment and operationalisation of the National Health Insurance Fund. This can be done by actively supporting development and delivery by relevant workstreams, including the provision of data, and/or by the Scheme becoming the basis for the NHI Fund as envisaged in Cabinet Memorandum 13 of 2008 from National Department of Health.

e) The Scheme's commentary on the NHI White Paper is structured as follows:

   i) Recommendations related to the implementation plan for NHI are contained in paragraphs 3)a) and 3)b) of this document.

   ii) Inputs on the work to be performed under the six workstreams contemplated in section 414 (page 84) of the White Paper and the capability of GEMS to support this work are made in paragraph 4) of this document.

2) Alternative Implementation Process

a) Consolidation of medical schemes

   i) The employer contributions to medical schemes operating as closed schemes in the public sector are deemed as additional revenue, i.e. section 308 (page 58) refers. Noting that employer medical assistance subsidies form part of public sector employees' conditions of service, and is therefore a matter of mutual interest subject to collective bargaining, the Scheme is concerned that such a step of mobilising employer subsidies into additional revenue for NHI may be met with significant resistance by employees in the public sector.

   ii) An implementation plan based on the phased amalgamation of the identified medical schemes over time (with employees belonging to these schemes retaining their subsidy

entitlement), may be more aligned from a legal and employment relations perspective. The resultant amalgamated scheme can then become the basis for the NHI Fund. A further advantage is that it will ease the establishment of governance and management structures of the Fund.

iii) Issues to be addressed under such a plan would be the stipulations of the Medical Schemes Act pertaining to scheme amalgamations as well as the provisions of the Competition Act relating to mergers. Employment relations issues such as unilateral changes to conditions of employment relating to the employer subsidies will also need to be addressed.

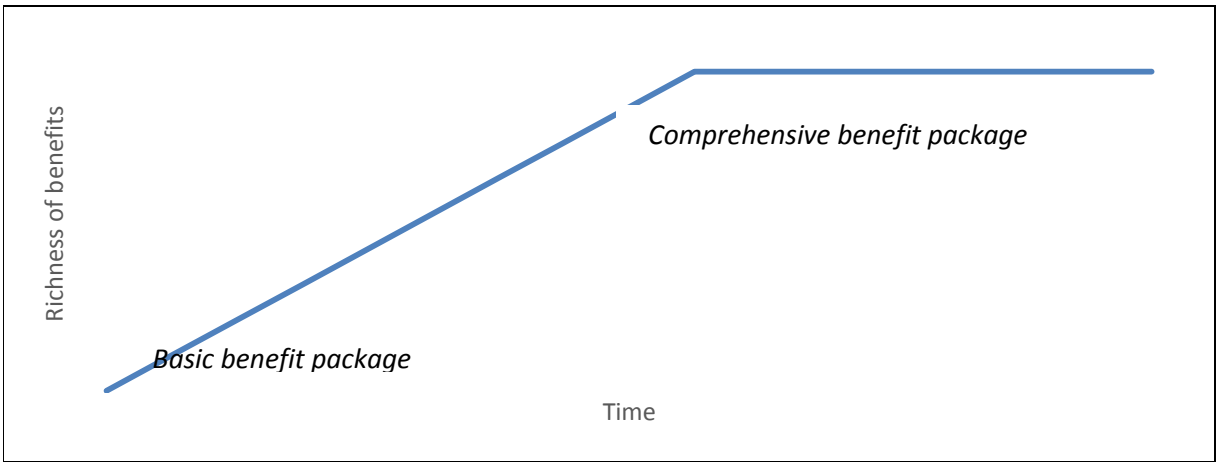
b) Consolidation of basic benefit package

i) NHI envisages the introduction a comprehensive array of healthcare benefits. However, it has been acknowledged that the NHI will not offer all benefits to everyone. This raises the question as to exactly what benefits will be encapsulated into the NHI especially in the context of finite financial resources.

ii) The Scheme is of the belief that the best way to realise a comprehensive benefit package is through the introduction of a basic benefit package across the NHI and existing healthcare funders during the period where medical schemes will be required to offer supplementary benefits. In other words, each medical scheme and the NHI should provide coverage for the (to be defined) basic benefit package.

iii) The basic benefit package can be incrementally enhanced as and when it is feasible to do so.

iv) Given the high cost of healthcare and other limiting factors, targeting too comprehensive a benefit package may undermine and delay the realisation of NHI. An incremental approach increases the chances of a more successful and more immediate implementation.



v) The Council for Medical Schemes initiated work in this area in 2008 and a body of work is available in this regard. Kindly refer to CMS Circular 6 of 2008 (attached as Appendix 1 hereto).

vi) The pace at which the basic benefit package should be enhanced will be a function of affordability and other extenuating factors. This is beyond the scope of this document. The structure of a basic benefit package that is attuned to the needs of members is presented below.

vii) **Benefit Design**

(1) In the context of the existing medical schemes environment, the Scheme has established a comprehensive low cost option that can be used as a template for a basic benefit package. This is the Sapphire benefit option.

(2) Key aspects of the benefit structure associated with the Sapphire option are detailed below:

(a) Family Practitioner Consultations (out of hospital)

(i) Benefits allow for an unlimited number of consultations with family practitioners. The unlimited nature of this benefit is necessary to ensure that members are not denied clinically appropriate access to primary care.

(ii) The key features of the benefit structuring are summarised below:

Preauthorisation is required subsequent to the fifth consultation. This is necessary to circumvent the possible abuse of benefits and the costs associated therewith.

Family practitioners are reimbursed at a predetermined rate. Patients are channelled to those practitioners who have contracted at this rate.

(b) Specialist consultations (out of hospital)

(i) Benefits allow for specialist consultations. Specialist consultations are limited by there being a requirement for a formal referral from the treating general practitioner.

(ii) Benefits are limited to predetermined tariffs determined by the Scheme. Members are encouraged to consult with specialists that charge these tariffs. Members have the freedom of choice to consult with any specialist irrespective of the tariffs that they charge. Members are liable for the resultant out of pocket payments.

(c) Pathology and Radiology (out of hospital)

(i) Benefits allow for an unlimited number of pathology and radiology tests. The unlimited nature of this benefit is necessary to ensure that members are not denied clinically appropriate access to primary care.

(ii) In order to ensure the clinically appropriate utilisation of this benefit:

Pathology tests must be ordered by the general practitioner (or the specialist) treating the patient.

The pathology tests that can be ordered are subject to a formulary.

(d) Acute and Chronic Medicines (out of hospital)

(i) Benefits allow for an unlimited number of acute medicine scripts. The unlimited nature of this benefit is necessary to ensure that members are not denied clinically appropriate access to primary care.

(ii) In order to ensure the clinically appropriate utilisation of this benefit:

Acute medicines must be prescribed by the general practitioner (or the specialist) treating the patient. Practices are profiled based on their ordering patterns.

The medicines that can be ordered are subject to a formulary.

Medicines must be dispensed at a network pharmacy. Network pharmacies have agreed to predetermined dispensing fees and are profiled based on their dispensing habits.

(e) Optometry

(i) Benefits are subject to strict limits. This is necessary to ensure that wasteful expenditure is avoided noting that optometry costs are not necessarily driven by clinical factors. For example, members may desire a new pair of glasses as their current pair is no longer fashionable. Nevertheless, care is taken to ensure that benefit limits do not limit access to clinically appropriate care.

(f) Hospitalisation

(i) Benefits allow for an unlimited number of hospitalisation in state hospitals. Private hospital care is not funded for barring exceptional circumstances. Members are restricted to public hospitals, except for the provision of maternity benefits, given that private hospital care is unaffordable in the context of a low cost benefit option.

(ii) Access to private hospitals should be seen as part of a comprehensive benefit package as opposed to a basic benefit package. As such, the Scheme is of the view that access to private hospitals should not be included in the initial basic health product offering.

(3) Portability - The extent to which the benefit design underpinning the existing Sapphire option could be used to underpin a basic benefit package for the NHI is considered below:

(a) Limitations

(i) Prescribed Minimum Benefits

- The Sapphire option is based on the legislated Prescribed Minimum Benefits (PMB) framework. For some of the benefit types, only PMB conditions are covered. The NHI benefit package is envisaged to be more service based and primary healthcare based. Adaptations to the existing benefit structure would be necessary.

(ii) Palliative Care

- The Sapphire option does not make specific allowances for palliative care. The NHI benefit is envisaged to encompass palliative care. Adaptations to the existing benefit structure would be necessary.

(iii) Community outreach and health promotion

- The community outreach and health promotion initiatives envisaged as part of the NHI are not encompassed within the Sapphire option. GEMS typically provides these services via adjunct programmes. This includes workplace wellness days and screening days.
- Preventative and promotive services are also provided for through dedicated benefits. Nevertheless, adaptations to the existing benefit structure would be necessary.

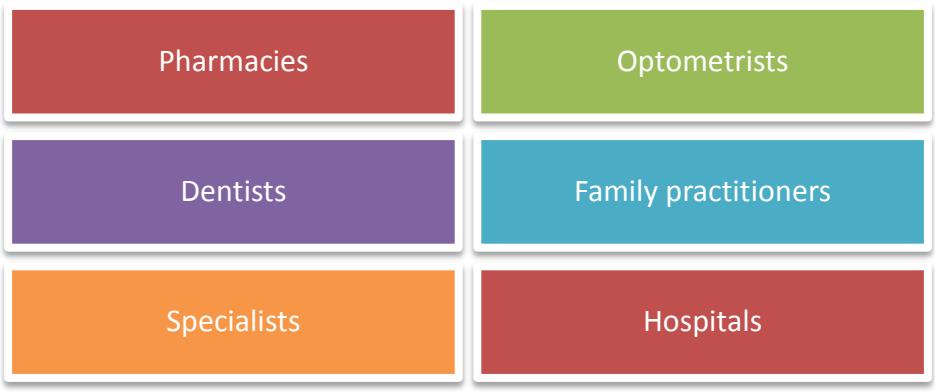
(iv) Fee for service

- The Sapphire option is predominantly associated with fee for service reimbursement models (a limited number of alternative reimbursement models have been implemented). The NHI is envisaged to be predominantly associated with alternative reimbursement models. Adaptations to existing reimbursement structures would be necessary.

(b) Successes to Emulate

(i) Effective Contracting, Private Providers

- The Sapphire option has proven that private healthcare providers are willing to contract on a basis that supports low cost benefit options. This includes but is not limited to the following service providers:



- Reimbursement mechanisms and other parameters of value are key to successful contracting. The fact that beneficiaries are unable to access care outside of contracted providers (without incurring benefit shortfalls) is a further lever in the contracting process.
- The contracting mechanisms used in relation to the Sapphire option could be emulated under NHI.
- More information on the contracting and management of the GEMS healthcare networks is in paragraph 3)b) below.

(ii) Effective Contracting, Provincial Hospitals

- The Sapphire option is underpinned by contracts with the provincial departments of health. These contracts make it possible for members to be admitted to state hospitals and for the Scheme to settle the costs associated therewith.
- The contracting mechanisms used in relation to the Sapphire option could be emulated under NHI. Nevertheless, a focus on improved coding systems and billing systems at state hospitals would be of further benefit to the NHI. The Scheme conducts annual "roadshows" to the provincial health departments with a focus on improved billing to the Scheme.

(iii) Formularies and Treatment Guidelines

- Formularies and guidelines instil a philosophy of rationing. Rationing is essential to maintaining affordability. Rationing is explicitly accounted for when contracting with healthcare providers.
- The Sapphire option is underpinned by formularies and guidelines:

Formularies relate primarily to the medicines that can be dispensed and the pathology tests and radiology investigations that can be ordered.

Guidelines relate primarily to the list of procedures that can be performed and under what circumstances these procedures can be performed.

- The rationing techniques used in relation to the Sapphire option could be emulated under NHI.

(iv) Proactive Risk Management

- The Sapphire option is underpinned by comprehensive risk management strategies. Using a combination of clinical and actuarial skills, clinical and financial risks are proactively identified on an ongoing basis. Risk mitigation strategies are subsequently developed and implemented.
- The risk management techniques employed by GEMS could be emulated under NHI.

(4) Scalability

(a) Experience on the Sapphire option would prove invaluable in costing the NHI benefit package. Costings must account for differences in the clinical and demographic profile of members as well as differences in the benefit structure.

(b) GEMS has developed well-established administrative processes to underpin the Sapphire option. These processes could easily be adapted to support the NHI. This would allow the NHI to bypass the administrative complexities that would otherwise hamper a newly established funder.

(5) Summary

(a) GEMS is of the firm belief that the best way to establish a comprehensive NHI benefit is by first establishing a basic benefit package. The basic benefit package can be incrementally enhanced as and when it is feasible to do so.

(b) The existing Sapphire option provides a template on which the basic benefit package can be constructed. As a precursor to the NHI, the adapted Sapphire benefit template should be adopted by all schemes to form the first building block for NHI.

3) Supporting the six work streams contemplated in section 414 of the NHI White Paper

a) Introduction

i) Although the published terms of reference for the 6 workstreams do not contain a high level of detail, it is assumed that the workstreams will be responsible to, amongst others, deliver the groundwork necessary to:

(1) Implement a process for accrediting and contracting primary healthcare providers and to enable the NHI Fund to act as an active purchaser of healthcare services;

(2) Develop a recommended procurement policy and system for the central and strategic sourcing of goods and services;

(3) Develop recommendations relating to the governance and management structures of the NHI Fund, including the governance structure that will support the National Health Commission in discharging its role;

(4) Develop the stakeholder management structures and arrangements necessary for the coordinated effort of the institutions that will be established; and

(5) Recommend a "consumer" education and communication strategy.

b) Accrediting and contracting primary healthcare providers and the active purchasing of services:

i) In the broadest sense, the service rendering facilities or suppliers of healthcare services in the NHI will form a large, complex and diverse **healthcare provider network**, regulated by central institutions for purposes of participating in the network. The institutions will be performing a regulatory as well as a contracting role. As such, it is our view that the principles of healthcare provider network development and management find application in the NHI as envisaged under the White Paper.

ii) The policy statements contained in Chapter 8 of the White Paper are closely aligned to GEMS' current rollout strategy for contracting healthcare providers and the management of healthcare provider networks. Under the Scheme's current Three-Year Strategic Plan, GEMS has moved from passive contracting to an activist payer for healthcare services.

iii) GEMS' focus on coordination of care and strategic purchasing ('activist paying') of healthcare services underpins its approach to building and maintaining sustainable provider networks.

iv) GEMS employs key principles in the management of networks that enable a shift from volume to value of healthcare services. Establishing any network requires fundamental capabilities and maintenance of networks requires ongoing reporting and evaluation to monitor and manage network access, cost efficiency and quality.

v) The full spectrum of provider network management includes the contracting and management of integrated networks of general or family practitioners (FPs), specialists, hospital, day-case facilities, renal dialysis, rehabilitation / drug and alcohol and other facilities. There are also interdependencies with hospital tariff negotiations, design and implementation of disease management programmes and the establishment of specific specialist networks, management of peer review and the development of industry relationships with healthcare professionals.

vi) Fundamental to successful networks that deliver value-based care are the principles of cost efficiency, quality and access. The following are deemed to be key enablers for a successful network:

(1) **Accessibility:**

(a) Access is defined by benefit design and is guided by affordability, appropriateness and acceptability of services.

(b) Geo-Mapping or Geographic Information System (GIS) matches members to healthcare providers. As a network enabler, it predicts where network access needs to be bolstered in order to meet the needs of members.

(c) The Scheme's contracted managed care organisation has developed a provider locator tool which is used during preauthorisation to find providers in close proximity to where the patient stays. The agent captures the procedure or diagnosis for which preauthorisation is being sought along with the patient's postal code. The tool then provides the agent with hospitals and doctors who can provide the required service. The tool also gives the agent the ability to filter for network providers only.

(2) **Outcomes Monitoring:**

(a) Ensuring value-based healthcare services for GEMS (good clinical outcomes achieved in a cost effective manner)

(b) Reliable data is the basis of all informed decision making. The GEMS service providers are able to use its repository of data for providers, services and members to inform decisions about network development.

(3) **Monitoring and Evaluation:**

(a) Ensuring cost efficient, quality healthcare services within the network through profiling and appropriate contracting.

(b) A profiling tool called the Risk Equalised Performance Index (REPI profiling tool) developed by the Scheme's contracted managed care organisation, i.e. Medscheme, supports the network initiatives of GEMS by reporting on the quality and cost effectiveness of care provided by FPs.

(c) Total in-hospital costs are a focus area and proxy outcomes measures are included. The profiling tool is used to review individual practices.

(d) Hospital profiling includes an individual hospital's quality and cost efficiency metrics. Hospitals' operational efficiencies as well as their willingness to participate in reimbursement models that transfer an element of appropriate financial risk to the provider are also considered in profiling. Hospital profiling provides efficiency scores on an individual hospital level for hospital cost, total cost per event, length of stay as well as associated cost elements such as anaesthetist, pathology and radiology costs. The report is shared with hospital groups who are encouraged to act on inefficiencies.

(4) **Positive Working Relationships:**

(a) Good relationships with leadership bodies support the network initiative.

(b) The Scheme has strong relationships with FP and specialist leadership bodies facilitated through formal engagements from which sustainable contracting solutions are designed

(c) The Scheme engages with hospital groups to address strategic matters. Hospital groups have been consulted on the managed care organisation's monitoring processes (e.g. quality and cost efficiency metrics) to ensure that the tools are robust.

(5) **Communication:**

(a) Liaison with providers, members and other affected or interested parties to ensure the objectives and rules are understood and adhered to.

vii) **Steps in the process of building networks:**

(1)

viii) GEMS' current method of contracting heath care provider is essentially similar to that which is outlined in the White Paper and encompasses the following main actions:

(1) Select (accredit) providers considering the range and quality of services, and their location

(2) Establish service agreements/contracts

(3) Develop formularies (of generic drugs, surgical supplies, prostheses etc.) and standard treatment guidelines

(4) Design, implement and modify provider payment methods to encourage efficiency and service quality

(5) Establish provider payment rates

(6) Secure information on services provided

(7) Monitor provider performance and act on poor performance

(8) Audit provider claims

(9) Protect against fraud and corruption

(10) Pay providers regularly

(11) Develop, manage and use information systems.

ix) GEMS has successfully established a paediatric and obstetrics & gynaecology specialist network using the key enables and steps above. GEMS is currently in the process of rolling out a specialist physician network which will be followed this year by an Anaesthetist and Psychiatrist network

c) Develop and implement a procurement policy and system for the central and strategic sourcing of goods and services:

i) Under the Scheme's current Three-Year Strategic Plan (2014 to 2016), the Scheme introduced the strategic sourcing of identified categories of healthcare services in order to reduce costs.

ii) To this end, a strategic sourcing policy and methodology was developed and implementation commenced focussing on prostheses, devices and medicine. The ongoing development of the Scheme's strategic sourcing capabilities will take place. In line with the features of NHI to proactively identify health needs and determining the most appropriate, efficient and effective mechanisms for optimising and leveraging spend, strategic sourcing as a discipline is critical.

iii) In keeping with the policy statement in section 387 (page 77) of the White Paper, a centralised NHI procurement function is planned with reforms to current procurement systems and practices. The GEMS Supply Chain Management Policy and systems were developed incrementally over a period of 10 years and the Scheme now has a comprehensive and rigorous policy in place with the necessary capacity to deliver the procurement of goods and services in keeping with the policy. The principles underlying the GEMS Supply Chain Management Policy are to:

(1) Grow and increase the participation of service providers in GEMS requirements;

(2) Encourage small providers to participate;

(3) Avoid the creation of monopolies;

(4) Promote best practice in supply chain management;

(5) Stimulate empowerment through procurement; and

(6) Manage GEMS' risks through procurement decisions made.

iv) The Scheme's Supply Chain Management Policy can be shared with the appropriate workstream through the NHI consultation processes.

d) Set up the governance and management structures of the NHI Fund, including the structure that will support the National Health Commission to discharge its role.

i) In keeping with section 421 (page 85) of the NHI White Paper, the governance and management structure of the NHI Fund, including the National Health Commission, will be established during the latter stages of Phase II of the Implementation Plan.

ii) The White Paper does not specifically refer to the applicable regulatory framework but it is assumed that the Public Finance Management Act will apply.

iii) On a corporate governance level, the NHI Fund will be required to apply the King Report on Corporate Governance that will be in effect at the time (the King IV Report is expected to be effective by 2017). As such various governance provisions in the PFMA, Companies Act and the King Report may be applicable and will need to be considered to ensure that the NHI Fund is placed on a sound governance basis early on.

iv) An important area of clarity to be provided is on whether the National Health Commission will function at board level or whether a board for the NHI Fund will be established in keeping with the regulatory framework believed to be applicable. Following on this, an appropriate governance structure for the Fund in respect of a Standing Committee Structure will need to be established in line with statutory and business requirements.

v) Although relevant transitional measures will be provided for in the legislation establishing the NHI Fund, the Scheme's experience is that the governance and management structures of an entity such as the NHI Fund should be established earlier in the process. This is due to the capacity that will have to be established in the NHI Fund and related decision making, i.e. the recruitment of key resources and the development and/or procurement and implementation of operational systems and processes. The GEMS experience and learnings related to implementation steps, sequencing and timing can be shared with the relevant NHI workstreams.

vi) Capacity and funding requirements related to the establishment of the necessary operational structures should not be underestimated. With the establishment of GEMS, full insourcing was initially considered. However, it was found that outsourcing enabled the earlier operationalisation of the Scheme. The Scheme has commenced with the gradual and careful insourcing of certain functions and is in the process of building the necessary ICT infrastructure to support the process.

vii) It is the Scheme's view that an NHI Implementation Risk Register across the various worksteams should be developed in order to develop a consolidated view of the potential key risks and their impact should they realise.

e) Develop the stakeholder management structures and arrangements necessary for the coordinated effort of the institutions that will be established.

i) As a second point, it is noteworthy that there is provision for more than one central authority in the National Health Insurance system. The scope of authority of the Office of Health Standards Compliance, the National Health Insurance Fund, the District Health Authorities and the National Department of Health will be stated in the legislation. However, the rules of engagement between these entities and the providers of healthcare will have to be formally and clearly stated and buy-in from the various role players concerned will be critical. For this purpose, a period of consultation between these role players is deemed essential during the implementation process. The NHI Fund's relationship with and engagement and with the entity to be responsible for regulating the medical schemes industry (the Financial Sector Regulation Bill refers) also needs consideration.

ii) Formal engagement structures supplemented by continuous informal engagements should strengthen the system significantly. The entities should work cohesively, from a joint platform and should jointly accept responsibility for the optimal functioning of the system. Avoiding fragmentation would go a long way in ensuring successful governance in the NHI. An example would be on how to make the authorities accessible to the public in an effective manner that would enable the public to submit complaints, concerns and suggestions for improvement. A central complaint management arrangement between the authorities should assist with this and would enable the authorities to address performance issues that would normally not be brought to their attention.

iii) The development and implementation of a formal Stakeholder Management Strategy with engagement planning is seen as a critical step to be taken early on in the process.

f) "Consumer" education and communication.

i) Although participation in the NHI is mandatory, it still remains important to get public buy-in and social activation to ensure successful implementation of the NHI. Factors that will contribute to buy-in and social activation are as follows:

(1) Positioning and the education campaign: It will be necessary to position NHI as comprehensive, effective and efficient with emphasis on quality service.

(2) An overarching and sustained campaign to educate consumers on the NHI based on the following:

  (a) NHI benefits – care that can be accessed, what will be covered and what will not be covered;

  (b) points of access – awareness around participating facilities and other points of access e.g. primary care teams;

  (c) process of access – how to access, what is required to qualify for access, where to address queries; and

  (d) cost of access – contribution costs, what will be offered free and what will be paid for at point of service.

(3) Understanding the targeted audience and their communication needs:

  (a) Identify the segments of the target audience in line with their needs;

  (b) Identify held perceptions, behaviour, practices and beliefs that may impact on buy in; and

  (c) Differentiate, position and prioritise communication points based on the segments.

(4) Factors that will need to be addressed during this process:

  (a) Contributing consumers: Will consider the NHI as a grudge purchase that limits choice – address service and quality issues

  (b) Non-contributing consumers: Used to current public healthcare system – re-orientating around the changes in processes and rules for access.

  (c) Consumer behaviour:

    (i) Drive behaviour change around preventative care, wellness, compliance as well as practicing early intervention by utilising primary care facilities.

    (ii) Campaigns to counteract overuse, abuse and fraud.

4) Understanding the communication environment:

  a) Buy-in from the various targeted audiences will be determined by the social, political and economic. Emerging environmental factors to be addressed include:

    i) Individualism vs Social Solidarity –

      (1) A growing culture of individualism and self-interest can negatively impact on the concept of universal care based on social solidarity.

      (2) This is further aggravated by the emerging negative sentiments by employed citizens on being overtaxed, sustaining the social security model (e.g. social grants etc.) and general perception of misuse of tax and mismanagement of funds, which includes concerns around fraud and corruption.

(3) At a macro level this needs to be addressed through accountable and transparent leadership that articulates social solidarity as a strategic policy imperative, social engagements with key stakeholders, public engagements and hearings.

(4) At a micro level this requires engagements and sustained education on the necessity of a social solidarity model, selling the immediate and long term benefits thereof such as lower cost, reducing wastage and better national health outcomes. This will require a sustained and multi-pronged campaign that aims to change perception on the concept of social solidarity. Such a strategy could take years to bear the required results and should be consistent across all government communication on various programmes.

ii) Economic pressures and inequalities:

(1) There are real economic pressures on South Africans, with rising healthcare costs one of the main concerns. A successful communication strategy will communicate the financial liability of contributing citizens versus the value of being able to access services through the NHI.

iii) Burden of disease

(1) The communication strategy will need to also focus on education to effect behaviour change in terms of lifestyle and managing one's health in order to realize the positive health outcomes envisaged through the NHI. This education drive should be supported by efficient operations that ensure easy access to primary and preventative care, timeous delivery of medication etc.