Discovery Health Response to Health Market Inquiry Request for Input for Proposed Regulatory interventions for Licensing of Health Facilities

Overview

Discovery Health Pty (Ltd) ("DH") notes the discussion document published by the Health Market Inquiry ("HMI") on 14 February 2018 regarding the licensing of health facilities.

We support the need for transparency and consistency in the approach to licensing of health facilities as well as the need for a process that takes account of the variations in healthcare needs across the country.

Specific Observations and Comments

1. **Commitment to the principles of Universal Healthcare Coverage (UHC)**
   We have expressed our support (in a number of forums) for the goal of achieving UHC in South Africa and the National Health Insurance (NHI) policy's aim to address inequity in access to facilities.

2. **Current proposals**

   We duly note that the current proposals include:

   1. A standardized national licensing regime to be implemented by provincial departments.

   2. A mandatory reporting requirement that will facilitate monitoring of needs.

   3. Preference for innovative models of care and underserviced areas.

   4. Transparency and administrative fairness.

   We are generally supportive of these proposals in principle, and we wish to submit that our inputs and recommendations should be considered in this context.

3. **The current healthcare facility licensing regime may create barriers to entry**
   We concur that the current licensing regime creates some barriers to new market entrants and hampers the development of innovative models of healthcare delivery. Current licensing for public and private facilities also does not adequately take into account current or projected health service needs. This leads to duplication of services and also some excess supply of resources in concentrated areas. As we have pointed out in prior submission, excess supply leads to increased supplier induced demand for healthcare services, due to asymmetry of information between

healthcare suppliers and consumers. Any changes to licensing requirements therefore need to take into account the implications on utilisation.

4. **Inconsistencies between the National Health Act and the provincial regulations**
   We share the expressed concerns that there are inconsistencies between the National Health Act and the provincial regulations. Better alignment in this regard will create more certainty and facilitate planning. This planning process should also consider the decentralization of public facility management to appropriately qualified public facility managers who will be appropriately incentivized to improve clinical and operational efficiency, and also to be more responsive to the needs of the communities they serve.

5. **Certificate of Need**
   The uncertainty associated with the status of the Certificate of Need has created uncertainty across various categories of healthcare service providers, especially hospitals, pharmacies and general practitioners. The High-Level Panel on the Assessment of Legislation and the Acceleration of Fundamental Change (HLP) that was chaired by former president Kgalema Motlanthe included the recommendations that the National Health Act regulations and licensing requirements for pharmacies be revisited. The recommendations are included in this submission for reference purposes (refer to Annexure A).

   Further to this, in the hospital market particularly, there is evidence of excess supply of certain tertiary services, which are constructed to deal with competitive issues including doctor movement between private facilities, rather than based on the underlying need in a region. This is particularly evident in cardiac angiogram theatres, laminar flow theatres, high end radiology scanners and other such expensive capital projects. A certificate of need should regulate the licensing of such facilities to ensure the facilities are licensed based on well-demonstrated market needs.

6. **Centralization of healthcare facility licensing**
   We support the centralization of healthcare facility licensing, with the proviso that this is based on a clear policy aim of ensuring more equitable and efficient distribution of health facilities, guided by accurate data on population characteristics and needs. This highlights the importance of establishing a patient information system as well as the collection of data on healthcare resources in the public and private sectors as recommended by the HLP. It is important that there is a comprehensive, independent and robust process for the collection, analysis and dissemination of this information.

7. **Current healthcare regulations impede the introduction of innovative, cost-efficient healthcare delivery models**
   A particular concern is that many current regulations seem to impede the establishment of “novel” facilities which could introduce cost efficient models of healthcare delivery (e.g. day clinics and HMO-type facilities). It is our view that such facilities have a significant role to play in the management of healthcare costs in

general, and in-hospital costs in particular. This would be further enhanced by a revision of the Prescribed Minimum Benefits (PMBs) for medical aid schemes aimed at placing more focus on primary and promotive care.

The need to promote the establishment and growth of day clinics and sub-acute facilities is why we have not objected (with some provisos) to the extension exemption that has been granted to NHN for collective negotiation of tariffs. In this regard, the ratio of sub-acute and day surgery beds, to acute beds, in the SA healthcare market is much lower than comparable global benchmarks. There is also a need for innovative approaches to be used in developing facilities aimed at addressing the healthcare needs of underserved communities. There is an opportunity for planning to include the development referral centers and appropriately resourced satellite facilities to ensure reasonable access and effective co-ordination of care.

We also recommend that a similar approach is taken to promoting the development of multi-disciplinary primary care practices, as well as the development of specialized centers of excellence where appropriate. This would entail addressing the HPCSA rules regarding employment and association of medical professionals.

8. **Inadequate co-ordination between regulatory bodies**

We support the assertion that there is inadequate co-ordination between regulatory bodies such as the HPCSA and CMS. There is clearly an opportunity for greater collaboration that would enable a better understanding of healthcare system capacity, resource distribution and utilization, in order to ensure value to medical scheme members and patients in general. As we have pointed out in prior submissions, some of the regulations of the HPCSA hinder the emergence of integrated practice teams, and reforms to these regulations will be critical to support the positive effect of a more effective licensing framework.

9. **The role of the Office for Health Standards Compliance (OHSC)**

We note that the monitoring of facility capacity, quality and distribution is also weak. This would be enhanced by the collection of data for a national patient information system as well as the enhancement of the oversight role of the OHSC, in inspections of health facilities in the public and private healthcare sector. It should be noted that the role of the OHSC is inspection and there needs to be a clear process for following through on quality issues identified, coupled with a framework for appropriate sanctions for non-compliance. There may be a requirement for a transitional phase in enforcing standards to ensure that they are properly understood and embraced at facility level.

The resource requirements of the OHSC also need to be assessed and acted upon, because the effectiveness of the Office is dependent on the availability of adequate and appropriate skills and resources.

Over and above this, we are convinced that the mandate and focus of the OHSC should also be extended beyond structural compliance, to include healthcare

process and outcome measures over time. A substantive health informatics and data management strategy is required in order to measure both process and outcomes for the purpose of understanding quality.

10. Issuing and maintenance of practice numbers to healthcare providers

We agree with the observation that there is a lack of clarity regarding the Board of Healthcare Funders (BHF) process for issuing practice numbers. In our responses to the HMI analysis published in December 2017, we submitted that the BHF practice details are not necessarily updated and this would have affected the analysis of data such as practice allocations. For example, the reports suggest that there are over 200 General Practitioners performing more than 10 caesarean sections per annum, a result which not evident in our data. In this specific example it is likely that the specialty details have not been updated, leading to this result. It is concerning that this may also have distorted the case mix adjustment used in the analysis. We also receive recurrent anecdotal feedback from healthcare providers of intense frustration with the inefficiencies of this process, the stagnation of the rules for registration and frequent errors.

11. Mental health facilities

An area we would like to highlight that we have found to be of particular concern is the licensing of private mental health facilities. The increase in the number of facilities and the geographic concentration, combined with the PMB requirements, have been associated with a significant escalation in claims expenditure for medical schemes, in part due to supplier induced demand. A revision of licensed facilities as well as relevant PMB requirements need to be considered in this regard.

12. Hospital mergers and acquisitions

We commend the approach and process followed by the Competition Commission when assessing the potential anti-competitive effects of hospital mergers. The broadly consultative process and data driven analysis is excellent. We recommend that facility licensing authorities should be mandated to apply a similar level of detail and rigour in their assessment processes in this regard.

13. Secondary license transfers

When health facility licenses are issued on the basis of need (as is currently claimed to be the case), then there are adverse social consequences if/when facility licenses not being commissioned. There seems to be a secondary license transfer market for facility licenses that are not commissioned once granted by the licensing authorities. This is a very concerning practice that should be eradicated as a matter of urgency. We recommend that licenses should be issued on a non-transferable basis, with explicit timeframes for commissioning of the health facilities.

14. Supplier Induced Demand

We would like to draw attention to the submissions that we have made regarding Supplier Induced Demand and the associated evidence that we have also submitted with respect to hospital beds. It is critical that a scientific and objective process is

adopted in assessing need as there is clear evidence that the availability of hospital beds increases demand, particularly in a fee for service environment. Our data indicated a positive and statistically significant relationship between the increased supply of hospital beds and utilisation rates (demand), after adjusting for the changing disease burden and referral patterns within a region. Our analysis suggests that the increase in utilisation is associated with an increase in supply of hospital beds. From an actuarial perspective, we need to price for any and all factors that may influence utilisation. This association has a material financial impact, with a significant adverse impact on scheme affordability for members. Further, this increase in utilisation (of particularly medical admissions), coupled with the increase in length of stay and reduced severity of admissions, seems to suggest that this observed increase in utilisation is inefficient, given that it is not fully explained by demand-side dynamics and clinical needs.

15. **Healthcare provider payment mechanisms are not aligned to value based care**
    The predominant fee for service payment mechanism in the private healthcare sector, coupled with the Medical Schemes Act requirement for PMB coverage at cost, provides limited incentives for professional bodies to support healthcare service provider engagement with alternative (value based) reimbursement mechanisms.

We would be happy to discuss or to provide further clarity on the points we have raised above, should this be required.

21 February 2018

Annexure A

Equitable Access to Quality Healthcare: Recommendations of the High Level Panel on the Assessment of Key Legislation and Acceleration of Fundamental Change

- **Recommendation 2.16:**
  Parliament should express its support for the introduction of a system of universal health care coverage underpinned by the principles….: access to health care as a right, social solidarity, equity, health care as a public good and social investment, affordability, efficiency, effectiveness and appropriate levels of care. To monitor equitable service provision, there should be a **national patient information system** that augments existing health information systems that will track patients as they receive services across the country. ….. To monitor use of the health care system, both in the public and private sector requires that data be systematically collected. Although the National Department of Health has been working with the Health Information Systems Programme (HISP) to develop a National Health Information Repository and Data Warehouse (NHIRD) which collates information from various vital statistics and other health indicator datasets, the facility-based District Health Information System, the BAS public financial management system, PERSAL human resource system and a range of household survey datasets, this data is not in the public domain, nor does it include comprehensive data on the private sector. Moreover, the data does not include the patient medical record that will allow health care providers to access the information for treatment purposes regardless of where the services are provided. Various initiatives have been introduced in the last few years, such as 'PHC re-engineering' and the 'Ideal Clinic' programs to increase access to healthcare. However, there are aspects of these initiatives that require more attention, particularly institutionalising the Ward-based Outreach Teams (WBOTs; i.e. community health workers) and reaching agreement on their status within the public health system. Community health workers are critical in promoting equitable access to healthcare through their 'close to client' service provision; international evidence demonstrates that they make considerable contributions to improved health outcomes. Community health workers are also key providers of preventive and promotive health services. The long-term sustainability of a universal health system is closely linked to the effectiveness of preventive and promotive interventions, particularly in relation to the growing burden of morbidity related to non-communicable diseases.

- **Recommendation 2.17:**
  The Panel recommends that Parliament introduces legislation to allow for community health workers to be formally employed within the public health system and be based at all primary healthcare levels.

- **Recommendation 2.18:**
  To ensure that data is publicly available for the purpose of serving patients and planning, monitoring and evaluating services, the Panel recommends that Parliament should introduce legislation that would create integrated and comprehensive data on resources and services in the public and private health sector that is routinely updated and is publicly available. Confidential data that involves identifiers will not be publicly available.

- **Recommendation 2.19:**
  Some of the reforms that have received considerable support among a wide range of stakeholders are:

    1. There needs to be a focus on building the institutional and management infrastructure and skill levels of the public health sector specifically. One way to do this will be through decentralizing management authority to individual public sector hospitals and health district or sub-district level for primary health care services, along with appropriate governance mechanisms. The results of pilot studies must be monitored to inform decisions in future.
    2. Centralised allocation of healthcare resources. An assessment needs to be done of the merits of such a policy.
    3. Establishing public agencies outside of the Department of Health for strategic purchasing, quality assurance and other functions. A focus on building more healthcare infrastructure such as hospitals and clinics.
    4. Allowing and encouraging the private sector to train and employ doctors and nurses within strict guidelines to alleviate the acute shortages. Currently many recently qualified doctors are unable to get posts in public hospitals and given the shortage of doctors employing them in the private sector will help alleviate the doctor shortage.

- **Recommendation 2.20:**
  The Panel recommends that Parliament sets up an independent task team of all relevant players in the public and private sectors to evaluate whether there should be legislation passed regarding voluntary or mandatory membership of medical schemes, for the implementation of the NHI to ensure that high-quality, affordable health care is delivered to all South Africans, regardless of race, income level or geography.

- **Recommendation 2.21:**
  Parliament should enact legislation that:
    - requires that the National Health Act regulations are developed and promulgated in order to introduce a certificate of need for newly certified

professionals to ensure that underserved populations access quality health care, particularly medical specialists.

- regulates the licences for pharmacies to ensure that new ones are located where the need is. This can be achieved by amending the Medicines and Related Substances Control Act and the Pharmacy Act.