Medscheme submission

Health Market Inquiry's call for submissions on

Proposed Regulatory Interventions for Licensing of Health Facilities

February 2018

A Member of AfroCentric Group
medscheme

Contents

1. Introduction

Medscheme welcomes the HMI's initiative to address the current issues of health facility licensing in South Africa and propose regulatory interventions. Medscheme would like to take this opportunity to recognise the vital importance of a standardised, effective and efficient licensing process that takes into consideration national health policy, norms and standards, the uniqueness of different facility types, competition, equity, needs, quality and innovation. Such initiatives will go a long way in improving cost efficiency, quality and appropriate access to healthcare services.

Medscheme Holdings (Pty) Ltd ("Medscheme"), an accredited managed care organisation and administrator of various medical schemes, hereby presents a response to the Health Market Inquiry ("HMI") Discussion Document, published on 14th of February 2018 calling for submissions on the Proposed Regulatory Interventions for Licensing Health Facilities. The general and specific comments outlined in the sections that follow are intended to support the process and foster further engagements between the HMI and Medscheme.

2. Medscheme comments on Proposed Regulatory Interventions

2.1 Observations relating to regulatory failures in health facility licensing

Medscheme agrees with the observations contained in this section, but would specifically like to comment on the clauses below:

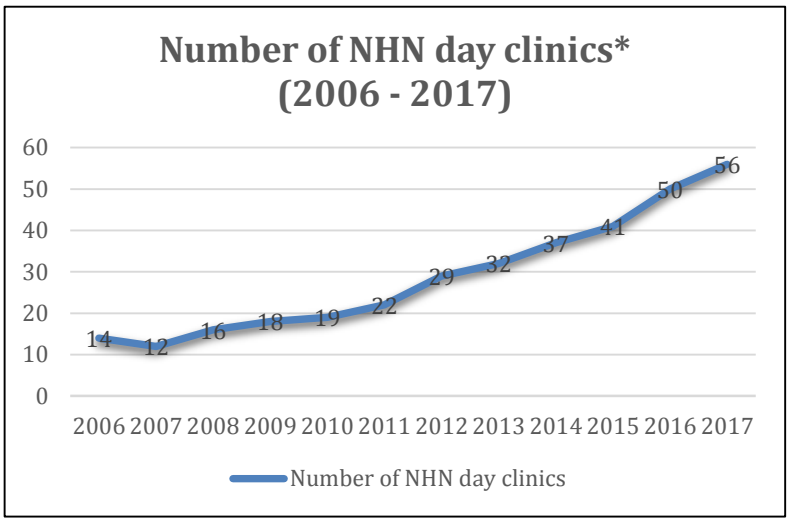
> *17. Regulation 158 in its current form appears to be dated and not compatible with current market requirements. For example, the manner in which Regulation 158 is drafted makes it primarily relevant for the establishment of acute based facilities, thus limiting the establishment of novel facilities which could introduce entry of innovative and cost-efficient models of healthcare delivery. This further frustrates entry by alternative providers that provide more cost-efficient models of healthcare delivery and that could challenge the traditional model of large general acute facilities. We note for example that day facilities and other Health Management Organisation type facilities are relatively scarce in South Africa and markedly lagging international trends. The HMI has been told that the cost-effectiveness of day hospitals and hospitals with new, more efficient formulas of delivery are not factors considered in the licensing process.*

Medscheme agrees that the current regulations focus on acute hospitals and do not take into consideration cost efficiencies of different and innovative delivery mechanisms. There is no shared framework or policy to indicate the DOH's stance on the licensing of innovative and efficient facilities. An example of this is of mental health outpatient facilities: these facilities offer an alternative and gatekeeping function for most mental healthcare users that would otherwise have been admitted to a more costly inpatient mental health facility. The Gauteng DOH licensed one of these outpatient facilities, but the Western Cape DOH did not prioritise the licensing of this facility type in terms of regulation 187.

It should however be noted that there has been a significant increase in the number of day clinics licensed and commissioned over the past few years, particularly in the National Hospital Network group of hospitals. The graph below indicates a 300% increase in NHN day clinics since 2006. (Please note that this is an understatement as the day clinic numbers in the graph *exclude* ophthalmology facilities licensed as day clinics. In 2017, 13 of the NHN ophthalmology clinics are day clinics.) It is however not clear whether the increased number of day clinics is due to a DOH licensing policy.

Additionally it should be noted that in Medscheme's experience, the differential in costs between the NHN acute facilities and day clinics is not as significant as what is reported internationally. Medscheme's experience is that these day clinics are approximately 12% more cost efficient than acute facilities. However if ophthalmology day clinics are taken into account, the differential is only about 4%. Internationally Hospital costs are reported to be 25% to 68% lower for day surgery than for the same procedures on an inpatient basis[1].

1 Castero *et al*., 2007



* Excludes ophthalmology day clinics

Source: NHN presentation to HMI (2006-2015) and NHN list of facilities provided in 2016 and 2017.

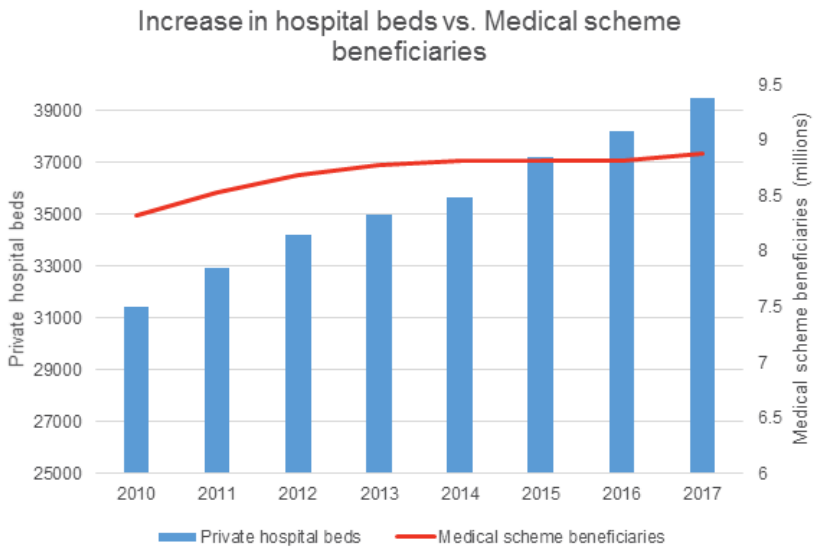
18. It has further been alleged that the impact on innovation is compounded by the fact that there is lack of coordination between various regulatory bodies, such as the Health Professions Council of South Africa ("HPCSA") and the Council for Medical Schemes ("CMS"), who are relevant in accrediting different players and health establishments who may wish to collaborate to offer innovative forms of care.

In Medscheme's initial submission to the HMI in 2014, we proposed that the HMI considers recommending regulatory change to overcome the systemic flaw posed by the Health Professionals Council of South Africa (HPCSA) adjudication process and ethical rules relating to both who is allowed to employ doctors and under what circumstances are they allowed to do so. We believe that this hinders innovative models.

19. The HMI notes that, the current licensing framework, both in the public and private sectors, is not based on current or projected need. Further, it does not seem that equitable distribution of facilities is embedded in the licensing process, as we observe many underserviced markets, whereas licensing seems to favour markets with excess capacity. This is an area which the CON sought to remedy. The licensing framework is however currently administered by provinces with no standardised needs assessment (both qualitative and quantitative) and is open to influence, and possibly manipulation by incumbents.

Medscheme agrees with the HMI's concern that neither needs nor equity are considered in the licensing process and that there is no standardised needs assessment. We agree that the system is open to influence and potential manipulation. This is of significant concern to Medscheme as on the one hand the over-supply of facilities in certain regions leads to inappropriate supply sensitive care (supply induced demand) and on the other hand there is limited access to appropriate healthcare in certain areas.

Over the past 8 years, South Africa has seen a 26% increase in hospital beds but only a 7% increase in scheme membership over the same period. There is a disproportionate increase in private hospital beds compared to medical scheme membership. Scheme membership increased by 6% from 2010 – 2013, with a corresponding 9% increase in hospital beds. Since 2013 beneficiary growth has almost plateaued (1.1% increase), yet hospital beds have increased by a further 12.8% from 2013 to 2017. For the NHN group 647 additional acute hospital beds were added to the group in 2017 alone, an 11% increase. In many cases these new facilities are in metropolitan areas where there is sufficient supply of these facilities.



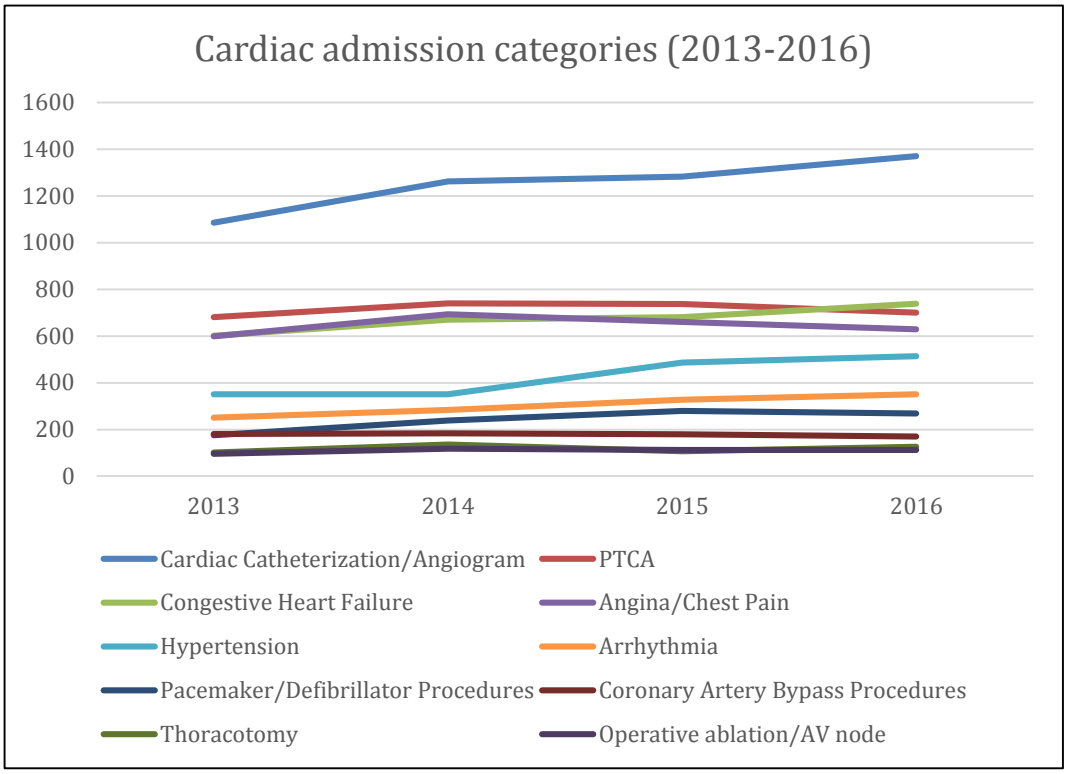
One might argue that this increase in hospital beds is off a low base. This however is not the case - South Africa already has approximately 4 private hospital beds per 1,000 medical scheme beneficiaries and in some parts of the country there are as many as five to six beds per 1,000. This is nearly double the ratio seen in efficient systems. The UK has 2.5 hospital beds per 1,000 population and New Zealand has 2.8.

While Medscheme aims to encourage competition among hospitals, it is particularly concerned that the increase in hospital beds is leading to supply sensitive care. Supply sensitive care is defined as health care delivered at a volume that responds to availability of provider supply and in ways that can't be explained by other factors such as burden of disease. Research done by Medscheme supports other international research by showing a strong positive correlation between the number of hospital beds and hospital admissions (all else being equal).

A further concern is what appears to be ad hoc licensing of additional specialised beds such as ICU, HCU and neonatal ICU beds. Alex van den Heever has presented data that indicates that South African private hospitals have almost 36 ICU/HCU beds per 100,000, whereas other international averages are 11.6/100,000 in France, 11.0 in Switzerland, and only 6.6 in the UK. Nonetheless we continue to see new specialised beds being commissioned in hospitals.

We have a similar concern regarding the increase in cardiac catheterization laboratories. In an analysis that we conducted in January 2017, there were 13 catheterization laboratories in the private sector in Cape Town. The international norm for catheterization laboratories is 1 laboratory per 450 000 to 600 000 population[2]. Based on this norm, the insured population in Cape Town should have access to between 2.5 and 3.4 laboratories. KZN has also seen a significant increase in the number of licensed cardiac catheterization labs in the past few years. Unfortunately we do not have accurate data on these cardiac cath labs in KZN as this data is not made publically available. The concern is that this increase in cardiac cath labs is leading to supply sensitive care - we have noted in our data that the number of cardiac catheterizations being done has increased significantly, but the number of these that require interventional procedures is not increasing proportionally, as illustrated in the graph below. This illustrates the concern that cardiac catheterizations are potentially being done unnecessarily.

2 Heart 2003;89:827-829



An additional concern relates to those facilities that currently do NOT require licensing. Renal dialysis is an example. Dialysis facilities only require licensing in the Western Cape and to some extent in the Eastern Cape. For the other provinces, clinical technologists are required to obtain a PCNS number from the BHF, and can then set up any number of facilities without licensing requirements, limitations or quality control. There are no prerequisites in terms of clinical oversight, staffing, facility infrastructure, equipment and processes in these provinces. This has resulted in a significant increase in the number of dialysis facilities, many of which are of sub-standard quality and which pose clinical risk to the patients. Medscheme has had to do site inspections of some facilities because of this adverse clinical risk and substandard infrastructure. Some have been so poor that our schemes have declined funding until the facilities have improved their infrastructure. A meeting was held with the Office of Health Standards Compliance (OHSC) late in 2017 but their view was that they have not been given the mandate to inspect these facilities, because no regulations or standards have been published against which the facility can be measured.

Similarly we are concerned that Substance Abuse facilities are licensed by the Department of Social Development for a period of 5 years. These facilities should be subject to DOH licensing with annual review and structured inspections.

20. Furthermore, monitoring and reporting of facility capacity and distribution is weak. There is no obligation to report back periodically by facilities on issues of major policy concern, and there is no central database, either nationally or provincially of current facilities (including types) and numbers of beds, area of distribution, and the extent of use by market players. This type of reporting is essential in the case of healthcare markets.

The lack of a central database of licensed facilities is of significant concern to Medscheme. We receive communication from the Western Cape DOH on licence requests and are given the opportunity to object/comment on these requests, which we do. However we are not aware of similar processes in other

provinces. We therefore have no countrywide knowledge of new licences requested and whether these have been granted or declined. Our other concern is that there are many licences that have been issued but not commissioned, yet we have no knowledge of these.

Similarly, we have no knowledge of withdrawn licences and the reasons for the withdrawal, nor do we know if a facility later gets reinstated and what the effective date of reinstatement is. This should be addressed by the central database. We are also aware that there are issues where the licensing authorities do not conclude their inspections and issuing of licenses before expiry of the current licenses.

Medscheme has therefore established its own database, and requires that all new facilities provide a copy of their DOH licence before we will activate the facility on our system. These details are captured in a database. However, where additional beds or facilities are licensed for an *existing* facility, we rely on the hospitals to update us with this information. This is not always willingly supplied.

21. The HMI has also observed that there is no requirement that new licenses be commissioned (within a certain period), thus creating a sub-market for the sale of licenses. Further, the sale of licences or changes in ownership, do not seem to be scrutinized by the provincial departments and importantly the competition authorities. This may impact on competition (concentration) and present a distorted picture of market entry.

Medscheme agrees with this observation, particularly as it relates to the sale of licences. While the Competition Commission appears to scrutinize the impact of mergers on competition (including smaller mergers e.g. Netcare-Lakeview), the issuing of new licences and/or purchase of existing licences is not apparently scrutinized. It is far too easy for a hospital group to buy up an uncommissioned licence in an area which will afford them dominance. The Competition Commission does not appear to scrutinize these sales.

22. There are no requirements for review and renewal of licenses which would allow for monitoring and evaluation function to ensure continued need and maintenance of quality. Moreover, licenses are granted in perpetuity and this robs the market of a significant management tool to ensure appropriate quality care.

Medscheme's understanding is that DOH licences need to be renewed on an annual basis by the DOH. However there is no standardisation in the review and evaluation process across the provinces. In 2016 we conducted an audit across all hospital groups and established that several facilities had not renewed their licences or had failed their licence renewal requirements, some for a period of years. This was specifically a problem in KZN, but there were issues in other provinces as well. There seemed to be little incentive for these hospitals to renew their licences. The KZN DoH welcomed Medscheme's approach to decline authorisations at those facilities that did not have renewed licences as this incentivised the facilities to update ensured that these facilities became compliant.

Medscheme now conducts random audits across facilities in which we request submission of the facility's updated licence. Where licences are not in order we decline funding at those facilities until such time as their licences are in order.

A further issue is that some facilities transgress the conditions of their licences, for example being registered for 30 beds meanwhile admitting 50 or more, with additional beds just added at their discretion. Alternatively, a licence is given specifically for Oncology beds (to accommodate immune-compromised patients) and these are then simply used for any other surgical patients as demand requires.

A licence renewal should follow an inspection and therefore these cannot be back-dated to cover indefinite retrospective periods – where funding was denied due to previously denied licences, a funder cannot be

expected to retrospectively honour claims from a period when no valid licence applied. This renewal process must be transparent and free from manipulation by connected parties.

23. There are no conditions attached to licensing such as obligations to report on quality, occupancy, staffing capacity, management of Remunerative Work Outside the Public Service (RWOPS), etc. These are reasonable expectations of features of well-regulated healthcare markets, internationally, which currently do not exist in the South African market.

Hospital groups have traditionally been reluctant to share bed occupancy rates, quality metrics as well as staffing ratios per facility, as they regard this as proprietary information. These metrics are reported on in Annual Reports, but at an aggregated level. This does not allow a regional comparison across facilities and does not assist in assessing need. Some of the hospital groups have recently started sharing quality metrics at a facility level, but definitions across the hospital groups are inconsistent.

2.2 Possible Regulatory Interventions

Medscheme agrees with the regulatory interventions proposed by the HMI. In addition we would like to propose that the HMI considers the following in its recommendations:

- Private and public healthcare sector information should always be considered in assessing market needs.
- The facilities that require licensing should be extended to other services such as renal dialysis centres and substance abuse treatment facilities.
- Licences numbers should always be location-specific and pertain to a single facility – so for example, if one clinical technologist owns 5 facilities, each one should be separately licensed and monitored. This should be reinforced through site-specific practice numbers to support accountability. This will enable funders to track quality metrics and outcomes for a specific facility.
- The licence database should include information on where and why licences have been withdrawn as well as information relating to the reinstatement of licences. Licensing authorities should have a service level agreement in place to ensure that their inspections and issuing of licenses is done before expiry of the current licenses.
- Amended regulations should ensure that there is clarity and alignment between R158 and R187.
- Medscheme's position is that the HPCSA's current adjudication process of healthcare professionals be retained but that the limited employment agencies, the criteria for employment of practitioners and those regulating multidisciplinary group practices are changed in order to allow structuring of innovative health co-operatives or affiliations with administrators and managed care organisations. This should be aligned with CMS. These structures of co-operation and affiliation will encourage more appropriate competition i.e. competition based on quality and efficiency of care.