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HEALTH FUNDERS ASSOCIATION

Working with our members for their members

07 September 2018

Mr Clinton Oellermann
The Health Market Inquiry
Trevenna Campus, Block 2A,
4th Floor,
70 Meintjies Street,
Sunnyside,
Pretoria.

Dear Mr Oellermann

Health Funders Association's (HFA's) response to the Health Market Inquiry (HMI) provisional report.

1. Introduction

The HFA welcomes the opportunity to comment on the provisional report of the Health Market Inquiry (the HMI). The HFA acknowledges the extent of the work done by the HMI over the period of operation including extensive engagement and analysis. The resulting provisional report is a valuable resource for understanding the complex dynamics in the healthcare environment. This response reflects the views of the medical schemes and administrators who are members of the HFA on the provisional report. We would also welcome the opportunity to engage further, and provide evidence or analysis if necessary, on any of the points herein.

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At the outset we must express some concern that many of the technical issues regarding the analysis of medical scheme experience that were included in our previous submission do not appear to have been addressed. We have referred to some of these concerns in the more detailed commentary below, however we request that these concerns are properly engaged with before the report is finalised as some of the tables included, particularly in the appendices are incorrect and/or misleading.

At the outset we must express some concern that many of the technical issues regarding the analysis of medical scheme experience that were included in our previous submission do not appear to have been addressed. We have referred to some of these concerns in the more detailed commentary below, however we request that these concerns are properly engaged with before the report is finalised as some of the tables included, particularly in the appendices are incorrect and/or misleading.

The HFA has also considered the recently-published MSA and NHI Amendment Bills while reviewing the HMI's provisional report. There are areas of overlap and in some cases the Bills appear aligned with the HMI's recommendations, although we note that further clarity is needed in many of these areas. On behalf of the HFA's members we would like to specifically raise a concern regarding the extended powers proposed to be vested in the Registrar and Council for Medical Schemes. An appropriate balance of power and delegation of authority needs to be maintained between Parliament, the National Department of Health, the Council and the individual schemes and their trustees, and provision for safeguarding all parties must be included. The HFA will be investigating this issue further.

2. Funders

2.1 Complexity of products

The report refers to the complexity of medical scheme products and the difficulties that members experience understanding their benefits and the extent of coverage. This culminates in member apathy to switching to other schemes. The report also suggests that the complex product structures are deliberate and designed to confuse members. The HFA members totally disagree with this suggestion as product complexity is a feature of health products globally due to the nature of the benefits relating to medical treatment. In the South African context this is exacerbated by the inefficient regulatory environment, particularly the lack of clarity relating to the definition of Prescribed Minimum Benefits (PMBs). Complex benefit structures lead to dissatisfied beneficiaries, high claims queries and multiple interactions which add to the complexity of benefit administration. Great effort has been expended by our members in making benefit structures understandable and accessible.

2.2 Benefit design

The HMI suggests that medical schemes have introduced a wide range of benefit options as a way to induce beneficiaries to self-select, based on their own perceived risk, which is often termed innovation. The HMI has expressed the concern that the range of options and lack of transparency to

members means that competition between schemes is on demographics (attracting the young healthy) rather than lower contributions and richer benefits (value for money). The growth of savings options, and declining comprehensive options is cited as evidence of this.

The HFA acknowledges the HMI's recommendation and agrees that it is the incomplete implementation of a social solidarity framework that is the driving factor and that the concerns noted above can be addressed through risk equalisation and the revision of the PMBs away from a Hospi-centric, curative approach. It is the complex, and poorly-defined construct of the PMBs that has led to a complexity in benefit design.

The HFA shares the concern that members are confused by multiple benefit options and lack of comparability. Standardisation of benefits is not necessarily in the interests of consumers, nor is reducing the number of benefit options, which will have a negative impact on competition and consumer welfare. However, a standardised framework presenting benefit options and an option classification system as proposed by the Council for Medical Schemes (CMS) will assist in addressing these concerns.

The HFA notes the view that medical savings accounts increase this complexity as consumers do not always know whether the administrator paid their claims from their savings or the risk pool. This highlights the need for member education and the important role that brokers play in this regard. It also suggests that savings options require members to have a certain level of financial sophistication in order to plan their benefit expenditure. Savings options do not tend to be targeted at lower income consumers. The migration of membership towards savings suggests that medical scheme members value having some discretion in how their benefits are allocated.

The HFA welcomes the proposed standardised mandatory base benefit package incorporating PMBs and with risk equalisation and a supplementary offering based on CMS rules and standards which may be risk rated. It must, however, be recognised that risk adjustment is a highly complex mechanism and serious regard must be given to how it is implemented, including which entity should be responsible for overseeing this process. The members of the HFA are prepared to support the analytical work required to assess the feasibility of this recommendation, the manner in which it should be administered and the implications for existing medical scheme members.

2.3 Member communication

The finding that medical scheme members are not receiving adequate information regarding their benefit packages is noted with concern. Our members place considerable emphasis on their communication strategies using multiple channels including brochures, websites, call centres and roadshows. One of the challenges is getting medical scheme members to engage with the communication material and educational opportunities and not waiting until they are needing to make a claim or access care.

We also note the finding that patients often do not have information on costs and have no metric for measuring reasonability. This is a symptom of the current fee for service environment. A move to more appropriate alternative reimbursement models (ARMs), as advocated by the HMI, will reduce the need for medical scheme members to engage with the costs of each treatment.

2.4 The role of brokers

We note the findings that brokers have an important role in assisting medical scheme members to navigate the complexity of benefit options. We are concerned, however, with the suggestion that the value of broker commission is measured only against new members i.e. by dividing total commission by membership growth. Brokers play an important role in the annual benefit selection process as well as assisting members with accessing benefits and making claims. This is why the commission is structured on a level monthly basis. The calculations should thus consider the full set of members who have appointed brokers.

The HFA supports the principle that medical scheme members should be aware of the appointed broker, where applicable and that broker fees should only be charged to a medical scheme member if they are accessing such services. Further, if such services are not delivered, the medical scheme member should have the ability to opt out. We note the recommendation that this is allowed for on an annual basis and this needs to be balanced against the need for some income certainty for brokers to ensure that the advice remains accessible and affordable.

2.5 Scheme governance

We note that HMI finds that access to trustees by medical scheme members is limited and trustees are not necessarily directly engaged with the scheme member's complaints. This concern is noted by HFA and will be addressed with our members. The HFA promotes the fiduciary duties of trustees in terms of acting with impartiality with respect to all members and balancing the sustainability of schemes with the delivery of benefits.

We note that the HMI supports a longer period of and e-voting options for trustee elections, with auditor confirmation at the Annual General Meeting (AGM), and possibly a single AGM date for all medical schemes. The HFA is supportive of the principle of encouraging medical scheme members to engage with the governance of medical schemes. Measures need to be in place to ensure that inappropriate lobbying does not take place.

Furthermore, HFA notes that the HMI has recommended that schemes must take more responsibility for containing supply induced demand and for developing and implementing effective ARMs. The fee for service environment, Health Professions Council of South Africa (HPCSA) rules and lack of negotiating powers on the part of medical schemes (particularly following the 2006 Competition Commission ruling with respect to the National Health Referencing Price List (NHRPL) inhibit these developments.

The HMI also recommends that medical schemes should be more active in obtaining information from administrators, particularly on managed care and fraud cost savings and ensuring that these are passed on to their members. The HFA responds that our members are active in this regard and this is a key aspect of engagement between the trustees and their contracted administrators and managed care organisations (MCOs). Further, our members are of the view that the savings achieved are passed on to members as any surplus allows for lower contribution increases in subsequent periods.

The HMI also notes the need for medical schemes to be engaged in negotiating for volume and high-quality outcomes and for meaningful models that positively incentivise positive healthcare provider behaviour. The HFA responds that this is more a function of the obstacles in the environment rather than a lack of effort in this regard by schemes. The HFA also disagrees with the finding that trustees do not have adequate skills in this regard but supports the notion of encouraging greater skills development and access to information and support for trustees. This is an important key role for the HFA.

The HMI recommends the capping of remuneration for scheme officers and also suggests a link to performance. The overall effect of such a measure on non-healthcare costs needs to be considered (as it may lead to widespread remuneration at the capped level). Current guidelines with respect to the process for establishing remuneration have been published by the CMS and this does not appear to have been referenced.

The HMI notes that the regulatory environment of scheme governance needs to ensure more oversight and transparency and that existing governance is ineffective. The HFA response on this point is that regulatory interventions are inconsistent across schemes and do not always consider implications on the stability and integrity of risk pools but are more reactive to individual complaints. The HFA notes the increased powers of the CMS and the Registrar proposed in the MSA Amendment Bill, and is concerned about the implications for the carrying out of the Trustees' fiduciary duties. The HFA recommends that a more cohesive approach be adopted by the CMS in ensuring compliance with regulatory requirements.

2.6 The administrator market

The HMI finds that medical schemes tend to be closely aligned with "for-profit" administrators and are quasi profit maximizing schemes. It is also noted that the delineation of non-profit schemes and for-profit administrators and MCOs tends to distort competition. The HFA refutes the statement regarding quasi profit maximizing schemes as medical schemes are by nature mutual funds and surpluses accrue for the benefit of the scheme members. Administrators and MCOs are contracted for specific services. These organisations do not have access to surpluses accrued in the medical scheme organisations they administer. There has been extensive historic debate regarding the merits of for-profit insurance versus mutual entities with respect to efficiencies and cost, however the HFA supports the current social solidarity framework noting that there are several key protective measures for risk pools that are required to ensure that this framework operates optimally. These include risk equalisation and mandatory membership to operate with the community rating and open enrolment inherent in the current medical scheme framework.

The HMI has raised concerns that trustees do not hold administrators to account, that the responsibilities of trustees are abdicated to administrators and that trustees rely on administrators for innovation. The HFA refutes the statement that trustees do not hold administrators to account. Each of our members has implemented its own governance mechanism and operating model, guided by their trustees. These have policies, structures and processes to ensure that independence is held, and that appropriate monitoring is in place to enable trustees to hold administrators to account. In terms of innovation, product development recommendations and contract structuring do often emanate from the administrators and MCOs and are interrogated and enhanced in consultation and full discussion with trustees. Where medical schemes have the resources to employ full-time staff there is the opportunity for more development and innovation to be driven directly by the medical scheme, but this implies additional cost for the scheme.

The HMI states that medical schemes should expect their administrators to manage moral hazard and supplier induced demand. The HFA supports this statement and it is a key aspect of the contractual arrangements between medical schemes and their administrators. The HFA notes that the environmental constraints, notably the difficulty of implementing alternative reimbursement

mechanisms due to limited negotiating power, as well as the structure of PMBs and the requirement for them to be covered, are significant obstacles. The HFA supports the HMI recommendation to provide maximum FFS tariffs for PMBs to deal with these concerns.

3. Providers

3.1 Competition in the provider market

The provisional report of the HMI acknowledges the challenges that medical schemes have in negotiating tariffs. This arises from the constraints imposed with respect to the 2004 Competition Commission ruling with respect to fee negotiations as well as the dominance of the hospital groups. The HMI notes that only Discovery Health and GEMS have the ability to match the market power of the hospital groups.

The HFA shares the concern expressed by the HMI with respect to anticompetitive arrangements and the unilateral power of corporate practices. It is also a concern that some specialist associations may be a platform for collusion, and the HFA suggests that this warrants further investigation.

The absence of a reasonable price list published by the Department of Health is a real challenge, particularly with respect to PMBs, and this has left the inflation adjusted 2006 NHRPL as the only reference point which is not always appropriate. The HFA supports the concern regarding the absence of central body to agree on coding and guidance on new technologies.

The concerns around the effectiveness of ARMs because of carve outs is supported by the members of the HFA and this is a symptom if imbalanced negotiations. HFA members have also struggled to set up effective networks for specialists. A key concern is that the HPCSA regulations frustrate innovation.

The HMI has noted that there is limited innovation in provider reimbursement models (ARMs) and suggests that ARMs predominantly initiated by the hospital groups and have low incidence and effect. The HFA members dispute that the limited innovations are due to lack of effort on the part of funders but rather reflect the environmental barriers noted above. The HFA is of the view that the proposed amendments to the HPCSA rules are an urgent requirement for innovations that have been worked upon to be implemented. Our members have cited several examples where discussions with provider groups have progressed only to be thwarted by HPCSA requirements. The HFA members have also experienced the inconsistent application of HPCSA rules as noted in the HMI report.

The HFA concurs with the HMI finding that fee for service tariffs are a reflection of market failure as they do not consider quality of care and they promote supplier induced demand. The HFA is concerned by the finding that a review of the 2004 order is not required but supports the process of a multilateral forum as proposed, and strongly supports the recommendation for bilateral negotiations with corporate providers.

The HFA notes that the HMI finds that provider networks have a net positive impact on competition and are beneficial to consumers in terms of treatment with removing balance billing. They also benefit providers due to contractual certainty and agrees that selective contracting on patient volumes, price and quality is required for alternative reimbursement models (ARMs) to be effective.

3.2 Quality measurement

The HMI notes that quality indicators in respect of delivery of healthcare services are not readily available. This is of great concern to members of the HFA and this led to the formation of the Health Quality Assessment (HQA) by the industry, and with regulatory participation, in 2000. The HQA has done extensive work on the development of appropriate indicators and also data collection

requirements. Data collection is a significant consideration as it needs to be ensured the data specifications are completed consistently across different schemes. There is an opportunity for the work of the HQA to be further developed and enhanced through more widespread involvement by medical schemes and also support from the regulator.

The HFA supports, and intends to act further on the recommendation that the industry should be developing and publishing further measures of quality.

3.3 HPCSA

The HMI has made several specific findings with respect to the HPCSA. These include:

- The HPCSA is not consistent in application of rules and permits shareholding but not employment.
- The HPCSA rules on employment compel facilities to offer other forms of incentives which are not necessarily promoting the interests of patients.
- Alternative models have been proposed to the HPCSA without success. The HPCSA tends to adopt reactive approach.
- The HPCSA stance on ARMs has hindered development (and therefore had adverse cost and cover consequences for medical scheme members).
- That no register exists to assess numbers of practitioners working in public and private sector.
- The backlog of HPCSA complaints and limited penalties means that there is inadequate deterrence for unethical conduct.
- There has been a lack of explicit addressing of points raised by Ministerial Task Team investigation into the HPCSA.
- The HPCSA is over-occupied by concerns about professional autonomy – the HMI has expressed that it is not unethical for doctors to take account of financial consequences of care for their patients.
- The HPCSA rules on hospital shareholding are not consistently enforced.

The HFA believes that these are very serious findings that are having direct and current effects on the cost of cover and the clinical governance of care and these need to be urgently addressed. The HFA supports further action by the Competition Commission in addressing these concerns and our members can confirm that there are meaningful savings that can arise from allowing multi-disciplinary practices to operate and the employment of doctors so that the use of ARMs can increase.

4. Cost drivers

In this section, we note the key cost drivers that have been identified by HFA members and comment on how they have been addressed on the HMI report.

4.1 Anti-selection

The HMI finds that there has been a lack of attention to the regulatory framework in the private healthcare sector and that the partially regulated environment creates incentive for risk selection. The incomplete implementation of the social solidarity framework is a key problem that has been identified by HFA members in their previous submissions.

The HMI also notes the phenomenon of members buying down to cheaper options in order to address affordability constraints and that this has an adverse effect on schemes. This is a very significant issue

and it is very concerning that the assessment of cost increases has not properly addressed the plan mix effect. It is not adequate to use claimed amount instead of benefit amount to address this problem as this assumes that members will always submit claims for benefits that are not covered.

It is concerning to all HFA members that expenditure in private healthcare is high and is increasing above inflation, making medical scheme premiums less affordable. The HMI notes that there is evidence of anti-selection but that this is not a key driver of annual increases (although there is a progressive effect which is leading to decrease in depth and range of covered services). It is very concerning that this effect has been understated by the HMI. The voluntary nature of a risk pool based on open enrolment and community rating makes it highly conducive to anti-selection and the waiting periods permitted provide very limited protection to medical schemes. The HFA is very concerned that this incorrect lack of importance assigned to anti-selection will be used to support the proposed relaxation of waiting period requirements in the Medical Schemes Amendment Bill which will have dire consequences on the costs of cover, affordability and hence levels of coverage. This effect is felt most keenly by open schemes. Our members have estimated that the effect of the proposed relaxation of waiting periods will have an immediate effect of increasing contributions by 4% to 8% which is likely to lead to around 500 000 beneficiaries no longer able to afford cover and that a spiral effect could ensue with further increases and loss of cover. It is not apparent that the costs and unintended consequences of implementing the proposed amendments have been considered at all. It is vital that the HMI properly addresses the point of anti-selection.

The HFA welcomes that the role of mandatory membership is acknowledged by the HFA and we are disappointed that it is deemed to be not appropriate in the current environment. We support that current areas of inefficiency need to be addressed, and there are immediate opportunities to do this through the amendments to the HPCSA rules. However, while we acknowledge the high levels of unemployment, the HFA is of the view that introducing mandatory membership above a specified income band will have significant benefits in terms of affordability and that progressive introduction of income-based mandates will increase access to those who are unlikely to see the benefits of the NHI Fund for some time. Encouraging those who can afford it to provide for themselves has been a key part of national health policy since 1994 and ensures that public resources are expended on those who need it the most.

4.2 PMBs

The PMB analysis presented in the HMI report remains a concern for HFA. Our previous submission, as well as those of our members, highlighted that relying on ICD10 codes on their own to identify PMBs is a fundamentally flawed approach. It is for the very reason that the PMBs are not accurately identified on diagnosis code alone that the CMS has had to publish algorithms that have been the subject of much discussion and debate. The PMB analysis presented by the HMI makes no reference to these realities and is misleading in suggesting that PMB flags provided in the data are anything other than ICD10-based flags as defined in the HMI data specification. It is extremely damaging to our members that the PMB analysis suggests that non-PMBs have not been paid in full or have been paid from savings. This assertion needs to be substantiated by credible data and evidence. The level of PMB expenditure noted is also therefore inaccurate.

The conclusions drawn relating to lower compliance on out of hospital PMBs with payment from savings is therefore also incorrect. The finding that the PMBs are not a primary driver of cost escalation is incorrect, particularly as PMBs are found to be an increasing component of medical scheme expenditure.

HFA members are concerned that evidence of "dumping" of non-PMB patients with limits exhausted on the State has been found and request that the extent of this is disclosed.

The HFA supports the finding that the PMBs require revision, with particular reference to primary care benefits. However, it is important that such a review does not lead to a simple addition to the current PMBs which will have an adverse effect on affordability and access to cover. The revision of PMBs should consider members' needs, including adequate protection from catastrophic expenditure. Further consideration is also required on how the revised PMBs (and the base benefit package) would relate to the 'comprehensive health service benefits' and the "comprehensive benefit package" as proposed in the NHI and MSA Amendment Bills. The HFA is seeking further clarity on these proposed amendments.

4.3 Supply side factors

The HMI notes that the bulk of the increase in claim expenditure can be attributed to expenditure on private hospitals and medical specialists. The HMI also notes that expenditure increases do not seem to all be due to aging population/disease burden and that this additional factor is considered to be supplier induced demand. Without detracting from the urgent need to address supplier induced demand, our members are of the view that some of the effects noted above have been conflated with supplier induced demand in the analysis. For example, the requirement to cover PMBs at cost is a significant factor in encouraging providers to identify treatment as relating to a PMB and to increase the cost of such treatment.

4.3.1 Hospital analysis

The hospital concentration analysis presented is inconclusive and we suggest that this is due to the patient exposure not being accurately assessed as well as the lack of risk adjustment. The concerns regarding the number of creeping mergers in the hospital market are also noted. The HFA is concerned that this aggregation has an adverse effect on competition.

The HMI has also addressed the impact of increasing numbers of hospital beds, and particularly that the number of private beds has increased over time while the number of public beds has reduced, without concomitant changes in the population covered.

The analysis presented in the HMI report indicates that beds and doctors per 100 population are a positive indicator of increased utilisation. This is consistent with findings determined by some members of the HFA and suggests an urgent need to address the licensing process as well as creating appropriate incentives for managing exposure to hospital-related expenditure.

4.3.2 Utilisation trends

The HMI is of the view that utilisation is the key driver which is driven mostly by admission rates and to a lesser extent by length of stay and level of care. The HMI notes that the increase in day admissions is only marginal and day cases do not appear to be substituting acute days. The high length of stay relative to OECD countries is also noted as well as higher levels of ICU usage.

The members of the HFA have made similar findings, particularly with respect to escalating hospital admissions, particularly medical admissions. These may be associated with instances where practitioners may be admitting patients when not required or keeping patients in hospital longer than needed. There are significant challenges for schemes in countering the advice of practitioners in this regard, particularly in respect of PMBs.

The HFA supports the HMI finding that higher hospitalisation rates and associated higher expenditure are making medical scheme membership more expensive and less accessible.

4.3.3 Competitiveness of the provider market

The HMI report refers to the OECD report that hospital services are expensive given the level of income in the country. In our previous submission we have noted concerns with the OECD analysis but welcome that the reference to the income level of South Africa has been included in the HMI report. It is important to highlight the huge disparities in income levels in our country as evidenced by our GINI co-efficient. Medical scheme cover is currently out of reach of the majority of South Africans in terms of affordability, as is private hospital access. This is more of a function of income disparities than relative cost of healthcare services when compared to other countries on a purchasing power parity (PPP) basis. This has been extensively addressed in previous submissions.

The HMI concludes that adverse incentives are key drivers in "unexplained" escalation factors. These incentives relate to hospitals competing in attracting specialists. The HMI finds that the main objective of the relationships between practitioners and hospitals is not aligned with consumer interests and that there may be inconsistent application of HPCSA rules. It is also notable that the practitioners found to be most in demand by hospitals are those driving financial expenditure at facilities rather than clinical assessment.

The HFA supports the concern expressed by the HMI that there is inadequate focus on economic consequences of medical decision making in medical training and that there is a need to consider the value to individual patients, as well as the collective of patients and the population, in terms of how finite healthcare resources are to be allocated.

4.3 Role of managed care

The HMI notes that the increase in managed care costs has exceeded CPI but has not resulted in containment of overall healthcare costs. This is a difficult statement to support since there is no opportunity to assess a medical scheme population where managed care has not been applied.

It is the experience of our members that the application of managed care techniques, particularly clinical pre-authorisation, disease management, the use of networks and formularies and the application of evidence-based protocols, have positive effects both in terms of cost savings and in terms of quality of care.

5. Recommendations

This section specifically addresses the recommendations made in the provisional report of the HMI.

5.1 Scheme benefits, consumers and role of administrators

The recommendations are noted as follows with HFA commentary:

- Scheme options be restructured to include a base benefit option which is standard across all schemes, and that this option would be risk equalised across schemes through a risk adjustment mechanism (RAM). Schemes would then be free to provide supplementary options which may be risk rated.

  Comment: This proposal is supported however it should be noted that risk adjustment is a complex structure and needs to be carefully constructed to have the desired effect. The HMI also recommends that the CMS initially facilitate this process but then this should be moved to an

independent body to avoid conflict of interest. The HFA supports the proposal of independence and will provide further input on this aspect once more details on the proposed structure are provided.

- The current tax credit regime should be reconstituted to take the form of a cross-subsidy administered through the RAM to address the needs of low income members.

  Comment: The concept of an income subsidy is supported, and it is important to note that the tax credit currently plays an important role in creating access for lower income earners.

- The PMB package for the base benefit option would be regularly reviewed and updated (at least every 3 years) with more detailed information provided to members on accessing PMBs. PMBs need to include more out of hospital cover to reduce incentives for admissions.

  Comment: This recommendation is supported.

- Governance of schemes should be strengthened, and Trustees should demand more accountability from their administrators to manage claims inflation.

  Comment: The HFA submits that Trustees do hold administrators accountable and that a range of initiatives are in place to manage costs and to address market failure where possible. The HFA is of the view that more consistent enforcement of current regulatory provisions is required and that there are environmental factors that hinder the ability of schemes to manage inflation.

- Remuneration for scheme officers should be capped and linked to scheme performance.

  Comment: This needs to be carefully constructed to ensure that it does not lead to an overall increase in scheme expenses.

- There should be public reporting of the outcomes of managed care arrangements in terms of savings achieved.
  Comment: It is noted that there is currently some reporting, and this could be expended. Transparency in this regard to demonstrate value is supported however it should be noted that accurate measurement of savings is a great challenge and difficult as the HMI analysis has demonstrated that isolating the elements of cost changes is highly complex.

- Schemes need to be more actively encouraging AGM participation by members and members should be made more aware of the CMS.

  Comment: This recommendation is supported.

- Brokers should be remunerated on an "opt-in" basis with full disclosure of fees.

  Comment: As noted above, this recommendation is supported on the basis that rules can be set for the frequency and process aimed at ensuring members are aware of the advice available and this remains accessible.

- A discount to encourage and incentivise younger, healthier members to enter earlier should be considered.

  Comment: The principle of encouraging early entry into the risk pool is supported but too high a discount would remove the cross-subsidy benefit of attracting younger lives and could actually reverse the age pooling effect. Consideration should be given to combining this with extending underwriting measures to protect the risk pool from higher cost late entrants. It is critical that the design, viability and associated impact of any proposal, such as this one, is assessed fully before it is implemented. The HFA will engage further on this aspect once further clarity is provided to ensure that any such proposal is properly considered and appropriately designed.

- Competition in the schemes market should be increased by the introduction of 'regional' schemes, which could be protected from volatile claims risk through reinsurance.

  Comment: No detail is provided to support this proposal and further information and analysis is requested to demonstrate the envisaged structure and how this would enhance competition.

5.2 Suppliers of healthcare

- There are detailed reporting requirements for facilities and a new licensing framework under a Supply Side Regulator for Health (SSRH) which would be established under the National Health Act. The SSRH would be an independent public entity and would oversee proper healthcare resource planning and monitoring.

  Comment: The principle of supply side regulation in a more coordinated way is supported however the HFA suggests that ways to use existing structures more effectively are explored before a new complex regulatory structure is implemented. The establishment of the SSRH will be complex and to ensure sound regulatory outcomes, the HFA submits that there needs to be proper institutional design for the regulator to ensure good governance and effective independent regulatory decision-making; clarity on the role and purpose of the SSRH; well-designed rules and regulations with clear principles for accountability and transparency, among other factors.

- A moratorium on new beds for the three large hospital groups should be considered.

- *Comment: While the HFA is concerned about the dominance of the three large hospital groups, the impact of the market cap needs to be properly considered. We suggest an approach regarding proper assessment of need in licensing, incentives for ARMs and encouraging the development of alternative levels of care are considered as more refined and targeted tools.*

- Practice code numbers for public and private facilities should be managed by the SSRH. Practitioners must also register the facilities at which they operate to allow for inspections and prevent fraud. The Office of Health Standards Compliance (OHSC) would be incorporated into the SSRH.

  Comment: As noted above, we have some concerns regarding the complexity of the proposed regulatory structure. We do support the need for linking of codes which may be facilitated by revising the HPCSA rules so that ARMs can be implemented. We also strongly support measures to combat fraud which is a key concern for HFA members. We also note the dire need to strengthen the resources of the OHSC so that it can deliver within the existing mandate.

- Economic value assessments should be published to stimulate competition, mitigate information asymmetry and facilitate strategic purchasing by funders.

  Comment: We strongly support the need for evidence-based assessments.

- The Outcomes Measurement and Reporting Organisation (OMRO) should be implemented in a phased way with the first phase being a voluntary measurement and reporting system leading to the establishment of a statutory entity.

  Comment: The need to quality measurement and supporting is strongly supported however there are existing structures which can be strengthened. This can be incorporated into the phased approach.

- The CMS should include metrics on supplier induced demand in its published reports and work with stakeholders to determine appropriate format and frequency.

  Comment: This is a noble suggestion but there needs to be clarity on how this is defined. As is evidenced from the HMI analysis, unpacking the elements of cost changes is highly complex and needs to be done rigorously and consistently to be of value. There also needs to be proper consideration regarding the entity responsible for this function, and in particular, whether the expertise to engage in this exercise resides with the CMS or elsewhere.

- The public sector should be engaged in strategic purchasing from the private sector.

  Comment: This recommendation is supported, and it is noted that this is a component of NHI policy. There will be further benefits if ARMs are encouraged.

- The HPCSA must undertake a review of its ethical rules to encourage group practices and global fees and to remove the ban on the employment of doctors by facilities. The rules should consider the competition perspective in general. Specific rule references have been provided and this includes full disclosure of the practitioners' interest in treatment provided including facility shareholding and financial interests in medicines and products used or dispensed.

  Comment: This recommendation is supported in the strongest terms and the HFA encourages urgent action in this regard.

5.3 Provider pricing

- There are two proposals for addressing tariff setting:

  - Regulated pricing: this will require meaningful participation by all stakeholders with submissions on tariffs. The SSRH will then publish FFS tariffs which are only binding on PMBs. There would be an appeal mechanism to an arbitrator for stakeholders.
  - Multilateral forum: this would be managed by the SSRH to determine tariffs. There would be a formal engagement/bargaining process leading to tariffs being set by the SSRH which would also only be binding on PMBs and a reference point for other benefits. There would be provision for appeals to an arbitrator.

- Bilateral negotiation and the development of ARMs should be encouraged.

  Comment: The HFA supports the principle of maximum FFS tariffs for PMBs and permitting bilateral negotiations on ARMs in a more unfettered way. While the multilateral approach is preferred, HFA members have some concerns regarding the complex regulatory structure and suggest that existing structures can be employed more effectively. Whilst the determination of tariffs is complex, the HFA submits that there is an urgent need to address the current uncapped pricing of PMBs, as PMBs are a significant and increasing component of medical scheme expenditure. The HFA will provide further input on this aspect once further details on the proposal are provided to help ensure that this is effectively implemented.

- Coding systems need to be standardized across the health sector. This will be coordinated by the SSRH.

  Comment: The standardization of coding is supported in principle and concerns regarding the complexity of the proposed SSRH are noted.

- Provider network agreements need to promote transparency in terms of pricing, health outcomes and location with reasonable access a key consideration. Contracts need to measure and reward quality care. Balance billing should not be allowed under network contracts.

  Comment: This recommendation is supported by the HFA and we note that significant progress in this regard can be made if the HPCSA rule changes are urgently implemented.

- Facility and pathology Designated Service Provider (DSP) arrangements need to be more competitive and involve open tender processes.

  Comment: The HFA supports this recommendation.

6. General remarks

The HFA appreciates the opportunity to provide further input to the HMI. We are concerned that the HMI report has not adequately addressed the market for pharmaceuticals and consumables. These are important contributors to cost escalations and there is also significant prevalence of supplier induced demand in this space. Of particular concern is that Single Exit Prices are not regulated neither are they reviewed after they are initially set and are simply escalated annually. Further, there is evidence of ever-greening of patents which keeps prices artificially high.

The HFA is also concerned that measures to promote the expansion of access to cover for lower income earners have not been considered. There was extensive work done in this regard with the Low-Income Medical Scheme (LIMS) work in 2006 and the Low-Cost Benefit Option (LCBO) framework in 2015. There is currently an interim exemption structure for some insurance products however there is an urgent need to provide benefits of real value coupled with the associated protection of the social solidarity-based risk pool to these lives.

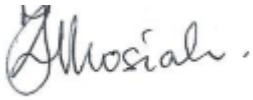
The HFA further submits that any recommendations emerging from the HMI need to be considered in the light of the proposed significant changes in the health care system in South Africa, as reflected in the recent NHI and Medical Schemes Amendment Bills.

The members of the HFA would be willing and happy to engage further with the HMI with respect to any of the points raised in this response. HFA is happy to co-ordinate such engagements where required and requested by the HMI.

7. Conclusion

HFA appreciates the opportunity to give comment and endorses the objectives of the HMI. We believe the HMI has a pivotal role to play in resetting the national integrity compass, aligning and creating visibility in relation to all efforts in this regard.

Yours Sincerely



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Lerato Mosiah
CEO

cc: Mr. T. Mosomothane - Chairman