



## **H e a l t h M a r k e t I n q u i r y**

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Promoting Healthy Competition

### SEMINAR

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Excessive utilisation and Supplier Induced Demand

22 February 2019

## INTRODUCTION

1. This note briefly sets out the background to the purpose of the HMI hosting a seminar for stakeholders on excessive utilisation of healthcare services and supply induced demand on the **22<sup>nd</sup> February 2019**.
2. On 5 July 2018, the Health Market Inquiry (HMI) published its Provisional findings and recommendations report (provisional report).<sup>1</sup> A finding of the HMI was that of increased utilisation over and above that which can be explained by the level of ill-health or age of the population who are members of medical schemes.
3. The HMI triangulated data in its efforts to understand this. Some issues common to both providers (doctors and facilities) were presented in 'Chapter 8 Excessive utilisation and supplier induced demand'.
4. A number of stakeholders have responded in written submissions to the HMI's provisional report with varying degrees of both support for and disagreement with the HMI's findings. The purpose of this seminar is to provide a forum for focused debate where views of stakeholders can be expressed and to provide the HMI panel with an opportunity to consider relevant points of view and possible solutions in preparing its final report. The HMI is cognisant that stakeholders had not seen some of these analyses before.
5. This note will not repeat what is in the provisional report and stakeholders are referred to the relevant chapters; in particular Chapter 8.
6. The HMI takes it as given that all responses related to excessive utilisation and supplier induced demand – for brevity referred to as SID hereafter - have already been submitted in the written responses to the provisional report.
7. Stakeholders are welcome to review the opinion of others' with regard to the HMI SID findings; these have been published on the HMI website, at the following link <http://www.compcom.co.za/12138-2/> .
8. Stakeholder submissions have been read with due diligence and are guiding our approach to the seminar.

## HMI FINDINGS ON SUPPLIER INDUCED DEMAND

9. The HMI explained that supplier induced demand can result from the phenomenon whereby, in most cases, health practitioners both advise of the need for a service and then provide that

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<sup>1</sup> Available online at: <http://www.compcom.co.za/provisional-findings-and-recommendations-report/>

service. Since practitioners are typically paid by volume of services provided (fee for service), a revenue-maximising professional will tend to recommend more, rather than fewer services (page 376). In an insurance market this is more likely to happen as there is low or no payment at the point of care. It is also more likely to occur in markets with asymmetrical information as patients are not in a position to know what they need. Further, when someone is ill they may not be able to apply their mind well enough to make an informed decision. As indicated on page 377 we examined this effect for practitioners (where the agency relationship on behalf of patients is most obvious) as well as facilities (where the benefiting entities do not act as agents for patients, but might be able to influence the practitioners, who do).

10. Many factors can influence occurrence of overuse and SID and some examples can assist understanding this. Factors influencing SID can be

- a. patient related behaviour such as expecting, even demanding, interventions, and or treatment and or admission to hospital which may result in overuse or inappropriate use of health resources and in some cases may not result in improved health outcomes.
- b. provider behaviour driven (e.g. a greater propensity to make a diagnosis because this guarantees reimbursement by a payer, opening a new hospital, increasing the number of ICU beds, hospitals competing for doctors who then admit patients, monitoring doctors admission rates, buying new equipment which providers may be more likely to use to ensure that it is paid off, purchase and use of technology to appear to be up-to-date without having protocols in place to ensure appropriate use (such as TAVI) or where evidence of cost-benefit is still missing (e.g. robotic prostate surgery) or more frequent use of technology where benefit to health has been questioned (e.g. yearly breast cancer screening). Any of these can lead to overuse and where such use is not driven by patient well-being but by income generation then this leads to SID. As noted previously, without any overt collusion, interests of doctors and hospitals can coincide.

11. Overall the HMI found that there is an excessive use of services or use of higher levels of care than can be explained by the level of health, age, and level of cover (among other factors) of the medical scheme population (page 376 paragraph 1). We also found that utilisation of recent joiners was at a higher level than those who had been members for a longer period of time (page 389 best summarised in figure 8.9 see also page 388 paragraph 34). This implies that people join a medical scheme when they anticipate that they may need care.

12. We found that, compared to similar populations, hospitalisation and some interventions and use of high care wards was higher in South Africa. High level care use was significantly higher in South Africa Provisional report page 378 paragraph 11, page 380 figure 8.2, page 379 Figure 8.1, page 382 Figure 8.4).

13. We demonstrated that the supply of doctors and hospital beds in a particular location was associated with the level of utilisation of care of the population who lived in that location (best illustrated on page 389 figure 8.9).
14. The HMI concluded that adverse selection (or anti-selection) is an issue but that there are interventions in the market to limit this: waiting periods and late joiner penalties. There however still appears to be evidence of SID after adjusting for adverse selection.
15. We concluded that there are less robust or obvious methods to control the supply side of the market. Where such regulatory methods exist, such as licensing of hospitals, in its current form, it is not optimal. In one public seminar<sup>2</sup> a large majority of stakeholders whose primary responsibility is to manage scheme members' funds and protect scheme members' interests, was unable to provide robust examples and evidence of managing SID. It was hard to find evidence that the proportion of income invested by schemes in pre-authorisation and managed care brought down scheme membership fees. Fraud has been found to be a problem and efforts to curb this is occurring; again direct benefit to scheme members is not clear.
16. The HMI has found over time that the rising costs of overuse and SID has largely been passed on to scheme members in the form of higher membership fees and or limiting cover rather than vigorous control of the supply side. There are some mechanisms to influence patient behaviours such as various forms of co-payments or the implementation of medical savings accounts but much less evidence of trying to control providers. We do note that recently, but only recently, DSPs for hospitals have become a feature of the market.
17. The HMI views the levels of SID in the market is a manifestation of market failure. As indicated in the provisional report it illustrates either the inability or the lack of will on the part of funders to manage this.
18. The HMI is interested in the drivers that be changed through improved competition; for example:
  - a. New health technologies often drive up costs. Where these cost increases are accompanied by better outcomes this may be justified. Some interventions are just too expensive and may not be justified even if beneficial. Where the evidence for improved outcomes is absent or ambiguous, there is a real role for an institution to either generate or acquire the relevant evidence, and ensure that both providers and patients are aware of costs and benefits. Transparency on value, a feature of a competitive market. must be promoted
  - b. Provider behaviours can be influenced, through medical training, regulation, and incentives inherent in reimbursement. These are thus of particular interest to the work of the HMI.

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<sup>2</sup> Proposed regulatory interventions for the Licensing of Healthcare Facilities Date: 1 MARCH 2018

19. Overall there is still no best single method to address SID. Policy makers tend to choose a combination of interventions. Supply-side measures aim at affecting market supply or directly controlling the provision of services they include: price or fee controls, utilisation reviews or service monitoring arrangements, managed care, technology controls, capping of services, determining the appropriate number of providers, development and use of clinical practice guidelines, change of reimbursement structure. Payment reform has been attempted less and more successfully in many countries. A feature of the South African market that we have pointed out is poor development of and support for innovative new practise models that can change incentives.
  
20. Our recommendations cover many of these options and include: the introduction of a single comparable base scheme option with a risk adjustment mechanism to drive competition between schemes so as to force more vigorous supply side negotiations, a health technology assessment function to curb inappropriate purchase and utilisation of health care technology as well as provide best guidance on treatment options, methods to control prices, changes in the HPCSA ethical rules to promote innovation in models of care to allow for group practices and alternative care models so that fee-for service ceases to be the dominant payment mechanism, changes to training curriculum and importantly measurement of and transparent reporting of health outcomes to allow for value purchasing. We have also advised that the HPCSA should pay more attention to competition in the execution of its duties such as enforcing its ruling on shareholding. The HMI is interested to hear stakeholder views about how these may curtail overuse and SID. We are also interested to know if there are other mechanisms that we may not have put forward.

## **APPROACH TO THE SEMINAR**

21. The HMI is aware that gaining common understanding among stakeholders is important. To achieve this, the seminar will be divided into two parts. The first part will deal with the findings in our provisional report.
  
22. We have assessed the responses to our analyses and conclusions on SID and will respond to the critique received in the written submissions. We will not respond on a stakeholder by stakeholder basis but rather will group similar issues together. We have categorised the issues as follows: definitional issues, the data itself, questions on geographic boundaries, the inferences drawn from the results, and questions about the appropriateness of comparisons made. Thereafter we would like to engage in debate with stakeholders.
  
23. The second part of the seminar will be devoted to how to deal with overutilisation and SID. The HMI is aware that overutilisation is a multifaceted problem and a range of recommendations to deal with it is required. The HMI is concerned that the range and nature of its current

recommendations may not be sufficient to address this problem and want to discuss these with stakeholders.

24. We do not anticipate that there are new issues over and above what has already been submitted to us in the written responses. Thus we are not inviting further submissions; stakeholders have already had an opportunity to provide such.
25. Stakeholders that wish to present at the seminar must provide us with such presentations no later than the **31 January 2019**. To ensure that sufficient time is allowed for debate and discussion the HMI will select the final presenters based on the submissions and will limit the time allocated to each presentation. The format and list of speakers will be furnished to attendees at a point in time closer to the date of the seminar.
26. **This is an invitation to attend the HMI seminar on supplier induced demand at the HMI's offices on the 22<sup>nd</sup> of February 2019. Please RSVP no later 31 January 2019, at [healthinquirydirector@compcom.co.za](mailto:healthinquirydirector@compcom.co.za)**