CHAPTER 10: RECOMMENDATIONS

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INTRODUCTION

1. The South African private health sector suffers from multiple market failures. The sector comprises a complex set of interrelated stakeholders who interact with one another in an imperfect environment replete with information asymmetry, a lack of transparency and moral hazard. The HMI has found that there are a number of features of the private healthcare sector, including the conduct of some of these stakeholders that have an adverse effect on competition.

2. The HMI has thus developed a set of recommendations aimed at addressing the competition concerns identified, but also at introducing changes that will promote competition to the benefit of consumers and the long-term sustainability of the market. These recommendations are made in the context of broader policy considerations.

3. In particular, the HMI considered government policy such as the NHI and the NDP in order to locate these recommendations within the context of current national objectives. This is done on the understanding that the interventions proposed here are important not only for competition, but in the public interest at large.

4. These are the provisional recommendations of the HMI. The recommendations are made in line with section 43C(1) of the Competition Act, which states that upon completion of a market inquiry the Commission must publish a report of the inquiry "*with or without recommendations, which may include…recommendations for new or amended policy, legislation or regulations; and recommendations to other regulatory authorities in respect of competition matters.*"

5. Stakeholders are requested to provide submissions in respect of the proposed recommendations. Submissions should focus on the stakeholder's view of the recommendations, the proposed manner of implementation, the proposed entity responsible for implementing the recommendation, and the proposed timelines.

6. Submissions should be as detailed as possible and any views or opinions expressed should be substantiated, as far as possible, by evidence.

PRINCIPLES CONSIDERED IN DESIGNING RECOMMENDATIONS

7. At the onset, it should be stated that the HMI's findings and recommendations were based on the evidence and information provided by the stakeholders through written and oral submissions, as well as its own research and analyses of data and information collected.

8. The HMI considered some well-accepted jurisprudential principles in determining these recommendations. Though noting that these principles derive from enforcement actions, which are quite different from a market inquiry, the HMI is of the view that these principles are still relevant as these recommendations may have notable effects on the rights and duties of affected parties.

9. One of the principles extracted from the South African jurisprudence is that of "appropriateness", referred to in Section 49D(1) of the Competition Act.[1]

10. In the *Competition Commission v SAA and others*[2] the Tribunal stated that "appropriate" simply means "suitable":

> *"…it is suitable in the sense that it is an agreement that suits the contending interests of the Commission, as the proxy of the public interest, and the respondent, and in that sense, can be said to be appropriate as between themselves".*[3]

11. The principle of appropriateness suggests that the remedy must be measured against the harm it wishes to address, the effect on the stakeholders involved, and the purpose it wishes to achieve. Simply put, there must be a fit between the recommendations made and the harm they wish to address.

12. The HMI also considered the factor of practicability, that is, whether its recommendations would be practical to implement. We evaluated whether there were any legal and structural hurdles to the implementation of the recommendations and where those existed, how they could be dealt with.

13. Lessons were also drawn from the criteria used by the UK CMA when considering its remedial action. For example the CMA considers how comprehensively the possible remedy options (individually or as a package) address the adverse effects on competition

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[1] Section 49D(1) states: *If, during, on or after completion of the investigation of a complaint, the Competition Commission and the respondent agree on the terms of an appropriate order, the Competition Tribunal, without hearing any evidence, may confirm that agreement as a consent order in terms of section 58(1)(b)*

[2] Case Number: 83/CR/Oct04

[3] At paragraph 47

and/or the resulting detrimental effects on customers and whether they are reasonable and practicable.

14. The CMA also explicitly considers the effect of the remedial action on consumer benefits. In the health sector, it is imperative to ensure that any recommendations made by the HMI do not negatively affect the patient, but rather increase benefits to them.

15. The South African private healthcare system is subject to many distortions that have an adverse effect on competition. These recommendations focus on the key interventions necessary to correct harm to competition and improve access and affordability of private healthcare. The interventions we have proposed are closely interrelated and market failures may persist if a partial approach to the implementation of the recommendations is adopted. The recommendations should thus be seen as a package.

16. In some cases, the HMI has proposed an explicit sequence for implementation. In others, we have made the interdependencies known and have cautioned against piecemeal implementation. In considering these recommendations, stakeholders should thus have regard to the links between recommendations as well as the sequence of implementation, where specified.

RECOMMENDATIONS FOR FUNDERS

17. Overall, the HMI finds that competition in the funders market is neither as vigorous nor as effective as it could, or should, be. This is true of both administration services and medical schemes.

18. In both the administration and open scheme markets, one large player (Discovery Health in administration and DHMS in open schemes) leads the market, especially in terms of growth, innovation and profitability. Other players largely follow its lead. Restricted schemes, by their very nature, do not compete with open schemes nor do restricted schemes compete with each other. The HMI found that there is limited competition between schemes on factors that increase the value of medical scheme cover (in terms of both cost and quality) and limited evidence of efforts to design and implement alternative reimbursement models to contain expenditure and encourage value-based contracting. The HMI believes that there are failures in regulation, governance and adverse incentives associated with the current market structure that contribute to this lack of competition and innovation.

19. At the heart of the failure of funders to deliver better value to consumers lie multiple problems: a profound lack of transparency (including on scheme options and quality of outcomes), a lack of accountability of schemes to members, and a failure of governance that align scheme interests too closely with that of administrators. The lack of incentives operating at scheme level weakens schemes' resolve to hold administrators to account for delivering value to members. Health care costs and administration costs fees are increasing and benefit packages cover less care.

20. The Inquiry has also found that all schemes have failed to adequately manage supply-induced demand. Given that supply-induced demand is known to exist in healthcare markets (and has been shown to exist in South Africa too), we would expect medical schemes to force their administrators to actively manage this in the interest of protecting scheme members' health and the financial sustainability of the scheme. The ability to effectively manage SID should also be a competitive differentiator for administrators. The widespread inability to manage and supply-induced demand suggests a lack of effective competition in the market for administration.

21. With respect to the lack of transparency, consumers simply do not know what they are purchasing and cannot hold funders accountable. There are too many plan options, very little understanding of what they cover, how the plans compare, and no measure of the value that consumers are receiving. In the absence of such information, consumers may simply choose what they can afford.

22. Ideally the trustees of schemes should be interceding on behalf of members to ensure that they receive value for money and that administrators are delivering the best possible value to scheme members. But, the governance of schemes is problematic.

23. There are few incentives to ensure that scheme employees, trustees and principal officers always act in the best interest of consumers. And even if they tried, administrators generally have far more analytical capacity and 'know how' than schemes and generally make decisions on behalf of schemes, even on key issues of strategy. The 'separation' between schemes and administrators often seems artificial, particularly in the case of large open schemes. This failure in governance is severe and is a major concern for the Inquiry.

24. A unique feature of the South African private market is that not-for-profit-schemes are administered by for-profit administrators. Our overall observation is that the interests of

the for-profit administrators are dominant; scheme members and trustees are too weak and or disempowered to force administrators to align to schemes members' interests.

25. The incentive alignment between restricted schemes and their members (from whom trustees are often appointed) is closer than that between open schemes and their disparate members. In closed schemes, particularly employer-based schemes, the cost of scheme administration influences the employer directly if they subsidise membership or indirectly if employees are dissatisfied with their health cover. We have found that closed schemes tend to have lower healthcare related costs, on average, than open schemes. For instance, non-healthcare expenditure for GEMS was amongst the lowest at 7.5% in 2015.

26. However, even if restricted schemes exert some pressure on administrators, nonetheless administrators face insufficient pressure from schemes. Non-healthcare costs for the 10 largest schemes in South Africa range from 5% to 13.4% of gross contribution income compared to only 3% of GCI on average for OECD countries. Additionally, during annual negotiations it seems that trustees are generally satisfied with CPI-linked increases in member contributions year after year.

27. We find no evidence that schemes demand information on the costs saved by administrators related to, for example, managed care or fraud control and whether the related savings are passed on to scheme members.

28. The Inquiry has considered various options to address this failure in governance. We have decided that it is not practicable to recommend that administrators be converted to not-for-profit entities or that schemes be allowed to become for-profit entities in order to resolve the incentive constraint. We cannot trust that for-profit schemes will deliver better value for consumers given multiple information failures and adverse incentives shown to exist in the South African healthcare sector.

29. Therefore, the panel recommends measures to strengthen governance to ensure that schemes place greater pressure on administrators to deliver value to members, that members place greater pressure on schemes to improve value for money, and measures that enable the regulator (the CMS) to exercise more effective oversight over funders.[4]

[4] The Medical Schemes Bill, 2008 which sought to strengthen scheme governance, among other things, have not yet been implemented.

30. The Inquiry would like to see an environment in which schemes promote alternative models of care that lower healthcare expenditure. This includes:

30.1. multidisciplinary team-based care,

30.2. investing in models of care where appropriate providers provide primary care,

30.3. re-affirming/strengthening the care co-ordinator role of GPs,

30.4. investing into innovation forms of care,

30.5. employment of doctors in specific value-based quality-assured managed care service provision, [5] and

30.6. designing alternative reimbursement models that shift more of the risk of excess utilisation onto providers.

31. To improve transparency and promote competition we propose:

31.1. The introduction of a stand-alone, standardised, obligatory 'base' benefit package that all schemes must offer. The package must include cover for catastrophic expenditure, i.e. the current Prescribed Minimum Benefits (including making provision for treating PMBs out of hospital) and; additionally, include, primary and preventative care. The base option would include a standard basket of goods and services and will thus be easily comparable across schemes.

31.2. The introduction of the base package must be accompanied by a system of risk adjustment (see below), which will remove schemes' incentives to compete on risk factors such as age, and will instead encourage schemes to compete on value for money and innovative models of care.

31.3. Supplementary cover can be provided for care not included in the base package. We recommend that the CMS develop standards and requirements for all options for supplementary cover. This will improve transparency and assist consumers in comparing products, coverage and value across the industry.

31.4. That administrators must report publicly on the value and outcomes of all ARMs, PPNs and DSP arrangements they have entered into on an annual basis. These reports must be presented in a simple and accessible way, so that it allows consumers to see how much administrators have saved from these arrangements.

[5] Cataract surgery and joint replacement were put forward as examples from stakeholders during the inquiry

32. To improve governance and align schemes' interests with those of consumers, we propose:

32.1. That the remuneration packages of employees of schemes, particularly that of trustees and Principal Officers, be linked more explicitly to the performance of schemes. Performance will be measured in terms of the value delivered to members. Presently, the remuneration of Principal Officers and Trustees is poorly connected to performance. We propose that the remuneration of Principal Officers and trustees be set at a minimal base level and that the rest of their package be linked to clearly-defined quantitative objectives of the scheme such as reductions in non-healthcare costs, administration costs etc.

32.2. That administrators' comparative performance on metrics such as non-healthcare costs; the value of PPNs, DSPs and ARMs, claims payment ratio, and the proportion of PMB and non-PMB claims paid from risk versus those paid from savings be published annually for each administrator compared to a national average. This publication should be produced by the CMS.

32.3. That schemes encourage member participation in its Annual General Meeting (AGM). This includes:

32.3.1. Modifying the requirements for attendance at the scheme AGMs to ensure adequate representation of members who are not employees, brokers, officers, consultants or contractors of the scheme or its administrator and do not have a material relationship with anyone contracted to or employed by the scheme to provide administrative, marketing, broker or managed care services. In other words, all conflicts of interest must be avoided.

32.3.2. That members must be notified of the scheme AGM in a timely manner and the AGM must be held at a time convenient for members (e.g. after office hours or on weekends).

32.3.3. That AGMs make use of technology to facilitate participation of members who are not there in person.

32.3.4. That the CMS review its criteria for election of trustees such that sufficient time and appropriate information is available to members to consider and choose trustees and that electronic election of trustees is

possible to avoid abuse of proxy votes. Election of trustees must be conducted over an extended period and completed and audited prior to the confirmation of the election results at the AGM.

32.4. The CMS's contact number must be included on the medical scheme card, to allow members to have direct access to the CMS.

32.5. A set of core competencies for trustees also needs to be developed, taking into account the diversity of expertise required.

32.6. The CMS's proposed remuneration framework that seeks to cap Board of Trustees and Principal Officer Remuneration and align remuneration with performance should be implemented. The remuneration framework should take into account concrete indicators of improvements in the scheme's performance which must be linked to the performance of individual trustees.

32.7. That the broker system is an active opt-in system so that the interests of brokers and scheme members are more closely aligned. Members will be required, on an annual basis, to declare if they want to use the services of a broker. For those that do, the scheme will facilitate the payment to the broker. Members who chose not to use the services of a broker will pay proportionally lower scheme membership fees.

33. To improve regulation and ensure that the basic obligatory package is appropriate, we recommend that:

33.1. The mandated cover for Prescribed Minimum Benefits must be revised to make provision for out-of-hospital and cost-effective care for PMBs. This will remove the current incentive to admit patients to hospital, often at higher cost, for PMB care.

33.2. The PMB package be expanded to include primary and preventative care.

33.3. This revised PMB package should make hospital plans obsolete and will be replaced by the obligatory standard package.

33.4. The services provided for in basic obligatory package can be extended over time as cost savings allow for greater depth or breadth of care.

33.5. That PMBs be reviewed regularly, as provided for in legislation.

33.6. That the Council for Medical Schemes produces a biennial report on the value of managed care services including the extent to which risks and benefits are shared

between contracting parties and how savings are passed on to scheme members by lowered premiums or increased range of benefits.

34. To facilitate competition, we recommend facilitating the entry of regionally-based schemes. Innovation in the healthcare sector almost always starts small. New innovations will often be limited to particular services or geographies. However, schemes and administrators mostly have national membership and thus prefer national coverage. Facilitating the entry of regionally-based schemes may provoke different forms of competition in the market. However, if these regionally based entrants were to enter the current medical schemes environment, they would have to compete on risk selection, and thus face demographic risk and claims risk when beginning with only a few members. To mitigate this, the inquiry proposes reinsurance for small new entrants.

35. Below, we provide more detail on these recommendations, where necessary.

ACHIEVING STANDARDISED BENEFITS

36. The mandatory minimum benefits, referred to as prescribed minimum benefits (PMBs) are currently only available in the form of diagnosis treatment pairs, rather than simple standard benefit designs, making it impossible to compare between schemes and options. To address the lack of comparability across scheme options and inability of consumers to compare the value of these options, the HMI proposes that a standardised benefit package be developed that must be offered by all schemes (the obligatory 'base benefit option').

37. Every person joining a medical scheme must buy the base option. The base option would cover catastrophic expenditure as well as some level of out-of-hospital and primary care. However, simply standardising the standard benefit package would not address the issue of affordability.

38. Because schemes would still be subject to the principles of open enrolment and community rating, the standard benefit option may be easy to interpret but would still be expensive in the absence of a legislated risk adjustment mechanism. Without risk adjustment, schemes would still have an incentive to compete on risk factors such as age rather than factors such as value for money and innovative (alternative) models of care.

39. Therefore, alongside the standardisation of benefits, a risk adjustment mechanism must be implemented. The risk adjustment mechanism will "equalise" risk associated with the standard benefit option across all schemes, with lower risk schemes being net payers and higher risk schemes being net receivers of disbursements from the risk adjustment fund.

This will remove the current incentive for schemes to compete on low level competitive factors such as attracting a younger population.

Risk Adjustment Mechanism

40. Risk adjustment would be of little use if it is not applied to a standard basket of benefits. In the absence of a standard package, it would be impossible to measure the risk across schemes fairly. Therefore, as indicated above, the HMI proposes that a risk adjustment mechanism be implemented for the base benefit package to be offered by all schemes.

41. The HMI recommends that the proposed risk adjustment mechanism (RAM) be initially facilitated by the CMS but will migrate to a separate authority established for this purpose with full independence from the executive to avoid a conflict of interest with the CMS's regulatory role.

42. The HMI has not decided on the most appropriate mechanism to achieve the risk adjustment. In principle, schemes could be required to pay money into a risk adjustment fund on the basis of their respective risk. That is, low risk schemes would pay money into the risk adjustment fund while high risk schemes would receive risk adjustment subsidies from the fund.

43. To address the needs of low-income scheme members, it is recommended that the current tax credit regime be reconstituted to take the form of a contribution subsidy administered through the RAM rather than though the South African Revenue Services. In this way the RAM would be able to integrate both a risk and income adjusted subsidy in a manner consistent with similar arrangements around the world.

44. For the RAM to operate efficiently, the following measures must be in place:

    44.1. All medical schemes must, by law, be required to belong to the RAM,

    44.2. A database of all insured beneficiaries and the relevant demographic information to determine the prospective risk status of each beneficiary must be developed and maintained by CMS,

    44.3. A set of mandatory minimum benefits that all insurers must offer (the "base package" in our terminology) must be defined and implemented,

    44.4. The administrator of the RAM (the CMS) must establish technical capability to provide within-financial-year financial transfers between schemes and the central

fund based on the extent to which schemes' inherent risk profile vary from the average for the industry, and

44.5. The administrator of the RAM must have legislated structural independence from any party with a commercial interest in the risk adjustment outcomes (which may include other regulators, the government executive, medical schemes and related parties, healthcare providers, etc.).

45. With the base benefit package and the RAM in place, schemes would have stronger incentives to differentiate themselves on factors such as efficiency, level of non-healthcare costs, procurement, volume management and generally offering demonstrable value for money to beneficiaries.

Additional/Supplementary benefits

46. In addition to the base benefit package, schemes will be allowed to offer additional (supplementary) benefits for care not included in the standard benefit package.

47. The following principles apply to supplementary benefit packages:

47.1. Supplementary benefits can only be sold to those who have base cover.

47.2. Risk rating will be allowed on supplementary benefit packages (SBPs) provided that base cover is comprehensive[6]. Should the base cover be limited such that supplementary cover becomes a 'must have', then the supplementary cover must also be excluded from risk rating.

47.3. Supplementary benefit packages should be easily comparable across schemes. This means that they will need to conform to rules set by the CMS as the appropriate regulatory body.

Prescribed Minimum Benefits (PMBs)

48. The HMI proposes that the PMB package (which will be included in the base benefit package) must be reviewed and updated at least every 3 years. This is consistent with existing legislation and in line with current initiatives by the CMS to review the PMBs.

[6] This caution is required as the base cover is yet to be defined.

49. To facilitate scheme members' understanding of PMBs, including what they are entitled to and when additional (out-of-pocket) payments may arise, schemes must, at a minimum, provide the following information:

    49.1. The ICD-10 checklist and plan formulary description for each PMB,

    49.2. The list of DSPs for the treatment of PMBs, and

    49.3. During the pre-authorisation process, members should explicitly be told whether their choice of service provider or treatment course has additional cost implications and what alternatives are available.

50. Treatment plans and formularies will not be binding on schemes, but will constitute a minimum level of care. The development and review of formularies and treatment plans will likely be a resource-intensive process which must be run in an inclusive, comprehensive and reputable manner.[7]

ANTI-SELECTION MEASURES

51. The SID analysis presented in Chapter 8 confirms that there is anti-selection in the market. What is not clear to the inquiry (nor is known to stakeholders) is whether the current legal provisions against adverse selection (waiting periods and late joiner penalties) offset the financial implications of anti-selection. Without this knowledge it is difficult to know whether additional steps must be taken to address anti-selection. Presently, one of the ways in which anti-selection is managed is that schemes are able to impose a late joiner penalty on an applicant who is 35 years or older when joining a medical scheme for the first time. The late joiner penalty is calculated on the basis of the applicant's age, the number of years since the applicant was a member of a medical scheme and the number of years that the applicant had no cover at all. The late joiner penalty discourages consumers from joining a scheme later in life, when they are older and more likely to require care. We recommend that an incentive be put in place to encourage younger members to join schemes. This could take the form of a regulated discount on the medical scheme premium for new joiners younger than 35 to nudge younger members to join. The discount can be determined by the Minister of Health in consultation with the CMS.

[7] This function will be assigned to the Supply Side Regulator for Healthcare that we propose in section X below.

52. The HMI affirms that non-risk benefits (such as medical savings accounts) should not attract any waiting periods as schemes do not bear any risk for any claims paid from non-risk benefits. Further, savings accounts cannot be part of the basic obligatory package.

53. We note that stakeholders submitted that mandatory membership of all people earning above a defined income threshold would reduce anti-selection risk. This is true and though the inquiry supports the principle of mandatory membership, we do not believe that it should be implemented within the current flawed system. At this stage, mandatory membership would simply add more beneficiaries into a system with high and rising costs, significant SID, limited competition and no incentives to create value for members.

Recommendations on the broker regime

54. We believe that brokers play an important role in advising members but that their interests should be aligned more closely to those of applicants/members. The HMI makes the following recommendations:

    54.1. That the broker system must change to an active opt-in system so that the interests of brokers and scheme members are more closely aligned. Members will be required, on an annual basis, to declare if they want to use the services of a broker. For those who do, the scheme will facilitate the payment to the broker. Members who chose not to use the services of a broker will pay proportionally lower scheme membership fees.

    54.2. Members must be free to choose any licensed broker they wish and not just those with contracts with particular schemes,

    54.3. Brokers who are marketers for a specific scheme (and are thus not independent) should earn lower commissions than independent agents,

    54.4. Medical schemes must report broker fees separately to the CMS from distribution and other marketing fees. The CMS must also make these separate figures available in the annual report

55. As a condition of registration, medical schemes must also be able to deal directly with the public without the use of brokers. This would include administering membership applications.

56. The provider side of private healthcare markets suffers from several structural, behavioural and regulatory imperfections that harm competition and undermine access to healthcare. The main supply-side failures that our recommendations seek to address are:

    56.1. The highly concentrated structure of the facilities market. At a national level, the three largest hospital groups have a market share of approximately 90% based on hospital admissions and 83% based on registered beds.[8] Also, in the majority of local markets, concentration levels are alarmingly high according to several recognised metrics commonly used to screen for concentrated markets. One of the challenges of this, from a competition perspective, is that it affords the three biggest hospital groups "must-have" status in bargaining for contracts with funders which reduces funders' countervailing power.

    56.2. The fragmented and poorly-enforced licensing regime for facilities. The licensing framework varies across provinces, is not clearly formulated, lacks transparency and operates without access to basic data such as the number of people in the catchment area, number of beds, per speciality and ward type. Without these data it is unclear how the need for new facilities or more beds is assessed. Additionally, the licensing process does not take factors such as competition, innovation, and supply-induced demand into account, nor does it routinely seek input from stakeholders with in-depth knowledge of health dynamics, such as funders, when assessing applications.

    56.3. The merger regime is not effective at identifying and assessing dominance in hospital markets, principally because of the weaknesses in dealing with creeping mergers within the framework of the existing legislation.

    56.4. The supply-side regulatory system is fragmented, with little synergy and cooperation between various regulatory and oversight bodies mandated to oversee providers.

[8] Claims data excluded some smaller schemes, if members of these schemes systematically use hospitals other than the three big hospital groups then the admission rates may be overestimated but not to a degree to change the overall conclusion

56.5. Inadequate and inconsistent enforcement of rules by the HPCSA. Self-regulation of the medical professions seems to have failed to work in the interest of consumers and has not encouraged models of care that expand access and improve affordability. The interpretation of some of the HPCSA's Ethical Rules and the manner in which they have been enforced has, in fact, maintained the *status quo* provision of high-cost healthcare, prevented the formulation of multidisciplinary models of care, and stifled innovation and competition.

56.6. The lack of consistent and standardised reporting of health outcomes.

56.7. The lack of transparency on the pricing of healthcare goods and services.

56.8. The failure to implement evidence-based guidelines and treatment protocols.

56.9. The lack of an effective framework for health resource planning and economic value assessments of, for example, new healthcare technology.

56.10. Serious levels of supplier-induced demand and the continued predominance of fee-for-service as the primary mode of reimbursement for healthcare goods and services.

57. Many of the recommendations to address these failures require adjustments to the existing legal framework, and/or the passage of new laws, rules, and regulations. In cases where we cannot afford to delay the implementation of the recommendations owing to the length of the legislative process, interim steps have been proposed.

58. For effective and efficient regulatory oversight of the supply-side of the healthcare market, the Inquiry recommends the establishment of a dedicated healthcare regulatory authority, referred to here as the Supply Side Regulator for Healthcare (SSRH). However, some of the recommendations proposed to deal with significant supply-side failures cannot wait for the establishment of a new regulatory authority. In these cases, interim proposals are made for existing regulatory or interim bodies to oversee the implementation of the recommendations.

59. First, we set out four key areas of supply-side regulation that are currently lacking in the South African private healthcare sector and make recommendations in this regard. Thereafter, we provide an overview of the institutional structure of the SSRH.

THE SUPPLY-SIDE REGULATION OF HEALTHCARE

60. The current regulatory measures on the supply side have been limited and fragmented compared with other countries where there is often a single, dedicated supply-side regulator. In South Africa, the supply side has generally been left to operate within a fragmented, poorly enforced regulatory system, with weak oversight. It is clear that the existing regulatory system does not go far enough in terms of achieving optimal healthcare outcomes and appropriate access to quality healthcare services.

61. Supply-side regulatory measures aim to affect the behaviour or operation of health care service providers and usually include four critical pillars:

    61.1. healthcare capacity planning,

    61.2. economic value assessments,

    61.3. implementation of appropriate payment mechanisms, and

    61.4. outcome measurement, registration, and reporting.

62. Healthcare capacity planning seeks to govern the number and distribution of providers for current and future needs through mechanisms such as licensing and accreditation.

63. The primary purpose of economic value assessments is to ensure rational use of health resources. It often includes comparative analyses of alternative courses of action, such as an analysis of the cost-effectiveness of new technology or the development of clinical treatment protocols to assess the cost and clinical effectiveness of health interventions.

64. Payment mechanisms shape the structure of payment systems for health services to achieve cost effective positive health outcomes for the covered population.

65. Outcome measurement and reporting facilities competition on the basis of improved health outcomes and enables value-based payment.

66. A consolidated approach to supply side regulation is required within a coherent supply-side framework. Importantly, existing functions that contribute to supply side regulation must be complementary to and work in a coordinated manner with the additional supply-side regulation proposed here and the workings of the proposed SSRH.

Healthcare Capacity Planning

67. Healthcare capacity planning includes the assessment of available capacity, planning for future healthcare needs and demands, and the licensing of facilities. The HMI recommends interventions in two areas: developing a coordinated facility licensing framework to replace the existing fragmented system and implementing a new practice code numbering system.

Facility Licensing

68. The National Health Act provisions dealing with the issuing of certificate of need (CON) need to be implemented in a manner that gives effect to the constitutional right of access to healthcare services.[9] The Minister may issue appropriate regulations for the granting of the CON in line with a centralised national licensing framework for all health establishments, including day clinics, hospitals, sub-acute facilities as well as primary care facilities such as dental surgeries, GP rooms and primary care clinics. The extension of the licensing regime beyond acute facilities can be implemented over time. Provincial health authorities will remain responsible for assessing and granting licences according to the principles set out in the national licensing framework.

69. The licensing framework should be based on a comprehensive national plan that takes capacity in both the private and public sectors into account. New licences will be issued in line with the national plan and should have regard to diversity of ownership of facilities, should consider whether the supply of beds and practitioners bears reasonable relation to the population served, and should prioritise innovative models of care. The national plan will be developed in a consultative manner with relevant stakeholder representation facilitated by the Department of Health.

70. Regular monitoring, inspection and reporting will be embedded in the licensing framework to ensure that a reliable database of supply side services is established. Licensed establishments will, at a minimum, provide the following information to provincial departments of health on an annual basis:

    70.1. Number of operational beds, operating theatres, Intensive and High Care Units;

    70.2. Bed allocation by type and changes to bed allocation, by type, over the previous calendar year;

[9] Section 36, 37, 39 and 40 of the amended NHA. See Chapter 2, Regulatory Framework, para 43 and 48.1.

70.3. Ownership of the group/establishment and any planned acquisitions that have been notified but not yet assessed by the competition authorities;

70.4. Occupancy rates by unit and/or bed types;

70.5. The names of practitioners who work from or have admission privileges to the facility by discipline; and

70.6. Documentary proof of approval for RWOPS for public sector practitioners who work from, or have admission privileges to, their hospitals

71. Provincial DoHs (PDoHs) should report annually on the data and information collected from health establishments. Reporting should follow a standardised format to be determined by the SSRH with automatic updates to a national database accessible to NDoH and all PDoHs and be available in the public domain.

72. The renewal of a facility's licence will be dependent on the facility meeting its annual reporting requirements. Initially, penalties (to be determined by the SSRH) may be levied on facilities that do not comply but continuous infringements should lead to revocation of a facility's licence.

73. The Inquiry proposes that the new licensing framework should have two phases. In the first phase, an interim license may be granted. The applicant must, at a minimum provide the following information:

73.1. Information on the proposed site indicating whether it has already been acquired or an indication of a tentative right to acquire,

73.2. High-level description of the need identified, including hospital type as well as the type and number of beds proposed, and

73.3. Initial, high-level architectural drawings.

74. The applicant will then be given a deadline for the submission of the second part of the application. In the second phase, a permanent licence may be granted. Submissions required for the phase 2 include, at a minimum:

74.1. A comprehensive market study, highlighting local demographics, the business case for the facility, and how the facility plans to introduce new/innovative models of value-based care;

74.2. Letters of support from local funders managing at least 50% of the insured local population. Examples of funders in this context include medical schemes, large employers (e.g. mines), government agencies (e.g. Compensation Fund);

74.3. Social and environmental impact studies;

74.4. Practitioner recruitment plan;

74.5. Final architectural drawings;

74.6. A provisional financing agreement; and

74.7. A comprehensive project plan for construction with detailed timelines.

75. Stakeholders will have the opportunity to object to the application. Their reasons for objection must be based on the principles and objectives of the national health plan and licensing framework.

76. No facility licence will be issued without confirmation that a specific site has been identified. Applicants who do not already own the site should provide proof that they have secured the right to acquire the site should the application succeed. This is essential for any useful need assessment to be done and should reduce the issuing of licences to parties that have no real capacity to operationalise them.

77. Licences will not be evergreen, failure to progress without adequate explanation of reasons for delays and mitigation thereof will lead to licences lapsing.

78. The inquiry has made detailed proposals for a revised licensing framework that supports beneficial use of the licence by the applicant. However, these principles will not address the problem of concentration.

79. We have considered a number of options on how to address this, including divestiture and imposing a moratorium on issuing licences to the three large hospital groups, namely, Netcare, Life and MediClinic. The moratorium would require that these hospital groups should not be granted licences for new facilities, nor licences or permission to increase the number of beds within existing facilities until such time as the national market share of each of the big three hospital groups, by number of beds, is no more than 20%. The

moratorium will be in place until new entry or growth in the private sector achieves a better competitive balance.

80. Divestiture raises a number of questions such as proportionality, its effectiveness and whether it is the less intrusive means. Moratorium raises similar issues including how to measure whether a better competitive balance has been achieved. We would be reluctant to rule out these remedies without hearing the stakeholders' views on them.

81. To further address concentration, the inquiry recommends that the appropriate regulator(s) - in our view, both the SSRH and the PDOHs – develop a set of criteria for assessing local concentration. The assessment framework should specify the maximum allowable level of concentration of private hospitals at the local level. These concentration levels may vary according to local conditions, i.e. available public hospital capacity and insured population capacity

82. The inquiry notes that the OHSC's mandate, which extends to quality inspections and accreditation of private facilities, will remain. Licences will only be issued to facilities and practices that have been certificated by the OHSC. Close collaboration between the SSRH and the OHSC will be required.

83. To further address the sale of hospital licences, which we believe materially affects competition and transformation in the sector, we recommend that the sale of licences be jointly notified to competition authorities, the SSRH and the PDOHs. The competition authorities should assess the effect of any sale on competition and the public interest. Given the current concentration in the market all transactions must be notified.

Practice Code Numbering

84. The HMI recommends that the practice code numbering service, which is currently managed by the Board of Healthcare Funders, be assigned to the SSRH where it will be housed in its Facility Licensing Unit (see Figure 10.1).

85. Practice code numbers must be allocated to both public and private facilities to support strategic public purchasing from private providers in the National Health Insurance framework, and *vice versa* to support inclusion of public hospitals in private funders' provider networks, for example.

86. The issuing of practice code numbers to practitioners requires close collaboration with the regulators for all health professionals (HPCSA, SAPC, AHPSA, SANC, SAPC etc.) who must provide proof of registration of each applicant. Practitioners should be issued with

an individual, unique practice number to be used for re-imbursement, irrespective whether the payer is a public or private sector purchaser.

87. The format of practice numbers should readily identify the type of practitioner (e.g. whether the practitioner is a GP, physician, anaesthesiologist or physiotherapist), whether they are in full- or part-time practice,[10] and whether the provider (also) works in the public sector.

88. Practice numbers should be unique, and be issued to each practitioner for life to avoid confusion and to facilitate monitoring of practitioner profiles over time. Practice numbers should only be changed in specified circumstances, such as when a former GP qualifies and starts practising as a specialist. The old GP number must not be reallocated to another practitioner.

89. Group and multi-disciplinary practices must have their own practice numbers, separate from those of the practitioners within the practice. Claims submitted by group practices should include both the group and individual practitioners' practice numbers. Funders will only pay claims that reflect both numbers and claims information must contain both numbers. Public sector practitioners allowed to do private practice work will use their practice number when doing locum work. This is essential to ensure that individual and group practice profiles can be analysed without confusion.

90. Practice numbers must be renewed on an annual basis and will only be reissued on conditions set by the regulator (the SSRH). The inquiry recommends that the minimum conditions for renewal must include the following:

    90.1. The applicant must submit an annual return containing information on the practitioner's specialty, employment and an up-to-date address indicating the location of their practice. Where the provider practises in more than one location, they may provide the address where they spend most of their practice time.

    90.2. Practitioners' premises must be registered and will be allocated a facility practice number separate from that of the practitioner.[11] The facility practice number where care was provided must be captured in all claims to funders, with defined exceptions, e.g. roadside emergency. Proof of location of premises will be a core requirement

[10] We note that 'full-time practice' will have to be defined. This should be done by the SSRH, in consultation with relevant regulatory entities.

[11] We note that it may take time for every practice location to be licensed and this condition will be applied mindful of this possibility

for practice number renewal for both practitioner and premises. This is essential to enable routine and random inspections by the OHSC; to reduce the scourge of "ghost" practices and practitioners as well as to minimise claims fraud. Cleaning up of practice locations is a necessary step in improving resource planning and to support growth of meaningful provider networks to service both private and public sector funders.

90.3. Practitioners who work from facilities not owned by themselves, e.g. anaesthesiologists, will submit supporting documentation from management of the relevant facilities.

90.4. Practitioners employed in the public sector who also work in the private sector must produce a certificate from the provincial health authority indicating that the practitioner has approval to do remunerative work outside the public sector.

91. Practice numbers will only be issued if providers comply with all relevant reporting functions of outcomes registries relevant to their area of work.

92. To be clear, practice facilities/premises will be licensed by the SSRH licensing unit after certification by the OHSC, while regulatory entities like the HPCSA remain responsible for the certification of qualified practitioners. Practice numbers will only be issued to providers who have valid licences or certification from the relevant body.

93. Given the enormity of the task of extending licensing to establishments which provide primary care, e.g. doctors' rooms, the OHSC may outsource some of its proposed functions but will remain accountable for all work done by its service providers.

Economic Value Assessments

94. The Inquiry could not find good evidence of publicly available cost-effective standards of care and treatment protocols being used in the healthcare sector. This makes it difficult to assess the appropriateness of certain courses of treatment and to evaluate quality of care and value for money in the healthcare sector. The Inquiry recommends that this be remedied. Specifically, standards of care, evidence-based treatment protocols and processes for conducting health technology assessments to assess the impact, efficacy and costs of medical technology, medicines and devices relative to clinical outcomes must be developed.

95. The process of developing HTAs, pharmaco-economic and standards of care evaluations should be based on standard accepted approaches. Where appropriate, collaboration with

representatives of patients, academia, regulators such as SAHPRA and CMS, and national and international experts should be ensured.

96. Findings of the economic value assessments should be published to stimulate competition in the market, to mitigate information asymmetry, and to inform decisions about strategic purchasing by the public and private sectors.

Health Services Monitoring

97. Currently, there is no standard mechanism for measuring the performance and outcomes of practitioners and facilities. Individual providers do not have the necessary information and data to analyse and compare outcomes of services provided against peers.

98. Patients, practitioners and funders lack information on outcomes of healthcare. Individual funders measure the performance of practitioners they contract with to varying degrees. This leads to a situation where the same practice could be deemed compliant by one funder and non-compliant by another because of different methodologies used. This is untenable.

99. In line with requirements for greater transparency and more objective benchmarking, a standard system should be developed to monitor the quality and outcomes of healthcare services. This requires the development of standard metrics that can be used to analyse the performance of a wide range of facilities and practices.

100. The Inquiry recommends that the requirement to measure quality and outcomes will eventually be legally enforceable,[12] if necessary, by the SSRH in partnership with the proposed Outcomes Measurement and Reporting Organisation, discussed in a separate section below. Given the importance of developing an outcomes registry, we also recommend a phased approach to implementation.

Health Services Pricing

101. One of the most frequent complaints made to the Inquiry is that there is currently a “tariff vacuum” in the private healthcare sector that makes it very difficult for schemes and members to estimate and compare the costs of care amongst providers.

[12] The Minister has extensive powers to prescribe norms and standards to measure the quality of healthcare services and monitor quality. See Chapter 2, Regulatory framework, para 46 and 48.2.

102. This tariff vacuum is often linked to the 2003/04 decisions by the competition authorities confirming that the previous tariff determination process (so-called "collective bargaining") amounted to collusion in contravention of the Competition Act. The parties to the collusive agreements consented to these findings. After this finding, the CMS's National Health Reference Price List (NHRPL) temporarily provided some clarity on reference prices for healthcare goods and services. The NHRPL was followed by a NDOH-led process to determine a Reference Price List but, as discussed in Chapter 3 (Health Sector Overview), the RPL was struck down by the courts. No regulated tariff determination process has been implemented since.

103. As a result, fee-for-service prices are now largely determined bilaterally between individual providers and funders (either individual schemes or with administrators on behalf of all the schemes they administer), or between associations of providers and funders.[13] Fee-for-service tariffs, regardless of how they are negotiated, are a reflection of market failure within the private healthcare system. These prices do not consider quality of care, nor do they consider or try to reduce supply-induced demand.

104. While many of the structural changes recommended in this report seek to redress the incentives that maintain fee-for-service, it is very likely that fee-for-service contracts will remain a significant feature of the market for the foreseeable future. There is therefore a need to directly address the market failures involved in the setting of these prices.

105. The Inquiry's recommendations on the pricing of health services are made with the following principles in mind:

    105.1. Ensuring greater access to quality healthcare services by improving affordability of private healthcare goods and services;

    105.2. Reducing price uncertainty for healthcare services;

    105.3. Introducing fixed tariffs for PMBs to manage healthcare expenditure;

    105.4. Standardising coding systems to facilitate the monitoring, analysis and publication of expenditure trends and health outcomes;

    105.5. Promoting innovative models of healthcare funding and delivery; and

    105.6. Promoting competition among service providers.

[13] The Inquiry is concerned about the collective negotiations by provider associations on behalf of their competing members. See Chapter 7.

106. Before we set out our recommendations regarding an appropriate tariff determination structure, we discuss why price determination cannot revert to the pre-2004 situation of collective bargaining. Thereafter, we propose an alternative.

The Competition Authorities' Previous Decisions on Collective Bargaining

107. The Inquiry received a number of submissions suggesting that the competition authorities' decision to prohibit collective bargaining is responsible for the tariff vacuum and proposing that the decision be reviewed. The NDoH and BHF submitted that a rule of reason analysis should have been applied and that the conduct did not amount to a *per se* prohibition of the Act.

108. While the HMI does not support a review of the 2004 consent orders, the HMI's recommendations seek to balance both a pro-competitive outcome as well as an interpretation of the Competition Act that is in line with the constitutional imperative of equitable access to healthcare. In this regard, the HMI does not recommend a blanket ban of collective bargaining, but rather proposes that bargaining should be facilitated by the SSRH, to safeguard against collusive behaviour among competitors and foreclosure of new entrants.

109. The Inquiry has two proposals to remedy the "tariff vacuum"; a regulatory solution with multilateral inputs and a multilateral price-setting mechanism where stakeholders conduct tariff negotiations under a framework determined by the Supply Side Regulator. In both cases, failure to reach agreement and/or fundamental disagreements with the outcomes will be resolved through a compulsory arbitration mechanism.

Proposal 1: Regulated pricing

110. Multilateral price-setting where competitors determine prices collectively (whether through associations or other groups) without regulatory oversight will likely contravene the Competition Act. At the same time, the Inquiry does not support unilateral price setting by a regulatory entity without meaningful participation by stakeholders. With this in mind, the first option we put forward is that the regulator, in this case the SSRH, assumes responsibility for setting fee-for-service tariffs within the following framework:

    110.1. Stakeholders representing providers, funders, government and civil society will make simultaneous submissions on FFS tariffs within a multilateral setting which will be managed and governed by the SSRH.

110.2. The SSRH will determine the FFS after consideration of stakeholder presentations and its own research.

110.3. Tariffs related to (current) PMBs will be binding.

110.4. FFS tariffs for other (non-PMB) services will have the status of reference prices from which stakeholders may deviate.

111. In cases where stakeholders want to challenge the tariffs confirmed by the SSRH, we propose a deadlock-breaking mechanism.

Multilateral Forum (MF)

112. We recommend that FFS tariffs be determined by the Health Services Pricing Unit of the SSRH. This will occur after extensive consultation with stakeholders through what we refer to as a multilateral forum.

113. For practitioners in particular, the multilateral forum is essential because bilateral negotiations between all funders and all practitioners are not logistically feasible. There are thousands of practitioners in solo or small group practices and it would not be practical for each practice to meet and negotiate tariffs with each funder timeously before the start of a new benefit year.

114. The MF will be managed by the SSRH and will comprise representatives of registered service providers, funders, government and members of civil society.

115. The SSRH will have powers to call for and receive relevant information from stakeholders timeously in order to establish prices for the private health sector. The SSRH will proactively set and communicate terms of reference, guidelines and the legal framework within which participants will present their proposals. Participating stakeholders, working under the direction of the SSRH, will be expected to interact freely in response to presentations made by any other participant. Ultimately, stakeholder representatives will lodge binding written submissions in support of their proposed fees.

116. After due consideration of all stakeholder representations and its own research, the SSRH will determine and publish tariffs for the new benefit year.

117. FFS tariffs for what we currently refer to as PMBs will be binding on all stakeholders without any balance-billing or co-payments allowed. In other words, this process will set the maximum PMB tariffs that can be charged by service providers.

118. All other (non-PMB) FFS tariffs, will have the status of reference tariffs. These tariffs may only be exceeded if the patient's informed consent has been secured by the practitioner, or if the higher tariffs are an outcome of negotiations between funders and practitioners.

119. There should be formal co-operation between the SSRH and regulators like the HPCSA to set and publish clear guidelines on what may constitute unethical billing practices.

Mandatory deadlock breaking mechanism

120. In the event any stakeholder wishes to dispute the tariffs determined by the SSRH, the matter may be referred to an independent arbitrator to facilitate timely conclusion of the process ahead of a new benefit year. The fee structure for utilisation of the arbitrator's services should discourage abuse but also not be punitive.

121. Stakeholders will not be allowed to bring any new information before the arbitrator. That is, they may not change or supplement the information they have already provided to the multilateral forum. This will curtail abuse of the multilateral process and compel stakeholders to submit their best available supporting data and motivations during the engagements at the MF.

122. The decision of the arbitrator will be binding on all parties.

Proposal 2: Multilateral Tariff Negotiation

123. Though the multilateral tariff negotiation forum shares some features with the regulated option, the fundamental difference is that the stakeholders are encouraged to bargain and reach agreement within a framework set by the regulator (the SSRH). If they fail, the regulator will refer the dispute to the independent arbitrator for final decision.

Multilateral Tariff Negotiation Forum (MNF)

124. The multilateral forum will be constituted of the same stakeholders as above; that is, providers, funders, government and civil society. Instead of presenting their tariff proposals to the regulator for tariff determination as in option 1 above; the stakeholders will prepare individual proposals and present them simultaneously within the forum. Stakeholders will then negotiate FFS tariffs within a multilateral negotiating forum accommodated and governed by the SSRH.

125. The tariff negotiations will be governed by a framework developed by the SSRH. The SSRH will be duly mandated by law to organise, lead and govern the MNF. The SSRH will issue guidelines for the negotiations, specifying rules and condition for the negotiations process, including the information sharing regime.

126. The terms of reference will set the conditions against which the outcomes of the multilateral negotiations will be assessed. The conditions will, *ex ante*, specify the outcomes that will be deemed compatible with the public interest and public policy objectives, including NHI. Conditions may include the maximum average tariff increase, the maximum acceptable increase in expenditure, or even expenditure per speciality. It may also include metrics such as acceptable levels of utilisation and admission growth, a trade-off between tariffs and volumes, and specific commitments to quality or outcomes improvements.

127. In addition to the information provided by stakeholders, the SSRH may call for additional relevant information from stakeholders or other parties in support of the tariff negotiation process. The legal framework within which it calls for and shares information will be consistent with competition law principles and the public interest.

128. Similar to Option 1, the tariffs for PMBs will be binding with no balance billing allowed. Other FFS tariffs will be considered reference prices. Once the stakeholders reach agreement, the outcomes of negotiations will be submitted to the SSRH. The SSRH will validate and publish these outcomes.

129. If stakeholders cannot reach agreement, or if the SSRH rules that the tariffs do not conform to the legal framework, the matter will be referred to an arbitrator for final determination. Similar to option 1, the determination of the arbitrator will be binding on all parties.

130. Final PMB and reference tariffs must be published by the SSRH, the CMS, and funders. Service providers must do the same at each site of patient contact (e.g. consulting rooms and hospital reception areas) in a manner that is accessible to consumers.

Bilateral Negotiations

131. Price-only determination as envisaged under both options above are essential to eliminate price uncertainty and overcome logistical bottlenecks. However, if the private sector is restricted to price-only contracts, this would preclude critical elements of strategic

purchasing and stifle much needed innovation. Importantly, that would delay the shift from FFS to ARMs and the incorporation of other efficiency and quality enhancing interventions.

132. Bilateral negotiations between providers and funders are wholly supported by the HMI. All stakeholders should strive to migrate from FFS to alternative, performance-based contracts with meaningful risk transfer to mitigate against over-utilisation of resources. This ideal can only be achieved through bilateral negotiations.

133. Bilateral negotiation is currently the negotiation format of choice between funders and corporate entities (such as facilities and pathologists). We initially considered radiologists to belong to this group but the HMI has since accepted the argument put forward by the Radiological Society (RSSA) that there exists approximately 135 billing entities in radiology in the private sector.[14] It would therefore not be logistically feasible to expect the same corporate provider conditions to apply to radiology groups with respect to bilateral negotiations as the primary means of determining prices.

134. Our reasons for recommending the continuation of bilateral negotiations between funders and corporate providers are the following:

    134.1. Pathology practices are few in number and current experience proves that most, if not all pathology groups can negotiate with all funders; and

    134.2. There are only a small number of facility groups. Bilateral negotiations are currently the main method of tariff negotiations between facilities and funders.

135. In summary, the set of pricing recommendations set out above have been made with the following key considerations in mind:

    135.1. Reversion to the collective bargaining format in place prior to 2004 is not an option;

    135.2. Stakeholder submissions and analyses conducted by the HMI have shown that expenditure is high and continues to rise, while consumers continue to face higher premiums, out of pocket payments and gradually reducing scheme benefits; and

    135.3. There is reasonable justification for regulatory intervention if the industry is to remain sustainable.

136. However, the HMI further recognizes the following:

[14] See RSSA submission dated 24 October 2017, p1

136.1. Stakeholder-led negotiations have not yielded outcomes with a positive impact on expenditure and remains a possibility that sector participants may continue to settle for mutually beneficial pricing levels at the expense of the consumer;

136.2. Unilateral determination of prices for healthcare services by a regulator risks missing pertinent information from stakeholders, hence the emphasis on meaningful engagement within the legal competition framework;

136.3. The regulator should not be the player and the referee. This is why we propose an independent arbitrator as deadlock-breaking mechanism.

Establishment of an independent supply-side regulator for healthcare (SSRH)

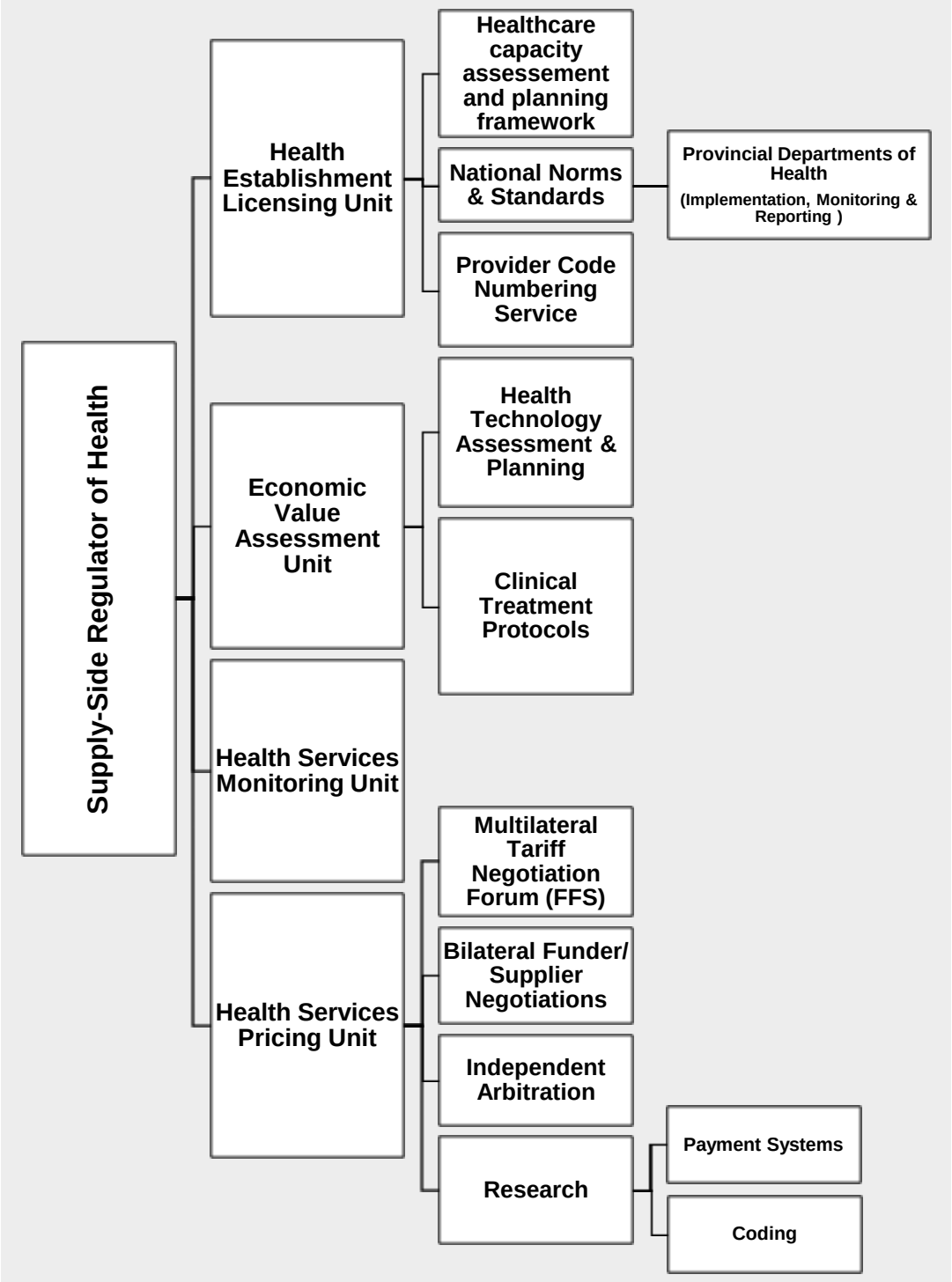
137. As indicated above, the Inquiry recommends that an independent supply-side regulator be established to oversee and manage functions related to healthcare capacity planning, economic value assessments, the determination and implementation of appropriate payment mechanisms (including the determination of fees via the MNF), and outcome measurement, registration, and reporting. Locating these functions within a single supply-side regulator will ensure coherence in policy development and implementation.

138. The SSRH can be established through the National Health Act which gives the Minister wide ranging powers. The SSRH should be an independent public entity, with its own executive and a board appointed by the Minister following a transparent, public nomination process. It is recommended that work to set up the SSRH begins immediately with the objective of getting to regulatory body functional within five years of publication of the final Inquiry report.

139. It is important to emphasise that the SSRH should be an independent public entity and that its independence be explicitly affirmed in its founding legislation. Other mechanisms that should be considered to ensure the independence of the institution include being clear on the role and functions; specifying that though the governing body is appointed by the Minister it should have sole powers to appoint its accounting officer and other senior staff members without interference; that it has financial autonomy, and that the long-term strategy, and key performance areas of the regulator be independently determined.

140. The proposed structure of the SSRH is presented diagrammatically below (Figure 10.1). It will be comprised of four units responsible for the key areas of supply-side regulation set out above.

FIGURE 10.1: PROPOSED ORGANISATIONAL STRUCTURE FOR SUPPLY-SIDE REGULATOR FOR HEALTHCARE



A. PRACTITIONER PAYMENT MODELS AND CODING SYSTEMS

Practitioner payment models

141. FFS models of remuneration currently dominate the industry. This means that funders and patients bear the entire financial risk, which is clearly is not sustainable.

142. The HMI has found that ARMs have not been widely adopted and, where adopted, not much effect on utilization and the transfer of risks have been shown.[15]

143. It is important that the sector adopts alternative payment models that promote financial risk sharing and contain costs and volumes, while preserving or increasing quality of care.

144. Our position resonates with that of the National Commission on Physician Payment Reform in the USA which, in 2013, stated, “Our nation cannot control runaway medical spending without fundamentally changing how physicians are paid”. They find that FFS is inherently inefficient and generates ‘problematic’ financial incentives. Accordingly, it recommends a phased transition from ‘price-only’ FFS to reimbursement models that reward physicians and facilities for value and quality.

145. The HMI strongly supports a transition from FFS to alternative reimbursement models but is not in a position to prescribe how this should happen. There will always be a place for FFS in particular in trauma care. The Inquiry has hopes to encourage a variety of alternative forms of practice and methods of payment and would like to promote stakeholders to engage in effective ARMs with real risk-sharing and a commitment to providing better value for money.

146. However, the Inquiry is also aware that merely urging providers and funders to implement ARMs is not enough. Various recommendations we have made which include; a change scheme governance to align scheme interests more closely with members; the recommendation that schemes report on what they have done to promote value-based contracting, address supply-induced demand and contain non-healthcare expenditure; the review of the HPCSA ethical rules to allow for multidisciplinary practices and global fees; the encouragement of geographic based new entrants into the market. These all provide avenues that should encourage a move away from fee for service.

[15] See: WTW Report on Analysis of Medical Schemes claims data – a focus on facilities

Coding systems

147. We recommend that coding systems across the sector be standardised to facilitate meaningful sharing of information. This is particularly important in relation to monitoring of quality of care, provider payment, maintenance of coding systems in line with evolving developments in medical care, introduction of new technology, and to prevent unilateral manipulation of codes to adjust tariffs.

148. Coding systems are integral to adoption of provider payment systems. They are essential to a well-functioning healthcare system, and potentially affect all stakeholders' financial and clinical interests in different ways. A coding system, therefore, is essentially a public good that needs to be developed and maintained as such.

149. For this reason, we recommend that management of coding systems should reside within the same SSRH unit that is responsible for pricing of healthcare services. The SSRH will similarly co-ordinate the process by engaging stakeholders in executing its research function in this regard. Given that this is a highly specialized area, the SSRH should have the mandate to outsource certain parts of its work to independent experts (e.g. academics). However, the SSRH, as a public institution, must remain accountable for the final output and integrity of the process.

150. The SSRH should be responsible for the adoption and standardization of actual alphanumeric codes, descriptors and relative value units. We recommend that motivation for new codes or modification of existing ones be submitted to the SSRH coding unit for consideration and final determination. Rules for introducing new codes or modification of existing ones is the responsibility of the SSRH coding unit, must be done by a multidisciplinary team and be developed in consultation with stakeholders and published.

151. Presently, the healthcare sector uses Current Procedural Terminology (CPT) codes, among others. It is our understanding that SAMA is the custodian of these codes owing to its longstanding arrangement with the American Medical Association. SAMA has submitted that it should remain the custodian of the coding system. We do not agree that coding should be the exclusive property of only one group of stakeholders. Standardisation of coding systems, including DRGs, can promote competition and must be in the public domain. However, if the sector decides that the CPT system remains the preferred one, SAMA may need to be compensated fairly for its intellectual property rights in this regard.

PROVIDER NETWORKS

152. We have concluded that provider networks in general have a net positive impact on competition and should continue to be an option in the sector's drive to provide quality care based on value. The benefits of preferred- or designated provider networks to consumers include that consumers can receive more favourable pricing and certainty that they will receive treatment without facing balance billing.

153. Networks are also beneficial to providers because they ensure that providers will receive direct payment, they can expect that members will be preferentially directed or steered to their facilities, and they have defined rights around disputing claims and payments.

154. Provider networks are thus one of the most effective tools that can be deployed to drive competition, especially among corporate service providers.

155. However, there are some concerns associated with provider networks. These include the potential exclusionary nature of networks and a reduction in consumer choice. To ensure that networks are beneficial to consumers, the inquiry recommends the following:

    155.1. The structure of network agreements must promote transparency regarding pricing, health outcomes, and location of practitioners and facilities;

    155.2. Reasonable patient access to service providers must be a key consideration in development of provider networks,

    155.3. Network arrangements should not restrict service providers from charging fees that are lower than those negotiated even by their own network managers;

    155.4. Network contracts should contain an element of sustainable risk transfer;

    155.5. Network contracts should be designed to ensure that they measure, monitor and reward delivery of quality care;

    155.6. Any provider who can match network FFS prices set up by any medical scheme network should be allowed to provide services to the same scheme population. However, selective contracting on patient volumes, price and quality must be allowed for ARM agreements to be effective;

    155.7. Network arrangements must progressively reduce fragmentation of service delivery and promote integrated delivery among clinicians, without introducing incentives for supplier induced demand.

155.8. Network arrangements must promote competition among health care product suppliers, i.e. avoid product exclusivity without selected network suppliers having been involved in competitive bidding;

155.9. Arrangements must promote local funder/provider contracting;

155.10. No penalties must be levied on consumers for emergencies and poorly accessible network providers; and

155.11. No balance billing for services provided by approved network providers must be allowed.

156. Facility and pathology DSP arrangements, in particular, should be far more competitive than they are at present. Some of the recommendations that are worth considering include the following:

156.1. DSP partners should only be appointed after an open tender process and results of the process must be lodged with the SSRH and published.

156.2. Tenders should be advertised broadly through popular media in addition to websites of the SSRH, CMS, affected medical schemes and administrators. Advertisements should remain open for at least one calendar month.

156.3. DSP contract arrangements should not be longer than two years. We make this recommendation to eliminate evergreen contracts while leaving the door open for new entrants to compete. Testing the market regularly in an open manner will have a positive effect on competition as well as expenditure in the long run.

OUTCOMES MEASUREMENT REPORTING SYSTEM

157. One of the key competition challenges we identified is that there is no reliable information available on health outcomes in the private healthcare sector. This information would allow patients to better care and providers. It would also improve the ability of healthcare funders to meaningfully compare costs and quality on value for money when contracting with providers. Further, providers would be able to use these data to track and compare performance and make necessary changes where outcomes fall below industry benchmarks.

158. The lack of outcomes information seriously impairs competition and consumer choice in South Africa and also limits providers' ability to continually improve the service they provide. Radically improving the availability of information on quality of care will allow doctors to compare results and improve treatments. It will also provide funders the information they need to improve contracting.

159. There are several key requirements for putting a reliable outcomes measurement system in place. It requires defining quality indicators, collecting standardised data through a central IT-platform, auditing the data, performing necessary risk-adjustment of the data, measuring quality using the indicators and disseminating the results to providers and ultimately to the general public and funding sector. Fortunately the process does not have to start from scratch as there are international exemplars to inform and kick-start this process.

160. The Inquiry recommends that the primary objective, in the initial period, should be to build capacity to measure and report on *patient-centred outcome indicators*. Other facets of quality such as structure, process, and patient experience indicators are less pressing and can be added at a later stage.

161. A nationwide system of measuring and reporting relevant outcomes information addresses our main findings that:

    161.1. there is no information available to the public in South Africa to choose doctors and facilities, the appropriateness of treatments, and to compare the quality of providers that funders contract ,

    161.2. funders themselves generally lack sufficient outcome information to contract with providers on the basis of value for money

161.3. the individual provider model of care operational in South Africa results in fragmented knowledge about the health status of a patient making health outcome difficult to ascertain,

161.4. GP's lack information to direct clients and patients to the best possible treatment in terms of costs and expected outcomes,

161.5. the NHI and OHSC, who carry a nationwide responsibility for the quality of care provided, also generally lack basic information on outcomes of care – both public and private.

162. Implementing a national system of outcome measurement cannot take a top-down approach. It requires broad and active participation of the entire clinical community. International experience has shown that clinicians are the critical success factor in developing useful outcome registries.

163. The participation of patients and their representatives is also paramount to ensure that the system is valuable and reports on metrics that improve patients' health outcomes and delivers better value for money.

164. The HMI recommends that the outcomes measurement reporting system be implemented in a staged process with two phases.

164.1. The *first phase* should be a voluntary phase that should be completed within 3 – 4 years from the publication of the HMI's final recommendations. During this phase the participation of doctors and facilities is critical: they must take the lead to form a collaborative body to oversee a voluntary outcomes measurement and reporting system. The body should define standards for South Africa and could draw from existing registries and freely available and tested indicators (such as ICHOM). Funders, patients' organisations and regulators must also be encouraged to participate in this first voluntary phase.

164.2. Providers and funders should take responsibility for financing this first phase of voluntary participation. Initiatives for co-funding formulas in the Netherlands and Scandinavia may serve as a model.

165. The HMI proposes that the data collected in the first phase be released only to participating providers in individual feedback cycles aimed at improving the outcomes measurement and reporting system. Results and experiences from this first phase should then be used as an input towards developing the OMRO in the second phase.

166. In the *second phase*, an appropriate statutory entity must be established to oversee the outcomes measurement and reporting process. A working title for this entity is the

Outcome Measurement and Reporting Organisation ('OMRO'). The National Department of Health, in consultation with relevant stakeholders, must take the lead in drafting the enabling legislation for the OMRO. The industry should aim for OMRO to be fully functional within 6 years of the conclusion of this inquiry.

167. During the second phase Government's involvement is more critical – both in finding a sustainable funding mechanism for OMRO, and in establishing a truly independent governance structure which is crucial to ensure that doctors, patients and funders trust the information generated. Information collected in the second phase must also serve to empower the consumer to choose the provider, treatment, scheme and plan that serves the consumer best. Through the empowerment of the consumer, competition between providers and funders will be enhanced.

168. During our engagements with stakeholders it became clear that the OMRO must be strictly independent from government and the private sector for it to have credibility amongst providers, patients and funders. This is essential. It became also clear that the majority of respondents opt for a new and dedicated organisation, and not one of the existing organisations.

169. OMRO should have board members that are appointed by the Minister of Health following a public nomination process. Its board must consist of members reflecting the interests of doctors, patients, facilities and funders, and may comprise representatives of government, academia and regulating institutions. But it is emphasized that the OMRO itself is *not* a regulator; it must be organisationally separate from government, private or public providers and regulatory institutions.

170. In order to give effect to mandatory provision of data, the OMRO will depend on the legislated legal powers of the SSRH, which will allow it to collect outcomes data from providers. Mandatory provision should start applying in the second phase.

171. The preferred funding model for the OMRO is a hybrid model with levies from schemes being the primary source of funding, complemented by government and voluntary funding. However, a large portion of its funding should come from healthcare related levies. The exact mechanics of how the model would work should be determined by the stakeholders, in consultation with the DoH and the National Treasury. What is essential is that the funding model should guarantee organisational independence and continuity of resources.

Recommendations to address over-servicing and SID

172. We identified over-servicing and SID as a feature in the private facilities market that may undermine competition and consequently harm consumers. In this respect, the HMI recommends to the CMS to include metrics of SID in its published reports. The CMS need not conduct the analysis themselves but must publish information on what schemes/administrators are doing to cut back on supply induced demand.

173. To facilitate effective management of SID and to improve availability of data more generally, the Inquiry recommends the collection of anonymised data as was done for the HMI. The relevant regulatory authority (in this case, the CMS) must, in collaboration with stakeholders, define the format in which data should be submitted and how frequently it should be done. The CMS must also specify penalties for non-compliance and rules for secure storage and access to the data.

Recommendations to increase synergies between public and private facilities

174. In Chapter 6 on Facilities, we have found that there are a number of local markets where limited public sector capacity can be augmented by existing private bed capacity. It is not clear to the Inquiry why government has not already engaged in strategic purchasing in these markets. Nevertheless, the Inquiry recommends that strategic purchasing of available private capacity to supplement capacity in the public sector need not wait for the NHI. Government could, and should, already contract with the private sector where it needs capacity.

Review of regulatory environment governing practitioners

Review of HPCSA Ethical Rules

175. The HPCSA must undertake a review of its ethical rules with a view to:

    175.1. Reviewing all rules from a competition perspective.

    175.2. Re-phrasing rules to be more permissive or enabling in nature, including that:

    175.3. Encouraging group practices;

    175.4. Promoting the use of global fees.

176. In particular, the Inquiry makes the following recommendation:

    176.1. Sub-rules 7(4) and (5) should be clarified and should allow for ARMs such as global fees, subject to certain conditions. Rule 7 should not be considered an all-

out prohibition of innovative models. The HMI recommends changes to the wording of this ethical rule in order allow for fee sharing under appropriate circumstances.

176.2. Rules 8 and 8A should be crafted in a manner that allows multi-disciplinary practices and partnerships, and provide clear guidelines on the grounds that will lead to a ban or prohibition by the HPCSA. The HPCSA should also request the full details of these arrangements in order to determine whether there are any concerns that arise from them, and to remedy those where appropriate.

176.3. Rule 18 should be written in a permissive manner and should not be interpreted as a blanket ban on the employment of practitioners. There are cases where the employment of doctors would support value-based contracting and these should be considered on the merits. The inquiry considers that the alignment of medical practitioners and hospital interests is too close there and is coincidental benefit of increased utilisation of facilities that accrue to both medical practitioners and hospitals. At this point, the Inquiry does not advocate unrestricted and unmonitored employment of doctors. In the current market, unrestricted employment of doctors could have serious unintended consequences for consumers and the industry as a whole. The Inquiry recommends that employment of doctors should not be prohibited, but employment of doctors should be conditional. There are other forms of employment of doctors outside of employment by for-profit private hospitals. Where such employment can demonstrate that it is pro-competitive and adds value and that benefits accrue to consumers, it should not be encouraged. The HMI would welcome well-motivated proposals where employment of specified categories of doctors by the private sector would be a net positive for the sector as a whole.

176.4. With regard to Rule 23A, the HMI recommends more effective monitoring of practitioners' financial interest in facilities. Practitioners who own shares in facilities should declare this information to the HPCSA on an annual basis and this information should be published by the HPCSA on its website and all facilities where affected practitioners work.

176.5. At the very least, the following information should be clearly declared to the patient:

176.5.1. Cost of medical care: specifically, if practitioners charge more than any prevailing reference prices not approved by funders, informed consent should be backed up by signed documentation;

176.5.2. Ownership of shares (Rule 23A) at the facility where the doctor provides services. Shares acquired through the open market (stock exchanges) should be exempt from declaration;

176.5.3. Financial interests in any product used (e.g. prostheses), dispensed or prescribed by practitioners (e.g. medicines).

177. The Inquiry also recommends that the HPCSA review its requirements for approval of training institutions such that training includes:

177.1. an understanding of medical coding of procedures;

177.2. the cost and value implications of health care; and

177.3. an understanding of the purpose of HTA-like bodies and their methods.

178. These modules should also be included in continuing medical education so that post graduate providers also gain this knowledge.