HEALTH FUNDERS ASSOCIATION

HFA MATTERS

From the desk of the CEO

Lerato Mosiah, HFA CEO

The South African economy saw a turbulent start to 2018 with various phenomena such as "corruption", "state capture", "junk status" and the looming 2019 ANC elections shaking things up. The healthcare sector has not gone unscathed with major and disturbing revelations emanating from the Life Esidimeni case and the outbreak of Listeriosis, to mention a few. These political, socio-economic factors have all had a bearing on the funding industry. Adding to these are the myriad of poorly managed attempts to amend policy in the health arena, leading to policy uncertainty throughout the industry.

HFA's role as an advocacy industry body that promises to be the unified voice of members, has become more vital than ever. It is our duty to support and guide members and users of their services during this challenging time, to make informed, constructive and professionally-driven decisions as they respond to policy reforms.

We are pleased to be able to highlight a few of our significant achievements from 2017, which include::

- *Submission of position statements and/or comments on*
  - *The NHI White Paper*
  - *PMB review process*
  - *Global Fees*
  - *DSP undesirable business practices*
  - *Loss-making schemes and options*
  - *Beneficiary Register*
  - *Solvency framework*
- *Representation on several task groups and sub committees at the CMS and HMI*
- *Convened industry consultative forums to allow dialogue on the NHI, PMB review, solvency framework and Beneficiary Register.*

The overarching objective of the Association is to be viewed as 'the' industry body that is not only a unifier of the industry, but also a thought leader that engages stakeholders - the regulator in particular - on developing the private sector funding industry. We will serve the best interests of our member schemes and their beneficiaries by driving healthy, constructive dialogue around transformation and evolution of the industry. Our involvement as members of BUSA serve this purpose with regard to the project of finding a pragmatic model for the delivery of Universal Health Care for all South Africans.

As we approach the second half of the year, we will focus on entering into strategic relationships with other professional associations and entities who share a common goal of developing a sustainable industry. As part of our objective to encourage industry dialogue and collaboration we will hold consultative forums and principal officer indabas throughout the year.

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"As a newly formed industry body, we are satisfied that our energies are being focused correctly, as is evidenced by our growing membership, which now stands at 53% of principal members of the total market."

INSIDE THIS ISSUE

From the CEO's desk, cntd.

HFA will drive more dialogue with stakeholders and respond to critical issues such as the NHI White Paper implementation, the PMB review process and the HMI report due out in the third quarter of 2018.

As a newly formed industry body, we are satisfied that our energies are being focused correctly, as is evidenced by our growing membership, which now stands at 53% of principal members of the total market.

We would like to thank all our members for their relentless support in growing our Association to where it is today. We look forward to more engagement and collaboration with you all in ensuring that we achieve our 2018 goals and beyond.

HFA joins BUSA

The Health Funders' Association (HFA) has become a member of Business Unity South Africa (BUSA).

BUSA, a formally recognised representative of organised business in South Africa at the National Economic Development and Labour Advisory Council (NEDLAC), has led and made significant strides on several challenges facing the country.

Recently, NEDLAC established a Task Team on National Health Insurance to give consideration to the White Paper on NHI published in June 2017. Through the network of business partners, BUSA has instituted several working groups which provide input to the NEDLAC NHI Task Team to address aspects of the White Paper. Inputs from working groups, which include, governance; finance; provision; and, regulatory, will be presented to the NHI Task Team which in turn will present a document to Cabinet.

> ***HFA has pledged its commitment to providing expertise and participation in the working groups and Task Team***

Lerato Mosiah, CEO of HFA said that she believes it imperative for private healthcare industry, with its spend of more than R150 billion annually to be represented on this important structure especially as it navigates its way towards universal health care that is affordable, appropriate and sustainable for all South Africans.

Mosiah added that amongst BUSA'S ten policy priorities was an 'Affordable comprehensive social security framework for future generations', adding that BUSA is committed to engaging with stakeholders in the health funding space to advance shared areas of interest.

HFA, which now represents more than half of medical scheme members through its member medical schemes and which represents some of the country's largest administrators, such as Discovery Health, MMI and PPS, has pledged its commitment to providing expertise and participation in the working groups as well as the Task Team.

Mosiah said that HFA was looking forward to constructive engagement with business, government and organised labour with an end result that will see all South Africans being able to access good quality and affordable health care.

A 'New Vision' for CMS

Newly appointed Chairman of CMS, Dr Clarence Mini spoke recently at an IHRM seminar where he outlined the Council's 'New Vision'.

He began by stating that to regulate a R150 billion plus industry would require more resources and extra capacity within the CMS, saying that he had already spoken to both the Minister of Health and Treasury about necessary resources. He added that one of the functions which had been outsourced because of this lack of capacity was the PCNS, which now needed 'beefing up'.

Dr Mini said that the document emanating from the HMI would be handed over to the Minister of Health, but that it would end up with the CMS as the implementing agency. To this end, Dr Mini urged schemes to get involved with the CMS in relation to those issues which were being addressed by the HMI, such as managed care, governance, price regulation, quality and costs.

Dr Mini pledged to visiting each of the 82 medical schemes to garner support for the CMS' new vision and to have one on one meetings which would provide the CMS and the scheme to have open discussions with one another.

NHI:

On the topic of NHI, Dr Mini said although the government had stated its intention to have a single funder system, his view was that there is hope that government would see the sense in having multiple funders, thereby protecting the medical schemes industry. He added that it had also been acknowledged by some members of government in the past that the private sector should lead the process.

He said that the CMS would provide technical support to the NDoH for NHI and related projects which included: consolidation of options, smaller schemes and government funded schemes; consolidation transition arrangements; the PMB review and consolidation of financial arrangements; and, price regulation.

Dr Mini stated that, in terms of the NHI White Paper, all government schemes would be consolidated under GEMS. He said that the CMS is proposing a forum for all government schemes to come together to discuss areas of consolidation and added that the Minister of Health is working on the proposal and obtaining legal advice to ensure that there is no collusion.

Regarding consolidation of smaller schemes, Dr Mini acknowledged the varied nature of the smaller schemes and the reasons for their existence. He added that CMS would work closely with these smaller schemes where consolidation was concerned.

Escalating costs:

Dr Mini said that the CMS recognised the severity of fraud, waste and abuse in the industry and the extent to which these factors increased healthcare costs. He added that CMS would be building anti-fraud capacity and that they would be working with schemes and other industry players who had fraud management interventions in place to deal with the problem.

Dr Mini also broached the issue of state tender prices for medicines, in light of the emergence of biologics which could put scheme budgets under severe pressure. He suggested that, first government schemes and then all schemes should be able to benefit from these prices, adding that the CMS would request the Minister of Health to intervene.

Managed care:

One of the major focus areas for CMS would be that of managed care organisations, especially those who have not 'stepped up to the plate'. He added that managed care organisations had the capacity to initiate forms of care coordination, as it has been shown by GEMS that members can be made to see their GPs before going to a specialist. He stated that it is international best practice that GPs are accessed before specialists and that at least one benefit option on all schemes should include care coordination where this rule applies.

Continued overleaf

Dr Clarence Mini, CMS Chair

A 'New Vision' for CMS, cntd.

At least one benefit option on all schemes should include care coordination where the rule applies that members should see a GP before visiting a specialist.

Coding:

Dr Mini acknowledged that a good coding system facilitates appropriate billing processes, assists in fraud prevention and provides member protection

He said that many health care providers are not using correct coding and that medical schemes are not on top of the coding regime in SA. He added that a central coding authority was critical as coding disputes have no final arbiter at the moment adding that coding is currently in the 'wrong hands' with various codes located with different stakeholders.

Health technology assessment:

Dr Mini said that this capability would reside with CMS who would acquire expertise and knowledge from those with experience in this field.

CMS, a key coordinator of regulators within SADC:

Dr Mini said that the CMS would establish ties with all SADC regulators with a view to harmonising the scheme regulatory framework in SADC and providing sound policy advice to the SADC secretariat on scheme regulation. He added that the CMS would need a strong policy unit in order to be the 'go to' entity for all policy issues.

He reported that several neighbouring countries had taken steps towards implementing NHI.

Research and innovation:

Dr Mini said that CMS would like to create a knowledge generation platform for research and would partner with academic institutions industry bodies and schemes who conduct research.

He said that the CMS would work towards exposing students to the medical schemes environment and urged delegates to open their doors to students wishing to do internships.

In conclusion, Dr Mini said that he would like the CMS to be involved in the global innovation happening in the sphere of health, by sending people to these companies to learn directly from this innovation, especially where the innovation pertained to IT.

YOU'RE INVITED...

HFA CONSULTATIVE FORUM

Join HFA on the 6th June at 10h00 for a Consultative Forum on two important topics:

- Using **BIG DATA** for **BIG GAINS** in preventing **MEDICAL SCHEME FRAUD**

  Speaker: **Marius Smit—Discovery**

- **HFA** and **BUSA: STRATEGIC IMPERATIVES** for the **FUTURE** of the **PRIVATE HEALTH FUNDING SECTOR**

  Speaker: **Laurraine Lotter—BUSA**

Date: 06 June 2018 at 10h00

Venue: HFA Boardroom, Country Club Estate Office Park,
21 Woodlands Drive, Building 2, Woodmead

RSVP to Maureen Litchfield at maureenl@hfassociation.co.za

Amendments to the Medicines Act: implications for companies and funders

The CEO of HFA attended a recent industry seminar on changes to the Medicines Act where health law expert, Elsabe Klinck of EK&A provided clarity on the new Medicines Regulations and the Medical Device Regulations, saying that the Medical Device Regulations (Dec 2016) were still part of the unamended Act while the Medicines Regulations (August 2017) were under the new, amended Act.

She said that there were changes under the definition of a medical device, which now included, e.g. disinfectant used for medical devices, adding that those things now classified as devices will be treated differently and that there could be downstream implications. Other products such as pregnancy tests, glucometers, HIV & rapid test kits, etc. are all now classified as devices.

Combination medicines and combination devices are not defined in the act. However, Klinck said that in order to determine whether something was a medicine or a device one had to look at the primary purpose, i.e. where a syringe is pre-filled then it would be deemed a medicine.

She added that where a substance interacts with the body, it is considered a medicine but where it provides a structural support for a medicine, it would be a device.

Klinck said that although there was no SEP for devices, the June 2017 amendments required that all medical device companies had to apply for licenses. This, she added was a priority as schemes and hospitals would only be permitted to procure from companies who were licensed or who had applied for a license. Importantly, under section 22(H), it is a criminal offence to act as a wholesaler or manufacturer if the entity is not licensed.

Acceptable business practices should be allowed such as, free services where a device company calibrates a device or where a pharmacy will call to remind a patient to fetch medication

No regulations have been envisaged for sections 18(A) and (B) which deal with bonusing, rebates, discounts and incentives. This, she said was problematic as, for instance, sampling was outlawed except for exhibition and appraisal purposes. Without regulations to provide guidance, under these sections, it would be difficult, for example, to give a patient a glucometer to test because there was no clarity on the details, such as the length of time, etc.

Under the old Act, section 18(B) excluded 'the free supply of medicines for the purposes of clinical trials, donations of medicines to the State, tendering to the State and quality control by inspectors'. However, this no longer appears in the Act which means that donations are outlawed altogether. This means, for example, that the new Nelson Mandela Children's hospital is not permitted to accept donated equipment because it is outlawed.

Klinck argued that acceptable business practices should be allowed, for instance, free services such as where a device company will calibrate a device or where a pharmacy will call to remind a patient to fetch medication. Other examples include where loan sets of spanners to work with a particular piece of equipment are provided to a hospital. Klinck also believes that consignment stock should be allowed.

However, Klinck said that section 18(A) could provide an opportunity for proper risk sharing models such as those where a manufacturer will pay for one cycle of a medication and funder pays for two.

The advertising regulations are also problematic, according to Klinck as they only allow Class A and B products to be advertised. Since most devices fall into Class C, it means that manufacturers are not permitted to provide brochures on their products and devices like pregnancy tests are not permitted to be advertised.

Regulation 33 deals with information which must be included on a prescription. Klinck says that an original signature is required and that some areas of the prescription is not allowed to be typed. She added that the age and gender categories potentially raise issues but that the compulsory inclusion of ICD10 codes is a positive step for epidemiological purposes.

Dr Elsabe Klinck, EK&A

NHI News …..

Medical scheme body presses on with consolidation draft plan
Industry consolidation is in line with government policy on National Health Insurance
19 April 2018 - 05:52
By Tamar Kahn
Business Day

The Council for Medical Schemes expects to finalise a draft consultative framework on consolidating the medical schemes industry within two months, acting CEO Sipho Kabane says.

Industry consolidation is in line with government policy on National Health Insurance (NHI), but is likely to run into fierce opposition from industry players and civil servants.

The framework would contain proposals for consolidating government-funded schemes for public servants, reducing the number of the scheme's benefit options and consolidating schemes that had less than the statutory requirement of 6,000 members, Kabane said.

Click here to read more

NHI gets cash, but detail vague
February 22, 2018
Kerry Cullinan
Health-E News

The National Health Insurance aims to make a package of essential healthcare free to all citizens and legal residents of South Africa through compulsory employee contributions to a national NHI Fund – a noble cause with a hefty price tag.

But the health department's attempt to introduce the scheme has floundered over the past five years, – partly dogged by huge management weaknesses in the public health sector.

According to yesterday's Budget Review, the NHI will get R4,2-billion made up of allocations of R700 million, R1.4 billion and R2.1 billion over the next three years. This money will come from "an amendment to the medical tax credit".

Click here to read more

Should you wish to submit an item for inclusion into HFA Matters, please send it to Maureen Litchfield at maureenl@hfassociation.co.za