HEALTH FUNDERS ASSOCIATION

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Newsletter

We are delighted to bring you this first edition of the HFA newsletter. This quarterly publication will keep you updated with the association's activities and will highlight other important events making news in the industry. I trust you will find it informative and useful.

In this edition, we feature our Inaugural Consultative Forum, held on the 28th March where three critical issues were presented by industry experts and debated by the audience.

Several significant recent developments in the industry, including the DG of Health's recent pronouncements affirming a central role for medical schemes in the build up to NHI, will require smart and responsive leadership from HFA. As thought leaders within the industry, I believe there will be an expectation on our members to come up with innovative solutions to ensure a smooth transition to universal health care. (Please see the article on page 3.)

The proposed beneficiary registry along with the solvency review and the introduction of low cost options is going to need all the collective wisdom which this industry can provide, and I believe that through HFA's progressive and credible response to these issues, our representation will grow exponentially within the next few years.

The PMB Review

The PMB Review process, whilst since been put on hold by the Registrar, was presented at the recent HFA Consultative Forum.

Boshoff Steenekamp, a senior strategist at MMI, prefaced his presentation by emphasising that the process offered the opportunity to review the PMBs with policy priorities, such as universal coverage, in mind.

He said that it was imperative that the process was iterative, and that there was broad acceptance by all participants, while warning that the technical complexities of a process of this kind made for a high risk of failure.

Steenekamp highlighted the challenges associated with the current PMB package and commented that various aspects, like FFS, the lack of a tariff determination process, the hospi-centric nature of the package and a lack of incentives to maintain and improve health were major stumbling blocks.

He added that while there had been various policy interventions aimed at realizing UHC, like the Taylor Commission, the REF, etc., these had not all been realized and had therefore not brought us closer to UHC.

Steenekamp explained that while the role of a health system included aspects such as purchasing, pooling, service delivery, benefit design and revenue collection, the South African health system had not done well on most accounts except that of revenue collection.

He added that this was evidenced by the fact that although the country spends 7.9% of its GDP on health, outcomes were bad.

He said that addressing health policy challenges and implementing a sound health financial strategy would require revision to the way in which revenue was raised, purchasing, benefit design, overall system architecture and governance. He added that priority should be given to those areas which would provide a solid foundation for the future development of a system that could be feasibly implemented given current and expected future contextual constraints.

Click here for the full report

Inside this issue:

The Beneficiary Registry

Altair Richards

Altair Richards of ENS who addressed delegates on the proposed establishment of a medical scheme beneficiary registry (BR) at the HFA Consultative Forum explained that the registry is intended to be a central repository containing certain personal information of all medical scheme beneficiaries in South Africa, to be provided to the CMS by medical schemes and their administrators.

She added that, amongst others, the NDoH required the information to verify whether patients visiting public sector facilities were members of medical schemes. However, she added that the CMS' scope seemed to be much broader as it had requested information such as, names; ID numbers; citizen status; marital status; race; gender; physical addresses; email addresses; cell phone numbers; whether the member is subject to any exclusions; waiting periods, etc.

CMS cited the reasons for collecting such information as:

- assisting the public sector in avoiding fraud;
- mitigating against duplication of medical scheme membership;
- geomapping analysis;
- resource planning;
- membership history;
- understanding health seeking behaviour;
- improving risk profiling;
- improving the CMS annual statutory returns; and,
- being able to assign a unique ID number to each beneficiary.

Richards added that the basket of information called for does not align with the reasons for the information stated by the CMS and added that there were questions around the need for non-anonymised vs. anonymised data and whether there could be less intrusive ways for health facilities to, for example, perform verification processes on patients.

Richards continued by suggesting that all the reasons cited for needing the information could be achieved through anonymised information and a 'look-up' facility which linked to data held by the various administrators.

Click here for the full report

HFA Strategic objectives

- Represent the best interests of the industry in an ethical, inclusive, impartial, proactive, effective and efficient way.
- Develop and nurture constructive relationships with the members of medical schemes, the public, policymakers, regulators, and all relevant stakeholders in the healthcare system.
- Engage constructively in the policy and regulatory environment.
- Create an environment for the industry to engage on specific regulatory and industry matters having regard to all relevant laws, including competition law.
- Remain responsive, relevant and dynamic in interactions with members and in seeking to support the industry.
- Ensure ongoing cost-effectiveness and value for members.
- Subscribe to the need for competition within the industry for the achievement of accessible, affordable, high quality and innovative private healthcare.

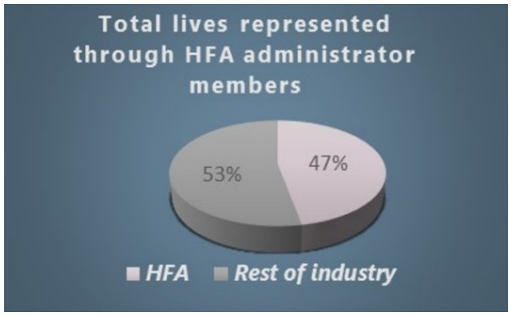
Global Fees

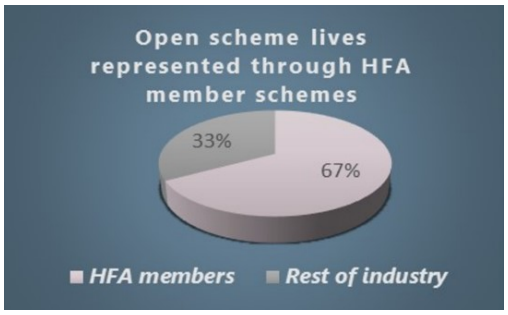
The Health Funder's Association was invited by the HPCSA to attend a Global Fee Workshop on the 22nd May 2017, after the South African Society of Anaesthesiologists complained that global fees were not permissible according to HPCSA rules and regulations.

The HPCSA furthermore, urged health professionals not to sign agreements with medical schemes who insist on bundled fees, citing risks of underservicing and uncertainty regarding doctor autonomy and liability.

HFA's view is that the fee-for-service model has been responsible for many of the problems within the private health sector and that well-structured global fee models allow for innovative and efficient ways of delivering healthcare. HFA, on behalf of its members, will therefore be engaging with the various professional associations to explore global fee models which will address the concerns cited by the HPCSA and which will allow for progressive new delivery models.

Who we represent





Source: CMS Annual Report 2015

Towards Universal Health Care

During May, the DG for Health, Ms Precious Matsoso, invited those organisations representing medical schemes to a meeting to discuss ways in which the private sector could play a meaningful role in the proposed NHI.

Precious Matsoso

By way of introduction, Ms Matsoso provided a background to the NHI programme, making reference to the UN Resolution on universal health care, the NDP and the SDGs as the pillars around which the health reform would be structured.

She invited the industry to work with government in developing a system which would address equity and access issues and provide universal health care to all South Africans. She added that the NHI workstreams (particularly Workstream 4) had recognised the need for medical schemes to continue to exist within the NHI system and that the private sector infrastructure, which currently covered 8.8 million people, would be required in the build-up to NHI. She committed to providing comprehensive feedback on the proposals which emanated from the various workstreams.

Ms Matsoso called upon the industry to work on developing a comprehensive service benefit (CSB) offering which would be affordable and which could be rolled out across both the public and private sectors. She also requested that the industry consider a transitional model, using the current infrastructure. To assist with these reforms, the DG indicated that she would put a transitional team together, made up of representatives from the industry.

HFA welcomes this move by government and is committed to assisting in achieving a health system which is equitable, accessible and provides quality healthcare.

Solvency Review

Emile Stipp from Discovery Health opened his address at the HFA Inaugural Consultative Forum by stating that a solvency review had been on the table since 1995.

He said that the current 25% solvency requirement, whilst simple and easy to calculate, was introduced to the Netherlands in 1958 but that the rationale for this formula was no longer relevant.

He said that the disadvantages of the current system include:

- It does not account for the actual risk that a scheme faces;
- Schemes which priced for deficits could hold lower reserves;
- High reserves are inefficient and costly.

> *"Under the current framework, schemes that price for deficits can hold lower reserves".*

He added that while other insurers could take reinsurance, medical schemes could not.

He also stated that the only source of income for medical schemes is derived from members and when medical schemes increased their premiums, they risked the loss of young and healthy members.

Emile Stipp

Stipp commented that the initiative to review the current framework and consider a Risk Based Capital (RBC) model had been initiated by the CMS and added that both the CMS and ITAP had developed RBC frameworks, which he would compare during his presentation.

He stated that the objective of the ITAP framework was to develop an internal model for use by CMS to prospectively identify medical schemes at high risk of failure and to highlight schemes for further investigation, to allow CMS to intervene timeously. He suggested that the ITAP framework should be extended to become the full RBC model.

Stipp stated that the main risks facing schemes included, their liability; their operational risks; and, their assets. He explained that the RBC assesses risk associated with assets and if a scheme invested all its assets in a risky asset class then it would need a greater solvency percentage.

He said that IBNR was the main liability facing a scheme and that the RBC model would factor in underestimation of IBNR.

Click here for a detailed comparison of the ITAP RBC and the CMS RBC

Become a Member!

Value proposition

- Serving the best interests of our members through constructive engagement on specific regulatory and industry matters.
- Providing knowledge management to augment members' understanding of the critical issues and risks they may be faced with, which may impact the long- term sustainability, development and success of their respective organisations.
- Building constructive long-term relationships with key relevant industry stakeholders to effectively represent the views of members on critical industry issues.
- Achieving our objectives through the formation of a cost-effective and efficient operating model which strives to deliver excellence at all times.

Member Benefits

- Access to research and submissions by experts on current and impending legislation and other issues facing the industry.
- Invitation to industry consultative forums and seminars.
- A regular newsletter keeping members up-to-date with current news, articles, research, events and classifieds.
- Voting rights for ordinary members.
- Representation on the HFA Board, sub-committees, working groups and other decision-making forums.
- Access to newly-released global research and journal articles.
- Information on local and international events.
- Representation to healthcare provider associations, hospital groups, CMS, NDoH and other relevant entities.

Industry Events

'Scenario Planning for the Future of the Private Sector'

Several of the finest minds in the industry came together at an IHRM Seminar on May 30th to debate the future of the private health sector.

Professor Alex van den Heever, who chaired the discussion, introduced the topic by posing several high-level questions on the way in which the industry could be structured and operate in the future.

One of these was around universal cover, and the need for a viable model, adding that the PMBs had not worked well and review of the PMBs should ensure that they fit into a coherent view of the private sector framework, going forward. He suggested that a review of the system should take cognisance of the fact that users of the system have little power and that while insuring health was necessary, insurance principles did not belong in healthcare. He urged that rationing and inclusion/ exclusion criteria should be a societal discussion.

Van den Heever said that the current system does not allow consumers to make choices on the basis of quality and that the market had chosen to compete on the basis of demographics and paying brokers rather than cost and quality. He added that the introduction of competition based on quality would change the DNA of the system.

He added that there were two established models for healthcare, one, a consumer driven model and two, a purchaser model. By way of example, he cited a scenario in which hospital groups formed medical schemes.

Van den Heever suggested that policy changes in pricing of healthcare is a strategic imperative but warned that healthcare must emphasise a combination of price and quality and not price alone.

He commented that the industry needed to have clear quality and coding standards which should be mediated under a single authority.

From a broader perspective, van den Heever suggested that the HMI is an important intervention in raising the understanding of healthcare markets but warned that the outcomes of the inquiry may not be what the NDoH was hoping for.

He urged the industry to put its mind to the strategic imperatives within the healthcare sector and the broader economy which could create an enabling environment in terms of innovation, citing the example of North Korea where the government made significant investment into IT which had an enabling effect on innovation in many sectors, including that of healthcare.

Panellists, which included Dr Johan Oelofse of Spesnet, Boshoff Stteenekamp of MMI, Christoff Raath of Insight Actuaries and Consultants, and Johann Serfontein of Healthman agreed that a regulatory reboot was necessary, especially around the issues of fragmentation, investment, aligning of resources, billing and coding. To highlight the point, Dr Oelofse commented that the global fee issue demonstrated the need for more progressive legislation around billing and coding. Boshoff Steenekamp, in emphasising the issue of regulatory reform, suggested that an industry discussion around the who, what and how of UHC was imperative, adding that compulsory membership was crucial in a cross-subsidized environment.

Christoff Raath pointed out that the last time regulations in the private sector were significantly reviewed was in 2003,which in his opinion amounted to policy neglect, adding that the NHI discussions at Polokwane had effectively put paid to all reform except that relating to NHI.

Johann Serfontein highlighted the need to protect the 'missing middle' which would be negatively affected by the demarcation regulations and added that low cost benefit options were a vital component to ensuring that this cohort of the population enjoyed protection.

But while Serfontein and others presented a variety of innovative solutions which, if implemented, could positively alter the industry's future scenario, it was clear that a cohesive approach to the future of the industry was necessary.

To this end, it was suggested that an industry 'Codesa' be held to ensure that the move towards UHC is progressive, well planned and ensures the ongoing viability of the sector.

Log on to www.IHRM.co.za for more information on the seminar and to view the presentations.

We welcome contributions from our members and other interested parties. Should you wish to submit an item for inclusion, please send it to Maureen Litchfield at maureenl@hfassociation.co.za

To remove your name from our mailing list, please email maureenl@hfassociation.co.za

Questions or comments? E-mail us at maureenl@hfassociation.co.za