WHO Comments on the Report of Health Market Inquiry: Provisional Findings and Recommendations

World Health Organization (WHO) appreciates the efforts of Government of South Africa, and in specific, the Competition Commission for initiating the Market Inquiry into the state of competition in the private healthcare sector to identify the underlying causes of rising healthcare costs in South Africa. We congratulate panel members and its directors on conducting the enquiry through a rigorous and transparent process as well as preparation of comprehensive and lucid draft of the report. The preliminary report is a milestone and will be crucial in informing the policy discourse around the health systems and policy reforms in private sector under the National Health Insurance.

OVERARCHING COMMENTS:

- **Findings of the report:** WHO feels that the report is a product of thorough research and adequate stakeholder consultation and therefore reflects a fair and clear picture of the health market in the country. The report provides a detailed analysis of the healthcare system and comes out with evidence based findings that the market is highly concentrated, with very limited competition and strong entry barriers. The evidence for supply induced demand, confusion created by multiplicity of options, not enough measurement of quality of care in private sector and the resultant rising out of pocket payments and premiums with dwindling range of services all indeed are largely a result of regulatory failures at several levels- as the report makes the case.

- **Recommendations of the report:**
    - WHO agrees with most of the recommendations including the need for improving the regulatory framework by an act of Parliament. These regulatory interventions however need to be aligned with the process of the National Health Insurance (NHI) reform and the future role of the medical aid schemes as supplementary health insurance on top of the NHI coverage. We therefore urge the Government to consider your recommendations while finalising the Medical Schemes amendment Bill and the National Health Insurance Bill, as well as all legislative changes linked to that process. This includes the proposal to standardize options offered by medical schemes, introduction of “base options”, redistribution or funds between options, introduction of reinsurance, risk rated supplementary insurance rules, strengthen Council for Medical Scheme’s (CMS) oversight, discount of premiums for younger members, need to improve governance rules of medical aid schemes, broker opt-in system, process of tendering Designated Service Providers (DSPs) and reforms of the Prescribed Medical Benefits (PMBs).
    - We fully support the rationale and the need for measuring and publishing quality and outcomes in the healthcare sector, need for planning of capacities, use of health technology assessment, improvement and standardization of information system.
    - WHO however does not support the suggestion for establishment of a new dedicated healthcare regulatory authority, Supply Side Regulator for Healthcare (SSRH). We

believe that its proposed functions can be implemented through existing structures of the Health Professions Council of South Africa (HPCSA) and other bodies and regulators such as Departments of Health (National and Provincial) , Council for Medical Schemes and the Office of Health Standards and Compliance (OHSC).

- **Some Limitations:** WHO believes that the Health Market inquiry conducted a robust research into the private sector however falls short on generating evidence regarding the impact of private healthcare sector on the household out of pocket payments. This limits the ability of report to fully appreciate the risk of financial hardship for individuals and families while accessing care through the medical aid schemes. This area may not be directly under the purview of this inquiry- however such issues were raised by the individuals during the public hearings. Unfortunately, we did not see any analysis which would help to understand the extent to which the medical schemes beneficiaries face catastrophic out of pocket payments or forego necessary care, or need to rely on the public sector services despite being 'covered' by medical schemes. We believe that the costs in private sector can have substantial negative effects on consumers which the Report did not shed enough light on.

DETAILED COMMENTS ON THE RECOMMENDATIONS

Transparency, Accountability and Governance

We appreciate that the commission has identified lack of transparency, accountability and governance on part of healthcare funders; which does not allow the members to get best value for money.

To improve transparency, recommendations related to 'Standardized Base Package' with inclusion of additional primary and preventive service to form a part of Prescribed Minimum Benefit (PBMs) is very much needed. The same is also reflected in Medical Schemes Amendment Bill, 2018 where the government has proposed to abolish PMB with Comprehensive Benefit Package (CBP). Recommendation to abolish hospital only plans will also add value to the medical schemes. Regular public reporting of value and outcomes from Alternative Reimbursement Models (ARMs), preferred provider networks (PPN) and DSPs will surely improve transparency in the industry and will inform the funders and beneficiaries.

To improve governance of medical schemes, the recommendation on performance linked package for Trustees / Principal Officers(POs) is a great idea but at the same time there should also be (upper and lower) ceiling on the remuneration paid to Trustees / POs to contain cost of Non-Health Expenditure by the schemes. Other initiatives on conflict of interest, annual general meetings (AGM), election of trustee, publication of performance data of administrator, access to CMS will also likely improve governance of Medical Schemes.

We believe that trying to augment competition by regionally based schemes may not be the right approach. The regional based smaller scheme is likely to have limited membership base which may leads to high overheads, limited risk pooling and limited negotiation capacity with healthcare providers. This kind of schemes may increase the cost of premium because of the scale of operations.

Risk Adjustment Mechanism (RAM)

Given highly fragmented Medical Schemes market catering to different group of population with heterogeneous risk profile, we appreciate the idea of creating fund for Risk Adjustment Mechanism (RAM). This is in line with the principle of risk pooling and efficient resource allocation. The measures proposed for establishment of RAM could be facilitated and vested with CMS.

Benefit Package

The commission has rightly recommended updating of Prescribed Minimum Benefit (PMB) to include preventive services which is already been addressed in draft Medical Schemes Amendment Bill, 2018 out for comment by replacing PMB with CBP (Comprehensive Benefit Package). The provision for review of the benefit package at least 3 year is reasonable and appreciated. This should be institutionalized through available scientific techniques of designing benefit package such as Health Technology Assessment and, considering cost-effectiveness, economic feasibility and administrative feasibility of introducing new benefits to the package. Inclusion of prevention and promotion oriented primary care such as vaccination according to the national recommendations, as well as reimbursement of care in outpatient settings according to the Standard Treatment guidelines would also improve efficiency and responsiveness.

Similarly, we support simplifying and standardization of benefit options with a “base option” offered by all schemes, which will be aligned in content to the NHI coverage. However the point 37 of chapter 10 is a bit confusing - The idea of setting up base cover option based on Catastrophic Expenditure is rather abstract since Catastrophic Expenditure is a relative term and linked to income of the individual/household. The language of this recommendation needs to be re-articulated based on this premise- maybe it could say ‘base option covering health services responsible for catastrophic expenditures in most vulnerable groups/ poorest populations’

Anti-selection measures

The report suggests that there is evidence of scope for adverse selection under medical aids. The draft Medical Scheme Amendment Bill has proposals aimed at addressing anti-selection by eliminating waiting periods and measures around late joiner penalty. At the same time, introduction of measures to increase affordability of lower income South Africans, young and historically disadvantaged population groups in South Africa would help reduce anti-selection.

Broker system

We believe that brokers are largely marketing agents of the medical schemes and put additional financial burden on individuals. The Medical Scheme Amendment Bill has also proposed to eliminate broker system but active opt-in system is more flexible. Complicated benefit packages and insurance plans would require some sort of counselling of individuals- therefore it would be essential to ensure

simplified information on benefit package and terms of medical aid are available to help individuals make informed decisions.

Supply-side regulations of Healthcare

We consider most of the recommendations from HMI report as either requiring improving the enforcement of the current regulatory framework or introduction of new regulation by the National Department of Health or the Parliament.

However as noted above, we do not support the establishment of a new dedicated healthcare regulatory authority, Supply Side Regulator for Healthcare (SSRH) or the Outcomes Measurement and reporting Organization (OMRO). Empirical evidence suggests that establishing new agencies and bodies to make-up for weakness of existing agencies is less effective and efficient path- instead sustained financial investments and capacity building, strengthening Governance and accountability of exiting agencies is likely to yield better results.

Therefore we are of the opinion that existing structures need to strengthened for the enforcement of clearly distributed rules and regulations; the HPCSA and other bodies and regulators such as Departments of Health (National and Provincial), Council for Medical Schemes and the Office of Health Standards and Compliance (OHSC).

Certain enabling aspects would include;

- The CMS's Registrar could be provided with executive powers to act on behalf of the interests of the medical aid scheme beneficiaries as well as to improve the functioning of the whole medical aid industry, especially when suspicions arise that the governance arrangements do not represent the interests of the beneficiaries.
- Development of comprehensive national health information system describing the providers: each health establishment to have a standard national registration number, with mandatory obligation of reporting information on capacity, conduct, processes and outcomes
- Standardised healthcare services: universal national coding of procedures and diseases
- Transparency and accountability in conduct of purchasers such as the medical aid schemes (expanding the reporting to the CMS) and their relationships with the brokers and administrators and other third parties.
- Review the Ethical rules of the HPCSA to stop preventing alternative reimbursement mechanisms, and risk sharing arrangements between purchasers and providers
- Standardize the licensing process of private establishments to be aligned with the need for such care and their negative effect for the availability of human resources for health in public facilities,

Price negotiation and regulation

We agree with the report that the current price negotiation have not yielded positive outcomes for consumers and we agree that sector participants may continue to settle for mutually beneficial pricing levels at the expense of the consumer. Price regulation is thus one of the areas which needs a

different, well-structured centrally- regulated process as well as changing the Competition Act or the interpretation of such conduct by the Competition Tribunal. Any negotiation with a wider social purpose of improving affordability and access to care for the population should be exempt from the concerns of "collusion" in the legislation as is done in other countries. Private providers who refuse to participate in the process (designing the methodology, providing input data, consultation process) should be barred from receiving reimbursements from medical aid schemes and the governance role of the whole process needs to be put in the hands of the Minister of Health in collaboration with the Council for Medical schemes.

Among HMI report proposals for price negotiation we see the Proposal 1 being better suited to the situation in South Africa, where the NDoH assumes the role of the SSRH. The obligation for private providers to participate in the process with sizable fines for non-cooperation will help achieving the desired aims of increased affordability of health services for South Africans. The price regulation of pharmaceuticals is an example how all benefit from affordable products. We believe that the independent arbitrator has to be nominated by the Minister of Health and that the responsibility for the standardization of coding systems should reside within the NDOH.

Practitioner Payment Models, Reporting and Coding Systems

The recommendation of the commission to gradually move from Fee-For Service (FFS) model to Alternative Reimbursement Mechanisms (ARMs) is welcomed by WHO. The global evidence on reimbursement suggest that FFS is highly inefficient and generates financial incentives for over provisioning of healthcare services.

The recommendation on regular reporting by Medical Schemes on Value-based contracting, supply-induced demand and cost-containment on non-healthcare expenditure should be extended to public domain and should also be extended to report tangible savings achieved by implementing these measures using robust methodology. The impact of the saving on premium rate (Pass on the benefits to members) should also be reported publicly to make consumer well informed.

The uniform coding system is essential to regulate healthcare provider payments in the market. The commission has rightly recommended implementation of uniform coding system which can be used to generate information for different level of decision making. The provision of standardized coding system is also articulated under NHI Bill under Section 34(3). Hence, we believe that the recommendations on procedural and disease coding for healthcare should be aligned with NHI Bill. The ownership of the coding system should be of the Government. There may be resistance from private sector as they have heavily invested in individual coding systems and related IT infrastructure. The recommendation should articulate mode of transition to the new system of coding with minimum financial implications and disruption for the healthcare industry.

Outcome Reporting and Measurement System

To promote transparency and accountability among healthcare providers, practitioners, funders and patients (consumers) regular measurement and reporting of health outcomes is of utmost

importance. We do not agree with the recommendation of setting-up an independent body like Outcome Measurement and Reporting Organization (OMRO) as this will lead to further fragmentation and dichotomy in functions and roles of CMS, OHSC amongst others. We would suggest this function to be vested with existing agencies such as CMS or OHSC- A separate unit could be established and representation from public and private healthcare providers, academia and patients' representatives should be ensured. Licensing and inspections should collect reliable outcomes measures which would be defined by the National Department of Health in cooperation with the OHSC and CMS.

CMS should monitor quality of services and health outcomes achieved by individual options and medical aid schemes. This could be done by expanding its Annual Statutory Returns data and publication of the Annual reports and impose the principles of Health Technology Assessment for any new intervention to be covered by the PMBs (whatever new form they take).

Government should provide stewardship to this initiative, rather than such mechanisms being driven by health practitioners and/or funders on their own. Identification of indicators to be monitored should be aligned with global standards and best practices with some local adaptation.

Review of HPCSA

With the changing market structure for healthcare in South Africa there is a need for reviewing HPCSA rules related to healthcare practitioners. We appreciate the recommendations by commission and agree that rules should be adequately amended- especially those relating to provider payment mechanism, multidisciplinary practice and employment of doctors by hospitals. But at the same time monitoring of implementation of these rules is also of utmost importance. The flexibility without effective monitoring and regulations may lead to cartel and supplier induced demand. The flexibility to implement ARMs is highly appreciated but the mechanism should be implemented with adequate review of evidence from other countries. Monitoring and public reporting of financial interests of practitioners with facilities will surely improve transparency and accountability.

Improving Competition and need based licencing

The high concentration of the private hospital market and its relatively high profitability is one of the main findings of the market inquiry which may also need to be referred to the Competition Tribunal.

We believe that harmonized capacity planning should be undertaken which includes assessment of available capacity, planning for future healthcare needs and demands. This should then be reflected in the licensing of private health facilities as well as in the government's decision for future investment into the healthcare capacity. Licensing process with its monitoring and inspection system should be integrated between the OHSC, CMS and provincial departments together with information from medical aid schemes. Licensing and inspections should collect reliable outcomes measures which would be defined by the National Department of Health in cooperation with the OHSC.
