Private healthcare cost drivers

BHF
2014
Is Healthcare cost a problem?

- StatsSA
  - Medical inflation
    - CPI + 4.3% (2009-2013)
  - Health insurance of Household Expenditure
    - 3.4% (2006-2007)
    - 7.2% (2010-2011)

The investigation should look at all cost drivers that affect affordability to access care, not just service provision costs.
Outline

- What we want!
- Competition & Health
- Cost drivers overview
- Burden of disease
- Benefits provided
- Information Asymmetry
- Hospital costs
- Devices and rebates
- Medicine
- Specialist costs
- Other cost of services
- GPs
- Quality of care: driver of cost
- Adherence problems
- Regulatory impediments/drivers of cost
- Non Healthcare cost
What BHF wants?

Distinguish **Medical Aid** from **Insurance** (financial risk management)

- To fund and measure quality care delivered to positively impact beneficiaries’ health status
- Make health benefits affordable
  - Drive efficiency
  - Assure sustainability
- The progressive realisation of providing more evidence based benefits

*Better health, better lifestyle, longevity!*
Constitution: Section 27

• Right to access healthcare services
• Recognition that resources are limited

• Executive empowered to make it happen for all citizens
  – Public sector
  – Private sector

Healthcare service access (public/private) is a human right
Competition & Health

• ...that competitive free markets deliver allocative, productive and dynamic efficiency. Allocative efficiency is also known as Pareto efficiency after the Italian economist Vilfredo Pareto and means that resources in an economy over the long run will go precisely to those who are willing and able to pay for them.

• Most people cannot afford to pay for healthcare services.
• Applicable to commodities i.e discretionary expenditure.
  – The logical person will search and then pay the lowest price for a product.
    • Thus largely applicable to discretionary items.
• Assumes that both parties involved in transaction have equal power.
Competition & Health

• “Health services”

• Small element of discretion when one considers health needs
  • Thus healthcare should be seen as essential service (similar to education, water, sanitation, electricity, ports, fuel, medicine, pharmacy, interconnect fees that often enjoys regulatory protection).
  • Nice to have: limited scope.

• No discretion during an emergency. No time or interest to search for lower prices. **Interest is in getting better.**

• Information asymmetry.

• Unequal power!
Competition & Health

“Health services”

• Generally, selection of service provider is based on trust/location.
  • Not on lowest price
• Patient referrals in the value chain is based on trust/location and not price.
• Selection of hospital is not based on price but on where the Dr/specialist practices.
• **No transparency in pricing for health services.**
• Informed consent (ethics & NHA) is not fully practiced.

• Medical fund/scheme is a collective of members – stokvel, not for profit.
  • Role includes protection of members from abusive pricing
# Commodity or public good

<table>
<thead>
<tr>
<th>Commodity</th>
<th>Healthcare service - Public good</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discretionary</td>
<td>Limited discretionary</td>
</tr>
<tr>
<td>Information often available</td>
<td>Information asymmetry</td>
</tr>
<tr>
<td>Equal power</td>
<td>Unequal power: victim</td>
</tr>
<tr>
<td>Price shopping</td>
<td>Select provider based on trust/region</td>
</tr>
<tr>
<td>Competition: lower prices</td>
<td>Competition: higher prices</td>
</tr>
</tbody>
</table>

“price competition” in SA healthcare: ridiculous notion
Competition & Health

Inelastic Demand

Milk $0.80

$2.40... but I still need it!
Competition & Health

• Health service is not a commodity. No price elasticity
  –Competition does not lead to lower prices in health!

• Price competition in health.
  - Who can get away by charging the most and look “angelic”/ethical
  - Who(service provider) can get the highest price

• Irrespective of place of health service (public or private)....Regulators have an obligation to protect the public from price exploitation.

• Service providers are entitled to fair remuneration!
Medical scheme claims per beneficiary (2010 prices) from 1981 to 2010

- Hospital rebates on materials removed
- NAP and rebates on materials introduced

Prof. A vd Heever
SA: 2004

• CC intervenes in health: “low hanging fruit”
  – Healthcare cost increases.
  – BHF had a filter/dampening effect

• NDoH intervenes on perverse medicine price and dispensing fee
  – Price decline (about 17-19%), managed pricing and sustained affordability.
  – Very few service provider and medicine suppliers out of business
Summary

• Health services: market force/price failure

• Regulated pricing provides some protection!

• Need to extend regulated pricing to all other health services and health product suppliers
Health cost drivers: Public perspective

Contributions

- Employer Policy
- Employer Subsidy
- Disposable Income

Plan Selection
- Code
- RVU
- Volume

Regulated Items
- Reserves (Currently R10B overcapitalised)
- Non Healthcare Cost
- Effect of anti-selection

Lack of Regulated Reform
- Mandatory Membership
- Slow Tax reform
- Other
Health cost drivers

Demand
- Burden of disease
- Information Asymmetry
- Benefit provision
  - Demand for Cancer, hospital, Optical and Special dental benefit
  - Inadequate Prevention and Promotion

Cost Drivers

Supply
- Claims
  - Code
  - RVU
- Volume
- Quality of care

Other
- Regulatory impediments
Health cost drivers

• There is excessive use of the word “utilization” to explain rising costs to funders.
  – This needs to be unpacked
    • More disease
    • Billing problems
    • Coding problems etc
    • Adverse outcome of poor quality or benefit limitations
  – Consider quality of care bought to explain rising utilization.
    • Poor quality or bad benefit design might lead to more complication that require specialists and hospitalisation
Burden of disease

• Insignificant age profile change in the last decade

• Double hump age distribution
  – 20-30 year age group: migration out of schemes. Loss of cross subsidisation!
  – Need for limited mandatory membership of higher income earners, initially

• High and rising, non communicable disease burden
Burden of disease

• Undiagnosed disease burden (2012)
  – Present with complications and resultant higher cost
  – Hypertension: currently 10%; expected 15%
  – HIV: currently 2%; expected 3-4%
  – Diabetes/Asthma: currently 3%; expected 5-6%

• Rising obesity levels
  – No/limited benefits provided

• Lack of adequate risk identification and management (systemically)

• Effect of member distribution by brokers

• Effect of anti-selection in private sector
Benefits: Member Demands

- Hospitalisation benefit
- Cancer therapy benefit
- Special dentistry benefits
- Optical benefit

*Inefficient healthcare delivery systems for above!*
Benefits

• Current PMB
  – Hospi-centric & specialised care
  – Discriminatory and poorly structured
  – Ill-defined and Inefficient
  – Potential for diagnosis creep and becoming unaffordable

• Revise PMB
  – Comprehensive, efficient and promote access to care irrespective of diagnosis
    • Expand benefits through inclusion of public sector based benefits
    • Specify primary care and evidence based preventive care benefits
    • Service based rather than diagnosis based – this solves discriminating nature of current problem
PMB costs suggesting upcoding by providers

<table>
<thead>
<tr>
<th></th>
<th>Events per 1 000 beneficiaries</th>
<th>Claim per event</th>
<th>Claims PLPM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-PMB</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>8.92</td>
<td>5 051.25</td>
<td>45.05</td>
</tr>
<tr>
<td>2013</td>
<td>8.26</td>
<td>5 017.37</td>
<td>41.46</td>
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<tr>
<td><strong>PMB</strong></td>
<td></td>
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<tr>
<td>2012</td>
<td>23.99</td>
<td>21 791.21</td>
<td>522.76</td>
</tr>
<tr>
<td>2013</td>
<td>24.84</td>
<td>23 455.20</td>
<td>582.73</td>
</tr>
</tbody>
</table>
Benefits

• In current environment
  – Erosion of gatekeeper role of GPs and dilution/reduction of primary care benefits.
  – Promote inclusion of primary care benefits and preventive care benefits as risk benefits
    • More cost effective method to mitigate downstream costs
  – Eliminate non evidence based (marketing) benefits
    • PSA testing, Cough mixtures etc.
  – Revise and align (to health policy) Annexure C
    • exclusions

Within control of Regulator and Schemes
Information asymmetry

• Private healthcare is a complex system!
• Victim mindset when ill...”do/pay anything to get better”
• Lack of adequate knowledge
• Lack of adequate “informed consent”
• No published prices by service providers as required by CPA

This could be applicable to all stakeholders!
Claims for Health Services
Claims

Private health providers are NOT more efficient, accountable or medically effective (than public sector) by Anna Marriott 2009, Oxfam

Further supported by:
Hospital Claims
Claims

• Hospitals
  – Additional reference:
    • August 2007, Carte Blanche video

– Rebates
  • Suppliers price R10
  • Nappi price published R20
  • Off invoice discount/rebate R10
Medical scheme claims per beneficiary (2010 prices) from 1981 to 2010

Prof. A vd Heever, Medical Schemes Report
Sharp increases in costs from 2000-2005, stable from 2006-2008, sharp increases 2009-2012,
‘99 annual increases (%) for Hospitals

<table>
<thead>
<tr>
<th>Service</th>
<th>% Increase</th>
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<tr>
<td>Ambulance</td>
<td>8</td>
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<tr>
<td>Dental</td>
<td>8</td>
</tr>
<tr>
<td>Biokin.</td>
<td>5</td>
</tr>
<tr>
<td>Homeopath</td>
<td>5</td>
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<td>Physio</td>
<td>6</td>
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<tr>
<td>Medical Pr</td>
<td>8</td>
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<td>Anaes</td>
<td>13</td>
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<tr>
<td>Path</td>
<td>11.9</td>
</tr>
<tr>
<td>Wards</td>
<td>14</td>
</tr>
<tr>
<td>Maternity</td>
<td>20</td>
</tr>
<tr>
<td>Mental health</td>
<td>20</td>
</tr>
<tr>
<td>Rehab</td>
<td>8</td>
</tr>
<tr>
<td>Day clinic ward</td>
<td>15</td>
</tr>
<tr>
<td>Emergency units</td>
<td>20</td>
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<tr>
<td>Specialised wds</td>
<td>20</td>
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<tr>
<td>Eximer lazer th</td>
<td>8</td>
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<tr>
<td>Minor &amp; special th</td>
<td>30</td>
</tr>
<tr>
<td>Major th</td>
<td>31.2</td>
</tr>
<tr>
<td>Procedure &amp; equipment</td>
<td>33</td>
</tr>
<tr>
<td>Day clinic th</td>
<td>16</td>
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<tr>
<td>Gases</td>
<td>8</td>
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<tr>
<td>Oxygen etc</td>
<td>16</td>
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<td>Blood collection</td>
<td>20</td>
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<table>
<thead>
<tr>
<th>Year</th>
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<tr>
<td>2000</td>
<td>4.5</td>
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<td>2001</td>
<td>8-11</td>
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RSOB Meds & Materials: wording change to NAP
Early Analysis

Device and Medicine Cost increase rather than decrease

BHF. Dr. Herc Hoffman. 2002
NAP progress

• 2004
  – Single Exit Price regulations for Medicine
  – Response by Hospitals:
    • Fee adjustment for loss of profit (4-5%) by some hospitals

• 2008
  – Added further ±6% to facility/tariff fee for NAP
  – Effective 13% increase
Double Dip estimate

- 2012: R37.6B paid to hospitals
- Tariff Items: 70%
  - R26.32B
- Double dip re-adjustment (where applicable, some exceptions)
  - = Tariff-(Tariff x (100/((100%+5%)+6%)))
  - =R2.45B
- 4.7%-10% discounting should be applied to tariff and alternate re-imbursements
- R2.5B x 15 years = R37B in 2013 money terms
- No repentance; no willingness to do the right thing!
UK Competition Enquiry

Competition Markets Authority's (CMA's) final report on its investigation into privately funded healthcare services in the UK estimated that the market power of the UK's three biggest private hospital groups - Netcare's joint-venture BMI Healthcare, HCA and Spire - resulted in a consumer detriment of £115m-£174m a year between 2009 and 2011, equivalent to about 10 percent of the private revenue of these firms.
Adjusted effect of Network on hospitalisation cost (2004-2006)
Age has been adjusted

Price does matter!
Followup study

- Similar study using current cost in progress.
- Will be made available when completed...Soon.
Life: Unusual itemized billing
Joint replacement

AGE MODIFIER
300.0 @ R3.69
MULTI DAY SURGERY
1.0 @ R1993.00
THEATRE PER 15 MIN
7.0 @ R2114.00
GENERAL WARD
2.0 @ R2389.00
HIGH CARE WARD
3.0 @ R7901.00

LIFE FAERIE GLEN HOSPITAL
T/A LIFE FAERIE GLEN HOSPITAL
Reg.No.96/16745/07
# 2013 average costs

<table>
<thead>
<tr>
<th></th>
<th>Funder</th>
<th>Life</th>
<th>Mediclinic</th>
<th>Netcare</th>
<th>NHN</th>
<th>DoH</th>
<th>NAMAF</th>
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<td><strong>C/Section</strong></td>
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<tr>
<td><strong>A</strong></td>
<td></td>
<td>24 373</td>
<td>25 293</td>
<td>25 249</td>
<td>24 981</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>B</strong></td>
<td></td>
<td>22938</td>
<td>22671</td>
<td>23583</td>
<td>22487</td>
<td>15379</td>
<td>21431</td>
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<tr>
<td>Per Diem</td>
<td></td>
<td>127.4%</td>
<td>97.3%</td>
<td>95.5%</td>
<td>97.2%</td>
<td>67.6%</td>
<td>82.3%</td>
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<tr>
<td><strong>C</strong></td>
<td></td>
<td>26107</td>
<td>21447</td>
<td>25144</td>
<td>27325</td>
<td>19810</td>
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<td><strong>D</strong></td>
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<td>23579</td>
<td>22991</td>
<td>24385</td>
<td>21244</td>
<td>7510</td>
<td></td>
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<tr>
<td><strong>V Delivery</strong></td>
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<td><strong>A</strong></td>
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<td>14 188</td>
<td>14 611</td>
<td>15 913</td>
<td>14 066</td>
<td></td>
<td></td>
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<tr>
<td><strong>B</strong></td>
<td></td>
<td>14679</td>
<td>14605</td>
<td>14331</td>
<td>13922</td>
<td>9618</td>
<td>12821</td>
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<tr>
<td>Per Diem</td>
<td></td>
<td>121.9%</td>
<td>83.2%</td>
<td>92.8%</td>
<td>111.4%</td>
<td>68.4%</td>
<td>91.2%</td>
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<tr>
<td><strong>C</strong></td>
<td></td>
<td>17202</td>
<td>17057</td>
<td>18488</td>
<td>16848</td>
<td>15656</td>
<td></td>
</tr>
<tr>
<td><strong>D</strong></td>
<td></td>
<td>13593</td>
<td>13990</td>
<td>14973</td>
<td>11858</td>
<td>4730</td>
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<tr>
<td><strong>Cataracts</strong></td>
<td></td>
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<tr>
<td><strong>A</strong></td>
<td></td>
<td>9 293</td>
<td>9 431</td>
<td>10 129</td>
<td>11 408</td>
<td></td>
<td></td>
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<tr>
<td><strong>B</strong></td>
<td></td>
<td>9209</td>
<td>10736</td>
<td>9948</td>
<td>9847</td>
<td>4440</td>
<td>11507</td>
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<td></td>
<td>?Including prosthesis</td>
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<tr>
<td><strong>C</strong></td>
<td></td>
<td>8328</td>
<td>8477</td>
<td>9753</td>
<td>11222</td>
<td>6674</td>
<td></td>
</tr>
<tr>
<td><strong>D</strong></td>
<td></td>
<td>8557</td>
<td>9312</td>
<td>10394</td>
<td>10240</td>
<td>6655</td>
<td></td>
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</tbody>
</table>

**NHN exemption by CC:**
Apparently Inflationary effect

A+C: Smaller schemes
B+D: Larger group
Day admissions

• Day clinic (Dis 77) fees are less than fees charged for day admissions by Hospitals (57/58)

• Anomaly must be addressed!

• Dis 57/58 hospitals must be paid same as that of Day Clinics for the same type of service
Private Hospital Market concentrated

Percentage of total acute beds

Life  Medi-Clinic  Netcare  Independent
Market concentration

• Based on Section 4(1)a of Competition Act (2009) Private hospital groups are a complex monopoly
  – Control >75% trade/services by <5 players
  – Competition Tribunal allowed mergers to take place in the early 2000s

• Market concentration and domination by few since 2004
Allegations of coercion/strong arm tactics during price negotiation

• ...against some hospital groups
  – “double digit increase if we not put on your DSP list”
  – “Bulldog tactics”

• Fragmented funding industry: balance of power
“In 2012, 36.7B of premiums went to Hospitals, an annual increase of 8.5% after inflation”

Prof. Alex vd Heever
Sept. 2013
Anthony Felet, Duncan Lishman and Fatima Fiandeiro, Do Hospital mergers lead to healthy profits?

Source: Calculations using Netcare financial statements (1997-2011) and Mediclinic financial statements (1988-2011)
Anthony Felet, Duncan Lishman and Fatima Fianceiro, Do Hospital mergers lead to healthy profits?
Private Hospital Distribution:
Licenses follow the money, not need for access

<table>
<thead>
<tr>
<th>Provinces</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gauteng</td>
<td>26.5%</td>
</tr>
<tr>
<td>Western Cape</td>
<td>24.4%</td>
</tr>
<tr>
<td>Free State</td>
<td>16.8%</td>
</tr>
<tr>
<td>KwaZulu Natal</td>
<td>15.7%</td>
</tr>
<tr>
<td>North West</td>
<td>14.7%</td>
</tr>
<tr>
<td>Mpmum alanga</td>
<td>14.6%</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>13.6%</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>12.1%</td>
</tr>
<tr>
<td>Limpopo</td>
<td>8.6%</td>
</tr>
</tbody>
</table>

South Africa: 17.6%

Certificate of Need: Proclaimed April 2014. Awaiting regulations
Private bed distribution

- chase where the money is (Gauteng and WC)
  - Not where the need is!
Claims

• Hospitals
  – Effect of vertical integration
    • 2002: Medicross purchased by Netcare
      – increase hospital referrals to Netcare
    • Netcare 911, ER24
    • Dialysis units
  – Alternate re-imbursements
    • Lack of standardised trim points for outliers
    • Lack of standardised groupers
    • Slow progress on National Coding Standards
  – Public sector not a worthy competitor at this stage
    • Promote payments
    • Need to address revenue retention policy by provinces
    • Differentiated amenities and role of funders
    • Revise UPFS billing structure
If the very underutilised minor theatre was excluded from the analysis, overall utilisation rose to 48%.

Hartmann D, Sunjka B. Private theatre utilisation in SA: A case study. SAMJ. May 2013, Vol 103, no.5
Recommendations

• Private hospital groups based on Section 4(1)a of Competition Act (2009) – complex monopoly
  – Control >75% trade/services by <5 players
  – Competition Tribunal allowed mergers to take place in the 2000s
• Effect of Group on pricing must be neutralized
  – Seriously consider unbundling!
• Need for coding and price standardization, including downward adjustment for double-dip!
  – Up to 10%
• Alternate re-imbursements
  – Comments provided; BHF has done some work on trim points
• Public sector as a worthy competitor (UPFS needs fixing)
• NHA: Certificate of need recently promulgated: urgent need for regulations
UNU-Case Based Groups (CBGs) - public domain

• Open source casemix grouper for developing countries

• ICD10/ICD9-CM
  – ICD9-CM/CPT crosswalk required

• Need for research in SA

• Trim points

• Case mix as a basis for remuneration!
Claims: Device Suppliers
Role of device suppliers

NAPPI Prices: Nett. Acquisition Price (misrepresented) -

- Rebates
  - Suppliers price R10
  - Nappi price published R20
  - Off invoice discount/rebate R10

- Nappi price listing, with Medikredit, as Nett Acquisition Price by Device Supplier
Claims: Device suppliers

- Device suppliers initial response to rebate exposure in 2007

<table>
<thead>
<tr>
<th>Medikredit</th>
<th>4 Jan 2008</th>
</tr>
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<tbody>
<tr>
<td>Number of Products with a Price Reduction</td>
<td>1739 (out of &gt;90000)</td>
</tr>
<tr>
<td>Average % Reduction</td>
<td>-22%</td>
</tr>
</tbody>
</table>
Claims: Device suppliers
Price movements: Aug 2007 to June 2008

• Products in existence for the entire period (90k device items)
  – Increases 48%
  – Decreases 5.8%
  – Incr. & Decr. 4.1%

• New device items 19k+
  • ???Old product....re-registered as new

• In-hospital NAP changes ...with double dip

• NAP prices outside of hospitals is not addressed!!!!
  • Approximately R1B
# 2012 NAP as shared by hospitals

<table>
<thead>
<tr>
<th>Nappi Name</th>
<th>Nappi list price</th>
<th>NHN</th>
<th>Netcare</th>
<th>Mediclinic</th>
<th>Life</th>
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</thead>
<tbody>
<tr>
<td>JELCO CATHETER IV PINK 20G</td>
<td>42,96</td>
<td>20,47</td>
<td>3,96</td>
<td>4,79</td>
<td>5,19</td>
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<tr>
<td>STERICAN NEEDLES 21G GREEN</td>
<td>1,59</td>
<td>0,80</td>
<td>0,21</td>
<td>0,20</td>
<td>0,17</td>
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<td>K Y JELLY SACHETS</td>
<td>6,22</td>
<td>4,87</td>
<td>0,91</td>
<td>1,02</td>
<td>1,27</td>
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<td>W3208 SUTURE</td>
<td>171,49</td>
<td>170,44</td>
<td>72,21</td>
<td>126,82</td>
<td>96,17</td>
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<td>0,74</td>
<td>0,77</td>
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<td>WEBCOL ALCOHOL SWABS</td>
<td>0,18</td>
<td>0,21</td>
<td>0,08</td>
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<td>0,18</td>
</tr>
<tr>
<td>ACCU-CHEK ACTIVE STRIPS</td>
<td>2,58</td>
<td>3,40</td>
<td>1,98</td>
<td>3,33</td>
<td>1,94</td>
</tr>
</tbody>
</table>
Claims: Device suppliers

• Devices
  – Device supplier: Continue to misrepresent Nappi prices
  – Ongoing rebate practice
  – Rebates impact: *approx R1B outside hospital*
  – Double dip by hospitals

NAP: Nett Acquisition Price
Claims: Device suppliers

• Devices
  – Device companies and its representative body must explain the continued distorted NAPPI list pricing and apparent misrepresentation

  – BHF’s Dr. Rajesh Patel was verbally informed (October 2007) by SAMED that coercion played a role!

  – SAMED must explain coercive events of 2007
Claims: Device suppliers

• Devices: distorted NAP (retail price) listing by device companies
  – **Regulatory offence**
    • Consumer Protection Act
      – BHF nor Medical Schemes cannot lodge complaint (apply for exemption
      – CC other: limit resources to investigate
    • “trade practice” – Competition act
      – “Abuse of dominance”: effect of coercion
    • Criminal: ?fraud – price misrepresentation
Claims: Device suppliers

• NAPPI Price misrepresentation:
  • CC, CC other, Hawks, Commercial Crimes: role to protect the public
  • Initiate investigation/enquiry!
  • CC Enquiry is urged to recommend that Consumer Commissioner/Hawks intervenes in NAPPI list price apparent misrepresentation by device suppliers, and billing by health service providers including that of hospitals
  • Allegations: Investigate apparent diversion of rebates to other accounts (artificial increase in the cost of purchase and service delivery)

• Role of Auditors: before and after 2007 exposure!
• IDC: funding of device companies for job creation at the expense of public exploitation (small part)
Medicines
• Prices in Africa, cheaper than SEP
  – Decrease generic prices in SA; too expensive!
    • Example of anaesthetic gas
  – Research appropriateness or otherwise the marketing costs of pharma: more regulatory intervention needed
  – Logistic fee to retailers cum wholesalers (?coercion allegations)

• Price regulation
  • P/E
  • International benchmarking
Medicine Claims

• Review drug funding policy
  – Change PMB medicine benefit and funding to EML
  – Incr. Generic use
    • Application to Cancer benefits (funders)
  – Promote therapeutic switching
  – Access to Biologicals at state tender prices through centres of excellence
  – Funding for the lowest price rather than MMAP?
Medicine Claims

• Medicine benefit considerations for funders
  – Tiered funding
    • EDL
      – formulary, generic or min. Pricing (100%)
      – non formulary, generic
      – ethical.
    • Non EDL
      – Generic
      – ethical
      – new
  – Co-pay not aligned to social funding philosophy!
    • Carrot or stick
Specialist and other provider costs
• Code x RVU x Utilisation = Cost
“23.3% went to specialists, an annual increase of 10.3% after inflation”

Prof. Alex vd Heever
Sept. 2013
BHF analysis of specialist claims
2008-2012

Specialist costs

- CPI 5-6%
- Provider tariff adj. Mostly CPI+1%
- Medical CPI 9-10%
- Specialist (medical and dental but excluding radiologist and pathologist) inflation: average 15-18% pa. from 2008-2012
  - Effect is more than can be explained by tariff and health and demographic factors
## ITAP Inflation Committee

<table>
<thead>
<tr>
<th></th>
<th>Weighted average</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan mix</td>
<td>2.05%</td>
<td>3.51%</td>
</tr>
<tr>
<td>Demographic impact</td>
<td>1.52%</td>
<td>1.86%</td>
</tr>
<tr>
<td>Residual utilisation</td>
<td>1.05%</td>
<td>3.19%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4.61%</strong></td>
<td><strong>2.83%</strong></td>
</tr>
</tbody>
</table>

### RESIDUAL UTILISATION

**broken down by discipline**

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Weighted average</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>0.37%</td>
<td>4.09%</td>
</tr>
<tr>
<td>Specialists</td>
<td>4.70%</td>
<td>5.30%</td>
</tr>
<tr>
<td>GPs</td>
<td>-1.93%</td>
<td>10.06%</td>
</tr>
<tr>
<td>Pathology</td>
<td>3.60%</td>
<td>4.12%</td>
</tr>
<tr>
<td>Radiology</td>
<td>3.00%</td>
<td>3.80%</td>
</tr>
<tr>
<td>Medicine</td>
<td>-0.47%</td>
<td>5.17%</td>
</tr>
<tr>
<td>Other disciplines</td>
<td>1.36%</td>
<td>4.87%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1.05%</strong></td>
<td><strong>3.19%</strong></td>
</tr>
</tbody>
</table>

**Source:** Preliminary results of ITAP Inflation Committee
Presented on 7 March 2013
PMB claims – trends

General surgeons

Spend per life per month. Not adjusted for inflation.
PMB claims – trends

Spend per life per month. Not adjusted for inflation.
PMB claims – anaesthetist behaviour

Charges as % tariff for 10 of the largest anaesthetist practices in South Africa Health Monitor. BHF Conference 2013.
Challenges - PMB claims paid higher than Scheme rate

Source: GEMS Presentation at CMS Indaba on 1 March 2013, Cape Town
Unfortunate role of CMS

• in driving up specialist cost for PMB (Regulation 8)
  – Office of Registrar forcefully implementing one opinion of 2 differing opinions of the appeal committee. Different opinions not resolved!
  – Circular 56 of 2010
  – Decision of appeal committee does not set precedence! Appeal committee is not Higher court.
  – Appeal committee did not consider legitimacy of codes invoiced. (maybe not included in arguments)
Regulation 8 problem:

- Mainly specialists claims!
- Section 32 of MSA has context and has been ignored!
  - Legislation vs Regulation
Specialist cost driver

Effect of HPCSA ethical rule

– History

– Specialist as primary care suppliers
  • General physicians, Paediatrics, O&G, Surgeons etc

– Price inefficiency (next slide)

– Inconsistent with Government policy

– Erosion of GP role, and consequent revenue dilution for GPs

– Reluctance by office of HPCSA to address
Effect of HPCSA ethical rule

• Gynae Acc for Pap (Check-up)
  – Price inefficiency
    • Pap smear (2013 scheme rates & single specimen)
      – Nurse <R350
      – GP R450
      – O&G R1600 (including sonar)
    – CMS office interpretation of Reg8 compounds claim liability

<table>
<thead>
<tr>
<th>Date</th>
<th>Reference</th>
<th>Patient</th>
<th>DR Mod Code</th>
<th>Qty</th>
<th>Original M/A Portion</th>
<th>Member Liab</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>17/01/2014</td>
<td>092.6-&gt; 0191 FIRST VISIT</td>
<td>0191</td>
<td>81090</td>
<td>1.00</td>
<td>1160.00</td>
<td>0.00</td>
<td>1160.00</td>
</tr>
<tr>
<td>17/01/2014</td>
<td>092.6-&gt; PELVIC ORGAN SCAN</td>
<td>0191</td>
<td>5100</td>
<td>1.00</td>
<td>1224.00</td>
<td>0.00</td>
<td>2205.00</td>
</tr>
<tr>
<td>17/01/2014</td>
<td>092.6-&gt; 4692859003 DISP GLOVE</td>
<td>0191</td>
<td>0201</td>
<td>1.00</td>
<td>4.00</td>
<td>0.00</td>
<td>2209.00</td>
</tr>
<tr>
<td>17/01/2014</td>
<td>092.6-&gt; 617762*002 SPECULUM</td>
<td>0191</td>
<td>0201</td>
<td>1.00</td>
<td>17.50</td>
<td>0.00</td>
<td>2226.50</td>
</tr>
<tr>
<td>17/01/2014</td>
<td>092.6-&gt; 735531865 KY CREDIT CARD</td>
<td>0191</td>
<td>0201</td>
<td>1.00</td>
<td>2.50</td>
<td>0.00</td>
<td>2229.00</td>
</tr>
</tbody>
</table>

V.A.T. of R273.74 included
Effect of HPCSA ethical rule (2013)

New Born Assessment

• Utilisation
  – GP 11%
  – Paed 89%

• Cost
  – GP R528
  – Paed R697

Circumcision

• Procedures: GP 57%, Specialist 43%
• Prof fee: GP R650, Specialist R1000
• Total Costs with Hosp: GP 38%, Specialist 62%
• Inefficiency: If GP does all: 25% total cost reduction; more if GP does all in rooms!
<table>
<thead>
<tr>
<th>Procedure code(s):</th>
<th>Procedure code description:</th>
</tr>
</thead>
<tbody>
<tr>
<td>0614</td>
<td>Arthroplasty: Debridement large joints</td>
</tr>
<tr>
<td>0592</td>
<td>Synovectomy: Large joint</td>
</tr>
<tr>
<td>0646</td>
<td>Knee: Total replacement</td>
</tr>
<tr>
<td>0497</td>
<td>Resection of bone or tumour with or without grafting (benign)</td>
</tr>
<tr>
<td>0755</td>
<td>Muscle and tendon repair: Infrapatellar of quadriceps tendon</td>
</tr>
<tr>
<td>0831</td>
<td>Knee: Open tenotomy</td>
</tr>
<tr>
<td>0829</td>
<td>Knee: Quadriceps plasty</td>
</tr>
<tr>
<td>0009</td>
<td>Assistant: The fee for an assistant is 20% of the fee for the specialist surgeon, with a minimum of 36,00 clinical procedure units. The minimum fee payable may not be less than 36,00 clinical procedures units</td>
</tr>
</tbody>
</table>
## Surgery for “Shoulder Pain”

<table>
<thead>
<tr>
<th>Procedure code(s):</th>
<th>Procedure code description:</th>
</tr>
</thead>
<tbody>
<tr>
<td>0667</td>
<td>Arthroscopy (excluding after-care) (modifiers 0005 and 0013 not applicable)</td>
</tr>
<tr>
<td>0614</td>
<td>Arthroplasty: Debridement large joints</td>
</tr>
<tr>
<td>0615</td>
<td>Arthroplasty: Excision medial or lateral end of clavicle</td>
</tr>
<tr>
<td>0617</td>
<td>Shoulder: Acromioplasty</td>
</tr>
<tr>
<td>0497</td>
<td>Resection of bone or tumour with or without grafting (benign)</td>
</tr>
<tr>
<td>0853</td>
<td>Excision: Small bursa or ganglion</td>
</tr>
<tr>
<td>0661</td>
<td>Aspiration of joint or intra-articular injection (not including after-care) (modifier 0005 not applicable)</td>
</tr>
</tbody>
</table>

**Mx Care Interventions:** Member co-payments for unauthorized & payments rejections
Solution to protect member: HPCSA complaint
Nasoplasty for Boxer (cosmetic and functional component)  
ENT & plastic surgeon

<table>
<thead>
<tr>
<th>Procedure code(s):</th>
<th>Procedure code description:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1085</td>
<td>Total Nasal Reconstruction</td>
</tr>
<tr>
<td>0293</td>
<td>Contour Graft to the dorsum</td>
</tr>
<tr>
<td>0507</td>
<td>Harvesting of Cartilage</td>
</tr>
<tr>
<td>Rule J</td>
<td>In view of the complexity of this surgery</td>
</tr>
<tr>
<td>1022</td>
<td>Functional reconstruction of nasal septum</td>
</tr>
<tr>
<td>1030 x 2</td>
<td>Endoscopic turbinectomy: Laser or microdebrider</td>
</tr>
</tbody>
</table>

Duplicate codes
Appears to be routinely included on bills
Xray/CT apparently does not support this intervention
## Duplicate billing: lack of proper guide to billing

<table>
<thead>
<tr>
<th>Claim No</th>
<th>Account No</th>
<th>Date From</th>
<th>Time From</th>
<th>Date To</th>
<th>Time To</th>
<th>Patient</th>
<th>Price Code</th>
<th>Mod X</th>
<th>Unit</th>
<th>Cost</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0000028 0001 73</td>
<td>04/08/14</td>
<td>04/08/14</td>
<td>12 DEMI A</td>
<td>TR1101</td>
<td>5</td>
<td>1.00</td>
<td>Tonsillectomy (dissection of the tonsils)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0000028 0002 73</td>
<td>04/08/14</td>
<td>04/08/14</td>
<td>12 DEMI A</td>
<td>TR2799</td>
<td>1.00</td>
<td></td>
<td>Procedures for pain relief; intrathecal injections for</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0000028 0003 73</td>
<td>04/08/14</td>
<td>04/08/14</td>
<td>12 DEMI A</td>
<td>TR1105</td>
<td>1.00</td>
<td></td>
<td>Removal of adenoids</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0000028 0004 73</td>
<td>04/08/14</td>
<td>04/08/14</td>
<td>12 DEMI A</td>
<td>TR2799</td>
<td>1.00</td>
<td></td>
<td>Procedures for pain relief; intrathecal injections for</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0000028 0005 73</td>
<td>04/08/14</td>
<td>04/08/14</td>
<td>12 DEMI A</td>
<td>TR1052</td>
<td>1.00</td>
<td></td>
<td>Instrumental exam nasopharynx incl</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0000028 0006 73</td>
<td>04/08/14</td>
<td>04/08/14</td>
<td>12 DEMI A</td>
<td>TR2799</td>
<td>1.00</td>
<td></td>
<td>Procedures for pain relief; intrathecal injections for</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0000028 0007 73</td>
<td>04/08/14</td>
<td>04/08/14</td>
<td>12 DEMI A</td>
<td>TR5209</td>
<td>1.00</td>
<td></td>
<td>Myringotomy: Bilateral</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0000028 0008 73</td>
<td>04/08/14</td>
<td>04/08/14</td>
<td>12 DEMI A</td>
<td>TR2799</td>
<td>1.00</td>
<td></td>
<td>Procedures for pain relief; intrathecal injections for</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total: $1,759.25
Anaesthetist coding unbundling

- New codes: severity carve out
  - Trend over numerous years
- Codes not inappropriate into scope of practice e.g.
  - Neonate
  - Obesity
  - Critically ill

**Method of implementation leads to cost add-on because procedure fee not reduced after carve-out**

Majority claims charged at 200-300% of scheme rate (70+%)
Specialist cost

- Pathology (4-5% of MS payout; R6B+ for all private revenue)
  - Forms
    - Lack of HPCSA response to complaint in 2006. Lack of action to its task team recommendations.
    - Implementation could save up to R0.4B overnight
  - Coding anomalies
    - Redundant codes and misuse for new tech
    - Duplicate codes
    - Code bundling e.g. U&E, mod. Lipogram (some charging for calculated LDL)
  - Point of care testing entry into market
    - Currently lab prices charged
  - Role of MP:
    - Completeness of clinical info on form
    - Ordering unnecessary tests (biggest contributor to cost)
  - Pathologist: default Z coding....may prejudice member’s access to PMB benefit
## Pathology lab prices 2007

<table>
<thead>
<tr>
<th>Test</th>
<th>Med Aid</th>
<th>Cash</th>
<th>% Difference</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>FBC/Platelet, ESR</td>
<td>121.30</td>
<td>59</td>
<td>51</td>
<td>±25</td>
</tr>
<tr>
<td>HbA1c</td>
<td>109</td>
<td>78</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>U&amp;E Creatinine</td>
<td>150</td>
<td>94</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>HIV ab Elisa</td>
<td>108.70</td>
<td>70</td>
<td>35</td>
<td></td>
</tr>
</tbody>
</table>

NPG: Prices for the indigent.
±2007 Netcare Financials

- Ampath: subsidiary of Netcare
- Netcare was asked to selloff Ampath
- Net profit margin: 25%
- Extrapolate:
  - R7m profit per registered pathologist
  - Excludes salary earned
    - Locum income estimate <R1m

Above: included in BHF submission to RPL process
Specialist cost

• Oncology
  – Increasing incidence & longer survival
  – Revise “facility based codes” fees
    • Introduced to circumvent effect of SEP and dispensing fee regulation
  – PMB benefit (needs review)
    • Not consistent with current practice; vague benefit entitlement

– Recommend Hospital EDL for meds
– Promote and fund generics
– Biologics
  • Fund through centers of excellence (Public sector)
  • Should be funded at tender prices
Specialist costs

- Unchecked entry of new technology
- Coding and Billing for new technology in an absence of any framework
  - Problem with rule C
Specialist cost

• Problem with
  – Codes and unbundling
  – Fees RVU
  – CMS/HPCSA Act and Regulations

• HPCSA responsible for Scope of Practice and thus coding related to it, without trivializing NHA chapter 9.

• “Market failure”: Need regulated prices to protect public!
Specialist cost

• Clean up coding by regulatory bodies
  – Align coding with scope of practice
  – Uncontrolled unchecked entry of new and or high technology

• Split billing practice (illegal practice)
  – Role of HPCSA (HPCSA advised of some practices)
  – Role of medical aids
    • To educate members
    • Encourage submission of all healthcare related claims/receipts
GPs: Problem of revenue

- Early 1990s to 2010
  - 200% increase in GPs (PCNS)
  - 22% increase in medical aid lives
  - 22% increase in SA population

- Patient dilution (40%)
  - Gauteng av: 16/day (MFamMed study)
  - Av per day 24-32 (3-4/hr)

- GP: Lives 1:2500
  - Assuming 16m served by private GPs
  - Need 6400 GPs
  - PCNS: 12,000+

2010. R Patel, BHF
Optometry costs

• Essential service for activity of daily living
• Optometry (2007)
  – Frames: R50-R150 wholesale, sold for R500-R1200
  – 50% cash discount to medical aid pricing
  – Buy one get one free
  – Problem mainly with frames and lens pricing
• Dec 2013
  – MA quote: R2700+
  – Cash price: R1900 (including “generic transitions” and frames R500)
Other Areas

• Dialysis
  – Artificially expensive
  – consider device NAPPI pricing effects
  – Role of hospital groups (ownership)
  – Quality of dialysis centers in outlying areas and small practices
Quality of care
Quality of Care

• Code x RVU x Volume
• Higher utilization of expensive referred care is often due to poor ongoing outpatient care!

• Warranties and CPA do not offer financial protection for adverse outcomes related to substandard care!
  – General lack of accountability
## Screening 2010/2011

<table>
<thead>
<tr>
<th>Service</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammogram coverage (2 years) (50-74 years)</td>
<td>20.2</td>
<td>25.7</td>
</tr>
<tr>
<td>Cervical Cytology coverage (3 years) (20-65 years)</td>
<td>29.9</td>
<td>36.6</td>
</tr>
<tr>
<td>Colorectal cancer screening age &gt;= 50</td>
<td>2.9</td>
<td>3.1</td>
</tr>
<tr>
<td>Dentistry consultations &gt; 2 years</td>
<td>21.5</td>
<td>33.3</td>
</tr>
<tr>
<td>TSH coverage for new borns</td>
<td>22.4</td>
<td>24.8</td>
</tr>
<tr>
<td>Circumcision &lt; 1 years %</td>
<td>1.6</td>
<td>1.7</td>
</tr>
<tr>
<td>Glaucoma screening &gt;= 65</td>
<td>17.1</td>
<td>17.1</td>
</tr>
<tr>
<td>Bone density coverage</td>
<td>4.9</td>
<td>4.9</td>
</tr>
<tr>
<td>Flu vaccine coverage age &gt;= 65</td>
<td>8.8</td>
<td>16</td>
</tr>
<tr>
<td>Pneumococcal coverage &gt; 65</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Hypertension - Consultation</td>
<td>3.9/1.1</td>
<td>3.9/1.1</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Hypertension - cholesterol</td>
<td>29.9</td>
<td>30.2</td>
</tr>
<tr>
<td>Hypertension - creatinine</td>
<td>37.9</td>
<td>39.7</td>
</tr>
<tr>
<td>Hypertension - ECG</td>
<td>23.6</td>
<td>23.4</td>
</tr>
<tr>
<td>Hypertension - admission for stroke (CVA)</td>
<td>3.5</td>
<td>3.7</td>
</tr>
<tr>
<td></td>
<td>2010/2011</td>
<td>2011/2012</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>IHD - consultations</td>
<td>3.2/1.5</td>
<td>3.3/1.5</td>
</tr>
<tr>
<td>IHD - Aspirin coverage</td>
<td>69</td>
<td>69.3</td>
</tr>
<tr>
<td>IHD - Beta blockers</td>
<td>48.7</td>
<td>49.1</td>
</tr>
<tr>
<td>IHD - cholesterol tests</td>
<td>45.9</td>
<td>46.5</td>
</tr>
<tr>
<td>IHD - flu coverage</td>
<td>7.1</td>
<td>14.6</td>
</tr>
<tr>
<td>IHD - Statin meds</td>
<td>78.5</td>
<td>78.4</td>
</tr>
</tbody>
</table>
Diabetes: 2007 and CDE
Not Case-mix adjusted!

CDE: n =13312; 7-10% of FFS Diabetics
Substandard Care: 1:4
Quality of care

• C section 70% (2012)
  – Reproduction: physiological process
    • Care: Midwifes and GPs
  – Unashamedly, physiological process made into pathology
  – Obstetrician C/S fee represents “over-remuneration”
    • An O&G practitioner/leader
  – Public demand (majority) vs medical necessity
C/Section interesting observation: one funder

% of C/S cases

% of Neonate ICU admissions
Quality of care

• C section 70% (2012)
• High frequency event thus cost driver
  • Major revenue generator for hospitals
• Hospital cost is ±60% higher than that of Vaginal delivery
  – Maternity: 40 per 1000 females
    • R250-450m unnecessary expenditure
Proxy Medicine Compliance %

**HIV Proxy Compliance %**

- 2000: 38%
- 2001: 39%
- 2002: 56%
- 2007: 38%

**Compliance by Age Group**

<table>
<thead>
<tr>
<th>Claim Year</th>
<th>00-04</th>
<th>05-14</th>
<th>15-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65-74</th>
<th>&gt;75</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Chronic Condition**

<table>
<thead>
<tr>
<th>Chronic Condition</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ankylosing Spondylitis</td>
<td>48%</td>
<td>101%</td>
<td>45%</td>
<td>49%</td>
</tr>
<tr>
<td>CAD</td>
<td>62%</td>
<td>69%</td>
<td>66%</td>
<td>67%</td>
</tr>
<tr>
<td>CCF &amp; CMO</td>
<td>36%</td>
<td>65%</td>
<td>72%</td>
<td>62%</td>
</tr>
<tr>
<td>Chronic Glaucoma</td>
<td>52%</td>
<td>61%</td>
<td>57%</td>
<td>65%</td>
</tr>
<tr>
<td>Diabetes Mellitus Type 1 and 2</td>
<td>49%</td>
<td>55%</td>
<td>52%</td>
<td>49%</td>
</tr>
<tr>
<td>GERD</td>
<td>44%</td>
<td>42%</td>
<td>56%</td>
<td>41%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>67%</td>
<td>78%</td>
<td>70%</td>
<td>66%</td>
</tr>
<tr>
<td>Hypothyroidism</td>
<td>60%</td>
<td>74%</td>
<td>69%</td>
<td>68%</td>
</tr>
<tr>
<td>Rheumatoid Arthritis</td>
<td>32%</td>
<td>63%</td>
<td>59%</td>
<td>55%</td>
</tr>
<tr>
<td>Systemic Lupus Erythematosis</td>
<td>84%</td>
<td>76%</td>
<td>43%</td>
<td>48%</td>
</tr>
</tbody>
</table>
Quality of care

• Review treatment guideline communication
• Promote accountable funding
  – Funders: emphasis on health governance
  – Providers: P4P (with withhold)
  – Role of managed health care
• Regulator (CMS/Professional Councils)
  – Lack of stewardship
  – Standardised HC reporting (NSDA)
  – Emphasis on quality
Regulatory Impediments
Regulatory Impediments

• Medical Scheme Act & Regulations
Regulatory Impediments

• Medical Scheme Act & Regulations
  – 25% reserving (inefficient)
    • Currently about R10B unnecessary capital and blocked.
    • Consider risk based reserving research & policy consideration
      – Recent proposal by ITAP
    • CMS refuse to entertain industrywide research through the ITAP process.
  – Absence of mandatory membership of higher earning younger population
    • Demographic double hump profile

(Above two could reduce contribution by at least 15%: why no policy review?)
Regulatory Impediments

• Medical Scheme Act & Regulations
  – Current problematic PMBs
    • Poorly structured and unconstitutional content!
      – Diagnosis and severity based (ill-defined), limited set of conditions
    • Regulated benefit with regulated price!
      – With Reg.8: unintended limitless liability
    • Regulation 8 to be address based on point 2 above
    • Lack of price certainty make PMB less affordable, particularly for lower income earners (No income cross subsidy)
Regulation 8 and upcoding PMB Impacts as % contributions

PMB impact on **in-hospital** claims

<table>
<thead>
<tr>
<th></th>
<th>Non-PMB</th>
<th>PMB</th>
<th>Weighted</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Actual increase</strong></td>
<td>-8.0%</td>
<td>11.5%</td>
<td>10.2%</td>
</tr>
<tr>
<td><strong>Impact as % of contributions</strong></td>
<td>-0.56%</td>
<td>2.36%</td>
<td>1.79%</td>
</tr>
</tbody>
</table>
Regulatory Impediments

• Medical Scheme Act & Regulations
  – Consolidation of schemes and “benefit plans”
    • Benefit from efficiency of scale and cross subsidisation
    • Minimum number of beneficiaries: 3000
    • Volatility effects of small population
  
• Scheme consolidation but increase in plans/options
Regulatory Impediments

- Medical Scheme Act & Regulations

<table>
<thead>
<tr>
<th>Year</th>
<th>Lives</th>
<th>%</th>
<th>Broker fees R(m)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>7 020 223</td>
<td></td>
<td>230</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>8 679 473</td>
<td>23.64%</td>
<td>1,449</td>
<td>530.00%</td>
</tr>
</tbody>
</table>

- Review role of broker & re-imbursement policy
  - What service? Who benefits? Who should pay? What to pay?
Regulatory Impediments

• Medical Scheme Act & Regulations
  – Review non healthcare cost drivers
    • Review regulated maximum (should not be based on % of contribution)
  – Redefine role of managed healthcare
    • Cost saving tools or
    • QA and alternate re-imbursement
  – Absence of health impact reporting
    • Accountability for health and more governance entrenched into law
• Medical Scheme Act & Regulations
  – CMS submitted recommended changes to MSA
    • What was the 10 year vision?
    • What policies were formulated?
    • What was the level of consultation?
Regulatory Impediments

- **NHRPL:**
  - Study design flaws in cost methodology
    - Consultants should have addressed limitation by:
      - Data validation
      - Larger sample sizes
      - etc
  - Cost methodology used by CMS then NDoH
    - Underestimate work hours (40hrs)
      - Therefore overestimate cost input per hr.
      - “Health Professions Council (HPCSA) capped intern hours at 60hrs a week, 30 in one continuous shift, and 80 hours overtime a month.” (80 hours per week for interns)
  - Sample size requirement: NDoH accommodated low levels
- **Court case**
  - Technical flaws in process rather than methodology
  - Vacuum not filled immediately after court case
  - Most submission were flawed research – this does not change
Medical specialists unrealistic 300% of scheme rate demand!

Regulatory fee/negotiating forum could solve some of current problems!

Small group but large impact on cost
Regulatory Impediments

• Providers
  – HPCSA ethical rule that erode gatekeeper role of GPs
    • Result in inefficient care delivery (specialists as GPs) ; self directed referral
      – See earlier comments and examples
  – Lenient action taken against delinquents. No loss recovery with penalty imposed.
  – Oversupply of GPs and pharmacists in urban areas and scarcity in outlying areas
  – Role of unregulated agents “clearing houses” and “bureaus”. Lack of accountability by health professionals.
  – Dental therapist services on dentists account...billing misrepresentation!
  – Unregulated, fragmented and largely corporate owned emergency services!
Regulatory Impediments

• Providers
  • 6 professional Councils: need for alignment
  • One is Dental Technicians Council:
    – lack of accreditation and inspection of labs
    – Mostly private sector
    – Council publish fees: ?pervasive influences in fee determination
    – **Lack of quality of care monitoring by all Regulators! Re-active responses.**

  – Partner with public sector to become worthy competitor to private sector (UPFS needs some fixing)
    • Need to strengthen billing capacity
    • Move to ACG/DRG billing for hospitalisation and UPFS for outpatient and unclassified.
Regulatory Impediments

- Absent device regulation and perpetuation of rebate practice
  - Lack of action from CC and Consumer Council
  - CC: “trade practice” not defined
  - Regulators (CC &CC) requested to intervene; abuse is too great to ignore
  - Device suppliers must be held to account...
  - Source of coercion?

<table>
<thead>
<tr>
<th>Nappi Name</th>
<th>Nappi list price</th>
<th>Highest discount</th>
<th>Lowest discount</th>
</tr>
</thead>
<tbody>
<tr>
<td>JELCO CATHETER IV PINK 20G</td>
<td>42.96</td>
<td>91%</td>
<td>52%</td>
</tr>
<tr>
<td>STERICAN NEEDLES 21G GREEN</td>
<td>1.59</td>
<td>89%</td>
<td>50%</td>
</tr>
<tr>
<td>K Y JELLY SACHETS</td>
<td>6.22</td>
<td>85%</td>
<td>22%</td>
</tr>
<tr>
<td>W3208 SUTURE</td>
<td>171.49</td>
<td>58%</td>
<td>1%</td>
</tr>
<tr>
<td>ECG ELECTRODE ADULT</td>
<td>1.68</td>
<td>56%</td>
<td>0%</td>
</tr>
<tr>
<td>WEBCOL ALCOHOL SWABS</td>
<td>0.18</td>
<td>56%</td>
<td>-17%</td>
</tr>
<tr>
<td>ACCU-CHEK ACTIVE STRIPS</td>
<td>2.58</td>
<td>25%</td>
<td>-32%</td>
</tr>
</tbody>
</table>

?Misrepresented NAP
Regulatory Impediments

• CC ruling: healthcare service is a public good, not a commodity. Need to rescind/amend 2004 decision to move on.

• Uncontrolled entry of unchecked healthcare technology into SA

• No national coding and pricing for healthcare services (Pricing commission)
  – Need for national coding and billing standards
  – NERSA model for pricing

• No over-arching health facility regulator
  – OSC &R158
Regulatory Impediments

• Disjointed/fragmented/unco-ordinated regulatory agencies
  – NDOH creates dental therapists and sonographers disciplines to fill the gap in public sector. HPCSA allow these professionals to go into private practice.
  – NDoH has EDL/EML. MSA and regs has Algorithms for chronic meds.

• …does not create environment for efficient integrated care provision, particularly in private sector
Regulatory Impediments

• Chapter 9 of NHA powers on health information must be effected by NDoH
  – Standardise coding
Regulatory Impediments

• “Tariffs” or price list are published VAT inclusive.
  – Not all suppliers registered for VAT
    • Overcharges for those not registered and no means to check. Admin overkill if checks for each claim
  – All price lists/tariff must be published VAT exclusive.
  – Claims submitted must include VAT number
    • MSA regulation to include this.
- New SAMA Codes per year
- Lack of CC action...disregard of consent order
Health Promotion

- Information asymmetry
- Multi-stakeholder education programs
  - Address public perceptions
- Taking accountability by all stakeholders
- Guideline distribution and communication
- Healthy lifestyle
- Managed Healthcare interventions
  - Redefine role of managed healthcare
- Promote preventive care interventions
Non Healthcare Cost

- Administration fees
- Effectiveness/Value of Managed Health Care
- Trustee remuneration
- Broker fees
Non-health expenses as % of contributions

Source: CMS Annual Reports 2002 to date
Administration Cost

• Over time
  – Closed scheme merger into open scheme: incr. cost
  – Price decline in real terms

• Need more consolidation to extract economies of scale

• Switching fees
  – Policy review
Managed Healthcare

• Quality Assurance
  • Narrowing of variance
  • Health outcomes & impact

• Alternate re-imbursements
  – Incentives
  – disincentives
### “Problems” with “Managed Care”

<table>
<thead>
<tr>
<th>What do we do?</th>
<th>What should we be doing?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost savings</td>
<td>Quality assurance</td>
</tr>
<tr>
<td>Disease focus</td>
<td>Person focus</td>
</tr>
<tr>
<td>Process (narrowing of variance)</td>
<td>Outcomes and impact</td>
</tr>
<tr>
<td>Process (Pre-auth/Case Mx)</td>
<td>Intelligence/risk stratification</td>
</tr>
<tr>
<td>Patient focus</td>
<td>Population focus</td>
</tr>
</tbody>
</table>
## Managed Care at work

<table>
<thead>
<tr>
<th>Condition</th>
<th>Status</th>
<th>% of Patients</th>
<th>At Baseline</th>
<th>At Follow up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Mellitus 1&amp;2</td>
<td>Well Controlled</td>
<td></td>
<td>37</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>Partly Controlled</td>
<td></td>
<td>44</td>
<td>46</td>
</tr>
<tr>
<td></td>
<td>Uncontrolled</td>
<td></td>
<td>19</td>
<td>14</td>
</tr>
</tbody>
</table>

### Hospital Admission Rate per 1000 lives

<table>
<thead>
<tr>
<th>Condition</th>
<th>Hospital Admission Rate per 1000 lives 2011 (pre DM programme)</th>
<th>Current Hospital Admission Rate per 1000 lives Jan – Dec 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>51</td>
<td>13</td>
</tr>
<tr>
<td>Cardiac failure</td>
<td>336</td>
<td>121</td>
</tr>
<tr>
<td>COPD</td>
<td>279</td>
<td>90</td>
</tr>
<tr>
<td>Diabetes Mellitus 1&amp;2</td>
<td>39</td>
<td>17</td>
</tr>
</tbody>
</table>
Case study 1 – when the brakes come off

Number of events per beneficiary per month

Gender and Age

Other schemes

Scheme with minimal managed care
When trustees thought problem has gone away

MONTHLY EXPENDITURE

MONTHLY EXPENDITURE

- Medicine Management – DUR model
- No DUR
- Medicine Management – DUR model
Trustee & PO Remuneration

• Trustee accountability
  – Risk vs Reward
  – Small vs large scheme

• Consider CMS Councilors’ remuneration adjusted for risk carried
## Broker fees

- **Medical Scheme Act & Regulations**

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</tr>
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- Review role of broker & re-imbursement policy
Some Constraints

• Appears to be insufficient accountability for health at all levels
• Government activity and reforms are slow
• Paucity of health risk management skills
  – Private sector
  – Government
• Healthcare service related litigation
  – Too much
• Progressively litigious provider groups
  – Maintain status quo
Activities

• Increase accountability
• Improve quality of care and transparency related to it.
• Price regulation; not reference pricing
• Minister/NDoH to review all health legislation and regulation to achieve cohesion