

Managed Care



DEC 2013



news

CMS Council for Medical Schemes

The Managed Care Issue

Editorial

In this issue of CMS News we explore managed healthcare in all its facets.

Forty-two years after the announcement of a new national health strategy by the Nixon administration in the United States of America (USA), and the development of health maintenance organisations (HMOs), we ask ourselves what difference has managed care made to medical schemes and its members in our own country? It is expected that in the US a new "Obamacare" national healthcare system will have an impact on the health maintenance organisations.

What constitutes effective managed healthcare? How has managed care evolved, if at all, and where, in a perfect world, should managed care ideally lead the people of South Africa?

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'A word or two' from the desk of Dr Monwabisi Gantsho

*Chief Executive of CMS &
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Introduction

South Africa is not alone in its quest to find a workable, cost-effective healthcare funding model. However, in doing so we will have to deploy all the available resources in our armoury in order to combat the challenges that we are faced with. It can be argued that Managed Healthcare is possibly one of the more significant vehicles at our disposal.

The current trend in terms of lack of industry growth is very worrisome. Growth in the healthcare funding sector is at present hampered by the fact that too few young people are joining medical schemes while existing members grow older or are exiting the market.

During the 2011/2012 financial year the beneficiary growth rate was a mere 1.8%. In the period 2010 - 2013 the percentage increase in membership has

been decreasing from 3.1% in 2010 to 1.8% in 2013 even though the economy has been marginally improving.

The National Health Reference Price List (NHRPL) offered considerable hope for the healthcare funding sector but this important process was rendered invalid by a High Court ruling in 2010 following an objection by the Competition Commission. This has left a tremendous vacuum within the private healthcare sector where providers are now charging as much as 700% above medical schemes rates thereby placing an onerous burden on the already hard pressed South African healthcare consumer.

When studying the healthcare provision models of a number of countries throughout the world, it is all too clear that global healthcare is in crisis.

Healthcare expenditure is rising worldwide and has in many instances far outstripped the Gross Domestic Product (GDP) of individual countries.

Despite the long-time deployment of HMO models in the USA, the Organisation for Economic Cooperation and Development (OECD) reveals that the USA's expenditure on healthcare is two-and-a-half times more than the OECD average, and yet ranks with Turkey and Mexico as the only OECD countries without universal healthcare cover. The USA spends 17% of its GDP on healthcare, more than any other developed nation, with poor outcomes hence healthcare has become nothing short of a political hot potato there.

According to the Kaiser Foundation, USA, access to employer-sponsored health insurance has been in decline among low-income workers while healthcare premiums have risen by 114% in the past decade. Rising healthcare costs have placed a heavy burden on companies conducting business in the USA, thereby putting these businesses at a competitive disadvantage in the international marketplace. The concept of managed care, which has served private healthcare consumers in our country for many years, originates in part from the HMO models of the USA. It has made a positive contribution to the financial sustainability of medical schemes.

There is a great deal to be learnt from healthcare systems employed by countries such as Cuba. This system is has been examined in detail by

the Chairperson of CMS, Professor Yosuf Veriava, formerly of the Witwatersrand School of Clinical Medicine. He describes the Cuban system as an "interdependent, integrated system of healthcare". According to Prof. Veriava, the Cuban health indices are outstanding with the infant mortality rate at approximately 4.8 to 1 000. The doctor-to-patient rate on the other hand stands at six doctors per 1 000 people.

In our search for practical and workable healthcare models, we can also look closer to home to major mining houses, some of which have for many years harnessed HMO models to proactively address the health and wellbeing of employees within the sector. Healthcare costs are firmly contained with the use of a fully integrated primary healthcare referral system. One of the reasons why this model has served the industry so well is because primary healthcare facilities and mine-owned hospitals are managed and operated by full-time healthcare practitioners in the employ of mining houses.

The entire system is pulled together by the company medical scheme. All the individual components of the system make for a holistic, fully integrated model. Read more about the lessons that can be gleaned from the mining sector HMO model in the article entitled 'Alternative healthcare financing and delivery models'.

According to Dr Aaron Motsoaledi, our Minister of Health, the effective monitoring of healthcare service delivery and overall performance of

the health system requires functional health information systems capable of producing real-time information for decision making. Globally, information and communication technology has emerged as a critical enabling mechanism to achieve this. The CMS has already adopted this initiative and started with the real time monitoring (RTM) system in the industry.

Without doubt one of the greatest challenges faced by the private and public healthcare sectors are the critical shortage of healthcare professionals, which hinders healthcare delivery in many ways. The focus should therefore be on how to use scarce resources more effectively with the aid of technology. According to an article entitled 'Healthcare management: An e-health perspective', written by Dr Richard Weeks, there are already too few specialists to train doctors in specialities and sub-specialities. E-health, through the use of distance education, telemedicine and computerised health information systems, is seen as a possible solution to this problem.

South Africa's eHealth Strategy for the public health sector provides the perfect roadmap for achieving a well functioning national health information system with the patient located at the centre. I firmly believe that this is what is needed to take the South African private healthcare sector forward towards a new dispensation.

With outcomes and costs being overriding concerns within the greater healthcare landscape, one possible solution to our spiralling cost cycle is the consideration of employment of doctors by private hospitals. While ethics and professional

independence are factors to be considered, it can be argued that there may be considerable merits in such an arrangement to enhance the management of controls, patient outcomes and costs.

Without managed care we would be in a much worse situation today, the challenge is to demonstrate its value. Since its introduction within the private healthcare funding arena there has been much debate about whether managed care is doing the job it is supposed to do, namely to reduce healthcare expenditure while improving patient outcomes. If managed care is indeed making a difference, how can we quantify its success? Is it time to take a fresh look at how we apply managed healthcare?

In closing I would like to leave you with the following poignant words from Prof. Veriava: "In Cuba, people live like the poor but they die like the rich." This is because of a healthcare system that is fully integrated and efficient at every level. This is something worth aspiring to, even within the high-tech, South African private healthcare systems.



Important CMS Information



The Council for Medical Schemes (CMS) governs the medical schemes industry and therefore complaints lodged should be related to the relevant medical scheme.

Should you have any other complaints relating to any other aspect of the health industry please see the website addresses to visit listed on page 14.

How to avoid Disputes:

- ⇒ Understand the rules of your medical scheme.
- ⇒ Read all correspondence.
- ⇒ Study your benefits guide.
- ⇒ Familiarise yourself with the terms and conditions of the benefit option you have chosen.
- ⇒ Pay your contributions in full and on time every month.

How to resolve Disputes:

- ⇒ Speak with your medical scheme first. The law requires all schemes to establish dispute resolution committees.
- ⇒ Give full details of your complaint and include any supporting documents.
- ⇒ If you are not satisfied with the outcome of your complaint to the scheme, lodge a written complaint to the Registrar of Medical Schemes at the Council for Medical Schemes (CMS).
- ⇒ There are a number of ways in which you can contact us. All the contact details can be found on the back pages of this newsletter.
- ⇒ If you feel aggrieved by the decision of the Registrar, appeal his/her decision to the Appeals Committee of the Council.
- ⇒ If you feel aggrieved by the decision of the Appeals Committee of the CMS, appeal to the Appeal Board.
- ⇒ Rulings of the Appeal Board can be appealed in the High Court.



Measuring the value of managed healthcare

Prof. Praneet Valodia

Executive Manager, Independent Clinical Oncology Network (ICON)



Introduction

The development of methods to measure the value of managed healthcare is important to ensure that beneficiaries of medical schemes receive interventions that offer therapeutic value. From a medical schemes' perspective such methods allow the implementation of interventions which are clinically effective and those that have been shown to improve cost efficiency.

Sound decisions require accurate knowledge of complex, interdependent variables.

The development of intelligent health systems is important to convert complex data into parameters that measure health outcomes.

There are a number of methods that can be used to measure the value of managed healthcare, such as the (i) pre-post intervention methods for health outcomes measurement, (ii) benchmarking against a comparator, (iii) return on investment (ROI), (iv)

trend analysis, (v) the total population approach, and (vi) survival analysis.

This article briefly discusses some of these methods and the challenges associated with the measurement of outcomes. These methods can be applied by managed care organisations or provider networks that have systems in place for the collection and reporting of information.

A few of the common methods that may be used to determine the value of a managed healthcare programme are briefly described below.

Health outcomes

Health outcomes can be broadly classified into three types, i.e. clinical, economic, and humanistic

outcomes. The latter involves quality of life and satisfaction outcomes.

The health outcomes method is of particular value when determining the value of disease management programmes. Health outcomes research is defined as a scientific discipline that evaluates the effect of healthcare interventions on patient-related, if not patient-specific, economic, clinical, and humanistic outcomes.

The relationship between interventions and outcomes needs to be scientifically understood. In understanding this relationship the confounding variables that influence this relationship should be carefully controlled. Such a method also allows individual patients to be tracked over time to determine who is responding to the intervention.

The health outcomes approach is depicted in figure 1:



Figure 1

Figure 1 indicates the basic principles of how health outcomes can be assessed. The measurements occur according to a timeline. The date when the intervention is performed is the starting point in this assessment. Three time periods are involved: (1) the baseline period (during which claims and clinical information is collected), (2) the intervention period (during which the managed care intervention takes place), and (3) the post-intervention period (during which data is collected and measurement takes place). The difference in parameter measurement between the baseline and post-intervention periods is the outcome which reflects the value of managed healthcare.

There are many variations of this method. It is important that a good baseline for the parameter in question be obtained so that a good comparison of the post-intervention data against the baseline can be made. The intervention period can be varied based on the time it takes to optimise the patient's therapy for a selected disease state. The post-intervention period can be programmed as the period which is three months before the last intervention date. System-driven measures can be implemented to ensure that the intervention and post-intervention periods do not overlap, according to each patient's timeline from the start to the end of their participation in a disease management programme, whether offered by a managed care organisation or a provider.

Population versus individual health outcomes assessment

Ideally each patient should be tracked over time. It is hoped that each patient will provide readings during the baseline and post-intervention periods.

This is often not the case as patients default from the programme. The following scenario may arise where one has a reliable data point in the baseline period but no data point in the post-intervention period. Therefore, an outcome for the specific patient cannot be measured.

Alternatively, one may have no data point in the baseline period but a data point in the post-intervention period and therefore again have difficulty in measuring an outcome. In such circumstances, and if the sample size is large enough, such information can be used in a population approach to measure outcomes. In this case, the pre- and post-intervention data is measured in two groups separately where the patients are not the same. A huge variation often occurs around the average and statistical comparisons should therefore be carefully performed.

If these patients are considered using the individual health outcomes approach then the missing data needs to be accounted for by using a Bayesian approach or a technique called the “last observation carried forward”.

An approach may be to only include patients in the analysis who have a pre- and post-intervention data point. This may present a problem, as the sample size may be too small.

Clinical data

Clinical data is probably easier to manage from a system perspective. If a patient has hypertension, the blood pressure levels will be collected during the baseline period. The more recent levels should be given a greater weighting in the assessment of a baseline.

With clinical data it is easier to handle missing data points in the post-intervention periods. In this case, for example, the blood pressure reading during the last month of the intervention period can be carried over to the post-intervention period.

Claims data

Claims data poses a particular challenge in that the baseline and post-intervention periods may be of different lengths or time periods.

For example, in the baseline period there could be six claims for nebulisation in eight months and in the post-intervention period there could be three nebulisations in a three-month period.

This requires the programmed system to automatically calculate the number of nebulisations in the same unit (e.g. nebulisations per month) for the baseline and post-intervention periods so that a direct comparison can be made to determine an outcome.

Health outcomes can also be measured by comparing an intervention group with a control group (patients not receiving an intervention). It is important that patients are matched for severity of disease for these assessments to be meaningful. A disadvantage of this method is that it does not allow one to understand the relationship between a specific intervention and an outcome. But this method does allow an understanding at a high level, for example, whether a disease management programme is producing an outcome. Such a method is not “real-time” but retrospective.

Benchmarking

This method is commonly used, probably due to the availability of claims data for this type of analysis.

The challenge with this method is that matched controls or comparators are required. This can best be achieved by using propensity scoring. Risk adjustment in the intervention should be performed and control groups should be used. Control for risk using age, gender, and the number of chronic conditions is not sufficient to adjust for risk. In other words, these variables do not sufficiently explain the variation in the benchmarked parameters.

It is important that severity of disease and other variables are taken into account when adjusting for risk. A common error made in oncology reports, for instance, is when year-on-year costs are compared without matching patients according to stage of cancer, spread of disease etc.

Therefore, to ensure accurate reporting of costs, it is important that clinical information be incorporated into the analysis. The main disadvantages of this method are that (i) it does not allow one to understand the causal relationship between the intervention and the outcomes, (ii) it does not allow tracking of individual patients, and (iii) it does not allow knowing what percentage of the population is responding to an intervention.

Return on investment

Return on investment (ROI) can be used as a measure for programmes such as Medicine Risk Management and Hospital Risk Management. ROI is calculated by dividing savings by the cost of offering a programme. This measure shows what the ROI will be for every Rand spent by the medical scheme on a managed care programme.



ROI should be interpreted with caution within a managed care environment because there may be times when a medical scheme is willing to spend more to prevent downstream costs, e.g. on vaccination programmes, high-cost biological medicines for oncology, and screening tests. These factors should be taken into account in the final evaluation.

Trend analysis

This requires selected parameters to be monitored over a long time to determine a trend. Unlike most other approaches, this approach may help with “regression to the mean” as it takes into account the fluctuations in the parameter over time. An application of this is when claims cost is often compared to medical inflation over time on a year-to-year basis to determine the value of a programme.

Challenges with measuring the value of managed healthcare

From the common methods that may be used to determine the value of a managed care programme described above, it is clear that all have their advantages and disadvantages. A combination of these methods is probably required.

In South Africa we need to start with the basics in taking the measurement of the value of managed healthcare further. There seems to be a misinterpretation of what is expected with the measurement of the value of a particular programme or intervention. A definition of what is meant by “health outcomes” should be broadly discussed and accepted.

There are numerous challenges with measuring health outcomes. Most of these, however, can be controlled.

Some of the common issues to consider are the following:

- To measure outcomes, it is important that the collection of data be planned beforehand so that all the confounding factors that will influence the results can be controlled, e.g. minimising selection bias. Structured questionnaires should be used when collecting clinical information for health outcomes measurements.
- Developing a questionnaire is a complex process. Such questionnaires should be sensitive enough to measure a change in a parameter pre- and post-intervention to report on outcomes. In designing such a questionnaire, the following should be taken into account as a minimum: bias (selection, interviewer, misclassification, recall); variability, reliability, and reproducibility in responses from patients; and expected clinical effect sizes etc. Decision trees could be used if one wished to automate the entire process.
- Selection bias can, for example, occur when patients are selected who are a high cost due to hospitalisation. One can expect the cost to be lower the following year irrespective of whether the patient was intervened on. Probability theory indicates that the likelihood that the patient will be hospitalised the next year is small. Hence, irrespective of whether the patient was intervened on, the cost for

the next year is expected to be less. This is often interpreted as a cost saving when in fact it is only a normal phenomenon of regression to the mean.

- Inter- and intra-scheme variability in measurement should be clearly understood. It is important that differences in measurement between schemes and within schemes are accounted for as far as possible. This variation should be understood and interpreted.
- When measuring outcomes it is important to know which patient groups are clinically susceptible, i.e. whether an intervention will make any difference.
- When measuring the value of managed healthcare it is important to understand clinical and statistical differences in the interpretation of the results. A result may be statistically significant but clinically irrelevant.

Concluding remarks

This article was written from practical experience in the area of managed care. I hope that it will inform discourse on how to measure the outcomes of healthcare interventions and hence the value of managed healthcare.

***For more information on ICON
please go to www.cancernet.co.za.***





Is there value in managed healthcare?

Louis Botha
CEO, Health Quality Assessment (HQA)



A good starting point for a debate on whether there is value in managed healthcare is to examine why managing healthcare is necessary in the first place. Medical schemes cannot deny membership or apply risk-rating based on the health status of eligible applicants so the only remedy they have is to manage their underwriting risk.

Another question that comes to mind is how managed healthcare should be defined and what it is supposed to do. There are many views and definitions of managed healthcare. For example, its purpose may be to:

- save costs;
- ration the application and provision of care;
- manage the “fat” out of the system;
- apply risk stratification and predictive modelling;

- develop capitation networks and innovative remuneration models;
- promote wellness, health, and quality of life;
- promote prevention and early identification of health risks;
- manage diseases;
- avoid, mitigate, share, and/or transfer risks;
- coordinate the delivery of quality care.

If the value of managed healthcare is to be examined, then the next logical question is: from whose perspective should it be examined, given the many parties involved?

- The **member or patient** needs adequate cover and access to affordable, quality healthcare. Members are consumers and want the freedom to choose.

- The **employer** needs healthy and productive employees and a lower cost of healthcare benefits.
- The **Department of Health** needs to provide access to quality healthcare for all South Africans and must perform better in terms of the country's health outcomes, as reported by the World Health Organisation (WHO).
- The **Medical Schemes Act** requires medical schemes to operate within the stipulations of the current regulatory framework and to act in the best interests of medical scheme members.
- **Medical schemes** need financial stability and sustainability and need to offer access to quality, affordable healthcare in a competitive environment. They are also required to maintain reserve levels of not less than 25% and to offer prescribed minimum benefits (PMBs) in a system of open enrolment where risk-rating is not allowed.
- The **managed care organisation** needs an acceptable return on investment.
- The **doctor, hospital or other clinical provider** needs an acceptable return on investment in a hassle-free environment.

Therefore, how should the "value" of managed healthcare be determined?

- Does it refer to the return on investment from the medical schemes' perspective?
- Does it refer to "more health for Rand" from the members' perspective?
- Should it be reflected in health outcomes

measurement and benchmarking?

- Is it of short-term or long-term value?
- Is it net of penalties?
- Have timing differences been accounted for?

With so many parties involved in healthcare, a relevant question is: where does the accountability sit for the patient's health? Are doctors not supposed to be responsible in the first and the last instance for treating their patients? Managed care organisations these days offer protocols, treatment guidelines, disease management programmes and wellness programmes.

We must question whether members of medical schemes are taking enough responsibility for their own health and wellness. Is it not time that medical schemes and health-conscious members received some form of protection against members who are careless about their health, who are inactive or obese, who smoke or drink and do not follow their disease care plan? We need to decide whether managed care should enter the space of the doctor or whether it should merely monitor doctors' clinical results.

The value of managed care points to the results which managed care organisations are able to deliver to their medical scheme clients. These results are measured against the service level agreements in place. We have to ask: what beliefs are driving the contents of these service level agreements? That wellness, prevention, and early risk identification can lead to lives saved, lower the cost of tertiary treatment, and increase the quality of life? Or that it costs money and that there can be no real value in such actions?

What should the value of managed care be measured against? Can it be said that a managed care organisation is good because it performs well in a benchmark exercise, or should it also be measured against appropriate standards based on sound clinical studies? Such standards should be relevant for the environment and socio-economic conditions in which the managed care organisations are operating. Ideally these criteria should be standardised, as differences in performance should not be the result of different standards.

An industry can have the best systems, processes, standards, and measurements in place but in the end the outcomes of measurements and conclusions drawn are dependent on the quality of the data in the system. We must question: what is the current status of data in our healthcare industry and what can be done to reach a higher level? We have to ensure that we capture and collect sufficient data accurately and in real time in order to inform effective decision-making.

It is essential that we ascertain the current status of reporting on the results from managed care initiatives and whether there is perhaps a need for a set of generally accepted reporting standards.

Are boards of medical schemes able to assess the value of the managed care they receive and to interpret the managed care reports presented to them? Can the standardisation of standards, reporting, and more emphasis on trustee training close this gap?

The question of whether there is value in managed healthcare is too complex to be fully answered in a short article such as this. However, I hope I have raised a number of important issues to consider

which perhaps ought to be debated in order to provide more clarity to those responsible for governing medical schemes on behalf of medical scheme members.

For more information on HQA please go to www.hqa.co.za.



Should you have any other complaints (please see page 5) relating to any other aspect of the health industry please find the website addresses to visit listed below.

- *For complaints against Health Professionals (doctors) – www.hpcs.co.za*
- *For complaints against Private Hospitals – www.hasa.co.za*
- *For complaints against Nurses – www.sanc.co.za*
- *For complaints against Brokers – www.faisombud.co.za*
- *For complaints in respect of other health insurance products – www.osti.co.za (short term insurance ombudsman) or www.ombud.co.za (long term insurance ombudsman)*



The value of managed healthcare: a medical scheme's perspective

Dr Stan Moloabi

Executive: Healthcare Management, Government Employees Medical Scheme (GEMS)



Bleak as the South African private healthcare landscape may appear, there is little doubt that it would have been significantly worse off had managed healthcare principles not been implemented throughout the industry over the last number of years.

The case for managed care

Throughout the 1990s, the medical schemes sector experienced cost-inflation well in excess of the consumer-price-index (CPI). The very high rates charged for discretionary, non-lifesaving interventions such as tonsillectomies, the insertion of grommets in children's ears and hip replacements for arthritis is often cited as being among the reasons for this cost explosion. Up until fairly recently, medical schemes had little interest in the interventions performed by doctors or the cost associated with these, and simply reimbursed all the fees charged.

In recent times there have been a number of responses to spiralling cost-inflation. In some cases employers have simply abandoned their role in providing healthcare cover, while in other instances medical savings accounts, managed care and limited benefit packages have been introduced.

The rise of Healthcare Management Organisation (HMO) models

The Healthcare Management Organisation (HMO) movement was given a major boost in the United States of America (USA) with the enactment in 1973 of the Federal Health Maintenance Organisation Act. This, however, happened only after healthcare had attained 12% of the gross national product.

Managed healthcare was introduced specifically to better manage healthcare benefits and costs by

making arrangements that controlled the use of healthcare services and providers. The emphasis on HMOs at this time reflected the perspective that the fee-for-service system rewarded healthcare professionals for providing more services rather than appropriate services, and did not incentivise them to make savings.

In South Africa, American models such as Southern Healthcare JV, introduced by the private healthcare industry in the early nineties, resulted in some spectacular failures as they were implemented for all the wrong reasons. Since then a great deal has changed and while some question the successes of managed healthcare, most South African medical schemes have implemented its principles in some or other form and are reaping considerable cost savings as a result thereof. The fact is that today few medical schemes would consider dropping managed care.

The business of a medical scheme

In terms of Section 1 of the Medical Schemes Act 131 of 1998, the 'business' of a medical scheme involves taking on a liability in return for a premium or contribution. This means that medical schemes should make provision for members and their dependants to obtain the relevant healthcare services. Medical schemes are furthermore responsible for defraying expenditure incurred in the rendering of relevant healthcare services and should either render the healthcare services themselves where applicable, or ensure that services are provided by a supplier or group of suppliers in terms of a specific agreement. Medical schemes have considerable financial risks that can be exacerbated by excessive claiming patterns. Putting the appropriate tools in place to manage these risks is therefore an imperative.

Managed care defined

Managed healthcare means the clinical and financial risk assessment and management of healthcare with a view to facilitating appropriateness and cost-effectiveness of relevant healthcare services within the constraints of what is affordable, through the use of rules-based and clinical management-based programmes.

By definition managed care must include a governance, coordination and service delivery component. Managed care tools employed can include appropriate interventions such as for pre-authorisation, treatment protocols and medicine formularies. So, for example, a formulary drug will be used that is clinically appropriate, efficacious and cost effective. When such a medication is declined by a beneficiary who for some or other reason opts to use another drug instead, a co-payment may be imposed by the medical scheme.

Why managed healthcare?

Rationing of healthcare resources is both necessary and unavoidable, as costs will become totally unsustainable if not contained. This is best demonstrated by the tremendous escalation in the use of biologicals within the European Union (EU) and the USA between 2000 and 2008.

In this instance we saw the use of drugs such as Erlotinib (brand name Tarceva) used in the treatment of advanced pancreatic cancer and certain lung cancers climb to just under US\$1 billion in the EU between 2004 and 2006 and to approximately US\$2.7 billion in the USA between 2003 and 2008.

Basic managed care primarily looks at price and utilisation management, and with good reason. Aspects such as billed claims and more cost-efficient levels of care, as well as evidence-based cost benefit, all ensure that more beneficiaries have access to healthcare funding and cheaper healthcare contributions.

Figure 2 below demonstrates how at least R1 billion in medical scheme funds can be saved.

Hospital claims value processed	R 10 044 692, 305
Hospital claims re-pricing savings	R 942 218, 043
Total chronic prevalence as at December 2012	15.1%
Annual MPL savings	R 64 117, 589
Annual MEL savings	R 50 033, 075

Figure 2

Facilitation of access to cost-effective quality and affordable care

The new frontier of managed healthcare lies in integrating price and utilisation management with the facilitation of access to quality and affordable care through provider network management and beneficiary clinical risk management.

The GEMS networks are an initiative aimed at working with providers to improve member access to primary providers who are incentivised to provide quality care that improves clinical risk. The benefits of compliant networks include access to network providers for members, the putting in place of a profiling tool with chronic disease

monitoring, generic medicine utilisation and re-admission rate indicators, and the introduction of low-contribution options which are particularly meaningful to previously uncovered lives.

Beneficiary risk management recognises that multiple co-morbidities exponentially increase clinical risk as well as the fact that 50% of the Scheme's costs relate to 5% of the Scheme population.

By assisting beneficiaries to understand their healthcare conditions and to take ownership of their personal wellbeing which includes complying with medication prescribed, taking charge of their lifestyle and engaging meaningfully with their primary healthcare provider, some impressive results have been achieved. Successes include the reduction of medical admissions by 34 per 1 000 selected lives as well as the reduction in emergency admissions by 41 per 1 000 selected lives and a reduction in average LOS (length of stay) by 0.27 days.

The benefits of generic substitution

Generic substitution of oncology and chronic medicines has enormous benefits for medical schemes and their members. One of the key advantages of using a higher proportion of generic medicine is that the use of chronic or potentially chronic medication benefits, which are generally funded from acute medication benefits, are reduced. However, unfortunately 56% of oncology medication does not have generic substitutes at this stage.

Nevertheless GEMS research (see figure 3 on page 18) conducted between January 2011 and

Generic substitution and cost – oncology and chronic medicines

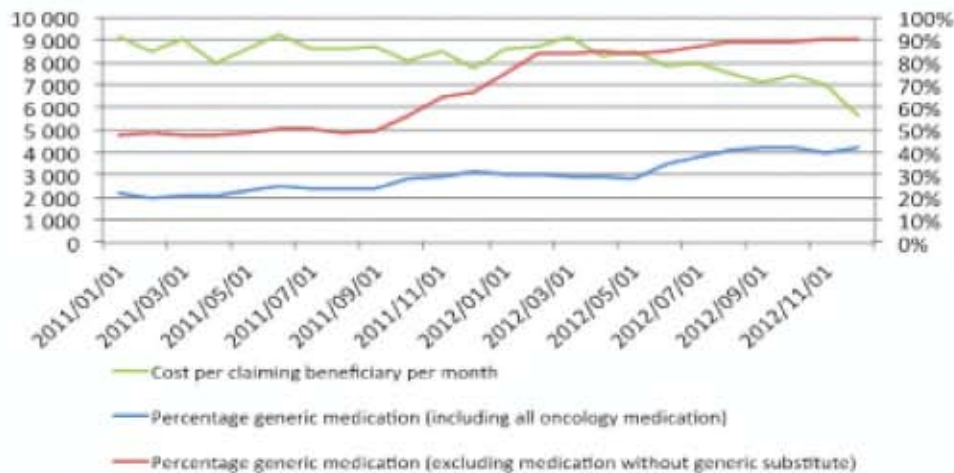


Figure 3

November 2012 points to a reduction of just below 60% in the cost per claiming beneficiary per month in instances where generic substitution was used for oncology and chronic medicines. Over the same period, the percentage of generic medication usage, including all oncology medication, steadily increased by 90%, while the percentage of generic medication, excluding medication without generic substitute, climbed by 40%.

Enter Prescribed Minimum Benefits (PMBs)

Prescribed minimum benefits (PMBs) remain one of the greatest challenges in the healthcare funding sector with figures pertaining to PMB claims that are higher than the Scheme rate growing exponentially during the past three years. In 2010 PMB claims paid above the Scheme rate stood at R539 963 601. By 2012 this figure had soared to R1 157 629 069, more than double that of 2011. This attests to the immense challenge faced by medical schemes in this regard.

GEMS case study pertaining to anaesthetists

In a specific GEMS case study pertaining to anaesthetists, as many as 77% of claims were found to be PMB related. This highlights the significance

of PMBs in the context of claims received by anaesthetists. In 2012, the claimed amount, as a percentage of the GEMS tariff as it applied to PMB claims, was 157%. In other words, anaesthetists on average charged 57% more than the scheme tariff on PMB claims. The gap between tariffs and claimed amounts is widening considerably. For example, in 2012 these payments are estimated to have cost GEMS an additional R90 million on anaesthetists alone.

In a study regarding the billing practices of anaesthetists, it was found that 55% of practices charge between 100% and 140% of the Scheme tariff, while 21% of practices charge more than 200% of Scheme tariffs. A further 4% charge more than 300% of tariffs.

The graphic in Figure 4 reflects a change in the professional cost per admission of 12.7%, as adjusted for the case mix, while the change in reference to admissions which are not eligible for PMB status is 7%. On the other hand, the change in reference to admissions eligible for PMB status is 14.6%.

Essentially the role of managed care is to analyse trends while negotiating prices with designated service providers.

Cost per admission trend

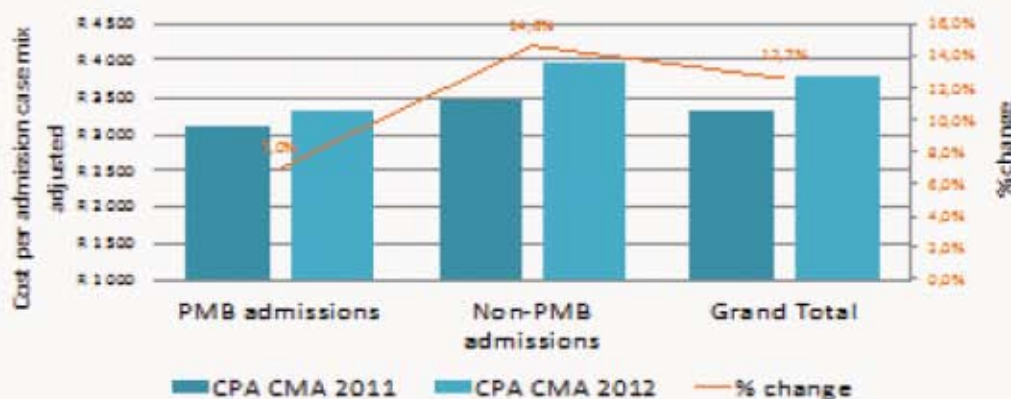


Figure 4

General measurement challenges

At present we cannot firmly gauge the degree of success being achieved with managed care on a consistent level. There is a distinct lack of availability and comparability of market prices as well as a lack of consistently defined quality data. This is further exacerbated by the fact that there are no proper control studies against which success or failure can be measured against. Added to this is the constant state of flux within the healthcare environment and the uphill battle that is being waged when it comes to PMB cost containment.

It is imperative that measurement strategies be put in place to clarify the intentions of managed healthcare programmes. In this way the definition of outcomes to be measured can be significantly broadened while the appropriate tools can be employed to allow for changes in case mix, risk profile etc. The creation of benchmarks to measure against over time is particularly helpful.

The GEMS service provider network

It is the role of managed care companies contracted by GEMS to constructively engage,

integrate, interface and participate with each other in the delivery of care to beneficiaries.

The integration of these services is core to the successful implementation of managed care. Appropriate checks and balances and peer review are therefore an integral part of the managed care model which must at all times achieve a balance.

In conclusion

Without doubt, managed healthcare continues to be an integral part of the healthcare funding process and is likely to remain so into the future. For managed healthcare to be successful, a clear rules-based approach to clinical risk management must be employed. The overall objective must not be to simply ration or cut costs. It must instead be an innovative, thorough process that must involve and receive full buy-in from all the relevant healthcare stakeholders.

For more information on the Government Employees Medical Scheme (GEMS) please go to www.gems.gov.za.



Perceptions of managed care in medical schemes

Prof. Manie de Klerk

*General Manager: Out-of-hospital Programmes,
Metropolitan Health Risk Management*



Introduction

This article addresses managed care and the interaction of value between two stakeholders, the client and the managed care organisation. General principles and processes are discussed that are valuable to contemplate in all similar stakeholder relationships.

Principles

Financial outcomes, access, and clinical outcomes are important to companies and clients who deal with managed care.

It is generally accepted that there are two financial outcomes to managed care interventions:

- post-intervention savings (usually most evident in the first year or two after the intervention has been implemented); and

- continued control of costs (related to the new base from where the intervention steers the financial outcome).

Clinical interventions should be informed by evidence-based medicine with the objective of managing the cost of healthcare, the quality of healthcare, and access to that care.

There should also be discussion at client-Managed Care Organisation level.

Processes

Clear contracting is needed in managed care. This area is constantly developing and should be supported by clear deliverables and standards of performance stated through a service-level agreement (as per the CMS guideline).

This promotes understanding between the managed care organisation and the medical scheme. There are a few potential pitfalls that hamper delivery and performance. One important pitfall is the complexity of contracts. Simplicity in terms of measurable requirements and practicality of delivery of these must inform the process. It is also important to state what is not included in a managed care contract.

Realistic expectations should be fostered, requiring a mature relationship between the servicing managed care organisation and the client. This process is realised through dedicated clinical meetings where contract deliverables are discussed in term of outcomes.

The outcomes discussion

An outcomes discussion is usually centered on two extremes: severe number crunching (including financial statistics) and clinical outcomes.

The discussion is influenced (and sometimes informed) by the ability to discern time periods that relate to large schemes and smaller schemes and therefore large and small units of data. In small schemes it is advisable to look at the total impact of a programme rather than searching for the controlled environment of matched pairs of enrolled versus unenrolled members. The dynamics of enrolment frequently nullify the second approach.

Utilisation of reports to improve process and report progress

The purpose of reports is not only to report on outcomes, but also to determine the content

of and actions on clinical risk. A team approach between client and provider is important and can be created by defining a workgroup environment where regular, mature discussions and planning take place. This journey should be travelled in line with client strategy and should be an evolutionary one.

Concluding remarks

Managed care is a complex environment which can be affected by internal and external factors that influence both the client and the managed care organisation. A mature approach to outcomes and the utilisation of reports are key principles in a successful provider-and-client relationship.

**For more information on
Metropolitan Health go to www.mhg.co.za.**





Managed healthcare – Where is the patient?

Fanie du Toit

*Patient advocate & NGO representative
Administrator for the National Kidney Foundation of South Africa*



The term “managed healthcare” (MHC) presents one with a picture of an organised and, in the very true sense of the word, healthy and caring system. It does not, however, begin to describe the vastness and intricacies of the principles and context that is implicated by the concept.

With its origins in the USA, the definition of managed care is “a health plan or system that seeks to control medical costs by contracting with a network of providers and by requiring preauthorisation for visits to specialists” (Webster’s College Dictionary, 2010). But the question to ask is whether MHC lives up to its implied role. This question cannot be answered easily and the perspectives differ widely. Each sector that has a part in MHC would present a different picture of the impact that MHC seems to have in general healthcare.

Historically the “contract” for healthcare was between the doctor and the patient. In the early days of health insurance the funder became the third party to this equation but with the growth in the health sector and the dawn of the MHC era, various other partners were added to the equation, like the funder’s administrator, the service provider, and the service provider’s administrator.

Once the pharmaceutical role players are added to this chain, the list of role players (each expecting their share in the reward or payment system) can easily be as many as 10 or even more to link with one singular “incident” such as a visit to a general practitioner. Once the incident is escalated to a more specialist level, the list can actually double or even triple in volume, while costs increase at an even more alarming rate.

Keeping in mind that the patient simply wants a correct diagnosis and effective treatment, the question to ask is whether the MHC system is doing that. To answer this question one needs to rely on an outcomes-based evaluation of healthcare in general. This in itself is not possible in South Africa, simply because the statistics and records on which to base the evaluation are not always available.

In the private sector statistics are recorded and reported on in as far as the success of the MHC provider is measured as return on investment for the shareholders. The fact is that these figures – compared to the shocking lack of statistics in the public sector – provide as much information on the status of healthcare in South Africa as can be obtained from the public sector.

The reasoning behind this statement is that the private sector does not measure the non-funded treatments and procedures that patients often can only access through the public sector.

This is supported by the fact that funders in some instances, and for a varied number of protocols, have the public sector as a designated service provider. Unfortunately this collaboration between the public and private sectors is often found to be intentional only and not supported by actual service agreements – leaving the patient out in the cold.

When considering that the role of a governing body is to “set rates, monitor contracts and enrolment practices, make sure that plans have sufficient networks of doctors, oversee quality and performance, and ensure consumer protections for

members” (Bergal, 2013), the question needs to be asked whether enough has been done to ensure that these principles are incorporated into the South African health system. This would be an even more pertinent question to ask the proposed plans for National Health Insurance (NHI) that looks set to include partnerships between public and private enterprises.

The oversight role of government can also not be negated or neglected in managed healthcare and the mere fact that a service is offered does not measure the outcome which would be defined as the effect on the patients’ health. “Even if there’s an intent to aggressively monitor, you have to figure out whether and how they’re doing it.

And measuring quality is really, really tough. We can say immunisation rates have gone up or waiting times are down But measuring whether outcomes have changed substantively is very elusive and difficult to get at,” says Michael Sparer, Professor of Health Policy at Columbia University (cited in Bergal, 2013). This unfortunately rings true in the South African context as well, maybe not specifically on the immunisation issue, although an argument could be raised that if the immunisation programme itself were monitored more closely, there would not have been a need for the recent public drive on immunisation.

The underlying concern if the principles of MHC are not implemented and monitored properly, is that it is the patient who has to bear the consequences. It is at this point of disillusionment with the healthcare system, whether it is the public or the private sector, that patients seek the services of a person or organisation that would

assist them in sourcing the care that they have been denied.

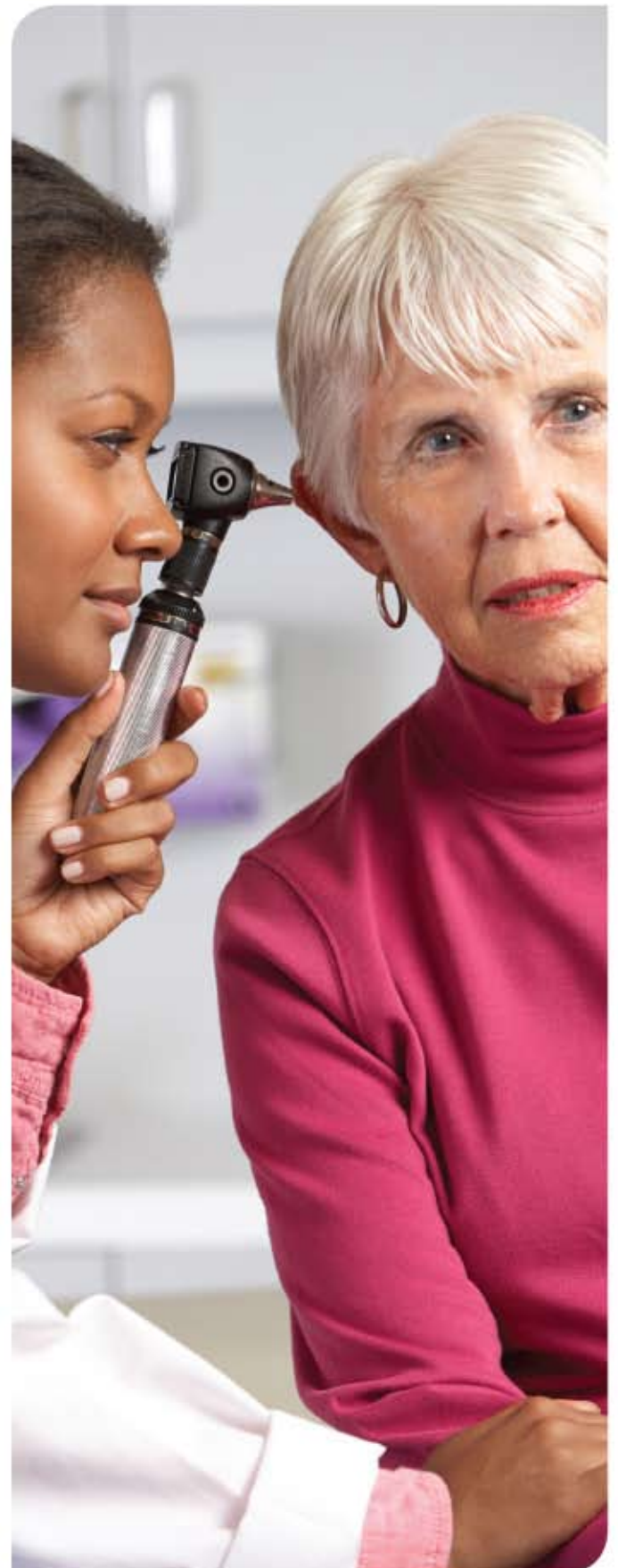
This would then be the point at which health-related non-governmental organisations (NGOs) are contacted to assist with their desperate plight for care. When considering the outcomes-based model that was described earlier, logic then tells us that NGOs are the “missing link” in the proper evaluation of any health system.

The more noise is made by NGOs, the more the delivery of services can be questioned. In South Africa the history of public organisations having to stand up for service delivery in the health sector paints a picture that is not always sunny and bright.

So what is the role that health-related NGOs or civil society organisations have to play? Traditionally the role of NGOs was that of patient support. This meant that a platform was created for patients with similar diseases and circumstances to interact and for the organisations to provide them with guidance and information on how to live with their disease.

With the growth in MHC, the role of these organisations had to change. It was no longer sufficient to lend an ear to the patient and provide some comforting words of support; patients needed somebody to fight for their rights and provide them with a voice as a partner in the health sector.

In South Africa the involvement of civil society ranges from the very active and sometimes very politically oriented to those that stay within their



traditionally localised role of patient support. In the last few years civil society has made a huge impact on benefits that patients are entitled to and we have seen some great examples of patients' rights being enforced through actions and programmes that were driven by these organisations.

Another development that affects health systems is the international collaboration of organisations working together to influence policy and direction for the future of healthcare. This collaboration is, however, not a one-way street where only demands are made, but it also includes the vital aspect of preventative action.

A shining example of this is the NCD Alliance with their slogan of "Putting non-communicable diseases (NCDs) on the global agenda".

The NCD Alliance has been successful in bringing the focus on NCDs through advocacy on the highest level of interaction in the global health arena. Of significance is the Global NCD Action Plan 2013 to 2020 of the World Health Organisation (WHO) that sets out a roadmap to achieve global NCD targets that WHO members (including South Africa) have agreed to.

With this as the starting point, "[t]he responsibility for action on NCDs has now shifted from the global level. It is imperative that governments have strong NCD policies, funding for NCDs, health systems-strengthening initiatives and effective policy implementation that can ultimately lead to improved health outcomes. Civil society has a key role to play in supporting their governments to meet their commitments and holding them

accountable on national progress on NCDs" (www.ncdalliance.org). This is a clear and direct call for government to include civil societies in the planning for the future of healthcare in South Africa, especially with the NHI system in the first stages of trial implementation where many lessons are learnt.

Many NGOs are no longer sitting on the sidelines but have become active and vocal advocates wanting to be part of the resolution that was the initial intent of MHC: quality services at an affordable price for the patient. By involving NGOs, there is an opportunity for growth in the South African health sector to work together to avoid the pitfalls or "managed care backlash" that "portrays managed care in an unflattering light." (Fox and Kongstvedt, 2007). What is evident from this is that some of the problems that NGOs have identified in South Africa are the very issues that were raised in the international and specifically the American context.

However, in the South African MHC system it seems that we have a long way to go before we will reach the point where we would be able to say, as also quoted from Fox and Kongstvedt (2007), that "[t]he managed care backlash has now become mostly an echo. The volume of HMO [health maintenance organisation] jokes has declined, news stories about coverage restrictions or withheld care are now uncommon, and there is little or no state or federal attention paid to placing restrictions on managed care plans".

Note that health maintenance organisations are the equivalent of MHC organisations.

Until such time that a defined benefit or basket of care is available and known to the patient, with government being at the forefront of ensuring this minimum standard of care, it is indeed the patient who will be at the receiving end of the growing pains in the development of MHC in South Africa.

It is important to note that one of the major focus areas for healthcare internationally is the prevention of disease rather than the reactive treatment of disease. Many NGOs have been on the forefront of public education and awareness about the disease groups that they represent and with the WHO focus on prevention there is even more reason for government to team up with NGOs.

NGOs have a huge role to play in ensuring that the standard of care is sufficient to serve the patient's needs, and many of them would welcome an opportunity to work with government rather than having to play the role of policing the developments in the MHC sector on behalf of the patients that make up the membership of these NGOs.

It is, however, clear that for MHC "what started out with simple roots has become complex, and will only become more so" (Fox and Kongstvedt 2007).

***For more information on the NKF
please go to www.nkf.org.za.***





The patient and managed care

*Lauren Pretorius
CEO, Campaigning for Cancer*



As a cancer patient advocacy organisation we constantly have to find the middle ground between the relevant facts in a matter and the emotional position taken to healthcare by patient-consumers. As South Africa grapples with providing healthcare services to a population whose average life expectancy is increasing, where long-term chronic diseases are steadily on the rise and innovations in medical technology and the provision of health services continue to evolve with ever increasing cost implications, new complexities in the delivery of and access to healthcare arise each day. These factors set a complex background to a system of defined and, currently, inflexible formulas to limit risk and ensure sustainability of medical scheme funds.

There is, however, one glaringly obvious fact that we, on behalf of all patients, need to point out: that our Constitution and the Bill of Rights affords

the right to access healthcare to every South African.

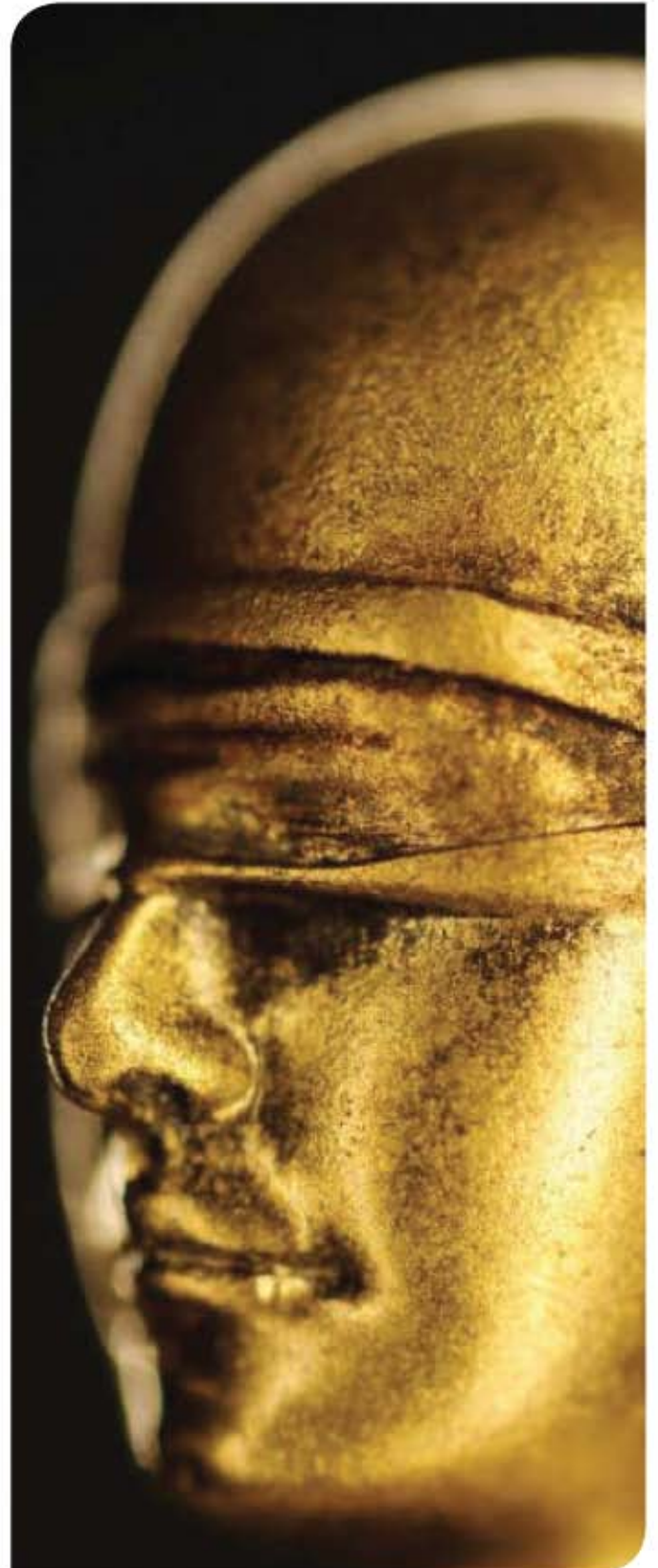
It is because of the very existence of these rights that the terms such as “appropriateness”, “risk”, “efficacy” and “necessity”, which are bandied about in relation to managed care, become worrisome and cause for our attention, as patient advocates. It’s also the point that we first encounter the emotional reaction of a patient-consumer to managed care.

Each year Campaigning for Cancer helps patients understand and navigate the managed healthcare sector in relation to the right to access treatment and the escalation of decisions to deny treatment plans. Most recently, we have dealt with patient cases that highlight managed care as having had both catastrophic health-related and financial implications for the patient.

Take Debbie*, a young mother of three who was diagnosed with an exceptionally rare cancer. Worldwide only 300 to 500 people are diagnosed with this type of cancer per year. Debbie's doctor knows this is an exceptional case and seeks help in formulating a treatment plan from an international centre that has had experience with treating this particular cancer.

The centre provides her oncologist with a treatment plan but certain components of the plan are not included in her scheme's managed healthcare protocols. However, the treatment regimen, which is novel, has shown amazing evidence-based results for the centre.

The irony of this case is that, according to the General Regulations to the Medical Schemes Act, 1998, Debbie's disease is a PMB. Four years later Debbie would not be alive if she had not received the prescribed medication, according to her doctor's previous experience of the regimens approved by managed care protocols. Debbie's young children are now four years older and she has had the opportunity to raise them. But the family faces catastrophic financial implications because a managed-care decision means they will have to cover the costs of all of her treatment; a treatment that costs significantly less than the treatment that would have been prescribed had Debbie been diagnosed with a HER2 positive breast cancer. Debbie and her family find themselves in a situation where managed healthcare was unable to adapt and accept the evidence-based medicine of an international expert.



“Appropriate” in the above scenario would have been for those in the managed-care setting to weigh the particular facts of the case with the capacity of the already allocated cancer benefit Debbie purchased to deal with her condition and treatment. “Appropriate” is not the rigid application of a set of protocols. In this scenario the inflexibility of managed care discriminated unfairly against a patient diagnosed with an unfashionable cancer.

When we explore the term “efficacy” in relation to managed care and in the case of a patient with Chronic Myeloid Leukemia (CML), another PMB condition, we must take into account the broader context of the practical results of denying access to life-saving medication. In recent years innovations in medication have resulted in a diagnosis, which was once viewed as a death sentence for patients, becoming a manageable disease with patients living more than 20 years post diagnosis.

To date, the facts put forward by managed-care circles was convincing in relation to the high cost of this innovative medication and therefore the resulting exclusion of this medication by most schemes. However recently a generic version of the medication was launched at over 50% less than the cost of the originator, once deemed unaffordable. Yet managed-care principles still deny patients access to the generic and, as a result, patients are forced to resign from their scheme in order to access the originator through the state sector.

While some might blame the access programme or the costs of innovative medication, fundamentally this scenario highlights where managed healthcare

falls short in a broader context of access to healthcare. The majority of patients who elect to forgo their private medical cover in order to access medicines in the state sector invariably have other co-morbidity factors resulting in the state now being responsible for managing the treatment of these illnesses as well. Does this not add weight to the argument that managed healthcare is, more often than not, failing the patient-consumer?

Yet, if we are to explore managed care in relation to the factual and emotional high ground, no situation brings the topic more into focus than the coverage of terminal or end-of-life care in the case of cancer.

The Constitution of the Republic of South Africa, 1996, the International Human Rights Charter, the South African Patients’ Rights Charter, the Medical Schemes Act and the WHO Guidelines on pain relief and end-of-life care should be the starting and ending point for any managed-care programme and are the undeniable “facts” we as advocates will base any request on for accessing treatment for the patients we represent.

Add to this the responsibility of patient advocates and advocacy organisations also to bring to light the “facts” of the emotional burden managed care can place on a patient and their loved ones. This is epitomised in the story of the Nkosi family*. Mrs Nkosi* fought a long and difficult battle against cancer and eventually her doctor had to break the bad news to the family that her cancer was now terminal and the best they could do was ensure she was not in pain and was comfortable in the last few weeks of her life.

Mr Nkosi had taken as much leave from work as he was able to and so he needed to return to work on a part-time basis. He was also responsible for the care of their two children, both under the age of 10. As his wife's disease progressed it became apparent that she would need continued care. They requested that their medical scheme cover the costs of a nurse to care for Mrs Nkosi at home for a few hours a day. The scheme denied this request stating that, in terms of managed-care protocols, the situation constituted frail care and was not covered by the scheme. However, the scheme would agree to admit Mrs Nkosi into hospital.

The daily costs of a home nurse are significantly less than the costs of admitting a patient to hospital, in addition Mrs Nkosi's children would have limited visitation with their mother if she were in hospital due to hospital visitor policies. The Nkosis faced a decision: should Mrs Nkosi stay at home and not receive adequate pain control and medical care or should she be admitted to hospital but be denied the opportunity to spend her last days in the comfort of her home surrounded by her children and family? In the case of the Nkosi family, are we really able to say that managed-care protocols provided the appropriate "necessity" of cover?

Fundamentally, the principle of managed care is to provide health services within the constraints of the resource settings in which we find ourselves. This is accepted but the effect of the decisions that are being made in the name of managed care results in healthcare constraints being placed on patient-consumers.



Managed care programmes must continually explore not only the facts in relation to the way in which services are provided but also the emotional and practical impact of these managed-care formulas, protocols and decisions on patient-consumers and their families. It appears, from the patient-consumer's point of view, that the emphasis of managed care is incorrectly placed on saving money and not people. If we, as healthcare service providers, want honestly to understand the effect that managed care has on stakeholders, perhaps we should place the emphasis on the practical implications that managed care has on the patient-consumer, as we are all, ultimately, here to serve the patients.

*Patient name changed to protect confidentiality.

**For more information on
Campaigning for Cancer,
go to www.campaign4cancer.co.za**



OUR VALUES

The values of the council stem from those underpinning the constitution and its specific vision and mission.

Being an organisation to a rights-based framework where everyone is equal before the law, where the right of access to healthcare must be protected and enhanced, and where access must be simplified in a transparent manner. The values below are key requirements of all employees at the Council for Medical Schemes

- 1. Ubuntu - We need each other to achieve our goals.*
- 2. We strive to be consistent in our regulatory approach.*
- 3. We approach challenges with a "can-do" attitude.*
- 4. We are proud of our achievements.*
- 5. We are occupied by doing something of value.*



Integrating the financing and delivery of healthcare

Nondumiso Khumalo

Senior Health Economist, Research & Monitoring Unit, Council for Medical Schemes (CMS)



According to the National Department of Health, South Africa faces a quadruple burden of diseases, consisting of a maturing HIV/Aids epidemic and high levels of tuberculosis, high maternal and child mortality, ever-increasing levels of non-communicable diseases, as well as a persistent increase in the incidence of violence and injuries. As indicated in a recent study by the Council for Medical Schemes, within the medical schemes population, changes in the epidemiological profile and an increase in the number of identified chronic conditions – such as cardiovascular diseases, cancer, diabetes, arthritis, and respiratory diseases – are a major source of hospitalisation, leading to high healthcare costs and long-term disability within the medical schemes population (CMS Prevalence Report, 2013).

Other factors which may have an impact on healthcare costs include the impact of new medical technologies, anti-selection behaviour, fee-for-

service reimbursement, induced demand, and over-utilisation, all of which drive up private healthcare costs, necessitating effective utilisation management, including a review of alternative healthcare delivery and financing models.

Within this background, the introduction of managed healthcare models enables medical schemes to interrogate clinical decisions made with regards to the type, frequency, and/or duration of the services provided to members. This broad definition of managed care includes managing healthcare delivery through the application of evidence-based medicine with the objective of managing costs, quality, and access to healthcare services.

Health maintenance organisations (HMOs) are one form of a managed care model. This model seeks to proactively address the escalation of costs within the medical schemes environment by integrating

the functions of insurance and healthcare provision costs effectively (Wholey et al., 1992).

Wholey et al. argue that HMOs provide a joint product consisting of health insurance coverage of a comprehensive package of services in exchange for a premium. Typically, HMO premiums are reasonably affordable while the healthcare package is comprehensive. In South Africa, an example of such models is found within some mining sector medical schemes. This article provides an overview of HMO operational models as reviewed by the Research & Monitoring Unit at the Council for Medical Schemes (CMS).

Legislative Framework

The legislative framework informing health service delivery within the mining industry in South Africa includes the following Acts of Parliament:

- Medical Schemes Act 131 of 1998
- Mine Health and Safety Act 29 of 1996
- Compensation for Occupational Injuries and Diseases Act 130 of 1993
- Occupational Diseases in Mines and Works Act 78 of 1973
- Health Professions Act 56 of 1974
- Income Tax Act 58 of 1962

Other statutes that have an indirect bearing include the National Health Act 61 of 2003, the Medicines and Related Substances Act 101 of 1965, the Pharmacy Act 53 of 1974, the Labour Relations Act 66 of 1995, the Basic Conditions of Employment Act 75 of 1997, and the Road Accident Fund Act 56 of 1996.

Mining Sector medical HMO operational models HMO operational model

Within this model, the provision of healthcare services is through a referral system from the medical scheme's Primary Health Care (PHC) centres to the employed and/or contracted specialists and mining hospitals. The PHC facilities are operated and managed by the medical scheme and staffed by full-time healthcare practitioners such as nurses, allied healthcare professionals, and general practitioners, including support staff.

Most of these facilities are rented by the medical scheme on an arms-length basis from the local mining companies or health service. While the beneficiaries of the scheme are at liberty to utilise the services of private professionals in the respective regions, the PHC centres almost exclusively restrict their services to the beneficiaries of the scheme.

Employment of doctors

The employment of healthcare practitioners in South African mines dates back to the early years of the twentieth century and should be seen within the context of interstate agreements with labour-source countries (Botswana, Malawi, Mozambique, and Lesotho) to provide comprehensive healthcare services to the migrant workforce, including addressing the problem of scarcity of healthcare facilities and healthcare professionals in the mining areas.

The mining sector has statutory obligations to provide medical surveillance, emergency care, as well as the treatment, rehabilitation, certification,

and compensation of employees with occupational injuries and diseases. The sector also has to ensure a healthy, productive workforce in a physically demanding and inherently risky work environment. Mining facilities are therefore staffed by full-time healthcare professionals (such as nurses, general practitioners, and specialists), and include supporting services such as pharmacies, basic radiology, pathology, and physiotherapy.

The employment of doctors within the mining sector models facilitates opportunities for unique provider arrangements with benefits towards cost containment and better health outcomes. Such arrangements eliminate the perverse supply-side incentives associated with fee-for-service reimbursement. In the context of such models, medical schemes do not interfere with the clinical independence of health professionals other than to require their participation in peer review processes and quality improvement programmes. Health professionals are also involved in the development and monitoring of programmes and interventions such as the medicine formulary and treatment protocols.

Coordination of care

The mining sector models provide unique lessons on coordination of care. Beneficiaries belonging to mining medical schemes access healthcare services within the HMO facilities according to scheme rules and their own health requirements. Research shows that healthcare provision is well coordinated, with a strong referral system from the scheme-owned PHC centres to the employed and/or contracted specialists and mining hospitals. Within the PHC centres, patients are first seen by

primary healthcare nurses who then refer them to general practitioners or allied healthcare workers, depending on the patient's medical need.

In certain instances, patients requiring healthcare while outside the HMO facility have access to a designated service provider (DSP), or they can access healthcare within another mining sector HMO where the medical schemes have entered into a partnership arrangement.

Other benefits in coordination of care include the following:

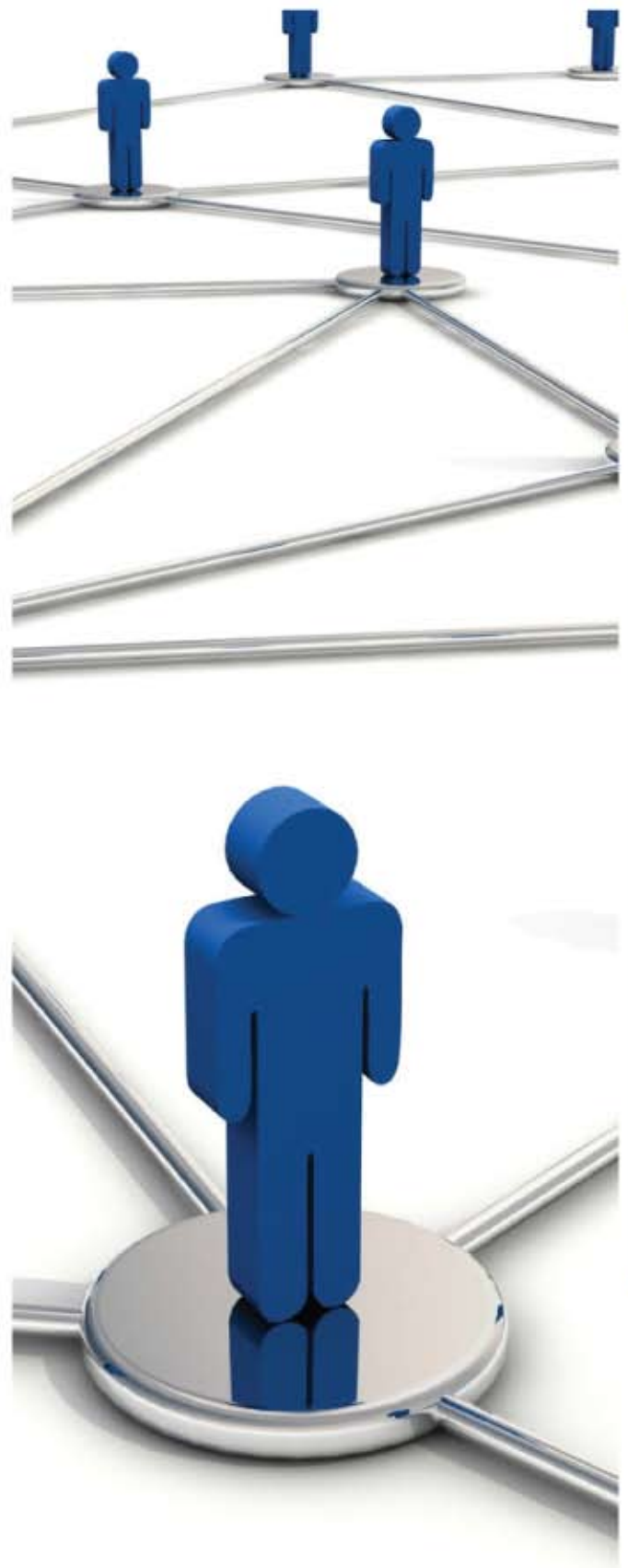
- PHC centres serving as gateway facilities with a strong referral system to higher levels of care;
- effective communication and coordination of healthcare between nursing care, medical care, laboratory requirements, x-ray facilities, and record-keeping within facilities;
- good cooperation between doctors in the hospitals and PHC centres;
- ongoing communication between doctors, specialists, and hospital clinicians;
- use of agreed treatment care pathways and protocols between the funders (medical schemes) and the providers (especially hospitals and specialists);
- use of real-time and off-site case management;
- member education about health facility location, operating times, and access requirements; and
- strong interface between employment requirements and adherence to treatment

for sick patients, including enrolment on appropriate managed care / wellness programmes.

Benefits of HMO Models

The key benefits of HMO models in the mining sector include the following:

- access to a comprehensive occupational and non-occupational healthcare service from mine medical facilities for beneficiaries;
- cost-effective service delivery;
- integration of primary healthcare with secondary healthcare requirements;
- coordinated care through patient channelling and an effective referral system;
- vertical integration between the health insurance entity and healthcare service providers;
- active case management (real-time and/or off-site) to determine hospitalisation requirement versus day-case admission requirement;
- use of standardised clinical protocols by the hospitals and specialists;
- reduction of reimbursement rates for providers through the monitoring of health outcomes;
- employment of doctors reimbursed through salary payments; and
- mitigation strategies against provider-induced demand and overuse of services by beneficiaries.



There are clear benefits of HMO models within the mining sector, but there are also some challenges which threaten the sustainability of these models:

- rising healthcare costs (which will make it difficult to keep contributions affordable in the long term);
- beneficiary competition with other medical schemes, leading to the problems of reduced risk-pooling for the mining medical schemes and different reimbursement methods used by schemes;
- inconsistency in the review and processing of claims between mining schemes and other schemes serving one catchment area;
- difficulty in coordinating care with government healthcare facilities, i.e. provincial clinics and hospitals;
- staff retention and high vacancy rate (support staff and healthcare professionals combined); and
- the views of the Health Professions Council of South Africa (HPCSA) about employment of doctors by medical schemes.

Conclusion

Integrated healthcare delivery and financing through managed care models such as health maintenance organisations (HMOs) can lower healthcare expenditure by reducing the quantity of services provided without compromising quality.

Reimbursement of healthcare providers mainly through capitation and salaries limits the use of fee-for-service reimbursement which leads to significant savings for medical schemes.

Cost-control measures such as effective monitoring and management of curative care, the integration

of PHC and/or wellness to the healthcare delivery model, use of a nurse-based healthcare system supported by general practitioners, and effective referral to specialists' care and hospitalisation result in huge savings for mining medical schemes.

The mining industry benefits from the advantages of health promotion and preventative care by coordinating workplace health initiatives and curative health delivery. The interface between employment requirements and adherence to treatment programmes by beneficiaries, including enrolment on appropriate managed care / wellness programmes, contributes towards cost-containment strategies benefiting medical schemes.

Empirical evidence on managed care from countries such as the USA suggests that managed care, when implemented effectively, has the potential to yield savings. For example, Douven et al. (2010) cite US studies which show that prices attained by managed care organisations (who traditionally are focused on DSP-type arrangements) are generally 10-20% less than insurers. Cutler (2000) found that HMOs have a 30-40% lower expenditure on the treatment of heart disease than traditional insurers, primarily due to lower unit prices rather than different treatment patterns. In addition, Ho (2005) cites Miller and Luft (1997) who show that HMOs spend approximately 10% less than indemnity insurance.

Contact details



RECEPTION

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