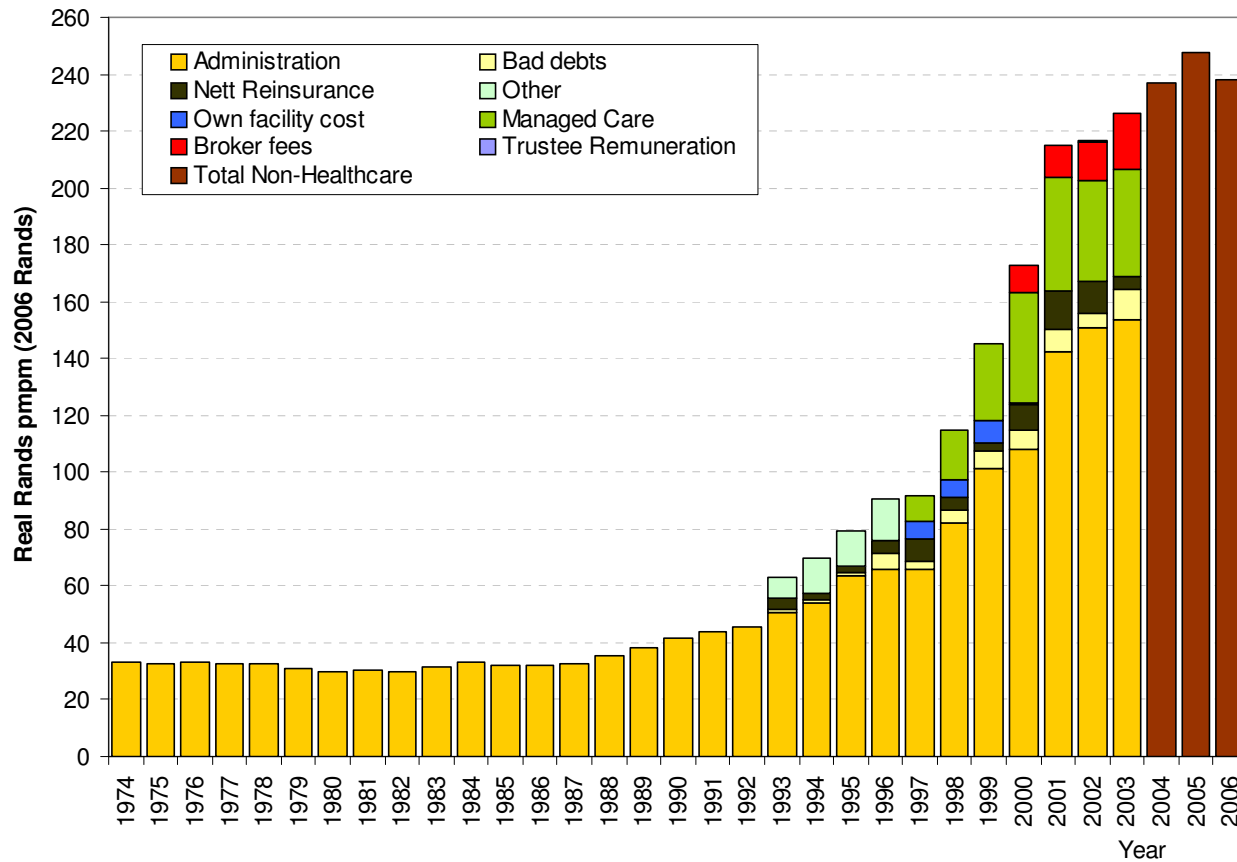


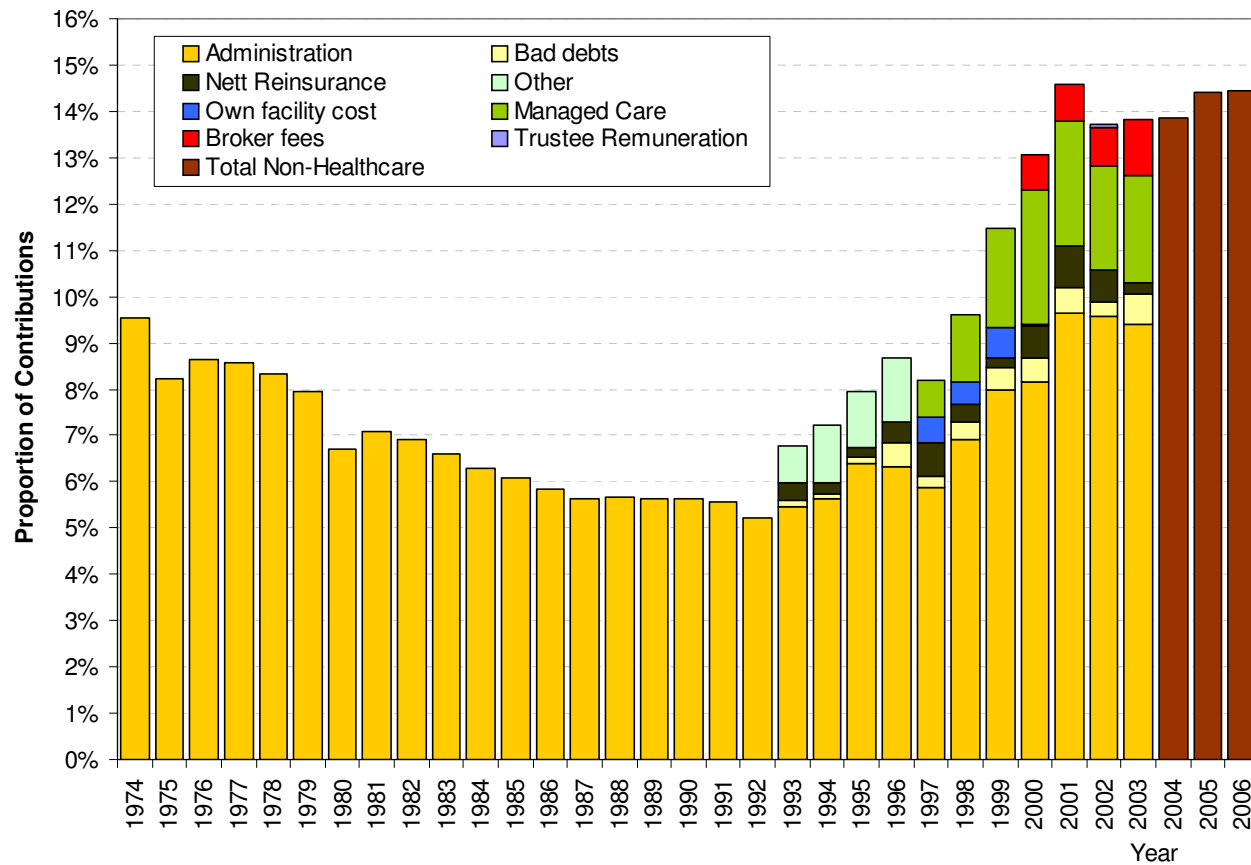
Should there be an NHRPL process for administration and managed healthcare costs?

NO !

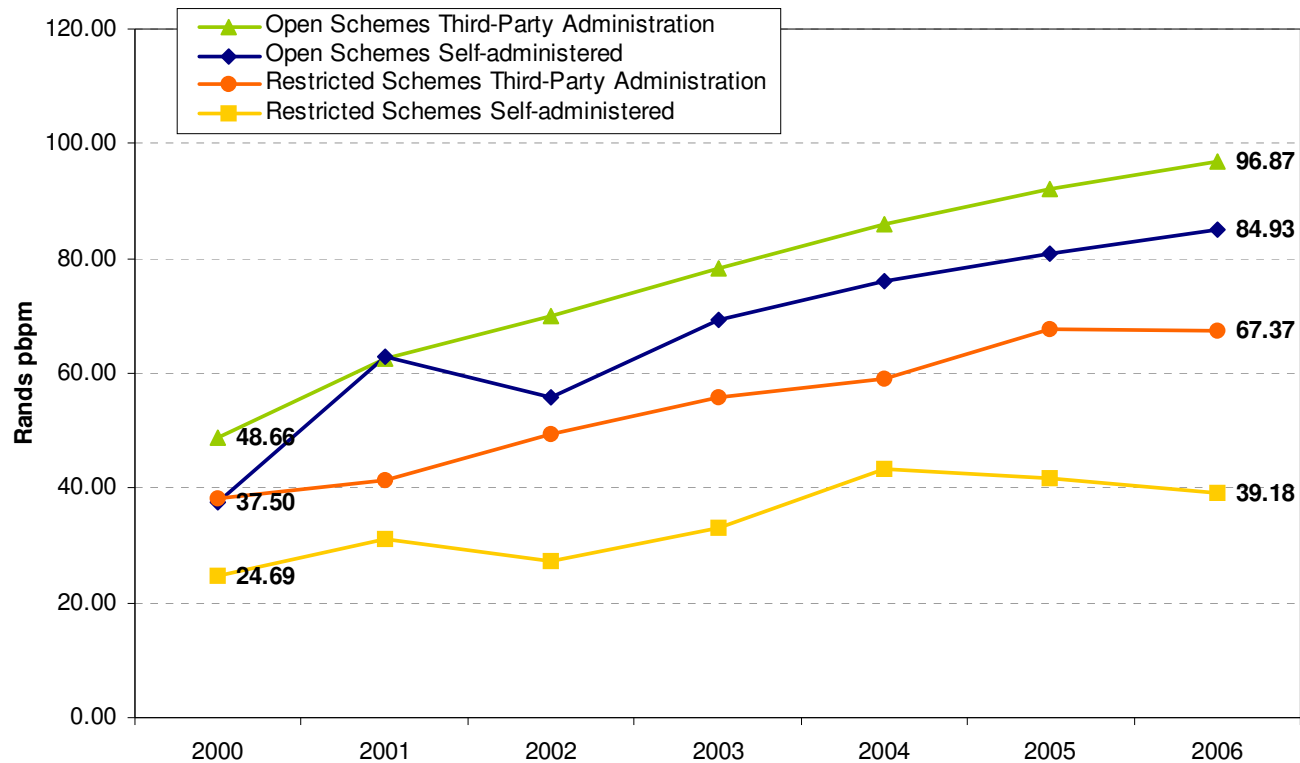
Historic Non-Healthcare Costs in 2006 Rands pmpm



Historic Non-Healthcare Costs as a percentage of Contributions

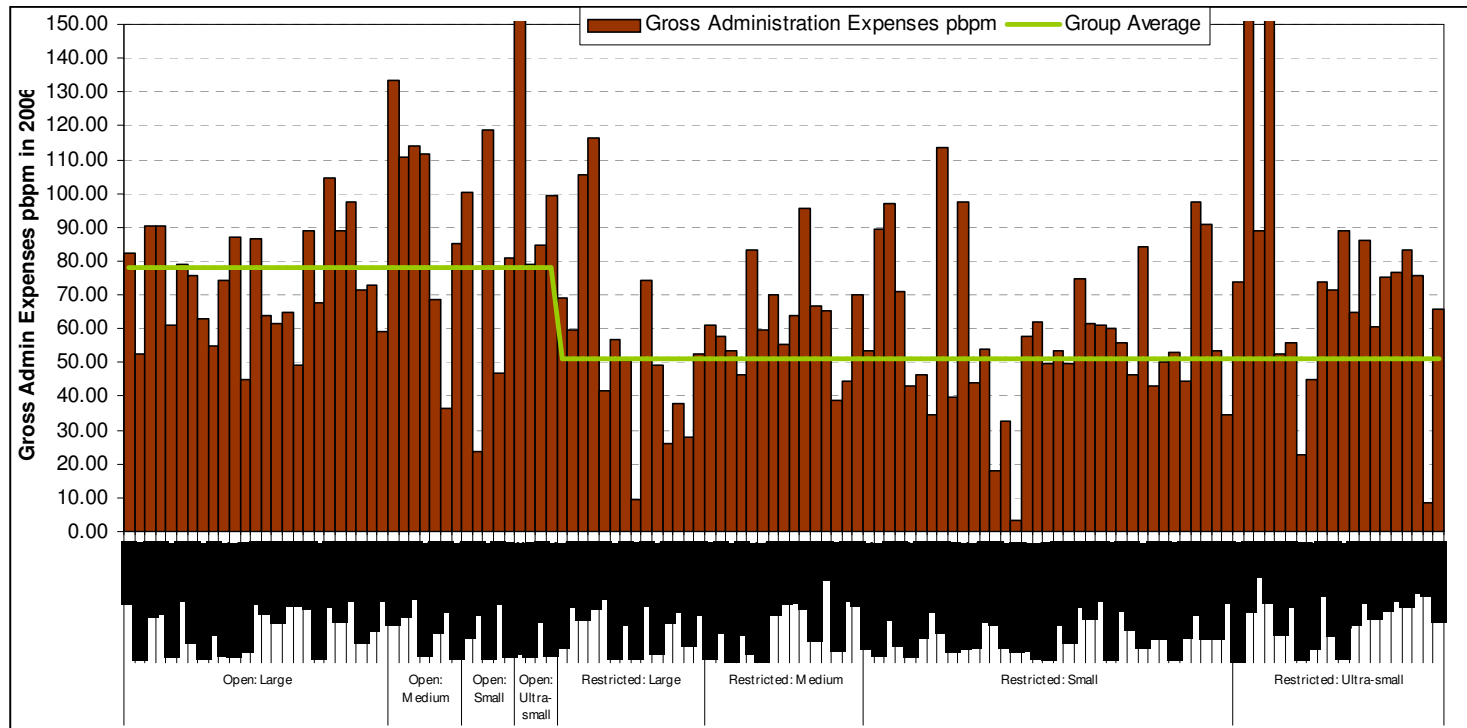


Gross Administration and Managed Care Expenditure by Type



Source: Council for Medical Schemes Annual Report 2006/7

Gross Admin Expenses by Scheme 2006



Very wide range with little relationship to size of scheme.

Source: Council for Medical Schemes Annual Report 2006/7

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Examples Gross Admin Expenses 2006

- Open Scheme average: **R78.0** pbpm
- Restricted Scheme average: **R50.9** pbpm

- Polmed: **R28.1** pbpm
- SAMWUMED: **R25.8** pbpm
- GEMS: **R46.4** pbpm [2007 Annual Report: **R27.00** pbpm]

- Platinum Health: **R9.30** pbpm
- Impala Medical Plan: **R3.50** pbpm

Source: Council for Medical Schemes Annual Report 2006/7

Gross Admin Expenses by Administrator 2006

Administrator Name	Gross Administration Expenditure	PABPM	As % of GCI
	2006 R'000	2006 R	2006 %
Discovery Health (Pty) Ltd	2 118 130	91,0	12,0
Medscheme Holdings (Pty) Ltd	900 841	61,7	9,6
Metropolitan Health Group (Pty) Ltd	529 530	44,4	6,8
Self administered	558 554	60,7	8,4
Old Mutual Healthcare (Pty) Ltd	274 532	64,0	10,5
Sovereign Health (Pty) Ltd	216 152	66,3	9,1
Allcare Administrators (Pty) Ltd	201 610	77,8	13,9
Rowan Angel (Pty) Ltd	178 058	73,0	11,9
Sizwe Medical Services (Pty) Ltd	123 952	71,5	10,7
Multimed Healthcare Administrators (Pty) Ltd	83 186	64,7	7,6
Triangular Health (Pty) Ltd	51 195	43,3	7,5
Resolution Administrators (Pty) Ltd	104 582	88,9	19,8
Sigma Health Fund Managers (Pty) Ltd	120 526	104,7	14,9
Status Medical Aid Administrators (Pty) Ltd	77 438	79,3	11,6



**There is
transparency.**

Source: Council for Medical Schemes Annual Report 2006/7

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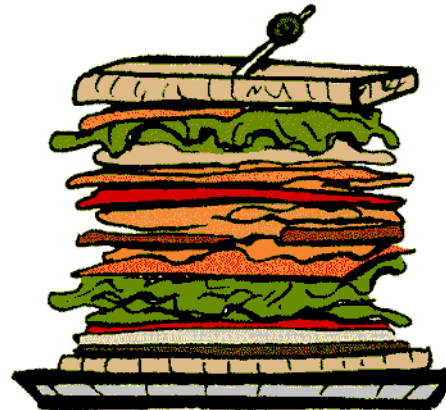
Are the Incentives Properly Aligned?

Incentives under Fixed Fee per Member

- To attract as many schemes with as many members as possible
(Income=price x volume)



- To add additional services



Incentives under Fixed Fee per Member

- To do only as much thereafter as will retain the client (minimize expenditure)
- Every additional person hired to provide better service reduces administrator profit (maximize profit)



SAMA Insider

April 2008



What drives healthcare inflation ?

Cutting the
Gordian Knot 

Fee-for-Service

- People are economic animals.
- **We get exactly what we incentivise.**
- If we insist on paying a fixed fee for admin and managed care, we should not be surprised if:
 - Number of services offered increases;
 - Unnecessary services added - duplication;
 - Price of services increases;
 - Quality of service is adequate – not great.
- Fixing prices or setting benchmark prices does not address the core problem of the **incentives** we have created.



Managed Care: Fee per Diseased Person

- Find diseased members ...
- Then do only enough to retain the client.

Risk Equalisation Fund

- Promised introduction of REF saw MCOs begin to hunt for beneficiaries with the CDL diseases.

Impact of Switching to Retrospective Hospital Payments

- Countries with an emerging health insurance model tend to start with a mixture of retrospective methods of payment and traditional item-by-item funding of medical facilities. [i.e. fee-for-service]
- Insurers in the Czech Republic, Hungary and the Russian Federation
- This encouraged hospitals to **increase workload** and contributed to higher **internal efficiency** of hospitals [from command and control].
- But structural inefficiency has worsened owing to the **growth of inappropriate admissions** and a **lack of constraint on using costly methods of care**.
- Czech Republic: introduction of retrospective payment system: **health expenditure increased by almost 40 per cent in 2 years**.
- Need for tougher regulatory requirements for health insurers to use less open-ended provider payment schemes.

The Blame Paradox and FFS Issues

- “What happens is this:
All stakeholders in the healthcare system consistently blame each other for the price and inflation pressures. The paradox is that each players position, when considered on its own, appears noble and justified. Yet when you consider them collectively, they contradict one another.”
- “As long as medical schemes pay for hospital care line-by-line and service-by-service, rather than at an agreed rate per day, or better still a fixed amount per procedure **as in any other market** it will be difficult to rein in costs”
- **Adrian Gore in Sunday Times, 5 October 2007**
- <http://www.hst.org.za/news/20041700>

Deloitte.



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Investigation into a
Procedural Coding System
For South Africa

Prepared by Actuarial & Insurance Solutions at Deloitte
And Dr Mark Ferreira

For the Board

Audit . Tax . Consulting . Financial Advisory .

DRG-based Payments to Hospitals

Is there a need for a generally available DRG grouper?

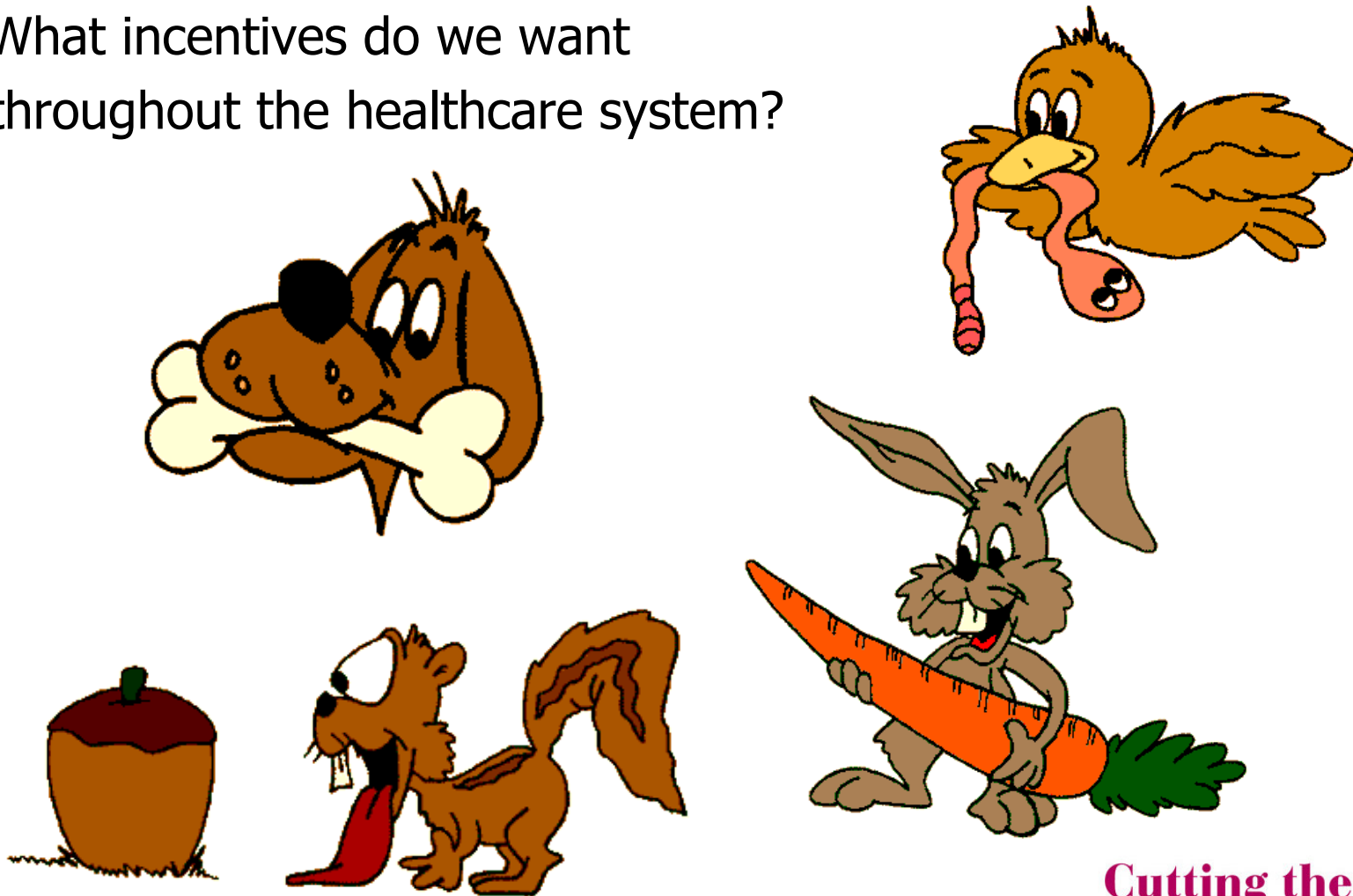
The answer to this was a unanimous “yes” from funders, and a cautious “yes” from hospital groups. Some hospital groups were more enthusiastic than others. Other players did not really have an opinion on the need for a grouper, as it would mostly be used in a hospital context. Two of the three hospital groups indicated that they believe a DRG tool would be a good thing, but one of these was undecided about whether they believe they should be reimbursed on the basis of DRGs, rather than fee-for-service.

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Incentives

- What incentives do we want throughout the healthcare system?



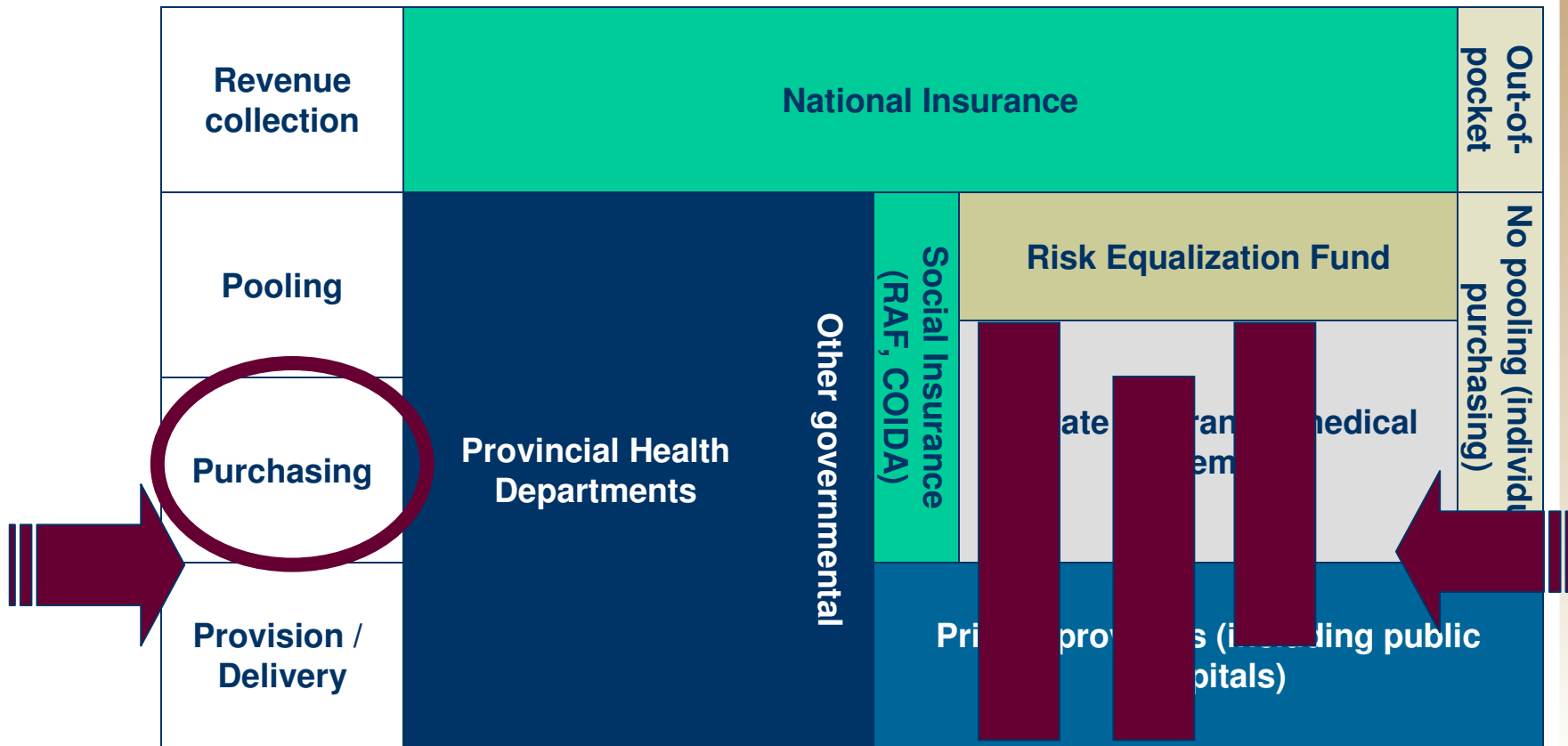
Medical Schemes and MCOs as a Technical Issue *

- What is the best way to organize for **efficient delivery** of healthcare?
- Medical Schemes Act allows schemes to deliver care – very few do so.
- What is the private sector really good at?
- What is it not good at?
- Should schemes be “de-mutualised” and have member shareholders? Member and provider shareholders? Member, employer, union and provider shareholders?
- Should MCOs be allowed to gather and pool funds?
- Should schemes be different from MCOs?

*See 2007 BHF slides and work by Nicholas Barr, Professor of Public Economics, London School of Economics

The Most Appropriate Vehicle ?

Kutzin Framework diagram



How do we best align incentives in the interests of the members ?



Australian Government
Private Health Insurance
Administration Council

Australia

- Demutualisation to become for-profit private health insurers under the Private Health Insurance Act, 2007:
 - NIB Health Funds Ltd (sixth largest- 6%)
 - MBF Australia Limited (second largest – 18%)
 - Australian Unity ?
 - Federal government pledged to privatize Medibank Private if re-elected, while Labor opposed the move (27% of market)
- BUPA already operates on a for-profit basis (10%)
- Another five for-profit entities in market.
- “Perhaps 60% of health insurance business will be in the hands of listed or for-profit companies.”

European **Observatory** on Health Care Systems Series

**Regulating entrepreneurial
behaviour in European
health care systems**

Edited by
Richard B. Saltman
Reinhard Busse
Elias Mossialos

Encouraging entrepreneurial behaviour

while protecting core social values

- www.euro.who.int/observatory/

Managed Competition

- A key aspect of health care reform in several European countries has been to strengthen 'market mechanisms' and 'entrepreneurial behaviour' while maintaining risk pooling and solidarity.
- Two intriguing economic ideas have caught the attention of health policymakers:
- Economically motivated health care purchasers who collect information on consumer needs, plan the most cost-effective medical interventions and contract selectively with the most efficient health care providers.
- A more competitive environment in which purchasers contract with both consumers (insured) and health care providers should be encouraged.
- (van de Ven 1990, 1994; Enthoven 1991).

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Source: Regulating Entrepreneurial Behaviour in European Health Systems



Regulate Admin Costs ?

- In non-competitive environments, the administration costs of purchasers are regulated. In some CEE and CIS countries, such as the Czech Republic, Poland, the Russian Federation and Slovakia, a ceiling for administration costs has been established as a percentage of social health insurance revenue (in the range **2–7 per cent**).
- Having an efficient health insurance administration should not be confused with minimizing costs of administration 'at any price'.
- Arranging prudent contracts with health care providers requires better trained and, therefore, more expensive personnel, as well as investments in management information.
- ...
- This work requires better entrepreneurial skills than retrospective payment ...

European **Observatory** on Health Systems and Policies Series

Purchasing to improve health systems performance

Edited by
Josep Figueras
Ray Robinson
Elke Jakubowski

Strategic Purchasing

- www.euro.who.int/observatory/



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Core Objectives and Actual Systems

- European national policy makers broadly agree on the core objectives that their health care systems should pursue. The list is strikingly straightforward:
 - Universal access for all citizens;
 - effective care for better health outcomes;
 - efficient use of resources;
 - high-quality services; and
 - responsiveness to patient concerns.
- It is a formula that resonates across the political spectrum ...
- Yet this clear consensus can only be observed at the abstract policy level. Once decision makers seek to translate their objectives into the nuts and bolts of health system organization, common principles rapidly devolve into divergent, occasionally contradictory, approaches.

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Source: Purchasing to Improve Health System Performance



Improving Health System Performance

- *WHO World Health Report 2000* put forward strategic purchasing as a major option for improving performance of health systems.
- It argues that where a purchaser model exists, countries should move from **passive purchasing** – whereby a predetermined budget is followed or bills are simply reimbursed retrospectively –
- to **strategic forms of purchasing** in which proactive decisions are made about **which health care services should be purchased, how and from whom.**
- The question of determining the appropriate purchasing agent – that is, what configuration buys health services more cost-effectively and according to the needs and wants of the population it represents – has yet to be answered.



Payment for Performance

Payment for Performance (P4P):
International experience and a
cautionary proposal for Estonia

- www.euro.who.int/Document/HSF/P4P_Estonia.pdf

**Health Financing Policy Paper,
Division of Country Health Systems**

**By: Alan Maynard
2008**

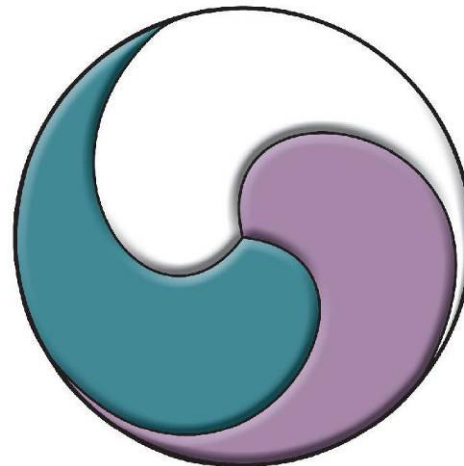


Purchasing and Delivery Incentives

- Want incentives aligned between society, the administrator / MCO, the fund and the healthcare providers.
- No “holy cows” and no easy answers – need a dialogue and consensus about what incentives would work best in South African healthcare.



integrated
healing



Body, Mind, Soul

Professor Heather McLeod
hmcleod@iafrica.com
www.hmcleod.moonfruit.com