'Capitation agreement' is now defined as an agreement whereby the scheme pays the person a fixed fee in return for delivery of specified benefits - or for a person arranging the delivery of specified benefits to all or any members of a scheme. SAMA is of the opinion that in negotiating and executing these agreements, the rules of the HPCSAin terms of fee-splitting, farming out etc., also have to be considered.

'Evidence-based medicine' refers to the 'conscientious, explicit and judicious use of current best evidence in making decisions about the care of beneficiaries whereby the actual clinical experience is integrated with the best available external clinical evidence from systematic research'.

'Managed health care' is defined as risk assessment and health care management clinically and financially with a view to facilitating appropriateness and cost-effectiveness of relevant health care services within the constraints of what is affordable, through the use of rule-based- and clinical management-based programmes'.

'Rule-based and clinical management-based programmes' refer to a set of formal techniques designed to monitor the use of, and evaluate the necessity, appropriateness, efficacy, and efficiency of health care services, procedures or settings, on the basis of which appropriate managed care interventions are made.

Medical practitioners are entitled to challenge the scientific basis of these programmes. They should also be able to enter into discussions with schemes (with their peers) on the conclusions reached by means of the use of these programmes. Doctors should also be mindful of dual loyalty situations, and remember that their primary duty is towards their patients.

'Managed health care organisation' refers to a person that has contracted to a scheme in terms of regulation 15a. A 'participating health care provider' is someone who has contracted directly with a scheme or who is delivering a relevant health service to the beneficiaries of a scheme. It should be noted that a 'designated provider' therefore is not necessarily the same as a 'participating health care provider'. One could therefore be a designated service provider without having a managed care agreement with a scheme.

A 'protocol' is defined as 'a set of guidelines in relation to the optimal sequence of diagnostic testing and treatments for specific conditions and includes, but is not limited to, clinical practice guidelines, standards treatment guidelines, disease management guidelines, treatment algorithms and clinical pathways'.

Regulation 15A: Prerequisites for managed care arrangements (changed *in toto*)

The regulations stipulate that the managed care agreement should be a written contract. Doctors should ensure that these agreements do not violate the HPCSA's policy on perverse incentives or ethical rules on issues such as commission, rentals of rooms, turnover etc.

The regulations also stipulate that the existence of a managed care agreement does not absolve the scheme from its responsibility towards its members, if any other party to the arrangement (e.g. the provider) is in default with regard to the provision of any service in terms of the agreement.

The limitation of rights or entitlements imposed by a managed care agreement must be submitted to the Registrar of Medical Schemes, 30 days before such limitations are to take effect. This would include limitations in terms of formularies (inclusions and exclusions), protocols and coverage of disease states.

From 1 January 2004, the person with whom the scheme enters into an agreement must be registered as a managed health care organisation with the Council.

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PRACTICE MANAGEMENT

MODELS OF PRACTICE MANAGEMENT

Health care costs have risen above inflation over the last decade and have placed health care services beyond the reach of many South Africans.

Akey component of managed care initiatives is the reduction in costs and this provides the single most important reason for the introduction of managed care in the South African health care market. Managed health care has grown in the USA, because it allows employers to purchase health care services for their employees at a lower cost than traditional insurance.

The health care sector will in future allow for a combination of fee-for-service and managed care systems. Managed care will probably constitute the main growth area in the private sector. It may also provide the vital interface between the public and private sectors.

Managed care initiatives introduced within the South African market to date have had a variable success rate. Comprehensive initiatives have generally failed due to hostile relations with providers, an American approach to health care delivery, over ambitious plans and the inability to recognise new business requirements. Focused initiatives such as pharmacy benefit management and utilisation management have however yielded beneficial results.

Key features of managed health care delivery systems are:

- integration of services;
- increased competition;
- need for information;
- new payment methods such as capitation;
- quality assurance mechanisms;
- cost-containment procedures;
- formation of strategic alliances, and
- regional variations.

The core elements of managed care are control of patient access to providers and utilisation management. The objective is to optimise the use of resources while monitoring the quality of care provided, as well as the outcomes.

Two common elements in all managed care systems are therefore the presence of an authorisation system and a restriction on a member's choice of provider. Member benefits are normally reduced in instances where unauthorised services are accessed outside the managed care system.

Managed Care versus Fee-for-service

Managed care is about comprehensive care. It manages preventive, promotive, rehabilitative and curative care. Sponsors of managed care systems in South Africa include traditional medical schemes.

Many tools or techniques are used to achieve the goals of managed care systems. Examples of such tools or techniques are provider networks, fee schedules, risk-sharing arrangements, contracts, clinical guidelines, utilisation review programmes, formularies, financial incentives and quality assurance programmes.

Managed care is still regarded as synonymous with the system of health care delivery that prevails in the United States of America. An evaluation of other international health care delivery systems however indicates that managed care principles are increasingly incorporated into these systems. There are also significant differences between the United States and South Africa, which makes a duplication of American-style managed care models impossible.

In addition, primary care providers in the USA are defined as family practitioners, internists, paediatricians and in some instances obstetricians and gynaecologists. These differences as well as other demographic, economic and geographic factors will determine the model of managed care to be implemented in SA. It is therefore recommended that terms such as 'coordinated' or 'integrated care' rather than 'managed care' should be used in the South African context.

No ideal managed care model exists. For a better understanding of the principles of managed care, it is useful to briefly review some of the models and payment methods applicable in the USA.

Models

In addition to caring for private patients, providers can form part of a network that negotiates terms and conditions for health care delivery with managed care organisations for their members. They could also be employed by the managed care organisation and care exclusively or predominantly for the members of that organisation. Some examples are:

- Health Maintenance Organisations (HMOs)
- Preferred Provider Organisations (PPOs)
- Exclusive Provider Organisations (EPOs)
- Point-of-service
- Physician Hospital Organisations (PHOs)

Health Maintenance Organisations (HMOs)

A health maintenance organisation (HMO) refers to the arrangement between administrators of a payer (funder) and providers of health care, for the provision of an agreed set of health services to an enrolled group of persons for a prepaid sum.

HMOs provide, offer or arrange comprehensive health care services through a network of providers for their enrollees in return for a prepaid fee. Services usually include primary, emergency, acute hospital and extended care as well as rehabilitation. Some providers are placed at risk for medical expenses. Primary care providers are often used as gatekeepers. An HMO can be viewed as a combination of a health insurer and a health care delivery system.

Under the Federal HMO Act, an entity must have three characteristics to qualify as an HMO, namely:

- An organised system for providing health care or otherwise assuring health care delivery in a geographic area
- An agreed upon set of basic and supplemental health maintenance and treatment services
- A voluntarily enrolled group of people
  - * The basic HMO models are:
  - * Staff model HMOs
  - * Group model HMOs
  - * Independent Practice Associations (IPAs)
  - * Direct contract models
  - * Network model HMOs

The major difference between these models relates to the relationship between the HMO and the participating providers.

Staff model HMO

In this model the HMO owns the hospitals and employs all the health care professionals who provide or arrange for covered services to members of the HMO in its own facilities. The providers are paid salaries, but additional incentives such as performance bonuses, after-hours work and call-outs also exist.

In certain instances, independent providers will be sub-contracted to deliver services that the employed doctors are unable to deliver. This is a form of closed panel HMO. Vaalmed used to be an example of such a model in SA.

Group model HMO

A group practice is a separate legal entity that operates either as a single or a multi-specialty practice. Akey feature of a group practice is the sharing of facilities, equipment, accounting systems and support staff. In the group model HMO, the HMO contracts with the group practice for the provision of health care services to its enrolled members at a negotiated rate or on a capitated basis. The group in turn compensates the individual providers (e.g. salary, dividend or profit share) and is responsible for contracting with hospitals for care of their patients. The group can be restricted to provision of care for the HMO enrollees only or it can be allowed to care for non-HMO members as well as private patients.

Independent Practice Associations (IPAs)

The Independent Practice Association (IPA) is a group of independent doctors which practices in their own consulting rooms. The HMO in this model contracts with the IPAwhich in turn contracts with individual providers for the delivery of care in return for a negotiated fee. The IPAdoctors continue to see fee-for-service (non-HMO) patients. The HMO usually reimburses the IPAon a capitated basis whilst the IPApays the providers on a fee-for-service or capitated basis. This type of system combines pre-payment with the traditional means of delivering health care. Providers must usually meet pre-determined credentialling criteria to participate in the IPA. IPAs provide a broad choice of participating doctors and create the ability for providers to negotiate as a group. Providers retain the ability to directly negotiate and contract with other managed care plans and private patients.

Direct contract model

In this model the HMO contracts directly with doctors in private practice, rather than through an intermediary such as an IPA, to provide health care services to the enrolled members. Individual practitioners are usually paid on a fee-for-service or capitation basis and are generally also free to see non-HMO and private patients.

Network model

In the network model the HMO contracts for health care services with multiple single specialty or multi-disciplinary group practices to deliver health care to members usually on an all-inclusive capitation basis. Each group is usually financially responsible for reimbursing specialist referrals, hospitalisation and ancillary services. This model is distinguished from group models that contract with a single group practice, from IPAs that contract through intermediaries and from direct contract models that contract with individual doctors.

Preferred Provider Organisations (PPOs)

Preferred Provider Organisations (PPOs) are entities through which employers and payers contract to purchase health care services for their members from a selected group of providers (preferred providers) at a discount (predetermined fee).

Participating providers in PPOs usually agree to abide by utilisation management and other procedures implemented by the PPO and agree to accept the PPOs reimbursement structure and payment levels (usually fee-for-service). The employer and/or payer often establish financial incentives in the form of increased benefits for their employees to use the participating preferred hospitals and other health care providers and limit the size of the preferred provider panels. In contrast to typical HMO coverage, PPO coverage permits members to use non-participating providers at an extra cost. Some PPOs require providers to share in the financial risk. Others employ the gatekeeping concept.

Exclusive Provider Organisations (EPOs)

Exclusive Provider Organisations (EPOs) are similar to PPOs in their organisation and purpose. However, members covered by an EPO are required to receive all their covered services from providers in the EPO.

The EPO does not cover services received from other providers. Some EPOs also use a 'gatekeeper' approach to authorise non-primary care services.

Point-of-service

This model is a combination of an HMO and a PPO.

The patients are generally required to select a primary care doctor who acts as gatekeeper. Although there is benefit coverage for non-participating providers, there is a penalty in instances where the patient decides to receive care outside the network. This model allows patients to decide whether they wish to receive services inside or outside the network at the time that the service is required.

Physician Hospital Organisations (PHOs)

APhysician Hospital Organisation (PHO) is a separate entity that is jointly owned and operated by hospitals and their affiliated doctors.

The integrated entity is used for negotiations, contracting, risk-sharing arrangements and an organised approach for doctors and hospitals to work together on managed care issues such as utilisation management and quality improvement. Many PHOs have been unsuccessful as a result of the conflict and divergence in goals between the hospital management and the participating health care providers.

This article is the first in a series drawn from notes of the Foundation for Professional Development's course on Managed Care.