NEWS

BOARD OF HEALTH FUNDERS OF SOUTHERN AFRICA CONFERENCE, MAY 2004

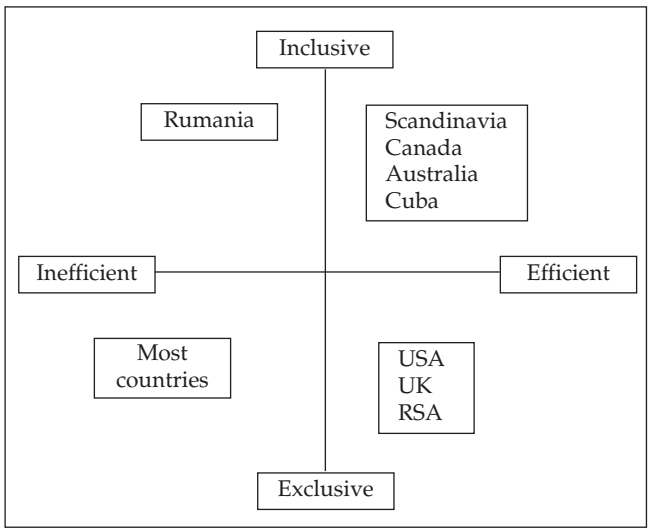
Winning strategies for the future

Keynote address: **Clem Sunter,** *Chairman of the Anglo American Chairman's Fund*

If the health sector goes down, it will impact on every industry in South Africa. Health care providers will leave the country. This was the view of one of South Africa's most notable scenario planners. In previous writings he had predicted the 'gilded cage scenario' in which the USA protected itself by putting a cage around itself, which has happened post-9/11. This has been resented by the rest of the world.

One of the most influential factors on the economy for the next 2 years is the oil price, which Clem Sunter believes may go as high as $50 per barrel. The world is in for tough times, he said. It is against this background that one must develop winning strategies for health care delivery. The industry could take the 'high road', i.e. negotiation, or the 'low road', i.e. confrontation.

The 'gameboard' of health care delivery could be viewed as a matrix:



Efficient and exclusive provides the best health care if one has money. Inefficient and exclusive: Health care can be obtained if one has the money. Efficient and inclusive: Australia, Canada and Scandinavia have the *per capita* income which allows them to put health care systems in place. Cuba's health care system is tightly controlled. Inefficient and inclusive: One simply cannot get health care.

Change from efficient/exclusive to efficient/inclusive, without landing in inefficient/exclusive or inefficient/inclusive, has to take place against a background of a war against HIV/AIDS.

It is clear that South Africa has to develop a more inclusive health care system.

Reg Magennis, *Director of Elixir Health Consulting,* followed with his presentation based on a discussion document titled, 'Key drivers shaping the structure and performance of the South African private health care delivery system: Towards an agenda for debate and response by stakeholders.' This discussion document was developed by Magennis from a survey of a panel consisting of 9 leaders in the health care delivery field.

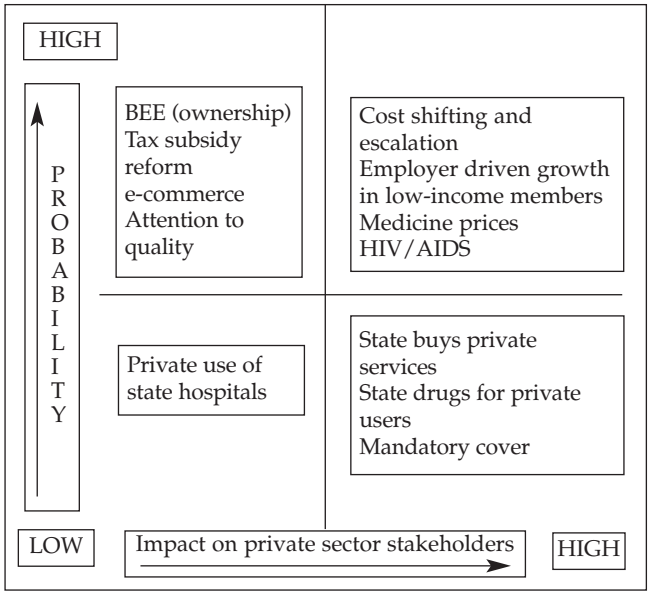
The paper identifies 13 key drivers for health care delivery systems:

- Affordability — the cost of health care is becoming too high for the less affluent.
- Policy intent and sequencing — the move towards social health insurance (SHI). If the desired response is not achieved, more regulation may follow.
- Medicine price reforms, formularies and generic substitution – role players could behave in a way that negates desired outcomes.
- Public sector services to covered persons.
- Integration within the private sector market — a move towards a fully integrated funding and delivery system.
- Quality of the investment environment — investment money may move out of the stock market and, if so, it is questionable whether future investments will be sustained.
- Pessimism/despair of professional practitioners.
- Civil servants medical scheme — this has the potential to set the benchmark for future health care systems.
- Alternative reimbursement systems — managed health care organisations, inclusion of doctors and other professional practitioners, risk sharing, data sharing, etc.
- Co-operation between private stakeholders and the Department of Health (DOH) — holistic co-operation between the DOH and the private sector.
- Risk Equalisation Fund (REF) — this will have a low impact initially, but has great potential for reform.
- Transformation and black economic empowerment (BEE).
- Mandatory contributions — will have a great impact in the next 5 years.

The possible outcomes in the next 5 years could be as shown in the matrix below:

The outcomes will impact on:

- medical schemes
- administrators
- specialists
- manufacturers — increased generic-branded differential
- GPs — growth in lower income sector; network alliances with hospital groups
- pharmacies — integration/alliances with primary care delivery.



There are thought to be two major options:

- Private sector stakeholders play the regulations to the best short-term advantage and the DOH responds with more regulations; or
- There is recognition of the high economic risk of failure and the DOH and the private sector try to co-operate effectively.

They would have to monitor the impact of regulations, set goals and agree on corrective action.

During the debate in this session, the following points were raised, among others:

- The most important point is affordability. There is a need to set stringent targets and goals.
- Inclusivity will not be achieved by lowering costs, but by increasing income. More needs to be done to sell the schemes to current customers and to work with government on inclusivity issues.
- In countries such as Scandinavia, Canada and Australia most of the population is economically productive. In South Africa, we should strive to get people to 'make less in the bedroom and more in the factory'.
- On the question of transformation, there are two aspects to consider:
  - Facilitation of access to health care; and
  - BEE in the health care industry.

Dr Kgosi Letlape, *Chairman of the South African Medical Association,* speaking from the floor, said that despite the changes that have taken place in South Africa, there is still a large sector of the population that does not have access to health care. We need to bring in fresh ideas, possibly from outside South Africa. 'Medical apartheid' is a time-bomb waiting to go off. He suggested a National Health Forum as a step forward to reach the objectives of transformation.

The two major points emerging from the debate were:

- The need for the establishment of a National Health Forum; and
- Setting goals with measurable increments.

Past, present and future

Dr Kamy Chetty, *Deputy Director-General of Health and currently Acting Director-General,* reviewed the past 10 years in the health care delivery industry, and presented some thoughts about the future. She said that significant strides had been made in the health sector: deracialisation of health services, integration of fragmented departments, improved access, stabilisation of the medical schemes industry, and a comprehensive programme to deal with disease.

New clinics have been built, public hospitals have been revitalised and upgraded, spending on primary health care has increased, and community service has added doctors, dentists and pharmacists to the staffing complement. There has been a decrease in morbidity and mortality. The country should be polio-free by 2005, there have been no measles deaths since 1999, and malaria deaths have been decreasing.

One of the problem areas is the containment of the TB epidemic. Despite high DOTS coverage multidrug resistance is increasing. The quality of DOTS support and nutritional supplementation is an area of concern, as is the high prevalence of non-communicable chronic disease — hypertension, diabetes and asthma being the most worrying.

The next major initiative will be SHI, which aims to make health care available to all citizens in an equitable manner within a unified health care system. Three components have been proposed:

- mandatory cover
- risk-related cross-subsidies
- income-related cross-subsidies (see the report of the presentation by Professor Heather McLeod on the REF below).

Dr Chetty said we should build on the successes of the past and deal with those issues which have not been successful. A health charter will be developed, which will deal with issues like access, equity, quality of care, ownership, corporate social investment, etc.

Dr Chetty concluded by saying that the private sector has an important role to play, which the DOH has no wish to destroy, but government's role must be to consider equity, access, affordability, quality and sustainability.

Dr Siva Pillay, *a member of the Council for Medical Schemes (CMS),* presented a snapshot of the current situation, but emphasised that this is a living, ongoing process with constant change.

A prospective approach is to be followed in a regulating as opposed to a passive one, leaving the industry to the vagaries of the market, economy, and disease patterns. The types of regulations which are anticipated are:

- risk-based regulation, which puts schemes into high-,

medium- and low-risk categories
- thematic regulation, concentrating on treatment of beneficiaries and the public, risk assessment plans and risk mitigation plans for high-impact schemes
- managed health care and risk transfer to review current capitation contracts, assess the appropriateness of forms of risk transfer, and proposal of mechanisms to ensure the appropriateness of risk transfer.
- research-based regulation – sound research into trends in private health financing – this will involve internal research, as well as study visits and hosting of regulators from other countries
- participative regulation – involving consultative processes with stakeholders
- developmental regulation – developing knowledge, skills and abilities of key decision makers in relation to scheme governance and enhancing consumer awareness
- compliance-based regulation – tough enforcement actions against non-compliance.

All of the above are to be carried out in a fair and transparent manner, with integrity, professionalism and respect; maintenance of cost-effectiveness, not unduly impeding innovation, while facilitating fair competition.

Before ending, Dr Siva discussed the question of tariff setting. The DOH and the CMS has set up a task team, which will develop an independent approach to this vexed question.

Paying for value: Applying evidence to health care benefit design and funding

Keynote talk: **Professor J Volmink**, *Director, Cochrane Centre*
How can evidence-based medicine (EBM) help funders of health care? EBM is defined as the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient.

Why should EBM be used?

History confirms that:
- doctors (and patients) generally overestimate the value of medical treatment
- doctors have an enormous propensity to do harm
- damage is promoted by medical arrogance
- the risk of inflicting harm can be reduced through making decisions based on the best available evidence.

Professor Volmink said that lessons could be learned where accepted clinical practice is altered as a result of evidence:

Pregnancy. The antenatal visit schedule has generally included 14 visits. Randomised controlled trials (RCTs) have shown that in low-risk pregnancies the number of visits can be reduced without untoward effects.

Lesson: It is important to differentiate between medical ritual and evidence-based practice.

DES (diethylstilboestrol). From the 1940s DES was given to pregnant women to prevent miscarriage. A RCT comparing DES to placebo showed that there was no difference in prematurity, pre-eclampsia or perinatal mortality. Twenty years later, the daughters of the women who had had DES developed cancers and infertility. Even sons had testicular problems.

Lesson: Plausible biological theories are not a good substitute for reliable evidence from empirical research.

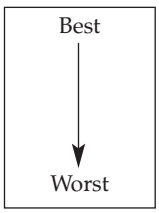
Anti-arrhythmic drugs for heart attacks. Studies showed that abnormal beats can be suppressed with anti-arrhythmic drugs. In 1991, the *New England Journal of Medicine* published a trial which showed that patients who received anti-arrhythmics were more likely to die than those who did not.

Lesson: Clinical experience is necessary but is not sufficient for making good decisions.

Colloids v. crystalloids for resuscitation of critically ill patients. A Cochrane review of 30 RCTs showed that there is no evidence that human albumin reduces mortality. It may, in fact, increase mortality. The proponents of albumin supplementation criticised the results.

Lesson: Vested interests often lead to vociferous and unrelenting resistance to evidence.

Best-to-worst evidence:



Systematic reviews of RCTs
One good quality RCT
Observational studies
Opinion of respected authorities based on clinical evidence, descriptive studies or reports of expert committees
Someone once told me …

Professor Volmink concluded, 'One should practise humility-based medicine — one cannot always know all truths'.

Dr Derrick Burns, *Medical Director, Solutio Health Risk Management*, titled his talk, 'Evidence-based resource allocation – a doctor-patient perspective'. He said that paying for value means ensuring access to optimal health care benefits within existing resource constraints through funding what is proven to be scientifically appropriate. The process must be credible and legitimate; the criteria must be consistently applied; the decision must be publicly accessible; and there must be recourse to appeal. The criteria should be based primarily on EBM but also on economic and ethical principles. They must stand up to comparison with standard best practice. They must be set against local and community contexts.

'Evaluation of technology' was the title of the talk given by **Dr Manie de Klerk**, *Director of Clinical Services, Qalsa*. There is a need for evaluation of technology.

The new technology must be safe and cost-efficient, it must prevent harm and improve the quality of patient care.

Five questions about new technology need answers:
1. Have the legal requirements been met?
2. Is there evidence that it does what it claims?
3. Is there evidence from independent observers?

4. Is it applicable in a relevant setting?
5. Is it cheaper or better than present technology?

A stepped approach is best, where clinical and evidence-based information is used. There is a need for a single guideline per technology/disease, but the challenge is how to deal with vested interests.

Dr Brian Ruff, *General Manager, Clinical Risk Management, Discovery Health,* spoke on funding decisions and the role of health economics. Health economics is the tool used to provide a balance between new expensive treatments and improved quality of care. This would require analyses.

One type is a cost-effectiveness analysis (CEA) where two treatments are compared. The inputs are the costs, and the outputs are outcomes measured in 'natural' units such as years of life saved.

A cost utility analysis (CUA) uses the cost of multiple treatments as inputs, and a combination of different measures combined into a 'single' measure as outcomes. This uses 'soft' measures such as pain, suffering and disability combined into QALYs. One may find that there may be more benefit, but at a much higher cost.

'Health economics' is an aid to decision making, and although not perfect, it is the best we have.

Risk equalisation fund

Open medical schemes are compelled to accept anyone as a member and may not base contributions on the member's age or state of health. The schemes are also compelled to provide the prescribed minimum benefits (PMBs) for a list of 25 chronic conditions. Therefore, if a scheme has a high number of members with the conditions listed in the PMBs, it will have to spend more than a scheme with a low membership requiring PMB coverage. The REF will compensate those schemes that have more older and more sickly members.

Professor Heather McLeod, *Chair of the REF Formula Consultative Task Team (FCTT),* staff member of the universities of Cape Town and Pretoria, and EXCO member of the CMS, provided an update on the progress towards the implementation of the REF.

The REF is designed to redistribute and allocate funds for the expected costs of people insured, and to prevent competition between medial schemes on the basis of risk selection. Competition would be encouraged based on cost and quality of health care delivery.

There are 3 issues of unfinished reform on the agenda for implementation of SHI:

- risk related cross-subsidies
- income-related cross-subsidies
- mandatory cover.

It has been agreed that there is urgency to introduce SHI. Risk equalisation is an essential prerequisite. A shadow operation of the REF will start in January 2005, with the first monetary flows in January 2006. The final definitions of chronic conditions will be completed by the end of May 2004. The REF contribution table is to be published each year in August. It is suggested that the REF makes quarterly contributions to medical schemes. Risk factors should be updated periodically. The REF should be administered by the CMS, but a separate entity may be required for supervision.

Draft legislation for the SHI Equity Fund Act is currently under review by the DOH.

In order to improve competition, it has been proposed that a basic benefits package be instituted. This should cover members for risks which could jeopardise their livelihoods if no insurance existed. It would contain a reasonable, socially acceptable minimum level of services. Added to this would be a choice from a limited number (3 - 5) supplementary benefits packages. This will reduce competition based on a large number of benefits packages and increased price competition between schemes. Details of contributions for these supplementary packages are being calculated.

The FCTT recommends that medical schemes be forbidden to pay brokerage fees, which should reduce contribution levels. A minimum subscription period of 12 months is suggested. The Registrar of Medical Schemes will produce an annual brochure covering all schemes, including a simple reply card that members can use to announce switches from one scheme to another.

There is a need for a concerted effort towards cost containment, and the responsibility for this should be clearly placed in one particular body. At present, there is no-one responsible for cost containment.

Further proposals include the application of certain funds from SARS to the REF, and a mandatory contribution from the public, which can be phased in starting with the highest income-earners and progressing down the scale of incomes.

The timetable suggested by Professor McLeod will see full implementation of the REF by January 2006.

George Marx, *Consulting Actuary, Health Monitor Group,* ended the session with some caveats. He said that the scheme design is going to be a 'total new ball game'. If a meaningful prescribed minimum package (PMP) is to be developed, members may request a choice of providers. If we cannot afford a PMP with SHI, and if we have to cut benefits from PMPs, everything outside them should be outside the purview of the DOH.

The challenge to the DOH and CMS is about the demarcation between PMBs and other benefits. The balance could be left to competition or private schemes and providers. The DOH should focus on designing a meaningful PMP and leave the rest outside the medical schemes industry.

Funders were warned not to start building anything outside the Medical Schemes Act, as there is still a long way to go before new legislation is implemented.

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