MANAGED CARE:
THE SOUTH AFRICAN CONTEXT

Danie Kolver
Head of Accreditation
Council for Medical Schemes
Overview

- Relevant terms defined
- Developments post initial rollout
- Objectives - revised standards
- Some perspective on managed care delivery in future
- Why we should monitor and control pharmaceutical expenditure.
RELEVANT TERMS DEFINED

- Managed health care means “clinical and financial risk assessment and management of health care with a view to facilitating appropriateness and cost effectiveness of relevant health services within constraints of what is affordable through use of rules based & clinical management based programmes”

- Rules based & clinical management based programmes = “a set of formal techniques designed to monitor the use of and evaluate clinical necessity, appropriateness, efficacy and efficiency of health care services, procedures or settings on basis of which appropriate managed health care interventions are made”
DEVELOPMENTS POST INITIAL ROLLOUT

1. We were able to become familiar with & distinguish between:
   – Risk transfer arrangements
   – Risk sharing arrangements
   – Outsourced services with little or no value added
   – Arrangements to manage benefits in terms of the rules
   – Contracted and subcontracted DSP arrangements
   – Switching operations
   – Benefit management tools and gadgets
DEVELOPMENTS  (continued…)

2. Need to deal with unique exposure and risk:
   – in cases where capitated risk transfer arrangements are structured which lead to financially unsound entities being accredited; or
   – where mco’s are unable to control and manage downstream risks sub-contracted by them

3. Too often no price transparency when combination of services is provided

4. Critical review of business models, scope and duties of those accredited
5. Distinguished between clinical protocols within the meaning of Act and application or benefit management tools/processes
6. Our experience and unfolding of managed care gave rise to the need for revising standards for accreditation; and
7. To implement all standards simultaneously.
OBJECTIVES : REVISED STANDARDS

1. Aimed at detailed evaluation of activities

2. Comprehensive scope that covers:
   - Legal compliance & financial soundness
   - Assessing *bona fide* operation and arms length relationship
   - Fitness and propriety as entity
   - Infrastructure, skills and ability
   - Clinical oversight
   - Demonstrated value added concept
   - Services are rendered in accordance with protocols / formularies and utilization review processes
   - Maintain the confidentiality, security and integrity of data and information.
3. Capitation fees

- constitutes bona fide transfer of risk from scheme to managed care organisation
- in interests of scheme members
- capitation fee is commensurate with extent of risk transferred

4. Financial soundness based on annual financial statements duly audited by auditor in accordance with IFRS and gaap

- soundness relates to business being conducted in a manner to ensure that it is always in a position to meet liabilities.
5. Policies and procedures in place to ensure access to documents setting out:

- description of programmes & procedures
- appealing against utilisation review decisions by aggrieved party
- any limitations applied to entitlements, restrictions, protocol requirements & formulary inclusions / exclusions

6. Utilisation review activities

- undertaken in accordance with written protocol
- procedures to evaluate clinical necessity, appropriateness, efficiency and affordability of care and measures to intervene where necessary
7. Documented clinical review criteria based upon evidence-based medicine incl. cost–effectiveness, affordability and periodically evaluated to ensure relevance

8. Provision must be made for appropriate exceptions where a protocol or formulary is ineffective or cause harm to patient without penalty to patient

9. Transparent and verifiable criteria available for decision-making which affects funding decisions and periodically evaluated

10. Availability of appropriately qualified staff to perform clinical oversight
11. Detailed business process map of operational functions
   ✓ Integration of services, systems and functions
   ✓ Mechanisms to identify, measure and manage business and related risks

12. Functional Ethics Committee & quality management programmes

13. Integrated information system to collect, maintain, analyse and retrieve data with integrity, yet secured and confidential

14. Off-site data storage, backup policy and disaster recovery process in place.
MANAGED CARE DELIVERY IN FUTURE

SOME PERSPECTIVE
Figure 8: Trends in the number of beneficiaries from 2000 to 2008
Figure 17: Total benefits paid (2008 prices)
Figure 18: Total benefits paid per beneficiary per month, 2008 prices

Rands, PBPM

<table>
<thead>
<tr>
<th>Year</th>
<th>General Practitioners</th>
<th>Dentists</th>
<th>Provincial Hospitals</th>
<th>Medicines</th>
<th>Ex-Gratia Payments</th>
<th>Medical Specialists</th>
<th>Dental Specialists</th>
<th>Private Hospitals</th>
<th>Supplementary and Allied Health Professionals</th>
<th>Other Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>100</td>
<td>150</td>
<td>120</td>
<td>50</td>
<td>20</td>
<td>150</td>
<td>20</td>
<td>100</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>2001</td>
<td>110</td>
<td>140</td>
<td>110</td>
<td>55</td>
<td>25</td>
<td>160</td>
<td>25</td>
<td>110</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>2002</td>
<td>120</td>
<td>130</td>
<td>100</td>
<td>60</td>
<td>30</td>
<td>170</td>
<td>30</td>
<td>120</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>2003</td>
<td>130</td>
<td>120</td>
<td>90</td>
<td>65</td>
<td>35</td>
<td>180</td>
<td>35</td>
<td>130</td>
<td>13</td>
<td>8</td>
</tr>
<tr>
<td>2004</td>
<td>140</td>
<td>110</td>
<td>80</td>
<td>70</td>
<td>40</td>
<td>190</td>
<td>40</td>
<td>140</td>
<td>14</td>
<td>9</td>
</tr>
<tr>
<td>2005</td>
<td>150</td>
<td>100</td>
<td>70</td>
<td>75</td>
<td>45</td>
<td>200</td>
<td>45</td>
<td>150</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>2006</td>
<td>160</td>
<td>90</td>
<td>60</td>
<td>80</td>
<td>50</td>
<td>210</td>
<td>50</td>
<td>160</td>
<td>16</td>
<td>11</td>
</tr>
<tr>
<td>2007</td>
<td>170</td>
<td>80</td>
<td>50</td>
<td>85</td>
<td>55</td>
<td>220</td>
<td>55</td>
<td>170</td>
<td>17</td>
<td>12</td>
</tr>
<tr>
<td>2008</td>
<td>180</td>
<td>70</td>
<td>40</td>
<td>90</td>
<td>60</td>
<td>230</td>
<td>60</td>
<td>180</td>
<td>18</td>
<td>13</td>
</tr>
</tbody>
</table>
FUTURE LANDSCAPE FOR MANAGED CARE

1. No need to draft dedicated or specific legislation for managed care

2. Changing environment demands accountability

3. Cost effectiveness of a technology may change over time and decisions may have to be reviewed

4. Major challenges to balance:
   – which interventions to target and to what extent given clinical outcomes and funding priorities
   – relationships and various expectations with members’ ability to fund benefits
   – accountability and professional autonomy
Future landscape (continued...)

5. Accreditation to be justified:
   – based on interventions aimed at cost effective, improved health outcomes
   – demonstrated value proposition as prerequisite for ongoing accreditation
   – therefore, need to assess the compounded impact over time to address cost and clinical outcomes

6. Close scrutiny of risk transfer arrangements given their exposure to risk & likely negative effect
7. Need to prevent hosting arrangements and inappropriate contracting where the mco becomes the *de facto* medical scheme

8. Clear definition of and need to revisit all capitation products and network arrangements

9. Identify and manage inappropriately disguised re-insurance arrangements in terms of Sec 20 of the Act

10. On-sight inspections to verify fitness and propriety.
Future landscape (continued...)

Value proposition to be assessed on:

- Improved access at appropriate levels
- Cost – price transparency & cost efficiency analysis
- Reimbursement mechanisms – test sustainability and healthcare provision
- Reporting – proof of health outcome measurements
- Innovation – differentiation factors

Quality care to be measured:

- Impact on scheme members
- How is quality measured
- How is it monitored
- Compare indicators with local and international standards
- Demonstrate use of protocols & formularies and illustrate focus on health outcomes
- Relative effect of interventions.
Why should we monitor and control pharmaceutical expenditure?

- Expenditure patterns by therapeutic group may need decisive action, education and likely alternative approach:
  - anti-hypertension at 10.8% and
  - anti-depressants at 4.7% of total expenditure
- High disease burden
- Likely scope for gaming the system
- Ageing of the population and HIV / AIDS create additional pressures on the health care system
- Remains a very high consumer of healthcare budget.
- Price of pharmaceuticals increasing significantly (Biologicals!!)
- Drugs have beneficial and **DETRIMENTAL** effects
- Difference between efficacy and effectiveness
What really matters?

“Not everything that can be counted counts, and not everything that counts can be counted. What really matters is not always obvious.”

– Albert Einstein

Just because data were collected, analyzed and reported does not mean they are relevant to the clinical question at hand – but it mattered to somebody.

Source: Prof Marc Blockman  MAG conference 2009
I THANK YOU....