SAMA CONFERENCE 2018

Alternative Remuneration Models and

Patient Centered Care

Dr. Stan Moloabi

GEMS COO
The GEMS Mandate

**Values**

“Excellence, Integrity, Member Value, Innovation, Collaboration”

**Mission**

“To provide all members with equitable access to affordable and comprehensive healthcare, promoting member well-being.”

**Vision**

“An excellent, sustainable and effective medical scheme that drives transformation in the healthcare industry, aligned with the principles of universal health coverage.”

**Mandate**

To ensure that there is adequate provisioning of healthcare coverage to public service employees that is efficient, cost-effective and equitable; and to provide further options for those who wish to purchase more extensive cover.
“Overall, the market is characterized by high and rising costs of healthcare and medical scheme cover, highly concentrated funders’ and facilities’ markets, disempowered and uninformed consumers, a general absence of value-based purchasing, ineffective constraints on rising volumes of care, practitioners that are subject to little regulation and failures of accountability at many levels”
“Practitioners are usually the point of entry into the health care market. Due to their superior health care knowledge, they act as agents for consumers. Practitioners are able to influence healthcare expenditure in two ways: through their own activities, such as diagnoses and treatment, and through the services and treatments they recommend, which include referral for further investigation, treatment, and hospitalization. Overall, medical practitioners drive much of the health care expenditure in the sector.”
“Fee-for-Service (FFS) models of remuneration are known to stimulate oversupply which results in wasteful expenditure and incentivises practitioners to provide more services than needed. This incentive is intensified by the current unregulated pricing environment.”
“The ethical rules of the Health Professions Council of South Africa (HPCSA) are cited as the reason for lack of innovation in models of care and development of alternative reimbursement models. It is our view that the HPCSA is not sensitive to the benefits of competition in creating incentives for affordable and quality care”.

Patient Centred Care as part of Care Coordination
Patient Centred Care as part of Care Coordination

In the absence of substantive interventions, care coordination is poor and hence the need for care coordination to be enforced across schemes and options.

Nearly one in two beneficiaries consult with multiple general practitioners.

Beneficiaries who consult with multiple general practitioner generate higher costs.
GEMS established the Emerald Value Option (EVO) in 2017 which is underpinned by care coordination. The option demonstrates the benefits of care coordination.

- Admission rate: -12%
- Specialist visit rate: -14%
- Cost per admission: -21%
- GP visit rate (relative to specialists): 21%

Fewer admissions, fewer specialist visits and more GP visits
“Applied across the medical schemes industry, it is estimated that EVO like care coordination principles could save up to R20 billion per annum”

Minister Ayanda Dlodlo, Public Services and Administration Budget Vote
Alternative Remuneration (Reimbursement) Models are already part of Care Coordination within the GEMS environment
Hospital ARMs
### Alternative Reimbursement Models – Implemented

<table>
<thead>
<tr>
<th>Tranche 1</th>
<th>Tranche 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedures</td>
<td>Clinix</td>
</tr>
<tr>
<td>Caesarean Delivery</td>
<td></td>
</tr>
<tr>
<td>Cataract Procedures</td>
<td></td>
</tr>
<tr>
<td>Knee Replacement</td>
<td></td>
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<tr>
<td>Laparoscopic Cholecystectomy</td>
<td></td>
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<tr>
<td>Vaginal Delivery</td>
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</tbody>
</table>

*Implemented*  
*Not implemented*  
*Pricing to be agreed on*

The highlight for Q2 is that GEMS reached and arrangement with NHN to implement both tranches with effect from July 1st 2018.
ARMs with DoH
Objective is to partner with Tertiary Hospitals and be part of leveraging these Centres of Excellence (COE’s).

The COE initiative aims to:

1. Partner with public hospitals to build medical expertise;
2. Ensure the delivery of affordable, quality health care;
   - Not only to GEMS members
3. Manage costs and payment of services through alternative reimbursement models (ARMs)
   - Proposed ARMs based on UPFS + %
<table>
<thead>
<tr>
<th>Hospital</th>
<th>Procedure</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>SBAH</td>
<td>Cataract surgery</td>
<td>Scheduling follow-up meeting</td>
</tr>
<tr>
<td>CHBAH</td>
<td>Cochlear implants</td>
<td>Agreement on TAVI and CI</td>
</tr>
<tr>
<td>CM-JAH</td>
<td>Breast Cancer surgery</td>
<td>Account recon complete, Schedule follow-up meeting</td>
</tr>
<tr>
<td>Frere/CMH</td>
<td>Arthroplasty</td>
<td>Rescheduling meeting</td>
</tr>
<tr>
<td>HJAH</td>
<td>Arthroplasty</td>
<td>Rescheduling meeting</td>
</tr>
<tr>
<td>Ink. Albert Luthuli</td>
<td>Cochlear Implants</td>
<td>Initial engagement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Claims challenges raised – awaiting schedule of unpaid claims for recon</td>
</tr>
</tbody>
</table>

- Breast pathology & reductio
- Liposuction for lipodystrophy
- Cochlear implants
- Arthroplasty
- TAVI
- Bariatric surgery
## Global Fee as ARMs – GEMS Initiatives Underway

<table>
<thead>
<tr>
<th>Structure</th>
<th>GF-ARM</th>
<th>PPI(^1)</th>
<th>UPFS+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global-Fee</td>
<td>Global-Fee</td>
<td>Global-Fee</td>
<td>Global-Fee</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pricing</th>
<th>Profit based</th>
<th>Cost based</th>
<th>Cost based + Profitability incentive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk cover</td>
<td>Prospective Stop loss Carve out</td>
<td>Retrospective Annual recon</td>
<td>Retrospective Quarterly recon</td>
</tr>
<tr>
<td>Incentive</td>
<td>Financial Risk transfer Improved efficiency</td>
<td>Reduced administrative burden</td>
<td>Reduced admin burden Improved efficiency</td>
</tr>
</tbody>
</table>

\(^1\)PPI - Provider Payment Initiative
% of Total GEMS claims paid as ARMS

- **JANUARY**: 92.60%
  - Fee for Service: 7.40%
  - ARMS: 95.20%
- **FEBRUARY**: 91.40%
  - Fee for Service: 8.60%
  - ARMS: 90.80%
- **MARCH**: 90.20%
  - Fee for Service: 9.80%
  - ARMS: 80.40%
FP Filler Project
Less than ideal Specialist coverage
- Approx. 30% members travel distances of > 30Km
- Specialists (and most other professionals) based mainly in 3 provinces:
  - Gauteng, Western Cape, KZN
Invited FPs with post-basic qualifications:
- Diploma in Child Health - DCH(SA)
- Diploma in Gynaecology and Obstetrics - Dip Obst(SA)
- Diploma in Ophthalmology - Dip Ophth(SA)
- Diploma in Mental Health - DMH(SA)
- Diploma in Anaesthesics - DA(SA)
<table>
<thead>
<tr>
<th>Qualification</th>
<th>No of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diploma in Child Health - DCH(SA)</td>
<td>44</td>
</tr>
<tr>
<td>Diploma in Gynaecology and Obstetrics - Dip Obst(SA)</td>
<td>38</td>
</tr>
<tr>
<td>Diploma in Ophthalmology - Dip Ophth(SA)</td>
<td>0</td>
</tr>
<tr>
<td>Diploma in Mental Health - DMH(SA)</td>
<td>6</td>
</tr>
<tr>
<td>Diploma in Anaesthetics - DA(SA)</td>
<td>84</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>172</strong></td>
</tr>
<tr>
<td>Master of Medicine in Family Medicine(MMED Family Medicine) or FCFP(SA) Fellow of the College of Family Physicians</td>
<td>49</td>
</tr>
<tr>
<td>Other qualifications</td>
<td>74</td>
</tr>
<tr>
<td><strong>Total respondents</strong></td>
<td><strong>295</strong></td>
</tr>
</tbody>
</table>
### GP Filler: Provincial distribution

<table>
<thead>
<tr>
<th>PROVINCE</th>
<th>DCH</th>
<th>Dip Obst</th>
<th>DMH</th>
<th>DA</th>
<th>TOTAL</th>
<th>% TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gauteng</td>
<td>15</td>
<td>7</td>
<td>0</td>
<td>29</td>
<td>51</td>
<td>30%</td>
</tr>
<tr>
<td>Western Cape</td>
<td>16</td>
<td>11</td>
<td>0</td>
<td>20</td>
<td>47</td>
<td>27%</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>5</td>
<td>5</td>
<td>0</td>
<td>17</td>
<td>27</td>
<td>16%</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>9</td>
<td>22</td>
<td>13%</td>
</tr>
<tr>
<td>Free State</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>3%</td>
</tr>
<tr>
<td>North West</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>2%</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>9</td>
<td>5%</td>
</tr>
<tr>
<td>Limpopo</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>2%</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>2%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>44</td>
<td>38</td>
<td>6</td>
<td>84</td>
<td>172</td>
<td>100%</td>
</tr>
</tbody>
</table>
GP Filler: Conclusions

- Urban concentration of skills similar to Specialist patterns
- DCH, Dip Obst, DCH, DMH:
  - No indication of “specialisation” in respective fields (from claims analysis)
  - No advantage in creating a “filler” network
- DA:
  - FP network will bolster existing Specialist network
  - Conditions for participation – min 80% Anaesthetic work
  - Will have a financial cost impact
Progress made on GEMS FP Networks ARMs
Determining FP ARMs using Profiling tool

- Profiling tool is good at analysing claim but not at identifying a subset of provider types
- Currently being reviewed
  - We have engaged with various FP societies and are reassessing what is achievable
  - Aim is to finalise the review by September 2018

- Principles:
  - Universally acceptable to all role players
  - Simpler
  - Tracks quality and cost outcomes
  - Identifies high-value FPs
  - Enables self-assessment
  - Encourages improving performance (cost and quality outcomes)
  - Enables effective peer management
  - Ultimate Objective is to move towards Value Based Reimbursement of FPs
FP ARMs

- **Undergoing review** (parallel with the profiling tool)
- **Considerations:**
  - Incentivise and reward better outcomes
  - High value FPs
  - Differential network rates
  - Recognition of post-basic skills, e.g. opening up of certain restricted codes, etc.
- Review to be finalised September 2018
Sustainable Healthcare Funding
Sustainable Funding is possible

Over R40 billion per annum can be liberated by making the healthcare system more efficient

- Care Coordination (R20 billion*)
- Fraud, waste and abuse (R10 billion*)
- Review of regulation 8 (R4 billion*)
- Risk based capital (R6 billion*)

Note: *Values are estimates
R40 billion could significantly contribute towards the funding of the health priorities put forward by the Minister of Health
The Way Forward
Family Practitioners and Healthcare Funders need to work together more closely to ensure the sustainability of healthcare funding and lay a foundation for UHC.
A “CODESA” is needed whereby all stakeholders agree on a new healthcare dispensation which improves access.

A process of grand tradeoffs whereby all concerns of all addressed in the long term interests of the country.

Further challenges to overcome include:

- Affordable pricing of healthcare services needed.
- Healthcare funding must become more sustainable.
- ARMAs must become the dominant FP Remuneration.
- Provider driven peer review is essential.
- Care coordination as part of Value Based Remuneration results in better outcomes.
Conclusion

A winner is a dreamer who never gives up.

- Nelson Mandela

All South Africans need to work tirelessly towards advancing universal healthcare irrespective of the challenges and ARMs are an integral part of the work that is required.
“As we enter a new era, we are determined to confront the challenges that we face and to accelerate progress in building a more prosperous and equitable society …

The time has now finally arrived to implement universal health coverage”

President Cyril Ramaphosa, SONA 2018
Thank You!