Managed care trends

*Dr Andrew Good

Background

The amount South African medical schemes spend on managed care has steadily increased over the last 13 years.

In 2011, schemes spent R2.44 billion on managed care (not insignificant considering GPs were only paid R5.35 billion from schemes risk benefits).There is little doubt that schemes are increasing their expenditure on medical input in the system. The best measure of this is the increasing amount schemes are spending on managed care.

As can be seen by Graph 1, the amount schemes spend on managed care is significant when compared to the amount scheme pay General Practitioners (Risk and savings benefits combined).

Medical schemes, we should never forget, are mutual societies belong ing to medical scheme members. These members elect trustees to make decisions on how members' money should be spent. So why are trustees investing more and more on managed care?

As mentioned in our previous article, The health industry's biggest challenges and our role in addressing them (HMR, NovDec, 2012), find the three greatest challenges our health sector face are the HIV pandemic, the non-performance of state health facilities and the increasing cost of belonging to a medical scheme. The main reasons trustees are investing in managed care are to manage the increasing cost of belonging to a medical scheme and to improve the management of chronic diseases.

What are the trends we are seeing in managed care?

Categories of managed care expenditure

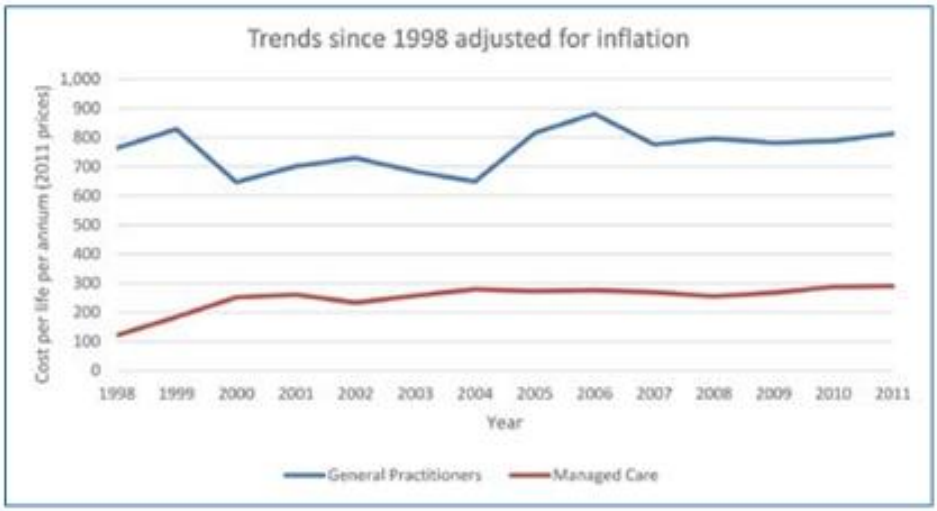
This is a difficult exercise to effectively analyse that medical schemes spent R2.44 billion in 2011, given the quality of data available for CMS. We do, however, see the following (Table 1):

From Table 1, the only notable trend in expenditure seems to be the 39% increase in clinical consulting services.

When we analysed the costs of managed care by activity, using the 2010 scheme data, we found the following:

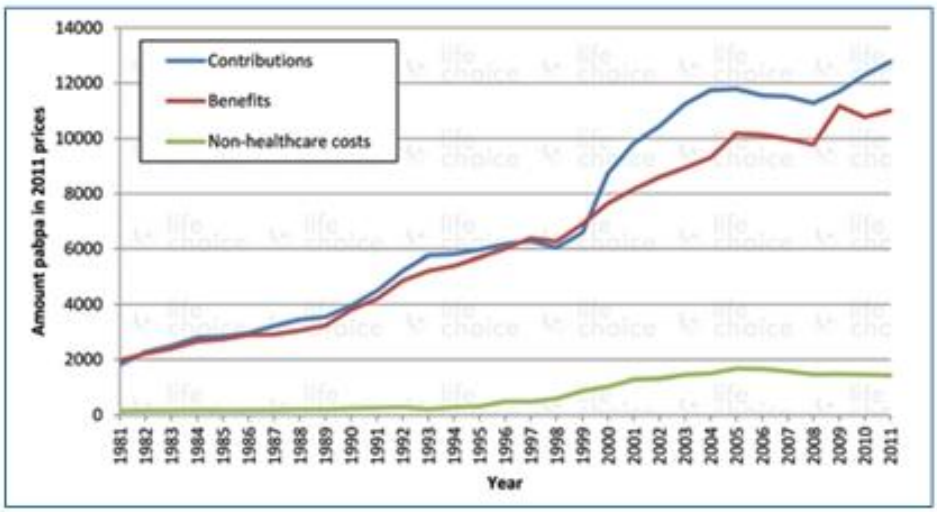
- Medical schemes reported just over 1.5 million hospital admissions in 2010. This means schemes paid managed care companies R586 to manage each and every hospital admission dealt with.
- Medical schemes reported that just around 2.6 million members have a chronic condition. This means that managed care companies are paid R337 to provide

Graph 1 - Managed care: Cost per life compared to total GP expenditure (2011 prices)



CMS annual returns (Lifechoice datawarehouse)

Graph 2 - The cost of belonging to a medical scheme (2011 prices)



CMS annual returns (Lifechoice datawarehouse)

Table 1: Percentage by category of managed care expenditure		
Category	**2010**	**2011**
Ambulance	9.44%	10.27%
Clinical consulting	3.99%	5.54%
DRM and education	18.27%	18.79%
HRM	30.37%	28.88%
MRM	17.76%	16.64%
Provider Mgt	20.16%	19.87%
Grand Total	**100.00%**	**100.00%**

medicine and disease risk management per person with a disease.

- Schemes reported a total of 120 000 members having HIV. The average amount schemes paid managed care companies to manage HIV positive individuals amounted to R933 per year per pax.

Given that the cost of benefits continues to rise above inflation, the jury is out on how effective the current form of managed care interventions are.

Worth stating is that despite around R500 million being spent on disease risk management initiatives, the latest, large private industry quality survey shows that key disease management measures are still a cause for concern. The survey illustrated that, on average, diabetics have an HBA1C test done every two years and the scheme members on antiretroviral medication for HIV only have a CD4 and viral load done every 2nd year, on average. Considering schemes spend almost a thousand rand per HIV member management, the level of HIV testing is a cause of concern.

Increased focus on provider profiling and peer review

We are seeing an increased focus by schemes investing in managed care processes involving provider profiling and peer review. This is most likely reflected in the increase in the clinical consulting category of managed care expenditure. While this is good, the question which needs to be asked is whether this will translate to meaningful change. For years, I have seen that when trustees are faced with information suggesting quality and scheme costs can be improved by working with certain hospital groups, provider groups or pharmacy groups, the trustees avoid making the tough decision to only use a favourable provider, as this decision will impact on member choice. The jury is still out whether trustees will cut out more expensive providers and hospitals, given the impact that these decisions will have on member convenience and choice.

An increased trend to working with providers, especially GPs

We see that more and more schemes are working and bringing providers, especially GPs, into their managed care models. These models see some tasks normally assigned to the battery of pharmacists and nurses in managed care companies, being moved back into the control of the GPs within the networks, to ensure care is effectively co-ordinated. However, we still see a variety of initiatives that take disease screening, chronic medicine management and control of access to specialists out of the hands of GPs. These must be addressed in order for GPs to be effective in co-ordinating care.

Provider-driven managed care

Provider-driven managed care is simply managed care initiatives controlled by doctors, working in a network they own that endeavours to eliminate “unmanaged care” and co-ordinate care, to ensure sustainability of the medical scheme industry.

There are many who feel that provider-driven managed care has the best chance of improving the sustainability of our health systems. An example of a provider-driven managed care in South Africa is the Independent Clinical Oncology Network (ICON). ICON is a network of oncologists that organising itself to ensure it is able to manage oncology in an effect to decrease unnecessary treatment and waste. They have developed an oncology authorisation system to ensure the cancer care offered within their network, is provided within the protocols they have developed and exceptions are managed by peer review. They also have the ability to analyse medical scheme data, to effectively demonstrate the value of provider-driven managed care to client schemes. They have clearly been pro-active in building their provider-driven managed care model.

In summary

Managed care expenditure continues to increase on a cost-per-life basis (adjusted for inflation). The categories of expenditure remain unchanged except for an increase in clinical consulting, which most likely reflects an increase in provider profiling and peer review activity.

The managed care models remain largely unchanged. While the increasing role of general practitioners is being brought into co-ordinating care, this does not yet reflect in scheme-managed care expenditure.

Provider-driven managed care, which probably has the best potential to eliminate waste within the system and stem healthcare inflation, is still largely ignored.

***Dr Andrew Good**, Clinical Director, Prognosys Actuaries and Consultants