INFOCUS

CMS Council for Medical Schemes

OPINION
11 JANUARY 2023
Research & Monitoring Division

The Nudge Theory:

CMS medical schemes beneficiaries' guide through health-seeking episodes

Phakamile Nkomo

Senior Policy Analyst

Accessing medical scheme benefits entitlements through Designated Service Providers (DSPs), could be a logistical nightmare for some beneficiaries of medical schemes.

Medical schemes design healthcare delivery networks for beneficiaries living with chronic conditions. These networks are used by those who opt for a cost-effective option with a closed network of designated service providers (DSP). Some beneficiaries realise the promise of cost-effective healthcare outcomes, while others maybe charged co-payment for using uncontracted healthcare providers. This two-faceted scenario fits the moral of the story of "The Pied Piper of Hamelin." Stick to the conditions or pay a fine for not paying the medical scheme's delivery network.

A health-seeking episode in the health market is a complex exercise for any common man, particularly for chronic routine care, and emergency health episodes if one is on a network health plan (benefit option).

One needs only to read the findings and recommendations of the recent Health Market Inquiry (HMI) Report published in 2019 by the South African Competition Commission.

Much like in the HMI findings; the Council for Medical Schemes (CMS), the regulator of the medical schemes industry, feels that beneficiaries should be brought from the periphery of the health industry.

Through consumer centred delivery paths that reveal value within value-based purchasing pathways. The coordination and implementation of medical scheme health delivery networks should incorporate the principles of transparency; and competition, primarily through the distribution of information on benefit options' DSP networks to beneficiaries.

This is the "nudge" required to assist beneficiaries to navigate health delivery networks when health care access is sought. The regulator's benevolent "nudge" on market conduct should usher beneficiaries through intentionally designed paths for securing cost-effective episodes and consumer (beneficiaries') satisfaction.

The CMS conducted a stakeholder analysis to identify factors that will enable an agreeable search environment for medical schemes beneficiaries. The stakeholder analysis solicited beneficiaries' interests, from submissions made in response to the CMS declaration on Undesirable Business Practices (UDBP) of 2017. The declaration pertains to how DSPs are implemented for pharmaceutical goods and services.

The interests emerging from beneficiaries' submissions covered four themes. From the perspective of consumers (beneficiaries), the intrinsic value of DSP networks will be realised in meeting their interests. Beneficiaries seek: i) access to providers within reasonable distances and travelling times; ii) improved convenience when accessing services from provider networks; iii) greater coverage by health providers at places where they live; iv) the removal of excessive constraints to accessing health services if they feel existing arrangement do not meet their needs.

Corroborating data from the CMSs Complaints and Adjudications Unit (CAU), on complaints associated with networks and DSPs, were analysed for the period of 1 January 2019 to September 2020. The analysis was a carried out by the Policy, Research & Monitoring Unit (PRMU). Thirty-nine percent (39%) of all health-seeking episodes in the dataset described instances in which beneficiaries had to partially pay for services listed as Prescribed Minimum Benefits (PMBs); as medical schemes held that beneficiaries accessed services outside DSP networks.

In eighty-eight percent (88%) of such instances, the CAU gave a ruling in favour of beneficiaries, as the Adjudications Committee found that there were mitigating factors that rendered such obtained services involuntarily obtained.

Meaning that; the beneficiary could not have reasonably obtained needed services with available DSP networks. This is just one example of travesties undone by the CMS's benevolent CAU rulings and how CMS's

Photo Credit: Relex Solutions

regulatory standards are monitored through the regulator’s market conduct monitoring mechanisms. Beneficiaries that are not successful in getting their complaints heard by the CMS Adjudication Committee are likely to hold a grim perspective of the quality of the medical schemes industry.

They are likely to have to pay a hefty co-payment and may need to take out a second bond on their homes to pay for healthcare costs related to major-medical and emergency services (catastrophic episodes).

Further to this, beneficiaries may change scheme options; thus suffering a three-month waiting period or twelve-month pre-existing condition penalty before being able to make claims for health care financing again. All of this can lead to market failure if reputational risk emanating from this type of market conduct is not put in check.

Circumventing this logistical nightmare would require us to take a leaf out of Richard Thaler’s (Nobel Prize winner for economics, 2017) “nudge theory”. This nudge would steer market behaviour to yield value for all stakeholders in serve to steer market behaviour to yield value for all stakeholders in delivery delivering quality and value to medical scheme beneficiaries.

Regulatory guidelines on UDBP have been developed for stakeholder engagement. The guidelines seek to ensure that "willing and able" candidates participate in medical schemes' tender procurement processes.

The guidelines promote the procurement principles of competition, transparency, cost-effectiveness, and equity. The guidelines are underpinned by two-stage independent processes of: i) selecting and announcing shortlisted tender candidates through a request for tender submissions and shortlisting successful applicants; and ii) which is then a subsequent bidding process. Thus removing "obscurity" from the tender processes.

In addition, and ii) allowing time for negotiated processes for historically disadvantaged candidates to form empowerment schemes to meet the sunk costs of meeting the administrative efficiency requirements made on contracted networks. As a criterion, the networks should also meet the access demands of beneficiaries based on medical schemes' geographical market where medical schemes have geographical penetration.

Institutional support will be given to the success of DSPs as they provide cost-efficient access to a vulnerable group of beneficiaries, who live in the most economically unequal country in the world. For example, banks were not closed because low-income groups were not accessing financial services.

Instead, institutional interventions were implemented for access to market financial markets. Remember the Mzansi account?

Phakamile Nkomo is a public policy analyst at the Council for Medical Schemes (CMS) with over 20 years in the research analysis on healthcare public policy matters. He has co-authored numerous healthcare research and public policy papers. Nkomo's main research specialisation is in providing evidence-based approach outcomes.

.