

05 MAY 2023. PRETORIA. **SOUTH AFRICA**

A Responsive Complaints Driven Regulatory Monitoring Framework in the Pipeline

Phakamile W.F. Nkomo

Senior Policy Analyst: Policy Research & Monitoring
p.nkomo@medicalschemes.co.za

A cross-sectional analysis of complaints in the Council for Medical Schemes (CMS) complaints database highlights the likely occurrence out-of-pocket expenses for the voluntarily or involuntary use of non-Designated Service Providers (DSPs) . This is according to a research study undertaken by CMS researchers titled: ‘Regulatory Framework Project; regulating by measurement and learning.’



#Research Review

Phakamile Nkomo has 22 years experience working at CMS. He specialises in policy analysis with research interest in choice analysis, stakeholder analysis, programme evaluation, regulatory economics, and human resources for health. Phakamile holds a B.Com. (UNISA), Master of Science in Public Policy (Heinz College, Carnegie Mellon University.)



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Physical Address:

Block A, Eco Glades 2 Office Park, 420
Witch – Hazel Avenue, Eco Park,
Centurion, 0157
Tel +27 12 431 0500

The study sought to identify trends in the view of ultimately developing recommendations towards a responsive regulatory framework for interpreting the outcome of clinical and administrative complaints in the CMS complaints database.

Of the key findings, hospital admissions and surgical admissions were flagged as drivers of escalating 'out of pocket' expenses and subsequently, major generators of most complaints that land at CMS.

This was attributed to behavioural patterns by either medical schemes or medical scheme beneficiaries, often driven by information asymmetries or gaps in the market.

Investopedia defines 'information asymmetry' as a situation where one party in a transaction has more information than the other.

In the research study, information asymmetry was said to be likely to arise when the medical schemes fail to fund medical treatment or the medical scheme beneficiaries knowingly or unknowingly claim for health services rendered at a non-DSP/non-network facilities.

“There are clear patterns between the nature of market conduct, on the part of medical schemes and member behaviour”



This here is identified to be behaviour that creates what is termed a moral hazard'. A morale hazard may create a situation where market participants lose confidence in the private medical scheme industry. Thus, systemic reputational risk occurs when beneficiaries and providers perceive that claims are not being paid.

Researchers used complaints data from the CMS Complaints and Adjudication Unit's database from medical schemes beneficiaries relating to networks and DSPs. The sourced and analysed complaints were from the period of January 2019 to September 2020 and comprised 244 observations relating to DSPs and Networks.

The data was analysed based on formulated classifications enabling analyses from a policy perspective and within a framework constituted by market conduct dimensions and attributes pertaining to health-seeking.

In describing ‘interactions among market agents’, the research study noted conduct outcomes such as moral hazard on either the part of the medical schemes or that of members. Also, analyses focused on principle-agent problems, where the medical schemes fail to pay the claims of beneficiaries, particularly for Prescribed Minimum Benefits (PMBs).

With a regulatory framework in place, CMS researchers envisage a future policy framework that will help model and interpret inter-agent behaviour in the complaints database. Also, the framework would help interpret the outcome of clinical and administrative complaints from a policy perspective, seeking to respond to errant market conduct. This work is timely from the perspective of the emerging COFI Bill and its far-reaching implications on consumer protection through monitoring market conduct.

It is worth mentioning that this is a work in progress. More research is envisaged in this regard.

Reviewed By: Phumla Xuza

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