HQA HEALTH QUALITY ASSESSMENT

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COMMUNIQUE THIRD QUARTER 2020

Industry Results Presentation and Clinical Quality Conference

HQA held its 16th annual Industry Results Presentation and Clinical Quality Conference on 5th August 2020, via Zoom. The meeting was well attended. More than 100 delegates, representing all segments of the South African Healthcare Industry, logged in and participated. The presentations were excellent and the strong line up of panelists added tremendous value through their relevant comments and by asking very pertinent and highly relevant questions.

The Conference was held in the 19th week since the Covid-19 lock down was introduced, a period in history to be remembered for the South African economy performing at an all-time low, the capacity of the healthcare system stretched to a limit, and the spirit of society in troubled waters.

How Covid-19 Changed the World and What to Expect from The Future

The first speaker, Professor Tobie de Coning from the University Stellenbosch, shared his views of South Africa's current state of affairs and some of the challenges that can be expected post Covid-19. He said millions of South Africans are vulnerable, the level of unemployment is unacceptably high, and far too many people are living from hand to mouth. Furthermore, the South African society suffers from moral bankruptcy, frequent social unrest and upheavals. The country has one of the highest inequality ratios in the world and was already on a slippery slope pre Covid-19. Many households are in financial trouble and many sectors of the economy have been crippled, if not destroyed by the pandemic. On top of it all, there are the challenges of having to deal with severe, long lasting droughts, climate change, and a huge young generation lacking appropriate skills and employment. Professor De Coning said a future desired state for South Africa is achievable, but it will require society to recognize the current reality and to develop a shared vision of that desired future. All value limiting behaviors should

be ruthlessly eradicated. True servant leadership in all spheres and dimensions of the South African society should come forward. Everyone should take co-ownership and co-responsibility, and show a sustained sense of urgency by demonstrating the 20miles a day mantra.

"It always seems impossible, until it's done." Nelson Mandela

Sharing the DICA Story

The next speaker, Professor Doctor Rob Tollenaar, Chairman of DICA (Dutch Institute for Clinical Auditing) shared some of the lessons from DICA's experiences of the past decade, with respect to setting up registries and developing outcomes. Prof Tollenaar explained that societies that do not measure quality can be characterized by:
-large variations in outcomes
-absence of actable information for doctors to improve
-no transparency of quality of care and patient outcomes
He said that only through ongoing measuring and reporting would outcomes improve and variations and costs reduce. According to Prof Tollenaar some of the major challenges en route to meaningful outcomes measuring are to reduce the burden of participation, to connect relevant data bases and to provide frequent reporting and feedback. Prof Tollenaar concluded with summarizing some of the key success factors for measuring and reporting on outcomes:
-follow a bottom up approach
-align to a national and international level regarding what to measure and what and how to share with professionals and stakeholders
-secure a trusted data partner
-develop a blue print (plug and play)
-begin with what can be measured and mature from there
-address the issue of transparency

Panel session chaired by Dr Jacqui Miot (CAB)

The first of the panelists, Shirley McGee (SAMA), wanted Prof Tollenaar to explain what the trigger is that would make doctors want to collaborate on the setting up of registries and measuring quality. He explained that once doctors realise that unless they do it proactively and in a scientific and hassle-free way themselves,

society will do it for them and it might be in a very different and possibly unacceptable way. So, the choice is to wait until a lot of insignificant indicators and paperwork is imposed on them or they do it themselves in a scientific way that would help them to see how good they really are and where they can improve. Another motivating factor should be that the data collected in these registries could and should be used for research and development in areas which is in the interest of improving the healthcare system.

Dr Roshini Naidoo from Discovery Health pointed to the absence of clinical quality in the curriculums of medical students and wanted to know how clinical quality could be integrated into the business models of the various role players in the healthcare system. Prof Tollenaar admitted that more work needs to be done in terms of the training of students and doctors on aspects of clinical quality and that it would require many years to accomplish. He also echoed Roshini's sentiments that clinical quality should not be managed in silos but should be integrated into every practitioner's daily practice and into the business models of the organisations involved in funding, administering and managing care. DICA's experience shows that the best way of achieving an integrated approach is to report as frequently as possible and to have regular quality meetings with the various professional groups.

Dr Samu Dube (Medscheme) remarked that clinical quality might be the subject that would unite the various role players in the South African healthcare industry. She asked Prof Tollenaar how greater transparency can be achieved, to explain the relationship between DICA and the Dutch Directorate and how incentives for doctors and hospitals can be aligned. Prof Tollenaar responded by saying that although the DICA data contains a lot of comparable information there is still a gap between that and the information that is made public. The best way forward is to share clinical quality information on an individual case basis, for example showing a patient the outcomes of the various treatment options available. The way to get doctors to collaborate is to add value in a hassle-free manner and to steer away from blaming and shaming. He explained how DICA works with a University on case mix methodologies for getting industry buy-in and stressed the importance of nation-wide debates on the value of reliable data.

Dr Paul Soko (LifeHealthcare) stated that he is in favor of 3 to 5 indicators per condition. He then explained the dilemma of hospitals sitting in the middle between doctors' concerns about complications and funders' needs for managing costs and asked how those conflicts could be managed. Dr Soko also wanted to

know how colorectal surgery could be linked to oncology. Prof Tollenaar acknowledged the dilemma of conflicting interests and said the solution is to provide actionable data to hospitals and doctors that would help them for example to understand why they might experience higher complications than others. He also explained how DICA went about setting up a registry for melanoma and the importance of appropriate risk adjustment and case mix. Adam Lowe (NMG actuary) explained the challenge of combining clinical and actuarial expertise for achieving industry acceptance of risk adjustment and case mix methodologies and wanted to know how DICA is doing this. Prof Tollenaar agreed with Adam that it is a real challenge as academic hospitals might have a very different patient profile than private hospitals. He concluded by emphasizing the importance of being transparent with all stakeholders.

"*If you want to go fast, go alone. If you want to go far, go together." African Proverb*

Highlights and Trends from the 2020 HQA Industry Report by Dr Johann van Zyl.

For this report data from 18 medical schemes was used, representing 115 benefit options and 7.29million beneficiaries, more than 80% of the insured lives in the medical schemes industry.
In general, coverage of process indicators, especially in the categories of prevention and managing those with chronic conditions, appear to be low. There are however areas showing steady improvement which is encouraging to see. Usage of in-hospital benefits remain high, although it stabilized somewhat over the last 9 years. An area of concern is the higher admission rates of beneficiaries with chronic conditions such as COPD, Ischaemic Heart Disease, Cardiac Failure and Diabetes.
In the Maternity and New-born category the consistent high cesarean section delivery rate is an area of concern, and the ratio is still on the increase.

Panel session chaired by Dr Boshoff Steenekamp (MHG)

In the panel session that followed on Dr Van Zyl's presentation Professor Morgan Chetty (IPAF) remarked that medical schemes and doctors should work together more effectively. He also highlighted the fact that PROMS (patient reported outcomes) are still missing from the clinical quality discussions, and the

vulnerability of poorer communities due to the limited primary care benefits offered by low cost options.
Dr Rajesh Patel (BHF) commented that although there are signs of improvement in some of the preventative measures it is happening too slow and a greater effort from medical schemes is required. He also said managed care should focus more on quality improvement and that greater transparency with members of medical schemes is needed. Preventative benefits are not sufficiently covered and also not effectively communicated to members. Dr Patel pointed to the importance of clinical quality becoming part of medical students' training. He also requested a greater focus on ideal prevalences and standards.
Michael Willie (CMS) referred to the positive growth in HQA's data set and the need to collaborate on discrepancies between the HQA and CMS indicator definitions. He also eluded to the importance of comparing apples with apples when benchmarking against international standards.
Dr Tryphine Zulu (GEMS) referred to Covid-19 and said that schemes would have been much better prepared for the pandemic had a complete picture of the vulnerable population been readily available. She also mentioned the ageing of the chronically ill population in the medical schemes' industry and the need to be prepared for an increase in claims. Dr Zulu said it is sad that the uptake of prevention and screening benefits is so slow and that members of medical schemes should be better educated in terms of what those benefits are intended for. It also appears as if the same small group of members are being screened over and over. Dr Zulu also mentioned that it is probably the low follow up rate of mentally ill patients that lead to the high readmission rates.
Shirley Collie (DH) agreed that the HQA results are not what they should be but that there are positive trends that should be acknowledged, and that are the result of the continued efforts of the HQA community over many years. She also supported the idea that clinical quality should be better regulated. Shirley stressed the importance of preventative benefits to be better utilized and shared some insights into the abnormal low uptake of preventative and screening benefits in the first part of 2020, due to Covid-19.
Dr Stefan Smuts (Mediclinic) felt that the HQA indicators in general had been well defined but that the changes that are taking place in the hospital sector do not reflect in the results. He referred to the higher admission and readmission rates in hospital being driven by an ageing chronically ill population suffering from comorbidities, whereas the younger population are receiving surgery in day

clinics. Dr Smuts requested HQA to measure readmissions within 5day, 10day and 30day periods and to distinguish between planned and unplanned admissions.

"Who we are today is the result of yesterday's choices. Who we will be tomorrow is the result of today's decisions." Pat Messiti

Annual General Meeting

At the well-attended AGM that followed after the conference Dr Unati Mahlati (DHMS) had been re-elected and Dr Niri Naidoo (Bankmed) had been elected as directors on the HQA Board.

The special resolution regarding HQA's revised MOI (Memorandum of Incorporation) had been adopted without any objections. The effect of the new MOI is that HQA's membership is now open to facilities and practitioners to participate voluntary in HQA's processes of developing quality indicators, data submission, measuring and reporting, on a similar basis as medical schemes. It also means that representatives from the facilities and practitioner associations are now eligible to be elected onto the HQA Board.

General

HQA is now entering a new phase and is looking forward to continue working with its current member organisations, as well as with professional associations, facilities and relevant stakeholders, en route to developing outcomes. HQA is also encouraged by DICA's willingness to allow HQA to learn from their journey.

Prepared by: Louis Botha
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