Private healthcare in SA - continued decline and a solution

By Dr Brian Ruff

10 Jan 2018

We entered 2017 reeling from a series of double-digit medical insurance premium hikes. It was becoming clear that schemes are in trouble; undercut by unregulated, selective insurance products and forced into tighter and tighter modes of managing care delivered. We were facing an affordability crisis then - that, without serious systematic change, schemes will be unable to derail their progression towards shrinking memberships and eventual collapse.

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Moving into 2018, scheme's reserves are under threat, memberships are stagnant and the system continues, for the most part, to tolerate overutilisation of hospital services while failing to invest in strengthening community-level care. Alternative fee models remain tentative and marginal, neither inspiring nor supporting any structural changes in the fragmented way healthcare services are delivered. In light of this, I predict the following for the coming year:

1. Demand will wane, negative sentiment will rise

Too few South Africans can afford medical insurance, and those pools are shrinking as a portion of the South African population (now below 16%). Those who continue to purchase cover do so because of the deterioration of public health services or a serious health condition, and they purchase the lowest cost plan available, with hospital only cover. As premiums continue to rise, with the country under serious economic strain, we will see even less demand for scheme cover. Negative sentiment towards medical schemes will grow due to rising premiums, benefit cuts, increasing co-payments and out-of-pocket spend. Many more people will experience failures of the system; such as denial of needed care until the point of hospitalisation. Patients will continue to be frustrated and confused by the very poor communication between their clinicians.

2. Overutilisation will continue to worsen

Relative to the stagnant demand for private care, we already have a serious oversupply of hospital beds in South Africa. Yet, investors continue to build new private hospitals and clinics. The structural problems are worsening, not improving. As scheme benefits currently work, many people can only access funding for treatment once they are in hospital. Doctors are happy to admit them, as their claims are then guaranteed to be paid. Too many beds drive a very costly form of overutilisation; every time a service is done in a hospital that could have been done in a doctors'

room, we spend R100 instead of R10. This pushes scheme premiums up and is a key driver of shrinking memberships and low scheme reserves.

3. Schemes will need to innovate in how they buy care for members

The crux of the problem in private healthcare, and what drives the health departments' intentions to implement a single National Health Insurance (NHI), is schemes' failure to deliver widespread access to quality healthcare. To date, as purchasers of care for their members, schemes have done too little to develop the community-level services that are required to balance the system and achieve better productivity. If schemes are to secure a place in the transition to an NHI and its management, they will need to put their efforts towards developing the supply of affordable care. They will need to dump the fee-for-service model that pays doctors working alone and axe hospital benefits that support over-utilisation, instead giving a solid boost to out-of-hospital benefit packages.

Who will drive needed reforms?

One space in which reform is beginning to happen is amongst groups of practising clinicians, who recognise the fault lines in the current set-up and are seeking better forms of payment; ones that support teamwork and reward outcomes (rather than the number of services performed). This involves forming independent multidisciplinary practices that, with deep knowledge of their community's health profile, can deliver holistic clinical and social care at the community level. Consulting together and being paid collectively, they can reduce costly hospitalisation by treating their patients in the community and using alternative facilities. As we are seeing in other countries, once these teams and systems mature and grow, they will increasingly demonstrate their value in terms of both reduced cost and better patient health outcomes – giving schemes, businesses and future NHI purchasing committees successful alternatives to the status quo.

ABOUT THE AUTHOR

Dr Brian Ruff is the co-founder and CEO of healthcare management company, PPO Serve. After three decades of work in both the public and private sectors, in both clinical and strategic roles, he formed the innovative company to reform the way healthcare is practiced and funded in South Africa.