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Fixing private healthcare through teamwork

By Nicci Botha

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With so much attention on trying to fix the woes of public healthcare, the private sector has kind of slipped under the radar, but it's not without deep-rooted problems of its own. The fact that it is under scrutiny by the Competition Commission speaks volumes.

Dr Brian Ruff, founder and CEO of healthcare management company, PPO Serve, attributes the current state of the industry to the shambolic way in which the private healthcare was allowed to evolve in the post-Apartheid era. “There was no policy framework,” he explains. “The nature of the crisis is accessibility and affordability, and an industry that has simply stopped growing."

Financial pressure on patients

Now the chickens are coming home to roost. People simply can no longer afford the bells-and-whistles type of medical cover and are now going for basic hospital plans. Only 16% of medical aid members are opting for comprehensive cover compared to the 80% of the past, he says. He points out, too, that only 8,8m people are covered by medical aid in the country, a figure that should be closer to 20m.

In addition, medical aid subscribers are seeing dramatic, above-inflation growth of premiums every year - between 2005 and 2014, medical aid contributions jumped at a pace 50% higher than the inflation rate. In 2015 and 2016, the average premium rate hike of South Africa's seven largest schemes ranged between 7,26% and 10,92%, exceeding the inflation rate of 6% over the two-year period. Ruff predicts double-digit inflation increases and potential benefit cuts when medical aids announce their new premiums at the end of the year, putting financially strained consumers under even more pressure.

Medical aids have attributed premium hikes to aging memberships, sicker patients and new technology, but in reality, the primary reason is excess of private hospital beds in South African metros. Again it goes back to the lack of policy in granting licences to private hospitals. The majority are in urban areas, where the money is.

“We are approaching four private hospital beds per 1,000 medical scheme members. In some parts of the country we have as many as six beds per 1,000 people. This is twice or three times higher than the ratios seen in efficient systems with good community delivered healthcare services.”

Glorious isolation

“Unlike other goods, where costs go down if there is an oversupply, in healthcare this leads to cost increases. When an insurer pays, it is just too easy to spend money without worrying about the value of the service offered,” says Ruff, who has worked in the healthcare industry for more than 30 years. In other words, the quality of the healthcare services provided does not come into the equation.

In addition, most healthcare providers operate in silos and in order to make a living, a practice almost becomes a production line without much focus on the patient. As result of this “glorious isolation”, as Ruff calls it, costs are driven up by diagnostic tests and protocols being repeated when patients encounter different disciplines as they move through the care chain.

Integrate Clinical Consortia

What Ruff is proposing, and is indeed formulating through PPO Serve, is a healthcare management system built on a number of reform principles similar to the Obamacare model, which is aimed at providing good patient value in terms of quality care at an affordable price.

The basis of the model is fairly straightforward. Clinicians work and get paid as a team for providing a tailored patient care plan, which is built around an IT system, to which all members of the team have access. This then effectively becomes the work-flow for the care team which suggests interventions and frequency of treatment. This proactive work is how to keep patients as well as possible.

“We’ve organised independent groups of doctors and allied health professionals, such as psychologists and nurses, into what we call Integrated Clinical Consortia (ICC), a name that the company has trademarked. ICCs are integrated multidisciplinary, accountable teams who practice quality medicine with collaborative colleagues and good support. It’s a commercial entity owned by the clinicians, so they earn together. Ultimately, ICCs shift care appropriately into a community setting, reducing costs by stopping unnecessary hospital admissions and unnecessary duplication of tests and procedures.”

ABOUT NICCI BOTHA

Nicci Botha has been wordsmithing for more than 20 years, covering just about every subject under the sun and then some. She's strung together words on sustainable development, maritime matters, mining, marketing, medical, lifestyle... and that elixir of life - chocolate. Nicci has worked for local and international media houses including Primedia, Caxton, Lloyd's and Reuters. Her new passion is digital media.

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