



HEALTH CARE IDEOLOGY CLASH COSTS PATIENTS DEARLY



Dr Ngubekhaya Gobinca, CEO of Qualsa, the managed health care arm of Metropolitan Health Group.

The head-on collision of socialist/capitalist ideology in health care in South Africa is creating a piece-meal system that is sending patient costs soaring, crippling skills availability and punishing the poorest of the poor. Unless a collective breath is taken and we stand back to reassess and re-align ourselves into a system with a more integrated approach, patient care, especially for those in the greatest need, will continue to deteriorate.

This is the shared view of a top health care strategist, a former tariffs chief of the Board of Healthcare Funders (BHF) and the MD of the country's biggest managed health care group.

Dr Johnny Broomberg, Discovery Health's head of strategy and risk management, Fiona Robertson, a former BHF tariffs chief and Dr Khaya Gobinca, MD of Qualsa, the managed health care arm of Metropolitan Health Group, shared several concerns.

They agreed that the most worrying feature of the current landscape was the 'failure to optimise' the public health care system by using the extensive skills and management acumen in the private sector to create greater delivery

capacity. Broomberg said this had dire implications.

'If you look at all the objective measures of maternal and infant mortality, the indicators show that we've been going backwards over the last two decades and that we're well short of the Millennium Development Goals.'

Existing PPPs not enough

While public private partnerships existed on a small scale at some tertiary hospitals, they were not enough to have a systemic impact on patient access or to help reduce private health care costs.

Gobinca and Broomberg said that instead of over-regulating private health care (based on social health care principles), government should use its own tertiary infrastructure and bulk-buying power to compete for lower income medical aid patients.

Said Gobinca: 'If government implemented public private partnerships more vigorously there would be no need for concern about the private sector and we'd be working together towards the same common goal'.

By entering the competitive market, government hospitals could charge reduced rates and still be profitable, presenting themselves as a viable alternative to private hospitals to both the insured and the uninsured, just like with the NHS in the UK.

The over-regulation they were referring to included the counter-productive Prescribed Minimum Benefits, the Competition Commission ruling forcing medical schemes to negotiate individually with professional groupings, disallowing private hospitals from employing doctors, draconian hospital licensing laws and the controversial pharmaceutical regulations.

They said that many of the new laws, while having noble intentions, were counter-productive because of insufficient attention to detail, poor interrogation or having been pushed through too quickly.

Broomberg said freeing up hospital licensing so more hospitals could compete and encouraging the re-emergence of once-thriving day surgery centres would help.

He cited the United States health care market where between 60% and 90% of all surgery was carried out on a same-day basis. 'What would you say it is here...10%?' he challenged.

By the late 1990s the three big local hospital groups had bought out all the 'stand-alone' private day surgeries.

Bring in the GPs!

Both men said contracting private GPs to do public sector primary health care would create greater accessibility and improve cost efficiencies. Getting rid of 'outdated' and overly strict 'minimum standard' building requirements for hospitals was another way delivery costs could be reduced.

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Broomberg said there were ways to build much lower-cost hospitals that did not compromise patient safety. He differed somewhat with Fiona Robertson, Medihelp's Provider Relations and Tariff Negotiator (and the former BHF tariffs chief), who said the



debate about which macro financing system to use needed urgent settling. 'We spend a lot of unproductive time on that macro policy debate, when on the ground real people are suffering from a lack of access and mothers and children are dying'.

'We should be fixing the broken car engine, not describing what kind of car we'd like to drive in 10 years' time,' he said.

Focus was needed on the detail that would make a difference today. Broomberg said highly focussed collaboration between the government and the private sector was required, 'not the conflict and regulation that has been the habit of the past few years'.

Robertson said deciding on a capitalist or socialist system was vital. 'If they want a social health or a national health system then they must march ahead very strongly on the originally proposed framework and fully implement it. But then there must be universal coverage, treasury cross-subsidies and tax breaks.'

'Maybe they didn't fully understand that big business will not listen to someone who is not driven by the same principles. Today we're living with that legacy.'

'I don't care about ideology, just get the wretched thing to work!' She added that when the Risk Equalisation Fund and open enrolment were first introduced, 'we had a time frame and plan with 2014 the date for social health care for all'. However, all the muscle went into changing medical scheme governance to align it with a social-type system, while 'nothing happened on the treasury side'.

'DoH have pushed very hard and very fast and it's been too fractured, there's been absolutely no shift whatsoever on ensuring mandatory cover, tax breaks or that the REF would be an equalising factor – it's becoming a worse and worse mess.'

Tightening the noose

Medical aids were 'tied up completely in this tight noose that would work in a social system, but they've not tied up the rest and service providers are not quantified or qualified'. Medical schemes were seen as the vehicle that would drive behaviour change by doctors.

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Robertson cited the lack of available hospital beds in both sectors and wondered 'what would happen if we had bird flu? – everything's already at full capacity!' She pleaded for everyone involved in health care to 'stop the bus'. What was needed was a full audit of available services and skills, a sober definition of the genuine needs and agreement on an end point.

She warned that 'within a year or two we won't have any community pharmacies left. These are the cornerstones of delivery in so many outlying areas and once the pharmacy fee is fully legislated, they will not survive'. She said the competition law did not affect doctors who could virtually 'bill whatever they like, ranging from three times the National Health Reference Price List (NHPRL) to five times (by some specialists). If private continues this way and you have a supply shortage, you just can't stop it,' she added.

Robertson warned that squeezing funders, pharmacies and hospitals while allowing a cost environment to become ever more opaque was dangerous. 'Netcare are now due to make more money in the UK than in SA, MediClinic is well entrenched in Dubai and Switzerland. Life Healthcare is the only pure one left. We have to stop and re-evaluate.'

Ngobinca said the faltering public health care sector was providing no effective alternative for patients seeking decent health care.

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Call for transparency

BHF spokesperson Heidi Kruger said that funders having to negotiate separate agreements and sign confidentiality notices with private hospitals before entering negotiations had created 'a complete lack of transparency'.

'If we had a system where everything was transparent and hospital specialists and everybody came to the party and we had audited submissions on real costs, rentals, technology and the real costs of wards, theatres and ICUs, then we'd get a fair and transparent tariff for each of the codes.'

There was 'simply not an adequate process to come out with what it costs to render health services – we need some kind of mandatory process for everybody to take part in and subject to rigorous scrutiny of the submissions. Let's interrogate the costs of a tonsillectomy for example – there must be a better way of arriving at a fair price'.

Kruger said medical devices, surgicals and disposables also needed a regulatory framework.

'We can't just fix it up piece meal, we must decide what kind of system we have. At the moment it's a hotch-potch of systems.'

Robertson, who left the BHF in 2004, agreed, adding that she felt pessimistic. 'I really don't believe we have the people at the top who have the capacity to pull this together in a hurry. We have very little time before we are in real trouble.'

Chris Bateman