

Medicine, health and funding in South Africa

A cardiologist's perspective on healthcare funding by Anthony Stanley.

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OVERVIEW

Medical inflation is soaring. The cost of treating disease is rising as the complexity, infrastructure and the relation to funders changes.

In South Africa there is the added problem of a large uninsured population. 47 million people and only 7.5 million are covered by medical insurance.

The public sector provides a basic service to the majority of uninsured. Access is difficult. Continuity in care is impossible. Working conditions are deteriorating. Staffing is increasingly difficult with highly trained staff migrating to the private sector, both locally and internationally. There is downward pressure on the quality of care. New technology is adopted late, aggravating the staffing and patient care.

Contrast this with a vibrant, rapidly growing private sector: Working conditions are good. Staff are happy. Patient satisfaction is high. Problems do exist but the system is efficient. As with all successes, the private healthcare system has its detractors. Firstly, the funders berate the private hospital groups and specialists as being greedy and corrupt. The image of the doctor has never been lower. Secondly, the government, which is committed to providing adequate health care to the majority of citizens, is eyeing the private healthcare system lasciviously. It seeks to regulate a successful industry with a view to providing facilities to more citizens.

So, we have two systems, both with high ideals. The one operates in a truly capitalist manner, the other socialistic and aiming to level the standard of care across all groups. The private healthcare is rated highly.

What are the reasons for this disparity? Why is it regarded as wrong for wealthier members of society to purchase better healthcare? Has the private sector abandoned social responsibility to the larger South African population? Is the funding industry a necessary commensal or a rapacious parasite? Should South Africa pursue a national health style system providing good care for all citizens and a smaller private sector servicing the wealthier members?

At the current time a lack of information regarding exactly what is happening in both sectors frustrates progress. Information is crucial for any successful plan to be implemented. Accurate data would provide insight into the exact state of play, for example, are specialists charging too much, is the private hospital industry profiteering and has the management of state facilities been efficient? Has affirmative action played a role?

The government has introduced legislation aimed at ensuring the access to healthcare is affordable and equitable. Further legislation is planned to control the private hospital industry, the providers and the funders. The resulting polarity is not ideal!

All stakeholders should work together to solve the conundrum. The government recently had a meeting to address this issue. This was the Minister of Health's Indaba on the private health industry. Unfortunately the private health industry was severely criticised by government and the funding industry.

What are the reasons for this criticism? My impression is that it has to do with the following factors:

- A coding system that is not transparent.
- A lack of data regarding the private practice costs.

- A lack of unity among medical practitioners.
- A system that encourages creative billing to allow adequate remuneration.
- The administrators' lack of knowledge of private practice at coalface.
- A lack of standardization in measuring systems and methods. This is demonstrated by the different interpretations of hospital admission data by the CMS and by HASA. Similar examples could be found with the interpretation of data by funders.

Producing equitable reform will require the willing participation of everyone in the health supply chain.

Recognizing the threat to the existing healthcare system and the danger of healthcare being "nationalized", SAMA has been exploring ways to remain part of the process of the supply of health services in this country. Essentially it involves the following:

- Creating unity amongst all stakeholders but particularly amongst medical practitioners. This would involve robust debate and a commitment to supply data.
- Participating in the development of a coding system that would satisfy billing requirements, provide statistical data and meet funder requirements in addition to being compatible with international systems. The three main areas of concern are remuneration, coding and (statistical) information.

Other stakeholders have recognized this problem and several investigations have been commissioned.

Recently four reports have been published. These are:

- The Board of Health Funders (BHF) report
- The Fifth Quadrant report commissioned by SAMA
- The Council for Medical Schemes (CMS) report
- The Hospital Association of South Africa (HASA) report.

The Board of Health Funders (BHF) report

The Board of Health Funders commissioned Deloitte's to perform a study as to which coding system may be best suited for South Africa. Little mention was made of the existing SAMA system. The

recommendation was that the Australian system be adopted for use in South Africa.

The Fifth Quadrant report

This report was commissioned by SAMA to investigate the current coding systems used throughout the world. The conclusion of this study was that the SAMA system would either have to undergo an extensive overhaul or another system adopted and cross mapped with our existing system.

Bearing in mind that health is now a global industry, a system that interacts with systems in other countries would be ideal. The report recommended adoption of the French system because it combines a classification system together with descriptors and is the most likely system to become the future international standard. The French system is flexible and is the only such system in active use. Importantly it is provider and setting neutral. A very important feature is that it will be possible to cross map directly to a high percentage of the existing items in the South African classification system.

Adopting the Australian system is not ideal as it does not follow international standards, presents difficulties in cross mapping to the current South African system, is less detailed than the French system and is currently used exclusively in a hospital environment and not in office practice, the latter meaning that it will not be setting and provider neutral.

The process is illustrated diagrammatically in Figure 1.

The professional association would provide the code and terminology portion (Figure 1). Great care must be taken with the wording of the

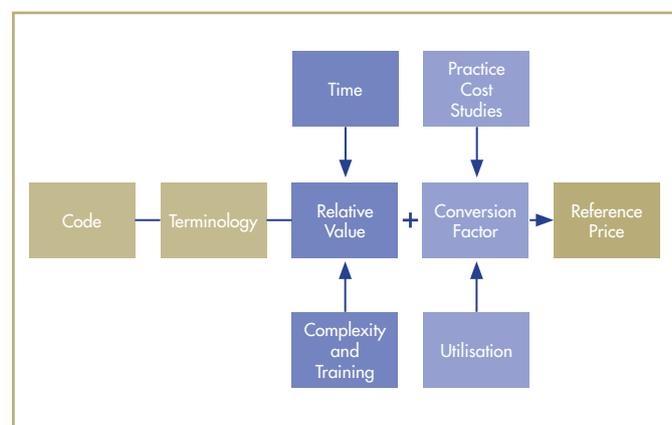


FIGURE 1: Schematic showing the work flow of the proposed coding system. Modified from Dr J. van Zyl presentation at Birchwood Conference centre.

descriptor, as it must have one only meaning. This section would define the condition being treated.

The relative value and conversion factor are where the fair billing will be decided. It will depend on the practice cost studies and time per procedure studies. The complexities and relativities will probably be adopted from the American CPT4 system.

This system will be compatible with international systems.

The Council for Medical Schemes (CMS) report

This report was mainly geared towards blaming the high costs on specialists and private hospital fees. Different interpretations were derived from the same data used in other reports.

The Hospital Association of South Africa (HASA) report

The stated mandate of this report was "to coordinate credible information and develop a well substantiated, unified response to issues raised during the Minister's Private Health Sector Indaba and in other forums."

The group recognized the importance of health as an "enabler of socio-economic progress", and committed themselves to finding "effective, equitable and viable solutions to fast tracking the delivery" of affordable healthcare to South Africa.

They highlight the global nature of medical inflation and the need for cooperation and partnerships between all stakeholders.

The healthcare sector is different from other commercial sectors in the following aspects:

- The presence of a third party payer.
- Emotion drives healthcare decisions.

Differences between public and private expenditure should take into account 14% VAT, the cost of capital, the cost of infrastructure, property rental and the state tender system for pharmaceuticals.

COMMENTARY

In general, difficult times lie ahead. However, by working together and sharing data we may be able to arrive at a point agreeable to all parties.

The currently envisaged system is utopian; one in which patients will get an excellent service for a fair price, hospitals will be full and economies

of scale will prevail. Doctors will be adequately remunerated and funders/administrators will make a fair profit while adequately covering their members. Training of all medical personnel will be run by contented, well paid academics with input from the private sector. These dreams will need to be tempered by reality.

Notwithstanding, the days of true fee for service remuneration are numbered. A new system of remuneration will be developed with or without us. By active involvement in the process we should be able to sensibly influence the development of a fair system of remuneration for practitioners while providing a world class service to most of our citizens. This will have to involve all the stakeholders at all levels of care.

SOURCES

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