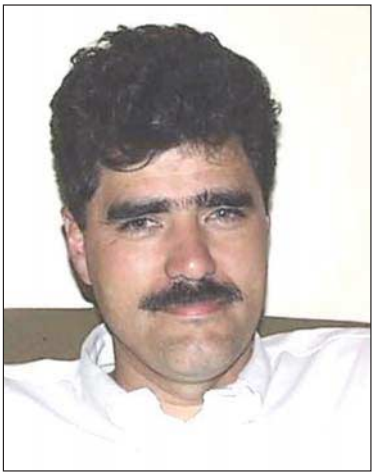
REACHING FOR A FAIRER HEALTH CARE DEAL



Eugene Allers

A national activist body was recently launched that aims to help doctors and patients get a fairer deal from private health care.

Rights, Education and Activism for Consumer Healthcare (REACH) hopes to become the watchdog organisation of 'dedicated individuals and corporate representatives who aren't afraid to stand up to medical aids and highlight the issues surrounding private health'.

However, it has already come under media fire for not openly disclosing that half of its membership consists of multinational drug firms. These include AstraZeneca, Aventis, Bayer, Boehringer Ingelheim, Bristol-Meyers Squibb, Eli Lilly, Ferring Pharmaceuticals, GlaxoSmithKline, Merck Smith & Dohme, Pfizer, Roche, Sanofi Synthelabo, Schering and Wyeth.

The two major generic drug manufacturers in South Africa – Adcock Ingram and Aspen Pharmacare – are not members, nor are any medical aids. This has led critics to claim that the new body is just a thinly veiled attempt to discredit the increased use of generics.

According to founder and executive director, Eugene Allers, pharmaceutical companies do provide some funding but are not the sole funders.

When asked whether such strong pharmaceutical representation was a threat to watchdog independence, he said 'it is a concern, but we are not going to sever our links with them. As a body we want to be seen as transparent and by excluding pharmaceutical companies, we wouldn't be acting transparently'.

South Africa's two major generic drug manufacturers and all medical aids are not members.

He said that these firms could play a role in providing advice on drug pricing and other issues. He added that other members included the Family Practioners Association, FAMSA, the Diabetes Association, the Alzheimer's and Related Dementia Association, the Depression and Anxiety Support Group, the Council for the Blind, the National Council of Women, and the National Medical Aid Members Association.

He said that some of the glaring issues that fundamentally affected doctors and patients included 'forced prescription' of generic drugs; 20% of the total health care pie going to medical aid administrators and brokers; the inappropriate capping of benefits in some schemes, and the lack of consumer knowledge of the Medical Schemes Act.

'There needs to be more transparency and co-operation between organisations, medical schemes and employers to design particular packages that serve health care. We're talking about someone's health here, not just downgrading your BMW from a 330 to a 320,' he said.

Allers, who is also president of the SA Society of Psychiatrists, said rewarding doctors for consultations in which they kept scripts capped at certain levels was perverse and could lead to underservicing. 'You can't make doctors decide on financial issues when they have to make medical decisions.'

He said that only nine out of 151 medical schemes did not discriminate against psychiatry and psychiatric patients. 'Only two medical schemes in the country, Polmed and Camaf, will pay for suicide attempts – the others say it's self-inflicted but fail to be consistent when it comes to smoking or drunken driving,' he complained.

As an example, Polmed needed a far higher psychiatric limit as police worked under emotionally stressful conditions. Over the past five years 7 000 police staffers were medically boarded on psychiatric grounds. Although Polmed's limit had recently been increased to R10 000 per family, other disciplines had far higher limits.

'Only in the last six months have hospitals, doctors and funders begun developing more effectively products for the lower income market.'

Allers said that REACH would also educate people about the new Medical Schemes Act that made it, for example, illegal for medical aids to take any condition into account which employees suffered from more than a year prior to joining.

Barry Swartzberg, MD of Discovery Health, told the *SAMJ* that his company offered generic drugs as an incentivised choice and questioned Allers' figure of administrators and brokers consuming 20% of health care costs.

'The issue is how effective are you at controlling the entire health care pie,

and by how much contributions are growing. If you can spend more on managing care and make the costs more affordable, that's a healthy thing'.

As for brokers, he said the debate was being finalised by the new regulations, yet believed they 'add enormous value'.

'They compare different schemes and put the most appropriate options to people. The problem with increasing access to medical aids is not about brokers, the entire industry has yet to find a solution to providing and funding health care in the lower end of the market', he said.

Only in the last six months had hospitals, doctors and funders begun talking and developing more effective products and medical savings accounts for the lower income market.

'Only nine out of 151 medical schemes do not discriminate against psychiatric patients.'

'The problem is that, in certain circumstances, its very difficult to manage every single event to get the best value for money. Generally limits are not a good thing and we should work towards better mechanisms for managing costs. If REACH can come up with one that is acceptable to everybody, we'd welcome it'.

Swartzberg said that for certain expenses like mental health, there was currently no solution on the table 'that says we can manage the costs and provide quality services – limits are a fairly crude mechanism'.

Pat Sidley, spokesperson for the Council for Medical Schemes, said any body assisting doctors or patients in understanding and working with the new laws, should be welcomed.

The Council had just published regulations to deal with brokers moving clients between medical schemes. It had warned various brokerages and asked several medical aids to explain the amounts they were spending on brokers.

'Whenever we see things are not good for our stakeholders, we act,' she said.

***SAMJ* Newsteam**

LOCAL HOSPITAL SOLUTION LASTS LONGER

The 'rescue' of UCT Medical Centre after German investors pulled out three months after its opening, has put 24% of ownership into the hands of 44 local doctors intent on salvaging tertiary facilities.

Renamed the UCT Private Academic Hospital after being secured for 'considerably less' than its R50 million worth of equipment and leasehold improvements, the remaining shareholding of the high-tech facility is split 26% to UCT and 50% to Westcare Hospitals.

At the helm of the new ship is Riël du Toit, the MD and controlling shareholder of Westcare Hospitals and a veteran investor in the industry. He believes they now have 'the best possible set-up' to deliver affordable world-class medical care and broaden the training platform for young doctors.

Du Toit reported that the investing doctors had put in between R19 000 and R60 000 each. 'They're a fascinating group of professionals. Many of them

Professor David Dent, head of UCT Surgery Dept with Riël du Toit, head of the UCT Academic Hospital. Pics courtesy of UCT Monday paper.

are within the actual UCT medical school system and really don't want the teaching platform to fall away.'

He explained that 'the Germans were in a country they didn't understand, trying to implement something never done before here. We've benefited from many aspects of their system.'

The *SAMJ* learnt from sources close to the former Rhon-Klinikum investors, that the sudden pullout followed a decision to downscale international operations, spurred in part by industrial relations problems in Germany and the rand/euro exchange rate.

'Delivering more cost-effective, affordable and top rate services to a wider range of people.'

'They were earning in rands and converting to euros. The project was conceived when the rand was far stronger. Also, their success in Germany was built around formulas and recipes, patient flows and payment of doctors and equipment – in this country where it's not that way, you need to be flexible,' one source said.

Many UCT academics who worked