Fee-for-service medical model outdated for best patient care

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MEDICAL science is evolving faster than ever before, so it is logical to become more innovative in payment for healthcare. In SA, where cash-strapped consumers are being squeezed by a sluggish economy and rising healthcare costs, the need to find alternative payment models that could achieve better patient outcomes without spending more money is becoming urgent. SA relies heavily on the fee-for-service model, in which healthcare providers are paid for their services. While it is the model for the provision of services in most industries, in healthcare it does not make for a long-term, holistic approach to managing health. As healthcare analyst Bob Berenson points out in The Journal of General Internal Medicine: “Fee-for-service, the predominant physician payment scheme, has contributed to the continuing decline in the primary care workforce and the capability to serve patients well.”

The model has become unsustainable. Providers must be incentivised to achieve better health outcomes for patients - either by actively preventing illness or by treating it as quickly and cost-effectively as possible. This does not mean scrimping on care; rather it is about reconfiguring how payment is made and what is paid for. Research has shown just increasing the amount of spend does not lead to healthier and happier patients. While initially there is an exponential increase in better patient outcomes, it ultimately plateaus. Other research has pointed to the devastating effect of waste on effective healthcare. Streamlining healthcare expenditure is a major concern in the private and public sector, especially as the country approaches a National Health Insurance (NHI). While red tape is wasting billions of rand, the Competition Commission has been approached about the inaccessibility of quality healthcare due to rising expenses.

In the public sector, Health Minister Aaron Motsoaledi argues SA achieves disproportionately poor health outcomes given its large investment in healthcare. This trend is not reversing despite an increase in expenditure. When SA transitions to the NHI, it will be even more important to maximise cost-effectiveness. Meanwhile, healthcare costs continue to rise. Medical funds will simply have to go further if patients are to receive the care they need. This does not mean the services of highly qualified medical professionals should be undervalued or underpaid. But rather than paying service providers according to the number of procedures, tests and investigations they carry out, they should be incentivised to provide the best possible patient outcome or to focus on preventative treatments. Medical scheme loyalty programmes that incentivise members to exercise, eat healthy foods or have regular health screenings are gaining popularity. Globally, the trends of medical schemes are even more progressive. In the US, capitation and bundled payments first took shape in the 1990s as Health Maintenance Organisations, clinic-type services run and owned by insurers, were established and

charged members fixed monthly fees. They ultimately lost support due to a conflict of interest, as insurance companies owned the clinics and the managed care process. Insurers were accused of cutting corners to cut costs. Today, however, a modified form of this model is being considered, known as care delivery groups, in which the conflict of interest is eliminated because ownership lies with the healthcare providers. The focus lies on quality outcomes and savings are achieved through more efficient clinical processes. Benefits are shared by insurers, healthcare providers and patients. The care delivery groups focus on bundled payments for the entire cycle of care. For example, if a patient has a hip replacement, she would pay a flat fee for the entire episode of care from diagnosis to rehabilitation, while measuring outcomes at specific points throughout the process. It is, therefore, in the interest of all parties to eliminate waste and improve outcomes, and each provider in the cycle is incentivised to do so. For hip surgery, this would include the surgeon, the anaesthetist, physiotherapist, hospital staff and prosthesis. The same principles would apply to chronic care. The bundled payment system means everyone will be paid, profits will be shared, good outcomes are aimed for, and certain catastrophic events are excluded This gives real meaning to the term “value”, which is much bandied about in healthcare. It simply means providing better outcomes at the same or a lower cost.

The American Health Catalyst’s head of financial engagement Bobbi Brown says: “The switch to value-based reimbursement turned the traditional model of healthcare reimbursement on its head. Much of this change is long overdue and quite exciting because it’s driving improvements to the delivery of care by mandating better care at a lower cost.” But, she warns, providers who are unable to achieve the required scores will also face the financial consequences. The time has clearly come to move away from the fee-for-service system. In certain circumstances, both capitation and the bundled model make sense, and many medical schemes have indicated their interest in pursuing these models. The era of provider-driven demand is long gone. Exciting times lie ahead, and patients stand to win.

By Dr Ernst Marais: Business Day