

Doing better with less

 By [Nicci Botha](#)

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Waste, fraud and abuse across the healthcare spectrum are contributing the high cost of healthcare, and ultimately patients are paying with their lives.



Image source: Getty/Gallo

"The overuse of care causes physical and psychological harm to patients. We need a new paradigm in medicine. We must do better by doing less," Louisine Alpern, co-founder of Medical Reviews International (MedRev) said at the Board of Healthcare Funders of Southern Africa (BHF) conference in Cape Town this week.

Her company has developed a clinical governance platform, which helps medical schemes save money and cut medical overuse through peer review process that evaluates whether the treatments doctors order for their patients were necessary.

When MedRev first gets involved at a scheme, the number of claims that are rejected is sky high. But once doctors realise their work is under scrutiny, they start to submit fewer and fewer claims to medical schemes, Alpern said.

She cited the example of a Swedish scheme, where three-quarters of spinal procedures and half of knee, hip and shoulder surgeries that were claimed were found to be unnecessary.

The reviews are conducted by independent specialists, who weigh the claims against evidence-based best practice, and

then provide the treating doctor with a full clinical report that includes advice on how to streamline their treatments.

“But we wanted to be sure the doctors are getting consistent advice,” she said. Therefore the specialists' advice is monitored, and the amount they are paid for their expertise is not linked to how many claims they deny.

The review process also needs to be ongoing, Alpern said. “When we stopped reviewing in Sweden, the number of claims jumped right up again.”

What SA does

Dr Hleli Nhlapo chairman of the Board of Healthcare Funders of Southern Africa (BHF) Healthcare Forensic Management Unit (HFMU) agrees with Alpern on doing better with less.

“In fact, there was a news report on a country where the doctors went on industrial action and the mortality rate actually dropped,” he said.

The HFMU's objective is to facilitating a unified approach to combating fraud, waste and abuse in the healthcare industry. It is an information and resource sharing group comprising the majority of medical schemes, administrators, management and administration entities and some insurers.

Members share information on fraud, over billing and over servicing in order to minimise fraud across the industry and to protect medical schemes from healthcare providers and medical scheme members who shift their wrongdoings from one medical scheme to another once “caught out”.

“Every member has access to what is loaded on the portal,” Nhlapo said.

The HFMU is a convergence of big data and statistics, clinical acumen and risk management,” Chris Adams, director of Verirad, said.

His firm verifies radiology and pathology claims for medical schemes, and part of the problem, he said, is that healthcare practitioners operate in siloes, rather than as a coordinated team.

In one instance, he said the lack of communication between doctors forced a 64-year-old diabetic patient to undergo the same blood tests twice in the space of three days. In another, a 59-year-old woman was sent for the same blood tests by her general practitioner, physician, and surgeon during her three-week hospital stay.

“We need to communicate with each other. We're losing money, and harming patients,” Adams said.

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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