Submission to Health Market Inquiry – Competition Commission SA

The healthcare financing regulatory framework and the impact it has on competition in the South African private healthcare sector.

Introduction: Contextualizing the bigger picture for the submission

At the risk of stating some obvious facts, for which I apologize upfront, it is important to present a full canvas first, before answering some specific questions posed by the Competition Commission's Inquiry team, to contextualize the bigger picture surrounding specific answers.

To be effective in contributing to the long-term discussion and implementation of Universal Care for All, it is of critical importance to carefully prioritize issues around competition and market forces to maximise impact; and to consider judiciously which implementation of sustainable governing policies regarding health care delivery and protection of the poor would *yield the best results for patients*. The focus must remain on the patient, at all times.

Healthcare management is vastly complex; many different models of structuring health care delivery, and how to fund universal access for all, has been proposed, implemented, found wanting and criticized. Some have had limited success, and those with the best results have been built on mutually beneficial public/private partnerships.

Suffice to stay with the basic core principles:

Health care management strategically centres around

- cost of access to health care/healthcare insurance;
- standards for coverage and
- the Structure of Healthcare Delivery.

The latter is by far the most important, as it

- drives cost, quality and efficiency, which will
- drive insurance/delivery cost, which in turn will
- determine the amount of coverage that is feasible. (Porter et al)[i]

South African health care delivery is divided, as in many other countries, into public and private sector delivery and broadly speaking funded via mostly tax (public) and health insurance (private), with substantial amounts self-insured or covered through co-pays or savings accounts; yet with vast differences in access, quality, cost and under/over servicing. Both sides of the equation need to be addressed to ensure sustainable universal access to a minimum level of care, based on sustainable competition and value for patients.

The NHI white paper proposes a theoretical model for implementation, however there is still very little substance in planning, and many serious issues described in submissions from the public have not as yet been addressed. The Phakisa ideal clinic process has been implemented in several PHC facilities with limited success. Provider contracting has been plagued by non-payments, lack of equipment, drugs and consumables. A large amount of work has been put into the development of quality audit documents, however, it only addresses *process issues, none of it address clinical outcomes nor value to the patient.* The words 'outputs' and 'outcomes' seem to be used interchangeably, and there is no indication how actual improvement to health will be measured via

clinical outcomes. Having enough staff and space in a clinic does not guarantee quality care, by any means. Private hospitals rely on a proxy measure of patient satisfaction which falls far short of health care outcomes. The industry in general suffers from a serious lack *of appropriate, standardized data* and the ability/understanding of clinical outcomes measurements to track value to patients.

Our goals need to focus on *patient-centric healthcare*, *value based payment and incentive systems* and *appropriate data collection and utilization for transparency and quality measurement*, to start correcting the structure of our health care systems to *create value for patients* and *ensure healthy sustainable competition.*

Issues that need addressing before we can discuss the feasibility of a NHI scheme and to address spiralling expenses in the private sector include, but is not limited to, the following:

- Current health care market regulation and the perverse incentives inherent in the public and private sectors, as well as the proposed NHI scheme.
- Commoditization of health care
- Misaligned incentives creating a market stuck in zero-sum competition and how to change that
- Industry structure, objectives, geographic differences and strategies need addressing in policy documents and health care acts.
- Realigning competition to drive innovation and quality improvements, as well as cost reductions and value for money spent
- Information and Measuring value to patients (via clinical outcomes) and making this public, to drive quality improvements and competition.
- Bleeding of tax-payers' monies into irregular expenditures and accountability therefor.
- Rampant fraud and misalignment of funds due to incomplete financial and fiduciary management procedures at coal face levels, lack of accountability and financial training of managers
- Procurement issues and misalignment in procedures to prevent fraud and poor utilization of available resources at all levels; inventory management policies and procedures need an overhaul and training of staff, audit procedures that will pick up issues in real time, systems that prevent issues.
- Training of clinical staff to be overhauled – bureaucratic behemoth with low outputs and quality issues – allowing private sector training across the board needs to be addressed. This includes a review of scope of practice for healthcare professionals, and the establishment of community level care-givers to assist with grassroots health data collection and training.
- Pricing of services – the NHI proposal (despite having many qualified professionals provide input) vaguely refers to 80's style pricing methodologies with some real issues and some potential – however, SA uses a different FFS scale than other first world countries. C*oding/valuation of services delivered need to be based on training, skill and time levels*, as for example, in RBRVS. Providers need to be consulted on pricing issues – as professionals, not via agents.
- Financial risk management issues surrounding risk pools and cost of administration needs addressing.
- Industry standards for data collection and interoperability needs addressing.
- Revitalisation of public health care facilities, relaxation of licensing in private sector – allow greater spread for primary health care and public health, build up Centres for Excellence for economies of scale and quality outcomes.

- Complete re-engineering of primary health care – patient focus, utilization of available resources, community based, upscaling of referrals to other levels based on value to patients
- Variables and factors related to supply-induced services
- Public/private sector collaboration and contracting.
- Quality of public health care and Government Policies of critical importance.
- Lack of accountability for current failures by Ministry of Health, (ruling party appointments appears to be made based on service to party and not necessarily capability to perform the job, judging by the department cv's posted online). Quality measures and score cards to be used to measure public service utilization of tax payers' monies.
- Clinical outcomes measured across public and private sectors per region to drive value for patients, based on patient needs in a community.

The issues of health care in South Africa cannot be solved by pointing fingers at sectors, nor specific players in the market or patients that drive unnecessary utilization due to ignorance. The reality we face is summarized;

- High and rising costs
- Restricted services, often falling far short of recommended care
- Lag in standards
- Restricting of innovation and blaming new technology for cost increases rather than embracing value enhancements
- Slow implementation of best practices – NO clinical outcomes measured as a standard
- Some over servicing – all part of misaligned incentives
- Cost and quality differences amongst providers and regions (but not measured, quantified, nor managed).

Patients – where are they?

As a global health care consultant and strategist, clinical outcomes and quality in health care specialist, I do realise I have come to the inquiry late – but I have been surprised by the lack of participation by the public. Submissions have been mostly provided by big industry players/groups and a few important specialists in the market (economists, actuaries, etc).

Patient centric health care demand that we take cognisance of the needs of patients, and structure our delivery mechanisms around that. The healthcare industry globally has been plagued by a paternalistic attitude by administrators and providers believing they know best (and no, carefully sculpted patient satisfaction questionnaires do not denote quality nor value for money).

Do we encourage patients/individuals to participate? I understand that submissions are open to the public and anyone can contribute, but maybe as the health care profession we can take more initiative to involve patients/members in the evaluation.

There is mention of a consumer survey where patients stated that current benefits are confusing – but what are their suggestions for improvement, their reasons for anti-selection, their perception of value for money?

Maybe a survey of patients' (and employers') perceptions of the issues in the market could be enlightening?

Driving competition via quality improvements

'To understand the business of healthcare, management requires the ability to integrate clinical data with financial and administrative data. The purpose of performance management plans should always be to transform that raw data into *actionable information.*

In many healthcare organizations, performance management is centred on financial reporting and operational productivity reports (patients/day, revenue per patient, patients/plan, etc.) and provider incentives lead to individual interest development.

Provider contribution to practice growth, clinical quality and outcomes, resource optimization, revenue collection improvements, supply management improvements, sustainable growth developed through potential market needs analysis, innovative product development based on health risk evaluation of practice communities, to name but a few, are seldom given the attention they deserve. Management receives reports that do not clearly guide action. And they simply do not address quality of care, or value to patient.

Quality Dimensions in Health Care

The definition of quality is rather elusive in health care. *Quality of health care and customer satisfaction is often confused, and it has been argued that they are entirely different constructs.* Quality is generally defined in terms of effectiveness (outcomes) and efficiency (utilization of resources). Numerous researchers and clinicians have grappled with the concept of measuring quality in health care, and many areas are addressed, such as:

- Evidence-based Practice
- Outcomes & Effectiveness
- Technology Assessments
- Effective Health Care
- Preventive Services
- Clinical Practice Guidelines

Health economics modelling allows for the *evaluation of Clinical Outcomes* and quality of life measures for different treatment modalities against cost of treatment, to determine ***best spend of health care dollars (rands).***

For physicians, medical group practices, hospitals and health systems, the issue is not which is the correct definition of quality, but rather that suggested dimensions are discussed, measured where possible and are given attention by management. Staff will deliver and give attention to what is under scrutiny by management, this is a simple fact of life.

It all may sound very academic and impractical to implement, however, there are some simple steps that can be taken to measure health care quality based on strategic goals for servicing a particular community.

Most importantly, making the effort to measure health care risks in a given population, health care needs, care seeking patterns, delivery of care and outcomes, becomes the most powerful consulting and marketing tools an organization can put together.' This will foster healthy competition in the private health sector. And eventually, the public sector too.

'Not only do you give proper attention to real improvements in health care quality in your delivery mechanism, it also provides you with powerful proof of your ability to deliver to diverse communities and provides opportunity for sustainable growth.'[ii]

(However, we do not need to be impractical about measuring clinical outcomes – most can be done by collecting data whilst documenting general patient care! The first Clinical Outcomes study in South Africa was performed by the author of this document in 1992, and she has implemented outcomes and quality programs globally, many in third world countries, with limited resources. Bespoke systems are nice-to-haves but are not mandatory.)

Current Zero-sum Competition in Health Care – a sad reality

Commoditization of Healthcare, perverse incentives, regulatory restrictions and loopholes have created competition

- To shift costs
- To increase bargaining power
- To capture patients and restrict choice
- To reduce cost by restricting services

There is no increase in Value for Patients in these forms of competition[iii]:

- Reduce value through added administrative cost
- Inappropriate cost subsidies in the system
- Gains for one participant always at a cost for another – pure cost shifting
- Slows innovation, lack of meaningful quality improvements and cost savings, stagnates industries
- Adversarial competition proliferates lawsuits, unnecessary layers of 'agents/representatives' to assist in negotiations, abuse of bargaining power - all produce direct and indirect costs to the market which is then borne by patients.

Competition has been stymied, stamped out, paralyzed by focusing on the wrong things, levels, conditions – value for patients not being one of them. Micromanaging providers, restrictions, administrative processes, attempts to level the playing field, increasing bargaining power by acquisition to save costs and driving internal referrals to maximize profits, with no attention to actual results. Focus on cost reductions and shifting of cost responsibility, rather than creating value for patients. Health plans today are so confusing that even players in the industry are unable to make informed decisions regarding value for money. See Annexure A for an evaluation of changes suggested for health plans to drive value.

SPECIFIC QUESTIONS

The author will only comment on some of the questions, and asks many more questions on the submissions provided to date. HMI questions provided in green, for reference.

Anti-Selection

20. Given the varying views the HMI has heard, we would like to assess the degree to which anti-selection occurs. In particular, the HMI is interested in the extent to which anti-selection affects medical scheme membership and the viability of the schemes and how this ultimately harms competition and the consumer. To do so, the HMI poses the following questions:

- What evidence, if any, illustrates the extent of anti-selection in the medical scheme market, what are the underlying drivers and how has this changed over time?
- How is this evidence related to developments in income, employment and demographics?

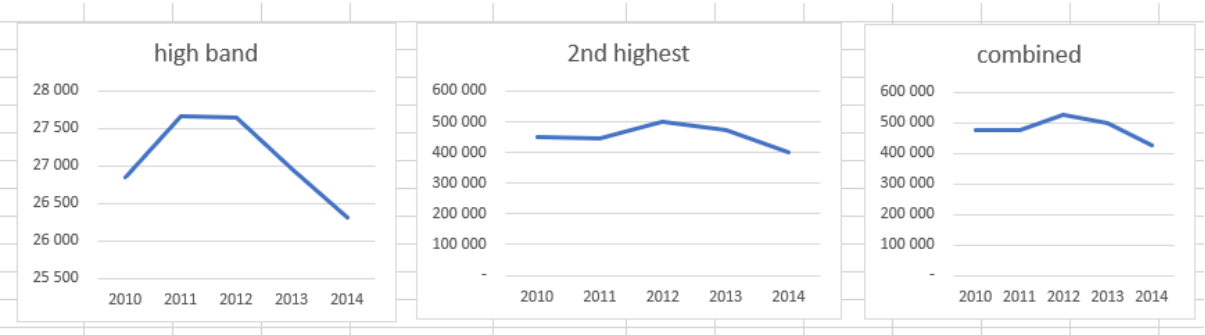
- Is the current level of underwriting effective at discouraging late joiners?
- Assuming that anti-selection is a real and important phenomenon in the South African healthcare market, what mechanisms can be introduced to limit anti-selection (particularly keeping in mind the overall country objective of moving towards a NHI)?
- How would these proposed mechanisms affect the number of beneficiaries and the level of contributions?
- What impact would these mechanisms have on low income earners that may spend unsustainable proportions of income on medical insurance (and in the absence of a low income benefit option)?

Affordability

The impact of affordability of medical cover has been played down in previous submissions, I believe. As I do not have access to data, it is hard to quantify the exact impact, nor am I qualified to comment in detail on the data provided, as there are more questions on the data groupings than answers. However, perusing the table provided by Alex van den Heever, "Table 1: Beneficiaries by contribution band, with the red highlights indicating a cross-subsidised option" I asked the question: are members leaving higher options when they are pushed into higher contribution bands? For example, it would appear by the number of members in the different high bands, that increases push them into higher bands – not very scientific but an observation from a healthcare data veteran.

	2010	2011	2012	2013	2014
2001 - 2500	449 197	447 796	498 042	473 809	46 186
2501 - 3000	26 846	27 659	27 644		401 095
3001 - 3500				26 964	26 315

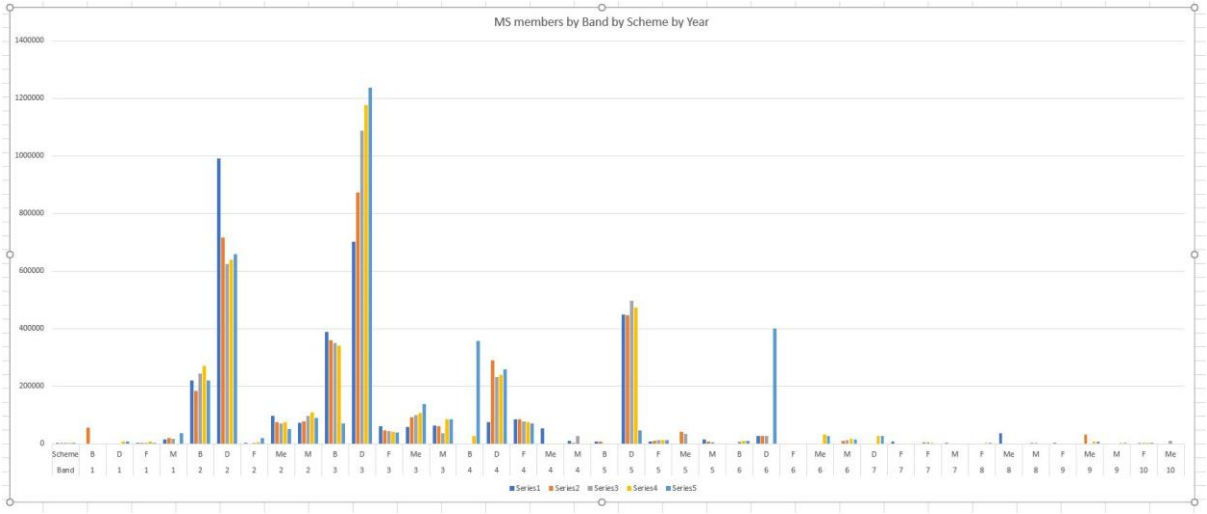
Similarly, the membership numbers in the higher bands eventually decrease as they go up:



It would have been good to have the data presented in real terms, so as to follow the effect of premium increases on option choices – however, I do understand the data was presented here for a different purpose (cross subsidization).

The most telling graph for me personally, is the following:

The data in the above table was graphed to present a visualization of spread of membership across the contribution bands presented, with increases/decreases per annum per scheme. The detail is not important for this purpose, simply the bigger picture. Adding a bell curve would be good, however you can picture it fairly easily.



See Annexure B for a larger version. Briefly, the data is sorted into bands, from 1 to 10, based on Alex's contribution bands, left to right. Then it is sorted by medical scheme, and within each the series 1-4 represents the years 2010 – 2014.

Membership numbers are heavily concentrated on the lower end of the scale, (to the left), where options presumably mostly consist of hospital plans only. (Data sorted by contribution, not option). Compared to the early nineties, when most members were on some sort of fairly comprehensive plan, this is a major shift, and I believe it points towards affordability. This does not discount any other reasons for anti-selection, I simply wanted to make the point that affordability has not been given the attention it requires.

It would be good to have this data presented as a percentage of income, in real terms.

It is also interesting to note in Figure 3 Medical scheme beneficiaries from 1997 to 2016 by scheme type; the number of scheme beneficiaries has remained practically stagnant for the last ten or twelve years in open schemes, despite population growth – it would be interesting to see these figures as a percentage of population. It seems the only growth has been in restricted schemes, as there is no choice (in most cases). Patients walking away could also be an indicator of lack of affordability and poor value for money. Stake holders' assertion that multiple benefit options are required to attract members does not seem to grow the market at all. If this was true, there would be a far more equal spread of members in the graph.

There has also been a lot of discussion regarding the scheme data analysis (more on that in the January 30th comments submission) regarding the cost drivers that are responsible for the escalation in medical scheme contributions – it would be of value to compare contribution increases with the actual benefit increases offered, as I suspect there will be some discrepancies.

26. …. Stakeholders told the HMI that medical schemes cross subsidise their benefit options to ensure the sustainability of their scheme as a whole. The higher contribution bands that provide more coverage (comprehensive plans) appear to be cross subsidised from the middle to lower contribution bands. These comprehensive plans typically have the sick and elderly as well as some of the "worried wealthy." If these plans had to be selfsufficient, then they would become more expensive. This would incentivise members, including the worried wealthy, to buy down to cheaper, less benefit rich, options. This results in a decrease in gross contribution income for the medical

scheme without an equal decrease in claims which could make the medical scheme unstainable. Ultimately, it could contribute to what the industry terms the actuarial death spiral.

27. It also appears that some medical schemes subsidise their low cost benefit options. This may suggest that if these options were not being cross subsided, then they would not be affordable and current members would be eased out of the market.

Comments – some employers mandate a comprehensive plan for their members, it is not necessarily the 'sick and elderly' or the 'worried wealthy', it is a really broad generalization – and strange to assume that if you are not sick nor elderly, you would only choose comprehensive cover if you are wealthy and a little bit paranoid. In my view a very paternalistic view point – can this statement be substantiated?

The claim that buying down, results in a decrease in gross contribution, without an equal decrease in claims flies in the face of the claim that the middle contribution bands have to subsidize the higher bands. If there are more members in the middle contribution bands and less in the higher contribution bands, there should be less cross subsidization, surely? Similarly, buying less rich benefit plans, would surely mean lower capability to claim – unless the schemes have the same level of hospitalization/catastrophic benefits for low, middle and high contribution bands. This would then surely be a concern regarding how risk in different areas are evaluated and costed – and needs addressing.

I would agree that if the middle contribution bands buy down to low contribution bands, it could result in the so called actuarial death spiral, and I do believe that this may pose a very real risk with the continued above inflation premium increases. If these increases are mostly driven by hospitalization costs, we need to investigate the cost drivers behind these increases.

So far, I have not found any mention of the costs associated with, nor measurements related to the reduction of HAI's (healthcare associated infections) or readmission rates, LOS (length of stay), etc. These quality measurements and associated costs should be figured into contracting with providers, to ensure the cost is not simply passed on to the already aggrieved patient, and then hidden in reports on average costs of procedures or treatment.

Cost of patient care should be calculated *on actual patient care costs* and not total operating cost for health care providers. Whilst overheads need to be allocated proportionately, (preferably ABC), excessive marketing cost such as "Special Deals" to attract providers to an enterprise, lavish entertainment or overseas trips to watch the World Cup (as much as we all love rugby, soccer and cricket) for example, should fall under 'the cost of doing business' and should be deducted from profits – passing those costs to the consumer (patient) can drive up hospital bills dramatically and will certainly make private health care unaffordable for most. I am categorically not accusing any hospital/group of such practices, I am simply stating that it seems to be a global trend in many private sectors, as a strategy to build provider relationships that will ensure the highest bed occupancies and increase bargaining power.

Late Joiner Penalties

Affordability in my view most definitely has an impact on younger people only joining by age 35, as they cannot afford it and then have to make choices as to either paying late joiner penalties for years to come, or bite the bullet and pay for at least a hospital plan.

Actuaries can comment on the specifics of calculating these penalties – I do believe we should rather look to *an incentive for younger people to join earlier*, for example by offering a larger tax break for

early joiners, or the schemes allowing them to pay contributions in accordance with income, and by joining prepaid primary care services at specified providers– the youth are more resilient when having to visit a specific provider (for lower contribution) than older patients that have established relationships with their providers. The youth hostel concept model comes to mind, or university student clinics.

Benefit Option Soup – Incomparability of Benefit Options

39. The HMI wishes to discuss possible changes to medical scheme benefit options that could improve competition within the market.

- Is the current level of competition between medical schemes on their benefit options effective, considering the information available and the complexity of the subject?
- What changes would allow members to compare the real value of medical scheme benefit options?
- What is the contribution (if any) of medical savings accounts to the member and to the medical scheme?
- What is the effect of current medical savings accounts on moral hazard, and how can the continued existence of these accounts in the medical schemes industry lower moral hazard, and improve competition between schemes?
- Will a simplification of benefit options improve transparency and accountability? To what extent will this incentivize medical schemes to compete on the merits – that is on value for money and innovative contracting where they can pass the benefits directly onto the members?
- How can benefit options be simplified to allow meaningful comparisons and increased competition?

Medical schemes have made it impossible for ordinary citizens and would be patients to make informed decisions on purchasing private health care. Please note informed decisions relate to full understanding of the benefits to be utilized, or penalties to be paid (e.g. out of pocket expenses) and groupings of benefit limits, as well as the ubiquitous terminology used by schemes in the small print and scheme rules to limit payments.

Having previously served as a Principal Officer for an open scheme, and a restricted scheme, during which time I spent many nights trying to simplify benefit offerings and scheme rules, in order to provide clarity and value for our members, I find the proliferation of benefit options a nightmare to navigate, let alone make reasonable comparisons. Plans offer bells and whistles to attract members, but clarity on benefit and value for money is obfuscated by confusing rules, groupings and terminology. Lots of hat and very little cattle – as they would say in Texas. Or in braai country, lots of sizzle and very little steak.

It is time to simplify, simplify, simplify. *The basic cornerstone of quality management lies in simplicity, as every level of complexity exponentially increase the risk of mistakes, lower quality and added cost.* And mistakes are plenty – just ask Dr David Green of Med Claim Assist – a company born of the need for members to get assistance to navigate the enormous red tape and unintelligible rules and explanations when a claim is denied or short paid. They have expanded their staff during the last year to cope with the volumes of assistance requests, and have had millions paid to

dissatisfied members due to incorrect claims assessment. I am not surprised that claims assessment mistakes are so common, given the complexity of the plans and their interpretation. Providing a clean claim from a provider point of view, having to navigate so many options, is quite a challenge too.

It is exactly this complexity that do not allow administrators to evaluate data for trends, patterns and links that could point to fraud perpetrated by both providers and members alike, the administrative burden is immense. In the nineties we ran tapes at night to extract data to analyse, and found unnecessary claims (whether due to fraud or ignorance on behalf of the members) in some cases as high as 30% of payments – setting up a data warehouse and dealing with these issues based on cost, volume and priority ensured major savings. There is no mention anywhere in the submissions regarding these issues. Notifying administrators of suspected fraudulent activity is mired in red tape, forms and scheme rules. In this digital age there is no reason not to be able to set up checks and balances to not only highlight trends but to prevent them.

The CMS proposed a benefit design framework as far back as 2006 – it is a logical step to take.[iv]

Increase competition in health plans, to start off with, by:

- Standardization of benefit groups – i.e.
    - the PMB package should be the foundation offering, and be exactly the same for all plans, no confusion for members, no 'plan rates' etc. Allow price differentials only on those utilizing prepaid services, or designated providers. An industry wide REF for the PMB package makes sense to me personally, however, I will leave that to the actuarial experts to discuss. Medical schemes will need to contract with providers.
    - Hospitalization (other than in-hospital treatment of PMB's) at different pre-set standardized access levels (i.e. day clinic, provincial or private hospital),
    - Chronic illness not included in PMB's, at different price levels based on standardized pre-set access levels, e.g. on provincial, private, or managed.
    - catastrophic illness defined clearly.
    - Then allow supplementary or other services in bundles, i.e. optometry, but standardized and clearly defined.
    - PMB package is standard, with buy up options as described.
- Implement basic outcomes measures for health plans and providers and link to contributions, payments and insurance. Drive competition based on value delivered. (quality/price). The professional regulation prohibiting doctors from competing should be reworked to limit them to not *advertise* their outcomes, however, outcomes should be published and available.
- Any additional non-clinical services to be managed and reported on outside of the medical component, i.e. allow health plans to compete on these offerings without it affecting medical cost and risk pooling.
- Absolute clarity to be provided on savings plans, including investment of contributions. Schemes use 'plan rates' to minimize payments for PMB and chronic conditions, and patients end up paying contributions, plus savings components and still have out of pocket expenses for mandatory coverage items (such as drugs) even though they are medically necessary, for conditions on the CDL. Administrators use the MSA rule that no CDL payments are to come from Savings accounts, and simply pass it back to an out of pocket expense.
- Contract Independent Provider Panels to evaluate medical necessity, not health plan staff.

- Publish outcomes measures for providers and health plans, initially for the industry and eventually for patients, in a phased approach.
- Limit administration fees per band of services, a percentage of spend provides only perverse incentives. Simplification of rules, offerings and options will reduce administration burden and cost for both plans and providers.
- Appoint an industry wide team to evaluate outcomes measurements, develop an adaptation of RBRVS (Resource based relative value scale) and CPT (current procedure terminology) for South Africa to align payments with education, skills and time levels for services rendered; with the view to develop additional incentives for value outcomes in episodes of care and/or condition specific care. Work towards bundled payments for treatments, based off fair profit for quality services. Prepaid (or capitated) services should only carry risk for specific treatments, not all healthcare, and should consider the population risk profile, e.g. basic primary care.
- Reward innovation to drive sustained value.
- Incentivise the use of technology that delivers proven value to patients

If treatment does not improve clinical outcomes, or inappropriate treatment is delivered, it will drive up cost – this is why clinical outcomes are crucial in reimbursement policies: incentivise to improve outcomes. Those confident of their practice will welcome measurements and not resist.

Preventive care is not covered here at all – proper preventive care (measured by clinical outcomes) will encourage earlier lifestyle changes and treatment to prevent disease progression, which has a huge impact on total health expenditure and lifetime health care cost (not to mention the patient's productivity over his lifespan).

Conclusion

It is imperative that we align all and any incentives with driving quality and value for the patient; measure actual clinical outcomes and not just process compliance or patient satisfaction; and provide measurements and reports that drive action, throughout the industry.

Competing on value delivered creates sustainable markets and services, and a refined and comprehensive value-based strategy can advance several important goals for healthcare organizations, among them

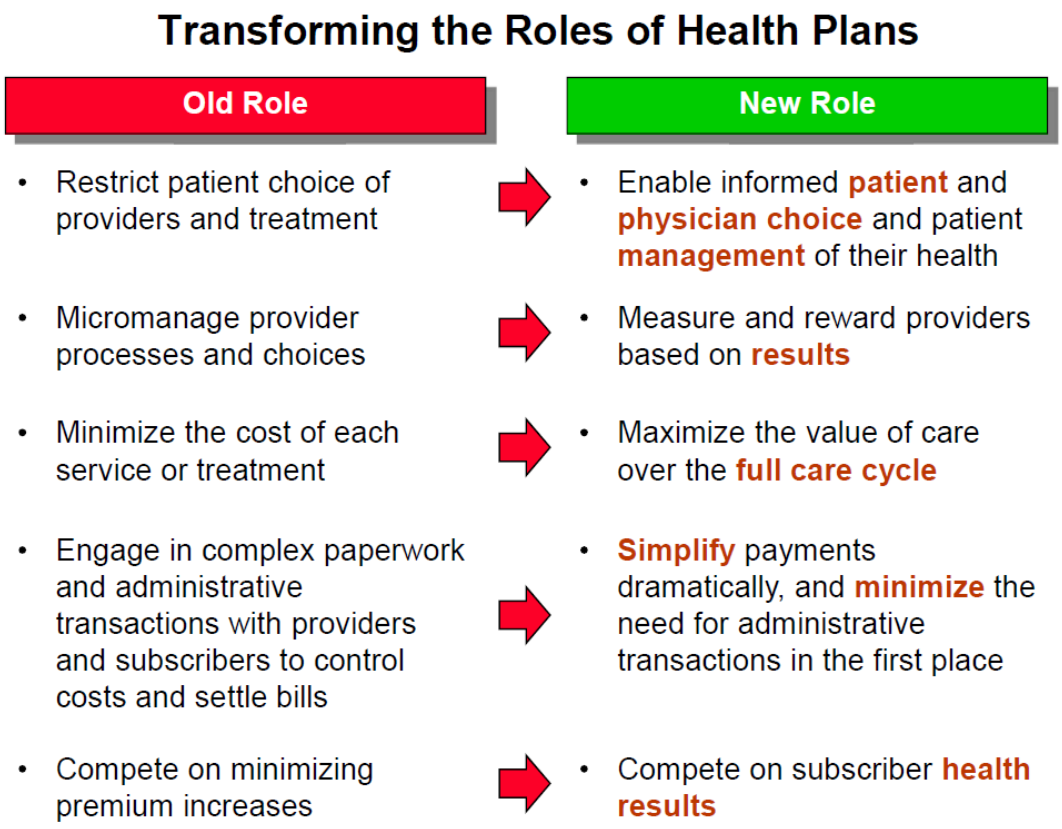
- enhancement of quality of care and improvement of patient outcomes.
- promotion of safe medical practices;
- sharing of evidence based clinical practices;
- increased efficiencies in care delivery;
- facilitation of appropriate utilization of services,
- alignment of financial incentives, and
- healthy competition practices.

Wilna Ehlers
Rubicon Performance Consulting
Creating Value through Sustained Performance Improvement

19 January 2018

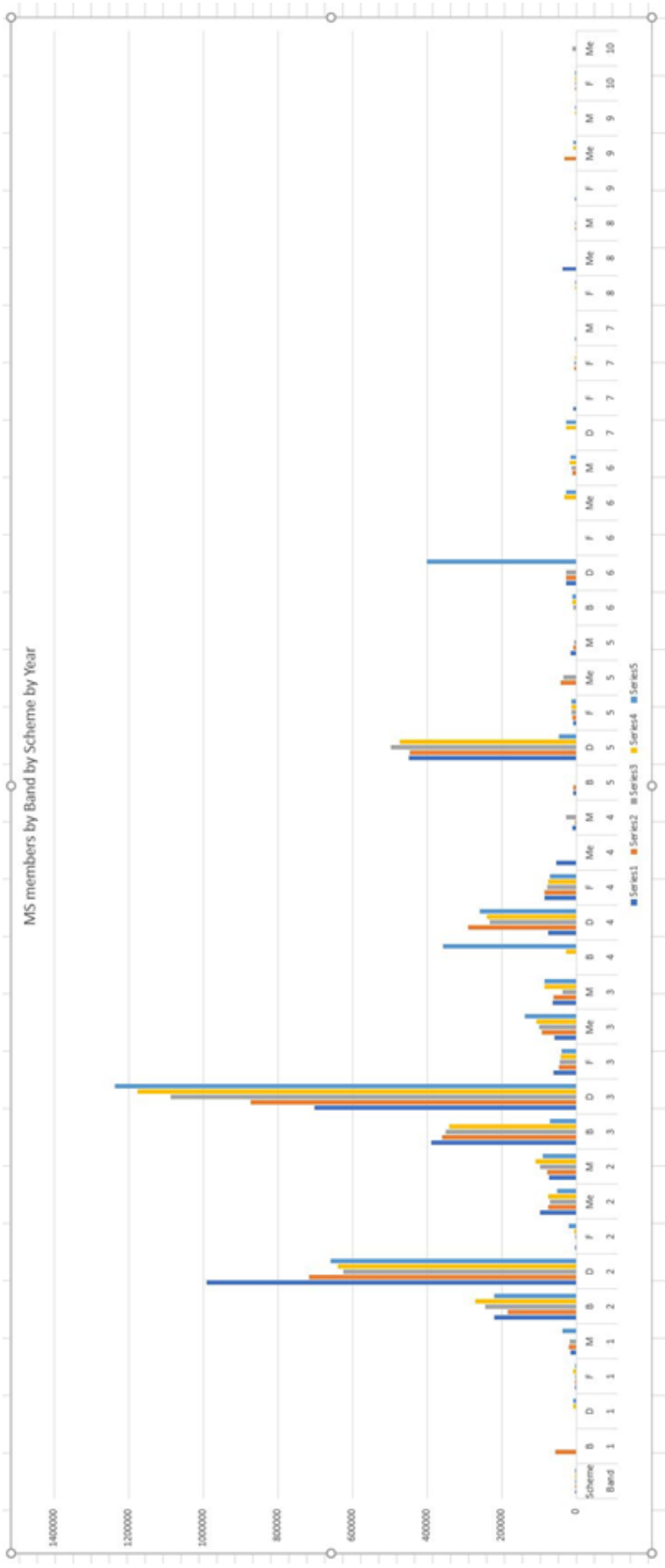
Annexure A

Transforming the Roles of Health Plans



v

Annexure B


MS members by Band by Scheme by Year
Series1
Series2
Series3
Series4
Series5
Scheme
Band

Band	Scheme Options - contribution band	Scheme	
1	100 - 500	B	Bonitas
2	501 - 1000	D	Discovery
3	1001 - 1500	F	Fedhealth
4	1501 - 2000	M	Momentum
5	2001 - 2500	Me	Medihelp
6	2501 - 3000		
7	3001 - 3500		
8	3501 - 4000		
9	4001 - 4500		
10	4501 - 5000		
11	5001 - 6000		

[i] Professor Michael E. Porter. Redefining Health Care:
Creating Value-Based Competition on Results
Harvard Business School
IHI IMPACT Spring Leadership Meeting
Boston, MA
June 27-28, 2005
[ii] Wilna Ehlers. Creating Value through Sustained Performance Improvement.
[iii] Porter – ibid I – adapted.
[iv] CMS Circular 8 of 2006 "Consultation on a Revised Benefit Design Structure for Medical Schemes."
[v] Porter – ibid i

Ms Ehlers has forty plus years' experience in the global Healthcare industry, working as a healthcare strategist, specializing in change management, clinical informatics, data and knowledge management, quality management and clinical outcomes; digital/systems strategy and marketing. She has worked or consulted in the health care service industry in many countries, in remote locations, academic and private hospitals, health plan management, third party payer, managed health care, private practice management, wellness and preventive health, manufacturing (pharmaceutical industry), primary care: as well as other industries.
Coming from both clinical and financial backgrounds, she holds a Master of Business Leadership (Cost Accounting), a post-basic degree in education and professional ethics (medical law), and several nursing qualifications. For her seminal master's dissertation in Management Accounting and Health Economics, she applied ABC costing to the medical field, incorporated Outcomes Research and developed QALY tables, both a first in the country.
She was an invited member to the *South African Health Care delegation to the USA* for the centenary celebrations of the National Medical Association in recognition of her development work in Primary Care.
She has developed a highly successful Aids Economic Evaluation Model and was a major architect for the Aid for AIDS Programme, now implemented in many African countries, and winner of more than 15 international awards; a Financial Management System for academic hospitals funded by the European Union, strategic and business plans for primary care clinics, community pharmacies, private group practices and wellness centres, to name but a few. She has developed strategy maps for several international companies, and implemented combo EMR-finance-inventory management systems (adapted and developed to her designs) with data-warehousing and targeted reports for over seventy countries.
She is currently consulting in South Africa as well as globally, with clients in the USA, Australia and the UK, working on m-Health applications and finalizing practical health care management online training programs to help alleviate the skills shortage. She is also involved in several other business endeavours at executive level.
wilna@rubiconpc.co.za