Guest editorial

Office-based surgery

STEPHEN GROBLER, ***MB ChB, MMed (Chir) (Cert Gastroenterol)***

Specialist Surgeon and Gastroenterologist, Universitas Netcare Private Hospital and Part-time Consultant Surgeon, Department of Surgery, Universitas Hospital, Bloemfontein

Stephen Grobler undertook his undergraduate and postgraduate surgical training in Bloemfontein. He did his subspeciality training in Surgical Gastroenterology in Bloemfontein as well as the University of Birmingham, UK and Cleveland Clinic in Fort Lauderdale, USA. He serves as councillor on management bodies for surgeons (Association of Surgeons of South Africa (ASSA) and Surgicom), laparoscopic surgeons (South African Society of Endoscopic Surgeons (SASES)), gastroenterology (the South African Gastroenterology Society (SAGES) and he is an honorary member of the Association of Laparoscopic Surgeons of Great Britain and Ireland (ALSGBI).

Current interests are gastroenterology, colorectal conditions, laparoscopic surgery, health informatics, practice guidelines, reimbursement and coding.

E-mail: sgrobler@global.co.za

This issue of your *CME* introduces the theme of office-based surgery (OBS). Traditionally minor surgical procedures are performed in side-rooms in practitioners' offices. The modern concept of OBS pushes the envelope to encompass a wider range of ambulatory procedures. In concert with the more invasive nature of the procedures, office-based anaesthesia (OBA) has developed as a specialised field.

The increased utilisation of the office setting has been driven mainly by the high costs of hospitalisation and theatre. There is also a shortage of beds and theatre time. In the USA ambulatory surgical centres (ASC) or day-clinics have proliferated and offer a wide range of procedures. The glamorous Beverley Hills Dr 90201 plastic surgery centres are upmarket examples. Many other disciplines have developed office-based or ambulatory techniques, including endoscopy, infertility and other gynaecological procedures, and dental and maxillo-facial procedures.

While the expanded concepts of OBS and OBA may seem obvious developments, they are not yet ready for prime time in South Africa. Driven by financial incentives and patient demand, they may be burdensome to show profit. Doctor comfort and 'one-stop shop' practice is fraught with financial and legal constraints. Most funders refuse to reimburse out-of-hospital costs adequately. Nevertheless, some have seen the light and encourage office-based procedures. Quality of care, standards and accreditation are poorly addressed in South Africa.

The skills for the performance and management of OBS are not taught in university residency programmes. Additional private mentorship and training is mandatory and often acquired abroad, e.g. in the USA.

Our team of authors have assembled a set of practical articles to provide guidance to practitioners and their support structures. They present a conservative, safe and practical approach to OBS. They may have an aura of 'Americanism' but we are still very much in the dawning of a new era in South Africa and can but learn from the experiences and mistakes of our American and Australian colleagues, who have carefully documented guidelines and regulations.

Health care

Health care in South Africa is in a serious crisis and faces numerous, possibly insurmountable, challenges. These include the world-wide economic downturn, state health care suffering catastrophic implosion in many areas, health care worker shortages and strikes and threatened reformation with the voyeuristic potion of National Health Insurance (NHI).

Our private health care system is a mess because economic behaviours driving it are irrational, often perverse and counterproductive. Unchecked spiralling costs and dominance by medical schemes and administrators under the guise of managed health care (MHC) are some of the vices.

Government attempts at heavy-handed control of the private sector will have disastrous effects. Yet, health care is the social right of all citizens and the responsibility of the government to deliver. The ultimate goal is that of a sustainable, universally accessible NHI system, more privately insured lives (more members of medical insurance schemes) and a cost-effective private sector.

Marketplaces require consumers who demand better products at ever better prices and producers who are rewarded for supplying both. The health care marketplace, by contrast, is distorted by third-party reimbursement that does not reward rational behaviour by either consumers or producers, and in many cases actually penalises it.

- The consumer of the medical product is often not the purchaser of that product and has no motive to determine its real value.
- The producer of the medical product determines the need for the product and is paid more for producing more of it; the producer has no incentive to reduce cost.

Fee-for-service medicine is perverse; it rewards doctors and hospitals financially for overtreatment, heroic treatment, redundant treatment or for any treatment at all, regardless of the economic or scientific merit or outcome. Private health care in South Africa is a fragmented, disintegrated, uncoordinated disaster!

Managed care to the rescue? Aggressive intervention by emboldened or embattled third party payers (medical scheme and administrators), positioning themselves as the champions of medical necessity and clinical consistency, yet driven by their own financial self-interest, attempts to bring some predictability to the system. MHC is harsh medicine for health care's appalling economics and dreadful history – akin to a near-lethal dose of chemotherapy for a sick health-care market, palliating the cancer, but the system remains sick. They have exacerbated the confusion and complexity of the system by installing a pervasive, costly infrastructure of heavy-handed and cumbersome command-and-control systems. The primary goals have been to reduce direct costs associated with medical decision-making, regardless of quality, outcomes and even long-term economics. This harsh medicine works only because the patient is so desperately ill! A hard place just got harder.

Now ... rescue us from managed care! Guidelines designed to promote cost-effectiveness for an entire population seldom succeed. In glaring contrast to the intensity involved in the doctor/patient relationship, the MHC 'covered member' alliance is a nuisance. Why? Because administrators don't diagnose or treat people, they process them!

Hospitals are only slightly better, but are generally considered large, impersonal expensive machines through which people move when sick, guided not by the hospital's protocols, but by their physicians' training and instincts.

A dichotomous situation has developed: managed care operators have allegiance to their shareholders to maximise savings, but doctors are ethically sworn to their profession – to do what is best for every individual patient. We are generally revered for our clinical judgement, autonomy and moral authority – earned through years of training and personal sacrifices. Doctors have an intellectual incumbency that will reign in the end, in stark contrast to the naked ambitions and hollow advertising of MHC marketeers.

The treatment plan[1,2]

A holistic application of five interrelated forces may consummate health care reform, driving down health care costs, simplifying and streamlining the systems and promoting quality care:

- Risk assumption, to correct fundamental problems in health care consumption and market economics. This embodies capitation and other alternative reimbursement strategies.
- Consumerism, to neutralise distortions in the health system created by the self-interest and faulty paternalism of providers and MHC, to galvanise competition among providers.
- Consolidation, to scale health care infrastructure properly, mobilise capital, spread risk across broader populations of patients and providers and allocate health care resources more efficiently.
- Integration, to correct the fragmentation and other infrastructural defects built into the medical delivery system.
- Industrialisation, to rationalise the haphazard use of services, increase economic predictability, improve quality and reduce costs.

More or less control? Competition and management must come from within the profession. When this transformation is complete, the answer to that most menacing of questions 'do you know who controls your health care?' will be, surprise, surprise, your doctor!

1. Kleinke JD. *Bleeding Edge. The Business of Health Care in the New Century.* Maryland:Aspen Publishers, 1998. http://www.hs-net.com

2. Grobler S. Beijing 2008 Olympic Games and ... 'Manto'; what do they have in common? *South African Gastroenterology Review* 2008; 6(2): 27-28.