



President's Message

Disruption and Disruptive Innovation

Sarel Malan, President: PSSA

The recent unrest in North West caused total disruption, and maybe even near collapse of health services in the province – this is however not the disruption I am referring to here. On the contrary, disruption of the status quo or disruptive innovation, leading to a total rethink of how we do things and the way we deliver public, if not national health, can probably prevent this from happening in the future.

In healthcare and especially in pharmacy in South Africa, innovation is no longer enough. Innovation might improve delivery and health outcomes, even income or profitability, but this would only mean sustainability and not progress. What is necessary in our time is disruptive innovation to make healthcare more efficient and accessible – thus changing how we think, learn, behave, do business and deliver health and pharmaceutical care. The purpose would be to deliver products and services that are not only better and less expensive, but more creative, useful, with a wider impact and ultimately scalable to enable service where it was not possible previously. Scalability is critical as disruption usually starts small, but through innovation and in time, replaces the old paradigm.

The business terms “disruption” and “disruptive innovation” were made popular by Clayton Christensen in 1997 through his book, *The Innovator's Dilemma*. In it he states that it is not just about meeting current needs, but anticipating unstated or future needs; this is only possible when you clearly know what your purpose and core business really is. Satisfying the less-demanding customers, the overlooked segments of the population, or creating a market where none existed before is usually where a disruptive business model originates. Disruption is then when this model becomes the main delivery mode through delivery/quality improvement and scaling up.

Traditionally medicine relied on the intuition, extensive training and experience of a specialist; enabling him to recognise patterns and make a diagnoses. New technologies have however caused a move from ‘intuitive’ to ‘precision medicine’ and in many cases costs drivers are no longer the treatment, but the diagnostics. With integration of healthcare infrastructure and professions, the benefits of disruptive innovation can be realised; someone other than a doctor can use technology to make a diagnosis and supply a routine, standard medication or therapy (Christensen *et al.* 2009. *The Innovator's Prescription: A Disruptive Solution for Health Care*). At the next level, the pharmacist, or other health practitioner, could diagnose and treat a number of ailments using standard algorithms and treatment guidelines, reverting to costly diagnostic technology only in certain cases and finally, referring more serious or complex cases to medical doctors and specialists.

The reality is however that innovation has to integrate with existing models and disruptive ideas require those in the system and those

writing the laws and regulations to embrace the change. These laws and regulations could be the reason for remaining in inefficient and high-cost models of healthcare delivery and policymakers should thus be sensitised to the hidden cost of regulations that inhibit innovation (Hwang and Christensen. 2008. *Disruptive Innovation in Health Care Delivery: A Framework for Business-Model Innovation*).

At the onset, disruptive products or services might typically be considered inferior by most in the existing system and they will thus not be willing to accept the change. As soon as the quality improves or is proven to their satisfaction, they will however adopt the new product or service. For this reason it is important to empower through legislation and to create opportunities for innovation within the existing system, building on those that work and once proven effective and efficient, making the change to the new way of doing and delivering the service.

Comments by stakeholders in healthcare indicate what they think are critical to bring about change in the current health marketplace. These include amongst others: “Delivering care at people's homes/doorstep.”; “Connecting the patient to their primary care provider and working together to provide the best treatment plan directed by evidence-based medicine.”; “Focus on more patient accountability and responsibility for their health.”; “... minimize the social factors in delivering the best healthcare (access, food, housing, transportation).”; “Getting rid of the vast majority of administrators and middle managers.”; and “Quality of care should not be determined on whether you live in a rural, suburban, or urban area.” (Dafny and Motha. 2017. *New Marketplace Survey: The Sources of Health Care Innovation*).

With all of the above as background, the scene is set for us to determine the role of the pharmacist in the future healthcare system of South Africa. Business as usual will not provide what is necessary for the sustainability and even advancement of community pharmacy. It will also not provide for universal access and delivery of services to all in a NHI environment. Though we move towards a single payer, can a single channel of provision and limited supply chain flexibility ensure supply security – maybe the current medicine supply crisis in North West provides some insight? How much value could be added by moving towards integrated health teams and integrated chronic disease and medicine management, pharmacist-run drug therapy or medicine management clinics and pharmacist-led clinics with effective referral systems? Could this be the disruptive innovation we need to deliver on universal access and facilitate complete uptake thereof?

Empowering legislation, innovation, disruptive thinking, and small beginnings within the current system should provide the answers we are all looking for.