Reaction to the NHI bill is ill-informed and a constructive discussion is needed – IOL 20 August 2019

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The National Health Insurance (NHI) philosophy is not complex, nor unusual. Its premise is the separation of the suppliers of healthcare services from the role of purchasing access to care. In line with international best practice (and similar to the reform plan for Eskom), it asserts that purchasing should be done by a competent agency equipped to enter into value based care (VBC) contracts with suppliers. It is a best practice solution to the current dysfunction, and scaremongering reactions are either poorly informed about the options or defending their role and profits. Instead, we need a constructive debate about how to achieve success.

At present, the public sector is funded by a 'supply driven' budget determined by existing facilities and staff, not population need. Funds are guaranteed regardless of production, service, and outcomes. There is no 'case mix' data about how sick patients in the system are, or where, and how they are treated. Managers do not know about the relative productivity of their own systems, and governance arrangements are working in the dark. Under the NHI, public services will be subject to market competition for contracts and be required to improve their productivity and service delivery, or face losing their contracts.

VBC contracts are also largely absent in the private sector, which is still funded by 'fee for service', paid to isolated and competing individual clinicians. This leads to fragmented services with big gaps and duplications in care. There is no financial support for the integrated team model, which is a feature of all high-performing healthcare systems. Fee-for-service has clinicians seeing low patient volumes and delivering high-cost care of variable quality. Productivity simply isn't a concern.

It is tragic that, despite the Medical Schemes Act of 2000 obliging medical schemes to do active purchasing for their members, they have failed to do so. Rather, they have interpreted their role to be securing low prices from providers per service. They have ignored rampant over-servicing from the oversupply of doctors, specialists, and hospital beds relative to scheme members in the country. This lost opportunity is well described in the Health Market Inquiry (HMI) provisional report, which shows how schemes failed their members by not commissioning and supporting new care delivery models. Only the shareholders of the administrators are happy.

In contrast, the separate purchaser role put forward by the NHI is the proper model for healthcare systems. Under it, providers - whether public, private or 'not for profit' - compete for local contracts, to deliver Primary Health Care (PHC) and hospital services, based on how well they deliver value. This competition will be a major wake-up call for both sectors and ultimately serve South Africans better.

Of course, the NHI needs to appoint a competent team to design robust and fair, strategic contracts. These VBC contracts must use case mix sensitive payment models that support the use of all available resources and assign funding according to local need and the delivery of

value. Accountability for producing the best outcomes, at the lowest cost, will sit with the providers - while financial risk is carried by the funder.

The NHI bill will drive a major shift towards developing a strong system of community PHC, reducing the hospital-based care that is compromising the efficiency of both sectors. VBC contracts will support multidisciplinary teamwork, a far more patient-centred and more effective model.

The challenge for all stakeholders is how best to transition to this model. Our debates should centre how to create a transition that is compelling and safe for those clinicians and hospitals that embrace the accountability model. We need realistic milestones and a strategy that poses no threat to their income. We at PPO Serve have demonstrated that this is feasible through a number of projects in maternity care, HIV treatment, and PHC teams.