PPO Serve comments on the NHI White Paper
December 2015

Introduction

The NHI Health Insurance for South Africa White Paper (10th December) has just been released, and it's important for the sector to understand its intent and debate its approach. Here are our views:

Consistent with the Green Paper, the proposal is based on an insurance model where the insurer is a single inclusive national fund that collects and pools contributions and undertakes selective purchasing / contracting from providers on behalf of the population.

For us, these are the **issues that arise**:

1. What problem are we solving?
2. 'Demand side' management by Health Insurers / Medical Schemes: what's their role? What are the virtues of a single vs. competing funds?
3. 'Supply side' provision – what is the policy aim for the design of the effective supply model; and how will this be engineered?
4. The tactical approach to achieve Universal Health Care in SA?

PPO Serve answers:

1. The **Problem** of the public sector is poor service and responsiveness, because it is not structured for its post-apartheid role and is badly managed. Many words written about this, were not going to add more here.

   By contrast, there is too little useful analysis of the performance of the private sector, which has a major, worsening crisis of affordability in regard to most South Africans (including current Scheme members) because it provides relatively poor 'value'. We don't agree that this can be mostly ascribed to aging and selection. Instead we believe sector performs relatively poorly.

   It has huge excess capacity relative to the currently covered population (it could easily deal with double the population) and consequently over-servicing is rife (in many regions) as providers struggle to meet their ('threshold'/ sustainable) income requirements. This process marginalises thousands of general practitioners; invalidates any role for mid-level workers and obliges specialists to take on the primary care role for which they are poorly suited.

   This is made worse by a Tariff schedule that fragments patient care because it rewards clinicians working alone and for each service they perform. (A better alternative would be to fund organised teams that are paid to look after the care of a population for which they are accountable and to get merit rewards for doing this well - more below)

   The result is that, while the sector is good at dealing with acute problems, it is badly structured to treat patients with complex medical and social problems, especially the aged. But it is on these patients that the bulk of healthcare costs are expended. They experience poor quality, expensive care, driven by unmanaged and plenty of unneeded hospital services. Fix this and you go a long way to getting better value and lower premiums.

2. Schemes and their Administrators / Managed Care efforts are failing to adequately **manage the 'production**' efforts of the private supply side. This is because Schemes don't competing on the overall 'value' proposition for consumers i.e. the member experience and outcomes of the system. Currently, they're mostly concerned with attracting healthy members, crudely restricting care and getting marginally better Tariff prices than other Schemes. They have a short term focus because cover is sold on an annual term. And because Scheme cover is sold nationally, they aren't involved in local level system performance and they just don't undertake the role of 'managers' of the system. Nor does anyone else.

   Would a single Scheme with local offices do better? Maybe, but the price is likely be a system that is also less responsive to consumers. We like the Dutch system where membership of a choice one of a number of competing Schemes is mandatory, and the State pays contributions for the poor.

3. A 'vision' of **an effective supply model** for the whole of SA is not evident in the plan at all, and in our view is the biggest weakness of the whole proposal.

   If purchase function (2. above) is solved, with what services would the Scheme (or Schemes) contract? Neither of the current models public or private (1. above) is an obvious basis from which to build a new system. Nor is there a clear policy vision nor aims for how the sector will be structured and how its processes will work. Paying differently – DRGs and capitation – are a requirement but experience tells that this alone does not lead to structural change. That takes a whole lot more:

   A clear vision of the system and the engineering required to achieve it needs:
   i. population level structural planning
   ii. a variety of new commercial organisational models based on teamwork and useful competition between integrated systems
   iii. supportive State funding
   iv. supportive State regulation
   v. clear process and outcome measures
   vi. outcome linked rewards

   Unfortunately, the document is largely silent on supply side reform, appearing to believe that the public sector needs a few tweaks to make it a viable basis and that any gaps can be contracted from private providers. This simply isn't realistic. In our view, the key to reform are new models of care delivery that are based on:

   i. population medicine and patient centered care
   ii. integrated team care
   iii. the value contract
   iv. strong self-governance and management
   v. modern patient care IT systems

   PPO Serve is based on this insight.

4. Also missing is any feasible **tactical approach** – today there is a two tier system that serve populations reflecting the enormous income and wealth disparities of South Africans. They have very different structures and organisation, costs and outcomes. How is it possible to achieve a

unified system in 14 years? We believe this is neither economically or politically feasible, nor is it practical. Is there a better alternative?

Developing countries with similar income inequality problems that have succeeded in healthcare reform have succeeded by understanding the economics of the healthcare system. Essentially they adopt an *incremental approach* with clear supply *strategies linked to demand within income bands,* with a *special focus on the 'gap' market* i.e. people neither wealthy nor poor.

New efficient delivery models of care are promoted that meet the affordability and care needs of the 'gap' market segment are key. These are not cheap and nasty nor offer a narrow range of therapies. They are affordable because they are efficient.

This is supported by State provide partial subsidies for access via Scheme premiums as well as for supply side innovation. It offers support in other ways too because supply side reform is the key to success.

Finally, systems that provide comprehensive care of good quality at affordable price have strong community level primary care services. They also rely on market driven competitive systems to deliver iterative population value and market equilibrium, within a population determined capacity plan.