NHI: Is a purchaser-provider split a good idea?

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Should there be a purchaser-provider split in South Africa's public health system?

The National Health Insurance White Paper envisages a purchaser-provider split. This split separates institutions that are responsible for (a) the purchasing and (b) the provision of health services. The NHI Fund will be the single purchaser of personal health services for the population. The Fund will contract directly with accredited public and private facilities, including accredited private hospitals and emergency medical services. The aim is to incentivise improved quality in the public sector, whilst reducing prices in the private health sector.

Purchaser-provider splits were first introduced internationally about thirty years ago to establish business-like relationships between organisation units and, in particular, to establish 'quasi-markets' into public sector provision. This was the central feature of the *New Public Management* programme, based on optimal contract theory, and it was associated with the increase in the salience of markets from the early 1980s onwards.

Yet, just as South African policy is moving in this direction, there are indications that purchaser-provider splits have not delivered what was hoped for in a number of countries. Thus a former executive in the UK National Health Service:

We made the judgement that we would ensure that the financial pressure was not evenly distributed between commissioning and provision, but was organised so that providers would take the bulk of responsibility. We always had to make a judgment about what was possible, and one of the dangers is people asking you to do things that they know – and you know – you cannot do[1].

And in Iran:

Our findings highlight that inexperience of newly established organizations, delayed payments, inappropriate and unrealistic medical tariffs, and the weak capacity of hospitals led to increasing out of pocket payments and the spread of under the table payments to run hospitals[2].

And in Sweden:

The disappointments include the following: contractual management being reduced to the purchaser buying last year's volume of care minus the savings required, the contract being very generally formulated and lacking legal enforceability, reducing the control effect because sanctions are lacking, contractual management not facilitating structural change, that producers, with their superior

knowledge of health care, have been dominant and that purchasers and providers have not always agreed, resulting in contracts not being signed and permits issued without contracts[3].

And In New Zealand:

In the 1990s and early 2000s, the New Zealand health care system went through a series of rapid changes that included – certainly in terms of its rhetoric if not necessarily its actual application – a fairly extreme example of the purchaser/provider split adopted in England and elsewhere. This produced a bitter standoff between managers and hospital clinicians – one so bruising that senior consultants at Christchurch Hospital, and much younger consultants who were junior doctors at the time, shudder when they recall it[4].

The problems are then:

1. *The political incentive to set payments too low*, amounting to a pretence that the system can deliver more than it is really able to. The result is accumulation of deficits by providers, and the emergence of dubious practices to try and manage their situations. In this respect, the monopsony position of a single payer system is decidedly a two edged sword.

2. Not only does a single payer have a monopsony, *providers often have a spatial monopoly*, especially when the distance between them is large.

3. *The turmoil of a radical change in the financing system with large reorganisation costs*, leading to a long period of actor confusion and poor outcomes because parts of the system are missing or not functioning as they are supposed to. This is similar to outcomes based education, which had to be abandoned because teachers couldn't adapt to it.

4. Even in advanced economies, such as Sweden, *the contracting process has been difficult*, *sub-optimal and incomplete*.

5. *Heightened tensions between managers and health professionals*. In South Africa, some of this tension already exists between medical aids and doctors. It would likely get worse if the NHI White Paper proposals are implemented.

Given that there are grounds for scepticism about reaping benefits from a purchaser-provider split, a key rationale for the NHI Fund is weakened. A single fund, potentially contracting with the majority of providers, is almost guaranteed to become sclerotic, politicised and formulaic in the contracts it offers. And the costs of setting it up will be prohibitive in a period of weak economic growth. We shall almost certainly be better off keeping the financial system we have, putting a greater emphasis on cost-

benefit studies, and devoting scarce fiscal resources to improving the provision of care rather than turning the system upside down.

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