PPO Serve

BETTER CARE · IMPROVED VALUE · INSPIRED TEAMS

The Potential Role of the SA Private Healthcare system in a Universal Health Care system in SA

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Dr Brian Ruff experience relevant to this talk

- **Wits MBBCh graduate 1983:** student politics SRC / MRC; NAMDA
- **Early work 1984 - 88:** SHO NHS in London; MO Alexandra Clinic
- **Specialisation:** Internal Medicine **89 - 92** / Rheumatology **95**
- **Transitional arrangement 93/4** PWV Task Team / Gauteng; **95/6** Hospital Strategy Project – rationalize post apartheid service - "Levels of Care"
- **UCT HEU 96** – post grad diploma healthcare finance, economics
- **Gauteng Health Department 96 – 98** Technical Task Team -– Case Mix need clear
- Treasury x 2 months
- **Clinical Risk Management Discovery Health 1999 – 2015:** : Case Mix tools (DRGs/Episode Grouper) – system performance analysis & alternative reimbursement contracts; Hospital Rating Index; Health Economic model; Care Coordination project with sub acute hospitals.
- **PPO Serve since 2015**: **Multi Disciplinary Teams (MDTs) contract case mix risk adjusted capitation + VBC fee** - leverage rare medical skills with Care Coordination to navigate the system - match case mix to LOC:
  - **The Value Care Team 2019 to present: stronger PHC reduces avoidable admissions – GEMS contract**
  - **The Birthing Team with Netcare & JMH:** O&G, midwives - CS rate reduced to 20% (closed 2021)
  - **The GP Care Cell with GHD:** GP Practices screen working poor for HIV, initiate and manage Rx (closed 2022)

Convergence to UHC – how do we achieve this?

Issue:

SA has 2 profoundly dysfunctional parallel healthcare systems:

- **public sector:** very poorly managed (mostly) - low productivity, poor quality
- **private sector:** hugely wasteful, inefficient - monopoly companies serve shareholders before patients (both demand & supply side) – very high % healthcare resources for small / shrinking % population

Healthcare systems mirror society:

- cannot ignore our profound income inequality
- but recognise unequal healthcare access perpetuates inequality

Solution: reform the value from both **towards convergence** – blur the differences, while economic parity improves.

Balanced vs. Skewed access system

			Adult Care	Child Care	Maternity Care	Total
			77%	20%	3%	100%
Facility type	**Visit Mix**	**Case Mix Index**	**PLPM**	**PLPM**	**PLPM**	**Total PLPM**
Central tertiary hospital	10%	**2.4**	314	82	12	
Regional hospital	20%	**1.3**	340	88	13	**Planned**
Local hospital	30%	**1**	393	102	15	**Match**
PHC	40%	**0.5**	262	68	10	
TOTAL	**100%**	**1**	**1,309**	**340**	**51**	**1,700**

PLPM = per life per month cost

Match demand and supply: is critical to achieve value when planning and managing the healthcare system i.e. – that the **patient's problem** is manged at the **right time** and at the **appropriate level and cost**

Data for illustrative purposes only

Horizontal Silos In Public Sector

			Adult Care	Child Care	Maternity Care	Total	
			77%	20%	3%	100%	
Facility type	Visit Mix	Case Mix Index	PLPM	PLPM	PLPM	Total PLPM	
Central tertiary hospital	10%	**2.4**	314	82	12		
Regional hospital	20%	**1.3**	340	88	13	**Planned**	
Local hospital	30%	**1**	393	102	15	**Match**	
PHC	40%	**0.5**	262	68	10		
TOTAL	**100%**	**1.00**	**1,309**	**340**	**51**	**1,700**	
Central tertiary hospital	10%	**1.50**	314	82	12		
Regional hospital	20%	**1.15**	340	88	13	**Blocked**	
Local hospital	30%	**1.00**	393	102	15	**match**	
PHC	40%	**0.80**	262	68	10		
TOTAL	**100%**	**1.00**	**1,309**	**340**	**51**	**1,700**	

Budgets, management follow Levels of Care (LoC) - not patients =

- **Well resourced tertiary hospitals:** spend linked to service & **low CMI** under used, = **poor Value**
- **Sick, high case mix patients** stuck at PHC level **= poor Quality**

Data for illustrative purposes only

Skewed access in the SA Private sector…….

			Adult Care	Child Care	Maternity Care	Total
			77%	20%	3%	100%
Facility type	**Visit Mix**	**Case Mix Index**	**PLPM**	**PLPM**	**PLPM**	**Total PLPM**
Central tertiary hospital	10%	**2.4**	314	82	12	
Regional hospital	20%	**1.3**	340	88	13	**Planned**
Local hospital	30%	**1**	393	102	15	**Match**
PHC	40%	**0.5**	262	68	10	
TOTAL	**100%**	**1**	**1,309**	**340**	**51**	**1,700**
Central tertiary hospital	**30%**	**2.4**	942	102	15	
Regional hospital	**30%**	**1.3**	511	102	15	**Skewed**
Local hospital	30%	**1**	393	102	15	**match**
PHC	**10%**	**0.5**	65	34	5	
TOTAL	**100%**	**1**	**1,911**	**340**	**51**	**2,302**
						135%

Unplanned hospicentric system: excess beds, FFS =overservicing + lone clinician

Wrong case mix match & spend follows patient => misallocation of resources = **huge waste, poor value**

⇒ **current Administrator / Scheme model is failing**

Data for illustrative purposes only

System management philosophy: Budget Control vs. Strategic Purchasing

Control: compliance with form:

- **Fixed** staff structures, fixed budget, rigid protocols & SOPs
- **No system outcomes:** gross adverse events only
- **Credentialing** but no accountability
- **IT systems/data** for control, not for clinical support nor performance measure
- **Disease guidelines**, not patient management

Value Based Care contracts:

- **Flexible,** responds to incentives; discretionary guidelines to achieve outcomes
- **Cohort Case Mix linked guidelines** for similarly complex patients with IT systems
- **Outcome measures case mix adjusted:** population 'disease burden index' / hospital DRG
- **Accountability for outcome scores** => drives iterative efficacy/ efficiency

Private Sector issues

The NHI road to UHC - Purchaser vs. Provider split (WHO):

Health Market Inquiry lesson: need high functional **Purchaser vs. Provider** system - **competent purchasers vs. competitive suppliers.**

The current private sector has neither – static, increasing costs:

Purchasers - Monopsony Administrators:

- **For profit TPAs** control 'not for profit' medical schemes – committed to FFS system => fragments care, overservicing, waste
- **TPA MCO licenses**: award themselves scheme care services contracts – perverse vertical contracts x2 profits; kills innovation

CoMS ineffective re Schemes not purchasing effectively

Will NHI be more effective as a purchaser?

Private Sector issues

Providers: Hospicentric system

Monopoly Hospitals

- 3 groups 94% bed days + region domination => no competition, little innovation
- Rich hospital PMBs 70 – 80% total scheme spend hospital campus

Neglected marginalized PHC system

- Poorly funded (GPs 4,5% - no OH PMBs); FFS funded 1 – 2 person GP Practices lack scale for efficacy; cannot compete with specialists for limited OH funds; Allieds absent in townships

No regulation for provider supply levels nor performance review

Can the NHI effectively commission system reengineering?

The PPO Serve 'Value Care Team' Solution – GEMS Population Medicine benefit:

The VCT is a Multi Disciplinary Team - integrates & strengthens Primary Health Care service to do **proactive patient care** - to reach out beyond the clinic between visits to optimise care and support patient needs**:**

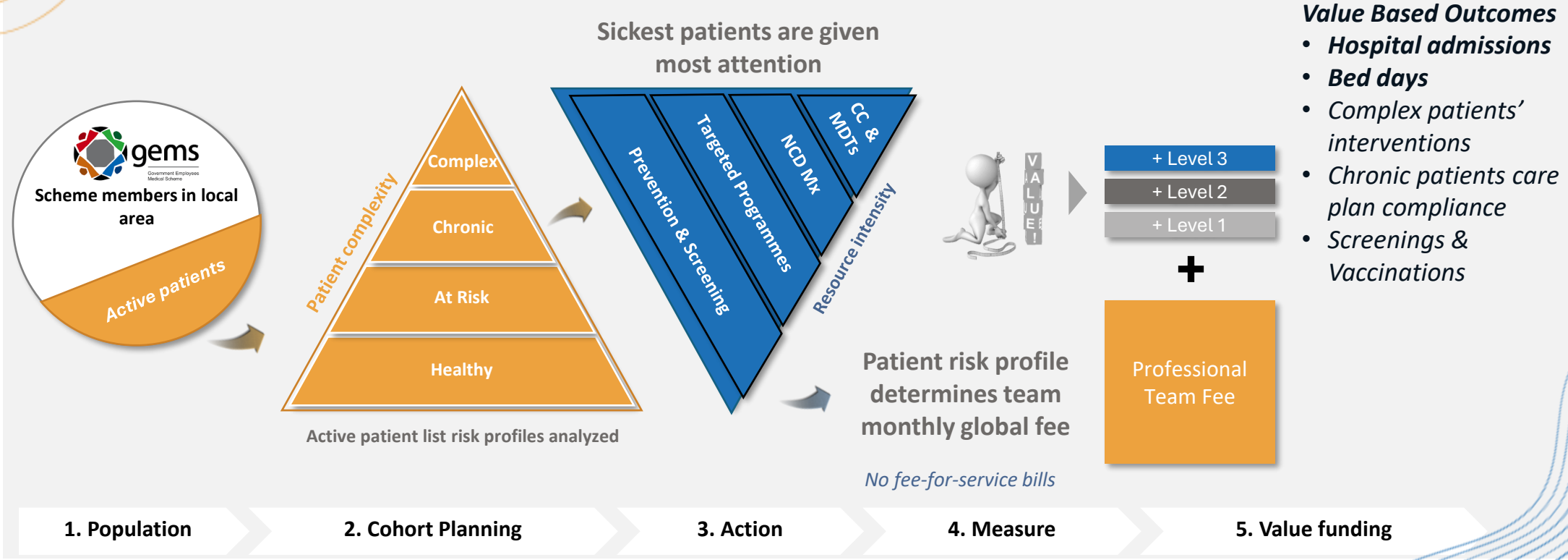
- **GP practices:** a local cluster of GP practices at **the core** - working with a Physician, and with…
- **MDT "support" clinical team:** a **Coach** manages a group of **Care Coordinators, Allied associates, palliative care & social partners** to support the practice patients
- **MDT meetings** held regularly to review cases; update Rx policies & adopt joint VBC Team projects

The Value Care Team

- Coach = the 'Practice Transformation Coach'
- Care Coordinators are Nurses or Clinical Associates

Functional Case Mix Model:

Match patient severity cohorts with intensity of services

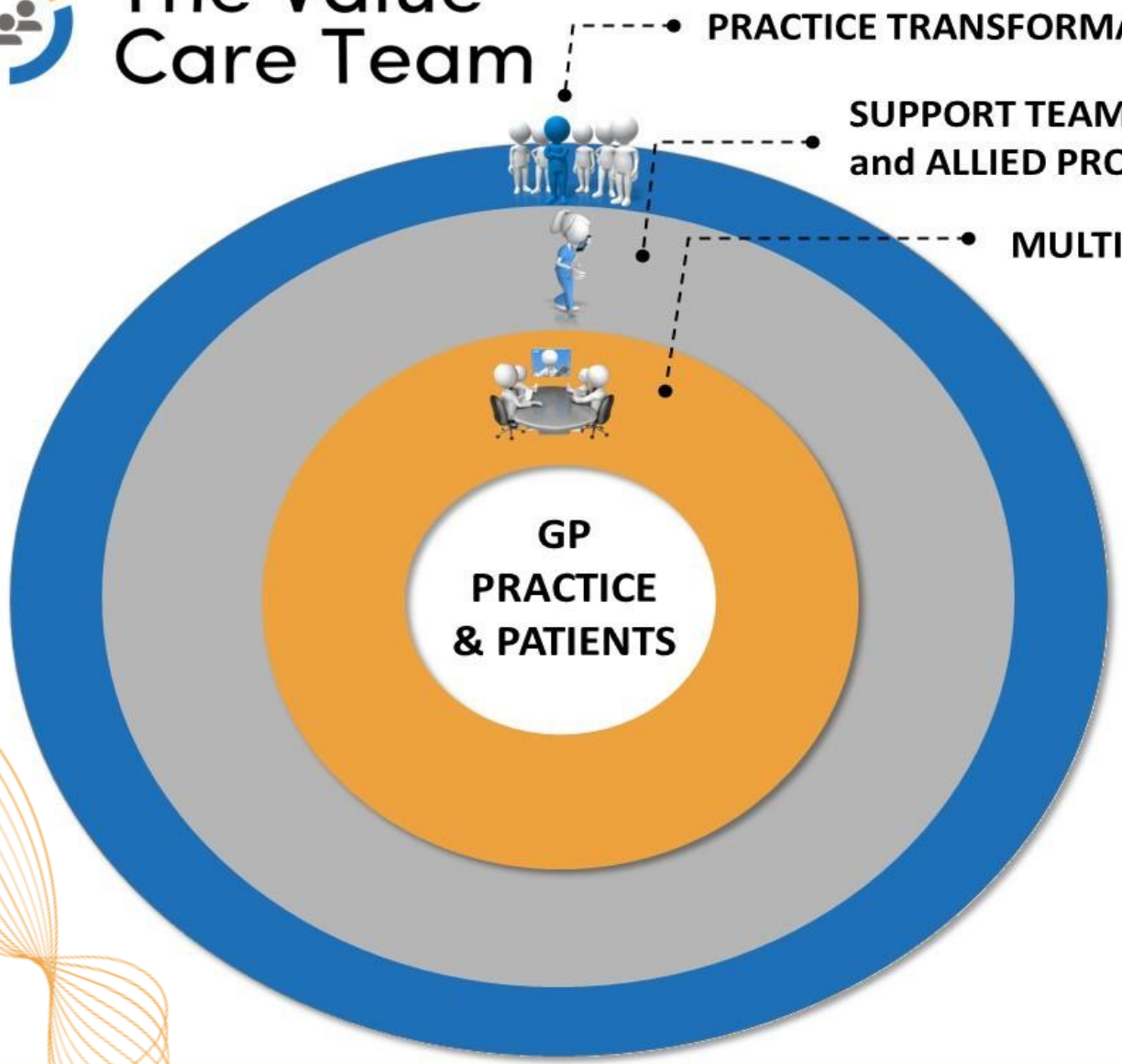


Link patient need with service provision

Focus is on stronger PHC role & funding, diminish hospital dependence

The Multidisciplinary Team Delivery Model

The Value Care Team



Features	Characteristics
Collaborating Team	• Shared support, improvement focus • Local system influence
LOCAL CHANNELS	• Clinical referral arrangements • Social support network
Intelligent Care System & Reports	• Proactive Care Plans per patient risk group • Outcome focus tasks
SCHEME VBC CONTRACT	• Risk adjusted monthly global fee • plus significant outcome linked fee

Horizontal and Vertical System Integration

Integration: host partners at MDT meetings => shared patient care

Vertical integration: for triage, referral & collaboration`

The Value Care Team

Multi-disciplinary Team

gems
Government Employees Medical Scheme

Palliative Care & Hospice | Mental Health Services

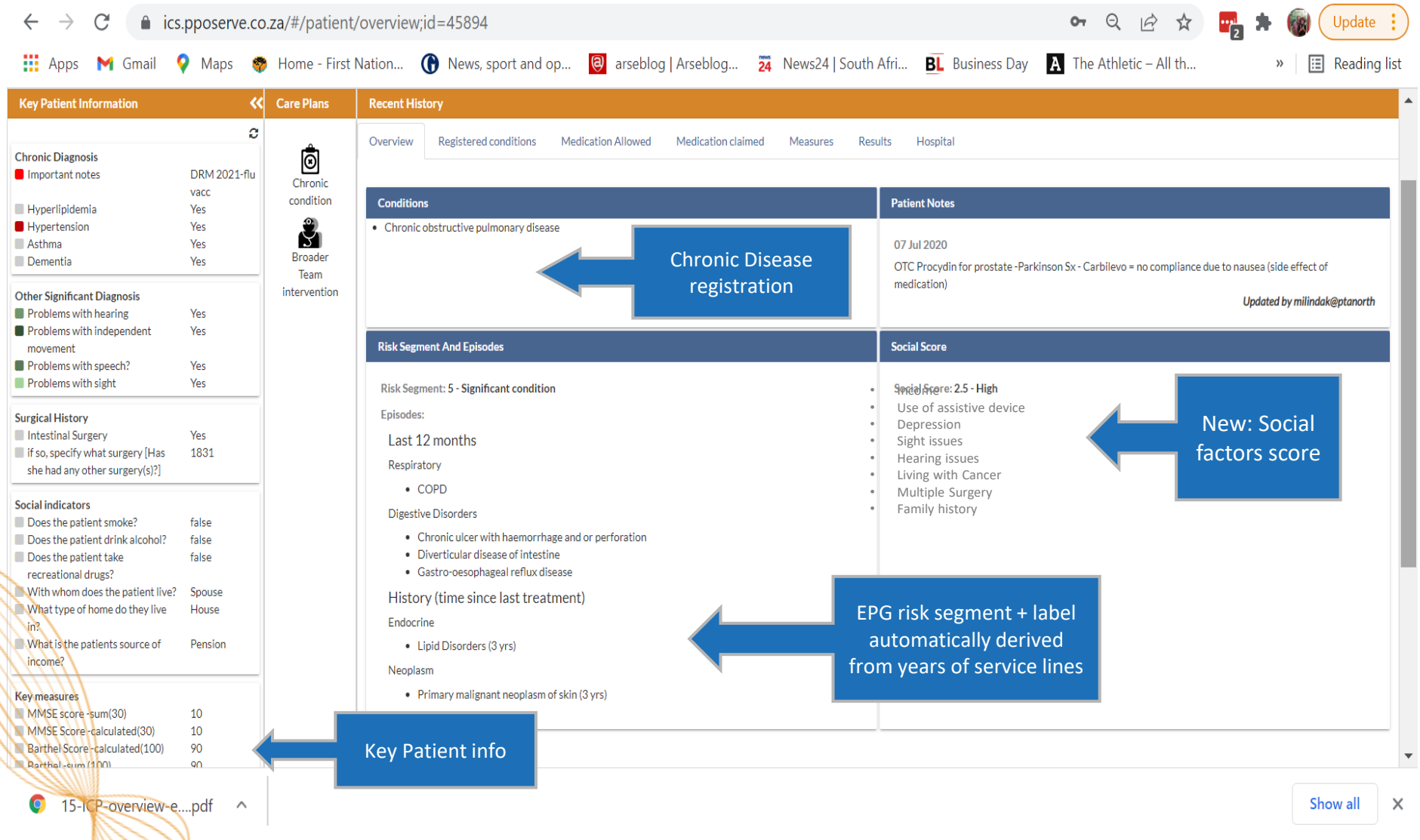
Community Services | LTC Nurses & Facilities | Social Welfare Services

Social & Physical Activity | Food & Transport | Housing

Horizontal: local service integration

The MDT is the nexus of local care for enrolled beneficiaries

The Value Care Team ICS for GEMS patients:
Patient Summary page



ICS Functions:

- **Collects new clinical & psychosocial data**
- **Shares clinical information -**whole patient view
- **Organised Workflow –** prioritised patients; Care Plans tasks for staff

The Multi-Disciplinary Team meeting