Percept NHI Policy Brief Series:

Provider payment mechanisms to ensure equity, quality and affordability

Neither the public nor the private-sector payment systems are currently achieving the best results. The NHI provides an opportunity to rethink payment systems in a way that puts the needs of clients at the centre. The way providers are paid creates financial incentives that can cause a provider to want to under- or over-service a patient. It will be important for the NHI Fund to get its payment approaches for different providers right in order to facilitate the right level of servicing and performance within a constrained fiscal envelope.

The 2019 NHI Bill mentions capitation, global budgets (public hospitals), diagnosis-related groupers (DRGs) as possible payment approaches. However, methods of payment tend to change over time as lessons are learnt. It is therefore possible that payment mechanisms will differ when the NHI is fully implemented – i.e. the naming of payment approaches is unnecessarily rigid.

Changing payment systems in the health sector means changing the ways that health providers are contracted; how health information is collected, analysed and used; and how healthcare is organised and delivered. The right payment system must be fair: protecting the purchaser, providers and users of healthcare from too much risk. The NHI Fund will need to properly consult a wide range of health providers, health users and experts, to make sure that capitation and case-based payment levels are fairly determined, affordable and motivate providers to improve quality. Setting prices will also need to be based on strong evidence. Regulatory neutrality and potentially a functional approach to achieving this type of payment system will be required.

We suggest a slow and phased approach, focussing on improving how health information is collected, and how health resources are used, in the public sector to begin with. This phased approach might also include testing whether the contracting of private services under the NHI is affordable and effective, experimenting with capitation for GPs and DRGs for some hospital services.

The South African provider payment environment

PUBLIC SECTOR: 'Line item budgeting'

In the public sector, budgets are decided at the start of the financial year with amounts set aside for specific providers, programmes, and types of care, with very little room for change. Staffing makes up over 60% of public health spending, and staff are hired mostly on a permanent basis. This leaves little left over, especially within clinical settings, for the goods and services required to deliver care.

A salaried system means the health department is better able to predict and manage costs, but it doesn't motivate or reward health workers for providing efficient, quality care. Because the salaries and posts are fixed, more, or different types, of workers cannot be hired when needed.

In direct contrast to line-item budgeting, fee-for-service can motivate providers to *over-supply* services because they are paid for every interaction, which is risky for the NHI Fund.

PRIVATE SECTOR: Fee for service (FFS)

In the private sector, each service or treatment has a fee attached. Providers therefore get paid for every client that they see and treat, and for everything that they do for that patient. This creates a risk for the purchasers of healthcare, because it is difficult to predict healthcare costs given that there is no cap on what the provider can be paid. Beyond fee-for-service there are a few other payment systems sometimes used in the private sector (capitation, per diems, fixed fees, global fees and value-based contracts).

Payment systems under the NHI Fund

Capitation for Primary Healthcare

Capitation means that providers are paid a set amount per client, in advance of the service, and for a defined period of time (usually a year). The amount per person is based on how much, and which, services they are expected to use, and how quickly and effectively those services can be delivered. This payment is made regardless of whether the person seeks healthcare or not.

Under the NHI, PHC services would be reimbursed based on capitation rates. Only providers who can offer multidisciplinary teams, including GPs, nurses and community health workers would be eligible to provider PHC care for NHI users. This reorganisation of care will be more difficult for the

private sector and GPs will need to feel confident that the volumes and ultimate reimbursement rate are worth the effort.

Capitation-based payment has the advantage of promoting equity, ensuring that funds follow clients and that rates are appropriate for the healthcare needs of the population. It also motivates providers to keep their populations healthy, since the more clients that use a health facility, the less profitable the capitation fee becomes. Therefore, under a capitation-based system, **risks are carried largely by providers**, who carry the costs if health services are used more than expected. This might mean that clients are under-serviced as a way of stretching primary health care funds.

It can also be difficult for health providers to judge whether capitation rates are fair or not, especially if not very much is known about how people are using health services in that area. By regularly measuring the health and progress of the population, and tracking which services are being accessed, the Fund could make sure that people are getting the health services they need and benefiting from them; while also making certain providers are fairly paid.

Diagnosis-related groupers (DRGs) for Hospital Care

Diagnosis-related groupers (DRGs) are a type of case-based payment system. Case-based payments are fixed in advance and are based on what treatment/procedure the client is in hospital for. The fee includes all the costs of a specific case: health worker fees, hospital fees, medicines and food. With DRGs, fees are set for different *categories* of cases admitted to hospital. Categorisation is based on the characteristics of the client (such as age, sex and illness profile), as well as the type of care they need (for example, a hip replacement).

Because purchasers of healthcare pay a fixed fee per category of client, providers are motivated to keep care affordable and use resources smartly: if they over-spend, they carry the costs. But, as with capitation, having a fixed fee per case may also result in under-servicing as a way of controlling spending. To ensure that the DRG payment system is not bringing down quality, The Fund will have to check their payments against the health outcomes of the clients, upping payments if necessary.

Price setting

Under the NHI, a purchaser-provider split will enable the NHI Fund to buy services from both public and private providers, which will require a set of prices that are fairly determined.

South Africa's fractured health system means that the costs and structures of providing healthcare vary significantly both within and between the public and private sectors. The public and private sectors pay different rates on loans, taxes and staff. Public hospitals, for example, are able to employ

doctors, while private sector hospitals are not. Even medicines are priced differently across sectors, although this will likely change under the NHI. Certain rules of the Health Professions Council of South Africa (HPCSA) that make contracting with teams and using alternative reimbursement approaches difficult also pose barriers to moving to new payment approaches.

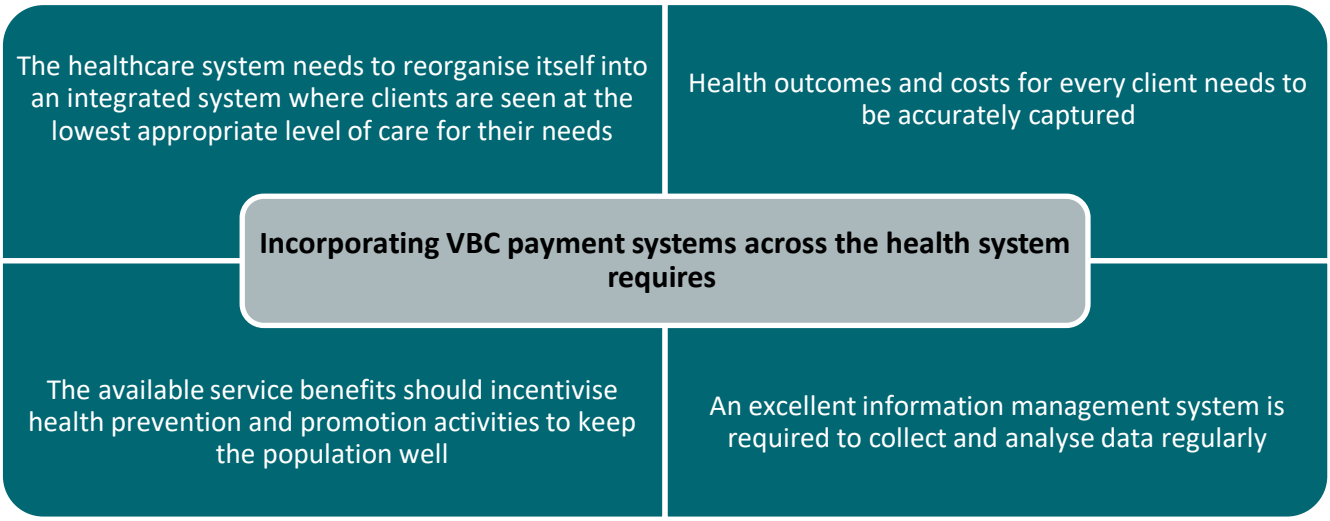
Deciding on an acceptable, affordable capitation fee or rate per DRG will require significant discussion and negotiation. To make this process easier, stakeholders could agree on an overall approach to costing, making it unnecessary to have in-depth discussions about the pricing of each DRG.

To make sure the right amount of funds are being allocated per case category (DRG), information about how resources are used, and to what impact, will need to be accurately captured. In the private sector, there is already a significant amount of pricing information, which would make it easier to move towards DRGs. DRGs need to form part of a wider payment system to make sure that research, training, and hospital infrastructure are also well funded. The complexity of implementing DRGs should not be underestimated – significant investments in the collection of clinical and costing data will be required, and it will take time for consistent coding practices to develop.

Value-based contracting as a future goal

The principle of value-based contracting is to give clients the most value for money: the best quality defined in terms of clients' improved health and wellbeing, per Rand spent. Because it relies on regular and robust information about healthcare quality, it is often more suited to mature health systems. The definition of quality depends on the type of care being delivered, and the health needs of the population. This makes VBC a complicated system, since different contracts need to be developed for different aspects of care and different sub-populations.

While there are pockets of VBC systems around the world, it has never been fully rolled out across a whole health system. Yet, even without full VBC, it is still possible to introduce value-based concepts into any payment system by allowing a portion of the fee to be dependent on quality of care. The NHI could work towards true VBC by incorporating some elements from the start to allow providers to adapt to this method of payment. Not including any value-based aspects of payment in the health system can pose a risk for clients, by not sufficiently prioritising their wellbeing.


The healthcare system needs to reorganise itself into an integrated system where clients are seen at the lowest appropriate level of care for their needs
Health outcomes and costs for every client needs to be accurately captured
Incorporating VBC payment systems across the health system requires
The available service benefits should incentivise health prevention and promotion activities to keep the population well
An excellent information management system is required to collect and analyse data regularly