INTEGRATED CARE MODEL - NEEDS SENSIBLE GLOBAL FEES

Dr Brian Ruff

Cape Town
16 -19 July 2017

The 18th Annual
BHF Southern African Conference

Private sector embracing universal healthcare

Organising Teams of Clinicians is crucial

to achieve higher quality with lower costs

Too many private hospital beds in metros

Poor OH benefits (very rich IH benefits)

Rising high Scheme premiums

High unnecessary hospital admission rate

Fee-for-service
Tariff for volume, not outcomes

Known factors
Aging members
New technology
Sicker patients

Fragmented weak system

Isolated clinicians
Tariff for clinicians working on their own

Scheme membership shrinking – less funded patients

PPO Serve: is a healthcare management service, helps organise clinicians into their own branded teams. Products: Population Medicine or Maternity care or Surgical episodes.

Method: clinical & social support products; data driven improvement; patient workflow system.

Fees for **teamwork & accountability** – from Schemes, State or individuals.

Multidisciplinary integrated, accountable teams = better quality at lower costs for patients & populations **– it's the key reform!**

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Current FFS tariff:

1. Pays **lone clinicians**, not teams
   - **Fragmented care** with gaps and waste
   - Lone clinician is the **wrong basis of competition** – turns specialists into primary care givers; undermines leadership & fosters value-destructive competition
2. Contains **no accountability** to patients for outcomes; undermines a culture of continual improvement
3. Leads to **over-servicing** by clinicians - striving for sustainable income

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Concerns with over-simple global fee models:

- **Underservicing**: 'Cutting corners' to maximise profits by doing less
- **Patient accountability** not addressed - no outcome measures are obligatory
- **Professional autonomy compromise**: = gives **financial risk** to clinicians - inappropriately transferred from Schemes:
  - new models ignore patient severity i.e. no risk adjustment
  - includes non-professional spend (hospital; x-ray etc.) which shortfall they must fund

➢ Having no balance sheet, they enter a **subordinate relationship** with a hospital or a corporate => may compromise autonomous clinical decisions

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Principles to align interests of patients, clinicians, Schemes:

- **New team models** of healthcare service delivery – that deliver EBM outcomes; driven by competition to add value to patients
- **Fees reflect value produced:** consistent outcomes for patients & populations:
  - **Value** is the best quality at the most prudent costs
  - **Quality** includes outcomes for populations & patient preferences
- **Carry no undue financial risk:**
  - Autonomous commercial clinician organisation competes & bills
  - May enter joint projects with hospitals/corporates - as equals; for specific purposes; limited periods (never subordinate)

Getting Global Fees right

Value based global fees: Structure and intent

	standard	chronic	complex	
Over 65	5	3	2	10
adult 40-65	26	10	4	40
female 20-40	12	2	1	15
male 20 -40	14	1	0	15
child	16	3	1	20
	73	19	8	100

Patient population

	standard	chronic	complex
Over 65	1,5	2,4	4,6
adult 40-65	0,6	1,7	4,3
female 20-40	0,7	1,1	4,2
male 20 -40	0,1	1,1	3,8
child	0,1	1,1	4,0

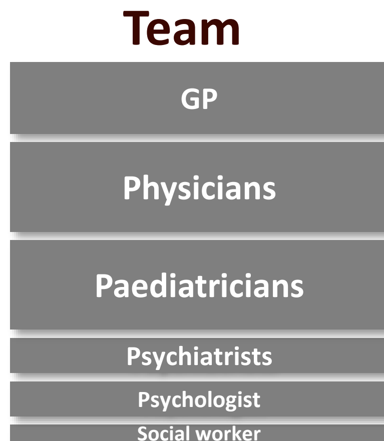
Disease Burden Index

Risk adjustment

	standard	chronic	complex
Over 65	7,7	7,2	9,2
adult 40-65	15,1	16,9	17,4
female 20-40	8,7	2,4	3,2
male 20 -40	1,0	1,3	1,1
child	1,5	3,2	4,0

Population Need

Team



Fee reflects need and professional team + management + support

Professional Team Fee

- Billable only by registered clinical team
- Carries no financial risk - professional / funder neutral
- Monthly or per episode
- Outcomes tracking obligation, may be link to Value fee

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Value based global fees - Structure and intent

+ Level 5

+ Level 4

+ Level 3

+ Level 2

+ Level 1

‘Add on’ value linked fee:

i. **Add fee** once value levels reached

ii. **Fee level** = higher levels = higher value vs. norm

iii. **Benchmarks** reviewed regularly – every 3 years?

- **$Value_{max}$ = $quality_{max}$ / $cost_{min}$**
- **Align** incentives: team; patient & Scheme
- Downstream cost measure & Quality measures e.g.:

➢ **Structure:** **Multidisciplinary Team**

➢ **Process:** **Complex patient assessments %**

➢ **Outcomes:** **PQI (avoidable admission rate); standardised mortality rate**

Value-add Contract example

Performance bands & Stars

Quality +

Higher quality
Higher cost

Higher quality
Lower cost

Cost +

Cost -

Lower quality
Higher cost

Lower quality
Lower cost

Quality -

Overall measure balances quality & costs -

Star system makes it easy to understand

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NHI White Paper July 2017 - new NB terms

- **CUP: Contracting Unit for PHC:** local District level units, contract to deliver PHC services for catchment area population. **Every patient registers** to access services.
- **Contracting Out:** government funded privately provided service.
- **Health Outcomes:** changes in health status for individuals& populations – requires data
- **Multi-disciplinary Teams:** 'one stop shop' - doctors, dentists, pharmacists, physios etc.
- **Quality of Care:** safe, effective, patient centered, timely, efficient and equitable provision to achieve desired outcomes. Clinical governance NB. Attracts bonuses.
- **Risk adjusted capitation:** monthly provider payment per head (not per service)
- **Strategic Purchasing:**
    - Active evidence based analysis of required service mix & volume, then
    - Select provider mix to maximise societal objectives. (Aims to constantly improve the performance of the healthcare system.)

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