

Value Care Team model in South Africa: small-scale pilot of performance-based capitation for better quality primary care

Summary

- The PPO Serve value-based care (VBC) pilot of its Value Care Team (VCT) model began in September 2019 and currently covers 5620 patients in Pretoria North, Gauteng province, South Africa. It is funded by the Government Employees Medical Scheme (GEMS), a closed, private voluntary insurance scheme for civil servants.
- The model aims to overcome the limitations of fee-for-service (FFS) payments, including supplier-induced demand, unnecessary admissions, and poor coordination and measurement of outcomes. It also aims to shift care to the primary setting to reduce hospital admissions and length of stay.
- The four components of the model include a multidisciplinary health provider team, a comprehensive risk management strategy, an information technology tool that triggers health interventions, and a contract between GEMS and PPO Serve that specifies a risk-adjusted capitation payment and a quality-based payment for providers.
- The average monthly payment is approximately 115 South African rand (US\$ 7.20) per patient, similar to the average FFS paid by GEMS to the practices. The performance payment is based on quality scores, ranging from 0 to 100 and multiplied by a baseline remuneration amount of 140 South African rand (US\$ 8.80). The best performing health providers receive approximately 240 South African rand (US\$ 15.00) per patient monthly. It amounts to 25–33% of a provider's income.

- No formal evaluation has been done. Trend data in 2021 indicate shorter hospital length of stays and fewer admissions, and higher rates of surgical admissions.

Key elements of the programme

- The local multidisciplinary team (MDT) is managed by a PPO Serve coach with a group of four general practitioner (GP) practices, involving some 17 GPs, three nurse care coordinators, and other allied health care professionals.
- A contract between the insurer and PPO Serve uses a performance-based capitation payment. The capitation payment is adjusted to account for the volume of patients and disease burden. Additionally, providers receive a performance payment.
- A comprehensive risk management strategy helps to identify individual and population risks and their associated clinical and social interventions.
- The Intelligent Care System (ICS) collates data from insurers and clinicians and generates operational and performance reports to drive continual improvement efforts and trigger proactive intervention tasks in care plans.

Results

- No formal evaluation has been done. Trends in 2021 suggest declines in hospital admissions and length of stay. The surgical admission rate was 20.5% higher than expected. Aggregated scores of performance quality for all GP practices showed a positive trend. However, some metrics were unchanged.

Facilitating factors

- The ICS, an integrated electronic information system that includes patients' records, facilitates continuity of care among providers, facilities and the funder. It forms the backbone of the VBC approach in which the measurement of quality (in this case, processes and outcomes) is critical for performance-related payment.
- GEMS is willing to experiment with VBC models.

Inhibiting factors

- The Value Care Team model's population is only a fraction of each provider's practice, which hampers the ability to drive population-level change. The focus on a small geographical area meant that appropriate providers were difficult to find, apart from nurse care coordinators.
- Small scale pilots imply higher implementation costs; efficiencies and cost savings from a large volume of care have yet to be realized.
- The effective functioning of the model relies on effective clinical leadership of the MDT and on providers who are interested in adapting their processes to improve care quality. The reluctance of providers to engage critically with performance reports hindered improvements in clinical practice.
- While the quality-linked payments are a significant proportion of reimbursement on the level of the individual patient, the low patient volume and the small scale of implementation meant that these incentives were insufficient to drive changes in providers' behaviour.

Lessons learned for other settings

- The regulatory environment in which a VBC model is employed must be conducive to developing alternative purchasing arrangements as well as service delivery. This includes regulations that govern fee-sharing and multidisciplinary teamwork.
- Capacities in leadership and governance for both clinicians and managers are critical. These include skills and knowledge about improving care quality, service delivery models and team management.
- Integrated and robust information systems that can follow a patient throughout their care journey are necessary for improving quality outcomes as well as preventing unnecessary or duplicated care. Additionally, automating the delivery of certain alerts and services to both providers and patients decreases the possibility of missed opportunities for care.

This policy brief is based on Smith A, Mosam A. *Value Care Team model in South Africa: case study*. Geneva: World Health Organization, Organisation for Economic Co-operation and Development; 2023.