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HEALTH PORTFOLIO COMMITTEE MEETING

5 March 2014

Dr Dumisani Bomela | HASA CEO

Hospital Association South Africa
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Presentation Structure

Requested by Health Portfolio Committee Chair:

1. Private hospital sector participation in NHI
2. Private hospital presence in rural areas
3. Private hospital embracement of primary healthcare

Additional

1. Growth in medical scheme industry
2. Demand for private healthcare
3. Private hospital price increases

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Private Sector Participation in NHI

Universal access – HASA supports Universal Access

- HASA supports Universal Access.
- The private hospital industry is ready to participate in collaborative work with the public sector right now.
- The service delivery need in SA is current and should not be deferred.

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Private hospitals can deliver on Public Health

This can be done today

- For example, government can contract private providers for certain procedures to alleviate waiting lists in the state hospitals e.g. for cataract surgeries. A suitable tariff must be determined, for a fixed volume of cases. This public-private-partnership model is used internationally e.g. NHS in the UK
- In 2012 the private hospital sector trained **XX** nurses and we would be happy to take a larger role in the training of nurses
- We are ready and willing to play a significant role in the training of doctors by extending the training platform to private facilities
- Private hospitals can use their expertise to share knowledge with the public sector on hospital management (example – twinning of hospital management)

What it requires is a mutually acceptable procurement arrangement with the DoH and this can be evaluated and monitored by an independent advisor

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Private hospitals can deliver on Public Health continues...

Examples of the role that SA hospitals play in Universal Access and Public Private Partnerships (PPPs):-

- Globally – in Switzerland and UK, SA hospital groups are already providing services in to public patients
  - Switzerland - plus/minus 60% Mediclinic patients
  - UK - plus/minus 35% of Netcare patients
- Africa – Lesotho
- Locally
  - PPPs are limited to build , operate and transfer
  - Emergency services
  - Collaboration in commissioning of new facilities

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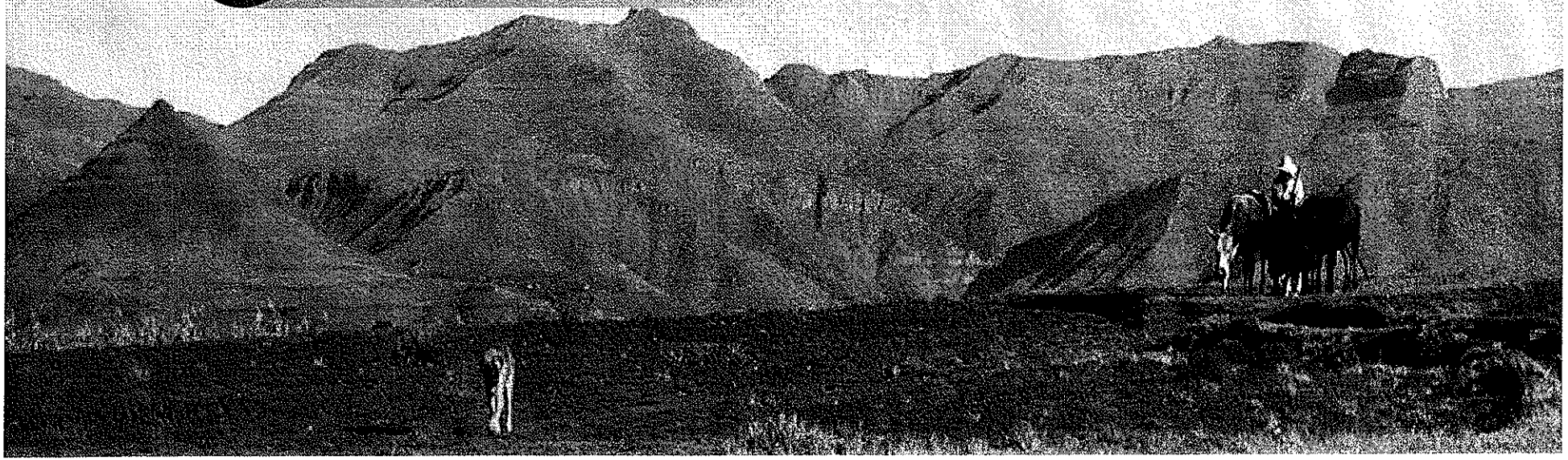
This has been achieved in the following setting…

Global Example

1. African country
2. Rural setting



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Lesotho: Old hospital

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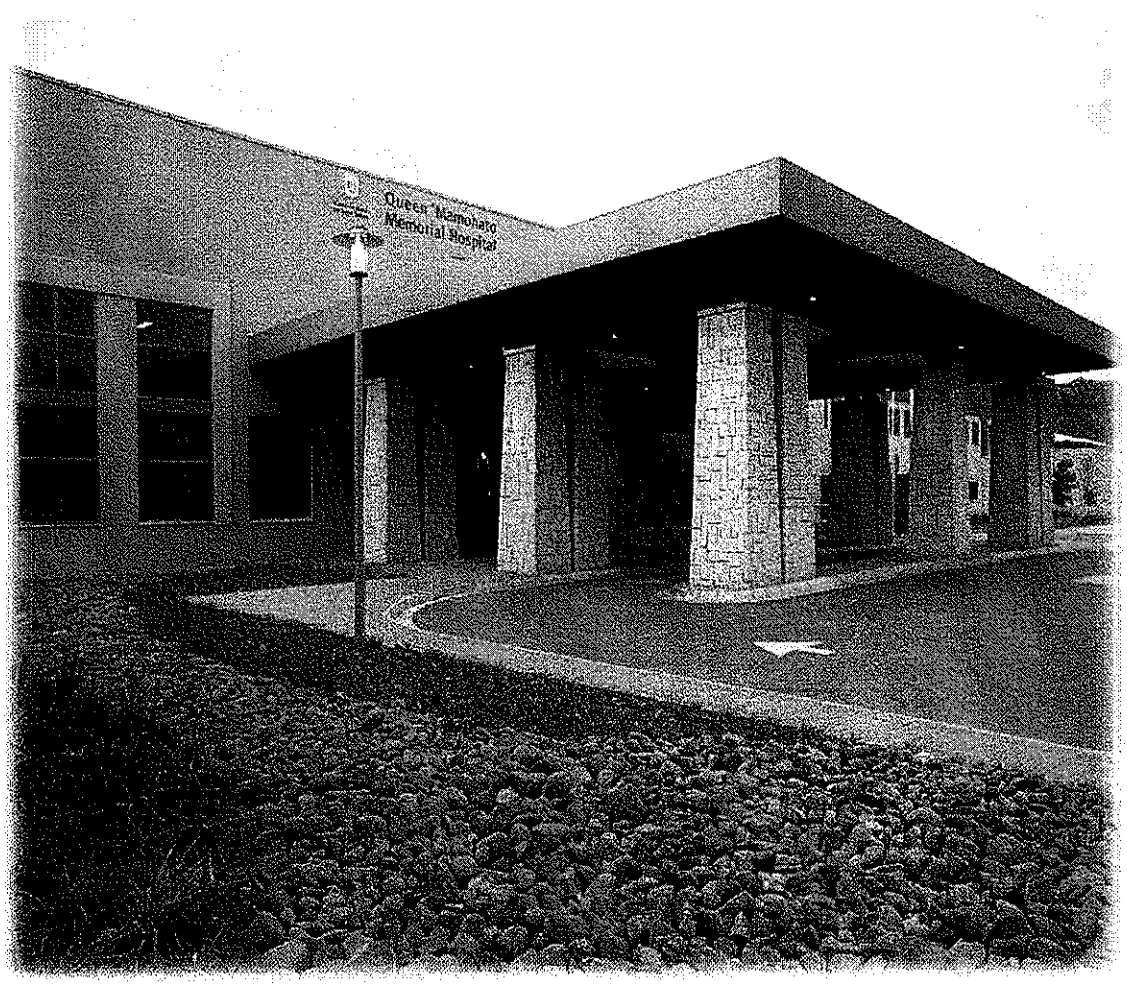
New hospital



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Key performance Indicators : Before and After

	Old Hospital (QMMH-IN)	New Hospital (QEII-IN)	%
Hospital beds	409	390	-5
Inpatient admissions	15 465	23 341	51
Inpatient days	91 808	116 648	27
Outpatient visits*	165 584	374 669	126
Deliveries*	5 116	7 431	45
Average length of stay	5.94	5.00	-16
Hospital occupancy	61%	82%	33
Death rate*	12.00%	7.10%	-41
Maternity death rate*	0.24%	0.21%	-10
Paediatric pneumonia death rate	34.40%	11.90%	-65
Still birth rate	4.00%	3.10%	-22

* Including filter clinics

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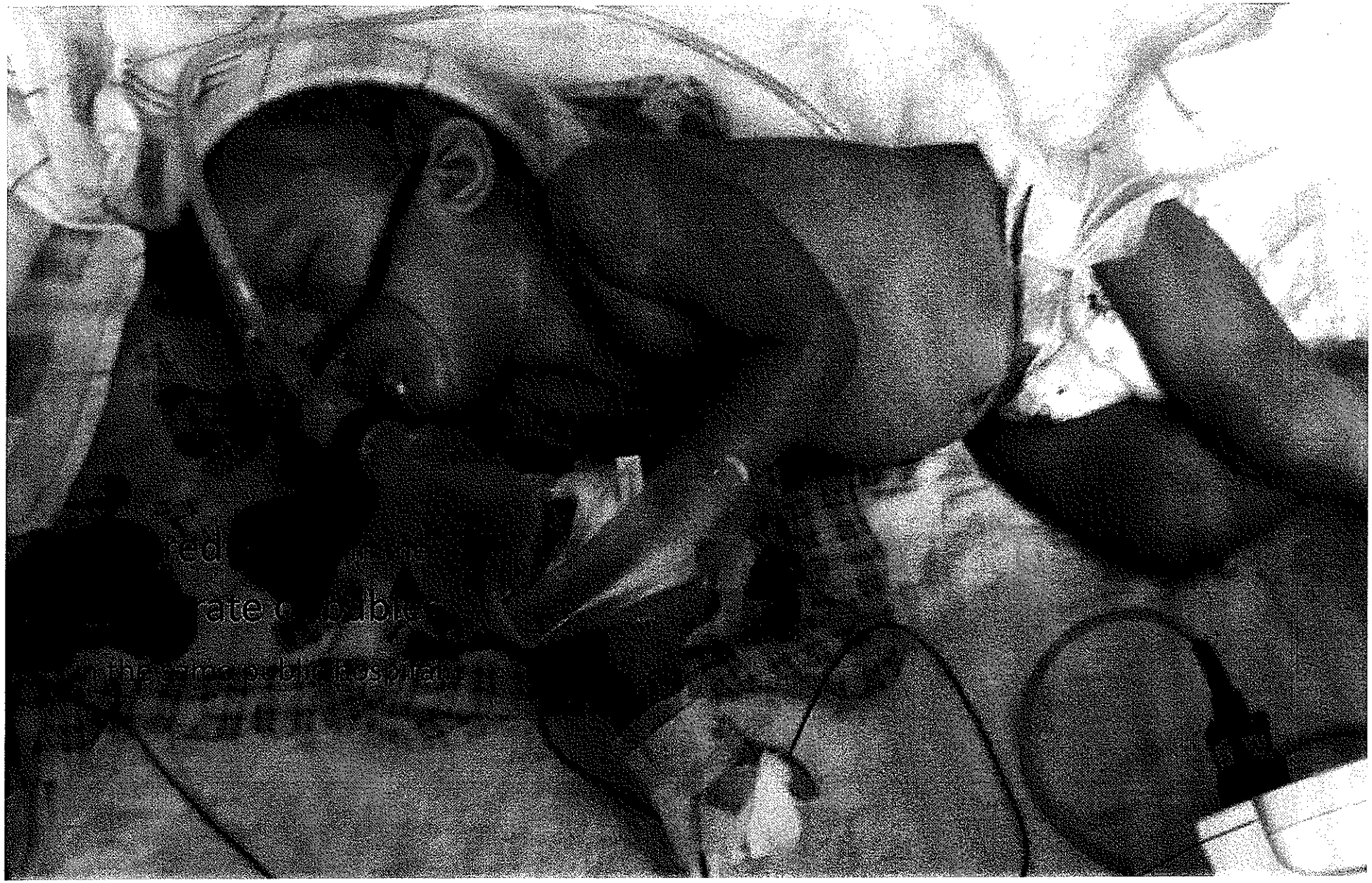

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How was this achieved?

Improving management and clinical systems

Protocols and well functioning pharmacy system with reduced drug stock outs and theft

A laboratory system providing test results within the hour

Waiting time for surgery significantly reduced

Support systems keeping the hospital clean and functioning

Standards, policies and guidelines requiring discipline and accountability

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Private hospitals are key to Sustainable Healthcare in SA

- We must work together to take advantage of the strengths of our healthcare system.

- The country must tap into the expertise that already exists with the private hospital sector.

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Distribution of Private Hospitals

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Distribution of Private Hospitals

- In the absence of contracting from public health in rural areas private hospitals footprint matches the footprint of medical scheme members as medical schemes contract with private hospitals.

- It is for this reason that most private hospitals are located in the urban areas.

- However, should government enter into public-private-partnership arrangements/contracts with private hospitals to deliver care in the rural areas, private hospitals would then be able extend their footprint deep into the rural areas.

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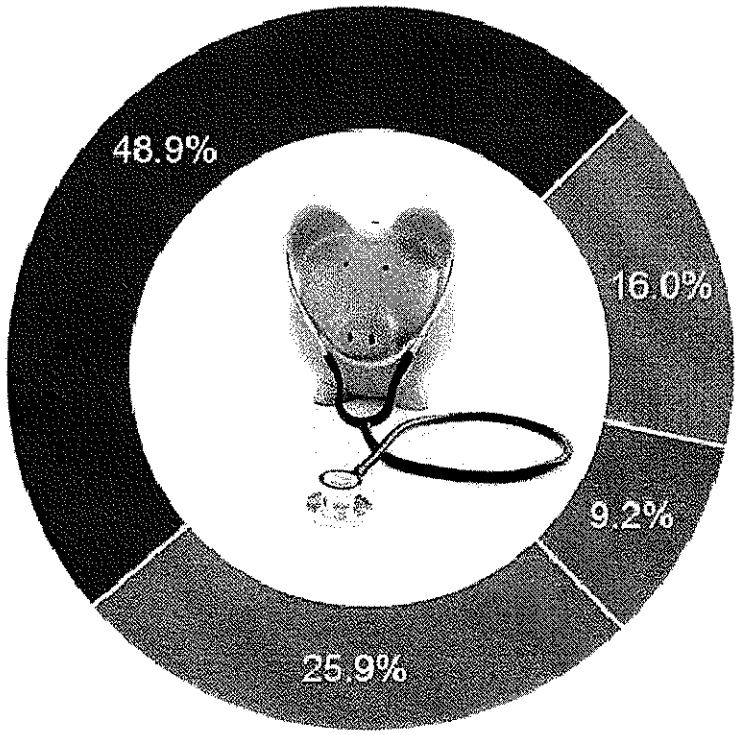
50% of SA Population do not earn an Income

Health Insurance Coverage*



- Covered by Medical Schemes
- Earning above tax threshold but not on Medical Scheme
- Earn below tax threshold and not on Medical Scheme
- Do not earn any form of income

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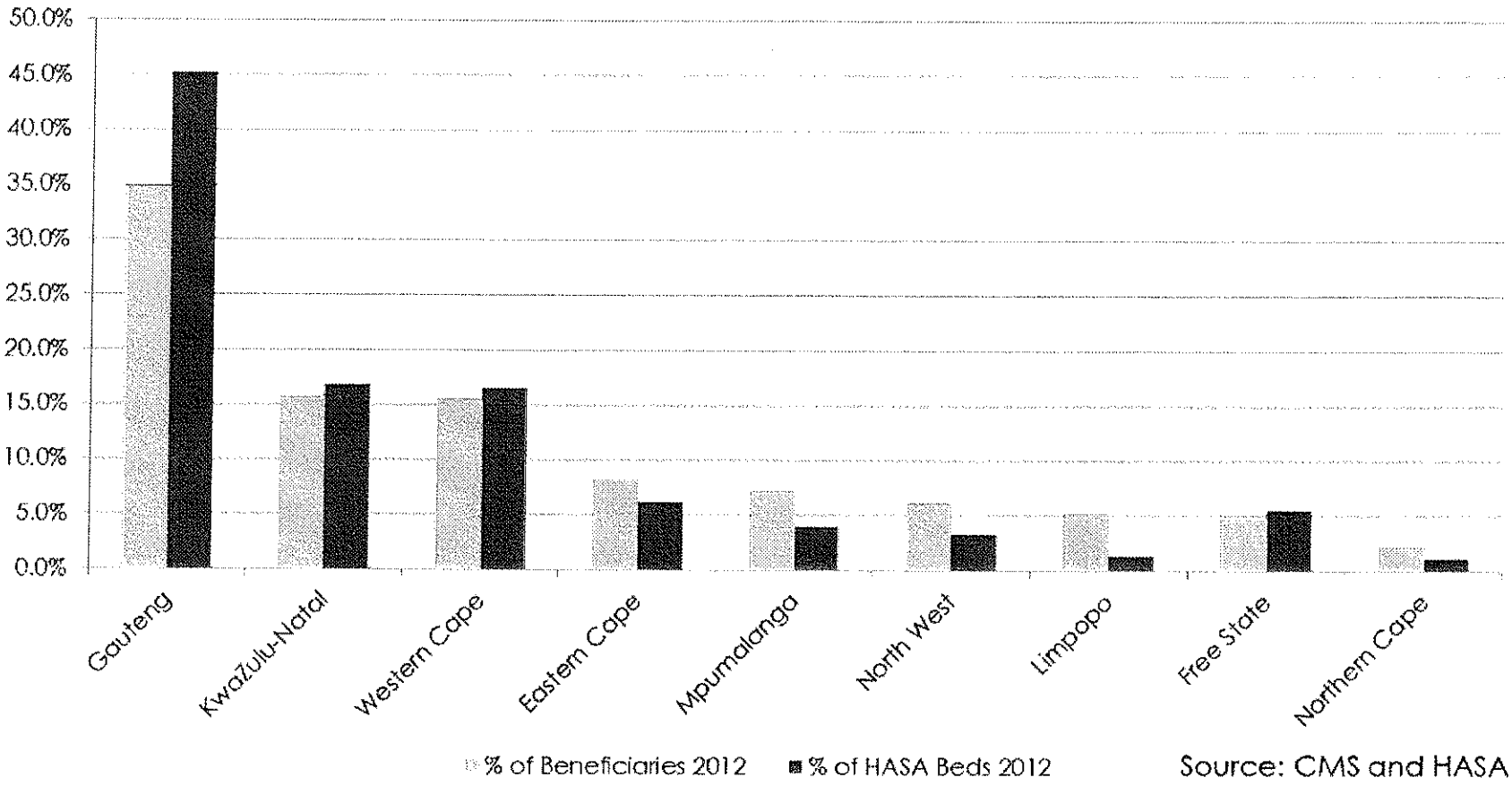
Distribution of Medical Scheme Lives and HASA beds



Source: CMS and HASA

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Primary Healthcare

Primary healthcare is **not** a Prescribed Minimum Benefit

- Primary healthcare is the bedrock of any health system
- In SA primary healthcare access in the private sector should be strengthened by making primary healthcare a Prescribed Minimum Benefit according to the Medical Scheme Act.
- We need strong primary healthcare and wider access to improve SA health outcomes.
- Medical schemes have limited benefits for primary healthcare and wellness – people then leave care for too late, and hospitalisation could have been avoided.
- This is a driver of the low growth is expenditure by medical schemes on primary healthcare since the introduction of Prescribed Minimum Benefits.
- One Hospital group has 86 primary healthcare clinics but are unable to employ Drs and can't integrate it into the healthcare value chain.

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Private hospitals in the Primary Healthcare System

- HASA supports that the PMBs be more inclusive of primary healthcare benefits
- It is difficult for private hospitals to make a difference in primary healthcare due to the regulations prohibiting private hospitals from employing doctors.
- Care continuation is difficult in the current fragmented environment
- However, private hospitals want to work with primary healthcare facilities in order to coordinate care and ensure seamless continuation of care for the patient.
- There needs to be policy stewardship encouraging integration between primary healthcare system and hospitals, even in the private sector.

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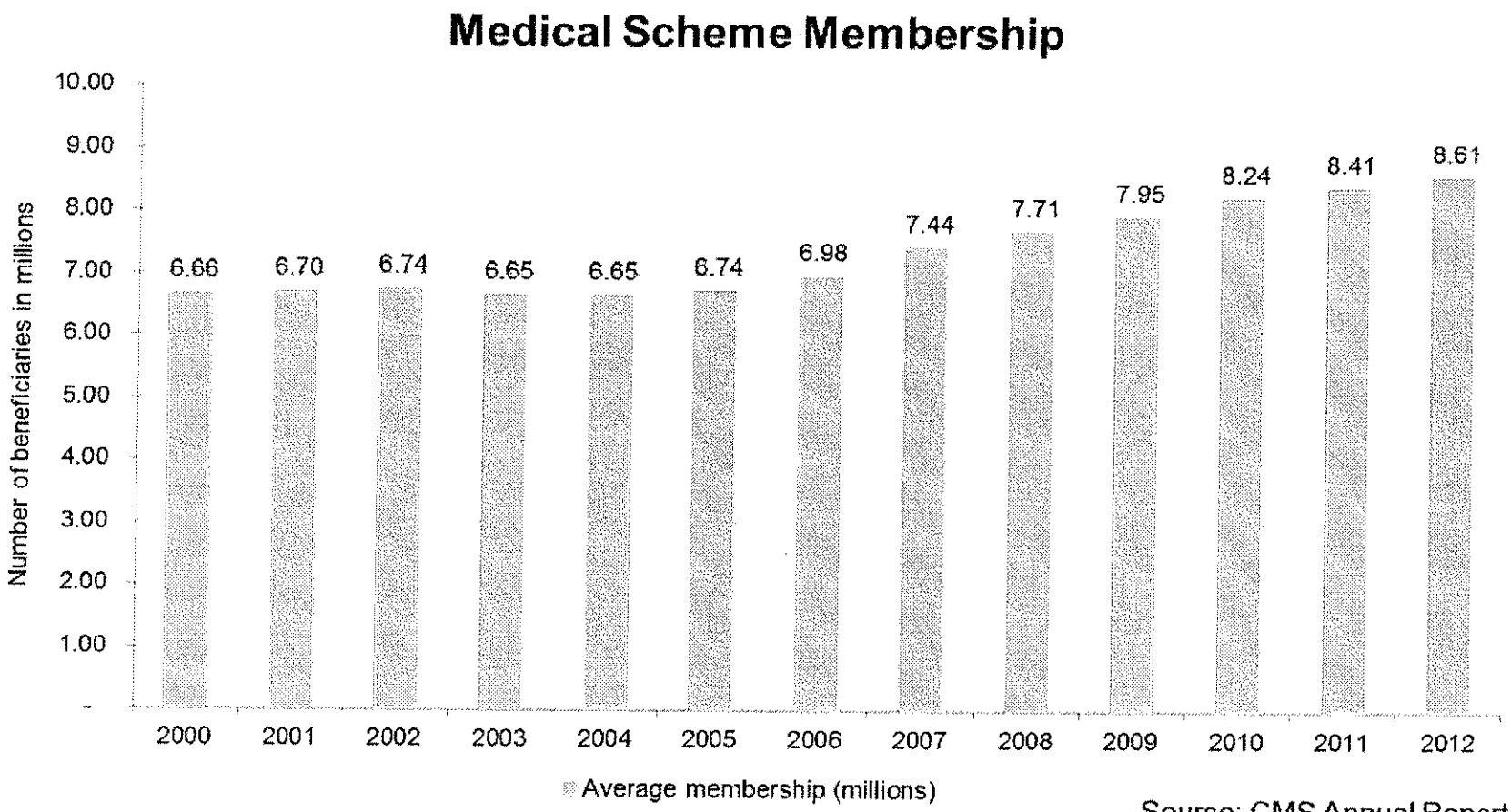
Growth is Medical Scheme Industry

2 million additional beneficiaries of medical schemes since 2000



Source: CMS Annual Reports

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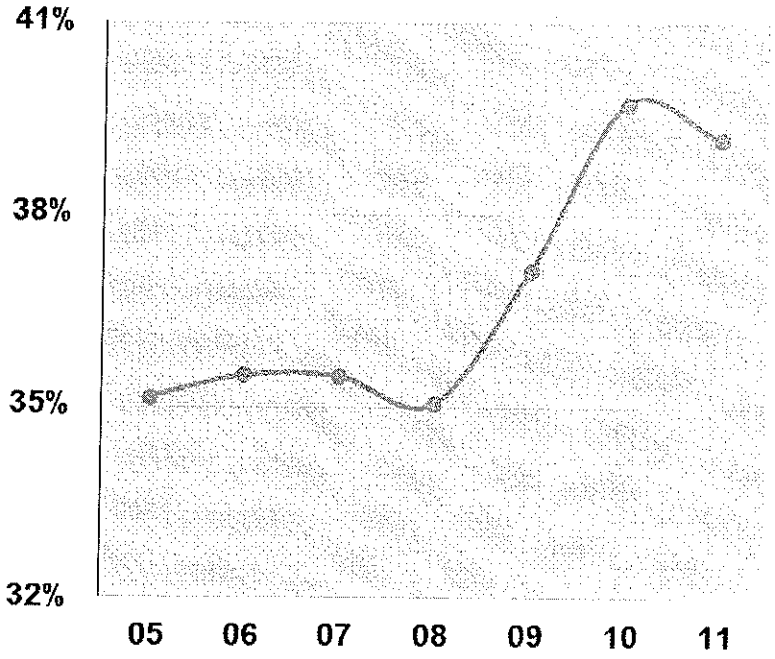
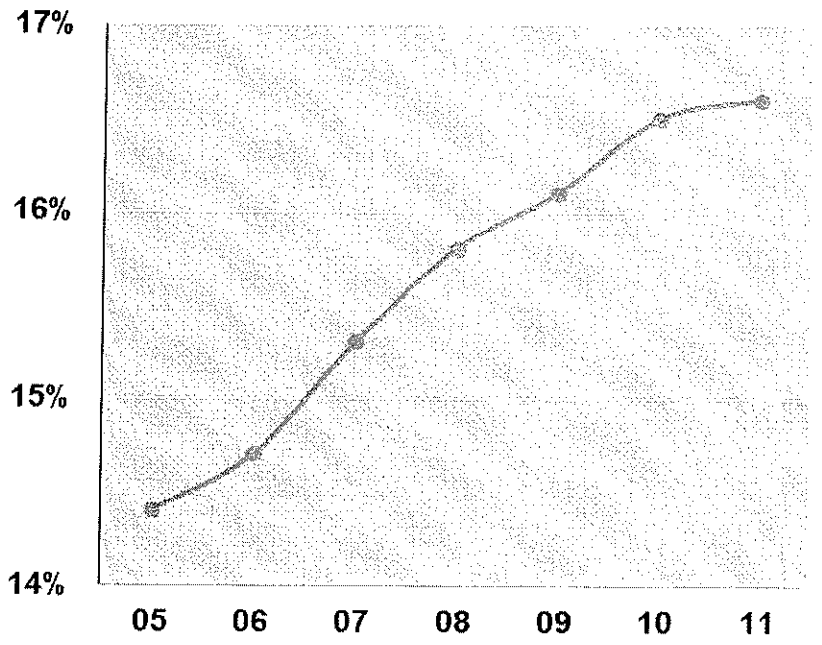
Increased access to private cover



% of formal labour force on medical scheme*



% of population on medical scheme

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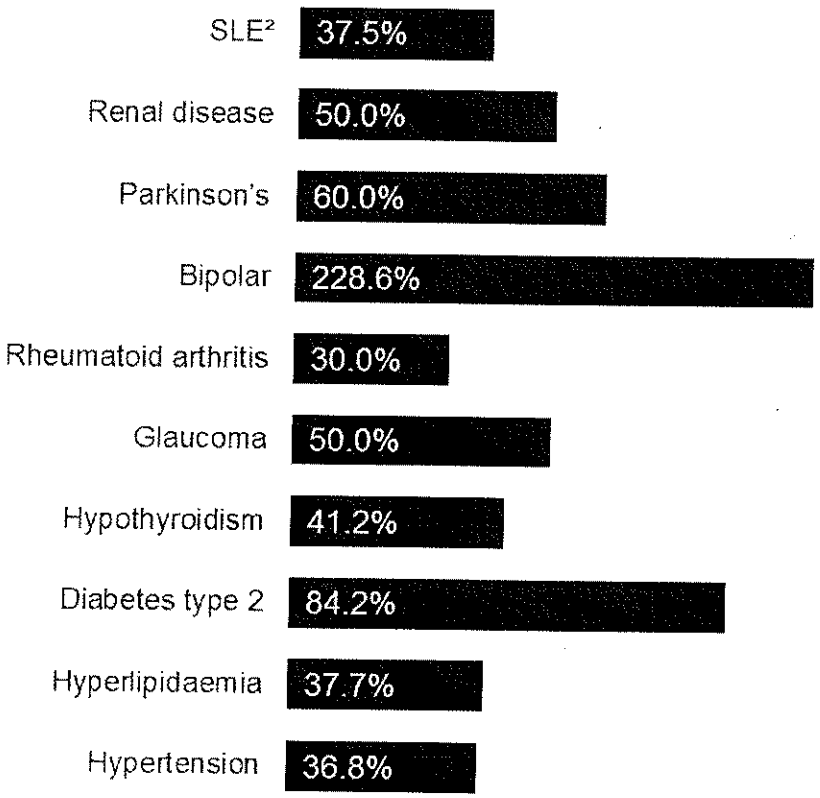
Demand for Private Hospital Services

Demand driven by growth in lives covered, ageing and burden of disease



Increased prevalence of chronic diseases (2006-2011) per 1 000 beneficiaries[1]

1. Source: Council for Medical Schemes, Annual Report 2012-2013
2. Systemic Lupus Erythematosus

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Private Hospital Price Inflation

Price inflation comparators: 2002-2012

Relative comparisons demonstrate that hospital inflation is well contained

PETROL/litre
▲239%

IWISA maize meal/2.5kg
▲213%

HIGH SCHOOL FEES/yr
(Grey College Bloem)
▲194%

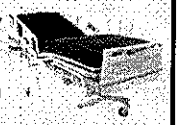
RICOFFY/750g
▲191%

COKE CANS/6 pack
▲172%

PnP MILK/litre
▲158%

LAYS CHIPS/125g
▲152%

PRIVATE HOSPITAL GROUP
revenue per patient day
▲109%



SKIP washing powder/2kg
▲100%

Source: Finweek (10 May 2012); Netcare Annual Results presentation (2012)

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StatsSA: Private Hospital Price Inflation

	Hospital Services	Medical Insurance
2010	6.90	13.10
2011	5.70	10.30
2012	5.10	9.40

Source: StatsSA (2013)

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Thank you

We'd welcome your Questions

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