BRIEFING ON THE PRIVATE HEALTHCARE SECTOR

Portfolio Committee on Health

27 July 2011

National Department of Health
OVERVIEW OF PRESENTATION

• Medical Scheme environment
• History of price regulation

KEY ARGUMENTS IN COURT CASE

CHALLENGES WITH THE RPL

POTENTIAL SOLUTIONS

INTERNATIONAL EXPERIENCE

TRANSPARENCY

NEGOTIATIONS

WAY FORWARD
MEDICAL SCHEME ENVIRONMENT
Beneficiary numbers continued to grow in 2008 and 2009 despite the recession...
Even though huge catch-up is still required, scheme demographics reflects improvement

Sources: Council for Medical Schemes Annual Reports to 1999 and OHS, GHS and LFS
Proportion of Medical Scheme Membership by Annual Income

Source: Lighthouse consulting
Non-health costs increased from 1998 to 2006, then decreased since CMS intervention
...Discovery still has very high non-health costs...

Administration fees should be low in large schemes.
...claims costs remained stable from 2005 to 2008, but increased in 2009...
... the cost drivers are hospitals and specialists...
Trends in Total Benefits Paid, 1997 - 2005

Source: Council for Medical Schemes
Benefits Paid to Clinical Support Specialists, 2002-2006

Source: CMS Reports
Benefits Paid to Medical Specialists, 2002 - 2006

Source: CMS Reports
PRIVATE HOSPITAL SECTOR
Distribution of beds across the country

Number of registered beds:

<table>
<thead>
<tr>
<th>Region</th>
<th>Registered Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gauteng</td>
<td>9,412</td>
</tr>
<tr>
<td>Kwazulu Natal</td>
<td>2,972</td>
</tr>
<tr>
<td>Western Cape</td>
<td>3,252</td>
</tr>
<tr>
<td>Other</td>
<td>4,830</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td><strong>20,466</strong></td>
</tr>
</tbody>
</table>

Translates to 7.5 million bed days per annum

Source: Lighthouse Consulting
Bed Occupancy by day of the week

Source: Lighthouse Consulting
Bed Occupancy by Age

Shape of demand for bed days:

Bed days per annum per 1,000 of the population

Age group

Source: Lighthouse Consulting
Breakdown of Benefits Paid to Private Hospitals, 2002 - 2006

Source: CMS Reports
Concerns with Private Hospital costs

• Prices are relatively high - lack of transparency
• Fee for service versus alternate reimbursement models
• Spare capacity exists – opportunity to reduce prices
• Relationship with Specialists
• Reluctance to accept price negotiation
• Technology push
• Preference for legal challenge rather than constructive engagement
...while hospital costs were stable (at a very high level) from 2004 to 2008, it increased again in 2009...
ADULT CIRCUMCISION CHARGES FROM DIFFERENT PRIVATE HEALTHCARE PROVIDERS.

1.

2.
2.1. Hospital fees: At about R10000.00.
2.2. Urologist: R1500.00
2.3. Anaesthetist: R1200.00

2.1. Hospital Fees: R8200.00 for thirty minutes in theatre,
2.2. Urologist: R2000.00
2.3. Anaesthetist: R1800.00.

One of the urologist can do the procedure in his rooms,
for R1500.00 (cash inclusive),

3.1. Hospital: R4184.00
3.2. Urologist: R1200.00
If the urologist do the procedure under local in his rooms at the same private clinic, he charges R1000.00 for cash which includes the local anaesthetic, the procedure and his/her fees.

4.1. Hospital Fees: R13880.00
4.2. Urologist: R1500.00
4.3. Anaesthetic: R900.00

5. G.P S' In the townships: R600.00 to R1200.00 (inclusive),

NB: Hospital fees are for general Anaesthetic and day procedure. No other night admission. Fees can fluctuate if the procedure gets longer. These were based on the minimum of 30 minutes theatre time.

All procedures quoted are- surgical excisions. No clamp procedure,
...hospitals demonstrated a large growth in their return on investment...
Comparison of ROE by Sector

Transport
Telecommunication
Media
Personal Goods
Platinum
Paper
Gold
Diversified miners
Resources
Pharmaceuticals
Healthcare
Beverages
General Retail
Food Retail
Energy
Construction
General Industrials
Financials
Banks
South Africa

2012
2011
2010
HISTORY OF PRICE REGULATION
History of RPL

• Scale of benefits – negotiation between funder – provider

• 2003 – Competition Commission ruling – collusion between funders and providers.

• Neutral body should be responsible for tariff selling.

• CMS established methodology for NHRPL – Voluntary participation.

• The NHRPL was used as a GUIDE to industry from 2004-2006.
History of RPL

• In 2007 RPL schedules were published by NDOH based on the NHRPL

• Tariff increases were too low - SAMA challenged the Schedules- - Schedules published without regulation.

• Regulations formalising the RPL promulgated

• SAMA continued to be unhappy – argued tariffs were too low

• HASA decided to participate in the RPL – methodology unsuitable.
Key arguments in the case

• Minister of Health did not consult with NHC. Judgement – NDOH could not provide concrete proof of consultation with NHC.

• 90(1)(u) – obtain info from private sector, (v) – making RPL regulations

• RPL establish actual costs – not determine what costs should be

• Unlawful delegation of powers MoH to DG

• Submissions via representative associations - unlawful

• Judgement did not challenge the Ministers / DG powers to publish an RPL.
Challenges experienced with RPL process

- Associations were required to submit info – response bias
- “Independent” consultants – paid by association for technical work
- Poor correlation between financial data supplied – verification process
- Methodology not suited to health establishments
- Output is reference price – national reference range
- Coding challenges – fee for service
- Resources to deal with all submissions timeously
- Relationship between RPL and market prices.
International Experience with Price Regulation

• TWO OPTIONS
  - Administered Pricing
  - Price Negotiation

• Price Negotiation – more successful

• Bargaining chamber – Netherlands, Belgium, Portugal, UK, Switzerland
- Providers can opt out – inform patients – no state contract
- Authority – oversees negotiation
  - assess affordability & sustainability of tariff
  - tariff is maximum
Transparency

• Providers need to share their financial information with authority – full participation.

• Authority needs to analyse the above information and provide summary statistics to funders & providers.

• Cost information should form the basis of the negotiations.
Thank you