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A CASE FOR INNOVATION TO INCREASE VALUE

SAFHE / CEASA 2019

PRIVATE HOSPITAL INDUSTRY

ECONOMIC VALUE

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Private hospitals contribute R55.5bn to the national economy, equivalent to 1.28% of GDP

- **525 facilities** with 40,514 beds
- 53,500 directly employed; total of **248,504 jobs supported**
- Activities generated government **tax revenue of R 16.4bn** throughout the economy

Source: Econex – Private Hospitals' Contribution to the South African Economy (2016/2017)

POLICY DEVELOPMENTS
UNCERTAINTY FOR PRIVATE HEALTHCARE

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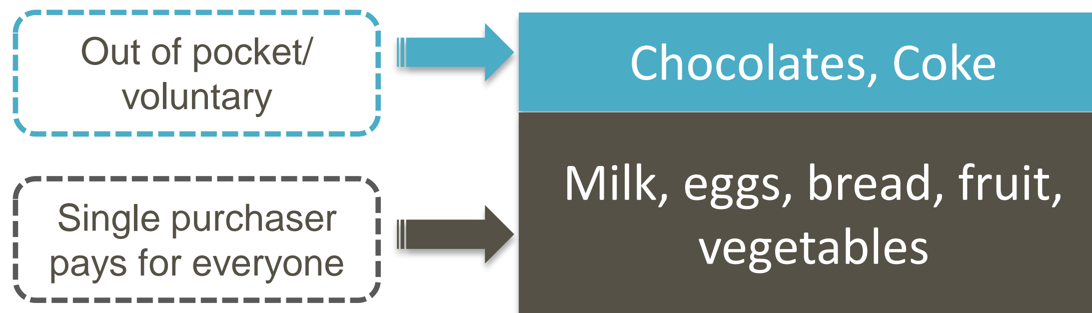
Transition from two-tier model to single purchaser with complementary medical scheme coverage

- *"…restrict the extent of benefits offered by medical schemes, having regards to the benefit and services coverage under the NHI Fund thereby eliminating duplicative costs for the same benefit."* Medical Schemes Ammendment Bill, section 17

Selective contracting with private healthcare providers only during final stages of NHI roll-out



HEALTHCARE PRINCIPLES

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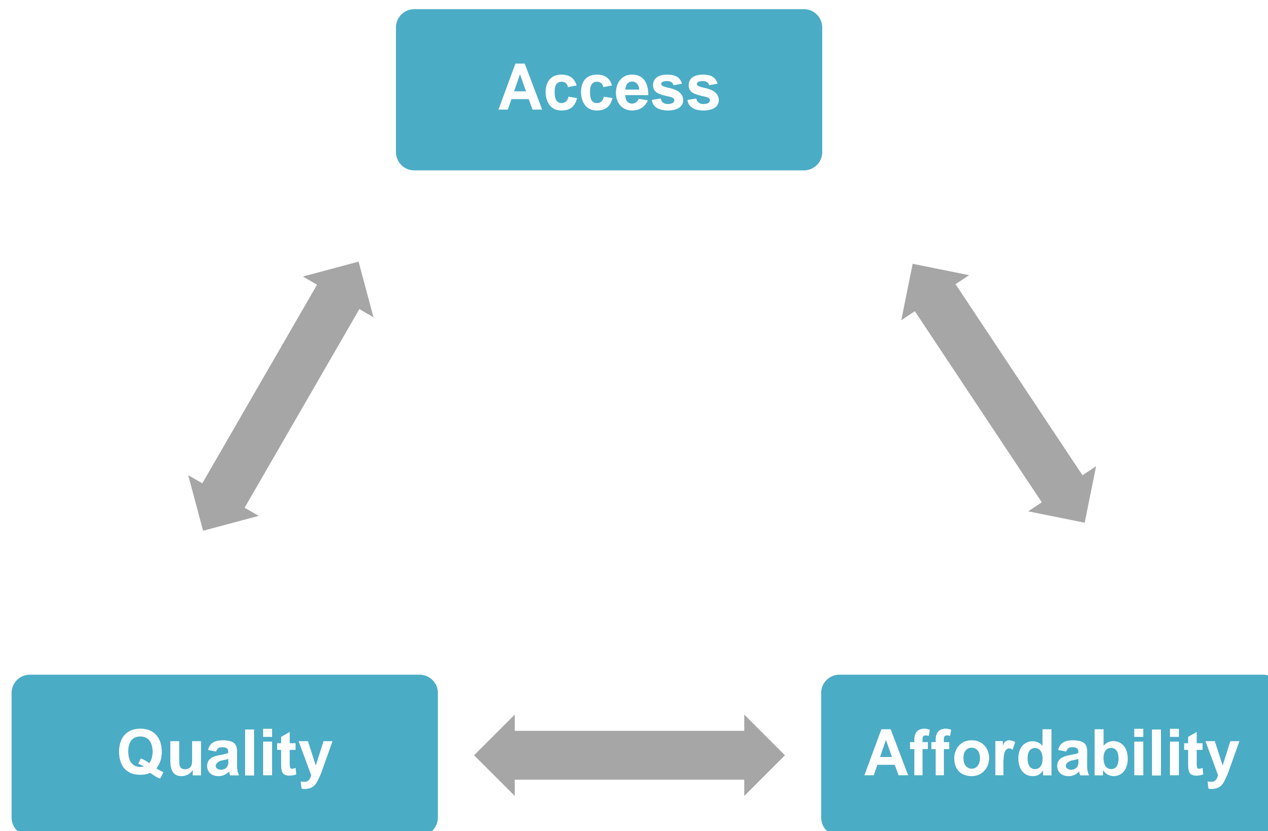

PERCEIVED PROBLEM

INCORRECT COMPARISONS

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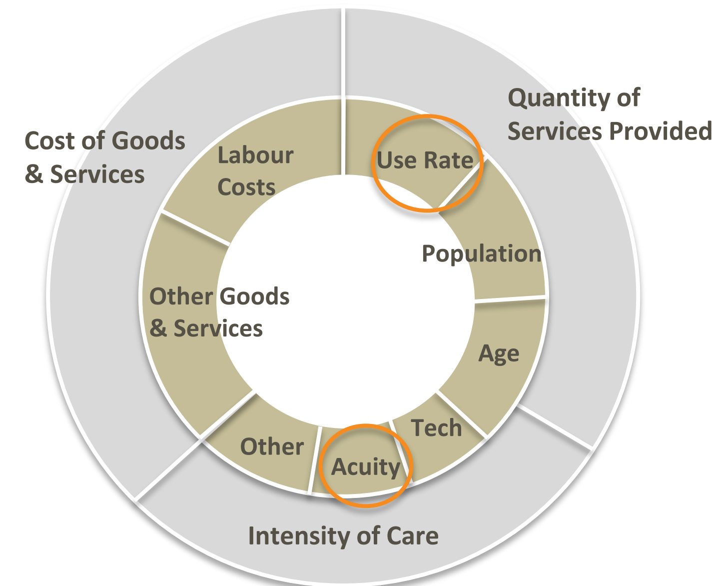
Cost of an admission in a private hospital is only 5.8% higher than the cost in a public hospital (Ramjee 2013)

- Adjusted for structural differences such as VAT, public hospitals access to pharmaceuticals at State tender prices and cost of capital in the private sector
- Intuitively this result should not be surprising, given that both hospitals in the public and private sectors face similar input costs

Cost of private healthcare is the result of demand and supply-side dynamics

- price + volume + intensity
- increasing burden of disease
- access e.g. public sector essential drug list has approx. 700 products vs 20 000+ products available in private sector



PRACTICAL PROBLEMS

HUMAN CAPITAL

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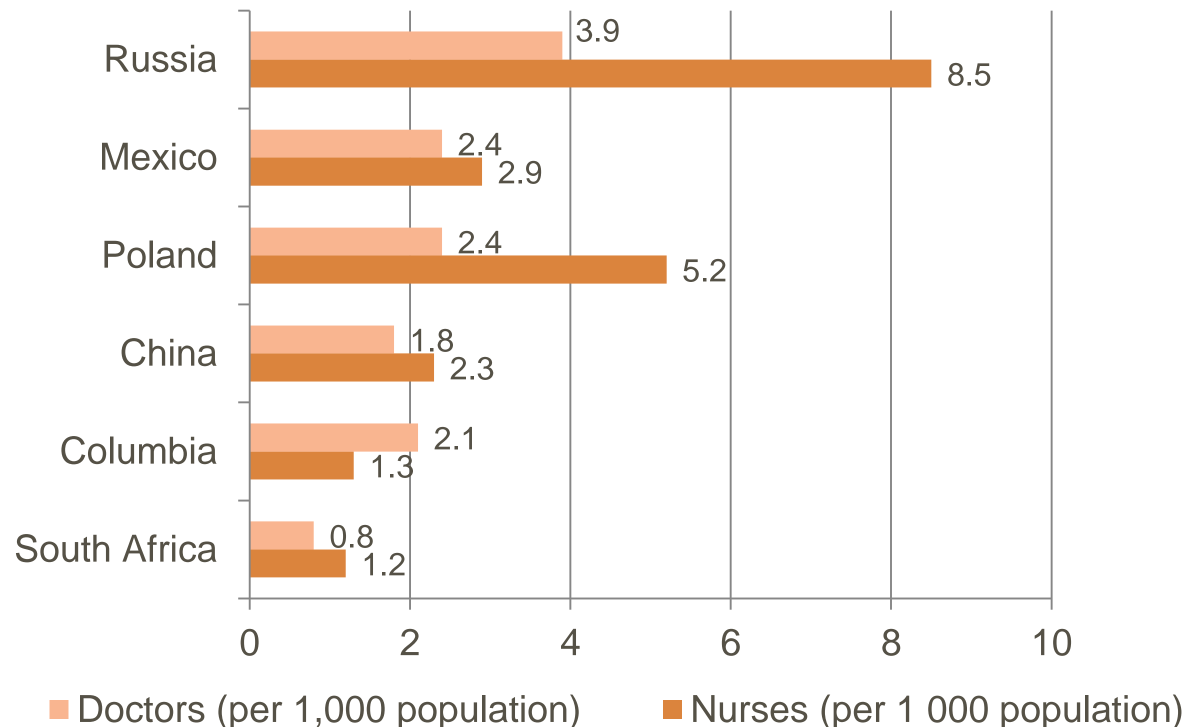
Access limited by scarcity of healthcare professionals:

- National primary care visits rising from 2.5 to 3 visits per capita uninsured
- South Africa's annual consultations per person lags the OECD's average of 6.6

Solutions beyond expanding training capacity

- Training is costly
- Won't solve structural problems in both public and private delivery



Source: Blecher et al. 2017. Health Spending at a Time of Low Economic Growth and Fiscal Constraint. Health Systems Trust, 20th Edition South African Health Review 2017; OECD data

COST OF PRIVATE CARE DELIVERY

LABOUR AND CAPITAL INTENSIVE

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Staffing costs are high due to scarce skills

Significant capital costs

- Buildings often specialized according to regulations
- Medical equipment mainly imported and complying with European and American patient safety and quality standards

Other operational cost drivers

- Maintenance of specialised equipment
- High users of electricity and water
- High and fluctuating exchange rate

MANAGING HIGH HOSPITAL COSTS

LIMITED IMPACT OF EXISTING MECHANISMS

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	Impacts Utilisation	*Impacts Costs*
Gatekeeper model	Yes	Not on cost per case basis
Chronic disease programs	Yes	Same
Alternative sites/ day clinic	No	Somewhat
DRG reimbursement	No – can increase	Caps costs
Reduce number of beds	Yes	Not on cost per event – impacts waiting list
Improve Quality	Yes – LOS	Slightly

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Chro		
Alter		
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"Green" Technology	No	Slightly

How do we reconfigure hospitals to reduce *fixed costs*?

SOLUTIONS

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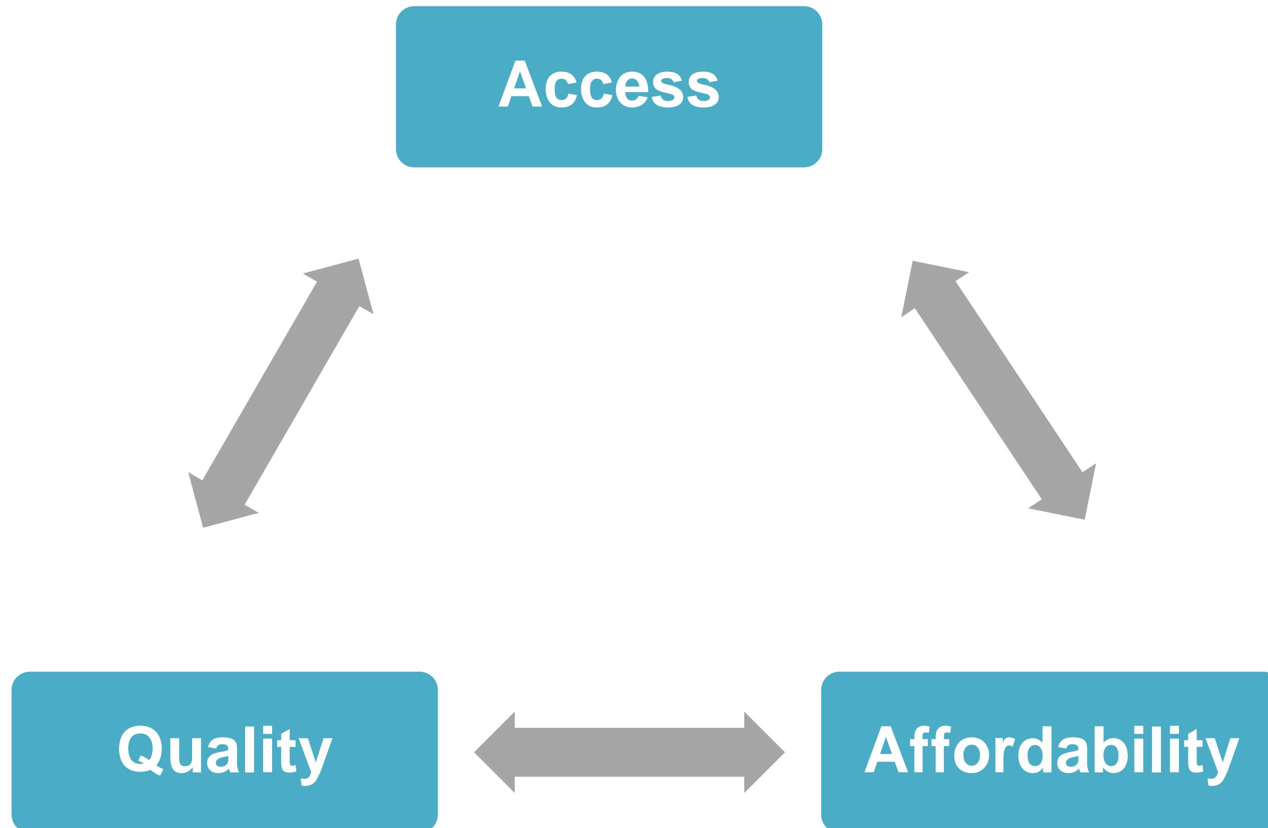
LOWER COST, GREATER ACCESS, SAME OR BETTER QUALITY



SOLUTIONS

THINKING DIFFERENTLY

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- How do we **build** at lower cost?

  Currently R3.5 million to build an acute hospital bed

- How do we find “hands” to **improve access** at a lower cost than that of a human hand?

  Access is limited by scarcity of healthcare professionals

- How do we **integrate health care information** cheaply to equip professionals with the best possible information to make decisions?

- How do we **optimize the use** of expensive equipment to give more people access?

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THANK YOU