



Network Healthcare Holdings Limited

Investor Day

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Outline

- Regulation
- Affordability – cost vs. price analysis
 - Price analysis
 - Utilisation
 - Cost of public vs. private delivery
 - Expenditure on healthcare : private vs public
- Access: population accessing private care
- Quality



National Health Reference Price List (NHRPL)

- Key points

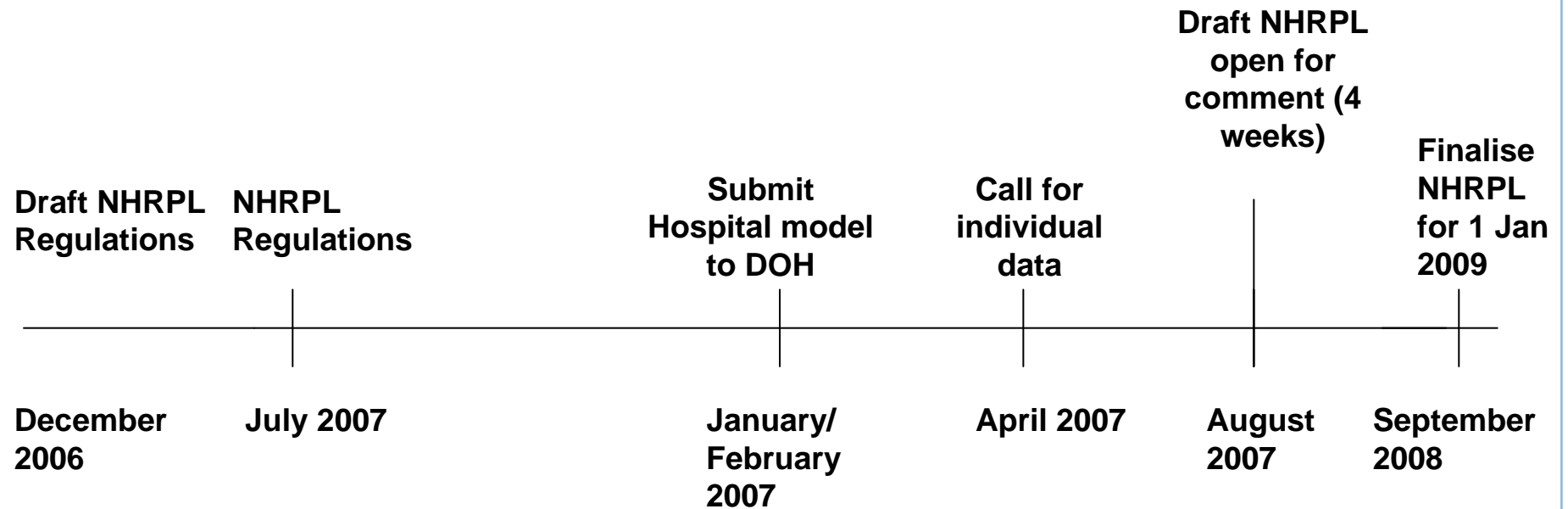
- Sec 90 (1) (v) is the enabling provision in the National Health Act 2003
- The primary purpose is the determination of the process
- Capacity for service providers to submit an appropriate model for approval

- Impact

- Independent analyst to build a hospital model for private industry (HASA). First phase:
 - 🚚 Hospital delivery model inclusive of all input costs
 - 🚚 Address how new technology will be objectively costed
 - 🚚 Address annual escalations logic
 - 🚚 Geographic cost differences, grade of facility (level of specialisation), etc
- Second phase being debated : Utilisation models
- Sustainability report



NHRPL time-line





Medical Scheme Amendment Bill

■ Key points

1. Provides for risk equalisation among schemes
2. To amend provisions relating to benefits provided by medical schemes
3. Previous pricing configurations based on income & number of dependants. This prohibits plans where prices vary on alternative provider contracts. Efficiency will be third leg of pricing configuration.
4. LIMS - variations to regulations relating to products which cater specifically for low income persons

■ Impact

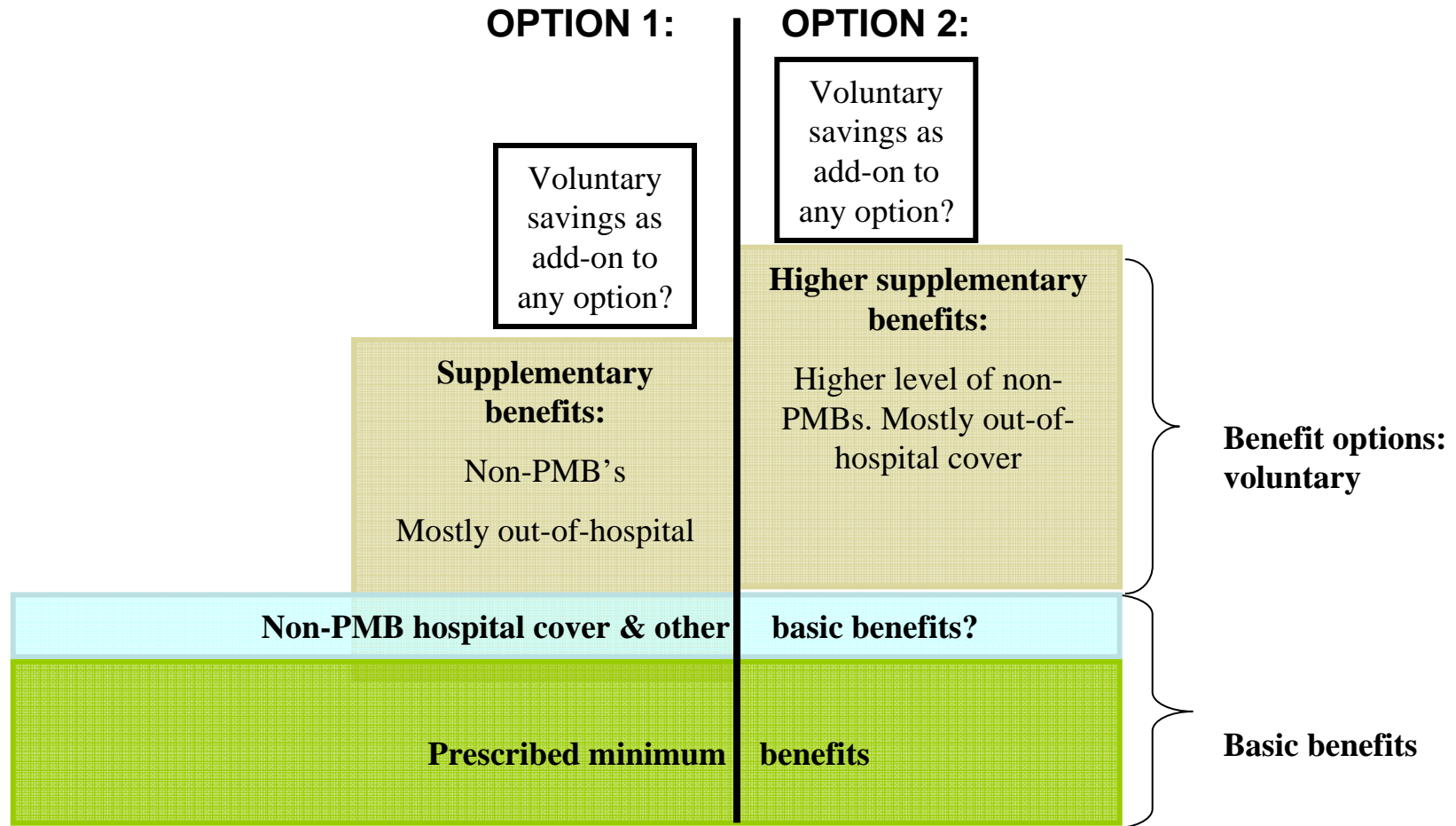
- Circular 8 :“Silo-type” benefit option framework no longer allowed.
 - 🚚 Common scheme benefits and buy-up for supplementary benefit options
 - 🚚 Should not vary in price except to account for different service provider contracts
 - 🚚 Foster the development of selective contracting between medical schemes and medical service providers.
- Netcare medical scheme will be a net contributor to the REF





Medical Schemes Amendment Bill

Move away from “silo structure” to “Circular 8 structure”:



Source: Deloitte & Touche





REF positives

- Enables growth of risk pool = increase access
- More uniformity across benefits. Can't arbitrarily deny benefits.
- Improve price competition among schemes.
- Reward those most efficient service providers

REF Negatives

- Schemes forced to compete on price alone
- Discourages funder competition

PMB positives

- Prevent transfers to public hospitals when benefits run out
- Provide benchmarks on what is covered & cost thereof

PMB Negatives

- Current PMB's focus on cure rather than prevention i.e. favours tertiary over primary treatment
- Impedes innovation in benefit design





International Benchmarking

■ Key points

- Benchmark against Spain, Australia, Canada, New Zealand
 - 🏠 Same geographical structure
 - 🏠 Presence of a single buyer in the form of Social Health Insurance

■ Impact

- Lower input costs
- “The use of countries with single buyer does not mean South Africa is going to go this route soon, it is an ideal situation to have, but only after a stable social health insurance has been introduced.” DOH 7 Nov 2006

■ Time Line

- Pricing committee hope to conclude end September 2007, publication still in this year.

	UK	SA
Suprane 240ml	£58.62	R1275.36
Isoflurane (Forane) 250ml	£10.00	R406.70
Sevoflurane (Ultane) 250ml	£98.40	R 1,832





Regulations: Quality assessment

- Private hospitals appear to rank well on quality measures (Monitor 2003)

“While the quality of Healthcare in the private sector may be perceived to be good, it is difficult to evaluate it intelligently in the absence of robust Health Quality Assurance systems in place. This matter is crucial when this perceived quality is used to justify the high cost.” MOH BHF 2007

- Ministry to establish :

1 **Inspectorate of Health Establishments**

- Sec 77 of NHA 2003: provincial inspectorate to monitor and evaluate compliance with the Act

2 **Office of Standards Compliance**

- Sec 78(2)(a) of NHA 2003 : Advise Minister on norms and standards of quality of health services.



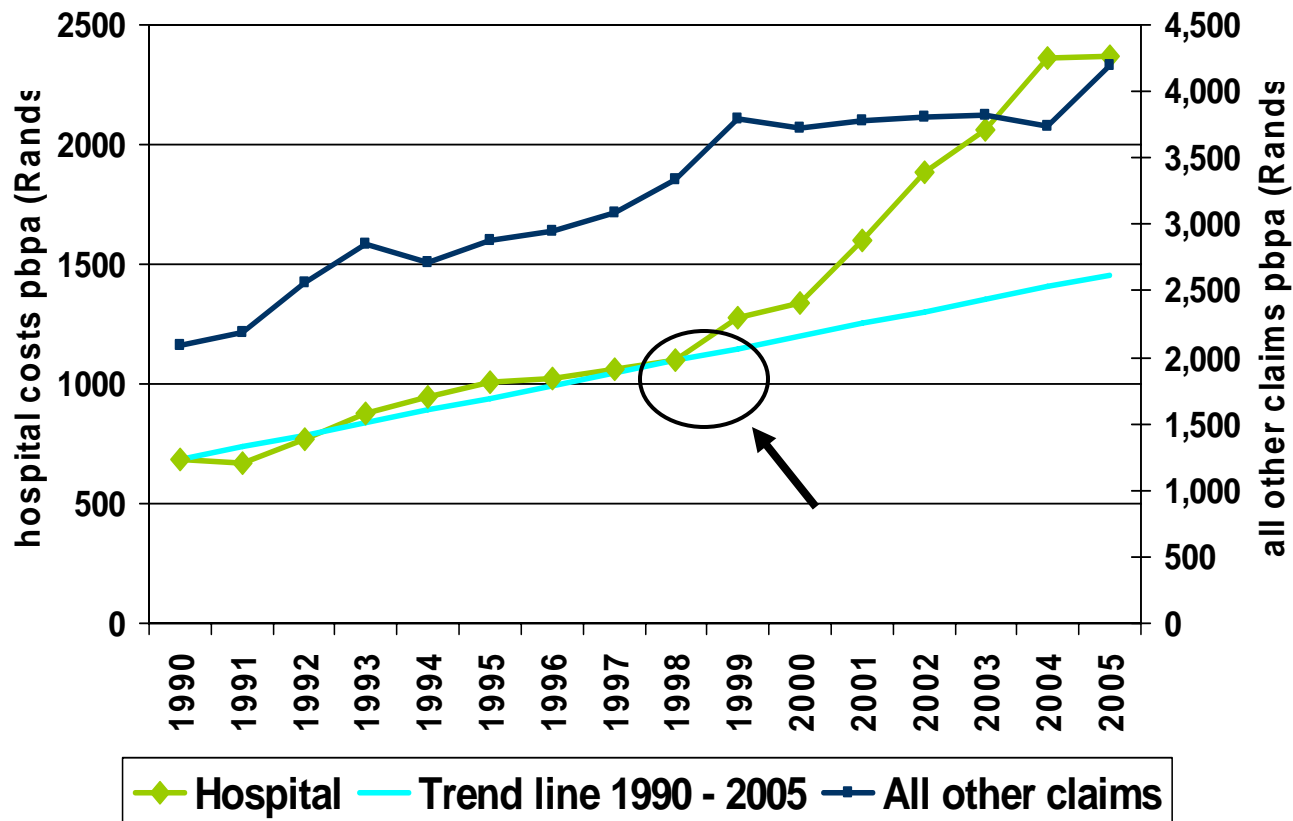


Cost versus price and Utilisation



Escalation in medical scheme expenditure on hospital care

Per capita hospital expenditure, in medical schemes: 1990-2005



Source: Alex van den Heever



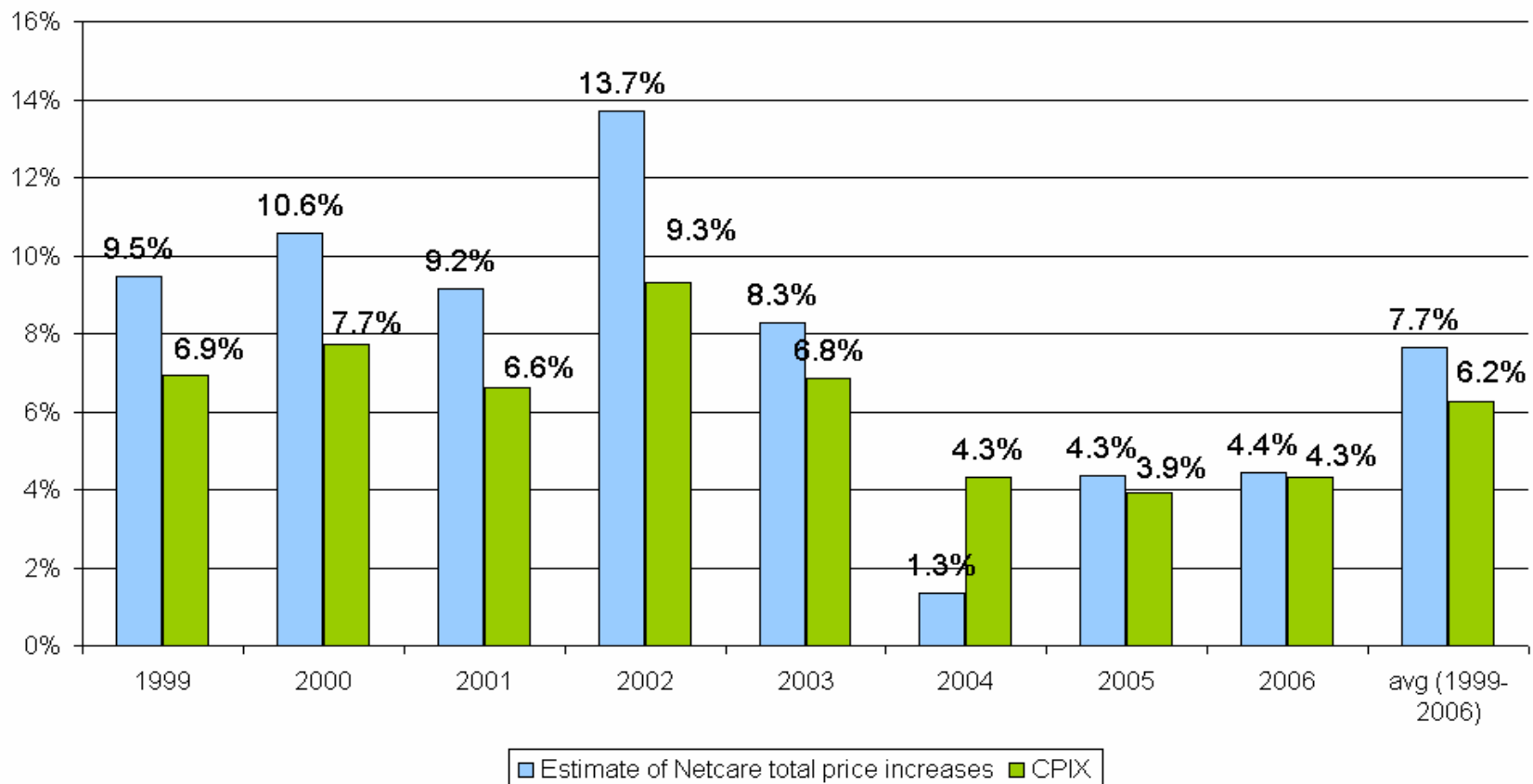
Potential drivers of total cost increases

- Price – ward, theatre & equipment
- Price – drugs, surgicals & consumables
- Utilisation - ward, theatre & equipment
- Utilisation - drugs, surgicals & consumables

Utilisation - increased admissions, change in case-mix, more chronic diseases, new technology, obesity, aging etc.

Price increases are not the obvious drivers of increased hospital expenditure

Total price increases vs. CPIX (1999-2006), 1.4% above CPIX



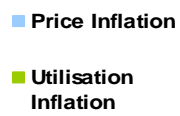
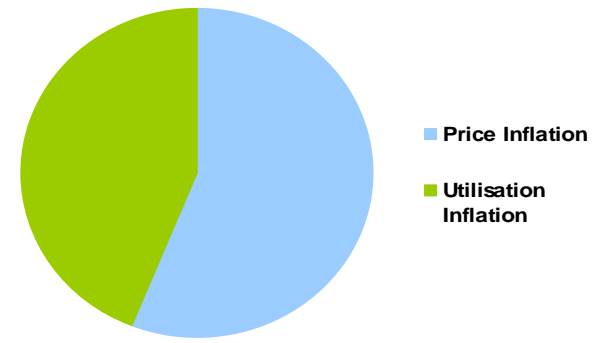
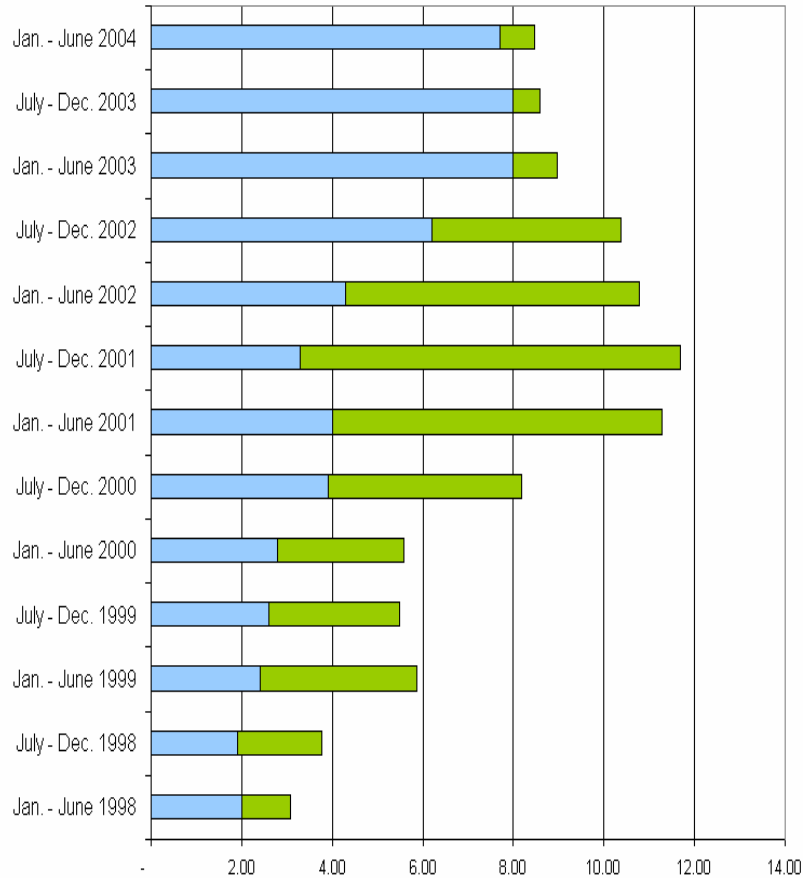
Actual vs. predicted expenditure reveals interesting utilisation trends

Year	Hospital Tariff Increase	Predicted Ward, Theatre & Equipment spend (price effect only)	Actual Ward, Theatre & Equipment Spend
1998			R 3,710,295
1999	8.0%	R 4,007,119	R 4,838,381
2000	7.5%	R 4,307,652	R 4,948,141
2001	6.0%	R 4,566,112	R 5,129,996
2002	7.0%	R 4,885,739	R 6,023,018
2003	9.8%	R 5,365,031	R 7,644,261
2004	9.7%	R 5,885,975	R 9,670,506
2005	7.1%	R 6,305,645	R 10,407,349

Source: CMS, BHF official increases 1998-2002, Netcare 2003-2005

	R'000	7 yr Compound Annual Growth
Predicted CMS spend on private hospital (ward, theatre & equipment) 2005	R 6,305,645	7.9%
CMS spend on private hospital (ward, theatre & equipment) 2005/6	R 10,407,349	15.9%
Increase in patient days and/ hospital resource	R 4,101,704	

USA: Hospital inflation drivers: 44% utilisation, 56% price



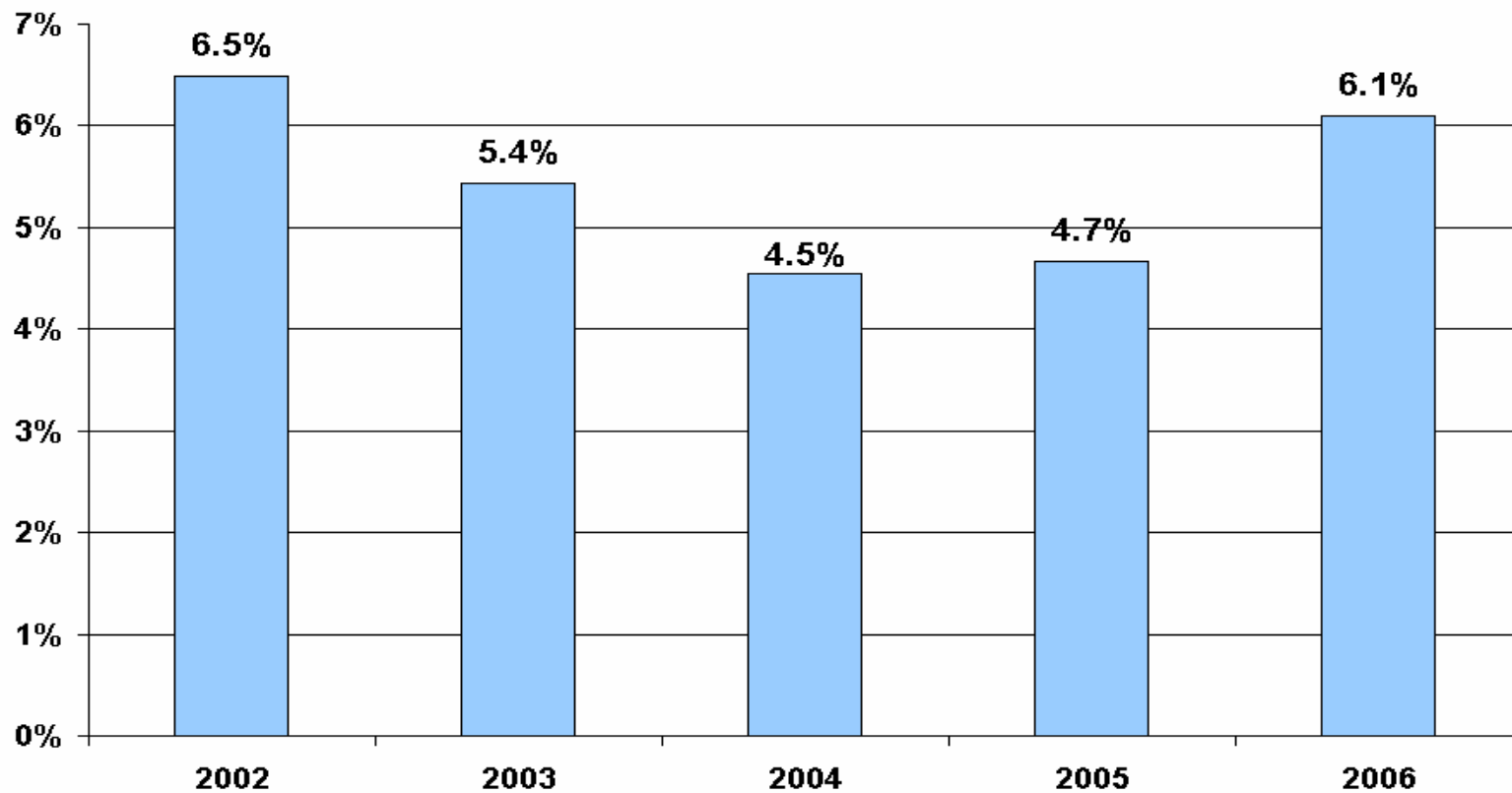
Sources: Data on hospital spending are from the Milliman Health Cost Index: both hospital inpatient & outpatient services. Data on hospital prices are from the Bureau of Labor Statistics





Growth in patient days of 27.2% in 2001-2005

Industry Growth in Patient Days, 27% growth (2001-2005)

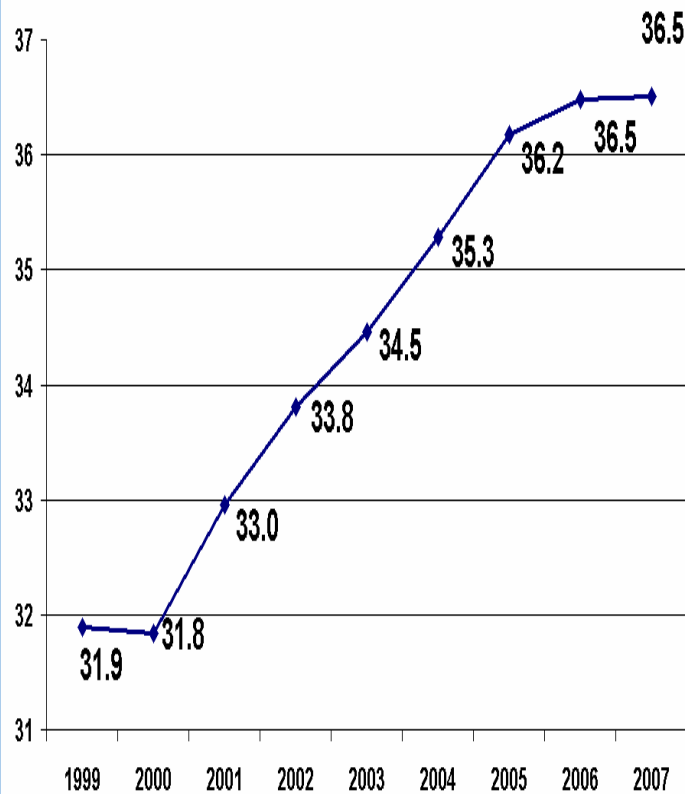


Source: Regional Business Analytics

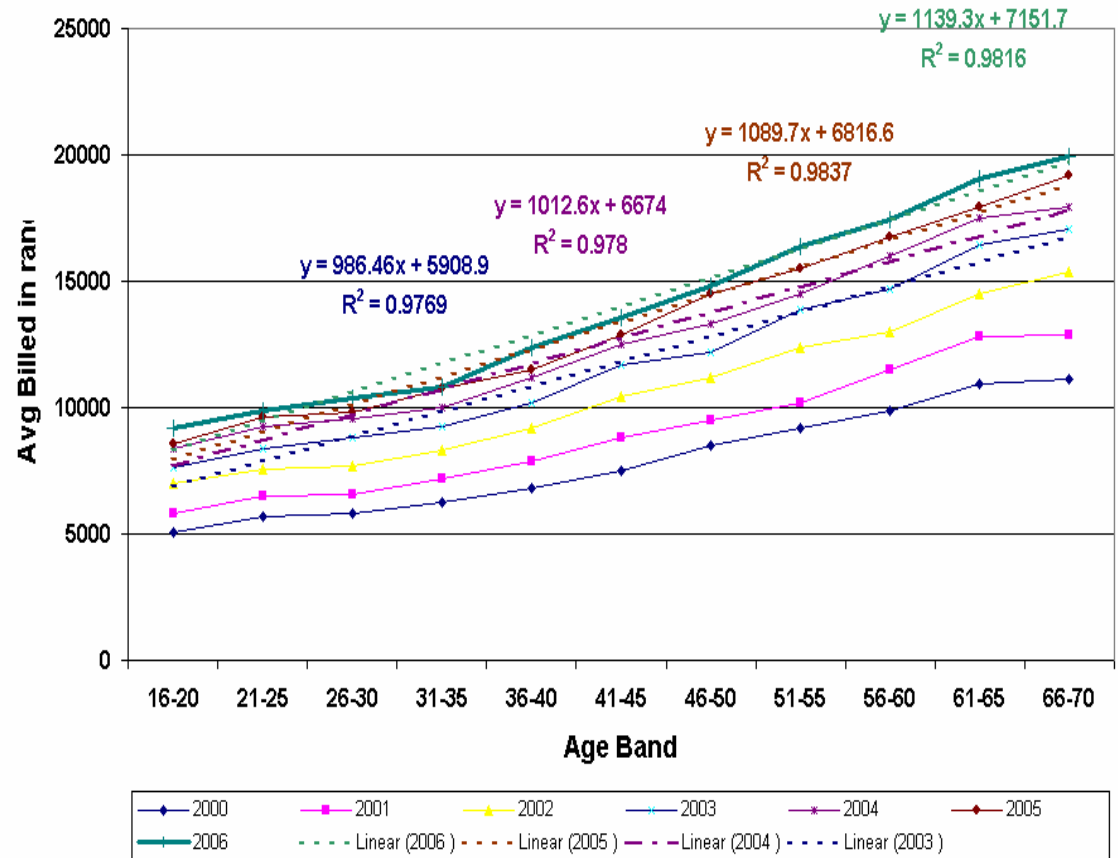


2001 - 2006 aging profile alone added R230m to top line

Discovery Health : average age of admission

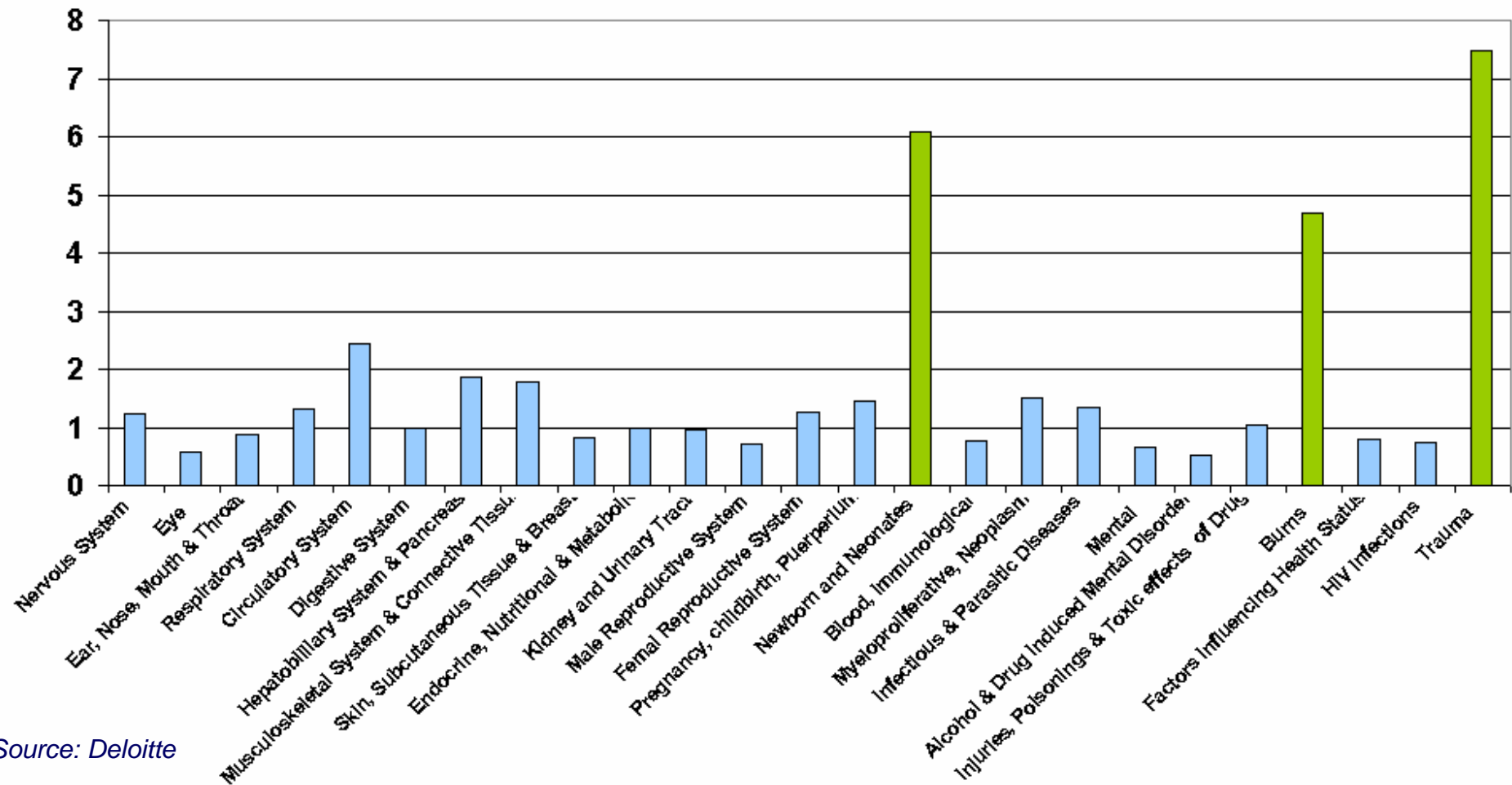


Average Billed vs Age Band



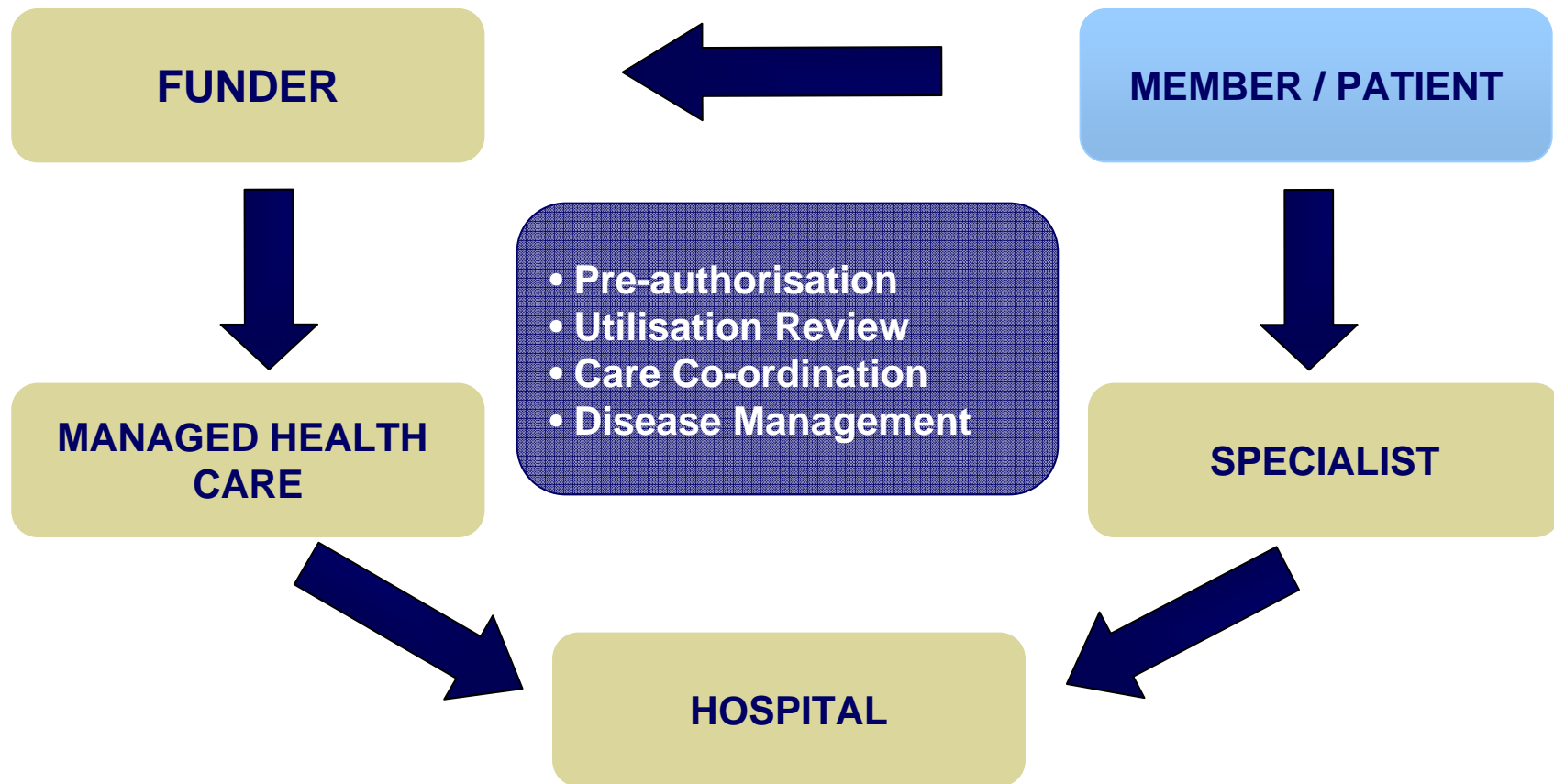
Change in nature of admissions : case-mix

Risk Factor Estimate by Major Disease Categories



Source: Deloitte

Managed Health Care: R3bn spent policing utilisation of health services





Population accessing private hospitals





In 2005 private hospitals catered for between 6.8m - 9.1m lives

2005		DISTRIBUTION OF FUNDING	POPULATION SERVED (EST.)
TOTAL TURNOVER IN PRIVATE HOSPITAL	R21,017,183,603		9,055,391
MEDICAL AID FUNDING	R15,863,749,000	75%	6,835,000
PRIVATE FUNDING	R5,153,434,603	25%	2,220,391

Source: HASA ; Stats SA





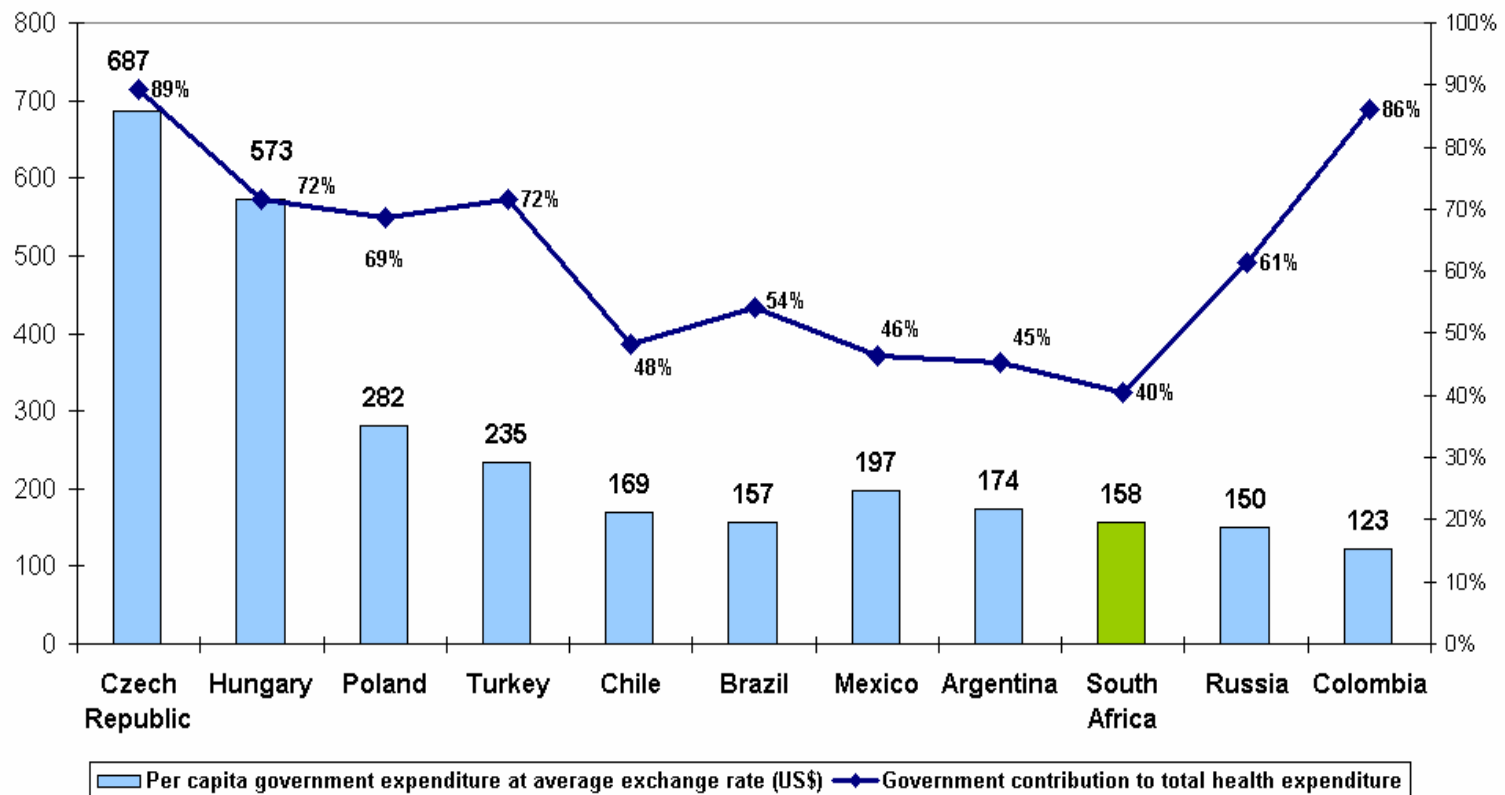
Public versus private expenditure





It is not uncommon to find high private financing of healthcare in developing countries

Per capita government expenditure on health in developing countries and government contribution to total (WHO 2004)

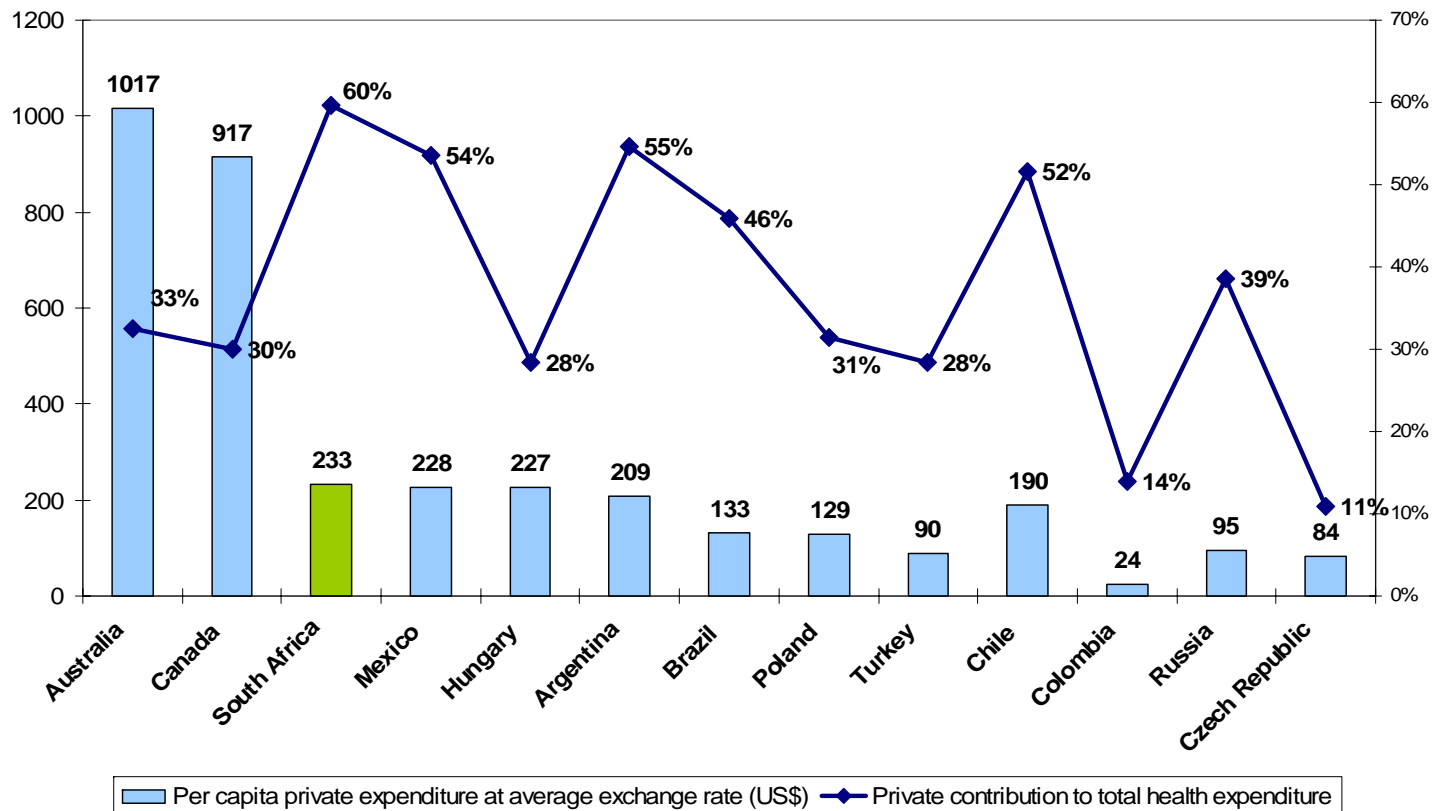


Source: WHO



SA private expenditure on par with similar GDP per capita countries

Per capita private expenditure on health and private financing contribution to total health expenditure

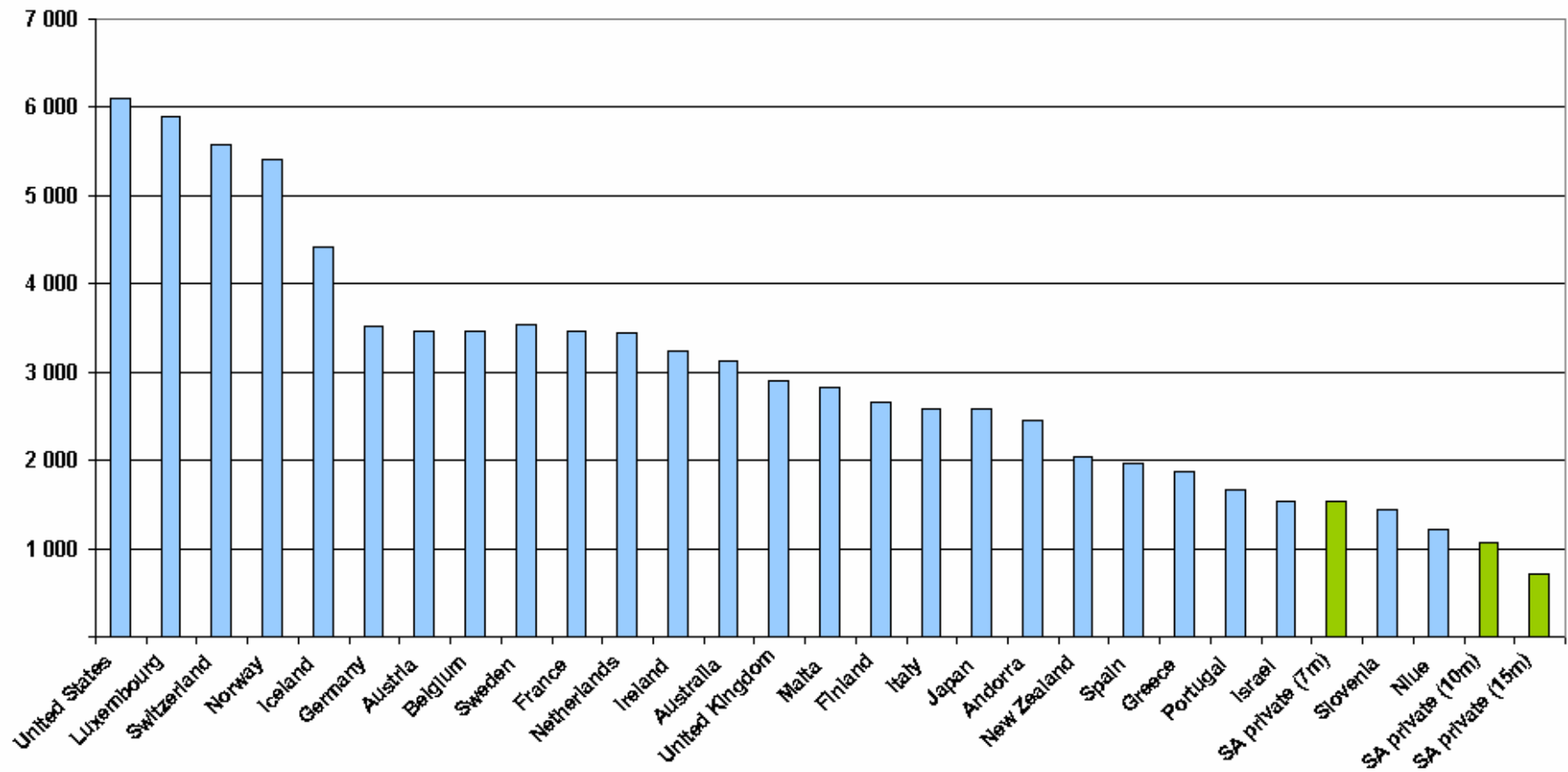


Source: WHO



Not a perfect system but indications of relative efficiency

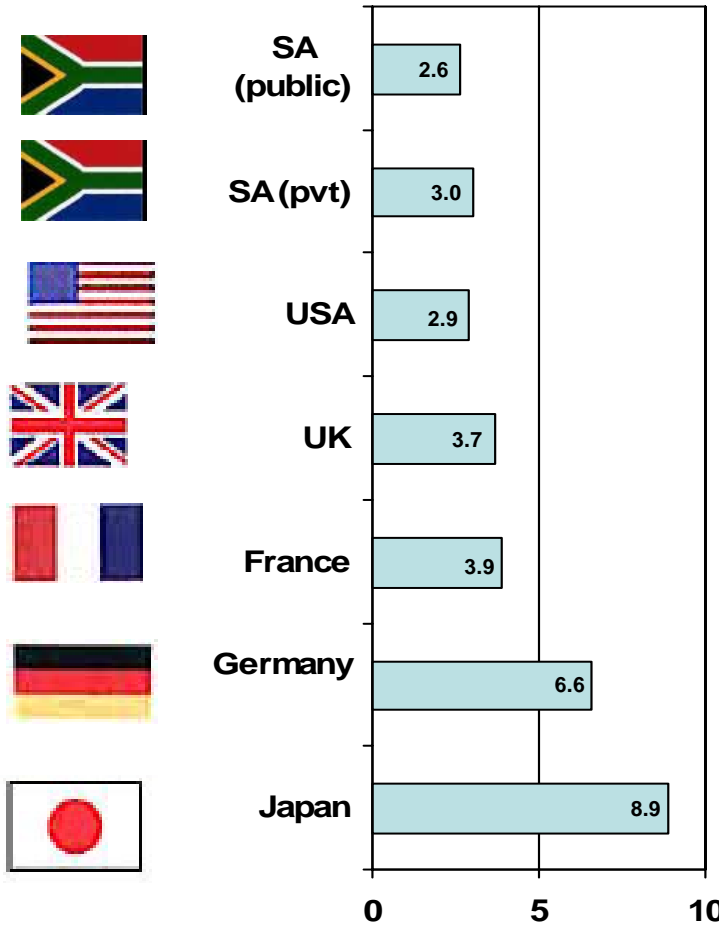
Per capita total expenditure on health at average exchange rate
(US\$)



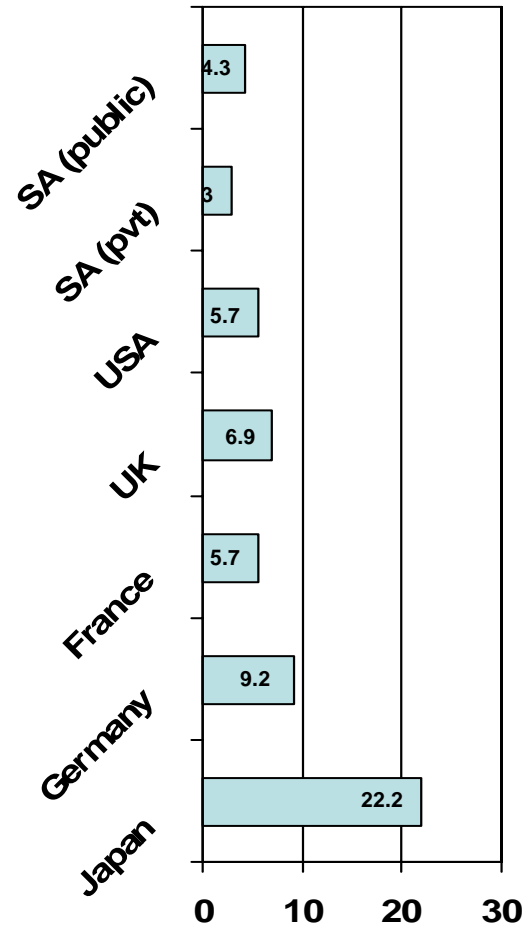


Hospital capacity versus efficiency

Acute care beds per 1000 pop. 2002 (SA: on 2006)



Average length of stay (ALOS)



Source: Mckinsey October 2006, SA ALOS HASA (based on all inpatient data)

