GAUTENG DEPARTMENT OF HEALTH

Submission to the Health Market Inquiry

8 March 2016
Outline of our submission

- Introduction
- Background on provincial health system (private and public sector services)
- Presentation of issues relating to hospital licensing and market entry in Gauteng
  - Enabling regulatory framework
  - Process for licensing private hospitals in Gauteng
- Licensing in Gauteng is permissive of market entry
- Concluding remarks
INTRODUCTION
SA’s performance on public healthcare

... SA spends 8.6% of GDP, countries left and above trend spend less but better performance relative to cost

Overall, South Africa getting poor performance relative to cost

Countries sitting above the trend line are producing relatively better performance for the cost per capita inputs that they are investing

Performance vs. Cost Comparison, 2008

... most critical health indicators are worse than those of comparable middle-low income countries that spend much less than 8% of GDP on healthcare (Christian, Crisp 2012)
Gini coefficient = 0.67; differential apportioning of resources vs. 68/100 use public facilities; real exp decreasing

- The slides summarises that public sector with more patients has the lowest number of health personnel.
- Gini coefficient for SA is on the high side as 0.67
Our private sector competes with well developed countries, whilst the public sector competes with its own peers of the developing countries. Making South African health system to look very divided and unequal.
The private health care sector in South Africa

Private health care is provided at a cost that few can afford. The cost of private health care is excessive and is increasing at significantly higher rates than the rate of inflation. Private health care is skewed in favour of very costly hospital care despite the burden of disease indicating that access to less costly primary health care services should be prioritised. The lack of pricing regulations which means users are overcharged and / or forced to make unaffordable out-of-pocket co-payments. Information failures that limit patients’ choice of medical scheme and contributes to users end up with inappropriate or insufficient health insurance – ex-gratia.
Health market inquiry

• We therefore welcome the Health Market Inquiry which seeks to reveal possible reasons for the high cost of private health care, identify whether anti-competitive behaviours exists within various private health care markets, and deduce how these behaviours may affect outcomes such as health care costs, access and affordability for consumers.

• We believe the HMI is timely given the prioritisation of universal health coverage as a national health system goal.
GDOH stewardship role

• As the GDOH, we believe we have a duty to exercise stewardship over the provincial health system – across both the private and public health care sectors.

• We jealously guard our duty as derived from Section 27(2) of the Constitution and reflected in R158.

• Hence we have made it our duty to put in place instruments that can guide us in our endeavour to promote fair distribution of health, accessibility, affordability, efficiency and effectiveness of the provincial health care system.
Our submission is grounded by our belief that

• Every person has the right to access affordable and accessible health care – as enshrined in section 27 of the constitution of SA.

• As part of its stewardship role, the GDOH endeavours to satisfy the Constitutional mandate of progressive realization of access to quality and affordable health care for the people of Gauteng.

• There is a financial burden that is inherent with provision of quality health care, but that it can be achieved without our citizens having to incur catastrophic financial expenditure.
Focus of our submission: licensing and market

• Broad issues raised during the HMI
• To what extent do licensing processes limit market entry of private facilities and equipment?
• To what extent provinces have provinces been or not been restrictive in allocating licenses?
• Some stakeholders: argue that
• Regulation is inappropriate and state involvement should cease so that the private sector is allowed to establish hospitals as determined by market forces.
• The licensing processes and criteria (the manner in which the processes are applied) are protracted, inefficient, and not transparent, which hampers market entry.
BACKGROUND
Gauteng province

- Mid-year population estimates by province, 2015

<table>
<thead>
<tr>
<th>Province</th>
<th>Population estimate</th>
<th>% of total population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Cape</td>
<td>6 916 200</td>
<td>12,6</td>
</tr>
<tr>
<td>Free State</td>
<td>2 817 900</td>
<td>5,1</td>
</tr>
<tr>
<td>Gauteng</td>
<td>13 200 300</td>
<td>24,0</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>10 919 100</td>
<td>19,9</td>
</tr>
<tr>
<td>Limpopo</td>
<td>5 726 800</td>
<td>10,4</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>4 283 900</td>
<td>7,8</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>1 185 600</td>
<td>2,2</td>
</tr>
<tr>
<td>North West</td>
<td>3 707 000</td>
<td>6,7</td>
</tr>
<tr>
<td>Western Cape</td>
<td>6 200 100</td>
<td>11,3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>54 956 900</strong></td>
<td><strong>100,0</strong></td>
</tr>
</tbody>
</table>
3 Metropolitan and 2 District Municipalities
Dual health care system in Gauteng

- Mirrors national picture:
  - Private sector
    - Caters for 28.2% of the population*
    - Funded through medical schemes, out-of-pocket payment
  - Public sector
    - Caters for 71.8% of the population (large uninsured population)*
    - Funded by government funding, minimal out-of-pocket payments (for hospital services)

Gauteng

- 28.2% of people in Gauteng have access to medical aid*
- 18.1% of the national population*

Medical scheme coverage by province: 2014

## Health service providers in Gauteng

### Private for-profit
- **Providers**
  - Independent practitioners
  - Hospitals: three major hospital groups
- **Others:** e.g. traditional health practitioners
- **Mostly curative services**

### Public sector
- **Provision by government (GDOH)**
  - Provincial and local government
- **Key service delivery platforms:**
  - District health services (DHS) – primary care
  - Hospital services
- **Promotive, preventive and curative services**

### Private not-for-profit
- **Main focus - specific issues (e.g. HIV) or groups (e.g. pregnant women)**
- **Preventive, some curative**
- **Advocacy and social mobilization**
Health service delivery platforms

District Health System

- District hospital
- Community health centres
- PHC clinics
- School health services
- Household (WBOTs)
- Private general practitioners
- Other private, incl. not-for-profits

Hospital Services

- Public sector hospitals:
  - Regional
  - Provincial/Tertiary
  - Central
  - Specialised

Private sector hospitals
## Public and private sector hospital BEDS: by district

<table>
<thead>
<tr>
<th>Approved hospitals</th>
<th>EKU</th>
<th>JHB</th>
<th>SED</th>
<th>TSH</th>
<th>W. RAND</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public sector</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>District</td>
<td>300</td>
<td>660</td>
<td>374</td>
<td>1156</td>
<td>475</td>
<td>2 965</td>
</tr>
<tr>
<td>Regional</td>
<td>2037</td>
<td>568</td>
<td>800</td>
<td>400</td>
<td>800</td>
<td>4 605</td>
</tr>
<tr>
<td>Tertiary</td>
<td>840</td>
<td>485</td>
<td>-</td>
<td>857</td>
<td>-</td>
<td>2 182</td>
</tr>
<tr>
<td>Central</td>
<td>-</td>
<td>3906</td>
<td>-</td>
<td>2484</td>
<td>-</td>
<td>6 390</td>
</tr>
<tr>
<td>Specialised</td>
<td>-</td>
<td>427</td>
<td>-</td>
<td>1444</td>
<td>820</td>
<td>2 691</td>
</tr>
<tr>
<td><strong>TOTAL PUBLIC</strong></td>
<td>3 177</td>
<td>6 046</td>
<td>1 174</td>
<td>6 341</td>
<td>2 095</td>
<td>18 833</td>
</tr>
<tr>
<td><strong>Private sector</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL PRIVATE</strong></td>
<td>3 188</td>
<td>6 150</td>
<td>994</td>
<td>4 898</td>
<td>1 046</td>
<td>16 276</td>
</tr>
</tbody>
</table>

* GDOH: Phase 1 Long Term Plan  
**GDOH Private Licensing Sub Directorate
PRIVATE HOSPITAL LICENSING AND MARKET ENTRY
Enabling legislative and policy instruments support the attainment of health care access for all

- Constitution of South Africa. Act 61 of 1996, Section 27 (2)
- National Health Act 61 of 2003
- R158 Regulations of 1980
- National Development Plan, 2012
- National Health Insurance White Paper, 2015
Licensing regulations

• The Regulations governing private hospitals and unattached operating theatres (No. R 158 of 1 February 1980) provides for provinces to license new private health establishments and approve extensions to existing facilities

• R158, Section 2:
  – *No person shall erect, establish, extend, conduct, maintain, manage, control or render any service in a private hospital or an unattached operating-theatre unit or permit or arrange for treatment to be provided therein unless such private hospital or unattached operating-theatre unit or proposed private hospital or unattached operating-theatre unit has been registered in accordance with the provisions of these regulations.*
Licensing regulations (cont’d)

• Regulation 158, Section 7 (1)
  – No person shall erect, alter, equip or in any other way prepare any premises for use as a private hospital or unattached operating-theatre unit without the prior approval in writing of the Head of Department.

• Regulation 158, Section 7 (2) (i)
  – Any person intending to establish a private hospital or an unattached operating-theatre unit shall first obtain permission in writing from the Head of Department, who, after consultation with the Director, shall satisfy himself as to the necessity or otherwise for such a private hospital or unattached operating-theatre unit before granting or refusing permission.
GDOH private hospital licensing process

- Private Licensing Directorate in the GDOH responsible for licensing:
  - All new private hospitals and extensions to existing already registered hospitals and
  - All private unattached theatre units.

- The Sub-Directorate (Administrative Office)
  - Receives and processes licensing applications
  - Co-ordinates the adjudication of licensing applications
  - Compiles and maintains information on the licensing process
  - Carries out prescribed inspections – in loco site
Applicant submits a letter of intent to the Private Licensing Directorate

Applicant is issued an application form and a tracking number

Applicant returns completed application form to the Licensing Directorate

Adjudication Committee assesses applications based on key considerations and makes recommendations to Head of Department (HOD)

The HOD makes a final determination.

The outcome of the application is communicated to the applicant

Successful applications undergo a further process (verification of the facility location, human resource, building plans)

Due process needs to take place for each application – this takes time.
Adjudicating applications: key considerations

- Residential growth and development in planned area of entry
- Indication of the insured population in the area – LSM and medical aid membership
- The promotion of equitable distribution of healthcare services
- Promoting the appropriate mix of public and private services
- Service demand
- Health need (epidemiological profile in the proposed area)
- Fair distribution of the proposed facility and relation to existing hospitals
- Demonstration of availability of human resources and training of health personnel
- Financial sustainability
Transparency

• At time of application, applicants are duly informed of:
  – The process of application
  – Required documentation needed in support of the application

• The key considerations are reflected on the application form as direct requests for information such as:
  – Population to be served
  – Epidemiological profile of catchment population

• Location of other private facilities in proposed location
  – Demand for services

• Post adjudication, applicants are duly informed of:
  – Success or failure of application and the main reasons thereof
  – Offered an alternative to appeal the outcome to the MEC
Rejection does not deem the process restrictive

Of 11 applications for new hospitals - adjudicated in 2014

<table>
<thead>
<tr>
<th>Reasons for approving (3)</th>
<th>Reasons for not approving (8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Planning to render services to an underserved area.</td>
<td>• The proposed hospital would be too close to existing hospitals within the same hospital group.</td>
</tr>
<tr>
<td>• Planning to render services in an area where the nearest hospital (different hospital group) has a high bed occupancy rate.</td>
<td>• The proposed hospital would be too close to other existing hospitals in another hospital group.</td>
</tr>
<tr>
<td>• Planning to cater to underserved health needs in the area.</td>
<td>• A lack of information to illustrate or indicate demand hospital.</td>
</tr>
<tr>
<td></td>
<td>• Previously approved facilities are uncompleted and applicants are seeking approval for new facilities.</td>
</tr>
</tbody>
</table>
Private hospital licensing in Gauteng: permissive rather than restrictive of market entry
Licensing has not limited market entry

- Arguments have been made that licensing restricts market entry of private hospitals
- Observations in Gauteng contradict this argument
- The number of private sector hospitals (and beds) has increased over the years in Gauteng
- The number of private sector beds is high relative to the population served (high bed density)
- The available private beds are not optimally utilised (suggesting demand is not as high as it is claimed)
Increasing number of private hospitals and hospital beds
Increase in number of private hospitals

Increasing number of private sector hospitals over the years in Gauteng:

– 2006: 95 hospitals
– 2015: 154 hospitals
– 2016: xx additional hospitals approved but not yet operational)

• Increasing number of private hospitals beds
No. of private sector general hospital beds in Gauteng: 2010 - 2014
No. of private sub-acute hospital beds in Gauteng: 2010 - 2014

No. of beds per facility ranges **from 4 to 42**

No. of private day hospital beds in Gauteng: 2010 - 2014

No. of beds per facility ranges **from 2 to 30**
Disproportionately high number of private hospital beds relative to the population served (bed density)
Hospital bed density

- No. of beds per given population
- A core indicator of bed availability (World Health Organization)
- No stipulated norms or targets due to variation in health systems and disease burdens amongst countries and regions

NDOH proposed bed density norms for acute (general) beds

<table>
<thead>
<tr>
<th>Hospital bed type</th>
<th>Bed density norms (No. of acute beds per 1000 people)</th>
</tr>
</thead>
<tbody>
<tr>
<td>District</td>
<td>0.66</td>
</tr>
<tr>
<td>Regional</td>
<td>0.33</td>
</tr>
<tr>
<td>Tertiary and</td>
<td>0.13</td>
</tr>
<tr>
<td>Central</td>
<td></td>
</tr>
</tbody>
</table>

All beds: 1.12
Bed density

• **South Africa:** bed density
  (including acute, sub-acute, specialised, and day beds, both public and private sector)

  = 2.8 beds per 1000 people

• **Gauteng:** bed density
  (including acute, sub-acute, specialised, and day beds, both public and private sector)

  = 2.5 beds per 1000 people
Gauteng: disproportionate number of hospital beds in the private sector relative to the population served
<table>
<thead>
<tr>
<th>Public health care sector</th>
<th>Private health care sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population covered*</td>
<td>Population covered*</td>
</tr>
<tr>
<td>9 771 580</td>
<td>3 297 772</td>
</tr>
<tr>
<td>TOTAL useable public beds**</td>
<td>TOTAL useable private beds***</td>
</tr>
<tr>
<td>16 359</td>
<td>16 081</td>
</tr>
<tr>
<td><strong>Bed density</strong> (number of beds per 1000 <em>uninsured people</em>)</td>
<td><strong>Bed density</strong> (number of beds per 1000 <em>insured people</em>)</td>
</tr>
<tr>
<td>1.7</td>
<td>4.9</td>
</tr>
</tbody>
</table>
This means

• The availability of hospital beds is significantly higher in the private than the public sector
  – The ratio of uninsured to insured people in Gauteng is 75:25

• The ratio of public to private hospital beds in Gauteng should be 75:25 but is 50:50
• Expansion over the years has been in the metropolitan areas, in wealthier suburbs

• There has been limited expansion into previously-disadvantaged areas despite the potential users of private hospitals in these areas (e.g. increasing number on GEMS)

• Many of the recent approvals (planned new hospitals) are concentrated in areas that already have a high concentration of private beds
The arrows in the map below show the concentration of private beds in the Gauteng's affluent areas

- Arrow 1 – Pretoria East
- Arrow 2 - Centurion
- Arrow 2- Sandton & Midrand
- Arrow 3 – Johannesburg
- Arrow 4- Kempton
Sub-optimal utilisation of the available private hospital beds
Private general hospitals in Gauteng - median bed occupancy rates (BOR): 2010 - 2014

- **Minimum**
  - 2010: 15%
  - 2011: 16%
  - 2012: 9%
  - 2013: 13%
  - 2014: 10%

- **Maximum**
  - 2010: 99%
  - 2011: 96%
  - 2012: 95%
  - 2013: 92%
  - 2014: 89%
Private sector general hospitals: 2014

Bed Occupancy Rate

% of hospitals (N=85)

- <31%: 3.5%
- 31% - 40%: 8.2%
- 41% - 50%: 11.8%
- 51% - 60%: 14.1%
- 61% - 70%: 31.8%
- 71% - 80%: 27.1%
- 81% - 90%: 3.5%
32 of 85 hospitals (37.6%) have bed occupancy rates below 60%
20 hospitals (23.5%) have bed occupancy rates below 50%
SUMMARY
Summary:

• the granting of licenses in Gauteng has not been restrictive enough
  – As evidenced by:
    – Oversupply of private health care beds
    – Steady increase over the years with no real proof of matched demand
    – Hospitals have low bed occupancy rates which indicate underutilization
• Begs the question: Is there real demand for private hospital beds, or is this supplier-induced demand?
• Hospital beds concentrated in geographical areas with high population incomes and bed densities
• Suggests that: The licensing framework should but has not adequately regulated the profit-driven conduct of hospitals
CONCLUDING REMARKS
Conclusion

• The Gauteng health system has suffered unintended consequences of less stringent application of the licensing regulatory framework.

• Skewed distribution of private facilities and their concentration in affluent areas (due to non consideration of residential planning and fair distribution requirements)

• Under-utilisation of existing facilities (due to non consideration of the service demand requirements)

• RWOPs issue. Maldistribution of specialists between sectors (due to insufficient attention to HR implications of licensing new private hospitals)
• The GDOH recognises the rights of the private health sector to freely trade, but effective regulation is imperative if the right to health care is to be realized.

• We believe the work of the HMI will contribute to a better understanding of the problems relating to private sector regulation in Gauteng and the country as a whole.

• We anticipate the findings of the HMI will have particular relevance for the Gauteng provincial health system which has the largest private health sector in the country.
THANK YOU