NEWS

EMPLOYERS SHOW CONTINUED CONCERN ON HEALTH CARE

The control of health care costs continues to be one of the most important issues facing employers, with concern about the ongoing affordability to both themselves and their employees of the continuing escalating contributions well above inflation rate, Old Mutual's 2005 Healthcare Survey has found. Of the companies surveyed, 69% now have a documented health care strategy in place, compared with 20% in 2003. In addition with the impact of HIV/AIDS perceived as the main driver of health care costs, 71% of the companies have documented their HIV/AIDS strategy and a further 8% say they will do so within the next 12 months.

Of almost equal concern, with the current focus on a social health insurance (SHI) and the need for greater coverage of low-income employees, is the need to bring all employees onto a health plan. While all 100 employers surveyed say that they want to play a part in the process of transformation and in the decisions that affect both employer and employees, 62% say they do not understand the impact of the SHI on the health care industry and that they would like more information on its roll-out and that of other initiatives aimed at transforming the industry. Nevertheless 82% believe that employers should subsidise employee health care costs in the new SHI environment, although they are not willing to pay more than the total amount that they currently contribute in subsidies for employee health care.

The risk equalisation fund (REF) also raises a number of issues for employers and it is clear that there is a lack of understanding as to how the REF will help to equalise contributions across the industry. The overriding concern voiced is the belief that schemes will decrease their risk management interventions as they perceive that there is less incentive to manage risk. Another concern is that there is nothing in place to limit chronic medicine utilisation. Employers also believe that the REF will impact negatively on the wealth and morale of schemes that manage risk well.

Pensioner prefunding is also of some concern and 42% of the employers surveyed provide no post-retirement health care funding. Unless the cost of health care inside medical schemes can become more affordable it is unlikely that the average pensioner will be able to self-fund the full contribution.

The other major issue is member education and it would appear that employers have recognised the need, in an ever-changing and increasingly complex health care environment, for ongoing information and communication. It is also an area where much guidance is sought by employers, including professional advice from consultants, brokers and others.

In order to make the results meaningful across a broad range of companies, the survey targeted a random sample of employers in the private, parastatal and public sectors, with the primary focus on larger employer groups (more than 200 employees) and including a sample of small-medium enterprises (SMEs, 50 - 200 employees).

BROADENING EDUCATION FOR MEDICAL STUDENTS

Medical training at South African universities may be of world standard, but medical students will benefit from more on-the-job experience, two recently launched initiatives suggest.

Hospital experience

One of these is a partnership between the University of Pretoria (UP) and Netcare, which will allow students to work in Netcare private hospitals as well as public community clinics in order to gain practical and relevant experience. The initiative is aimed not only at health science students but will include engineering, nursing, education and business management students.

Speaking at the launch of the initiative, Professor Callie Pistorius, vice chancellor and principal of the University of Pretoria, said that it adds a 'whole new dimension' to the education of students at the university and would provide health science and other students with an important 'bridge' between their studies and the world of work. Hospitals also require clinical and mechanical engineers, nurses, and educators, Pistorius noted, adding that private hospitals have to run as businesses and therefore also require business management.

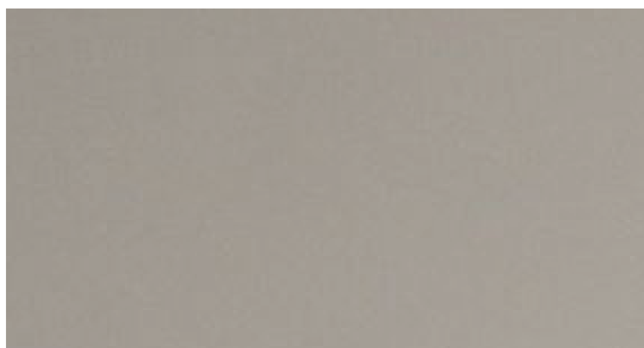
As part of the agreement, Netcare also has made a R250 000 donation to the university that will be used to create a lecturing post in the community health department.

Hellfire internship programme

Hellfire, an internship programme for promising graduate scientists, was launched by bioindustry incubator Acorn Technologies in September 2005 with R8 million earmarked to fund the project over 3 years.

The brainchild of Acorn, CEO Dr Peter Breitenbach, said the Hellfire programme will promote 'innovation through internship' by placing scientists in working positions at life science businesses for 1 year on a full-time basis. During that time they will be given dedicated mentorship and on-the-job training and they will complete extensive leadership and personal skills development with Cape-based Learn to Lead as well as technical and business training through Wits Business School's MBA-accredited Management Advanced Programme. The aim of the programme is to promote skills development, job creation, entrepreneurship, life science innovation and technology transfer from research bases to the marketplace.

'There is a huge demand for management candidates in the life science arena, but a chronic shortage of suitably skilled human capital,' says Breitenbach. 'Through Hellfire, we believe



The first intake of Hellfire interns at the project's launch in Cape Town.

we can develop a reliable feeder market of first-rate management material.'

In the initial phase Acorn has selected 15 interns from over 200 applicants and has based them at 12 different Western Cape-based institutions and firms, including Stellenbosch University, the Medical Research Council, Biovac Institute, Genecare Molecular Genetics, Vision Biotech and Synexa Life Sciences.

Hellfire is co-funded by the Godisa programme, an initiative of the departments of Science and Technology and Trade and Industry.

Emma Buchanan and Jonathan Spencer Jones

SA PRIVATE HEALTH CARE CHEAPER THAN USA AND AUSTRALIA

The cost of private hospital health care in South Africa is up to 50% less than in the USA and Australia, while the average length of stay (LOS) for patients is similar to, if not less than in these countries, a comparative analysis across a variety of medical procedures recently conducted by the Hospital Association of South Africa (HASA) has found (Table I).

For example, the average combined cost of ward and theatre fees, drugs and surgical equipment for an uncomplicated caesarean section in a private hospital in South Africa is almost half of the cost in Australia and a quarter of that in the USA. Where complications arise, the overall cost of a caesarean section in a private South African hospital drops to 49% of that in Australia and just 19% of that in the USA. Likewise, the cost of a colonoscopy in a private South African hospital is one-third less than the cost of the identical procedure in Australia and approximately 30% of the cost in the USA, while a tonsillectomy costs approximately 58% less than in Australia and less than 10% of the cost levied in the USA. A big-ticket elective procedure such as a hip replacement is considerably less costly, coming in at 77% of the cost in Australia and 58% of that in the USA (and 79% and 46% respectively if the procedure is complicated). A vasectomy, on the other hand, costs just 10% of the cost in the USA.

Table I. Average hospitalisation costs for benchmark procedures in the USA, Australia and South Africa (Aus$ = R5.00; US$ = R6.00; exchange rates at the time of the research)

	USA		Australia		South Africa
Procedure	**US$**	**Rand**	**Aus$**	**Rand**	**Rand**
Caesarean section	9 767	58 602	5 889	29 445	15 431
Caesarean section with CC	12 710	76 260	6 061	30 305	14 853
Colonoscopy	1 960	11 760	1 061	5 305	3 548
Hip replacement	19 358	116 148	17 382	86 910	67 087
Hip replacement with CC	26 800	160 800	18 644	93 220	73 553
Tonsillectomy (over age 17)	8 287	49 722	1 668	8 340	4 845
Tonsillectomy (below age 17)	7 736	46 416	1 668	8 340	4 428
Vasectomy	6 650	39 900	-	-	3 883

Table II. Average length of stay (days) for benchmark procedures in the USA, Australia and South Africa

Procedure	USA	Australia	South Africa
Caesarean section	3.4	5.9	4.0
Caesarean section with CC	4.4	6.1	4.0
Colonoscopy	2.5	0.6	1.0
Hip replacement	4.6	9.5	5.6
Hip replacement with CC	6.9	12.5	8.2
Tonsillectomy (over age 17)	1.9	1.7	1.0
Tonsillectomy (below age 17)	1.8	1.7	1.0

Length of stay

The average length of stay (LOS) for these procedures in South Africa is significantly lower than in Australia and very much on a par with those in the USA (Table II).

For example, the average LOS for an uncomplicated caesarean section is 4 days in a private hospital in South Africa, compared with 3.4 days in the USA and 5.9 days in Australia. Patients who undergo a straightforward hip replacement in South Africa's private hospitals spend an average of 5.6 days in hospital, while the LOS for the identical procedure in the USA and Australia is 4.6 and 9.5 days, respectively.

Advocate Kurt Worrall-Clare, acting CEO of the HASA, says that these figures show the application of world-class medicine, leading-edge medical technology and solid hospital management expertise in South Africa's private hospitals translates into real value-for-money health care and they confirm the high levels of effective managed care in this sector.

TOWARDS DIAGNOSES-RELATED GROUPS

Diagnoses-related groups (DRGs) and 'casemix' are commonly used in some parts of the world, and discussions are now under way about introducing them into South Africa.

'We've been working with DRGs for the past three or four years and found them to be very interesting,' says Dr Warrick Sive, group medical advisor at Life Healthcare, which organised a recent workshop at which DRGs were introduced to the wider medical community.

A DRG is a patient classification scheme that provides a means of relating the type of inpatients a hospital treats (i.e. its 'casemix') to the costs incurred by the hospital – or put another way, a method of classifying hospital inpatients into groups which have comparable clinical profiles and use similar resources. The concept was first mooted as far back as 1913 but started to be investigated seriously only in the 1960s by a team from Yale University. DRGs were formally introduced in the USA in 1983. Subsequently they have been taken up elsewhere, notably in the UK, Europe, Australasia and the Middle East, with some countries adapting one of the US versions and others developing their own systems.

The reasoning underlying the DRG concept is that if the hospital understands the types of patients that it treats and the costs of providing that care, it is enabled to introduce clinically sound strategies to manage costs in cooperation with the treating doctors. Critical to this process, however, is the maintenance of quality, thereby improving efficiency and allowing greater access to health care through a more rational use of available resources.

DRGs are based on primary diagnostic codes (ICD10 in South Africa) to group patients in a manner that makes clinical sense in terms of the presenting pathology. The groups are then further refined using procedure codes (in South Africa CPT4 currently) and further ICD10 codes to stratify the patients according to comorbidities and complications (CCs). For example, in the Australian model, ADRG R60 (acute leukaemia) is coded into:

- R60A: Acute leukaemia with catastrophic CCs (cost weight: 11.84)
- R60B: Acute leukaemia with severe CCs (cost weight: 4.29)
- R60C: Acute leukaemia without catastrophic or severe CCs (cost weight: 1.70).

Note also that each DRG has a cost weight, which reflects its relative costliness.

Sive explains that Life Healthcare has been using DRGs for billing purposes, but their true value is as a clinical tool for use in costing and quality management. Thus DRGs may be used by hospitals for quality assurance internally or for comparing hospitals, either against one another or against some other measure such as a national average.

Participants in the recent DRG workshop, from left front: Lizzi Mahlangu, Department of Health, Dr Boshoff Steenekamp, CMS, and Professor Beth Reid, University of Sydney; rear: Dr Warrick Sive, Life Healthcare, Luisa Whitelaw, Discovery, and Miriam Cassim, Department of Health.

DRGs also may be used as a funding 'tariff', as in the US, Europe, Singapore and Australia, enabling funders (including governments) to pay for outcomes rather than inputs – the challenge then shifting onto the provider to deliver those outcomes at an agreed cost. A further advantage for a public health sector is that the state is placed in a position to implement policy decisions by translating them into prospective payments for the types of service the policy demands. Thus instead of a global budget, state hospitals can be funded in terms of what they are required to produce, rather than on the basis of what they cost, irrespective of outputs.

Sive says Life Healthcare's experience has been that it is 'a long road' to properly understand DRGs, but that they are proving to be potentially very useful. One hurdle in their introduction is the demand for rich coding information and Life Healthcare has facilitated the development of a DRG knowledge base. However he notes that if they are to be useful at national level, rather than just internally, for benchmarking across hospitals, groups and sectors (private and public), then a nationally accepted standard will have to be determined that all groups will use. But therein lies a significant problem as the ICD10/CPT4 DRG grouper system is not to be maintained internationally, with South Africa the only country to use CPT4 for hospital coding together with ICD10. This then raises the hard question of which procedure coding system should ultimately be used for clinical grouping and management of hospital activity in South Africa.

Looking forward, Sive says there is a subcommittee on DRGs of the private health information systems committee (PHISC) which is discussing their potential use and issues such as coding implications. However the views of the national department of health will of course ultimately drive any national standardisation process.

Information for this article was drawn from presentation materials by Professor Beth Reid, Faculty of Health Sciences, University of Sydney, who was the keynote speaker at Life Healthcare's DRG workshop.