Private Hospital Review 2008

Examination of factors impacting on private hospitals
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CHAPTER 1

EXECUTIVE SUMMARY

1. Introduction

The Hospital Task Group respectfully submits this document for review and consideration by the Honourable Minister of Health and all stakeholders in South African healthcare.

This document has been compiled by the Hospital Task Group (HTG), a representative body of the private hospital sector established by the Hospital Association of South Africa (HASA). Our mandate has been to coordinate credible information and develop a well substantiated, unified response on behalf of the private hospital sector, to issues raised during the Minister’s Private Health Sector Indaba and in other forums.

The private hospital sector’s recognition of healthcare as a primary enabler of socio-economic progress both for individuals and for our country as a whole, and the critical importance of broadening access to affordable quality healthcare informs all aspects of this submission. Our commitment to finding effective, equitable and viable solutions to fast-tracking the delivery of these imperatives is also reflected throughout.

The information contained in this report has been compiled and is presented in a spirit of constructive engagement. It represents a sincere attempt to resolve issues and concerns so that the sector as a whole can move forward to meet its very real challenges. We have made specific reference to the arguments of certain stakeholders that, in our view, lack accuracy or sound foundation, and we issue a call for all relevant stakeholders to develop and agree on standardised definitions and measurements with which to evaluate the private hospital sector.

We understand that the issues that currently characterise the healthcare debate can be contentious, and we welcome constructive discourse. However, it is our contention that if inaccuracies and unsubstantiated accusations continue to characterise the debate, and if sweeping statements are made to an already confused and polarised public, we will diminish our ability to cooperate effectively in designing and maintaining a sustainable system to meet the healthcare needs of the South African people.

Please note that references in this document in the first person, including “we” and “our”, refer to the HTG and the private hospital sector. Also, the terms “funder” and “medical scheme” are used interchangeably.

2. Broad Issues and Concerns

One of the key concerns in South African healthcare is inequity in service delivery, funding and lack of access to adequate, quality healthcare. The challenges facing the local healthcare sector are not unique. The fundamental problem, where the cost of private healthcare cover continually outstrips general salary inflation, is a worldwide phenomenon. While the issue of affordability remains a critical healthcare issue throughout the world, it is particularly pertinent in developing countries.

Delivering on expectations of affordability within South African healthcare will require innovative programmes and partnerships that are founded on both patient need and economic sustainability. We cannot afford to place the sustainability of the healthcare sector at risk. The challenge therefore, is to meet this need through effective partnerships that share and optimise resources.

3. Differentiating Sector Characteristics

The healthcare sector has a number of features that differentiate it from other sectors in terms of how consumers measure cost versus benefit received in healthcare services or products.

3.1 The presence of a third party payer

In most instances, healthcare consumers do not pay directly for the services they utilise. Rather, healthcare tends to be funded indirectly via tax, insurance premiums or medical scheme contributions. Consumers are largely insulated from the true cost of healthcare and, as a result, the incentive to manage their utilisation of healthcare services is not encouraged.
3. Differentiating Sector Characteristics (continued)

3.2 Emotion drives healthcare decisions

It is widely acknowledged that patients’ decisions regarding the utilisation of healthcare services are primarily driven by their emotions and the desire to be healed at any cost. Healthcare treatments and interventions are often associated with a great deal of fear and uncertainty, and often a patient is unable to apply rational decision-making.

These factors impact directly on the utilisation of healthcare services, of which hospitalisation is the largest component, accounting for approximately a third of total medical scheme expenditure, due to the resource intensive nature of hospital services and associated infrastructure.

4. The Role of the Private Hospital Sector

The private hospital sector plays a substantial strategic role in South African healthcare and is fundamental to the delivery of healthcare services: treating approximately 3 million patients a year with over 1,5 million being in-hospital admissions.

An effective private hospital sector makes an important contribution by addressing the healthcare needs of the country’s employed population. To this end, the case for maintaining a strong private hospital sector aligns with Government’s policy objective of alleviating pressure on the State, enabling it to concentrate its efforts on treating patients who depend on it for their medical requirements.

5. Synopsis of Responses

In responding to various stakeholder concerns, we have consolidated these into themes, reflected in the different Chapters which are presented as self-contained responses to specific issues. However, considerable interdependency exists between the Chapters, reflecting the complex inter-related nature of the issues facing the healthcare sector.

Chapter 2, Public versus Private Expenditure, reviews national and international patterns of expenditure on health, and argues that South African trends are not unique. It goes on to caution against superficial comparisons between public and private healthcare expenditure. It further concludes that on the basis of expenditure per capita South Africa does not rank well against international benchmarks and that high private funding of healthcare is not uncommon in developing countries.

Chapter 3, Access and Affordability, discusses these key issues in the context of the private hospital sector’s acknowledgement of its role in making healthcare accessible to all South Africans. It tables four ways in which improved access to hospital services can be achieved in the context of both the private and public sector. It further outlines effective reform to facilitate cheaper delivery of hospital services.

Chapter 4, Council for Medical Schemes: Definitions and Reporting Measures, outlines the private hospital sector’s concern that a lack of agreed measurement standards and credible analysis exists within the sector, giving rise to misrepresentations and misunderstandings that hamper efforts to develop solutions to the problems facing the sector. We argue that effective reforms will be enabled by widely-accepted, accurate healthcare data measurement procedures and definitions.

Chapter 5, Medical Scheme Expenditure on Private Hospitals, explores the drivers of rising hospital-related spending by medical schemes. We draw attention to this as a global phenomenon and go on to demonstrate that increased utilisation, affected by factors such as case-mix, length of stay, level of care and a gradually ageing medical scheme population, amongst others, are significant drivers of expenditure increases.

Chapter 6, Transparent Pricing, provides context to the long-standing commitment of the private hospital sector to developing transparent pricing models, and outlines the interactions between HASA and RAMS (Representative Association of Medical Schemes), now the Board of Healthcare Funders, that have taken place with regard to this development. The private hospital sector is committed to the NHRPL cost benchmark process.

Chapter 7, Alternative Reimbursement Methodology, provides an overview of Alternative Reimbursement Models and their current and future application in the private hospital sector. We argue that there is a place for the Fee for Service model in certain respects, as not all services can be effectively delivered in alternative formats. We also demonstrate that Alternative Reimbursement Models are already being applied within the private healthcare sector, but warn against their use as a stand-alone solution to the complex problem of delivering affordable quality healthcare. We argue that in addition to this, special consideration should be given to the position of the independent hospitals.
Chapter 8, *Impact of New Health Technologies*, addresses the issue of technology as a driver of escalating health costs. We argue that the introduction and adoption of technological advancements in healthcare are influenced more by the healthcare funding industry’s policies and controls than demographic trends and inflation. We also point to the unfortunate tendency to focus exclusively on increases in per person spending on healthcare, rather than on the broader benefits of improved healthcare that new health technologies make possible.

Chapter 9, *Countervailing Power of Medical Schemes*, addresses concerns raised regarding bargaining power imbalances between the private hospital sector and the medical scheme industry. We contend that the sector has no specific advantage in negotiations, and challenge the Board of Healthcare Funders’ application for a collective bargaining process as counter-effective.

Chapter 10, *Private Hospital Sector Capacity and Occupancy Levels*, clarifies definitions and constraints in respect of capacity within private hospitals.

Chapter 11, *Quality of Private Healthcare in South Africa*, highlights key areas of the clinical governance systems, processes and measures utilised by the private hospital sector. It also makes reference to the newly established HASA Quality Sub-Committee, and provides current data to assist in assessments of quality.

Chapter 12, *Training of Healthcare Personnel*, outlines the sector’s substantial commitment to addressing the shortage of healthcare professionals in the country, in both the public and private sectors. It also gives recommendations on collective initiatives to help alleviate the current shortage.

Chapter 13, *Appropriate Returns*, addresses the unsubstantiated claims that the private hospital sector is generating super-normal profits at the expense of those utilising its services. It also provides details on investment and economics as they apply to the sector, to provide a basis for informed debate on reasonable shareholder returns in the sector in return for ongoing investment.

Chapter 14, *Transformation in the Private Hospital Sector*, outlines the sector’s progress in achieving transformation objectives, and provides the current Black Economic Empowerment scorecards for the major private hospital groups.

Chapter 15, *Corporate Social Investment*, provides details on a selection of initiatives undertaken by the private hospital sector to improve healthcare access and affordability.

Chapter 16, *Hospital Pharmacy Ownership*, clarifies the ownership and role of institutional pharmacies. It argues that hospital ownership of their pharmacies encourages efficiencies.

Chapter 17, *Proposed Code of Ethics for Private Hospitals*, is presented as a draft Code of Ethics for the private hospital sector which the sector would like to finalise with the Department of Health. It is then to be monitored and implemented by the HASA. It reflects the sector’s commitment to the highest ethical standards in delivering quality healthcare.

6. Conclusion

The HTG has in the course of this document proposed solutions that we believe will help to address the perception or the reality of stakeholder concerns. Some of these include:

- Producing widely-accepted, accurate hospital utilisation data;
- A commitment to transparency on surgical rebates;
- A commitment to investigating further alignment of incentives such as alternative reimbursements;
- A commitment to participating in an industry technology assessment forum;
- Publication of national and regional sector occupancy levels;
- Publication of sector quality indicators;
- A sector Code of Ethics that specifically addresses alleged perversity;
- A commitment to ongoing transformation objectives; and
- National training and skills development initiatives.

In representing the private hospital sector in this submission, the HTG welcomes constructive comment on its contents. We hope that our proposals and suggestions are debated and tested in the spirit in which they have been submitted, and contribute to a concerted and cooperative attempt to find solutions to the challenges in South African healthcare, and to take up the opportunities to extend the benefits of good health to all South Africans.
CHAPTER 2
PUBLIC VERSUS PRIVATE EXPENDITURE

1. Introduction

This Chapter reviews national and international patterns of expenditure on health, and argues that South African trends are not unique. It goes on to caution against superficial comparisons between public and private healthcare expenditure.

Certain questions raised in the South African Health Review 2007 are pertinent to the debate on public sector versus private sector expenditure on healthcare, such as: “Do private sector models of health service financing and delivery represent the ‘gold standard’ to which our entire health system should strive?”, and: “Can some of the challenges faced by the public health sector be laid at the door of an under-regulated private sector?”.

We believe the answer to both questions is no. Private sector models are by no means a ‘gold standard’. We believe that the private sector is working diligently to achieve excellence in health service delivery, aligning incentives by sharing risk, publishing quality outcomes and trying to engender a deeper understanding of utilisation drivers. But we acknowledge that there is still much to be done in ensuring that more South Africans can access healthcare at the right level of intensity and affordability to meet their diverse needs.

An area of concern that requires clarification is the reference to the disproportionate aggregate annual cost of private healthcare at R75 billion for 7,1 million medical scheme beneficiaries compared to the public sector spend of R59 billion for 38 million people.

We caution stakeholders against too superficial a comparison between public and private healthcare spending given the complexity of this issue by virtue of the regulatory and operational realities. In order to make meaningful comparison between private and public expenditure one needs to eliminate from the spend on private healthcare value-added tax at 14%, the cost of capital, the cost of infrastructure, property rental and the substantial private sector cross-subsidy of pharmaceuticals.

Furthermore, the assumption that only medical aid beneficiaries consult in the private sector is inaccurate. Stats SA’s General Household Survey 2006 indicates that: “For the private sector, the most interesting findings are where people went for a consultation, and whether or not they belonged to a medical scheme. According to this statistic, nearly 1,1 million non-medical-scheme members visited a private sector facility in June 2005. What is an even more fascinating is that more non-medical-scheme members visited the facilities than members. This, again, indicates that many more South Africans are using private sector facilities than simply those who belong to a medical scheme.”

2. Public versus Private Sector Expenditure

The fact that South Africans’ disposable income spent on private healthcare is equivalent to 60% of total spend on health, certainly raises many points in this debate, including:

- Are South Africans spending a disproportionate amount on private healthcare?
- Is the public health sector system underfunded?

The South African Health Review states that “South Africa’s overall level of health spending is relatively high by international standards”. An appraisal of health financing should take into account the size of the country’s economy and the size of its population. South African health expenditure is prejudiced by both a relatively small fiscus and a relatively large population, explaining why South Africa ranks poorly in an analysis of its health expenditure per capita, as per Graph 1.

Graph 1: Total national expenditure on health per capita in selected countries.


Graph 1 clearly demonstrates that South Africa’s national expenditure on healthcare does not rank well on the basis of expenditure per capita. Notwithstanding the ongoing debate as to how many people access the private sector – be it only the 7.1 million individuals on medical aid or the 10 – 15 million lives as espoused by the private sector with specific reference to Statsa’s General Household Survey – Graph 1 reflects that South African private expenditure per capita does not appear excessive relative to international benchmarks.

It is not uncommon to find high out-of-pocket financing of healthcare in developing countries, as a result of restricted government spending. Graph 2 shows the relatively lower percentage contributions to healthcare expenditure by governments in developing countries, with few exceptions.

**Graph 2: Government spending on health per capita in selected countries.**

![Graph showing government spending on health per capita in selected countries.](image)


Furthermore, Graph 3 below illustrates a corresponding higher percentage contribution by the private sector to health expenditure in these developing countries with South Africa being no exception.

**Graph 3: Private sector spending on health in selected countries.**

![Graph showing private sector spending on health in selected countries.](image)

A thorough analysis of healthcare access, cost and quality was undertaken by the Monitor Group and published in December 2003. South Africa’s private healthcare sector was ranked in the top five in the world, notwithstanding the significantly lower per capita expenditure in the private sector of $232 compared to both Canada at $917 and the USA at $3371.

This is demonstrated in Graph 4 which shows the relative performance of South Africa’s private sector and public sector, and the country average in this independent study.

Graph 4: Ranking by quality of outcomes.

![Graph showing the ranking by quality of outcomes](image)


3. Conclusion

South Africa is not unique among developing countries in either its higher relative out-of-pocket expenditure for health, comparatively lower public sector expenditure or correspondingly higher healthcare expenditure by the private sector. We refer you to the SA Health Review: "The authors note progress towards addressing allocative efficiency and geographic equity challenges in the public health sector, but are of the view that there still appears to be inadequate public sector healthcare funding for the population served".

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CHAPTER 3
ACCESS AND AFFORDABILITY

1. Introduction

This Chapter sets out the private hospital sector’s proposals to address the critical challenges of access to and affordability of quality healthcare in South Africa, in the hope that these proposals will promote a concerted and collective effort to make real progress in meeting these goals.

The lack of access to adequate quality healthcare for a large portion of South Africans is a major challenge that needs to be urgently addressed. The topic of access and affordability needs to be debated on two fronts: access and affordability of medical scheme membership and access and affordability of hospital services.

The medical aid industry caters for the healthcare needs of the employed or working population. Currently, approximately 12.6 million South Africans are believed to be employed in both the formal and informal sectors of the economy. It is estimated that there are 5.4 million formally employed and a further 4.2 million informally employed South Africans (and their families) who have no medical cover.

While the medical aid industry provides cover for the healthcare needs of a large percentage of employed individuals, the overburdened State sector is required to provide medical care to those who are not economically active, or who earn too little to afford medical scheme contributions.

This chapter is dedicated to the topic of access and affordability of hospital services in South Africa. However, the point needs to be made that in a scenario of private hospitals being made not-for-profit (ignoring for a moment the consequential disinvestment) medical scheme affordability would not be substantially improved: given that private hospitals contribute approximately 35% of medical scheme claims and that listed hospital groups trade at an average operating profit of approximately 15% – 16%, the removal of all private hospital profit in South Africa would result in a total reduction in hospital spend by medical schemes of approximately 5.5%. In the scenario of all of this saving being passed on to the medical scheme member the average South African medical aid contribution per month would be reduced from R2500 to approximately R2361 per month. This exercise serves to contextualise the cost of private hospitals in the broader debate of medical scheme viability.

2. Improved access to hospital services can be achieved in one of four ways:

2.1 Within the existing infrastructure of approximately 28 000 beds:

Graph 1: Distribution of hospital beds in South Africa

The private sector contributes a mere 22% of the hospital bed capacity in South Africa. Chapter 10 delves into occupancy and spare capacity in the private sector. It is made clear in Chapter 10 that the topic of access can only be addressed in an environment conducive to further investment in hospital services given the current high occupancy levels within the private sector.

2.2 Investment in additional infrastructure in both the private and public hospital sector

"However, private hospitals in South Africa are currently running at approximately 60 – 65% capacity utilization, including weekends. At a push you might be able to increase volumes by 15% but in theory this would only allow a further 1 million or so people to access private healthcare without expansion to capacity...". Further investment in additional private hospital beds is dependent on the investment environment: "...if returns on new build hospitals are not sufficient, and that depends on prices charged, then they won't be built and government's aim of getting millions more to private healthcare won't be achieved".8

The public sector can have a much greater impact on access due to the fact that 80% of hospital beds reside in the public sector. It is also cheaper to deliver hospital care in the public sector due to:

- VAT exemption
- Lower cost of financing
- Cheaper pharmaceutical due to private sector cross-subsidies.

2.3 Reforms to facilitate cheaper delivery mechanisms

According to JP Morgan:9 "In its current structure, the South African hospital and medical insurance market is however ill-equipped to deal with the envisaged expansion, since it provides either exceptions (private) or very poor (public) care, then what is required is something in between. Logically legislation should enable cheaper forms of limited access healthcare to come to the market."6

The private hospital sector’s recommendations to improve affordability and create an environment conducive to cheaper hospital delivery models include the following:

a) Changes to legislation governing the provision of healthcare services

- Allowing the private hospital sector to employ doctors would:
  - Ensure greater standardisation of drugs and pharmaceuticals currently used by doctors;
  - Facilitate the introduction of clinical pathways that have been proven to reduce variability in outcomes and hence the overall cost of care, in line with international best practice; and
  - Ensure the staffing of waiting list programmes within affordable parameters. Under Fee for Service (FFS) reimbursement, doctors charge per procedure, but under an employment contract doctors are paid a fixed fee, irrespective of volumes.
- Purchasing pharmaceuticals at internationally benchmarked prices, thus reducing healthcare delivery costs.
- Providing a concession on charging VAT on State patients who are treated in the private sector.
- Changing Regulation R158 and R187 which governs the building of hospitals to allow for the development of cheaper models of care.
- Eliminating barriers to competition by reviewing existing licence obstacles.

b) Additional reforms

- Reform within the Health and Welfare Seta is recommended to alleviate bottlenecks in approving and awarding learnerships to potential students.
- Reform within the South African Nursing Council (SANC) is recommended to ensure:
  - Consistency in the number of students permitted to be trained per year and per course, to enable long-term planning in training;
  - Rapid approval of courses; and
  - Prompt approval of training facilities and clinical facilities.
- Establishing a process for defining appropriate measures for clinical quality outcomes.
- We refer you to Chapter 12 on additional effective reforms on nurse training.
- A fundamental flaw in global health policy is the lack of focus on patient value. As stated by Porter and Teisberg: "Public programmes can and should guide patients to excellent providers"7. Results-based referrals are essential.
- State backlogs could also be effectively addressed by buying specific services, including clinical services, from the private hospital sector.
- A review of Prescribed Minimum Benefits in the context of low income schemes.

2.4 Through Public Private Partnerships (PPP) and Public Private Initiatives (PPI)

The draft Health Sector Charter defines a PPI as a "Public private interaction in terms of which one or more persons or entities involved in healthcare within the public sector interact with one or more persons or entities involved in healthcare within the private sector or the NGO sector with the object of achieving a mutual benefit or goal and includes, but is not limited to a Public Private Partnership. PPIs include public financing of health services provided by the private and/or NGO sector; private financing or publicly provided health services; innovative healthcare delivery models and business models for health practices; delivery models aimed at retention and effective distribution and utilisation of skills; use of public assets for the provision of health services by the private sector; use of private assets for the provision of health services by the public sector."

PPP is a form of PPI. The use of the term PPP in South Africa has a specific meaning and usually refers to partnerships that have been approved by and registered with the National Treasury. A PPP is defined as "a contractual arrangement between a public sector institution and a private party in which the private party performs an institutional function or uses State assets and assumes substantial financial, technical and operational risk in the design, building and/or operation of the project, in return for a benefit."8

PPPs are a product of intense and protracted negotiations. According to the South African Health Review: "PPPs will not materialise unless the projects can be proved to be affordable, there is risk transfer to the private sector partners and the public sector gets value for money from the partnership."9

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With reference to current PPP models in the healthcare sector in South Africa, providers are requested to offer traditional Build, Operate and Transfer (BOT) services, but not clinical services. However, the collective experience of members of South Africa’s private hospital sector who have entered into PPPs with the UK’s National Health Service (NHS) to provide clinical services across a wide spectrum of disciplines, has proven that PPPs run on this basis are both feasible and sustainable. The UK Government’s contracts with the private sector span a five-year period and are carefully monitored in terms of the quality of care and patient outcomes. Tariffs charged within these PPP structures are aligned with NHS recommendations, making private healthcare more affordable and accessible to greater numbers of patients.

South Africa’s private hospital sector welcomes the acceleration of and participation in PPPs to assist the State in establishing additional health facilities. We would also embrace the opportunity to partner with Government in offering clinical services to State patients on elective procedure waiting lists.

The pricing model of State surgical waiting lists would be positively affected by the procurement of drugs and surgicals by the State, provided they met the specifications of the clinical pathways and equipment used in surgery.

Given changes to legislation and volume guarantees, which would lead to inherently lower cost structures, it would be possible for the private hospital sector to render clinical services at more affordable rates. Projects of this nature could be implemented as joint ventures where, for example, the private sector could offer the use of a facility and clinical pathways under the guidance of a private specialist in consultation with personnel from the State, be they doctors, nurses or registrars.

2.5 Other access initiatives

- Although most private hospitals are located in urban or peri-urban areas, individual hospital groups continue to find ways to support under-serviced communities. For example, in sponsoring a mobile eye clinic that supplies ophthalmic services in rural areas in partnership with the South African Council for the Blind. Other examples include sponsoring refresher training courses for nurses and supplying consumables for cervical cancer screenings in outlying areas through the Cancer Association of South Africa.

- Examples of PPPs in nursing include training State nurses in various provinces and in infection control, assisting with clinical placements for first year students, and where requested, accommodating learners from the public sector.

- In terms of new PPIs, the private hospital sector would embrace the opportunity to work with the State on initiatives to improve access and reduce the State’s burden of care. Potential examples include, but are not limited to, the following:
  - Sharing resources on a lease or service basis, where under-utilised space or equipment exists.
  - Generating joint health promotion and screening campaigns to combat lifestyle diseases and raise awareness.
  - Training nurses, technicians and mid-level healthcare workers by offering basic and post-basic courses.
  - Training paramedics.
  - Within well-defined and mutually agreed guidelines, providing spare capacity in private hospitals to treat State patients. The private hospital sector commits itself to publishing regional occupancy levels on a bi-annual basis to facilitate this possibility.
  - Implementing further programmes designed to reduce waiting lists of patients for elective surgery, such as cataract removal and joint replacements.
  - Providing mobile clinical services to rural areas.
  - Enhancing capacity within the public sector by providing management and administrative support. For example, the private hospital sector would be willing to second managers to the public sector and engage in a twinning of facilities to enhance co-operation and the application of best practice. This could entail formalising skills transfer, including in-service training of public sector managers in the private sector and vice versa.

3. Conclusion

The private hospital sector continues to respond to the growing demand to assist indigent patients with emergency medical and hospital services, irrespective of their ability to pay, demonstrating the sector’s commitment to good corporate citizenship. Over the last three years, the private hospital sector has committed annual expenditure significantly above R120 million in this area.

The logical approach to improving access to hospital services in a country short of capacity is to attract further investment in hospital infrastructure. Additional reforms would be required to ensure a more efficient health delivering system.

The introduction of PPPs has been a significant healthcare reform in South Africa. PPPs have, in recent years, accelerated the efficient delivery of healthcare services at affordable rates. These initiatives have also resulted in major infrastructural investments that have brought about positive economic and social benefits.

Effective PPIs and PPPs present opportunities to strengthen the entire healthcare system and reduce the fragmentation in healthcare service delivery. In so doing, these partnerships will ensure the efficient utilisation of available resources, the reduction of inequities and improved access to the benefit of all South Africans.

The private hospital sector believes that addressing infrastructural, clinical and training bottlenecks will be more effectively achieved by expanding existing partnerships. We look forward to constructive engagement with the Department of Health and other stakeholders in the implementation of carefully planned, effective strategies for healthcare access and affordability.
CHAPTER 4
COUNCIL FOR MEDICAL SCHEMES: DEFINITIONS AND REPORTING MEASURES

1. Introduction

This Chapter deals with the private hospital sector’s concerns regarding the definitions and measurements used by the CMS, and subsequently by a range of industry stakeholders, to evaluate the industry. It provides examples of these concerns and recommendations for resolving these issues cooperatively.

To ensure that the current debate around private hospital costs is resolved in the best interests of the increasing number of South African citizens accessing private healthcare, discourse must be based on commonly accepted assumptions and accurate information.

The majority of concerns raised by the Council for Medical Schemes (CMS) at the Private Health Sector Indaba in September 2007 referenced the CMS Annual Report as well as additional research, now in the public domain, commissioned by the CMS or its advisors. Most other concerns raised at the Indaba came from the Board of Healthcare Funders of South Africa (BHF), whose submission was also based on the CMS Annual Report.

It is important to note that the private hospital sector and the CMS disagree on the method used to produce data in evaluating specific aspects of private hospitals. We argue that in many respects the CMS data is not reflective of the reality in which private hospitals operate, and that this in turn influences the interpretation of this data by other influential stakeholders.

We have made formal representations to the CMS with regard to some of these disagreements and they have been discussed accordingly, but with limited traction.

The private hospital sector is unified in calling for the introduction of standardised definitions and measurement criteria to form the basis for all future industry evaluations. This will require adapting and developing operationally relevant statistical models and maintaining the highest degree of accuracy in data collection.

To be comprehensive, any analysis of the sector must include a review of the impact of increased trauma, burden of disease, age and chronic disease profile and levels of obesity of patients being hospitalised, as well as the impact of technological advances on early diagnosis and new treatment modalities, factors discussed in more depth in Chapter 5.

We believe this intervention is fundamental to a strong and sustainable private healthcare sector and will allow us to focus collectively on debating and meeting the real challenges of providing access to affordable quality healthcare to more South Africans, most effectively.

2. Disparity in Definitions and Measurement Criteria

We have concerns with the CMS’s utilisation definitions and with the quality and consistency of the utilisation data captured by medical schemes.

The BHF’s recent submission to the Private Health Sector Indaba appears to use the latest CMS Annual Report as its only source of data, as per the following excerpt:

“With respect to internal [sic], the paper will focus on core costs relative to CPIX, locating the discussion within the broader economic environment shaping the country’s development trajectory. In light of the preceding discussion on transparency this paper uses audited data routinely captured, scrutinised and in the public domain – namely data presented by the Council of Medical Schemes. (CMS, 2006/7)”

While the CMS reports are constructed from audited financial statements, the measurement of health provider utilisation figures are not audited to the same degree. More importantly, definitions for utilisation measures differ considerably among various medical scheme administrators. For example, certain administrators capture only in-patient hospital admissions (‘number of admissions’), while others also include either hospital emergency unit admissions or outpatient visits.
Additional inconsistencies occur in recording bed-days, and therefore the length of stay. Certain administrators count same-day cases as zero days (and one admission), while others will record these as one-day cases (and one admission).

Thus, the data reported by the CMS comprise a weighted average of a number of different utilisation definitions. These diverse and inconsistent measures skew the results significantly. This, in turn, impacts on the interpretation of this data by other stakeholders. Trends in utilisation reported by the CMS tend to be further skewed as a result of the considerable churn within the medical scheme industry, with members moving from one scheme to another, all with different definitions for utilisation measurement.

3. Volume and Price Changes

The CMS has set a measurement norm of total expense divided by the total exposure (medical scheme population) as the basis for its reported information. We contend that the CMS data should differentiate adequately between volume changes and price changes.

The lack of distinction between these two measures results in industry statistics being misinterpreted and quoted out of context, even by industry bodies such as the BHF. The most common error is the inclusion of volume changes in analysing price inflation. One example is the BHF’s submission to the Private Health Sector Indaba, which illustrates a lack of understanding of the CMS reporting measures.

Note the following excerpt from this submission, presented by the BHF:

> *Table 1* (see below) highlights the relation of key costs relative to CPIX for both healthcare and non-healthcare medical aid expenditure.

<table>
<thead>
<tr>
<th></th>
<th>Increase from 2005 in total benefits paid (CMS Annual Report 2006-7)</th>
<th>Increase above CPIX (4,7%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Hospitals</td>
<td>13,6%</td>
<td>8,9%</td>
</tr>
<tr>
<td>Medical Specialists</td>
<td>17,5%</td>
<td>12,8%</td>
</tr>
<tr>
<td>General Practitioners</td>
<td>17,2%</td>
<td>12,5%</td>
</tr>
<tr>
<td>Drugs</td>
<td>8,8%</td>
<td>4,1%</td>
</tr>
<tr>
<td>Administration</td>
<td>7,3%</td>
<td>2,7%</td>
</tr>
<tr>
<td>Managed Care</td>
<td>9,6%</td>
<td>4,9%</td>
</tr>
<tr>
<td>Broker Fees</td>
<td>7,1%</td>
<td>2,4%</td>
</tr>
</tbody>
</table>

As is evident from Table 1, the costs of purchasing healthcare from the three largest medical aids far exceeds CPIX, with non-healthcare expenditure closer to CPIX levels. Table 1 highlights the hyper-inflationary increases of healthcare costs demonstrating the relative power imbalance between medical aids and providers, with medical aids essentially pricetakers in a relatively unregulated provider environment vis-a-vis price regulation.

Although the increases for healthcare are in the double digit figures, what is alarming about this trend is the 7,7% increase in GP utilisation (CMS, 2007:54) coupled with a decrease in length of stay in private hospitals and a concurrent decrease in number of beneficiaries admitted to private hospitals (CMS, 2007:54). Notable also was the slight decrease in the proportion of pensioner beneficiaries (CMS, 2007:50).

*In a context of decreased utilisation and declining pensioner ratio, the need for greater transparency of private providers (including hospitals) cannot be ignored at this juncture if the health system is to succeed in tackling costs in order to improve access to quality healthcare*.

The excerpt quoted above demonstrates that, in the BHF’s opinion, there is no volume or utilisation impact on expenditure whatsoever.

The CMS Annual Report 2006-7 certainly contributes to this misconception. In the section *Utilisation of benefits* (page 54), stating that “admissions to private hospitals decreased” is a misrepresentation. The fact is that the private hospital sector has seen consistent increases in volumes year on year.
The CMS could more accurately reflect the data point as, “individual beneficiaries who visited private hospitals either once or more than once has decreased”. This indicates that the volume increases published by the hospital sector are a function of either increased private admissions or increased multiple visits by medical scheme beneficiaries:

1. In the section Number of visits and length of stay in hospitals (page 54 of the Medical Scheme Annual Report 2006), to state “the average length of stay in private hospitals was 1,27 days in 2006” creates another misrepresentation.

2. In reality, the actual length of stay in the private sector is approximately three days, which compares well with global benchmarks as demonstrated in graph 1 below.

3. The CMS’s data could be more accurately communicated as: the average number of private hospital days per beneficiary, for all beneficiaries (whether admitted to hospital or not).

**Graph 1: Average length of stay.**

![Graph 1: Average length of stay](image)

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

4. Utilisation

The private hospital sector strongly believes that utilisation, in the form of both increased volume and increased acuity or length of stay, has had a material impact on the increases in total hospital expenditure per member per month experienced by medical schemes. This has been highlighted by various stakeholders:

- Medi-Clinic’s 2007 annual financial report: “On a comparable basis, the revenue growth of 11% was achieved through a 5% increase in in-patient bed-days, a 5% increase in the average income per bed-day and a 1% change in the case profile of patients treated.

  The increase in utilisation was evident in both surgical and medical cases. The number of patients admitted to our hospitals increased by 5% while the average length of stay remained fairly stable.”

- Netcare’s 2007 annual results: Revenue from the South African hospital and trauma business increased by 12,7% to R7 782 million. The increase in revenue is organic and can largely be attributable to a 5,9% and 2,0% increase in total and inpatient admissions, respectively. As a result, patient days increased by 4,5% with the average length of stay increasing slightly to 3,32 days. Maternity patient day growth was 6,4%.

- Reporting in the USA points to a similar trend over a number of years (refer to Table 2 on next page).
Table 2: Decomposition of the hospital spending trend 1999 – 2006. Annual percentage change per capita

<table>
<thead>
<tr>
<th>Year</th>
<th>Hospital Spend</th>
<th>Price</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>5.8%</td>
<td>2.5%</td>
<td>3.2%</td>
</tr>
<tr>
<td>2000</td>
<td>7.0%</td>
<td>3.3%</td>
<td>3.6%</td>
</tr>
<tr>
<td>2001</td>
<td>11.8%</td>
<td>3.6%</td>
<td>7.8%</td>
</tr>
<tr>
<td>2002</td>
<td>10.7%</td>
<td>5.2%</td>
<td>5.2%</td>
</tr>
<tr>
<td>2003</td>
<td>8.7%</td>
<td>8.0%</td>
<td>0.7%</td>
</tr>
<tr>
<td>2004</td>
<td>8.5%</td>
<td>7.1%</td>
<td>1.3%</td>
</tr>
<tr>
<td>2005</td>
<td>9.0%</td>
<td>4.3%</td>
<td>4.5%</td>
</tr>
<tr>
<td>2006</td>
<td>8.0%</td>
<td>3.9%</td>
<td>3.9%</td>
</tr>
</tbody>
</table>

Source: Ginsburg P.B., et. al., The Centre for Studying Health System Change, Washington D.C.

Referring to Table 2, an analysis of CMS utilisation data reveals that the definition of utilisation per 1000 beneficiaries is not consistent with the universal definition, being the total number of admissions in a year per 1000 beneficiaries. The CMS counts multiple admissions for a given beneficiary in one year only once, which distorts the utilisation pattern.

The CMS 2006-7 Annual Report states that a private hospital admission rate of “171 per 1000 beneficiaries” was achieved. However, if the universal definition is applied the rate increases to 273, based on the number of admissions in 2006 as per a fact sheet recently supplied to Medi-Clinic by the CMS. This large discrepancy highlights the urgent need for standardised definitions in measuring utilisation.

The CMS fact sheet also reports that 9 016 232 days were purchased by medical schemes from the private hospital sector during 2006. However, taking into account the 27 612 registered private hospital beds in 2006, this would imply an 89% occupancy rate for private hospitals. This figure is significantly higher than that calculated by the private hospital sector, namely 65.5%. The discrepancy is significant, especially considering that the revised figure includes all private hospital admissions, while the figure based on CMS data relates only to medical scheme admissions.

Another example of how the presentation of data can obscure the impact of price and utilisation is seen in the following excerpt from the BHF submission to the Private Health Sector Indaba:

"Notable too (see table 3) is the trend in overall contributions relative to gross claims in highlighting the power imbalance in the purchaser-provider relationship governing medical schemes and private healthcare providers. Gross contributions have increased almost on par with CPIX and gross contributions per beneficiary are in fact below CPIX. This merely reinforces the purchaser-provider imbalance that threatens to undermine attempts to strengthen the health system overall through extended coverage.

Table 3 (see below) highlights the relation of contributions and claims relative to CPIX”.

<table>
<thead>
<tr>
<th></th>
<th>Increase from 2005</th>
<th>Increase above CPIX (4.7%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total contributions</td>
<td>6.2%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Total gross claims</td>
<td>12.1%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Gross contributions per beneficiary</td>
<td>2.6%</td>
<td>(2.1%)</td>
</tr>
<tr>
<td>Gross claims per beneficiary</td>
<td>8.2%</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

This excerpt demonstrates that the BHF views the impact of price negotiations as the sole reason for the increase in claims in excess of contribution increases. Again the impact of utilisation increases has been ignored.

10Based on data from the three major hospital groups and calculated independently by Regional Business Analytics.
These examples make it clear that different utilisation definitions provide the context for time-consuming misunderstandings and recriminations between stakeholders, and public misperceptions of capacity within the private hospital sector. This could be avoided by all stakeholders cooperating to standardise definitions and measures.

5. Price versus Utilisation Impact on Annual Hospital Expenditure by Medical Schemes

To contextualise and isolate the impact of price increases in the private hospital sector, refer to Table 4 below that reflects the average total annual price increases for the period 1999 to 2006.

Table 4: Average annual price increases.

<table>
<thead>
<tr>
<th>Year</th>
<th>Weighted average total hospital price increases</th>
<th>CPIX</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>9,0%</td>
<td>6,9%</td>
</tr>
<tr>
<td>2000</td>
<td>10,1%</td>
<td>7,7%</td>
</tr>
<tr>
<td>2001</td>
<td>9,7%</td>
<td>6,6%</td>
</tr>
<tr>
<td>2002</td>
<td>12,6%</td>
<td>9,3%</td>
</tr>
<tr>
<td>2003</td>
<td>8,5%</td>
<td>6,8%</td>
</tr>
<tr>
<td>2004</td>
<td>3,0%</td>
<td>4,3%</td>
</tr>
<tr>
<td>2005</td>
<td>4,6%</td>
<td>3,9%</td>
</tr>
<tr>
<td>2006</td>
<td>5,4%</td>
<td>4,3%</td>
</tr>
<tr>
<td>Average (1999-2006)</td>
<td>7,9%</td>
<td>6,2%</td>
</tr>
</tbody>
</table>

Source: Regional Business Analytics & Hospital Task Group.
1999-2002 Basket (42% Medi-Clinic; 58% Netcare).
2003-2006 Basket (32,5% Life Healthcare; 27,5% Medi-Clinic; 40% Netcare).

Table 4 shows that on average prices increased by 1,7% above CPIX in the eight years from 1999 to 2006. Considering higher medical inflation and consistent increases in nursing costs over this period, the private hospital sector has been effective in containing price increases. This demonstrates the private hospital sector’s ability to absorb high input cost increases through increased operational efficiencies.

6. Other CMS Research

The CMS reports and data are widely utilised within the health sector, specifically in submissions to the Competition Commission on hospital mergers. In this regard, the CMS has criticised the private hospital sector based on factual inaccuracies, with recent examples in the SA Health Review 2007 including:

- “As demonstrated in a recent submission to the Competition Commission, there are clear indications that these major groups are using their oligopoly power to charge excessively high prices and not to engage in price competition with each other.”

  – This line of argument was sufficiently countered in the Competition Tribunal12. Table 2 highlights that price increases for the industry exceeded CPIX by 1,7%. At 7,9%, it falls comfortably below medical inflation at an average 9,5% for the period.

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12 Webber Wentzel Bowen. Closing Arguments. Annexure: Mr van den Heever. Non-confidential version: “The central proposition of van den Heever’s thesis is that there was a “trend break” in the increase in private hospital costs in 1999. He suggests that: “this concentration coupled with the relationships with specialists, both direct and indirect, were sufficient to prevent any price competition from alternative hospital service providers”. As discussed below, the evidence does not support van den Heever’s theory and there are obvious and fatal flaws in his theory, most notably the fact that tariffs were set by centralised bargaining until 2003, which means that an increase in concentration would have no impact on bargaining power.” Page 8.
• “While private hospital admission rates did not increase dramatically, there were increases in high cost services such as caesarean section, magnetic resonance image (MRI), CT scans and angiograms.”\(^{13}\) ... “When expensive high-technology equipment is purchased by owners of private hospitals, substantial pressure is applied on clinicians to use this equipment to earn revenue for the hospital.”\(^{14}\)

- In response we refer to the non-confidential version of the closing arguments in the Netcare/Community Healthcare Group hearing: “Van den Heever also concedes that hospitals do not own CT scanners or MRI machines, but that these are owned by radiology practices ... He then seeks to make inferences relating to "profit sharing arrangements" between the radiology practices and the hospitals, but is forced to concede that this is, again, unsubstantiated speculation on his part.”\(^{15}\)

• “Given that many private specialists have a stake in the financial performance of private hospitals through share ownership or other forms of financially beneficial relationships, such as rent-free or subsidized consulting rooms within hospitals.”\(^{16}\)

• “Specialists are only entitled to these financial benefits if they meet targets for use of hospital facilities...”\(^{17}\)

Refer to Chapter 17, section 9.1.7 in this report which proposes a HASA Code of Ethics in this regard.

At the very least, it can be reasonably expected that such categorical statements should be substantiated by accurate and verified evidence or data. Under cross-examination during the Community Healthcare and Netcare competition hearing, the author of the CMS submission was unable to provide any such evidence or substantiate such comments.\(^{18}\) Even so, some healthcare industry stakeholders continue to accept these baseless allegations as fact.

7. Conclusion
For policymakers to structure effective reforms, it is vital that they are based on a comprehensive understanding of the drivers of healthcare expenditure. The private hospital sector has on many occasions made representations on the impact of utilisation, yet our submissions continue to be undermined by inaccurate and misleading statements to the contrary.

The importance of producing widely accepted, accurate hospital utilisation data cannot be overemphasised. To develop solutions that make healthcare more affordable, the healthcare sector as a whole needs to understand the prevailing patterns of utilisation of hospital services. Once consensus is reached, the real work of designing and implementing these solutions can begin as we will be able to establish whether the focus needs to be on price, on utilisation, or on both these factors.

The private hospital sector recommends that HASA and the CMS meet to formulate a process in which we can assist the CMS to corroborate and analyse medical scheme utilisation data on an annual basis. Further research will need to be commissioned to understand the drivers of increased volume and case-mix severity, which are discussed in the following Chapter.


\(^{14}\)McIntyre D, Thiede M. South African Health Review 2007 Chapter 3: page 42

\(^{15}\)Competition Tribunal Transcript, Community Hearing, page 429.


CHAPTER 5
MEDICAL SCHEME EXPENDITURE ON PRIVATE HOSPITALS

1. Introduction

This Chapter explores the drivers of hospital expenditure for medical schemes. It demonstrates that it is predominantly the increase in utilisation that is driving expenditure increases in excess of salary inflation.

Healthcare policymakers worldwide face the perplexing challenge of how to curtail medical inflation most effectively. This situation is not unique to South Africa, and nor is there likely to be a simple solution to arresting this trend.

Graph 1 below shows the increases in medical scheme contribution rates relative to inflation for South Africa and the United States. It illustrates that medical inflation exceeds general inflation in both countries, a situation faced by most countries globally. Note that in the United States the extent of this excess is greater than in South Africa.

*Graph 1: Increase in private healthcare contributions (USA and RSA).*

![Graph 1: Increase in private healthcare contributions (USA and RSA).](image)

The private hospital sector recognises that providing affordable healthcare is imperative if the sector is to be sustainable. However, it is important to understand that increased utilisation of hospital services is the main driver of hospital expenditure to medical schemes, and not price increases as advocated by some stakeholders. Price increases for the private hospital sector have on average exceeded CPIX by 1.7% per annum since 1999.

2. Rising Medical Scheme Claims for Private Hospital Services

Graph 2 below reflects the average annual increase in expenditure on health and non-healthcare categories by medical scheme members since 1999. Given the relatively high increase for hospitalisation, and that approximately a third of the healthcare Rand is spent on this category, it is understandable that hospitalisation is scrutinised.

Graph 2: Average annual increases in medical scheme claims per beneficiary per annum (1999-2006).

The Council for Medical Schemes (CMS) contends that there is a relationship between the increase in medical scheme hospitalisation expenditure and an increased concentration of hospital ownership. The CMS concludes that this must be attributable to a systematic change in the market power of the hospitals in relation to the medical schemes from 1999 to 2004, allowing the hospitals to negotiate higher price increases from year to year.

The private hospital sector believes that this view is without foundation. Rising medical scheme expenditure is a function of both price inflation and the increasing utilisation of hospital services. The CMS cost analysis is based on a fundamental error of consistency since the market power argument relates to price increases, but the rising expenditure quoted to substantiate this argument is impacted by both price and utilisation.

The increase in expenditure on hospitalisation services over time is the result of an:

- Increase in **prices**, which comprise:
  - negotiated tariff increases;
  - non-tariff increases effected by the Department of Health through Single Exit Pricing (i.e. ethicals); and
  - non-tariff increases determined by surgical manufacturers.

- Increase in **utilisation**, which comprises:
  - increases in the number of admissions; and
  - increases in the average billed per admission in excess of price inflation.
3. Price increases
To explain the drivers of increased utilisation of hospital services, it is necessary to set out accurately the factors that impact price increases of hospital services.

3.1 Increases in hospital prices, including tariff and non-tariff items
The market power concentration argument espoused by the CMS does not take into account that from 1995 to 2002, tariff negotiations between hospital groups and medical schemes were conducted collectively, with all hospital groups represented by the Hospital Association of South Africa (HASA), funders by the Board of Healthcare Funders (BHF), and medical professionals by the South African Medical Association (SAMA). It follows then that any consolidation within the private hospital sector would not have impacted on the balance of negotiating power with respect to tariff increases during that period.

Graph 3 indicates private hospital tariff price increases relative to CPIX during this period, which is when the CMS believes that consolidation and an ensuing lack of negotiating power among the medical schemes gave rise to increased hospital expenditure. The graph clearly shows that the CMS argument lacks foundation.

Graph 3: BHF ward, theatre and equipment tariff increases versus inflation.

During this period, non-tariff price increases (including drugs, surgical items and medical devices) were affected by price inflation on imported goods due to the currency collapse between 1997 and 2003. During this period the Rand depreciated by over 70% to the US Dollar. Non-tariff price increases during this period mirrored the currency trend, as indicated in Graph 4.
Graph 4: Price increases in drugs and medical devices over currency performance.

[Graph showing price increases from 1999 to 2002 with data points for ZARUSD change and Drug and Surgical Basket Change (60%NTC/40%MDC).]

Source: Reuters: Ecoclin and Prudential Portfolio Managers.

Having evaluated tariffs and non-tariffs separately, it is important to understand the combined impact of price increases passed on to medical schemes, as indicated in Graph 5 below.

Graph 5: Total hospital price increases versus inflation.

[Graph showing weighted average total hospital price increases and CPIX from 1999 to 2006 with average data from 1999 to 2006.]

Source: 1999-2002 Basket (42% Medi-Clinic: 58% Netcare); 2003-2006 Basket (32,5% Life Healthcare: 27,5% Medi-Clinic: 40% Netcare).

The seven-year average of pure hospital price escalations including non-tariff items, absorbed by the medical scheme industry has exceeded consumer inflation by 1,7% per annum, well within medical inflation for the period.
3.2 Medical scheme expenditure – the impact of price only
Considering the hospital price increases that the medical schemes have absorbed, the impact of utilisation can be estimated (see Table 1). Since 1998, an additional R7 billion has been spent by medical schemes on hospitalisation or reasons not attributed to price changes. It is fair to conclude that this increased expenditure is thus attributed to increased utilisation.

Table 1: An illustration of the impact of price versus utilisation increases.

<table>
<thead>
<tr>
<th>Year</th>
<th>Private hospital total price increases to medical schemes</th>
<th>Predicted medical scheme expenditure based on annual price increases alone R'000</th>
<th>Estimate of price inflation impact on medical scheme expenditure R'000</th>
<th>Implied cumulative utilisation increases since 1998 R'000</th>
<th>Actual medical scheme expenditure based on price and utilisation R'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6 024 720</td>
</tr>
<tr>
<td>1999</td>
<td></td>
<td>6 566 945</td>
<td>542 224 80</td>
<td>704 892</td>
<td>7 271 837</td>
</tr>
<tr>
<td>2000</td>
<td></td>
<td>7 230 206</td>
<td>663 261 42</td>
<td>654 162</td>
<td>7 884 368</td>
</tr>
<tr>
<td>2001</td>
<td></td>
<td>7 931 536</td>
<td>701 330 00</td>
<td>530 822</td>
<td>8 462 358</td>
</tr>
<tr>
<td>2002</td>
<td></td>
<td>8 930 910</td>
<td>999 373 56</td>
<td>1 575 071</td>
<td>10 505 981</td>
</tr>
<tr>
<td>2003</td>
<td></td>
<td>9 690 037</td>
<td>759 127 33</td>
<td>2 157 467</td>
<td>11 847 504</td>
</tr>
<tr>
<td>2004</td>
<td></td>
<td>9 980 738</td>
<td>290 701 11</td>
<td>5 283 663</td>
<td>15 264 401</td>
</tr>
<tr>
<td>2005</td>
<td></td>
<td>10 439 852</td>
<td>459 113 96</td>
<td>5 417 162</td>
<td>15 857 014</td>
</tr>
<tr>
<td>2006</td>
<td></td>
<td>11 003 604</td>
<td>563 752 02</td>
<td>6 699 557</td>
<td>17 703 161</td>
</tr>
</tbody>
</table>

Source: CMS, Regional Business Analytics: 1999-2002 Basket is 42% Medi-Clinic: 58% Netcare; 2003-2006 Basket is 32.5% Life Healthcare: 27.5% Medi-Clinic: 40% Netcare.

Note: The total price increases shown above is a weighted average for both tariff and non-tariff (pharmaceuticals) items.

Hospital price increases have therefore attributed roughly 60% to increased expenditure by medical schemes on hospital services. The remaining 40% is due to increased utilisation, which is the main reason for hospital expenditure outpacing general salary inflation over the past number of years.

4. Utilisation increases
It is helpful to reiterate that increases in expenditure attributable to utilisation can be split into:
- Increases in the number of admissions; and
- Increases in the average billed per admission in excess of price inflation.

4.1 Increase in number of admissions
Graph 6 shows the increase in hospital admissions for medical schemes from 2002 to 2006. During this period the total number of admissions increased by approximately 13% in total, or just over 3% per annum, based on ‘same store’ 2002 hospitals. We purposefully exclude hospitals that have been acquired or built in this period in order to reflect only pure organic growth. These numbers could therefore underestimate the growth in hospital admissions in this period. Notwithstanding, in reconciling total change in expenditure on hospitals with changes in price and changes in admission there will be a residual utilisation figure that can be attributed to increased acuity, increased level of care, increased length of stay, greater drug usage per bed-day or new technology.
It is important to note that hospital admissions are not controlled or driven by hospitals. The decision to hospitalise a patient rests in the hands of an independent doctor, the patient and the medical scheme.

A number of factors drive increases in patient admissions to hospital:

- An increased burden of chronic disease. Chronically ill patients tend to be hospitalised far more often than those who are healthy. The prevalence of chronic diseases such as diabetes is increasing in South Africa, as discussed in more detail later in this Chapter.
- The progression of the HIV pandemic. This leads to increasing hospital admissions as more individuals progress to the later stages of the disease.
- The gradual ageing of the medical scheme population. On average, older people go to hospital more frequently than younger people.
- Advances in medical technology. New technologies can increase hospital admissions in the following ways:
  - The introduction of less invasive technologies leads to a greater number of procedures. Less severe cases, which would not have been operable in the past, may now be treated (e.g. laparoscopic surgery);
  - Due to better outcomes, doctors are more willing to perform certain procedures and patients are more willing to undergo certain treatments (e.g. coronary artery stent procedures);
  - Improvements in the quality of outcomes or associated risks of a procedure can lead to an increased number of admissions (e.g. knee replacement surgery, with positive results for elderly patients’ level of mobility – one hospital group saw knee replacements as a proportion of total admissions, increase by 31% from 2002 to 2006); and
  - In the long term, technological advances reduce the risks associated with performing certain procedures on older patients, leading to a greater number of such procedures taking place (e.g. hip replacements).
- Medical scheme benefit design. There are sufficient grounds to argue that the progressive reduction in day-to-day medical scheme benefits has altered healthcare usage patterns, with sick members consulting their physicians at a later, more severe stage of illness. This results in hospital admissions that could have been avoided through more appropriate preventative and primary care.
4.2 Increase in average billed per admission in excess of price inflation
The second driver of increases in the amount billed by a hospital over time, the increase in the average billed per admission, is impacted by the following five factors, in addition to price increases.

4.2.1 Changes in case-mix
The case-mix refers to the distribution in the nature of cases treated and allows the resource intensiveness of cases to be measured. For instance ear, nose and throat cases would be less resource intensive than multiple trauma cases. As the case-mix becomes ‘heavier’ over time, so the average billed per admission will increase in line with it. For example, the proportion of caesarean section deliveries relative to normal deliveries has increased over time in the private hospital sector. This can be attributed to an older maternity profile, the mother’s wish to plan more accurately, the doctor’s wish to reduce medico-legal liability risk, or other causes. The fact that caesarean sections are more costly than normal births means that this shift in case-mix increases the average cost of a delivery.

The case-mix is affected largely by the age profile of patient admissions and the chronic conditions of these patients. For example, older people tend to be hospitalised more often for severe cases such as cardiac procedures when compared to younger patients. On the other hand, younger patients tend to be hospitalised more frequently for conditions such as tonsillectomies than older patients.

4.2.2 Increased length of stay
An increased average length of stay will increase the average billed per admission. The introduction of managed care during the 1990s led to a reduction in the average length of stay for hospital admissions. This trend has levelled out, and there are signs that the phenomenon of an ageing population will contribute to a reversal in this trend over the next few years.

4.2.3 Increased level of care
Changes in the level of care for an average admission impacts directly on the average billed amount. As the severity of cases increase, the proportion of higher costing ICU and high care ward days will increase relative to general ward days.

4.2.4 Residual severity not reflected in the level of care
Even within a given level of care, such as ICU, changes in the amount of drugs and level of nurse attention per patient day can change over time. This also leads to a change in the average billed amount per admission.

4.2.5 The introduction of new health technologies
We have devoted Chapter 7 to new health technologies due its importance as a driver of utilisation. However, it is important to note that most new technologies lead to additional expenditure but also improved treatment outcomes for patients. The introduction of drug-eluting stents is a good example of a new technology that yielded higher volumes and therefore can be termed an expensive medical technology.

4.3 Other factors affecting utilisation
To fully understand utilisation increases, a number of factors (some of which have already been alluded to) need to be discussed in greater detail.

4.3.1 Impact of burden of disease
In South Africa, statistics suggest a trend toward increasing burdens of communicable and chronic diseases. Medical scheme expenditure on hospitalisation is further affected by the burden of disease in the medical scheme population.

Disease prevalence and its progression affects the number of hospital admissions as well as the severity of a given admission, which in turn impacts on the number of bed-days and the level of care required for these bed-days (e.g. high care compared to general ward requirements).

For example, the progression of the HIV/Aids pandemic can be monitored by considering admissions for specific respiratory, gastrointestinal and infectious disease categories as a proxy for HIV/Aids-related admissions. Medi-Clinic has conducted an analysis that shows the proportion of turnover (for medical schemes business) related to these three categories in the 16 to 55 year age band has increased by 175% from 1,6% in 2001 to 4,4% in 2006. This has led to an increase in volumes recorded by the hospital group. Graph 7 opposite illustrates this increase, based on 2001 same-store hospitals.
The progression of the HIV/AIDS pandemic is a well-documented phenomenon, but is not the only disease significantly affecting hospital expenditure. Graph 8 shows the increase in the proportion of admissions of patients with cardiac-related chronic ailments for the three major hospital groups between 2002 and 2006. Thereafter, Graph 9 illustrates the situation for diabetes as a chronic disease. Both these diseases impact on the severity of a hospital admission, even if the admission is not directly related to the disease, due to the risk factors affecting these patients.

Graph 8: Cardiac chronic diseases and the percentage of total admissions in SA’s major hospital groups.
While some of the increase in chronic disease prevalence in hospital admissions can be attributed to an improvement in coding over time, it does not fully explain this trend. According to Sue Frye, the manager for the Durban branch of The Diabetes Association of South Africa, there are two to four million diabetics in South Africa. Furthermore, she reports that the death rate related to diabetes is expected to increase by 25% in the next 10 years.

The increase in prevalence of chronic conditions is further illustrated by the work done by the Risk Equalisation Technical Advisory Panel (RETAP). The initial pricing analysis for the Risk Equalisation Fund (REF) was done using 2002 data from Discovery Health and Medscheme. Both these administrators have consistently applied good clinical coding and the use of their data was therefore ideal. The 2002 data were used to price the expected cost of the Prescribed Minimum Benefits (PMBs) for different age bands for 2005 (see the dark line in Graph 10 below). However, the actual outcome for 2005 was considerably higher than the expected figures at the older ages (see the blue, yellow and orange lines in Graph 11), mainly due to a heavier prevalence of chronic conditions at these ages.
4.3.2 Impact of ageing on utilisation

As mentioned, the average age of the medical scheme population plays a major role in the average hospital expenditure per beneficiary. Older people go to hospital more often than younger people, and once they are admitted, on average they cost more than younger patients during their stay.

The medical scheme population has aged gradually over the past few years. While the CMS correctly points out that this increase has not been significant, the distribution by age of medical scheme beneficiaries highlights an interesting point. Graph 12 shows the increased membership of the more mature and very young age bands. The significant increase in the number of new babies registered as beneficiaries would cancel the impact of the older beneficiaries when the average age for the industry is calculated. However, Graph 13 shows that in general the older patients cost more per admission, while the treatment of neonatal and young babies is on average very expensive. The sharp increase in new babies covered by medical schemes, combined with more elderly beneficiaries, contributes to the increased expenditure by schemes.

Graph 12: Growth in medical scheme beneficiaries by age band since 2001.
Graph 13 indicates the distribution of an average private hospital bill (indexed) by age band and highlights the importance of understanding the age profile of patients being hospitalised.

Higher hospital costs will occur in circumstances where there is an increase in neonatal patients or older patients. The aged require more costly treatments as a result of the following:

- Older people are, on average, admitted for more severe types of cases as explained in the section on case-mix earlier in this Chapter.
- Older people have less active immune systems, leading to more infections requiring costly antibiotic treatments, and decreased mobility, which necessitate higher lengths of stay. This is illustrated in Graph 14 below, which is consistent with Graph 18.

Graph 14: Average length of stay in days (in-patient average 2000-2006).
• Older people are more prone to cancer and related diseases requiring invasive surgery.
• Older people tend to require ICU and high care post-surgery more than younger patients.
• Older people are more susceptible to chronic diseases, which in turn leads to higher complication rates.

Understanding changes in the age profile of patients is therefore essential as it impacts upon the average cost per hospital event. To understand more exactly the effects of ageing on cost, HASA undertook an analysis of the change in age profile in admissions to hospitals.

This research demonstrates:
• A strong relationship between age profile and hospital billings; and
• HASA’s age profile has deteriorated.

The data on which the ‘age creep’ is based shows that the average age of a patient in a private sector hospital in 2006 was 42.5 years compared to 36.9 years in 2002. This increase has resulted in an approximate age creep of 1.4 years per annum for the past four years.

**Graph 15: Weighted annual average age per annum.**

Each year of ageing has an associated cost. There is a strong, near linear relationship between age and hospital billings (see Graph 15 above). In 2006, the average cost creep per admission due to one full year of ageing profile was R203. The ageing patient profile in Netcare, Medi-Clinic and Life Healthcare hospitals alone cost medical schemes R936 million from 2002 to 2006.

**4.3.3 Impact of legislative changes on utilisation**

The Medical Schemes Act (MSA) of 1998, promulgated in 2000, has contributed to the increased utilisation of private sector hospitals with the introduction of Prescribed Minimum Benefits (PMBs), eliminating risk rating through the application of Community Rating and exposing medical schemes to adverse selection through Open Enrolment.

4.3.3.1 Prescribed Minimum Benefits

The impact of the introduction of PMBs, and the knock-on effect on medical scheme benefit design in favour of in-patient hospital cover, has not been adequately debated or quantified. This is a significant omission if an accurate and informed assessment of the drivers of utilisation is to be made.

PMBs further reduced the reliance on State hospitals in instances where benefit limits had been reached. Historically, depleted medical scheme benefits resulted in the transfer of patients from private to public hospitals. As a result of the MSA, this cover was now mandated within the private sector.

The introduction of PMBs ensured a more comprehensive and consistent level of hospital benefits for all scheme members. This, together with the barring of co-payments for PMB-related hospital admissions, will have resulted in more private hospital cover being funded by medical schemes as opposed to individual members and/or the State.
4.3.3.2 Community Rating
The MSA also dealt with risk rating which impacted on the risk profile of medical schemes. The introduction of Community Rating, which determines that medical scheme contribution rates may not differ based on a person’s age or state of health, led to the young and healthy experiencing a significant increase in contribution rates when the MSA came into force. Conversely, cover became more affordable for older and sicker individuals. As a result, younger and healthier individuals either remained outside the industry (did not join medical schemes) or left the industry, while a greater number of older and sicker individuals joined the industry. This adverse selection led to a significant deterioration of the medical scheme industry’s risk profile, far worse than the ageing impact would suggest.

In addition to Community Rating, the waiver of late-joiner penalties during an amnesty period when the MSA came into effect further exacerbated the deteriorating risk profile of medical schemes through adverse selection. The amnesty period, from January 2000 to March 2001, enabled previously uncovered individuals to join a medical scheme without incurring late-joiner penalties. While the increased age profile of beneficiaries certainly affected the industry, the escalating incidence of chronic diseases associated with the older patient band had a significantly greater impact on the private hospital sector.

4.3.3.3 Open Enrolment
The ongoing legal requirement of Open Enrolment ensures that the trend of increasing burden of disease continues over time. Open Enrolment dictates that no one may be declined membership of an open medical scheme, irrespective of their age or state of health.

4.3.4 Impact of Road Accident Fund cases on utilisation
Hospital services expenditure in relation to trauma, and particularly road accidents, was historically borne by the State, which would claim reimbursement from the Road Accident Fund (RAF). However, in recent years there has been a significant shift to utilising the private hospital sector for emergency hospital services. An indication of the increased incidence of these trauma cases is reflected in the 2005-2006 RAF Annual Report which records that new claims increased by 15.8%, from 164 517 in 2002 to 190 468 in March 2006.

Given that “vehicle accidents with injuries and fatalities have increased substantially in recent years” (RAF Annual Report 2005-2006: page 16), it would appear that the expense borne by medical aid schemes in respect of road accident claims has grown exponentially. The burden of these increased costs has proven largely irrecoverable from the RAF, and has therefore fallen primarily on the medical schemes, leading to an increase in private healthcare costs.

Besides the specific impact of road accidents, other data show a clear indication of an increase in trauma (which could be road accident related). For example, HASA commissioned research shows that brain injuries as a percentage of total patient days for the period 2002 to 2006 have increased by 137%, reflected in Graph 16 below. Brain injuries now comprise an admission category as large as tuberculosis.

**Graph 16: Percent of total patient days comprising brain injury. Brain injury as a percent of total patient days, 137% increase between 2002 and 2006.**

Source: Regional Business Analytics.
5. Confirmation of utilisation impact by a large funder

In 2006, Medi-Clinic performed a joint ‘truth of data’ exercise with one of the largest medical scheme administrators in South Africa. Table 2 – compiled by this administrator – clearly indicates that, after allowing for the utilisation impact of age and case-mix, hospital price inflation exceeded CPIX by only 2% per annum during the period 2000 to 2005. It should be noted that age and case-mix adjustments do not reflect the impact of new technology, which is commonly accepted to be approximately 1% per annum.

Table 2: Reconciliation of Medi-Clinic hospital claims by a large administrator.

<table>
<thead>
<tr>
<th>Measure</th>
<th>2000</th>
<th>2005</th>
<th>Annualised</th>
<th>5-year period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average hospital cost</td>
<td>5 917</td>
<td>10 347</td>
<td></td>
<td>74.9%</td>
</tr>
<tr>
<td>(a) Indexed Average hospital cost</td>
<td>100</td>
<td>175</td>
<td>11.8%</td>
<td>75.0%</td>
</tr>
<tr>
<td>(b) Attributable to case-mix</td>
<td>100</td>
<td>116</td>
<td>3.0%</td>
<td>15.9%</td>
</tr>
<tr>
<td>(c) Attributable to age</td>
<td>100</td>
<td>111</td>
<td>2.1%</td>
<td>10.9%</td>
</tr>
<tr>
<td>(d) Attributable to age &amp; case-mix</td>
<td>100</td>
<td>119.6</td>
<td>3.6%</td>
<td>19.3%</td>
</tr>
<tr>
<td>(e) CPIX</td>
<td>100</td>
<td>135</td>
<td>6.2%</td>
<td>35.1%</td>
</tr>
<tr>
<td>(a)-(d)-(e) Increase after case-mix, age and CPIX</td>
<td></td>
<td></td>
<td>2.0%</td>
<td>10.4%</td>
</tr>
</tbody>
</table>

Source: Administrator.

6. Conclusion

This Chapter has explained the drivers behind hospital expenditure for medical schemes. While price increases do play a role, it is the increase in utilisation that drives expenditure increases to well in excess of salary inflation.

While these conclusions may shed new light on the drivers behind hospital expenditure, they in no way affect our commitment to actively pursuing a solution to managing increasing medical costs that are adversely affecting all players in healthcare.

The objective of this information is to inform the public and stimulate debate, specifically by drawing attention to the analysis and commentary of certain influential stakeholders which is based on inaccurate or incomplete data.
CHAPTER 6

TRANSPARENT PRICING

1. Introduction

This Chapter provides context to the longstanding commitment of the private hospital sector to developing transparent pricing models, and outlines the interactions between HASA and RAMS (now the BHF) that have taken place with regard to this development.

To appreciate the interplay between the billing of drugs and medical devices, and Ward, Theatre and Equipment (WTE), it is important to understand the history of hospital billing, and the joint role played by the Hospital Association of South Africa (HASA) and RAMS (Representative Association of Medical Schemes), later re-constituted as the Board of Healthcare Funders (BHF), in agreeing a billing structure based on a zero cost model. Historically, the billing model that resulted from this process was one in which the billing of drugs and medical devices effectively subsidised WTE.

2. Zero-base Costing Model

In the early 1990s, HASA submitted a proposal to establish a transparent pricing model for annual tariff escalations. The parameters of this model, which included building costs, occupancy rates, return on investment, among others, were agreed to by both HASA and RAMS. However, although the zero-cost model made no allowances for certain costs to private hospitals such as annual leave and sick leave, or the cost of financing, it did compensate for these omissions by including a margin on the manufacturers list price of drugs and surgicals. Specific reference was made to the fact that pharmacy profits were used to achieve the required return on investment by subsidising the WTE tariffs.

3. Medical Schemes’ Access to Cost Structure Negotiations

It is important to note that the basis of engagement between RAMS and HASA was determined by the RAMS constitution.

Furthermore, medical schemes had unlimited access to information pertaining to these interactions through their representatives elected to serve on the main board, the tariff sub-committee and the hospital sub-committee of RAMS, which included the following members:

- Dr Brian Brink – Hospital Manager, Ernst Oppenheimer;
- Mr Peter Eustace – Anglo American;
- Dr John Cowlin – Medscheme;
- Mr Brian Cook – Mine Benefit Society;
- Mr Cunningham – Klerksdorp Medical Benefit Society; and
- Mr Roly Buys – General Manager, Vaalmed.

RAMS was thereby provided with a full understanding in respect of the pharmaceutical pricing structure used in the private hospital sector. Both RAMS and HASA were fully aware of the cross-subsidy principle applied in the hospital pricing model, and agreed to a process of eliminating the cross-subsidy from the pricing model over time.

4. Moving to a Transparent Pricing System

During the period 1990 to 1994, the price of pharmaceuticals was based on the manufacturer’s list price or Trade/Blue Book price plus 50%, less a discount of 10%. This amounted to an effective mark-up of 35% on the trade price, plus a dispensing fee of R2.49 to R2.70.

At the end of 1994, an agreement was reached between HASA and RAMS to reduce this 35% mark-up to 10%, plus a dispensing fee of R2.90, which came into effect on 1 January 1995. The WTE tariff was consequently adjusted, resulting in a cost neutral transfer. Although this agreement started addressing the cross-subsidies between pharmaceuticals and WTE, a significant degree of cross-subsidisation remained in effect.

In 1998, an agreement was reached to eliminate the 10% mark-up on the manufacturer’s list price or Trade/Blue Book price, with came into effect on 1 January 1999. Correspondence from RAMS, dated 21 January 1999, addressing the planned 10% reduction on drugs and consumables, stated clearly that “this will begin to address the cross subsidy of ward and theatre costs by drugs and consumables on a cost neutral basis”.
The joint agreement reached at that time refers to:

- The cost neutrality of the transfer where hospital WTE tariffs are adjusted;
- The definition of the terminology used by RAMS of net acquisition price as the manufacturer’s list price21; and
- RAMS and HASA forming a joint monitoring committee to monitor changes in pharmaceutical products pricing.

The commitment of the private hospital sector to continue with the process of achieving fully transparent pricing, and the need for the final reallocation of revenue source to WTE where the majority of the cost of hospitalisation resides, is evident in correspondence between HASA tariff sub-committee members after a meeting with the BHF in August 2000. Although no consensus was reached in this regard, the parties agreed to remove dispensing, broken bulk and container fees, replacing these with a fixed charge per day.

The  **Transparent Pricing Systems for Medicines and Scheduled Substance Regulations** (effective 4 May 2004 and gazetted on 11 November 2005) dealt explicitly with discounts on pharmaceuticals – from volume bulk discounts, other trade discounts off list price, bonus deals, and settlement discounts and rebates. The regulations resulted in a further cost neutral transfer of the profit achieved from such discounts to WTE by hospital groups.

These Single Exit Price (SEP) adjustments were negotiated individually between private hospital groups and medical schemes, and the SEP transfers to WTE were accepted by all medical schemes and went uncontested by the Council for Medical Schemes (CMS).

At this stage no adjustment was made for surgical discounts as it did not fall within the ambit of the Medicines and Related Substances Control Act. In 2003/4, Medi-Clinic, in collaboration with most medical schemes, started transferring the profit on surgicals to WTE on a cost neutral basis and made surgicals a cost centre. The rest of the private hospital sector is now implementing similar arrangements in conjunction with all medical schemes.

**5. Conclusion**

The private hospital sector remains fully committed to the principle of transparency in tariff negotiations with medical schemes. In addition, the major private hospital groups and independent hospitals have individually committed to increased transparency regarding rebates. The manner in which this will be implemented will depend on negotiations between individual hospital groups and the respective medical schemes.

It is necessary that all healthcare stakeholders honour the principles of transparency. While the private hospital is committed to transparency, it respectfully calls on administrators and medical schemes to do the same, specifically in the manner in which non-healthcare related costs are determined, the impact of capital raising (to meet reserve requirement) on admin fees, as well as the extent to which ‘administrator costs’, such as salaries, are incorporated in medical scheme expenditure.

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21 Confirmed by RAMS correspondence on 4 December 1998: “The Net Acquisition Price of pharmaceuticals is currently listed in the 1999 Pharmaceutical Scale of Benefits, as Blue Book prices as at 31/10/98.”
CHAPTER 7
ALTERNATIVE REIMBURSEMENT METHODOLOGY

1. Introduction

This Chapter contextualises the role of Alternative Reimbursement Models in private hospital billing and indicates the current penetration of these models.

Much discussion has taken place on the use of Alternative Reimbursement Models (ARMs) as a potential solution to address increases in healthcare expenditure.

ARMs aim to transfer risk from healthcare funders to healthcare providers, and in so doing to align incentives between the medical scheme and service provider. It is important to note that while the Fee for Service (FFS) model does have its flaws, it also has a number of advantages (such as transparency and fairness) that are often overlooked.

Interventions of a medical or surgical nature are carried out for a variety of reasons, including patient need, expert opinion and the ethical imperatives involved in treating patients. It is neither proper nor accurate to suggest that the FFS model is fundamentally inappropriate, as each procedure is inevitably subjected to an authorisation process (by the respective medical scheme), a managed care relationship, as well as the required ethical and clinical standards.

2. Background of fee for services

The FFS model is a reimbursement system where all services and products used in the delivery of healthcare are directly billed to a specific patient. The financial risk lies solely with the funder of the costs. It is argued that the FFS model does not sufficiently sensitise the provider of the healthcare services to the cost of delivering these services.

Notwithstanding, this system is not without vigorous checks and balances. In particular:

• Medical schemes authorise a procedure and/or intervention on application by either the member or the practising physician.
• Once authorised, a procedure is assigned a code used by the medical scheme and the healthcare provider to ensure compliance with procedures, formularies and clinical standards.
• The medical scheme and the healthcare provider, through a managed care relationship involving an independent third party, monitor authorisation and often approve requirements such as hospital days, additional interventions and pharmaceutical products on a daily basis.
• Once the intervention has been completed and the patient discharged, the medical scheme is presented with a final invoice. This provides an additional opportunity for the medical scheme to verify the final account as well as the products used, to ensure there have been no errors.
• In the event that an error is detected, the medical scheme is afforded the opportunity to request that this is rectified before payment is finalised.

In contrast, in the case of an ARM, the financial risk is transferred away from healthcare funders to healthcare providers. The amount of risk transferred depends on the type of alternative reimbursement agreed upon by the respective hospital and medical scheme or administrator.
Graph 1: Reimbursement risk continuum.

Graph 1 above reflects how payment models are classified based on the level of risk absorbed by the healthcare provider.

3. Reimbursement Models
The tables supplied below define the various funding models and set out the impact of these on both the provider and funder.

3.1 Fee for Service

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Funder impact</td>
<td>The risk of healthcare utilisation and expenditure resides with</td>
</tr>
<tr>
<td></td>
<td>the funder in a FFS model. As a result, funders establish many</td>
</tr>
<tr>
<td></td>
<td>rules to contain costs via authorisation requirements, benefit</td>
</tr>
<tr>
<td></td>
<td>limits, non-payment and co-payments.</td>
</tr>
<tr>
<td>Hospital impact</td>
<td>It is argued that little incentive exists to manage down the</td>
</tr>
<tr>
<td></td>
<td>utilisation of ethicals, surgicals, ward, theatre and</td>
</tr>
<tr>
<td></td>
<td>equipment. However, it is important to note that hospitals do</td>
</tr>
<tr>
<td></td>
<td>not authorise procedures.</td>
</tr>
<tr>
<td>Ethical/surgical</td>
<td>Funder risk at Net Acquisition Price on drugs and largely List</td>
</tr>
<tr>
<td>risk</td>
<td>Price on surgicals. Effective January 2008 most hospitals bill</td>
</tr>
<tr>
<td></td>
<td>surgicals at acquisition price (net of discounts).</td>
</tr>
<tr>
<td>Level of care risk</td>
<td>Funder risk subject to pre-authorisation by the scheme.</td>
</tr>
<tr>
<td>Length of stay risk</td>
<td>Funder risk subject to pre-authorisation by the scheme.</td>
</tr>
<tr>
<td>Admission rate risk</td>
<td>Funder assumes the risk of admission rate to hospital (subject</td>
</tr>
<tr>
<td></td>
<td>to pre-authorisation by the medical scheme).</td>
</tr>
</tbody>
</table>

3.2 Alternative reimbursement – per diems
In this reimbursement model the funder pays the provider a per day charge for a particular level of care (e.g. general ward versus care and treatment required in ICU) rather than a charge for all the items and services used. The day charge or per diem is a function of the hospital’s historical cost experience for that medical scheme’s member profile.
<table>
<thead>
<tr>
<th>Funder impact</th>
<th>The risk of healthcare utilisation and expenditure is shared between the funder and the hospital. The hospital specifically absorbs the risk of ethical and surgical price increases within a year, as well as utilisation in hospital (including ethical and surgical mix change). The balance of the risk remains with the funder.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital impact</td>
<td>The hospital is incentivised to manage down the price and utilisation of ethicals and surgicals. These items now become a ‘cost’ to the hospital. Different rates exist for different levels of care (e.g. general ward versus ICU).</td>
</tr>
<tr>
<td>Ethical/surgical risk</td>
<td>The hospital assumes both the price and utilisation risk, with carve-outs to FFS for complicated cases very expensive new technologies and significant currency exchange rate movements.</td>
</tr>
<tr>
<td>Level of care risk</td>
<td>Funder risk subject to pre-authorisation by the medical scheme.</td>
</tr>
<tr>
<td>Length of stay risk</td>
<td>Funder risk subject to pre-authorisation by the medical scheme.</td>
</tr>
<tr>
<td>Admission rate risk</td>
<td>Funder assumes the risk of hospitalisation subject to pre-authorisation by the medical scheme.</td>
</tr>
</tbody>
</table>

**3.3 Alternative reimbursement – fixed fees**

In this model, the funder pays the provider a pre-determined amount for specific hospital procedures. For example, the provider is paid a fixed fee for surgical procedures such as hip replacements, hernia repairs or cataract removals.

Again, the fixed fee per procedure is determined by the hospital’s historical cost experience for a particular medical scheme’s member profile. Most of the risk for in-hospital price and utilisation is transferred to the hospital.

<table>
<thead>
<tr>
<th>Funder impact</th>
<th>Both price and utilisation risk for ethical, surgical, ward, theatre and equipment is transferred to the hospital. Funders focus their activities on the appropriateness of admissions and the quality of care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital impact</td>
<td>The hospital bills a single case rate (fixed fee) for the procedure. The hospital assumes all in-hospital price and utilisation risks.</td>
</tr>
<tr>
<td>Ethical/surgical risk</td>
<td>The hospital assumes both price and utilisation risk.</td>
</tr>
<tr>
<td>Level of care risk</td>
<td>The hospital assumes the utilisation risk.</td>
</tr>
<tr>
<td>Length of stay risk</td>
<td>The hospital assumes the utilisation risk.</td>
</tr>
<tr>
<td>Admission rate risk</td>
<td>The funder continues to carry the risk of the number of hospitalisation events subject to pre-authorisation by the medical scheme.</td>
</tr>
</tbody>
</table>

**3.4 Alternative reimbursement – Diagnoses Related Groupers (DRGs)**

DRGs refer to a patient classification system that provides a clinically meaningful way to relate the number and types of patients treated in hospitals to the specific resources required by that hospital.

Within the DRG framework, the funder pays the provider a pre-determined amount for an admission that falls within a particular diagnoses category. This fee is based on the historic hospital cost experience for that medical scheme’s member profile. Most of the in-hospital price and utilisation risk is transferred to the hospital.

<table>
<thead>
<tr>
<th>Funder impact</th>
<th>As a result of the transfer of risk of utilisation and the price of ethical, surgical, ward, theatre and equipment to the hospital, funders rather focus their activities on appropriate admissions and the quality of care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital impact</td>
<td>The risk taken on by the hospital is higher than in per diem (cost per day) or fixed fee (cost per procedure) models as DRG categories are broad and contain multiple disease and procedure groupings.</td>
</tr>
<tr>
<td>Ethical/surgical risk</td>
<td>The hospital assumes both the price and utilisation risk.</td>
</tr>
<tr>
<td>Level of care risk</td>
<td>The hospital assumes the utilisation risk.</td>
</tr>
<tr>
<td>Length of stay risk</td>
<td>The hospital assumes the utilisation risk.</td>
</tr>
<tr>
<td>Utilisation risk</td>
<td>The funder continues to carry the risk of the number of hospitalisation events subject to pre-authorisation by the medical scheme.</td>
</tr>
</tbody>
</table>
### 3.5 Alternative reimbursement – capitation

This model results in the full transfer of the risk of hospitalisation and associated costs from the funder to the hospital. This risk transfer includes the hospital admission rate in relation to a medical scheme’s membership base. As a result, the full risk premium associated with hospitalisation is transferred to the risk-taker, in this case the hospital.

<table>
<thead>
<tr>
<th>Funder impact</th>
<th>Funders focus their activities on patient satisfaction and the quality of care provided.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital impact</td>
<td>The full risk of hospitalisation and the cost thereof is transferred to hospitals. Hospitals focus on managing the admission, utilisation and the costs of the hospital event. In this model, the incentive to under-service exists. It is very difficult to execute this model when the hospital has no management control over either the specialist or the referring doctor (in most cases a GP).</td>
</tr>
<tr>
<td>Ethical/surgical risk</td>
<td>The hospital assumes both the price and utilisation risk.</td>
</tr>
<tr>
<td>Level of care risk</td>
<td>The hospital assumes the utilisation risk.</td>
</tr>
<tr>
<td>Length of stay risk</td>
<td>The hospital assumes the utilisation risk.</td>
</tr>
<tr>
<td>Utilisation risk</td>
<td>The hospital assumes the risk of the number of hospital admissions.</td>
</tr>
</tbody>
</table>

### 4. Application of ARMs by the Private Hospital Sector

The extent to which alternative reimbursements have been applied in the South African market has been underestimated. Each of the three major hospital groups (Netcare, Life Healthcare and Medi-Clinic) has alternative reimbursements in place with medical schemes. It is widely known that at least two of these groups invoice a significant portion of hospital bills based on one or more of the ARMs, a collection of per diems, fixed fees and a small percentage of DRGs. All three of the above mentioned hospital groups have reiterated their commitment to ARMs. Independent hospitals, however, face significant challenges in negotiating ARMs due to their size, location and inability to control on a national level. This fact, with reference to the need for competition, should be considered when advocating ARMs over and above an FFS model.

As mentioned, some elements of FFS billing will remain in place for both hospitals and medical schemes for the reasons set out below.

#### 4.1 Hospitals

Hospitals are not in control of many of the relevant cost drivers, including the following:

- Certain admission categories (such as trauma) cannot be subject to a pre-determined price because of the high variance in costs on a case-by-case basis.
- Independent hospitals do not necessarily have sufficient volume to support the risk of pricing services based on ARMs. By definition, ARMs are devised in accordance with the principle of ‘average pricing’ and are thus dependent on economies of scale and manageable variances in cost.
- ARMs can place the financial viability of hospitals at risk for two reasons:
  - Traditionally, hospitals have not been in the business of managing risk and do not necessarily have the intellectual property to manage and price risk.
  - Managing risk is further complicated by the fact that third parties - the doctor and the managed care entity - make critical decisions regarding the hospital event, including:
    - whether the patient should be admitted to hospital and for which procedure;
    - the length of stay;
    - the level of care required; and
    - the type and amount of drugs and surgicals used.

#### 4.2 Medical schemes

- Small medical schemes do not necessarily have sufficient volumes to support the risk of pricing services based on ARMs.
- Some medical schemes do not want to move from FFS to ARMs as detailed FFS data assists them in understanding the drivers of expenditure, specifically in complex cases.
- The demand for ARMs declines significantly during periods of lower pharmaceutical inflation due to the lower perceived risk, as was evident between 2004 and 2006.
- Managed healthcare companies have a far more significant role to play in an FFS environment. This approach supports their business model and revenue streams.
5. Conclusion
The private hospital sector supports reimbursement models based on the following principles:

- Transparency;
- Fairness;
- Alignment of incentives between hospitals and funders; and
- Cost effectiveness.

Balancing these principles with the realities of providing quality healthcare is sometimes difficult, but the private hospital sector remains committed to finding meaningful solutions in the South African healthcare context.

As indicated, healthcare markets must have an element of FFS as alternative reimbursement is not relevant for all healthcare services, or there may be resistance from smaller medical schemes and independent hospitals to absorb risk. While the FFS model does not align the incentives of the provider, patient and funder to the same extent as ARMs, the transparency benefit of Net Acquisition Pricing for all pharmaceutical and surgical products, which the private hospital sector supports, will go a long way to reduce perverse incentives within the FFS model.

Although the attributes of ARMs cannot be overlooked, two important considerations must be noted:

- Transferring risk to hospitals should only be done for risks that the hospitals can manage. For example, expecting hospitals to assume hospital admission rate risk through capitation agreements is not feasible since hospitals do not determine nor influence the decision to admit a patient.
- As with all insurance contracts, transferring risk will attract a risk premium. The benefits of utilising ARMs will only be realised over the long term as incentives are aligned, and few immediate gains can be expected.

The large private hospital groups have the capacity and economies of scale to absorb risk without compromising the viability of their hospitals but for the same reasons ARMs can have detrimental consequences on the independent hospitals. Notwithstanding the commitment to ARMs, the private hospital sector advises caution in the application of ARMs as they are not a comprehensive solution to curb increased expenditure on hospital services. In the absence of understanding and addressing the drivers of increased utilisation of hospital services, ARMs will not in isolation address the issue of increased admissions to hospitals or changes in case-mix, demographics and the severity of diseases.
CHAPTER 8
IMPACT OF NEW HEALTH TECHNOLOGIES

1. Introduction

This Chapter provides insight into a critical pillar of the healthcare industry – advancing health technologies – and demonstrates the willingness of the private hospital sector to participate in an industry forum assessing their impact.

Health Technologies (HTs) are universally defined to include drugs, devices, medical and surgical procedures and the knowledge associated with these, in the prevention, diagnosis and treatment of disease as well as in rehabilitation. They include the organisational and support systems required to provide healthcare.

Worldwide, HTs are often seen as being a major cause of rising healthcare costs. Unfortunately, this view seems to focus only on increases in spending on healthcare, rather than on the significant benefits of improved healthcare that the spending on HTs makes possible.

A narrow focus on costs overlooks the value that patients and society in general derive from improved healthcare. While costs are undoubtedly central to the healthcare debate and the quest to provide affordable healthcare, they must also be considered in the context of the better healthcare outcomes that can be achieved, and the resulting benefits from a broader socio-economic perspective.

2. The Broader Realities of Technological Advancements

The definition of HTs is broad and encompasses all aspects of medicine, including:

- Pharmaceuticals, such as beta-blockers, antibiotics and statins;
- Biologics, such as vaccines, blood products, cellular and gene therapies;
- Medical devices, equipment and supplies, such as cardiac pacemakers, CT scanners, surgical gloves and diagnostic test kits;
- Medical and surgical procedures, such as psychotherapy, nutritional counselling, coronary angiography and gall bladder removal; and
- Support systems, including electronic patient record systems and telemedicine systems.

HTs can also be grouped according to their healthcare purpose, be it prevention, screening, diagnosis, treatment or rehabilitation.

It can be reasonably argued that HTs have been singled out in their association with escalating healthcare costs because measuring their value has traditionally been presented solely in terms of cost, with little consideration of the multiple benefits they bring and how these help to offset other costs. For example, new HTs often:

- Constitute a total cure for a patient’s condition, eliminating the need for costly ongoing treatment;
- Offer the patient a less expensive treatment option;
- Facilitate quicker recovery, which in turn equates to a shorter length of stay in hospital and broader productivity improvements;
- Improve outcomes and quality of life (e.g. the improved mobility of a person who has received a knee replacement and the positive influence this has on his or her quality of life and productivity); and
- Shorten the length of stay in hospital as a result of a less invasive procedure (e.g. laparoscopic procedures lead to shorter recovery times and thus a shorter hospital stay).

New HTs may add to health expenditure as advances make more services and treatment options available to patients who previously would have gone undiagnosed or been less successfully treated, such as PET scans, colonography, endovascular stents and navigational devices.

Even in instances where a specific new technology may reduce the unit price for a particular category of patient, it often increases net health expenditures by increasing overall volumes, for example, by making it possible to treat patients with only mildly symptomatic diseases or those who were previously too ill for such treatments.

Considering its complexity, the science of measuring the influence of medical advances on healthcare spending is not well developed. Market forces simultaneously determine the demand for HTs and their effect on healthcare expenditure.

Although some critics believe that HTs are the major driver of healthcare cost increases, the introduction and adoption of technological advancements is influenced more by the healthcare funding industry’s policies and controls (such as limits on benefits and funding exclusions) than by demographic trends and inflation. Clinical policies, as designed by managed care companies, may be restrictive in terms of focus on patient event rather than on patient condition. As a result, they recommend what they perceive to be appropriate and cost effective care per event instead of considering long-term outcomes and recurring healthcare problems.
3. Costs versus benefits
While HTs may often increase healthcare expenditure, they also tend to improve health outcomes for patients. It is imperative for the healthcare sector to improve the measurement of the effects that new HTs have on patients’ health and quality of life, and ensure that these technologies are evaluated and reimbursed using methods that are commensurate with their added costs and multiple benefits.

The problem remains that it is generally difficult to discriminate between cost-effective and cost-ineffective technologies. This is further complicated by the perspectives of different stakeholders. A social perspective will be very different to a funder’s perspective or even Government’s perspective. For example, patients may attach great value to a HT while a funder might see it as unaffordable. Nevertheless, at a micro level, measured outcomes will predominantly be influenced by patient selection, operator skill and site of care, factors that can be managed operationally from a provider perspective by both the hospital and physician.

4. Challenges and Key Issues
From a social perspective, the key question is not how much the technology costs, but rather whether the investment in a specific HT is worth the health gains realised.

HTs do not necessarily increase costs in isolation. Rather, the healthcare system and the incentives it contains are critical factors in determining real costs. This is influenced by factors such as how quickly healthcare professionals become proficient in a new technology and are able to achieve economies of scale through its implementation, which in turn will influence the length of time it takes before a HT becomes standard clinical practice.

A growing body of research suggests that patients worldwide strongly support medical innovation and are willing to pay for new HTs. Furthermore, the evidence relating to certain HTs demonstrates that they are cost effective if used for appropriately identified patients. This is a critical point since funders reserve the right to provide cover based on what is affordable to them, but this should have no influence over which treatment a patient should receive. For as long as a HT shows benefit, the choice should always be given to the patient in consultation with their physician.

In some cases the price of a new technology will decline as usage increases and competition between manufacturers drives down costs. In the medical devices market, the impact of competition and its effect on pricing are apparent, with fierce competition resulting in rapid cost adjustments in drug-eluting coronary artery stents.

The timing of adopting new technologies is also an issue that requires careful consideration, with early adoption not always being the best course of action.

The challenge for policymakers and the funding community is to introduce incentives that encourage the appropriate utilisation of new technologies. The challenge for the research community is to enable healthcare policymakers and users to better understand the circumstances in which a new HT adds value. The private hospital sector recommends that the concept of pay for performance should be investigated in this regard as it rewards positive outcomes.

5. Conclusion
HTs should not be broadly rejected purely based on cost if there is realisable value to a specific patient population. This is often a consequence of benefit limits in various medical scheme plans that curtail the provision of services based on an entire population, and so specifically deny deserving candidates. Furthermore, in the absence of national epidemiology data it becomes difficult to determine real price and value for a service if there is limited understanding of the nature and burden of disease.

The evaluation of both clinical effectiveness and cost effectiveness of HTs is a matter of great concern to diverse stakeholders – purchasers, funders, managed care organisations, hospitals, physicians, the Department of Health and patients. Clearly, there is a need to manage the introduction of new HTs and the associated costs, whether a new innovation or the migration of an existing technology.

The private hospital sector supports the establishment of an industry-wide Health Technology Assessment process that is transparent and consistent. This process should apply a multi-disciplinary approach to facilitate the systematic examination of technical performance, safety, clinical effectiveness, cost effectiveness, organisational implications, social consequences, and the legal and ethical considerations of applying a certain technology. The outputs of the process should ensure appropriate guidance, supported by evidence available in the international public domain, firstly to ensure patient access to the highest quality of care in both the private and public sectors, and secondly, to deliver this care at the best possible price.
CHAPTER 9
COUNTERVAILING POWER OF MEDICAL SCHEMES

1. Introduction

This Chapter reviews the arguments posed by the medical funding industry with regard to a perceived imbalance of negotiating power, and demonstrates that the private hospital sector has no specific advantage in negotiations and is, in fact, negotiating on an individual basis where funders benefit from joint negotiations under a handful of administrators.

Concerns have been raised by the medical funding industry and in particular the Council for Medical Schemes (CMS) about the balance of negotiating power between medical schemes and hospital providers. This argument stems from the fact that there are more medical schemes than hospital providers, with medical schemes of the opinion that this scenario unfairly favours hospitals during annual tariff negotiations.

This perception is further entrenched by the CMS making reference to the link between an increase in hospital expenditure and the concentration of hospital ownership, although there is little, if any, empirical evidence to substantiate this. The private hospital sector therefore refutes this view as unfounded.

It is not unreasonable to expect that any issues or concerns relating to the current tariff negotiation process between private hospitals and medical schemes should be validated with appropriate references to prevailing competition law. Furthermore, it is incumbent on those raising concerns about the efficacy of the current legal dispensation to provide empirical evidence, which has been independently verified, to support their respective claims.

2. Hospital Pricing Regime

The past few years have been marked by a change in the private hospital pricing regime. Prior to 2003, tariff negotiations between private hospitals and funders took place collectively, with the Hospital Association of South Africa (HASA) representing the interests of private hospitals and the Board of Healthcare Funders (BHF) representing those of medical schemes.

Due to the punitive action imposed by the Competition Commission regarding pricing collusion on hospital tariffs in 2002, all parties involved signed separate consent agreements with the Commission, stating that they would negotiate on an individual basis in the future. From 2003, as per the Competition Act of 1998 and the actions undertaken by the Competition Commission, private hospitals and funders have entered into annual negotiations individually and not collectively.

3. Impact of Consolidation on Hospital Price Increases

Graph 1 below reflects the distribution of hospital beds between South Africa’s private hospital groups and independent hospital providers. It is apparent that the bulk of consolidation in the industry took place before 2003.

Graph 1: Distribution of private hospital beds in SA.

Source: HASA 2006.
The fact that the majority of consolidation in the private hospital market occurred before 2000, and that joint negotiations between HASA and BHF were still common practice at the time, refutes the argument that the increased concentration of hospital beds led to greater hospital tariff increases due to an increase in negotiating power for the private hospital groups.

Graph 2 below demonstrates the changes in ward, theatre and equipment fees relative to inflation. Given that hospital tariffs increased in line with CPIX levels, the argument that there was a causal link between increased market share in the 1990s and the ability of the private hospital sector to push through higher price increases is clearly dispelled.

Graph 2: BHF hospital tariff increases averaged 7.5% from 1998 to 2002, equal to the inflation rate.

4. Concentration of Medical Scheme Negotiating Power
It is generally believed that medical schemes have less negotiating power because of the fragmentation of the market. However, to arrive at this conclusion, it is necessary to explore the various negotiation mechanisms that are followed, specifically collective negotiation, as well as the role of managed healthcare and payment practices.

4.1 Joint negotiation
Although there are approximately 130 registered medical schemes in South Africa, six medical aid administrators represented 71.6% of the medical scheme market in provider negotiations in 2006\(^2\). In each case, the administrator or managed care company jointly negotiated tariffs with private hospitals on behalf of all their medical scheme clients. During the same year, Discovery Health accounted for 36.4% of all open scheme membership, while the Metropolitan Health Group represented 46.7% of restricted scheme membership. The impact of Discovery Health’s negotiating power is further emphasised when one considers that total open scheme membership represents around 72% of the total medically insured market\(^3\).

4.2 Managed care
A patient may not be hospitalised unless a pre-authorisation process has been performed by the medical scheme or its managed care organisation (MCO). This authorisation procedure assesses and determines the medical necessity of a treatment plus the availability of the member’s benefits.

Ongoing case management determines the patient’s level of care and length of stay in hospital. Accordingly, the scheme or MCO can limit or narrow its exposure to costs. This process is labour-intensive and often requires hospitals to employ registered nurses as case managers, with the result that these nurses are removed from their direct ambit of patient care.

Medical schemes determine which medical treatment will form part of ‘covered benefits’ based on treatment protocols. This evaluation includes the use of new technology, equipment, drugs or other consumables.

\(^2\)The Competition Commission: Recommendations and Reasons on the Community Hospital Group hearing, page 23, the Commission notes (and does not challenge) the merging parties’ proposition that “six medical aid administrators account for more than 70% of the market from the customers’ side”.

4.3 Payment
The Medical Schemes Act (MSA) obliges medical schemes to settle their claims within 30 days of receiving them. However, a hospital is not allowed to levy a penalty for late payment. Payments that are not received within that period affect a hospital’s cash flow, which in turn impacts on the viability and optimisation of the facility.

In terms of medical scheme rules, granting an authorisation for a treatment or procedure is not a guarantee of payment, and medical schemes will from time to time reverse the payment of accounts for members even where hospital admission is granted via the initial pre-authorisation process.

Medical schemes can decide at their own discretion (sometimes at a much later date) that a member was not in ‘good standing’ at the time of hospital admission and that the pre-authorisation approval should therefore not have been granted.

Some of the reasons given by medical schemes for such instances include unpaid membership fees or the member’s resignation from the scheme. In these cases, hospitals have delivered services and incurred the costs in good faith, while the final decision to pay claims and settle an account (or not) ultimately rests with the medical scheme.

5. Conclusion
The trend towards consolidation in the medical scheme market and the resultant concentration of membership within a handful of administrators gives these administrators substantial market power and the ability to influence the performance of the sector.

With reference to the recent BHF call for the application of a collective bargaining process for medical schemes, the private hospital sector does not believe that this will lead to lower expenditure on hospitalisation as hospital price increases have been well contained with average increases since 1999 exceeding CPIX by 1.7%. Furthermore, such collective bargaining removes the incentive for hospitals to improve efficiency and innovate aggressively, to the benefit of the funding industry. In fact, the recent move to actual acquisition costs (net of discounts) for all surgical products came as a direct result of the independent bargaining process between a single hospital group and a single funder/administrator. While this pricing model was discussed in depth during the BHF/HASA collective bargaining process, it failed to realise this outcome.

The private hospital sector wishes to place on record that it seriously questions the basis of this collective bargaining request by the BHF, and calls on the Competition Commission to independently validate this request and the BHF’s reasoning for it.

To do so, we recommend that the Commission:
• Independently verifies the accuracy of the allegation that consolidation in the private hospital sector has led to increased prices, and provides empirical evidence in this regard. This will require the Commission to:
  – Establish that there has been no outside reason for this consolidation, by which we mean there was no regulation and/or policy effects, such as the Department of Health’s moratorium on hospital licences, outside the control of the hospital sector which resulted in consolidation (if any).
  – Establish that consolidation has resulted in higher costs than if it had not occurred.
• Establish whether the claim that medical schemes have no countervailing power to negotiate is in any way reflective of actual practices within the market, and whether legislation has not given medical schemes substantial power over and above that of providers.
• Establish whether medical scheme administrators that negotiate on behalf of more than one medical scheme are acting in accordance with the provisions of competition law.

The BHF’s request implies that no collective negotiation currently exists. This is, however, contradicted by the fact that Metropolitan, Old Mutual and Medscheme dominate the restricted scheme market and Discovery and Medscheme do so in terms of the open scheme market.

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CHAPTER 10
PRIVATE HOSPITAL SECTOR CAPACITY AND OCCUPANCY LEVELS

1. Introduction

This Chapter clarifies the dynamics of capacity and bed occupancy, and challenges the basis for the CMS’s claims of supplier induced demand within the private hospital sector.

The extent of free capacity within the private hospital sector is a frequently debated issue. The Council for Medical Schemes (CMS) regularly argues that there is considerable spare capacity within the private sector, giving rise to so-called ‘supplier induced demand’. Supplier induced demand can be defined as the amount of demand created by doctors, which exists beyond what would have occurred in a market in which consumers are fully informed.25

To investigate the validity of these arguments, it is necessary to thoroughly examine the dynamics of capacity and bed occupancy.

2. Constraints on Occupancy Levels

It is necessary to consider the following issues and constraints when looking at occupancy in hospitals.

Firstly, 100% bed occupancy is neither practical nor possible for the following reasons:

• All hospitals require vacant beds at all times to accommodate emergency admissions.
• Quoted occupancy rates are calculated as averages that include periods of abnormally low occupancy (such as weekends and holiday seasons). For example, an occupancy rate of 74% constitutes week-day occupancy of around 80% and weekend occupancy of between 50% and 60%. During the December/January and June/July holiday seasons, occupancy rates fall as a result of doctors taking leave and patients postponing elective surgery. The average occupancy rate for a whole calendar year is therefore not a true reflection of available capacity in a hospital at any given point in time.

Graphs 1 and 2 illustrate the differences in week-day and weekend occupancy levels for the private hospital sector.

Graph 1: Private hospital occupancy rates by type of day.

Source: Netcare, Life Healthcare and Medi-Clinic data for the 2006 calendar year.

Graph 2: Private hospital occupancy rates by day of the week.

Source: Netcare, Life Healthcare and Medi-Clinic data for the 2006 calendar year.

Graphs 3 and 4 illustrate the impact of doctors taking leave over the December/January holiday season, and patients choosing not to be admitted to hospital for elective procedures during this time.

Graph 4: Private hospital occupancy rates by type of day averages and for the three-week peak period of December/January holidays.

Source: Netcare, Life Healthcare and Medi-Clinic data for the 2006 calendar year.
Graph 4: Private hospital occupancy rates by day of the week averages and for the three-week peak period of December/January holidays.

Source: Netcare, Life Healthcare and Medi-Clinic data for the 2006 calendar year.

- Occupancy rates are expressed as a percentage of registered beds. However, occupancy can never exceed the number of supervised beds available. With the current shortages of healthcare professionals, especially professional nursing practitioners, higher occupancy levels are specifically inhibited.
- Hospital beds in certain types of wards can only be filled with specific patients, with maternity and paediatric wards two cases in point. As such, vacant beds do not necessarily constitute spare capacity.

High occupancy levels (80% and above) precipitate the following risks:
- Strained support services, such as cleaning, linen, catering, administration and security;
- Increased pressure on nursing procedures and patient care;
- Added burdens on nurses result in a relative or absolute decrease in staff to patient ratios;
- Literature suggests that an increase in adverse events (falls, skin lesions, medication errors, etc.) occur as occupancy levels approach 90%; and
- A major concern at high occupancy rates is infection control.

3. Conclusion

Although the data published in the CMS Annual Report is deemed to be an accurate and credible source of information by numerous stakeholders, the private hospital sector has specific concerns in the way the CMS defines and measures occupancy and capacity levels. Please refer to Chapter 4 which deals with similar concerns in terms of measurement and definition in CMS reporting.

Clearly, it is fundamental that the dynamics of capacity and occupancy in the private hospital sector are properly understood and measured, to provide a sound basis to investigate increased access to the private hospital services.

As noted in Chapter 3, the private hospital sector commits itself to publishing regional occupancy levels on a biannual basis to facilitate proposed partnerships with the Department of Health in treating State patients.
CHAPTER 11
QUALITY OF PRIVATE HEALTHCARE IN SOUTH AFRICA

1. Introduction

This Chapter briefly discusses some key areas of the clinical governance systems in effect in the private hospital sector. It also contains suggestions for ways that the sector can further enhance quality measurement by applying national and international benchmarking.

In recent months, references to quality outcomes in the private versus the public healthcare sector have been raised on at least two occasions, namely at the 2007 Board of Healthcare Funders (BHF) Conference and the Private Health Sector Indaba. The key issue raised relates to whether the higher cost of private healthcare leads to better quality outcomes for patients.

In response to this, it is necessary to provide stakeholders with proper context to this issue and to supply accurate data to assist in the assessment of quality within the private hospital sector in relation to the public sector and to international quality standards.

2. Defining Quality

Quality is a multi-faceted concept, and many different and legitimate views exist as to what makes up the critical elements of delivering quality care. Measurement and reporting standards must however allow for valid, meaningful comparisons.

Providing quality healthcare in line with global standards is a key driver for South Africa’s private hospital sector. Besides investing in facilities and advanced medical technology and infrastructure, individual hospitals and hospital groups have also made substantial investments in establishing systems and processes to manage and measure quality delivery across a broad spectrum of care. The independent hospitals are in the process of implementing quality policies and procedures.

The private hospital sector’s investment in establishing quality management systems has led to a number of the local hospital groups securing large international public sector clinical contracts, against contenders that included some of the best global healthcare organisations.

Many of South Africa’s private hospital groups follow the quality assurance systems for clinical governance originally developed by the National Health Service (NHS) in the UK.

Clinical governance is a comprehensive framework that ensures all individuals remain accountable for delivering quality healthcare to patients for the duration of their stay in hospital.

Clinical governance involves the application of and adherence to evidence-based medicine and international best practices delivered by skilled doctors. It also involves monitoring adverse events to identify clinical risks and mitigate their impact on patient safety. Clinical governance requires that hospitals ensure patients are satisfied with the level of care they receive and the manner in which they are treated in hospital.

3. Clinical Practice and Outcomes

Globally, there is a growing call for healthcare organisations and health professionals to ensure that the latest evidence-based medicine is used in the process of delivering care. To this end, considerable progress has been made by the major private hospital groups in South Africa, who have focused specifically on cardiac, accident and emergency, neonatal, and intensive care. Evidence-based initiatives that have been introduced include measuring compliance levels against international standards of care known to produce better patient outcomes. Programmes that monitor and collate specific benchmark measures (with a view to continuously improve clinical outcomes) have also been initiated.

The measurement of specific clinical outcomes is complicated by the diversity of patient co-morbidities, necessitating adequate case-mix management to address this issue. However, private hospital groups are generally well positioned to understand the limitations of the systems currently available in South Africa and are committed to sound case-mix management.

4. Medical Professionals – Skills and Competency

The private hospital groups have their own education divisions that train different levels of nursing staff. In addition, nurses receive ongoing on-the-job training and skills development during their active employment in South Africa’s private hospitals. Importantly, the medical expertise of doctors is also utilised to improve the competence of nursing staff through multi-disciplinary ward rounds.
Although doctors’ professional development is mostly regulated by the Health Professions Council of South Africa (HPCSA), many hospitals provide doctors with Continuous Professional Development programmes and additional educational opportunities.

The professional code of ethics and conduct of all healthcare staff is monitored by all private hospital groups, aiming to ensure that clinical competence and misconduct does not affect patient safety in any way. Good progress has been made in establishing a sound working relationship between the sector and the HPCSA to deal with such matters most appropriately.

5. Infection Control
South Africa’s private hospitals have a long history of infection control management practices which ensure that rates of nosocomial infections remain well below international trends, and that the risks related to hospital-acquired infections are well managed.

All private hospitals employ dedicated professionals to manage infection control. Infection control is governed by well-established, detailed protocols and policies with high levels of compliance. Ongoing surveillance and risk identification is further supported in many hospitals through the appointment of infection control nurses for the wards. These nurses are able to drive continuous improvement controls through ongoing training of healthcare personnel.

There are numerous examples of initiatives within the private hospital sector that have resulted in enhanced patient outcomes. The infrastructure and management systems related to infection control also play a vital role in the country’s broader healthcare framework by helping to address potential outbreaks of infectious diseases. We are pleased to note that there has been increased interaction and discussion with the Department of Health in this regard.

6. Patient Health and Safety
The need to ensure patient health and safety has over the last twenty years informed the basis for quality management in South Africa’s private hospitals.

Quality management includes the identification and management of patient-related risks, the reporting and analysis of incidents and adverse events, and the implementation of corrective and preventative programmes to minimise the risk of re-occurrence. Detailed statistics are available for a broad spectrum of identified risks and sustained improvement initiatives have been implemented to address key trends that have emerged.

Some common focus areas of measurement and improvement include:
- Medication errors;
- Slip and fall-related incidents; and
- Pressure sore incidents.

To assist with reporting, most private hospitals have electronic adverse event registers that allow staff to directly capture and alert senior management and medico-legal risk departments to any such occurrences. As the scope of reporting is aligned with national and international best practices, further improvements in health and safety related reporting can be expected in future.

7. Patient Satisfaction
Increasingly, patient perceptions of the quality of hospital care are being acknowledged. South Africa’s private hospitals have adopted a number of different systems to measure patient satisfaction, such as:
- Online electronic patient satisfaction measurement;
- Written questionnaires completed by patients during their hospital stays;
- Patient focus groups and post-discharge telephonic interviews; and
- Call centres that manage incoming complaints and queries, while also conducting outgoing customer satisfaction surveys.

Patient complaint management systems are formalised throughout the private hospital sector. A great deal of focus is placed on monitoring the outcome of complaints to ensure they are timeously and fully resolved, and that appropriate measures are instituted to prevent future incidents and improve service delivery.

8. Accreditation
For many years, the accreditation and certification of healthcare facilities and services has been a major objective for the private hospital sector. As some private healthcare groups have expanded internationally, they have sought international certification by organisations accredited by ISQua (International Society for Quality in Healthcare). As such, all the major private hospital groups, and a large percentage of independent hospitals, have well established quality certification systems that emphasise clinical governance and quality management.
9. Industry Co-operation and National Benchmarks

The private hospital sector recognises the need for increased industry co-operation around the establishment of national benchmarks and standardised measures for clinical outcomes. Recently, in a bid to standardise and improve quality processes in the private hospital sector, the Hospital Association of South Africa (HASA) created a specialised Quality Sub-Committee.

Table 1 provides a series of quality indicators and gives their definitions. These indicators will in future be published by HASA on an annual basis.

**Table 1: Quality Indicators and definitions.**

<table>
<thead>
<tr>
<th>Quality outcomes indicator</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mortality rates</td>
<td>Crude death rates as a percentage of total in-patient admissions.</td>
</tr>
<tr>
<td>2. Healthcare associated infection rates</td>
<td>Number of patients with a hospital acquired infection per 1000 patient days.</td>
</tr>
</tbody>
</table>
| 3. Patient safety          | Adverse events rate based on pre-defined list of adverse events per 1000 patient days.  
                             | Adverse events include falls, medication errors and pressure sores. |
| 4. Patient experience      | General patient satisfaction rating of services provided. |
| 5. Accreditation           | Current commitment to undergo local or international accreditation and how many facilities are accredited. |

It is important to note that a substantial amount of work still needs to be done to standardise the methodologies and measures among the private hospitals groups, and to link them to suitable international and national health benchmarks. This collaboration will continue in 2008 and will allow changes to be made in individual business processes prior to the publication of these indicators.

Annexure A reflects the outcomes of quality categories where definitions and methodologies have already been standardised.

The publication Healthcare Associated Infection Rates and Patient Safety has been purposefully excluded, as the preliminary results from the private hospital sector appear to be very low in comparison with international benchmarks. We suspect that a shorter length of stay in South African hospitals may be a contributory factor, but this will be further explored in 2008. Once the integrity of the data has been ascertained, the information will be communicated to stakeholders.

10. Conclusion

The South African private hospital sector will continue to provide quality healthcare in line with global standards. Through the newly established HASA Quality Sub-Committee, these efforts will gain momentum, equipping healthcare consumers, providers and Government with credible data to inform decisions in identifying trends, opting for quality services, managing patient safety risks, and developing healthcare policy. These data will be published in an annual report of private hospital quality indicators, which will facilitate national and international quality benchmarking for the private hospital sector.

The private hospital sector is committed to working with the Department of Health to determine national standards for the delivery of quality care to all patients, in keeping with the proposed Office of Standards Compliance, and welcomes the opportunity to discuss these matters.
<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>SA Private Hospital Industry</th>
<th>International Benchmark</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Crude Mortality rates</td>
<td>1.47%</td>
<td>1-3% USA</td>
<td>Internationally, methodologies vary as to which patient subgroups are included in total deaths, i.e. all in-patients, day cases, psychiatric and long-stay cases.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8.5% NHS (UK)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2% Helios (Germany)</td>
<td></td>
</tr>
<tr>
<td>2. Patient experience</td>
<td>Consistently above 80%</td>
<td>No comparator</td>
<td>Range presented as each hospital group makes use of different methodologies and tools to determine patient satisfaction.</td>
</tr>
<tr>
<td>3. Accreditation</td>
<td>Medi-Clinic: COHSASA (ISQua accredited) accreditation of 35 hospitals on a rolling three-year basis.</td>
<td>No comparator</td>
<td>Range presented as each hospital group makes use of different organisations for accreditation of its facilities.</td>
</tr>
<tr>
<td></td>
<td>Netcare: HAQU (ISQua accredited) Accreditation of 5 hospitals currently, 10 underway.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Arwyp hospital: First hospital to be ISO 9001 accredited.</td>
<td></td>
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</tbody>
</table>
CHAPTER 12
TRAINING OF HEALTHCARE PERSONNEL

1. Introduction

This Chapter covers the private hospital sector’s contribution to the supply, retention, repatriation and development of the required health personnel in South Africa, and proposes solutions to help address the current skills shortages in the sector.

Suitably qualified health professionals are the foundation of any sustainable healthcare system. Due to increasing consumer demand and population growth trends, the demand for healthcare personnel far exceeds the current supply. This is a global phenomenon, and one which is made apparent in South Africa by a vacancy rate among registered nurses of around 24% in the private hospital sector, and an even greater shortage of specialised registered nurses. Pharmacists are also in short supply with vacancy rates currently at an estimated 30%.

While the private hospital sector invests significantly and is intensely involved in the training and provision of nurses in South Africa, it is also engaged in the training of other healthcare personnel, such as pharmacists, paramedical staff, clinical technologists and care workers. In addition, the private sector offers bursaries to medical students and for postgraduate education.

The training and provision of healthcare personnel occurs within legislative and financial constraints, and the private hospital sector is committed to working with all stakeholders to implement feasible solutions within these parameters.

2. Current Nurse and Doctor Profile in South Africa

According to the South African Nursing Council (SANC) there were 196 914 nurses in the South African healthcare sector at the end of 2006; with 101 295 registered nurses, 39 305 enrolled nurses and 56 314 enrolled nursing auxiliaries. However, it must be noted that not all nurses registered with SANC are practising in South Africa, and those who remain in South Africa may not all still be nursing.

Between 1996 and 2006 there was an overall increase in the total number of nurses on the country’s registers from 172 520 to 196 914 (14% growth overall or 1,4% growth per annum). Nevertheless, the South African population increased from approximately 42,1 million to 47,5 million in the same period (12,7% growth). The current ratio of patients to one nurse is 241:1.

If the output of the different nursing training programmes is collated, it gives the impression that there are enough nurses in training to offset those who are leaving the country. However, when compared with the population’s growing health needs, this has proven to be insufficient for current requirements and the situation is expected to deteriorate unless significant resources are dedicated to educating nurses.

Table 1 below refers to a study conducted by the Human Sciences Research Council (HSRC) which reflects that the estimated shortage of nurses by 2011 will be over 18 000. This shortfall is predicted despite bridging programmes and some estimated success in halting the emigration of nurses.26

Table 1: Forecasts of active nurses in South Africa.

<table>
<thead>
<tr>
<th>Year</th>
<th>Projected population</th>
<th>Nurses needed</th>
<th>Replacement demand</th>
<th>Estimated supply</th>
<th>Estimated gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>45 349 800</td>
<td>155 484</td>
<td>6 599</td>
<td>5 837</td>
<td>762</td>
</tr>
<tr>
<td>2002</td>
<td>45 969 270</td>
<td>157 429</td>
<td>6 769</td>
<td>5 837</td>
<td>932</td>
</tr>
<tr>
<td>2003</td>
<td>46 558 520</td>
<td>159 447</td>
<td>6 842</td>
<td>5 837</td>
<td>1 005</td>
</tr>
<tr>
<td>2004</td>
<td>47 112 480</td>
<td>161 344</td>
<td>7 918</td>
<td>5 837</td>
<td>2 081</td>
</tr>
<tr>
<td>2005</td>
<td>47 629 350</td>
<td>163 114</td>
<td>8 618</td>
<td>5 837</td>
<td>2 781</td>
</tr>
<tr>
<td>2006</td>
<td>48 101 620</td>
<td>164 732</td>
<td>8 688</td>
<td>5 837</td>
<td>2 851</td>
</tr>
<tr>
<td>2007</td>
<td>48 528 670</td>
<td>166 194</td>
<td>7 688</td>
<td>5 837</td>
<td>1 851</td>
</tr>
<tr>
<td>2008</td>
<td>48 913 280</td>
<td>167 511</td>
<td>8 264</td>
<td>5 837</td>
<td>2 427</td>
</tr>
<tr>
<td>2009</td>
<td>49 252 100</td>
<td>168 672</td>
<td>8 881</td>
<td>5 837</td>
<td>3 044</td>
</tr>
<tr>
<td>2010</td>
<td>49 554 890</td>
<td>169 709</td>
<td>7 843</td>
<td>5 837</td>
<td>2 006</td>
</tr>
<tr>
<td>2011</td>
<td>49 823 220</td>
<td>170 627</td>
<td>7 706</td>
<td>5 837</td>
<td>1 869</td>
</tr>
<tr>
<td>Total demand</td>
<td>77 128</td>
<td>58 370</td>
<td>18 758</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: HSRC HRD report. Estimates to 2014 are not available but the authors estimate that the supply gap could be as high as 25 000 by 2014.

The data in Table 2 does not differentiate between nurses who are registered and nurses who practise nursing in South Africa, nor between registered nurses and enrolled or auxiliary nurses. By not analysing the breakdown in the specialisation level of nurses, this table may significantly under-forecast the supply gap in registered nurses.

The World Bank indicates that the scenario is bleaker regarding doctors and South Africa is already viewed as a country with too few doctors currently in practice. Emigration and low net appreciation rates mean that South Africa is likely to experience a shortage of General Practitioners (GPs) for some time to come (see Table 9 below).

Table 2: Estimated gap for GPs in South Africa in 2014.

<table>
<thead>
<tr>
<th>GPs in 2001</th>
<th>29 655</th>
</tr>
</thead>
<tbody>
<tr>
<td>Future GP demand at a ratio of 65 GPs to 100 000 population</td>
<td>32 854</td>
</tr>
<tr>
<td>Number of MBChB students</td>
<td>19 595</td>
</tr>
<tr>
<td>Net Emigration</td>
<td>-9252</td>
</tr>
<tr>
<td>Retirement</td>
<td>-9139</td>
</tr>
<tr>
<td>Demand Growth</td>
<td>-3119</td>
</tr>
<tr>
<td>Death</td>
<td>-586</td>
</tr>
<tr>
<td>Estimated Gap</td>
<td>-2 501</td>
</tr>
</tbody>
</table>

Source: Basic GP data HSRC, Death rates according to current mortality rates as given by Stats SA. Retirement based on estimates based of GP age structure as reported.

3. Nurses Training

The largest cost contributor in hospitalisation is staff costs, which comprise approximately two-thirds of all expenditure (excluding pharmaceuticals) and have been increasing above the inflation rate on a cost per patient day since 2003. The vast majority of staff costs relate to nursing. Hospital costs in the future, in the public as well as the private sectors, will depend heavily on developments in this category.

The staffing cost pressures in the hospital sector are likely to continue due to high existing vacancy rates. South African nurses are highly sought after, both domestically and internationally. Because of the demand for their skills, South African medical staff can easily secure attractive salaries and negotiate favourable working conditions.

It is in the context of the Draft Nursing Strategy for South Africa that we examine the concerns and criticisms levelled at private hospitals in this regard, and present coherent and constructive responses and potential solutions.

3.1 Training of registered nurses

The rationalisation of public sector nursing colleges has resulted in a reduction in the number of new nurses entering the industry. In 1996, 2 629 registered nurses graduated. This compares to the 1 493 public sector graduates in 2006. This has led to a significant mismatch in the supply and demand of registered nurses in both the private and public sectors. To try and alleviate the shortfall of registered nurses, the private hospital groups have invested significantly in nursing training.

27Shortages or surpluses within an occupation are difficult to forecast as there is usually a lack of information about certain aspects that may impact on supply or demand. For instance, in the case of physicians, there is a lack of data on human resources in the private health sector, as well as on the exact size of the current workforce. Many physicians occupy positions in the private and public health sectors simultaneously, which makes it difficult to accurately determine employment per sector.

On the other hand, a register of all practising physicians is maintained and a fairly neat match exists between the qualification required to become a medical practitioner and the occupation itself. This makes the comparison between demand and supply easier. Table 2 compares the projected number of positions to be filled by new entrants into the labour market, and the projected number of new graduates that will be produced by universities between 2001 and 2011. Growth in demand is calculated as the number of positions that need to be filled to maintain the current physician/population ratio of 65:100 000 as recommended as a minimum for a developing country. Demand arising from replacement needs is based on retirement, death and emigration. Net emigration has been estimated using Meyer, Brown, Kaplan ratios. Two factors that may well impact on future demand were not considered in the calculations: changes in healthcare needs and the impact of an increase in the number of vacant positions in the public health sector. This may well cause the supply gap to increase even further.

This investment is reflected in the increase of bridging programme graduates from 1,169 in 1996 to 2,364 ten years later, indicated in Graph 1 below.

**Graph 1: Annual number of registered nurse graduates in programmes leading to registration.**

![Graph](image_url)

According to SANC statistics, it is clear that the majority of registered nurses (54%) are qualifying via the private sector bridging programmes for enrolled nurses. This means that in 2006, the private sector funded and trained approximately 54% of registered nurses who qualified in South Africa. This is a considerable increase from a decade ago when 72% of all registered nurses graduated from public sector colleges and universities.

The private sector bridging programmes produce registered nurses who are only trained in general nursing, as opposed to the four-year diploma in which nurses are trained in general, psychiatric, community health and midwifery. It is not possible for the private hospital sector to train nurses for the basic four-year diploma as the sector is unable to offer complete clinical facilities for midwifery, psychiatry and community health.

It is alarming that over half of the registered nurses currently in training are trained only in general nursing, aggravating the urgent need for midwives, community health and psychiatric nurses in South Africa.

In terms of post-basic qualifications, SANC statistics show a decline in the number of nurses graduating in most categories. Of particular concern to the private hospital sector is the decline in the total number of nurses with post-basic qualifications in the specialty areas of intensive care, operating theatre and paediatric nursing, shown in Graph 2 on the following page.
Initially, private hospital groups set about training nurses for their own purposes to address Government’s concerns of the sector recruiting State-trained nurses, but the private hospital sector has progressively trained greater numbers of nurses serving also to supply the public sector. It is encouraging to note that over the past few years, there are numerous examples of nurses training partnerships between the private and public sectors.

### 3.2 Training in the private sector

The private sector currently trains approximately 6000 nurses per year (see Table 3).

#### Table 3: Private sector training of nurses.

<table>
<thead>
<tr>
<th>Group</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life College of Learning</td>
<td>1128</td>
</tr>
<tr>
<td>Medi-Clinic College</td>
<td>1228</td>
</tr>
<tr>
<td>Netcare Training Academy</td>
<td>3194</td>
</tr>
<tr>
<td>Arwyp Training Centre</td>
<td>158</td>
</tr>
<tr>
<td>Goldfields Training Centre</td>
<td>276</td>
</tr>
<tr>
<td>Total</td>
<td>5984</td>
</tr>
</tbody>
</table>


Table 4 and 5 reflect the nurses training initiatives undertaken by Netcare, Life Healthcare and Medi-Clinic at a cost of around R156 million per annum.

A number of the students graduating from these training programmes are currently employed by the State. The sustained collaboration between the Department of Health (DoH) and the private hospital sector augurs well for positive results in producing greater numbers of nurses in South Africa in the years to come.
Table 4: Basic nursing courses offered by the private hospital sector.

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 yrs leading to registration as enrolled nurse</td>
<td>1138</td>
<td>1909</td>
<td>2169</td>
<td>2276</td>
<td>2023</td>
<td>2373</td>
</tr>
<tr>
<td>2 yrs leading to registration as registered nurse</td>
<td>467</td>
<td>732</td>
<td>1067</td>
<td>720</td>
<td>827</td>
<td>1287</td>
</tr>
<tr>
<td>Undergraduate bursaries at universities (4-yr diploma) sponsored by private sector</td>
<td>109</td>
<td>197</td>
<td>166</td>
<td>201</td>
<td>225</td>
<td></td>
</tr>
<tr>
<td>Grand total basic students trained</td>
<td>1605</td>
<td>2750</td>
<td>3433</td>
<td>3162</td>
<td>3051</td>
<td>3885</td>
</tr>
<tr>
<td>% increase year on year</td>
<td>71%</td>
<td>25%</td>
<td>-8%</td>
<td>4%</td>
<td>27%</td>
<td></td>
</tr>
</tbody>
</table>

Source: Netcare, Life Healthcare, Medi-Clinic.

Table 5: Post-basic nursing courses offered by the private hospital sector.

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing 1 and 2 yr programmes e.g. ICU, OT, anaesthetics, neonatology, paediatrics, oncology, midwifery, education, renal, trauma</td>
<td>123</td>
<td>347</td>
<td>354</td>
<td>229</td>
<td>276</td>
<td>264</td>
</tr>
<tr>
<td>Nursing 6-month programmes e.g. ICU, OT, anaesthetics, neonatology, paediatrics, maternity, A &amp; E, orthopaedics, cardiothoracic, infection control</td>
<td>168</td>
<td>245</td>
<td>356</td>
<td>402</td>
<td>576</td>
<td>723</td>
</tr>
<tr>
<td>Clinical facilitators</td>
<td>2</td>
<td>1</td>
<td>28</td>
<td>28</td>
<td>53</td>
<td></td>
</tr>
<tr>
<td>Refresher/upgrade</td>
<td>20</td>
<td>55</td>
<td>85</td>
<td>56</td>
<td>111</td>
<td></td>
</tr>
<tr>
<td>Grand total post-basic students trained</td>
<td>291</td>
<td>614</td>
<td>766</td>
<td>744</td>
<td>936</td>
<td>1151</td>
</tr>
<tr>
<td>% increase year on year</td>
<td>116%</td>
<td>27%</td>
<td>-1%</td>
<td>21%</td>
<td>24%</td>
<td></td>
</tr>
</tbody>
</table>

Source: Netcare, Life Healthcare, Medi-Clinic.

3.3 Private and public sector nursing initiatives

Examples of public-private nursing initiatives include:

- Netcare assisting the Mpumalanga province with clinical placements for 147 of their first-year students on the four-year basic nursing diploma course.
- Netcare training 79 nurses in infection control for the KwaZulu-Natal and Eastern Cape provincial authorities.
- Life Healthcare training nurses on behalf of the following government departments:
  - Limpopo DoH: post-basic students, 76 in 2006 and 45 in 2007;
  - Gauteng DoH: training of NICU nurses since 2003;
  - Eastern Cape DoH: enrolled nurses, approximately 30 per annum;
  - Western Cape DoH: bridging course for Groote Schuur and Red Cross Hospital, 10 nurses in 2005/6; and
  - Free State DoH: enrolled nurses, National and Universitas hospitals, approximately 20.
- Medi-Clinic accommodating learners from the public sector on request. Two learners from the Standerton DoH will be embarking on short training courses. The group has previously accommodated several DoH learners at its Nelspruit, Sandton and Limpopo Learning Centres. Medi-Clinic has also attempted to render assistance in the Northern Cape but to date the SANC has declined to approve this initiative.

3.4 Nurses training – the way forward

There are a number of legislative enablers or reforms required to facilitate greater contribution by the private hospital sector to the training of nurses and alleviate training bottlenecks including:

a) Internal management issues at the Health and Welfare Seta (HWSETA) which have resulted in delays in approving and awarding learnerships to potential students.

b) SANC-private sector training has been constrained by:

- Protracted processes needed to get courses approved and secure the approval of training and clinical facilities;
- The inconsistent approach of SANC regarding the number of students permitted per year and per course which impedes the continuity of training programmes extending beyond one year;
- Administrative weaknesses, such as the recent problems with the leaking of SANC examination papers, resulting in delayed exams and hampering students’ progress through their training; and
- The present delays in implementing the new Scope of Practice and educational qualifications.
The private hospital sector believes that many of these obstacles can be overcome through collaboration between all nursing training providers, healthcare providers and SANC.

Accordingly, we propose the following initiatives:

1. The DoH has made attempts to create a forum where stakeholders can meet with the SANC to resolve problems. This process needs to be expedited in line with the Nursing Strategy. Ideally, forums should be provincially based.

2. Urgent talks involving all stakeholders need to be held regarding the future of nursing training in the private sector. Focus is needed on the issues raised in the higher education debate.

3. The future of bridging courses for enrolled nurses needs to be understood by all parties as at present this is the only way in which the private sector can contribute to the training of registered nurses.

4. The new Scope of Practice regulations for the various categories of nurses, in terms of The Nursing Act, Act 33 of 2005, needs to be published so that stakeholders can re-align their training strategies to these regulations with regard to nurses training.

5. A standardised training costing model needs to be agreed upon to make training more affordable, with respect to:
   - How students are funded (bursaries or gratuities instead of employment); and
   - The definition of experiential learning required by the SANC.

6. A collaborative effort is needed to forecast the number of nurses required to meet current and future healthcare needs in South Africa. This requires discussions on:
   - Appropriate ratios for the various categories of nurses;
   - Appropriate ratios for support staff to nursing; and
   - A clear definition of non-nursing tasks that could be delegated to other categories of health and/or support personnel.

7. Training providers, both public and private, should engage urgently at provincial level to share resources such as nursing training facilities and lecturers.

3.5 Other strategies for the supply of nursing personnel

The private hospital sector has been active in the repatriation of South African nurses who have been working abroad. To be most effective, this strategy should become a national initiative in conjunction with the DoH.

<table>
<thead>
<tr>
<th>South African nurses brought home from abroad</th>
<th>2006</th>
<th>2007</th>
<th>2008 (*forecast)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total repatriated</td>
<td>20</td>
<td>100</td>
<td>150</td>
</tr>
</tbody>
</table>

Source: Life Healthcare, Netcare.

As a short- to medium-term strategy, and until such time as South Africa can meet its own nursing staff requirements, the private hospital sector is recruiting foreign nurses. Medi-Clinic has recruited 12 nurses from India, and is processing a further 131 applications. Netcare has applied for a corporate permit to recruit at least 500 nurses from India, and Life Healthcare intends to do likewise.

The private hospital sector has launched an initiative to improve the image of nursing as a desirable profession and to attract school leavers. The production of a DVD, in collaboration with the DoH, is nearing completion and will require the co-operation of the national Department of Education to ensure comprehensive distribution.

4. Other Categories of Healthcare Personnel

4.1 Paramedical staff

The private hospital sector is also involved in training paramedical staff as reflected in Table 7 below. There is significant opportunity for partnerships between the public and private sectors regarding standardisation and sharing of scarce resources in this regard.

<table>
<thead>
<tr>
<th>Paramedical Personnel</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007*</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAA</td>
<td>92</td>
<td>239</td>
<td>232</td>
<td>225</td>
<td>258</td>
<td>480*</td>
</tr>
<tr>
<td>AEA</td>
<td>42</td>
<td>52</td>
<td>99</td>
<td>97</td>
<td>45</td>
<td>120*</td>
</tr>
<tr>
<td>CCA</td>
<td>6</td>
<td>28</td>
<td>30</td>
<td>5</td>
<td>5</td>
<td>12*</td>
</tr>
<tr>
<td>Grand total basic successful students</td>
<td>134</td>
<td>297</td>
<td>359</td>
<td>352</td>
<td>308</td>
<td>612*</td>
</tr>
</tbody>
</table>

% increase year on year 122% 21% -2% 13%

*Number in training in 2007, Source: Netcare.
4.2 Pharmacy training
Table 8 indicates the contribution of the private hospital sector to training pharmacists. Efforts are also underway to attract interns into pharmacies.

Table 8: Number of pharmacists in training.

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>60</td>
<td>19</td>
<td>41</td>
<td>21</td>
<td>40</td>
<td>52</td>
<td>33</td>
</tr>
</tbody>
</table>

Source: Netcare, Medi-Clinic.

4.3 Phlebotomists
A phlebotomy course already exists under the auspices of the Health Professions Council of South Africa (HPCSA) but this appears to be dormant. It is vital that both the private and public sectors revitalise the provision of this training.

According to a pathology industry representative there are an estimated 6 000 nurses, many of whom are registered nurses, who are employed by pathology laboratories for services that should be rendered by phlebotomists. An increase in the number of phlebotomists, who would be far more cost-effective, would release a number of these registered nurses back into nursing.

4.4 Surgical technology assistants
Netcare and Life Healthcare have been running in-house programmes for surgical technology assistants similar to the training offered to surgical technologists in the USA and Operating Department Practitioners in the UK.

The competency of the graduates of these programmes has been recognised by the medical profession, and the Hospital Association of South Africa (HASA) is currently seeking formal accreditation of this course from the South African Qualifications Authority (SAQA). The recognition of this two-year programme by the HPCSA would help to relieve the shortage of staff working in operating theatres in both the public and private sectors. It is suggested that this course becomes a mid-level worker programme under the auspices of the Clinical Technology Board of the HPCSA.

4.5 Care workers
A number of courses are presently available for care workers in South Africa. These are greatly facilitating the delivery of care in the primary, acute, rehabilitative and chronic sectors.

However, there is a need for all stakeholders to collaborate on a review of all these courses to achieve standardisation and ensure cost-effective training across the board. This would require a SANC review of the future of current nursing assistant/auxiliary programmes.

5. Conclusion
The private hospital sector is contributing substantially to the training, supply and recruitment of healthcare personnel in South Africa. Furthermore, the sector is committed to make additional investments and to partner with the public sector and other stakeholders in this critical endeavour.

As stated by Schussler and Kruger:

“While the health care sector in general will be well served with administrative personnel, there will still be a skills shortage if there is not a significant extra spend on education in the higher education sector. The skills shortage will most likely be felt at the professional level. Nurses, Pharmacists, GPs, Specialists and other important managerial skills will be lacking overall in the South African health landscape in 2014.”

There is an urgent need for the private and public sectors to formulate appropriate strategies collectively and to standardise the training of healthcare personnel. This will help to make South Africa self-sufficient in this area, quickly and cost-effectively, enabling the delivery of affordable, quality care to its citizens.

CHAPTER 13

APPROPRIATE RETURNS

1. Introduction

Although the private hospital sector has for some time been accused of generating superprofits, it should be noted that these accusations remain wholly unsubstantiated. Nonetheless we believe it is in the best interests of the healthcare sector to address these concerns rationally, so that constructive debate can continue and unity of purpose be achieved in resolving the challenges we face in providing access to affordable quality healthcare to more South Africans.

The private hospital sector commends the progress made by Government in introducing the National Health Reference Price List (NHRPL), which will involve an independent process to provide a better understanding both of the cost drivers in private healthcare and guidance on a fair, appropriate and sustainable return on investment for the private sector.

We recognise that it is difficult for some stakeholders to reconcile the delivery of healthcare with a profit motive. However, we firmly believe that it is possible to balance the interests of different stakeholders in a free market system that drives competition among private sector providers and encourages cooperation between public and private sectors. This can result in increased efficiencies, better patient outcomes and greater patient satisfaction, inter alia, besides multiple benefits for healthcare broadly.

The basis for any sustainable healthcare system remains a healthcare practitioner’s obligation to deliver appropriate care, and his or her right to clinical independence when treating patients in private sector hospitals. We understand that the commercial need to generate appropriate returns for shareholders can never be at the expense of the quality or cost effectiveness of care, if our sector is to grow and develop, and our businesses are to be sustainable enterprises able to contribute commensurately to national development objectives.

2. Cost of Capital

A business raises funds to enable the investment of such funds in creating or expanding a business, such as a hospital. Such funds will need to be returned to the provider of the funds with interest to compensate the funder for the risk in loaning out the capital. Earning at least the cost of capital is the basic expectation that debt and equity providers of capital have of companies competing for their funds.

3. Return on Investment versus Economic Profit

Return on Investment (ROI) measures the profit generated from the capital employed by a business. However, companies only succeed in ‘creating value’ for shareholders if they generate a return on investment in excess of the cost of capital, return on investment below the cost of capital will destroy enterprise value. Returns above the costs of capital result in attracting further investment in the sector. Investors would choose to invest their funds elsewhere, for instance in fixed-interest securities that would guarantee a return equal to the cost of capital.
Superprofit is a term used when a company or sector earns cash flow returns on investment significantly in excess of the cost of capital. This can occur when organisations have monopolies or market exclusivity for a period of time, which is sometimes due to patents, an arguable level of superprofit is when a company earns a return double that of cost of capital. The concept of superprofits is explained by reviewing the Cash Flow Returns on Investment (CFROI) earned by Microsoft given its market power, set out in Graph 31. The blue bars on the top graph indicate the CFROI while the green line shows the cost of capital in the market. Any indicators significantly above the green line represent superprofit.

Graph 31: Cashflow return on invested capital (CFROI) of Microsoft reflecting superprofits.
It is important to understand the interplay between returns generated and the cost of capital. For example, Company A may have a higher CFROI than Company B, but it may also create less value than Company B because its cost of capital is higher. The profitability of a business cannot be evaluated by only looking at the income statement and cash flow. It is imperative that one fully understands the balance sheet of assets and liabilities, and how these assets are funded.

Economic profits are bolstered lower capital requirements and lower cost of capital. Organisations that require high capital investments offer investors lower economic returns.

4. Required Returns
Risk and return are inextricably linked. Markets price the required return based on the forecasted risk of an investment; the higher the perceived risk, the higher the required return.

Graph 1: The natural order of risk pricing

To attract investment into a business, an investor must be rewarded for the following:

- The time value of money – an investor can alternately invest his funds in cash and earn a risk-free return, for which the investor must be rewarded.
- Inflation premium – R1 in 2000 was worth far more than R1 in 2007 because of the impact of inflation. An investor must be rewarded for the uncertainty with respect to future inflation rates. This ‘inflation premium’ is added to the risk-free return.
- Equity risk premium – the investor must also be rewarded for taking the risk of investing in a specific business. This would include the equity market risk, the equity sector risk (in this case, the private hospital sector) and the risks specific to the business in question (e.g. Netcare and Medi-Clinic will have different exposures to different risks).

The general assumption is that the greater the risk, the greater the risk premium required to attract funding. The higher the risk, the higher the required return that investors will demand, hence the greater the cost of capital to a company. The ability to understand and manage risk is key to investing. It is the prospect of earning higher returns than the cost of capital that attracts capital to competing companies.

In practice, companies that do not exceed their cost of capital tend to go out of business rapidly. Such firms will not have excess capital to invest in new projects and investors will withdraw funds due to a lack of growth prospects and better business investment options elsewhere. As a matter of course, all sustainable companies must exceed their cost of capital most of the time. This is best explained by looking at any stock exchange index and comparing the cash flow returns on investments to the cost of capital.
5. Hospital Performance Relative to the Johannesburg Stock Exchange
An analysis by First South Securities (February, 2005) indicated that South Africa’s private hospital sector did not earn superprofits: “The JSE Securities Exchange SA Pharmaceutical sector with a CFROI of 25% performs better than the Healthcare sector (hospital stocks) with a CFROI of 12%.”

Their view is reinforced by the performance of the listed hospital groups relative to the top quartile of South African listed companies: “The top quartile of South African companies in ValueSearch has a three year median CFROI of 19%” (First South Securities: February 2005).

The business of operating hospital assets is not generating excessive profits over the cost of capital and that this business model would not be considered a superprofit generator.

Karl Liebenbergh, head of research at Coronation Asset Management summarises the situation correctly:
“With all the bad press our .... hospitals get, one would think these are oligopolies that rip the consumer off and earn superprofits. While that may be the public’s perception, it’s not the truth ... Local private hospitals earn no better than average returns on capital, and below average returns when one adjusts the capital base for the replacement cost of capital ... Our market is wide open to any entrant that may want to take advantage of any superprofits the incumbents may earn. Yet experience suggests the opportunity just isn’t there.”32

6. Conclusion
We have provided some context to how market forces operate, and evidence from different sources to demonstrate that the private hospital sector does not generate superprofits by any reasonable measures, at the expense of healthcare funders or the South African citizen utilising our services. The sweeping accusations levelled at the private hospital sector are not based on economic fact, and we hope stakeholders will resist unfounded generalisations in order to focus on the real issues of healthcare provision.

3211 September 2007.
CHAPTER 14
TRANSFORMATION IN THE PRIVATE HOSPITAL INDUSTRY

1. Introduction

This Chapter outlines the private hospital sector’s progress in achieving South Africa’s transformation objectives, as a function of the sustainable development of the healthcare sector and the country as a whole.

The private hospital sector understands implicitly the importance of transformation, not only within the individual hospitals and organisations themselves, but also in the economy and society in which we operate.

Recognising that broad-based black economic empowerment (B-BBEE) is a framework that not only redresses the exclusions and imbalances of Apartheid, but also drives South Africa’s sustainable growth into the future, the private hospital sector continues to support and interact with Government and other stakeholders to address South Africa’s transformation challenges, specifically as they relate to the healthcare sector.

The private hospital sector has committed itself to the Department of Trade and Industry’s (DTI) Codes of Good Practice for Broad-Based Black Economic Empowerment (Codes) as gazetted by the DTI in February 2007. Annexure B to this Chapter provides the latest BEE scorecards for the three major private hospital groups.

2. Transformation Focus Areas

The private hospital sector is committed to the fundamental principles and aims of the draft Health Sector Charter, which aims to facilitate and effect transformation in the health sector in key areas.

2.1 Access to health services

Access to quality healthcare is a major challenge facing the healthcare sector. We have dedicated Chapter 3 to a fuller discussion of this issue, but outline some private hospital sector initiatives to improve access as follows:

- There is a growing demand to provide emergency medical and hospital services to indigent patients on behalf of the State, a challenge that is increasingly being met by the private hospital sector, with services rendered irrespective of the patient’s ability to pay.

- The private hospital sector welcomes participation in, and acceleration of, Public Private Partnerships (PPPs) to assist the State in establishing additional health facilities. The private sector would further welcome the opportunity to partner with Government in offering clinical services to State patients on elective procedure waiting lists.

- Public Private Initiatives (PPIs) present an opportunity to strengthen the entire healthcare system and reduce the current fragmentation in health service delivery. See Chapter 3 for further details.

- The private hospital sector supports the introduction of the Government Employee Medical Scheme (GEMS) and discussions towards the Low Income Medical Scheme (LIMS), which will expand medical cover to previously uninsured markets.

- In June 2007, during the public sector strike which affected State hospitals, individual private hospital groups made arrangements with their local public sector hospitals to manage and re-direct all emergencies to the respective private hospitals. The local private hospitals also made arrangements with supporting specialists to manage the patient load.

- Individual private hospital groups provided Government with assistance in crisis management during the waterborne disease outbreak at Empangeni in KwaZulu-Natal and Delmas in Mpumalanga, and assisted the South African Police Services during the influenza outbreak.

- Although most private hospitals are located in urban or peri-urban areas, individual private hospital groups are extending assistance to under-serviced communities. Please refer to Chapter 15 for additional detail.

- Given the shortage of nurses in the country, an aggressive recruitment campaign has been instituted by the major hospital groups to attract nurses back to the country, with some success. During 2007, a total of more than 100 nurses were successfully recruited back to South Africa.

- Individual hospital groups conduct ‘open days’ to market nursing as a profession. To this effect, schools are invited to participate in the ‘Proud to be a Nurse’ campaign.
During 2007, average expenditure by the private hospital groups on training exceeded three percent of payroll. Specific training initiatives included:

- Academic grants and bursaries provided by individual hospital groups, largely for the training of nurses and specialists;
- Continued Professional Development (CPD) programmes; and
- Leadership and Management Development programmes.

The private hospital sector is proactively involved in important national initiatives to strengthen the healthcare delivery system, including:

- Participating in the South African Institute of Health Care Management (SAIHCNM);
- Participating in the Professional Nurse Leaders Forum;
- Participating in the South African Hospital Theatre Society, Federation of Infectious Diseases for Southern Africa, and its sub-group, The Infection Control Society of South Africa;
- Participating in appropriate SETAs;
- Nurses training (refer to Chapter 12); and
- Formulating guidelines for organ transplants in private hospitals.

2.2 Equity in health services

While a significant shift has occurred in ownership within the private hospital sector, equity at management control and employment levels remain a challenge. This continues to be actively addressed within the sector.

The private hospital sector continues to make progress in transforming its supplier base by supporting and developing B-BBEE businesses. However, some initiatives are being constrained by a relatively low level of adoption of the B-BBEE Codes amongst suppliers. This is being addressed which should result in increased compliance and accreditation of suppliers to the private hospital sector.

2.3 Quality of health services

The private hospital sector continues to invest in facilities, advanced medical technology and infrastructure. Individual hospital groups have made substantial investments in designing and creating systems and processes to manage and measure the quality of delivery across the full spectrum of healthcare.

Also, some private hospital groups have successfully expanded their operations internationally, and as such their quality assurance systems have been developed according to internationally recognised standards and adapted for local use.

Chapter 10 provides a detailed discussion on quality management in the private hospital sector.

2.4 Black Economic Empowerment

Currently, approximately 40% of South Africa’s private hospital sector is black-owned. Some of the smaller hospital groups are almost exclusively black-owned, such as the Clinix Health Group, Joint Medical Holdings and Melomed Hospital Holdings.

In 2005/06, a number of significant BEE transactions took place in the private hospital sector:

- A BEE consortium, comprising Mvelaphanda Group and Brimstone Investments Limited, acquired majority ownership of Life Healthcare (previously Afrox Healthcare).
- Netcare concluded a BEE transaction that transferred 160 million shares to the Health Partners for Life (HPFL) Trusts in a deal worth R1 billion. Coupled with its BEE retail and company holdings, Netcare’s BEE share ownership was 17,3% (2006: 17,8%), with black female ownership at 7% of votable shares as of 30 September 2007.
- Medi-Clinic concluded a R1,1 billion Black Ownership Initiative resulting in a 15% black-owned shareholding. The initiative’s beneficiaries were Phodiso Holdings Limited, Circle Capital Ventures Limited and Mpilo Trust.

As is common in other sectors, the challenge of accessing empowerment funding is significant and the high capital requirements and infrastructure costs in the private hospital sector remain a barrier to further ownership transactions in the sector.
3. Conclusion

The draft Health Sector Charter aims to improve healthcare access and quality. It also seeks to fast-track B-BBEE in the healthcare sector. Although the private hospital sector has made significant investments in the national healthcare system, through emergency services and PPP and PPI initiatives, significant opportunity remains to strengthen national healthcare delivery and reduce the fragmentation in service delivery.

The private hospital sector remains wholly committed to the process of finalising the Health Sector Charter. Until it is adopted, the private hospital sector will continue to focus on improving its performance in all aspects of the DTI's Codes of Good Practice for B-BBEE.

ANNEXURE B

Empowerment scorecard of SA's major private hospital groups.

<table>
<thead>
<tr>
<th>Element</th>
<th>Weighting/target score</th>
<th>Life Healthcare</th>
<th>Netcare</th>
<th>Medi-Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ownership</td>
<td>20,00</td>
<td>10,14</td>
<td>13,59</td>
<td>15,32</td>
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<tr>
<td>Management Control</td>
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<td>4,07</td>
<td>5,12</td>
<td>4,98</td>
</tr>
<tr>
<td>Employment Equity</td>
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<td>11,28</td>
<td>4,38</td>
<td>4,51</td>
</tr>
<tr>
<td>Skills Development</td>
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<td>6,80</td>
<td>11,76</td>
<td>9,02</td>
</tr>
<tr>
<td>Preferential Procurement</td>
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<td>11,34</td>
<td>1,05</td>
<td>9,54</td>
</tr>
<tr>
<td>Enterprise Development</td>
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<td>15,00</td>
<td>15,00</td>
<td>5,00</td>
</tr>
<tr>
<td>Socio-economic Development</td>
<td>5,00</td>
<td>3,06</td>
<td>5,00</td>
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</tr>
<tr>
<td>Operational Capacity</td>
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<td>A</td>
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<tr>
<td>Scorecard Rating</td>
<td>BBB</td>
<td>BBB</td>
<td>BBB</td>
<td></td>
</tr>
</tbody>
</table>

Life Healthcare Group and Netcare were rated by the BEE Rating Agency, Empowerdex, while Medi-Clinic undertook an internal assessment.
CHAPTER 15
CORPORATE SOCIAL INVESTMENT

1. Introduction

This Chapter illustrates the Corporate Social Investment contribution made by the private hospital sector and provides a selection of the many projects undertaken.

For many years, the private hospital sector has contributed significantly to Corporate Social Investment (CSI) in South Africa. Given the legacy of Apartheid and its impact on the healthcare system, great emphasis is placed on committing resources to initiatives that directly impact healthcare delivery.

In keeping with CSI best practice (utilising core assets and competencies to achieve sustainable initiatives), the bulk of this CSI activity is dedicated to providing access to healthcare, particularly to the most underprivileged members of our society. The private hospital sector has moved beyond making philanthropic donations, and seeks to leverage its resources to assist in the national drive to broaden access to quality healthcare.

The private hospital sector also makes a substantial contribution to skills development and training for healthcare professionals. Please see Chapter 12 for further details.

2. Emergency Medical and Hospital Services

There is a growing demand to assist the State in providing emergency medical and hospital services to indigent patients, a challenge that is increasingly being met by the private hospital sector, with services rendered irrespective of the patient's ability to pay. For example Netcare and Life Healthcare have spent approximately R120 million to provide services to indigent patients in the past three years.

It should be noted that this cost is borne directly by the private sector, and constitutes a unique cost pressure not generally experienced by other stakeholders in the healthcare supply chain.

Specific projects designed to improve access for those most in need include:

- Rape Crisis Centres – since Netcare established these centres in 33 of its hospitals, 4 000 victims of sexual assault have been provided with assistance free of charge. The services include forensic help, trauma counselling and anti-retroviral treatment. Over 85% of patients treated are indigent or have no medical cover.
- The Community Intervention Centre – at Medi-Clinic’s Milnerton Hospital, provides a free trauma and crisis intervention service for the Blaauwberg community. The Centre works with the South African Police Service, providing trauma support either on-site or at their trauma rooms, and currently handles up to 200 trauma cases a month. Cases include rape, suicide, domestic violence, attempted suicide, murder, armed robbery, family crisis, death, severe medical trauma and child abuse. These services also extend to patients and hospital staff.
- In 2007, Nelcare provided emergency assistance to over 15 300 indigent patients through Netcare 911 and Medi-Clinic via ER24 to approximately 8 000 indigent patients.

3. Elective Surgery

Individual hospital groups as well as various independent hospitals work closely with the provincial Department of Health to assist in reducing the waiting period on public sector surgical waiting lists, on a pro bono basis. There is usually an agreement with the department of surgery at the local provincial hospital and the private hospital as to the number of procedures to be undertaken.

Examples of procedures performed include:

- Cataract surgery for indigent patients – in the recent past Netcare has performed 1 270 cataract extractions through its Sight for Life programme, and 1 000 cataract extractions in peri-urban areas through Life Healthcare’s sponsorship of the Mobile Eye Care Unit.
- In 2006 the private Pretoria Eye Institute (part of the National Hospital Network) performed free cataract surgery on 315 patients from underprivileged communities, most of whom were on state hospital waiting lists. In addition, 504 pre-school children from different day care centres were screened by optometrists working with the hospital.
• Right to Sight Campaign – in 2003 the Lenmed Clinic (also part of National Hospital Network) joined this eye-care campaign to eliminate blindness in South Africa. Their support has helped to increase the number of free cataract procedures from 25 000 to 100 000 a year over five years in both the public and private sectors. In partnership with the Bureau for the Prevention of Blindness, Lenmed is helping to ensure that individuals from underprivileged communities are being assisted.

• Cleft Lip and Palate Programme – this programme sponsors surgical procedures to repair cleft lip and palate deformities for children from six months to 19 years old who come from disadvantaged backgrounds. For example, Netcare’s Parklane Clinic performs these corrective surgeries at no cost if the patient cannot afford the surgery, using the services of highly respected plastic surgeons, ENTs, orthodontists and speech and hearing therapist to improve the lives of these children.

• Hip and Knee Joint replacement surgery – in an effort to reduce public sector waiting lists, surgery is performed at private hospitals by supporting specialists on a pro bono basis.

• Cochlear implants and surgery – Netcare’s Linksfield Clinic, in conjunction with Bidvest and 94.7 Highveld Stereo, embarked on a campaign to help eight patients who could not afford cochlear implants and surgery in 2007.

• Paediatric Cardiac Surgery – launched in November 2003, the Walter Sisulu Paediatric Cardiac Centre for Africa performs life-saving cardiac surgery on indigent children throughout Southern Africa. Based at Netcare’s Sunninghill Hospital, this institution has helped repair heart defects in numerous underprivileged children since its inception.

4. Community Health Education and Awareness and Health Screenings

As per the national health calendar, various hospitals work together with their local communities to promote community health awareness and health screenings. Often these activities are undertaken in communities where easy access to private hospitals does not exist. Community shopping areas and local schools are also targeted with great success.

Examples include:

• Diabetes, hypertension and cholesterol testing;
• Cervical cancer screenings;
• Eye testing;
• ’No to Smoking’ programmes; and
• Providing HIV/AIDS and mental health awareness material and talks.

Isipingo Hospital, for example, has an excellent community involvement programme providing medical rescue services to road accident victims. The programme is co-ordinated by the matron of the hospital, and assists with a permanent not-for-profit medical rescue team that manages and operates the roads at Van Reenen during peak traffic periods, working with other emergency services in the area. They also deliver other services to the local community, including training in emergency care.

5. Academic Grants and Bursaries

The private hospital sector awards substantial sponsorships and donations to universities, largely for the training of specialists and other healthcare professionals. Sponsorships are also provided to employ additional healthcare professionals to serve indigent communities.

For example, Medi-Clinic contributed R1,1 million to the Health Science faculty of Stellenbosch University, to assist it in maintaining a high standard of education. Part of the grant is used to fund four Masters students from previously disadvantaged backgrounds. Medi-Clinic also supports the universities of Limpopo, Pretoria and Wits with equipment and bursaries.

Netcare has launched the Hamilton Naki Scholarship to mark the 40th anniversary of the world’s first heart transplant. The main objectives of the scholarship are to:

• Identify and select candidates of high calibre who demonstrate the capacity and commitment to make a difference in healthcare academics in South Africa;
• Provide financial support for selected clinical scholars to undertake doctoral or post-doctoral training in leading institutions locally or abroad for three or more years;
• Support candidates in establishing themselves in South Africa or to commence an independent academic career upon completion of research training for a further period of one or more years; and
• Provide support to a candidate as may be determined by the independent Selection Committee and approved by the Trustees.
6. Prevention of Waterborne Diseases
There are currently 3,242 schools across the country who do not have access to clean running water. Netcare has contributed to the installation of 13 pumps, powered by merry-go-rounds, that fill holding tanks making 2,500 litres of water available to schools. The tanks are also used to display health awareness and educational messages.

7. Youth Development
Individual hospitals are involved in the ‘Take a Girl Child to Work’ initiative and the ‘Proud to be a Nurse’ campaign to promote careers within the healthcare sector.

In 2004, as part of its CSI programme, Kimberly Medi-Clinic adopted a creche in Donkerhoek, Galeshewe, a disadvantaged community in the city. The Tselepoile Creche cares for over 40 pre-schoolers, improving the development of the children and giving their parents the time to earn an income.

8. Revitalisation of Public Sector Hospital Facilities
The private hospital sector has made donations towards the upgrading of State hospitals. Netcare, for example, contributed R2 million towards the building of a new operating theatre at the Red Cross Children’s Hospital, the only specialist children’s hospital in Sub-Saharan Africa.

Financial support and capacity building are provided to non-governmental, community- and faith-based organisations. Many of these are ‘start up’ businesses, such as soup kitchens, home-based care centres and youth residences, which require coaching and mentoring to assist them to adhere to relevant legislation, and develop appropriate programmes.

The only post-basic qualifications available to nurses in Zambia are Midwifery and Theatre. All other skills are learnt on the job, including the care of critically ill adults, children and neonates. Medi-Clinic is helping to address this by sharing information and advanced skills with Zambian nurses at the CFB Medical Centre.

9. Employee Involvement Programmes
The private hospital sector is directly involved in assisting disadvantaged communities through the participation of their employees. Projects include building houses, repairing windows, painting facilities and providing recreational equipment.

10. Conclusion
While the details of the Public Health Enhancement Fund in the draft Health Sector Charter are yet to be finalised, the private hospital sector continues to support disadvantaged communities in its CSI initiatives, believing this to be a business imperative.

The sector is putting processes in place to quantify the consolidated investment in such initiatives. This discussion has provided a selection of examples to demonstrate the private hospital sector’s extensive involvement in CSI initiatives. It points to the private hospital sector’s commitment to improving healthcare access and affordability in South Africa, in accordance with national priorities, and our dedication to finding sustainable ways to respond to the health needs of the marginalised members of South African society, a contribution that cannot be ignored in any commentary relating to the sector.
CHAPTER 16
HOSPITAL PHARMACY OWNERSHIP

1. Introduction

This Chapter clarifies the ownership structure and role of institutional pharmacies, and in so doing seeks to address any misconceptions or concerns that exist in this regard.

Concerns regarding the ownership of pharmacies by private hospitals were raised at the Private Health Sector Indaba. The concerns were not detailed, and were not corroborated by any evidence to support the contention that such ownership is not in the best interests of consumers.

2. Function of Hospital Pharmacies

The Regulations Governing Private Hospitals and Unattached Operating Theatre Units state that a private hospital shall be conducted on premises where adequate and satisfactory provision has been made for facilities which enable the immediate supply of all necessary pharmaceutical products.

It is critical that each private hospital has a pharmacy on its premises, operated and controlled by a qualified pharmacist. By law, this pharmacy is required to hold the requisite licence that permits it to possess and sell the scheduled substances needed to treat patients in hospital.

3. Hospital Pharmacy Ownership

In terms of the Pharmacy Act, a hospital pharmacy is classified as an “institutional pharmacy”. Given that an institutional pharmacy is central to a private hospital’s operations, it follows that the pharmacy and hospital are held under common ownership, which is sanctioned by regulation. The amendment to Section 22A of the Pharmacy Act removed the previous prohibition against corporate ownership by non-pharmacists.

Section 22A now provides for the following: “The Minister may prescribe who may own a pharmacy, the conditions under which such person may own such pharmacy, and the conditions upon which such authority may be withdrawn.”

Accordingly, a private hospital or private hospital group is no longer precluded from owning an institutional pharmacy. Common ownership also facilitates greater efficiencies and savings by consolidating the administrative functions of the pharmacy and hospital, for example.

4. Hospital Pharmacy Pricing

The price at which pharmaceutical products are dispensed is subject to the applicable Single Exit Price (SEP). While this regulation allows for a dispensing fee, private hospital groups have chosen not to charge this, treating the institutional pharmacy division as a cost centre. In light of this, the question of pharmacy ownership is therefore largely academic.

As much as 50% of private hospital billings are already based on some form of alternative reimbursement model, with fixed charges per day or a fixed charge per procedure. Hospitals therefore have every incentive to replace more expensive branded drugs with cheaper generic alternatives. Hospital groups have started tracking generic substitution and the sector will be in a position in the near future to publish the extent of generic substitution at a sector level.

A collective commitment by the private hospital sector to advocate alternative reimbursement as the preferred method of billing will continue to drive cost-reducing behaviours.

5. Conclusion

Following the introduction of the SEP regulations, institutional pharmacies adhere to these regulations and in effect are cost centres. Contrary to some perceptions, there is no correlation between corporate ownership and the prescription patterns of independent clinicians.

Corporate ownership of pharmacies is permitted by current regulations in South Africa. This is in line with international law, which recognises that it is neither improper nor unethical for hospitals to own pharmacies, and is the case in many developed and developing countries. This ownership structure also results in administrative efficiencies.

CHAPTER 17
PROPOSED CODE OF ETHICS FOR PRIVATE HOSPITALS

1. Introduction

This Chapter is presented in the form of a draft Code of Ethics, submitted for review and comment by the Minister of Health.

The proposed Code of Ethics aims to guide the private hospital sector through the Hospital Association of South Africa. It is submitted in the spirit of self-regulation, showing the sector’s commitment to the highest ethical standards, in all aspects of the profession.

The code outlines expected ethical conduct with regard to access, emergency medical treatment, responsibilities of the hospital manager, informed consent, and confidentiality and privacy. We specifically refer the reader to Section 9 of the draft regulations, *Perversity and Undesirable Business Practices*, which outlines specific regulations intended to prevent and dissuade individual or group action resulting in perverse incentives within the private hospital industry.

We welcome comment from all stakeholders, particularly the Minister of Health, on the contents of this draft Code of Ethics, and look forward to its adoption in due course.

PROPOSED CODE OF ETHICS FOR PRIVATE HOSPITALS

No. 1 (First Draft) for Comment

The Minister of Health, by virtue of the powers vested in him/her by section 90(1)(a) and 90(1)(l) of the National Health Act 2003, has after consultation with the private hospital industry made the following regulations:

1. Definitions

**“Emergency medical condition”** means –

(A) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in –

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) With respect to a pregnant women who is having contractions;

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

**“Emergency medical treatment”** means the provision of reasonable and appropriate treatment by a registered health professional as may be required to stabilise the emergency medical condition.

**“Kickback”** means any form of enrichment offered or given to a health care professional or health care establishment which encourages or incentivises that professional or establishment to act in a manner which is detrimental to the interests of a patient.

Note 1: A kickback as defined above includes any form of enrichment offered or given which encourages either overservicing or underservicing of a patient;

Note 2: A kickback includes an offer or the giving of enrichment in terms of the definition above, in the context of both an above board transaction (for example in the terms of a written contract) or a clandestine transaction between two or more parties.

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24 As drafted by Adv. K. Worrall-Clare BA.LLB. PG Dip (ForenAudCrimJust), Chief Executive Officer (HASA) at clientl@mweb.co.za with reference to both national and international law.

25 The Emergency Medical Treatment and Labour Act, 42 USC Sec. 1395dd.
“Overservicing” means to supply, provide, administer, use or prescribe any health care service or health care product:
(a) which is medically or clinically not indicated; or
(b) which is unnecessary or inappropriate under the circumstances; or
(c) which is not in accordance with a generally recognised treatment protocol or procedure; or
(d) without due regard for both the financial and health interests of the patient.

“Underservicing” means to supply, provide, administer or prescribe any health care service or health care product:
(a) in a quantity, at a level or to an extent which is inadequate or insufficient to meet the patient’s health care needs;
(b) in a quantity, at a level or to an extent which is less or lower than the quantity, level or extent required by generally recognised treatment protocols and procedures;
(c) which is inappropriate to or which would generally be considered to be ineffectual in, the treatment of a particular health condition.

“Patient” means a person/user admitted to a private hospital for the purpose of treatment;

“Treatment” means the maintenance, observation, nursing and medical care and supervision of a patient.

“User/Patient” means the person receiving treatment in a private hospital (health establishment), including receiving blood or blood products, or using a health service, and if the person receiving treatment or using a health service is-
(a) below the age contemplated in section 39(4) of the Child Care Act, 1983 [Act No. 74 of 1983], “patient” includes the person’s parent or guardian or another person authorised by law to act on first mentioned person’s behalf; or
(b) incapable of taking decisions, “patient” includes the person’s spouse or partner or, in the absence of such spouse or partner, the person’s parent, grandparent, adult child or brother or sister, or another person authorised by law to act on the first mentioned person’s behalf.  

2. Application of the Code of Ethics
2.1 All private healthcare establishments which are members of the Hospital Association of South Africa shall adhere to the provisions of this Code of Ethics, as amended from time to time.

2.2 Associate members shall, where applicable, also be bound by the provisions contained in the Ethical Code and Policy Statements of the Association, as amended from time to time.

3. Aims of the Code of Ethics
3.1 This Code of Ethics, as approved by the Board of Directors of the Hospital Association of South Africa, seeks to:
(a) Establish a framework of applicable ethical rules founded on principles of fairness, best practice and acceptable professional conduct.
(b) Describe those responsibilities incumbent upon either the healthcare establishment or group thereof, to ensure that appropriate ethical standards are applied.

3.2 Empower the Hospital Association of South Africa with the right to receive complaints from the public, investigate those complaints and where applicable, institute disciplinary proceedings against any member suspected of violating the Code of Ethics in any way whatsoever.

4. The Role of the Hospital Association of South Africa
4.1 The Association is hereby authorised to publish a Code of Ethics for all members of the Association.

4.2 In addition to such publication, the Association may publish applicable policy statements which provide clarification, interpretation and minimum standards applicable to specific provisions and/or terminology provided for in such Code of Ethics.

4.3 That Code of Ethics and/or policy statement/s may be amended from time to time, and in the event of such amendment being approved by the Board of Directors, the Association shall publish such amendment to all members within 7 (seven) days of such approval.

4.4 The Association may receive complaints and/or requests from either members of the public, users, stakeholders, healthcare professionals or any other interested party with regard to any violation, or suspected violation of this Code of Ethics.

36Section 1 of the National Health Act, 2003.
4.5 Upon receipt of such complaint, the Association may request the complainant to provide appropriate and detailed information pertaining to such complaint, and in this regard shall:

(a) Ensure that if such complaint involves or pertains to any user, then such user (where applicable) has authorised the complaint personally.

(b) That any medical and/or personal information pertaining to such user shall be kept private and confidential, and shall not be published outside of any disciplinary proceedings without the written authorisation of that user (where applicable).

4.6 In the event of such a complaint being duly authorised by the complainant, and upon receipt of detailed and appropriate information, the Association may initiate an investigation which shall be conducted in accordance with the Rules and Procedure Manual applicable to Disciplinary Proceedings.

4.7 Upon completion of such an investigation, the Association may initiate disciplinary proceedings against any member, and such member shall in accordance with the Rules and Procedure Manual submit to such proceedings.

4.8 The powers and responsibilities of the Association with regard to such an investigation and disciplinary proceedings shall be provided for in the Rules and Procedure Manual approved in accordance with the Hospital Association of South Africa’s Articles of Association.

5. The Code of Ethics

5.1 Access:

5.1.1 Private health establishments recognise that the right to access healthcare is a progressive right founded in the Constitution of the Republic of South Africa.

5.1.2 In accordance with that right, private healthcare establishments may:

(a) Partner with other healthcare providers and/or stakeholders in the development and/or delivery of programmes designed to ensure appropriate access to healthcare.

(b) Promote shared economic programmes amongst national and/or provincial government, healthcare providers, employers, medical schemes and users which work to address the need for improved access and service delivery.

(c) Undertake the above provided that such programs are ethical, quality driven and based on sound economic principles which neither undermine nor jeopardise the economic integrity and/or sustainability of the private healthcare establishment/s concerned.

5.2 Emergency medical treatment:

5.2.1 Where a healthcare establishment has an emergency unit, and is able to render ‘emergency medical treatment’, then such a healthcare establishment shall:

(a) If any user comes to, or presents him or herself at the emergency unit of that healthcare establishment, and a request is made, or such a request is made on the patient’s behalf for examination or treatment for an emergency medical condition, then the healthcare establishment shall provide for an appropriate medical screening examination within the capability of the healthcare establishment’s emergency unit, including ancillary services routinely available to that emergency unit, to determine whether or not an emergency medical condition exists.

(b) Should such an ‘emergency medical condition’ be determined to exist by such medical screening and/or examination, then the healthcare establishment shall provide the necessary and appropriate stabilising treatment for such an emergency condition.

5.2.2 No person, regardless of one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth shall be denied emergency medical treatment for any emergency condition.

5.2.3 Emergency medical treatment in situations deemed to be mental health emergencies shall be in accordance with:

(a) Section 9(1)(c) of the Mental Health Care Act, 2002, which provides for emergency situations in mental health care, and stipulates in 9(1)(c) that an ‘emergency’ is when, due to mental illness, any delay in providing care, treatment and rehabilitation services or admission may result in the (i) death or irreversible harm to the health of the user; (ii) user inflicting serious harm to himself or herself or others; or (iii) the user causing serious damage to or loss of property belonging to him or her or others.

(b) Section 9(2) read together with regulation 8 of the General Regulations, provides that when such an emergency (as contemplated in section 9(1)(c) of the Act exists, and the patient is in need of admission, then the person or health establishment that provides such treatment and/or rehabilitation, must report such to the relevant review board.
5.2.4 No private health establishment shall delay an appropriate triage for an emergency condition in order to establish the patient’s payment and/or insured status.

5.2.5 The private health establishment shall have the right to reasonable compensation for any and all emergency medical treatment rendered to a patient in terms of section 27(3) of the Constitution of the Republic of South Africa.

5.3 Tendering for emergency medical treatment services:
5.3.1 Private health establishments may tender for appropriate emergency healthcare services provided that those tenders:
   (a) Are ethical both in terms of this Code of Ethics, as well as those ethics codes applicable to healthcare professionals as published and amended from time to time by the Health Professions Council of South Africa.
   (b) Are based on appropriate and quality driven standards of healthcare.
   (c) Ensure that appropriately qualified healthcare professionals are involved in that service delivery, and that internationally accepted standards of triage are adhered to.

6. Responsibilities of the Hospital Manager
6.1 The hospital manager shall-
   (a) Ensure that a copy of this Code of Ethics is made available to all members of staff, as well as healthcare professionals working with that healthcare establishment.
   (b) That the conduct of all employees and healthcare professionals working in or with that healthcare establishment is based on the principles of ethical conduct, integrity, the best interests of users and appropriate standards.
   (c) That he/she and his/her employees comply with all laws and regulations pertaining to healthcare establishments and healthcare service delivery.
   (d) Maintain competent and proficient healthcare workers, professionals and other staff working in or with such healthcare establishment.
   (e) Ensure that the rights of users are adequately provided for in his/her healthcare establishment, and in doing so may publish appropriate standards and employment conditions binding on all staff and personnel working in and with that health establishment provided that such standards and employment conditions are based on applicable law, standards and ethical codes.
   (f) Refrain from any activity which would either impugn the dignity of the healthcare establishment or bring the healthcare professional into disrepute.

6.2 In particular, the hospital manager shall ensure that policy is enacted pertaining to the following user rights as recognised in law, although not limited to:
   (a) The right to informed consent, as provided for in section 6, 7 and 8 of the National Health Act, 2003.
   (b) The right to have his/her medical and personal information treated as confidential and private, as provided for in section 14 and 15 of the National Health Care Act, 2003.
   (c) The right to a healthy and safe environment.
   (d) The right to information pertaining to his/her medical treatment, health insurance and the right to challenge any decision with the appropriate authority pertaining to such.
   (e) The right to choose his/her health establishment and/or medical treatment.
   (f) The right to be treated by a healthcare professional who is clearly identifiable.
   (g) The right to refuse medical treatment.
   (h) The right to a second opinion.
   (i) The right to complain.

7. Informed Consent
7.1 All procedures which are performed in a private health establishment shall be compliant with the National Health Act, 2003 (hereinafter referred to as the Act).

7.2 In accordance with sections 6, 7 and 8 of the National Health Act, no health service shall be performed without first having obtained informed consent from the patient concerned.

7.3 It shall be the responsibility of the treating healthcare professional to obtain informed consent from his/her patient.
7.4 Informed consent shall apply equally to all medical and surgical procedures.

7.5 Failure to obtain informed consent may be considered an assault against the bodily integrity of the patient, and could expose both the health professional and the health establishment to potential liability. For this reason the health establishment shall confirm that informed consent has been obtained, and this shall form part of the admission policy applicable to all patients.

7.6 Informed consent in situations deemed as a medical emergency: Informed consent is not necessary in those cases which constitute an emergency, and where any delay would jeopardise the patient further, the health professional (treating practitioner) and staff employed by the health establishment may provide whatever health services are necessary to stabilise the patient.

7.7 Informed consent and mental health: Section 9(1) of the Mental Health Care Act stipulates that treatment, care and/or rehabilitation may only be provided to mental healthcare users with their informed consent. In particular, section 9(1)(a) stipulates that: A health care provider or a health establishment may provide care, treatment and rehabilitation services to or admit a mental health care user only if (a) the user has consented to the care, treatment and rehabilitation services or to admission.

8. Confidentiality and Privacy

8.1 All employees, healthcare professionals and healthcare workers working for or with the health establishment are obliged to protect the privacy and confidentiality of all medical records and/or information pertaining to any user admitted either as an inpatient or outpatient, including any personal information belonging to that user.

8.2 Any and all disclosure of confidential information concerning a user shall be in accordance with section 14(2) of the National Health Act, and no information shall be disclosed unless:
   (a) the user consents to that disclosure in writing;
   (b) a court order or any law requires that disclosure; or
   (c) non-disclosure of the information represents a serious threat to public health.

8.3 A health worker, employee, healthcare professional or agent of the hospital that has access to the health records of a user may disclose such personal information to any other person, healthcare provider or health establishment as is necessary for any legitimate purpose within the ordinary scope and practice of his or her duties where such access or disclosure is in the interests of the user. This includes, but is not limited to, disclosure internally between health professionals, pharmacists and nursing staff.

9. Perversity and Undesirable Business Practises

9.1 The activities listed below are regarded as unethical behaviour on the part of hospitals and/or hospital management. It is also unethical for any healthcare professional or other healthcare establishment to encourage a hospital to engage in these same activities.

9.1.1 The purchase from any healthcare professional of any orthodox medicine, complimentary medicine, medical device or scheduled substance or health related product for use within a private hospital or in the treatment of a patient of a private hospital where:
   (a) such medicine, device, substance or product does not form an integral part of the scope of practice of that healthcare professional; or
   (b) where that healthcare professional participates in the manufacture, for commercial purposes or trade, of such medicine, device, substance or product without the explicit permission of the relevant professional board.

9.1.2 Permitting a healthcare professional to bring into the hospital, for use either within the hospital or in the treatment of a patient of that hospital, any orthodox medicine, complimentary medicine, medical device or scheduled substance or health related product where:
   (a) such medicine, device, substance or product does not form an integral part of the scope of practice of that health professional; or
   (b) where that healthcare professional participates in the manufacture, for commercial purposes or trade, of such medicine, device, substance or product without the explicit permission of the relevant professional board.
9.1.3 Advertising or encouraging the use of the services of any healthcare professional in a manner:
   (a) which would constitute a violation of the ethical rules of the healthcare profession to which that healthcare professional
       belongs had the healthcare professional so advertised or encouraged the use of his services himself.
   (b) which unfairly promotes the services of a particular healthcare professional or which is detrimental to the interests of other
       healthcare professionals in pursuing their profession.

9.1.4 Engaging in or advocating the preferential use of any medical device, the services of any healthcare professional or any medicine or other health-related product where such activity is based on the expectation of, or is in return for, a kickback.

9.1.5 Overservicing or directly or indirectly, assisting, encouraging or pressurising, healthcare professionals to overservice patients.

9.1.6 Underservicing or directly or indirectly assisting, encouraging or pressurising healthcare professionals to underservice patients.

9.1.7 Renting out premises to a healthcare professional at a reduced or zero rental on the understanding, whether express or implied, that such a healthcare professional will achieve a certain turnover.

9.1.8 Unfairly discriminating between one healthcare professional and another in terms of rentals charged by a hospital for premises occupied by the these individuals.

9.1.9 Sharing of fees or profits with healthcare professionals who have not rendered any service in respect of which those fees were charged or profits were earned except where that healthcare professional owns shares or has some other financial interest in the hospital which is not contrary to the professional and ethical rules of his profession.

9.1.10 Contracting with healthcare professionals to work in a hospital or service offered by that hospital on the condition or understanding that the healthcare professional generates a particular amount of revenue for such a hospital or service.

9.1.11 Engaging in any activity which directly or indirectly encourages, assists or pressurises a healthcare professional or healthcare establishment to further that professional’s or establishment’s own interests in a way which is detrimental to the interests of a patient.