

Private hospitals offer wide-ranging NHI assistance



Marella O'Reilly, Acting Registrar of the Health Professions Council of South Africa.

Picture: Chris Bateman

The Hospital Association of South Africa (HASA) has mooted the idea of training critically needed specialists in its member hospitals while reaffirming its commitment to helping patients stranded by State shortcomings.

The idea is being jointly explored by HASA's CEO, Advocate Kurt Worrall-Clare and Marella O'Reilly, the Acting Registrar of the Health Professions Council of South Africa (HPCSA) to iron out legal obstacles, *Izindaba* reliably learnt. The move, on the back of HASA members saving lives during the recent public service strike when 1 300 often-unattended babies and adults in State facilities were transferred to private facilities, is a further potential watershed moment in critically important future public/private partnerships. However, its efficacy in terms of

the current regulatory set-up was questioned by veteran clinicians and academics at the coalface. They said the fee-for-service of private surgeons, together with HPCSA rules, prevented registrars from obtaining the vital incremental hands-on experience in private hospitals. According to the 2007 SA Health Review, 73% of general practitioners and 75% of specialists work in the private sector where they – and 40% of nurses – cater for only 15% of the population.

Worrall-Clare punted several other ideas during his presentation at the South African Medical Association (SAMA)'s conference on the future National Health Insurance (NHI), early this October in Midrand, Gauteng. He said that provided well-defined guidelines were mutually agreed upon, spare capacity in private hospitals could continue to be used

to treat State patients. HASA members had committed to publishing regional occupancy levels bi-annually to facilitate this. Other areas where public/private initiatives (PPIs) could flourish included providing management and administrative support by seconding managers to the public sector or twinning facilities to enhance best-practice care. This would include a two-way skills transfer across both sectors. Further possibilities included sharing (spare) resources on a lease or service basis, generating joint health promotion and screening campaigns and training nurses, technicians, paramedics and mid-level health care workers via basic and advanced courses. Existing programmes such as mobile clinical services to under-served rural areas (e.g. the 'Right to Sight' Campaign and the already far-reaching Walter Sisulu Paediatric Foundation project), plus the supply of consumables for cervical cancer screening, could be expanded.

Don't ignore specialists – plea

Worrall-Clare pleaded for all stakeholders in the debate to involve specialists in the design of the new NHI 'interventions', 'because we cannot presume they will follow our hospitals in offering services to the NHI. (By regulation, private hospitals may not employ doctors, and NHI participation is voluntary.)

Over a third of all medical graduates in South Africa over the past 8 years were now living overseas, he added. 'You could say this is political but there's no doubt that it's mostly service-related issues (driving the exodus),' he added.

Another speaker, Professor Martin Veller, head of vascular surgery at Charlotte Maxeke tertiary hospital (a public sector facility) and chief of surgery at Wits University, said the country needed another 1 200 - 1 300 general surgeons alone, three times the existing number. 'Our general surgeon/patient ratio has been static for the last decade and stands at half that of similar developing countries,' he said. Over a third of all medical graduates in South Africa over the past 8 years were now living overseas, he added. 'You could say this is political but there's no doubt that it's mostly service-



Professor Martin Veller, Head of Vascular Surgery at Charlotte Maxeke tertiary hospital.

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related issues (driving the exodus), he added. 'Some 50 - 60' general surgeons were being trained annually in South Africa. Double this number was needed to achieve NHI goals. At current output levels, doubling-up would take another 20 years. 'The problem is we have far too few medical graduates – not only do medical schools need to increase capacity but we need more medical schools, and quickly,' he asserted.

South African hospital groups in the UK had successfully entered into PPIs with that country's National Health Service, providing a wide spectrum of care across multiple disciplines. Contracts ran over a 5-year period and were carefully monitored for quality assurance and patient outcomes.

Worrall-Clare said HASA could bring management skills, clinical services and a history of highly efficient public/private partnerships to the NHI table and 'help plot the way forward'. South African hospital groups in the UK had successfully entered into PPIs with that country's National Health Service, providing a wide spectrum of care across multiple disciplines. Contracts ran over a 5-year period and were carefully monitored for quality assurance and patient outcomes. Tariffs within these PPI structures were aligned with NHS recommendations, making private health care more affordable and accessible to greater numbers of patients.

HASA would 'embrace' the opportunity to partner with the South African government in offering clinical services to State patients on elective procedure waiting lists. The pricing on State surgical waiting lists would be significantly reduced by the bulk procurement of drugs and surgical equipment by the State. Given changes to legislation and volume guarantees, the private hospital sector would be able to render services at more affordable rates. Worrall-Clare said one example would be offering the use of a facility and clinical pathways under the guidance of a private specialist in consultation with State staff, be they doctors, nurses or registrars.

'There are significant weaknesses needing reform in both sectors but it is imperative that we show respect for one another and engage if the NHI is going to succeed,' he added. Veller strongly backed this, saying dismal conditions of service in the public sector and a general lack of respect, driven by 'an adversarial approach between management and what happens on the ground', were chiefly responsible for the lack of doctor retention.

State hospital managers hamstrung

Worrall-Clare said what 'manifestly' set his sector apart currently was that private hospitals had full autonomy and engaged directly with their clinicians on 'how much they can spend on new equipment and the like', plus projections for the next financial year. He found it 'astounding' that heads of department in the public sector could not hire or fire certain categories of staff. 'This cannot continue under any new system. They must have the appropriate power and accountability. If they fail to deliver, replace them. In the private sector if a hospital manager doesn't deliver or is inefficient they are replaced.' Nothing stopped his members from extending their existing training programmes to the public sector. The historic animosity between the two sectors was already being broken down, with several hospital managers meeting on a regular basis. 'The tide is turning. They're helping one another, even to the point where equipment is being volunteered. I want to re-emphasise: if we respect each other, we'll find solutions,' he added.

It was crucial that the dynamics and reporting structures, accountability and hiring and firing practices be 'profoundly understood' before any relationships were entered into between sectors. Regulations, rather than entire (legislative) acts, may need changing to enable, for example, the

private hospital sector to train registered nurses instead of offering just the bridging courses they were currently limited to. 'We can expand our capacity for training but we need to address current impediments in the system,' he said, citing 'significant' Nursing Council delays in issuing registration certificates for successful nurse graduates. 'We end up paying salaries to people who cannot function,' he complained.

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HASA members had increased their output of trained nurses from 198 in 1998 to well over 6 000 per annum currently. Nursing Council statistics for last year showed that public institutions had trained 2 365 enrolled nurses while the private sector had trained 5 128. The equivalent figures for auxiliary nurses were 1 106 and 4 673.

Private hospitals – 'let us train'

Worrall-Clare suggested setting up a private training academy for doctors, using state-of-the-art facilities in his sector. 'If private medical schools exist within international jurisdictions (many of which served critical training needs), then there's no reason why South Africa cannot consider the same. I think we need to rock the boat in terms of how we think. We must try and expand what the private sector does in terms of training public sector resources. Many of our staff are willing to assist. In preliminary discussions with our specialists, many said they'd be prepared to act as academic staff, even part time. This must be done with reference to the HPCSA and its requirements to ensure ethical, qualitative and legislative compliance. We should be sitting around the table discussing these things prior to the NHI, because if it's approved, we'll only inherit the benefits in several years. Programmes need to be put in place now,' he said.

Chris Bateman