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Private Hospitals

Abstract

Private hospitals play a significant role in the South African health system. Access to private hospital services however, is still very limited largely because they cost significantly more than services in the public sector. Beneficiaries of medical schemes are the primary customers of the private hospital industry, although an increasing trend of self-funding patients has been reported.

The changing preferences of the medical scheme population have influenced a significant shift from utilisation of public hospitals to private hospitals since 1990. As a result, private hospitals have experienced substantial growth with the total number of private sector beds increasing by 32% since 1998 to the current estimated 27 500 beds. Private hospitals however, are concentrated in the major metropolitan areas with most hospitals found in Gauteng, KwaZulu-Natal and the Western Cape. Private hospital facilities are predominantly owned by three major hospital groups i.e. Netcare, Medi-Clinic and Life Healthcare. Collectively, these groups own and operate more than three quarters of all private sector beds and more than 80% of all private sector theatre facilities.

The private hospital industry consistently attracts the attention of health care funders and regulatory authorities regarding its cost structures and pricing practices. A perception prevails that the fee-for-service reimbursement mechanism implemented by medical schemes encourages over-servicing thus driving cost-escalation in the environment which makes private hospital services unaffordable for the majority of South Africans. Conclusions highlight the need for the implementation of a comprehensive approach to regulate private hospital services with focus on costs, quality and transparency.

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Introduction

Private hospitals have a significant function in the health system. They reduce the geographical distance to the nearest health facility for many in the population and they alleviate pressure from a substantially overburdened public hospital infrastructure. Private hospital services however, generally cost more than services at public hospitals and are therefore accessible to wealthy households and those with private health insurance. Private hospitals comprise the single largest component of expenditure by medical schemes followed closely by expenditure on medical specialists, which is not unusual due to the nature and intensity of services offered in these settings.[1] Of concern, however, are the steep increases in expenditure on private hospitals and the number of medical specialists during the last few years.[2]

This review relies extensively on secondary data largely because private hospitals are reluctant to release information they deem confidential. Relatively accurate data on the distribution of private hospital facilities are maintained by the Hospital Association of South Africa (HASA). HASA is a representative body catering for the interests of approximately 95% of all private hospitals in South Africa. Additional insight into the operations of private hospitals was obtained through direct consultations with HASA and some of the major hospital groups. The review also drew extensively on documents obtained from the Competition Commission and Competition Tribunal.

The chapter focuses on the distribution of private hospitals in South Africa and the types of services provided by private hospitals; an assessment of ownership and market share within the sector; the relationships that private hospitals have with other providers; and the response of private hospitals to the issue of infection control.

Distribution of private hospitals

Overview

The majority of private hospitals in South Africa can be classified as short-stay hospitals, where most patients are admitted for less than 30 days. The average size of a private hospital is small with an average number of beds below 200. A number of private hospitals were initially small concerns established by doctors and were later acquired by the big hospital groups. The few large private hospitals that exist are associated with the mining industry and are thus not strictly for-profit.

Beds

Private-for-profit hospitals offer the largest number of hospital beds outside of the State and the ownership of beds is mixed between independent groups and large hospital groups. Beds in private hospitals primarily serve beneficiaries of medical schemes although hospitals are reporting increasing patronage by the non-medical scheme population. Private hospital beds grew substantially in the 1990s largely paralleling a distinct shift from the use of public hospitals by insured patients.[3] The growth in private hospital beds occurred despite a reported moratorium imposed by the government to achieve equity between the private and public sectors. Cornell et al. state that private hospital companies were able to sidestep this moratorium by building alternative facilities that consisted of wards with a full nursing complement,[a] but without nearby theatres and other services that would classify the facility as a hospital.[4] Table 1 presents the distribution of private hospital beds by province in 2006.

Private beds constitute 21% of total hospital beds in South Africa. The ratio of surgical beds to medical beds leans in favour of surgical beds. According to a private hospital informant this is attributable to surgical admissions comprising the majority of inpatient hospital admissions across all provinces. The ward fee, for a general ward or intensive care unit (ICU), is the same for a medical or surgical patient. However, the overall cost of a surgical admission is higher due to the use of theatre and surgical items such as prostheses.

a So-called 'step-down' facilities.

Table 1: Private hospital beds by province, 2006

	Bed type (Number)									
Province	**Medical**	**Surgical**	**Maternity**	**Neonatal ICU**	**ICU**	**Specialised ICU**	**High care**	**Paediatric**	**Psychiatric**	**Day ward**
EC	340	473	152	29	53	7	42	124	85	60
FS	768	895	110	24	52	34	173	156	118	113
GP	2 900	4 738	1 029	343	746	224	456	1 092	563	818
KZN	828	1 143	322	60	139	42	126	333	125	284
LP	133	274	78	19	27	0	15	85	0	24
MP	183	367	111	38	24	20	23	120	0	42
NC	56	155	30	7	14	0	3	28	0	6
NW	226	197	70	14	32	0	13	49	29	40
WC	960	1 450	442	73	197	61	113	389	266	317

Source: HASA Annals,[b] 2006.[5]

b Data on private hospitals were compiled from the Health Annals 2006, a document published by HASA. The publication contains a comprehensive breakdown of facilities and services offered by private hospitals in South Africa and neighbouring countries. The information provided is not limited to applicable members of HASA, hence it is considered fairly representative of the private hospital sector.

Table 2: Private hospital beds by ownership, 2006

Hospital group	Bed type (Number)									
	Medical	Surgical	Maternity	Neonatal ICU	ICU	Specialised ICU	High care	Paediatric	Psychiatric	Day ward
Community Health Care	100	169	37	18	35	6	33	57	0	12
Clinix Health Group	208	106	67	9	19	0	4	72	26	0
Independent	894	837	257	45	106	43	67	254	617	297
Joint Medical Holdings	100	85	42	6	10	0	16	40	28	40
Life Healthcare	1 587	2 394	588	141	315	91	209	572	240	451
Medi-Clinic	1 290	2 509	653	180	323	113	271	602	115	464
Melomed	63	86	40	7	9	8	11	70	26	31
Mining	586	563	33	0	27	0	125	74	20	42
Netcare	1 566	2 943	627	201	440	127	228	635	114	367

Source: HASA Annals, 2006.[5]

The distribution of hospital beds by ownership is presented in Table 2. The data reveal that Netcare owns the highest number of surgical beds. Netcare also has the highest presence in Gauteng, which explains the higher number of surgical beds in this province.

A 34% increase occurred in the number of private for-profit hospitals during the period 1998 to 2006 (161 hospitals in 1998, compared to 216 hospitals in 2006).[3,5] This rate of expansion matches that reported by Södurlund et al. during the period 1990 to 1998.[3] The distribution of hospitals, beds and theatres by ownership is shown in Table 3.

The number of beds increased by approximately 32% from 20 908 in 1998 to 27 586 in 2006.[3,5] The growth in number of private hospital beds occurred at a time when the public sector was reducing the number of beds in virtually every province.[8] Boulle et al. suggest that the reduction in the number of beds in the public sector may have been a reflection of a trend towards shortening the average length of stay of acute admissions and de-institutionalisation of mental health care.[8]

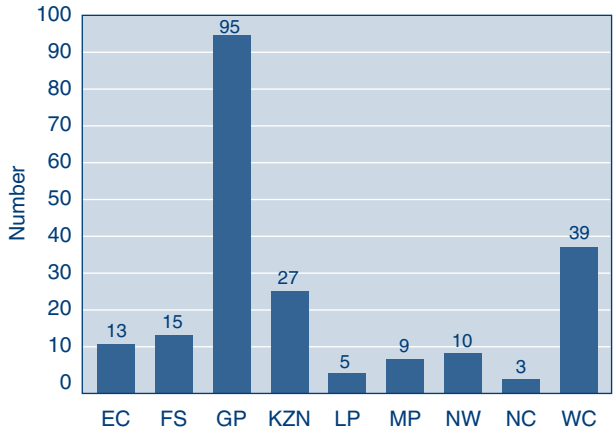
The reduction of hospital beds and public perceptions of quality in the public sector impacted positively on private hospitals by precipitating a change in preferences of the medical scheme population away from public hospitals. The population covered by medical schemes has thus been a major driving force behind the growth of private hospitals. Södurlund et al. assume the user population of private hospitals to be equivalent to that of medical scheme beneficiaries.[3] The perspective of private hospitals is that they may not be as dependent on the medical scheme population as is being argued. However, Figure 1 clearly illustrates an observable trend showing that private hospital facilities are located where medical scheme members are mostly situated.

Table 3: Distribution of hospitals, beds and theatres by ownership, 2006

Hospital group	Number of hospitals	% of hospitals	Number of beds	% of beds	Number of theatres	% of theatres
Community Health Care	4	1.9	467	1.7	18	1.9
Clinix Health Group	4	1.9	511	1.9	10	1.0
Independent	54	25.0	3 417	12.3	125	12.9
Joint Medical Holdings	4	1.9	367	1.3	20	2.0
Life Healthcare	56	25.9	7 300	26.4	257	26.5
Medi-Clinic	44	20.3	6 401	23.2	234	24.2
Melomed	3	1.4	351	1.3	12	1.2
Mining	5	2.3	1 470	5.3	16	1.7
Netcare	42	19.4	7 302	26.4	276	28.5
Total	216		27 586		968	

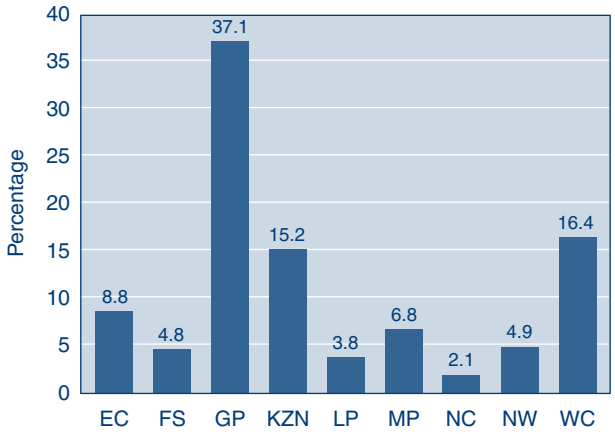
Source: HASA Annals, 2006;[5] Netcare Annual Report, 2006;[6] Medi-Clinic Annual Report, 2006.[7]

Figure 1: Distribution of private hospitals by province, 2006



Source: HASA Annals, 2006.[5]

Figure 2: Percentage of medical scheme beneficiaries by province, 2005



Source: Council for Medical Schemes, 2006.[9]

The distribution of private hospitals by province almost mirrors the distribution of medical schemes beneficiaries by province as illustrated in Figure 2.

Gauteng has the highest number of private hospital beds followed by the Western Cape, with the least number of beds located in the Northern Cape. The Free State is characterised by the presence of a number of mine facilities however, the hospital beds at these facilities are not always available to the general public. If the mine hospital beds are excluded the number of beds per 1 000 population for the respective provinces are as follows: Gauteng (5.09), Western Cape (3.81), KwaZulu-Natal (3.27), and Mpumalanga (1.98).

The above picture has only changed slightly from that reported by Cornell et al. in 2001.[4] Gauteng, Western Cape and KwaZulu-Natal still have the highest concentration of private hospital beds. Limpopo, Eastern Cape and Mpumalanga are still among the provinces with the lowest numbers of hospital beds per 1 000 medical scheme population. These provinces are predominantly rural and rural dwellers who are medical scheme beneficiaries thus face limited access to private hospital services.

Table 4: Type of health service by ownership, 2006

Hospital Group	Type of service (Number)								
	Theatres	Joint replacement	Cardiothoracic	Vascular surgery	Neurosurgery	MRI scanner	Catherisation labs	24 hour emergency	Trauma units
Community Health Care	18	4	3	2	3	4	2	4	3
Clinix Health Group	10	3	0	2	3	0	0	3	1
Independent	125	16	8	10	10	6	6	25	6
Joint Medical Holdings	20	2	0	2	1	0	0	2	2
Life Healthcare	257	32	13	23	25	16	9	34	18
Medi-Clinic	239	35	12	30	23	24	10	41	20
Melomed	12	2	2	1	1	0	1	2	1
Mining	16	4	0	0	1	1	0	5	4
Netcare	276	28	20	24	22	21	13	31	20

Source: HASA Annals, 2006.[5]

Private hospital services

There are nine categories of players in the private hospital industry. Netcare, Medi-Clinic and Life Healthcare are the largest hospital groups collectively accounting for 66.5% of all private hospitals, 75.6% of all private hospital beds and 80% ownership of theatres. The majority of private hospitals outside of the three major groups are affiliated to the National Hospital Network (NHN).

A breakdown of the types of services offered by private hospitals by ownership is illustrated in Table 4.

Netcare owns the highest number of theatres at 276. This is correlated to the fact that Netcare owns the highest number of surgical beds. In general, the differences between hospital groups in terms of the types of services offered are not statistically significant with the exception of the independent hospitals which own significantly fewer theatres compared to the three major hospital groups.

The selection and provision of services by the private hospital industry is guided by the expectations of shareholders. In addition, the tendency by the industry to engage in non-price competition leads to certain investment patterns emerging that may be duplicative. Nonetheless, the function fulfilled by the private hospital industry is important and significant attempts are made by the industry to ensure that the highest quality of services is provided. The industry has established facilities that the public sector would otherwise not have provided due to competing priorities.

The growing trend in the private sector to develop 'centres of excellence' can yield benefits to patients who require specialised care at a hospital that has such centres. At present, only Netcare provides 'centres of excellence'. The most well known of these is the Walter Sisulu Paediatric Centre for Africa located at the Sunninghill Hospital. This facility is run by a paediatric cardiac team that conducts cardiothoracic procedures on babies and children. The team has performed over 5 000 corrective surgical procedures on babies and children over a period of 15 years. The Walter Sisulu Paediatric Trust Fund was established and its aim is to broaden access to the facilities available at the Centre to underprivileged children throughout the African continent.[c]

c Walter Sisulu Paediatric Trust Fund: http://www.wspcc.org.za

Human resources

Doctors

Doctors play a central role in ensuring the success of a hospital. Decisions that determine the content of hospital care are made by doctors, making them indirect sellers of hospital services. However, doctors are also dependent on the hospital to supply a complete service to patients, thus making the relationship between private hospitals and doctors one that is mutual.

In terms of the ethical rules of the Health Professions Council of South Africa (HPCSA), private hospitals are barred from appointing doctors and other health professionals, with the exception of nursing staff. Since private hospitals cannot appoint doctors directly, they adopt an approach of incentives to attract various health care professionals to establish their practices within hospital premises. Both Medi-Clinic and Netcare openly declare that they invest in infrastructure to enhance the satisfaction of doctors practising at their facilities.[6,7] The implementation of incentives by private hospitals to attract medical specialists to their facilities, although beneficial to the hospitals themselves, impacts negatively on equity of access to medical specialists and cost-containment in the health system. An estimated 7 000 medical specialists work in the private sector compared to 4 000 employed in public hospitals. Of the 4 000 specialists in the public sector, some also practice in the private sector under a limited private practice scheme (LPP) allowed by the State. It is therefore difficult to obtain accurate data on the distribution of medical specialists between the public and private sectors, and a conclusion can be comfortably reached that the vast majority practice in the private sector.

The pronouncements by private hospitals on business strategy suggest that demands of the medical practitioners they seek to attract are important determining factors on decisions to invest on infrastructure and technology.[6,7]

The chairperson of Network Healthcare Holdings Limited states:

"Netcare's success over the years has been attributable largely to its doctor centric model, which places professional satisfaction at the centre of its operations."[6]

The business strategy statement by Netcare states the following when it comes to physician partnerships:

"Netcare places physicians at the centre of its business model providing them with state-of-the-art facilities, skilled nurses and the latest medical technologies. We also work hard to retain our physicians by supporting their professional development."[6]

The Medi-Clinic Group also shares this approach to relationships with doctors when it states:

"Sound long-term doctor relationships built on ethical and fair business practices will always be one of the cornerstones of the strategic approach of the group."[7]

Under the existing context whereby private hospitals depend on doctors to generate demand for hospital beds, it is to be expected that hospitals will implement incentives to attract doctors, particularly specialists to establish practices at their premises. These incentives however, add to the overall cost of health care thus further exacerbating the widely acknowledged cost-escalation problem. This phenomenon is illustrated in the supply of magnetic resonance image (MRI) scanners in the private sector. There are a total of 72 MRI scanners in the private hospital sector.[5] The cost to acquire MRI scanners is substantial and their presence in many hospitals is duplicative resulting in allocative inefficiency in the sector.

The view of private hospital groups is that the attraction and retention schemes outlined are ethical and not unique to private hospitals. The public sector also pursues schemes to attract and retain health care personnel such as the scarce skills allowance, rural allowance, permitting remunerative work outside of the public service and procurement of latest medical technologies. The implementation of incentives in the public sector is however informed by a different set of priorities, largely as a means to improve access to health care services to populations that would otherwise not have such access. The private hospital sector, on the other hand, implements these incentives to compete thus engaging, for example, in unnecessary duplication of expensive medical equipment.

The behaviour by hospitals profiled above has led to the international development of the medical arms race (MAR) hypothesis which predicts that hospitals will intentionally invest in expensive medical equipment purely as a strategy to attract medical specialists and to stay ahead of the competition.[10]

The inability of private hospitals to employ doctors is also identified as an obstacle to the establishment of staff type health maintenance organisations (HMOs), an innovation that could impact positively on attempts to create a product

for low income earners.[d] The Consultative Investigation into Low Income Medical Schemes (LIMS) concluded that it would be impossible to develop integrated delivery systems unless corporate entities are able to employ health professionals.[11]

Nurses

Hospitals are highly dependent on nursing staff for the success of their operations and this is true for all hospitals both in the public and private sectors. Currently, an overall shortage of nursing personnel is affecting both sectors. The shortage has contributed to an observed migration from the public to the private sector of all categories of health workers. Two factors have contributed to the shortage of nurses in particular, emigration and a reduction in the output of nurses from nursing colleges. The shortage of nurses is considered by the private hospital industry to be a serious constraint and risk factor limiting the industry's potential for growth.[6] In an effort to mitigate nurse shortages Netcare established a Training Academy to train nurses and paramedics. The output of the academy in 2007 is expected to be 3 410 nurses and paramedics.[12] These efforts however, are claimed not to be adequate to sustain the demands of the rapidly growing private hospital sector.

The concern that the country is not training adequate numbers of nurses has existed for many years. Latest figures indicate that the total number of nurses (enrolled and professional) registered with the South African Nursing Council increased from 130 290 in 2003 to 136 619 in 2005, reflecting an increase of approximately 5%.[13]

Private hospitals claim that the shortage of nurses is making it difficult for hospitals to contain costs since the biggest component of cost in hospitals is staff costs. Staff costs are estimated by Schussler to be as high as 77% of total costs in the private hospital sector.[14] Private hospitals also claim that they are compelled to compete for limited nursing staff by offering more attractive remuneration. The competition for limited nursing staff occurs not only amongst the private hospitals nationally, but they also have to contend with active recruitment of nurses by overseas countries, who offer better remuneration packages.

Remuneration may not be a significant factor contributing to the migration of nursing staff from the public to the private sector. Reasons explaining the migration from public to private in the South African health care sector is not known. It is possible however, that nurses are generally attracted to the private sector by reduced workloads due to a lower bed occupancy rate and improved professional resources when compared to the public sector.[15]

Financing of private hospital services

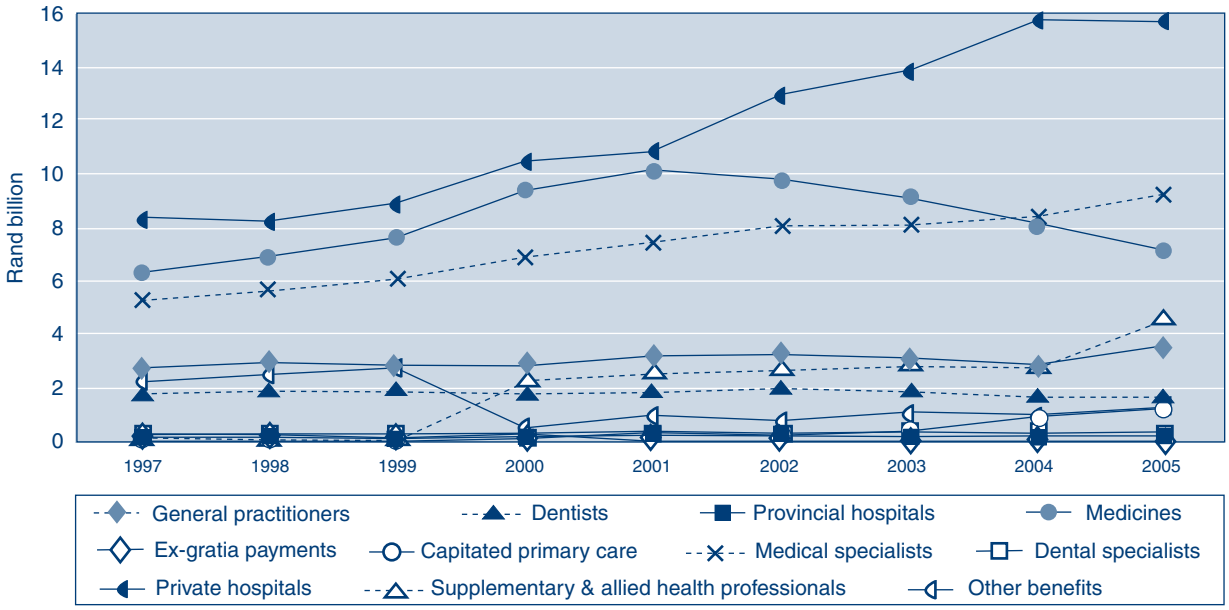
Medical schemes

As previously indicated, private hospitals primarily serve the population covered by medical schemes. Private hospital care is beyond the reach of most individuals not covered by medical schemes. The viability of private hospital operations is consequently heavily dependent on the medical scheme environment. Hospitals are nonetheless reporting growth in other non-medical scheme business, particularly from the self-pay market.[16] HASA Health Annals estimates the annual turnover of the private hospital industry at R17.5 billion.[5] This amount is higher than the total amount spent by medical schemes on private hospitals in 2005 (approximately R16 billion).[9] During consultations for this review representatives of private hospitals claimed their total revenue collection to be as high as R4 billion more than the total amount spent by medical schemes on private hospitals. Based on this amount of R4 billion, they argued that the population served by private hospitals is substantially higher than just the medical schemes population. HASA estimates the population covered by the private sector to be as high as 10 million individuals. Information from the General Household Survey conducted by Statistics South Africa (StatsSA), HASA and the Council for Medical Schemes (CMS) is not adequate to verify this claim.

Currently, there are approximately 7 million beneficiaries of medical schemes. Medical schemes conduct the business of what is referred to internationally as health insurance: they accept premiums in exchange for defraying expenditure incurred by enrollees for health care services. Payment for health care services by medical schemes is conducted through packaged benefits called options and each medical scheme may offer several of these options to its members. The majority of these options make provision for private hospital cover as part of the benefits.

d Interview, HASA official, Johannesburg, 4 May 2007

Figure 3: Total benefits paid by medical schemes, 1997-2005 (in 2005 prices)



Source: Council for Medical Schemes, 2006.[9]

In 2005, medical schemes collectively spent R15.86 billion for private hospital services. This amount reflects a significant increase from the R8 billion that was spent by medical schemes on private hospitals in 1997, as shows in Figure 3.

As Figure 3 illustrates, private hospitals have benefited significantly from the growing expenditure by medical schemes. Changes to benefit design by medical schemes may explain, at least partly, the change in hospital expenditure patterns. The tendency by medical schemes to shift cover for some out-of-hospital services to savings plans or self-payment by members may be a factor contributing to more members being hospitalised to access hospital benefits which are covered under the risk pool. An alternative explanation may be advanced, that the increasing expenditure by medical schemes on private hospitals is in fact the major cause of these changes in medical scheme benefit designs. Increasing concerns have emerged that if expenditure on private hospitals was to continue to grow in line with the observed trends, sustainability of the medical schemes environment may be threatened. Any collapse in the medical schemes environment would inevitably have a ripple effect on the private hospital industry.

Other sources of revenue

Out-of-pocket payments

The proportion of the revenue collected by private hospitals over and above receipts from medical schemes attributable to out-of-pocket payments is not known. It is expected nonetheless, that out-of-pocket payments are increasingly making a contribution to the income of private hospitals. There is also a growing trend by some individuals and households, not covered by medical schemes, to elect to use private hospitals for specific procedures. It was reported by Netcare that this trend is prevalent and increasing in maternity cases.[16]

Foreign patients

There are three categories of foreign patients that get treated in South Africa's private hospitals: medical tourists; South African citizens who live abroad but often return to South Africa to access health care services; and citizens of other African countries notably from North Africa. A breakdown of the contribution that each of these categories of foreign patients makes to the revenue of private hospitals is not available but it is estimated that they contribute R280 million annually.[e]

e Interview, HASA official, Johannesburg, 4 May 2007.

Medical tourism

High costs of care and long waiting lists in industrialised countries have contributed to the growth of a trend whereby citizens of those countries travel to other countries, mostly in the third world, to obtain medical, dental and surgical care. Some object to the use of the phrase 'medical tourism' and argue that it has connotations of cosmetic procedures.[f] Whereas internationally, medical tourists travel to specifically seek medical or cosmetic procedures, in South Africa some companies implement medical tourism literally by combining it with safari tours.[17] None of South Africa's private hospital groups have however identified medical tourism as a significant focus area.

Hospital costs

Context

Expenditure on private hospitals by medical schemes has increased significantly since 1990. Perceived declines in the quality of public hospitals coupled with the movement of specialists and general practitioners away from the public sector have led to an increase in the utilisation of private hospital beds.[2] Whereas in 1990, public hospitals made up roughly 20% of hospital benefits paid by medical schemes, this had fallen to about 3% in 2004.[18] As early as 2004, the CMS stated that *"expenditure on hospitals is a particular concern, with the country's three large hospital groups accounting for more than 80% of the private hospital market and with the strength of their bargaining power considerably outweighing that of medical schemes"*.[18] The concern even then was that private hospitals were systematically consolidating and that this trend was fuelling cost-escalation in the medical scheme environment. The CMS noted that if current medical scheme expenditure trends continued to grow, lives covered would decline, low income products could not emerge and the sustainability of the private health funding industry would be threatened.

Hospital market concentration

Very little data exist on the private hospital market prior to 1990. It is contended that in the late 1980s, the hospital market was highly disaggregated and no hospital groups existed at a national level.[19] During the 1990s, however, a new trend began to emerge where private hospitals were increasingly consolidating through mergers and acquisitions.[9,20] By 1999, hospital consolidation had reached a high level and the three major hospital groups controlled most of the acute beds in South Africa. The consolidation trend was accompanied by significant increases in costs which became evident from 1997.

The private hospital industry disagrees with the perspective that concentration fuelled rising costs and argues that expenditure increased as a result of three significant forces.

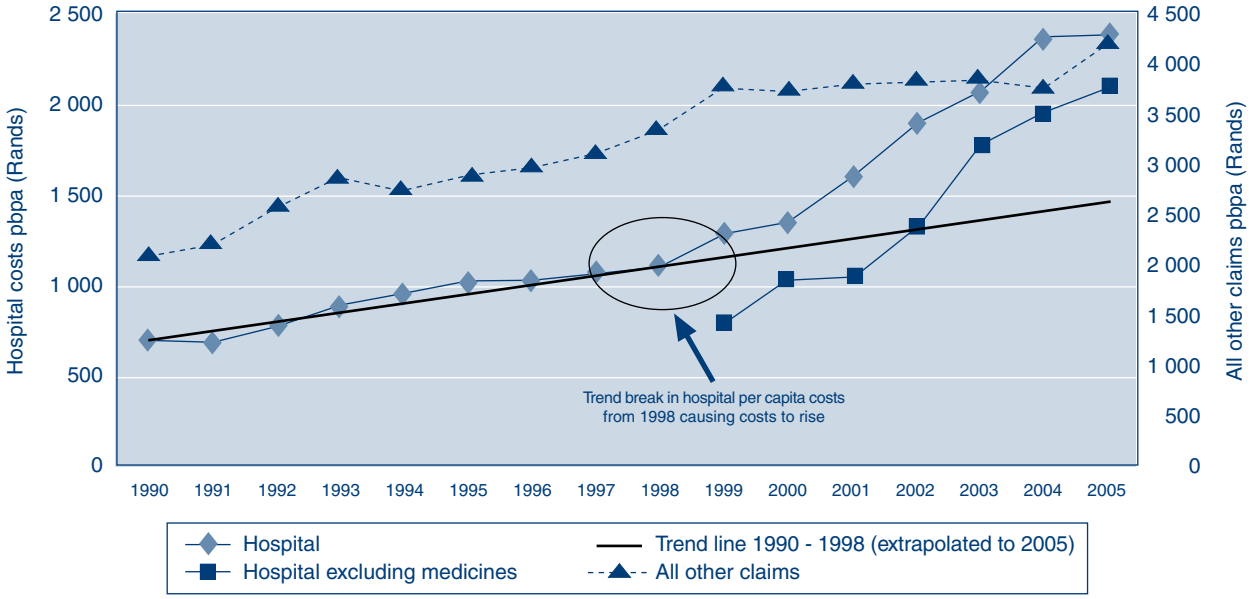
- The near 60% collapse in the Rand from 1998 to 2002 which caused list prices on imported drugs and surgical supplies to rise substantially.
- Changes to the Medical Schemes Act (Act No 131 of 1998) which eliminated risk-rating thus effectively compelling medical schemes to register older and less healthy members (who would require more hospitalisation).[20]
- Annual escalation of inpatient days coupled with a change in case-mix.

The CMS has advanced a strong argument that concentration is a significant cause of the observed escalation on expenditure on hospitals. The CMS has subsequently been involved in a number of Competition Tribunal matters in order to raise awareness among the competition authorities of the impact of increasing market concentration on hospital costs. The involvement of the CMS was motivated by the intention to assist medical schemes to contain expenditure. Concentration amongst private hospitals is undesirable because it avails market power to hospitals and any firm with market power may increase prices and / or lower quality without suffering economic harm.[1] The consolidation amongst private hospitals was seen within the context that it directly resulted in medical schemes paying more for hospital services.

The views advanced by the CMS and the private hospital industry indicate wide disagreement on the extent of market concentration and its impact on hospital costs. In submissions to Competition authorities, the private hospital industry had disputed vehemently that it possesses market

f Interview, HASA official, Johannesburg, 4 May 2007.

Figure 4: Hospital cost trends from 1990 to 1995, Rand per beneficiary per annum, constant 2005 prices



Source: CMS Annual Reports, 1990 to 2005.[23]

power and that it uses this power to affect both price and utilisation of its facilities thus fuelling cost-escalation in the private health care sector.[21,22] The CMS reports however, that the private hospital market has experienced a period of increasing concentration between 1996 and 2006, with key metropolitan areas (Johannesburg, Cape Town, Pretoria and Durban) and the national market regarded as being concentrated from 1999 and 2001.[22] The CMS further argued that a trend break occurred in 1999 with cost-escalation gaining momentum directly as a result of a systematic change in market power between hospitals and medical schemes. This trend break is illustrated in Figure 4. According to the private hospital industry, there were other occurrences around 1998/99 that make it difficult to attribute the trend-break to private hospital concentration alone.

In a recent judgement, the Competition Tribunal commented, *"We agree with the CMS that the private hospital market is a highly concentrated one, and that regulatory barriers have contributed to some extent to these levels of concentration."*[21] The Competition Tribunal recommended that an extensive and focused enquiry was needed to investigate factors influencing the increased utilisation of hospitals and the increase in hospital costs experienced by medical schemes.[21]

Private hospital relationships with other providers

Specialists are key drivers of hospital utilisation and costs. It has been estimated that they generate around 70% to 80% of hospital costs incurred, aside from their own costs.[18] In its submissions to the Competition Tribunal, Netcare noted the importance of the role played by specialists when arguing against further attempts to consolidate by the competitor group, Medi-Clinic.[21]

The reliance of private hospitals on specialists to generate utilisation for their facilities has led to concerns that private hospitals may be implementing incentives that encourage specialists to over-utilise their services. It is however, extremely difficult to prove over-servicing on a case-by-case basis, except in the most obvious cases.[21]

In an effort to address potential over-servicing, medical scheme administrators have implemented preauthorisation requirements for all hospitalisation episodes. There has also been significant investment in case managers who serve as a conduit between medical schemes and hospitals to monitor treatment and care given to the patient. A systematic analysis of the impact that case-management has on over-servicing has not yet been conducted.

An argument exists in the health economics literature that doctors, especially those that perform procedures, induce demand for their services from patients.[24] The theory of supplier-induced demand suggests that doctors are able to

generate demand in order to maintain prices in the market.[25] The pattern of investment by South African private hospitals suggests that inducement could be occurring. Private hospitals have a high number of surgical beds and substantial investments in theatres have been made. It is therefore likely that private hospitals and doctors could enter into arrangements that ensure such facilities are utilised. In order to conclusively quantify the occurrence of supplier-induced demand in the private hospital sector, a full scale enquiry into referral trends and patterns needs to be conducted. A comparative study needs to be conducted between the medical scheme population and the non-medical scheme population to assess whether doctors refer more insured patients for specific categories of hospitalisation than non-insured patients.

Partnerships with specialists however, are not the only relationships that private hospitals seek to develop with other providers. An analysis of subsidiaries of the two publicly-listed hospital groups, Medi-Clinic and Netcare, revealed interests in entities that provide ambulance, pathology, pharmacy, radiography, and managed health care services amongst others. Investing in some of these facilities enables private hospitals to provide a broader range of services on the same premises thereby reducing the need for patients to travel long distances for example to undergo x-rays and blood tests. This type of integration further raises concerns around the potential for inappropriate tests to be conducted and referrals to be made.

Regulation of private hospitals

Private hospitals are mainly regulated in terms of licensing requirements implemented at the provincial level. This form of regulation is limited to ensuring that hospital facilities meet quality standards as determined by the Department of Health. Inspections are conducted at the provincial level and a recommendation is made for the license to be issued or declined.

Hospitals will in future be required, according to section 36 of the National Health Act (Act 61 of 2003) to apply for a certificate of need (CoN).[26] The objective of this provision is to ensure the equitable and fair distribution of access to health care services within the country. Regulations to the Act are however still outstanding and the specific CoN requirements have not yet been finalised.

Apart from processes discussed above, there is no other form of direct regulation for private hospitals. The existing forms of regulation are indirect through legislative tools which include the Medical Schemes Act (Act 131 of 1998), the Health Professions Act (Act 56 of 1974), and the Medicines and Related Substances Control Act (Act 101 of 1965).[20,27,28] There is a growing recognition of the need for direct regulation of private hospitals in order to curb increasing costs.[g]

Profitability in the private hospital sector

Only two of the three major hospital groups are listed on the Johannesburg Stock Exchange (JSE), with Life Healthcare having de-listed in 2005. The earnings of Netcare and Medi-Clinic have been made available in the public domain. In addition, Netcare acquired a controlling stake in the General Healthcare Group in the United Kingdom in 2006, further rendering it difficult to make a year-on-year comparison in financial performance in 2005 and 2006. Available figures suggest that the private hospital sector is consistently profitable with significantly high ratios of operating earnings before interest, taxation, depreciation and amortisation (EBITDA). A seven-year review of the financial performance of both Netcare and Medi-Clinic reveals a consistent trend of growth in earnings. The Competition Tribunal characterises the private hospital industry as having *"opaque vertical relationships and a guaranteed source of funding from medical schemes"*.[21]

Monitoring quality in private hospitals

Section 47 of the National Health Act makes reference to the following critical statements with respect to: *"Evaluating services of health establishments:*

(1) All health establishments must comply with the quality requirements and standards prescribed by the Minister after consultation with the National Health Council.

(2) The quality requirements and standards contemplated in subsection (1) may relate to human resources, health technology, equipment, hygiene, premises, the delivery of health services, business practices, safety and the manner in which users are accommodated and treated.

(3) The Office of Standards Compliance and the Inspectorate for Health Establishments must monitor and enforce compliance with the quality requirements and standards contemplated in subsection (1)."[26]

g Interview, health sector official, Health Professions Council, 2005.

Monitoring quality in hospitals is essential because of the vexing question of nosocomial or hospital infections. Nosocomial infections, though acquired in hospital, may only appear after discharge, making it difficult to identify the source of the infection. In addition, some infections may be community-acquired but only begin to manifest after a hospitalisation episode. Even more critical however, is the fact that hospital-acquired infections can be fatal as was reported in 2005 when 19 babies died at Mahatma Gandhi Memorial Hospital in KwaZulu-Natal.[29]

Doctors are reported to send specimens for testing only if they suspect the presence of a nosocomially acquired infection and these amount to only a third of all hospital-acquired infections. The rest are simply treated based on an assumption that the infection is present. An informant submitted that private hospitals face a constraint in influencing doctors' compliance with infection control procedures because doctors are not employees of the hospital.[h] Nonetheless, hospitals have in place physician advisory boards that interact with the clinical governance processes at the hospital. There are also internal peer review panels that concentrate largely on conduct and ethical issues within the hospital.

There has not been a standardised system or legislative requirement for private hospitals to submit information on clinical outcomes.[i] Implementation of infection control at private hospitals has thus been left to the discretion of each hospital and practices range from having at least one person responsible for infection control, the establishment of elaborate structures and committees to initiatives based on the World Health Organization (WHO) surveillance model.

Hospitals can also elect to participate in the Council for Health Services Accreditation of Southern Africa (COHSASA) programme. Participation in the COHSASA programme is voluntary although some provincial departments of health consult with the organisation for information that would assist to improve patient safety.[30] The majority of private hospitals were however, not enrolled on the COHSASA programme at the time of compiling this review. Both Medi-Clinic and Netcare hospitals have also undergone the International Organisation for Standardisation (ISO) quality accreditation.

Private hospitals and Black Economic Empowerment

The proposals in the Health Charter include substantial changes in the levels of ownership, concentration and representation of black persons across the value chain within the health sector. The private hospital industry has moved rapidly to implement Black Economic Empowerment (BEE) strategies and all stakeholders in the sector have demonstrated commitment to supporting the imperatives of the Broad-Based Black Economic Empowerment Act (Act 53 of 2003).[31] A number of BEE initiatives took place, especially among the three major hospital groups in 2005. A BEE consortium comprising of Mvelaphanda Group and Brimstone Investment Limited acquired majority ownership in the Life Health Care group that was previously controlled by Afrox Healthcare.

During 1995, Netcare established a BEE and Transformation Committee that would subsequently implement a holistic strategy centred around the main pillars of the draft Health Charter. The Health Partners for Life transaction was implemented involving 10% of Netcare's shares worth R1 billion and the range of beneficiaries in this deal included women and children, nursing, doctor and sports organisations.[6]

In December 2005, Medi-Clinic concluded the R1.1 billion Black Ownership Initiative that resulted in an immediate 15% black shareholding being introduced. Beneficiaries of the initiative comprised Phodiso Holdings Limited and Circle Capital Ventures Limited whom Medi-Clinic refers to jointly as the strategic black partners. Importantly, both the Netcare and Medi-Clinic black ownership deals included shareholding by employees.

Black representation in the private hospital industry is, however, not limited to the BEE initiatives existing among the three major hospital groups. There are a further three substantially smaller hospital groups that are almost exclusively black-owned. These are the Clinix Health Group, Joint Medical Holdings and Melomed Hospital Holdings. These hospital groups, as already indicated are far smaller with both Joint Medical Holdings and Melomed Hospital Holdings operating three hospitals each whilst the Clinix Health Group operates six hospitals. The Clinix Health Group has presence in Gauteng whilst Melomed Hospital Holdings and Joint Medical Holdings operate in the Western Cape and KwaZulu-Natal, respectively.

h Interview, health sector official, Health Professions Council, 2005.

i Interview, private hospital informant, Johannesburg, 10 May 2007.

The private hospital industry faces a challenge in terms of diversifying procurement of supplies to include black-owned suppliers of goods and services. Whilst both Netcare and Medi-Clinic have made specific commitments to implement preferential procurement strategies, no concrete decisions have emerged in this regard with both hospital groups stating that they are waiting for the finalisation of the Health Charter.[6,7]

Mechanisms to increase affordability of private hospital services

Only a few wealthy individuals and households can afford to self-fund admission to a private hospital without experiencing financial difficulty. This is because a routine admission to a private hospital facility is generally beyond the affordability for the average South African.

Efforts to increase affordability of private hospital services have not been aimed at compelling private hospitals to undercut their prices in ways that would threaten financial viability. Focus has rather been on utilising the excess capacity that exists in the private health care sector and specifically in private hospitals. Attempts are also underway to ensure that existing pricing practices are enhanced to become more transparent and efficient. Lower bed occupancy rates in private hospitals have led to expectations that these beds could be utilised to facilitate access to low income earners. Efforts to increase utilisation of excess private hospital beds however, require additional input by medical specialists and the shortage of specialists limits the potential for this to occur.

Existing pricing practices and cost structures in the private hospital industry are opaque and health care funders find it difficult to engage effectively with hospitals in price negotiations. Currently, only the Medi-Clinic private hospital group publishes its tariff schedule on its website.[j] Concerns exist that the prevailing fee-for-service reimbursement mechanism creates incentives for specialists and hospitals to adopt a 'more is better' mentality. This situation has led to various stakeholders adopting a view that greater transparency in the pricing of hospital services could significantly improve affordability.

j Available at: http://www.mediclinic.co.za

Conclusions

Private hospitals have experienced rapid growth, which gained remarkable momentum since 1990. During the same period, members of medical schemes significantly shifted preferences from public to private hospitals. The growth of the private hospital sector has been accompanied by a dramatic escalation of costs in private health care and this has raised concerns around the affordability of medical scheme premiums.

In general, far more resources are being spent on private hospital services which cater for the hospitalisation needs of only 7 million beneficiaries of medical schemes than on public sector patients. This exacerbates the inequalities that already exist between the public and private sectors in terms of affordability and accessibility to health care. The private hospital industry, though making a significant contribution to the overall health system, engages in non-price competition which can result in inefficient decision making on where to locate facilities or acquire advanced medical equipment.

The industry's pricing and cost structures are also difficult to understand and the existing doctor-centric model increases potential for incentives to over-service patients. Arguments in this regard prompted the Competition Tribunal to conclude that a detailed inquiry into physician-hospital relationships needs to be conducted.[21]

A moratorium on growth of hospital beds was not effective in limiting hospital cost growth as private hospitals innovated means to bypass this moratorium by building step-down facilities. Furthermore, the attempt to control increases in number of hospital beds was too blunt an instrument to contain cost escalation because changes in bed type within a hospital also has a significant impact on resource requirements.

Significant merger and acquisition activities took place during the 1990s and continued into 2006. Private hospitals have grown in Gauteng, Western Cape and KwaZulu-Natal, which are provinces with the highest medical scheme population. The trend amongst private hospitals has been to invest in surgical beds (rather than other types of beds) and theatres as they generate more revenue for hospitals. The CMS has been involved in a number of Competition Tribunal matters in order to raise awareness among the competition authorities of the impact of increasing market concentration on costs.

The industry has demonstrated commitment to improve the representation of black persons in its ownership structures, although challenges remain on the procurement side.

Recommendations

A comprehensive approach to directly regulate private hospital services needs to be implemented which prioritises concerns and issues relating to costs and quality.

In relation to regulation of quality, it is of particular concern that regulatory oversight of private hospitals on infection control is practically nonexistent. This needs to be urgently remedied given concerns for the safety of patients

In relation to private hospital costs, there is definitely a need for regulatory intervention to ensure greater transparency in fee setting. It is therefore necessary to introduce a mandatory requirement for the industry to provide a minimum data set comprising tariff schedules, costs, quality indicators, complications and any other relevant information. This must be supplemented by regulatory interventions aimed at redressing imbalances in negotiating power between funders and providers, and a suggestion for a statutory framework for collective bargaining is supported.

Clear statutory prohibitions need to be put in place to prevent perverse incentivisation of doctors by hospitals, and to eliminate other areas of conflict of interest among parties in the supplier chain. This should be supported by ongoing research into physician-hospital relationships, as was proposed by the Competition Tribunal.

At the same time, opportunities should be considered to allow for mutually productive relationships between doctors and hospitals to be developed, which do not involve inappropriate incentivisation for referrals and over-servicing. In this regard, the HPCSA ruling against employment of doctors by hospitals needs to be reviewed.

Many of these proposed regulatory mechanisms would be more easily supported by a national private hospital licensing framework, as opposed to the current fragmentary system of licensing at provincial level.

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