In-depth:

The deals that will see public sector patients in private hospitals

22nd June 2020 | Kathryn Cleary

It's been 109 days since South Africa's first case of COVID-19. What started out as tens, then hundreds of new confirmed cases per day has now turned into thousands. As the number of confirmed cases is about to cross 100 000 and the death tally nears 2 000, the country's public healthcare sector is already running low on hospital beds in some areas. The epidemiological modelling government relies on projects substantial ICU bed shortages as the epidemic peaks. As a result, the Department of Health has expedited negotiations to purchase much needed beds from the private sector.

The ins and outs of these negotiations are anything but simple, Nicholas Crisp, a public health consultant with the Department and also head of the National Health Insurance (NHI) office, tells Spotlight. "That's why it's taken so long. Not because any of the parties have been disinterested, but because it's quite complicated," he says.

Crisp is one of the people leading the way on these negotiations, which have come in response to nothing short of an emergency.

Echoing the sentiments expressed by Minister Zweli Mkhize in a personal and poignant Sunday Times column, Crisp fears that the public has yet to understand the size of the pandemic and that the worst is still to come. "The size of the tsunami coming is going to more than stretch the capabilities, it will exceed the capabilities of the health system, despite all of the additional measures we've put in place," says Crisp. "I think the people need to be able to understand that this is really big what's coming."

Despite the lockdown and preparations put in place by government, "it doesn't matter what we do," says Crisp. "There are only so many nurses and doctors in the country, there's only so many beds and there's only so much oxygen."

Previously, civil society organisations including SECTION27 sent letters to Mkhize calling for contracting with the private sector in anticipation of these bed shortages, but they've received little feedback.

"In letters to the Minister on 8 April and 12 May we laid out a number of principles for contracting with the private sector in a way that ensures rights realisation and learns from international experience in the COVID-19 response. One of the contracting principles was transparency. Unfortunately, this has been lacking from this process. It has, for a long time, not been clear where we are with the agreements – whether the intended service level

agreements are in the pipeline and what the considerations are," says SECTION27 Attorney Nkululeko Conco.

The negotiations

Explaining the negotiations to Spotlight, Crisp explains that from the beginning of the pandemic, public and private sector players have been in conversation, and while the public sector has taken a knock – so has private. "We've got to find as many ways as we possibly can to work together to manage the wave, we can't stop it, but we can certainly manage it, and one of the ways is to create a framework where the public sector- which is going to get stretched long before the private sector- is able to purchase whatever care it can't provide in the public service from the private sector," says Crisp.

This framework takes the form of a service level agreement (SLA), and there are SLAs for each player involved including private hospital groups, specialists, radiology groups, laboratory groups and allied health workers, to name a few. The SLAs are valid for the duration of the State of Disaster. Each province is responsible for its own contracting, and will have their own unique set of SLAs.

"All these various players in the private sector are separate and independent and we have legislation that prevents us from getting everyone around the table and saying 'ok guys let's negotiate one big deal'. We have to discuss and form consensus with each of these parties separately and that's been extremely difficult," says Crisp.

Although Spotlight has not seen a copy of any SLA, according to Crisp, they contain what are called ethical and governance forums. The ethical forum relates to decisions on patient care, where both public and private sector parties will have to work together to agree on the best possible care plan. "[The] governance framework of monitoring and managing all of these parties and checking that they're not over serviced [or] they're not under serviced and every patient is treated equally as one, that mechanism is being produced [in the SLAs]. Time will tell how easy it is to manage, but the parties have all been open to that as one of the mechanisms that must be in place," says Crisp.

The product

While the public sector knows it needs beds, the kind of bed it needs is something that doesn't quite exist in the private sector.

Crisp explains that the public sector will be purchasing what's called a critical care bed, which is an all-inclusive combination of high-care and intensive care. "[The private sector is] designed to deliver and knows its costing on ICU, separate from high-care. Because of the way the private sector has evolved over the years, the bulk of their critical care is in ICU, not high-care. From the public sector perspective we know that those beds cost a fortune, the way the patients are cared for in ICU beds is an all-out plan to spend as much as necessary to get the patient to survive, and [for] COVID-19 that's not necessarily the answer," says Crisp.

“We’ve spent a lot of time discussing what a critical care bed [is] and how to weigh the difference between a high-care and an ICU bed and arrive at a reasonable agreement about what exactly the public sector thinks it’s going to buy.”

The public sector will also purchase general and palliative care beds, each at a different price.

The costs

These private sector beds won’t be free, but the cost will come at a discount.

Crisp says that private sector parties have agreed on cost-recovery pricing, in other words, pricing that won’t generate a profit. “From day one, players in the private sector said we recognise that this is a national crisis, we don’t want to make money out of this but we need to recover our costs,” says Crisp.

He emphasised that despite the complicated process, engagements between all parties in both sectors had been positive. “Convincing everyone that buying a bed, not only is it worth it, it is unavoidable that the public sector will have to buy beds from the private sector. The question was how to make it as affordable as possible, and the doctors said we’ll come in at whatever you pay your public servants, we’ll do it for the same, and hospitals said we will take it down to absolute cost-recovery.”

The prices of each bed per patient, per diem are as follows:

Critical care global tariff R16 156

General care total tariff R3 449

Palliative care total tariff R1 142

“We’re dealing with taxpayers’ money, we certainly can’t waste it, and we know that we need to spend as much as we can in the public sector because the public sector will always be cheaper than buying out, but we still need this as an option,” says Crisp. “If any message must come across on this process it should be that the parties have been remarkably open with one another and tolerant of one another’s problems and we reached a point where we can at least start with the prices we’ve set.”

Although these tariffs may be lower than normal, some have criticised the use of a per diem rate and fear that without a ceiling, the private sector could profit. “You don’t know if that patient is going to be there for three days or 15 days, and if they’re there for 15 days even though you’ve managed to reduce the per diem value, you have a very big expense on your hand and an unpredictable one,” says Professor Alex Van Den Heever, Chair in the field of Social Security Systems Administration and Management Studies at the Wits School of Governance.

“In a private sector contract, a per diem rate creates incentives on the provider side, because once the patient goes below a certain intensity [of care] requirement, [the private sector] is making quite a big surplus potentially. If they keep you in longer, they make more of a profit, but the actual intensity of care drops,” he explains.

Western Cape leads the way

Paying for these beds will be up to each province, but it’s unclear where the money will come from in provincial health budgets to make such purchases. There are also concerns over the possibility of provincial budget constraints negatively affecting patient care. The Western Cape is the first province to make significant progress on their SLAs, following the province’s announcement at the end of May that they would purchase 300 beds from the private sector.

In a press briefing last week, Provincial Head of Health Dr Keith Cloete said that the province was close to signing several agreements. “Our team is working around the clock, my latest information is that there is a combination of hospital groups, administrators, radiology, EMS, that we can start signing for a specific area and we are very close to signing,” he said.

Cloete said that the province had made provisions in the projected expenditure, and that they were not waiting for any additional funding or the announcement of the COVID-19 budget this Wednesday. “We’re already saying that this will be part of the expenditure that we will incur and managing in relation to that,” he said.

Concerns over budget constraints and patient care

While the Western Cape leads on SLAs, Van Den Heever warns that the province doesn’t have the resources to go beyond a certain point. “The problem here is that as far as I understand with some of these contracts, when the money runs out, basically the contract ends. Now imagine that you’re sitting with 200 public sector patients in private hospitals, imagine the situation when you have to take [those people] back to general wards in the public sector because that’s what you’re going to have to do if you run out of money,” says Van Den Heever. “There’s every possibility that the money will be blown very quickly if there is a severe surge which is another question, but it’s likely to be the case in at least 3, maybe 4 provinces,” he says.

Considering Van Den Heever’s concerns, Crisp assured Spotlight that private hospitals would only be able to move patients once they were stabilised, and that no critically ill patient could be removed from care. “Once an agreement is signed, the parties would need to honour the agreement,” says Crisp. “Provincial Health Departments will need to be careful about referring only as many patients as they can pay for. This is why they are eagerly waiting for the budget announcement so that [provinces] can decide how much they can set aside for purchasing what they cannot provide themselves.”

Adding to this, Conco says that one idea behind the Disaster Management Act is that resources will be pooled together or directed towards whatever the disaster is, so in theory whatever resources have been in reserve should be directed to provinces to negotiate these agreements. “Our experience as a nation makes us very wary of global costs for health services where provinces could make decisions based on their financial constraints or other considerations which do not necessarily place the appropriate value on health outcomes and the right to health,” he says.

Links to the NHI and the Health Market Inquiry

Although these negotiations have the public and private sector working together, Crisp clarifies that this is not the same type of contracting as we will see under National Health Insurance (NHI). “The NHI is a financing mechanism, and the published routes for paying for [public and] private providers to deliver will be done through a completely different mechanism, not this. But, where this is going to be useful is that the relationships are hopefully building trust,” he says.

In relation to the Health Market Inquiry (HMI), a provisional report about the private healthcare market published in 2018 and the final version published last year, Crisp called these negotiations a “different ball game”. “This is an attempt of health professionals and companies to say we need to do our best, we’re not going to chip in because we don’t have reserves to chip in but we’re going to make sure that we care for as many people as we possibly can with the resources available. It’s a different question from the Health Market Inquiry,” he says.

However, one recommendation in the HMI was to move away from a fee-for-service model, and this is exactly what these negotiations are doing. “Fee for service is neither sustainable nor administratively feasible during the exceedingly high demand of COVID-19,” says Crisp. “There are too many unknowns in the COVID-19 response and clinical care is changing as the epidemic unfolds. So, [these] SLAs aim to achieve a single, easy to administer, fair-value arrangement for all parties.”

Professor Sharon Fonn, one of the Panel members of the HMI, says that these negotiations could have been made easier had the recommendations of the HMI been implemented. She explains that the HMI motivated for a supply side regulator which could have helped to identify where and what beds, and where and what providers were available.

Fonn points out that before the pandemic, private hospital occupancy rates made little sense. “Based on the findings and analysis of the data during the HMI, hospitalisation in general, and admission to high care and ICU in particular, is very high, un-understandably high, not related to the demographic and disease profile of the population they serve,” she says. “The hospital sector and doctors, in particular specialists, will do well to understand that their future lies in making their resources available and affordable to the South African population.”

The HMI also called for a comprehensive quality assessment system, which would report outcomes for specific diseases and transparency about hospital quality that produces uniform risk-adjusted comparative results for each hospital, says Fonn. “The COVID-19 pandemic only emphasises the value of the recommendations of the HMI,” she says.

Prior to the pandemic, Crisp says there were multiple meetings and discussions about the HMI recommendations. “As soon as there is breathing space I am sure this will be back on the agenda. The same goes for the NHI. The Parliamentary timetable was disrupted by COVID-19 but needs to pick up again.”

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