

10 Public Hospital Reform

10.1 Purpose

The public hospital plays a central role in South Africa's health system. Public hospitals serve the needs of the vast majority of the population. They also take responsibility for the teaching and training needs of the country's health service personnel. Public hospitals have typically operated within a bureaucratic environment with key operational decisions made centrally by provincial or national health departments.

This environment appears to have diminished the responsiveness of public hospitals to environmental change both within the public and private health arenas. The evidence points strongly to the fact that public hospitals are not well placed to take advantage of alternative revenue sources or to benefit from any future mandatory contributory environment.

The purpose of this section is to provide a specific proposal concerning the future reform of public hospitals. The intention is to propose a design that would be consistent with both current and future policy needs. The proposal is based on a review of policy options to date, discussions with key role-players in the Department of Health, selected hospital CEOs, external consultant support, and the Treasury Department.

10.2 Overview of Policy Process and Trends Since 1994

During 1995 and 1996 a project to evaluate the reform of public hospitals was commissioned and made a number of recommendations relating to:

- (a) Decentralisation;
- (b) Revenue retention;
- (c) Differentiated amenities;
- (d) Hospital tariffs;
- (e) Governance; and
- (f) Human resources.

The central thrust of the final report was that public hospital management should be significantly decentralised. It further recommended that the policy of revenue retention would be enhanced by this decentralisation. An important recommendation involved the establishment of differential amenities within public hospitals to enhance fee payment. Revenue retention was seen as likely to be enhanced through both the introduction of revenue retention and differential amenities

The Hospital Strategy Project found that provincial governments were not regularly updating or managing their tariff schedule adequately. They consequently recommended that a better, and possibly simpler, tariff system be adopted and regularly updated.

Attempts have been made by the national Department of Health to introduce this framework. However, implementation remains minimal and ineffectual at this stage. The following processes are noted:

- (a) **Hospital Decentralisation and the development of Performance Management Agreements (PMAs):** Attempts were made to delegate certain operational responsibilities to hospital managers in accordance with a contract to be entered into with the provincial Department's of Health. The process appears to have faltered. Problems exist with the support for managing contractual arrangements within provincial Department's of Health, and in the insufficient degrees of freedom given to hospital managers to cope with the obligations flowing from the PMAs.
- (b) **The development of a Uniform Public Hospital Fee Schedule (UPFS):** An all inclusive fee schedule was developed by the national Department of Health. Implementation has been slow due to the weak and non-standardisation of billing systems within public hospitals.
- (c) **Retention of Revenue pilot projects:** Two pilots were implemented in the 1998/99 financial year in Gauteng and Western Cape to test revenue retention options within the existing financial framework of the public sector. The pilots demonstrated clearly that the success of revenue retention was too dependent on the discretion of provincial treasuries. It also indicated that the existing regulatory framework was inadequate and there is consequently a need for a dedicated regulatory framework for public hospitals. The pilots did indicate that even minimal revenue retention changed the behaviour of hospital managers. Despite the obvious advantages to revenue retention, the failure to progress in this area suggests strongly that confusion exists as to how this should be achieved within the given financial framework of government. Insufficient attention has however been given to the creation of an entirely new framework.
- (d) **Appointment of Chief Executive Officers (CEOs) as heads of hospitals:** The appointment of CEOs has done little to achieve the improved management of hospitals. Problems in hospital management stem largely from the inability of hospital managers to directly manage their institutions.
- (e) **Hospital rehabilitation:** Attempts to compensate for backlogs in capital expenditure on public hospitals has proven to be inadequate. Funds for this purpose are allocated via conditional grants to provinces after approval of project proposals. The funds themselves are small relative to the capital needs of the hospital system and difficult to access. The

result is an under-utilisation of the available funds due primarily to the inherent structural inefficiencies inherent in the over-centralised and onerous allocation process.

10.3 Review

In conjunction with the Department of Health, the Committee of Inquiry held a number of workshops on public hospital reform. Various specific problem areas with public hospitals were highlighted and reported on below.

10.3.1 Incentives to identify private patients and bill

There are currently no incentives for public hospitals to identify private patients. As the fee revenue goes to provincial treasuries public hospital managers find it logical to turn away private patients where possible. Private patients result in uncompensated costs for public hospitals.

10.3.2 Flexibility to negotiate alternative forms of reimbursement

Increasingly medical schemes have different tariff schedules. It is becoming important for them to negotiate differential tariffs to use their market power more effectively.

10.3.3 Opportunities for making specialist units and services available to the paying market

Specialist services can be maintained for both public and private patients Renal units, cardiology, burns, etc. are examples of services which medical schemes would wish to contract for without any need for a differential amenity. The broader patient and funding base will serve to preserve these services for public sector patients.

10.3.4 Treasuries and their approach to separate operational accounts for public hospitals

Most treasuries appear unhappy about separate trading accounts for public hospital own revenue. It appears treasuries would like to redistribute these funds away from health services. This would be the only logical explanation for disallowing separate trading accounts.

10.3.5 Willingness to pay for public hospital services

According to results from the Willingness and Ability-to-Pay study, most people are only prepared to pay for public hospital services, whether directly or through any form of prepayment, if there is an improvement in the public hospital system.

10.3.6 Consequences of a lack of revenue retention at public hospitals

In the absence of a coherent revenue retention system many informal arrangements outside of the health system are starting to occur. The University of the Witwatersrand has established a PTY Ltd company (Wits Consortium) which is a wholly owned tax exempt company. Wits Consortium has purchased its own dialysis facility and is negotiating directly with medical schemes. Funds are then distributed to doctors on the Wits staff establishment. This option currently only benefits Wits staff, but does not benefit the public health system in any explicit way. Pharmaceutical trials are also being operated through Wits Consortium on public hospitals without adequate compensation for staff time used or patient expenses.

10.3.7 Consequences of a lack of public hospital autonomy

The lack of a formal system around revenue retention and proper hospital autonomy is resulting in backdoor mechanisms which are damaging the performance and morale of public sector staff. Public hospitals are “privatising” to the detriment of public patients. This implies that many public hospitals are effectively cross-subsidising the private sector – where publicly employed staff who serve private patients and are reimbursed by medical schemes. There are signs that this is occurring on a large scale.

10.3.8 Redistribution of retained revenue

The redistribution of revenue has to be balanced against the incentive to collect it in the first place as well as the need to cover any costs incurred.

10.3.9 Opportunities for offering public sector services to private medical schemes

The public sector is well positioned to provide services to a substantial portion of the private market, at reasonable cost if they were able to engage more flexibly with the private medical schemes. It is near to impossible at the moment for a hospital to negotiate and implement contracts with medical schemes. Too much has to happen at the provincial level – and they don't have the time or the inclination.

10.3.10 Risks that public hospitals could lose their public character

Increased autonomy and interaction with the private sector could change the public sector character of public hospitals. This could be avoided, however, if a coherent policy environment were created.

10.3.11 Cost implications for the private sector of public hospitals selling services to private medical schemes

Being able to sell public sector hospital services to private medical schemes should result in a dramatic decline in costs for the private sector.

10.3.12 Public/private partnerships

There is currently no clear policy framework within which public/private partnerships (PPPs) are set up. As a consequence PPPs are largely ad hoc.

10.3.13 Equity and resource allocation

There is a general concern about equity in the allocation of resources, but there is no clarity as to what the redistributive objectives are. They are not explicit.

10.3.14 Public health system incompatibility with the medical scheme reforms

The public health system has not engaged strategically with the intentions and opportunities raised by the Medical Schemes Act reforms.

10.3.15 Arbitrary nature of relationships between provincial health departments and Treasuries

There are general concerns about the arbitrary nature of engagements with provincial treasuries. No clear guidelines or principles relating to budgeting or to revenue retention are evident. They largely appear to make them up as they go along.

10.3.16 Revenue generation undermined by treasuries

All revenue generation objectives can currently be undermined without much difficulty by provincial treasuries. This applies to any future social health insurance proposals as well as to conditional grants.

10.3.17 Need for hospital autonomy

The ability to manage must be decentralised to the hospital level. This needs to be a prior consideration to revenue retention. The inability to generate revenue from private sources is a symptom of over-centralisation.

10.3.18 Lack of political will with respect to decentralisation process

There was a feeling that the decentralisation process utilising European Union consultants could not get the job done due to a lack of political will. The problem is centralised authorities appear unwilling to relinquish direct controls.

10.3.19 Problems with dividing up management responsibility in public hospitals

Various PPP proposals involve the dual management of public facilities with the private sector directly managing a portion of the hospital. Such systems should not be permitted, as the hospital CEO should have full control over the entire facility. This would not preclude options which recognise this.

10.3.20 Problems with the centralisation of capital budgets for public hospitals

The centralisation of the capital budgets for public hospitals results in low levels of maintenance expenditure. Public Works departments have their own agendas and time scales for delivering. Their procurement processes are also dubious. If the funds were allocated directly to the hospital, and the hospital were in control of the procurement process, public hospitals would be maintained far better than at present. Capital backlogs are occurring primarily because the public hospitals themselves have little direct control over capital and maintenance expenditure.

10.3.21 Global budgets for public hospitals

There is a need for comprehensive global budgets for public hospitals. This coupled with greater autonomy will substantially change the performance of public hospitals. Many of the existing problems will resolve themselves.

10.3.22 Relationship between hospital autonomy and social health insurance

There appears to be no point in introducing a system of social health insurance in the absence of hospital autonomy and where treasuries can undermine health department budgets.

10.3.23 Link between the funding of public hospitals and national policy

There is currently no direct link between national health policy and the funding of public hospitals. If the current system is maintained there is little chance of this situation changing.

10.3.24 Centralisation of health budget coupled with decentralisation of operational control

The option of centralising health budgets coupled with the decentralisation of operational control to the lowest level possible should be considered. The centralisation/ring-fencing of the budget protects the health budget within the confines of national health policy, while the decentralisation of operational control ensures the efficient management of those funds.

10.3.25 State of public hospitals

The current state of public hospitals affects revenue generation. Basic amenities need to be improved generally. This needs to be coupled with an up-front investment in differential amenities.

10.3.26 Differential amenities versus differential services in public hospitals

Although differential amenities are supported, differential services should not be introduced into the public sector. The latter should not preclude the possibility of permitting a private hospital patient to opt for their own doctor. Here the public hospital will be reimbursed for the facility fee, while the doctor would be reimbursed separately by the patient or medical scheme. This approach is consistent with most major industrial country systems, such as Australia, United Kingdom and France.

10.4 Hospital Decentralisation

10.4.1 Comprehensive Approach

The need for public hospital decentralisation has been long acknowledged as an essential part of the reform process. However, elements of hospital reform are happening outside of a broader reform context. Decentralisation cannot be seen separately from revenue retention, differential amenity options and certain reforms in the financial and budgeting framework. Without this reform process, it is unlikely that consistency with the Medical Schemes Act and potential mandatory contributory environments can be achieved. Although these latter reforms will impact on coverage and the direction of the overall health system, without public hospital reform, the public hospital system will merely not participate in the evolving system.

It will also be important for this new environment to be established in national rather than provincial legislation, with areas of provincial discretion clearly specified in the Act. The Act should also provide for transitional arrangements with some flexibility built in to permit the national Department of Health to implement the process in a reasoned manner. A co-operative process with the Treasury Department would be essential.

10.4.2 Differential Amenities

Based on previous recommendations and the current review it appears unlikely that a mandatory or voluntary contributory system will want to make use of public hospitals unless some degree of differentiation occurs. Based on the consultation process engaged in by the Committee the following guidelines and preconditions are suggested for differential amenities:

- Differential amenities should not amount to a differentiation in services;
- The public hospital should at all times retain its public character;
- Consideration needs to be given to an injection of funds to improve basic services and amenities up front;
- The management of a differential amenity should at all times remain the direct responsibility of the hospital manager or CEO;
- Differential amenities should not be created as a separate independent provider system, but should always remain part of an existing public sector hospital;
- Staff should serve both the general and differential amenities in accordance with normal procedures and rotations;
- Over time, with improved funding and management the underlying need for differential amenities should diminish.

10.4.3 Financial Framework

The financial framework consistent with a decentralised public hospital model needs to ensure that the CEO or hospital manager has full control over financial matters. Although consideration will have to be given to transitional measures, an ultimate structure is presented here which gives the appropriate degree of autonomy:

- Public hospitals should operate their own bank accounts and receive budget allocations from the provincial government on an agreed draw-down schedule;
- The budget allocations to public hospitals will be represented in the White Books as global transfer payments;
- The public sector Financial Management System will only record the transfer payment, thereafter bank account records provided in the reporting process will be used to assess expenditure trends;
- The CEO or hospital manager needs to become the accounting officer;
- The hospital should provide detailed financial reports to the province in an agreed format;
- Revenue taken in from private patients would be retained directly by the hospital and will be reported on but not appropriated by the legislature;

- The public hospital would report to the province on all revenue, including that from private patients;
- The budget allocation needs to include funds for both major and minor public works;
- All procurement should be subject to an internal tender process;
- Equipment purchases will occur in accordance with policy decisions made by the provincial Department of Health – but not subject to review for financial purposes;
- The implementation of differential amenities or expansions of the hospital should be in accordance with an agreed policy framework developed and monitored by the provincial Department of Health;
- The Hospital Board must have fiduciary responsibility and held individually accountable for the financial position of the hospital;
- The hospital will need to be audited by the Auditor General's Office;
- Hospital deficits will result in overdrafts at the bank, and as such a clear policy will need to be formulated to deal with liquidity problems faced by any particular hospital;
- Each hospital operating a separate bank account, irrespective of size, will require a senior Chief Financial Officer (CFO);
- All procurement of drugs and consumables, normally part of a central tender process, can be ordered via any central procurement process, and payment made to the provincial treasury within an agreed period of time;
- The employment of staff on a temporary or full-time basis will be at the discretion of the hospital within an agreed policy framework based on an agreed staff establishment;
- The staff establishment will be generated by the hospital in consultation with the province Department of Health (this is a reversal of the current approach where the province determines the staff establishment without much consultation with the hospital).

The emphasis of the above framework is to shift the key operational workload and decisions onto the hospital. The key role of the provincial Department of Health shifts exclusively to policy development and monitoring of compliance. Decisions concerning staff, equipment and capital programmes will then be based on health service priorities and not budget control. Budget control now becomes the clear responsibility of the CEO, as the accounting officer, and the hospital board who have a fiduciary responsibility to ensure the solvency of the institution.

10.4.4 Governance Structure

The decentralisation of hospital accountability and responsibility suggests a far more meaningful role for the hospital board and CEO. The following provide a range of the roles and responsibilities that should ensure appropriate governance if introduced:

The Provincial Department of Health:

The provincial Department of Health will liaise directly with the hospital concerning all matters affecting health policy. To ensure a direct relationship with the hospital, at least one or two department officials could sit on the hospital board of major hospitals. The Department of Health will take responsibility for negotiating the medium-term contracts and reporting process for all public hospitals. The department would need to develop policy in the following key areas:

- Regional service norms;
- Staff norms;
- Equipment;
- Framework for differential amenities and private hospital patients;
- Tariffs;
- Quality standards and reporting;
- Borrowing guidelines and oversight (as with the new structure hospitals will be in a position to borrow funds directly for capital programmes);
- Solvency requirements;
- Equity requirements.

The Hospital Board:

- The Board will be appointed by the MEC for Health in a particular province;
- Chairperson will report to the MEC for Health;
- The Board will have fiduciary responsibility for the hospital;
- A range of appropriate skills and individuals of good standing should sit on the Board;
- The Board will appoint the CEO;
- The CEO will report to the Board;
- The functions of the board will be to provide effective oversight, but not to become involved in the day-to-day running of the hospital;
- Examples of the functions of the Board would include the following:
 - oversee and approve the policy directions adopted by the CEO within the framework of provincial policy;
 - oversee and approve the contract with the provincial Department of Health;
 - approve and monitor the human resource strategy;

- approve and monitor the equipment plan;
- approve and monitor the financial plan; and
- review and evaluate expenditure reports.

The CEO:

- The CEO is appointed by the Board;
- The CEO will be the accounting officer;
- The CEO will manage, appoint and determine the contracts of the senior management team including the Chief Financial Officer;
- Responsibilities will include:
 - The day-to-day management of the hospital;
 - Report to the Board on a regular basis;
 - Develop and implement approved policies with respect to finance and service provision;
 - Develop plans consistent with provincial policy;
 - Enter into contracts with all external parties;
 - Develop and enter into agreements and contracts with the provincial Department of Health; and
 - Develop and manage the finances.

10.4.5 Human Resources

A key performance factor in the health system involves the quality and motivation of personnel. This requires appropriate remuneration policies, career advancement opportunities and adequate oversight and discipline. To achieve the right mix the hospital should be given as much scope as possible to determine its human resource strategy. This will include the ability to determine flexible contract arrangements for medical and nursing staff who may wish to work part-time in the private wards or in the private sector. However, the establishment of staff privileges should at all times be at the discretion of the CEO. If contract arrangements are abused or conducted inappropriately, the privileges could be withdrawn.

10.4.6 Relationship to Private Sector

As the CEO will have the ability to enter directly into contracts with the private sector, the development of direct contracts with medical schemes for specialised services or differential amenity wards will be greatly improved. The contract will be entered into with the CEO and the funds will be paid directly into the hospital bank account.

Special arrangements in terms of billing, tariffs and reporting can be negotiated directly. If up-front capital is required to develop a new service, in terms of such a contract, the funds could be

obtained either through borrowing against future revenue or through a grant from the provincial health department. The latter will usually occur if there is a consequential improvement of services for non-paying patients.

The flexibility of these arrangements should not impact on the public character of the hospital provided a consistent policy environment has been created to ensure this. Over time, the more flexible operational and revenue environment could lead to a basic improvement in the quality of public hospitals, removing the necessity for explicitly separate amenities.

10.5 Findings and Recommendations

This report finds that the current regulation and governance structure of public hospitals is inconsistent with existing reforms such as those relating to the medical schemes, and all future options relating to a potential social or national health insurance system. It also finds the current structure harmful to effective service delivery irrespective of the revenue source. A review process looking at public hospital consistency with the Medical Schemes Act and potential Social Health Insurance options came to the conclusion that:

- (a) Public hospital reform is the pivotal reform element holding back overall health systems reform.
- (b) Hospital decentralisation cannot advance without consideration of a completely revised governance structure.
- (c) Hospitals should ultimately operate their own bank accounts.
- (d) Hospital boards should be given greater accountability in future, to the extent of their having fiduciary responsibility for the hospital.
- (e) The CEO should be the accounting officer of the hospital rather than the Head of the provincial health department.
- (f) The new structure should be established in national rather than provincial legislation.
- (g) Transitional issues should be allowed for in the legislation.
- (h) Implementation should occur with the co-operation of the Treasury Department.