



SAVING LIVES: WHO PICKS UP THE TAB?



The extent of all emergency medical air cover in South Africa.

Graphic courtesy of Star Trauma Air Rescue.

The three top private hospital companies in South Africa claim they lost R87 million last year providing expert emergency pre-hospital care to patients for whom the state should be responsible.

They say they are being 'prejudiced by their competence' in meeting the basic medical ethical obligation to save lives.

This complaint came last month from advocate Kurt Worrall-Clare, the acting CEO of the Hospital Association of South Africa (HASA), who believes the private sector is subsidising state health care services in what he describes as an 'unfunded mandate'.

Worrall-Clare cited these figures during an *Izindaba* interview probing his recently released 'Recommended emergency treatment policy for private hospitals'.

He said his policy paper was

prompted by the silence in the existing legal framework 'about what constitutes a medical emergency'.

It is illegal for any hospital or health care worker to delay conducting a triage of a patient in an emergency condition in order to first establish the patient's payment and/or insured status.

Most players in emergency rescue agree that the lack of a national co-ordinated response system means that millions of South Africans are forced to rely on a largely inefficient and ailing public health care system, often costing lives, particularly in peri-urban and rural areas.

Just 18% of South Africans are medically insured, leaving the state

sector with a huge burden of care – and both sectors urgently need a more efficient single overall operating system.

South Africa has 11 dedicated emergency rescue and treatment helicopters, none of them owned by the state. All are used to some extent on fixed or *ad hoc* contract by 6 of the 9 provincial governments.

Whose tools to use?

The truth however is that the combined EMS capacity of the public and private sector is vastly under-used and poorly co-ordinated with profit versus service delivery primary motives and ensuing behaviour causing daily conflict and competition.

The conflict ranges from isolated accident scenes through to disaster response planning and execution.

Izindaba found a pervasive lack of trust between key players in the two sectors.

We were told of private ambulance crews in several provinces 'stealing' patients from provincial crews at accident scenes and delivering them to their parent company hospitals or ignoring provincial protocols for distribution of patients to hospitals after disaster incidents.

One top private hospital emergency co-ordinator said it took her an average of 7 - 9 hours to transfer a stabilised, indigent patient from her private hospital to any state one.

'As soon as they hear you're from a private hospital you get the run-around – sometimes I advise relatives to take them there in their own car just to get them admitted,' she said.

While the debate on the relative merits of ground versus air emergency transport from accident scenes rages between Netcare 911 (predominantly road) and Star Helicopters (exclusively air), cost considerations often result in



patient-unfriendly operational anomalies.

'Managing' EMS health care

Star Helicopters' KwaZulu-Natal operations manager, David Doull, says his fee-for-service rescue helicopter remains earthbound 81% of the time because of strict financial controls put into place by the private and public sector.

He believes early advanced intervention and early definitive care to be 'the cornerstones of cost-effective trauma care' and that helicopters, appropriately used, provide this.

Netcare however says the recent tripling of casualty units in both sectors has reduced the need for helicopters. It uses a 'consensus' guideline that includes medical and logistical criteria for EMS helicopter dispatch.

Star was called out by the KwaZulu-Natal health department on average just 11 times per month over the last 6 months.

Over the same period medical aids used Star 5 times per month, Workman's Compensation (injuries on duty) twice per month with payment for 5 additional responses declined by various parties.

Over a 12-month period (2001), in the South Central (Umlazi) district of Durban alone, 990 people per month were seriously injured in vehicle accidents (150 deaths per month) – with just 2 provincial ambulances allocated to the district.

Over the same period Durban 'north central' saw 2 820 serious injuries per month with 360 deaths per month (3 ambulances allocated) (source: InterDisciplinary Accident Research Centre, University of Natal, Durban).

Country-wide last year 3 600 people per month were seriously injured in road accidents alone, 630 of them suffering permanent disabilities, with an additional 930 dying per month (source: ArriveAlive statistics).

Doull said experience has shown that air ambulances can cut down the call-out to tertiary care time by 68%, resulting in more lives saved and vastly improved patient outcomes.

Adds Doull, 'we're geared towards use. Last year we needed to find about R15 million outside of the medical industry just to keep functional (nationally)'.

Star is a specialised trauma air rescue non-profit operation that operates 3 helicopters partly in an *ad hoc* arrangements with governments in Limpopo, KwaZulu-Natal and Gauteng.



Advocate Kurt Worrall-Clare, acting CEO of the Hospital Association of South Africa.

Doull said Star was often called out by private emergency agents for indigent patients for whom the state subsequently refused to pay.

He cited annual KwaZulu-Natal figures showing that in 2002 private emergency services paid for 30% of the primary response calls they made to Star, dropping to 22% in 2003, and 8% last year.

Doull believes part of the problem in his province is an atmosphere of mistrust and mutual dislike between provincial health services and private services.

Who comes to the party?

Dr Ryan Noach, Director of Netcare 911, the country's largest private emergency rescue outfit, said that having so few provinces in formal agreements to pay for professional expert air or ground rescue contributed to significant financial losses incurred by Netcare 911.

The Red Cross Air Mercy Service (AMS) has formal service agreements with the Western Cape, KwaZulu-Natal and the Northern Cape.

Public sector EMS capacity and efficiency varies hugely between provinces.

Netcare 911 provides a single helicopter and *ad hoc* advanced life support to the Gauteng DoH, ambulance training and inter-hospital transfers in the Free State, *ad hoc* overflow ambulance services and EMS training in the Eastern Cape, ambulance training to the North West Province and *ad hoc* inter-hospital transfers in Mpumalanga.

One provincial EMS chief said of Kurt Worrall-Clare's cost complaint, 'basically they want somebody to pay for their loss leader, which is their ambulance service and claim to be angels while trying to recover all this money'.

He added, 'asking us to pay for their emergency responses is just not on. I've told them they're a business and it's their business risk'.

Noach says Netcare 911, after a difficult period, now pays for itself.

Who plans the party?

Red Cross Services Manager, Dr Philip Erasmus, believes the state 'should be putting the bigger plan in place', by taking primary responsibility for establishing public/private/NGO partnerships, similar to the Red Cross aeromedical model' (see 'Where compassion grows wings').



They should be determining the needs and decide how they are going to address them,' he said, adding that up to 90% of Red Cross air mercy responses were for state patients.

However, both Dr Peter Fuhri, national director for emergency medical services and disaster management, and Dr Thabo Sibeko, Chief Director of Hospital Services, said extensive plans were in place to improve matters and labelled criticisms as unfair and 'too sweeping'.

Several top state administrators and provincial paramedics spoken to by *Izindaba* viewed Netcare as the 'big brother bully' in the market, alleging that the group refused to attend round table meetings or join official stakeholder bodies.

The provincial EMS chief alleged that Netcare 'stand outside any arrangement we make, they just don't want to co-operate. It's very unfortunate because there is clearly a middle ground'.

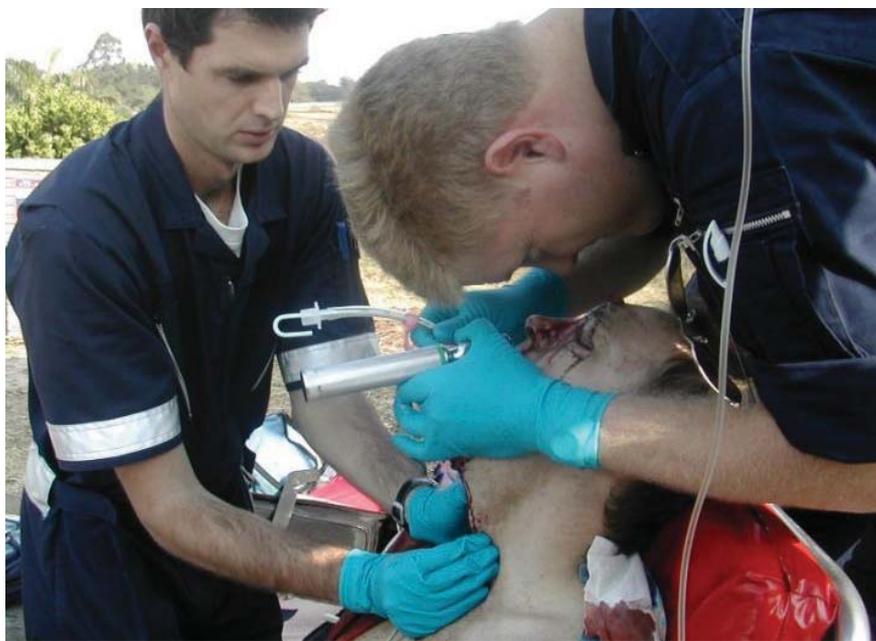
However, Noach said Netcare had 'a burning desire' to partner and facilitate co-operative working arrangements wherever possible to mutual benefit'.

Netcare had approached the health department 6 months ago to be included in the national committee of EMS (public/private) but were 'turned down in writing'.

Netcare 911 and its private hospital brethren claim they make no distinction between the indigent, poor or medically insured, responding to life-threatening emergencies whenever asked and wherever possible – but several provincial paramedics contest this.

Netcare 'fills the gap'

Adds Noach, 'our dilemma is that the 082 911 number is the best known in the country. When we hand the call over to the provincial emergency services their response is frequently inadequate and the callers revert to us, querying the delay. We then respond irrespective of the patients' financial status.'



Star's Dr Zane Perkins applies cricoid pressure on a patient while Netcare 911 paramedic Niel Noble entubates prior to loading her in the helicopter.

He agrees with Worrall-Clare that 'we are picking up the responsibility of state health care delivery, which we recognise is partly our responsibility as a health care company with a humanitarian spirit'.

Doull believes there is reason for hope, citing recent willingness among top Kwazulu-Natal health officials to improving helicopter services to rural areas 'so that the patient can be put first'.

'Proof' of how patients were not being put first was the dramatic drop in Star's call-out rate from 2001/2 to the present.

Worrall-Clare says his policy paper does not give advice to private hospitals on how to collect payment from uninsured, indigent or poor patients 'because each case is unique'.

However he emphasises that health care providers have the right to be paid for emergency medical services.

'This is vital for the economic viability of the hospitals and the continued provision of these services,' he warned.

Solution offered

Noach believes the solution to be straightforward, even for peri-urban and rural areas where emergency services are the most deficient. 'We simply establish a public-private partnership with one call centre taking calls, one resource management centre with all vehicles tracked real time and all emergencies plotted on a mapping system.'

Instead of duplication, allocation and efficiency would then be 'optimised'. Several top public sector EMS chiefs agree with him.

Noach says that 'to have an uninsured patient with a spinal injury in Standerton (for example) requiring helicopter evacuation and a helicopter available but no funding (ending in a state road ambulance being used) is simply diabolical and very frustrating'.

Noach added, 'the problem is not capacity but the political will for everybody to sit around a table and discuss what is best for the man in the street'.

Worrall-Clare said that private pre-hospital care figures from last year,



(excluding billing by consulting health care practitioners) indicated that private hospitals were subsidising the public sector by R87 million in written off emergency rescue bills.

The Netcare group wrote off R54 million, Life Healthcare (formerly Afrox), R21 million, and Medi-Clinic 'about R12 million'.

He rebuffed suggestions that this was a 'small portion' of their overall profits, saying that the return on equity for the average South African hospital group stood at about 14%.

'That is not super profiteering at all – it's a reasonable return, and of that, a vast sum is reinvested in building maintenance, repairs and new technology, to name but a few. Potentially these costs have a huge impact, especially if unregulated,' he added.

Even if the pre-hospital care losses could be recovered from tax, this would take 3 years (in which to prove that every attempt was made to recover the money).

Bigger hospitals had the economies of scale to absorb this operationally, but their smaller private counterparts would be 'placed in serious jeopardy'.

Who sets the norms?

Norman Weltman, an executive director of the Netcare group, which holds 68% of the hospital market, said the biggest question to ask was whether the private sector should ascribe to public sector norms or vice versa.

'I have sympathy with what the minister has inherited, but the minute you become prescriptive to the private sector – and our doctors are sought after world-wide – and erode your human resources it becomes much harder to remedy.'

He cited the shortage of 38 000 nurses in Gauteng, adding that even with the best equipment and infrastructure, the

country would be crippled without trained professionals.

The public sector was a very long way from delivering 'health care on demand' and was failing to reach the majority of people.

Weltman said that by contrast, private South African hospitals were rated the fourth best in the world.

'I believe that the public sector can ascribe to our norms over time,' he said, adding that the solution lay in joint initiatives between the two sectors, with the state buying services from the private sector.

He conceded that the two sectors needed to communicate 'far better' than they were doing at present.

Basic differences that were 'often overlooked' included that private hospitals did not cost the taxpayer a cent, paid market-related prices for drugs, had huge overheads and could not legally hire doctors directly.

Worrall-Clare said better liaison was needed between public and private hospitals if they were to meet their constitutional obligation to provide improved health care access for all, especially when it came to bed availability.

Private hospitals were often accused of 'dumping' patients. Worrall-Clare found this 'a bit rich, when you consider how much money we spend'.

Ethics of emergency care

In his policy guideline paper, he says that the Constitution, ethical rules of the Health Professions Council of South Africa (HPCSA) and the National Health Act stipulate that no person may be refused emergency medical treatment, yet leaves doctors in the lurch when it comes to the precise definition of emergency treatment.

Given the 'vastly divergent perspectives' of patients (or their family members) and those of doctors, a definition was 'particularly pertinent'. Health care professionals were 'in a very difficult position'.

Hospital services chief, Dr Thabo Sibeko, said a model that included air ambulances was currently being developed to assist all provincial emergency medical services and would be completed this financial year.

Worrall-Clare's policy recommendation, in essence, deems a medical emergency to be any condition where death or irreparable harm to the patient will result if there are undue delays in receiving appropriate medical treatment.

State responds

Sibeko said of Noach's single EMS control centre idea, 'no-one has ever put this on the table'.

Sibeko doubted that public/private EMS would work, 'because of the profit motive'.

Hundreds of millions of rands had been recently spent on ambulances to increase capacity in all provinces, he added.

Fuhri said regulations he had developed for both pre- and in-hospital care would be included in the National Health Act – and that he had been 'at pains' to consult the private sector.

These regulations included minimum levels of staffing and equipment and minimum norms and standards for staff and would 'hopefully' come into effect early next year. The controversial Certificate of Need 'might fall within this,' he revealed.

'Unfortunately there are just too few paramedics within the system – only about 1 000 of the 25 000 on the total emergency care register (HPCSA) are registered for advance life support,' he said.

A national strategic plan to improve EMS across provinces was also nearly complete while he intended to access road accident funds to boost emergency centres and pre-hospital EMS.

Chris Bateman