Western Cape Government
Health

PUBLIC PRIVATE HEALTH FORUM
LENTEGEUR HOSPITAL CONFERENCE CENTRE
02 JUNE 2017
09:00-12:30
MINUTES

THEME DISCUSSION: LICENSING OF PRIVATE HEALTH ESTABLISHMENTS

Present and Apologies

See attendance register attached as annexure to the minutes.

1. **Welcome and introduction**
   Dr Beth Engelbrecht, Head: Department of Health

Dr Engelbrecht opened the meeting and welcomed everyone present.

She alluded to the importance of resilience in any health system. She referred to the National Health Act which indicates the power and responsibility of the Province. Chapter 4 specifically advises on the plan and the development of the public and private sector care. It also guides the control of the quality of care at all establishments. Therefore as part of a resilient system it is in the best interest for the private and public sectors to collaborate.

The Department is responding to the continuous budget reduction by exploring investing in leadership development and strengthening the primary healthcare system. An illustration of leadership development is upskilling a healthcare worker on a farm in Witzenberg. The farm workers no longer need to attend a facility since they have a trained farm care worker to provide the service. This person cannot work in isolation and will be linked to the hospital system. This is how the Primary Health Care (PHC) is strengthened and the same will be done for hospital systems as well as emergency care.

The question was raised as to why the private sector should be regulated rather than be guided by market forces. If there is more supply available, will it influence utilisation? Today's discussion will also aim to respond to this question.

Government needs to protect the public from cost, quality and equity concerns. There are a few fragmented regulatory bodies that engage with the private sector. There is a need for a coherent system for both sectors.

She introduced Minister Mbombo and confirmed her passion for health and human rights. She further acknowledged the speakers and mentioned in preparation of today inputs were received from all sectors.

2. **Policy considerations:**
   Dr Krish Vallabhjee, Chief Director: Strategy & Health Support, WCGH

Dr Vallabhjee mentioned that the private health sector is well established and is a valuable asset. It is important to move away from old ideological positions that the public sector serves the poor and is "all good" and the private sector serves the rich, makes huge profits and "all bad". We need to develop a shared commitment, within the resource constrained environment and an escalating burden of disease, to improve the health of our people.

He compared the burden of disease in the country to global statistics which indicated that we are not getting optimal health outcomes for the money that is being spent, when compared to similar countries. Medical aid members have decreased in numbers but expenditure has increased in the private sector. This expenditure is not sustainable. South Africa's medical procedures are more expensive than most countries. The number of beds is disproportionate as there is underutilisation in the private sector at an average bed occupancy rate of 65%. He questioned whether supply induced demand is fuelling the cost escalation? The Health Market Inquiry (HMI) raised the concern that the role of the Department is to monitor the quality of health care of the total population and not just the public sector. Currently, standards inspected in the private sector only measure physical infrastructure attributes. It is noteworthy that 60% of complaints are from the private sector services as reported by the Office of Health Standards Compliance (OHSC). The increase in medico-legal litigation is a serious concern, and how much of it is due to quality of care issues and how much fuelled by touting for cases and the litigation appetite in our society?

Health expenditure in the public sector has been stagnant but has substantially increased in the private sector although the public sector serves the majority of the population and is responsible for the overall health of the country. The Constitution and Legislature guides stewardship for health partnerships and healthcare, however, there are still challenges in both public and private sectors.

He suggested strategies to mitigate challenges in the supply side such as health planning, health technology assessment, practice guidelines and payment policy. On the demand side it would be cost sharing and increased consumer information.

His concluding remarks included the serious challenges from both sectors and suggested cost effective ways to address services. We have to bend the curve on chronic conditions and a greater focus on prevention and PHC is required. He reported on global evidence of market challenges in healthcare that affect costs, quality and distribution. A coherent framework is needed. The National Core Standards (NCS) will become applicable to the private sector once regulations are passed.

3. Locating the licensing of private facilities within a wider provincial-level strategic health policy framework:

Professor Alex van den Heever, Chair: Social Security Systems Administration and Management Studies, Wits School of Governance

Prof van den Heever mentioned that he looked at strategic areas that the Department can look at to develop an improved regulatory framework. Regulation deals with structural features of a system so that it works better. The Constitution allows Provinces to legislate and regulate according to their requirements.

He explained how the disciplining features of a market do not exist when it comes to insured healthcare and therefore prices and product quality will not optimise through competition (as would be the case for other kinds of product – e.g. the market for smartphones). Quality of care can also not be measured in relation to each product - it should be in relation to episodes of care. These are important features of the health system that, when missing, result in systemic market failure – one consequence of which is supplier-induced demand.

For markets to work at least three factors must be internalised into the decision to purchase: price/cost; demand; and product quality. For instance price/demand/quality trade-offs need to form part of the implied contract when a decision to purchase occurs. No such trade-offs are possible in the private market for healthcare in South Africa. Prices are set without any trade-off with respect to demand or quality. Health insurance undermines the

first trade-off (price/demand) and the absence of transparency undermines the price/quality and demand/quality trade-offs). As a consequence the market cannot be said to properly regulate the commercial activities of providers. Consumers are therefore vulnerable to product suppliers who are able to influence demand – something that is not possible in conventional product markets.

Supply can therefore be increased together with demand to capture revenue. An indicator of this can be found using intensive care unit (ICU) and high care (HC) bed to population ratios. The private sector has more ICU and HC beds per 100,000 populations than Switzerland and the UK. This suggests that these bed numbers have been increased to escalate revenue. ICU beds are charged out at tariffs that are considerably more than normal ward beds and they are increasing at a rate more than the medical scheme population. Healthcare supply induced demand is accepted internationally. He noted that the present licensing framework accommodates this excess supply; it also does not establish a regulatory framework that protects the public.

When considering a framework, some areas should be the same for private and public. Areas that can be tied to a licensing framework are:

- Supply management – There is a need for public oversight, facilities need to supply information and supply-related decisions should be considered.
- Reporting – Regular reporting on operational services, activities, events and legal incidents.
- Ownership diversity
- Protecting public services – Framework to regulate public and private services and remunerative work outside the Public Service (RWOPS) that is auditable.
- Critical care strategy – ICU and HC beds need to be managed better. Develop funding framework.
- Quality of care – Office of Health Standards Compliance lacks regulation of quality. There is a need for public disclosure of quality care and suspension of license based on assessments.
- Regulator – Should be independent. Decisions taken should be reviewable.

4. Overview of the licensing application and inspection process in the Western Cape:

Mr Ndoda Mavela, Deputy Director: Licensing & Inspectorate (HOD & Minister Office)

Mr Mavela explained that the objective of the regulation is to protect the public, to improve cost efficiency and quality care, to promote staff and patient safety and to integrate resources of public and private sector. The Western Cape uses Provincial Notice (PN) 187 as opposed to Regulation 158 as the rest of the country; reason being, it became outdated against the new models of care such as step down facilities and rehabilitation. The criteria within PN 187 are more specific and explicit with the consideration of applications. It also makes provision for public comment and participation. There has been greater flexibility with relocation of facilities based on the need of the services. It included the infrastructure needed for the new models of care and made provision for reporting. Norms and standards were developed and applied when considering applications. PN187 allows for penalties and other relevant fees.

There is a clear set of criteria for the application process which also considers a wide range of aspects including the distribution of the number of beds, bed types and the mix of beds across the Province. There has also been a focus on the quality of services rendered by service providers which would be strongly considered when processing applications for the extension of existing services. Those applications are scrutinised to see if there is

any creation of perverse incentives. The application process has very strict timelines. From time of receipt, the application is scrutinised to ensure all information is received over a 30-day period. All new applications will be published in 2 newspapers for public comment over 30 days, after which it will be adjudicated by a committee. The committee forwards recommendations on the application to the HOD. Based on outcome of applications, the applicant can appeal within a 7-day period. The Ministry appoints advisors to advise her in the process of considering appeals. The appeal process takes 90 days to finalise. Approved and new facilities are inspected. There is a fee structure that is currently under review. The challenges that are experienced can be addressed through engagements with the Department and the applicant.

The Licensing & Inspectorate Unit has been mandated by the Mental Health Care Act 17 of 2002, Regulation 15 of 2004 as well as the Guidelines for the licensing Community Mental Health Facilities (CMHF), 2008 to include CMHF. PN 180 deals with regulation of licensing and inspectorate processes for Ambulance services in the Province that is in line with the Western Cape Ambulance Act promulgated in 2010. CMHF and Ambulance services follow the same aspects of principles to that of PN 187, only their timelines differ.

The Province has done well in the development and implementation of a licensing service for more than a decade. National Health Insurance (NHI) will have an impact on services. The National Department is in the process of promulgating a National EMS Act and Regulations.

Dr Engelbrecht confirmed that the authority of the Minister and HOD is separate. There has never been an application where she changed the recommendation made by the committee. One of the criteria for licensing is complaints and quality assurance mechanisms. Complaints have been recorded, investigated and responded to during annual inspections. She mentioned that they aim to function with ethical behaviour and culture.

5. Funder input – managed healthcare / cost management approaches:

Dr Roshini Moodley Naidoo, Strategic Risk Management, Discovery Health

Dr Moodley Naidoo presented the claims experience of schemes administered by Discovery Health from the economical point of view for both supply and demand. They have been focussing on concerns and opportunities around new hospitals for the last 18 months. Claims experience around new hospitals has been higher than expected in terms of demographics, age, gender and clinically adjusted. Medical inflation is divided into 3 components such as tariffs, demand utilisation which is disease burden of population and supply utilisation which are factors to do with delivery systems. The big components are new technologies such as devices and medicines as well as what happens in the hospital environment. Claims inflation is more than 5% over CPI, which is better than some countries but not optimal. Medical inflation is not just about tariffs. Tariffs make up the least amount of which is 0.5% over CPI of which 6.1% trended over the last 8 years.

On the demand side, lifestyle diseases are becoming problematic to control globally. These chronic diseases are the largest risk. Non-communicable diseases are responsible for 75% of deaths globally. The Discovery Health scheme is also aging and have seen an approximately 60% increase in chronic patients over a seven year period, which leads to an increase in claims. In 2016 on the supply side, claims were R1.4 billion more than expected. This was mostly in hospital. One example of new technology increasing costs is the shift to robotic prostatectomy procedures which resulted in a cost increase of 87% over 4 years. Admission rates increased by 2% in 2016 and new hospitals influence dynamics in a region and results in a higher admission rate. There are also quality variations between hospitals. A risk management exercise was done internally and interventions were rolled out

which resulted in a R100 million in surplus. The Council for Medical Schemes (CMS) reported in September 2016 that most schemes had adverse results. GEMS have also indicated an increase in admission rates when new hospitals open in a region. There are still variations in quality of care between public and private hospitals. Patient experience surveys are recognised globally as a good way to measure quality care. Discovery Health has a survey that measures the patient experience and the results are published under an initiative called PaSS, on their website.

Licensing is a complex discussion involving many factors.

Discovery Health views the following topics as important short to medium term trends:

- Specialisation: centres of excellence
- Setting: day clinics are urgent care centres
- Transparency: measurement and reporting of quality metrics
- Value: contracts and partnerships based on efficiencies and clinical and patient reported outcomes.

6. Group panel inputs and open discussion

The panel members were: Dr K Vallabhjee, Prof A van den Heever, Dr R Moodley Naidoo, Dr W Smith, Mr K Worrall-Clare, Dr A Pillay and Ms M Da Costa.

The panel members that did not present provided brief 5 minute inputs towards the discussion.

Dr Anban Pillay, DDG Health Regulation & Compliance Management, National Department of Health

Dr Pillay mentioned that South Africa has a two tier health system but it should ideally be one. Resources are limited to manage the burden of disease which is triple compared to other countries; therefore both sectors have to work smarter together. The way the two sectors interact structurally is problematic.

The aim of NHI is not to destroy sectors but rather to create an integrated system that can respond to these challenges. The OHSC focus largely on structural quality currently but it is important that they move to quality outcomes. The 60% complaints received from the private sector is as a result of the nature of the private sector – it is able to raise issues better. The restructuring of the reimbursement system is critical and needs to be changed to become service based rather than outcomes based. There are challenges around costs in both sectors therefore we should explore how to reduce costs to be more accessible without destabilising the system.

The National Department of Health is looking at a National guideline around hospital licensing. This stems from a very strong issue raised by the HMI as well as from applicants. The concern is that there are disparities in the way that Provinces deal with licensing issues which can be linked to RWOPS in the public sector.

The White Paper on NHI is currently undergoing the Cabinet process.

Dr Wayne Smith, Emergency Medical Services (EMS) representative

Dr Smith mentioned that EMS is a small component but is often the front door to health services in the country and in the Province. Very recently the Ambulance Act was passed in the Western Cape and they issue licenses to both the private and public sector.

Equal access to health care has not improved because there isn't a National model that recommends the number of ambulances required and the geographical distribution of such services and as such there may be a metro bias. The data does not exist at present to offer any opinion on the cost effectiveness that may have been achieved, due to the implementation of the EMS Act. The focus has changed to improve quality of the services being offered. Dr Smith explained that response cards do not bring patients to hospital. One can find ambulances chasing response cards which often cause the traffic congestion in Cape Town.

In terms of quality, from the perspective of staff, he explained the R100 model where EMS staff is working for the private sector by being paid R100 for every patient they pick up. The RWOPS is a concern in that some private services make use of state EMS staff, which then moves from one shift to another without rest. This may have an inherent risk associated with it for all concerned – driving patients at often high speeds. Etc. The RWOPS policies should be looked at in partnership with the private sector.

Another aspect of quality is stock. The Department is working very hard making sure that the right equipment is in the ambulance vehicles to ensure that quality care is delivered to patients. Dr Smith exclaimed that we should try to move away from the concept of a station wagon ambulance, as they do exist! This is evident when patients are being put at the back of the station wagons - they cannot be accessed. Also, making sure that the ambulance is upgraded so that they can be billed on advance life tariff but the patient cannot be upgraded because of the patient benefit. Dr Smith concluded that he is proud to be working in a team together with the licensing team, private sector and the NGO community providing ambulance services.

Ms Melanie da Costa, Chairperson of the Hospital Association of South Africa (HASA)

Ms Da Costa mentioned that private healthcare across the country is not informed by population metrics alone; it's a function of formal employment. The licencing process needs to cater for this. The contentious issue raised by DoH is that the distribution of private beds is not aligned to the population like Brazil (where DOH purchases services from private providers). The explanation is the source of funding in the private sector. Infrastructure is also not in place where there are no clients.

On the issue of regulatory intervention to explore how cost can be reduced one must assess cost drivers i.e. whether it is price or demand. Discovery's increase of healthcare by 11% per annum of which 45% is utilisation of which 70% is due to demand drivers and 30% is the residual unexplained variable. The report by various medical aid schemes to the HMI indicates that demand drivers should be focussed on, specifically how to address adverse risk. The unintended consequence of the regulatory introduction of Community Rating is that it resulted in adverse risk i.e. the young and healthy that opts out of schemes as premiums increase because there are no incentives for them to stay on and the aged and sickly that join because they have incentive. Mandatory cover for formal employed could be incorporated into the regulations to address adverse risk and Insight actuaries have calculated that it can result in savings of up to a third of contributions. If the total contributions by medical aid schemes are R140 billion and 30% is R42 billion which could be the saving. The amount spent on hospital is R50 billion. She expressed disagreement with the analysis supporting supply induced demand. She applauded Discovery for making significant efforts in addressing abuses in the system through Dr and hospital engagement. She added that it is in the interest of funders to not list services that are not needed for their member base as is done in Ireland. This will assist to manage the private healthcare services.

Mr Kurt Worrall-Clare, CEO of National Hospital Network (NHN)

Mr Worrall-Clare mentioned that private sector is not opposed to regulation but rather to "bad" regulation which does not achieve the objective. Some of the key challenges are that there are inconsistencies in the country as to how licenses are allocated per Province. Regulation 158 has been looked at as the bench mark but it was drafted in 1988 and is not designed to address new facilities. A mental institution does not have the same standards as an acute facility because they provide different services yet the same standards are applied regarding infrastructure and this affects costs. Bad deposition can impact on cost as well. We are one of the few countries in the world where the maximum guarantees for a license is 10 years. This means that the cost must be recovered in a short time which results in consumer costs being higher. Looking at the medical schemes' view on supply induced demand, it is encouraging to see Discovery Health has a different approach and that there are new answers within the regulation that will need to be considered. The blanket approach is not the answer; each region should be looked at individually.

Dr Engelbrecht mentioned that it has been 13 years that the PPHF has met to discuss health issues and the same topic has never been repeated. This demonstrates the complexity of the health system and that it is not easy to manage. Considering the different perspectives makes one understand what the balancing tricks are in terms of governing a system to be able to have the best impact and unified value.

Prof van den Heever referred to the comment by Discovery about the age related changes within the system and that it is a component of demand change. Long term trends indicate that the current medical aid age is the same as in 2000. Discovery has aged but the system hasn't. That does not explain the utilisation changes that are seen. A large part of the changes related to chronic conditions are not necessarily demand induced. It might be added to supplier induced because that is where the patient meets the doctor. If there is an incentive to drive up utilisation, it will be concentrated around chronic conditions.

Some insurers in other countries do not list new hospitals; why is this not done in SA even though it is within their interest. There is an oversupply of ICU and HC beds but they are not being removed because there are probably incentives driving this behaviour. Discovery has not been aggressive in their approach to design interventions. Quality mechanisms that allow patient experience is not an indication of quality care. There are no details of systematic information. To publish information is great but it should not be at the discretion of the schemes. The certificate of need framework that was proposed at a National level in the last few years is not the benchmark for an appropriate regulation regime. It is important to note that unintended consequences occur both for the implementation of bad regulation as well as for non-implementation. That is where a rational, transparent and coherent approach is needed.

6.1. Ms Lumka Godlwana from the Society of Private Nurse Practitioners (SPNP) enquired who among the panel members is dealing with the PHC element because it is one of the critical issues. Based on discussions today it seems that there is no focus on PHC? It is challenging trying to bring the PHC service to communities therefore access to communities should be improved using regulations. Nurses would also like to be included in the discussions.

Dr Vallabhjee responded that to address the burden of chronic disease effectively, PHC will have to be the starting point. It is a vacuum at the moment. The regulatory framework covers entities such as hospitals, but not PHC and GP practices and emerging new service delivery models.

Dr Moodley Naidoo responded that there is an opportunity to improve PHC in the country as there are many current gaps. There is no single co-ordinator of care or a regulatory framework that enables coordinated care. She reflected on a recent news article about the shortage of nurses in the private sector and this spills over to the PHC environment. Clinical staff needs to seize the opportunity by looking at international models and how they are innovating particularly regarding new roles such as nurse practitioners. The Department has taken the approach to bridge gaps in care but this is still not enough. Hospitals should explore extending their services into the community. GP's should be more included in the PHC than currently. We need to rethink how healthcare is offered.

6.2. Ms Jenni Noble from Medscheme asked about the licensing of renal dialysis facilities. The Western Cape is licensed but the rest of the country does not have a process for licensing? Is there a process to address this? There is a huge problem with the poor quality at these facilities.

Dr Engelbrecht responded that the Department looks at the utilisation and timeframe as one of the criteria when licensing. Western Cape uses PN 178 and not PN 185 which is more advanced. The framework can be reviewed to include penalties. The National Department is developing guidelines for licensing. Since the component of the National Health Act has not been activated, the authority regarding licenses lies with the Provinces. The Provinces should then move to a new regulatory environment. This does not necessarily mean that the Provinces will be uniformed.

Mr Worrall-Clare responded that National has legislature issued to all Provinces but the interpretation can be different. Legislature should be more clear and specific to obtain consistency and efficiency with regulation among all Provinces. Private sector also needs more consistency which will allow more tolerance.

6.3. Mr Japie Du Toit from Life Healthcare Group referred to the two examples mentioned of unethical behaviour and enquired how the Department can act towards this?

Dr Smith responded that they have become aware of the problems through discussions in meetings. The Department does not have the resources to deal with the issue. He would like to appeal to the private sector to look at how they can stop doing it. They are also working close with National to see how they can include it in the EMS legislation, act and regulation.

Prof van den Heever responded that kickbacks can be dealt with legally. Introducing regulation for ethical behaviour within the framework at the licensing stage is problematic because the perception is that it is dealt with by the Health Professions Council of South Africa (HPCSA). However, it is much more coherently regulated at the facility level. It is an important area and applies to all facilities.

Dr Engelbrecht added that the critical point is how to bring clarity around the penalties related to unethical behaviour into the regulatory framework.

6.4. Mr Ramzie Abrahams from Summit Clinic asked about more flexibility in the regulatory framework in terms of construction of the building after the license has been issued.

Dr Vallabhjee responded that the Department is flexible to extensions based on appropriate motivation and requests. When a license is awarded and the facility is not built, it has negative consequences as it deprives other emergent parties from successfully applying for a licence in the same area.

Ms Da Costa responded that the moral of the story is we have not seen capacity as required because of a lack of flexibility in the licencing regime. If there was faith that the licensing system was more consistent, one would have seen providers take beds off stream when there is a period of excess capacity.

Funder's have not delisted new hospital builds, even though there are much complaining about this additional capacity, as they tend to be independent and primarily BBBEE (Broad-Based Black Economic Empowerment) owned. (This was countered with the argument that the new Black-owned hospitals can be accommodated by dropping hospitals falling under the three large groups.)

Mr Worrall-Clare responded to Ms Da Costa's comment saying that if criteria such as Broad Base Economic Empowerment for licensing is taken away then the big groups will be more empowered which is not in the interest of the country. He agreed that there should be more flexibility in the licencing regulations because of the various role players.

Prof van den Heever added that medical schemes don't make the decisions – administrators do. The responsibility lies with the administrators of the scheme. However they are accommodating new supply in the system.

One option is for schemes to own their own hospitals and break up the market – however, they don't do this – possibly for reasons that the administrators have conflicts of interest with hospital groups. If the market fails in their regulatory role then the province needs to explore which components are failing and address the problem systemically. Once it is determined what the market can and can't regulate then the framework can be designed accordingly.

6.5. Dr Leslie Ramages from Rondebosch Medical Centre referred to Prof van den Heever's comment about the hospital that popped up opposite Red Cross Hospital. The hospitals function differently - one is a children's hospital and the other is an acute hospital for all ages. The existence of the acute hospital is not as a result of an oversight by the Department. It has been through planning. He commented on the increase of chronic/lifestyle diseases and mentioned that it is due to lifestyle and not supply. The public need to be educated about prevention.

Prof van den Heever responded that private facilities located close to public facilities create problems such as stealing and encouraging moonlighting by nurses and other staff. Problematic relationships forms which leads to the down-grading of the quality of care at the public hospital.

He further mentioned that lifestyle diseases are also as a result of age but SA has a young population – and the medical scheme population has not aged from 2000 to the present. This therefore cannot explain the cost increases seen in the system from 2000.

Dr Engelbrecht added that as a community we need to reduce lifestyle diseases. The signs of high risk are already present in youth. The focus should be on working together to prevent chronic disease.

6.6. Ms Jacqui Stewart from COHSASA mentioned that the concern with regulation is that they guide the minimum standard and don't encourage real improvement. Discussions can be encouraged about how licensing should set a limit as to who can enter the market. Converse with both sectors to look at real improvement. There are some small but good examples such as Best Care Always.

Prof van den Heever responded that regulation can be designed to achieve leveraged effects and to impose a standard. The OHSC has minimal criteria and has achieved very little effect. Their information is of little value as it is not made public and fails to form part of a coherent accountability framework. Regulation can be set by making information available or by implementing strategic interventions to change how a system behaves.

6.7. Ms Jackie Maimin from the Independent Community Pharmacy Association (ICPA) mentioned that in aid of licensing establishments and as we move towards NHI with the focus of patient care and continuity of care, it is critical that this framework enables multidisciplinary practices.

Dr Moodley Naidoo responded that multidisciplinary teams will be considered going forward. The opportunity should be brought into the regulation. It is not possible for a single doctor or a single provider to take care of a patient with these lifestyle diseases. It is also more meaningful and valuable to have experts coming together. This will be advocated very strongly in terms of funding. This can also lead to sharing responsibility of clinical outcomes. It is very innovative to implement MDT's in both sectors.

Dr Engelbrecht added that clinical councils should form part of this discussion but unfortunately this is where the prohibition lies. The public sector however promotes multidisciplinary teams.

7. Closing Comments

Minister Mbombo mentioned that the topic for today stems from engagements that took place with the HASA as well as the bigger medical aid groups such as Life Care, Mediclinic, Netcare, Melomed as well as the South African Municipal Workers Union National Medical Scheme (SAMWUMED). They will also be meeting with the Western Cape representative of COHSASA, Ms Clara Findlay, who forms part of the Provincial Health Council. The HOD will take these ideas forward for discussion with relevant role-players. The PPHF meeting is one of many engagements that will take place at various levels. The Council is chaired by the Minister and includes stakeholders from the community as well. Engagements are concurrently running with National to allow the Western Cape to innovate the policy and set the standard for all Provinces. The focus is on National Norms and Standards.

Since the stakeholders operate across Provinces, we would like to see what is happening in other Provinces as well. Provincial Health is responsible for the health of the population of the Western Cape, regardless of if you are insured or not. Chapter 6 of the Health Act refers to the certificate of need. The National Health Act of 1977 is supposed to be used by all Provinces. Licensing and inspection does not guarantee better clinical outcomes or governance. It does not work. Provincial Health spends too much money and resources on the control of private facilities through licensing therefore we struggle to implement it for ourselves. At least the Department is transparent whereas clinical outcomes cannot be measured in the private sector. How can we ensure that the right tool is being used which will enable the Department to measure the health outcomes, quality care and the patient centred care.

The OHSC is still in its infancy. The regulator forming part of the framework will be considered as well as what measures can be taken. Explore how to standardise services geographically and share data to ensure continuum of care. Explore how to implement these ideas without infringing on the constitutional rights. Moving towards a patient centred care should come from the passion towards patients. Management of ethical behaviour is also

being considered. We should also review the current measures that we have in place. The Department measures compliance but that does not address the quality of services.

Dr Engelbrecht thanked everyone for attending and their participation. She highlighted appreciation for the panel members and the speakers' efforts. She added that one of the issues raised was that there are areas that need to improve. The fundamental issue is that there is a policy vacuum. The policy need to regulate the extent, it should regulate how the system behave from demand, supply side and structural issues as well as strategic challenges. She referred to Minister's comment that quality cannot be ignored. She reflected on examples of ethical behaviour and mentioned that the Department is focussed on protecting the public and demand ethical behaviour. Everyone will be engaged in the process going forward. Regulation 187 will be reviewed concurrently with the issues that have emerged today and the NDOH will be included.

Next meeting will be 11 October 2017.

The meeting closed at 12h35.

Speaker Presentations of the meeting will be available on the PPHF website:
https://www.westerncape.gov.za/general-publication/public-private-health-forum-pphf

ANNEXURE A

PRESENT	
Nomafrench Mbombo	MEC: WCGH
Beth Engelbrecht	Head: WCGH
Abigail Newman	Robin Trust Care Network
Achmat Salie	Morton & Partners
Ahmed Bayat	Independent Community Pharmacy Association (ICPA)
Ahmed Chohan	Melomed Hospital Holdings
Akhona Stemele	Clicks Group
Alex van den Heever	Wits School of Governance
Allan Sweidan	Akeso Psychiatric Clinics
Alta Allen	Helderberg Society for the Aged (HSFA)
Alvina Simpson	Mediclinic Milnerton
Anban Pillay	National Government Department of Health
Andrea Zanetti	Faircare Health
Annastatia Smith	WCGH
Annette Olls	Lifehealthcare Vincent Pallotti Hospital
Ansuyiah Padayachee	Life Healthcare Group (Pty) Ltd
Anthony Hawkridge	WCGH: HIA
Anton Rossouw	Life Path Health
Anwar Brown	Medicross
Ashraf Jedaar	Summit Clinic
Aubrey Swanepoel	T-Systems
Bert von Wielligh	Cure Day Clinics Holdings
Beverley Pedro	Medscheme
Bibi Goss-Ross	Advanced Health
Billy Ditsoane	MMI Holdings Ltd
Bonanzo Gerber	Bonshell
Bridget Adams	Quinhealth
Carolyn Clark	PwC
Cathy Miller	Robin Trust Care Network
Charlene Jones	Life Healthcare Group (Pty) Ltd
Charmaine Odendaal	T-Systems
Chris Tilney	Netcare
Christine Malan	Life Healthcare Group (Pty) Ltd
Claire Fourie	National Renal Care
Clara Findlay	Mediclinic Southern Africa
Clinton Van Zitters	Aspen Pharmacare
Colleen Marco	CANSA
Daniel van Dalen	Life Path Health

Debbie Regensburg	Society of Private Nurse Practitioners (SPNP)
Diliza Mji	Busamed
Dirk Truter	Netcare Blaauwberg Hospital
Donald Jansen	MediRite Pharmacies
Donald McMillan	Allmed Healthcare Professionals
Doriska Posthumus	Mediclinic Milnerton
Dries Kok	Spescare
E A van Wyk	Netcare N1 City Hospital
Ebrahim Bhorat	Melomed Hospital Holdings
Edmund van Wyk	Mediclinic Southern Africa
Elaine Beale-Roberts	Alpha Pharm
Elizabeth Coertse	Coertse Oncology
Ellen Conradie	Private
Ellen Conradie	SASOHN
Elsie Bester	Winelands Radiology
Ernst Marais	Isimo Health
Eugene Samuels	Vencorp Placements
Flicky Gildenhuys	Ixande
Gakeem Basardien	WCGH
Gerrit Cloete	Medscheme
Graham Holt	Pharma Dynamics
Hazel Cooper	Omnicare
Helen Du Plessis	Sentinel Motherhood Clinic
Hélène Rossouw	Spear Health
Henri van Niekerk	Winelands Radiology
Hettie Van Merch	WCGH
Ismail Bhorat	Melomed Hospital Holdings
J Moosa	Rondebosch Medical Centre
Jackie Maimin	Independent Community Pharmacy Association (ICPA)
Jaco Vorster	Royal Haskoning DHV (Pty) Ltd
Jacqui Stewart	Council for Health Service Accreditation of Southern Africa (COHASA)
Janette Mostert	Infinity Clinic
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Jessica le Roux	WCGH
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Johann Joubert	T-Systems
Juan-Michael Fritz	WCGH

Judith Ludwick	Private Practice
Kandel de Bruyn	WCGH
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Kay Cupido	Road Accident Fund (RAF)
Keith Nagel	Hutz Medical
Kim Lowenherz	WCGH
Kirsten Bobrow	WCGH: HIA
Koos Franken	Phillips HealthTech
Krish Vallabhjee	WCGH
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Lameesa Ismail	Western Cape Department of Health
Leanne Bagley	National Renal Care
Len Deacon	LDA
Leonie Esterhuizen	Road Accident Fund (RAF)
Liz Morris	WoundNet
Lizelle Alexander	Mediclinic
Lizeth Kruger	Dis-Chem
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Mandla Stephans	Revive Care
Marcus Chetty	Renalmed
Marietjie Gericke	Medscheme
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Mark Peach	HASA
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Matthew Prion	Life Healthcare Group (Pty) Ltd
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Ronita Mahilall	St Luke's Hospice NPC
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Tayla Adams	WCGH
Ted Hands	Ixande
Varn Diab	MMI Holdings Ltd
Vaughan Petzer	Medtronic Integrated Health Solutions
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Vijay Dahya	Cape Radiology
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APOLOGIES	
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