SUBMISSION TO THE MARKET INQUIRY INTO THE PRIVATE HEALTHCARE SECTOR

OCTOBER 2014

The Society of Private Nurse Practitioners of South Africa is a voluntary association which represents Registered Professional Nurses who are self-employed, independent practitioners. The Society has prepared this submission following discussions with other Professional Nursing organisations and Specialist groups who operate within the private and public sector forum.

The members of the Society and associated professional forums believe that this inquiry is well situated to identify and address the policies which influence the cost drivers of private health care, as well as the anti-competitive aspect which limit access to affordable professional health care. In reflecting on the scope and roles of nurses in the public sector, it is evident that Registered Professional Nurses have the expertise and capacity to contribute toward the provision of affordable health care, but in the private sector this is constrained by a range of policies and practices which influence practice or enable access to specialist nursing care in the hospital and community settings.

1. PROFILE OF PRIVATE NURSE PRACTITIONERS

Role of Private Nurse Practitioners

The Society represents nurse practitioners in independent private practice based the community and clinics, as well as in nursing agencies.

Members provide nursing services directly to patients on four levels:

- Home-based care, general nursing and wound care, which includes step-down and chronic care in patients’ homes;
- Specialised nursing services including midwifery, childbirth preparation, ante- and post-natal services, school health services, psychiatric nursing and counselling, lymphoedema drainage, dermatology, advanced wound care, laser therapy, incontinence management and stomaltherapy;
- Primary health care includes clinic and pharmacy-based services, immunization and contraceptive services, wound care, screening for and monitoring of chronic diseases.
• Occupational health services include wellness screening and monitoring, contraception, monitoring of chronic diseases, treatment of acute illnesses at a primary health level in the workplace, as well as providing preventive occupational health care.
  (This listing reflects the most common clinical services, and is not meant to be exclusive)

Although most practitioners provide direct clinical care, the Society also represents Registered Nurse Practitioners who function in clinical, educational and management consultancy roles to private and public sector organisations.

1.2 Representation

The Society is a registered Non-Profit Organisation which represents its members in various forums; sets and monitors standards of care through peer review mechanisms; marketing and continuing professional development; and serves as a point of contact between patients and the private practitioners.

The Society is a member of the Professional Societies Forum and is also a stakeholder representative in meetings with the SA Nursing Council with respect to continuing education. In the past the Society has represented Private Practitioners in the annual discussions with the Board of Healthcare Funders with respect to tariff setting and development of procedural codes for medical scheme patient claims.

Although there are over 3000 nursing practice numbers issued by the PCNS under the auspices of the Council for Medical Schemes and the Board of Health care Funders, the Society is currently undertaking research to establish the actual number of Registered Professional Nurses in private practice. The initial data indicates that fewer than 500 can be classified as independent practitioners, with an additional 650 working in pharmacy based clinics. The balance appear to be in full time employment, many in the state sector, and retain the numbers to enable them to provide services out of regular duty hours.

The Society current has a membership of 140 paid up members, although there are substantially more private practitioners who are not currently affiliated or are in part time practice.

1.3 Geographical distribution

Members are distributed across all 9 provinces, in urban and rural regions, with the administration and registered office being based in Cape Town. There are currently 3 regions, being the Cape, KwaZulu Natal and parts of the Eastern Cape, and Gauteng and northern provinces. In many rural areas the private nurse practitioner is the only health care provider in villages or towns which may otherwise be serviced on a weekly basis by mobile public health service.

Many of the practitioners in the rural areas are highly skills Registered Professional Nurses with additional qualifications and extensive primary health experience obtained in the public sector, who wish to serve their communities without being in an employment relationship. Customised container-based independent nursing practices are currently being piloted in key townships as a means to take affordable healthcare to communities, reducing the burden on the public clinics and attracting clients who would not normally attend the clinics.
Narrative: Experiences and concerns

1.4 Policy & regulatory framework relating to private practitioners

1.4.1 Statutory bodies

1.4.1.1. South African Nursing Council

Private Nurse Practitioners are registered with the South African Nursing Council in their personal capacity and are licensed to practice within their scope of practice.

Currently the Council is in the process of developing regulations regarding Private Practice. In spite of requests to contribute toward the development of these regulations, through participating in research as well as direct discussion, members of the Society were instructed to await the publication of the regulations and then submit comments. This approach conflicts with the principles of openness and cooperation, and contrasts with the same organisation’s approach which included Society representatives in the discussions regarding Continuing Professional Development.

It also is a concern that the Council members and staff from the National Department of Health who are responsible for developing the regulations appear to have no direct experience as Private Nurse Practitioners. The Society has been engaging with the newly appointed Chief Nursing Officer in the National Department of Health and remain hopeful that this may contribute toward a better understanding of how the regulatory process may limit the role of private practitioners in urban and rural areas as providers of affordable healthcare services.

1.4.1.2 Council for Medical Schemes

The Council for Medical Schemes initially included Registered Professional Nurses in their stakeholder groups. Nurses who currently participate are included due to other positions which they may hold. The non-inclusion of nursing support in the Prescribed Minimum Benefits is of grave concern, as the Registered Professional Nurses provide extensive community based care which is affordable, not only to medical scheme beneficiaries, but also to lower income patients without medical schemes who do not wish to attend the public clinics, either due to time or other constraints.

1.4.1.3 Health Professions Council of South Africa

Group healthcare practices provide a comprehensive primary health care service for clients and patients. However there is a restriction on the inclusion of any healthcare provider who is not registered by one of the Boards of the HPCSA, in these practices due to the current Rules of the Health Professions Council. This affects Registered Professional Nurses, Pharmacists and Social Workers. As a result of this anomaly, a Registered Professional Nurse may be an employee, but not a partner or associate. This undermines the role, autonomy and independence of the nurse as a recognised professional member of the team. It also impacts on billing practices, as the BHF states that practitioners may only bill for procedures carried out by themselves. As a result, nursing is either being billed indirectly as an overhead, or alternatively incorrectly as having been carried out by the medical practitioner.

The Society strongly believes that this restriction should be removed as it is not in the best interest of a patient requiring a multidisciplinary approach. Examples of the conditions which are better
managed with a full team include the management of diabetic foot ulcers, advanced wound care, midwifery and obstetrics, paediatric and GP practices. The Nurse Practitioner is utilised in most other countries to provide the triaging and ongoing care. The Society believes that in a setting where there is a shortage of medical practitioners, multidisciplinary practices will provide a more affordable and better quality care than is presently being carried out. The intention is not to exclude the medical practitioner, but to ensure that the costs of care are correctly billed and reflected.

1.4.1.4 National Department of Health

Licensing and Permits related to extended scope of practice

The National Department of Health currently will not license Private Practitioners to diagnose and prescribe medication, irrespective of their qualifications and experience. While the reasoning is based on the delays in the adoption of the regulations required under the Nursing Act of 2005, the existing regulation 38(A) which has not yet been replaced has been interpreted in this manner. The anomaly is that a practitioner may have been authorised to carry out these primary health functions on one day, are deemed not competent the following day, all things being equal, if they resign and enter private practice.

The Society believe that the application of the proposed regulations will continue to exclude private practitioners.

A secondary factor is combining the regulation to diagnose and prescribe with that of dispensing, as well as the reluctance of Pharmacists to dispense nursing prescriptions. The reason provided has been that they do not know who the authorised nurses are; however this listing is available and regularly updated by the National Department of Health on their website and is easily integrated into the current IT programs being used in the pharmacy practices. The delays in the publication of these regulations have been acknowledged, having first been published for public comment in 2009. No further feedback has been forthcoming and this remains a critical requirement. It is our understanding that the regulations required to support the enactment of the Nursing Act of 2005 are still not ready for implementation. This delay of 9 years is having a negative impact on the ability of nurses to function effectively, and particularly to enable private practitioners to provide affordable health care to a large portion of the South African population.

The impact is that patients requiring certain vaccinations, contraceptives and primary health medicines, particularly in rural areas, are required to pay medical practitioners for prescriptions which are then administered by the nurses.

The exception to this is Occupational health where the Registered Professional Nurses are issued with these licenses although they are operating under conditions similar to the private independent practitioners.

Teenage pregnancies have reached critical levels in South Africa. Research has shown that teenagers do not want to attend the public reproductive health services and would rather attend a private practitioner service to ensure confidentiality and be treated in a manner they find acceptable. The refusal of the National Department of Health to issues appropriate S22 (C)(1) in spite of various provinces having entered into public private agreements with the service providers continues to put these teenagers at risk.
The Society recognises that this process must be subject to regulation and control to protect the clients and patients, the ongoing delays are unacceptable. Regrettably, there are not being afforded in the public sector, where such authorisation to prescribe is delegated at times to inadequately trained personnel.

1.4.2 Non Statutory bodies

1.4.2.1 Board of Healthcare Funders

The Board of Healthcare Funders, although no longer in a position to set tariffs, represents most Medical Aid schemes, with the exception of Discovery Health. The designation of tariff codes for procedures has historically been part of the tariff setting. In the past the BHF has not only decided on the conditions under which nurses may provide services, they have also controlled the tariff codes which have been recognised.

This has been a major cause for concern as over time the BHF has unilaterally decided what procedures nurses may charge for and the qualifications required in order to render particular services. These decisions do not have any foundation in the statutory regulations under the Nursing Act of 2005. Requests for additional tariffs for services which have a direct impact on the national health indicators have been refused, including Contraception / family planning, HIV testing and management of Sexually transmitted diseases on the grounds that these are the responsibility of the public sector. However these procedures have codes for other healthcare professionals and are being provided in the private sector.

As indicated in the research by van der Berg and McLeod (2009), “Although the 16% of the population belonging to medical and bargaining council schemes receive good health services, public healthcare quality is so inadequate that 30% of people without medical scheme cover pay for private treatment out of pocket”. Many of the nurses provide their services to this sector of society.

In the current scenario, the code for lymphedema drainage, a major side effect of radical surgery, particularly for breast cancer patients, only applies for physiotherapists, although internationally and in South Africa, over 50% of trained practitioners and the training providers, are Registered Professional Nurses. This is a specialised procedure which forms part of palliative care in many instances. Currently the Society is engaging the BHF as well as the CMS to address this matter. Discovery Health, although not a member of BHF, has stated that they will not reimburse nurses for this procedure as there is no procedural code.

1.4.2.2. Medical Schemes and Administrators

1.4.2.2.1 Procedural codes

The Society regularly engages the majority of Medical Scheme Administrators or directly with schemes requesting nursing services or who accept the evidence where nursing interventions impact positively on patient care and the associated costs, but are then not willing to reimburse nurses due to the lack of a procedure code. A current example is the role of Perinatal Education which has been shown to reduce the Caesarian section rates and also increase breastfeeding and reduce post-natal depression. In a country with one of the highest Caesarian section rates for private patients globally, it is imperative that this shortcoming relating to procedural codes be resolved to ensure that maternal care is appropriate and the cost of birthing be made more affordable.
Through the mechanism of the previous tariff guide, the BHF has decided that only certain nurses may claim for Stomaltherapy or Psychiatry, with the needs for Masters degrees in the latter. The recent amendment to the regulations whereby the SA Nursing Council may designate specialisations should contribute toward resolving this problem. However, cognisance needs to be given to those practitioners with the appropriate expertise who are unlikely to return to academic studies late in life. If these practitioners are employed in the public sector, this expertise is recognised.

1.4.2.2.2. Reimbursement for medical devices and associated nursing care

Another area of major concern is the reimbursement by medical schemes for certain medical devices directly to medical equipment companies, who then take responsibility for providing the nursing care through independent contracts with the nurses. This situation has arisen because of the inconsistent decisions the medical schemes apply to the reimbursement of nurses for these procedures.

As prescribing / authorising medical practitioners are less likely to utilise devises where they are required to arrange the medical scheme authorisation and nursing care required, the industry has taken on this function. This has two significant areas of risk. There are incidences where the companies have contracted inappropriate healthcare practitioners to provide the care which does fall within their scope of practice. Secondly, the nurse who is being reimbursed by the equipment and devices company is very unlikely to change the woundcare product in the event of it not being the best choice for the patient and is a perverse incentive. While various cases are being addressed through industry forums and the Societies, it remains an area of major concern.

1.4.2.3 Hospital policies

Policies in private hospitals have resulted in private midwives not being able to care for women during birth in the safe setting of a hospital. This removes the client’s right to choose the safest and most appropriate birth option.

Due to the high cost of staff, the private hospitals have reduced the specialist nursing positions, such as advanced wound care, stomaltherapy, perinatal care and diabetic nurse educators. Where the medical practitioners require these services, in the absence of such specialists in a hospital, private practitioners have been called in to provide care. Most schemes have advised patients and the hospitals that the hospital should be providing all nursing care and they will therefore not reimburse for these services. Patients are therefore required to carry this additional cost themselves.

One recognises that it is unrealistic for hospitals to have full time specialist nurses on the staff, as this is a key cost driver, however the provision of this level of care by general ward staff can be equated with having a General Practitioner (medical) doing advanced procedures which are the scope of a specialist. Access to specialist nursing care can significantly reduce the duration and cost of hospitalisation in most instances. No other profession is restricted in this manner by the funders or hospital management if a need has been identified by the attending medical practitioner.

Private and Private hospitals also have policies whereby hospital nurses are discouraged from accepting nursing care instructions from private nurse practitioners and require these to be signed off by a medical practitioner who do not have expertise in the field of care being required. The consequence is that the private practitioners either need to remain with the patients, return frequently to carry out procedures or additional medical visit are required. The nature of this
relationship has cost implications in terms of the cost of care for patients while hospitalised, as well as the impact on patient direct cost and income of the healthcare practitioner.

Discussion: The cost of a normal birth assisted by a midwife includes the ante-natal and post-natal care, promotion of breast feeding. The risks associated with maternal and infant outcomes in a low risk pregnancy cannot be mitigated in totality due to the nature of giving birth. A midwife who is able to assist the woman to birth in a hospital / clinic setting where assistance is readily available in the event of unexpected complications arising enable these risks to be reduced. In all instances, an obstetrician or medical practitioner backup is pre-arranged. Midwife assisted births reduces the chance of having a Caesarian sections, and as a result extended hospitalisation and costs.
# 2. RELATIONSHIPS WITH STAKEHOLDERS

<table>
<thead>
<tr>
<th>A. Stakeholder</th>
<th>B. Nature of relationship</th>
<th>C. Names of firm(s) dealt with, where applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Schemes</strong></td>
<td>Funders: often supportive in order to reduce costs, but also Regulator: Limits patient choice due to internal and external policies; will not reimburse if not procedural code exists.</td>
<td>All schemes</td>
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<tr>
<td><strong>Medical Scheme Administrators</strong></td>
<td>Policy development / implementation on behalf of schemes; Often request advice and evidence but claim to be unable to influence the restrictions emanating for the lack of procedural codes</td>
<td>All administrators</td>
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<tr>
<td><strong>Managed Care Companies</strong></td>
<td>Funders May utilise PNPs to carry out key projects or provide agency level nursing care</td>
<td>Majority managed care companies</td>
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<tr>
<td><strong>Health Insurers</strong></td>
<td>Limited: PNPs are often service providers for wellness screening, provision of phlebotomy and other services</td>
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<td><strong>Facilities</strong></td>
<td>Policies limit access to specialist nursing care. Very few hospitals have a mechanism to accredit PNPs to treat or admit own patients, particularly obstetric / maternity care. This is done in the name of the medical practitioner and therefore is not currently measurable.</td>
<td>Mediclinic Group, Lifehealth Group; Netcare Group; Melomed as well as other smaller independent units. Public hospitals – varies within health districts</td>
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<td><strong>Medical Suppliers</strong></td>
<td>Primarily suppliers, Agency: certain devices suppliers contract with PNPs to apply and provide care to their clients / patients</td>
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<td><strong>Primary care practitioners</strong></td>
<td>Relationships vary extensively. In many settings there is a strong collegial relationship, but this is restricted by the HPCSA group practice ruling. In other settings there is strong dissent between practitioners who may be threatened or unsure of the service being provided.</td>
<td>The Society regularly meets with individuals and representatives of bodies representing medical practitioners, with varying levels of achievement and cooperation</td>
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<tr>
<td><strong>Medical Specialists</strong></td>
<td>Strong collegial relationships, particularly where a multidisciplinary approach is required for optimum patient care</td>
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<tr>
<td><strong>Allied Professionals</strong></td>
<td>Varies, but mostly there is a multidisciplinary approach</td>
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<tr>
<td><strong>Members of the public</strong></td>
<td>Clients / patients / families</td>
<td></td>
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<tr>
<td>Other</td>
<td>Statutory bodies</td>
<td>Representative organisations</td>
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<td>Regulatory</td>
<td>Regulatory – in addition to the regulatory functions of nursing, private nurse practitioners work in a range of settings, either in association with other professions, or allied to the practitioners. Legislation and regulation provide a number of significant barriers and challenges to enabling affordable health care for clients and patients. Regrettably there is little insight into the services which private practitioners can provide</td>
<td>Cooperation in terms of stakeholder groupings where common areas of interest exist</td>
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<td></td>
<td>SA Nursing Council, Council for Medical Schemes; South African Pharmacy Councils; Health Professions Council of SA</td>
<td>Board of Healthcare Funders; SAMED; DENOSA; various medical IPAs; Pharmaceutical Society of SA; SA Society of Occupation Health Practitioners; Nursing Education Association; SA Society for Stomalhetapy; ANASA;</td>
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3. **CONCLUSION**

The potential of nurses to contribute toward primary and curative health care for patients who wish to access private services, particularly those expert services not freely available in the public sector or hospitals, needs to be recognised. Patients should be able to exercise greater choice in utilising funding from their schemes. Provision of including Registered Professional Nurses in group practices will enable the General practitioner to provide the gatekeeping role, but contribute toward containing the cost of health care.

In addition to reducing the cost of health care, self employment and job creation through nursing entrepreneurship will be encouraged and patients will be able to access affordable health care.