The role of private hospitals in South Africa

Part II. Towards a national policy on private hospitals

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Abstract **This paper reviews some aspects of present state policy on private hospitals and sets out broad policy guidelines, as well as specific policy options, for the future role of private hospitals in South Africa. Current state policy is reviewed via an examination of the findings and recommendations of the two major Commissions of Inquiry into the role of private hospitals over the last 2 decades, and comparison of these with the present situation. The analysis confirms that existing state policy on private hospitals is inadequate, and suggests some explanations for this.**

Policy options analysed include the elimination of the private hospital sector through nationalisation; partial integration of private hospitals into a centrally financed health care system (such as a national health insurance system); and the retention of separate, privately owned hospitals that will remain privately financed and outside the system of national health care provision. These options are explained and their merits and the associated problems debated. While it is recognised that, in the long term, public ownership of hospitals may be an effective way of attaining equity and efficiency in hospital services, the paper argues that elimination of private hospitals is not a realistic policy option for the foreseeable future. In this scenario, partial integration of private hospitals under a centrally financed system is argued to be the most effective way of improving the efficiency of the private hospital sector, and of maximising its contribution to national health care resources.

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Part I of this study provided some evidence that present state policy on private hospitals is inadequate and that a comprehensive and rational policy is now required.[1] This paper briefly reviews some aspects of present state policy on private hospitals and explores policy options for the future of private hospitals in South Africa.

Aspects of present state policy on private hospitals

Two major Commissions of Inquiry have examined the role of private hospitals in South Africa over the last 2 decades. The De Villiers Commission[2] was set up in 1972 and reported in 1974, and the Browne Commission of Inquiry into health services, set up in 1980, reported on private hospitals in its eighth interim report in 1986.[3] This article examines the findings and recommendations of these commissions on a range of important issues concerning private hospitals, and then locates present state policy within the context of these recommendations. While such a review does not provide a comprehensive analysis of all aspects of state policy on private hospitals, it does give a useful insight into several important policy issues and their handling by the State in recent years.

Control over development and standards

The De Villiers Commission found that the establishment, registration and standards of private hospitals lacked uniformity and consistency, and argued that these processes be centrally and uniformly controlled. The Browne Commission found that although the Regulations on Private Hospitals and Unattached Operating Theatre Units (No. R158), which took effect in April 1980, and were implemented subsequent to the report of the De Villiers Commission, satisfactorily covered these issues in theory, there nevertheless remained a lack of co-ordination and planning in the provision of health facilities. It is thus recommended that a system of hospital accreditation be developed to ensure uniformity of standards, and that the Department of National Health and Population Development be empowered to penalise hospitals, if the industry fails to develop adequate controls of its own accord.

In practice and until recently, the degree of control exerted over the development of private hospitals during the years since these commissions has been extremely loose and fragmented, despite their recommendations. At the time of writing, applications for the building of private hospitals still have to be directed to different departments, depending on which area the prospective hospital falls into. Some of these departments appear to have norms and guidelines for the construction of hospitals, but these are not co-ordinated between departments and are erratically applied. Until around 1987, it appears that licences were granted almost automatically. Since 1987, there has been substantial tightening of control by some of the authorities; the Department of National Health and the Department of Health and Welfare Services of the House of Assembly now appear to have imposed an informal moratorium on further construction. The House of Delegates, on the other hand, still appears to grant permission for private hospital development quite readily. There have been recent examples of applications that were refused by one authority and then granted by another.

Similar problems characterise the system of inspecting the building standards and quality of care in private hospitals. This is also undertaken by various departments, leading to the erratic and inconsistent application of the guidelines that do exist. As a result, standards in private hospitals may, and do, differ greatly.

The Department of National Health and Population Development seems to be committed to a system of uniform standards, and tight control over the development of private hospitals (personal communication — C. Slabber). However, substantial changes are required before this becomes a reality. There is now a joint com-

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mittee of the relevant government departments and representatives of the private hospital industry, which has been charged with investigating Regulation R158, and recommending improvements to it (personal communication — B. Davidson). The outcome of this initiative remains to be seen.

Methods of payment

The De Villiers Commission argued that the system of fee-for-service charging by private hospitals led to excessive use of services, and should be replaced by a comprehensive fee system. The 'Browne Commission' found that this recommendation had not been implemented and once again recommended that a comprehensive, all-inclusive fee system be devised and implemented. As noted elsewhere,[1,4-6] there is now reliable evidence that the fee-for-service system generates perverse incentives and excessive utilisation of resources in these hospitals.

Contribution to training

On the question of the training of nurses, the De Villiers Commission maintained that the extent of contribution to training should be taken into account when the establishment or re-registration of a private hospital is being considered. The Browne Commission again found that these recommendations had not been implemented, and reiterated them.

This recommendation has also not been acted upon. A few private hospitals are involved in some aspects of staff training. For example, two of the fee-for-service hospital groups run nurse's training colleges at present, and some of the contractor hospitals participate in training programmes for state-employed nurses; other hospitals run certain post-basic training courses. However, there is no uniform requirement that private hospitals contribute to the training of health professionals. Some of the fee-for-service hospital groups have in the past, and more recently, recommended to the Minister of Health that a nurse training levy be applied to private hospitals. At the time of writing, the Government had yet to respond to this proposal.

Private patients using public hospitals

The De Villiers Commission recommended that attempts be made to encourage private patients to use public sector hospitals. The Browne Commission confirmed that public hospitals had the capacity to accommodate private patients. However, as is now well known, the privatisation policies implemented at the time and after the release of the Browne Commission report led to precisely the opposite of what the report suggested.[7,8] Over the past few years, private patients have been actively discouraged from using public sector hospitals and have been referred to the private sector whenever possible.[9] It now appears that the possibility of public hospitals competing with private hospitals for private patients is again on the policy agenda, particularly in the case of academic hospitals.

Doctors' interests in private hospitals

The De Villiers Commission recommended that the State consider prohibiting doctors from obtaining direct or indirect interests in private hospitals or unattached operating theatre units, and compel doctors to dispose of any interests they may already possess. The Browne Commission found that this recommendation had not been implemented and argued that such a measure should not be undertaken by a government committed to free enterprise. In this regard, it is important to note that the South African Medical and Dental Council (SAMDC) recently passed a ruling which requires doctors to declare publicly their interests in private hospitals. To date, though, there have been no instances in which the SAMDC has enforced this ruling. The ruling has also been opposed by the Medical Association of South Africa, which has requested the SAMDC to rescind its ruling.[10]

This brief analysis suggests several explanations for the inadequacy of present state policy on private hospitals. One important explanation is that despite the existence of a potentially adequate regulatory framework, implementation of policy within that framework has been erratic and inconsistent. This has been due, in part, to the fundamental changes in areas of state policy in recent years, e.g. the switch from a completely *laissez faire* policy on new private hospital development during the era of privatisation to the present policy of much tighter control. Even where policy has not changed as dramatically, it has been implemented inconsistently and at times arbitrarily. This latter problem is largely the result of apartheid in health care and, more recently, of the tricameral system with its different health bureaucracies, each controlling private hospital development in different areas.

Another important explanation for the inadequacy of present policy is the fact that current legislation still does not address several of the major problems highlighted by both Commissions of Inquiry. Although the State claims to have policy on a wide range of these issues, and to implement that policy, the evidence suggests otherwise. Currently implemented state policy on private hospitals appears to aim only for *some* degree of control over the establishment of such hospitals and the standards maintained by them.

The evidence cited earlier[1] and this analysis confirm our belief that a review and revision of existing policy on private hospitals is now an urgent priority. Such a review should examine not only the nature of legislation, but also the mechanisms for its implementation. Some guidelines for a revised policy and some broad policy options are discussed below.

Towards a national policy on private hospitals

A rational and comprehensive policy on private hospitals should have several goals. It should aim to retain the advantages of private hospitals, such as managerial efficiency, while at the same time enhancing their economic efficiency and reducing the extent to which they undermine the public sector. In so doing, policy should aim to maximise the contribution of private hospitals to the whole national health system.

Policy makers face several options; at this stage, it is unclear in which direction our health care system is moving and which of those presented here is more likely to emerge. In any case, certain general policy guidelines for the private hospital sector will be essential, given that private hospitals should be considered a part of the national health care resource and should therefore contribute maximally to the overall health care system. This cannot be left to the workings of the market, but will require a co-ordinated policy framework.

Where private hospitals operate on a profit basis, an objective tension can exist between quality of care objectives and the objective of maximising profits; similarly, there is the possibility of tension between the wider needs of the health care system and the needs of profit-seeking hospitals or groups of hospitals. Some possible guidelines for policy are explored here.

General guidelines for policy on private hospitals

Control over development and quality of care

Effective control over the development and functioning of private hospitals should be exercised by a responsible national health authority. This will require the development and consistent application of guidelines to ensure that private hospitals fit within the planned needs of the overall national health system. Such guidelines might pertain to the appropriate numbers of beds for different regions, the types of care delivered by different hospitals, standards of care and the use of expensive technology. Although a voluntary system of accreditation and monitoring by the private hospital sector itself should be encouraged, this should not replace the role of the central authority.

Certain immediate steps could be undertaken to achieve these goals. Control over private hospitals could be centralised under one department. This department would then publish a uniform set of guidelines on all aspects of private hospital development and operation. Attention might also be given to the development of a statutory council, similar to the SAMDC, which will have the mandate and the power to monitor private hospitals.

Maximising the contribution to the public sector

Tax subsidies to private hospital care should be investigated with a view to reducing or eliminating them altogether; all revenue thus generated should go to the public health sector.

Private hospitals could participate in a *limited* range of direct staff training. Such training might focus on aspects of care not currently provided in public sector settings. Extensive training in these settings is not appropriate for the training of future South African health workers since the curative, high-technology model of medical care in many private hospitals is contrary to the primary health care approach now recognised as most appropriate for health sciences education strategy.

Efficient methods of payment

The elimination or modification of the fee-for-service system is critical to the attainment of efficiency in those hospitals which rely on it. Another priority should be a move away from incentives that encourage inpatient care to those that encourage ambulatory care, e.g. in day clinics and outpatient departments.

Appropriate alternatives to the fee-for-service system need to be investigated. Such alternatives would almost certainly involve a shift from a retrospective payment system to a prospective payment system in which the incentives for the efficient use of resources are very powerful. Examples of prospective payment include global budgets, inclusive daily payment systems and more complex forms such as the 'Diagnosis Related Group' system. These are discussed in more detail below.

Global budgets

Under this system, hospitals are allotted a fixed budget per year, calculated on the basis of a specific formula. This system is currently applied in the public sector in South Africa (although the absorption of budget shortfalls and surpluses by the central authorities generates severe financial inefficiency). It is also successfully applied in the payment of privately controlled hospitals in the Canadian national health insurance system.[11] Payments could be determined on a historic cost basis, and could then be adjusted for the effects of changing demands on these hospitals.

The use of a global budget for private hospitals would result in significant improvements in financial efficiency; this is already the case in industrial hospitals. The payer would know the costs of hospital care in advance, as would the hospital which would then be able to plan in advance and would have strong incentives to rationalise treatment and use resources effectively.

Inclusive daily payment system

Under this system, a hospital is paid a fixed amount per patient per day. It is used in several European countries at present, and is the method of payment in the contractor hospitals in South Africa. It is probably best suited to hospitals that provide relatively simple care, usually to long-term, chronically sick patients, since it is easier to estimate the average daily patient cost in such cases. However, it is also possible to develop this system to cope with more complex acute medical and surgical care.

Both these systems therefore create strong incentives to economise on resource use and so reduce costs. However, both also create incentives to undertreat. Another problem which they share is an incentive to prolong the length of stay. This occurs because the earlier days of an admission are usually more expensive than later ones. By decreasing the number of admissions, the hospital therefore reduces the proportion of more expensive early days. These problems could be countered by monitoring of the quality of care and lengths of stay, or by the creation of incentives for improved productivity.

'Diagnosis related group' (DRG) payment

Under this system, the hospital receives a lump sum for the whole period of care, with the amount paid determined according to the diagnostic category into which the patient is classified. This system thus recognises that there are significant differences in the treatment requirements for different illnesses. Once again, the advantages of this system are the fixed and predictable cost and, in this case, a strong incentive to reduce the length of stay.

One of the potential problems of this system is that hospitals can classify patients into higher paying categories (so called 'bracket creep' or 'diagnostic escalation') in order to increase income. Another is the tendency to discharge a patient too early and then re-admit them soon afterwards in order to be paid for two admissions.

This system was introduced in the USA in the early 1980s by Medicare (the federally financed system that finances health care for the elderly), in an attempt to reduce massively escalating hospitalisation costs. The effects were significant.[12] Aside from 'bracket creep' other problems include the potential for compromise on the quality of care (although extensive studies have not been able to settle this issue definitively[13]) and the increased complexity of administration involved in this system.

It may be that this system is too complex for broad application in South Africa. However, it might be possible to develop a partial DRG system as a part of another payment system.

Shifting hospital care to the outpatient setting

Evidence from the USA suggests that up to 50% of surgical episodes could be handled in a day clinic rather

than on an inpatient basis in a hospital setting (personal communication — J. Cowlin). Numerous other non-surgical illness episodes could likewise be managed outside hospitals. These observations apply to both the public and the private sectors. In the private sector, a shift of this kind will require major changes to present payment systems. Any of the methods described here could be applied in order to reward the use of day clinics or other forms of ambulatory care more highly than inpatient care.

Other approaches to cost containment

A shift towards ambulatory care and a more efficient payment system, will contribute to cost containment in the private hospital sector. It is important to note, however, that other approaches to this are also possible. These might include the development of health maintenance organisations (HMOs) or public sector purchasers of primary health care (as in the present reforms to the UK's National Health Service), both of which might purchase hospital care from either public or private hospitals. It is possible that under these systems, some fee-for-service payment to hospitals might be retained. These options will not be explored further here.

Changing the relationship between doctors and private hospitals

It is our view that this matter cannot be left to the workings of the market, as suggested by the Browne Commission. The ability of doctors to induce demand for medical services has been extensively documented.[1] Where doctors have direct or indirect financial interests in a hospital, they face incentives to increase utilisation. This creates the possibility of conflicts of interests, and may lead to excessive and unnecessary utilisation of hospital services. This is clearly a complex policy issue; in some cases, e.g. a HMO, it might be necessary for doctors to have an interest in the hospital, while in others such interests should be avoided. This issue thus requires investigation to facilitate the development of satisfactory policy.

At present, the competition between profit-based private hospitals to attract specialists creates the unfortunate situation in which hospital managers may be pressurised to acquire the latest technologies. Conversely, hospital managers are also known to pressurise doctors to maintain certain levels of admissions or use of facilities. Both of these situations need to be prevented, although the complexity of regulating this area is obvious. Once again, these problems require further investigation.

These are broad guidelines within which policy on private hospitals should be defined. Against this background, this article will examine more specific policy options for the future of private hospitals in South Africa. A wide range of policy options for private hospitals are theoretically possible. These range from the elimination of the private hospital sector by means of nationalisation to the retention of the sector as it stands at present, with a series of options between these two extremes.

Many believe that public ownership of private hospitals would be an effective method of achieving many of the policy goals defined earlier. Once all hospitals were publicly owned, they could either be directly controlled by the State or handed over to the control of communities. The advantages here would be the elimination of the equity problem since all would have access to these beds, and the efficiency problems would be reduced by means of better reimbursement systems and direct control over budgeting, distribution and utilisation of resources. In the long term, therefore, many argue that public *ownership* of the bulk of hospital facilities is a desirable scenario for South African health services. Such hospitals need not be centrally owned, but could be owned by local communities. They need also not necessarily be publicly managed, but could instead be managed privately where this proved more efficient.

In our view, however, this option is extremely unlikely in the foreseeable future. In the short, and possibly the medium term, to bring the majority of privately owned hospitals under public ownership is not a realistic policy goal. It would be politically problematic, since major resistance from private hospital owners can be expected. In addition, it is not clear that the State would be able to afford the necessary capital expenditure required to purchase all these hospitals. Another problem is the potential shortage of skilled management required to take over the running of the private hospitals. Finally, it may be possible to achieve many of the policy goals set out earlier without the drastic step of nationalisation.

It is thus likely that there will be a sizeable sector of privately owned and run hospitals, at least for the foreseeable future. Current policy development must take account of this reality. Given this scenario, two further policy options are available. The first involves partial integration of private hospitals into a centrally financed health care system; one example of this would be a national health insurance system (NHIS).[14] The second involves the retention of separate, privately owned hospitals that would remain, for the most part, privately financed and outside the system of national health care provision.

Policy options for the private hospital sector

Option 1. Partial integration of private hospitals into a centrally financed health care system

This option envisages elements of the private hospital sector drawn into a national system of health care provision. The proposed mechanism is the establishment of a NHIS, under which current medical aid contributions would be replaced by compulsory contributions from all those in formal employment. Public funds would be used to contribute on behalf of those who were unemployed or too poor to contribute.

This would bring public and private finances for health care together into a single pool, controlled by the health authorities. This money could then be used to pay for a package of health services (including hospital services) for all citizens, provided by a combination of private and public providers. This would lay the basis for a single system that guaranteed all citizens access to a uniform range of essential hospital care that would be free, or nearly free, at the point of use. Those who could afford to would be able to buy additional care not covered by the basic package of goods and may be allowed to take out private health insurance to pay for this. One example of this can be found in Australia, where accommodation charges in private hospitals are not paid for by the NHIS, but can be paid for with additional insurance cover.

Under this system, several kinds of private hospital ownership could continue to exist. However, the pooling of financial resources would create a powerful single purchaser of hospital care which would act on behalf of all citizens and be able to ensure cost-effective care by negotiating appropriate methods of payment with pri-

vate hospitals and paying only for appropriate tests and procedures.

In addition to improving the equity and efficiency of the private hospital sector, this system would also improve geographical distribution of private hospital sector beds in the long run, as it would create financial incentives for private hospital owners to contract hospitals in rural or other underserved areas.

The objections to this model have been dealt with in detail elsewhere.[1,15] A NHIS would result in a dramatic expansion of the private hospital sector. This is sometimes objected to on the principle that profits should not be made from health care. There is also the danger that, even if some of the present problems of the private hospital sector were addressed, the overall effect on the public sector would be a negative one.

Whether or not a NHIS would in fact result in an expansion of the private hospital sector would depend on policy choices made within the NHIS framework. One such choice, argued for above, is that private hospitals should in the long run play a limited and shrinking role in the provision of hospital care.

A NHIS would allow the attainment of this long-term goal in several ways. It may pay for only a limited amount of care in certain or all private hospitals. At the same time, the increased finances available to the public sector hospitals would allow them to compete favourably with the private sector in many instances. In addition, the emergence of community owned, non-profit private hospitals could be encouraged, and these too would compete with private profit-based hospitals. These factors and stringent regulation of the private hospital sector would ensure that only the most efficient of these hospitals would continue to exist under a NHIS. The tax subsidies to private hospital care could also be eliminated, so that the true cost of this care was borne by its users. One result of this system could in fact be the shrinking of the profit-based hospital sector, as has occurred in Australia.

In the short term, this system will allow for the retention of private ownership of hospitals within a publicly financed system of health care, while avoiding many of the problems that currently characterise the private hospital sector. In some instances, private ownership and management may be more efficient than their public sector equivalents; if this is the case, and if the equity and other problems described above can be limited, then it seems that many of the objections to the private hospital sector within a NHIS are weakened.

Option 2. Retention of privately financed and owned private hospitals

In the absence of a centrally financed health care system, the fee-for-service, charity/welfare and industrial hospitals will remain privately owned and privately financed. Within this general scenario, several other developments might also be expected. The removal of the tax subsidies to private hospital care and tighter regulation of private hospitals may render some of these hospitals less competitive than they are at present. Public hospitals might be allowed more financial and managerial independence, and are likely to begin competing with private hospitals for patients.

At the same time, deregulation of the medical schemes and the entire private health sector may occur. This will, in turn, introduce new purchasers of hospital care, such as HMOs and insurance companies, into the system. Greater competition between private hospitals will result. This increased level of competition is likely to encourage the emergence of some of the more efficient methods of payment discussed above. It is also likely to encourage a shift to day clinic and ambulatory care.

While increased competition and the accompanying elimination of the less efficient private hospitals form a likely scenario, this option will still allow greater flexibility to the private hospitals than would a NHIS. Control over these hospitals will be more difficult. So will the attainment of a long-term goal of public ownership of the majority of hospitals in the country.

Implications of the policy options for private hospitals

These two broad policy options would impact differently on the different groups of private hospitals. The implications for each are examined in more detail below.

The fee-for-service and charity/welfare hospitals

A NHIS would have a dramatic impact on the functioning of these hospitals. Some aspects of care might become accessible to the whole population, while other aspects not covered by the NHIS could be paid for by additional insurance coverage.

In return for agreement to pay for care in these hospitals, however, a NHIS would be very likely to enforce major changes to both the methods of payment and which services the system will be prepared to pay for. For example, the NHIS might refuse to reimburse the hospitals for a wide range of services that might be better performed elsewhere.

To the extent that such hospitals could function as efficiently as or more efficiently than public sector hospitals, the NHIS might encourage their use. If, however, they did not prove as efficient, they would ultimately be likely to close. Alternatively, their role might gradually be reduced in ways discussed earlier. Either way, some of these hospitals might remain to provide luxury care for the few who are able to afford the full costs of such treatment.

In the absence of a NHIS, the escalation of costs in fee-for-service hospitals will soon make care in these hospitals unaffordable, even for members of medical aid schemes. Medical scheme payouts are likely to fall further and further behind actual hospital charges. This is likely to force medical schemes to investigate methods of containing hospital costs. In this event, it is likely that some, or all, schemes will begin to experiment with alternative methods of payment.

The contractor hospitals

Under a NHIS, contractor hospitals could continue to provide long-term care on an inclusive daily payment basis. A major danger is that of underservicing. This will need to be prevented by ongoing monitoring of standards and quality of care.

The question of whether these hospitals should provide acute medical and surgical care on an inclusive daily payment basis is more difficult. The complexity of acute care means that an inclusive daily payment presents opportunities for compromise on the quality of care. However, there are several possible solutions to this: doctors and other staff may be employed by a separate establishment, thereby preventing hospital management from enforcing cost-saving measures that will compromise quality of care. Standards of care would also have to be strictly monitored.

The major proviso here is that these hospitals would have to provide care as cheaply and efficiently as the

public sector, or more so. If they are unable to do so, then the public sector should take over the provision of care. Of course, it may not be a simple matter of terminating contractors, since contractor hospitals may only be built on the basis of guarantees from the State as to their use. This would suggest that contracts between the State and these hospital owners must give the State the ability to enforce payment limits and to withdraw from the contract should these limits be exceeded.

A NHIS presents the best opportunity for ensuring that contractors provide care only as long as they are more efficient than the public sector. The increased finances available to the public sector would allow it to use presently uncommissioned beds, or to build new ones, as an alternative to and in competition with the present contractor sector. In addition, central control over financial resources would mean that other private hospital operators could be encouraged to enter the contractor market, thereby expanding competition. In the absence of a NHIS, many of these arguments still apply. The State should monitor standards of care in the contractor hospitals very carefully and the relative efficiency of these hospitals should be regularly confirmed.

However, there is a danger in the present contractor hospital arrangement that the State will remain locked into the system, making the threat of termination of contracts an empty one. This is because the public sector currently lacks the facilities and the managerial expertise necessary to provide this kind of service on a large scale.

The industrial hospitals

It was argued earlier that, where possible, these hospitals should also be opened to non-company employees in the communities where they are located. Under a NHIS, this would be made possible as the NHIS could pay the industrial hospital for the care provided to non-employees. Such payment could again be on the basis of a DRG or a global budget system. This arrangement might be very advantageous for the industrial hospitals, allowing them to offer services to a wider community, and also possibly to achieve economies of scale in some instances.

Even in the absence of a NHIS, the State should give consideration to subsidising these hospitals to provide services to non-employees in local communities. Provided that the standards of care are acceptable, these hospitals would then become an additional resource for all in these areas.

SANTA and province-aided hospitals

These hospitals are in fact privately owned and have their operating budgets paid by the State on a global budget basis. This system should be retained or expanded under a NHIS, even in the absence of such a system. One model for the expansion of this system is to hand over control (and even ownership) of the present public sector hospitals to community boards, while maintaining public financing.

The advantage of this system is that while public financing guarantees access to all citizens and eliminates perverse incentives, local ownership and management may allow for greater efficiency and more flexible responses to local problems.

Conclusion

This paper has presented general guidelines for a policy on private hospitals in South Africa and has set out two broad options for such policy development. South Africa may move towards some form of NHIS, which will integrate public and some aspects of private hospital care within a public financing mechanism, or it may retain entirely separate public and private hospital sectors. These will impact very differently on the private hospital sector. The paper has argued that a NHIS will more effectively maximise the contribution of the private hospital sector, and will certainly lessen its negative impact on the public sector. Irrespective of whether such a system emerges, however, certain general policy issues concerning the private hospital sector now merit urgent attention. It is vital to note, however, that no policy on private hospitals will be effective as long as the fragmentation and duplication that still characterise the health services in South Africa persist. The removal of these irrationalities must therefore be regarded as a prerequisite for the development of an effective policy on private hospitals.

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