SPECIAL ARTICLE

Limited private practice at academic hospitals — an 'in-house' group practice

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The teaching and training of health care professionals in South Africa is at serious risk of declining standards. There are many reasons for this, but one important reality is that it has become increasingly difficult to attract and retain high-calibre academic staff. For many individuals the academic environment has become unattractive because of deteriorating local conditions, better career opportunities and living conditions overseas, and remuneration packages which compare very unfavourably with the private sector and the Western world. The State was unable to increase salaries sufficiently to retain key medical personnel and in 1991 the Cabinet therefore agreed to the introduction of limited private practice (LPP) in the public sector hospitals as an inducement. Has LPP achieved its objectives? How has it affected patient care, teaching and research? We report on the experience of the Academic Health Complex: Cape Town (AHCCT), which includes Groote Schuur Hospital and Red Cross War Memorial Children's Hospital.

Process and principles

The Cabinet agreed in principle to LPP in 1991 and authorised its introduction in August 1992. Between June 1991 and November 1992 the Faculty of Medicine of the University of Cape Town spent a considerable amount of time in gauging the opinion of Faculty members, examining systems elsewhere in the world and considering the advantages and disadvantages of LPP.

A working group developed a model which was debated and modified in the hospitals, Faculty, the University and the AHCCT Supervisory Board and ultimately accepted by all parties. Accounting and legal implications were determined, structures were developed and LPP commenced on 10 May 1993.

The following principles, which complied with guidelines prescribed by the cabinet and the Cape Provincial Administration, were accepted:

1. A preference for improved remuneration rather than the introduction of LPP was consistently expressed. It was,

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however, considered preferable to introduce LPP under the prevailing circumstances than not to do so.

2. LPP should function as a group practice, confined to the facilities within the AHCCT. Exceptions to this rule would rarely be allowed, and only for a limited time period and only if facilities within the AHCCT were proven to be inadequate for LPP.

3. Time spent by practitioners entering LPP would be limited to an additional 20% of their normal working hours, generally 56 hours per week.

4. The number of beds available to LPP patients would be limited to a maximum of 15% of beds in use.

5. All patients seen within LPP would be registered with the appropriate AHCCT hospital, would have hospital folders and would be treated by the practitioner as routine outpatient, specialist clinic, ward or theatre patients. LPP patients would not receive priority over other hospital patients.

6. The billing of all LPP patients would be in accordance with the Representative Association of Medical Schemes Scale of Benefits. To ensure financial accountability, all accounts and payments would be processed through a central billing service.

7. There would be close liaison with the hospital management, through frequent scheduled and *ad hoc* meetings. Before LPP was introduced at ward/clinic level, a workshop with all affected personnel, including the LPP practitioners, nursing, clerical and ancillary staff would be held.

8. Appropriate recompense for the use of hospital resources would be negotiated and the hospital would not lose income as a result of introducing LPP.

9. The general impact of LPP would be monitored by the AHCCT Supervisory Board in respect of patient care and the Faculty of Medicine in respect of teaching and research.

The LPP structure as developed at the AHCCT can be subdivided into four basic functions. These are policy development, management, practice and administration. These functions are the responsibility of four distinct bodies.

Policy development. Determination of policy is the responsibility of the Supervisory Board of the AHCCT. The Provincial Health Authority, the University of Cape Town, the Department of National Health and Population Development and 'the community' are represented on this body.

Management. Management is the responsibility of the Group Practice Management Committee (GPMC), which is responsible to the AHCCT Supervisory Board. The GPMC consists of representatives of the Faculty of Medicine of the University of Cape Town, the hospitals within the AHCCT and the practitioners engaged in LPP. It is primarily responsible for formation and implementation of agreed policy, for negotiating agreements and resolving conflict. GPMC also monitors LPP activities on behalf of the Supervisory Board.

Practice. The practice is the responsibility of the practitioners. It is currently divided into 20 functional units representing specific disciplines. At the end of April 1994 there were some 140 practitioners engaged in LPP who are represented by elected members on the practitioners' committee which ensures that unit and individual interests are addressed and that problems are referred to the GPMC when necessary.

Administration. The administration of LPP is performed by a separate company, the Cape Town Medical Group Financial Services (Pty) Ltd (CTMGFS), which was established to handle the financial aspects of LPP. As a commercial company, CTMGFS has appointed auditors and is obliged to conform with the requirements of the Companies Act. In addition, the Fees Administration section of the CPA has free access to the company's books.

Mechanisms exist to regulate the participation of practitioners, the admission of patients, the submission of accounts and the distribution of income. Each department or discipline determines distribution of net income to its registered practitioners.

A number of control mechanisms exist to ensure that LPP does not exploit the hospital or patients and that other patients are not disadvantaged. These controls include: (*i*) the use of standard ward/clinic facilities, systems and personnel for the handling of LPP patients, as far as is possible; (*ii*) a limit to the number of beds available to LPP patients; (*iii*) twice-weekly meetings with the hospital to review and discuss the effects of LPP on the hospital in general and to solve specific problems that arise from time to time; and (*iv*) complete transparency of the CTMGFS accounting system so that the hospital, the hospital's auditors and the University are fully informed regarding LPP income and the manner in which it is distributed.

The continuance of LPP is currently being debated again, particularly in the light of recent criticisms regarding its need and desirability. Chief and principal specialists have recently received substantial remuneration increases, in particular through the introduction of a car scheme, and the need for LPP is therefore perceived by some to have ceased. This perception is incorrect, since the car scheme does not necessarily increase the practitioners' income and some principal specialists may in fact be significantly disadvantaged in terms of cash income and tax payments. Other medical personnel, e.g. specialists, medical officers and medical superintendents who constitute the majority of doctors in the public sector, have not received any additional benefits. (The additional notch on the salary scale and 3.4% general salary increase do not compensate for inflation.)

Survey

In April 1994 a survey of opinions on LPP was carried out in order to ascertain how Faculty Board members and LPP practitioners viewed the effects of LPP. Of the 260 questionnaires which were distributed, 58% were returned.

Three distinct groups of respondents can be identified, as follows: (*i*) practitioners in LPP only; (*ii*) practitioners who are members of Faculty Board and in LPP; and (*iii*) staff who are Faculty Board members only.

The three groups of respondents were also subdivided according to their practice specialty and rank to permit a more detailed analysis of responses.

Results of the survey indicate the following trends.

Should LPP be retained?

Approximately 83% of staff who are on Faculty and in LPP, 81% of those in LPP only and 22% of those on Faculty Board only are in favour of retaining LPP (Fig. 1). The majority (55%) of those who are members of Faculty Board only disagreed with the retention of LPP.

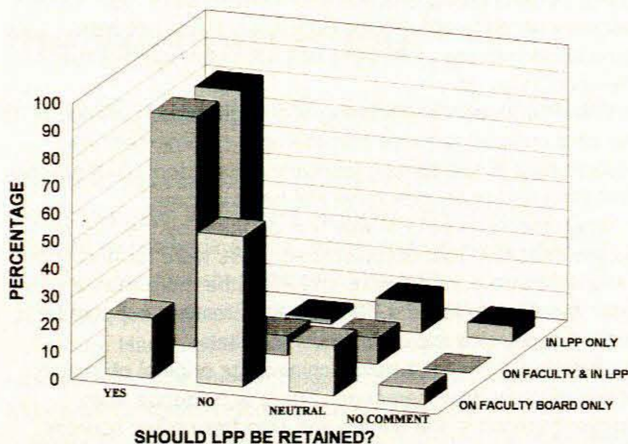

Fig. 1. Opinions of the three constituencies polled as to whether LPP should be retained at the AHCCT.

Responses of those in favour of retaining LPP were further analysed to indicate opinions in each specialty. Not all specialties belong to LPP, Psychiatry (PSYCH) and Paediatrics (PAEDS) having not joined as yet. Members of Faculty who are not qualified to enter LPP are collectively categorised as 'AUX'. The overall results are presented in Fig. 2.

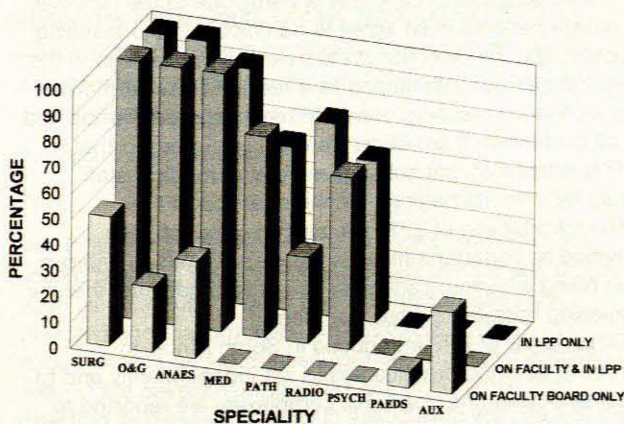

Fig. 2. Percentages within each of the specialist groups polled who expressed themselves in favour of retaining LPP within the AHCCT (SURG = surgery; O&G = obstetrics and gynaecology; ANAES = anaesthesiology; MED = internal medicine; PATH = pathology; RADIO = radiology; PSYCH = psychiatry; PAEDS = paediatrics; AUX = those not eligible to enter LPP).

Has LPP helped retain staff?

Some 83% of those on Faculty Board and in LPP feel that LPP has played a role in encouraging staff to remain in hospital practice, whereas only 52% of those who are in LPP only share this view. This may possibly be due to the fact that this group depends to a large degree on the added income from LPP and, at the time of the survey, expressed a certain degree of frustration about delays in payment from private practice billing and negotiations with the hospital in respect of hospital expenses.

Influence of LPP on patient care

The general trend was that those staff members who are in LPP feel that there has been no effect on patient care. A significant number of those both on Faculty Board and in LPP feel that to some extent LPP may have enhanced patient care, and general comments indicate that this may be due to improved morale of staff, a greater awareness of patient needs, better time management and improved patient facilities. Concern was expressed by respondents not in LPP that patient care might deteriorate. Some felt that in time indigent patients may be neglected due to the potential temptation to increase numbers of LPP patients. Several practitioners from PSYCH and PAEDS expressed concern that the commercial nature of private practice may lead to increased interpersonal conflict between practitioners. A senior nursing management representative has indicated that the nursing personnel from certain disciplines generally believe that LPP has improved the quality of patient care.

Influence of LPP on teaching and research

Fig. 3 shows that the majority of those in LPP feel that teaching and research are not affected by private practice, and in some cases practitioners feel that there is an improvement in these areas. This is due to the wider range of patients that LPP provides compared with the indigent patient profile. LPP patients must agree to be part of the teaching programmes and therefore have contact with both graduate and undergraduate students. A significant number of members of Faculty Board believe that teaching and research have deteriorated. This opinion is not shared by those in LPP, who appear more concerned that teaching and research will deteriorate if LPP is discontinued, resulting in a further loss of specialist staff. The view is also expressed that standards have deteriorated but that this is due to the general decrease in staffing levels and not due to LPP.

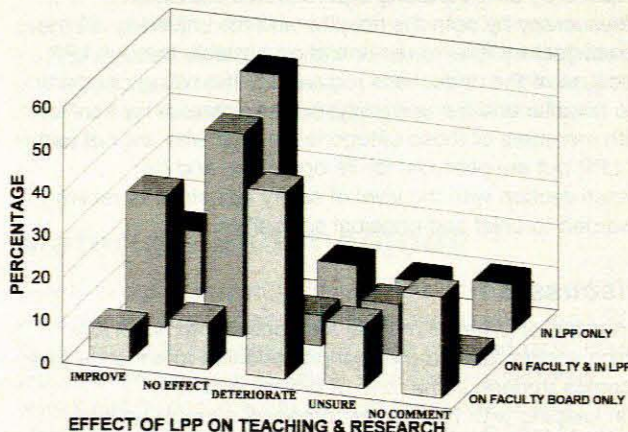

Fig. 3. Opinions of the three constituencies polled as to the influence that the introduction of LPP has had on the teaching and research activities within the AHCCT.

General comments

The effect of remuneration on key opinions was also analysed for those practitioners in LPP. For this purpose respondents were subdivided into 'Salary A', which included chief and principal specialists, who have recently benefited from increased remuneration packages, and 'Salary B' for senior specialists and specialists, who have not. Fig. 4 gives the results. In general Faculty Board members in LPP are the most positive in their assessment of LPP, and particularly those on Salary A level. Those on Salary B level and in LPP only appear more uncertain and express concern about inadequate remuneration from the State, including the failure of the State to address the remuneration of the lower levels of specialists when making recent salary adjustments.

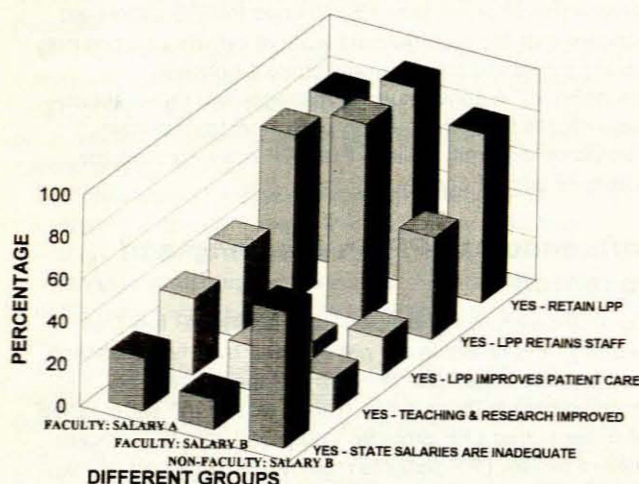

Fig. 4. Key opinions on the retention of LPP and the effect that it has had on various activities within the AHCCT, as expressed by practitioners in different salary groups and who are engaged in LPP. (FACULTY: SALARY A = chief and principal specialists who are members of Faculty Board; FACULTY: SALARY B = senior specialist and specialist who are members of Faculty Board; NON-FACULTY: SALARY B senior specialists and specialists who are not members of Faculty Board).

Other comments expressed by a number of respondents included: (*i*) concern over the increased administration required by LPP, including a perceived increase in bureaucracy by both the hospital and the university; (*ii*) the unsatisfactory level of remuneration possible through LPP because of the deductions required by the billing company, the hospital and the university; (*iii*) the potential for conflict with members of those categories of staff who are not part of LPP but are essential for its operation; and (*iv*) dissatisfaction with the level of salary adjustments recently awarded to chief and principal specialists.

Discussion

A number of different models are applied internationally which enable salaried medical practitioners to enhance their incomes through some form of private practice.

In keeping with the Cabinet proposal a group type of private practice was introduced at the AHCCT. At the time of its introduction the South African Medical and Dental Council (SAMDC) disallowed practices comprising more than 24 members. Legislation has only recently been passed which permits group practice and incorporation, but because of many other pressing issues, it has not been introduced into the LPP of the AHCCT, although it is the intention to do so.

The introduction and running of a large group practice of the kind outlined requires considerable commitment and resources. It is functioning relatively satisfactorily, but some problems and obstacles must still be overcome.

When the issue of LPP was first debated by the Faculty a survey indicated that approximately 60% were for and 40% were against the introduction of LPP. Little more than a year after implementation of LPP there is increasing support for it in the Faculty and the associated hospitals.

LPP may or may not have achieved its original objective of retaining medical personnel. There is evidence from opinions voiced in the survey and also from other sources that it has tipped the balance in favour of staying in academic hospital service. Medical staff resignations will have to be analysed over a period of time before the effect of LPP on staff retention can be adequately assessed.

Patient care, particularly that of indigent patients, has not been adversely affected. Perhaps this is not surprising, since the majority of LPP patients were already in the hospital system. There is an increasing opinion that the introduction of LPP is leading to improved quality of patient care for all patients. This is perceived to be due to the introduction of improved administrative systems and to a greater consciousness of patients communication needs by all levels of staff.

From the survey and from initial evidence it appears that teaching and research have not been detrimentally affected by the introduction of LPP. This is partly due to the fact that all private patients must agree to participate in the teaching process, and the diversity of the sickness profile seen in the hospitals has been enhanced as a result. Improved morale and motivation resulting from LPP have apparently impacted on all medical staff activities. Concern is expressed that if LPP is withdrawn, the subsequent loss of medical staff would be more damaging than the retention of LPP.

The introduction of LPP has, as a by-product, also provided an important stimulus for the hospitals to improve their billing systems, particularly for private patients, thereby increasing hospital revenue from fees.

Other forms of LPP introduced in South Africa, in particular allowing practitioners to act independently and to practise outside the academic complexes, are reported to have given rise to many unacceptable features. The group practice introduced at the AHCCT has been operating for a little more than a year and should be reviewed in another year or two to gauge its effects adequately. The early results, however, are very encouraging and seem to vindicate the thorough debates and planning which preceded the introduction of LPP in this form.

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(Since the submission of the manuscript, considerable administrative progress has been made through the appointment of a full-time manager of LPP. There are currently 176 registered practitioners.)