

Debt management and revenue–enhancing strategies: A case study of the Hospital Fees Department at the Red Cross War Memorial Children’s Hospital for the period 2008 – 2012

DEON CONWAY POGGENPOEL

Student ID: 2622292



UNIVERSITY of the
WESTERN CAPE

A mini–thesis submitted in partial fulfilment of the requirements for the degree of Master’s in

Public Administration

UNIVERSITY of the
WESTERN CAPE

Dr Leon Gilbert Pretorius

School of Government

Faculty of Economic and Management Sciences

University of the Western Cape

Bellville, Cape Town, 7535

Western Cape, South Africa

Declaration

I, Deon Conway Poggenpoel, hereby declare that “Debt management and revenue–enhancing strategies: a case study of the Hospital Fees Department at the Red Cross War Memorial Children’s Hospital for the period 2008 – 2012” is my own work and pledge that it has not been submitted before for any degree or examination in any other university, and that all of the sources used or quoted have been indicated and properly acknowledged.

Full Name: Deon Conway Poggenpoel

Student ID: 2622292

Signature: _____

Date: December, 2015



Acknowledgements

Firstly, I would like to thank my beloved God for providing me with the wisdom and strength to complete the research study.

Secondly, I would like to express my deepest gratitude to the University of the Western Cape, and specifically to my supervisor Dr Leon Gilbert Pretorius. I would like to thank him for his professional guidance, support and patience during the preparation and writing of this mini-thesis.

A special thank you goes to Mrs. Luan McArthur–Grill, a friend and academic colleague, for setting the time aside to assess the commencing stages of my research paper and for providing me with the invaluable feedback all the time.

Another thank you goes to Mr. Marc Meldau, Senior Administrative Officer of the Hospital Fees Department at the Red Cross War Memorial Children’s Hospital, for encouraging me to complete the research study and to utilise the academic accomplishment to progress further in my career.

Likewise, I would like to thank Mr. Daniel Ndaleni for being a good listener and for his eagerness to chat over certain areas of the research paper.

Finally, I would like to thank my beloved wife Ophelia Poggenpoel for her continuous love, encouragement, patience and support to pursue the Master’s degree programme, and after completing the mini–thesis. I am blessed to have her as a pillar of strength, especially during the long and immersive hours. My final appreciation and love goes to my beloved 6 year old son, Troy Joshua Poggenpoel, for allowing me sufficient time to complete the research study.

Abstract

Red Cross War Memorial Children's Hospital (RCWMCH), located in Cape Town, South Africa, is the only hospital in sub-Saharan Africa dedicated to children. It renders world-class public health-care services to sick children; 95% of which come from the poor, local and distant communities and require specialised treatment to recover. This case study aims to explore the factors associated with debt management and revenue-enhancing strategies in the Hospital Fees Department (HFD).

The primary objective of the study is to examine the way in which the hospital manages outstanding debt and identify different empirical methods to improve revenue collection. In order to ensure the cost recovery of services, members of the public are billed and the expectation is, of course, for the bills to be paid. The hospital has a Hospital Information System (HIS) in place that consists of Clinicom and the Accounts Receivable System (ARS). The business design of Clinicom ensures that patient information is recorded and billed correctly. The ARS, on the other hand, ensures the collection of debt and reconciliation of state funds.

The reason for choosing the HFD is that this component influences service delivery and funding. The importance of cost recovery to improve service delivery coincides with the Constitution of the Republic of South Africa and it is for this reason that people have the right to basic services. By making for sure revenues are collected, it ensures that the improved health-care services, to which they are entitled, are delivered to members of the public at the RCWMCH. The primary approach employed to collect information is made using structured questions and interviews with the members of the public and the RCWMCH management. The secondary approach is through the use of books in the field of finance, the HFD annual reports and policies.

The study concludes with findings and makes recommendations to the RCWMCH management, the South African government and the academic arena at large. The researched information can be used as a tool to manage outstanding debt and improve revenue collection for the RCWMCH and other hospitals that face similar circumstances.

Keywords: Red Cross War Memorial Children’s Hospital, Patient, Revenue-enhancing strategies, Hospital Fees Department, User fees, Debt management, Health-care, Children, Hospital, Government, Cape Town, Western Cape, South Africa.

Table of contents

Declaration	i
Acknowledgements	ii
Abstract	iii
Keywords	iv
List of figures	xii–xiii
List of tables’	xiii
Acronyms and abbreviations	xiv-x
CHAPTER 1: INTRODUCTION	1–7
1.1. Introduction	1–2
1.2. Background to the research	2–4
1.3. Theoretical framework	4–5
1.4. Problem statement	5
1.5. Objectives of the study	5-6
1.6. Significance of the study	6
1.7. Outline of the study	7
CHAPTER 2: RESEARCH METHODOLOGY	8-11
2.1. Introduction	8
2.2. Qualitative research	8
2.3. Research design and instruments	9

2.3.1. Research instruments	9
2.3.2. Sampling	9
2.3.3. Sampling methods and techniques	9
2.3.3.1. Primary approach	9
2.3.3.2. Secondary approach	9
2.3.4. Criteria for choice of sample size	10
2.3.5. Rationale of data analysis procedures	10
2.4. Limitations of the methodology	10
2.5. Scope of the study	10
2.6. Ethical considerations	11
2.7. Summary	11
CHAPTER 3: LITERATURE REVIEW	12-31
3.1. Introduction	12
3.2. Definition of the research subject	12-13
3.3. Magnitude of the subject	13-14
3.3.1. The significance of cost recovery	14-16
3.4. International scholarship among developed countries	16-23
3.4.1. The Unites States of America’s public policy approach to debt and revenue	16-17
3.4.1.1. Public health-care hospital structures in the United States of America	17-18
3.4.1.2. Categories of payers for health-care services in the United States of America	18-19

3.4.1.3.	Debt and revenue management procedure in California, United States of America	19-22
3.4.2	United Kingdom’s public policy approach to debt and revenue	23
3.4.2.1.	Public health-care hospital structures in the United Kingdom	23
3.4.2.2.	Categories of payers for health-care services in the United Kingdom	23
3.4.2.3.	Debt and revenue management procedure in the United Kingdom	23
3.5.	International scholarship in an emerging country	24-25
3.5.1.	Chinese Taipei’s public policy approach to debt and revenue	24
3.5.1.1.	Public health-care hospital structures in Chinese Taipei	24
3.5.1.2.	Categories of payers for health-care services in Chinese Taipei	24-25
3.5.1.3.	Debt and revenue management procedure in Chinese Taipei	25
3.6.	International scholarship among developing countries	25-28
3.6.1.	Brazil’s public policy approach to debt and revenue	25
3.6.1.1.	Public health-care hospital structures in Brazil	26
3.6.1.2.	Categories of payers for health-care services in Brazil	26
3.6.1.3.	Debt and revenue management procedure in Brazil	26
3.6.2	Chile’s public policy approach to debt and revenue	26-27
3.6.2.1.	Public health-care hospital structures in Chile	26-27
3.6.2.2.	Categories of payers for health-care services in Chile	27
3.6.2.3	Debt and revenue management procedure in Chile	27
3.6.3	Tunisia’s public policy approach to debt and revenue	28

3.6.3.1	Public health-care hospital structures in Tunisia	28
3.6.3.2	Categories of payers for health-care services in Tunisia	28
3.6.3.3	Debt and revenue management procedure in Tunisia	28
3.6.4.	Outline of researched international best practices and theoretical framework	29-30
3.6.4.1.	Best practices among developed countries	29
3.6.4.1.1.	USA’s best practices	29
3.6.4.1.2.	United Kingdom’s best practices	29
3.6.4.2.	Best practices in an emerging country	29
3.6.4.2.1.	Chinese Taipei’s best practices	29
3.6.4.3.	Best practices among developing countries	30
3.6.4.3.1.	Brazil’s best practices	30
3.6.4.3.2.	Chile’s best practices	30
3.6.4.3.3.	Tunisia’s best practices	30
3.7.	Summary	30-31
		
CHAPTER 4: POLICY AND INSTITUTIONAL FRAMEWORK		32-41
4.1.	Introduction	32
4.2.	Statutory and Procedural Provisions	32
4.2.1.	The Public Finance Management Act (PFMA)	31–33
4.2.2.	The Hospital Fees Procedure Manual Chapter 18	33–39
4.2.3.	The Uniform Patient Fee Schedule (UPFS)	39-41
4.3.	Summary	41

CHAPTER 5: THE PREVAILING DEBT MANAGEMENT AND REVENUE PRACTICES
AT THE RED CROSS WAR MEMORIAL CHILDREN’S HOSPITAL_____ 42–50

- 5.1. Introduction_____ 42
- 5.2. Overview of admissions and registration procedures at the RCWMCH____ 42–43
- 5.3. Follow-up procedures on outstanding accounts_____ 43-49
- 5.4. Summary_____ 49

CHAPTER 6: DATA PRESENTATION AND ANALYSIS _____ 50–83

- 6.1. Introduction_____ 50–51
- 6.2. The primary approach results for category non-medical aid and medical aid members of the RCWMCH_____ 51–65
 - 6.2.1. The position of clients living in South Africa who are medical and non-medical aid members_____ 51–52
 - 6.2.2. The position of the medical and non-medical aid members on distance from the Red Cross War Memorial Children’s Hospital_____ 52–53
 - 6.2.3. The quality of service delivery level between medical aid and non-medical aid members at the RCWMCH_____ 53–54
 - 6.2.4. The speed of service delivery level between medical aid and non-medical aid members at the RCWMCH_____ 55–56
 - 6.2.5. The level of knowledge displayed by the reception officer reported by medical aid and non-medical aid members at the RCWMCH_____ 56–58
 - 6.2.6. The level of experience displayed by the reception officer perceived by medical aid and non-medical aid members at the RCWMCH_____ 58–59
 - 6.2.7. Awareness of a client help desk reported by medical aid and non-medical aid members at the RCWMCH_____ 60
 - 6.2.8. Medical fees awareness reported by medical and non-medical aid members at the RCWMCH_____ 61

6.2.9. Affordability of hospital fees charged to medical aid and non-medical aid members at the RCWMCH_____	62–63
6.2.10. Method of payment preferences for medical aid members and non-medical aid members at the RCWMCH_____	63–64
6.2.11. Non-medical aid members’ policy for free services at the RCWMCH _____	64–65
6.3. The primary approach results for medical aid members at RCWMCH_____	65–67
6.3.1. The benefits of knowledge about medical aid options_____	65-66
6.3.2. Medical aid members’ responsibilities to obtain authorisation_____	66
6.3.3. The question of sufficient funds on the medical aid members’ selected options _____	67
6.4. The primary approach results for the RCWMCH management_____	68–78
6.4.1. Employment levels at the Hospital Fees Department_____	68-73
6.4.1.1. Experience levels among the Hospital Fees Department officials _____	69
6.4.1.2. Officials’ formal exposure to training courses_____	69-70
6.4.1.2.1. The impact training courses in relation to debt management and revenue-enhancing strategies_____	70-71
6.4.1.3. Employees association with the members of the public_____	71
6.4.1.3.1. The effects of employees association with members of the public in relation to debt management and revenue- enhancing strategies_____	72
6.4.1.4. Employees involvement in communicating the outstanding debt _____	72
6.4.1.5. Employees involvement in communicating and collecting revenue _____	72–73
6.4.2. The management of outstanding debt_____	73-75

6.4.2.1. Processes in place to manage the outstanding debt	73-74
6.4.2.2. How debtors are persuaded to pay the outstanding debt	74
6.4.2.3. A threshold for outstanding debt	74
6.4.2.4. Major reasons for having outstanding debts at the RCWMCH	74-75
6.4.3. Processes in place to collect revenue	75-78
6.4.3.1. Methods of improving revenue collection	76-77
6.4.3.2. The total number of employees associated with revenue collection	77
6.4.3.3. The importance of accomplishing revenue collection	77
6.4.3.4. The importance of collecting additional revenue	77-78
6.5. Financial totals from the RCWMCH for the period 2008 – 2012	78-80
6.5.1. Analysis of financial totals	79-80
6.6. Summary	81-83
6.6.1. Primary findings concerning medical aid and non-medical aid members	81-82
6.6.1.1. Primary findings regarding the RCWMCH management	82-83
6.6.2. The main secondary findings of financial totals for the period 2008 – 2012	83
CHAPTER 7: CONCLUSION AND RECOMMENDATIONS	84-86
7.1. Summary	84-85
7.2. Recommendations	85-86
7.2.1. The study’s recommendations to the RCWMCH on debt management	85-86

7.2.2. The study’s recommendations to the RCWMCH on enhanced revenue collection_____	86
7.2.3. The study’s recommendations for future studies _____	86
REFERENCES_____	87–90
APPENDICES_____	91–97
APPENDIX A: Quantitative Questionnaire of the Non-Medical aid members of RCWMCH_____	91–93
APPENDIX B: Quantitative Questionnaire of the Medical aid members of RCWMCH_____	93-95
APPENDIX C: Qualitative Structured Questionnaire of the RCWMCH Management_____	95-97
APPENDIX D (i): Provincial Government: Western Cape: Department of Health: Hospital RXH (MR014.1)_____	98
APPENDIX D (ii): Provincial Government: Western Cape: Department of Health: Hospital RXH (MR014.1)_____	99
APPENDIX D (iii): Provincial Government: Western Cape: Department of Health: Hospital RXH (MR014.1)_____	100
APPENDIX D (iv): Provincial Government: Western Cape: Department of Health: Hospital RXH (MR014.1)_____	101
APPENDIX D (v): Provincial Government: Western Cape: Department of Health: Hospital RXH (MR014.1)_____	102
APPENDIX E (i): RCWMCH In-Year Monitoring Report_____	103
APPENDIX E (ii): RCWMCH In-Year Monitoring Report_____	104
APPENDIX E (iii): RCWMCH In-Year Monitoring Report_____	105
APPENDIX E (iv): RCWMCH In-Year Monitoring Report_____	106
APPENDIX E (v): RCWMCH In-Year Monitoring Report_____	107
APPENDIX E (vi): RCWMCH In-Year Monitoring Report_____	108

List of figures

Figure 1: Federal government payer for health-care services	17
Figure 2: The Hospital Revenue Cycle	20
Figure 3: Follow-up procedures on outstanding accounts	47
Figure 4: Non-medical aid members living in South Africa	51
Figure 5: Medical aid members living in South Africa	51
Figure 6: Non-medical aid members living a distance from the RCWMCH	52
Figure 7: Medical aid members living a distance from the RCWMCH	52
Figure 8: Quality level of service delivery among non-medical aid members at the RCWMCH	53
Figure 9: Quality level of service delivery among medical aid members at the RCWMCH	53
Figure 10: The experienced speed of service delivery among non-medical aid members at the RCWMCH	55
Figure 11: The experienced speed of service delivery among medical aid members at the RCWMCH	55
Figure 12: Reception officer's knowledge on non-medical aid members at the RCWMCH	57
Figure 13: Reception officer's knowledge on medical aid members at the RCWMCH	57
Figure 14: Reception officer's experience perceived by non-medical aid members at the RCWMCH	58
Figure 15: Reception officer's experience perceived by medical aid members at the RCWMCH	58
Figure 16: Client help desk awareness reported by non-medical aid members at the RCWMCH	60

Figure 17: Client help desk awareness reported by medical aid members at the RCWMCH	60
Figure 18: Medical fees awareness among non-medical aid members at the RCWMCH	61
Figure 19: Medical fees awareness among medical aid members at the RCWMCH	61
Figure 20: The level of fees affordability experienced by non-medical aid members at the RCWMCH	62
Figure 21: The level of fees affordability experienced by medical aid members at the RCWMCH	62
Figure 22: Non-medical aid members' payment preferences at the RCWMCH	63
Figure 23: Medical aid members' payment preferences at the RCWMCH	63
Figure 24: Awareness of the policy for free services	64
Figure 25: Knowledge of medical aid options	65
Figure 26: Medical aid members' responsibilities to obtain authorisation	66
Figure 27: The sufficiency of funds within the medical aid members' selected options	67
Figure 28: Employment levels at the Hospital Fees Department	68
Figure 29: Hospital Fees Department - Experience levels of employees	69

List of tables

Table 1: Financial Totals of the HFD at RCWMCH for the period 2008 – 2012	78-79
Table 2: Comparison of the main findings between non-medical aid and medical aid members	81-82

Acronyms and abbreviations

AP	- Allied health practitioner
ARS	- Accounts Receivable System
BAS	- Basic Accounting System
BNHI	- Bureau of National Health Insurance
CENABAST	- Central Supply Clearinghouse
COD	- Cash on Delivery
CT	- Cape Town
DOH	- Department of Health
DRG	- Diagnosis Related Group
FONASA	- National Health Fund
GP	- General Practitioner
HFD	- Hospital Fees Department
ICD 10	- International Statistical Classification of Diseases 10th Revision
ISP	- Public Health Institute
OECD	- Organisation for Economic Co-operation and Development
NHI	- National Health Insurance
NHS	- National Health Service
NOBs	- Normas Operacional Básicas
NPM	- New Public Management
NP	- Nursing practitioner
PBE	- Public Benefit Entity
PFMA	- Public Finance Management Act

PHI	- Public Health Institute
PMI	- Private Medical Insurance
SA	- South Africa
SP	- Specialist medical practitioner
SUS	- Unified Health System
RCWMCH	- Red Cross War Memorial Children's Hospital
UPFS	- Uniform Patient Fee Schedule
UK	- United Kingdom
US	- United States
WCGDOH	- Western Cape Government Department of Health



CHAPTER 1: INTRODUCTION

1.1. Introduction

The nature of this research study is to demonstrate the importance of good debt-management and recognise the improved cost-recovery methods for the financing of public health-care services at the Red Cross War Memorial Children's Hospital (RCWMCH). The Hospital Fees Department (HFD) at the RCWMCH is the selected sample. The core responsibility of this financial business unit is to ensure that the cost of health-care services accessed by members of the public are invoiced and recovered.

One of the main developments in South African public hospitals, and in particular at the RCWMCH, has been the introduction of user fees. An example of a user fee is when a patient fee is charged to members of the public for the medical services rendered. The collection of such user fees is a mandatory function of the HFD. The payment of user fees by consumers (patients) and the budget expenditure on public health-care services at the RCWMCH can be seen as a shared responsibility of costs between the organisation and the end user.

Griffin (1988:21) states that the combination of low growth in government resources devoted to health-care and the pressure for additional services and private expenditures for health has led to the realisation that user fees provide the best hope for raising additional resources for public health-care systems.

The charge and collection of user fees provide assistance with the expenditure on health-care services at the RCWMCH. As a result, the HFD collects a revenue budget on an annual basis determined by the Western Cape Government Department of Health (WCGDOH). With the aim of increasing finances for public health-care spending, the HFD is obligated to achieve the collection of revenues and reduce the increase of debt on the organisation's debtor's books.

In line with good debt management practices and improvement in the recovery of state funds, it is anticipated that the success of revenue collection would accrue more funding and contribute towards the operating costs of the health-care services. Excess funds create the opportunity for the RCWMCH to expand on health-care spending and infrastructure.

This chapter is organised into six sections. It starts off with the background to the research, followed by the theoretical framework, the problem statement, objectives of the study, significance of the study, and it ends off with the outline of the research.

1.2. Background to the research

Khoza argues that:

Apartheid left a deep-rooted problem of poverty and inequality in South Africa. For the majority of people in [South Africa], apartheid meant [d]iscrimination in the quantity and quality of education, housing, health-care and social security. Some of the problems inherited in the apartheid era are still visible today. As a result, even the policies and laws developed since the beginning of democracy are struggling to address the size of these problems. Poverty and HIV/AIDS are serious challenges facing SA today (2002:21-22).

The concentration of diseases in South Africa draws attention to the fact that the population is not in good health and at the same time does not have the access to health-care services. Societies are compelled to make use of the public health-care facilities, despite encountering the hardship of not having the ability to pay for these services. The inheritance of apartheid meant the adoption of unemployment, rural geographical differences and racially segregated areas such as Khayelitsha and Mitchell's Plain in Cape Town, South Africa.

The provision of health-care services is a basic right of South Africans. Since the country inaugurated a new democratic practice in 1994, the RCWMCH is obligated to ensure, according to the Bill of Rights documented in the Constitution of the Republic of South Africa (108 of 1996), that this entitlement is delivered. The primary core function of the RCWMCH is to provide public health-care services, but more specifically to provide these services for children.

The RCWMCH was built in 1956 and is the only standalone, specialist hospital dedicated entirely to children in Southern Africa. The hospital is a public tertiary- and secondary-level hospital in Cape Town, South Africa, and is dedicated to delivering world-class paediatric treatment, care, research and specialist training. As a referral hospital, patients include very sick children who need highly complex interventions to recover. The hospital is managed by the Western Cape Government Department of Health with an operational budget of R523 million for the 2010/2011 Financial Year. The Children's Hospital Trust works in partnership with the Department of Health on specific projects to

raise critical, complementary funding to ensure that the hospital remains a world-renowned centre of excellence in paediatric health-care (<http://childrenshospitaltrust.org.za>).

Being the only dedicated children's hospital in sub-Saharan Africa, the Red Cross War Memorial Children's Hospital admits approximately 250,000 paediatric patients annually; 95% of whom are from indigent or underserved local and distant communities (<http://www.lionheartedkids.org>).

The inauguration of a democratic South Africa in 1994 amended Chapter 18 of the Procedure Manual: Hospital Fees Structure (2011: 6.4.11) to ensure that "[f]ree medical services to children under the age of six years [was] implemented on 1 June 1994 (in accordance with Notice No. 657 published in the Government Gazette on 1 July 1994)".

It is against this background that this research study examines debt management and revenue-enhancing strategies in the HFD at the RCWMCH. The establishment of budgets and the availability of sufficient funding to remedy inequalities are important for the RCWMCH, since the hospital is the lifeline for rendering health-care services to the neighbouring communities. Public financing is received from the WCGDOH and the obligation of the RCWMCH is to ensure that budgets are spent on health-care services. The question of sufficient funding prompts an endless discussion and it is considered that the success of good debt management and improved revenue-enhancing strategies would assist with expenditure.

In the past, the process of debt management and revenue collection at the RCWMCH was mainly performed internally; however, the WCGDOH made the decision to employ outsourced corporate organisations. The corporate organisations are Smit and Genote, Vericred Debt Collectors, Alexander Forbes Compensation Technology and Medicred. Each corporate organisation holds its own core assignment and works closely with RCWMCH and the WCGDOH. The debt collector, Smith and Genote, recover written-off debt to the amount of R350 that is received after 90 days and a percentage of the proceeds are donated to the RCWMCH Hospital Trust. Vericred Debt Collectors, as per WCDOH contract no. 76/2010, collect outstanding debt above R350 that is older than 120 days. The responsibility of Alexander Forbes Compensation Technology, as per WCDOH contract no. 82/2008, is to negotiate the payment of motor vehicle accident claims lodged with the South African Road Accident Fund. As per WCDOH contract no. 08/2009, Medicred ensures that medical aid claims are electronically submitted to medical aid societies for payment.

A revenue budget of approximately R26 086 326 million (calculated as the average revenue collected from the period 2008 to 2012) for patient fees is collected every year and the assigned corporate organisations have the contractual obligation to support the RCWMCH to accomplish revenue targets. Beyond the revenue budget of the RCWMCH, there is no limit to the amount of additional revenue collected within a financial year and according to Griffin (1998:33), a hospital's revenue raising potential is enormous.

On a daily basis, debt increase for the HFD is the result of fees charged to patients who access the medical services of the RCWMCH. Patient fees charged are levied in accordance with a system of gradual charges, which are considered in respect of the declared income of the family and along these lines the mean test is applied. The totals billed are considered to be within a family's capability to afford the full amount for medical services rendered, and the application of the means test applies to fully subsidised and partly subsidised hospital patients. Fully subsidised hospital patients that are exempted from paying medical services include patients registered in the social pensioner's category and non-medical aid patients below the age of six years. Partly subsidised hospital patients involve patients who are charged according to the declared income of the family up to the total amount of R100 000 per annum. The collection of the HFD revenue budget is largely dependent on the patient fees charged to private patients. External organisations mainly fund the payment of private patients and include the medical aid societies, such as the Road Accident Fund and the South African National Defence Force. Further payments in the private hospital patient category are received from foreign patients.

The fees structure and the collection of outstanding debt for the RCWMCH are directed by Chapter 18 of the Hospital Fees Procedure Manual and the Uniform Patient Fees Structure (UPFS). The expansion of the legislation will be discussed in Chapter 4.

1.3. Theoretical framework

The theoretical framework of the research focuses on the meaning of a theory and provides an explanation of how the selected theory associates with the research subject.

According to Charles (2012:8), a theory can be described as representing a set of related ideas and assumptions that are drawn upon to explain a particular phenomenon. The most appropriate theory considered with this research subject is the transaction cost theory created by Coase (1975). According to Roland Coase (1975), transaction cost refers to the

cost of providing for some goods or services through the market, rather than having them provided from within the firm.

The outsourcing of operations from the RCWMCH and the WCGDOH establishes the connection with the transaction cost theory through a contractual undertaking with private organisations. This business decision demonstrates the shift towards the privatisation and adoption of the New Public Management (NPM). The relationship with private organisations can be considered a benefit for the RCWMCH and the WCGDOH in view of the level of expertise and experience that private organisations hold. Through a public and private partnership, the expected outcome for the RCWMCH and the WCGDOH would be that administrative costs are reduced and revenue collected for more health-care funding is available to members of the public.

1.4. Problem statement

The demand for public health-care services is growing in South Africa and in particular at the RCWMCH. As a result, the increasing need exerts immense pressure on the South African government and the RCWMCH to finance more services and afford members of the public access to public health-care services. There is an obligation placed on South Africa and the RCWMCH to perform, considering the growth of public users since 1994. Although services are provided to each person, the concern remains that the poorest of the poor cannot afford to pay for services due to unemployment and poverty. These imbalances and inequalities leave people desperately dependant on social grants.

Since 2008, South Africa has slumped into a recession and this prevented members of the public from paying for health-care services. In effect, people started making use of loans to service their debts. Debt levels on fees not paid are increasing at the RCWMCH. The hospital has a current debt and revenue-collection strategy. The question is whether the debt and revenue-collection strategy is actually addressing the challenges of the increasing debt and revenue collection process.

1.5. Objectives of the study

The primary objectives of the research are to examine the way in which the RCWMCH manages its debt, and recognise different methods optimised in the recovery of state funds.

The study's other fundamental objectives are:

- To review the literature on debt management and revenue strategies.
- To identify policies and their empirical application.
- To identify which policies are applicable to the RCWMCH.
- To determine and document the existing debt management and revenue practices within the RCWMCH.
- To establish the financial performances of the RCWMCH.
- To know whether the HFD succeeds in collecting its revenue budget within a financial year.
- To know the percentage rates of success or failure against debt calculated during the period between 2008 and 2012.
- To perform an analysis on the factors and constraints that facilitates debt management and revenue collection at the RCWMCH.
- To draw conclusions and make recommendations.

1.6. Significance of the study

To follow is a list outlining the significance of this study, which is:

- To render information on debt management and collection practices at the RCWMCH.
- To provide an international approach to the methods used to manage debt and recover monies.
- To provide information on how policies are aligned with processes.
- To disclose the financial totals of the RCWMCH.
- To show how the billing for health-care services match the collection of revenues.
- To provide a breakdown of public responses in relation to the payment of health-care services.

1.7. Outline of the study

This study is divided logically in seven chapters.

Chapter 1 aims to orientate the reader on the concepts of the study, rationalise the decisions for choosing to research this topic and to explain the background of the research, the theoretical framework, the problem statement, the objectives of the research, and the significance of the research.

Chapter 2 aims to discuss the study's research methodology and methods to be used. It also shows the scope of the study, research design and instruments, limitations of the study, and concludes with the ethical statement.

Chapter 3 aims to synthesise the pedagogical literature on debt and revenue-enhancing strategies. It further outlines the concept of debt management and the importance of cost recovery. It also draws on similar international examples available on the subject and makes known what is available and achievable, and what is not.

Chapter 4 aims to discuss the policy and institutional framework, and make available the legislative rules that necessitate compliance applicable to the RCWMCH.

Chapter 5 aims to discuss the prevailing debt management and revenue practices, focus on a case study and reveal the existing strategies in place at the RCWMCH. It further addresses the participants in the process and the procedures in line with the policies introduced by the WCGDOH and RCWMCH.

Chapter 6 aims to present the findings of the research, show the analysis of the factors and constraints to facilitate debt and revenue strategies, provide final insight on the findings of the research.

Chapter 7 aims to conclude the study by presenting the summary and recommendations pertaining to the study. An opportunity is created to make use of the closing remarks regarding the best methods used in managing debt and improve revenue collection.

CHAPTER 2: RESEARCH METHODOLOGY

2.1. Introduction

This chapter aims to discuss the study's research methodology and methods used to collect data. It begins by orientating the reader on the research conceptual framework used, the research design and instruments applied when collecting the data, the limitations of the methodology encountered, the scope of the study, ethical considerations and wraps up with a summary of the chapter.

2.2. Qualitative research

This study utilises a qualitative research methodology. In his profound account, *Methodology: Methods and Techniques*, Kothari differentiates between qualitative and quantitative research methodology as:

Quantitative research is based on the measurement of quantity or amount. It is applicable to phenomena that can be expressed in terms of quantity. Qualitative research, on the other hand, is concerned with qualitative phenomenon, i.e., phenomena relating to or involving quality or kind (2004:3).

He further explains that:

Qualitative research is especially important in the behavioural sciences where the aim is to discover the underlying motives of human behaviour. Through such research, we can analyse the various factors which motivate people to behave in a particular manner or which make people like or dislike a particular thing (2004:3).

Similarly, Barbie and Mouton define qualitative research design as:

[T]he study that emphasises studying human action in its natural setting and through the eyes of the actors themselves, together with an emphasis on detailed description and understanding phenomena within the appropriate context, already suggest what type of designs will be methodologically acceptable (2001:278).

2.3. Research design and instruments

2.3.1. Research instruments

The related method to be used in obtaining information and data is primarily documentary, comprising of structured interviews and questionnaires.

2.3.2. Sampling

The approach to gathering samples for the research study is non-probability sampling. The option of random sampling from a list containing names of everyone in the population of the study is not practical and, therefore, not considered (Barbie & Mouton, 2007:166).

Purposive or judgemental sampling is employed when it is appropriate to select the sample on the basis of one's own knowledge of the population, its elements and the nature of the research aims. In short, it is based on one's judgement and the purpose of the study, according to Barbie and Mouton (cited in Charles, 2013:30).

2.3.3. Sampling methods and techniques

The following research methods and techniques are applied in order to collect information.

2.3.3.1. Primary approach

Interviews with public officials in the area of finance are to be conducted. The nature of the interview process includes compiling an interview schedule of open questions. The questions asked would be appropriate to the objective of the research. The interviewees, in title order, are the Case Manager and the Senior Administrative Officer of the HFD at RCWMCH.

With regards to members of the public, a schedule of closed questions will be compiled in order to collect data. The motivation for asking closed questions is due to time constraints of patients needing to move between treatment areas and parents that are sensitive as a result of their child's medical condition. Closed questions are considered easier to administer and offer a shorter response time than open questions.

2.3.3.2. Secondary approach

A secondary approach to the collection of information is to include books, reports, policies and documents.

2.3.4. Criteria for choice of sample size

The following criteria pertain to the sample.

- Participants are to be registered patients of the RCWMCH.
- Parents of patients are to be 16 years of age or older.
- Participants are willing to take part.
- Participants do not have to fall into a specific gender or race demographic.

2.3.5. Rationale of data analysis procedures

Frequency tables will be drawn and included in a pie diagram in order to interpret closed questions (Polit and Hungler 1995:209, 698).

For open-ended questions, a quantitative content approach will be applied with the aim of quantifying emerging characteristics and concepts. Polit and Hungler (1995:209, 698) confirm that concept analysis is the process of analysing verbal or written communications in a systematic way to measure variables quantitatively.

2.4. Limitations of the methodology

On no account can conclusions or inferences be drawn from the research sample to include all children's hospitals in the country or continent. This is only a mini-thesis, which provides less information when compared to a full thesis. The research study is specific to the RCWMCH and does not apply to other hospitals. Should more case studies on the same topic be included for other hospitals in other provinces of SA, the research study would be more representative.

2.5 Scope of the study

The areas of concentration for this section focus on:

- Debt management.
- Revenue-enhancing strategies.
- Medical aid and non-medical aid patients.
- The period between 2008 and 2012.
- The HFD at the RCWMCH and not surrounding hospitals or clinics.

2.6. Ethical considerations

The declaration below is stated to ensure that ethical research standards are upheld and is as follows:

- Not to violate the rights and welfare of the research contributors and disclose any names.
- Not to exclude people from the service.
- Not to offend people and disrespect their constitutional rights.
- Not to use the research study as a means for self-gain.

2.7. Summary

This chapter outlined the conceptual framework used for the research, the research design and instruments applied when collecting the data, the limitations of the methodology encountered, the scope of the study and stated the study's ethical considerations.



CHAPTER 3: LITERATURE REVIEW

3.1. Introduction

Public demonstrations are experienced continually around the world, and, in most instances, demonstrations occur with the aim of persuading governments to spend their budgets on the most needed services. In this chapter, the first part of the research examines the meaning of debt and the management of debt. The second part focuses on the importance of cost recovery and the approaches considered increasing revenue collection. A comparative study is carried out among developed, emerging and developing countries in order to present an example of international best practice.

3.2. Definition of the research subject

The Longman Dictionary of Contemporary English (1978) defines “debt” as something owed to someone and defines “management” as being associated with those who are in charge of a firm or industry (ibid). According to Brandy (2011:98), in accrual-based accounting, income is entered into the accounts when it becomes due so the account comprises of money that has been received plus debt that is owed to an organisation.

However, the management of a debt situation necessitates the responsibility of debt managers to ensure that state debt is controlled. Coombs and Jenkins (2002:166) provide support and confirm that any public sector organisations must be concerned with the proper control of its debtors. Coombs and Jenkins (2002:166) further argue that the management of debtors not only applies to those services that are provided to clients on a voluntary basis and may be withdrawn if a bad payment record exists, but also to clients who are already in possession of a service such as a housing council.

The importance of strategy formulation is highlighted when establishing and improving methods to collect revenue. The Longman Dictionary of Contemporary English (1978) defines “strategy” as a skilful, general plan. Coombs and Jenkins (2002:166) provide support and confirm that “[a]s the Audit Committee points out: [t]he prevention of arrears is by far the most effective strategy.” This view of enhanced revenue strategies allows an organisation to benefit from additional cash-flow and avoid the need to borrow any finance for further expenditure.

An important comment from Coombs and Jenkins (2002:60) states that “[i]n the public sector, revenue and its relationship to costs have become increasingly important.”

3.3. Magnitude of the subject

Debt collection and patients’ bad debt underline the core framework of debt management. The Healthcare Business Market Research Handbook (2008) confirms that self-pay recipients of medical care accounts for 3% to 4% of the health-care expenditure. As a proportion “it represents about 16% of outstanding accounts receivable.”

The subject extends over a variety of phases. According to the Healthcare Business Market Research Handbook (2008), the areas for the increased revenue and guaranteed collection from self-pay debtors include:

- Capturing patient information at the time of service.
- Requiring early verification of insurance.
- Instituting processes to reduce claims denial.
- Offering greater buying-power in managed-care contract negotiations.

Debtors that do not settle their accounts create a slowdown in cash-flow and present a challenge to revenue collection. The Hospitals Accounts Receivable Analysis (cited in the Healthcare Business Market Research Handbook, 2008) reveals that “bad debt (excluding charity care) for the U. S. hospitals is approximately 3.3% of gross revenue”. This requires “hospitals to allow bad debt, as more patients’ bills go unpaid”. The detriment of the “extra work of collecting unpaid deductibles and co-payments,” is that it “costs hospitals money”.

According to Coombs and Jenkins (2002:166), effective debt management and a stringent collection practice require the following criteria to be met:

1. A close working relationship between the service departments and the recovery departments or sections to ensure that problem cases are identified as soon as possible.
2. Accurate, complete and timely information available to all staff involved in the arrears process.
3. A standard recovery procedure that works through an automatic system and is reviewed regularly to be put in place.
4. To ensure that any action should be quick and effective.

5. Firm action to be taken against poor payers (subject to point 3) to demonstrate that the organisation is prepared to apply sanctions.
6. Consideration be taken of the cost of recovery, since once legal action is pursued the process is expensive.

3.3.1. The significance of cost recovery

The importance of the research subject justifies the decision to include the rationale of cost recovery. According to McDonald and Pape (2002:17): “cost recovery refers to the practice of charging consumers full (or nearly full) cost for providing services such as water and electricity”. As with RCWMCH, fees are charged and according to McDonald (2002:18) it is regarded as “a particular service by a service provider”.

The involvement of cost recovery as a responsibility of RCWMCH and the HFD can be seen as a fiscal funder to grow the economy of South Africa. As a consequence, the neoliberal view on cost recovery exemplifies the way in which governments across the world view the importance of increased financial capital and economic prestige. According to Adam Smith (1976), neoliberalism is best defined as:

an approach to economic and social studies in which control of economic factors is shifted from the public sector to the private sector. Drawing on principles of neoclassical economics, neoliberalism suggests that governments reduce deficit spending, limit subsidies, reform tax law to broaden the tax base, remove fixed exchange rates, open up markets to trade by limiting protectionism, private state-run business, allow private property and back deregulation. (<http://www.investopedia.com/video/play/neoliberalism/>).

McDonald (cited in McDonald and Pape, 2002:22) provides a specific view on fiscal arguments that justifies the importance of cost recovery and considers that “the single most important reason given for cost recovery is the need to balance the books”. One can argue that when medical services are rendered and billed, as in the case of the RCWMCH, there is the expectation that the full cost of the services will be recovered from the patient to ensure the expenditure cost is reclaimed. According to McDonald (cited in McDonald and Pape, 2002:22), a further fiscal argument demonstrates that cost recovery is considered “a matter of good public fiscal practice, allowing governments to reduce tax burdens and thereby attract and retain human and financial capital”. In the case of the RCWMCH, the HFD accepts the

responsibility of the debt collection procedure, and, as a result, it creates the opportunity to gain financially for public spending. At the same time, it allows the RCWMCH to remain a world-acclaimed paediatric hospital.

McDonald further mentions:

that cost recovery in lower-income areas, it is argued, reduces the need for cross-subsidisation from industry and higher-income households, making a country or a municipality a more financially attractive place to locate (cited in McDonald and Pape, 2002:22).

One can reason that the reduction of cross-subsidisation enhances the collection of revenue in order to better deliver services to members of the public. The fiscal view further shows how serious “cities and towns” are; to the extent that they compete with each other in order to grow into “a more financially attractive place to locate to” (McDonald and Pape, 2002:22). A statement made in the “Water Supply and Sanitation Policy White Paper” (RSA 1994:23 cited in McDonald and Pape, 2002:22) confirms “that if government does not recover the operating and maintenance costs there will be a reduction in finances available for the development of basic services for those who have nothing”.

In addition, there are a few moral arguments that support the importance of cost recovery. McDonald (cited in McDonald and Pape, 2002:24) declares that “rights and responsibilities” are the first arguments. McDonald (cited in McDonald and Pape, 2002:24) states that when “people have the right to a service like water; they also have the responsibility to pay for it”. The provision of health-care services is a basic right to all members of the public, according to the Bill of Rights as documented in the Constitution of the Republic of South Africa (108 of 1996). The RCWMCH, for example, must ensure this right is delivered. The process is judged as a shared task, however, as “these rights are met with responsibility” (McDonald cited in McDonald and Pape, 2002:24).

In a campaign to educate members of the public about paying for services, “the Department of Water Affairs and Forestry, for example, has taken out half-page newspaper advertisements titled: Knowing your water and sanitation rights and obligations” (McDonald cited in McDonald and Pape, 2002:24). According to the Municipal Systems Act (RSA 2000a, 5.2.6), the payment for services is emphasised and this obligation applies across the board, with residents having the duty to pay for all of their municipal services (McDonald cited in McDonald and Pape, 2002:24).

In 1995, Mr. Nelson Mandela joined and supported the campaign to encourage members of the public to pay for their services (McDonald cited in McDonald and Pape, 2002:24). McDonald highlighted that “[f]inally it is argued that only by paying the full cost of a good or a service can one appreciate its true value” (McDonald cited in McDonald and Pape, 2002:25).

3.4. International scholarship among developed countries

3.4.1. The United States of America’s public policy approach to debt and revenue

Since 1965, effective management of the United States of America’s payment system and rates for hospitals has mainly been guided by the Medicare and Medicaid programmes (Baltazar). According to the American Hospital Association 2009a (cited in Rauscher, 2010:34), the Medicare and Medicaid programmes “represent 55% of care provided by U. S. hospitals.” According to the United States Congress (1995:7), “[t]here is no single U.S hospital system. The U.S health-care system may be described as insurance-based with patient-based payment as the pre-dominant approach to reimbursing hospitals for services, but really it is a combination of systems, some overlapping and others existing independently.”

For the purpose of this research study, the Medicare programme, according to the United States Congress (1995:7), is understood as “federally funded primarily through payroll taxes on employers and employees” and the Medicaid programme “is a tax-financed state-federal health-care programme” (ibid:10). Both programmes are government payers (Figure 1) of health-care services that are administered by the Healthcare Financing Administration (The United States Congress, 1995:139).

Figure 1: Federal government payer for health-care services

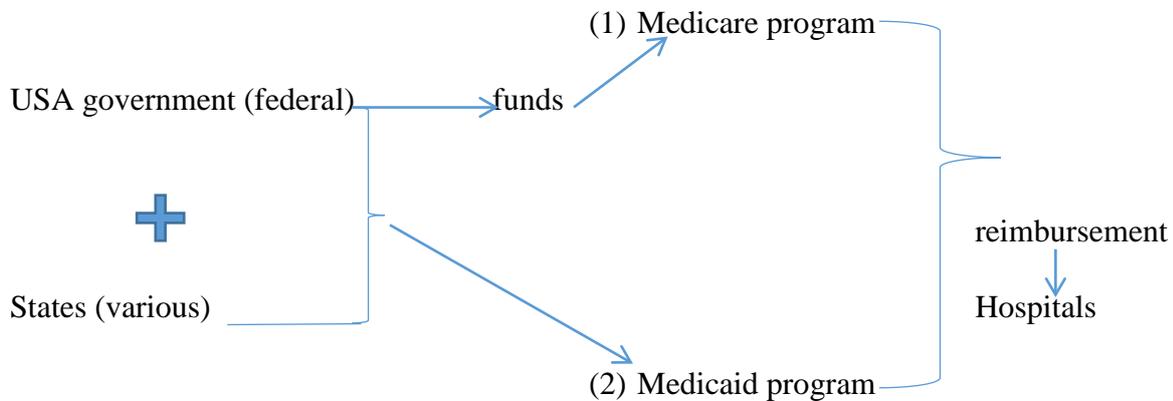


Figure 1 suggests “that government payer’ reimbursement policies and practices play an important role in hospitals’ performance at managing the revenue cycle” (Rauscher, 2010:34).

3.4.1.1. Public health-care hospital structures in the United States of America

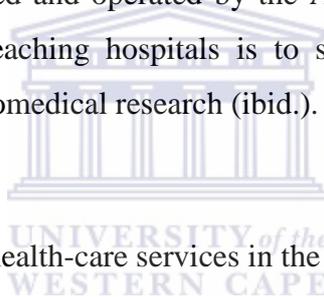
According to Laschober and Vertrees (cited in U.S. Congress Office of Technology Assessment, 1995:135-136), the grouping of hospitals in America includes:

- short-term (acute care) hospitals
- teaching hospitals
- long-term care institutions
- public
- private non-profit
- private for-profit
- designated by the main type of services provided-- such as general, speciality or referral services

An important feature of the American health-care system is that a community hospital is the leading type of hospital in the US. Those that fall into the category of community hospital include private non-profit, private for-profit or owned by state and local governments (ibid.).

Laschober and Vertrees (1995:136) further indicate that “[c]ommunity hospitals are non-federal, short-term facilities serving the general public”. The management of private non-profit hospitals is performed by universities, churches and other charities and these hospitals are exempted from paying tax on possible surplus income (ibid.). Private for-profit hospitals are managed by individuals and partnerships or co-operations, and are required to pay tax on additional income (surplus) collected (ibid.). Public community hospitals are managed by states and local governments, and provide health-care to large numbers of the public who are uninsured and who do not have the means to make a financial contribution for medical services they receive (ibid.).

According to Laschober and Vertrees (cited in U.S. Congress Office of Technology Assessment, 1995:136), United States (US) federal government hospitals are hospitals owned and managed by the federal government. The responsibility of these hospitals is to provide health-care services to active military personnel, veterans and Black Americans. Furthermore, the federal government of America owns speciality, long-term hospitals, which are responsible for the treatment of psychiatric patients, long-term care and rehabilitation. Teaching hospitals are also owned and operated by the American federal government. The prime responsibility for these teaching hospitals is to supply primary- and tertiary-care, clinical education and perform biomedical research (ibid.).



3.4.1.2. Categories of payers for health-care services in the United States of America

According to Laschober and Vertrees (1995:142), in dominant order, “[t]he largest payer of hospital costs remains private insurers.” The second largest source of hospital funds is the federal Medicare programme. Since 1983, owing to the rising expenditure from the Medicare programme, cost control measures were put in place that resulted in the implementation of a prospective payment schedule, which replaced the previous retrospective payment approach (Laschober & Vertrees, 1995:138). This approach controlled hospitals as the billing rates were set in advance through the Medicare programme. Under this arrangement, payments for each discharge are considered in line with “the national standardised payment amount, which represents the average payment for the typical Medicare amount” (ibid.). According to Laschober and Vertrees (1995:142), “cases are categorised by diagnosis-related groups (DRGs), which are groups of medically similar cases that require comparable resource use by hospitals”.

The third largest source of hospital funding is the Medicaid programme. According to Laschober and Vertrees (1995:142), this programme “pays hospital expenses for many low-income and disabled people”. Figure 1 illustrates the funding support between the federal government and the various states as well as the Medicaid programme.

3.4.1.3. Debt and revenue management procedure in California, United States of America

According to Rauscher (2010:9), hospitals in California presented an example of a hospital revenue cycle management practice for the period between 2004 and 2007. Rauscher (2010:11-12) defines a hospital cycle management practice as “the practices a hospital designs and implements to maximise the amount of patient revenue and the speed of patient revenue collection”. Figure 2 shows organised phases in Californian hospitals to recover outstanding debt and enhance revenue collection.



Figure 2: The Hospital Revenue Cycle

Before patient contact:

Development and implementation of revenue cycle management policies, procedures, performance measures and standards.

Third-party payer contract negotiation and management.

During patient contact:

Front-end tasks

Patient scheduling and registration, precertification and insurance verification

Core tasks

Provision of services and medical documentation

Typical duration: 15-19 days

(Measured as days of charge entry lag)

Charge entry coding

After patient discharge:

Back-end tasks

Billing, claims preparation and claims editing – Follow-up and denials management

Typical duration: 57-68 days

(measured as days in accounts receivable)

Cash collection and posting

Source: Rauscher (2010:13)

The competence of a hospital management cycle, according to Rauscher (2010), relies on more attention being directed to the front-end of the revenue cycle than the back-end. Cleverley and Cameron (2007, cited in Rauscher, 2010) state that:

Starting with appointment scheduling and continuing through registration: a hospital staff member registers the patient, collects the patient's demographics, clinical and insurance information, verifies the insurance information and validates the type of coverage provided by the health plan and the eligibility of the patient for services to be provided, which frequently requires obtaining a referral or preauthorisation of services (14).

From the stage of registration, two activities are highlighted to increase the collection of revenue.

The first activity, indicated by Rappuhn (cited in Rauscher, 2010:14), is “[c]omputing the deductibles and co-payments to provide patients with information about how much they are expected to pay out of pocket.”

The second activity, according to Rappuhn (ibid.), involves “providing patient financial education and counselling to help identify patients who have only limited health insurance coverage but may be eligible for a public insurance program, such as Medicare, Medicaid or State Children’s Health Insurance Program”. May draws on Rappuhn (2003) and states that:

[t]hese activities reduce the amount of staff time spend preparing bills and the amount of outstanding self-pay patient balances, and increase the speed of revenue collection and the likelihood that the account will be paid off, thereby reducing bad debt expense (cited in Rauscher, 2010:15).

Figure 2 illustrates that the provision of health-care services to members of the public is the core function and the stage of revenue generation. According to Cleverley and Cameron, in terms of payment guarantee:

[a]n important aspect of providing service is documenting all services provided in the patient’s medical record, parts of which are used in the billing process and communicated to third-party payers to trigger payment (cited in Rauscher 2010:14).

May draws on Cleverley and Cameron (2007) and indicates that:

The length of time from point of service to charge entry is a critical factor in the effectiveness of hospital revenue cycle management, as lags in charge

entry result in delays in billing and cash collection, and reduce speed of revenue collection (cited in Rauscher 2010:15).

The final stage before a bill is generated requires a diagnosis and a procedure code to be captured, according to Cleverley and Cameron (cited in Rauscher 2010:14).

Berger (cited in Rauscher 2010:15) points out that “[a]ccurate and detailed medical documentation gives medical coders the opportunity to apply for the optimal level of reimbursement and thus maximise the amount of patient revenue”. The billing and collection stage, after the patient is discharged (Figure 2), is the area most associated with the revenue cycle management mentioned by Wood (ibid.).

According to Zelman et al. (ibid.), “[u]p to date, well-operated billing policies and procedures help prepare accurate and timely bills”. Quality assurance and auditing of bills, as seen in Figure 2, is an essential feature in the billing process. Cleverley and Cameron (ibid.) provide support and state that:

An important task in the billing process is claims editing, which aims to detect potential errors in claims before they are submitted to payers, thereby ensuring that the hospital receives the maximum payment for the services provided and shortening the time from claim submission to actual payment.

Figure 2 further shows the importance of having a follow-up and denial management stage.

According to Eldenburg, Schafer and Zulauf (ibid.):

When bills are not paid in a timely manner, follow-ups and denial management can help the hospital management increase the amount of patient revenue through a claims recovery process whereby previously denied claims are corrected and resubmitted.

In closing the hospital revenue cycle, Figure 2 ends with the desired collection and allocation of payments received. This means that “the patient’s account is reconciled by recognising (additional) contractual allowances, charity care services or bad debt” (Rauscher 2010:16).

3.4.2 United Kingdom's public policy approach to debt and revenue

According to the Organisation for Economic Co-operation and Development (OECD) (2012:229), the United Kingdom (UK) public policy approaches consist of a “publicly funded and publicly owned hospital” and are directed through a National Health Service (NHS). The OECD (2012:229) confirms that the focus of responsibility of public hospitals in the NHS is to provide emergency hospital services. The UK policy framework is underpinned by the patient's choice of service provider. This means that patients can decide to be treated in public hospitals or private hospitals for routine elective care, (OECD, 2012:230).

3.4.2.1. Public health-care hospital structures in the United Kingdom

The predominant public health-care structure in the UK includes both publicly- and privately- funded organisations (OECD, 2012:229).

3.4.2.2. Categories of payers for health-care services in the United Kingdom

According to the OECD (2012:231), “the NHS is a provider of health-care services free at the point of use”. For most private medical insurance (PMI) patients who access privately-funded organisations, they “typically have either a corporate policy obtained through their employer, or an individual policy obtained directly from a PMI provider” (OECD, 2012:232).

3.4.2.3. Debt and revenue management procedure in the United Kingdom

Revenue management, according to the OECD (2012:230), is centred on providing patients with the ability to choose between providers of routine elective care, and the need to attract patients. The OECD (ibid.) adds that:

In order to earn revenue given the [p]ayment by [r]esults system of tariffs ensures providers have an on-going incentive to offer the highest quality care. Providers that are successful in attracting patients will be able to earn revenues that can be reinvested in other services.

3.5. International scholarship in an emerging country

3.5.1. Chinese Taipei's public policy approach to debt and revenue

According to the OECD (2012:297), Chinese Taipei's public policy approach follows a National Health Insurance System (NHI). The NHI commenced in March 1995 and is considered "a compulsory social insurance programme" that provides "equitable medical services to all citizens from birth". The OECD (2012:297) confirms that the NHI of Chinese Taipei "is a self-sustained system".

As a form of financial security, according to the OECD (ibid.), "the Bureau of National Health Insurance (BNHI) is required by law to maintain a reserve fund equal to one month of medical expenditures at least". The BNHI, as a result, serves as the administrator for the payment of health-care services. According to the OECD (ibid.), "patients need not bear the cost of treatment covered under the scheme, and the contracted medical care institutions then apply for reimbursement from the BNHI under the Department of Health".

3.5.1.1. Public health-care hospital structures in Chinese Taipei

The OECD (2012:297) confirms that the public health-care hospital structure in Chinese Taipei consists of medical institutions such as hospitals and clinics. These are separated into public and private institutions. The OECD (ibid.) mentions that members of the public do not pay for medical services, and experience no restrictions on accessing health-care.

3.5.1.2. Categories of payers for health-care services in Chinese Taipei

The OECD (2012:299) confirms that "the National Health Insurance payment system follows a global budget payment system". The arrangement is that before the beginning of each year, "the medical community and contributors negotiate the appropriate total amount of the medical payment of this Insurance for the following year".

Included in the Chinese Taipei NHI, according to the OECD (2012:299), is the Diagnosis Related Groups (Tw-DRGs) reimbursement system, which was implemented in 2010, and aims "to raise the quality and efficiency of health-care services by rewarding hospitals that are able to treat patients quickly and release them". The Diagnosis Related

Groups (Tw-DRGs) reimbursement system is an incentive guarantee that allows hospitals to participate in a pay-for-performance programme. The OECD mentions that:

The pay-for-performance programme utilises appropriate incentives, through adjusted payment of fees to medical institutions, to guide health-care service providers to progress towards integrating and continuing health-care, and base reimbursement on health-care quality and performance (2012:299).

3.5.1.3. Debt and revenue management procedure in Chinese Taipei

In terms of debt and revenue management in Chinese Taipei, according to the OECD (2012:297), “at present the chief source of revenue is premiums paid collectively by the insured, employers, and the central and local governments, and is not derived from general taxation”. The payment of insurance premiums allows individuals to qualify for insurance cards. This enables the individual “to receive medical services provided by any contracted medical care institutions for illness, injury or maternity upon presentation of the card” (ibid).

3.6. International scholarship among developing countries

3.6.1. Brazil’s public policy approach to debt and revenue

According to Onofri (2010:38), Brazil passed a new health-care system in 1998. Fleury (cited in Onofri, 2010:38) also confirms that within the health-care system they “devised a decentralised model with focus on the municipality”. Almeida draws on Fleury and adds that:

Guidelines regarding health-care were particularly detailed to include the blueprint for a unified and decentralised system called the Unified Health System (SUS) that embodied a clear conception of cooperation among different governmental levels (cited in Onofri, 2010:38).

According to Onofri (2010:38), “Sistema Unico de Saude” (SUS) allow all citizens of Brazil access to health-care.

3.6.1.1. Public health-care hospital structures in Brazil

SUS, according to Onofri (2010:38), “comprises of the centres for health-care and hospitals”. These centres are considered the main providers of health-care.

3.6.1.2. Categories of payers for health-care services in Brazil

Funding for health-care in Brazil is “characterised by tax-supported monopoly systems of government provision and funding”, according to Blank and Burau (ibid: 38).

3.6.1.3. Debt and revenue management procedure in Brazil

The division of health-care funds “originates from the federal level, and the other half is under the responsibility of states and municipalities”, according to SUS (ibid.).

3.6.2 Chile’s public policy approach to debt and revenue

In Chile, the public policy approach consists of both public and private sector involvement in health-care services. According to the OECD (2012:141), towards the end of the seventies the public sector experienced competition with the private sector in providing health-care services in Chile. As a consequence, the OECD (2012:141) confirms the “establishment of private health insurers, called “ISAPRES” in 1981”. The citizens of Chile can, therefore, choose to be involved with the private system or the public system.

In the public sector, “FONASA” is accountable for public sector resources. Since 2005, for both the public and private sector, a Health Regulator identified as “Superintendencia de Salud” has existed and is authorised to supervise ISAPRES and FONASA (ibid.).

3.6.2.1. Public health-care hospital structures in Chile

According to Missoni and Solimano (2010:30-31), the Ministry of Health is in charge of the Chilean health system and is responsible for establishing policies and reinforcing compliance of these policies. The following sectors report to the ministry of health:

1. Health Services
2. National Health Fund (FONASA)
3. Health Superintendence
4. Public Health Institute (ISP), which is responsible for regulating drugs and medical inputs
5. Central Supply Clearinghouse (CENABAST), which procures products for the public sector

3.6.2.2. Categories of payers for health-care services in Chile

According to the OECD (2012: 141-142), payers for health-care services in Chile are grouped as follows:

1. Independent workers or people out of work are not obliged by law to have health insurance; neither in the public, nor in the private systems: i.e. they have the option to pay directly to the providers, for the health assistance they need.
2. Affiliates to the public system are divided into four groups: A, B, C and D. A and B, i.e. the poorer of the groups, receive health services for free (i.e. without paying a deductible) from public suppliers. B, C and D may receive services from private suppliers under the “free choice” system. However, for B affiliates, attending private health suppliers is costly, and in the case of C and D the deductibles they must pay to the private providers are significantly higher than the one they must pay to the public supplier.

3.6.2.3 Debt and revenue management procedure in Chile

According to Edlin (2009), health-care is funded by a universal income tax deduction of at least 7% of every worker's salary and supplemented by government to cover necessary elements and public health programmes (<http://managedhealth-careexecutive.modernmedicine.com>).

3.6.3 Tunisia's public policy approach to debt and revenue

Health insurance is in place in Tunisia and is managed by the “Caisse Nationale d'Assurance Maladie”. The population of Tunisia are compelled to belong to the government's welfare scheme (<http://en.april-international.com>).

3.6.3.1 Public health-care hospital structures in Tunisia

Health-care facilities and hospitals in Tunisia are state-owned and provide free medical services to the entire population. The composition of public hospitals includes health centres providing primary care, district and regional hospitals, and university hospitals.

Private health-care exists in Tunisia as well, and the insured are able to receive treatment. The treatment requires approval, and for this the illness should be severe and/or chronic and in need of full health insurance cover: “[t]his is known as Affections Prises en Charge Intégralement (APCI) or fully covered conditions” (<http://en.april-international.com>).

3.6.3.2 Categories of payers for health-care services in Tunisia

The contributions received towards the provision of health-care in Tunisia allow for reimbursement, on behalf of the insured, to service providers. The condition is that “the costs incurred within the public health centres are reimbursed if the insured attends one of three levels of infrastructure within the public system” (<http://en.april-international.com>).

3.6.3.3 Debt and revenue management procedure in Tunisia

The cumulative fee of 6.75% of contributions paid to the Tunisian government is determined as a shared obligation: “2.75% is paid by the employee directly from their salary and 4% by the employer” (<http://en.april-international.com>).

3.6.4. Outline of researched international best practices and theoretical framework

3.6.4.1. Best practices among developed countries

3.6.4.1.1. USA's best practices:

(i) The employment of a prospective payment schedule to replace the previous retrospective payment schedule. The significance is that expenditure is controlled by the disbursement of claims from service providers.

3.6.4.1.2. United Kingdom's best practices:

(i) The freedom of choice is provided for patients in that they are able to choose from whom they would like to receive medical treatment. The cost of health-care is paid for through general taxation, and citizens are not charged at the point of service.

(ii) The establishment of a competitive approach to quality care in that the more patients' providers attract, the more opportunity exists to earn revenues that can be reinvested in other services.

3.6.4.2. Best practices in an emerging country

3.6.4.2.1. Chinese Taipei's best practices:

(i) Medical services are provided from birth.

(ii) Confirmation that patients do not bear any cost of health-care.

(iii) Members of the public have the benefit of choosing the health-care facility of their choice.

(iv) The budget decisions that are determined before the year commences, in order to make certain an appropriate expenditure budget, are available for the next year.

(v) The implementation of a diagnosis related re-imburement group that rewards hospitals for their quality of service and service delivery turnaround time.



UNIVERSITY of the
WESTERN CAPE

3.6.4.3. Best practices among developing countries

3.6.4.3.1. Brazil's best practices:

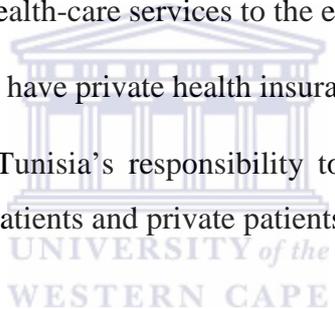
- (i) A decentralised health-care system to ensure provision of health-care to all citizens.

3.6.4.3.2. Chile's best practices:

- (i) The appointment of a health regulator to govern service delivery of health-care services between private health centres and public hospitals.
- (ii) The option of independent workers or the unemployed to pay service providers directly for health-care services.

3.6.4.3.3. Tunisia's best practices:

- (i) The provision of free health-care services to the entire population.
- (ii) The people's choice to have private health insurance.
- (iii) The government of Tunisia's responsibility to reimburse service providers on behalf of both the public patients and private patients.



3.7. Summary

The chapter outlined an understanding of the following:

Debt occurs when something is owed to someone. In the case of the RCWMCH and the HFD, debt occurs when members of the public access health-care services and are unable to pay for the medical services rendered. The result is that members of the public owe the RCWMCH an outstanding fee. The chapter also revealed that debt management requires a high level of control. The importance of control to manage debt indicates how necessary it is to have procedures.

The chapter further highlighted the rationale of cost recovery. Pre-1994 South Africa serves as a reminder that, for the most part, members of the public refused and, therefore, did not pay for services. Since the inauguration of democracy in 1994, members of the public in SA were required to pay for services and encouraged to show their responsibility in supporting the growth of the economy. The findings on collection practices and improving collections demonstrated the importance of additional funding, and that additional cash flow is able to provide an increase in improved health-care services.

The practices among the developed, emerging and developing countries demonstrated a common significance in the implementation of a national health insurance. General taxation and premiums were identified as the predominant sources of funding for governments. Public funding is administered by governments, and assumes the responsibility to reimburse payment of claims to service providers. In closing, it is reasonable to interpret that a national health insurance across international countries has become the decided structure in the provision of health-care to members of the public.



CHAPTER 4: POLICY AND INSTITUTIONAL FRAMEWORK

4.1. Introduction

The legislation and policies to follow are directly associated with the research subject and the content is important for the South African government and the RCWMCH. The legislative frameworks referenced include the Public Finance Management Act, Chapter 18 of the Hospital Fees Procedure Manual and the Uniform Patient Fee Schedule (UPFS). The inclusion of information about policy and institutional framework aims to demonstrate the ways in which it is relevant to the research subject.

4.2. Statutory and Procedural Provisions

4.2.1. The Public Finance Management Act (PFMA)

The job of the Public Finance Management Act (Act 1 of 1999) in relation to debt management and revenue collection is:

to regulate financial management in the national government and provincial governments; to ensure that all revenue, expenditure, assets and liabilities of those governments are managed effectively and efficiently; to provide for the responsibilities of persons entrusted with financial management in those governments; and to provide for matters connected therein.

The management of debtors in the Public Finance Management Act (Act 1 of 1999, Section 38 (1)(c)(i) requires that revenue managers “take effective and appropriate steps to collect money owed to the department, trading entity or constitutional institution”. The HFD holds the responsibility of performing debt collection activities with members of the public who are indebted to the state and the RCWMCH. For the most part, debt collection commences at the front-end of the RCWMCH, where the reception officer requests payment for the bill. In the event that the bill is not paid, the comprehensive (Figure 7) Accounts Receivable System (ARS) assumes responsibility. It is programmed to send debtors an invoice 14 days after the bill is issued to serve as a reminder of medical services rendered, and that the bill remains outstanding. In the case that the bill has not yet been paid, a first statement at day 30, followed by a second statement at day 60, is posted.

At day 75, the debt collection clerk is required to telephone the debtor to encourage the member of the public to make payment.

The ARS is programmed so that should payment not be received, a final letter of demand is sent before the debt is handed over to the debt collector. According to the Public Finance Management Act, public officials are required:

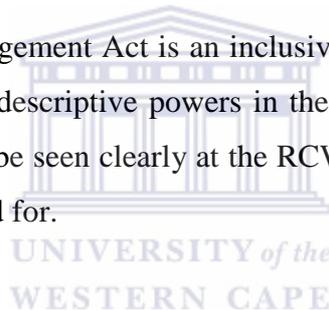
to maintain proper accounts and records for all debtors, including amounts received in part payment, and referral of a matter to the state attorney, where economical, to consider a legal demand and possible legal proceedings in a court of law.

Revenue management, according to the Public Finance Management Act requires:

reporting to the executive authority and treasury any impending--

- (a) under collection of revenue due;
- (b) shortfalls in budgeted revenue; and
- (c) overspending of the department's vote or a main division within the vote.

The Public Finance Management Act is an inclusive piece of legislation that requires public officials to exercise their descriptive powers in the effective interest of the state and members of the public. This can be seen clearly at the RCWMCH, where the performance of revenue is reported and accounted for.



4.2.2. Chapter 18 of The Hospital Fees Procedure Manual

For debt management and revenue collection to succeed at the RCWMCH, the HFD is required to act in accordance with Chapter 18 of the Hospital Fees Procedure Manual. This chapter consists of fourteen principles that support the HFD to ensure sound financial practise regarding services billed and fees recovered.

According to Chapter 18 of the Hospital Fees Procedure Manual, "Principle One specifies that emergency medical treatment shall be afforded at any time to any patient, without question or delay, at any state hospital".

This principle endorses members of the public's entitlement to health-care services in line with the Bill of Rights in the Constitution of the Republic of South Africa (108 of 1996,

Chapter 2, Section 27). Consequently, the RCWMCH is compelled to render emergency medical treatment, regardless of the patient's medical and financial condition.

According to Chapter 18 of the Hospital Fees Procedure Manual:

Principle Two specifies that every patient has the right to choose as a patient and/or tax-payer how and by whom he/she wishes to be treated, provided he/she is prepared to pay the tariffs applicable to private patients and subject to the availability of appropriate facilities. Should someone wish to be treated as a hospital patient, then he/she will not have a choice of medical practitioner.

This principle specifies the members of the public's right and freedom of choice in the selection of a private or public practitioner. The principle does, however, underline the payment responsibility for specific medical services. The complex recovery of medical costs for both public and private patients highlights the importance of debt management. To encourage members of the public to pay for services according to this principal creates the prospect to accrue more funding; in order to assist in the improvement of service delivery at the RCWMCH.

According to Chapter 18 of the Hospital Fees Procedure Manual:

Principle Three specifies that any private patient or public patient who could be treated by the private sector will be admitted to and/or treated at state hospitals if --

- (i) specifically requested by such patient with the knowledge of his/her private practitioner, and
- (ii) requested by a private practitioner to treat and/or admit such patient who is under his/her care.

This principle demonstrates the RCWMCH's ability to receive patients from various sectors and render medical treatment at the hospital. The acceptance and treatment of both private and public patients creates financial opportunity, since the patients are billed for the medical services in order to collect more revenue.

According to Chapter 18 of the Hospital Fees Procedure Manual:

Principle Four specifies that certain illnesses that may affect the community as a whole, if they are not contained or controlled, are automatically treated free of charge as well as treatment for certain categories of patient or levels of care as determined by the Provincial Government-of-the-day.

The inclusion of this principle demonstrates how serious South Africa and the RCWMCH are about the health-care of members of the public. This principle creates no financial opportunity to generate revenue, and focuses instead on the condition of the patient. The result is that the RCWMCH and SA commit to free health-care treatment and, as a consequence, are required to recover costs from paying patients to create a platform of cross-subsidisation.

According to Chapter 18 of the Hospital Fees Procedure Manual:

Principle Five specifies that academic hospitals require patients from all socio-economic groups for sufficient training and research purposes, but they are bound by limited infrastructures. The admission of patients to these hospitals will continually have to be measured against these two criteria.

Since the RCWMCH is a world-class public facility, the hospital is required to perform research in health-care and, therefore, needs the support of local citizens. The way in which expenditure is created from the treatment of patients is similar to the way that research projects occur at the RCWMCH. Cost implications are created and the costs incurred are recovered from research funders.

According to Chapter 18 of the Hospital Fees Procedure Manual Chapter 18:

Principle Six specifies that all health services rendered by the state are chargeable. However, no emergency service may be refused if a patient cannot pay for it and no patient, including a private patient, will be required to meet all costs of essential medical services should such costs place an excessive financial burden on him/her.

In the case of the HFD and the RCWMCH, the policy is well-defined, pointing out that medical services rendered to members of the public are payable. On the other hand, even though the RCWMCH is a state facility, not all members of the public are exempted from

paying for medical services. For the RCWMCH and the HFD, the recovery of fees is significant and, for the most part, fees are recovered from paying patients. Principle Six, however, offers assistance to members of the public who require emergency medical treatment. The RCWMCH is compelled to render these services and not bestow financial hardship on public or private patients who are unable to pay for medical services. Members of the public that suffer financial pressure are assisted through the delegations cited in Chapter 4.

According to Chapter 18 of the Hospital Fees Procedure Manual:

Principle Seven specifies that if necessary, the onus to prove that additional subsidisation for health services is required rests on the patient concerned. If a patient refuses to do this, then he/she must be regarded as a private hospital patient or private patient.

As mentioned in Chapter 1, fees charged are levied in accordance with a system of gradual charges in respect of the declared income of the family, and along these lines the means test is applied. Principle Seven makes provision for members of the public to be billed in the approved manner. The fees charged at the RCWMCH are within a family's capability to afford the full amount for medical services rendered. The RCWMCH and the HFD indicate that in the event that a member of the public does not provide the required information, the hospital is liable to bill the patient the maximum fee, and recover the costs for the services rendered.

According to Chapter 18 of the Hospital Fees Procedure Manual:

Principle Eight specifies that an itemised fees structure may be put into practice where possible. However, such a structure may be introduced selectively at institutions. Where this is not possible, the prescribed tariffs are applied.

The RCWMCH has the Uniform Patient Fees Schedule (UPFS) in place that does not focus on itemised billing. One can reason that this is due to the subsidised classification of patients at RCWMCH, where, in all likelihood, most patients will never be in the position to pay for every item charged. The fees structure and charge at the RCWMCH is dependent on the declared income of the family, and, as a result, there is less dependency on a high collection of revenue.

According to Chapter 18 of the Hospital Fees Procedure Manual C, “Principle Nine specifies that hospital patients should pay additional charges for specific artificial aids”. Although the fees charged at the RCWMCH are more sensitive towards poor families, there should be no question as whether to bill hospital patients for the service and use of assistive devices. Consequently, this is one area in which the RCWMCH can enhance revenue collection, in order to accrue more funding for health-care services.

According to Chapter 18 of the Hospital Fees Procedure Manual, “Principle Ten specifies that hospital patients should be encouraged to pay cash for accounts rendered”. One can reason that the intention is to recover the cost as soon as possible and reduce the possibility of outstanding debt on the organisation’s debtor’s books. By the same token, the HFD is able to calculate the progress of their revenue budget within a financial year.

According to Chapter 18 of the Hospital Fees Procedure Manual:

Principle Eleven specifies that sufficient powers in respect of the management of hospital fees should be delegated to the lowest possible level of execution. Officials at the lowest appropriate level should have the power to manage hospital fees.

This principle makes provision for a decentralised decision-making method. It can be argued that the method is practical, especially when members of the public make applications for debt reduction regarding medical bills, or wish to make payment arrangements for their outstanding bills. At the lowest level of management, the platform for debt management and improved revenue collection is established.

According to Chapter 18 of the Hospital Fees Procedure Manual:

Principle Twelve specifies that the fees structure is determined in accordance with the medical schemes' scale of benefits. It is aimed at the individual, and the specific illness, including oral health, is not taken into consideration with the determining of such structure.

Since medical aid patients are regarded as full paying patients, one can argue that the charges for services are accurate. The RCWMCH and the HFD have a case management section in operation that audits medical aid folders to verify and make certain that related services are billed. A consequence of this is that medical aid societies are not in a position to decline payment, since the fees charged are in accordance with the medical aid scheme’s

rules. The procedure allows for full cost recovery of services and, as a consequence, raises the guarantee of revenue collection for the RCWMCH and the HFD.

According to Chapter 18 of the Hospital Fees Procedure Manual:

Principle Thirteen specifies that it is accepted that there are two main groups of patients, namely --

- (i) patients who, in terms of a specific means test and/or legal prescriptions, are dependent on the state for health services, and
- (ii) patients who would normally receive health services in the private sector but who may be treated in state institutions.

On this principle the Bill of Rights in the Constitution of the Republic of South Africa (108 of 1996, Chapter 2, Section 27) is clear regarding the entitlement of health-care services to members of the public. Principle Thirteen is clear to ensure medical services are provided to the poorest of the poor and to members of the public who would normally receive medical services at a private facility. One can commend the principle and the Constitution of SA for creating an all-inclusive approach to health-care services. The open, participative approach generates and collects more revenue for the RCWMCH and the HFD.

According to Chapter 18 of the Hospital Fees Procedure Manual:

Principle Fourteen specifies that a patient who would normally be classified as a hospital patient (H1, H2 and H3), or if the income of the person liable for the payment of the hospital account falls in the afore-mentioned categories, but is a member of a medical scheme, is regarded as a private hospital patient for tariff purposes only. However, if the medical superintendent is satisfied with the information given by such patient or person --

- (i) he may be reclassified as a hospital patient once the benefits enjoyed under the scheme are depleted;
- (ii) no charge other than that applicable to hospital patients may be levied for any service, treatment, appliance or prosthesis not covered by such medical scheme;

(iii) the charge, other than that applicable to hospital patients, for any service, treatment, appliance or prosthesis not fully covered by such medical scheme, may not exceed the amount covered by such medical scheme.

Through this principle, the RCWMCH and the HFD are compelled to debt-manage medical aid patient claims that are not settled by their respective medical aid societies. In the case of the RCWMCH and the HFD, medical aid claims are, for the most part, rejected towards the end of a year. This is due to medical aid members' benefits being exhausted. Debt management of the rejected claims requires the RCWMCH and the HFD to change the full rate to a fully-or partially-subsidised rate. The procedure allows for debt relief of the outstanding bill to afford a more reasonable total for settlement (Western Cape Government, Chapter 18 Procedure Manual Hospital Fees Structure, 2011: 18/1/1-18/1/4).

4.2.3. The Uniform Patient Fee Schedule (UPFS)

UPFS in relation to debt management and improving revenue collection “has been developed to provide a simpler charging mechanism for public sector hospitals. These tariffs are applicable to all patients treated at public hospitals. The UPFS replaces the itemised billing approach with a grouped fee approach” (<http://www.westerncape.gov.za>).



In the case of the RCWMCH and other public hospitals, the charging for medical services and the calculation of tariffs are dependent on:

- (i) The level of the hospital rendering the service.
- (ii) The category of medical staff providing the treatment.
- (iii) The patient's income (<http://www.westerncape.gov.za>).

As a public hospital in the Western Cape of SA, the RCWMCH is recognised as a Level 3 hospital. According to UPFS, Level 3 hospitals comprise of academic hospitals and offer most specialist services at all times (<http://www.westerncape.gov.za>). The cost of medical services at the RCWMCH is calculated in terms of the patient's income and is grouped in four income categories (<http://www.westerncape.gov.za>) as follows:

(i) Full subsidisation: H0-- Principally this category includes pensioners and the formally unemployed. For the purpose of this research study, pensioners and the formally unemployed receive most services free of charge. Qualification in the category requires patients to present documentary evidence. Below are people categorised as:

(a) Social pensioners who receive the following grants:

- Old age
- Child support
- Veterans
- Care dependency
- Disability grant
- Foster care

(b) Formally unemployed persons are supported by the Unemployment Insurance Fund (UIF) and are able to produce a formal document issued by the Department of Labour.

(ii) Partial subsidisation: H1 – Qualification for partial subsidisation as an H1 patient requires a single income to be less than R36 000 or a family income to be less than 50 000 per annum.

(iii) Partial subsidisation: H2 – Qualification for partial subsidisation as an H2 patient requires a single income to range between R36 000 to R72 000 or a family income to range between R50 000 to R100 000 per annum.

(iv) Partial subsidisation: H3 – Qualification according to income requires a single income of more than R72 000 or a family income of more R100 000 per annum.

Two components are necessary when billing full-paying patients according to the UPFS Fee Schedule. These include:

- 1.) The facility fee.
- 2.) The professional fee.

The example that follows demonstrates how fees are billed to a full-paying patient:

A patient, who has an outpatient hospital consultation, is charged, per visit, a professional fee plus a facility fee. The amount of the professional fee and the facility fee depends on the type of professional and the level of hospital providing the service. The amount of the facility fee depends on the level of hospital i.e., the UPFS facility fee at a level 3 hospital is higher than that of a level 1 and level 2 hospital (<http://www.westerncape.gov.za>).

4.3. Summary

The chapter has shown that the policies stated are relevant and appropriate to the research subject. As for the RCWMCH and the HFD, the members of the public remain entitled to the provision of health-care services.

Furthermore, the chapter revealed that public officials have the responsibility to account for state funds. The chapter also indicated that should under-recovery and shortfalls in revenue collection occur, it is required of public officials to provide reasons. Public officials hold delegated powers, and are required to manage public finances and act in the best interest of the state. The chapter disclosed crucial principles that should be followed by the RCWMCH and the HFD. For the most part, it emphasised the importance of the provision of health-care to members of the public.

At the RCWMCH members of the public are requested to pay out of pocket or access payment for medical services from their external funders. The policies are well-defined and although the RCWMCH is a public facility, members of the public are still required to pay for medical services. The billing process for services is more simplified and cost-effective than it was before. In order to benefit the public, the charging for medical services is not itemised. This ensures that the fees billed are affordable.

CHAPTER 5: THE PREVAILING DEBT MANAGEMENT AND REVENUE COLLECTION PRACTICES AT THE RED CROSS WAR MEMORIAL CHILDREN'S HOSPITAL

5.1. Introduction

This chapter aims to present an overview of the admissions and registration procedures followed at the Red Cross War Memorial Children's Hospital (RCWMCH). The chapter further reveals the debt management and revenue collection procedures performed at the RCWMCH. The procedures followed are in accordance with the policies and institutional framework stated in the previous chapter. The defined procedures support the RCWMCH and the HFD in collecting their revenue budgets and reducing debt.

5.2. Overview of admissions and registration procedures at the RCWMCH

The RCWMCH complies with the Provincial Administration Western Cape Department of Health (DOH) in South Africa (Finance Instruction G6:2004), in the way that they manage debt and collect debtors fees. The frontline personnel at the RCWMCH perform an important function in ensuring accurate administration of patient information. In relation to debt management and revenue collection, the gathering and recording of demographic and financial information of the person liable for the payment are essential at the RCWMCH. The point of contact between the frontline personnel and the member of the public is what initiates the billing of the flat fee; the consultation is billed before medical treatment commences. It is at this stage that debt management and revenue collection occurs, since the frontline officer is required to request the fees for the service.

According to the WCGDOH (Finance Instruction G6, 2004), frontline staff must "obtain accurate data on the appropriate inpatient admission form or the relevant electronic data sheet." The agreement to receive medical services takes place once "the person liable for the account [has] signed". In addition,

proof of income must be obtained within the first 48 hours of admission. If the admission staff are unable to obtain this information at the time of admission it is the

responsibility of the ward secretary to ensure that proof of income is obtained within 48 hours.

Obtaining the proof of income is an example of a backup-practice between the admissions staff and the ward secretary. One can understand the importance of billing the correct fee to the correct member of the public, and, more noticeably, the fee that is considered affordable in order to encourage immediate settlement of the bill. Considerable emphasis is placed on obtaining proof of income from the members of the public, however:

if all reasonable measures have been taken to obtain proof of income and externally funded and self-funded (H3 included) patients have still not been classified within the first 48 hours, they must be classified as private patients by default.

It seems then that the RCWMCH and the HFD are able to recover more funds in instances where the proof of income from members of the public is not received.

5.3. Follow-up procedures on outstanding accounts

Figure 3 illustrates that the follow-up procedure of outstanding accounts is facilitated by a computerised information system. The Western Cape Government Department of Health (WCGDOH) introduced the modern Accounts Receivable System (ARS) in 2001. The ARS programmatically furnishes information for the printing of accounts for debtors at scheduled times.

In terms of a H1 hospital patient, according to Figure 3, the reception officer makes direct contact with the patient. The patient is encouraged to pay the outstanding debt and receives a detailed statement on discharge or during a visit to the RCWMCH. The outstanding amount is pursued through the ARS, which programmatically sends a reminder of the account at day 30 for printing and posting, which is organised by an outsourced printing company. In the event that no activity on the outstanding account has occurred over the last 60 days, the account is scheduled for write-off by the ARS and is handed-over to the debt collector at day 90.

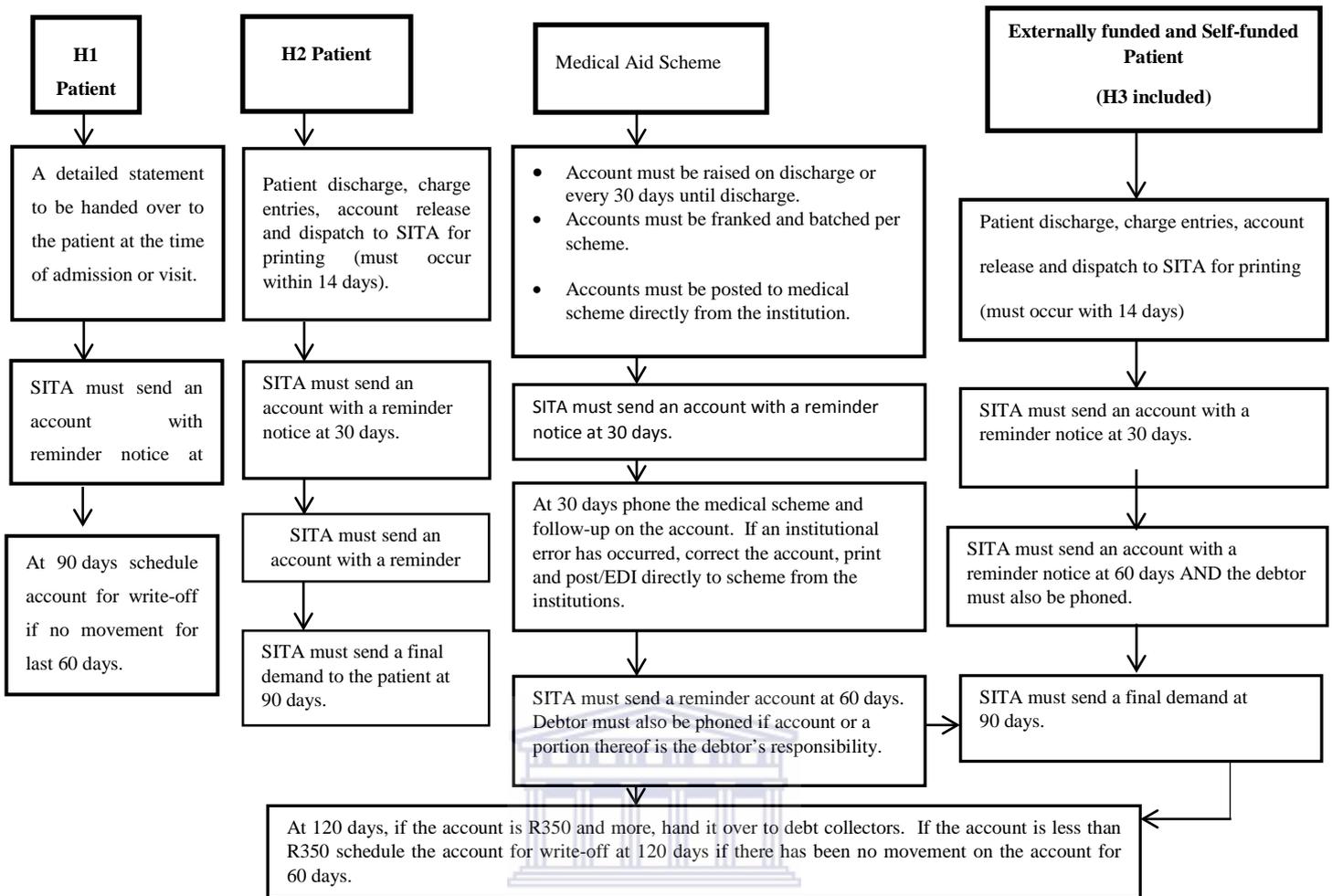
In terms of a H2 hospital patient, according to Figure 3, accounts are billed and generated within 14 days. During this period, medical services received by the patient must be captured and billed in order for the account to be printed and posted. At day 30 and day

60, statement reminder notices are printed and posted to debtors. The final stage of follow-up occurs once a final letter of demand is printed and posted in order to extract a reaction from the debtor.

In terms of a medical aid patient, according to Figure 3, an account is to be generated within 14 days. The period of 14 days allows for medical services to be captured, billed and audited. In 2009, the RCWMCH enhanced its revenue collection procedure of outstanding medical aid accounts by agreeing to a business partnership with the service provider Mediced. The main part of the business agreement was to ensure electronic medical aid claims submissions to medical aid societies. The terms and conditions of the business agreement required that the RCWMCH perform corrections on accounts. The addition of electronic follow-up procedure of outstanding medical aid accounts exemplifies an improved method of doing business at the RCWMCH. For the debt to be paid in this group, continuous follow-up takes place where reminder accounts are printed and posted on day 30 and 60. Telephonic communication is also made with debtor.

When it comes to externally and self-funded patients (H3 included), according to Figure 3, an account is billed within 14 days. Figure 3 provides an illustration of how a reminder account is dispatched at day 30 and day 60, and, in addition, the debtor is telephoned. As the last attempt to have the account paid, a final letter of demand is sent to the debtor. The follow-up procedure from day 120 continues on outstanding accounts that amount to R350 and more, as outstanding accounts are written-off in the ARS and handed over to the debt-collector named Vericed.

Figure 3: Follow-up procedures on outstanding accounts



Source: Western Cape Government: Department of Health. Finance Instruction, G6:2004

The inclusion of debt relief mechanisms is an important part of the debt management and revenue collection procedure in the HFD at the RCWMCH (Western Cape Government: Department of Health. Finance Instruction, G16:2003). The debt relief mechanisms Delegation 1, Delegation 2, Delegation 3, Delegation 5 and Principle 14 provide debtors at the RCWMCH with financial support to ensure that members of the public do not experience financial hardship. Furthermore, medical aid members, with support from the Prescribed Minimum Benefits (PMB), receive administrative assistance from the RCWMCH and the HFD, to the extent of one-on-one discussions with medical aid societies to ensure claims are settled.

The procedures and delegations are clarified:

Delegation 1, according to Chapter 18 of the Procedure Manual: Part IV, paragraph 29.2.3, reveals that:

the waiving of the total outstanding debt could be considered. The approval for the write-off of irrecoverable debt is subject to certain conditions/control measures and could be obtained at region/institutional level (up to R20 000.00) and at departmental level (above R20 000.00).

In addition, Section 11.4 of the National Treasury Regulations (cited in the Western Cape Government Finance Instruction, G7, 2007) indicates that the accounting officer “may write-off debt that is deemed uneconomical to recover”.

The application of Delegation 1 and the writing-off of state debt are authorised after the completion of a financial report. It follows that the financial report will establish if the monthly expenditure exceeds the gross monthly income or not. In the instance that the result is to the disadvantage of the debtor, the accounting officer will, in all likelihood, write-off the debt. The outcome means the debtor is free of the debt, and, as a result, the debt is reduced on the HFD and the RCWMCH debtors’ books.

Delegation Number 2, according to Procedure Manual Chapter 18: Part IV, paragraph 29.2.4, indicates that this delegation can be used:

if the debtor/patient is not in a position to pay his debt in one instalment. In terms of this delegation, approval can be granted at regional/institutional level to the patient/debtor to settle his/her account on an instalment basis.

The application of Delegation 2 renders financial relief and affords debtors the opportunity to settle their outstanding debt over an extended period of time. It is reasonable to interpret that this delegation is supportive, since it allows members of the public to decide on affordable instalments to repay the debt. This is of financial benefit to the RCWMCH and the HFD as the debt is still being recovered.

Delegation Number 3, according to Chapter 18 of the Procedure Manual, Part IV, paragraph 29.2.5, indicates that the:

delegation is used when patients/debtors apply for the reducing/waiving of debt on grounds of undue financial hardship. Depending on certain conditions/control measures and the level of delegation on which the case is

handled, it could be determined whether the applicant qualifies for assistance or has the ability to pay the debt. The guiding principle is that the application should firstly be made on the lowest possible level of delegation, before the debtor/patient applies to a higher level.

The debtor is required to complete a financial report in order to determine whether they qualify for debt relief or not. The financial totals must reveal whether the monthly expenditure of the debtor exceeds the gross monthly income. In the event that the financial results are to the disadvantage of the debtor, the delegated official will perform an internal calculation that will ensure a reduced fee is paid. In addition, this debt reduction will ensure debt is reduced on the HFD and the RCWMCH debtors' books.

Delegation Number 5, according to Procedure Manual Chapter 18, Part IV, and paragraph 29.2.6, indicates that:

this delegation is used to reclassify patients, who receive treatment on a continuous basis, to a lower patient category on grounds of undue financial hardship. The patient/debtor has to meet certain financial criteria to qualify for relief under this delegation.

The application of Delegation 5 pertains to members of the public who access medical services at the RCWCH on a continuous basis. The constant need for medical services, and the bills it incurs, creates huge debt and financial hardship to the debtor, especially since the debtor does not have the means to repay the debt. Through this delegation, debt relief is provided; however, a financial report is to be completed by the debtor. The completion of the financial report will give an indication of the debtor's financial stress. The financial information gained assists the accounting officer in deciding to which lower patient category the current account is to be reassessed. One would expect that the debtor's account be reassessed at the lowest possible patient category (H1); taking into consideration that most patients experience severe illnesses such as cancer. The reassessment to the lower patient category assists in the reduction of debt for the HFD and the RCWMCH.

Principle 14, according to Chapter 18 of the Procedure Manual, Principle Fourteen Part I, reveals that:

debtors and their dependants who ordinarily would have been classified as hospital patients (H1, H2, H3) in terms of the means test, but belong to a

Medical Aid Scheme, are regarded as private hospital or full-paying patients for tariff purposes. However, if proof is submitted that the medical aid benefits are depleted or certain illnesses/treatment are not covered, or the case does not resort under the Prescribed Minimum Benefits, the patient qualifies to be reclassified to a hospital patient (H1, H2, H3). The patient is then only responsible for either the applicable hospital patient tariff or the amount covered by the medical aid.

It is clear that Principle Fourteen only applies to members of a medical aid scheme. For members of a medical aid scheme, benefit funds are activated at the beginning of the year. This being said, benefits are easily depleted depending on the frequency of usage throughout the year. For the most part, medical aid benefits are exhausted towards the end of the financial year. The HFD and the RCWMCH assist members of the public who find themselves in this situation and reassess the claims according to the debtor's income. In these instances, the debtor's account is reduced to a more manageable balance. In the case of the RCWMCH, should the age of the child be below six, the bill is reassessed to a nil balance. For the RCWMCH and the HFD, debt is reduced on the organisation's debtor's books, and the advantage for the debtor is that financial relief is provided (Prescribed Minimum Benefits: Medical Schemes Act, 1998).

According to the Western Cape Government, Department of Health Finance Instruction (G16, 2003):

certain diagnosis and treatment pairs resort under Regulation 8 of the Medical Schemes Act (Act No. 131 of 1998) and the medical schemes are in terms of the Act, obliged to settle all applicable accounts in full. If patients or debtors, who are members of medical schemes, approach the hospital for debt relief, the staff must ascertain whether the account was submitted to the medical aid and/or the diagnosis/treatment falls under the above-mentioned Act. If the Prescribed Minimum Benefits are not applicable, the under-mentioned debt relief mechanisms could be applied to determine the debtor's ability to settle his/her accounts or if the cases qualify for debt relief.

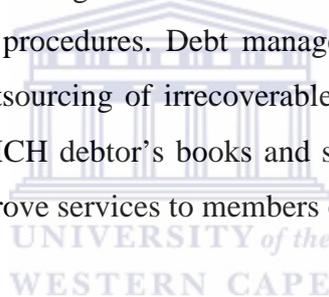
The procedure on Prescribed Minimum Benefits (PMB) is well-defined and under no circumstances can the medical aid scheme refuse settlement of the debtor's claim. The HFD provides administrative assistance to medical aid clients to ensure claims through the EDI

process are paid. The procedure of PMB further contributes towards guaranteed revenue collection for the HFD and supports the collection of revenue budgets (Western Cape Government: Department of Health. Finance Instruction, G16:2003).

5.4. Summary

This chapter focused on the functions that the RCWMCH frontline employees perform. The success of good debt management and revenue collection is dependent on the fact that correct information is recorded at the front-end patient administration sections of the RCWMCH. This chapter revealed that on completion of the admission and registration of patients, it is equally important to have the debtors sign liability for payment of the bill. A benefit for the RCWMCH and the HFD is that the frontline employees request payment for medical services and contribute towards revenue collection as well.

The chapter has also shown that the co-ordination of the account practices at the RCWMCH and the HFD are methodical. The follow-up procedure (Figure 3) for each patient category in the collection of outstanding debt at the RCWMCH is seen as progressive, which demonstrates compliance of the procedures. Debt management and revenue collection are further enhanced through the outsourcing of irrecoverable debt. The hand-over of patient's debt reduces debt on the RCWMCH debtor's books and simultaneously raises the potential for more finances in order to improve services to members of the public.



CHAPTER 6: DATA PRESENTATION AND ANALYSIS

6.1. Introduction

This chapter presents the data and results of the primary and secondary objectives of the research study. The outcomes contain a combination of qualitative and quantitative responses. Part of the blueprint for how to conduct the research includes organised questionnaires for both members of the public and the management of the RCWMCH (Mouton, 1998:74). Separate questionnaires are designed for non-medical aid members of the public, medical aid members of the public and RCWMCH management.

Financial totals from the RCWMCH are presented and show the debt levels and performance of revenue collection for the period 2008 to 2012. The categories and criteria of the primary objectives are as follows:

Representing non-medical aid members of the RCWMCH:

RQ1: Position of the client.

RQ2: Service delivery.

RQ3: Fees and affordability.

Representing medical aid members of the RCWMCH:

RQ1: Position of the client.

RQ2: Service delivery.

RQ3: Benefit option.

RQ4: Fees and affordability.

Representing the RCWMCH management:

RQ1: Management measures.

RQ2: Debt management.

RQ3: Revenue management.

The total population and size of the sample in the primary objective of participants is 42 and is grouped as follows:

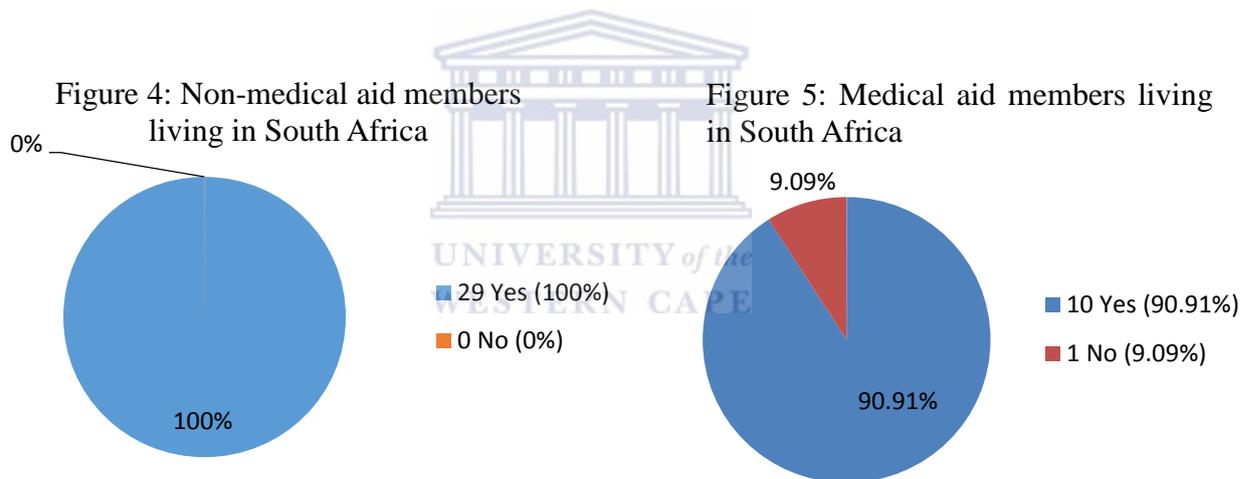
- (1) 29 participants were non-medical aid members.
- (2) 11 participants were medical aid members.
- (3) 2 participants were part of the management of the RCWMCH.

The information is organised into pie-charts. The information is presented numerically with percentage figures provided. The findings follow after each chart.

The category and criteria of the secondary approach include the financial totals of the RCWMCH for the period 2008 – 2012.

6.2. The primary approach results for the categories non-medical aid and medical aid members of the RCWMCH

6.2.1. The position of clients living in South Africa who are medical aid members and non-medical aid members.

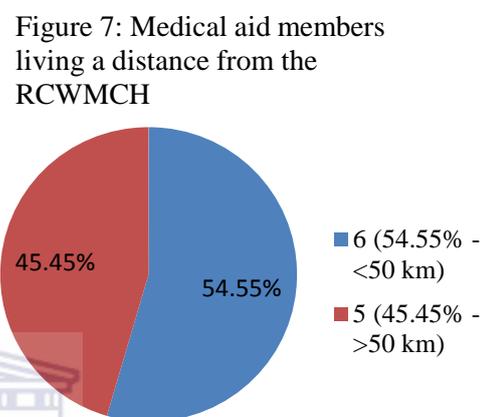
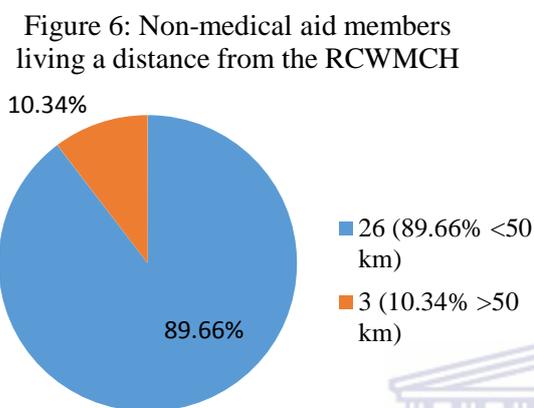


The number of clients living in South Africa who are non-medical aid members makes up a total 29 participants-- that is to say 100%. Comparatively, the number of clients living in South Africa who are on medical aid consists of 10 (90.91%) participants, whilst only 1 (9.09%) participant lives outside SA.

One can interpret the results for the non-medical aid members and medical aid members to be similar. The RCWMCH is positioned to serve the members of the public in the surrounding communities. It can be noted that the payment for medical services and

revenue collection are, for the most part, received from both non-medical aid and medical aid local South Africans. Furthermore, one can interpret that in order for the HFD to succeed with revenue targets, there is a reliance on the local members of the public for the payment of bills and revenue collection.

6.2.2. The position of the medical aid members and non-medical aid members on distance from the Red Cross War Memorial Children’s Hospital



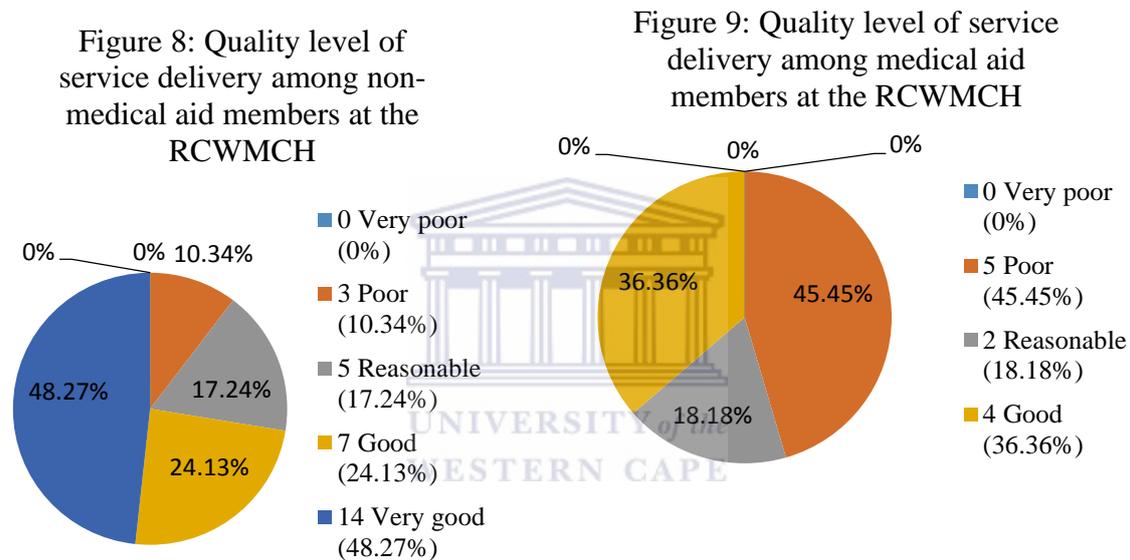
The enquiry into the non-medical aid members’ distance from the RCWMCH found that 26 (89.66%) participants lived less than 50 km away and 3 (10.34%) participants lived more than 50 km away. The enquiry into the medical aid members’ distance from the RCWMCH found that 6 (54.55%) participants lived less than 50 km away and 5 (45.45%) participants lived more than 50 km away.

When compared, the 89.66% (26) of non-medical aid participants living less than 50 km away, and the 54.55% (6) of medical aid participants that fell into the same category show a difference of 35.11%. One can establish that non-medical aid patients are much nearer in distance to the RCWMCH compared to medical aid patients. The results show that non-medical aid members have the advantage of being able to access health-care services much faster than medical aid members.

The results from participants who lived more than 50 km away showed that medical aid members total a difference of 30.11% over non-medical aid patients. It can be interpreted that medical aid members are at more of a disadvantage when accessing health-care services

as a result of the distance they live from the RCWMCH. However, one can reason that medical aid members who live further away from the RCWMCH have the financial means to belong to a medical aid scheme, in comparison to the non-medical aid members who live closer to the facility. The financial benefit for medical aid members is that the medical aid scheme societies are obliged to pay for medical services on behalf of their clients, whereas non-medical aid members are required to pay for medical services out of their own pockets. It is, thus, reasonable to interpret that payment for medical services is more dependent and guaranteed from medical aid members than from non-medical aid members.

6.2.3. The quality level of service delivery experienced by medical aid and non-medical aid members at the RCWMCH



The quality level of service delivery at the RCWMCH among non-medical aid members was as follows: 0 (0%) participants reported it as being Very Poor, 3 (10.34%) participants reported it as Poor, 5 (17.24%) participants reported it as Reasonable, 7 (24.13%) participants reported it as Good, 14 (48.27%) participants reported it as Very Good and 0 (0%) participants reported that they Don't Know. Looking at the medical aid members, the results show 0 (0%) participants reported Very Poor service, 5 (45.45%) participants reported it was Poor, 2 (18.18%) reported it as Reasonable, 4 (36.36%) reported it as Good, 0 (0%) reported it as Very Good and 0 (0%) participants reported that they Don't Know.

The cumulative total of non-medical aid members in the group Very Poor (0%) to Poor (10.34%) is 10.34% and compared to medical aid members the total in the same group is 45.45%. In this group there is an enormous percentage difference of 35.11%. This indicates that medical aid members are not pleased with the level of service they received from the RCWMCH. It can be interpreted that members of medical aid schemes look forward to receiving value for money, knowing that payment for medical services is guaranteed. Poor levels of service satisfaction with such a high percentage difference could result in members of the public seeking health-care services elsewhere. It is reasonable to interpret that this could result in the loss of revenue for the RCWMCH.

In the Reasonable group, non-medical aid members hold a total of 17.24% compared to medical aid members with 18.18%. Clearly, the totals for both non-medical aid and medical aid members in this group are almost the same. One can interpret the level of service to be sound, and that the fee for medical services is expected to be paid, as importance is placed on the well-being of the child.

When grouping the non-medical aid members in the range Good to Very Good and Don't Know, a total of 72.40% is found. Medical aid members in the same range show a total of 36.36%. Therefore, there is a difference of 36.04%, which shows that non-medical aid members are highly impressed with the level of service received from the RCWMCH. One can interpret the 72.40% with being connected to fully- and partially-subsidised patients that pay minimal to negligible fees for medical services. Should this be the case, no real increase in revenue collection can be expected for the RCWMCH.

The 36.36% of medical aid members who regard medical services to be good could be considered frequent and regular patients of the RCWMCH. It is reasonable to interpret from the findings that revenue will be received and paid for by these patients.

6.2.4. The speed of service delivery as experienced by medical aid and non-medical aid members at the RCWMCH.

Figure 10: The experienced speed of service delivery among non-medical aid members at the RCWMCH

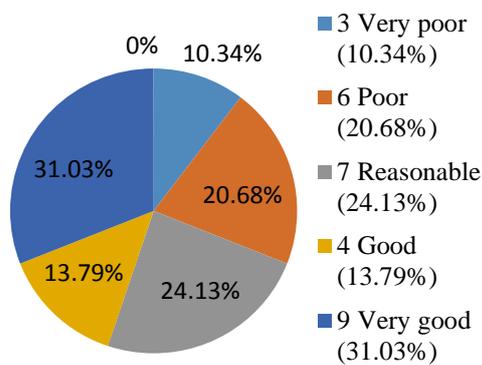
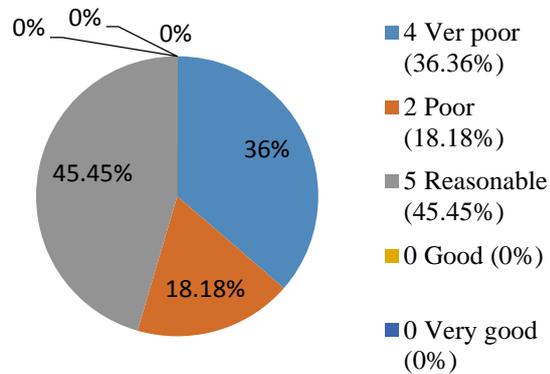


Figure 11: The experienced speed of service delivery among medical aid members at the RCWMCH



The speed of service delivery at the RCWMCH noted by non-medical aid members was found to be as follows: 3 (10.34%) participants reported Very Poor, 6 (20.68%) participants reported Poor, 7 (24.13%) participants reported Reasonable, 4 (13.79%) participants reported Good, 9 (31.03%) participants reported Very Good and 0 (0%) made up the category Don't Know. Compared to medical aid members whose totals included 4 (36.36%) in the category Very Poor, 2 (18.18%) reported Poor, 5 (45.45%) reported Reasonable, 0 (0%) reported Good and 0 (0%) reported Very Good and 0 (0%) marked Don't Know.

The group range Very Poor to Poor for non-medical aid members shows a cumulative total of 31.02% compared to the cumulative total of 54.54% for medical aid members in the same group. A comparative difference of 23.52% shows that medical aid members are not all happy with the speed of service at the RCWMCH. One can interpret that medical aid members expect more prompt service for the reason that revenue is guaranteed from medical aid societies. The results show that medical aid members are disappointed with turnaround times and make comparisons to private facilities where medical services are more punctual.

Although only one-third (31.03%) of non-medical aid members show dissatisfaction with the speed of service, it is reasonable to interpret that in general, members of the public are not prepared to spend an entire day waiting for medical services. The question of sufficient resources comes to mind and should this be the case, the RCWMCH runs the risk

of losing revenue, since members of the public could decide not to pay for medical services. The concern for the RCWMH and the HFD is that the outstanding debtors' balances could increase.

In the Reasonable group, non-medical aid members show a cumulative total of 24.13% compared to a total of 45.45% medical aid members. The 21.32% difference between the non-medical aid members and medical aid members is seen as high and borders on the same percentage as the Poor to Very Poor group. As previously mentioned, members of medical aid societies have high expectations of excellent service delivery as a result of their financial classification. The same cannot be said for non-medical aid members, but in general, members of the public expect faster service, even though the RCWMCH is a public facility.

The group Good to Very Good and Don't Know show a huge cumulative total of 44.82% for non-medical members compared to a total of 0% from medical aid members. One interpretation for the satisfaction amongst non-medical aid members is that in this group, members of the public are possibly not charged or only partially charged for medical services, and, as a consequence, are not particularly concerned with the speed of service. Should this be the case, revenue collection for the RCWMCH is minimal, which shows a greater reliance placed on medical aid members.

The 0% total from medical aid members in the same group shows that participants are unimpressed with the speed of service. This could be the result of operational and procedural issues experienced at the RCWMCH. A consequence of this could be that medical aid members seek out medical services elsewhere, which would result in loss of revenue for the RCWMCH.

6.2.5. The level of knowledge displayed by the reception officer reported by medical aid and non-medical aid members at the RCWMCH.

Figure 12: Reception officer's knowledge on non-medical aid members at the RCWMCH

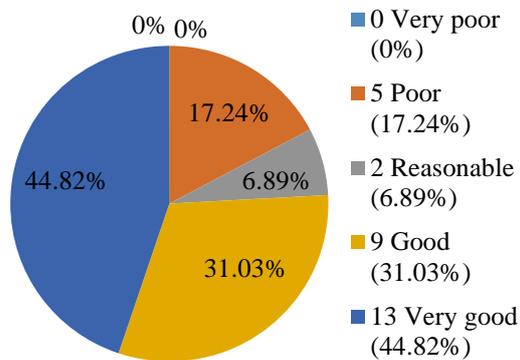
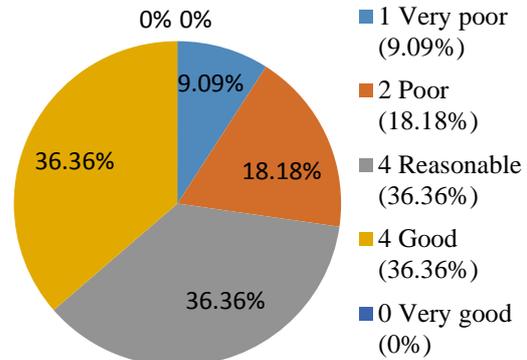


Figure 13: Reception officer's knowledge on medical aid members at the RCWMCH



The findings from how non-medical aid members experienced the reception officer's knowledge of the job at the RCWMCH are as follows: 0 (0%) found it Very Poor, 5 (17.24%) reported Poor, 2 (6.89%) felt it was Reasonable, 9 (31.03%) reported Good, 13 (44.82%) stated Very Good and 0 (0%) Don't Know. Compared to medical aid members whose totals include 1 (9.09%) for Very Poor, 2 (18.18%) for Poor, 4 (36.36%) for Reasonable, 4 (36.36%) for Good, 0 (0%) for Very Good and 0 (0%) for Don't Know.

The group range Very Poor to Poor for non-medical aid members shows a cumulative total of 17.24%, while medical aid members for the same range show a cumulative total of 27.27%. Between the non-medical aid members and medical aid members, a difference of 10.03% is noted. In this range, members of the medical aid societies regard the reception officer's knowledge of the job to be Very Poor and Poor. The results can be interpreted as a lack of working procedure; both when the reception officer performs manual tasks and when the reception officer captures data on the computerised system. As a consequence, the turn-around time of service delivery is even slower, which further gives rise to members of the public becoming angry and frustrated. The same argument can be used for non-medical aid members.

In the Reasonable group, medical aid members found the reception officer's knowledge of the job to be sounder by 29.47% (36.36%-6.89%). One can argue that these participants are more concerned with having their child treated or making sure their child

receives specialised treatment than they are with whether or not the reception officer has the necessary know-how.

In the group range Good to Very Good and Don't Know, the cumulative total of non-medical aid members is 75.85%. As for medical aid members, the cumulative total is only 36.36%. It is reasonable to interpret that non-medical aid members could experience more regular interaction with most of the reception officers than medical aid members would at the RCWMCH. One could, therefore, reason that reception officers recognise the non-medical aid members. However, not the same can be said about medical aid members.

6.2.6. The level of experience displayed by the reception officer perceived by medical aid and non-medical aid members at the RCWMCH.

Figure 14: Reception officer's experience perceived by non-medical aid members at the RCWMCH

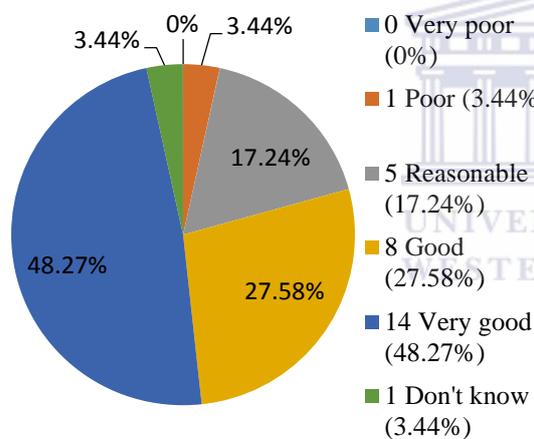
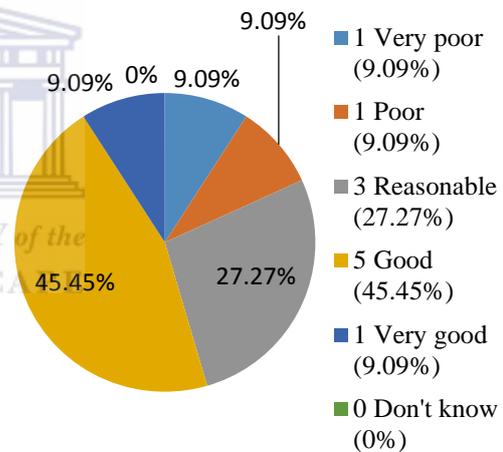


Figure 15: Reception officer's experience perceived by on medical aid members at the RCWMCH

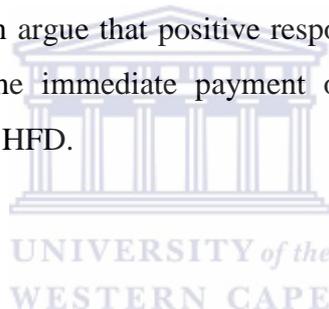


The criteria “service delivery” in the area “experience of the reception officer at the RCWMCH” among non-medical aid members consists of the following distribution of participants: 0 (0%) reported Very Poor, 1 (3.44%) reported Poor, 5 (17.24%) reported Reasonable, 8 (27.58%) reported Good, 14 (48.27%) reported Very Good and 1 (3.44%) reported Don't Know. Compared to medical aid members whose totals include 1 (9.09%), Very Poor, 1 (9.09%) Poor, 3 (27.27%) Reasonable, 5 (45.45%) Good, 1 (9.09%) Very Good and 0 (0%) Don't Know.

In the group Very Poor, only one medical aid participant indicated that their experience of the reception officer was bad. Non-medical aid and medical aid members in the group Poor make up a total of two participants. It is reasonable to interpret that for these low totals, members of the public could have dealt with support staff in the absence of the regular reception officers, where the support staff member could have shown better experience and skill to the public.

In the Reasonable group, the non-medical aid member's total is 5, compared to the 3 for medical aid members. The totals are almost the same and one can interpret that the non-medical aid members and the medical aid members regard the experience of the reception officer to be sound.

In the group range Good and Very Good, the total percentages for both non-medical aid members and medical aid members are above 50%. The cumulative total for non-medical aid members is 22 (75.85%). For the medical aid members, the cumulative total is 6 (54.54%). It is possible that in most instances members of the public have regular interactions with the same reception officer and, as a consequence, the validity of the assessments is maintained. Furthermore, one can argue that positive responses from members of the public create strong possibilities for the immediate payment of medical services and revenue collection for the RCWMCH and HFD.



6.2.7. Awareness of a client help desk reported by medical aid and non-medical aid members at the RCWMCH

Figure 16: Client help desk awareness reported by non-medical aid members at the RCWMCH

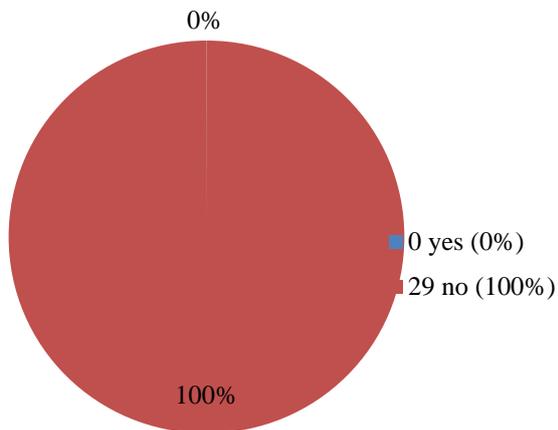
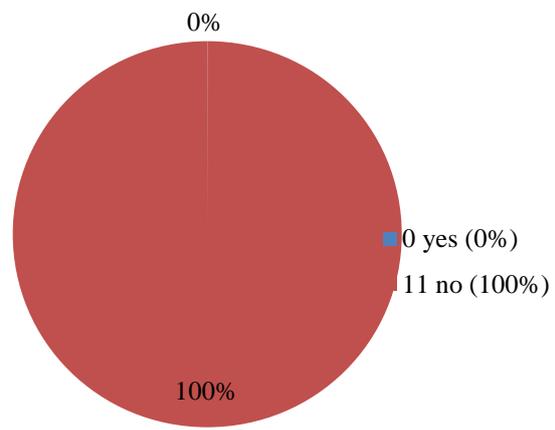


Figure 17: Client help desk awareness reported by medical aid members at the RCWMCH



The findings for whether non-medical aid members were aware of a client service help-desk at the RCWMCH consist of 29 (100%) participants who responded No and 0 (0%) participants who responded Yes. The medical aid members' knowledge of a client service help desk at the RCWMCH consists of 11 (100%) participants who responded No and 0 (0%) participants who responded Yes.

The 100% outcome for both non-medical aid members and medical aid members shows that the RCWMCH does not have a designated client service help-desk at all.

Limited space could be a reason for the RCWMCH not having a client service help desk. The absence of this support area could, however, pose serious implications to service delivery at the RCWMCH in future. In addition, there is a potential risk of revenue loss, especially in instances where members of the public are looking to make enquiries to settle outstanding bills.

6.2.8. Medical fees awareness reported by medical aid and non-medical aid members at the RCWMCH.

Figure 18: Medical fees awareness among non-medical aid members at the RCWMCH

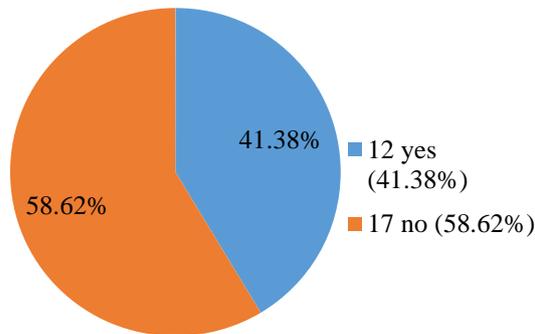
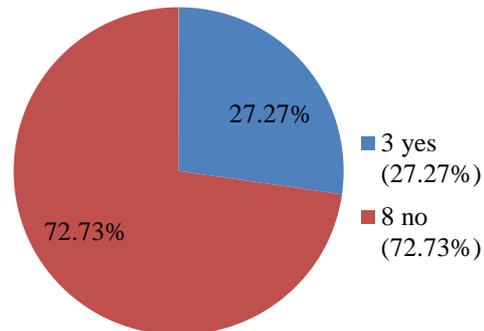


Figure 19: Medical fees awareness among medical aid members at the RCWMCH



The reported awareness of fees charged to non-medical aid members of the public at the RCWMCH consists of 12 (41.38%) participants who responded Yes to being aware of fees and 17 (58.62%) participants who responded No.

The results show a total of 58.62% non-medical aid patients are not familiar with the fees charged at the RCWMCH, and this suggests that, in all likelihood, these patients do not pay for services or are not educated on the fees structure. A total of 41.38% of non-medical aid participants are, however, familiar with the fees charged. It can be interpreted that these are patients that are knowledgeable about the cost implications when medical services are received from the RCWMCH and, as a consequence, would know how money to gather in order to pay the hospital.

The findings on medical aid members' familiarity with fees charged at the RCWMCH consist of 3 (27.27%) participants who responded Yes and 8 (72.73%) participants who responded No. The results show that only 27.27% of the medical aid participants are familiar with the fees charged at the RCWMCH, whereas a total of 72.73% indicate that they are not familiar with the hospital's fees structure at all. It can be interpreted that the 72.73% of participants were first time visitors to the RCWMCH or that no information is publicised to inform members of the public of the fees charged.

6.2.9. Affordability of hospital fees charged to medical aid members and non-medical aid members at the RCWMCH

Figure 20: The level of fees affordability experienced by non-medical aid members at the RCWMCH

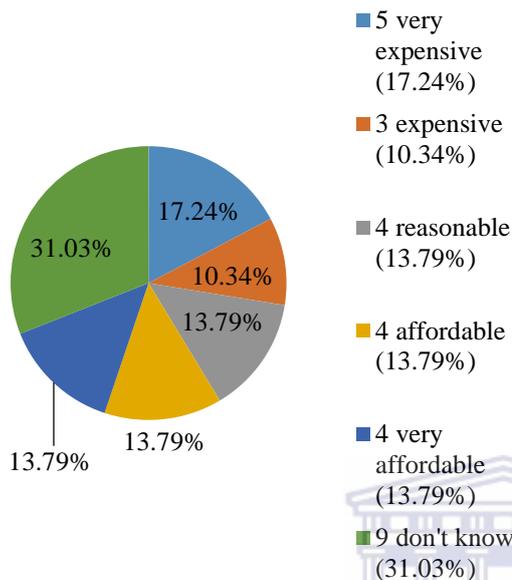
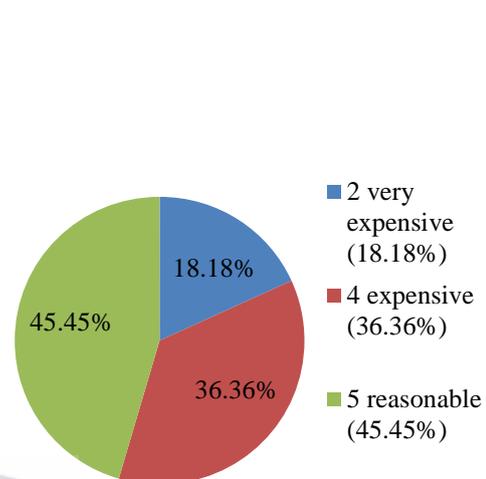


Figure 21: The level of fees affordability experienced by medical aid members at the RCWMCH



When non-medical aid members were asked about the affordability of medical fees charged at the RCWMCH, 5 (17.24%) participants found fees Very Expensive, 3 (10.34%) participants found them Expensive, 4 (13.79%) participants found them Reasonable, 4 (13.79%) participants found them Affordable, 4 (13.79%) found them Very Affordable, and 9 (31.03%) reported that they Don't Know.

The results show that a total of 27.58% (17.24% + 10.34%) of non-medical aid participants regard the fees charged to be Very Expensive and Expensive. One interpretation could be that this group is charged the maximum fee and, therefore, experiences financial difficulties. In all likelihood, this group would make applications for debt reduction. Consequently, the RCWMCH should not be dependent on this group for revenue collection.

A total of 41.37% (13.79% + 13.79% + 13.79%) of non-medical aid participants are pleased with the fees charged and this indicates that patients have the means to pay for services. The remaining 31.03% of participants fell into the Don't Know category and this

could indicate that they were never charged and were not aware of fees charged to members of the public.

When medical aid members were asked about the affordability of medical fees charged at the RCWMCH, 2 (18.20%) participants found the fees Very Expensive, 4 (36.36%) participants found them Expensive and 5 (45.45%) participants confirmed the fees were Reasonable.

The results show that 54.54% (18.18% + 36.36%) of participants indicated that the fees charged were Very Expensive and Expensive. The remaining 45.45% found the fees charged to be Reasonable, and this indicates that the members of the public will pay for services.

A total of 54.54% of participants confirmed the hardship of not being able to afford the payment of user fees charged by the RCWMCH. The outcome can be interpreted as a result of the patients being charged fees that fall into the maximum classification category.

6.2.10. Method of payment preferences for medical aid members and non-medical aid members at the RCWMCH

Figure 22: Non-medical aid members' payment preferences at the RCWMCH

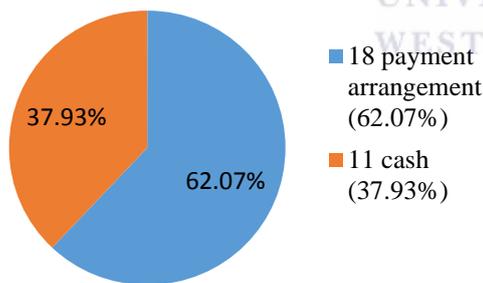
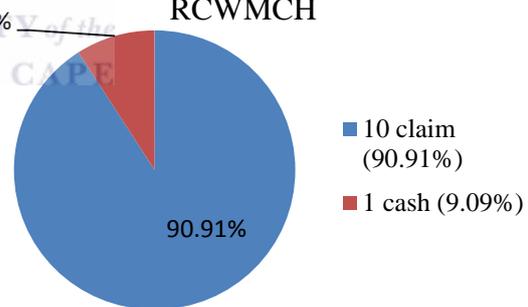


Figure 23: Medical aid members' payment preferences at the RCWMCH



It was found that in the group of non-medical aid members, 18 (62.07%) participants opted for a payment arrangement and 11 (37.93%) participants opted to pay cash to settle their debt.

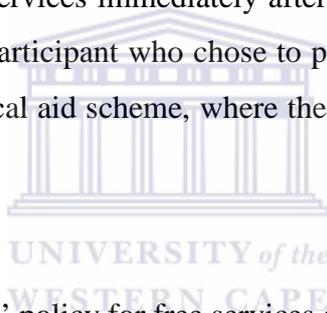
A total of 62.07% of non-medical aid participants opting for a payment arrangement indicates that patients do not have cash on hand and do not have the means to settle outstanding debt immediately by cash payment.

A total of 37.93% of non-medical aid participants choose to pay cash for services received immediately. This could indicate that these patients do not approve of outstanding debt and have the means to pay for the service immediately. On the other hand, the decision to pay cash for services gives the impression that this group does not wish to be harassed by the hospital's debt collectors.

It was found that in the group of medical aid members, there were 10 (90.91%) participants who preferred the claims process and 1 (9.09%) participant who preferred to pay cash.

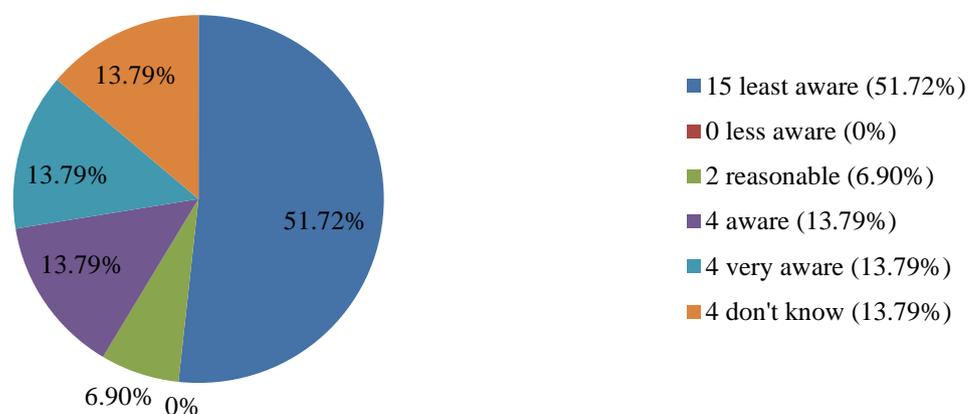
The results show that 90.91% of the medical aid participants chose the option to pay for medical services through the claims process, as opposed to only 9.09% of participants who choose to pay cash. This could be attributed to the terms and conditions of the medical aid scheme.

The 90.91% of participants opting for a payment arrangement shows that medical aid members are dependent on medical aid societies to settle their claims, and, at the same time, do not have the cash to pay for services immediately after each visit to the RCWMCH. It is possible that the one remaining participant who chose to pay cash could be as a result of the terms and conditions of the medical aid scheme, where the member is required to claim back for services received.



6.2.11. Non-medical aid members' policy for free services at the RCWMCH

Figure 24: Awareness of the policy for free services



The degrees of awareness regarding a policy for free services for non-medical aid members were found to be as follows: 15 (51.72%) participants reported being Least Aware, 0 (0%) participants stated they were Less Aware, 2 (6.90%) participants were Reasonably Aware, 4 (13.79%) participants were Aware, 4 (13.79%) participants were Very Aware and 4 (13.79%) participants reported that they Don't Know.

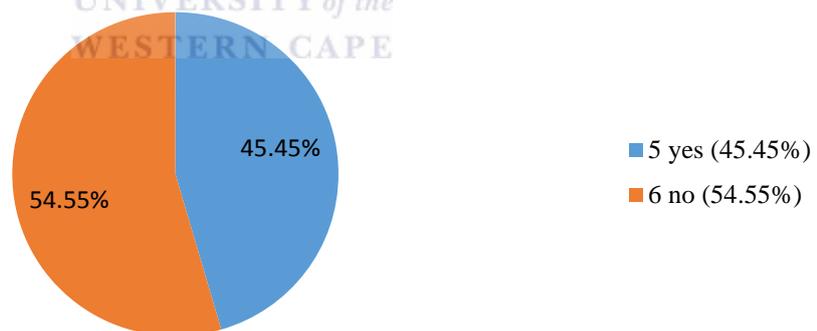
The results show that 51.72% of participants are unaware of a policy for free services. A total of 34.48% (6.90% + 13.79% + 13.79%) of participants are aware of the policy and the remaining 13.79% do not know of this policy.

On a rate basis, one could argue that the 51.72% of participants who are unaware of the policy could be paying the maximum H3 tariff for services, whereas 34.48% of participants who are aware of the policy are paying the lower H2 and H1 tariffs. As for the remaining 13.79%, it is interpreted that these are patients who are not required to pay and currently enjoy the policy for free services. As a consequence, the RCWMCH would not receive revenue.

6.3. The primary approach results for medical aid members at RCWMCH

6.3.1. The benefits of knowledge about medical aid options

Figure 25: Knowledge of medical aid options



When medical aid members were asked if they were knowledgeable about the medical aid options and their respective benefits, 5 (45.45%) participants responded Yes and 6 (54.55%) participants responded No.

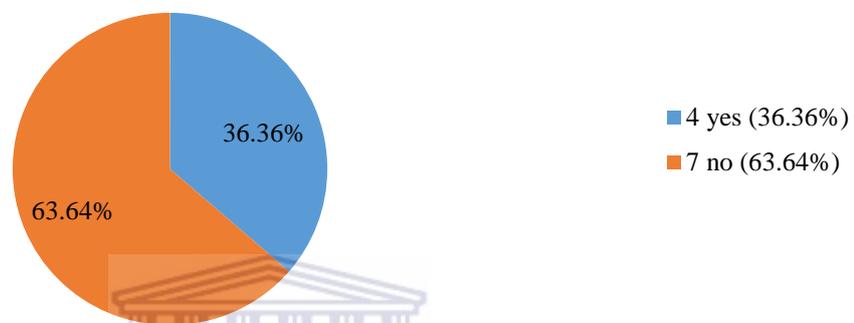
The results show that 54.55% of medical aid members are not knowledgeable about their medical benefits. It is possible that the 54.55% of patients with an absence of knowledge about medical aid benefits can be attributed to medical aid schemes' lack of communication

with their members. Furthermore, one can reason that the RCWMCH could not receive revenues as the selected options will not cover the specific treatment rendered to the patient.

The remaining 45.45% of participants, however, shows a level of education regarding their benefit options. It is reasonable to interpret that 45.45% of participants understand their options in a way that ensures the medical bills are paid to the RCWMCH.

6.3.2. Medical aid members' responsibilities to obtain authorisation

Figure 26: Medical aid members' responsibilities to obtain authorisation

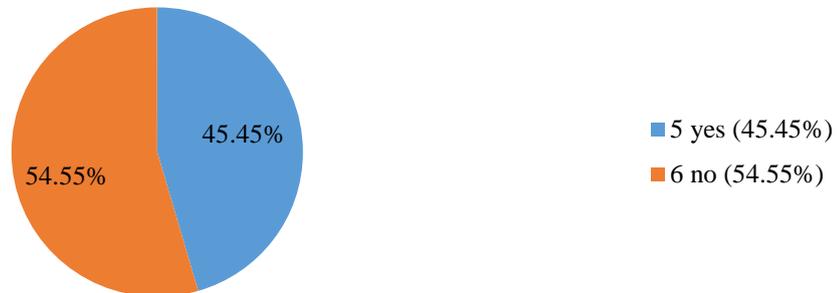


Looking at medical aid members' awareness of their responsibility to obtain authorisation, it is found that 4 (36.36%) participants responded Yes to being aware and 7 (63.64%) participants responded that they were not aware.

The results show that only 36.36% of participants who responded positively are aware that medical aid claims will not be paid without authorisation. The concern, however, remains with the majority of 63.64% of participants who were not aware of their responsibility. One could interpret this as a lack of communication from the medical aid societies in reminding their members to obtain authorisation. For the RCWMCH, this could remain a concern as it would result in medical aid societies not paying and, therefore, revenue would be lost.

6.3.3. The question of sufficient funds on medical aid members' selected options

Figure 27: The sufficiency of funds within the medical aid members' selected options



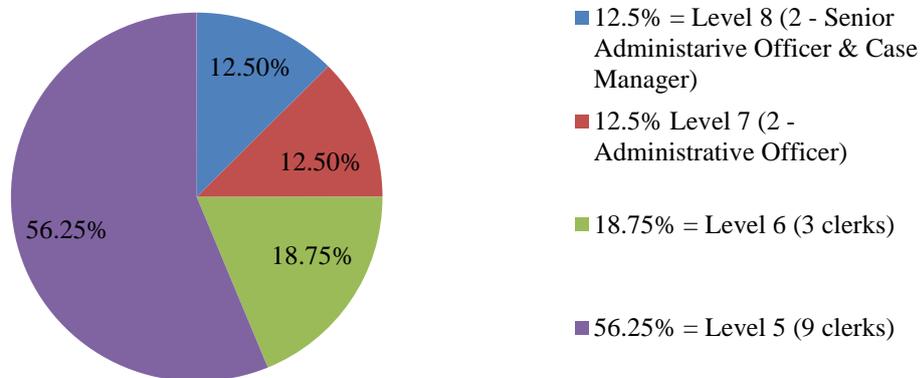
When medical aid members were asked whether the funds were sufficient, it was found that there were 5 (45.45%) participants who responded Yes and 6 (54.55%) participants who responded No.

The results show that 45.45% of participants indicated the availability of sufficient funds in their benefit option and, as a result, it can be assumed that the RCWMCH can expect payment. However, the remaining 54.55% of the participants revealed that no further funds were available. One can interpret that the use of the medical aid benefits by the 45.45% of participants is not that frequent, which contrasts with the 54.55% of participants who use the medical benefits more frequently. The responses from the 6 members who reported insufficient funds show that there is the need for continuous treatment and, therefore, the use of medical benefits due to the patient's medical condition. As a result, the benefits are exhausted much sooner. The result of insufficient funds is that the debt for medical aid members will be reduced, according to Principle 14, and, as a consequence, a lesser fee or no fee at all will be paid to the RCWMCH.

6.4. The primary approach results for the RCWMCH management

6.4.1. Employment levels at the Hospital Fees Department

Figure 28: Employment levels at the Hospital Fees Department



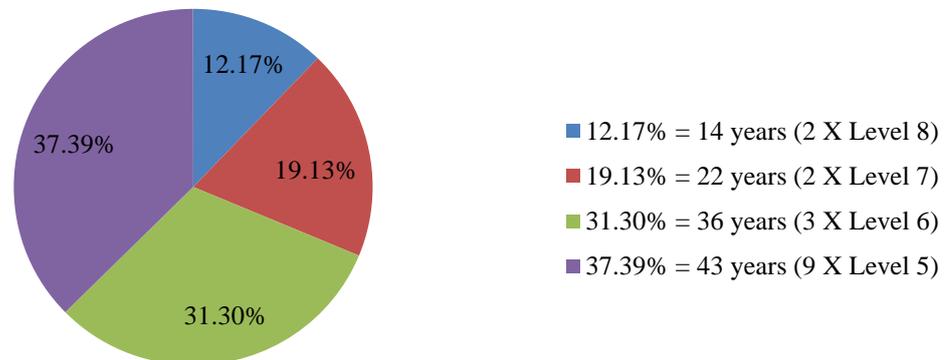
Participants were questioned on the employment levels of each employee in the HFD at RCWMCH. The response from the Case Manager indicated a case manager on Level 8 and 2 billing clerks on Level 6.

The response from the Senior Administrative Officer indicated 1 manager on a senior administrative level, 2 managers on an administrative officer Level 7, 1 clerk on Level 6 and 9 clerks on Level 5.

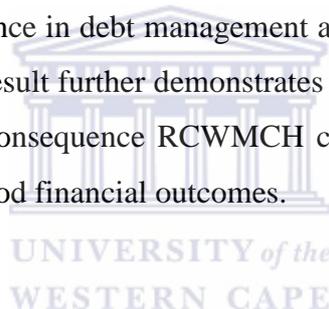
The information suggests that the employees of the HFD are managed through a Case Manager and a Senior Administrative Officer, who are both on Level 8. Sixteen (7+6+5) officials in total are employed with the HFD at the RCWMCH. This total is comprised of 25% (12.5% + 12.5%) of the officials, who are on a management level and 75% (18.75% + 56.25%) of the officials, who are on a lower level that is responsible for the operational duties of the HFD.

6.4.1.1. Experience levels among the Hospital Fees Department officials

Figure 29: Hospital Fees Department - Experience levels of employees



The accumulative experience of the employees in the HFD amounts to 115 years. The division of the experience is as follows: 2 (Level 8) officials with a total of 14 years, 2 (Level 7) officials with a total of 22 years, 3 (Level 6) officials with a total of 36 years and 9 (Level 5) officials with a total of 43 years. The total of 79 years between the level 5 and level 6 employees shows a difference of 36 years over the leadership of the HFD. One can reason that more reliance on the experience in debt management and revenue collection is placed on the lower level employees. The result further demonstrates that the lower level employees are reluctant to change jobs and a consequence RCWMCH can appreciate a stable work force and the commitment to ensure good financial outcomes.



6.4.1.2. Officials' formal exposure to training courses

The responses from the Senior Administrative Officer and the Case Manager on the exposure of employees to training courses are as follows:

All employees receive in-house training, on-the-job training and external training. Employees are also encouraged to complete various short courses in order to develop their skills relating to their job function. The staff members were exposed to the following courses:

1. Accounts Receivable System (ARS)
2. Clinicom
3. Basic Accounting System (BAS)
4. Computer courses (Microsoft Office applications)

5. Interpersonal skills
6. Conflict management
7. Project management
8. Uniform Patient Fee Schedule (UPFS)

i. Case Manager

1. Accounts Receivable System (ARS)
2. Clinicom
3. Uniform Patient Fee Schedule (UPFS)

The responses from the Senior Administrative Officer and the Case Manager showed that there was time set aside for competence building with the employees of the HFD.

6.4.1.2.1. The impact of training courses in relation to debt management and revenue-enhancing strategies

The employees developed better skills and were more successful at operating the ARS and the Clinicom Systems. The employees learnt how classification changes are completed in the ARS and Clinicom System in order to administer debt reduction and collect revenue. In the ARS courses, employees were trained to follow-up on outstanding debt telephonically on accounts that had grown up to the age period of 75 days.

The exposure to the UPFS helped employees to understand the importance of the policy, and how the policy relates to revenue collection. As a result of the UPFS knowledge gained, employees are more responsive to an understanding of the fees applicable to the different patient categories and are better skilled to communicate the ways in which bills are charged.

The completion of the Interpersonal Skills and Conflict Management courses prepared employees to have a better level of confidence when dealing with members of the public. Employees are better trained, more able to be professional and more capable of encouraging members of the public to settle their outstanding debt.

Employees trained in Microsoft Office enhanced their skills and understanding of computer software packages. In most instances, employees are requested to reconcile accounts for members of the public in order to provide the exact outstanding amount.

Precision in the use of computer software packages assists the HFD in the collection of outstanding amounts.

On the course on Project Management, employees learnt how debt levels are managed and achieved. Through an age analysis of outstanding debt, employees better understand the aged totals that have a better potential for collection; compared to other levels of debt that are prescribed and eligible for write-off in the ARS.

The employees exposed to and trained on BAS learnt the importance of how the state's finances are transacted and accounted for. Employees are now aware that regular reconciliations are performed and that transactions are to be administered before the end of a financial year.

6.4.1.3. Employees' association with the members of the public

The responses from the Senior Administrative Officer and the Case Manager regarding the employees' association with members of the public are as follows:

The association is linked to client care, especially regarding outstanding accounts. The staff members deal with enquiries personally, telephonically or in writing. The staff members' follow-up on outstanding invoices and deal with medical aid societies, SANDF and RAF cases, as well as payment arrangements and general enquiries.

In case management, we often see parents of children treated at the RCWMCH. We have associations for the following reasons:

- a. To discuss hospital accounts for services rendered. For example, children belonging to a medical aid scheme that require authorisation for a procedure or hospital stay.
- b. To do estimations of costs for services rendered.

A comparison of the responses indicates that the HFD is more dominate in its association with members of the public, as opposed to the limited contact experienced from the case management section. The case management section deals more with the members of the public that belong to medical aid schemes.

6.4.1.3.1. The effects of employees' association with members of the public in relation to debt management and revenue-enhancing strategies.

Bills posted to members of the public produce a reaction. The interaction between members of the public and employees establishes a platform that encourages immediate payment of outstanding bills or can provide financial assistance to members of the public who are not in a position to settle their outstanding bills.

Financial reports generated through the ARS compel employees to follow-up on outstanding debt through telephone calls, text messaging, emails, facsimiles and written communication. This process of debt collection raises the potential for further collection of revenue, since employees use the knowledge they received from training courses.

The employees grow to become expert professionals, particularly while dealing with external funders. The business relationship with external funders allows for outstanding bills to be posted to the correct person, which will ensure that bills are processed and paid more quickly.

6.4.1.4. Employees' involvement in communicating the outstanding debt

The response from the Senior Administrative Officer on the employees' involvement with the communication of outstanding debt is as follows:

The employees have a direct involvement in communicating the expectation that the debt will be settled ASAP. Therefore, telephonic contact is made with each debtor concerning the outstanding debt. This includes medical aid societies as well.

A single response was received and this indicates that the employees of the HFD are solely responsible for debt collection.

6.4.1.5. Employees' involvement in communicating and collecting revenue

The response from the Senior Administrative Officer regarding the employees' involvement in the communication of revenue collection is as follows:

The employees have a direct involvement regarding revenue collection. Debtors and medical aid schemes are both contacted in order to follow-up on outstanding invoices.

The staff members encourage payment of debt outstanding from foreign patients, RAF claims, SANDF and medical aid cases.

A single response was received and this indicates that the employees in the HFD are solely responsible for revenue collection.

6.4.2. The management of outstanding debt

The response from the Senior Administrative Officer regarding the management of cumulative outstanding debt is as follows:

The strategy is as follows: Staff members telephonically contact debtors for payment. Contact is also made with medical aid societies, and all medical aid statements are scrutinised. All requests from the medical aid scheme are investigated by the follow-up staff and once corrected; the invoices are forwarded to the said scheme for payment. All RAF cases are finalised, and all the necessary information is sent to the service provider as requested. SANDF invoices: New cases are forwarded to the Head Office with the relevant documentation, and old cases are constantly followed up. Once a certain time period is reached and no payment is received, the debt is written-off and referred to the debt collector for further follow-up of the outstanding amount.

A single response was received, which indicates that the HFD is solely responsible for the management of the outstanding debt.

6.4.2.1. Processes in place to manage outstanding debt.

The response from the Senior Administrative Officer regarding the processes followed to manage outstanding debt is as follows:

After 75 days contact is made with debtors requesting payment. All rejections and part-payments on medical aid statements are investigated and followed-up accordingly. After a certain period of time, all outstanding debt is written-off and handed over to the Department's debt collectors for further action. This includes medical aid cases and individually liable cases. If the medical aid funds are exhausted, the invoice is re-assessed according to the combined family income. If debtors cannot afford to settle their outstanding accounts, there are financial relief mechanisms in

place to try and financially assist those debtors. Income and expenditure are taken into consideration in order to try and assist the debtor if he qualifies for a reduction in the fees charged.

A single response was received and this indicates that the HFD is solely responsible for the processes managing outstanding debt.

6.4.2.2. How debtors are persuaded to pay outstanding debt

The response from the Senior Administrative Officer regarding how debtors are persuaded to pay outstanding debt is as follows:

Upfront payments: Payment arrangements are offered to debtors at no additional cost, i.e. interest-free. Foreign patients must pay the full amount plus a 25% contingency fee before the patient receives treatment.

A single response was received, which indicates that the HFD is solely responsible for persuading debtors to pay outstanding debt.

6.4.2.3. A threshold for outstanding debt

The response from the Senior Administrative Officer regarding the threshold for outstanding debt is as follows:

There is no threshold for outstanding debt at the RCWMCH.

The individual response received from the Senior Administrative Officer offers an interpretation that debt can be outstanding for any amount, and that no penalties will be imposed. This indicates that there is no policy or regulation in place from the WCGDOH.

6.4.2.4. Major reasons for outstanding debt at the RCWMCH

The responses from both the Senior Administrative Officer and the Case Manager regarding the reasons for debt being outstanding are as follows:

- Medical aid cases: Invoices incorrect or incomplete. As an example, incorrect or insufficient, or no ICD-10 code appearing on the invoices. No pre-authorisation obtained and level of care incorrect.
- RAF cases: Case has not yet been finalised at RAF.
- SANDF: There is an agreement between SANDF and the Department of Health; however, SANDF does not honour the agreement regarding payment of the outstanding invoices fully.
- Individuals liable for accounts: Various debtors are in the process of paying their outstanding invoices off by means of monthly or weekly instalments. Various debtors are intending to request financial relief, and some debtors just ignore the outstanding debt and refuse to pay.
- Foreign patients: Various foreign patients do not settle outstanding debt after the deposit is received.
- Medical aid patients:
 - 1) Length of stay not approved by medical aid schemes
 - 2) Level of care not approved by medical aid schemes
 - 3) Incorrect or no ICD-10 codes
 - 4) Treatment not authorised by medical aid schemes
 - 5) Benefits exhausted
 - 6) Medical aid exclusions
- H2 and H3 patients:
 - 1) Debtors unable to pay their accounts
 - 2) Debtors simply refuse to pay accounts

The responses received indicate that the HFD and case management are faced with unique challenges. It is reasonable to interpret that these challenges can have an impact on debt management and revenue collection.

6.4.3. Processes in place to collect revenue

The response from the Senior Administrative Officer on the processes in place to collect revenue is as follows:

Invoices are handed to debtors at reception points and payment is encouraged.

Invoices are posted to the debtor, and SMS's are sent out requesting payment. If no response is received, a demand and final demand are posted out. If the debtor is settling the outstanding balance by means of instalments, a statement is posted to the debtor. Debtors are also telephonically contacted and payment is requested. Letters and invoices are also posted to debtors and medical aid societies. The medical aid societies are also telephonically contacted. Incorrect invoices are rectified and supplied to the service providers concerned.

Medical aid cases: The service provider, namely Mediced, electronically submits invoices to medical aid societies. Failing all the above, the outstanding debt is then written-off and referred to the departments debt collectors for further follow-up and collection.

A single response was received and this indicates that case management is not involved in the collection of revenue.

6.4.3.1. Methods of improving revenue collection

The qualitative responses from both the Senior Administrative Officer and the Case Manager regarding the methods to improve revenue collection are as follows:

Various projects are in place in order to improve revenue collection. The projects are as follows:

- Overtime
- Staff from other departments are also utilised in the Hospital Fees Department in order to improve revenue collection.
- Discussions and meetings are held with various role-players in order to improve the best practices for revenue collection.
- Training, as well as medical aid workshops are provided by the Head Office,
- Reports are drawn, scrutinised and worked on.

Requesting reports to identify:

- ICD 10 coding not done.
- Authorisation has been slipped up on.

The responses indicate an aggressive revenue collection approach. One can reason the approach to be focused on the collection of the annual revenue budget and to make a concerted effort to over collect in order to make more funding available for better service delivery.

6.4.3.2. The total number of employees associated with revenue collection

The response from the Senior Administrative Officer regarding the total number of employees associated with revenue collection is as follows:

There are 12 employees associated with revenue collection.

A single response was received, which indicates that case management has no involvement with revenue collection.

6.4.3.3. The importance of accomplishing revenue collection

The response from the Senior Administrative Officer regarding the importance of accomplishing a revenue budget is as follows:

The Head Office, in conjunction with the RCWMCH, establishes a revenue budget that must be achieved. If this revenue budget is not accomplished, it could indicate bad management as well as poor performance by the Hospital Fees Department.

The State is answerable to the people. If the target is not collected, members of the public will not receive adequate services, since revenue assists with the expenditure of the hospital.

A single response was received as case management were unable to provide an answer.

The following section will concentrate on the importance of the collection of additional revenue.

6.4.3.4. The importance of collecting additional revenue

The response from the Senior Administrative Officer regarding the importance of the collection of additional revenue is as follows:

Additional revenue off-sets expenditure and also allows expansion of hospital services throughout the Western Cape and South Africa.

The response received highlights how crucial additional funding is to the RCWMCH and the DOH. This can be seen in the building of Mitchell’s Plain Hospital and Khayelitsha Hospital in the Western Cape, South Africa.

6.5. Financial totals from the RCWMCH for the period 2008 to 2012

The information in Table 1 below shows the financial totals of the HFD at the RCWMCH. By means of growth rate or percent change calculation, the figures are calculated to show the increase and decrease in the amounts during the period 2008 to 2012.

A percent growth rate – sometimes referred to as percent change, growth rate or rate of change – is a useful indicator to look at how a population is growing or declining in a particular area. Percent growth rate can be used in other studies besides population, such as employment, unemployment or economic factors. Any number from one time and any number from another time can be put into the calculation to determine growth rate (<http://www.ehow.com>).

The “percentage change or growth rate from one period to another is calculated as follows: Percentage change = [(value at end of period – value at beginning of period)/value at beginning of period] /100” (<http://www.ehow.com>).

Table 1: Financial Totals of the HFD at RCWMCH for the period 2008 – 2012

Period	2008	2009	Growth rate/% change	2010	Growth rate/% change	2011	Growth rate/% change	2012	Growth rate/% change	Average Growth rate/% change
Grand Total invoices billed	R26 381 444	R31 267 139	18.51%	R36 660 228	17.24%	R42 979 424	17.23%	R53 190 686	23.75%	19.18%
Revenue budget	R17 062 000	R19 420 000	13.82%	R19 689 000	1.39%	R21 235 000	7.85%	R21 905 000	3.15%	6.55%
Grand Total revenue collected from	R24 812 370	R20 250 682	-18.38%	R25 776 672	27.28%	R25 479 177	-1.15%	R34 112 732	33.88%	10.40%

invoices billed										
% revenue collected versus revenue budget	145.42%	104.27%	-28.29%	130.91%	25.54%	119.98%	-8.34%	155.73%	29.79%	4.67%
Grand Total debt outstanding	R1 569 074	R11 016 457	602.09%	R10 883 556	-1.20%	R17 500 247	60.79%	R19 077 954	9.01%	167.67%

Source: Provincial Government: Western Cape: Department of Health (MR014.1), 2013 and RCWMCH In-Year monitoring Report, 2008, 2009, 2010, 2011 and 2012

6.5.1. Analysis of the financial totals

The grand total of invoices billed shows similar percentage changes across the period from 2008 to 2012, with an average of 19.18%. It is reasonable to interpret that the percentage changes are attributed to the increase in patient numbers, and the demand for public health-care services at the RCWMCH.

The revenue budgets established across the period from 2008 to 2012 follow a similar percentage change, with an average of 6.55%. It is reasonable to interpret that percentage changes are a result of the rate of inflation in South Africa, and the increase in patient numbers at the RCWMCH. Noted as significant, is the period from 2008 to 2009 that presents the highest growth rate—that being one of 13.82%. One can interpret this significance as a result of a tariff increase on medical services at the RCWMCH.

The grand total of revenue collected from invoices billed shows varying percentage changes across the period between 2008 and 2012. A noticeable financial year is 2009, which reveals a downward percentage change of minus 18.38%. Less revenue was collected in 2009 than in 2008. The most common reason that was recorded in the In-year Monitoring Report for 2009 was the capacity constraints experienced in the HFD. On the other hand, in 2010 the HFD experienced a significant growth rate of 27.28%. The success was attributed to

successful project managing on outstanding medical aid claims, and the engagement of a progressive approach with medical aid schemes to settle outstanding claims. The year 2012 presented the highest growth rate on revenue collected. The success is attributed to the focus placed on the identification and prioritisation of high volumes of outstanding debt totals.

The percentage of revenue collected with regards to the revenue budget across the period between 2008 and 2012, presents varying percentage changes. The year 2008 shows an enormous over-collection of revenue-- up to 45.42%. It can be interpreted that the HFD formulated an aggressive revenue plan of action, and focused more on external funders, such as medical aid schemes and the Road Accident Fund, for payment of claims. The year 2009, on the other hand, shows a marginal growth rate collection of 4.27%, even though the revenue budget was achieved.

As mentioned before, the most common reason recorded in the In-year Monitoring Report for 2009 was the capacity constraints experienced in the HFD. The minus 28.29% change from 2008 to 2009 is significant due to the drop in revenue collection in 2009. The year 2012, on the other hand, shows the highest percentage of revenue collected across the period from 2008 to 2012. The collection performance of 2012 is calculated at up to 55.73%, with a growth rate from 2011 of 29.79%. As mentioned before, the success in 2012 is attributed to the focus placed on the identification and prioritisation of high volumes of outstanding debt totals.

The grand total of debt outstanding shows varying percentage changes across the period between 2008 and 2012. The growth rate percentage of 602.09% is highest during the period between 2008 and 2009. Noted as significant is that the grand total of invoices billed in 2009 present a growth rate of 18.51% from 2008, and, in addition, the percentage revenue collected versus the revenue budget over the same period shows a significant drop of minus 28.28%. It can be agreed that due to the challenges experienced in 2009, more debt should be outstanding. The same can be said for 2012, although, the grand total of invoices billed is the highest recorded, despite the focus being more on revenue collection.

6.6. Summary

A summarised account of the primary and secondary objectives is stated below. Regarding the primary objectives, Table 2 presents a comparison of the main findings among non-medical aid members and medical aid members. Also included are primary responses of the RCWMCH management. As part of the main secondary outcome, the financial totals (Table 1) of the RCWMCH are revealed and simplified.

6.6.1. Primary findings concerning medical aid and non-medical aid members

Table 2: Comparison of the main findings between non-medical aid and medical aid members

Criteria and Category	Non-medical aid members	Medical aid members
Criteria: Position of client		
Area: Lives in SA	Majority local citizens	Majority local citizens
Area: Distance from RCWMCH	Majority <50km	Majority <50km
Criteria: Service delivery:		
Areas: Level of service	Majority pleased with services	Majority pleased with services
Areas: Speed of service	Majority pleased with services	Majority pleased with services
Areas: Reception officer's knowledge of the job	Majority pleased with services	Majority pleased with services
Areas: Reception officer's experience of the job	Majority pleased with services	Majority pleased with services
Area: Awareness of the policy for free services	Majority aware	Not applicable
Area: Knowledge of a Client Service Help-	100% indicated	100% indicated absence

desk	absence of help-desk	of help-desk
Criteria: Benefit option		
Area: Knowledge of design of medical aid option.	Not applicable	Majority have no knowledge of option
Area: Awareness of the responsibility to obtain authorisation.	Not applicable	Majority not aware
Area: Sufficient funding in the benefits option.	Not applicable	Majority does not have sufficient funding
Criteria: Fees and affordability		
Area: Familiar with the fees charged at RCWMCH.	Majority not familiar	Majority not familiar
Area: Affordability of fees charged at RCWMCH.	41.37% pleased with affordability of fees	54.54% pleased with affordability of fees
Area: Option preferred to pay for services	Majority choose payment arrangement	Majority choose the claims process

6.6.1.1. Primary findings regarding the RCWMCH management

The HFD has the sole responsibility to ensure debt is managed, and that the annual revenue budgets are collected.

The HFD has a methodical process in place to manage debt and collect revenue. The primary findings demonstrate a correlation with follow-up procedures (4.1.1.2) for outstanding accounts that are performed in the HFD.

The HFD has projects in place to manage debt and improve revenue collection. More attention is focused on motor vehicle accident claims and medical aid claims than anything else.

The calculations regarding the years of experience in the HFD between employees (36 years) and employers (36 years) are equivalent. The years of experience demonstrate the depth and capability of debt management revenue collection in the HFD. One can reason that all duties are adequately administered.

A considerable amount of time is set aside for training and development of employees in the HFD to ensure this component succeeds in the debt management and revenue collection process. As a result, the HFD strives to ensure professionalism and customer satisfaction.

6.6.2. The main secondary findings of financial totals for the period from 2008 to 2012

It was found that 10.40% is the average growth rate of the revenue collected for the period from 2008 to 2012 and 167.67% is the average growth rate of the debt outstanding for the period from 2008 to 2012.



CHAPTER 7: CONCLUSION AND RECOMMENDATIONS

7.1. Summary

The Red Cross War Memorial Children's Hospital's admissions and registration procedures demonstrate that the front-end location is the most crucial activation area in a hospital. For both the RCWMCH and US model (Figure 2), immense importance is placed on the establishment for obtaining detailed information to support effective debt management and revenue collection.

Within developed, emerging and developing countries, governments publicise their decisions to centralise public expenditure on health-care services. International countries demonstrate the implementation of health insurance and the administrative processing of claims for reimbursement of costs to service providers. General taxation and premiums as revenue are recognised as the main source of funding across the researched countries.

Public policies validate an important feature of the RCWMCH. The objectives of public policies are achieved at the RCWMCH (Table 1), and account for public funds. The RCWMCH demonstrates the leading public policy implementation of the Hospital Fees Procedure Manual Chapter 18 and the UPFS. The conclusion is that the leading public policies serve as guidelines and operational tools to ensure that the RCWMCH manages its outstanding debt and collects revenue.

During the period between 2008 and 2012, the RCWMCH proved to be successful in the collection of revenue budgets (Table 1). The percentage grand total of revenue collected, versus the invoices billed during the same period, showed an average growth rate of 10.40%. One can conclude that such success is the result of the methodical revenue practices and the concentration of projects implemented at the RCWMCH. Similarly, the outsourcing of state debt for further debt recovery played an important role in the success of revenue collection at the RCWMCH. A conclusion is drawn that outsourced companies serve a vital part of the HFD collection strategy.

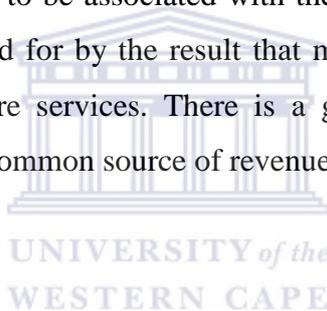
The delivery of health-care services, on the other hand, suffered the challenge of cost recovery of bills charged for medical services. The 167.67% average growth rate of the outstanding debt at the RCWMCH (Table 2) illustrates the public's inability to pay for health-care services. The current revenue collection processes implemented at the RCWMCH

do, however, show some resistance against the growing debt; as can be seen with an average growth rate of 10.40% in revenue collection performance during the period between 2008 and 2012 (Table 2).

By dividing the main topic into sections, knowledge on debt management and revenue-enhancing strategies was achieved. The research information validates the fact that an effective debt management and stringent collection practice is the solution to recover more fees for improved service provision to members of the public.

One can conclude that financial opportunities are created by governments in order to invest in public funds, so that interest can be accrued from the revenue received, to pay service providers for health-care treatment. The obligation of the government to pay for health-care services on behalf of members of the public is an advantage of the pressure ventured out of the payment eliminated at the point of service.

Through research participation, the RCWMCH demonstrates the quality of health-care service dedicated to members of the public. The results of the research indicate that the members of the public are proud to be associated with the RCWMCH. The level of health-care satisfaction can be accounted for by the result that more than 50% of members of the public do not pay for health-care services. There is a great reliance on private hospital patients, since they are the most common source of revenue received from external funders.



7.2. Recommendations

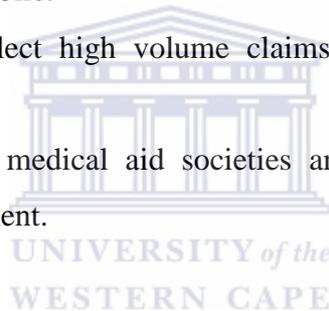
7.2.1. The study's recommendations to the RCWMCH on debt management are as follows:

- Promote the debt relief policy to members of the public.
- Re-introduce the services of provincial inspectors to visit debtors and ascertain reasons for bills not paid and provide possible financial assistance on the basis of merit.
- Write-off prescribed debt of over 3 years.
- Revise the user fees structure in order to create more affordable health-care services.
- Calculate a threshold amount for the public to be eligible for debt reduction or writing-off of debt.

- Increase income ceilings for families who qualify for a lower patient category and, therefore, are charged lower bills.

7.2.2. The study's recommendations to the RCWMCH on enhanced revenue collection are as follows:

- Capture UPFS service codes at each point of service.
- Capture International Statistical Classification of Diseases (ISCOD) codes at the point of service.
- Put into operation a pre-admission section at the front-end of the business process.
- Put in place a help-desk area for general public enquiries and guidance for unpaid bills.
- Provide parents with pro-forma claims before the final bill is posted.
- Quality check and control claims before release to medical aid societies and members of the public.
- Prioritise and collect high volume claims from medical aid schemes and debtors.
- Perform visits to medical aid societies and present outstanding claims to members for payment.



7.2.3. Recommendations for future studies

- To explore a more affordable method in assessing and billing patients for medical services.
- To investigate and improve internal billing processes in order to generate and collect more revenue.

REFERENCES

- Almeida, M. H. T. de. (2005). Recentralizando a federacao? Revista de Sociologia e Ploitica. Curitiba, 24(Junho de 2005):29-40.
- Barbie, E. & Mouton, J. (1998). The Practice of Social Research. Oxford: Oxford University Press, South Africa.
- Barbie, E & Mouton, J. (2001). The principles of social research. Oxford University Press: Cape Town, South African edition.
- Barbie, E & Mouton, J. (2002). The practice of social research. Oxford University Press: Cape Town.
- Barbie, E. (2004). The practice of social research. 10th edition. Thomson Wadsworth: United States of America.
- Blank, R. H. & Burau, V. (2007). Comparative Health Policy. 3rd Edition. Basingstoke: Palgrave Macmillan.
- Bureau of National Health Insurance. (2005). Brief NHI Profile, 2005. Department of Health, Executive Yuan, Taiwan, ROC: Bureau of National Health Insurance Press. Available from: <http://www.nhi.gov.tw>.
- Brandy, G. (2011). Financial Management and Accounting in the Public Sector.
- Charles, A. (2013). Evaluating processes for curbing workplace substance abuse within the City of Cape Town. Case Study: Safety and Security Directorate. Published Master's Thesis. University of the Western Cape, Cape Town, South Africa.
- Chen, Wen-Yi. (2006). National Health Insurance in Taiwan: Welfare Analysis and Hospital Competition. Corvallis: Oregon State University.
- Chi-Chen Chen, Shou-Hsia Cheng (2010). Hospital competition and patient-perceived quality of care: Evidence from a single-payer system in Taiwan. Health Policy, 98:65–73.
- Coase, R. H. (1975). The Nature of the Firm. *Economica*.
- Dias, R.M., Cook, T. W. & Freire, S. M. (2011). Modelling health-care authorization and claim submissions using the open EHR dual-model approach. BMC Medical Informatics and Decision Making, 11(1):60.

Fleury, S. et al. (1997). MUNICIPALIZACAO DA SAUDE E PODER LOCAL NO BRAZIL *Revista de Administracao Publica*, 31(5):195-208.

Griffin, C. (1988). User charges for health-care in principle and practice.

http://www.ehow.com/how_4532706_calculate-growth-rate-percent-ch Accessed 10/10/2014

<http://en.april-international.com/global/destination/the-health-care-system-in-tunisia> accessed 06/04/2015

<http://www.investopedia.com/video/play/neoliberalism/> accessed 15/09/2015

Khoza, S. (2002). HIV, infant nutrition and health-care: implications of the state's obligations in providing formula.

Lobato, L. (2000). Reorganizing the Health-care System in Brazil. (Chapter 5). Available from: http://web.idrc.ca/es/ev-35519-201-1-DO_TOPIC.html.

Longman Group Limited (1978). Longman Dictionary of Contemporary English.

McDonald, David A., and John Pape. Cost Recovery and the Crisis of Service Delivery in South Africa. London: Zed Books, 2002.

Missoni, E. & Solimano, G. (2010). Towards Universal Health Coverage: The Chilean experience. World Health Report Background Paper, No 4. Available from: <http://beforeitsnews.com/health-care/2012/03/health-care-in-chile-a-model-for-the-u-s-...>

Accessed 11 September 2013.

Onofrio, M. D. (2010). Public Health Policy in Brazil and Mexico: Changing problems – Common solutions? Aalborg University.

Organisation for Economic Co-operation and Development. (2012). Policy Roundtables. Competition in Hospital Services. Available from: <http://www.oecd.org/competition>.

Provincial Government. Western Cape: Department of Health. Outstanding Account Age Analysis 2011/11. Management Report 21.0.1.

Silva, A., de Carvalho, L. & de Medeiros, O. 2010. Public Debt: The Brazilian experience.

Soares, S. I. et al. (2007). The public-private mix in the Brazilian Health System: financing, delivery and utilization of health services. *Cienc. Saude coletiva*, 13(5). Available from:

<http://www.mongabay.com/copyright.htm>. Accessed 31 July 2013

South Africa. (1996). The Constitution of the Republic of South Africa Act, no. 108 of 1996. Pretoria: Government Printer.

South Africa. (1999). The Public Finance Management Act, no. 1 of 1999. Pretoria: Government Printer.

South Africa. Western Cape Department of Health contract no. 82/2008. Debt collecting service for certain districts of the Department of Health. Period expires 31 March 2012.

South Africa. Western Cape Department of Health contract no. 76/2010. Service to collect claims in respect of the Road Accident Fund on behalf of the Department of Health. Period 1 February 2011 to 31 January 2014.

South Africa. Western Cape Government: Department of Health. (2012). Contents: Government Hospital Tariffs: An Overview web resources. Available from: http://www.westerncape.gov.za/eng/pubs/public_info/G/87726/1. Accessed 04/02/2013.

South Africa. Western Cape Government: Department of Health. (2011). Procedure Manual: Hospital Fees Structure (Chapter 18). Pretoria: Government Printer.

South Africa. Western Cape Government: Department of Health. (2004). Finance Instruction (G6). Government Printer. Western Cape Government (2013). Available from:

http://www.westerncape.gov.za/eng/pubs/public_info/G/87726/1 accessed 21/02/2013

South Africa. Western Cape Government: Department of Health (2003). Finance Instruction (G16). Pretoria: Government Printer.

Thomson, S., Osborn, R., Squires, D. & Reed, S. J. (2011). International Profiles of Health-care Systems. The Commonwealth Fund. Available from:

www.sjsu.edu/faculty/watkins/coase.htm. Accessed 24/09/2014.

<http://managedhealth-careexecutive.modernmedicine.com/managed-health-care-executive/content/chiles-health-care-offers-public-and-private-plans?page=full>. Accessed 25/05/2015.

The United States of America. (1974). National Health Planning and Resources Development Act.

U.S. Congress, Office of Technology Assessment. (1995). Hospital Financing in Seven Countries. Washington, DC: U.S. Government Printing Office. Available from: <http://www.fas.org/ota/reports/9525.pdf>. Accessed 03/12/2012.



APPENDICES

APPENDIX A: Quantitative Questionnaire of the Non-Medical aid members of RCWMCH

Quantitative Questionnaire: Non-Medical aid members of RCWMCH

Criteria: Position of client			
1: Do you live in South Africa?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2: How far do you live from RCWMCH?	<input type="checkbox"/> <50 km	<input type="checkbox"/> >50 km	
Criteria: Service delivery			
3: On a scale of 1 – 5 with 5 being Very Good. Please rate the level of service.	<input type="checkbox"/> 1 Very Poor	<input type="checkbox"/> 2 Poor	<input type="checkbox"/> 3 Reasonable
		<input type="checkbox"/> 4 Good	<input type="checkbox"/> 5 Very Good
			<input type="checkbox"/> Don't know
4: On a scale of 1 – 5 with 5 being Very Good. Please rate the speed of service.	<input type="checkbox"/> 1 Very Poor	<input type="checkbox"/> 2 Poor	<input type="checkbox"/> 3 Reasonable
		<input type="checkbox"/> 4 Good	<input type="checkbox"/> 5 Very Good
			<input type="checkbox"/> Don't know

<p>5: On a scale of 1 – 5 with 5 being Very Good. Please rate the reception officer’s knowledge of the job.</p>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">1</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">2</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">3</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">4</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">5</div> <div style="border: 1px solid black; width: 40px; height: 40px;"></div> </div> <p style="text-align: center; margin-top: 5px;">Very Poor Poor Reasonable Good Very Good Don’t know</p>
<p>6: On a scale of 1 – 5 with 5 being Very Good. Please rate the reception officer’s experience of the job.</p>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">1</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">2</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">3</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">4</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">5</div> <div style="border: 1px solid black; width: 40px; height: 40px;"></div> </div> <p style="text-align: center; margin-top: 5px;">Very Poor Poor Reasonable Good Very Good Don’t know</p>
<p>7: On a scale of 1 – 5 with 5 being Very aware. Please rate your awareness of the policy for free services at RCWMCH.</p>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">1</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">2</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">3</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">4</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">5</div> <div style="border: 1px solid black; width: 40px; height: 40px;"></div> </div> <p style="text-align: center; margin-top: 5px;">Least Aware Less Aware Reasonable Aware Very Aware Don’t know</p>
<p>8: Do you know of a Client Service Helpdesk at RCWMCH that could assist you with an enquiry?</p>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 40px; height: 40px;"></div> <div style="border: 1px solid black; width: 40px; height: 40px;"></div> </div> <p style="text-align: center; margin-top: 5px;">Yes No</p>
<p>Criteria: Fees and affordability</p>	<div style="display: flex; justify-content: space-between; height: 40px;"> <div style="width: 25%;"></div> <div style="width: 25%;"></div> <div style="width: 25%;"></div> <div style="width: 25%;"></div> </div>
<p>9: You are familiar with the fees charged at RCWMCH.</p>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 40px; height: 40px;"></div> <div style="border: 1px solid black; width: 40px; height: 40px;"></div> </div> <p style="text-align: center; margin-top: 5px;">Yes No</p>
<p>10: On a scale of 1 –</p>	

<p>5 with 5 being Very Affordable. Please rate the affordability of the fees charged at RCWMCH.</p>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">1</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">2</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">3</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">4</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">5</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;"></div> </div> <p style="text-align: center;"> Very Expensive Expensive Reasonable Affordable Very Affordable Don't know </p>
<p>11: Which option is your preferred choice of payment for services?</p>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">1</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">2</div> </div> <p style="text-align: center;"> Payment Arrangement Cash </p>

APPENDIX B: Quantitative Questionnaire of the Medical Aid Members of RCWMCH

Quantitative Questionnaire: Medical Aid Members of RCWMCH

<p>Criteria: Position of client</p>	
<p>1: Do you live in South Africa?</p>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">Yes</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">No</div> </div>
<p>2: How far do you live from RCWMCH?</p>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;"><50 km</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">>50 km</div> </div>
<p>Criteria: Service delivery</p>	
<p>3: On a scale of 1 – 5 with 5 being Very Good. Please rate the level of service.</p>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">1</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">2</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">3</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">4</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">5</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;"></div> </div> <p style="text-align: center;"> Very Poor Poor Reasonable Good Very Good Don't know </p>
<p>4: On a scale of 1 – 5 with 5 being Very Good. Please rate</p>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">1</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">2</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">3</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">4</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;">5</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;"></div> </div>

the speed of service.	Very Poor	Poor	Reasonable	Good	Very Good	Don't know
5: On a scale of 1 – 5 with 5 being Very Good. Please rate the reception officer's knowledge of the job.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/>
	Very Poor	Poor	Reasonable	Good	Very Good	Don't know
6: On a scale of 1 – 5 with 5 being Very Good. Please rate the reception officer's experience of the job.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/>
	Very Poor	Poor	Reasonable	Good	Very Good	Don't know
7: Do you know of a Client Service Helpdesk at RCWMCH that could assist you with an enquiry?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Criteria: Benefit option						
8: You have knowledge of the design of your medical aid option.	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
9: Are you aware of the responsibility to obtain authorization from your medical aid?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
10: Do you have sufficient funding in	<input type="checkbox"/>	<input type="checkbox"/>				

your benefit option?	Yes	No				
Criteria: Fees and affordability						
11: Are you familiar with the fees charged at RCWMCH?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
12: On a scale of 1 – 5 with 5 being Very Affordable. Please rate the affordability of the fees charged at RCWMCH.	<input type="checkbox"/> 1 Very know Expensive	<input type="checkbox"/> 2 Expensive	<input type="checkbox"/> 3 Reasonable	<input type="checkbox"/> 4 Affordable	<input type="checkbox"/> 5 Very Affordable	<input type="checkbox"/> Don't
13: Which option is your preferred choice of payment for services?	<input type="checkbox"/> 1 Claim process	<input type="checkbox"/> 2 Cash				

APPENDIX C: Qualitative Structured Questionnaire of the RCWMCH Management

Qualitative Structured Questionnaire: RCWMCH Management

CRITERIA	RESPONSE
1. Management Measures	
What are the employment levels of each employee in the Hospital Fees Department at RCWMCH?	
What is the experience of each employee in the Hospital Fees Department at RCWCH?	
What training courses were the employees of the Hospital Fees Department exposed to in relation to their job functions?	

What association do the employees in the Hospital Fees Department have with members of the public attending RCWMCH?	
What involvement do the employees in the Hospital Fees Department have with the communication of outstanding debt?	
What involvement do the employees in the Hospital Fees Department have with the communication of revenue collection?	
2. Debt Management	
How is the cumulative outstanding debt on the debtors books of RCWMCH managed?	
What are the processes in place at RCWMCH to manage outstanding debt?	
How are debtors persuaded to pay outstanding debt?	
What is the threshold for outstanding debt in the Hospital Fees Department at RCWMCH?	
What are the reasons for debt being outstanding at RCWMCH?	
3. Revenue Management	
What are the processes in place at RCWMCH to collect revenue?	
What methods are used to improve revenue collection at RCWMCH?	
How many employees in the Hospital Department are directly associated with the revenue collection?	
How important is it for the Hospital Fees Department at RCWMCH to accomplish a revenue budget?	

How important is the collection of additional revenue to RCWMCH?	
--	--



APPENDIX D (i): Provincial Government: Western Cape: Department of Health:
Hospital RXH (MR014.1)

Hospital : RXH (MR014.1)		Provincial Government : Western Cape : Department of Health			Date: 16/09/2013	
Invoices Raised for Period : 2008-01 to 2008-12						
Patient Type	TypeCode	No Of Invoices	Total Amount	Average Amount	%Grand Totals	
Inpatient	09 H0	9	210.00	23.33	0.001%	
	10 H1	3976	258,782.00	65.09	0.981%	
	11 H2	507	399,933.40	788.82	1.516%	
	12 H3	164	1,287,670.40	7,851.65	4.881%	
	13 Private	1015	15,589,044.18	15,358.66	59.091%	
	14 Foreign Elective	5	149,839.75	29,967.95	0.568%	
	18 Day Admission Private	280	1,138,690.55	4,066.75	4.316%	
	19 Foreign Elective Day Admission	1	9,427.00	9,427.00	0.036%	
	24 Other Boarders	848	700,331.45	825.86	2.655%	
Sub-Totals for Patient Type : Inpatient		6,805	19,533,928.73	2,870.53	74.044%	
Outpatient	25 H1 MVA/State Employee	60	1,975.00	32.92	0.007%	
	26 H2 MVA/State Employee	32	8,571.40	267.86	0.032%	
	27 H3 MVA/State Employee	216	25,700.70	118.98	0.097%	
	28 Private	9680	3,654,791.30	377.56	13.854%	
	31 Foreign Elective	3	704.00	234.67	0.003%	
	32 H0	136	3,590.00	26.40	0.014%	
	33 H1	31870	1,035,425.80	32.49	3.925%	
	34 H2	5754	1,239,970.50	215.50	4.700%	
	35 H3	2843	876,787.55	308.40	3.324%	
Sub-Totals for Patient Type : Outpatient		50,594	6,847,516.25	135.34	25.956%	
Grand Totals		57,399	26,381,444.98	459.62		



APPENDIX D (ii): Provincial Government: Western Cape: Department of Health:
Hospital RXH (MR014.1)

Hospital : RXH
(MR014.1) Provincial Government: Western Cape : Department of Health Date: 17/09/2013
Invoices Raised for Period : 2009-01 to 2009-12

Patient Type	TypeCode	No Of Invoices	Total Amount	Average Amount	%Grand Totals
Inpatient	09 H0	10	235.00	23.50	0.001%
	10 H1	4227	275,698.70	65.22	0.882%
	11 H2	529	446,053.55	843.20	1.427%
	12 H3	199	1,479,400.25	7,434.17	4.731%
	13 Private	1073	18,358,397.15	17,109.41	58.715%
	14 Foreign Elective	14	583,460.10	41,675.72	1.866%
	18 Day Admission Private	372	1,273,341.95	3,422.96	4.072%
	19 Foreign Elective Day Admission	2	14,846.75	7,423.38	0.047%
	24 Other Boarders	414	294,115.00	710.42	0.941%
Sub-Totals for Patient Type : Inpatient		6,840	22,725,548.45	3,322.45	72.682%
Outpatient	25 H1 MVA/State Employee	38	1,290.00	33.95	0.004%
	26 H2 MVA/State Employee	31	10,081.20	325.20	0.032%
	27 H3 MVA/State Employee	29	8,618.60	297.19	0.028%
	28 Private	9864	4,884,278.55	495.16	15.621%
	29 Services	1	55.25	55.25	0.000%
	31 Foreign Elective	23	10,643.20	462.75	0.034%
	32 H0	142	3,715.00	26.16	0.012%
	33 H1	34950	1,129,099.65	32.31	3.611%
	34 H2	6210	1,358,581.85	218.77	4.345%
	35 H3	3170	1,135,227.60	358.12	3.631%
	Sub-Totals for Patient Type : Outpatient		54,458	8,541,590.90	156.85
Grand Totals		61,298	31,267,139.35	510.08	

UNIVERSITY of the
WESTERN CAPE

APPENDIX D (iii): Provincial Government: Western Cape: Department of Health:
Hospital RXH (MR014.1)

Hospital: RXH
(MR014.1) Provincial Government: Western Cape: Department of Health: Date: 17/09/2013
Invoices Raised for Period : 2010-01 to 2010-12

Patient Type	TypeCode	No Of Invoices	Total Amount	Average Amount	%Grand Totals
Inpatient	09 H0	5	125.00	25.00	0.000%
	10 H1	4176	356,484.55	85.37	0.972%
	11 H2	520	528,089.10	1,015.56	1.440%
	12 H3	279	1,548,160.30	5,548.96	4.223%
	13 Private	1217	23,548,739.00	19,349.83	64.235%
	14 Foreign Elective	14	243,760.35	17,411.45	0.665%
	15 Private Doctor	1	2,348.00	2,348.00	0.006%
	18 Day Admission Private	286	1,119,997.30	3,916.07	3.055%
	20 Private Doctor Day Admission	1	751.00	751.00	0.002%
	24 Other Boarders	287	135,319.50	471.50	0.369%
	28 Private	5	12,126.00	2,425.20	0.033%
	31 Foreign Elective	1	3,999.00	3,999.00	0.011%
	33 H1	6	1,568.50	261.42	0.004%
	34 H2	11	1,995.00	181.36	0.005%
	35 H3	2	1,262.00	631.00	0.003%
Sub-Totals for Patient Type : Inpatient		6,811	27,504,724.60	4,038.28	75.026%
Outpatient	25 H1 MVA/State Employee	14	495.00	35.36	0.001%
	26 H2 MVA/State Employee	30	11,634.40	387.81	0.032%
	27 H3 MVA/State Employee	16	9,397.85	587.37	0.026%
	28 Private	9865	5,305,169.21	537.78	14.471%
	31 Foreign Elective	30	10,612.05	353.74	0.029%
	32 H0	93	2,523.40	27.13	0.007%
	33 H1	31943	1,041,378.30	32.60	2.841%
	34 H2	6013	1,262,040.85	209.89	3.443%
	35 H3	3981	1,512,253.05	379.87	4.125%
	Sub-Totals for Patient Type : Outpatient		51,985	9,155,504.11	176.12
Grand Totals		58,796	36,660,228.71	623.40	

APPENDIX D (iv): Provincial Government: Western Cape: Department of Health:
Hospital RXH (MR014.1)

Hospital : RXH Provincial Government: Western Cape: Department of Health Date: 17/09/2013
(MR014.1) Invoices Raised for Period : 2011-01 to 2011-12

Patient Type	TypeCode	No Of Invoices	Total Amount	Average Amount	%Grand Totals
Inpatient	10 H1	4597	279,760.00	60.86	0.651%
	11 H2	533	383,632.15	719.76	0.893%
	12 H3	371	3,090,114.05	8,329.15	7.190%
	13 Private	1177	25,384,839.75	21,567.41	59.063%
	14 Foreign Elective	8	459,826.00	57,478.25	1.070%
	18 Day Admission Private	572	1,224,947.60	2,141.52	2.850%
	19 Foreign Elective Day Admission	1	4,168.00	4,168.00	0.010%
	24 Other Boarders	746	561,647.50	752.88	1.307%
	33 H1	1259	389,068.00	309.03	0.905%
	34 H2	112	36,729.00	327.94	0.085%
	35 H3	59	62,289.50	1,055.75	0.145%
	Sub-Totals for Patient Type : Inpatient		9,435	31,877,021.55	3,378.59
Outpatient	25 H1 MVA/State Employee	16	510.00	31.88	0.001%
	26 H2 MVA/State Employee	32	5,013.50	156.67	0.012%
	27 H3 MVA/State Employee	41	16,107.15	392.86	0.037%
	28 Private	10441	6,488,933.10	621.49	15.098%
	31 Foreign Elective	15	2,680.70	178.71	0.006%
	32 H0	6	280.00	46.67	0.001%
	33 H1	36471	1,219,593.70	33.44	2.838%
	34 H2	6783	1,389,274.75	204.82	3.232%
	35 H3	5009	1,980,009.75	395.29	4.607%
	Sub-Totals for Patient Type : Outpatient		58,814	11,102,402.65	188.77
Grand Totals		68,249	42,979,424.20	629.74	

UNIVERSITY of the
WESTERN CAPE

Hospital RXH (MR014.1)

Hospital : RXH (MR014.1)		Provincial Government : Western Cape : Department of Health			Date: 18/09/2018	
Invoices Raised for Period : 2012-01 to 2012-12						
Patient Type	TypeCode	No Of Invoices	Total Amount	Average Amount	%Grand Totals	
Inpatient	10 H1	4180	255,728.40	61.18	0.481%	
	11 H2	553	429,417.90	776.52	0.807%	
	12 H3	356	1,595,791.80	4,482.56	3.000%	
	13 Private	1132	38,014,655.65	33,581.85	71.469%	
	14 Foreign Elective	11	300,778.45	27,343.50	0.565%	
	18 Day Admission Private	471	1,173,546.75	2,491.61	2.206%	
	19 Foreign Elective Day Admission	3	7,311.55	2,437.18	0.014%	
	24 Other Boarders	74	91,979.50	1,242.97	0.173%	
	33 H1	1758	253,381.00	144.13	0.476%	
	34 H2	107	12,046.15	112.58	0.023%	
	35 H3	52	11,013.50	211.80	0.021%	
	Sub-Totals for Patient Type : Inpatient		8,697	42,145,650.65	4,846.00	79.235%
Outpatient	25 H1 MVA/State Employee	22	959.00	43.59	0.002%	
	26 H2 MVA/State Employee	24	2,900.60	120.86	0.005%	
	27 H3 MVA/State Employee	61	15,402.95	252.51	0.029%	
	28 Private	10582	6,443,428.40	608.90	12.114%	
	31 Foreign Elective	32	20,296.70	634.27	0.038%	
	33 H1	33539	1,123,543.05	33.50	2.112%	
	34 H2	6439	1,450,541.65	225.27	2.727%	
	35 H3	4140	1,987,963.60	480.18	3.737%	
Sub-Totals for Patient Type : Outpatient		54,839	11,045,035.95	201.41	20.765%	
Grand Totals		63,536	53,190,686.60	837.41	100.000%	

UNIVERSITY of the
WESTERN CAPE

APPENDIX E (ii): RCWMCH In-Year Monitoring Report REPORT: TOTAL AGRICULTURE AND PROTECTED OWN INCOME AS AT 31 MARCH 2008

REVENUE	PREVIOUS YEAR ACTUAL (2007/08)	Apr-03	May-03	Jun-03	Jul-03	Aug-03	Sep-03	Oct-03	Nov-03	Dec-03	Jan-04	Feb-04	Mar-04	Total Receipts (0-10)	Physical Forecasts	Total 2003/03 (15-16)	Budget 2003/03	Adjustments	Revised Estimate (16-17)	Over recovery (Under) (17-20)
Sales Goods & Servs Not City A&A	20,256,176	183,813	1,842,917	3,348,642	3,146,043	1,742,787	1,842,677	1,656,623	2,817,383	1,734,787	3,868,397	3,868,397	3,868,397	21,268,544	0	21,466,941	17,232,000	4,234,941	19,133,000	3,333,941
Mary's Estate - Buildings	84,324	1,120	1,120	1,264	1,264	1,264	2,267	2,267	1,214	1,704	880	880	880	28,162	0	28,162	15,000	13,162	72,000	(43,838)
Mary's Estate - Furniture	15,277	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	15,000	2,277
Mary's Estate - Planting Cover & Equip	211,400	15,000	21,000	23,477	23,477	23,477	13,629	12,007	14,041	11,000	16,007	16,007	16,007	204,414	0	204,414	210,000	4,414	210,000	(5,586)
Mary's Estate - Other Machinery & Equipment	343,000	44,000	44,000	44,000	44,000	44,000	44,000	44,000	44,000	44,000	44,000	44,000	44,000	500,000	0	500,000	200,000	300,000	200,000	300,000
Property Income	102,701	3,343	3,343	18,000	18,000	7,853	11,100	4,855	14,000	5,151	7,786	7,786	7,786	128,877	0	128,877	113,000	15,877	113,000	15,877
Request from Island Reports	142,320	14,007	12,847	14,000	14,000	13,247	13,780	13,847	15,267	16,300	17,300	17,300	17,300	178,000	0	178,000	148,000	30,000	148,000	30,000
Request from Island Reports	20,267,049	20,190	1,795,101	2,143,800	2,024,807	1,872,200	1,468,020	1,328,407	1,933,607	1,688,003	2,141,130	2,141,130	2,141,130	20,405,845	0	20,405,845	17,000,000	3,405,845	17,000,000	3,405,845
Special Events (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0
Health Services (Arbitration Services)	301	107	214	0	0	0	0	0	0	0	120	0	0	1,000	0	1,000	1,000	0	1,000	0

