and by how much contributions are growing. If you can spend more on managing care and make the costs more affordable, that's a healthy thing'.

As for brokers, he said the debate was being finalised by the new regulations, yet believed they 'add enormous value'.

'They compare different schemes and put the most appropriate options to people. The problem with increasing access to medical aids is not about brokers, the entire industry has yet to find a solution to providing and funding health care in the lower end of the market', he said.

Only in the last six months had hospitals, doctors and funders begun talking and developing more effective products and medical savings accounts for the lower income market.

'Only nine out of 151 medical schemes do not discriminate against psychiatric patients.'

'The problem is that, in certain circumstances, its very difficult to manage every single event to get the best value for money. Generally limits are not a good thing and we should work towards better mechanisms for managing costs. If REACH can come up with one that is acceptable to everybody, we'd welcome it'.

Swartzberg said that for certain expenses like mental health, there was currently no solution on the table 'that says we can manage the costs and provide quality services – limits are a fairly crude mechanism'.

Pat Sidley, spokesperson for the Council for Medical Schemes, said any body assisting doctors or patients in understanding and working with the new laws, should be welcomed.

The Council had just published regulations to deal with brokers moving clients between medical schemes. It had warned various brokerages and asked several medical aids to explain the amounts they were spending on brokers.

'Whenever we see things are not good for our stakeholders, we act,' she said.

***SAMJ* Newsteam**

LOCAL HOSPITAL SOLUTION LASTS LONGER

The 'rescue' of UCT Medical Centre after German investors pulled out three months after its opening, has put 24% of ownership into the hands of 44 local doctors intent on salvaging tertiary facilities.

Renamed the UCT Private Academic Hospital after being secured for 'considerably less' than its R50 million worth of equipment and leasehold improvements, the remaining shareholding of the high-tech facility is split 26% to UCT and 50% to Westcare Hospitals.

At the helm of the new ship is Riël du Toit, the MD and controlling shareholder of Westcare Hospitals and a veteran investor in the industry. He believes they now have 'the best possible set-up' to deliver affordable world-class medical care and broaden the training platform for young doctors.

Du Toit reported that the investing doctors had put in between R19 000 and R60 000 each. 'They're a fascinating group of professionals. Many of them

Professor David Dent, head of UCT Surgery Dept with Riël du Toit, head of the UCT Academic Hospital. Pics courtesy of UCT Monday paper.

are within the actual UCT medical school system and really don't want the teaching platform to fall away.'

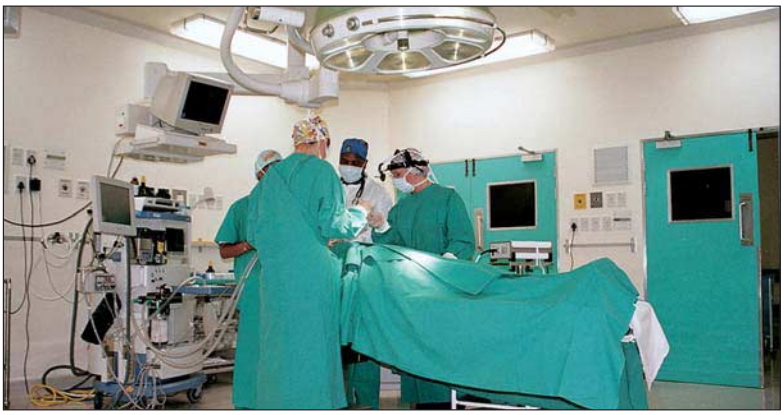
He explained that 'the Germans were in a country they didn't understand, trying to implement something never done before here. We've benefited from many aspects of their system.'

The *SAMJ* learnt from sources close to the former Rhon-Klinikum investors, that the sudden pullout followed a decision to downscale international operations, spurred in part by industrial relations problems in Germany and the rand/euro exchange rate.

'Delivering more cost-effective, affordable and top rate services to a wider range of people.'

'They were earning in rands and converting to euros. The project was conceived when the rand was far stronger. Also, their success in Germany was built around formulas and recipes, patient flows and payment of doctors and equipment – in this country where it's not that way, you need to be flexible,' one source said.

Many UCT academics who worked



Surgeons perform a procedure in one of UCT's four well-equipped operating theatres.

under the foreign project manager/doctor duo, privately heaved a sigh of relief with the scrapping of the system of 'clocking in and out', filling in patient treatment forms, plus being paid an overall fee of R250 per hour.

The previous managers found themselves squeezed between German principals sticking to a tried and tested first-world system, and the 'homeboys' insisting on flexibility around local health care dynamics.

This led to bitterness among managers and finger-pointing by their bosses when the 'sell-out' came just three months after the centre opened in March 2002. 'They had no time to even try to prove themselves,' one source said.

Du Toit confined himself to a single observation around the pull-out, but lauded the Germans for their integrated diagnostic system behind well-equipped consulting rooms.

'You can't change a health care system around a hospital – it needs to be the other way round,' he observed.

Du Toit, who was the CEO of the Port Elizabeth Medical Group before it was sold to Afrox, went on to buy the Swaziland Hospital. He said he was 'truly excited' by the new UCT project.

A tour of Groote Schuur Hospital had convinced him that alternatives needed to be found to alleviate financial and teaching problems, while still providing excellent services.

44 doctors invested between R19 000 and R60 each.

'What excites me is the opportunity for nitty-gritty co-operation. Groote Schuur still has some of the most amazing facilities that I have ever seen, like the state-of-the-art vascular catheterisation laboratory. However, some of the other vital equipment is 20 years old or more.'

The 'rescue' buy-out comes at a time of drastic and unprecedented cost cutting measures that have led to widespread alarm among tertiary hospital doctors, particularly at Groote Schuur Hospital, now under direct provincial financial management.

The national shift towards prioritising primary health care funding meant having to find creative ways to enhance teaching. Du Toit was confident the new hospital could lead the way for co-operative arrangements with other private facilities.

'There are elements of academic medicine in South Africa that are truly brilliant. It has passionate people with extraordinary skills that are not driven by money, they're simply turned on by what they do,' he said.

'Elements of our academic medicine are truly brilliant.'

He outlined the core function of the new hospital as 'creating the team concept. Doctors can refer to us with confidence, knowing that their patient will be assessed by some of the top specialists in the country and referred on objectively and appropriately'.

This multi-disciplinary approach would include, for example, cardiac, neurosurgery and complex pain clinics to bridge the historical divide between surgical and medical doctors.

Apart from its specialised units, Du Toit said the hospital was the only one of its kind in the country with 24-hour cover by intensive care specialists and other suitably qualified clinicians. 'And academics are more careful with first line medication, consumables and asking for tests,' he added.

In terms of cost-effective private health care, Du Toit said the existing synergies with Groote Schuur and UCT would mean lowering the cost basis. This would make it possible to give patients a more flexible and less expensive deal than elsewhere in the market.

Structuring 'packages' at fixed fees would provide an alternative for many patients without medical aid cover for procedures such as joint replacements, heart bypass surgery, transplants and spinal procedures as well as minor procedures.

The new arrangement would also make it easier for both Groote Schuur Hospital staff and UCT clinicians to do Remunerated Work Outside the Public Sector (RWOPS).

Du Toit concluded that his bottom line was 'delivering more cost-effective, affordable and top rate services to a wider range of people'.

Chris Bateman