REPORT:
STAKEHOLDER DIALOGUE ON DEVELOPING NEW SOUTH AFRICAN PRIVATE SECTOR MATERNITY CARE AND CONTRACTING MODELS

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Background

On October 5, 2024, the South African Medical Research Council (SAMRC), in collaboration with the Clinton Health Access Initiative (CHAI), convened a dialogue with key stakeholders to discuss models for developing new private sector obstetric care and contracting models in South Africa, particularly for caesarean sections. A diverse group of stakeholders, including representatives from the public and private health sectors, midwives, obstetricians, academic institutions, and non-governmental organizations were present. These included stakeholders from the National Department of Health, Network One Health, National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD), University of the Witwatersrand (WITS), South African Society of Gynaecological Oncology (SASOG), Society of Midwives of South Africa (SOMSA), Hospital Association of South Africa (HASA), Independent Midwife, Right to Birth, Board of Healthcare Funders (BHF), Medical Protection South Africa (MPS). The platform allowed for the exchange of insights, perspectives, and expertise on the challenges and opportunities in developing sustainable and accessible models of care.

The approach of the dialogue was to foster an open environment where stakeholders could freely engage in discussions, and participants were encouraged to share their views and confidentiality was maintained. The event provided an opportunity to document these discussions, which would help shape the future obstetric care strategies in the country.

Session One

The welcoming of the attendees was conducted by Tanya Doherty from South African MRC. Tanya mentioned that private sector has a high rate of caesarian sections, the aim is to present the proposed obstetric care model, discuss, and obtain feedback into this model. Lastly Tanya assured attendees about the confidentiality that is guaranteed, and the aim is to develop a paper on these discussions.

The opening presentation was from WHO on the epidemiology and global trends, use of caesarean sections and recommendations. This was followed by a presentation by HSRU, SAMRC on the proposed model, a presentation on the Legal /Regulatory framework was provided by the Clinton Health Access Initiative and a presentation on remuneration issues by Aligned.

Rationale

The rationale for the alternative private sector maternity care model was based on the following considerations from the presentations:

- Caesarean Section (CS) is effective when needed but presents higher risk in low-resource settings.
- CS rates have risen globally without significant benefits for maternal or infant health.
- Overuse of CS leads to health risks and higher healthcare costs.
- South Africa's maternal healthcare faces major challenges in both public and private sectors.
- WHO states CS rates above 10-15% offer no added benefit in reducing mortality.
- South Africa needs alternative maternity care models in the private sector.
- Public-Private Engagements (PPEs) could help address these challenges.

Key recommendations by WHO included

- Educational interventions that engage women actively in planning for their births
- Evidence-based clinical guidelines and requirements for a second medical opinion for a caesarean section decision in settings where it is possible
- Evidence-based clinical guidelines, performing regular audits of caesarean section practices in health facilities and providing timely feedback to health professionals about the findings
- A collaborative midwifery-obstetrician model of care for which care is provided primarily by evidence.
- Financial strategies for healthcare professionals or healthcare organisations.

Proposed model:

A potential alternative private sector maternity care model which draws on insights from research carried out on the care and contracting models used by five rural district hospitals in the Western Cape to contract private general practitioners (GPs) for maternity care

1. To establish hospital-based birthing centres (HBBCs)
2. The HBBC would operate with a public sector-type multidisciplinary team approach, with nurse/ midwife ward-based care supported by various levels of medical providers
3. Women choose a HBBC or an individual provider
4. The HBBC would be responsible for providing all the prenatal, delivery and postnatal care.
5. Risk-based antenatal and intrapartum care.

6. The HBBCs should be remunerated through a global fee for the full maternal care

Reflections on the Legal /Regulatory framework identified

Regardless on the type of service model, the following pieces of legislation are critical:

- National Health Act.
- NHI White Paper
- NHI Act
- HPCSA
- CMS
- Regulation R158

Session Two

Stakeholders' response to the proposed model

Speakers	Recommendations
Speaker 1	Although considered a good initiative, a range of issues were identified. • Patient safety and liability were identified as major concerns. • Liability concerns extend beyond individual care, affecting the broader healthcare system. • There is a need for clear responsibilities for the liable party and indemnity issues, should the responsibility lie with the doctor or the state? **Proposed actions that first need to take place:** • Improve patient safety to reduce negligence claims. • Define indemnity responsibilities to clarify liability. • Recognize that these issues extend beyond financial considerations and impact overall care delivery. A proposal was further made for the audiences to review the article; The threat of litigation of private obstetrics and gynaecology doctors, whereas in the public sector patients lay litigations against the minister.

Speaker 2	The viewpoint was that there is a systemic dysfunctionality: • Identified a "doom loop" within the proposed model which could lead to interdisciplinary competition among healthcare professionals rather than collaboration, non-scalable, low-capacity service structures, high variation in clinical practices, poor health outcomes, and high indemnity costs. The speaker agreed with the identified problems within the private healthcare sector, specifically noting the following key issues: • Fragmentation is highly maintained by fee for service (FFS), desire for autonomy, weak governance, professional liability • Low productivity birth centers and sole/Individual practice that compete rather than collaborate, both non-scalable • No enforceable, systematic way to address Inappropriate care in the private sector at present, financial and regulatory interventions Ineffective • High levels of inappropriate care such as CS medicolegal risks and remuneration model • No framework to mobilize the private sector resources to serve the broader population without replicating the patterns of inappropriate use. • Mainstream the team-based models in the private sector and optimize them for public-private engagements to increase access to their scarce expertise for a broader population with the NHI in mind. • Annual accreditation is short-term, a review of the process needs to be done. Implementing the alternative model iteratively and incrementally, alongside existing practices, serves as a critical strategy to mitigate fear of the unknown and concerns about potential loss of income and autonomy. **Recommendations on the proposal**

	• Public sector like the multidisciplinary team with midwife-based ward care, various levels of providers must be standard in the private sector. • Annual accreditation: a three-year circle preferred to effect change management. • Any intervention must address existing birth center and solo practice concerns and constraints. • Care models in the public and private sectors must incorporate the 6 key success factors proposed. • Private hospitals must be allowed to establish home-based birth centers (HBBCs); HPCSA and amendment of ethical rules. Market concentration issues: Health Market Inquiry (HMI) • Time-based remuneration (TBR) supported on the condition that the MDT owns the HBBC. • HBBCs must be responsible for the provision of prenatal, delivery, and postnatal care with a specialist backup. • Remuneration through a risk-adjusted global fee reflecting patient risk profiles and needs, Recon with TBR. • The model must be suitable for mixed purchasers in the current environment, cash and medical aid scheme purchasers.
Speaker 3	**Recommendations** • Education and knowledge from expecting mothers and empowerment are essential as only 38% of CS are considered essential. • The role of general practitioners would be an important one to consider (fee for service in the private sector) • Indemnity and legal liability • Regulatory constraints from a funding perspective depend on how the risk is coded. • Enforceability of guidelines and compliance to practicing clinicians • Differences in perceptions about the birth journey

	• Upskilling is important in making sure we are using resources at the right level. • A focus on the outcomes and demonstrating patient safety. • Limiting out of pocket cost, however people choose out of pocket cost based on what they have been told by the provider. • Health ID and encourage record keeping and managing liability, however there is limited take-up. • Neonatal risk should be a consideration of the project, adding to the risk and cost of maternity care. • Feasibility of global fees and establishing a good transition pathway is crucial
Speaker 4	It was acknowledged that both the public and private sectors face significant challenges, often exploiting each other's shortcomings. To truly serve the nation, both sectors must collaborate and prioritize the country's best interests. Stakeholders' goals and strategies should be aligned to benefit the entire nation, encompassing all provinces and communities—across private and public sectors, rural and urban areas, and regardless of socioeconomic status. **Recommendations** • The model based on WC is not a representative sample of the model of other provinces. This model does not clarify funding models for the services. Improve clinical governance issues such as staffing, and deal with the increase in caesarians. • Development of guidelines & protocols is essential, every site must conduct morbidity and mortality review meetings, where minutes are kept, actions assigned to individuals and there is a follow-up to hold individuals to account. Such systems are less stringent to non-existent in the private sector.
Speaker 5	**Reflections on the proposed maternity model** • The episode-based global fee approach aligns with the planned hospital reimbursement model under

	NHI, specifically with Diagnosis-Related Groups (DRGs). • There is potential to explore outcomes-based payments as part of the reimbursement strategy for Home-Based Birth Centers (HBBCs) and contracted healthcare professionals. • Including antenatal and postnatal care in the episode of care makes sense for continuity but may pose integration challenges with public sector services under NHI, as these are currently provided at clinics. • The initial approach suggests that these services should be part of the core primary care, reimbursed via capitation. • Under NHI, public and private providers will use the same reimbursement structure for identical services, except in cases where there is a compelling reason for a different approach.
Speaker 6	The push and pull factors of Human Resource for Health (HRH) need to be addressed in the public sector. These refer to the various elements that either drive healthcare professionals away from (push factors) or attract them to (pull factors) working in the public sector: **Demand Side:** • Understanding the factors influencing women to access private healthcare, including their preferences and expectations through research. • Investigate restrictions on registrars working in Home-Based Birth Centers (HBBCs) in private practice, potentially due to HPCSA regulations. • Addressing the existing deficiencies in the public sector, particularly in critical services such as anesthetic/epidural and neonatal/pediatric care. • Exploring options for proposed indemnity cover and understanding the available alternatives. **Regulatory Side:** • Consider initiatives such as the Little Life and GEMS managed care projects.

	• Challenges exist in establishing or modifying insurance funds to support healthcare initiatives. • While NHI is widely supported as a concept, concerns remain about corruption and the influence of tender-preneurs affecting its implementation.
Speaker 7	The speaker first dived into the Reasons Why Women Use Independent Midwives: • They are trusted, culturally sensitive, skilled, and respectful. • Offer a personal, one-on-one relationship, knowing their clients well. • Provide continuity of care throughout the maternity journey. • Ensure consistent and reliable information. • Use a scheduled appointment system, often incorporating group health education. • Deliver effective and personalized care. **Challenges independent midwives experience** • BHF support midwives poorly • Most medical aids only pay BHF rates • Public hospitals refuse admission • Telephones are not manned/out of order in hospitals • Midwife records/diagnoses are not accepted **Recommendations** • Coherent referral system - staff should understand, and respect guidelines and criteria • When a midwife refers, she needs access to the appropriate level of care • Communication system that works (telephonic) • Reliable transportation with appropriately staffed/stocked ambulances • Interprofessional collaboration (perinatal audit meetings/guidelines) • Maternal and child resources need to be ringfenced **Proposed model of care**

	• Midwives should be frontline primary care providers. GPs can be involved with pregnant women with an underlying medical condition and caesarean sections. Mothers should have the opportunity to choose their care provider. • Midwife specialists and obstetricians should do complicated births • Coherent referral system - staff should understand, and respect guidelines and criteria • Teamwork at all levels - simulation/debriefing sessions/audits • Salaried based on skills • Group insurance • Birthing center member attend monthly M&M meetings/audit/statistic • Fully support indemnity
Speaker 8	**Obstetrician and Midwife Supported system** The current and proposed approach to a collaborative system supported by obstetricians and midwives, focusing on improving the quality and consistency of maternity care was provided as: Both Obstetricians and Midwives collaborate throughout the process from: • Antenatal care, managing both high-risk and low-risk pregnancies. • Confinement, ensuring best practices are followed during the intrapartum period. • Delivery, managing both normal vaginal deliveries (NVD) and C-sections. • Post-Natal care **PROPOSED APPROACH:** Where they are now: - Professionals collaborate on an ad-hoc basis to deliver care. - Best-practice care protocols are in place but are paper-based. Digitalization of the system is required.

	Where they want to be: - A formalized maternity team led by the obstetrician - Digital platforms supporting clinicians to care for patients as a team **Recommendations** • Secure team-based reimbursement from schemes, ensuring comprehensive care from ante natal to post-natal care and guaranteeing Specialist income • Ensure no negative impact of the pilot on current indemnity policies and engage with insurers for longer-term risk reduction • Preserve patient choice in care decisions, safeguarding the trust relationship between patient and specialist
Speaker 9	There is support for initiatives that target inappropriate care, despite the sector's adherence to outdated British models and inadequate HPCSA oversight. However, regulatory challenges, such as those under Regulation 5 of the Medical Schemes Act, complicate the adoption of team-based approaches. The current model is too simplistic, failing to account for the complex factors driving high C-section rates: • Demand-side issues: Influenced by media portrayals of labor and maternal preferences for scheduled C-sections. • Supply-side issues: Weak HPCSA oversight, high indemnity costs, staff deskilling, and lack of health governance (e.g., missing M&M meetings to review C-sections). • Financial incentives that favor C-sections further entrench these practices. Team-based care and clinic-based birthing units are positive steps, but stakeholder buy-in is uncertain due to the

	profitability of the current system (e.g., higher fees for C-sections). **Recommendations:** • There is a need to study the failures of the PPO Serve maternal care program and exploring the Swiss model, potentially with Mediclinic's involvement. • While exploring alternative reimbursement models, such as fixed fees and smaller time-based fees, monitoring and management are essential. • Event-based global fee reimbursement is unlikely to succeed, and population-based reimbursement faces challenges due to clinics' limited experience with such models. • All alternative reimbursement models must consider cost management, including using strategies like Tukey's rule to identify cost outliers, especially as hospital groups move further into the insurance business. **Comments & alternate considerations** • The team-based approach is supported as a positive step forward. • Establishing birthing units within clinics is also seen as a good initiative. • A key concern is identifying what would motivate stakeholders to shift from the current model. • The existing arrangement is highly profitable for both doctors and clinics, which creates resistance to change. • In 2023, the cost difference between normal vaginal delivery (NVD) at R25,000 and C-section at R55,000 highlights the financial incentives that drive the preference for C-sections, making it challenging to encourage a shift towards less invasive care options.
Speaker 10	**Midwife-based multidisciplinary team. Obstetrician-led (accountability level)**

	The speaker proposed an Integrated Maternity Team that is currently being implemented by the Network One experience that emphasizes a multidisciplinary approach led by midwives, with accountability resting at the obstetrician level. **Integrated Maternity Team Structure:** • The team is midwife-driven, supported by GPs, allied staff such as clinical associates, sonographers, and social workers. • Midwives act as care coordinators, while an obstetrician and gynecology, lead consultant, oversees clinical accountability. • The team follows established SOPs, utilizes electronic medical records with decision support, and operates within a structured routine of team governance, contract management, and data analytics to guide care and develop data-driven products. • The infrastructure includes purposefully designed outpatient and community services, complex obstetric clinics with ICU access, and chronic care clinics managed by GPs and supporting specialists. **Teaming was considered the key activity, which provided** • Shared meanings and values that transcend Individuals and geography • Providers selected for relational competencies and commitment to change • Real-time coaching in the management of unexpected and painful events **Change management approach** • Structure emerges from stable forms of communication that permit the different parts of the organization to operate together as a whole. • 'Real life', ongoing communications (memos, meetings, and electronic communications), or organizational processes, and not as static formal reporting relations

	Specific concerns about midwives • There are huge concerns in ensuring midwives, leading to the current requirement of a substantial co-pay for their coverage. • The team's rationale for a high deductible is to mitigate the risk of midwives increasingly handling cases beyond low-risk pregnancies and deliveries, which could pose greater liabilities. • The co-pay structure is designed to secure buy-in from insurers and provide an added layer of protection against the potential escalation of high-risk practices.

Session Three

Discussions

- It was highlighted that collaboration between sectors is required for NHI implementation. There was a general belief that for NHI, multidisciplinary models could play an important role in bridging gaps.
- The major challenge is overcoming decades of mistrust between the public and private sectors, along with barriers in the system.
- Patient voices were considered essential, especially regarding respect for care and addressing health disparities. It was considered important to assess how women feel about their antenatal care experiences, whether their concerns are being heard, and to develop indicators that reflect their interactions with the healthcare system. The focus should be on women-centered care and value-based contracting, rather than just system efficiencies or numbers.
- Clarity is needed regarding payment structures and which services are excluded, as this is a rights-based issue. Value-based care should be prioritized over fee-for-service models.
- Doctors often feel disconnected from policy discussions due to time constraints and the complexity of issues like rising healthcare costs and high cesarean section rates. Obstetrics is a team-based field, yet doctors frequently lack opportunities to contribute their perspectives.
- From a regulatory standpoint, a systems approach and multidisciplinary teams are critical. Public-private collaboration need to be highlighted more, and stakeholders must decide on critical outcome measures in line with OHSC guidelines.

- The model’s ultimate goal is equitable, high-quality healthcare for all women. Discussions should continue on indemnity, remuneration, and improving the model through input from different sectors.
- Community participation is missing in the current model. It is important to consider the role of citizens in healthcare governance, they need to be recognized and be presented within the government structure.
- Insights from a SAMJ article highlight the potential of midwife-led units with access to private doctors, based on a participant's experience in setting up a birthing unit at a regional hospital.
- When developing private sector contracting models, access to services must be considered for both urban and rural settings. Access in remote areas is an issue, how to cater for the rural settings in the model. The basic model needs to include urban and rural settings. In the Western Cape, high-density obstetric units catch low-risk patients, while community-based MOUs should also be integrated.
- The regulatory framework, including HPCSA rules 10 and 18, requires revision, especially regarding remuneration for medical doctors.
- Women's perspectives and preferences must remain central, and hospitals should create environments that make patients feel welcomed and safe. Understanding what women want is essential and it has been published in the literature (Patient Voice).
- Partnerships between regulatory bodies and private healthcare providers need to be strengthened to address the dominance of the medical model and improve collaboration. Midwifery guidelines are required on best practices.
- Issues such as indemnity, skill maintenance, and performance measures for services are essential to the model’s success.
- Proper education on patient rights, informed consent, and ethical practices is needed, along with addressing the maldistribution of resources.
- Contracting private hospitals for designated birth centers could be an affordable option if publicly funded models are not feasible.
- Successful public-private partnerships involve training, financial incentives, and opportunities for both obstetricians and midwives, supported by strong regulatory frameworks and alternative reimbursement models.
- The model needs to stipulate the various streams that can be used for funding hospitals, doctors, and midwives.
- The role of clinical associates, who work under doctor supervision, needs clarification, particularly in partnership with midwives for multidisciplinary care.
- The proposed model looks promising on paper, but key challenges, such as indemnity and patient volume, must be resolved to make it viable.
- Health systems on roles and responsibilities defined, the access to supplies and facilities, risk management and governance and referral relationships.

- Quality of Care on provision of care, experience of care, competent and motivated human resources on patient autonomy.
- The model may provide equity for all women to have quality health care.
- Partnerships with different regulatory bodies, patience's voice, inter-disciplined collaborations, indemnity for the team, maintenance of skills.
- Patients must be educated for best decision making.

- From the discussion of the day, this is a summary of the key themes (or possible work streams to be considered) from the discussion and to explore through further stakeholder engagement (which was supported by the floor):
    1. Mapping the integrated care model, evidence based clinical protocols for the patient journey including clinical governance.
    2. Maternity integrated team: terms of reference for the team. Whether it will be obstetrician-led and midwife-led teams?
    3. Operating model: should it be hospital or community-based birthing center. What are the pros and cons of the models?
    4. Innovative funding mechanism: Funders to come up with radical solutions for funding of obstetric care. This will require mapping of episode of care benefits
    5. Alternative indemnity cover that will assist in the medico-legal processes
    6. Technology and digitization of the process of the maternity journey

Closing remarks

- The research provides a solid foundation for testing and implementing the model.
- Key issues identified during engagement with the department need to be addressed as part of the model's development.
- Relationships with funders could be a starting point for the model's success.
- Involvement from clinicians, academics, health departments, civil society, hospitals, and funders is important.
- A model cannot be finalized without thorough consultations, and refinements will be necessary.
- Discussions on the way forward require broader engagement.

- A vote of thanks was given, and the MRC will document the outcome of the process academically.

Next Steps

- The initiative is part of an ongoing research study. The model is not yet finalized and remains a work in progress.
- The process involves two main parts:

    - An academic process for the MRC to analyse inputs received at the dialogue. MRC will do a thematic analysis of the inputs received at the dialogue through a qualitative analysis of the transcript. This will include an outline of key inputs received under main thematic areas such as legal indemnity, health professional training, health professional regulatory framework, etc. MRC will outline main issues that will need to be resolved for any new model of care for the private sector to be feasible.
    - An online feedback meeting with all stakeholders where the main findings regarding inputs and recommendations from the dialogue will be shared followed by a discussion on roles and responsibilities for taking the work forward.
- A meeting is scheduled with the National Department of Health to give feedback on the dialogue and discuss next steps to align and support the work of the NHI Branch.