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GENERAL NOTICE

NOTICE 117 OF 2012

NOTICE IN TERMS OF SECTION 41(1)(C) OF THE NATIONAL HEALTH ACT, 2003 (ACT 61 OF 2003)

THE MPUMALANGA PROVINCE'S AMENDED HOSPITAL FEES MANUAL IN SCHEDULE HERETO, IS PUBLISHED FOR GENERAL INFORMATION IN RESPECT OF PUBLIC HEALTH FACILITIES IN THE PROVINCE.

THE AMENDMENT IS IN RESPECT OF THE HOSPITAL FEES MANUAL PUBLISHED IN PROVINCIAL GAZETTE EXTRAORDINARY NO.1917 DATED 31ST MARCH 2011.

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HOSPITAL FEES MANUAL**CONTENTS**

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CHAPTER ONE

Preamble:

The Uniform Patient Fee Schedule is covering all patients attending provincial health establishments. Fees for subsidized (hospital) patients are to be expressed in terms of the percentages of the UPFS.

PRINCIPLES

PRINCIPLE ONE:

Emergency medical treatment shall be afforded at any time to any patient, without question or delay, at any health facility, including a clinic, community health centre, or hospital.

PRINCIPLE TWO:

Every patient has the right to choose by whom s/he wishes to be treated, PROVIDED s/he is prepared to pay the tariffs applicable to full-paying patients and subject to the availability of appropriate staff and facilities. Should someone wish to be treated as a **subsidized or self funded** hospital patient, then s/he would not have a choice of medical practitioner.

The choice of facility shall be in line with prescribed service delivery guidelines as determined by the Health Authority and from time to time (e.g. Patient's Rights Charter, levels of service, PHC principles).

PRINCIPLE THREE:

All health services rendered by the state except primary health care facilities are chargeable. However, no emergency service may be refused if a patient cannot pay for it and no patient, including an externally funded patient, will be required to meet all costs of essential medical services should such costs place an excessive financial burden on her/him.

PRINCIPLE FOUR:

Some illnesses (Chapter 3, paragraphs 3(d), 3 (p)) which may affect the community as a whole if they are not contained or controlled are automatically treated free of charge.

PRINCIPLE FIVE:

Fees levied for private patients will be in terms of the Uniform Patients Fees Schedule (UPFS) being implemented nationally. The private fee tariffs are determined by the UPFS and subsidized fees are expressed as a percentage of the UPFS.

PRINCIPLE SIX:

Externally funded patients will pay the full rate prescribed by the UPFS. In cases where services are rendered by a private health care practitioner, the patient or her/his funder will be liable for the facility fee component of the UPFS tariff to the public health facility concerned. It is the responsibility of the private practitioner to render an account to the patient or his/her funder

for any professional fee to the private practitioner. In case the private practitioner did not turned up, the patient must be reclassified as a hospital patient and be billed accordingly.

PRINCIPLE SEVEN:

Patients who are not externally funded are eligible to pay reduced fees for services received. The onus rests on the patient to prove her/his eligibility to be categorized as a subsidized patient. If a patient refuses to do this, then s/he must be classified as a H3 but in a case where the patient is a first visit and did not bring along the proof he/she must be classified as a H1.

PRINCIPLE EIGHT:

The eligibility of a patient to pay reduced fees will be based on a standard means test or the membership of the patient to certain groups exempted from paying for public health services. The means test and exempted groups are described in Chapters 3 and Chapters 5 respectively.

PRINCIPLE NINE:

Patients paying reduced fees will be encouraged to pay cash. In such cases a payment receipt with an invoice will be produced. In cases where the reduced fee cannot be paid in full and the patient is not re-classified into a group exempt from payment a credit agreement must be entered into with the patient or his/her guardian.

PRINCIPLE TEN:

Patients funded by a medical scheme registered in terms of the Medical Schemes Act, 1998 (Act No 131 of 1998 as amended) are governed by the provisions of that Act with regards to the minimum benefits for which the funder is liable. For the purposes of charging services not covered by the funder, the patient will be liable for the payment of the outstanding balance.

PRINCIPLE ELEVEN:

Fees will be reviewed on an annual basis when necessary.

PRINCIPLE TWELVE

All citizens of South Africa must produce their South African Identification Documents for every visit to a health facility. Non-citizens must produce their passports or any other valid documents.

CHAPTER TWO

DEFINITIONS

The following definitions apply only in the determination of the fees structure and for the calculation and levying of fees.

ALLIED HEALTH PROFESSIONAL

is an allied health service professional who provides services to patients. This category includes, but is not necessarily limited to, clinical psychologists, social workers, physiotherapists, orthotics prosthetics, radiographer, occupational therapists, speech and hearing therapists, dietitians, paramedics and chiropractors.

AMBULANCE

means a vehicle especially equipped for the purpose of providing emergency medical care for a patient during the period of transportation.

AMBULANCE STANDBY SERVICE

means a service where a request has been made for an ambulance and crew to be made available / to be present during any event at a specific place.

BASIC ORAL HEALTH CARE SERVICES

at clinic level consist of primary prevention oral health services (oral health education, tooth-brushing programmes, and fluoride mouth rinsing programmes, fissure sealant applications) and basic treatment services (examination, emergency extractions, relief of pain and infection control, atraumatic restorative treatment (ART)).

BOARDER

is a person whose presence, in the opinion of the responsible doctor, is essential to the patient's recovery and who receives board and lodging from the hospital.

BOARDER BABY

means a new-born infant of a mother who is still a patient in hospital.

CASUALTY PATIENT

means a patient treated as an emergency case, usually at a Casualty unit of a Department hospital.

CONSULTATION VISIT

is an occasion where the healthcare professional personally takes down a patient's clinical history, performs an appropriate clinical examination and, if indicated, prescribes or administers treatment or assists the patient with advice.

DAY PATIENT

means a patient admitted and discharged on the same calendar date in a day ward.

DAY WARD

is a ward into which patients are admitted and discharged on the same calendar date.

H1 AND H2

The medication fee is included in the consultation outpatient visit fee.

MEDICAL REPORTS

the completion of a report for legal, insurance or any other purpose.

EXTERNALLY FUNDED PATIENT

a patient whose health services are funded or partly funded in terms of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No. 130 of 1993), by the Road Accident Fund created in terms of the Road Accident Fund Act, 1996 (Act No 56 of 1996), or by a medical scheme registered in terms of the Medical Schemes Act, 1998 (Act No. 131 of 1998 as amended), or who is treated on the account of another state department, local authority, foreign government or any other employer.

FACILITY FEE

is the component of many tariffs applied in the UPFS to reflect the overhead costs of providing the environment in which healthcare services are delivered to patients.

FOREIGN PATIENT

See under Non South African Citizen

FULL PAYING PATIENT

This category of patients includes but is not limited to externally funded patients, patients being treated by their practitioner and certain categories of non-South African citizens. They are liable for the full UPFS fee.

Any patient belonging to one of the following groups: -

Group	Description
Externally funded patients	1. Patients whose services are funded or partly funded in terms of: (a) The Compensation for Occupational Injuries and Diseases Act, 1993 (Act No 130 of 1993) (b) The Road Accident Fund created in terms of the Road Accident Fund Act, 1996 (Act No 56 of 1996) (c) A medical scheme registered in terms of the Medical Schemes Act, 1998 (Act No 131 of 1998) 2. Patients treated on account of: (a) Another state department (b) Local authority (c) Foreign government (d) Any other employer
Patients treated by a private practitioner	Any patient treated by his or her own private practitioner in a public health care facility will be liable to pay the full facility fee component for services rendered by the private practitioner at the facility and the full UPFS fee (H3 classification) for any other service received by the patient.
Non South African citizens	Non South African citizens excluding the following: (a) Immigrants permanently resident in the RSA but who have not attained citizenship; (b) Non South African citizens with temporary residence or work permits; (c) Persons from SADEC states (e.g. Mozambique, Zambia, etc.) who enter the RSA illegally.

HIGH CARE UNIT

is a specially-equipped unit which is set up for the care of patients who need close observation but at a lower level than the intensive care unit and where medical and nursing staff are available on less than a full 24-hour basis.

Patients qualifying for full subsidization : H0

Patients in this group receive all services free of charge. Patients must provide proof in terms of the conditions set out in the table below in order to be classified in this group. The default classification for a person without income is therefore H1.

Patients qualifying for full subsidization: H0

Group	Description
Social pensioners	<p>Proven recipients of the following types of pensions / grants are classified as social pensioners:</p> <ul style="list-style-type: none"> Old age pension Child support grant Veteran's pension Care dependency grant Pension for the blind Family allowance Maintenance grant Disability grant Single-care grant – persons with mental disorders in need of care discharged from hospitals from the mentally ill but has not been decertified. <p>Should the social pensioners also belong to a medical scheme, they will be regarded as full paying patients.</p>
Unemployed	<p>Proof of unemployment must be produced.</p> <p>Note: (i) If proof of the pensions/grant or the unemployment insurance fund card is not produced. (Contributors record card (UF 74))</p>
Persons re-classified as H0	<p>If a patient cannot afford the fees due on the basis of his or her original classification then the patient may be re-classified as H0 by the person in charge of the health care facility or the PAAB Super User.</p>
People with disabilities.	<p>People with temporary or permanent disabilities who have been classified by a therapist and can produce a card.</p>

H1, H2 and H3 PATIENTS

This is a default group for subsidized patients and the level of subsidization depends on the assessment of income (frequently called the means test)

Patients qualifying for PARTIAL subsidization: H1,H2 and H3 (self funded)

Category	Means Test	Subsidization (pay as % of UPFS tariffs)
H0	As categorized on page 7	Exempted from paying all fees
H1	Individual: Income equal or less than R36 000 per annum Household: Income equal or less than R50 000 per annum.	Consultations: 20% (with no differentiation for emergency consultation). Inpatients: 1% (see notes below) Patient and Emergency Transport: 5% Assistive devices: 25% All other services: Free Calculated amounts should be rounded to the nearest R5 to facilitate cash accounting.
H2	Individual: Income between R36 001 and R72 000 per annum Household: Income between R50 001 and R100 000 per annum	Consultations: 70% (with differentiation for emergency consultations) Inpatients: 7% per day with differentiation on the basis of the bed types Patient and Emergency Transport: 15% Procedures, imaging and oral health: 50% Assistive devices: 75% All other services: Free Calculated amounts should be rounded to the nearest R5 to facilitate cash accounting.
H3 (Self funded)	Individual: Income between R72 001 and above per annum Household: Income between R100 001 and above.	All services listed in the UPFS for 2009 at full price

Notes:

The H1 inpatient is expressed as a percentage of 7 days of the UPFS General Ward in patient fee to approximate the average length of stay of in-patient in this category. Although the fee calculation is based on 7 days for H1 patients this fee will be applicable for each 30 days of inpatient stay or part thereof. No differentiation is made on the basis of the bed type.

CHAPTER THREE

FREE SERVICES

1. "Free patient" means a hospital patient who proves s/he receives a social grant or is unemployed or any patient classified as H0.
2. Free examination, and free medical, hospital and related treatment (including transport related to the treatment) may be given to a person as defined in par. 1 above.
3. Free medical examination, free treatment and free services may only be given to:- (*NB: See definitions section*)
 - (a) Any H0 boarder, (H1, H2 and H3 will pay according to the UPFS);
 - (b) Any boarder baby, excluding a boarder baby of a private patient;
 - (c) A relative, as per definition for diagnostic purposes;
 - (d) Any person suffering from a suspected or confirmed communicable, formidable or notifiable disease as follows:-
 - (i) venereal diseases (excluding complications) only on an outpatient basis and including: syphilis, gonorrhoea, chancroid, LGV (lymphogranuloma venereum), non-specific urethritis, venereal warts, granuloma inguinale, ulcus molle and herpes genitalis;
 - (ii) pulmonary tuberculosis;
 - (iii) leprosy;
 - (iv) cholera;
 - (v) diphtheria;
 - (vi) plague;
 - (vii) typhoid and paratyphoid;
 - (viii) haemorrhagic fevers;
 - (ix) meningococcal meningitis;
 - (x) AIDS – Treatment as well as the initial diagnostic procedures and attendant laboratory services specifically for HIV test are free.
 - (xi) malaria;
 - (xii) Note: When the patient is admitted to hospital for any other reason/illness and it is established that he/she also suffers from any of the above-mentioned illnesses, the patient is assessed according to the prescribed tariffs.
 - (e) A person to whom services are rendered in terms of the Criminal Procedures Amendment Act 42 of 2003 as well as the following services at the request of the responsible authority
 - (i) **assault:** SAPS 308 and J88 well completed must be submitted in case of examination of the alleged victim, the taking of specimens and the completion of the necessary documentation;
 - (ii) **rape:** the examination of the alleged victim, the taking of specimens and the completion of the necessary documentation, including prophylactic treatment for sexually transmitted infection and prevention of pregnancy, according to the recommended national guidelines;
 - (iii) **persons with mental disorders:** the examination of prisoners and detainees for medico-legal purposes with a view to their committal for observation in terms of the Mental Health Act, Act 17 of 2002;
 - (iv) **post-mortem examinations:** the carrying out of autopsies and attendance at exhumations.

- (f) Any officer of the Department who, in the performance of her/his official duties, handles or comes into contact with any drug, poison, gas, radio-active substances, radio-therapeutic or diagnostic equipment or other electronic equipment and is for this reason required to undergo medical examination and treatment;
- (g) The following persons who are treated for family planning purposes:-
- (i) an outpatient treated at a family planning clinic;
 - (ii) an inpatient in a family programme for the purpose of a sterilisation operation;
 - (iii) a male or female patient after a failed family planning programme sterilisation procedure in a state hospital;
 - (iv) a patient who visits a clinic or hospital on recommendation of family planning staff, including free transport to such clinic or hospital, for the specific purpose of being sterilised, notwithstanding the fact that such procedure is performed by a private doctor, however excluding sterilisation for clinical reasons; and
 - (v) post vasectomy persons for scheduled sperm counts.
- (h) Personnel in the employ of the Department who are injured on duty, and for whom the Department accepts liability;
- (i) Persons to whom general health advisory services (including oral health and visits to ante-natal clinics) are provided;
- (j) Persons who present themselves for immunizations and other measures to combat notifiable infectious diseases;
- (k) School children, excluding those children whose medical and/or dental health care might be covered by a medical aid or insurance, who are referred with a letter of authority from the school nursing services for basic primary oral health care services, for all treatment arising from such letter of authority;
- (l) Committed children, who in terms of the Child Care Amendment Act of 1996 are committed to the care of a children's home or foster parents;
- (m) Any person suffering from any of the following diseases:
- (i) kwashiorkor;
 - (ii) pellagra;
- (n) Mentally disturbed patients admitted to psychiatric hospitals in terms of the Mental Health Act 17 of 2002.
- (o) Services in respect of termination of pregnancy to be rendered free of charge and if complications have developed as a result of the termination, until the patient has been cured or the conditions as a result of the complication have stabilized, under the following conditions:
- (1) Upon request of a woman during the first 12 weeks of pregnancy;
 - (2) From the 13th to the 20th week of pregnancy if a medical practitioner, after consultation with the woman, is of the opinion that:-
 - (a) continued pregnancy poses a risk to the woman's physical or mental health
 - (b) a substantial risk exists that the foetus will suffer from a severe physical or mental abnormality
 - (c) the pregnancy resulted from rape or incest
 - (d) the continued pregnancy will significantly affect the social or economic circumstances of the woman
 - (3) After the 20th week of pregnancy if a medical practitioner, after consultation with another medical practitioner or midwife, is of the opinion that continued pregnancy would
 - (a) endanger the woman's life
 - (b) result in severe malformation of the foetus
 - (c) would pose risk of injury to the foetus.

- (p) Pregnant women and children under the age of 6 years. Notice 657 of 1994, dated 1 July 1994. As from 1 June 1994, free health services must be provided to:
- (i) Pregnant women for the period commencing from the time the pregnancy is diagnosed to forty-two (42) days after the pregnancy has terminated, or if a complication has developed as a result of the pregnancy, until the patient has been cured or the conditions as a result of the complication have stabilized;
 - (ii) Children under the age of 6 years;
 - (iii) Non-citizens of South Africa who are in groups mentioned in par (i) and (ii), and who incidentally develop a health problem whilst in South Africa.
Free health services include the rendering of all available health services to the persons mentioned above, including the rendering of free health services to pregnant women for conditions not related to the pregnancy as well as people with disability.
- (q) The following persons are excluded from the free health services:
- (i) Persons and their dependents who are members of a medical scheme (if a benefit fund or sick fund does not cover a free service, eg. Pregnancy- then such service must be rendered free of charge to hospital patients – written proof thereof must be provided). If however the afore-mentioned persons and their dependants request a termination of pregnancy, such service must be rendered free of charge.
 - (ii) Non-citizens of South Africa who visit South Africa specifically for the purpose of obtaining health care.
 - (iii) Children under the age of six years and pregnant women, if the aforementioned children/women have been treated in provincial hospitals and institutions by their private doctors.
 - (iv) Ambulance services, and patient transport services { excluding transport between hospitals for hospital patients, as well as the transport of patients who request a termination of a pregnancy or visit a hospital/clinic on the recommendation of family planning staff/district surgeons for the specific purpose of being sterilized}.
 - (v) Treatment of conditions that are not specifically related to the pregnancy or to the termination of a pregnancy.
 - (vi) Prosthesis and other artificial aids (e.g. wheelchairs); - excluding children under the age of six as well as patients classified as H0
 - (vii) Optometric aids (supply of spectacles); - excluding children the age of 6 years as well as patients classified as H0
 - (viii) Persons injured on duty and who must receive medical treatment in terms of the provisions as set out in the Compensation for Occupational Injuries and Disease Act.
 - (ix) Persons injured in motor vehicle accidents and who must receive medical treatment in terms of the provisions as set out in the Road Accident Fund
 - (x) A patient referred from a day hospital, community health care center or clinic to a hospital, for admission as an out / in-patient, is personally liable for the account raised except for the patient classified as H0.
 - (xi) Persons who make use of the services of medical practitioners of their choice instead of those made available by the Health Care Facility.

CHAPTER FOUR

CATEGORIES OF HOSPITAL PATIENTS

NON-PRIVATE

1. Hospital patients are assessed according to family income (*means test*), and placed into four distinct groups based on proven income. Annexure A should be completed in this regard on the **first visit of every patient**, and reviewed **annually**.
2. Dependents are not to be taken into account for establishing the groupings and persons are only to be grouped in terms of family units. Family units include a married couple, single parent or a single person with a dependent as defined in the Income Tax Act.
3. Social pensioners, other than those who may be defined as externally funded, who furnish proof that they receive social pensions/allowances are automatically classified as H0 patients.
4. Social pensioners include recipients of an old age pension, a war veteran's pension, pension for the blind, disability grant, maintenance allowance, child support grant, or a family allowance are also free.

CATEGORIES OF HOSPITAL PATIENTS

EXTERNALLY FUNDED

These are:-

- (a) Persons/patients whose health services are funded or partly funded by in terms of the Compensation for Occupational Injuries and Diseases Act (COIDA), 1993 (Act No 130 of 1993);
- (b) Persons/patients whose health services are funded or partly funded by the Road Accident Fund in terms of the Road Accident Act (RAF) 1996, (Act No 56 of 1996);
- (c) Persons/patients who belong to a medical aid scheme in terms of the Medical Schemes Act, 1998 (Act No 131 of 1998);
- (d) Persons/patients who are treated on the account of another department, local authority, foreign government or any other employer.
- (e) Persons, regardless of income, who are treated by their own doctor at or in a Departmental hospital. In case the Private Practitioner does not turn up, the patient must be reclassified according to the means test and pay as a self funded patient (H3).

CHAPTER FIVE

**APPROVED UPFS 2012 FEE SCHEDULE FOR EXTERNALLY FUNDED PATIENTS
TREATED AT PUBLIC HEALTH CARE FACILITIES**

CODE	DESCRIPTION	BASIS	Professional Fee R	FACILITY FEE							
				LEVEL 1		LEVEL 2		LEVEL 3			
				R	c	R	c	R	c		
01	<i>Anaesthetics</i>										
0111	Anaesthetics Cat A – General medical practitioner	Procedure	160.00								
0112	Anaesthetics Cat A – Specialist medical practitioner	Procedure	241.00								
0121	Anaesthetics Cat B – General medical practitioner	Procedure	273.00								
0122	Anaesthetics Cat B – Specialist medical practitioner	Procedure	411.00								
0131	Anaesthetics Cat C – General medical practitioner	Procedure	960.00								
0132	Anaesthetics Cat C – Specialist medical practitioner	Procedure	1441.00								
02	<i>Confinement</i>										
0210	Natural Birth – Facility Fee	Incident		2963.00		2963.00		344900			
0211	Natural Birth – General medical practitioner	Incident	1607.00								
0212	Natural Birth – Specialist medical practitioner	Incident	2075.00								
0213	Natural Birth – Nursing practitioner	Incident	1944.00								
0220	Caesarean Section – Facility Fee	Incident		4664.00		4664.00		5429.00			
0221	Caesarean Section – General medical practitioner	Incident	1607.00								
0222	Caesarean Section – Specialist medical practitioner	Incident	2075.00								
03	<i>Dialysis</i>										
0310	Haemo – Facility Fee	Day		1063.00		1063.00		1217.00			
0311	Haemo-dialysis – General medical practitioner	Day	202.00								
0312	Haemo-dialysis – Specialist medical practitioner	Day	253.00								
0313	Haemo-dialysis- Nursing Practitioner	Day	162.00								
0320	Peritoneal Dialysis – Facility Fee	Session		163.00		163.00		187.00			
0321	Peritoneal Dialysis – General medical practitioner	Session	33.00								
0322	Peritoneal Dialysis – Specialist medical practitioner	Session	39.00								
0323	Peritoneal Dialysis – Nursing practitioner	Session	22.00								
0330	Plasmapheresis - Facility Fee	Session		1063.00		1063.00		1217.00			
0331	Plasmapheresis - General medical practitioner	Session	202.00								
0332	Plasmapheresis - Specialist medical practitioner	Session	253.00								
04	<i>Medical Reports</i>										
0410	Medical Report – Facility Fee	Report		102.00		102.00		125.00			
0411	Medical Report – General medical practitioner	Report	192.00								
0412	Medical Report – Specialist medical practitioner	Report	296.00								
0421	Copies of Medical Report, records, X-Rays, completion of certificates / Forms - General medical practitioner	Copy	96.00								
0422	Copies of Medical Report, records, X-Rays, completion of certificates / Forms - Specialist medical practitioner	Copy	148.00								
0425	Copies of X-rays films, ultrasounds etc.	Copy	96.00								
05	<i>Imaging</i>										
0510	Radiology, Cat A – Facility Fee	Procedure		54.00		54.00		60.00			
0511	Radiology, Cat A – General medical practitioner	Procedure	53.00								
0512	Radiology, Cat A – Specialist medical practitioner	Procedure	99.00								

0514	Radiology, Cat A – Allied health practitioner	Procedure	52.00			
0520	Radiology, Cat B – Facility Fee	Procedure		148.00	148.00	170.00
0521	Radiology, Cat B – General medical practitioner	Procedure	143.00			
0522	Radiology, Cat B – Specialist medical practitioner	Procedure	278.00			
0524	Radiology, Cat B – Allied health practitioner	Procedure	138.00			
0530	Radiology, Cat C – Facility Fee	Procedure		687.00	687.00	784.00
0531	Radiology, Cat C – General medical practitioner	Procedure	441.00			
0532	Radiology, Cat C – Specialist medical practitioner	Procedure	1355.00			
0540	Radiology, Cat D – Facility Fee	Procedure		1752.00	1752.00	2002.00
0541	Radiology, Cat D – General medical practitioner	Procedure	1621.00			
0542	Radiology, Cat D – Specialist medical practitioner	Procedure	3383.00			
06	<i>Inpatients</i>					
0610	Inpatient General ward – Facility Fee	Day		544.00	694.00	1312.00
0611	Inpatient General Ward – General medical practitioner	Day	113.00			
0612	Inpatient General Ward – Specialist medical practitioner	Day	197.00			
0620	Inpatient High care – Facility Fee	12 hours		845.00	1056.00	1514.00
0621	Inpatient High Care – General medical practitioner	12 hours	59.00			
0622	Inpatient High Care – Specialist medical practitioner	12 hours	112.00			
0630	Inpatient Intensive care – Facility Fee	12 hours		2775.00	2775.00	3317.00
0631	Inpatient Intensive Care – General medical practitioner	12 hours	65.00			
0632	Inpatient Intensive Care– Specialist medical practitioner	12 hours	125.00			
0640	Inpatient Chronic care – Facility Fee	Day		319.00	319.00	319.00
0641	Inpatient Chronic care – General medical practitioner	Day	37.00			
0642	Inpatient Chronic care – Specialist medical practitioner	Day	86.00			
0643	Inpatient Chronic care – Nursing practitioner	Day	22.00			
0650	Day patient – Facility Fee	Day		453.00	572.00	838.00
0651	Day patient – General medical practitioner	Day	113.00			
0652	Day patient – Specialist medical practitioner	Day	197.00			
0653	Day patient – Nursing practitioner	Day	65.00			
0660	Inpatient Boarder/Patient companion – Facility Fee	Day		261.00	261.00	261.00
0663	Inpatient Boarder/Patient Companion – Nursing practitioner	Day	22.00			
0670	Inpatient General ward – Facility Fee	12 hours		273.00	348.00	656.00
0671	Inpatient General Ward – General medical practitioner	12 hours	57.00			
0672	Inpatient General Ward – Specialist medical practitioner	12 hours	98.00			
0673	Inpatient General Ward – Nursing practitioner (MOU)	12 hours	37.00			
0680	Inpatient Chronic care – Facility Fee	12 hours		160.00	160.00	160.00
0681	Inpatient Chronic care – General medical practitioner	12 hours	18.00			
0682	Inpatient Chronic care – Specialist medical practitioner	12 hours	41.00			
0683	Inpatient Chronic care – Nursing practitioner	12 hours	13.00			
07	<i>Mortuary</i>					
0710	Mortuary – Facility Fee	Day		138.00	138.00	158.00
0720	Cremation Certificate – Facility Fee	Certificate		138.00	1381.00	158.00
08	<i>Pharmaceutical</i>					
0810	Medication Fee – Facility Fee	Prescription		24.00	24.00	30.00
0815	Pharmaceutical IP	Item	Varies			
0816	Pharmaceutical –TTO	Item	Varies			

0817	Pharmaceutical - Chronic OPD	Item	Varies			
0818	Pharmaceutical – Oncology IP	Item	Varies			
0819	Pharmaceutical – Immune Suppressant Drugs IP	Item	Varies			
0820	Pharmaceutical Flat Fee – Chronic OPD	Item	Varies			
0825	Pharmaceutical Flat Fee – IP	Item	Varies			
0827	Pharmaceutical – Acute OPD	Item	Varies			
0828	Pharmaceutical – Oncology OPD	Item	Varies			
0829	Pharmaceutical – Immune Suppressant Drugs OPD	Item	Varies			
0830	Pharmaceutical Flat Fee – Acute OPD	Item	Varies			
09	<i>Oral Health</i>					
0910	Oral Care Cat A – Facility Fee	Procedure		21.00	21.00	23.00
0911	Oral Care Cat A – General medical practitioner	Procedure	36.00			
0912	Oral Care Cat A – Specialist medical practitioner	Procedure	30.00			
0914	Oral Care Cat A – Allied health practitioner	Procedure	26.00			
0920	Oral Care Cat B – Facility Fee	Procedure		62.00	62.00	73.00
0921	Oral Care Cat B – General medical practitioner	Procedure	70.00			
0922	Oral Health Cat B – Specialist medical practitioner	Procedure	111.00			
0924	Oral Care Cat B – Allied health practitioner	Procedure	57.00			
0930	Oral Care Cat C – Facility Fee	Procedure		384.00	384.00	440.00
0931	Oral Care Cat C – General medical practitioner	Procedure	425.00			
0932	Oral Care Cat C – Specialist medical practitioner	Procedure	729.00			
0940	Oral Care Cat D – Facility Fee	Procedure		1510.00	1510.00	1728.00
0941	Oral Care Cat D – General medical practitioner	Procedure	1303.00			
0942	Oral Care Cat D – Specialist medical practitioner	Procedure	2674.00			
0950	Oral Care Cat E – Facility Fee	Procedure		5086.00	5086.00	5812.00
0951	Oral Care Cat E – General medical practitioner	Procedure	4383.00			
0952	Oral Care Cat E – Specialist medical practitioner	Procedure	8993.00			
10	<i>Consultations</i>					
1010	Outpatient Consultation – Facility Fee	Visit		67.00	67.00	81.00
1011	Outpatient Consultation – General medical practitioner	Visit	75.00			
1012	Outpatient Consultation – Specialist medical practitioner	Visit	173.00			
1013	Outpatient Consultation – Nursing practitioner	Visit	43.00			
1014	Outpatient Consultation – Allied health practitioner	Visit	45.00			
1020	Emergency Consultation – Facility Fee	Visit		136.00	136.00	162.00
1021	Emergency Consultation – General medical practitioner	Visit	113.00			
1022	Emergency Consultation – Specialist medical practitioner	Visit	259.00			
1023	Emergency Consultation – Nursing practitioner	Visit	65.00			
1024	Emergency Consultation – Allied health practitioner	Visit	67.00			
1030	Follow-Up Outpatient Consultation – Facility Fee	Visit		67.00	67.00	81.00
1031	Follow-Up Outpatient Consultation – General medical practitioner	Visit	75.00			
1032	Follow-Up Outpatient Consultation – Specialist medical practitioner	Visit	173.00			
1033	Follow-Up Outpatient Consultation – Nursing practitioner	Visit	43.00			
1034	Follow-Up Outpatient Consultation – Allied health practitioner	Visit	45.00			
11	<i>Minor Theatre Procedures</i>					

1110	Minor Procedure Cat A – Facility Fee	Procedure		319.00	319.00	383.00
1111	Minor Procedure Cat A – General medical practitioner	Procedure	111.00			
1112	Minor Procedure Cat A – Specialist medical practitioner	Procedure	212.00			
1120	Minor Procedure Cat B – Facility Fee	Procedure		319.00	319.00	383.00
1121	Minor Procedure Cat B – General medical practitioner	Procedure	163.00			
1122	Minor Procedure Cat B – Specialist medical practitioner	Procedure	371.00			
1130	Minor Procedure Cat C – Facility Fee	Procedure		319.00	319.00	383.00
1131	Minor Procedure Cat C – General medical practitioner	Procedure	258.00			
1132	Minor Procedure Cat C – Specialist medical practitioner	Procedure	579.00			
1140	Minor Procedure Cat D – Facility Fee	Procedure		319.00	319.00	383.00
1141	Minor Procedure Cat D – General medical practitioner	Procedure	681.00			
1142	Minor Procedure Cat D – Specialist medical practitioner	Procedure	1534.00			
12	<i>Major Theatre Procedures</i>					
1210	Theatre Procedure Cat A – Facility Fee	Procedure		1033.00	1514.00	1745.00
1211	Theatre Procedure Cat A – General medical practitioner	Procedure	111.00			
1212	Theatre Procedure Cat A – Specialist medical practitioner	Procedure	212.00			
1220	Theatre Procedure Cat B – Facility Fee	Procedure		1563.00	2294.00	2641.00
1221	Theatre Procedure Cat B – General medical practitioner	Procedure	163.00			
1222	Theatre Procedure Cat B – Specialist medical practitioner	Procedure	371.00			
1230	Theatre Procedure Cat C – Facility Fee	Procedure		2685.00	3940.00	4547.00
1231	Theatre Procedure Cat C – General medical practitioner	Procedure	258.00			
1232	Theatre Procedure Cat C – Specialist medical practitioner	Procedure	579.00			
1240	Theatre Procedure Cat D – Facility Fee	Procedure		6886.00	10100.00	11640.00
1241	Theatre Procedure Cat D – General medical practitioner	Procedure	681.00			
1242	Theatre Procedure Cat D – Specialist medical practitioner	Procedure	1534.00			
13	<i>Treatments</i>					
1310	Supplementary Health Treatment – Facility Fee	Contact		43.00	43.00	52.00
1313	Supplementary Health Treatment- Nurse practitioner	Contact	38.00			
1314	Supplementary Health Treatment – Allied health practitioner	Contact	38.00			
1320	Supplementary Health Group Treatment – Facility Fee	Contact		34.00	34.00	37.00
1324	Supplementary Health Group Treatment – Allied health practitioner	Contact	26.00			
14	<i>Emergency Medical Services</i>					
1410	Patient transport service – Facility Fee	100km		286.00	286.00	286.00
1420	Basic life support – Facility Fee	50km		782.00	782.00	782.00
1430	Intermediate life support – Facility Fee	50km		1057.00	1057.00	1057.00
1440	Advanced life support – Facility Fee	50km		1757.00	1757.00	1757.00
1450	Emergency service standby – Facility Fee	Once-Off		400.00	400.00	400.00
1451	Emergency service standby – General medical practitioner	Hour	537.00			
1452	Emergency service standby – Specialist medical practitioner	Hour	723.00			
1453	Emergency service standby – Nursing practitioner	Hour	305.00			
1454	Emergency service standby – Emergency care practitioner	Hour	N/A			

1455	Emergency service standby – Basic life support practitioner	Hour	126.00			
1456	Emergency service standby – Intermediate life support practitioner	Hour	192.00			
1457	Emergency service standby – Advanced life support practitioner	Hour	337.00			
1460	Rescue – Facility Fee	Hour		837.00	837.00	837.00
1461	Rescue – General medical practitioner	Hour	1255.00			
1462	Rescue – Specialist medical practitioner	Hour	1881.00			
1463	Rescue – Nursing practitioner	Hour	837.00			
1464	Rescue – Basic life support practitioner	Hour	N/A			
1465	Rescue – Basic life support practitioner	Hour	128.00			
1466	Rescue - Intermediate life support practitioner	Hour	153.00			
1467	Rescue – Advanced life support practitioner	Hour	348.00			
1470	Emergency transport air services fixed wing	Flying Hour		7701.00	7701.00	7701.00
1480	Emergency transport air services helicopter (Single Engine)	Flying Hour		8457.00	8457.00	8457.00
1490	Emergency service standby – Facility Fee	Additional 50km		185.00	185.00	185.00
15	<i>Assistive Devices & Prosthesis</i>					
1510	Assistive Devices & Prosthesis - Item Fee	Item	Varies			
1520	Prosthetic Devices- Item Fee	Item	Varies			
1530	Dental Items – Item Fee	Item	Varies			
16	<i>Cosmetic Surgery</i>					
1610	Cosmetic Surgery Cat A – Facility Fee	Procedure		2173.00	2173.00	2482.00
1611	Cosmetic Surgery Cat A – General medical practitioner	Procedure	1253.00			
1612	Cosmetic Surgery Cat A – Specialist medical practitioner	Procedure	1877.00			
1620	Cosmetic Surgery Cat B – Facility Fee	Procedure		4886.00	4886.00	5586.00
1621	Cosmetic Surgery Cat B – General medical practitioner	Procedure	1484.00			
1622	Cosmetic Surgery Cat B – Specialist medical practitioner	Procedure	2227.00			
1630	Cosmetic Surgery – Cat C – Facility Fee	Procedure		7892.00	7892.00	9021.00
1631	Cosmetic Surgery Cat C – General medical practitioner	Procedure	2510.00			
1632	Cosmetic Surgery Cat C – Specialist medical practitioner	Procedure	3765.00			
1640	Cosmetic Surgery Cat D – Facility Fee	Procedure		13332.00	13332.00	15236.00
1641	Cosmetic Surgery Cat D – General medical practitioner	Procedure	2816.00			
1642	Cosmetic Surgery Cat D – Specialist medical practitioner	Procedure	4143.00			
17	<i>Laboratory Services</i>					
1700	Drawing of Blood	Contact		26.00	26.00	26.00
1710	Laboratory Test	Varies				
18	<i>Radiation Oncology (Refer to proposed list)</i>					
1800	Radiation Oncology (NHRPL less VAT)	Item	Varies			
19	<i>Nuclear Medicines</i>					
1900	Itemisation of Isotopes	Item	Varies			
1910	Nuclear Medicine Cat A - Facility Fee	Procedure		488.00	488.00	488.00
1912	Nuclear Medicine Cat A: Specialist medical practitioner	Procedure	243.00			

1920	Nuclear Medicine Cat B- Facility Fee	Procedure		488.00	488.00	488.00
1922	Nuclear Medicine Cat-B Specialist medical practitioner	Procedure	730.00			
1930	Nuclear Medicine Cat C- Facility Fee	Procedure		488.00	488.00	488.00
1932	Nuclear Medicine Cat C - Specialist medical practitioner	Procedure	1431.00			
1940	Nuclear Medicine Cat D- Facility Fee	Procedure		488.00	488.00	488.00
1942	Nuclear Medicine Cat-D Specialist medical practitioner	Procedure	2190.00			
1950	Positron Emission Tomography (PET) Cat E - Facility Fee			4735.00	4735.00	4735.00
1952	Positron Emission Tomography (PET) Cat E - Specialist medical practitioner		2367.00			
20	<i>Ambulatory Procedures</i>					
2010	Ambulatory Procedure Cat A - Facility Fee	Procedure		102.00	102.00	125.00
2011	Ambulatory Procedure Cat A - General medical practitioner	Procedure	37.00			
2012	Ambulatory Procedure Cat A - Specialist medical practitioner	Procedure	74.00			
2013	Ambulatory Procedure Cat A - Nursing practitioner	Procedure	22.00			
2014	Ambulatory Procedure Cat A - Allied Health Worker	Procedure	22.00			
2020	Ambulatory Procedure Cat B - Facility Fee	Procedure		102.00	102.00	125.00
2021	Ambulatory Procedure Cat B - General medical practitioner	Procedure	5300			
2022	Ambulatory Procedure Cat B - Specialist medical practitioner	Procedure	81.00			
2023	Ambulatory Procedure Cat B- Nursing Practitioner	Procedure	30.00			
2024	Ambulatory Procedure Cat B- Allied Health Worker	Procedure	30.00			
21	<i>Blood and Blood Products</i>					
2100	Blood and Blood Products	Varies				
22	<i>Hyperbaric Oxygen Therapy</i>					
2200	Hyperbaric Oxygen Therapy- Facility Fee (Flat Fee)	Session		355.00	355.00	355.00
2210	Hyperbaric Oxygen Therapy- Facility Fee	Session		1072.00	1072.00	1072.00
2211	Hyperbaric Oxygen therapy - General medical practitioner	Session	452.00			
2212	Hyperbaric Oxygen therapy - Specialist medical practitioner	Session	452.00			
2220	Emergency Hyperbaric Oxygen Therapy - Facility Fee	Session		1080.00	1080.00	1080.00
2221	Emergency Hyperbaric Oxygen Therapy - General medical practitioner	Session	660.00			
2222	Emergency Hyperbaric Oxygen Therapy - Specialist medical practitioner	Session	660.00			
23	<i>Consumables (Not included in Facility Fee) Buy-outs</i>					
2300	Consumables not included in the facility fee	Item	Varies			
24	<i>Autopsies</i>					
2410	Autopsy- Facility Fee	Per case		67.00	67.00	81.00
2411	Autopsy- General Practitioner	Per case	75.00			
2412	Autopsy- Specialist Practitioner	Per case	173.00			

CHAPTER SIX**FEES – OTHER****7.1 MORTUARY FEES**

Persons who die in a departmental health facility, FREE for the first 24 hours, and thereafter charged according to the UPFS tariffs and level of the hospital. The storage of people that die outside the hospital is charged at the UPFS rate on a daily basis. This charged fee shall be liability to the next of kin or the funeral undertaker to remove the corpse at the hospital. H1 and H0 mortuaries are free of charge provided the corpse is removed by the next of kin and **not by the undertaker.**

7.2 ARTIFICIAL AIDS, ASSISTIVE DEVICES, AND ORAL HEALTH PROSTHETICS

All assistive devices should be sold at a cost price taking into consideration the category of the patient.

7.3 COSMETIC SURGERY

A patient who presents at a departmental hospital for the purpose of undergoing elective cosmetic surgery must be billed at **private rates**, in cash, prior to admission (UPFS fees apply).

7.5 NOTES ON CHARGES FOR HOSPITAL PATIENTS (i.e. NON-PRIVATE)

(a) **OUTPATIENT VISIT:** When an outpatient is admitted as an inpatient during an outpatient visit, **the basic outpatient tariff falls away.** The conversion is done electronically through PAAB.

(b) **ALLIED HEALTH SERVICES:** A comprehensive package is applicable where:-

- (i) A SERIES of therapeutic or rehabilitation treatment regimes is given;
- (ii) TRAINING OR COUNSELLING is given to patients with impairments or disabilities in any way; and
- (iii) GROUP THERAPY (i.e. where one person trains/counsels/rehabilitates two or more individuals) is practiced preceding or following acute stage of individual treatment e.g. coronary thrombosis, diseases of lifestyle such as diabetes and hypertension, psychiatry and pre- and post-natal exercise sessions.

The fee for these comprehensive services is payable per contact, in cases of each private patient – **see the UPFS schedule.**

(c) **LONG TERM PATIENTS:** Patients who for medical reasons have to be hospitalized for a continuous period of more than 30 days and who require continuous nursing and medical care are to pay the applicable tariff per 30 days or part thereof.

See the schedule of prosthetic devices.

Where crutches are supplied, they should be sold as per the percentages of assistive devices of the cost-price considering the classification of the patient. Glucometers if supplied should be sold at cost-price.

7.6 PATIENT TRANSPORT AND AMBULANCE SERVICES FEE:

A patient making use of patient transport or ambulance services (EMS) should pay a tariff according to the patient classification. Patients to be charged are the one collected from home to the public or private hospital or from the scene of the accident to the public or private hospital.

A patient transported from one public hospital to another is free. The charging of the transport should be calculated from 1km distance at a minimum rate.

- Where an ambulance is requested for deployment on a standby basis, a charge of **facility fee once off is levied plus the professional fee charged on an hourly rate**. The Head of Department or such other person duly authorized by her/him may authorize the conveyance by **air-ambulance** of a patient who requires emergency, casualty or inpatient treatment. A charge for such conveyance will be levied.
- The Head of the Department or such other person duly authorized by her/him may authorize the use of a **private ambulance service**, for a patient that requires emergency life saving transport where no departmental transport is available within a reasonable period. The normal departmental rate will be levied to the patient in such circumstances.

7.7 REPORTS AND CERTIFICATES:

7.7.1 FREE REPORTS AND CERTIFICATES

The following medical reports/certificates should be completed **FREE**:

(1) medico-legal services in respect of:-

- (i) assault
- (ii) rape
- (iii) driving a motor vehicle while under the influence of alcohol or drugs having a narcotic effect;
- (iv) mentally ill persons for the purposes of observation in terms of the Mental Health Act, 1973;
- (v) certification/confirmation of death;
- (vi) post mortem examinations;
- (vii) court cases

(2) Medical reports for private practitioners in respect of Compensation for Occupational Injuries and Diseases (COIDA) {formerly Workmen's' Compensation Act (WCA)} cases treated by medical personnel in the employ of the Department

(3) Medical reports for review of disability for social support grants.

7.7.2 OTHER REPORTS AND CERTIFICATES

All other reports and certificates may be completed and issued on request and only with the written permission of the patient to any authorized person. All patients to be charged at full UPFS tariffs. Tariff to be charged will include the **Facility fee as per the level of the hospital plus the professional fee**.

Copies of medical reports are also charged as per the UPFS tariffs.

7.8 BOARDER CHARGES

An application for a boarder to be admitted must be written by the doctor who treated the patient and approved by the Superintendent.

- | | |
|-------------------------------------|---|
| (i) Boarders, boarder baby: PRIVATE | As per the UPFS tariffs.
+ plus nursing fee (if utilised) |
| (ii) Boarders: HOSPITAL PATIENTS | to pay the H1, H2 or H3
tariffs applicable to the patient. |

7.9 CREMATION CERTIFICATE

UPFS tariffs to be charged for the completion of a cremation certificate according to the level of the hospital

CHAPTER SEVEN

PROCEDURES

8.1 DIAGNOSTIC SERVICES RENDERED IN TERMS OF THE COMPENSATION FOR OCCUPATIONAL DISEASES IN MINING AND WORKS AMENDMENT ACT 208 OF 1993.

8.1.1 Where the director of the Medical Bureau for Occupational Disease (MBOD) refers ex mineworkers or other clients for X Ray and / or other examinations, an account is sent from the institutions for the prescribed diagnostic service to the Director, MBOD, at BOX 995 PRETORIA 0001.

8.2 LONG TERM PATIENTS

8.2.1 Long term hospital patients, including social pensioners, who are still accommodated in curative or psychiatric hospitals after a maximum of 90 days, become the responsibility of the relevant department which administers the person's pension benefits or is legally responsible for the person, and those departments should be charged the maximum daily fees applicable to a general ward in a regional hospital.

8.2.2 The Department of Population and Development will be responsible for those in need of care who do not require continual medical attention and trained nursing. Such patients should therefore be discharged.

8.2.3 When long-term hospital patients are brought to the attention of the medical superintendent, s/he should investigate the person's circumstances to determine whether the person satisfies the requirements that the Department of Social Services, Population and Development should meet the person's financial obligation to the Department for her/his further accommodation.

8.2.4 A committee comprising the medical superintendent, the hospital matron, the hospital manager / chief executive officer and a **medical social worker** and/or social worker from the Department of Social Services, Population and Development should conduct the investigation. The absence of the social worker shall not influence the decision of the committee.

8.2.5 Should the committee decide that the person no longer requires continual medical attention and trained nursing care; the hospital should treat the person concerned in terms of the above recommendations.

8.2.6 LONG-TERM PATIENTS LEAVE OF ABSENCE

The patient or her/his guardian must apply for leave. The application must be supported by the attending medical practitioner. The patient must indemnify the department and the Hospital in respect of any claims that may arise due to complications during her/his absence. The patient remains liable for hospital fees during her/his absence.

8.3. INJURY ON DUTY – COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT 1993

8.3.1 Whereas employees can be encourage to be treated at a public hospital, they may not be restricted to these public hospitals according to the COID Act, the exempted employer must pay all reasonable medical expenses consistent with the tariffs prescribed by the Compensation Commissioner. The employer may not demand or receive any contribution from an employee in the form of payment for medical costs in terms of section 77 of the COID Act. If the services are not available in the public hospital, the patient can be referred to a Private Hospital, in which case, the account will be paid by the public hospital.

8.3.2 The employer or delegate should fill in the relevant forms and send an account to the **Commissioner** for Occupational Injuries and Diseases as soon as possible (not less than 48 hours). The Department of Public Service and Administration (DPSA) guidelines prescribe that all medical expenses must be paid by the exempted employers who must budget for such costs.

8.3.3 Provincial Administrations are registered as exempted employers in terms of section 84 of the COID Act and are as such liable for the payment of compensation including reasonable medical expenses for their employees.

8.4 FUNCTIONAL EVALUATION – OCCUPATIONAL THERAPY

8.4.1 Where patients are referred to hospitals which render this specialized service in order to evaluate the patient's functional ability in relation to employment and development **private outpatient tariff** should be levied for every visit to the occupational therapy section. An estimate of the number of visits required is made beforehand and the firm of attorneys/institution concerned should then pay **IN ADVANCE** for the number of visits multiplied by the prescribed outpatient tariff, plus the tariff for medical report for the completion of the evaluation report. In cases where actual visits are less or more than the estimated visits, adjustments should be made.

8.5 PATIENTS WHO ARE HOSPITALISED IN DIFFERENT WARDS ON THE SAME DAY

8.5.1 The daily tariff is calculated in accordance with the tariff for the relevant ward where the patient is at midnight.

8.6 FOREIGN PATIENTS

8.6.1 The following procedures and regulations concern the treatment of foreign patients:-

- (a) Private hospital tariffs should be charged in cases where emergency medical services are needed.
- (b) Visitors who visit the Republic exclusively for medical treatment, as well as tourists who require elective procedures should furnish a **cash full amount for the full cover** of the costs for health services at the prescribed maximum rates. This rule applies in cases where prior arrangements have been made for such a service and the patient's passport has been endorsed accordingly.
- (c) An immigrant who lives in the country permanently, but has not yet acquired South African citizenship, foreigners with temporary work permits, as well as persons from neighboring states (e.g. Mozambique, Zambia, etc.) who enter RSA legally, are treated as South African citizens in terms of the appropriate tariffs and procedures.
- (d) The existing agreements between the health authorities of South Africa and various other countries remain unchanged.

8.7 SCHOOL CHILDREN

- 8.7.1 School children who can be classified as HO, H1, H2, or H3 patients and who are referred with a letter of authority from the school nursing services or oral health services are treated **FREE** for all treatment arising from such letter of authority.
- 8.7.2 School children who are **private** patients may be treated at a Departmental hospital / dental clinic and pay the private patient tariff accordingly.
- 8.7.3 The school nurse or oral health services official should write a letter of referral to the parent(s) advising that the child needs treatment. On production of that letter at a Departmental hospital, the treatment of the HO, H1, H2 or H3 school-child-patient would be free.

8.8 PATIENTS WITH MENTAL DISORDERS

- 8.8.1 Patients with mental disorders who undergo a hysterectomy as a sterilisation procedure, should be treated **FREE**.

8.9 ISSUING OF ACCOUNTS

- 8.9.1 Hospital manager and/or management has more powers in deciding whether or not an account should be set up, and must consider the following actions:-
- (a) Use of the delegation for free treatment or treatment at a reduced rate, where payments cannot be obtained on admission or attendance.
 - (b) This delegation may only be exercised where insufficient information exists regarding the debtor details or where financial and family circumstances are such that there is sufficient reason to believe that no payment will be received upon setting up an account.
- 8.9.2 Hospital Management should consider the following steps in the collection of revenue:-
- (a) Obtain cash payments as far as possible from patients not on medical aid.
 - (b) Obtain deposits of at least the prescribed outpatients and one day's inpatient fees, from patients who cannot supply a satisfactory guarantee.
 - (c) Place hospital patients on a lower group, on merit, where insufficient cash is on hand at attendance/admission.
 - (d) Allow H1 and H2 hospital patients free treatment on merit where no cash is available, and debtors are suspect.
 - (e) Set up ordinary accounts for all patients who:-
 - (i) are on an acceptable medical aid scheme; or
 - (ii) have provided an acceptable guarantee for the payment of the account; or
 - (iii) are private patients; or
 - (iv) are hospital patients who did not pay cash and could not satisfy hospital manager and/or management that relief should be granted in terms of the recommended delegations.
 - (f) Arrange a strategy for salary deductions, where possible.

8.10 TRANSFERS AND REFERRALS

- 8.10.1 The policy in regard to the charging of patients transferred between or referred to Departmental or state subsidized institutions are as follows:-
- (a) Charges must be raised at the prescribed rates, against all subsidized or private patients transferred or referred, by BOTH the transferring and receiving hospitals, as applicable.

- (b) The appropriate charge must be raised by the receiving hospital against hospital patients from a clinic or an outpatient department admitted as an inpatient at the receiving hospital.
- (c) The appropriate charge must be raised by the receiving hospital/institution where the referral is for the specific purpose of obtaining orthopaedic appliances or artificial aids.
- (d) No further charges must be raised against a hospital patient at the receiving hospital, if the patient is an inpatient at the referring hospital and is admitted or treated as an outpatient at the referred hospital. A patient **discharged** at the referring hospital and **at a later date** admitted at the receiving hospital, is **NOT** on transfer and must be **charged** accordingly.
- (e) A patient returned to the referring hospital admitted as an inpatient will **NOT** be charged again. A patient **discharged** from the receiving hospital, which **at a later date** presents for admission should be charged for that **(new) admission**.
- (f) Charges must be raised at the receiving hospital for all subsequent outpatient visits prescribed by the receiving hospital.
- (g) Referring institutions must ensure that the **appropriate revenue documentation** accompanies the patient, especially where accounts have to be set up for a hospital patient, or where a treatment at a reduced rate has been allowed in terms of the delegations.
- (h) An inpatient referral to a Regional Hospital will **NOT** create a new admission charge for that patient.
- (i) A patient, not previously admitted into another hospital, but referred to a Regional Hospital, even if then referred on to another hospital, will be charged for any admission to a Regional Hospital. This includes follow-up cases.
- (j) The referral hospital must arrange for the return of the deceased patient from the receiving hospital.

Printed by and obtainable from the Government Printer, Bosman Street, Private Bag X85, Pretoria, 0001. Tel. (012) 334-4507, 334-4511, 334-4509, 334-4515
Also available at the Provincial Legislature: Mpumalanga, Private Bag X11289, Room 114, Civic Centre Building, Nel Street, Nelspruit, 1200. Tel. (01311) 5-2133
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