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# Harnessing the private health sector by using prices as a policy instrument: Lessons learned from South Africa

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ABSTRACT

Governments frequently draw upon the private health care sector to promote sustainability, optimal use of resources, and increased choice. In doing so, policy-makers face the challenge of harnessing resources while grappling with the market failures and equity concerns associated with private financing of health care. The growth of the private health sector in South Africa has fundamentally changed the structure of health care delivery. A mutually reinforcing ecosystem of private health insurers, private hospitals and specialists has grown to account for almost half of the country's spending on health care, despite only serving 16% of the population with the capacity to pay. Following years of consolidation among private hospital groups and insurance schemes, and after successive failures at establishing credible price benchmarks, South Africa's private hospitals charge prices comparable with countries that are considerably richer. This compromises the affordability of a broad-based expansion in health care for the population. The South African example demonstrates that prices can be part of a structure that perpetuates inequalities in access to health care resources. The lesson for other countries is the importance of norms and institutions that uphold price schedules in high-income countries. Efforts to compromise or liberalize price setting should be undertaken with a healthy degree of caution.



## 1. Introduction

Most member countries of the Organization for Economic Cooperation and Development (OECD) have implemented universal health coverage (UHC)—in that they have achieved good health outcomes through universal access to care without financial hardship [1]. Rising health care spending, however, has pressured policymakers to maximize all available health resources and reduce waste and inefficiencies. As such, governments frequently draw on the private sector to promote sustainability, optimal use of resources, and increased choice of care.

In doing so, policy-makers face the challenge of harnessing resources and efficiency gains while addressing the market failures and equity concerns associated with private financing of health care. Continual deliberations are underway—across France, Australia, Germany, Israel, the United Kingdom, for example—about whether the private sector should play a greater role, what shape should this take, and the effect this may have on public health care services.

South Africa provides an extreme but interesting counterpoint in this debate. South Africa spent 8.4% of its GDP on health in 2015—but this aggregate belies a reality of two health systems with very different levels of resources [2]. Just under half of health spending serves 16% of the population who can afford to access private providers through private voluntary health insurance (called "medical aid").[1] Starting from a health system characterized by a dominant private sector, South Africa is struggling to find a path towards universal coverage. It shares elements of both National Health Service systems and social insurance (restricted "medical aid" schemes) but, to date, the government has not yet scaled the public system or funded the private system to fully serve its popu-

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[1] The authors rely on the WHO definition of private voluntary health insurance characterized by voluntary participation and universal access to a public health system.

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lation. The origins of these challenges are fiscal and deeply rooted in South Africa's status as a middle-income country, with fledgling economic growth, considerable inequality, and high numbers of people working in the informal sector contributing to a weak tax base [3,4]. A unique feature of South Africa's policy environment is the legal view that a health price schedule represents collusion [5]. The precedent established by this view has stopped the development of effective and enforceable regulations and norms for pricing to inform health stakeholders.

This paper describes the role of private voluntary health insurance in high-income settings, and how countries have utilized different policy instruments to ensure access. The development of the private health care sector in South Africa is then described as an example of a dual public-private health system, in which the concentration of resources in the private sector—and the prices they charge—has become a major challenge to expanding access to health services. We conclude with observations about what this may imply for debates in high-income countries over the appropriate mechanisms to govern private sector involvement to achieve UHC.

## 2. Role of private voluntary health insurance

Private voluntary health insurance (PVHI) performs different roles, typically shaped by the design of the statutory health coverage and delivery systems across different countries (Fig. 1). It can supplement public services to offer amenities, choice, or reduced wait times. The majority of people in Switzerland and Australia, for example, purchase supplementary insurance to enable choice of physicians within hospitals or access single hospital rooms. Other countries utilize PVHI to complement public benefits through coverage for user fees or additional services outside of the benefits package (i.e., Germany and France). Ireland dedicates 14% of total health expenditures on substitute coverage for less than 1% of their population ineligible for public benefits [6]. These variations in drawing on private insurance illustrate the different policy choices that countries have made about how to balance amenities, convenience and equitable access.

Across high-income countries, the public sector is the dominant payer, if not provider, of health care services, employing different policies to achieve a public-private balance. Such policies include public financing to influence outcomes—through, for example, policy decisions about the quantity and structure of public funding and purchasing. Public funding is the basis for advancing UHC in most countries; therefore, the institutions, policies and processes that determine the use of public funds and contracting health care providers (whether public or private) can play a critical role in driving equity, providing incentives for efficiency and quality, and ensuring accountability [6].

Another set of policies focuses on regulating and aligning the scope and incentives of private financing. Governments have intervened heavily to address adverse selection by setting the rules and boundaries for the conduct of PVHI through regulation, i.e., defining the scope of coverage, membership, reimbursement, co-payments and the re-allocation of risk. In OECD countries, governments have used such regulation to shape PVHI into playing specific roles, such as filling a financing gap (France), providing additional services and financial protection beyond the public benefit basket (Germany), or supplement public benefits (Belgium) (Fig. 1). Implicit in their regulatory and funding decisions is a view about how to balance public and private health resources to meet the country's overall health needs.

Across most OECD countries, price schedules have been used as the basis for public purchasing of services from the private sector and provide benchmarks for private insurers. Regulation in OECD countries generally enables collective bargaining on hospital prices, in particular. Developing credible prices has been common to OECD countries that have then come to draw on private sector facilities and providers to expand access to health services in recent years [7].

## 3. Development of South Africa's private health care sector

South Africa has the distinction of spending 43% of national health expenditures on PVHI – the highest share globally (Fig. 2) [2]. This does not reflect social norms of purchasing essential health services from the private health care sector for a large section of the population, as one might find in the US—the only rich country with close to a comparable structure of spending. Rather, it serves a small section of the high-income population who pay premiums for PVHI to access private hospitals and specialists. This unique situation has its roots in the history of South Africa. The origins of today's medical aid schemes lie with the mining industry and developed in the 1900s into a system of health facilities and services that were racially segregated and allocated different levels of resources [8].

In 1960, 169 schemes provided cover for over 368,000 members and their dependents [9], accounting for approximately 80% of the eligible population of whites (19% of the total population at the time) [10]. Race restrictions were lifted in the 1970s, after which the number of schemes increased, and membership became more racially diverse [11]. Major regulation of the schemes did not occur until the establishment of the Medical Schemes Act in 1967 when aspects of social health insurance were introduced (i.e., minimum benefits, community rating) [12].

The Medical Schemes Act of 1988 and the Amendment Act No. 23 of 1993 deregulated the sector, introducing risk-rated contributions and removing guaranteed minimum benefits. Some of these changes were reversed again after 1994, with a shift back to the pre-1980s principles of solidarity. By 1998, the Medical Schemes Act, No. 131 reintroduced prescribed minimum benefits and community rating [13]. By early 2017, there were 82 medical schemes: 60 employment-based and 22 open enrolment [14]. Among these, two Schemes – Discovery Health Medical Scheme and the Government Employee Medical Scheme (GEMS) – covered over half of total beneficiaries.

Unlike today, medical schemes primarily reimbursed fees in public hospitals before the 1980s [15]. While the poor were exempt from payment, those who could afford the insurance were required to cover the costs of hospital care. Thus, the government extended tax subsidies to employers to encourage them to provide insurance coverage for their employees. Today tax credits continue to be provided to subsidize the cost of medical scheme membership; in addition, public benefits are guaranteed to civil servants as a part of negotiated employment contracts. Some estimates suggest that such subsidies and benefits could amount to upwards of 30% of total medical scheme revenues [16].

Non-profit private hospitals were established by the mining industry and the church alongside medical aid schemes. For-profit private hospitals began to grow in the 1980s, galvanized by pro-market economic policies and declining public health investments accompanied by a sluggish economy following international economic sanctions [13,15]. The number of private hospitals increased more than three-fold between 1986 and 2014, accounting for 31% of total hospitals beds (Table 1) [17,18]. Specialists began working in both public and for-profit private hospitals, and invested as shareholders in the growing private network of hospitals, diagnostics and other support services [15]. As gatekeepers to hospitals, they were able to route patients covered by medical schemes into private hospitals that billed full cost recovery and profit margins on services.

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