

The private health sector in South Africa — current trends and future developments

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Summary

The private health sector is experiencing a crisis of spiralling costs, with average annual cost increases of between 13% and 32% over the decade 1978 - 1988. This trend is partly explained by the high utilisation rates that result from the combination of the 'fee-for-service' system and the 'third-party' payment structure of the sector.

Medical schemes have responded by promoting the idea of 'flexible packages', and have won the right to 'risk-rate' prospective members. It is argued that these measures will undermine the principle of equity in health care, and will not solve the problems of the private sector. Instead, a more significant restructuring of the sector is likely to emerge. This may take the form of 'managed care' structures, along the lines of the health maintenance organisation model from the USA.

The principles, advantages and problems of 'managed care' structures are described. These are shown to be potentially more rational and efficient than the current structure of the private sector. Although some resistance to 'managed care' structures can be expected, the convergence of interests of large employers and trade unions in containing health care costs suggests that their emergence is a likely development.

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The private health sector accounted for 43,6% of South Africa's total health care bill of over R9 billion in 1987. Despite this substantial share of total resources, the sector provided care for less than 25% of the total population.¹ The vastly greater per capita expenditure in the private health sector is partly a result of better standards of care, more sophisticated methods of diagnosis and treatment, and more luxurious facilities than in the public sector. However, it is also explained by significant financial inefficiencies and overutilisation of services in this sector. The cost to private individuals of health care has been increasing well above the rate of increase in private income. For this and other reasons the private health sector is currently confronted by a serious cost crisis.

A further factor confronting the private health sector is that a fundamental prerequisite of a more equitable health service for South Africa will be some redistribution of resources between the private and the public sectors.² The private health sector is therefore likely to be faced with a significant reduction of its share of total health resources compared with the situation at present.

In this paper we cite evidence to demonstrate the spiralling costs of private sector health care, and identify the major factors contributing to the cost spiral. We then examine the

solutions that important actors in the private health sector are experimenting with, and argue that most of these are short-term solutions with negative long-term consequences. In our view, only significant restructuring of the private health sector is likely to address the problems effectively. Finally, we suggest that a significant restructuring of private sector health care is inevitable, and that this restructuring is likely to lead to the emergence of new 'managed care' entities on a significant scale.

Cost escalation in the private health sector

Medical schemes in South Africa are, by law, non-profit-making. As such, their annual income (which comes from members' contributions) bears a fixed relationship to, and roughly equals, their annual expenditure on health services for their members. Furthermore, most expenditure in the private sector flows through medical aid schemes. For these reasons, the level of contributions to such schemes, and the rates of change in such contributions, are useful indicators of trends in expenditure on health services in the private sector. The average monthly contributions of members of all medical schemes combined increased from R20,44 in 1978 to R136,68 in 1988. Table I shows that the rate of increase has varied between 13% and 32% per year, with an average annual increase of 23%. Over the 11 years the contribution rate increased ninefold, compared with a fourfold increase in the consumer price index.

TABLE I. COSTS OF MEDICAL SCHEME COVERAGE, 1978 - 1988

| Year | Increase (%) | |
|------|------------------------|------------------------|
| | Monthly contributions* | Annual inflation rate† |
| 1978 | 32 | 10,9 |
| 1979 | 13 | 13,3 |
| 1980 | 25 | 13,8 |
| 1981 | 13 | 15,2 |
| 1982 | 17 | 14,7 |
| 1983 | 28 | 12,3 |
| 1984 | 26 | 11,7 |
| 1985 | 22 | 16,2 |
| 1986 | 22 | 18,6 |
| 1987 | 24 | 16,1 |
| 1988 | 22 | 12,9 |

*Report by the Registrar of Medical Schemes for the year ended December 1989.
† Central Statistical Services.

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Explaining these cost trends

The health sector in general is subject to a greater degree of cost escalation than most other economic sectors. Among the reasons for this are the ageing of the population, which

requires greater expenditure on health services, and the development and use of increasingly expensive technologies. In South Africa these factors have been aggravated by the increases in the prices of imported goods, such as medicines and equipment, due to the fall in the value of the rand in the 1980s.

However, there are additional factors, specific to the current organisation of the private health sector, that have contributed significantly to cost inflation.

These factors derive primarily from the absence of the conditions necessary for the free market to function normally. An effectively functioning free market requires informed consumers as well as free competition between suppliers. Neither of these conditions obtains in the health sector.

As a result, the usual market interaction between prices and the supply and demand for goods does not occur in the health sector. One important consequence is the well-documented fact that it is the providers and not the consumers of health care who make most of the important decisions about which services will be supplied. This phenomenon has been termed 'supplier-induced demand'.³⁻⁵

This market distortion is compounded by the particular incentives that govern the behaviour of both providers and consumers in the private health sector in South Africa. The vast majority of providers in the private sector are paid on a fee-for-service basis. There is extensive evidence, both local and international, that this method of reimbursement encourages practitioners to increase their supply of services, since it is clearly in their economic interest to do so.⁶

This situation is exaggerated by the fact that the vast majority of private sector consumers belong to medical aid schemes. In this so-called 'third-party' payment system, neither the patient nor the provider carries the immediate cost of service.

The incentive structure of the private health sector could thus hardly be worse from a cost point of view; providers are encouraged to increase the supply of services because they are paid on a fee-for-service basis, and because payment comes from the medical scheme there is no incentive for providers or their patients to attempt to contain costs.

The net result is that the rates of utilisation of goods and services in the private health sector are significantly higher than they would be with adequate controls and a different incentive structure.⁶ This overutilisation in turn explains, to a very significant extent, the rapidly increasing costs of private sector health care.

The consequences

The private health sector is in danger of pricing itself out of the market. Membership of medical aid schemes has been static in the white population for several years, and in recent years it has begun to fall significantly, declining from 87% in 1983 to 68,4% in 1988. Although the small present membership among the employed black population means that there remains the potential for expansion of membership of medical schemes, there is likely to be a ceiling to this expansion, since membership is becoming increasingly unaffordable for all but the wealthiest workers.

In response, the medical scheme administration companies have developed strategies designed to retain membership, without significant structural changes in the medical scheme system. Such strategies include the promotion of 'flexible packages', i.e. good comprehensive care at a high price, and limited cover at a cheaper price. These adaptive strategies are facilitated by recent legislative changes that allow for medical schemes to engage in 'risk-rating'.² Both these strategies undermine the basic equity principle of the healthy subsidising the sick. As a result, increasing numbers of people will be left

with inadequate health insurance coverage, because a decent package will be extremely expensive, or even unaffordable, especially for the elderly or those with serious illnesses.

In our opinion, therefore, tinkering with insurance arrangements will not solve the problems of the private health sector. In the longer term, the private sector will be forced to seek organisational changes that will allow for the delivery of more efficient and cheaper care. One example of these changes is to be found in the 'managed care' structures described below.

'Managed care' — integrated health financing and delivery

We use the term 'managed care' to refer to forms of private health care services that differ from the fee-for-service, 'third-party' payment system in two respects. Firstly, payment is fixed in advance and prospectively reimburses the provider for a specified range of services. Secondly, the functions of financing and providing health care services are integrated within one organisation.

The best-known organisational form of 'managed care' is the health maintenance organisation (HMO).⁷⁻¹⁰ The HMO competes with fee-for-service providers and other HMOs in offering a 'health plan' at competitive rates. By joining the 'plan', a member (or an employer on behalf of its employees) enters into a contract in terms of which the HMO will provide a wide range of health care services in return for a monthly contribution per member, fixed in advance. Members are thus restricted in their choice of providers, since they will only receive free services from providers within their own HMO; should they choose to go elsewhere, they will usually have to meet additional costs themselves.

HMOs differ in the manner in which they arrange to provide the package of services they guarantee to provide. The 'staff model' HMO employs its own doctors and other practitioners, and may either operate its own hospitals or contract with outside ones to provide inpatient care. The 'network model' on the other hand, does not employ its own practitioners, but contracts with individuals and group practices of general practitioners and specialists to provide care to its members. Several variations exist, but they do not differ in principle from the forms described here.

The theory underlying the operation of HMOs is that the integration of financing and provision of health care services will remove the 'perverse incentive' operating in the fee-for-service sector. Thus, an HMO that has contracted to provide a range of services to each member at a predetermined and fixed rate will have a strong incentive to ensure that its costs per member do not overrun its income from contributions.

In practice, this new incentive structure operates in several ways; doctors and other providers are paid a salary, a capitation fee or a reduced percentage of the fee-for-service tariff. In addition, providers may be rewarded for meeting cost targets in terms of investigations, rates of referral and rates of hospital admission. A well-documented source of cost saving within HMOs is control over hospital expenditure. Extensive use is also made of different forms of utilisation review within the HMO structure. An example here is the comparison of practitioners with their colleagues in terms of expenditure on different categories of service. Other methods of cost containment such as generic drug substitution may also be used.

Since it has significant influence over providers, either by employing them or by contracting with them on its own terms, this type of structure has the ability to contain costs effectively; and since it is committed to a certain level of income in advance, the incentive to contain costs in this way is a strong one.

Advantages of 'managed care'

Cost effectiveness

There is strong evidence to suggest that managed care structures will generate significant savings and thus be more cost-effective than current private sector care.⁹⁻¹³ Savings can in turn be passed on to members in the form of lower contributions.

Organisational advantages

The nature of managed care also throws up important organisational advantages. The integration of financing and delivery of services necessitates a high degree of co-ordination and planning within the structure. This is in strong contrast to the irrationality of fee-for-service care, in which a vast number of independent providers operate in isolation from each other and from those responsible for paying for their services.

Advantages in the mix of services delivered

Managed care structures tend to emphasise ambulatory over inpatient care. The reason for this is again the economic incentives in operation. Practitioners have an incentive to cut down on expensive inpatient care, and so are more likely to undertake comprehensive ambulatory care than in the private fee-for-service sector, where all providers in fact gain greater financial benefits from inpatient care than they do from ambulatory care. Comprehensive ambulatory care, in turn, is likely to emphasise a higher level of preventive and promotive measures than is undertaken in the fee-for-service private sector, since the provision of preventive care no longer depends on the 'patient's' willingness to pay.

There is also a tendency to bring providers together under one roof. This can be in the form of large group practices, or small health centres that may include both inpatient and outpatient facilities and dispensaries. The advantage here is that patients have access to a wide range of services and treatment at the same facility.

Control and accountability

The structure of a 'managed care' scheme creates the opportunity for substantial involvement by the members in the affairs of the scheme. One example is the nature of the contractual relationship between the scheme and providers. This allows the opportunity for regular and effective communication between members, the scheme administration, and providers. In addition, the expressed needs of members can be taken into account in the planning and provision of scheme services. None of this is the case in the fee-for-service sector, where the scheme administration, and scheme members, have little or no influence over the activities of private practitioners.

The building blocks of a future national health system

The inefficiency, lack of planning and co-ordination, and maldistributive effects of the present private health sector have been described here and elsewhere.¹⁴⁻¹⁷ Managed care structures have the potential to overcome many of these problems and to result in more efficient, more responsive, better planned and co-ordinated care, with a better mix between preventive and curative care. Such structures have the potential to become a part of the framework of a more equitable and efficient national health system in South Africa.

Objections to 'managed care'

Three of the important objections to 'managed care' structures that have been raised are the restriction of choice of providers, the potential for underservicing and inferior care, and the loss of autonomy of medical practitioners.

Unlike regular medical aid schemes, 'managed care' structures restrict members in the choice of providers and facilities to which they have access. Part of the solution here is in the maintenance of adequate quality control, and participation of members in all aspects of the scheme. This would allow the scheme to take action when members are dissatisfied with the services of one or more providers. In addition, such schemes would need to guarantee members the freedom to move between the different providers contracted by the scheme.

Concern has also been expressed that the cost-saving can operate to produce inferior levels of care and underservicing of members through fewer investigations, referrals and admissions. The potential for such problems is greater in the case of profit-making structures, where the imperative is to cut costs while keeping contributions competitively low.^{18,19} To the extent that quality of care in HMO settings has been objectively measured, there is no conclusive evidence that these structures deliver inferior standards of care.²⁰ One should note, however, that the litigious atmosphere that governs medical practice in the USA may mean that the situation there is not strictly comparable to that in South Africa.

These are challenges that need to be recognised and prevented. One approach is through the extensive use of peer review and other quality control methods, and the development of adequate channels to allow members to communicate their responses to the standard of care received.

Some degree of resistance from elements of the medical profession is likely to be another important obstacle to the emergence of 'managed care' structures. Such structures are likely to be viewed as encroaching on professional autonomy, and as further restricting the freedom of providers to determine their own fee structures.

While these problems have been experienced by doctors in some managed care structures,¹⁸ they are not an inevitable element of such structures. Doctors can be involved in all aspects of management, including the determination of fee structures and clinical practice policies. In these ways, encroachment of autonomy can be avoided.

It is also arguable that the nature of work in these structures can often be more rewarding than individual private practice. This is so because of the possibility of co-operation between different providers, and the interaction between providers and management in the development of sound clinical and management practices.

'Managed care' in South Africa?

We have argued that the rising costs of private sector health care threaten to leave large numbers of individuals and families without health insurance cover, and thus without access to health care. We have also argued that this trend is inherent in the current structure of the private health sector. We have suggested elsewhere that a national health service may offer the best long-term solution to the problems of equity, affordability and rational co-ordination in the health sector as a whole.²¹ Nevertheless, we believe that the emergence of various forms of 'managed care' is inevitable, and that only this development offers any long-term solutions within the private sector itself.

Some private health delivery systems in South Africa already conform to the basic principles of 'managed care'. Examples include the health services operated on the mines, and those

run by some large corporations. These are all 'in-house' schemes open only to the employees of the companies concerned.

There are also indications that other large employers, as well as some of the large trade unions, are investigating and in some cases already negotiating the development of these structures. This reflects the perception of the 'business community', a large purchaser of private sector health care, and that of the organised consumers of health care, that fee-for-service, 'third-party payment' private health care is not cost-effective, and that significant improvements are possible.

More recently, some of the medical aid administration companies are investigating 'managed care' options, reflecting their own perceptions of the limits to private care as currently structured.

The private health sector in South Africa is therefore on the brink of a period of substantial change. The traditional form of fee-for-service care is likely to remain in place for some time, but to provide care to a static and then diminishing proportion of the population. At the same time, 'managed care' structures, either in the form of extensions of the versions already in existence or through the emergence of a variety of new 'HMO'-like structures, are likely to provide care to an increasing proportion of those currently in the private health sector.

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Comment

The preceding article was submitted to various interested parties for comment. The following comments were received from Dr B. B. Mandell, Chairman of Federal Council, Medical Association of South Africa:

The authors have conducted an in-depth study into the present 'fee-per-service' system of providing private health care and in doing so have pointed out its increasing inability to cope with rising costs fuelled by patient demand and the escalating cost of advanced technology. If a system in operation is obviously failing, it is incumbent on those whose responsibility it is to ensure that a health care system of quality at reasonable cost is available to the population to seriously examine the fundamental reasons for the collapse of the system in an attempt to restore it to vigorous health if possible, but at the same time to explore alternatives in the event that the system cannot be resuscitated.

In examining the reasons for the system's present inability to cope with rising costs, necessitating subscriptions which annually far exceed consumer price indices, it is important to ascertain whether these problems have been occurring in other countries where the 'fee-per-service' system has been in existence for years. There is no doubt that they, too, are experiencing problems and for some time now have ineffectually tried to prop the system up. This has led the countries involved to investigate other systems of primary health care cover and in the USA spawned the HMOs of

the 1970s. Continued problems during the 1980s caused 'managed care' (HMOs) to proliferate and flourish in that country. Strangely enough, HMOs in one form or another were in existence in Europe at the turn of the century. Most failed, owing to their inability to recognise the vital importance of the doctor/patient relationship.

The failure of the present US system to thrive is due to a number of factors. The cost of pure health care expenditure is rising — in the USA the problem of AIDS alone has been estimated at 5 billion dollars in 2 - 3 years. The rising cost is being compounded by population growth, population demand for more and increasingly sophisticated medical services, and increasing longevity — the result of improving primary and preventive health care — requiring prolonged medical and nursing services. These demands are generated by increasing media involvement and the rapid advance of expensive medical technology. The desired market principles, which should provide the foundation of the system, fail and pure profit motives are prevalent, and thus the system is overheating. Since the introduction of the system in 1967, failure to deal with escalating demands through disincentives and education, has led the medical aid funds — unable to control doctor-generated costs of investigations, medicines, hospitalisation and medical and surgical technology — to restrict severely the benefits paid to members for services rendered by doctors. The problem, compounded by the system of guaranteed direct payment, has resulted in over-

servicing, possible tariffmanship, increased dispensing by doctors, more surgical interventions, increased specialisation and possibly a reduction in the quality of medical care, all in an attempt to ensure a reasonable income for long hours of hard work. As a result the whole system is less cost-effective. In addition, it certainly does not cater for 85% of the population, and is unlikely to do so in the foreseeable future. This is where South Africa is so different from Western communities. If the present system is experiencing so many difficulties in the almost pure atmosphere of First-World medicine, how can it possibly survive in a country where it serves 15% (the First-World component) and cannot possibly serve the 85% (the majority or Third-World component).

On the other hand, despite its faults, there is good in the system, and that good must stand in order to create quality control alongside any other proposed system, stimulating and promoting competitive market principles to which we are supposed to be committed. But first there must be some fundamental changes, such as patient education and disincentives to control patient demand; the promotion of self-medication and personal responsibility for one's health; abolishment of guaranteed direct payment for investigations and procedures; control of the cost of medicine; control of the introduction of high-tech equipment by increased peer review and physician parameters and, finally, the vital importance of restoring the doctor/patient relationship, without the introduction of a third party.

The system of managed care (HMOs) has been discussed in some detail by the original authors as an inevitable development in the private health care sector in South Africa. The question of a national health service for the whole country has been discussed by others in the past but

no mention of it is made in the article. It is the opinion of the Medical Association that such a system will not solve the present problems but merely aggravate them. Various models in the managed care system have been discussed but whatever system is introduced, the doctor/patient relationship must remain paramount. It was stated that HMOs had failed in Europe because they did not appreciate the importance of the doctor/patient relationship and because of a militant, unhappy and, in some cases, a poorly treated physician community.

In the USA, one of the major developments has been the independent practice association phenomenon and its offshoots. If this successful development of the managed care system is to prosper in South Africa, then it is important that the Medical Association be involved in its development, and it should develop alongside the 'fee-per-service' system. If it is found that through good physician management costs can be contained and the spiral of escalation can be reduced, then 'managed care' may be what the future holds for us.

In order to ensure that a quality system can be evolved, the Association intends holding a seminar which will examine all the available systems in depth. The authors of this paper, with excellent references to call on, have accepted that a 'managed care' system is an inevitable development in this country. The majority of these references come from the USA and this is why it is vital to hold a seminar in South Africa, considering the fact that our problems are so different from those elsewhere. The Association's involvement in primary health care and preventive medicine is vitally important, as is its involvement in medical care. Both are interrelated and must not be ignored, as the future health of the nation is in peril.