Private Sector Financing

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Accurate quantification of the financial and physical resources within the health sector is crucial to inform policy design and monitoring during implementation. The recent National Health Accounts project documented the total health care financing and expenditure during the years 1996/97 – 1998/99. This chapter summarises the results of the private sector component of the project, looking particularly at the increasing medical scheme expenditure, out-of-pocket expenditure and co-payments, and the limited impact of managed care. It suggests recommendations to improve the availability of data and for the key policy issues within the sector.

Introduction

The purpose of National Health Accounts

National Health Accounts (NHA) document the total health care financing and expenditure during a particular period. Accurate quantification of the financial and physical resources within the health sector is crucial to inform policy design and monitoring during implementation. A set of NHA reports are being completed for South Africa for the period 1996/97-1998/99,[1-5] covering the public and private sectors.[a] Some of main the points in the private sector report are highlighted here.

Outline of this chapter

This chapter summarises the financial and physical resources available during the period 1996-1998. It then goes on to examine the changes in medical scheme membership during the period, the financial stability of the schemes, and cost escalation in the private sector. The data collected during the National Health Accounts exercise can be used to:

- Determine whether particular policies had their intended effect
- Determine whether the concerns of planned policies are likely to have substantial impact or not
- Be better informed as to the situation prior to subsequent policies being implemented in order to better understand their impact.

The particular policies that will be discussed here in relation to the NHA data are:

- The moratorium and regulation on building of new private hospitals
- Limiting of dispensing practitioners to areas with no pharmacy facilities nearby
- The Medical Schemes Act.

Sources of data and problems

There were considerable difficulties in obtaining accurate and comprehensive data, particularly on the number of health care practitioners working in the private sector, out-of-pocket expenditure by users of the private sector, expenditure by private hospitals and direct expenditure by firms on health care at the workplace. Relatively accurate data are available on expenditure via medical schemes and that has allowed more detailed analysis than has been previously possible. (Policy recommendations concerning data problems are made later in the chapter.)

a The National Health Accounts team included researchers from the following institutions: Health Economics Unit, University of Cape Town; Centre for Health Policy, University of Witwatersrand; Department of Economics, University of Durban-Westville; Health Economics and Financing Directorate, National Department of Health, and an independent researcher.

Financial resources in the private sector

Health expenditure flows from the original sources (households and firms) through financial intermediaries to the providers. Table 1 shows the proportion of funds that flow through the different financial intermediaries. Medical schemes are the dominant intermediary with 73% of the funds. Out-of-pocket expenditure from households being the second major intermediary (22.5%), which, given data problems, is considered to be an underestimate.[b] As might be expected out-of-pocket expenditure by medical scheme members was significantly higher than by non-scheme members. However it should be noted that although the 1998 out-of-pocket expenditure data for medical scheme members are probably an over-estimate (as can be seen by the growth rate of 54% between 1997 and 1998), it represents an increase in expenditure by medical scheme members due to shrinking benefit packages and increased co-payments. When making out-of-pocket payments individuals rely solely on their own resources, with no possibility of cross-subsidisation between the sick and healthy, therefore out-of-pocket payments are the most regressive form of health care financing. Both the increase in out-of-pocket payments and the proportion of total expenditure it represents, is of concern.

Overall private health expenditure has grown annually by approximately 16% between 1996 and 1998, which is substantially higher than the annual Consumer Price Index (CPI) growth of 7%. The medical schemes and the mining industry provide medical aid coverage or health care for 17% of the population, who consume approximately half of the total national expenditure on health.[3] This coverage rate has fallen slightly, despite the substantial real growth in health expenditure. This has primarily been due to the fall in the number of mining employees with access to on-site health services, attributable to falling levels of employment. There has been an increasing reliance on public sector services due to reduced access to health services provided at the workplace, and because medical scheme coverage has failed to keep pace with population growth.

Using the routine data presented in Table 1 the ratio of public to private expenditure is 44:56. With the adjusted out-of-pocket data (up from 22.5% to 28%) this ratio becomes 41:59.[3]

b It is possible to adjust for the underestimate in out-of-pocket expenditure by non-scheme members (by comparing two sources of data). Total out-of-pocket expenditure would then rise to approximately 28%.

Table 1: Private sector expenditure by financing intermediary, 1998

Financing Intermediary	Percentage share 1998	Annual growth rates 1996/97	1997/98
Insurance/ Pre-payment	75.7%	21.6%	11.8%
Medical schemes	*73.0%*	*22.1%*	*11.9%*
Health Insurance	*1.4%*	*7.1%*	*3.5%*
Worker's compensation	*1.3%*	*11.7%*	*11.7%*
Firms direct expenditure	1.8%	-7.0%	2.6%
Mining industry	*1.4%*	*-10.2%*	*0.1%*
Other firms	*0.4%*	*6.9%*	*11.6%*
Household's out-of-pocket	22.5%	-2.8%	39.9%
Medical scheme members	*16.1%*	*-9.9%*	*54.3%*
Non-scheme members	*6.4%*	*13.2%*	*12.1%*
Total	**100.0%**	**15.4%**	**16.8%**
Total expenditure	33 254 000		
Consumer price inflation		8.6%	6.9%
Institutional coverage as % of population*	17.1%	0.3%	-1.1%

* Includes medical schemes and mines.

Source: Cornell J. *et al* (2001)[5]

Human and physical resources

Data on private practitioners were extremely difficult to obtain. The sources used had internal inconsistencies and estimates vary widely, and therefore what data are available should be used with caution. Table 2 compares the two sources used.[6,7] The only firm conclusion that can be drawn is that the majority of health professionals, except nurses, work in the private sector. Van Rensburg and van Rensburg estimate that 41% of nurses work in the private sector, although the accuracy of their estimates could not be established.

Table 2: Estimated private sector health care practitioners, 1998/99

Category of health practitioner	1998		1999	
	Number in private sector	Proportion in private sector	Number in private sector	Proportion in private sector
General practitioners	8 098	52.7	14 331	72.6
Specialists	4 701	76.6	5 888	75.2
Dentists	-		3 953	92.6
Pharmacists	8 159	85.0	3 363	76.3
Psychologists	-		3 586	94.2

Sources: 1998 data from Söderlund *et al* (1998);[6] 1999 data from van Rensburg and van Rensburg (1999)[7]

Table 3 examines the number of private sector hospital beds, which has grown on average about 9% per annum since 1994 despite the moratorium on creating new hospital beds. Private hospital companies were able to side-step this moratorium by the building of 'step-down' facilities – wards with the full nursing complement, but without adjacent theatres that would lead to the facility being classified as a hospital. Regulations that attempt to legislate directly for levels of quantity, price, or quality without understanding the motivations and intentions of the private sector can often fail – because possibilities for, and intentions to side-step the regulations have not been anticipated. Successful regulation of the private sector requires a qualitative understanding of the interests and intentions of both providers and financing agents.

Table 3: Total private hospital beds, and annual growth

Year	1983	1989	1994	1999
Hospital beds	8 220	11 117	16 415	23 706
Annual growth rate		5.9%	9.5%	8.9%

Note: Beds in mine hospitals are listed separately in Valentine and McIntyre (1994) and are thus not included in the above data. However, by 1999 a few mine hospitals had been privatised, and therefore would be included in the private hospital bed total for that year.

Source: Valentine and McIntyre (1994)[8] for 1983, 1989 and 1994 data; Engelhardt (1999)[9]

Table 4 shows the distribution of private hospital beds by provinces, with Gauteng, Western Cape and KwaZulu-Natal having the highest share of beds (81% of total beds). Nationally, the number of beds per 1000 medical scheme population (3.4) is similar to the public sector rate of (3.04), yet this hides enormous provincial differences in the private sector ranging from 0.7 beds per 1000 in the Northern Province to 4.7 beds per 1000 in Gauteng, Western Cape and KwaZulu-Natal.

Table 4: Distribution of private hospital beds and day clinics by province, 1999

Province	No. of Hospitals and Day Clinics	No. of Beds	% of Total Beds	Distribution of Medical Scheme Population %	Beds per 1 000 Medical Scheme Population
Eastern Cape	18	1 224	5.2%	13.5%	1.3
Free State	11	937	4.0%	5.4%	2.5
Gauteng	85	10 605	44.7%	32.2%	4.7
KwaZulu-Natal	28	4 974	21.0%	15.2%	4.7
Mpumalanga	8	804	3.4%	8.2%	1.4
Northern Cape	3	297	1.3%	2.0%	2.1
Northern Province	2	273	1.2%	5.9%	0.7
North West	9	795	3.4%	5.8%	1.9
Western Cape	36	3 797	16.0%	11.7%	4.7
Total private	200	23 706	100%	100%	3.4
Total public		105 441			3.04

Source: Cornell *et al* (2001)[5]

Medical schemes

Intentions of the recent Act

The key aims of the Medical Schemes Act of 1998 (that took effect from 2000) was both to ensure community rating of member contributions (so that contributions are only based on income and number of beneficiaries, rather than health risk or age), increased cross-subsidisation and coverage.[10,11] The data discussed below are from the period prior to the new Act taking effect. They will act as a baseline for examining what impact the new Act has had, as data become available.

Access to medical schemes, shifts in membership

Table 5 examines the percentage of the population that are beneficiaries of a medical scheme. Although the total number of individuals has marginally increased since 1996, the medical scheme population is falling as a percentage of the total population. This is a worrying trend, as it is the public health sector that is carrying the extra burden of caring for the growing population. It is hoped that with open access and community rating the new regulatory environment will lead to a change in this trend, with a positive increase in members.

Table 5: Medical scheme beneficiaries 1996-1999

Year	Total number of people who have access to a medical scheme (beneficiaries)	Percentage of population	Annual percentage change in total beneficiaries
1996	6 862 377	16.9%	
1997	6 902 697	16.6%	0.6%
1998	6 887 735	16.3%	-0.2%
1999	6 988 396	16.2%	0.01%

Source: Cornell *et al* (2001)[5]

Table 6 indicates that the proportion of pensioner members has remained generally static across the period, but with significant differences between the different types of schemes. Closed schemes are those that restrict membership to a particular employment or professional group. Open schemes do not restrict their membership, in theory. However, the use of risk rating, with premiums linked to health risk or age, acted as a selection mechanism to exclude the old or the sick. Evidence of this practice is seen in the lower pensioner ratios. Commercial schemes are open schemes that originated in the life insurance industry where selecting members on the basis of risk is well-established, and therefore one might expect such schemes to be more proficient at the practice. The pensioner percentages suggest that this is the case, with approximately 1.5% of beneficiaries that are pensioners in commercial schemes.

Table 6: Proportion of pensioner beneficiaries by scheme type 1997 - 1999

Type of schemes	Percentage of beneficiaries over 65 years		
	1997	1998	1999
Closed	4.8%	5.8%	5.7%
Open	3.0%	3.6%	3.0%
Commercial	1.49%	1.57%	1.45%

Source: Cornell *et al* (2001)[5]

Underlying the static growth in total numbers, disaggregation by scheme type shows growth of approximately 6% in open scheme membership, and a similar fall of approximately 7% in membership of other schemes (closed, non-reporting and exempted) (Table 7). Whether this growth in open schemes is due to a shift from closed schemes or new members is unclear, however the shift in members out of the closed schemes seems to have been younger members, leading to a slight increase in pensioners.

Table 7: Total beneficiaries by scheme type 1996-1998

Type of schemes	1996	1997	1998	Average annual change
Open	3 768 492	4 019 607	4 207 677	5.7%
Closed	1 914 537	1 737 825	1 603 767	-8.5%
Non-reporting[c]	749 939	734 313	698 595	-3.5%
Exempted[d]	429 409	410 952	377 696	-6.2%
Total	6 862 377	6 902 697	6 887 735	0.2%

Source: Registrar's office

Financial stability

Table 8 details the income and expenditure of medical schemes from 1996-1998. Despite the growth expenditure shown in Table 1, it would appear that contributions were not sufficient to match claims and non-claim expenditure in either 1996 or 1998. From 1997 to 1998 the growth in claims (both net and gross) exceeded growth in contributions, at a time when both managed care and administration costs were growing substantially. The result was operating losses in both 1996 and 1998, that only became a net profit due to income from other sources (such as investment). In the full report data is examined for particular types of schemes. Closed schemes made an operating loss in each year but had substantial sources of other income. The non-reporting schemes however, had much lower levels of other income (partially due to having much lower levels of reserves), and therefore made net losses in 1996 and 1998.

c Non-reporting schemes (Transmed, Polmed and Medcor) are schemes in state or parastatal sectors which, during the period under review were not subject to the Medical Schemes Act.

d Exempted schemes are schemes established in terms of labour legislation and are associated with Bargaining Councils. For the period under review, these schemes were not subject to the requirements of the Medical Schemes Act.

Table 8: Income and expenditure of medical schemes 1996-1998 (Million Rand)

All schemes	1996	1997	1998	Annual growth rate 1996/97	Annual growth rate 1997/98
Gross contributions	17 769	21 698	24 284	22.1%	11.9%
Gross claims	16 703	19 091	22 018	14.3%	15.3%
Net contributions	17 769	19 852	21 721	11.7%	9.4%
Net claims	16 703	17 919	20 272	7.3%	13.1%
Non-claim expenditure	1 422	1 714	2 204	20.6%	28.5%
Managed care		170	346		103.2%
Administration	1 110	1 255	1 641	13.1%	30.7%
Operating profit/loss	-356	218	-755		
Other income	1 044	949	975	-9.1%	2.8%
Net profit/loss	688	1 167	220	69.6%	-81.1%
Reserves	3 337	4 385	4 757	31.4%	8.5%
Members	*2 633 050*	*2 676 609*	*2 652 568*	*1.7%*	*-0.9%*
Beneficiaries	*6 862 377*	*6 902 697*	*6 887 735*	*0.6%*	*-0.2%*

Source: Cornell *et al* (2001)[5]

Key to terminology

- Gross contributions = all funds from members (including any employer subsidy)
- Net contributions = gross contributions – savings plan contributions – pre-funding plan contributions – other non-risk contributions
- Gross claims = savings + risk claims submitted by members
- Net claims incurred = claims incurred – savings claims – discount + low and no-claims bonus + adjustments for claims not paid or submitted
- Non-claim related expenditure = own facility costs + bad debts + provisions for bad debts + managed care expenses + administration costs + interest + net re-insurance flow (premiums – claims) + other
- Administration costs = administration fees + managed care expenses + administration costs (e.g. printing and postage, meeting costs etc.)
- Operating profit/loss = net contribution – net claims – non-claim expenditure
- Net profit/loss = operating profit/loss + other income
- Reserves at end of year = net profit/loss + transfers + other adjustments + reserves at beginning of year
- Beneficiaries = individuals who are covered by a medical scheme (member + family)

Table 9 shows that the number of open schemes with adequate reserves has steadily improved over the three years. A higher proportion of both closed and exempted schemes have reserves equal to 25% of gross contributions, in comparison to open schemes, due to being established much earlier and therefore having a longer period to accumulate reserves. However the proportion of closed and exempted schemes with adequate reserves seems to be falling. The Act has given schemes 5 years to accumulate sufficient reserves

(25% of gross contributions), and this requirement will have a significant impact on those with reserves below 25% as they will have to either increase contributions and/or reduce expenditure.

Table 9: Reserve levels by type of scheme 1996-1998

Percentage of schemes below 25% reserves	Open	Closed	Non-Reporting	Exempted	All
1996	73.7	39	0	26.1	48.5
1997	62.1	40	0	23.8	45.7
1998	59.6	42.7	0	29.2	46.9

Source: Cornell *et al* (2001)[5]

Cost escalation

By preventing risk rating and ensuring open membership the new Act, in theory, has removed the direct method of ensuring health risks were matched by individual contributions. Much of the opposition to the Act centred on the assumption that without risk rating in an open environment schemes would be less able to control costs. Table 10 shows that even in the risk rating environment prior to the Act, schemes were still unable to control costs - total expenditure in 1998 was R21 668 million, which grew nominally by 15% over the 3 year period.

Table 10: Benefit expenditure by provider group/benefit share and annual growth in expenditure 1996-1998

Provider group / benefit	1998	Annual growth	
		1996/97	1997/98
General practitioners	10.5%	18.0%	14.1%
Medical specialists	19.4%	16.5%	14.6%
Dentists	6.4%	5.2%	11.2%
Dental specialists	1.1%	18.4%	15.9%
Medicine (excluding hospitals)	24.6%	-5.5%	16.7%
Private hospitals (including medicine)	28.8%	40.7%	16.6%
Provincial hospitals (including medicine)	0.7%	-19.6%	-10.8%
Ex-gratia benefits	0.1%	0.0%	-25.2%
Other benefits	8.5%	24.6%	15.8%
Total benefits	100.0%	15.4%	15.2%

Source: Registrar's office

Expenditure on medicine and private hospitals amounts to the largest share of the total (24.6% and 28.8%), with medical specialists not far behind at 19.4%. Expenditure on provincial hospitals is very small and has fallen

considerably. This fall has occurred in all types of schemes, even the exempted ones, which tend to have a lower cost structure. The fall in expenditure on medicines (-5.5%), and considerable growth in private hospital expenditure (40.7%) in 1996/97 may be due to mis-recording of data – (expenditure recorded under private hospitals should have been recorded under medicines). In 1997/98 the growth rates seem more reasonable, and better data capture may have occurred.

Table 11 examines the expenditure on medicine in more detail. Medicines dispensed by pharmacists amounts to approximately 16% of total benefits, whereas that dispensed by practitioners amounts to 8% - suggesting that the policy to limit dispensing of medicines by practitioners may not have a substantial impact on total expenditure.

Table 11: Medicine expenditure: Share of total benefit expenditure 1997-1998

All schemes: Percentage of total benefits	1997	1998
Medicine	28.7%	29.1%
Hospital medicine	*4.5%*	*4.6%*
Medicine dispensed by pharmacists	*15.6%*	*16.7%*
Medicine dispensed by practitioners	*8.7%*	*7.9%*
Total benefit expenditure	100.0%	100.0%

Source: Registrar's office

Impact of managed care

From this data it is possible to draw some conclusions about the impact of managed care. Expenditure by schemes on managed care began to be recorded separately in 1997, and increased substantially in the following year. It would appear, however, that managed care has not led to schemes being able to contain overall growth in expenditure. Pharmacy benefit programmes may have had an impact on medicine expenditure in 1997, (although the fall in expenditure may have been due to a mis-recording of data), but rose again substantially the following year. Hospital authorisation programmes also seem to have had no impact on expenditure.

During the period under review, a significant new feature of benefit design was the introduction of personal medical savings accounts for day-to-day expenses. The intention was to create the incentive for members to control day-to-day expenditure by allowing any unused funds to be carried forward to the next year, and removing cross-subsidisation, forcing patients to rely on their own resources. However, growth in claims to schemes with savings accounts grew slightly faster (15.7%) than claims to those without savings accounts (14.9%), suggesting that there was no impact on expenditure.

Excessive expenditure on health care is not only driven by the lack of constraints on members due to third party payor insurance, but more

importantly due to an asymmetry of information between provider and patient on what interventions are required and suitable. The asymmetry of information limits the ability of patients to contain costs, when they have insufficient information to judge what level of care is necessary. Managed care initiatives in South Africa do not tackle the incentive that fee-for-service payments create for providers to over-supply health care. Until the incentives facing providers are changed, higher levels of expenditure due to provider-induced demand is likely to continue.

Data problems and Recommendations

The National Health Accounts exercise showed the desperate lack of data, particularly on out-of-pocket expenditure, health care providers, and direct health care provision by firms. There are no financial, staffing or utilisation data for health care providers. It is recommended that the national Department of Health consider developing a statutory return for private hospitals as a requirement for continued licensing. There are at least three potential sources of information on private practitioners (statutory councils, professional associations, and the practice code numbering system operated by the Board of Healthcare Funders). None of these sources was able to provide an up to date record of practitioners currently operating in the private sector. It is recommended that providing information be a requirement, linked to Continuing Medical Education, necessary to maintain registration. There is a particular dearth of information on traditional medical practitioners. Box 1 outlines some of the key recommendations for improving the data on the private health sector.

Box 1: Key Recommendations on improving data on private health sector activity

1. Develop a statutory return for private hospitals as a requirement for continued licensing.
2. Require private practitioners to provide current information on location and whether active, linked to Continued Medical Education necessary to maintain registration.
3. Continue to develop statutory returns for medical schemes, particularly on demographic information, geographic distribution of members, day-to-day versus major medical expenditure, and utilisation.
4. To critically evaluate the health-related questions in Income and Expenditure Surveys and October Household Surveys conducted by Statistics South Africa, as the only source of information on out-of-pocket expenditure.
5. To require firms to supply information on health services provided.

Policy conclusions

Recent policy initiatives have been fragmented, in that they attempt to deal with specific types of providers or financing intermediaries in isolation, and some of these policies appear to have had limited impact. Thus, it is critical to develop a coherent, integrated and comprehensive policy relating to the

private health sector. It is only when the inter-relationship between financing intermediaries and providers within the private health sector, as well as the inter-relationship of the public and private health sectors, is recognised and translated into appropriate policy that the overall national health system will function efficiently and equitably to meet the health needs of all South Africans.

Despite claims that only by risk rating will schemes be able to control costs, during the risk rating period (prior to 2000) medical scheme inflation was around 15%, substantially higher than consumer price inflation. Attempts at managed care – such as hospital authorisation, pharmacy benefit management programmes, savings accounts etc. - have not been able to stem rising costs. Instead managed care has simply contributed to the increase in administration costs. In their yearly negotiations over price increases providers and administrators compete with one another for their share of the 'contribution pie', while benefits available to the members shrink. Ultimately unless managed care is able to tackle provider incentives to over-supply, not just patient incentives, costs are unlikely to be contained. And unless members are fairly represented by scheme trustees in the price negotiations, benefits will continue to shrink.

Box 2 sets out the key policy recommendations from this chapter.

Box 2: Key Policy Recommendations for regulating the private sector

1. There is a need for a coherent, integrated and comprehensive policy relating to the private health sector that recognises the inter-relationship between private sector financing intermediaries (medical schemes) and providers, as well as the interconnection between the public and private health sectors.
2. Successful regulation of the private sector requires a qualitative understanding of its interests and motivations – such that responses and possible side-stepping of legislation can be anticipated (for example the creation of 'step-down' facilities).
3. Ongoing monitoring of the Medical Schemes Act is crucial to ensure that it achieves its objectives, and that any attempts to subvert the Act are tackled as soon as possible.
4. The private sector's attempts to limit growth in expenditure through managed care has had very little impact, partially because it has only attempted to deal with patient incentives to 'over-demand' care. Growth in expenditure will only be controlled if provider incentives to over-supply are contained.
5. Growth in out-of-pocket expenditure is of concern as it is the most regressive form of health care financing. It indicates that medical scheme benefits are shrinking and co-payments are increasing.
6. Unless trustees of medical schemes are able to represent members at the yearly negotiations between administrations and providers over how to distribute the 'contribution pie', benefits will continue to shrink and co-payments increase, while administration costs and provider payments continue to increase.

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