STRATEGIC PURCHASING FOR UNIVERSAL HEALTH COVERAGE: A CRITICAL ASSESSMENT

MEDICAL SCHEMES IN SOUTH AFRICA

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With universal health coverage included among the health-related Sustainable Development Goals, the issue of how to finance 'Health Care for All' remains at the centre of global policy debate. A core function of health care financing is purchasing – the process by which funds are paid to healthcare providers to deliver services. If designed and undertaken strategically, purchasing can promote quality, efficiency, equity and responsiveness in health service provision and, in doing so, facilitate progress towards universal health coverage.

The RESYST Consortium, in collaboration with the Asia Pacific Observatory on Health Systems and Policies, has critically examined how health care purchasing functions in ten low and middle-income countries to identify factors that influence the ability of health care purchasers and other key actors to take strategic actions.

This summary provides an overview of how health service purchasing functions in South African medical schemes, which provide private health insurance. It examines the medical schemes as purchaser and how they interact with three key groups: health service providers, the national government and their members. It compares actual purchasing practices with ideal strategic purchasing actions to identify design and implementation gaps and the factors that influence effective purchasing. Finally, it draws policy implications for what needs be done to produce the desired actions by groups involved in purchasing.

Figure 1: Description of the purchasing mechanism in South Africa

Purchaser	Medical schemes, or scheme administrators, purchase health services for members.
What services are purchased?	All medical scheme members receive Prescribed Minimum Benefits (PMBs) including inpatient care, specialist services and care for most chronic conditions. Each scheme offers a range of benefit options, which include the PMBs but vary in types of services offered and in the membership contribution required.
Who uses the services?	17% of the population; schemes target high- and middle-income formal sector workers but must accept all applicants, regardless of risk.
Who provides services?	Private retail pharmacies, general practitioners (GPs), hospitals and specialists.
How are providers paid?	A range of provider payment mechanisms exist: fee-for-service; some GPs receive capitation payments to serve lower income groups; some private clinics pay staff a salary; a limited number of schemes pay private hospitals per diem payments or diagnosis-related group (DRG) payments.

WHAT IS STRATEGIC PURCHASING?

The purchasing function of health care financing involves three sets of decisions:

1. Identifying the interventions or services to be purchased, taking into account population needs, national health priorities and cost-effectiveness.
2. Choosing service providers, giving consideration to service quality, efficiency and equity.
3. Determining how services will be purchased, including contractual arrangements and provider payment mechanisms.

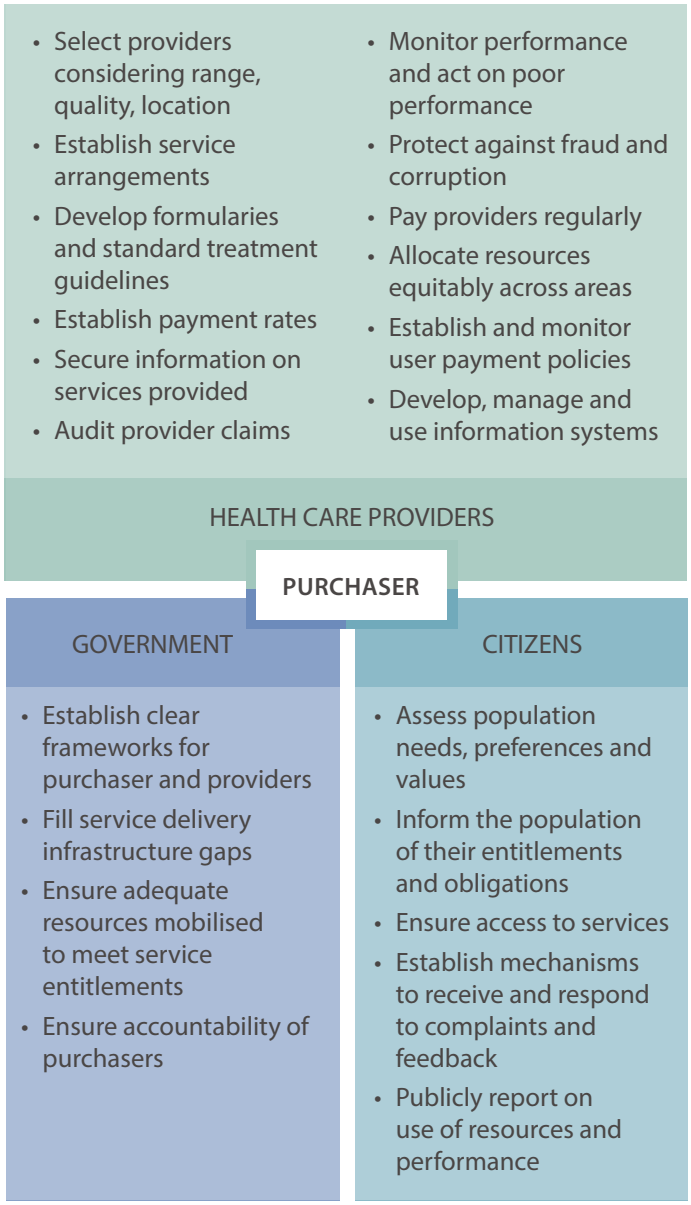
A critical factor in health system performance is the extent to which purchasing decisions are linked to provider behaviour and encourage providers to pursue equity, efficiency and quality in service delivery. This is strategic purchasing.

In strategic purchasing, a purchaser is an organisation that buys health services for certain groups or an entire population. The purchaser can use levers to influence the behaviour of providers to improve quality and efficiency in health service provision and facilitate equity in the distribution of health care providers.

However, purchasing mechanisms operate within each country's regulatory framework and, in strategic purchasing, government is required to play a stewardship role by providing a clear regulatory framework and appropriate guidance to ensure that public health priorities are linked to resource allocation and purchasing decisions.

As the purchaser buys health services for people, it is important for the purchaser to ensure there are effective mechanisms in place to determine and reflect people's needs, preferences and values in purchasing, and hold health providers accountable to the people. The key strategic purchasing actions are shown in Figure 2.

Figure 2: Strategic purchasing actions relating to healthcare providers, government and citizens



KEY FINDINGS

1. STRATEGIC ACTION BY PURCHASERS IN RELATION TO PROVIDERS

Medical schemes, or scheme administrators, purchase health services for members from private retail pharmacies, general practitioners (GPs), hospitals, specialists and other independent practitioners.

Use of economic power and the design of benefit options to contain costs

- Medical schemes (administrators) and private healthcare providers negotiate an average price increase every year. The proposed average cost increase relates to projected cost increases for health care service provision. While private health care providers hold decision-making power over the price of health care services, the medical schemes (administrators), as purchasers, use the size of their membership and decision-making power over the contents of benefit options to negotiate contractual arrangements with health care providers (although, to a certain extent, the contents of benefit options are pre-determined by government regulations on the PMB, which every medical scheme is required by law to provide). Also, medical scheme administrators have become aware of the influence of provider payment mechanisms on the behaviour of health care providers and some scheme administrators have introduced payment mechanisms, other than fee-for-service, to encourage health providers to contain costs.

An ineffective regulatory framework results in fragmentation in health care service provision

- Health Professionals Council of South Africa (HPCSA) regulations, which do not allow hospitals to hire specialists, also prevented multi-disciplinary group practices. Private hospitals provide space for specialists to deliver health care services. Specialists are paid directly by medical schemes on a fee-for-service basis. As a result, professional health services are characterised by weak coordination and poor information flows. These factors all contribute to increasing costs and may also impact negatively on quality of care.

Action required to manage cost escalation and monitor quality of care

- The biggest challenge currently faced by the medical schemes is cost escalation in private health service provision and obtaining information on the quality of private health service provision for monitoring purposes. Cost escalation has been driven by a combination of factors including tariff increases, premium increases, increases in volume of health care services, and increases in non-health expenses. While significant resources are spent in the private health care sector, there are no effective mechanisms to monitor and regulate quality of services supplied by private health care providers. Resolving problems with both the cost and quality of health care services requires reform, or establishment, of a regulatory framework on the standard of care supplied by private health care providers, which will require strong collaboration from Government.

2. GOVERNMENT RESPONSIBILITIES IN STRATEGIC PURCHASING

The medical schemes in South Africa are regulated by the Council for Medical Schemes (CMS), which oversees the operation of medical schemes to ensure that they operate in accordance with Medical Schemes Act (MSA). The CMS is governed by a Board, which is appointed by the Minister of Health. Any entity carrying out the business of a medical scheme must apply for registration with the CMS. The CMS registration mechanism ensures that schemes meet certain conditions, including that the scheme will not unfairly discriminate against any person, on any grounds, and that the scheme operates in keeping with public interest.

The absence of a regulatory framework for private health care provision has enabled private providers to influence the price of the health care services covered by medical schemes. This has resulted in price escalation, making schemes unaffordable to many South Africans.

The MSA aims to facilitate the operation of the private health system in line with public interest

- The MSA and associated regulations aim to ensure that medical schemes operate in the interests of citizens by:
  1. Enforcing community rating and forbidding risk rating;
  2. Requiring all applicants, regardless of risk status, to be accepted by the medical scheme to which they apply;
  3. Detailing a minimum package of benefits that all medical schemes are required to offer all members. However, the MSA only benefits those formal sector workers who belong to schemes.
- In addition, geographical variation in the distribution of private healthcare providers disadvantages scheme members in rural areas where members pay the same premiums as their urban counterparts but have less opportunity to access benefits due to a scarcity of providers.

The MSA ensures delivery of entitlements to beneficiaries by requiring financial capacity in purchasers

- Medical schemes are required to maintain accumulated funds of at least 25% of gross annual contributions. Schemes that fail to meet solvency requirements are required to provide the CMS with business plans addressing the situation and, after the plans have been approved, the CMS closely monitors the scheme to ensure that solvency levels improve and the scheme remains viable.

Revision of the regulatory framework is necessary

- As a result of policy gaps in regulation of the private health care services, health care providers are able to influence the price of health care services in the private sector. Some sections of the MSA are unclear, allowing for a variety of interpretations, which can be a source of dispute; and some sections of the MSA are out-of-date and require revision to address current health issues, such as new technologies and advances in epidemiological changes. The CMS faces various challenges due to the lack of adequate enforcement mechanisms in the MSA. The CMS want the governance section of the MSA to be amended to provide greater authority to them so that they can better regulate the medical scheme industry. In January 2014, South Africa's Competition Commission began a market inquiry to investigate the private health sector. The Commission is particularly concerned about high prices in private health care service provision and is investigating the general state of competition in the sector to determine what types of policy or regulatory changes are necessary to address the recent price escalation.

3. STRATEGIC PURCHASING ACTIONS IN RELATION TO MEDICAL SCHEME MEMBERS

The MSA describes the original intention of medical schemes to be close to that of 'mutual' insurance, that is, schemes are owned entirely by members. Regulations demand that at least 50% of the members of the Board of Trustees, the governing body of a medical scheme, must be members of the scheme. The Board of Trustees must ensure that: adequate and appropriate information on rights, benefits, contributions and duties is provided to scheme members; the confidentiality of members' medical records is respected; and the interests of members are protected.

An 'exit' mechanism exists

- While medical scheme enrolment is quite often a condition of employment, members can leave a medical scheme if they are not satisfied with services / insurance products. This motivates medical schemes, particularly open schemes, to try to meet the needs of members and to provide a range of products to cover the diversity of membership as losing members means losing power to negotiate with health care providers and a loss of income from insurance premiums.

Engagement with members is limited

- Although medical schemes endeavour to reflect members' needs and preferences and develop attractive benefit packages by looking at utilisation data, claim data and data on the purchase of medical scheme products, direct engagement with medical scheme members is limited. While medical scheme members are informed of changes in benefit entitlements annually when membership is renewed, they are not well informed of their entitlement to contribute to purchasing decisions (including decisions on benefit entitlements) by submitting complaints/suggestions, attending annual meetings and other ad-hoc events organised by medical schemes and related organisations.

The functioning of Boards of Trustees can be improved

- Although there are a number of well-functioning Boards of Trustees, quite often Trustees, particularly in open schemes, are not fully aware of their responsibilities in terms of informing medical scheme members of their entitlements and ensuring accountability between the scheme and the members, and, in some cases, Trustees require technical training to help them successfully contribute to scheme management. Medical scheme administrators often take over the tasks that are intended for Trustees.

CONCLUSION AND POLICY IMPLICATIONS

When negotiating contract arrangements, medical schemes attempt to use economic power and information on the design of benefit plans to contain costs and influence the price of health care service provision, but many schemes are too small to do this successfully. Currently, the majority of medical schemes use fee-for-service payments and do not have regulated fee schedules, which can allow providers to increase the volume of services supplied. Additionally, medical scheme purchasers are challenged by the absence of effective mechanisms to monitor the quality of services delivered by private health care providers.

Medical schemes are private, voluntary, not-for-profit insurance mechanisms, however they are complex in operation as the groups of actors that the medical schemes work with are for-profit organisations (including administrators, brokers, private heath care providers, etc.). As the medical scheme industry has grown since the current MSA was developed, a gap has formed between how the law defines the relationship between members and medical schemes (purchasers) and how medicals schemes actually operate, particularly for open schemes.

Policy gaps are evident in the absence of a regulatory framework for private health care provision, which allows private providers to influence the price of the health care services covered by medical schemes. In addition, there is a lack of clarity in some areas of the regulatory framework for medical schemes bringing about multiple interpretations. The regulations do not deal with many emerging issues, such as new technologies and epidemiology, affecting the quality of health care supplied to members. Furthermore, enforcement mechanisms in the current medical schemes regulatory system are weak and the regulatory body is not given sufficient authority to effectively control the industry.

The provision of appropriate stewardship by government and regulatory bodies to ensure public health priorities are met in purchasing decisions, i.e., establishing an environment where strategic purchasing can be undertaken, may require changes in laws and regulatory frameworks, including revision of the MSA to strengthen enforcement mechanisms and establishment of a regulatory framework to control the price and quality of health services in the private sector. This, in turn, requires willingness, commitment and leadership at the central government level.

ABOUT THE BRIEF

Written by

Ayako Honda and Di McIntyre from the Health Economics Unit, University of Cape Town, South Africa.

Further information

Purchasing project webpage: http://resyst.lshtm.ac.uk/research-projects/multi-country-purchasing-study

Email: Ayako Honda ayako.honda@uct.ac.za

Related resources

RESYST topic overview and fact sheet (2014) **What is strategic purchasing for health?** http://resyst.lshtm.ac.uk/resources/what-strategic-purchasing-health

Hanson K. (2014) **Researching purchasing to achieve the promise of Universal Health Coverage.** Presentation at the BMC Health Services Research Conference, London. http://www.slideshare.net/resyst/researching-purchasing-to-achieve-the-promise-of-universal-health-coverage-37722050

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