

Chapter 6



The public-private mix

The purpose of this chapter is to examine the relationship between the public and private sectors in health care.

It explores the ways in which the two sectors interact; asks whether the behaviour of the private sector is detrimental to the goals of the public health sector, and if so, in what way; examines how the government should respond; and questions whether it is possible for the public sector to benefit from working with the private sector.

Having described the interaction between the two sectors, and the negative impacts of private sector behaviour, it is argued that the public sector can benefit from interaction with the private sector, as long as the government is successful in its attempts to regulate the private sector. If the public sector spreads its resources too widely trying to meet the needs of too many, it may damage capacity already existing, failing to care for those who need it most. Engaging with the private sector may enable the public sector to concentrate on the poor, while at the same time working towards a less segmented system under social health insurance that could yield benefits in terms of better access, improved equity and social cohesion.



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Introduction

This chapter aims to:

- ❖ outline the current role of the private health sector within South Africa
- ❖ describe current forms of public-private partnerships in health
- ❖ describe possible changes in the relative sizes and resources available to the two sectors
- ❖ discuss alternative forms of regulation of private sector
- ❖ briefly outline the Social Health Insurance proposals, their potential benefits, and problems.

The role of the private sector within South Africa

South Africa had one of the most expensive and ineffective health systems in the past regime. In 1992/93 the country was spending 8.4% of its GDP on health care (public and private expenditure), amongst the highest in the world, yet South Africa ranked below 60th in terms of the “health status indicators”. This was attributed to the fact that the private sector spent over 60% of the total spending on a beneficiary population of less than 20% of the country’s total. The remaining 80% of the population are dependent on the public health services, which were spending the remaining 40% of the resources.¹ Given this maldistribution of resources, monitoring health expenditure by the source of finance and by beneficiary type is important.

The National Health Accounts Project, commissioned by the national Department of Health, is in the process of gathering data for years 1996–1999. Table 1 shows the source of finance and the extent of insurance coverage for the years 1992/93 and 1995. There are substantial problems with both the 1992/93 and 1995 data.



Table 1: Expenditure on health care by source of finance 1992/93 and 1995

Source of finance	1992/3 Million rand (1) HER estimates	Percentage of total	1995 Million rand IES estimates (3)	1995 Million rand Registrar data & re-esti- mates of IES	Percentage of total
General Tax Revenue	11 447				
Local Authorities	225				
Public sector Total	11 672	38.9	16 500 (4)	42.0	
Medical Schemes	12 064	40.2	10 842	16 123 (5)	41.0
Medical Insurance	923	3.1	688	1 023 (6)	2.6
Industry	1 162	3.9	1 426 (7)	3.9	
Out-of-pocket expenses	4 184 (2)	13.9	1 292	4 213 (6)	10.7
Private sector total	18 333	61.1	18 642	58.0	
TOTAL	30 005	100.0	39 285	100.0	
MA Coverage	22.8	18.0			

Notes/Sources:

1. Adapted from table 3.5 McIntyre *et al*¹
2. Calculated using the methodology described in the text
3. Estimates from the Income and expenditure survey
4. From McIntyre *et al*²
5. From Valentine N³ using data from the Medical Schemes Registrar.
6. Calculated from Income and Expenditure survey (1995), and increased by a factor of approximately 50% to allow for under-estimation.
7. No data for 1995 were available for industry expenditure, and it has been assumed for the purposes of this table that the proportions have remained relatively stable.

The public share of expenditure would appear to have risen slightly between 1992/93 and 1995, and the private sector has fallen. This fall is matched by a fall in the proportion of the population with medical scheme coverage. It is hoped that the National Health Accounts Project will be able to provide a more accurate picture, particularly of the change since 1995.

There is considerable doubt as to the accuracy of the estimates of out-of-pocket expenditure. The 1992/93 estimate of out-of-pocket expenditure, published in the Health Expenditure Review (HER), was calculated using:

- a) the number of GPs in private practice (which was found to be somewhere between 6 000 to 10 000)
- b) the average consultation fee charged to those who pay cash
- c) the number of visits per person per annum by non-medical scheme members
- d) the income derived from dispensing medicine.



The 1995 Income and Expenditure Survey (IES) carried out by Statistics SA, has been used to calculate the 1995 estimates of out-of-pocket expenditure in Table 1. However, IES data are viewed as considerable under-estimations. If data on contributions to medical schemes by members gathered from households by the IES is compared with the Medical Schemes Registrar data to which all medical schemes have to report their income, the difference between the two figures is in the order of approximately 50%.^a The Medical Schemes Registrar data is assumed to be more accurate and is reported in Table 1. If the IES figure for out-of-pocket expenditure is increased by a similar factor (as done in the table), the figure rises to R4.2 billion.^b This figure is comparable to the 1992/93 estimate of R4.1 billion.

Table 2 shows the distribution of health personnel between the two sectors for the years 1989/90 and 1998. In 1998, 62% of GPs, 77% of specialists, 88% of pharmacists, and 89% of dentists worked in the private sector, meeting the needs of approximately one fifth of the population. In 1989/90 nurses were the only category of staff where a greater number were working in the public sector. (Only 21% were working in the private sector.) The 1998 data suggests that this is changing - nearly half of all nurses now work in the private sector, with greater numbers of higher skilled staff working in the private sector.

Table 2: Proportion of the health personnel in the private sector in 1989/90 and 1998

	1989/90	1998
General practitioners	53%	62%
Specialists	66%	77%
Professional nurses		50%
Enrolled nurses		45%
Auxiliaries		31%
All categories of nurses	21%	43%
Pharmacists	89%	88%
Dentists	93%	89%

Sources: McIntyre,¹ Söderlund⁴



a For further discussion see Valentine.³

b This is assuming that the extent of the under-reporting is the same for the two types of expenditure, which is not necessarily the case.

Why is the private sector important?

The public and private sectors within health care are often perceived as two distinct entities – a public sector, providing care for the majority of the public, and a private sector, providing care for the wealthy who are able to afford medical scheme coverage. If the concern of the Department of Health is meeting the health needs of the poorer majority of the population, why should it be concerned with the private sector? Private providers are primarily motivated by the aim of making a profit, and as a result their objectives do not coincide with the public goal of providing universally acceptable health care for the whole population. This mismatch of objectives results in particular problems for health provision:⁵

- ❖ the profit motive may override good clinical practice
- ❖ a failure to address public health issues, such as prevention
- ❖ a lack of integration with government health services
- ❖ attraction of health professionals out of the public sector
- ❖ the provision of poor quality care, or inappropriate services and distribution of facilities.

Yet the Government is unlikely to either ban the private sector (politically unfeasible and practically impossible given government capacity), or ignore it, given the impact of private sector provision on the public sector. It is argued here that the government's response to the private sector has to have three aims:

- ❖ To plan for the impact of changes that are likely to influence the absolute and relative distribution of resources between the two sectors
- ❖ To build constructive public-private partnerships from which the public sector can benefit.
- ❖ To influence private sector behaviour through regulation – both in the form of legislation, and through a framework of incentives (financial and non-financial). The aim of regulation should be not only to limit the problems listed above, but to ensure that the public health sector benefits from its interaction with the private sector and vice versa.

In the following sections of this chapter, the public-private mix will be described in greater detail, (examining the formal interaction between the two sectors), and then two of these issues will be discussed further: the possible changes in the relative distribution of resources between the two sectors, and regulation.

What is the public-private mix?

The phrase the “public-private mix” refers to the formal and contractual relationships between the two sectors. The “mix” can take various forms, dependent on whether the private sector is involved in financing and/or providing health care. The typology below sets out the broad categories of relationship.

- ❖ *Public financing for private provision of care for public sector patients.* For example *contracting out* – where a public hospital may purchase clinical (such as laboratory, dialysis or radiological) or non-clinical services (such as management advisory services, laundry, security, catering, paramedic and air ambulance services) from a private provider. The total value of such contracts at hospital level has been estimated as 9.4% of the total hospital budget.⁶ District Surgeons or District Medical Officers provide care to public patients on a sessional basis. Departments of health sometimes subsidise either specific programmes, services or the institutions themselves such as the South African National Tuberculosis Association (SANTA) and non-governmental organisation (NGO) AIDS initiatives.



- ❖ *Private financing of private sector care for private patients using public facilities.* For example, *leasing out of public beds/wards for private patients*, where private providers pay to use public facilities. Or some forms of *limited private practice*, where public sector doctors are allowed to spend a specified number of hours in private practice.
- ❖ *Private financing of public provision of care for public sector patients.* This refers to “*out-of-pocket and medical aid payments*” by private individuals for care at public facilities, such as user fees at state hospitals. This type of interaction is not of primary concern in this chapter.

The nature of these types of relationship often varies according to level of care, and the history of the interaction between the two sectors. As an example, the different types of public-private mix within the hospital sector are described in greater detail.

Historical and current public private partnerships in the hospital sector

Private not-for-profit hospitals (churches, mines, SANTA, etc.)

These institutions and services have been a feature of the South African health system for many years. The State often entered into agreements with such organisations in order to ensure that the operators would keep the facilities open to public patients. The relevant department paid for the public patient care or met operating deficits of the provider depending on the negotiated contract. The operator’s service was a part of the health system.

Treatment of public patients in private hospitals

There are several chronic case hospitals that are owned by Lifecare, a private company, that provide services exclusively to the State for the care of public patients. There are also examples of private wards and special units, special equipment, etc. being made available to the public service as extensions to public facilities. This is discussed in the chapter on State-aided Hospitals (chapter 9).

Hybrid hospital partnerships

There are a few examples of hospitals that the homeland governments commissioned as “turn-key projects”. They were built with private capital and managed by private providers for the State, who paid patient-day and bed-day tariffs for the recurrent services. The circumstances of each hospital are different and there are lessons to be learnt from each model. They include:

- ❖ Evuxakeni Hospital, a psychiatric and chronic care institution in Giyani, Northern Province (1986)
- ❖ Shiluvana Hospital, a general community hospital that replaced Douglas Smit Mission Hospital in the Northern Province (1987)
- ❖ Matikwana Hospital, a new general community hospital in Bushbuckridge on the border between Northern Province and Mpumalanga (1989)
- ❖ Hewu Hospital, a new general community hospital near Queenstown in the Eastern Cape.

There are also examples of hospitals being shared between the public and private sectors, such as at Uitenhage and Thabazimbi.

Treatment of private patients in public hospitals

If the patient requests the services of his or her own private practitioner in the State facility, then such practitioner treats the patient in the public hospital. In the past there was an Ordinance in some provinces preventing public sector doctors from rendering care to private patients. This was designed to protect the income of the private doctor. This is no longer the case and care is rendered to the patient by the first competent practitioner available irrespective of whether he/she is a State employee, private practitioner, has sessions or not.

In several areas the departments of health have started upgrading facilities and are creating “private wards” with greater sophistication for full-paying patients. The departments bill the private patients for use of the facilities and for the professional services of any full-time staff, and the private practitioner bills the patient for his or her own services only. However, there are reports of private practitioners billing for services that they have not rendered, and the departments of health frequently fail to bill private patients at all, and therefore lose revenue.

Case Study: A feasibility study of leasing out public facilities and services in two academic hospitals in the Western Cape

Methodology

Hospital beds can be leased with or without support services. It is important to assess the availability of beds, and particular support services (such as clinical services, non-clinical services, human resources, hospital management and parking) by:

- ❖ *geographic area*
- ❖ *level of hospital care (academic, district hospital)*

It is necessary to evaluate the feasibility of each option taking into account:

- ❖ *The local supply and demand of public hospital facilities*
- ❖ *The capacity of the public hospital to administer a leasing contract*
- ❖ *The cost to public hospitals of providing facilities/services to be leased, to establish a suitable price for the leasing contract*
- ❖ *To assess the other implications of leasing that may be detrimental to public sector goals, such as the loss of staff to the private sector, and preferential treatment of private patients.*

Results

- ❖ The study showed that there was spare capacity in public hospitals available in terms of beds, equipment for pathology, radiology, catering and cleaning, theatre time, and parking space.
- ❖ There was barely sufficient human resource capacity for existing level of public service, and therefore no spare capacity to provide extra services to accompany leased beds.

Potential Benefits

- ❖ Extra revenue, if charges to private leases are maintained above rising costs
- ❖ Hospitals' assets (building, and equipment) are maintained and not allowed to fall into disrepair.

Potential problems for individual public hospital

- ❖ Insufficient capacity within the public hospital to administer, monitor and enforce leasing contracts
- ❖ Loss of public hospital staff to the private sector may be increased by close proximity of the two employers.

Broader implications for the public sector

- ❖ Equity and tiering in autonomous hospitals.

Given the potential and incentive for generating considerable amounts of revenue, it is important that private sector patients are not given preferential treatment, to the detriment of public patients. The incentive among public hospital managers to favour private patients may increase if the hospital concerned is financially autonomous and therefore has greater control over the generated revenue. Monitoring to ensure that a sufficient proportion of resources continue to be available for public patients is therefore crucial.

Source: Sinanovic E and McIntyre D (1998)⁷

The changing public-private division of resources

The private sector has grown considerably in the last 10 years.⁴ The majority of the population had access to, and used the services of the public sector in the past. However the resources in the public sector have decreased and the negative impact on services has encouraged those who can afford it to switch to the private sector. This section will look at the likelihood of continued growth, and how, if the growth does continue, it will affect the ability of the public sector to provide care to those who need it.

Factors that may affect future growth of the private sector

- ❖ Economic growth, and with it growing personal income, enables individuals to pay for private care. There is slight evidence of this in South Africa. African membership of medical schemes that has grown from 24% of total members in 1990 to 36% in 1995.⁴
- ❖ However, there is evidence that the private sector has become saturated with some types of providers, for example general practitioners,⁴ given the limited number of individuals who can afford private care. As a result, both funders and providers are looking at new arrangements (such as modified fee-for-service or capitation) that would enable lower costs and premiums. This in turn would make medical scheme membership affordable to a greater proportion of the population. Social health insurance (SHI), if introduced in the form of the 1997 proposals, may support the expansion of the private sector, by making it mandatory for all those above a certain income level to purchase insurance, either through SHI or privately.
- ❖ The new Medical Schemes Amendment Act, with the prevention of risk selection, prohibits medical schemes from reducing costs by shifting expensive patients on to the public sector. Medical schemes can therefore *either* pass on increased medical cost to patients through premiums, potentially leading to a reduction in the demand for private health care, *or* modify the reimbursement system to encourage providers to limit the provision of health care and the resulting expenditure. (The role of reimbursement systems is discussed in greater detail below.) Private hospitals may accept a change in the reimbursement mechanism, rather than face a fall in demand for private care.

Impact of private sector growth on the public sector

An integral part of the growth of any sector of the economy is the flow of resources to or from that sector – in this case, health personnel, funds and patients. The public sector will be affected by the relative proportions of the flows.^c

- ❖ If the movement of health personnel out of the public sector exceeds that of patients, then staff shortages will occur. This is obviously a very real issue in South Africa at the moment. Higher private sector wages has led to outflow of personnel, often increasing the work burden on those who are left. The AIDS epidemic, along with free primary health care, is likely to have compounded the problem by increasing the demand for public care.
- ❖ If the growth in the private sector is accompanied by, and partially driven by economic growth, tax revenue will also rise, (even if tax rates remain constant). If the health budget remains a constant proportion of total government expenditure, public sector resources available to the health sector should increase. Therefore an outflow of patients to the private sector may be accompanied by an increase of resources available to the public sector.
- ❖ If, and when, economic growth does occur, it can not be assumed that the health budget will remain a constant proportion of total government spending. It could be argued that as a larger proportion of the population, particularly the political elites, turn to the private sector, firstly, political support for the aims of the public sector may dwindle; and secondly, the voicelessness of the poor may lead to the neglect of suitable services even if political will to improve equity is maintained. As a result, the proportion of government expenditure allocated to health may be allowed to fall.⁸

In the short term, the outflow of staff from the public sector, particularly nurses, has probably left considerable shortages which may only worsen. This, combined with the increase in the demand for care due to the impact of AIDS, may stretch resources in the public sector such that those who can turn to the private health sector, albeit for minimal levels of care, will do so. Evidence of those without medical aid using the private sector can be seen in Palmer's discussion in this Review (as well as the growing number of private clinic chains, such as Primecure, and Carewell).

If, in the long term, the public sector attempts to stretch its resources too far to meet the needs of too large a proportion of the population, the result will be to weaken the capacity of the public health sector, thereby reducing the quality of care it can provide. It may be necessary to focus the health sector's energies towards those that need it most. Either way the private sector will expand its activity further in order to meet demands that the public sector cannot.

The public sector could pro-actively use public-private partnerships as a means of increasing the resources available to the public sector, enabling it to improve the quality of care. Regulation would be crucial to ensure both that those using the private sector receive a reasonable quality of care, and that the public sector benefits from public-private partnerships.



^c It is likely that the recent purchase of military hardware (approximately 25 billion rand) has significantly reduced the possibility of increasing social spending for several years, wiping out any benefits that may have resulted from the recent years of fiscal restraint due to GEAR.

Government response to the private sector

The need for partnerships in health has been recognised for many years. Since the 1994 elections, even if the desired nature of the partnerships is not clearly specified, this need has been documented as a policy objective in the White Paper for the Transformation of the Health System in South Africa.^d

Section 2.4 of the White Paper elaborates on “Integrating the Public and Private Health sectors”.

“The activities of the public and private health sectors should be integrated in a manner that makes optimal use of all available health care resources. The public-private mix of health care should promote equity in service provision.”

Section 3.10.5 deals with “Regulation of the Private Sector”. The introductory paragraph states that:

“The regulatory responsibility and capacity of the public sector is probably the single most important determinant of the public/private mix in many countries. Many of the policies mentioned above seek to co-ordinate public and private sector activities, and to use regulation as a means of influencing private sector behaviour rather than of control.”

More recently in a draft policy framework on “Public/private partnerships in the health sector” (August 1999), it is stated that one of the main issues for consideration is:

*“The development of legislation, regulations and policies that control, **support**, or have an impact on (public-private) partnerships.” (p3) (Author’s emphasis).*

These statements vary in their apparent policy aims from a “unified national health system” and “pooling of resources” which seem to imply some form of merging of the two sectors, or at least a closer relationship (with perhaps a greater level of social cohesion as an additional policy goal), to the practicalities of regulation and how to support and ensure beneficial partnerships. The following section discusses how regulation can be used to influence private sector behaviour, and is then followed by a brief look at the potential role of SHI.

Regulating the private sector

There are various organisations that are involved in regulating the private sector:

- ❖ The national and provincial Departments of Health
- ❖ Parastatals (such as the new Medical Schemes Registrar)
- ❖ Professional organisations (such as South African Medical Association and the Health Professions Council of South Africa).

Often the State hands over the authority to monitor and enforce standards of care in the private and public sector to a parastatal, or to a professional organisation. Professional organisations are generally run by members of the profession and are concerned with accreditation, professional training, examinations and disciplining members for poor professional conduct. Professional organisations may have relatively easy access to information about provider behaviour and have the professional knowledge enabling them to regulate. However, their objectives may be too closely aligned with the providers, whom they are supposed to be regulating, for them to pay a sufficiently independent monitoring role.⁵ Such a situation is called “regulatory capture.”

d Government Gazette No 17910 dated 16 April 1997: Notice 667 of 1997

There are a variety of other *mechanisms* that can be used to regulate the private sector. *Legislation* is important, for example, to ensure practitioner registration, adequate training and minimum standards for premises. Legislative attempts to directly control either price or quantity are clumsy, and can lead to the development of “illegal” markets or private players simply leaving the profession or sector. For example the banning of limited private practice (as of September 1999) attempts to control the neglect of public duties by public doctors. The ban may lead doctors who have developed private practices – not all of whom are abusing their public sector positions – to leave the public sector altogether. As an alternative it may be possible, through a public equivalent of Independent Practitioner Associations or faculty practices within academic hospitals, to monitor, and therefore prevent, the neglect of public patients in favour of private ones. The alternative is to make use of a provision in the public service for “Remunerative Work Outside the Public Sector” (RWOPS). However, any solution that allows private work in public facilities would have to be designed carefully to prevent the monitoring function from being subject to “*regulatory capture*”.

Another example of government policy controlling the supply of care, is the requirement to obtain a certificate of need before additional hospital capacity can be built or leased to the private sector in a particular area.⁹ This could apply to a “service”, a facility, items of equipment or to human resources. For example practice licences could be limited by a quota system.

Government has implemented a measure of control over human resource deployment with the introduction of community service for doctors. This is discussed in chapter 17.

Attempting to control supply/quantity in this way has so far failed to prevent the creation of extra facilities. Instead, a loophole has been exploited resulting in buildings being built, but under a different name – as “step-down” facilities. Patients are admitted to hospital for a day for an operation, and then are moved to the “step-down” facilities that have no theatre but are effectively additional private sector wards. These facilities do not require a licence. An alternative regulatory policy may be to enable reimbursement mechanisms to limit the excess supplier induced demand for health care that is creating the unnecessary demand for extra health facilities in the first place, rather than banning an increase in supply.^e *Purchasing agents*, be they consumers, private insurance schemes, medical schemes or the state itself, can play an important role in determining private provider behaviour, because the provider is dependant on the purchasing agent’s decision to purchase the service. For example, the state can use the fact that it is the largest purchaser of drugs (*its monopoly power*) to negotiate more favourable prices from private suppliers.

Different *payment mechanisms* imposed by purchasing agents can affect provider behaviour.

- ❖ *Payment per patient within catchment population (capitation)* limits costs but encourages a provider to see as many patients as possible.
- ❖ *Payment for each service (fee-for-service)* encourages provision of as many services as possible for each patient, and can result in unnecessary ones, thus increasing expenditure.
- ❖ *Payment per length of stay (where the payment per day decreases with increase in total number of days)* encourages providers to shorten the length of stay, and thus reduce costs, and potentially quality of care.
- ❖ *A fixed prospective payment (based on per head of population, length of stay, diagnosis-related groups etc.) where any additional cost is shared between the payer and provider.* This encourages cost containment without forcing providers to carry the full burden of any extra costs, but requires a fairly sophisticated information system.

e Söderlund⁴ provides evidence of excessive supplier induced demand by comparing the rates of tonsillectomies, myomectomy (insertion of grommets into the eardrum) and hysterectomy in the private sector, with data from the UK National Health System and South African mine hospitals.

Chapter 5 in this Review provides an example of legislation being used to regulate private health care financing through the private medical schemes industry. The aim of the 1998 Medical Schemes Amendment Act is to ensure that the benefits of sharing the cost of health care between individuals, within an insurance scheme, are not lost as a result of the private scheme attempting to maximise profits by charging individual premiums according to individual health risk. As a result medical schemes can no longer control costs by raising the premiums of “expensive patients”, forcing such patients to leave the private sector because they cannot afford the premiums. This leaves the only option open to medical schemes to control rising medical expenditure to be to use their power as *purchasing agents*. For example:

- ❖ schemes can require that *authorisation is obtained from the scheme before hospitalisation*. This helps to ensure that the provider is not “selling” an inappropriate service.
- ❖ *Chronic medicine schemes* enable bulk purchase, and therefore supply of cheaper regularly purchased drugs.

Both of these methods are being used by the South African medical schemes industry. However there are other methods that could be used by medical schemes in their role as purchasing agents. For example:

- ❖ *peer profiling*, that identifies practitioners who frequently prescribe unnecessary drugs or procedures; or
- ❖ *payment mechanisms* described above. These may control costs, but may also reduce quality of care, and therefore need to be accompanied by monitoring of quality of care.

The long-term effect of the new medical schemes legislation will depend on whether the medical scheme administrators are able to ensure that providers have incentives to contain, rather than maximise, health expenditure. Partnership with the private sector requires that the quality of service can be monitored (and even regulated).

Both Schneider and Palmer in the subsequent chapters raise the issue of ensuring quality of care at primary level. The two main regulatory issues are:

- ❖ *Quality of care in terms of respect shown to the patient*. The standard regulatory approach to quality is to provide consumers with a choice of provider, enabling them to “vote with their feet”. Yet this is not always possible or cost-effective. Instead a more inclusive approach is needed to improve the human quality of care, through providing greater support of frontline providers, particularly nurses, by rewarding good practice, monitoring patient outcomes and providing feedback, as well as communicating the goals and content of health-sector restructuring.¹⁰
- ❖ *Technical quality of care, on which the patient rarely has sufficient information to assess the provider’s ability/decisions*. Hopefully, technical quality will be improved through the continuing professional development programme that is necessary for re-accreditation. Managed care could also play a role, if it is designed to monitor quality as well as cost.

Schneider *et al.* (chapter 7), argue that in the private sector quality of care is being hampered by the flat rate charge system, where the GP will only prescribe drugs to the value of the flat charge once his consultation fee has been deducted. Palmer’s chapter (chapter 8) indicates that there is a substantial proportion of patients (at least 12%) who are using private care, and who cannot afford the high premiums of currently available private insurance. As a result, their access to the correct drugs is being restricted because of the flat charge system and the financial hardship imposed by the alternative – paying for the full cost of the drugs out of pocket. Including primary health care within social health insurance, or creating a pre-payment scheme that meets the needs of these individuals, would considerably increase access to better quality care.

However, regulation of the private sector does not just require an understanding of the range of possible mechanisms and their effects. Crucially it requires the human resource capacity to design and monitor the regulation of both stand alone private sector activity and public-private contracts.

Social Health Insurance: a way of improving the public-private mix?

The creation of either a national health service or a national insurance scheme will be extremely difficult, both financially and politically. There is a limited amount that the government can do to change the current distribution of resources between the public and private sectors, in the short to medium term. So SHI must be considered as an option. Social health insurance has been mentioned, firstly, as a way of providing the benefits of insurance to a greater proportion of the population, secondly, as a policy that the private sector expects to assist its expansion, and thirdly, as potentially the first step towards a more cohesive health sector, expanding coverage with time. The outcome will obviously depend on the final form of the policy

The proposed SHI, as it currently stands, would involve mandatory cover for hospital care for all formal sector employees earning above a certain income level (approximately R20 000 per annum), either through SHI, or opting out to purchase private cover. Various issues have to be examined in further detail to assess what particular form the policy would take and its implications. For example, who will the scheme include and who is able to afford the necessary contributions? Are potential members willing to pay insurance premiums for public hospital care? What are the implications for equity, in terms of the distribution of the tax burden and proposed benefits? What will be the impact on employment if wage costs rise as a result? How acceptable is the policy to different stakeholders such as the unions and the Department of Finance? Do public sector hospitals have sufficient financial management capacity to bill the SHI fund for individual patients? What are the implications for excluding primary health care from the package? All these questions need to be answered if the SHI policy is to be implemented successfully.

Conclusions

The private sector spends a least 60% of the resources in the health sector on 20% of the population, and has attracted large numbers of trained personnel away from the public sector. It is driven by profit, unconcerned with public health issues, and its activities can result in inappropriate services – in terms of type of service, quality of care and in distribution of facilities, equipment and human resources. Yet the Government can neither abolish the private sector nor ignore it. The Government has to use regulation as a means of influencing private sector behaviour, and to enable the construction of public-private partnerships from which the public sector can benefit. It is the extent of government capacity to design, implement and monitor the regulatory system that will determine the success of the interaction between the two sectors.



