The role of insurance in the achievement of universal coverage within a developing country context: South Africa as a case study

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system of social assistance grants reaching upward of 15

Within fifteen years seven more funds of this nature were established as the mining economy grew. Health insurance arrangements preceded the establishment of any government structure to supervise health care which occurred for the first time only in 1919 following the establishment of the Union of South Africa in 1911, which consolidated four separate countries following the Anglo Boer war, and the influenza epidemic of 1919. By 1940 around forty eight occupational schemes existed. Only from 1956 were medical schemes regulated for the first time. Due to the rapid growth of South Africa's economy the number of schemes increased to 169 by 1960 with beneficiaries almost exclusively white. By 1990 the number of schemes peaked at around 230 with

of social solidarity. Contributions were differentiated on the basis of income, with higher income groups paying more. Differentiation on the basis of health status was prohibited by law. Schemes also needed to comply with a system of mandatory minimum benefits based on the scale of benefits, which specified the proportion of reimbursement required of a consultation, procedure, or tariff. From 1980 schemes were required to pay in full any invoice submitted directly by registered medical practitioners compliant with the scale of benefits. Where an invoice exceeded the scale of benefits schemes reimbursed the member only after they had initially settled the account. This mechanism served as an incentive for healthcare service providers to comply with the scale of benefits as members could be slow and irregular in settling accounts [15].

Over this period medical schemes primarily reimbursed the expenses of private health professionals and hospital services located in the public sector. Access to public hospitals was, and still is, subject to a means test affecting everyone over the tax threshold and quite a few below [15]. For anyone over the tax threshold a medical scheme was therefore essential to avoid catastrophic health expenses associated with private specialist and public hospital services.

To encourage employers to provide medical scheme coverage a tax subsidy was available where an employer paid the medical scheme contribution. This has since been altered to an allowable deduction in the hands of an employee to cater for the self-employed. All low-income groups have always had access to a free public health service which, apart from a few exceptions, was formally segregated on the basis of race from 1948. Interestingly, due to this configuration white taxpayers did not have free access to public services, although they did have a portion of their contribution indirectly subsidised through the tax rebate.

1984, couched in the pro-market language prevalent at the time, which argued that this would make medical schemes more affordable. The objectives underpinning the amendments to the Medical Schemes Act of 1967 stressed these "positive" intentions: "To have a medical scheme the ordinary person will be able to afford"; and "To prevent the socialisation of medicine" [15]. This led to the first significant deregulation of health insurance in South Africa.

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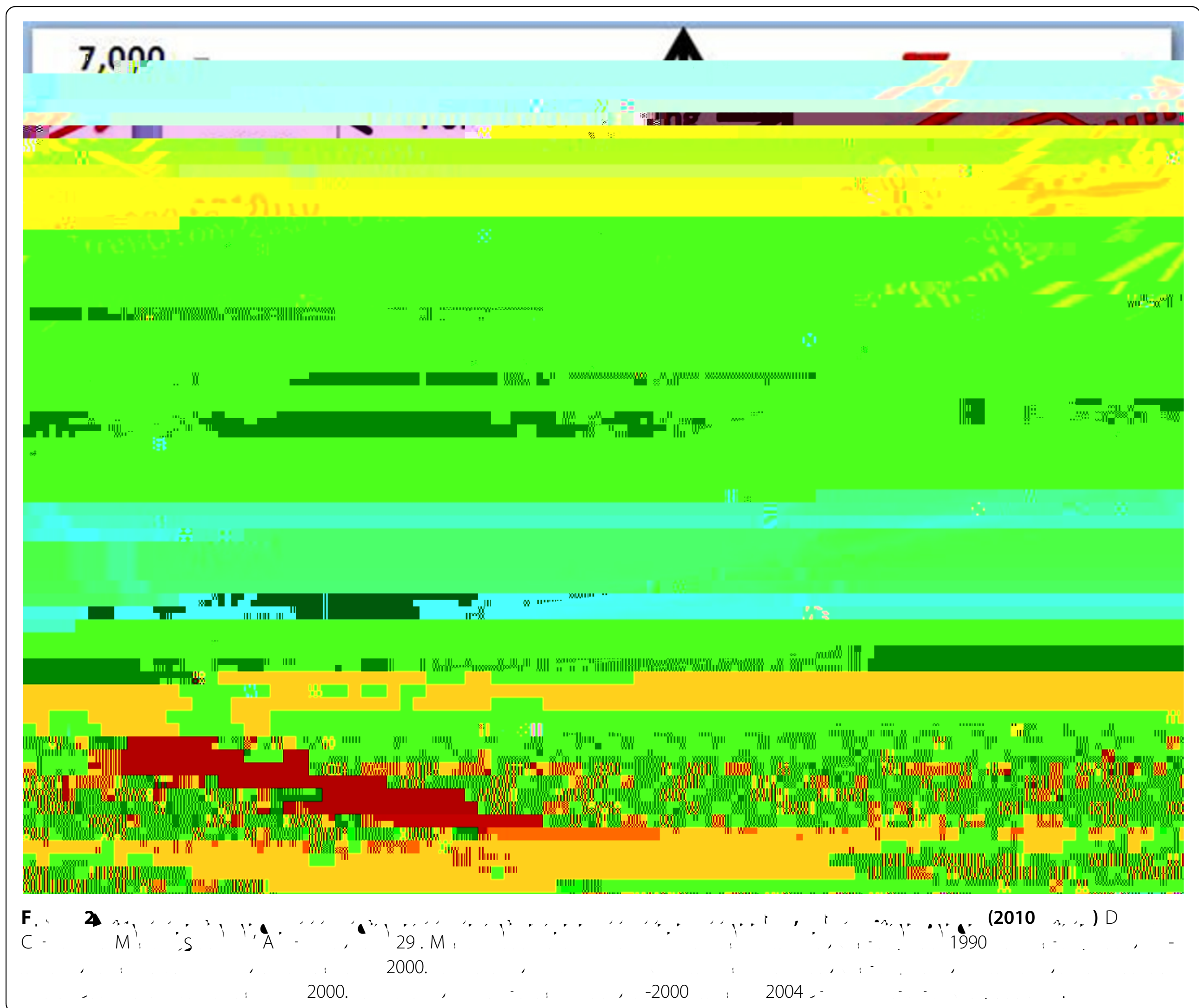
In accepting the "pro-market" arguments, the ability to set premiums on the basis of the risk of claiming were implemented by government in 1989. From this period contributions could be set on the grounds of the number of dependents, income, age, geographic area, claims experience, extent of cover provided, period of membership, and the size of the participating group [15].

This remarkable deregulation however was not sufficient to permit commercial or open medical schemes (which serve multiple employers and sometimes individuals) to emerge. The requirement to comply with mandatory minimum benefits determined in relation to the scale of benefits constrained their ability to undercut the occupational schemes. Risk rating was not enough.

Industry lobbies successfully influenced the government to implement a material further deregulation from 1 January 1994, just prior to the new democratic dispensation that would bring in a new government from May 1994. This removed the requirement for mandatory minimum benefits [15]. In 1993 government also made membership of a medical scheme voluntary for government employees, allowing them to choose their own open scheme. The former mandatory government-sponsored schemes, of which there were four, were consequently converted into open commercial schemes. Three other public sector medical schemes remained closed and mandatory: the police force scheme; the parliamentary scheme which includes all judges; and the scheme for correctional services (prisons) staff.

The changes rapidly transformed the system of medical schemes with inter alia.: a substantial shift away from occupational schemes into open commercial schemes (from 50% of all beneficiaries in 1994 to over 70% by 1999) (figure 1); the use of illegal commissions to incentivise employers to close their occupational schemes and shift to open schemes [16]; and the explicit discrimination against older and sicker members within open competing medical schemes [15].

Price competition between commercial medical schemes occurred on the basis of risk-selection (the selection of beneficiaries on the basis of health status) and risk-rating



membership declines. Competing medical schemes therefore faced no market-related penalties for passing cost increases on to contributors, provided they kept their increases in line with those of other schemes. The pricing strategies therefore focused exclusively on gaining market share from occupational schemes rather than competition amongst commercial schemes, further dulling incentives to be cost-efficient.

The incentive-driven behavioural change of schemes affected the behaviour of medical service providers during this period as schemes had little interest in serious cost containment. Poor regulation of specialists from a competition perspective allowed successful horizontal collusion (between specialists) to foreclose early attempts by schemes in 1997 to introduce forms of selective contracting [19]. Such scheme initiatives could have influenced subsequent hospital and specialist cost trends.

Whereas doctor-owned hospitals emerged during the 1980s, corporate ownership of hospitals became a major trend only during the 1990s, with significant and rapid market consolidation into three corporate groups by 1999, a period of roughly ten years. Although the hospital market was technically not an oligopoly in 1999, it was a mere two years thereafter [16]. From 1994 only three hospital groups bought independent hospitals. At some point during the early 1990s a market power threshold was crossed which accelerated the consolidation by the three groups. (Figures 2 and 3).

This market power was initially directed at independent hospitals who were vulnerable to non-price competition against the more revenue secure hospital groups. Their increasing and stable surpluses were used to chase demand by competing for specialists rather than competing for patient volumes (demand) though price discounts. Specialists, who operate independently of

hospitals in the private sector (they are not employed by hospitals), are actively attracted to hospital groups by capital investments in specialised medical equipment and practice management support. As certain hospital groups achieved sustainable revenue flows through the predictable demand provided by the specialist referrals, they were better positioned than independent hospitals to invest in the capital equipment required to attract more specialists. As independent hospitals lost their ability to retain specialists, demand for their services declined, exposing them to inevitable takeover by any one of the cash flush large hospital groups. As a result whereas in 1998 44.7% of private hospital beds were still in independent hands, by 2002 only 30.2% remained. By 2006 this had dropped to 16.2% (figure 3) [16].

Once the hospital consolidation passed an important concentration threshold in 1999, their market power, initially directed against independent hospitals (competitors), could now be directed against medical schemes who became price takers. Thus although a trend break in rising private hospital costs occurs only from 2000, the conditions for this trend break were established during the 1990s. (Figures 2 and 3).

The demographic make-up of medical schemes also became more inclusive from the mid-1980s to 1999 with a surging black middle class taking up coverage. Whereas in 1984 only 14.8% of scheme beneficiaries were black [20], by 1995 it improved significantly to 37.6% with whites at 48.6% [21]. These positive trends continued through 2000, with black beneficiaries substantially exceeding whites by 2007 with proportions at 42.8% and 39.8% respectively. By 2010 black beneficiaries constituted nearly half of all beneficiaries at 46.3% (3.8 million beneficiaries) with whites now well below at 35.7% (3 million beneficiaries) [22]. The differential improvement in black membership from 1995 is attributable to

growing black middle class. It is likely that by 2012 black beneficiaries will exceed 50% of the total.

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During the 1990s plans were made to reintroduce a regulatory regime framed around a preferred private health insurance entity that had evolved to date, the medical scheme. Parallel insurance operating through more conventional insurance regimes were regarded as unregulatable as they had no standard institutional structure or regulatory regime. Short- and long-term insurance arrangements were also subject to much lighter regulatory supervision through the Financial Service Board reporting to the Minister of Finance.

However, a return to the pre-1994 framework could no longer accommodate the altered and rapidly evolving nature of the private health system. The existence of competing commercial medical schemes, together with a supportive broker system, was now an unavoidable reality. The continuous decline in occupational schemes, particularly the smaller ones, was now systemic. Cost containment had also become an evident problem, with non-health costs also reaching alarming levels [16].

The new regulatory model now needed to reconstitute social solidarity that also generated incentives to manage costs. A policy framework tabled in 1995 talked to new measures (that had never existed before) as well as some that had been removed in 1989 and 1994 including: community rating (contributions that could not be differentiated on the basis of health status); open enrolment, whereby open commercial medical schemes would not be able to deny membership to applicants (removing their ability to risk-select); mandatory minimum benefits with an emphasis on catastrophic health expenses; inter-scheme risk-equalisation, which sought to affect inter-scheme financial transfers to ensure that all schemes faced the same prospective demographic risk profile; and mandatory membership to deal with anti-selection (where people only take up cover when needing health care). The proposed framework also incorporated recommendations for income-based cross-subsidies, to be achieved through a risk-equalisation mechanism, and mandatory participation for income earners [23].

multiple risk groups, even if there are disproportionately more poor risks.

Significant market pressure consequently exists to keep the better risk groups in the comprehensive options as they stabilise the pricing for their lucrative corporate clients who demand comprehensive coverage. Virtually all open schemes therefore deliberately over-price their low-cover options to cross-subsidise their comprehensive options.

Without risk-equalisation, however, government cannot easily expand the package of mandatory minimum benefits as this would compel schemes to consolidate options and destabilise the pricing of schemes with older and sicker demographic profiles. Scheme consolidation would also accelerate through the death spiral mentioned earlier, with a market equilibrium reached only when all the remaining schemes are broadly similar in demographic profile, which is most likely after significant consolidation. Although

motivations provided by the relevant parties to the initial negotiations. The overall process would generate price transparency and reasonableness in the bidding process. It would also systematically remove the abuse of market power as a basis for price setting. Importantly prices remain determined by way of negotiation between the principals rather than by government (i.e. an administered price) with government's role to design a fair process for the negotiations [25].

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