

SPECIAL ARTICLE

Implications of the development of managed health care in the South African private health care sector

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The South African private health care sector has been looking to managed health care (MHC) to control the unsustainable cost escalations of the last decade. This paper draws on experience of MHC in other countries, particularly the USA, to assess its potential for solving the private sector's difficulties. In addition, it looks at problems which may be associated with MHC in a South African setting. The conclusion reached is that MHC alone cannot be seen as a panacea for the private sector's financial problems, although it may produce a degree of savings and be part of a solution. It is argued that MHC *per se* seems unlikely to compromise equity, quality of care or the public health care sector, and that it may potentially promote national health policy objectives. However, if MHC's benefits are to be maximised and potential negative effects controlled, ongoing monitoring of MHC, coupled with an appropriate regulatory and incentive environment, will be required.

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The South African private health care sector has been confronted with costs rising at rates well above inflation, increasing financial insecurity and declining membership of medical schemes in the face of rocketing premiums.¹⁻³ Managed health care (MHC) is being promoted in an attempt to solve this crisis and MHC plans are becoming widespread: Since the private sector serves about 20% of the South African population, and accounts for over 55% of total health expenditure, it is important to examine the possible implications of MHC for South Africa.⁴

MHC is proposed as a solution to the cost escalation problems inherent in the existing third-party payment/fee-for-service (FFS) system of health finance in the private sector. MHC is perhaps best described as a *management process*, involving contractual arrangements between health care funders and providers. MHC's most important characteristic is that funders (medical schemes) have

increased influence over provision of health care. This is achieved through intensive auditing and management systems, as well as payment arrangements which give providers incentives to improve cost-effectiveness. These may range from managed FFS to capitation, salaries and bonuses. The MHC approach controls costs through measures such as utilisation review to monitor wasteful practices by providers and patients; consumer education and incentives to reduce unnecessary health care utilisation; incentives, practice guidelines and drug formularies to promote cost-effective management of particular medical conditions; controlled access to expensive services; avoiding duplication of buildings, administration and equipment; and negotiating discounts on supplies and services.

MHC techniques can be applied through many organisational models, including group or staff health maintenance organisations (HMOs), independent provider associations (IPAs) and preferred provider organisations. Variations exist within these types too.

The introduction of MHC in the South African private sector raises several critical questions which are explored in subsequent sections.

MHC and cost-containment

In the USA,* which has the most extensive experience of MHC, there is mixed, scarce and methodologically problematic evidence about the ability of various types of MHC to effect cost savings.⁵⁻⁸ Overall health care expenditure has continued to rise at close to the previous rate. The significance of a modest decline in the rate of increase in health care spending since 1990 is controversial.⁹⁻¹² In the Philippines, where HMOs were largely unregulated and actively encouraged, they were found to have higher premiums than equivalent insurance packages after a decade.¹³

Some studies have suggested that group and staff model HMOs, and schemes using capitation or salaries to pay providers, may have been more effective in reducing costs than other MHC types, including IPAs.¹⁴⁻¹⁷ However, others have questioned this conclusion.⁵ Furthermore, savings have tended to be once-off, largely due to a decrease in hospitalisation.

This probably occurs primarily because MHC has so far proved unable to control doctors' and clients' enthusiasm for increasingly expensive, and often cost-ineffective, new technology, suggesting that, although MHC can lead to some cost-containment, health care costs can only ultimately be contained through rationing of access to particular services.^{7,18-20} However, it could be argued that certain cost driving factors in the US health care environment, such as vested interests, powerful lobby groups and litigiousness, may be less significant in South Africa, improving chances that MHC will provide longer-term cost savings. Some authors have contended that MHC's failure to solve cost problems may be due, at least in part, to insufficient application of MHC.²¹

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* Some caution should be used when extrapolating from US experience to South Africa. Their economies and societies differ significantly, as may the MHC models applied in each country.

In addition to concerns that MHC cannot contain cost-ineffective use of new technology, it is also not clear whether MHC adequately controls 'non-price competition' between providers, where competition occurs on the basis of perceived quality, which can lead to cost-ineffective duplication of high-tech equipment and facilities to attract the custom of doctors and patients.^{22,23} However, this is more likely to limit than cancel out MHC savings and should be amenable to regulation.

Another concern is that some cost 'saving' may simply represent cost shifting: providers and suppliers recoup revenue lost due to MHC measures through increased charges in other areas of activity.^{24,25} Furthermore, providers and funders may also not need to undercut competitors by large amounts to achieve market share, so savings may be relatively small.

Cost-containment by MHC in South Africa may therefore be limited if other important environmental factors such as technology adoption, litigation, ability to shift costs and inadequate competition on the basis of price, are not addressed. The exact type of MHC plans and provider payment mechanisms which emerge are likely to be crucial determinants of potential cost saving.²⁶ While US experience suggests that FFS IPAs, the most prominent model in South Africa so far, produce limited savings, they may have the benefit of avoiding significant capital constraints and problems of population distribution in the South African context. They may also acclimatise South African doctors and patients to MHC, allowing for the subsequent evolution of more cost-effective models.

Even a once-off reduction in medical scheme expenses (which seems possible through control of high hospital and pharmaceutical costs) would provide real benefit to those served by the private health sector. In addition, MHC management may be part of a longer-term solution by increasing doctors' and patients' awareness of, and incentives to reduce, cost-ineffective practices. Even if rationing proves to be the only remedy to cost escalation, MHC may still have a role in providing incentive structures and information which encourage doctors to make cost-effective decisions.²⁷

Concerns over quality

By focusing on cost-containment, MHC may create incentives for providers not only to avoid overtreatment but also to *undertreat*. Where providers' incomes improve when they cut costs (e.g. capitation or bonus systems), they may generate savings at the expense of quality. Limits on patients' choice of provider may also reduce competition for patients and thus quality of care. MHC proponents argue that quality can be ensured by peer and utilisation review, quality assurance programmes, ongoing medical education and development of optimal treatment protocols.

American data provide no conclusive evidence of declining quality of care under MHC, and some studies suggest that it may even improve.^{5,6,28,29} However, politically weak and unsophisticated client groups or groups such as the mentally ill,³⁰ rural poor or elderly may be less able to identify poor service or to protest against it. Rigorous quality review will therefore be critically important to protect disadvantaged groups in South Africa. In addition, if MHC schemes are to maintain reasonable quality, they should

ensure that they focus on *cost-effectiveness*, not simply *cost cutting*.

A related criticism of MHC is that, although theory suggests that it promotes preventive care to avoid the need to provide more expensive curative care,³¹ in the short term preventive care may cost MHC plans more, leading to its neglect.³² Regulation might therefore be required to induce plans to provide preventive services, e.g. immunisation.

Administrative costs and capacity

MHC requires significant capacity in administration and information systems. Estimates of American administrative costs vary,^{33,34} and are not directly comparable to those of South African medical schemes. However, evidence suggests that these costs should be offset by savings they produce. In for-profit HMOs in the Philippines, however, only 55% of revenues were spent on health services.¹³

A major concern is whether the private health care sector in South Africa has adequate administrative capacity (managers, computer systems, accountants). If it does not, MHC schemes may fail to control costs and maintain quality, or may become insolvent with significant service disruption. Adequate monitoring and scrutiny of schemes are therefore required.

Effects on equity

In principle, MHC should create access to affordable private health care for more South Africans in lower income groups.³¹ American experience is difficult to evaluate, but it seems unlikely that MHC has extended medical insurance cover to significant numbers of previously uncovered people.³⁵ In the USA MHC has, however, generally lowered out-of-pocket expenses, which are often a major obstacle for poorer people requiring medical care.^{7,17}

Particular concern has been raised that MHC plans may keep costs down by risk skimming, whereby they deny cover to poor-risk, high-cost groups such as the elderly or chronically ill.³⁶ This is not a specific problem of MHC and occurs in all medical insurance markets unless it is prevented by regulation. Although the present Medical Schemes Amendment Act does allow risk skimming, this legislation could, and should, be changed.³⁷ In the USA, while members' risk profiles do seem to differ between various MHC schemes, there is no conclusive evidence that risk skimming is more prevalent under MHC than conventional health insurance options.^{7,17,38}

Overall, although MHC cannot guarantee to increase equity by extending quality health care to many more South Africans, it may well do so. At worst, assuming appropriate regulation, it is unlikely to exacerbate the disparities in South African health care which exist under the current FFS/third-party payment system.

Effects on the public sector

By cutting costs and making private care affordable to people who cannot afford current premiums, MHC may draw patients from the public sector, reducing public sector costs or freeing resources for it to extend care to currently underserved communities. This would have an indirect positive effect on equity.

MHC management techniques and expertise may also be used to considerable benefit to increase cost-effectiveness within the public sector.³⁹ Furthermore, it has been suggested that HMO-type units, within the private and/or public sectors, may be the optimal delivery units under a National Health Insurance-funded or alternative scheme to extend cost-effective, quality health care to more South Africans.⁴⁰ For these reasons, experience gained in MHC in a South African context may be of considerable long-term benefit to the country.

Concern has been expressed that costs may be shifted to the public sector if private patients with limited cover under a MHC plan are referred in an uncontrolled fashion to the public sector for secondary and tertiary care. Risk skimming could also shift higher-risk/cost patients into the public sector. However, these concerns require monitoring and regulation under any private health care system, not just MHC.

Whether MHC will increase the 'brain drain' from the public service is unclear. Most importantly, MHC itself is unlikely to be the dominant issue influencing practitioners' dissatisfaction with working conditions in the public sector. Several factors may counteract the brain drain if MHC succeeds. Firstly, use of primary care 'gatekeepers' may decrease demand for specialists in the private sector. Secondly, cost control measures may diminish the number of other health workers demanded by the private sector. Thirdly, downward pressure on some incomes within the private sector may emerge, reducing private/public disparities. Finally, if MHC does lead to affordable private coverage of more of the South African population, any 'brain drain' might have less net negative effect on care of public sector patients than at present.

In sum, MHC is unlikely to lead to new problems for the public sector if it is appropriately monitored and regulated, and it may well contribute to achieving adequate health care for all South Africans.

Population constraints

In certain areas the patient population may be too small, or too dispersed, to sustain HMO models which require large patient numbers to be viable, or provide services from certain fixed facilities only.³² However, since most patients in the private sector are currently in urban areas, and more viable MHC models may be developed, population constraints on MHC may be less significant.

Constraints on competition

A related issue is whether the private sector is large enough to support sufficient MHC schemes to allow for competition between them.⁴¹ A number of commentators, including the promoters of Managed Competition in the US at present, see competition as essential to maintain quality and reduce costs.⁴² Although evidence on the possibility and effects of competition are controversial,⁴³ it is unclear whether cost or quality control always require competition within the same geographical area. 'Yardstick competition', where private or public regulators or purchasers compare the performance of providers in different areas, may be feasible. Thus, even if populations in certain areas of South Africa may not sustain substantial competition, MHC may still be beneficial.

Conclusions

Overall, MHC alone is unlikely to be the long-term solution to the private health care sector's financial problems. A beneficial, once-off cost saving certainly seems possible. Dependent on the manner and extent to which MHC techniques are applied, and possible differences in the South African health care environment from that in the US, longer-term savings may also be attainable. The net effect on equity and the public sector may well be positive, particularly if it results in MHC schemes which are cost-effective resources for a national health system.

In general, negative effects are not likely to be great. Problems such as risk skimming, duplication and competition on the basis of non-price signals, and cost shifting to public sector hospitals require regulatory control by funders or government in any private health care system, not only MHC. Other potential difficulties can be attributed to the MHC process itself. These include the need for large administrative capacity, possible population constraints and threats to quality. Yet the costs and negative effects of these factors should be relatively small. Monitoring and regulation should ensure that MHC schemes are scrutinised to check their viability and quality, and avoid excessive administration costs, financial crises or breakdowns in service.

The introduction of MHC is likely to be an evolutionary process as funders and providers establish what is necessary and feasible in a South African context. Government should aim to create a regulatory environment that encourages the development of forms of MHC which maximise beneficial effects and minimise potential problems.

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