Regulating the for-profit private sector: lessons from East and Southern Africa

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Background

- In Africa, for-profit private sector promoted as:
  - an option for addressing health system failings
  - a good business opportunity
    (e.g. IFC 2007)

- Signs of expansion in East and Southern Africa
  - domestic, regional and international investors
  - government and donor subsidies
  - bank loans
    (Doherty 2011)

- A mix of:
  - poorly trained, widely dispersed, uncoordinated practitioners
  - single-proprietor facilities in poor condition
  - high-volume hospitals
  - ‘boutique’ hospitals
  - established and fly-by-night voluntary health insurance
    (Berer 2011, Doherty 2011, Doherty (in press))
Evidence that, if poorly regulated...

- distortions in services:
  - type
  - quantity
  - distribution
  - quality
  - price

- gut public sector HRH

- anti-competitive behaviour

- powerful alliances against regulation

- inequity:

  ‘comparable data across 15 Sub-Saharan African countries reveals that only 3% of the poorest fifth of the population who sought care when sick actually saw a private doctor’

(Marriott 2009: p3)
indulged in vertical and horizontal integration
reduced cross-subsidies through segmented benefit packages
encouraged hospital development in urban areas
employed restrictive practices regarding consumer choice
practiced tax avoidance
perpetuated high health care costs and co-payments

(Shamu, Loewenson et al. 2010)
And in South Africa

- voluntary health insurance covers 16% of population and accounts for 42% total expenditure
- majority of health personnel in private sector
- 3 hospital chains own ¾ beds
- continued risk-rating by medical schemes (400 plans)
- extensive and expensive challenges to new legislation:
  - de-regulation of health insurers in early 1990s (‘open’ schemes, cream-skimming, risk-rating, limited benefits, unethical reinsurance, brokers ‘churning’ members)
  - single exit price for pharmaceuticals
  - dispensing fee for pharmacists
  - regulation of dispensing doctors
  - demarcation between ‘mutual’ and ‘commercial’ health insurance
  - reinsurance
  - reference price lists
  - full payment for prescribed minimum benefits
- Competition Commission ‘market enquiry’ 2013–2015
  - price-fixing by hospitals, commercial interests of specialists in hospitals, excessive medical scheme administrative costs
    (van den Heever 2012, Doherty 2013, Doherty (in press))
Methods

- Qualitative:
  - document review of electronically available legislation
  - 7 semi-structured interviews
  - thematic content analysis

- Legislation categorised by:
  - level at which operates (Kumaranayake, Lake et al. 2000):
    - inputs (health professionals)
    - organisations (GP practices, hospitals, emergency services, insurers)
    - market
  - objectives:
    - volume
    - distribution
    - quality
    - price
    - promoting competitive behaviour

- Perspective: public health objectives
Limitations

- desk-based
- not a legal expert
- focus on:
  - formal sector (±10% of expenditure)
  - GPs and private hospitals (±30–70% of formal providers) and voluntary health insurance
  - legislation (as opposed to voluntary incentives)
- good info on only 8 out of 16 countries:
  - Botswana, Kenya, Namibia, South Africa, Tanzania, Uganda, Zambia, Zimbabwe

=> data triangulation, some checking by EQUINET contacts working at country level
## Findings: level of inputs

<table>
<thead>
<tr>
<th>LEGISLATION GOVERNING HEALTH PROFESSIONALS</th>
<th>DEGREE PRESENT</th>
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</thead>
<tbody>
<tr>
<td>volume: entry into health care market</td>
<td></td>
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<tr>
<td>volume: entry into private market</td>
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<tr>
<td>distribution</td>
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<td>quality: sanctions</td>
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<td>quality: continuing education</td>
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<td>price</td>
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## Findings: level of organisations

<table>
<thead>
<tr>
<th>LEGISLATION GOVERNING PROVIDERS</th>
<th>DEGREE PRESENT</th>
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<tbody>
<tr>
<td>volume: entry into health care market: H</td>
<td></td>
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<tr>
<td>volume: entry into health care market: C</td>
<td></td>
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<tr>
<td>volume: entry into private market: H</td>
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<td>volume: entry into private market: C</td>
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<tr>
<td>distribution: H</td>
<td></td>
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<tr>
<td>distribution: C</td>
<td></td>
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<tr>
<td>quality: curricula of training institutions</td>
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<tr>
<td>quality: process: H</td>
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<td>quality: process: C</td>
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<tr>
<td>quality: reporting requirements: H</td>
<td></td>
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<tr>
<td>quality: reporting requirements: C</td>
<td></td>
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<tr>
<td>prices: H</td>
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<tr>
<td>prices: C</td>
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<td>competition (competition law)</td>
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## Findings: level of organisations

<table>
<thead>
<tr>
<th>LEGISLATION GOVERNING INSURERS</th>
<th>DEGREE PRESENT</th>
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<tbody>
<tr>
<td>volume: entry into insurance market</td>
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<tr>
<td>specific health insurance</td>
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<td>regulation of number/distribution</td>
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<td>quality: standardized benefits</td>
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<td>quality: solvency</td>
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<td>quality: reporting</td>
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<tr>
<td>prices</td>
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# Findings: level of market

<table>
<thead>
<tr>
<th>Legislation Governing Providers</th>
<th>Degree Present</th>
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<tbody>
<tr>
<td>Health sector-specific</td>
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<tr>
<td>Health professionals</td>
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<td>Hospitals</td>
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<td>Clinics</td>
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<tr>
<td>Insurers: control of exclusion/waiting periods/risk-rating</td>
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<tr>
<td>General economy</td>
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<td>Competition law</td>
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Thus, in Kenya in the 1990s:
- rapid expansion unregistered clinics and labs
- unregistered providers providing care
- providers misrepresenting their qualifications
- pharmacists treated as businesses not health care providers
- doctors operating more than one clinic
- poor inspection of facilities
- corruption during licensing and inspection
- instances of medical malpractice and negligence

(Muthaka, Kimani et al. 2004)
Reasons for poor enforcement

- no formal policy on the private sector guided by public health objectives
- patchy regulatory frameworks
- stakeholders resist regulation
- expensive and slow to regulate
- ‘regulatory capture’
- regulatory authorities fragmented and have poor capacity
- government has very little information on the private sector
Conclusion

- has been some progress in last decade but this has been slow
- there are still many gaps in the legislation
- enforcement remains weak
- there is undue reliance on self-regulation

‘What I would say is that the angle [you] should also consider is the whole issue around the existence of a private sector and the effects that private sector has on the public health sector ... Some may say, well, why is it such an issue, why can’t the private sector just continue to flourish? The point is that when you have a private sector that is offering duplicative services that the public sector is also offering, the incentive is always that providers will want to service the rich at expense of the poor, particularly where resources such as skilled health professionals are in short supply. And the consequences of which is that it will destabilize the public health system ... This coexistence doesn’t actually work unless you have very good regulatory systems.’

(government official)
Recommendations

- develop own capacity to evaluate and develop legislation
- develop an over-arching policy on the private sector that keeps public health objectives in mind
- rationalise, harmonise and strengthen regulators
- address important gaps in the legislation (health insurance, quality of care, consumer protection)
- strengthen sanctions and incentives
- confront causes of cost escalation
- build alliances to counteract regulatory capture
- increase mandatory prepayment to achieve (publicly controlled) pooled financing:
  - negotiate down prices
  - use strategic purchasing
  - achieve compliance with accreditation and other monitoring requirements
Acknowledgments

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  - Pre-Congress Symposium on the Private Sector in Health
References