Achieving universal health coverage in East and Southern Africa: what role for for-profit providers?

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1. Introduction

There is increasing consensus that public financing is required to achieve the financial protection from the costs of using health care that is an essential component of the concept of universal health coverage (World Health Organisation 2010). However, the other dimension of universal health coverage is access for all to health care services that are both needed and of sufficient quality to be effective. However, many argue that, despite the fact that public services form the backbone of service delivery in most countries, private for-profit providers could play some role in extending access to quality care (International Finance Corporation 2007, Gilson, Doherty et al. 2008, World Health Organisation 2010, Balabanova, McKee et al. 2011). How this could be done effectively and in support of the principles of universal health coverage is the topic of this panel session.

This paper considers evidence on the effectiveness, equity and sustainability of for-profit private provision, and the effectiveness of government's stewardship of the sector, in East and Southern Africa. This is in order to draw conclusions about policy and regulatory requirements to encourage for-profit providers to make a more useful contribution towards achieving universal health coverage in the region. This is in the context of what seems to be a recent increase in the size of a formerly relatively small for-profit private sector in some countries in the region (Doherty 2011). This includes the emergence of 'boutique' hospitals (targeted at the high-income local market, ex-pats and foreign NGO workers, as well as medical tourism) in otherwise under-developed settings. As warned by the international literature that critiques the commercialisation of health care, such developments could worsen inequity and destabilise national health systems if inadequately regulated (see, for example, Mackintosh and Kovalev 2006).

Analysis of private sector provision is made complex by its complex nature, ranging from highly sophisticated hospitals in cosmopolitan cities to informal shops selling health products in remote villages. This paper restricts itself to examining the role of formal, for-profit health care providers: these are companies and individuals that

operate commercially and are supposed to be registered under, and comply with, countries' health (and other) regulations.

Even within this sub-category of the private sector there are important distinctions: for example, the financial pressures facing a general practitioner working in solo practice in his small home town are very different from those of a private hospital chain that operates on a national scale and is answerable to international investors. This means that policy and regulatory responses need to take account of the different incentives inherent in these different situations.

A final introductory remark is that most countries in the East and Southern African region have weak public health systems and receive considerable external support. South Africa is an exception to this general pattern with a better established – but still troubled – public system, and an extremely wealthy private sector. Very few governments have made it compulsory for parts of their population to contribute to mandatory health insurance and, where this does exist, coverage tends to be limited. In general, the for-profit private sectors in these countries are not well documented and little evidence exists on the health and equity outcomes of private services.

2. Methods

This paper draws on previous studies by the author that, between them, reviewed international experience relevant to for-profit provision of health care in East and Southern Africa, with a focus on understanding the regulatory implications. The earlier of these studies were based on reviews of the formal and grey international literature (Doherty 2011, Doherty and McIntyre 2013). The most recent of these, which looked at legislation governing the for-profit private sector, was based on a document review of existing legislation in the sixteen countries in the East and Southern African region, and seven semi-structured interviews with key informants (Doherty 2013a, Doherty 2015). More details on these studies' methods appear in the original reports and journal articles.

This paper also reflects briefly on the proceedings of the on-going South African Competition Commission's Market Inquiry into the Private Health Care Sector. This is the first such industry-wide inquiry in the region and has, as its major focus, an investigation into the causes of the high cost of private health care. As is self-evident, the high cost of private health care is one of the main reasons why integrating for-profit private providers into a universal health coverage policy and system poses a considerable challenge (although, as the following paragraphs make clear, there are many other concerns).

3. Findings and discussion

The last decade has seen increasing calls for expansion of private sector provision as a mechanism to improve access to health care in low- and middle-income countries (see, for example, International Finance Corporation 2007). These countries'

expenditure patterns reveal that a high proportion of health care expenditure is already privately financed (through out-of-pocket payments and, to a far smaller extent, through private health insurance). Thus, in 2012, 57 per cent of all health financing was from private sources in Sub-Saharan Africa, with just under a third (30 per cent) of this figure accounted for by premium contributions.[1] In addition, even the poor continue to use the private sector in countries with well-established public health systems, probably because of the privacy, convenience and the real or perceived higher quality that they offer (Balabanova, McKee et al. 2011).

In the context of this paper, though, it is critical to note that expenditure on the for-profit private sector is much smaller than the figures for private financing quoted above. This is because private financing includes out-of-pocket payments to the public and not-for-profit private sectors. Not-for-profit services can form a large part of the private sector in terms of the number of services provided: thus, the African Religious Health Assets Programme (2007) estimated that between 30 and 70 per cent of health service infrastructure belonged to the not-for-profit sector in some African countries.

In addition, high levels of private expenditure do not necessarily reflect high levels of coverage by for-profit private providers, because of the high prices associated with this component of the health sector. In 2012 in South Africa, for example, private providers consumed 49 per cent of total health expenditure (McIntyre, Doherty et al. 2014). However, figures from 2008 show that only 29 per cent of outpatient visits, and 18 per cent of hospital admissions, were accounted for by private providers (Alaba and Mcintyre 2012).

Further, utilisation of private care tends to be higher for high-income sections of the population. Marriott (2009: 3) found, for example, that *'comparable data across 15 sub-Saharan African countries reveal that only 3 per cent of the poorest fifth of the population who sought care when sick actually saw a private doctor.'*

Finally, while the for-profit private sector may meet the needs of some sectors of the population, it can have negative impacts on other sectors of the population and on the health system overall, distorting the type, quantity, quality, distribution and price of services, as well as leading to anti-competitive behaviour. These negative impacts have been captured particularly well by those working in the field of sexual and reproductive health, an area of health care delivery that is often under-provided, despite the global emphasis on maternal care in line with the Millennium Development Goals. The range of negative impacts that have been experienced by low- and middle-income countries are summarised by Doherty and McIntyre (2013) and reproduced in **Table 1**.

As **Table 1** shows, the private sector sometimes offers poor quality care, provides fragmented care, undermines allocative efficiency, and destabilises the public system on which the poor depend. This can be as true of high-tech, urban services as of the often isolated, solo practices that characterize much of the private provision in many

[1] These figures derive from the latest (2012) data in the World Health Organisation's Global Health Expenditure Database (http://apps.who.int/nha/database/Home/Index/en) and are expressed in terms of purchasing power parity.

countries in the region. This is not to say that many for-profit providers do not render excellent services and meet the needs of certain components of the population (particularly elites), especially where public services are sub-standard or poorly accessible.

Table 1: Negative impacts of for-profit private providers on national health care objectives in low- and middle-income countries

Impact	Reasons
While private provision enhances access to care for some segments of the population (especially the better-off), it can worsen inequity, especially where pubic services are not readily available to other segments of the population	• Serve only those able to pay • Concentrated in urban areas • Differentials in quality between public and private patients • Catastrophic financial impact on poor households
While some private providers render high-quality services, many are of poor quality, particularly where regulation is weak	• Poor at following national guidelines • Neglect critical services (e.g. pregnancy and child-birth services, sexually transmitted infections, screening and follow-up services) • Misuse pharmaceuticals (inappropriate choice of drugs over-prescribing and failure to inform patients of side effects) • Medicalise health issues, thereby skewing the uptake of services (e.g. recommending oral and injectable contraceptives as opposed to condoms which are better at preventing sexually transmitted infections) • Difficult to work with regarding quality improvement programmes • No quality control over illegal services (such as back-street abortions)
While private providers are often efficient in the business sense of maximising profits, they are often inefficient from the health systems perspective, especially when there is little competition between providers or where providers are paid a fee for service (as this incentivises over-servicing)	• Over-servicing, especially with respect to pharmaceuticals, diagnostic tests and costly procedures (e.g. Caesarians) • High prices and inflation • Corruption and fraud (e.g. theft, under-the counter payments and diversion of patients into private practices where public health workers also work in private practice, fraudulent submissions to health insurers • Subsidised private programmes not viable once donor or government subsidies withdrawn
While private provision can satisfy the needs of some portions of the population, often a large private sector undermines the integrity and sustainability of the health system overall	• Fragment preventive, diagnostic and curative services • Brain drain from the public sector • Not coordinated • Little community participation

Source: Ravindran and de Pinho (2005), Hanson, Gilson et al. (2008) and Berer (2011), summarised by Doherty and McIntyre (2013)

As well established by the international literature, such problems arise because of the incentives shaping the behaviour of private providers, especially when services are reimbursed according to a fee-for-service model (and most especially when these reimbursements are made through a third-party payer, such as a health insurance scheme) (see, for example, Afifi, Busse et al. 2003). Profit incentives encourage treatment according to the ability to pay (rather than need) and favour the provision of

expensive services. In other markets (such as the car industry), such tendencies would be counter-acted by market forces. However, it is well established that there is 'market failure' in the private health sector because of an asymmetry of information and power imbalance between patients and providers (Rice 1998, Bagchi 2007) .

One of the reasons why some for-profit providers have been successfully incorporated into national health systems in OECD countries (GPs in the UK being one example, and both GPs and private hospitals in the Netherlands being another) is because of these countries' strong regulatory and financing systems, which deal with the market-related distortions that would otherwise exist. This is not the case in low- and middle-income countries where regulatory systems – both through legislation and through strategic purchasing - are weak and there is limited competition between private providers (Hongoro and Kumaranayake 2000, Afifi, Busse et al. 2003, World Health Organisation 2010).[2]

Turning then to an examination of the regulatory capacity of countries in East and Southern Africa, a review of legislation in eight out of the sixteen countries found that most legislation is focused on controlling the entry of health professionals and health service organisations into the market through registration and licensing, with little attention paid to the behaviour of providers following entry into the market (Doherty 2015). Tables 2, 3 and 4 illustrate this by assessing the degree to which existing laws address specific national health system objectives. In the Tables, green cells indicate that laws exist in almost all eight of the countries reviewed, orange that they exist in about half of the countries, and red that no, or very few, countries have laws covering this area.

As **Table 2** shows, while health professions councils in all countries are integrally involved in defining scopes of practice, overseeing training standards, and applying sanctions against sub-standard care and unprofessional behaviour, there is little control of the fees charged by health professionals or limits placed on their total incomes, except in Kenya (Doherty 2015).

Table 2: Laws governing health professionals

Area of regulation	Health system objective	Extent to which laws exist
License to practice	Maintaining quality	
License to work in the private sector	Controlling volume of professionals	
Incentives/restrictions regarding location	Controlling distribution (encouraging rural practice, preventing over-supply)	
Sanctions for poor behaviour/practice	Maintaining quality	
Continuing education	Maintaining quality	
Ceiling on fees	Ensuring affordability	

Source: Doherty (2013b)

[2] While public services can also provide poor quality and inefficient care in these countries, at least there are some mechanisms inherent to the organisational structure and governance of the public sector that make it possible to identify and address these failings.

Further, health professions councils reportedly often appear reluctant to act against fellow health professionals, except in the case of more extreme breaches of professional codes of conduct (Doherty 2013a). Thus, a study on the situation in Zimbabwe over a decade ago found negative practices such as doctors referring patients to other services in which they had a financial stake, over-servicing of patients and false billing of health insurers (Hongoro and Kumaranayake 2000). In many countries there is also contestation between different types of health professional (and between existing health professional and new cadres such as mid-level health workers) around changing scopes of practice: this makes it difficult to re-configure health services in line with changing needs.

As **Table 3** shows, while private hospitals need to be licensed in all countries, there is little control of the number and distribution of these facilities. Formal 'certificates of need' are generally not required although some countries (Namibia, South Africa and Zimbabwe) require some justification that a new hospital is in the public interest although it is not clear how strictly these requirements are implemented (Doherty 2013a). While there tend to be minimum requirements for physical infrastructure, equipment and human resources, very little attention is paid to process criteria for the quality of care, although progress is being made in this regard in Botswana, South Africa and Tanzania (Doherty 2015). No country places a ceiling on the prices that its private hospitals may charge, although there are limitations on fees charged by accredited hospitals seeking reimbursement by the National Hospital Insurance Fund in Kenya and on fees reimbursed by private health insurers to hospitals for minimum benefits in Zimbabwe. Tanzania also lays out a process for the determination of hospital fees in its legislation.

Table 3: Laws governing private hospital and clinic facilities

Area of regulation	Health system objective	Service type	Extent to which laws exist
License to enter health care market	Maintaining quality Controlling volume of facilities	Private hospitals	
		Private clinics	
License to enter private health care market	Controlling volume of facilities	Private hospitals	
		Private clinics	
Certificate of need	Controlling distribution-encouraging rural practice, preventing over-supply	Private hospitals	
		Private clinics	
Monitoring of quality of care criteria	Maintaining quality	Private hospitals	
		Private clinics	
Reporting requirements	Maintaining quality	Private hospitals	
		Private clinics	
Ceiling on prices	Ensuring affordability	Private hospitals	
		Private clinics	

Source: Doherty (2013b)

Beyond these few constraints, generally the type and quality of services provided by private practitioners, clinic chains and private hospitals is not well regulated and patient rights are not well protected (Doherty 2015).

Furthermore, **Table 4** shows that there is almost no regulation that guards against anti-competitive behaviour. A study in Zimbabwe found that, at one stage, lack of anti-competition legislation and oversight meant that private health insurers could indulge in vertical and horizontal integration of health insurance and provider companies, encouraged hospital development in urban areas, employed restrictive practices regarding consumer choice of provider, and perpetuated high health care costs and co-payments (Shamu, Loewenson et al. 2010). Subsequently, the country's Competition Commission was able to intervene and act successfully against a number of mergers, acquisitions and verticalisation of health-related companies (Kububa 2004, Kububa 2009).

Table 4: Laws governing the health care market

Area of regulation	Health system objective	Extent to which laws exist
Health-sector specific		
Pertaining to health professionals	Maintaining quality; Controlling costs	
Pertaining to private hospitals	Maintaining quality; Controlling costs	
Pertaining to private clinics	Maintaining quality; Controlling costs	
Pertaining to health insurers	Maintaining quality; Ensuring sustainability	
Pertaining to the general economy		
Competition law	Maintaining quality; Controlling costs; Ensuring sustainability	

Source: Doherty (2013b)

Beyond these legislative gaps, poor enforcement of legislation has been documented in several countries in the region (Hongoro and Kumaranayake 2000, Kumaranayake, Lake et al. 2000, Soderlund and Tangcharoensathien 2000, Muthaka, Kimani et al. 2004, van den Heever 2012, Doherty 2015). Some health professionals practice without licenses and operate unregistered facilities. Inspection is often superficial or absent. There is also evidence of anti-competitive behaviour that goes unchecked. There is little monitoring by governments of quality and health outcomes, or attention to how the private health sector supports national health objectives.

Reasons for poor enforcement include a host of factors: there is often no formal policy on the private sector guided by public health objectives; regulatory frameworks are usually patchy; stakeholders tend to resist regulation or 'capture' legislation to safeguard their own interests; it is expensive and slow to introduce additional regulations; regulatory authorities are fragmented and have poor capacity; and governments have very little information on the private sector (Doherty 2015).

These legislative gaps and enforcement problems, together with the fact that prices are not contained in any meaningful way, either through price controls or active reimbursement mechanisms, mean that for-profit private care in the region is likely to become increasingly unaffordable for any but the wealthiest. This places a huge question mark over the issue of the feasibility of integrating for-profit provision into an equitable, affordable and comprehensive health system. **Box 1** illustrates these challenges by presenting the experience of South Africa in more detail. While South

Africa is unusual in the region because it is an upper-middle-income country, and because of its very large for-profit private sector (that is mainly urban-based and dominated by hospitals and specialists), it acts as a cautionary tale for countries seeking to expand their sectors without having the necessary legislation and regulatory capacity to curtail its excesses.

Box 1 shows that commercial interests responded very quickly to deregulation of the health insurance industry. It also shows that it is very hard to regulate (and re-regulate) the private sector, even when government has considerable capacity to do so (which, in the case of South Africa, is vested in its relatively well-resourced Council for Medical Schemes).[3] Further, it shows that regulating private insurers has little impact if they are not invested with sufficient power as purchasers to reduce cost escalation through negotiating down prices with private providers. The South African experience also demonstrates very convincingly the point that, in a developing country, a strong private sector can severely undermine public provision and the achievement of universal health coverage. Lastly, although not discussed fully here, the South African case supports the wider argument that private health insurance is not the route to follow for governments seeking to achieve a single risk pool and provide affordable care (although it may be appropriate for top-up insurance, as suggested in the South African draft policy on National Health Insurance (National Department of Health 2011)).

A final point to make is that the South African case demonstrates the intertwined nature of policy and legislation on the private health insurance and private provision industries. This is a point that is not addressed sufficiently in the literature. For instance, out-of-pocket payments (which are the most inequitable form of health financing) become onerous not only when public services charge user fees but when health insurance does not cover sufficient benefits or requires large co-payments (McIntyre, Doherty et al. 2014). Further, inadequately defined private benefit packages lead to 'gaming' by health insurers and providers attempting to shift treatment into or out of levels of care or treatment categories, depending on the financial benefits for their businesses (Doherty and Steinberg 2003).

Given this state of affairs in the region, what are the options for drawing for-profit provision closer towards the policy direction of governments seeking to achieve universal health coverage? A new dynamic in the regulation of the private sector has been the creation of Competition Commissions in many countries in the East and Southern African region. These institutions were set up to protect the various country economies against monopolies, regulate mergers, and prohibit unfair or restrictive trade practices.

[3] More information on the Council is available at https://www.medicalschemes.com.

Box 1: Challenges associated with private health care provision in South Africa

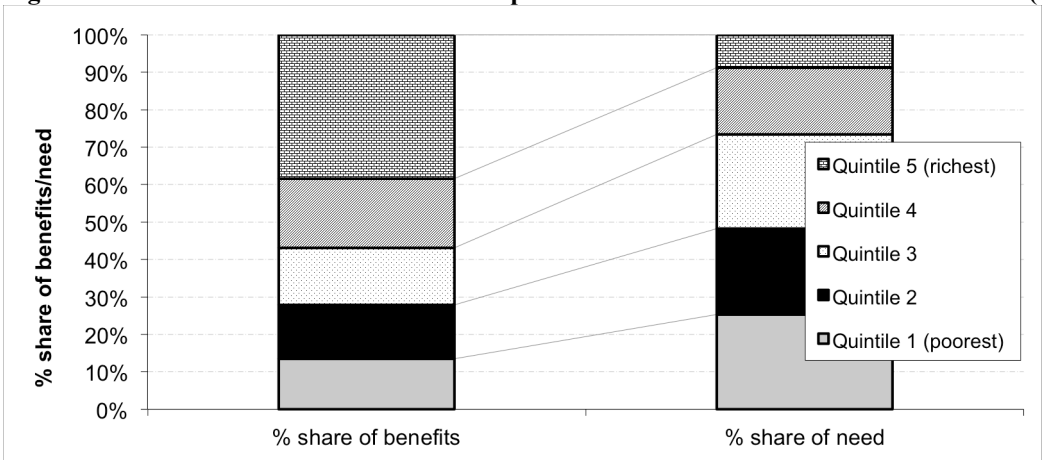
While parts (but not all) of the South African private health sector provide care of a high quality, it is expensive. In 2012, South Africa spent one of the highest proportions (43%) of health financing on private health insurance in the world (43%) (McIntyre, Doherty et al. 2014). 49% of total health expenditure was on private providers. Yet private health insurance covered only 17% of the population in 2012 (Republic of South Africa 2013). In 2008, only 29 per cent of outpatient visits, and 18 per cent of hospital admissions, were accounted for by private providers (Alaba and Mcintyre 2012). The country as a whole has poor health care indicators for a country of its economic status and still suffers from health and access disparities inherited from the apartheid era.

The reasons for this state of affairs are complex but include de-regulation of the health insurance (or, in South African terminology, 'medical scheme') industry shortly before the demise of apartheid in 1994, with the result that community-rating and standardized benefit packages were no longer a legal requirement. For a number of reasons, and contrary to expectations, this led to an escalation in private health care costs (Doherty and McIntyre 2013). A highly commercialized medical schemes environment came to dominate an industry that had previously been based on the principle of cross-subsidisation of costs by the rich, young and health on behalf of the poor, old and ill. This environment has remained despite partial re-regulation of health insurance in 2000.

This is partly because regulation of private providers remains weak. An ineffectual moratorium on the building of private hospital beds failed to prevent rapid expansion of the hospital sector (Doherty and McIntyre 2013). GPs and specialists are still paid largely on a fee-for-service basis and insurers have relatively limited bargaining powers to negotiate appropriate prices with providers or control treatment practices adequately. This is especially since a Competition Commission ruling a few years ago outlawed collective bargaining around tariffs. While there have been some successes in controlling some negative behaviours by the private sector (such as excessive pricing of pharmaceuticals and over-prescribing by dispensing doctors) other initiatives, such as attempts to regulate dispensing fees for pharmacists, have been resisted heavily. Medical schemes administrators and private hospitals are highly consolidated, with three administrators controlling 78% of medical scheme beneficiaries and 88% of hospital beds belonging to three hospital chains in 2012 (Republic of South Africa 2013).

The wider impact on the health care system has been that human resources have been attracted away from the public sector to work in the lucrative private sector (thus, by the late 1990s, 75% of specialists, 50 to 70% of GPs, and 40% of nurses worked in the private sector (Doherty and McIntyre 2013)). Most importantly, as shown by **Figure 1** (Ataguba, Akazili et al. 2011), high-income groups receive far more health services, proportionately, than is indicated by their need for care.

Figure 1: Distribution of health benefits compared to need for health care in South Africa (2008)



In two countries, Zimbabwe and South Africa, such Commissions have begun to turn their attention to their countries' private health sectors. Zimbabwe's Commission has acted successfully against a number of mergers, acquisitions and verticalisation (where health insurers oblige members to utilise providers owned by themselves) (Doherty 2013a). A National Incomes and Pricing Commission has also intervened in the cost of health insurance.

In the past, South Africa's Commission acted against suspected collusion in price setting between providers (especially the three main hospital groups) by prohibiting collective bargaining. Unfortunately, this prohibition was extended to health insurers as well, who had previously acted as a single block in tariff negotiations. This was the main instrument at their disposal to contain prices charged by providers. This debacle for the South African health sector reflected Commissioners' lack of awareness of the specific market dynamics affecting the health sector. It led to an extended period of attempts by the Board of Health Care Funders and South African Department of Health to establish recommended (but not compulsory) price lists but without success in influencing tariff negotiations.

More recently, amendments to the legislation governing South Africa's Competition Commission have allowed it to launch a market inquiry into the behaviour of the private sector (this means that it is not investigating any particular company but assessing the state of the entire market) (Republic of South Africa 2013). The Inquiry was initiated in 2014 and is due to present its report towards the end of 2015. Calls for submissions (and responses to submissions) have just closed. Commissioners are currently reviewing these submissions and preparing for public hearings. [4]

Under the new legislation, the private sector is obliged to participate in the Inquiry as and when requested, as well as submit information requested by the Commission (whereas previous inquires into other markets have had to rely on voluntary participation). The Commission has the authority to recommend changes to legislation, refer issues to other regulatory authorities and investigate individual companies on the basis of information revealed during the inquiry. This is the first health market inquiry in Africa although one was concluded in the UK in 2013.

Compared to its earlier pronouncements on tariff negotiations, the Commission has since developed a much deeper understanding of the dynamics at play in the private health sector, through the commissioning of background papers. It has also positioned its investigations within the context of national health objectives, understanding its role to be helping to realise the state's constitutional obligations to progressively realise access to health care as a fundamental human right (Republic of South Africa 2013).

The market inquiry provides a unique opportunity to investigate the behaviour of the entire for-profit private sector in South Africa, and its powers allow it to recommend policy and legislation to address problems, especially around cost escalation and anti-competitive behaviour. **Box 2** provides a list of the issues that the Commission will be investigating with respect to private hospitals and health professionals: it gives an idea of the areas of concern relating to the current drivers of service delivery and pricing

[4] For further details, see http://www.compcom.co.za/healthcare-inquiry/.

patterns, as well as concerns around fair competition voiced both by the industry and critics of the industry's practices. Amongst these are long-standing concerns about price-fixing by private hospitals, and the commercial interests of doctors in hospitals that affect their referral and treatment decisions.

Box 2: The scope of South Africa's Market Inquiry into the Private Health Sector

Health professionals

- The role of health professionals as an agent of the patient
- The role of gatekeepers in the management of the demand for health services
- The nature of competition in the market for health professionals, in terms of both price and quality
- The determination of tariffs and fees charged to health insurers and households making out-of-pocket purchases
- The inter-relationship between prices (fees and tariffs) and service volumes
- Contracting regimes and their relationship to competition
- Review of how price determination takes place and consider its implications for both the expenditure and quality of health services
- Inter-relationships between the public and private systems and any implications for competition and cost
- The implications that a market for salaried health professionals will have on provider competition

Hospital-based services

- The role of the hospital in influencing the demand for health care goods and services
- The relationship between hospital-based services and health care purchasers
- The nature and extent of competition between suppliers of hospital-based services
- The extent and impact of markets for substitutes (day hospitals, outpatient services, clinics, sub-acute facilities) on acute in-patient hospital services
- The relationship between hospitals and services such as emergency transport, pathology, radiology, medicines, consumables, and medical devices and the role of these services as systemic cost drivers
- The relationship between hospitals and doctors (GPs and specialists) and the role of doctors (GPs and specialists) as a systemic cost driver
- The relationship between hospitals and nurse practitioners, including the role of nurse agencies and the public sector
- The determination of tariffs/fees charged to medical schemes for out-of-pocket purchases
- The inter-relationship between prices (fees and tariffs) and service volumes
- The influence of changes in technology on costs and expenditure
- The influence of factors such as population morbidity and demographic profiles on costs and demand volumes
- The influence of market concentration on the costs and quality of hospital-based care
- The factors required to drive competition based on service cost and quality
- Alternative reimbursement arrangements and the extent to which they drive competition for hospital services
- Contracts between medical scheme intermediaries (third party administrators and managed care companies) and hospital groups outside medical scheme contracts
- The hospital licensing process and its influence on the market for hospital services

Integrity of the regulatory framework

- The influence of regulatory frameworks on the effective functioning of the private health market with specific emphasis on:
    - Social protection legislation incorporated into the Medical Schemes Act
    - The ethical rules applicable to health professionals
    - The application of a reference tariff schedule to determine when over-charging by health professionals occurs

Source: Republic of South Africa (2013: 88-90)

It is not clear, however, whether the Commission will, in practice, be able to deliver as hard-hitting a set of findings as would have been hoped for by the range of actors concerned about the private sector's negative impact on equity and the achievement of universal health coverage. This is because of: the sheer complexity of the sector and the Commission's brief; the substantial but nonetheless limited capacity of the Commission in relation to its task (in terms of funds, skills and time); the enormous power and technical skills of the dominant insurers and providers (which have monopolised much of the legal and accounting skills which would otherwise have been at the disposal of those stakeholders challenging private sector practices);[5] and difficulties ensuring that the voices of patients, patient groups and the general public are heard. Only time will tell whether the Competition Commission will be able to launch a successful strategy to balance market forces more effectively in the interests of more equitable care.

From this description of the South African situation, and the long list of issues to be addressed by the Commission regarding private provision (not to mention those relating to private health insurance which have not been addressed by this paper), it is clear that regulation through legislation is a complex, costly and necessarily on-going task.

A more productive avenue to explore might be the set of initiatives that seek to include private provision more effectively in national health systems strengthening mandatory prepayment for health care. As the international evidence attests, in order to harness private provision in the interests of wider society it is essential to create a single risk pool that strengthens government's position in: negotiating down prices with private providers; using strategic purchasing to incentivize private providers to provide equitable, comprehensive, affordable and effective care; and achieving compliance with accreditation and other monitoring requirements (World Health Organisation 2010). Such a financing strategy appears to offer the best chance of achieving a feasible inclusion of at least some for-profit providers into a unified health system.

Thus, for example, it is likely that the South African National Health Insurance Fund will seek to contract primary care practitioners on a capitation basis to serve local communities(National Department of Health 2011). It might also perhaps contract some limited services from private hospitals (which, at this stage, are far too expensive to consider for general hospital care). With respect to primary care provision, however, there are several unanswered questions. For example, how will private providers be able to provide the comprehensive, community-based care that characterises public clinics, given that this is so far from their current practice? How will new inter-disciplinary teams and scopes of practice be negotiated, given very strict constraints currently imposed by the Health Professions Council on employment

[5] Indeed, one of the major private hospital groups challenged the role played by a major consulting firm in providing technical support to the Commission. This was on the basis that the consulting firm had, at some points, provided services to the hospital group and therefore was privy to confidential information. This challenge was eventually settled out of court but illustrates the difficulties associated with mustering the technical skills necessary to analyse a powerful private sector where much of the information that would be public in the public setting is kept secret because it underpins companies' business strategies.

by doctors of other health professionals? How will capitation fees be set for private providers, given the very different cost structures faced by public and private providers, and given that risk needs to be shared fairly between the purchaser and provider? These questions illustrate the enormous difficulties that are confronted by policy analysts when trying to think through how to involve for-profit providers in any other way than strictly on their own terms.

4. Conclusions and recommendations

This paper presents evidence that, in low- and middle-income countries, for-profit private providers, especially private hospitals, are often costly and located in more urbanised areas. For-profit services are seldom comprehensive and, while they are often perceived to offer superior and more convenient care, there is minimal public monitoring of their quality. There is evidence that private care is subject to incentives that distort treatment decisions. The existence of private facilities contributes to the brain drain from the public sector and aggravates the fragmentation of the health system. Further, fair competition is obstructed through unfair practices (such as collusion) as well as unregulated practices such as the vertical integration of health care providers, pharmacies and health insurance companies. Lastly, powerful private sector alliances compromise governments' ability to regulate the sector in the interests of national health objectives.

At the same time, there are initiatives by international agencies, donors, African governments and others to expand the for-profit private sector in Africa (Doherty and McIntyre 2013). These include efforts to attract new local and international investors, encourage bank loans to private practitioners, and subsidise for-profit health care businesses. There is indeed evidence that the for-profit private sector is expanding in East and Southern Africa (Doherty 2011)although whether this expansion has had a positive impact on financial protection and access to quality care for the majority of the countries' populations is highly questionable, even though it might meet other national objectives, such as the growth of private enterprise in Africa. On the contrary, recent initiatives to encourage investment in the for-profit sector are finding it difficult to demonstrate a positive impact of these initiatives on health access for the poor (Brad Herbert Associates 2012, Marriott 2014).

This is not to argue against the fact that some, perhaps many, private providers make very particular contributions to the health systems in which they are located. People's preferences for some forms of private provision reinforce the notion that private provision should remain an option for governments seeking to provide universal health coverage (Balabanova, McKee et al. 2011). This paper does argue, though, that, in health systems such as those in East and Southern Africa where the private sector is poorly regulated and monitored, these benefits are often offset by the distortions that are introduced by the private sector overall. In particular, private provision is simply unaffordable for the vast majority of the populations in the countries in the region.

Policy-makers in the East and Southern African region (and in many other low- and middle-income countries) need to embark on a programme of action to strengthen

regulatory frameworks and instruments, and introduce active purchasing mechanisms, to incentivize appropriate behaviours by for-profit providers. Without these actions, investment by donors and funders in the expansion of the private sector seems inappropriate.

The range of actions should address the failings of the health insurance and health provision industries in tandem, as well as the interplay between them. They should include:

1. developing a sound evidence base on the nature and extent of the private sector, differentiating clearly between different components of the sector;

2. assembling evidence on arrangements that have allowed private provision to be incorporated successfully in universal health coverage strategies (together with the factors explaining the strengths and weaknesses of these arrangements);

3. exercising greater stewardship over the for-profit private sector by demonstrating political will and leadership;

4. developing an over-arching policy on the private sector that keeps public health objectives in mind;

5. conscientising Competition Commissions regarding the reasons behind market failures in health and necessary strategies to protect national health objectives;

6. conscientising Ministries of Trade and Development regarding the health system impact of their policies to attract investment into the private health sector and stimulate private health businesses;

7. strengthening government capacity to develop, implement and monitor legislation and other regulations;

8. making efforts to rationalise, harmonise and strengthen existing regulators;

9. addressing important gaps in the legislation (including that relevant to health insurers, health providers, health professionals, fair competition and consumer protection);

10. building strategic alliances with key stakeholders to counteract regulatory capture by groups with vested interests;

11. introducing a range of price controls for services;

12. strengthening sanctions against non-compliance with regulations;

13. ensuring greater transparency on the part of private providers with respect to their underlying costs and quality; and

14. evaluating the impact of the private health sector and its regulation on the health system, including on equity.

The length of this list underlines the extent to which intervention is required in the for-profit private sector to prompt it to meet national health objectives. It also underlines the current weaknesses of governments in the region in exercising oversight of the private sector. Accordingly, extreme caution should be exercised with respect to promoting further expansion of private provision or health insurance, until solid strategies such as those proposed above can be put in place. Given the capacity constraints facing governments in the region, it can be expected that progress will be slow in this regard.

A greater priority than expanding the private sector is surely the strengthening of public sector provision, not only to meet the needs of the majority but also to provide stiffer competition with private providers. As argued elsewhere, public provision must remain a core function of the public sector (Gilson, Doherty et al. 2008).

Equally importantly, it is a priority for governments in the region to strengthen mandatory prepayment for health care, especially through general taxation but also, where appropriate, through earmarked taxes, including payroll-based payments. As already discussed, the leverage provided by this instrument in incentivizing providers to comply with quality controls and contain costs is arguably far greater than through legislation alone.

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