

Public vs. Private Health Sector Rationing Mechanisms: Theoretical and Practical Considerations

Executive summary

1. Introduction

In light of the planned public health reforms in South Africa, it is necessary to take a step back and consider how the already scarce resources in the health sector will be allocated in the most efficient way under a system of universal coverage. The demand for healthcare is known to be unlimited and it is in this context that we consider in this study how the limited supply of financial, human and physical resources should best be distributed in order to obtain the greatest value. The distribution of scarce resources in the healthcare sector is termed 'rationing'. Rationing implies that priorities have to be set and decisions have to be made in order to determine the most equitable and effi-

cient way of allocating the limited resources amongst competing demands. Experience has shown that in the face of unlimited demand for healthcare, resources will be rationed, whether explicitly or implicitly.

This report considers the difference between rationing practices in the public and private health sectors in South Africa. The different rationing mechanisms, as well as the different underlying constraints and rationale for implementing specific rationing policies are considered theoretically, but also practically. As expected, it is found that the severity of rationing in the two sectors is directly linked to the specific resource constraints. Resources in the demand-driven private sector are much less restricted

than those of the public sector, and as such rationing policies are less severe. Health services may be less expensive in the public sector, but this comes at a cost to the patient who is faced with more severe rationing mechanisms which, in some cases, imply not having access to certain services at all. On the contrary, healthcare may be more expensive in the private sector, but rationing policies are much less severe.

2 Theoretical considerations

In the context of healthcare resources, rationing is defined as "withholding a potentially benefiting healthcare service to an individual to conserve limited resources"¹ or "allocating healthcare resources in the

This research was commissioned and sponsored by the Hospital Association of South Africa (HASA). The full report can be accessed on the Econex website: www.econex.co.za.

1. Friedenber, R.M., 2003. "Rationing in Health Care: Changing the Patterns of Health Care," *Radiology*, Vol. 227, pp.5-8

face of limited availability, [by] withholding beneficial interventions from some individuals. It is socially inevitable and prevalent.”² The point is made that rationing is a permanent feature of both public and private health systems, irrespective of the level of resource constraints.

Rationing mechanisms can be either explicit or implicit. Explicit rationing practices are clearly defined rules or policies which have been carefully designed and put in place to facilitate the allocation of scarce resources. On the other hand, implicit mechanisms are usually found in the absence of explicit rationing rules. These mechanisms include waiting lines or health professionals having to make the rationing decisions on an ad hoc basis (bedside rationing). The importance of transparency in rationing (related to explicit rationing mechanisms) is highlighted in this report, and our findings indicate that transparent, explicit rationing practices have helped legitimise rationing decisions before courts and tribunals in other countries.

It is found that there is a theoretical rationale for the difference in the severity of rationing between the public and private health sectors which is related to the specific resource con-

straints. In the supply-driven public sector where national resources are limited, rationing tends to be more severe and often also implicit in nature. The private sector which is demand-driven and faces less stringent resource constraints make use of explicit rationing policies that are often not as severe as those of the public sector. It is clear that lower prices, or free health services, in the public sector are associated with more strict rationing practices.

A short literature review indicates that rationing mechanisms in the public sector impact on the demand for services in the private health sector. Patients who are ‘rationed’ in the public sector sometimes access private sector services (at a higher cost). The issue of how a government should treat private healthcare in a system where healthcare is mostly provided publicly is addressed briefly. It is argued that patients who choose to access private health services should be subsidised because they have already contributed to the public system (through mandatory taxes or other contributions) and should be entitled to a subsidy up to the cost of similar treatment in the public sector. If the subsidy is structured appropriately, this could imply a net cost saving for the public sector as more people

are encouraged to use private healthcare services, while simultaneously lowering the burden of care in the public sector. In this way, the private sector can play an important role in alleviating pressure in the public sector. Patients who value their time more, and opt out of the public sector, due to long waiting times or other rationing mechanisms, help to clear the market and to lower the cost of overall treatment in the public sector.

3 Rationing in South Africa

This study looks at rationing practices in South Africa - in both the public and private health sectors - at length. A case study at a tertiary hospital in Gauteng’s public health service is considered and it is shown that there are many implicit rationing mechanisms at work. In most instances healthcare professionals were expected to use their discretion in making decisions regarding the eligibility of patients. This led to very subjective criteria being used to determine who would be able to receive care.

It is also pointed out that what adds to the problems associated with rationing at the tertiary level in the public sector, is the fact that health profes-

2. Boscheck, R., 2004. “Healthcare Rationing and Patient Rights,” *Intereconomics*, Nov/Dec, pp.310-313

sionals are unable to provide the necessary treatment at the clinic level due to a lack of human and other resources. In the hope of tertiary facilities having the required drugs, staff and other resources, the patients are referred there. This places an additional burden on the already overburdened tertiary care facilities and also implies that these facilities now have to provide services that should be provided at lower levels, thereby undermining the sufficient delivery of tertiary services. This situation affects the private sector too, with people not being treated in the public sector having to purchase private sector services, which rarely is within their means. As mentioned before, rationing is less severe in the private sector and patients would be able to access higher quality care faster in most instances, but this comes at a cost. While public care may be free or highly subsidised in the majority of cases, rationing can be rather strict in practice.

From the General Household Survey data, as well as data from the Demographic and Health

Surveys, one can see that long waiting times are the main complaint of patients in the public sector. In other words, waiting lines/queues are the most common rationing mechanism in this sector. While this is an implicit rationing mechanism, there are a few explicit rationing policies in the public sector. For example, there are strict rationing rules governing paediatric care in the public sector, as well as kidney dialysis or renal care. The well-known Soobramoney case where the plaintiff was denied care and died soon afterwards, is mentioned in order to highlight the reality of rationing in the public sector and to show the inevitability of rationing in this sector given the specific resource constraints. Although free or relatively inexpensive, care in the public sector therefore often comes at a high cost to those patients who are rationed – not only in terms of people dying in the more extreme cases, but also in terms of some people being left with no choice but to access the less rationed health services in the private sector, at a much higher cost.

In the South African private health sector, rationing occurs in a number of different ways on both the demand and supply side even though the system is essentially demand-driven without a defined budget and can overcome most supply constraints over time. However, while it may seem that there is no hard financial limit, medical schemes do have annual budget limits as determined by the total contribution income. Therefore, the main rationale for rationing in the private sector is still to control costs, but also to remain competitive.

Four basic rationing mechanisms aimed at minimising the costs of hospital admissions are discussed: pre-authorisation, case management, discharge planning and hospital account overviews. It is found that this case-by-case micro-management is an expensive process, while the effectiveness of this rationing method is questionable. There seems to be a move in the medical schemes market to ration at a higher level through more general tariff and fee negotiations.

About ECONEX

ECONEX is an economics consultancy that offers in-depth economic analysis covering competition economics, international trade, strategic analysis and regulatory work. The company was co-founded by Dr. Nicola Theron and Prof. Rachel Jafta during 2005. Both these economists have a wealth of consulting experience in the fields of competition and trade economics. They also teach courses in competition economics and international trade at Stellenbosch University. Director, Cobus Venter, who joined the company during 2008, is also a Senior Economist at the Bureau for Economic Research (BER) in Stellenbosch. For more information on our services, as well as the economists and academic associates working at and with Econex, visit our website at www.econex.co.za.

There is also increased focus on monitoring the specialist referral process, as well as ensuring that treatments are performed at the right level of care.

Other rationing mechanisms in the private sector include the use of Prescribed Minimum Benefits, co-payments and specifically benefit design. The design of different benefit options within medical schemes is a powerful rationing tool which can be used in a variety of ways. In some instances rationing decisions are moved from the medical scheme to the members themselves, through the use of block benefits and medical scheme savings accounts. Drug benefits also differ significantly between options and are directly related to the price paid by members. Formularies or generic reference pricing, where medical schemes offer to pay for medicines at the price of the lowest cost generic alternative, is often used to control costs.

Considering the various rationing mechanisms in South Africa's public and private health sectors, indicate that the level and methods of rationing between these two sectors are very different in practice. The ability of the public health-

care sector to serve the needs of the public is constrained by fiscal space, and rationing therefore becomes inevitable. In contrast, the demand-driven private sector has no defined budget and costs are driven up by increases in demand. As a result of the method of funding, the severity of rationing is far lower in the private sector, but it comes at a price to the consumer.

4 International Experience

Rationing practices from two developed countries (Spain and New Zealand), as well as from two developing countries (Uganda and Sri Lanka) are considered briefly. Valuable lessons for South Africa are learned through examples from these countries. In Spain, for example, it is shown that the extent of rationing is directly linked to the availability of resources, even at a regional level. The Spanish experience indicates that if a minimum benefit package were to form part of the planned health reforms in South Africa, the package needs to be standardised across all regions. Implicit rationing mechanisms in the form of waiting lists have proven to be quite effective in limiting the demand

of certain minor treatments and redirecting the demand to the private sector in Spain. However, it has also been shown that this form of rationing can lead to less equity in the health-care sector – a very important consideration for South Africa.

The New Zealand experience highlighted the importance of getting inputs from all stakeholders in developing the most suitable rationing policies over time. It is important to leave enough space for individual decision-making by health professionals, but still having control over the most efficient use of scarce resources. Evidence from New Zealand further indicates that even in a developed country context, rationing is inevitable.

The Ugandan case study points out that not having appropriate, explicit rationing policies in place adversely affect patients and also health professionals' ability to provide the required treatment timeously. Interestingly, one of the public sector rationing strategies in Sri Lanka is to encourage wealthier patients to purchase healthcare services from private providers. There are also private paying wards in Sri Lankan govern-

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ment hospitals. A number of other lessons can also be learned from the experience in Sri Lanka, such as the fact that the group of services that should be provided at each type of health facility must be clearly defined and implemented – incomplete service standard have hindered effective service delivery in that country.

The importance of fiscal space, and how the level of resource constraints are directly linked to the severity of rationing, is explored by comparing the gross domestic product per capita and public healthcare expenditure per capita for the countries mentioned above. Not only are wealthier countries found to be able to spend more on public healthcare because they have more resource available, but they are also able to allocate larger proportions of their national income to public healthcare. Similar to the difference between the public and private sectors within a county, countries with smaller fiscal capacity and thus fewer resources available to spend on public healthcare will be forced to initiate more severe rationing policies.

5 Moving forward

Finally, after considering the issue of rationing in theory and in practice, in South Africa and internationally, we turn our fo-

cus to the future: rationing policies in the public and private sectors will be an integral part of any comprehensive health reforms in South Africa. Ultimately rationing decisions imply inevitable trade-offs of restricted resources between competing demands. At a macroeconomic level resources have to be divided between the public and private sectors; specifically these two sectors compete for human resources (health professionals).

In light of the suggested National Health Insurance (NHI) reforms, it is vital to consider rationing options and strategies carefully given that the public sector health reforms envision that there will be only minimal co-payments in exceptional circumstances and therefore very little rationing by price. Moreover, it does not seem that there are any plans to implement the private sector demand management practices that are currently in place. If the explicit rationing strategies proposed are not sufficient, there will be considerable implicit rationing via waiting lines/lists and/or bedside rationing in the public sector. These rationing strategies are wasteful and often unfair.

Although the extent of rationing is less severe in the private sector, because the resource constraints are less stringent, there are a number of obstacles limit-

ing innovation the lower income market. This affects the possibilities for rationing scarce resource more effectively in the future. However, as a result of the demand-driven nature of this sector, it usually responds quickly to changes in the policy environment and rationing policies can be easily adjusted so as to accommodate future changes in regulatory or resource constraints.

The introduction of the NHI may necessitate more explicit rationing policies, such as a clearly defined benefit package. As mentioned in the NHI Green Paper, there will be instances where the NHI may be forced to impose co-payments in order to control utilisation and costs. This statement also requires that a benefit package will be explicitly defined, in order to effectively introduce such co-payments into the NHI system. These and other policy changes implies that the differences between rationing policies in the public and private sectors (specifically related to the underlying financial constraints) may therefore become even larger and also more prominent as these policies are clearly defined in the public sector.

With regards to future demand in the public sector, one would expect massive increases in demand if the planned health reforms were indeed successful. The large expected uptake in

demand will no doubt further increase the severity of rationing in the public sector, since it is essentially a supply-driven system and while demand can easily increase over night, so to speak, the supply of healthcare professionals, drugs, etc. will take much longer to respond. Furthermore, this increase in public sector demand will also affect the private sector and in this way the private sector will

continue providing individuals with access to a less rationed system, albeit at a higher cost.

This report contributes to the current debate concerning the suggested health system reforms in South Africa by exploring the differences between rationing in the public and private health sectors. The theoretical discussion, practical overview and considera-

tion of international experience, indicate that rationing is part of all health systems, but that the severity thereof is directly linked to the underlying resource constraints. In the public health system where resources are more limited, rationing will be stricter. However, rationing is found to be less severe in the private sector, although this comes at higher financial costs to the patient.

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