

Patient choice and referral

1 Introduction

One of the aims of national health systems or national health insurance is to contain health costs by controlling access to the healthcare system at the primary healthcare level. This is the system operating in most countries with successful national health insurance systems – with primary healthcare set as the only point of entry into the health system with referral to secondary and tertiary care clearly defined and monitored. Within limited budgets, policies to manage patient choice are one of the tools to accomplish the equity goal of universal access. Restricted choice is an inherent feature of such systems, and while developed countries such as the UK have recently adopted measures to increase choice, the opposite is true in developing

countries. It is only in countries with very large health budgets where governments can offer more choice between service providers. However, even a country with a very large health budget such as France, has had to implement measures to restrict choice in recent times.

In South Africa there is currently some confusion about how choice will be handled within a national health insurance environment. In our previous note it was argued that South Africa will have to move towards a more primary care driven system and that the role of the private sector will have to be clearly defined. While current NHI proposals in South Africa seem to favour the gate keeping model, i.e. registration of the entire population at a primary healthcare provider, no details are currently avail-

able on how such choice will be administered in practice. There are certainly indications that national health insurance members will be offered free choice of primary healthcare provider, including a choice between private and public providers. In this note we ask how choice should be handled under universal coverage in South Africa, by considering current practice in the country as well as some evidence from international best practice.

2 The economic rationale for restricting choice?

Healthcare is partly a moral necessity and partly an ordinary consumer good, the latter which is vulnerable to over-utilisation when freely provided. This can lead to spiralling healthcare costs and therefore the usual response is to ration

use in order to attain allocative efficiency¹ of scarce resources in the face of unconstrained demand. Rationing is implicit in prescribed benefit design, co-payments, gatekeeper decisions, utilisation reviews and capitation contracts. Given that rationing is an inevitable part of any healthcare system, the question becomes how to accomplish it efficiently and equitably.

The extent of provider choice and the type of referral practice used in a country can be important rationing decisions that lead to significant differences in the availability and utilisation of healthcare. Two types of restrictions on provider choice have been used to control the demand for healthcare. In national health systems with local services, choice is often restricted to a specific geographic area, allowing local authorities to control resource use and rationing. Choice can also be restricted to a specific network of providers, chosen by third party payers, or financial incentives can be created to favour network members over other providers. These restrictions or incentives are designed to steer demand towards

more appropriate services.² The question of the degree of restriction of free choice is a difficult one to answer in the healthcare context, due to the overriding goal of equity in the provision of healthcare. Recently there has been growing interest in finding ways to combine the equity goals of collective healthcare financing with demand control and competition in supply. Policies to manage patient choice are seen as a way to accomplish these objectives and are on the political agenda of several countries. It is argued that extended choice in healthcare provision promotes competition between providers, imitating the discipline imposed in private markets. It is believed to put downward pressure on prices or to increase the quality of services supplied.

One of the most popular methods of restricting choice at the primary care level is the gatekeeper model. According to the gatekeeper model a primary care physician acts as gatekeeper by controlling the patient's access to further specialist care. Each patient selects a primary care physician from the preferred provider

network, usually within a defined geographical area. The gatekeeper oversees all the patient's healthcare needs and becomes familiar with the patient's medical history, putting him in a position to prescribe appropriate treatment. Gatekeeping is intended to reduce consumer search costs and to steer demand for specialised services to ensure the appropriate use of different levels of care. The presence of gatekeeping is usually associated with more visits to primary care physicians and fewer visits to specialists, than in its absence. The effectiveness depends on the ability of gatekeepers to co-ordinate follow-up care, as well as on the availability of information on the quality and prices of secondary care services. In a number of countries patients are required to register with a primary care physician, but this feature is more prevalent in national health systems than in health insurance systems. In some countries patients are encouraged to register through strong financial incentives. In France for example, patients are exempt from certain co-payments if they register with a gatekeeper doctor.

1. Allocative efficiency is defined by economists as the point where the marginal cost of producing a good is equal to its marginal price, i.e. where scarce resources are allocated according to the utility derived from their use.

2. Santerre, R. E. And Neun, S. P. (2010): *Health Economics: Theory, Insights And Industry Studies*. South Western Cengage Learning: USA

In the UK National Health Service (NHS), GPs play a gate-keeper role and are responsible for patient referral to secondary care providers. Patients can only access secondary care with a referral from a GP and do not have direct access to specialists, except in special circumstances.³ Since April 2008, the implementation of the free choice policy means that patients can choose any appropriate secondary care provider that meets NHS eligibility criteria, including all NHS and many private sector providers.

Patients may choose the hospital that is recommended by the GP or according to any other criteria, such as reputation, waiting times or simply convenience. In 2009 the NHS Constitution made free choice a right for patients.⁴ NHS providers are obligated to accept all clinically appropriate referrals and are expected to manage their capacity to accommodate patients' choices.⁵ However, this increased choice in the UK was primarily the result of the general dissatisfaction of patients

with the rigidity of the system. In addition, promoting patient choice was seen by policy makers as a way to promote competition between providers. Free choice, together with fixed fees per episode of care, was designed to create incentives for providers to reduce their operating costs and become more technically efficient, including public providers. It was also seen as a means of using capacity in the hospital sector more efficiently, particularly when there were different waiting times at different providers. Since all hospital treatments are free at the point of use, providers cannot compete on price. This, together with freedom of choice, has refocused attention on competition through service quality.⁶ It was also argued that choice would lead to greater equity by providing choices within the NHS and reducing the motivation of the affluent to opt out of the NHS.

Another example of relative freedom of choice is the French healthcare system which allows freedom of choice of health-

care provider without referral or any limit on the number of consultations. However, several reforms have recently been put in place to restrict complete freedom of choice in the system in an effort to reduce overall healthcare utilisation and to curb ever-increasing costs. The traditional solution to over-utilisation is to increase co-payments or to cut reimbursement rates, but in France these measures have little effect since patients' co-payments are generally fully covered by voluntary health insurance.⁷

Another solution is to institute a referral system, as was implemented in France in July 2005 through a process known as coordinated care. This referral system is not an enforced obligation, but offers a financial incentive. Patients are either exempt from paying for consultations beforehand or only pay the portion that is not reimbursed by public insurance, instead of the full amount. Since 2009 the reimbursement rate can be reduced to 30% if a patient consults an unapproved

3. *The European Observatory on Health Care Systems (1999): Health Care Systems in Transition: United Kingdom. The London School of Economics & Political Science.*

4. *Socha, K. and Bech, M. (2007): Extended Free Choice Of Hospital - Waiting Time. Health Policy Monitor, October 2007.*

5. *The NHS England (2008): Operating Framework for 2008/09: Choice at Referral – 2007/08. Department of Health.*

6. *The NHS Confederation. (2009): New Providers: New Solutions: The Independent Sector Partnering with the NHS.*

7. *Imai, Y., Jacobzone, S. and Lenain, P. (2000): The Changing Health System in France. OECD Economics Department: Working Papers No. 269.*

physician.⁸ In principle, providers are rewarded for their performance with larger revenues, because patients are more likely to choose facilities that offer the best services. Facilities have no interest in neglecting quality, since lower quality would lead to fewer patients and less income. Thus, the system promotes direct competition between providers, which has improved the quality of services.⁹

Different countries have had different experiences with restricting choice or alternatively expanding available choice. Generally countries with limited choice have taken steps to extend it, while countries with unlimited choice historically have been trying to promote rational healthcare pathways, particularly by implementing a gatekeeper model. Some more specific examples are briefly discussed in the next section in order to develop some guidelines for South Africa based on international experience.

3 Experience in other countries

The OECD has recently published an informative paper on the health system institutional characteristics in 29 OECD countries. The information on patient choice is shown in Appendix 1. In general, countries have different degrees of choice at various levels of the healthcare system, depending on the specific system in place. Some specific examples that might be relevant for South Africa are discussed in more detail in this section.

Choice is often restricted for certain population groups, e.g. in the UK military personnel, the mentally ill and prisoners are not offered the same degree of choice as the general population. Another example is Thailand where public employees under the Civil Servants Medical Benefits Scheme, and private employees claiming under the Worker Compensa-

tion Scheme (for work-related injuries or illnesses) have free choice of health care provider. However, private employees claiming under the Social Security Scheme (for non-work related injuries and illnesses) and all other individuals covered under the Universal Coverage Scheme (UCS) are required to make use of a contracted hospital or its network with referral line, and registration is required. Under the UCS, referral to access secondary and tertiary care is required except in emergency cases.¹⁰ Beneficiaries under Universal Coverage are entitled to free health care at health centres and district hospitals forming part of the designated primary care network nearby their residence. Fee-waivers apply for access to higher care with a referral letter.¹¹ Data from surveys indicate that Thai patients prefer private treatment over public treatment.¹² In Mexico, public sector employees do not have a choice

8. Petkantchin, V. (2009): *France's Compulsory Public Health Insurance is no Model for US Health Reform*. International Policy Network: *Lessons from Abroad for Health reform in the US*.

9. Labrie, Y. And Boyer, M. (2008): *The Private Sector Within A Public Health Care System: The French Example*. Montreal Economic Institute: *Health Care Series*.

10. Bureau of Policy and Strategy, Ministry of Public Health, *Health Policy in Thailand 2009, 2009*.

11. Equitap, *Health systems profile – THAILAND*, available online at http://www.equitap.org/publications/profiles/hsp_tha.pdf

12. Yongyuth Pongsupap and Wim Van Lerberghe, *Choosing between public and private or between hospital and primary care: responsiveness, patient-centredness and prescribing patterns in outpatient consultations in Bangkok*, *Tropical Medicine and International Health*, Volume 11, Issue 1 (p 81-89)

in terms of their primary care doctor, as one is assigned to them by the system.¹³ This is a gatekeeping model where the family doctor has the power of referral to secondary or tertiary levels as necessary.

In the Lombardy region of Italy people are free to choose any physician they prefer, provided that the physician's list has not reached the maximum number of patients allowed (1,800 for GPs and 1,000 for paediatricians). All patients in Italy are registered with a general practitioner (GP) or a paediatrician.¹⁴ In Brazil and Chile people are also free to choose their healthcare provider. Although one would expect individuals in rural Brazil to prefer private treatment, long distances to the treatment source deter them from doing so.¹⁵ Transport costs significantly deplete household resources. Buses travel infrequently in rural areas, and travel to a town for treatment may take several days. Because of these factors rural individuals are less likely to travel long distances to seek treatment in urban private clinics.

In Chile, under FONASA, the public health insurance scheme, individuals have access to both public providers and a group of private providers associated with FONASA for this purpose. It will be shown below that the current proposals in South Africa seems to favour a primary care gatekeeping model with strict referral protocols to higher levels of care. Given limited resources, South Africa will have to implement restricted choice in order to contain healthcare costs under a NHI.

4 The SA realities

Given the international experience, the question that must be addressed is which system would best suit South Africa's specific circumstances. In Health Note 4 we pointed to some of the differences between the private and public sectors. In France for example, it is reported that there is no significant difference in the quality, price or waiting time between public and private hospitals. Public hospitals are perceived to be technically capable

and responsive to consumers and many people feel there is no need to use private hospitals to get quick treatment.¹⁶ The opposite is true of the UK where waiting times are considered a core reason for using private providers to access health services.

It seems that what is currently proposed in South Africa is essentially a gatekeeper model where the entire population will be registered at a primary healthcare facility closest to them. If more than one accredited provider is available close to the area of residence, patients will be able to choose which primary healthcare (PHC) provider they would like to register with (indicating free choice between public and private providers). Members will be entitled to request a change in provider once a year. In other words, people will be assigned to a PHC facility closest to them as a first point of entry into the system and then referred from there to specialists or facilities offering higher levels of care. The referral system will be implemented for services defined inside and outside

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13. Silvia Tamez and Nancy Molina, *Reorganizing the Health Care System in Mexico*, available online at http://www.idrc.ca/en/ev-35629-201-1-DO_TOPIC.html
14. Aleksandra Torbica and Giovanni Fattore, *The "Essential Levels of Care" in Italy: when being explicit serves the devolution of powers*, *Eur J Health Econ*. 2005 November; 6(Suppl 1): 46–52.
15. Charles A. M. de Bartolome, Stephen A. Vosti, *Choosing between public and private health-care: A case study of malaria treatment in Brazil*, *Journal of Health Economics*, Volume 14, Issue 2, June 1995, Pages 191-205
16. Green, D. G. And Irvine, B. (2001): *Health Care in France and Germany: lessons for the UK*. Civitas: Institute for the Study of Civil Society.
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the catchment area to ensure continuity and effective cost containment. Registration by facility and catchment area will aid capitation and accredited providers will be responsible for a defined population. Initially identity documents (IDs) will be used for registration, but eventually a NHI card will be issued which will store patients' medical records and allow for easy access to patient information and portability of services. This will ensure that all eligible citizens and permanent residents will have access to a comprehensive package of services.

The registration of the population within defined geographical areas and the documentation of all public and private providers will be vital for successful implementation of the overall NHI plan. Although the details may change, three distinct phases are currently planned to ensure that potential beneficiaries are registered and linked to accessible health-care facilities in their area.

1. The first is to provide a population and facility profile through geo-mapping;

2. The second is to define the catchment population; and

3. The third is to assess the functionality of each facility.

It seems that the District Health System will be the starting point for identifying the beneficiary populations, by identifying the basic planning and administrative demarcations or districts. The National Health Act stipulates that each health district is required to cover the same area as the Local Government district or have the same borders as the metropolitan boundaries. It will be vital that the population profile is known and that the population covered is accurately calculated. The existing stock and distribution of public and private health facilities will also have to be established. The problem currently is that the District Health System is not operating efficiently and that that public health facilities are stressed by the large demand and restricted budgets.

The reality in South Africa – and in most developing countries – is that universal coverage will necessarily imply restricted choice. Although the suggested health reforms seem to promise free choice of provider to all beneficiaries, the fact that individuals will have to register with a specific primary care physician implies that choice will be restricted. Referral will

be required to gain access to higher levels of care, restricting choice at the secondary level as well. While it is not currently clear exactly what referral mechanisms will be used, it is clear that the current freedom of choice in the private sector will not be extended to all beneficiaries of a national health system.

5 Choice of provider in South Africa

Rationing and restriction of choice are not new to South Africa. Managed care and rationing are essential features of all public healthcare systems and since the 1990s the private sector has also adopted many managed care practices. It is important to understand the different aims of rationing in the public and private sectors. In the public sector rationing follows naturally from an environment which is constrained by limited resources. The public sector has fixed budgets and very tight prioritisation is key to staying within the budgetary limitations. The focus is on allocative efficiency where scarce resources have to be allocated to the services that provide the best return for society as a whole. This provides a very real example of the notion of Pareto efficiency where allocative

efficiency is the point where no one can be made better off without making someone else worse off. In the public sector this choice becomes literally life for one meaning death for another. The public sector is the base system or the health safety net and as such rationing has to be used to allocated scarce resources.

In contrast, the private sector is a voluntary system and rationing is used for another purpose – to keep the system affordable by limiting increases in the contribution rate. While rationing is important the service must be able to provide services in unlimited quantity for members when they are really sick. Some of the main differences between the private and the public system are elaborated upon below.

5.1 Private healthcare sector

The private sector rations mainly through price and some gate

keeping efforts. At the first level, it is rationed by price through members' monthly contributions to the medical schemes and co-payments to providers. In some instances healthcare is further rationed by referral and pre-authorisation from medical schemes. The rapid rise of managed care also reached South African shores during the mid 1990s. Initially, managed care was perceived as an assault on the medical profession and was met by a lot of resistance from practitioners.¹⁷ According to Rothberg et al¹⁸ : "...nothing in South Africa's medical history has done more to unite the profession than the arrival of US-based Managed Care". Despite criticism of managed care, South Africa had in the past experimented with gatekeeping models. Some examples are Prime Cure, Carewell, Carecross and Medicross. These models produced mixed results

as GPs generally did not buy into the idea of managing downstream costs. Gatekeeping has been used more successfully in the mining environment. The issue of designing the correct incentives for GPs to act as gatekeepers is very important. These issues will be dealt with in detail in the next Health Note.

Some private medical schemes have also introduced 'public sector' options in order to reduce costs. An example is the Transmed scheme where a range of "State" options was introduced in 2000 in order to address rocketing claims experience in the scheme, threatening its existence. The scheme has a ring-fenced pensioner risk pool of approximately 35 000 lives with an average age of 71 years. Private hospitalisation for this risk pool is unaffordable. The implementation of a mixed public / private sector benefit structure has been successful

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.

17. *Gotlieb, D. (1999): Managed Care in South Africa: Where to Now? Available at: www.arthritis.co.za/managed%20care.htm*

18. *Rothberg, A., Magennis, R. And Mynhart, S. (1999): Managed Health Care. London School Of Hygiene And Tropical Medicine: Health Economics And Financing Programme.*

in turning the financial situation of the scheme around.¹⁹ In the private sector today, concepts such as pre-authorisation, risk-sharing, co-payments, provider networks etc. have become common. In order to ensure that beneficiaries of medical schemes have access to an essential benefit package irrespective of the size of their contributions, prescribed minimum benefits (PMBs) were introduced in 2000.

5.2 Public healthcare sector

In contrast to the private sector, there is no charge for primary healthcare in the public sector and the co-payments required for higher levels of care are minimal and often poorly enforced. In the public sector rationing occurs via a combination of various means. A recent research paper by McLeod, Grobler and Van der Berg (2010:5) describes rationing in the public sector as encompassing the following: "...by means of budget constraints; by long queues (at clinics or for getting certain elective surgery); by availability (limited ICU beds

or surgical beds); and by denial (no dialysis after a certain age and no resuscitation of very low-birth-weight babies)".²⁰

If patients are to be offered a free choice between public and private providers, there is some evidence from user surveys and official data that indicate that patients will prefer to register or be directed to the private sector. This is not surprising, as the quality differences between the private and the public sectors are stark and well known.

Evidence was already presented in Health Note 4 of uninsured patients utilising private sector GPs and out of patient private hospital services. A study by Palmer et al ²¹ (2003) reported on the phenomenon of 'shopping around' between different providers for different services. They found that patients tend to use the public sector for treatment of chronic conditions, but private clinics for curative care. During exit interviews they found that one third (30%) of private attendees who had been to another provider in the

previous six months had been attending the public sector for chronic care. This use of multiple providers was also reflected in the results of the record reviews at the private clinics. The authors concluded: "That these private clinics do not give automatic access to a doctor, or prescribe large amounts of medicine, indicates that other aspects of perceived quality, such as short waiting times and greater politeness of staff, might be important motives for private sector use". These views were also expressed in the Consultative Investigation into Low Income Medical Schemes (2006)²², where it was reported that there was a common perception that the public sector was good enough for routine care and minor illnesses, while the private sector was necessary for more serious health problems.

Although formal rationing mechanisms and protocols exist in the public sector, the provision of (mostly) free care have created a multitude of informal mechanisms to deal with current excess demand.

19. Van der Walt, A. (2005): *Alternative Delivery Models. Supply Side Work Stream 2: Draft Proposal and Implementation Plan.*

20. McLeod, Grobler and Van der Berg (2010). *Preliminary Estimate NHI: Methodology and Assumptions. A Briefing paper prepared for National Treasury.*

21. Palmer, N., Mills, A., Wadee, H., Gilson, L. And Schneider, H. (2003): *A new face for private providers in developing countries: what implications for public health? Bulletin of the World Health Organization 2003, Vol. 81, No. 4 (292-297).*

22. Broomberg, J. (2006): *Consultative Investigation into Low income Medical Schemes: Final Report, 7 April 2006*

E.g. a formal letter from a clinic is necessary to access hospital care, but these letters do not seem to be difficult to obtain, neither are they actually a hurdle if a sick patient arrives at a public hospital. As reported by Von Holt et al²³ : “In practice both the weaknesses of the referral system and the lack of comprehensive hospital coverage mean that regional and central hospitals often accommodate patients who ought to be treated in hospitals at levels above or below them”. A recent survey article²⁴ of informal rationing at a large public hospital in Gauteng provides some interesting examples of how demand is rationed in practice. The study reports that the first hurdle that had to be overcome by patients was meeting the entry criteria. Since the referral letter from the clinics was easily obtainable, medical staff had to devise other methods such as asking stretcher patients to “walk a few paces to see if they were severely ill or not” (2010:139). Patients were screened to determine eligibility for tertiary level care, but the research team were unable to obtain any guidelines on eligibility. Providers generally used

their discretion and their view of appropriateness often had a ‘moral character’. E.g. patients who have not defaulted on their treatment were generally viewed as more deserving of care. Schneider et al observed the following (2010:139): “Given the ambiguity regarding appropriateness, were patients able to influence how providers treated them? Expressions of pain (psychic or physical) made little difference. Attempts by patients or their relatives to communicate with staff were largely unsuccessful – as one said, ‘If you ask for something they just shout at you’. Patients with the least chance of being treated sympathetically were those considered to be disruptive, have hysterical symptoms or be less than truthful with staff, or who came across as unsure or vulnerable, typically middle aged women with many apparently unconnected symptoms’.

What is clear from the literature and surveys is that there are vast quality differences between private and public care, that patients generally prefer private care (especially for more complicated cases), and that the referral system in the

public sector is completely inefficient and patients have to devise other mechanisms to gain entry to higher levels of care. Healthcare professionals use their discretion in deciding who can be offered tertiary care and such decisions are often influenced by patient behaviour and not clinical conditions.

6 Challenges of offering free choice in SA

One of the most important public health issues in developing countries is the development of effective patient referral systems. Primary healthcare will not be successful unless hospitals can deal with referred patients effectively and refer patients who do not require hospital attention back to primary healthcare services. A study on patient referral mechanisms identified four major problem areas with referral systems in developing countries. The first was hospital congestion because of poorly-judged referrals and inappropriate self-referrals. The second was a lack of access due to barriers of distance, transport, and payment. The third was a lack of confidence in

23. Von Holt, K. And Murphy, M. (2007): *State of the Nation: South Africa 2007, Chapter 13: Public Hospitals in South Africa: Stressed Institutions, Disempowered Management*. Human Sciences Research Council Press: Cape Town.

24. Schneider, H., le Marcis, F., Grard, J., Penn-Kekana, L., Blaauw, D., and Fasson, D. (2010). *Negotiating Care: patient tactics at an urban South African hospital*, *Journal of Health Services Research & Policy* Vol 15 no 3: The Royal Society of Medicine Press.

public primary healthcare, leading patients to avoid those levels. The fourth was an inadequate flow of information to and from the hospital. The issue was further complicated by the fact that there is no optimal referral rate for each level of care.²⁵

6.1 Establishing proper referral mechanisms

All of these issues are also evident in the public healthcare sector in SA. It was already shown in the previous section that referral mechanisms do not work. The study by Von Holt et al²⁶ (2007) confirmed this: "...respondents in all of the hospitals commented that the system of referrals from primary healthcare clinics fails to screen out patients who should not be arriving at level 2 or level 3 hospitals. On the one hand, many patients simply bypass clinics or district hospitals and go directly to higher level hospitals; on the other, clinics are referring patients who should be diagnosed and treated at the clinics or at level 1 hospitals". Clearly, any referral system under a national health scheme should have clearly defined guidelines for referral and these

should be strictly employed. A further issue is that there is not a culture of using one primary care worker as a gatekeeper. A study of a managed care plan in rural Mpumalanga²⁷ found that sticking to one healthcare provider is a new culture in the previously unregulated healthcare market. This managed care plan was specifically designed for the employed but uninsured population. Important issues were identified in implementing such a plan in practice, i.e. the fact that migrant workers require a choice of more than one doctor to attend to the main member and the family left behind in the village/ town of origin. A strict interpretation of the restrictions (i.e. one doctor per member and family) caused much unhappiness among participants. Most patients found it necessary to visit other local healthcare workers when they were sick and could not go to work. The role of traditional healers will also have to be carefully considered when designing proper referral protocols. Currently public hospitals do not accept referral letters from private GPs, as the two systems are not currently compatible.

6.2 Geographic inequalities

Effective provider choice can be constrained by lack of access to healthcare services due to physician shortages and geographical inequalities in the distribution of physicians. In order to sustain the number of physicians, developed countries have implemented a number of policies. These have taken the form of policies affecting medical school intake, immigration and emigration, retention and retirement of physicians. Interestingly the level and growth rate of physician density over time has been higher in countries that have not controlled medical school intake centrally. Most countries suffer from an unequal geographical distribution of their physician workforce. Typically, rural and deprived urban areas experience shortages of physicians, while affluent metropolitan areas have surpluses.

In SA, the proposal is that in areas where there is more than one primary care provider, patients will be offered a choice, including a choice between public and private providers.

25. Omaha, K., Melendez, V., Uehara, N. and Ohi, G. (1998): *Study Of A Patient Referral System In The Republic Of Honduras. Health Policy And Planning, Vol. 13, No. 4 (433-445): Oxford University Press.*

26. See footnote 21.

27. Chabikuli, N., Murray, M., Fehrsen, S. G. And Hugo, J.F. (2008): *Choosing, Changing Or Adhering To A Registered Doctor In A Managed Care Plan: What Will It Take? A Qualitative Survey in Rural Mpumalanga, South Africa. South African Family Practice 2008, Vol. 50, No. 4 (66).*

Table 1: Cost experience of other countries' accreditation authorities

	Private Hospital bed numbers* 2008	Population Estimate 2009	Percentage share of private hospital beds	Percentage Share of total population
Gauteng	14 907	10 531 300	48.6	21.4
Limpopo	401	5 227 200	1.3	10.6
Mpumalanga	939	3 606 800	3.1	7.3
North West	1 341	3 450 400	4.4	7
Free State	2 228	2 902 400	7.3	5.9
KwaZulu-Natal	4 281	10 449 300	14.0	21.2
Western Cape	4 348	5 356 900	14.2	10.9
Eastern Cape	1 691	6 648 600	5.5	13.5
Northern Cape	353	1 147 600	1.2	2.3
Outside RSA	168		0.5	
Total	30 657	49 320 500	100.0	100

**All bed types from HASA members and known non-members*

However, as shown in Table 1, almost half of all private sector beds are found in Gauteng, while only 21.4% of the population lives there. The opposite applies to Limpopo province which has only 1.3% of private hospital beds while 10.6% of the population lives in that province. Clearly accessing private hospitals will simply not be an option for patients living in remote areas. Transport costs are also an important determinant in the seeking of care, as was clear from the discussion on Brazil. If patients under a national health system are to be offered

free choice, there will have to be some policy to address the issue of geographic inequality. In France for example, a national demographic plan was introduced in 2006 to reduce regional disparities in access and over-supply in certain regions. The plan set up incentives for doctors to practise in deprived areas and proposed measures for improving working conditions. Deprived areas are defined by medical density, where the number of doctors is 30% below the national average, and professional activity, where patient visits per capita

is 30% below the national average. Doctors working in these areas often face unattractive working conditions, including long working hours, which discourage them from establishing practices. As an incentive, public health insurance funds now offer 20% higher remuneration to doctors practising in these areas. Local authorities in rural areas also provide financial aid to doctors who wish to establish practices in their communities, including housing grants and study allowances. In addition, doctors providing out-of-hour services in these areas benefit

from a tax rebate on their income.²⁸ Similar incentives should be considered in South Africa.

6.3 Information systems

Increased information on quality and patient experiences is essential for patients to make informed choices about providers. The availability of information on quality and prices for users or purchasers also has the potential to enhance the quality and efficiency of services. In countries where health services are free of charge or have uniform prices set at the national level, information on quality is vital. In the UK for example, information is available on clinical outcomes, appropriate processes, patient experience and patient-satisfaction. This however is very difficult to implement as it requires standard coding systems, compliance amongst providers and advanced systems and analysis. In other countries prices may differ across providers. In France,

where co-payments are used, information on prices is readily available for consultations and procedures. In South Africa, such comparative information is not available at present, and this will restrict the choices of patients.

7 Conclusions

In essence, the current proposals for a national health system seem to favour unlimited choice at the primary care level, with restriction of referrals up the treatment hierarchy. However, as seen from the literature and international examples, there is a movement to restrict choice even in countries that have previously enjoyed free choice, such as France. While the UK has increased choice for secondary and tertiary care, they also use a gatekeeper model at the primary care level. In South Africa there are several hurdles that will need to be

addressed if proper referral and some choice are to be offered. Firstly, while there is a culture of managed care in the private sector, healthcare in the public sector is rationed by some formal as well as informal mechanisms. Since there are no clear referral guidelines in the public sector, referral is largely at the discretion of the healthcare provider, especially for accessing tertiary care. Furthermore, even if free choice of provider at the primary care level is given, there is no culture of staying with one doctor and this will have to be enforced in some way.

Geographic inequalities will mean that in practice, even if provided with a choice between the public and the private sector, most people will only be able to access the public sector due to large distances and high transport costs to access private facilities. In essence, the main challenge is the vast quality

ECONEX Services

Econex has extensive experience in competition economics, international trade and regulatory analysis. Strategic analysis was recently added as practice area. We have an established reputation for providing expert economic advice for high profile mergers and complaints that appear before the competition authorities. Some of the more recent highlights include the complaint against British American Tobacco, the merger between MTN and iTalk, the complaint against Senwes and the acquisition of KayaFM by Primedia. Apart from competition work we have also been involved in trade matters which included analyses of the effects of tariffs, export taxes and anti-dumping tariffs.

As a result of our work in competition analysis we also have invaluable experience in some of the sectors of the South African economy where regulation continues to play a role, e.g. the telecommunications, health and energy sectors. We use economic knowledge of these sectors to analyse specific problems for some of the larger telecommunications, health and energy companies.

28. Bourgueil, Y. And Chevreur, K. (2006): *Demographic Plan for Health Professionals*. *Health Policy Monitor*, 14/04/2006

differences between the private and public sectors. While these differences remain there will always be an incentive for patients to manipulate the system in order to gain entry into the private sector. Given the evidence on the use of innovative mechanisms by patients to gain entry to public hospitals, there will have to be careful planning of entry requirements and referral procedures. Practical questions will have to be considered such as would private sector providers only provide services to NHI beneficiaries once public facilities are full? Will access to private hospitals be possible only through referral from a public hospital? These are very real issues which will have to be addressed in order to ensure that a NHI does not immediately become riddled with the same problems as currently being faced by an overstressed public sector.

More Information

ECONEX regularly publishes Research Notes on various relevant issues in South African competition, trade and applied economics. For access to previous editions of Research Notes, or other research reports and published articles, go to: www.econex.co.za

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Appendix 1 - OECD Survey results

Country	Patient choice among provider			Gate keeping		Comparable information published on the service quality of providers	Regulation of the supply of physicians		
	Choice of a primary care physician	Choice of a specialist	Choice of a hospital	Registration with a primary care physician	Referral to access secondary care		Regulation of practice location	Any policy to address perceived shortages	Any policy to address perceived maldistribution
Australia	Free	Free	Incentives	No obligation & no incentive	Financially encouraged	Yes	No	Yes	Yes
Austria	Incentives	Incentives	Limited with exceptions	No obligation & no incentive	No obligation & no incentive	No	Yes	No	Yes
Belgium	Incentives	Free	Free	Financially encouraged	Financially encouraged	Yes	No	Yes	Yes
Canada	Free	Free	Limited with exceptions	No obligation & no incentive	Compulsory	No	No	Yes	Yes
Czech Republic	Free	Free	free	No obligation & no incentive	No obligation & no incentive	Yes	No	Yes	Yes
Denmark	Limited	Limited	Free	Compulsory	Compulsory	Yes	Yes	No	Yes
Finland	Limited	Limited	Limited	No obligation & no incentive	Compulsory	No	No	Yes	No
France	Free	Free	Free	Financially encouraged	Financially encouraged	Yes	No	Yes	Yes
Germany	Free	Free	Incentives	Financially encouraged	Financially encouraged	Yes	Yes	No	Yes
Greece	Incentives	Incentives	Incentives	No obligation & no incentive	No obligation & no incentive	No	No	No	Yes
Hungary	Free	Free	Free	Financially encouraged	Compulsory	Yes	Yes	Yes	Yes
Iceland	Free	Free	Free	No obligation & no incentive	No obligation & no incentive	No	No	No	Yes
Ireland	Free	Free	Free	No obligation & no incentive	Financially encouraged	Yes	No	Yes	No
Italy	Free	Free	Free	Compulsory	Compulsory	No	Yes	Yes	No
Japan	Free	Free	Free	No obligation & no incentive	No obligation & no incentive	No	No	Yes	Yes

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OECD Survey results continued

Country	Patient choice among provider			Gate keeping		Comparable information published on the service quality of providers	Regulation of the supply of physicians		
	Choice of a primary care physician	Choice of a specialist	Choice of a hospital	Registration with a primary care physician	Referral to access secondary care		Regulation of practice location	Any policy to address perceived shortages	Any policy to address perceived maldistribution
Korea	Free	Incentives	Free	No obligation & no incentive	No obligation & no incentive	Yes	No	No	Yes
Luxembourg	Free	Free	Free	No obligation & no incentive	No obligation & no incentive	No	No	No	No
Mexico	Limited	Limited	Limited	No obligation & no incentive	Compulsory	No	Yes	Yes	Yes
Netherlands	Free	Incentives	Free	Compulsory	Compulsory	Yes	No	Yes	Yes
New Zealand	Free	Limited	Limited	Financially encouraged	Compulsory	Yes	No	Yes	Yes
Norway	Free	Free	Free	Compulsory	Compulsory	Yes	Yes	Yes	Yes
Poland	Free	Free	Free	No obligation & no incentive	Compulsory	No	No	Yes	Yes
Portugal	Limited	Limited	Limited with exceptions	Compulsory	Compulsory	No	No	Yes	No
Slovak Republic	Free	Free	Free	Compulsory	Compulsory	Yes	No	Yes	Yes
Spain	Limited	Limited	Limited with exceptions	Compulsory	Compulsory	No	No	Yes	No
Sweden	Free	Free	Free	No obligation & no incentive	No obligation & no incentive	No	No	Yes	No
Switzerland	Free	Free	Limited with exceptions	Financially encouraged	Financially encouraged	Yes	Yes	No	No
Turkey	Free	Free	Free	No obligation & no incentive	No obligation & no incentive	No	Yes	Yes	Yes
United Kingdom	Limited	Free	Free	Financially encouraged	Compulsory	Yes	No	Yes	Yes

Source: Paris, V., Devaux, M. & Wei, L., 2010. "Health Systems Institutional Characteristics: A Survey of 29 OECD Countries," OECD Health Working Papers No.50. (Adapted from Tables 18, 19, 21 & 22)

Appendix 2 - practical examples of choice

Example 1: Choice in the UK

The majority of patient contacts with the NHS are with GPs and/or multi-professional teams in PHC settings. Over 99% of the population is registered with a GP who provides 24-hour access to a range of PHC services. Patients may select to register with any GP of their choice, although the choice is restricted within designated geographical practice areas. GPs are obliged to accept all patients requesting to be registered unless there are reasonable grounds for refusal, for instance because residence is outside the agreed boundaries or because the GP practice list is full (the average list is around 1,800 patients). The reason for refusal also has to be disclosed. There is a low incidence of people changing their GP, other than because of residential changes. Currently patients' medical records are held electronically by the GP practice with which they are registered. In 2005 the NHS implemented an information strategy which was designed to create an integrated electronic health record, to allow the secure transfer of data within the NHS and to link Primary Care Trusts (PCTs) and hospital trusts through a unified ICT system.

GPs are responsible for patient referral to hospitals and specialists and have an important 'gatekeeper' role in the system. Patients can only access secondary care with a referral from a GP and do not have direct access to specialists, except in special situations such as emergencies, cancer treatment and maternity services. Since April 2008, the full implementation of free choice means patients have the right to choose any appropriate secondary care provider that meets NHS eligibility criteria, including all NHS providers and many private sector providers that have chosen to participate. Patients may choose the hospital that is recommended by the GP or according to any other criteria such as reputation, waiting times, parking or simply convenience. NHS providers have an obligation to accept all clinically appropriate referrals and will be expected to manage their capacity to accommodate patients' choices. Patient transport services can be provided if the referring GP decides that there is a medical need. The Healthcare Travel Cost Scheme also covers travel costs for individuals that qualify for entitlement.

Example 2: Choice in France

The French healthcare system allows complete freedom of choice of healthcare provider without pre-authorisation for any procedure. Patients can visit any GP or specialist practising privately or working in a hospital, without referral or any limit on the number of consultations. Patients can take a variety of factors into account when making these choices, including courtesy, waiting times, cleanliness and privacy. However, the degree of choice varies across the country since doctors are unevenly dispersed. Business is generated primarily through reputation and doctors are only permitted to advertise in the yellow pages if they display their prices. The system promotes direct competition between healthcare professionals. It is usually possible to obtain an appointment with a doctor on the same day. To provide out-of-hours services specialised call centres have been made available and all GPs in a given geographical area have been put on a duty roster. According to consumer surveys patients have experienced a high level of satisfaction with their doctors.

Patients can receive secondary care from any public or private hospital of their choice and coverage is the same in both sectors. In practice there are some limits to this legally defined principle, such as geographical accessibility in rural areas and the co-payments made by patients. There is no significant difference in the quality, price or waiting time between public and private hospitals. Public hospitals are perceived to be technically capable and responsive to consumers and many people feel there is no need to use private hospitals to get quick treatment. However, waiting times may be highly variable between hospitals and have been exacerbated by a shortage of nurses and the implementation of the 35-hour work week. Nevertheless, patients have expressed a high level of satisfaction with secondary care. Patients can also be given authorisation for treatment abroad if the treatment is considered medically necessary and unavailable domestically.