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PUBLIC AND PRIVATE
ROLES IN HEALTH
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Reform Experience in
Seven OECD Countries

Claudia Scott

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SERIES EDITOR’S INTRODUCTION

Health services in many developed countries have come under critical scrutiny in recent years. In part this is because of increasing expenditure, much of it funded from public sources, and the pressure this has put on governments seeking to control public spending. Also important has been the perception that resources allocated to health services are not always deployed in an optimal fashion. Thus at a time when the scope for increasing expenditure is extremely limited, there is a need to search for ways of using existing budgets more efficiently. A further concern has been the desire to ensure access to health care of various groups on an equitable basis. In some countries this has been linked to a wish to enhance patient choice and to make service providers more responsive to patients as ‘consumers’.

Underlying these specific concerns are a number of more fundamental developments which have a significant bearing on the performance of health services. Three are worth highlighting. First, there are demographic changes, including the ageing population and the decline in the proportion of the population of working age. These changes will both increase the demand for health care and at the same time limit the ability of health services to respond to this demand.

Second, advances in medical science will also give rise to new demands within the health services. These advances cover a range of possibilities, including innovations in surgery, drug therapy, screening and diagnosis. The pace of innovation quickened as the end of the century approached, with significant implications for the funding and provision of services.

Third, public expectations of health services are rising as those
Public and private roles in health care systems

who use services demand higher standards of care. In part, this is stimulated by developments within the health service, including the availability of new technology. More fundamentally, it stems from the emergence of a more educated and informed population, in which people are accustomed to being treated as consumers rather than patients.

Against this background, policy-makers in a number of countries are reviewing the future of health services. Those countries which have traditionally relied on a market in health care are making greater use of regulation and planning. Equally, those countries which have traditionally relied on regulation and planning are moving towards a more competitive approach. In no country is there complete satisfaction with existing methods of financing and delivery, and everywhere there is a search for new policy instruments.

The aim of this series is to contribute to debate about the future of health services through an analysis of major issues in health policy. These issues have been chosen because they are both of current interest and of enduring importance. The series is intended to be accessible to students and informed lay readers as well as to specialists working in this field. The aim is to go beyond a textbook approach to health policy analysis and to encourage authors to move debate about their issue forward. In this sense, each book presents a summary of current research and thinking, and an exploration of future policy directions.

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University of Birmingham
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This book draws on research which has received financial support from two New Zealand organizations: the Health Research Council and the Faculty of Commerce and Administration, Victoria University of Wellington. My interest in public and private roles and interfaces and in health system reform spans a period of several years, and at various stages valuable research support was provided by Deborah Peikes, Pauline Ng, Kathy Nelson, Evan Roberts and Robbie Lane. In addition, I wish to acknowledge the contributions of a number of New Zealand and overseas colleagues who have provided information, analysis and peer review. Their valuable insights are reflected in the discourse contained within these pages. Any errors or omissions, however, remain, as always the responsibility of the author.
INTRODUCTION

The book develops a framework for examining the health reform experiences of seven OECD (Organization for Economic Cooperation and Development) countries with emphasis on the roles of funding, purchasing and provision and the impact of organizational changes on system performance. The seven countries analysed are: Australia, Canada, Germany, the Netherlands, New Zealand, the UK and the United States. All are western democratic societies and some have close affinities arising from former colonial ties or a common language and culture.

The countries vary in size, geographical spread and the levels of private and public sector involvement in the funding, purchasing and provision of health care. With such a wide brief, the coverage of country experiences has been selective rather than comprehensive. Sometimes focus is placed on interesting design features, even when the proposals were not implemented and do not depict the most recent developments.

Over recent years, many governments have introduced changes to the roles of and interfaces between public and private organizations within the health care system. The reforms have modified arrangements for the funding, purchasing and provision of health care. Sometimes reform designs have evolved from considerations within the sector; at other times they have been shaped by economic and public management reforms. Health reforms have placed renewed emphasis on formal contracting arrangements among funders, purchasers and providers. Pressures for greater diversity and responsiveness in services have led to a reduced role for governments in purchasing and providing services, greater decentralization of decision-making, and the delivery of services on a more competitive and contestable basis.
In some countries this has led to a more strategic role for public sector organizations, centred on the function of governance rather than service delivery. Some countries have adopted a ‘big bang’ approach to health reform while others have proceeded at a more incremental and leisurely pace. Many reform proposals have suffered ‘policy drift’, resulting in modification to reform designs during the implementation stage. Trends, influences and policy choices are discussed, including the potential for cross-national learning to inform public policy decision-making in a specific country context.

Some countries with quite diverse system features are now adopting similar strategies for reform. Other countries started from a similar point, but now take divergent pathways. These trends serve to increase the potential for cross-national learning. While each country’s reform design reflects a unique inheritance and economic, social and political context, the similarities across reform proposals are striking. One explanation for this is that the forces of globalization and mass communication have increased opportunities for countries to learn from one another. The reforms are important because of the value attached by individuals and groups to health and health care, the influence of health on the achievement of wider societal objectives and the significance of health care’s claim on public and private sector resources. Health systems have become more complex, involving diverse approaches to public and private roles and interfaces. In several countries private organizations have attained prominence within health care systems. Countries which have maintained a strong public role have implemented changes that utilize market and market-type instruments and strategies.

The analysis of health care systems can be informed by a number of different disciplinary perspectives. Political scientists provide insights into the distribution of power and the role of stakeholders and interest groups; economists focus on issues surrounding affordability, incentives and problems of market failure and government failure; sociologists consider the impact of different systems on communities and on particular socio-economic groups. Each discipline contributes its own concepts, theories and frameworks to a rich policy debate.

Some analysts study health reform experiences in the expectation of discovering ‘international best practice’. Others do so in search of new ideas and directions, or justification for particular local solutions. Countries can learn from one another, though
health system designs need to be fashioned to suit particular circumstances, having regard to values, priorities and the specific country context.

Powerful economic arguments, widely accepted within OECD circles, have linked the poor economic performance of many western countries to high levels of public spending and taxation. From this vantage point, effective health and social policy reforms are central to successful economic strategies for the future. Policy-makers are increasingly aware of the linkages between health policy reform and social and economic policy agendas. Interest in reform is widespread in the light of the substantial share of resources devoted to health care in many countries. Figure 1.1 shows levels of expenditure on health care as a percentage of gross domestic product (GDP) in the seven chosen countries from 1975 through to the mid-1990s. Comparisons show greater variations in shares among countries in 1998 than in 1975.

Several OECD countries have extended opportunities for private sector organizations to play a larger role in health care systems. While health reforms may be described, somewhat emotively, as involving policy choices between government and markets, most health systems combine government and market elements. Such complex systems involve both public and private organizations, including elements of cooperation and competition, planning and areas where markets operate with a minimum of government interference.

Even in areas where private markets operate freely, most require an underpinning of government to secure property rights, to foster competition, and to guarantee consumer protection. It is common for both public and private organizations to assume a variety of roles, including funding, purchasing, provision, regulation and ownership.

Some public health care organizations are being required to compete with private firms, and greater reliance is being placed on the private sector to support public policy goals. In some countries, increased competition and contestability among public and private sector organizations has been associated with higher transaction costs, raising questions as to whether these changes are justified in terms of gains to efficiency.

The complexity of new health care arrangements means that it is increasingly difficult to classify particular services unequivocally as either public or private (Burchardt 1997). Despite the growing importance of private sector developments within health care
Figure 1.1: Health expenditure as a percentage of GDP, 1975–98

Source: OECD (1998)

Year

United States

Germany

Canada

Netherlands

Australia

United Kingdom

New Zealand

% GDP

0

1975

1976

1977

1978

1979

1980

1981

1982

1983

1984

1985

1986

1987

1988

1989

1990

1991

1992

1993

1994

1995

1996

1997

1998
systems, public policy advisers in some countries have given insuffi-
cient attention to the interactions and interfaces among public
and private organizations.

Changes have been made both to the roles assumed by public and
private organizations and to the degree to which those roles are
separated or combined. Some reforms have brought about greater
separation (for example, creating distinct organizations to perform
funding and purchasing roles), while others, such as G P fundhold-
ing and managed care, have strengthened the linkages across roles.

Public and private interfaces, whether within or across different
roles, are becoming more important and more complex. Some
countries, while maintaining a strong commitment to public sector
financing, are reducing the sector’s role in purchasing and pro-
vision. New arrangements have shifted responsibilities to health
care professionals, individuals and private organizations who act as
agents for users and consumers. Issues are being raised concerning
the contracting arrangements and accountability provisions for pri-
ivate health professionals who deliver services across both the
public and private health care systems.

While there is a trend in several countries for governments to
reduce their roles, there are areas such as regulation where govern-
ment influence over private sector activity is increasing. The more
competitive environment surrounding purchasing and service
delivery has led to changes involving not only deregulation but also
re-regulation, with major impacts on health professionals, pur-
chasers, providers and health care organizations.

Fiscal constraints have led some governments to consider health
reform among strategies to limit, or reduce, the coverage provided
by the public sector. The introduction of funding systems based on
capitation and budget caps has helped governments to keep expendi-
itures under control. Some systems have introduced co-payments,
c o - i n s u r a n c e , or other provisions that require individuals to meet
part of the cost of care. With the notable exception of the United
States, many OECD governments assume responsibility for ensur-
ing that citizens have universal access to a basic package of core ser-
vices. Key issues in health care reform surround the definition of
public entitlements and the degree to which public support should
target specific groups or provide a uniform entitlement to all citi-
zens.

Policy choices involving the interfaces between public and pri-
ivate organizations are also important in providing for individuals to
supplement core services by the purchasing of insurance. Clear
public entitlements help individuals to judge their need for supplementary private insurance cover. Offsetting the benefits of greater clarity to the user, however, is the increased fiscal risk to the government entailed in making entitlements more explicit.

HEALTH OUTCOMES

Health care services are valued for their positive effects on health outcomes. Better outcomes occur when health status is improved or when care helps to maintain or prevent further deterioration in health status. Health care can be divided into personal health care for individuals and prevention, promotion and protection services for entire populations. Governments have always had a prominent role in overcoming public health risks and this is a major area of concern in less developed countries.

Table 1.1 provides information for the seven selected countries on health status, measured by potential years of life lost due to premature death and by life expectancy at birth. Relating this to Figure 1.1, there does not appear to be a simple positive relationship between health status and the share of resources devoted to health care. In particular, the United States does not perform well, relative to others, in terms of health status measures.

While, traditionally, mortality and morbidity statistics have been

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<thead>
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<th>Country</th>
<th>Potential years of life lost per 100,000 life years, 1995</th>
<th>Life expectancy at birth (years)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>Australia</td>
<td>3103</td>
<td>5193</td>
</tr>
<tr>
<td>Canada</td>
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<td>5451</td>
</tr>
<tr>
<td>Germany</td>
<td>3337</td>
<td>6505</td>
</tr>
<tr>
<td>Netherlands</td>
<td>3262</td>
<td>5139</td>
</tr>
<tr>
<td>New Zealand</td>
<td>4775</td>
<td>7342</td>
</tr>
<tr>
<td>UK</td>
<td>3616</td>
<td>5690</td>
</tr>
<tr>
<td>United States</td>
<td>4591</td>
<td>8401</td>
</tr>
<tr>
<td>Average</td>
<td>3709</td>
<td>6246</td>
</tr>
</tbody>
</table>

Source: OECD (1998)
relied upon as measures of health status, there is growing agree-
ment that quality of life as well as length of life is important when
establishing health status. Defining and measuring health and
health outcomes are themselves the subject of policy debate. A
medical model of health focuses on the treatment of disease and
illnesses, while more holistic approaches to well-being include
socio-economic as well as physical aspects of health, and relate indi-
viduals to the communities and societies in which they live.

The outcomes of population-based health promotion and disease
prevention programmes are often difficult to measure, since the
benefits are neither discernible immediately nor easily attributable
to specific individuals. Linking improvements in health status to
health care is also made difficult by the many factors and influences,
other than health care, which affect health status. These factors
include adequate housing, income, exercise, food, the company and
care of others, a good genetic inheritance and access to a safe and
healthy environment.

Perceptions about the determinants of personal and public
health will influence views about the appropriate role for the
government. Increasingly, personal health is being viewed in the
broad context of a community and society, rather than as a charac-
teristic largely attributable to an individual. Measures of health
status attach diverse weightings to individual, family, associates and
peers, the wider community, the trained health practitioner and
society.

Relative, rather than absolute, health status may be the more
important influence on an individual’s perception of health and their
propensity to seek health care. Sometimes the utilization of health
services is used to measure health, but this is a poor proxy because
it is often influenced by factors such as availability and cost. Health
services may also confer other benefits including information and
peace of mind. Definitive statements about the domain and range of
health outcomes remain elusive and, as in many aspects of health
policy, the contributions of different disciplines, which underpin bio-
logical, social and economic perspectives, all contribute (Macbeth
1996). Figure 1.2, adapted from an approach used by Hall et al.
(1993), utilizes the economist’s notion of a production function to
describe the complex arrangements among inputs, processes, out-
puts and outcomes in health care. The production analogy clearly
shows that both health care and non-health-care inputs and activi-
ties contribute to health outputs and outcomes, and that health ser-
vices influence outcomes other than health. These interrelationships
make it difficult to measure the precise contribution of health care outputs and interventions to maintaining or improving health outcomes.

Policy-makers are placing greater emphasis on measuring the outcomes of health and other interventions, and have become more aware of the influence of lifestyle factors and other socio-economic determinants on health status. Viewing health care in the wider context of economic and social policies requires that alternative approaches to fostering health gains be considered, including measures which reduce tax levels and increase private spending potential. This shift in focus is placing pressure on each funder,
purchaser and provider of health care to make connections between the production and consumption of health care outputs and improvements in health outcomes.

HEALTH POLICY GOALS

Many countries share policy goals and objectives regarding improvements in the health status and the well-being of their populations. However reform strategies are developed in a country-specific context and may reflect differences in the interpretation of similar goals and in the priorities and trade-offs attached to specific goals. The trend towards a greater sharing of roles with the private sector requires governments view public policy choices within the wider health care system.

The case for shifting the roles and interfaces among public and private organizations must rest on the capacity of different systems to support particular health policy goals. Though many different policy goals influence health system reforms, the discussion here emphasizes efficiency, cost containment, equity and choice when looking at system impacts.

Efficiency

Efficiency is concerned with ensuring that resource decisions give value for money, and it is important to distinguish between allocative and technical efficiency. Allocative efficiency is achieved when the right level and mix of goods and services is produced in the economy. This occurs when the marginal benefit equals the marginal cost, i.e. when the last pound spent on providing a service brings one pound’s worth of benefit. Technical efficiency (sometimes termed production efficiency) is achieved when health care outputs (in the form of goods and services) of a given quality are produced at least cost.

Health reforms are often undertaken with a view to improving allocative efficiency by modifying the level and mix of resources devoted to health care. Government strategies for determining the right level are varied, and none are particularly scientific. One approach assumes that existing levels have some legitimacy and so can act as a norm, to which adjustments are made in response to population, technology or policy changes. A second approach measures and benchmarks resource utilization in relation to some
OECD norm. A third approach links appropriateness to macroeconomic affordability, as measured by levels of health spending as a percentage of GDP or GNP (gross national product). Although governments are tempted from time to time to justify the level of resources devoted to health care by making comparisons with other countries, the ‘correct’ level of spending should reflect the values held in a specific country and the degree to which individuals and communities consider that additional health care expenditure will provide benefits which justify the costs.

Concepts of health care efficiency relate both to health care outputs and to health outcomes. While it is customary to regard the output of health care as particular interventions or services, the efficiency of the outputs of care should ideally be determined by health outcomes, in the form of improvements (or the prevention of deterioration) in health status. The impact of a specific intervention will vary across individuals, groups and societies. Therefore, comparisons of efficiency between public and private organizations must allow for variations in the health status of those receiving care.

Cost containment
Concern about levels of economic performance has encouraged a focus on cost containment as a specific health policy goal. While it is possible for cost-containment strategies to both lower costs and improve allocative and technical efficiency, there is no guarantee that this will occur. Cost-containment strategies may lead to efficiency gains, or alternatively, to a shifting of costs, with associated increases in overall system costs. Cost-shifting may take place with respect to health care providers, consumers, insurers or others. Public sector cost-containment strategies include measures which shift costs across different public agencies as well as those that limit costs overall.

The effectiveness of cost-containment strategies will depend on the degree to which the government has control over funding and delivery systems. Where facilities are owned publicly and health professionals are salaried, it will be easier for governments to contain spending than when health care is delivered privately and no explicit contracts exist between funders, purchasers and providers.

Governments may set budgets in advance for particular categories of health care expenditure, including constraints and expenditure limits which apply to both private and public health care
professionals and organizations. Public sector cost-containment strategies can also be achieved through measures that influence both the demand for and the supply of services. Strategies to reduce public sector demand include strengthening incentives (including tax concessions) to encourage private spending; measures to encourage or facilitate individuals’ opting out of the statutory system; and reductions to the scope and coverage of services. Governments may reappraise the benefits of services with a view to reducing service levels, increasing waiting times, or extending the level of cost-sharing with patients and providers.

Governments can affect supply by controlling the number of medical students and physicians, and the conditions under which providers can obtain reimbursement and funding for services. Public policies may have the ability to alter the number of doctors and hospital beds, the access of individuals to particular procedures and pharmaceuticals, the introduction of new technology, and the locus and nature of the service provided.

As health care systems have become more complex, opportunities to shift the costs of care among various parties have increased. Cost-shifting and cost-containment strategies are often presented as policy measures that will improve efficiency, though sometimes they lead to efficiency losses to the health system as a whole. Public policies need to consider reform strategies in relation to their impacts on both public sector resources and total health system efficiency. Risk management and risk-sharing strategies determine how financial responsibility for the costs of care are to be shared by users, providers, purchasers and funders.

**Equity**

The goal of equity, when applied to health care systems, concerns what is deemed to be fair in terms of arrangements for the funding, purchasing and delivery of health care. While many would define equity in health care as a basic minimum of care regardless of ability to pay, concepts of fairness are closely interwoven with a society’s view of the role of government in the economy and society. In countries where governments play a major role in health care, equity is defined as equal access for equal need, or even equal outcomes, the latter requiring a targeting of resources to those with the poorest health status. In other countries, however, access to health care is linked to employment and income status, and this too, is regarded as fair.
Equity can be defined in relation to geographical area, age, cultural and social background and kind of disability or illness. The term ‘equity’ can refer to the spread and ease of access to services as well as the appropriateness of the services to particular groups. There is often tension between the rights of individuals to exercise freedom of choice in behaviour and lifestyle, and the right of society to use coercive powers to encourage and constrain the consumption of health care. Equity in health refers to redistribution from the well to the ill, not merely a redistribution from rich to poor. Designing regimes for targeting assistance for health care is more complex than for services like education and housing, since resource requirements must be related both to health risk and to affordability.

Countries vary in the degree to which they aim to promote equity in the distribution of health status and health care. A society’s view of fairness depends on the degree to which health care is perceived as different from other goods or services. When health care is regarded as similar to other goods and services, and access is based on the income and employment status of individuals, governments will be reluctant to constrain individuals from purchasing additional health care with private resources. Some societies subsidize access to health care because they consider it to be a right, similar to rights of citizenship. The term ‘positive rights’ is used to describe the basic rights of citizens to health care and other social services, and to distinguish them from negative rights, such as freedom from interference. If health is treated as a positive right, this gives governments a mandate to treat access to health care differently from access to other goods and services.

Equity rarely means equality in the sense of all individuals receiving an identical or equivalent level of health care or enjoying the same health status. There will always be inequalities in health status and access to health care. Even setting aside the influences of genetic inheritance, education, income and lifestyles, individuals will have different preferences regarding acceptable levels of risk and desirable levels of care. Interventions by society in health care serve to moderate inequalities to a point where the differences among citizens are regarded as acceptable.

Considering health care as a production function, the meaning of equity or fairness can be related to inputs, processes, outputs or outcomes. One concept of equity places emphasis on equal access to inputs, processes and outputs for equal need. Another aims to achieve equal outcomes rather than equal inputs or processes. The
particular interpretation will influence both the nature and scale of the intervention and also the degree to which it targets resources, with a view to reducing differences in health status across the population.

Choice

The policy goal of choice pertains to issues surrounding access to health care and health care insurance. Few health care systems give autonomous individuals choice of service. Insurance is usually involved, and even in private systems, insurers and employers are influential in determining the level and nature of services received. When health care systems are funded by the public, the effective purchaser of the service is the government rather than the individual.

Choice in health care is increased with the range of health care interventions, technologies and providers, purchasers and insurers that individuals can access. Linked to the policy goal of choice is the notion of voice. Voice is increased when individuals and communities participate and have representation in health system decision-making. In health care markets, the preferences and interests of users of the service are often subservient to the preference of the funder, purchaser or provider of care.

The level of choice which is given to individuals or groups within a health care system is often related to the entitlement to care as defined by either a public or private funder. When substantial public funding is involved, governments have considerable potential to exert influence over the price, quantity and quality of health care that is delivered.

The health policy literature identifies several other health policy goals, including accountability and quality. Various elements of accountability can be identified, including political accountability, professional accountability and managerial accountability. The growing complexity of health care arrangements has increased the accountability requirements on public and private organizations and has led to greater attention being given to performance evaluation and monitoring.

Quality of care has also become an important policy goal, though perceptions of quality will vary among patients, politicians, managers, clinicians and other actors within the health care system. Not unlike the production of health care, quality can be related to inputs, processes, outputs or outcomes. Increasingly, quality is
perceived as something which transcends organizational boundaries and is system-wide. Quality occurs when good decisions regarding care are made so that resources are utilized effectively and better health outcomes are produced.

Designing a health care system which ranks highly across several policy goals is a difficult task. Particular goals are interpreted variously, as are the concepts of health and health outcomes. Although health reforms sometime achieve gains across a number of different policy goals, it is also common for gains in one area to be made at the expense of another. Over time, systems may alter the priority attached to particular goals, as some system design features prove more effective than others in achieving specific goals and objectives. The complexity of health care systems means that inevitably, and particularly within public health systems, there are diverse expectations among stakeholder groups, including the public, those receiving health care, politicians, managers and public sector agencies.

**PLAN OF THE BOOK**

This book adopts a comparative policy approach in discussing the systems and approach to health system reform experiences in seven OECD countries. Comparative public policy analysis is defined more appropriately as an approach and method rather than a distinct area of public policy studies. Comparative public policy evolved during the 1960s and 1970s, but was limited by inadequate attention to the context within which public policies were developed and by unrealistic expectations of the potential for studies in one country to provide policy lessons for others. De Leon and Resnick-Terry (1998) suggest that conditions exist for a renaissance in comparative policy analysis arising from a growing number of transnational policy issues, advances in communication technology and new conceptual bases.

A large policy literature reports varying degrees of optimism and pessimism concerning the benefits and pitfalls of making comparisons across countries to inform policy choices within a country. Rudolph Klein compares cross-national learning to ‘a multi-ring circus with different actors performing in each of them’ (Klein 1995: 7). Alan Maynard observes that the reluctance of physicians to be confused by facts in their everyday practice is paralleled by the reluctance of policy-makers to be informed by evidence when ‘redisorganizing’ health care systems in pursuit of perfection in
equity, efficiency and cost control (Maynard 1995: 49). Marmor suggests that comparative policy analysis suffers not only from the World Cup fallacy but also from the fallacy of comparative difference: the first aims to locate the best approach and to apply it indiscriminately to all other countries; the second suggests that the unique context surrounding any country limits the potential for learning across countries (Marmor, in Altenstetter and Bjorkman 1997).

Various approaches can be taken to applying the comparative method. A common approach has been to draw on the expertise of different country experts and to compile information from which to make comparisons. Some authors have used international databases and statistical techniques to explain variations across countries and to draw correlations across different variables (Heidenheimer et al. 1990; Castles 1999). Utilizing data and input from various sources inevitably compromises the comparability of those data and can qualify the conclusions drawn from such studies (OECD 1992, 1994; Ham 1997; Raffel 1997; Ranade 1998). The approach taken in this book is to develop an analytical framework which can be applied uniformly across the countries, clarifying the similarities and differences and thus facilitating cross-country comparisons. A second point of difference is the explicit attention which is given to the roles and interfaces of public and private organizations within health care systems.

Chapter 2 discusses roles and interfaces within health care systems, building on the discussion of health policy goals in this chapter. The separate roles of funding, purchasing, provision, regulation and ownership are defined, and consideration is given to interfaces within and between roles. Specific attention is given to three reform strategies which have been adopted in several OECD countries: the purchaser-provider split, managed competition and managed care. Theories of market failure and government failure are outlined briefly and provide frameworks within which to consider the merits of government intervention in the markets for health insurance and health care.

Health systems in Germany and the Netherlands are treated in Chapter 3, the US, Canadian and Australian systems in Chapter 4 and the UK and New Zealand systems in Chapter 5. Coverage of each country is selective, and discussion is focused on public and private roles and interfaces, reform proposals and aspects of system performance in relation to the policy goals of efficiency, cost containment, equity and choice. Chapter 6 draws on earlier chapters
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and other literature to reflect on trends and issues in health system reform. Further consideration is given to the potential benefits of cross-national learning and to key public policy choices surrounding public and private roles and interfaces.
Public, private and mixed health care systems. Health Care Delivery in Canada. Private sector delivery with public control. These distinctions are important when one turns to the question of public and private participation in the health care system, as each sector plays very different roles in the delivery and financing of medical services. Health care delivery refers to the manner in which medical services are organized, managed, and provided. Arguments for and against public/private health care. Should we leave health to free market or should public sector provide universal healthcare? Trying to introduce competition in healthcare is fruitless because in practice patients are not in a position to shop around choosing between different doctors. In healthcare, consumer sovereignty doesn’t apply to other markets. Public healthcare provision means everyone has access to this important public service. Left to the free market, there would be some who don’t have private healthcare insurance and would suffer. Health care is a merit good. People may underestimate the importance of going to doctor for a check-up. This could lead to some diseases being left unchecked and becoming more Government health agencies will need to develop comprehensive plans working collaboratively with the community, social agencies, and the personal health care system, including both the public and private sector. Public Health Agency Roles: Public health functions and agencies exist on the federal, state and local levels. Public health services should be considered part of the social safety net which is the responsibility of government to provide for all people. Stable funding is also necessary. One way of ensuring stable funding is by requiring organizations and institutions paying for personal health services to support public health in proportion to the amount they spend on personal health care.