Health Systems

Global trends in health care reform

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Health systems throughout the world are hard pressed to curb costs and safeguard quality. In general, the users of health services are having to pay more for them, and in some cases this is making the system unsustainable. Even where costs can be met, the payment mechanisms used can make a decisive difference in terms of equity and efficiency.

Reform is in progress in countries at all levels of development. Although no two sets of circumstances are the same, some underlying pressures for reform are common to groups of countries, and this article reviews several of these, giving special attention to the way they are affecting the principal actors in health systems.

Common to many, perhaps most, countries is a concern that the scale of government spending on health is at a level which is not sustainable. Reorientation of economic policy away from interventionism towards market approaches emphasizes this concern about sustainability. In too many countries this has resulted in a severe fall in the quality of publicly financed services. Other countries, such as the Republic of Korea, Switzerland and the United States, have maintained quality, but only at a rapidly growing cost, and they are therefore worried about the inflationary pressures on government commitments.

Also common in a large number of countries at all levels of development is the fact that reform in health care is part of a much wider process of social and political restructuring. This is equally true in central and eastern Europe, the republics of central Asia, sub-Saharan Africa, and Central and South America, where multi-party democracies are emerging. In all of these areas, health care reforms are part of an overall social transformation, rather than just fine-tuning in an isolated sector.

Reforms affect consumers, producers and governments

Thus common and fundamental questions are being asked about the role and responsibility of the different groups involved in the financing, production, consumption and regulation of health care. What should governments be responsible for? What should be the role of patients and families as consumers of care and as responsible citizens? How should professional associations and providers of care behave? Major differences – often conflicts – in underlying values and policy objectives are frequently revealed when these issues are dis-
Agents in health care financing

Out-of-pocket payments

Health services

Consumers

Providers of care

Government/Professional body

Purchasers of care (e.g. government, insurance agency)

Regulation

Insurance coverage

Taxes/insurance premiums

Claims

Payment

Regulation

Regulation

Consumers are paying more

The major change affecting consumers is that they have been asked to pay more for health care. This is, if anything, more true in poorer countries than in richer ones. As a general rule, the poorer the country is, the larger is the proportion of total health expenditures which come from private sources (in other words, the smaller is the share mediated...
through some public agency). Whether people pay through higher taxes or social security contributions, or simply in more cash to providers of care, differs according to the kind of system they are in; but probably the policy change that is easiest to implement, and thus the most widely used, has been the introduction or increase of user charges for government-provided services.

Sometimes this has worked well, and people have got more in exchange for the higher payments. Charges have been used to improve the availability of drugs, for instance. Increased charges may also have been used to improve the quality of the reception that patients get (officially or unofficially), or to give them greater choice in the matter of where to go for care. Often, however, there has been no accompanying improvement in services. The money has gone out of the health sector to the central treasury, and people have simply changed their patterns of health service utilization, and found alternative sources of care. In several countries drops in utilization of over 30% have been reliably recorded in the period following fee increases (1).

The policy of greater reliance on financial contributions from users is common in low-income countries for several reasons. First, as mentioned, charges are often administratively easier to manage than alternatives such as health insurance. However, cost-recovery policies themselves cost money to operate, and in many countries the net revenue from charging patients is very low: about 1% or 2% of total recurrent expenditure for health in countries such as Mozambique or Kenya. Secondly, in poor countries the tax base is small and the possibility of increasing it to improve health is often remote.Doubling per capita health expenditure would still not yield enough to make essential basic services available to everyone. Thirdly, there is a striking inconsistency in some countries, by which some people get free medication from the government while others must pay for the same drugs at a pharmacy.

Through mistakes and experience, we are now in a better position to understand how to manage cost-recovery so that it contributes more fully to overall health objectives such as equitable access to services of acceptable quality. Fee increases need to be one part of a package of changes, including retention of revenue at the collecting point, decentralized authority over spending decisions, community involvement in the management of local income, suitable banking and accounting support, and perhaps above all, visible improvements in the quality of care available from fee-collecting health facilities.

**Providers of care are being paid differently**

Whilst the shift in financing responsibility towards patients is principally an experience of low-income countries, changing the method of paying providers is a common experience in some middle-income and several higher-income countries. Changes in provider payment often accompany organizational change in the delivery of services. Thus, when the Health Maintenance Organization movement was growing rapidly in the United States in the 1970s, physicians joining these organizations often changed from a fee-for-service payment basis to salaries. In Thailand, when the health insurance scheme in Bangkok was recently expanded to cover some 3 million people, the participating physicians were paid on a capitation basis.

Naturally, provider payment mechanisms are something about which providers have strong feelings. Part of the pressure in many countries for the establishment of health insurance schemes comes from physicians, who see these as a way to raise their income above
the level of a poorly paid public employee through a fee-for-service mechanism. However, there are many alternative ways of paying providers: case payments, flat rates, and

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(increasingly commonly) mixed packages of capitation, fee-for-service and other types of incentive payment (2).

If we consider health facilities, such as hospitals or area health authorities, as the providers, rather than the doctors, a major common trend in the richer countries in recent years has been the use of global budgets (2). These are pre-set budgets establishing an expenditure ceiling but allowing flexibility at the facility or authority level in determining the composition of spending. These are common in Canada, Germany, the United Kingdom and the United States. Similar arrangements have also been initiated with primary care providers in Finland, Sweden and the United Kingdom, in which “fund-holding” arrangements for both primary and specialist care have been decentralized to be managed by the municipality or the provider group. It is too early to offer a clear assessment of the costs and benefits of these initiatives, but they reflect two current concerns: decentralizing decisions about the use of resources, and containing total costs.

**Government’s responsibility**

Governments cannot do everything, but there are some things only they can do. Thinking about the role of government in health has been influenced by the general debate on the relative competence of the market and the state. Issues of principle and practice have often been confused. The special characteristics of the health care market have sometimes been overlooked in this discussion, and it is noteworthy that the World Bank’s *World development report 1993* makes it clear that a pure market approach to the production and allocation of health care would be both inequitarian and inefficient. Government intervention (through regulation and financing) is therefore necessary in the interests of both justice and economics.

Experience has shown, of course, that government can also over-intervene in the health sector: there are many instances of both inefficiency and inequity in the public financing, and particularly the public provision, of services. Striking the right balance between market mechanisms and public direction is usually more of an empirical issue than a theoretical one, but the debate has affected some trends.

The nature of public intervention in health is now more broadly accepted in relation to policy-making, regulatory and monitoring functions, as is the need for public financing for some or all of the costs of services for the poor (3). The debate about the most efficient means of provision, on the other hand, continues. In some countries, the non-government sector (for instance the services provided through religious missions in much of Africa) is widely regarded as more technically efficient than the public sector. In others the “modern” private sector is essentially dualistic, with one part providing high quality care, and the other often associated with unlicensed practitioners, little or no mechanism for quality assurance, and at least the suspicion of widespread bad practice, particularly in relation to the use of drugs and injections.
Richer and poorer countries – two different reform experiences?

Two major types of policy emphasis can be distinguished. One group of countries has actively attempted to shift the boundary between public and private financing in health, transferring ownership and responsibility away from the public sector to different components of the private sector. Chile led the way in South America with a policy of returning health care to the market in the decade beginning in the 1970s. More recently, China was moving in a similar direction during the 1980s.

Chile’s commitment to privatization proved difficult to implement, at least initially, as the country was in deep recession, so resources for additional private spending were simply not available as real incomes were falling. Chile’s subsequent restructuring changed patterns of access to care, making it harder for the poor to get care, and mortality and morbidity trends in most age groups rose, reflecting growing inequities of access. Since 1990 Chile has been increasing the central government’s contribution to health financing, in an attempt to prevent further decline in equity.

China, by contrast, began to scale down the role of the state at a time of economic boom with growth averaging over 10% per annum in real terms for over ten years. Two trends summarize the nature of financing change in China: although overall health levels improved greatly owing to the country’s economic success, inequalities between richer and poorer provinces and population groups widened substantially, with important increases in morbidity, particularly tuberculosis. Many other countries have shifted policies towards the private sector gradually – legalizing private practice or the combining of private practice with public service, and contracting out ancillary services such as laundry, cleaning, catering, and equipment maintenance. In perhaps an even larger group the policy has been one of “passive privatization”, in which, with-out any overall policy direction, constraints and real reductions in the government budget have reduced the attractiveness of services available from these sources to the point that people have found themselves obliged to find alternative, non-government sources of care.

In the more industrialized countries, the emphasis on policy change has been much less on shifting the boundary between public and private financing, and more on improving performance under what in most cases is a preponderantly public system. This characterizes the concern in Western Europe, New Zealand and North America, which is to contain overall health costs. Most industrialized countries have managed to control total cost growth in recent years, largely by the adoption of global budgets. A more contemporary concern is the need to improve service quality in areas such as waiting time and the patients’ choice of doctors (4).

We can conclude by observing that clear statements of policy objectives in health are often lacking, and governments have an important responsibility in this area. The roles of the principal actors in health care delivery and consumption are in a state of flux. Government responsibilities are being scaled down, but public regulation is essential. Patients, rather than administrative units, are being more commonly regarded as the proper focus for planning resource utilization. New methods of paying providers have to accommodate cost-containment as well as the professional
needs of providers and equitable access for patients.

A transfer of responsibility to private financing sources exacerbates inequities, and on its own will do nothing to improve performance in the public sector. Public sector improvements are being explored through decentralization of fund-holding, contracted purchasing, overall budget control mechanisms, and in some cases a clearer purchaser-provider separation. In choosing the principal policy instruments, clear policy objectives are necessary. Formulating these is a government task, and cannot be privatized.

References


**Health financing – a Minister of Health’s point of view**

All governments are being challenged by the escalating costs of health care. Whether by crude measures of budgetary “capping” and the imposition of user fees, as in our region, or by the development of internal markets or the so-called “new public health”, evasive action is being taken by the State finance authorities to stem the tide of need and demand in the provision of health care services. … The problem for health is how to maintain, at least, our gains and perhaps add a little progress, without thereby “breaking the bank”. Unfortunately, the devices developed so far simply do not work. People, as patients, want the best – while the State tries ineffectively to turn back the tide of increasing and uncontrolled demand for health services. …

Joseph Stalin is recorded as saying: “One death is a tragedy, a thousand deaths are a statistic”. Sadly, this observation has been confirmed again very recently. One racing driver dies – the whole world mourns. An ex-President is buried – the flag remains at half-mast for 30 days; 200 000 Rwandans die – it is a statistic in the international media. Even worse, the one million children who die in Africa every year are not even noticed.

In this respect the world stands indicted in the same condemnation which must be applied to Stalin. We have to bring before the world’s conscience the uncaring attitudes of those who determine its monetary priorities, which result in such carnage. No longer should we, like dogs, be called upon to be grateful for the crumbs which fall from the rich man’s table. We need to establish once and for all those irreducible health rights which all the children, all the people of the world should be guaranteed by the global community, whether or not the states to which they belong can afford to allocate the resources for this.