EDITORIAL

Welfare states for sale: Neighbouring countries and the public–private mix

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Australians were battling over optional ways of financing health care for most of the last century. We start this century with the problem unresolved – and the subject of yet another Federal Government enquiry.

There has been less controversy over the ownership of care provider agencies, but interest has grown over the last decade. State and Territory governments claim different views but all have transferred work to the private sector, ranging from outsourcing of particular functions (like cleaning) to complete privatisation – where a private company builds, owns and operates a facility serving mainly the publicly insured. The Commonwealth Government has given indirect support to private providers (including its contentious new subsidies for private health insurance).

I spent most of last year looking at health care systems in neighbouring countries: China, India, Malaysia, Mongolia, New Zealand and Singapore. There was the opportunity to join in a few debates about the private–public mix and to note some differences in trends.

Malaysia has the largest proportion of financing from government general revenue, and seems happy with this arrangement. In spite of 18 years of radical social and economic change in the country at large, self-pay and private insurance remain minor sources. Other models of financing have been considered and rejected.

New Zealand is not too different in this regard. It has long believed in public financing from general revenue, although most people have had to meet a large share of the costs of primary medical services. The private health insurance sector has largely been left

to its own devices (and given hardly any government support). In fact, private health insurance membership declined from 51% to 33% over the last decade (Health Funds Association of New Zealand 1999). There have been trends towards increased self-pay over the last 15 years, but the impact of economic rationalism has generally been small in health financing.

Since independence, India has been committed to the funding of most of its health care from general taxation. However, it has never been able to find the resources to subsidise more than the most basic care. The government was responsible for only 18% of total health care expenditures in 1998 and most of the remainder were met through self-pay (Bos et al. 1999).

Health insurance for non-basic care has increased over the last two decades, but it represented only 3% of total expenditures in 1998. It is a government rather than a private sector activity by law. Insurance is compulsory for some low-income employees, and optional for other groups. Legislation was enacted in December 1999 which will allow private involvement in health insurance. The primary aim is to encourage greater cost-effectiveness through providing the government insurers with competition.

Like India, Mongolia has traditionally taken the approach of government financing from general revenue and has similarly been unable to afford the provision of more than elementary services. It has rejected the idea of private health insurance thus far, but it established a government-owned, employer-based insurance scheme in 1995. Around 60% of the population are self-employed or unemployed and their contributions to the scheme are therefore paid out of government general revenue.

Until 1984, Singapore funded government services largely from general revenue along Malaysian lines. From that date, its main policies have been '…to promote personal responsibility for one's health and avoid over-reliance on State welfare or medical insurance' and '…to rely on competition and market forces to improve service and raise efficiency' (Singapore Ministry of Health 1993).

The government has continued to subsidise care for low-income families from general revenue. However, much of the financing burden has been transferred to individuals who are required to self-insure in the form of health savings accounts. One might view this model as no more than an indirect form of taxation. However, there are distributional differences: people who are willing and able to insure at higher levels gain access to higher levels of care, and there are financial incentives to self-ration – to avoid care and therefore maintain one's savings.

China, like India, has relied heavily on self-pay. The government increased its funding significantly over the first two decades of the People's Republic, but its contribution has fluctuated (and often trended downwards) since then. Government expenditures were 13% of the total in 1997 (Bos et al. 1999).

Several employer-based insurance schemes were introduced after 1951, although there has been a lack of justification for this approach (Grogan 1995). They peaked at around 42% of total health care expenditure in the mid-1970s, but had declined to under 30%

by 1996 – mainly as a consequence of the decline of employment in government companies as privatisation accelerated. User-pay increased from 23% in 1980 to 54% in 1996. At present, the government is implementing a major reform to its employer-based insurance scheme which draws heavily on Singapore's savings account model.

With respect to ownership of health care provider agencies, Malaysia is again at one extreme. Eighty per cent of hospital beds are publicly owned as are most community health care facilities. The general policies of recent governments have been towards greater private involvement. However progress has been relatively slow in the health sector and has mainly consisted of outsourcing. Of particular interest, the government announced in early 1999 that it would corporatise the majority of government hospitals from 1 January 2000. There was a large public outcry, supported by community and health care professional bodies, and Dr Mahathir consequently agreed activation should be postponed pending a thorough review.

Mongolia is also dominated by publicly-owned services. However, it is presently taking the bold step of privatising its general practitioners (albeit with an economically and socially responsible, government-funded and needs-based capitation payment system). It has shown an interest in privatisation of other levels of care, but few investors have been attracted in view of the poverty.

New Zealand has moved much further towards privatisation. Indeed, it corporatised most government health care services in the early 1990s. However the government has found that it is hard to allow an essential provider of publicly-funded services to go out of business. In this respect, it has shared the experience of the United Kingdom government and its National Health Service trusts.

India has always had a mix of government and private care provider agencies. The government has concentrated on the primary care sector, whereas private participation has been encouraged for hospital (and especially tertiary) services. The main reason is simply that primary care is a more important matter in a country as poor as India. Private for-profit agencies would find it hard merely to cover their costs if they attempted to provide – in an ethical way – what the majority of Indians can afford. Charitable institutions manage to provide good care (with overseas donations in many cases) but they are trivial in size.

Singapore has again adopted a major reform agenda. Inter alia, it has corporatised the majority of government health care services and continued to stimulate the private hospital and medical practice sectors. One consequence is that admissions to private hospitals grew from 15% to 25% of total admissions in the decade following the change to its market model.

Finally, China has seen major swings in private sector participation. The first communist government encouraged a rapid decline, and the private providers were almost eliminated during the Cultural Revolution. However, the change to the 'socialist-market' model after 1982 has seen a rapid re-emergence of private agencies at most levels in the health care system. For example, medical practitioners in private practice grew from 1% to nearly 50% between 1982 and 1991.

One might expect that the large differences in political systems across these countries – from capitalist to socialist, democratic to autocratic, and well-organised or not – would result in major differences in attitudes towards the public–private mix. There are, however, some common themes.

First, the idea of the welfare state has been leaking at the seams, to varying degrees. Governments in all six countries are concerned about reducing their own outlays and some of them seem willing to accept many penalties to achieve this goal, including a changeover to (usually) less efficient private health insurance and the transfer of patients into less crowded private hospitals with higher charges and less control over excessive utilisation.

Second, government-mandated insurance schemes (such as those based on shared employer–employee contributions at the workplace) may be initiated by governments mainly to allow them to be seen to be low-taxing – and to reduce their exposure to criticism. Other arguments in their favour are unconvincing. For example, it has been argued in India, China, and Mongolia that they are necessary because of the difficulties in taxing (for reasons like low workforce participation rates or ineffectiveness of the tax authorities). However, if one can take health insurance contributions from employers and employees, then one could also tax them. Neither approach solves the problem of raising contributions from those outside the organised workforce. Moreover, there are many new risks, including the creation of multiple levels of health care for those on high and low salaries, and for the unemployed.

Third, few analysts believe ownership of health care agencies is important in a technical sense. It seems that the decision to promote either government or private ownership is more likely to be driven by dogma or political expediency than by analysis.

Market competition does not always cause private providers to be more consumer-focused and efficiency-conscious. In the case of Singapore, for example, there were obvious improvements in efficiency of the public hospitals after they were corporatised. However, Hsiao (1995) claims that '…the fees of private sector physicians rose at a phenomenal rate' and that Singapore is '…saddled with widespread duplication of expensive medical equipment and high-technology services'. Faced with continuing increases in health care costs, the government noted that '…the health care system is an example of market failure' (Singapore Ministry of Health 1993).

Governments can make public providers more cost-effective without the need to resort to market-place competition. Australian health authorities have demonstrated this very clearly in the last decade or so and it appears that the pressure on public hospitals has spilled over into the private hospital sector.

Fourth, corporatisation (or full privatisation) of public care provision may be a useful way of encouraging the prudent use of resources, especially if product cost data are lacking to support performance evaluation in the way that Australian States and Territories have been doing of late. However, when each individual provider rather than

the payer is in control of cost containment, there may be many more risks of cost-cutting at the expense of quality of care and equity of service.

Fifth, matters of ownership (whether of care provider agencies or insurance schemes) tend to take on a greater importance than they deserve, if political parties are allowed to set the debate. It is a challenge for health professionals in all these countries to ensure more important matters (like evidence, rationing and consumer involvement) are paid due attention.

Finally, countries worry about resource shortfalls regardless of their wealth. The difference is mainly in the way services are rationed and where the line is drawn between what is accepted to be basic as opposed to optional care.

What is the right answer? In an international context, the trends are well illustrated by views of the World Bank. Over most of the last two decades it has tended to argue that governments should concentrate on maximising competition, not only between care providers but also between health care purchasers (like private insurers or managed care companies). However, the Bank's views may be changing, especially with regard to financing. In its latest report for India (Naylor et al. 1999), it recommends that the government should increase its involvement in and control over the purchasing of health care. There should be '…continued, and ideally greater investment by government in the finance of health'. In short, the dominant view right now is that more benefits derive from competition between providers than between purchasers. As Anderson (1998) shows, international experience says little about the effects of ownership of health facilities, but clearly points to the risks of a market in health insurance.

Health care professionals in the six countries have much the same commitment as their Australian counterparts to caring for the disadvantaged as best they can. They also show similar levels of frustration when they try to make improvements.

Some of the difficulties can be resolved only by the health care professionals themselves: there are problems of communication between insurers and providers, and across professional cultures (clinical and non-clinical, and medical and non-medical) in all these countries. I remember a discussion with a group of Chinese clinicians in which I was told that difficulties between nurses and doctors had been largely overcome in recent times (partly because of reductions in salary differences). After the formal session was over, senior nurses came to explain it was not so. That they could not say this in the formal session was an indication that the communication problems still exist.

This said, the difficulties of care providers are exacerbated by broad socio-political agendas. The world-renowned systems analyst Russell Ackoff wrote a paper on development planning in India in 1966 and changed his views in another paper a decade later (Ackoff 1976). He admitted his earlier suggestions about resource and technology solutions had been misguided: all the important constraints were cultural. Inter alia, the Indian health care system can never be as equitable or efficient as health care professionals would like until there is progress towards eliminating cultural constraints pervading the broader society, including those manifested in the caste system.

Australia has a less fragmented society. However, where we fail to realise our potential, it is also often a consequence of the success of vested interests in promoting agendas that are inconsistent with equitable and cost-effective care. There are many such examples in respect of the public–private mix. If we act as if decisions on the balance are wholly (or even mainly) based on objective analysis in the community interest, we are probably deluding ourselves.

References

Ackoff R 1976, 'Development planning revisited', *Operations Research*, vol 23, no 5.

Anderson G 1998, *Multinational Comparisons of Health Care: Expenditures, Coverage and Outcomes*, The Commonwealth Fund, New York.

Bos E, Hon V, Maeda G & Preker A 1999, *Health, Nutrition and Population Indicators: A Statistical Handbook*, The World Bank, Washington DC.

Grogan CM 1995, 'Urban economic reform and access to health care coverage in the People's Republic of China', *Soc Sci Med*, vol 42, no 8, pp 1073–84.

Health Funds Association of New Zealand 1999, *An Insight Into the New Zealand Health Insurance Industry,* Health Funds Association of New Zealand Inc.

Hsiao W 1995, 'Medical savings accounts: Lessons from Singapore', *Health Affairs*, Summer, pp 260–6.

Naylor CD, Prabhat J, Woods J & Shariff A 1999, *A Fine Balance: Some Options For Private and Public Health Care in Urban India*, The World Bank, Washington DC.

Singapore Ministry of Health 1993, *Affordable Health Care: A White Paper*, Singapore Ministerial Committee on Health Policy, <http://www.gov.sg/moh/mohiss/afhltcr.html>.