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THE ROLE OF THE PRIVATE AND THE PUBLIC SECTOR IN HEALTH CARE

This paper concentrates on only one question from among the wide range of themes concerning the roles and relations of the private and public sector, namely the probable economic and social effects of a possible fundamental change in the structure of funding of the Hungarian health system resulting from a radically increasing share of the private sector. By way of introduction it is necessary to briefly mention two issues. One is the radically different developmental tendencies between the health care systems in Western Europe and in the USA. The other, related matter concerns the main features of the health market.

International experiences are well illustrated by the example of Great Britain. From the beginning of the 1980s the Thatcher government's rhetoric concerning health care was dominated by privatisation and the market. The most emphasized of the concrete aims was to switch health care funding from the state budget to health insurance. This was not a new idea; an association of English doctors suggested the same in 1970. In their proposal compulsory insurance would cover only a small necessary part of the services. Other services would be available under private insurance. But when the time of real decision came in 1989, Mrs Thatcher decided not to change the previous funding system and the NHS continued to be financed out of general taxation. The reason was certainly the consensus among the government's advisers that financing through the state budget provided the best means of controlling and restricting health care expenditure. Similarly important was the fact that the National Health Service was still very popular and that most of the population was against the privatisation of health care services. What is more, the government also rejected the suggestion of tax relief for private insurance (more precisely tax relief was introduced only above the age of 65). The brochure about health care reform emphasizes that the NHS continues to provide universal access to health care free of charge. The government review, originally aiming to reform the system of financing, changed its direction suddenly and became engaged in reform of service delivery.

The English story illustrates several things simultaneously. It provides an example of the widespread notion that the difference between rhetoric and reality in the case of health policy can be even bigger than usual — partly because health care is one of the least understood spheres of society. But primarily it shows that in the mid-70s in the developed Western countries a sea-change took place in health policy and since this time the search for new ways has been on.

The expansive phase lasting till the mid-70s could be described by the spectacular growth in health expenditure and the inflow of public money to the health care sector. (At present in the Western European countries 70 – 90% of total health care expenditure come from public sources.) During the sixties and seventies universal access to health

care based on public financing actually became general in Western Europe (public financing means in some countries compulsory insurance, in others financing out of general taxation). The growth rate of Health Care expenses significantly exceeding (in most countries by 60–80%) economic growth obviously could not persist forever. The sudden turn, whereby containing health expenditure became the central issue of health policy (often displacing other issues), can be explained by the sudden cessation of economic growth at the beginning of the seventies.

One of the most important conclusions of the eighties is that with Western European health care systems based on public financing it proved possible to restrain the rate of growth in health care expenditure, and to make its share within national production (in GDP) stable. In contrast, the USA health care system, based on mainly private insurance, was not able to do this, in spite of the fact that the Number One goal of American health policy since the middle of the seventies has been to contain health care spending. (I add in brackets that about 40% of health expenditure in the USA is funded from the government budget.) The share of health expenditure in GDP has continued to grow in the eighties and at present is about 13% of GDP in the USA. (Among the developed countries the share of health expenditure is the highest in the USA, and its continuous growth even threatens the competitiveness of the economy.)

So basic economic arguments have supported maintaining the dominance of public financing in the Western European countries, among others in the case of the previously mentioned British example.

Experiences from the eighties show that in the Western European health care systems — because of dominance of public financing — the collective purchaser does have the power to influence the level of health expenditure through bargaining with suppliers (not only by influencing the prices but the supply as well). Processes in the USA show that the basic interest of the private insurance companies is to select the 'low risk', and to deter the 'high risk' with direct or indirect (high price) instruments. Private insurance companies are in competition for market share, so they do not act together against the suppliers. They usually pass on service price increases to patients and employers. Some data to illustrate the problem: in 1964 in the USA the amount of health insurance premiums paid by the employers compared to their post-tax profit was 14%, while in 1987 it was 94%. (To understand this data one should know that health insurance premiums are included in production costs.) 22% of health expenditure went towards the administrative costs of private insurance.

Today in Hungary no one actor of the health care system is satisfied with the present condition of health insurance — with good reasons. Many people think that the spread of private insurance would be the answer. Although alternatives — in their economic and social consequences — concerning the roles and relations of private and public financing have not been adequately clarified. However, as a result of short-term decisions, the choice between the following two directions will probably take place without properly elucidating their implications:

a) One of the possibilities is a health care system based on basically public financing (through compulsory insurance and partly the state budget), and on the other hand

service provision based on institutions mainly owned by local governments and non-profit organizations. In this system private insurance and for-profit institutions have only a complementary or marginal role. (This is typical of Western European health care systems.)

b) The other possibility is that public financing would be steadily reduced to provide only a limited package of services covering mainly the elderly and the poor (similarly to the health care system in the USA). On the other hand private financing, that is the proportion of private insurance would radically grow.

Both directions imply a pluralistic health care system, implying the coexistence of public and private institutions, and of public and private funding. At the same time the two directions radically differ. One important difference is that in the first case private insurance plays only a complementary role while in the second case it is an alternative to compulsory insurance.

Clarifying the notion of compulsory and private insurance is necessary. With compulsory insurance it is the law that determines how and in what proportion individuals and employers have to contribute to the financial base of health insurance and what services are provided by such compulsory insurance. Compulsory insurance does not mean that it must be organized by only one centralized governmental institution. Its institutional system can be decentralized and can be organized by non-profit private institutions. As a source of revenue VAT could play a more important role, which would make it possible to reduce insurance contributions. In this I concur with the suggestion introduced, among others, by Sándor Kopácsi and István Kemény.

The usual arguments for the significant role of private insurance are the possibility of free choice, more flexible accommodation to needs and greater efficiency, while the usual counter arguments are the fragmentation of health care and the institutionalization of a 'two-tier' system. Both sides are right in certain points, but neither considers some basic questions. In the following I would like to outline what might be the results if a major shift were made toward private financing, such that only a small part of the services would be covered by compulsory insurance.

The change would probably bring several transitional advantages, e.g., insurance contributions could be reduced, which would be positive for entrepreneurs and employers for a short time. It would support the position of the state budget by reducing both the amount of compulsory health insurance expenditure and its deficit as well. The question is what negative effects would be countering these short term advantages. Most probably the dominant form of private insurance would be group insurance, which would mainly be bound to the workplace, that is, the employer would be its main purchaser. Dominance of private insurance would firstly mean that the determining position of the collective purchaser (that of compulsory insurance) in the health labour market and in the market of services would disappear. As a result, the market prices of services and doctors fees could continuously rise. Insurance companies could pass the growing prices on to their customers, i.e., mainly to the employers, by raising the insurance fee. The growth of the insurance fee would mean an increase in labour costs. Very soon would the problem appear that the amount — in this case the private insurance fee and not the compulsory

insurance contribution — paid for health insurance is too high for both employers and the economy.

A significant consequence of the above change would be the disappearance of the collective purchaser who could be a counter power against the suppliers. Interests and the mechanisms preventing the possibility of cost containment would be institutionalized. In Hungary, paradoxically, employers and certain governmental forces are the main supporters of the formation of a system which, in the long run, would harm mainly their own interests, by initiating such structural changes which make health expenditure impossible to contain and control. When considering a suggestion for a major shift toward private financing, short term interests dominate (again) and long term structural effects are neglected (as usual).

Under a system envisaged in the second scenario the better-off, since they would be properly supplied with private insurance, would not really support an expansion of resources for compulsory insurance. The limited total budget of compulsory insurance and the growing prices of services would lead to a reduction of quantity and/or quality of the services. Compulsory insurance would cover mainly the old and the poor. In addition to the fact that these strata would not have access to services above the compulsory minimum, the quality of the actual services provided by compulsory insurance would increasingly fall below that of the services available in the case of private insurance.

So it would depend on the workplace as to what kind of insurance an individual had (and whether he/she had one at all). Obviously with many jobs employers would not provide health insurance. With this system also the employer has the 'privilege' of choosing between the different insurance schemes, that is to determine the range of services. Those social groups would remain without insurance (or would end up in worse circumstances) whose health is generally poorer, and so who are in the greatest need of good health care.

A 'logical consequence' of a switch to a system based on private insurance would be a fragmented health care system with serious inequalities. Such a system in many cases — mainly with patients suffering from chronic diseases — would cause difficulties in other fields of life as well. It would restrict, for example, the possibility of changing jobs, hence private insurance companies usually do not offer (or only at a prohibitively high price) a new insurance scheme for an individual with chronic illness.

I emphasize that the problem is not whether inequalities would come into being, as they already exist, since the state-socialist health care system had great social and regional inequalities. The real question is whether inequalities would grow and become institutionalized or whether structures can be created which do not hinder (or may even help) the reduction of inequalities.

On the other hand, it is important in our differentiated and further differentiating society to create institutions which allow the rich to obtain the conditions and services which cannot be supplied by compulsory insurance. Experiences in the Western European countries show that this function can be fulfilled by a complementary private

insurance system functioning alongside comprehensive compulsory insurance (or a national health service).

The other scenario, the dominance of public financing is not free from tension either. The difference is that it has other tensions and other social consequences. The present critical state of the Hungarian health system can be described by the intensification of three serious conflicts:

a) a growing gap between needs deriving from the dramatically deteriorating health of the population and the structure and quality of the available services; as well as between consumer demands, expectations and the services provided;

b) a great difference between existing capacities (the number of doctors and hospital beds) and the available financial resources. In other words, between what the proper operation of the existing capacities would require and the actually available financial resources;

c) a growing tension between health expenditure and the income-generating capacity of the economy.

These three conflicts are closely related. One of the most difficult challenges for decision makers is that if health policy aims to solve any of these three conflicts on its own, then the other two will grow greater. No realistic possibility can yet be envisaged for solving all three together.

The choice between the two long-term directions outlined here mainly depends on the willingness of the better-off to maintain solidarity with the poor strata who mostly bear the burden of economic transition. Furthermore, it also depends on what the policy-making elite thinks about the questions of whether health and health care service are basic human rights, and whether society has to recognise social rights and if so what kind of rights. From this point of view experiences of the last two years do not provide grounds for much hope. No attention has focussed on, and no real objection was raised by the fact that the entitlement to compulsory insurance was defined in a way that certain — the most needy — strata were excluded. The question is whether in the present economic and political climate there is a real choice between the two outlined health care systems or whether we are inevitably drifting towards the second direction.

So far we have been talking about financing. Considering the roles of the private and public sector it is of fundamental importance to distinguish between the sphere of financing and that of service delivery. The dominance of public funding does not exclude the possibility of the dominance of private institutions on the service side, or a combination of private suppliers and institutions owned by local governments. In reality, in most West European countries the state has intervened into health care mainly as a purchaser (third-party payer) while the service sphere remained mainly unchanged (depending on the individual histories of the countries, private institutions or the local authorities play the dominant role). A typical example of the coexistence of public financing and private provision of service is Canada where everyone is entitled to compulsory insurance and most of the institutions are non-profit private ones.

One of the main features of the present West European reform tendencies is a compromise between the 'social' and 'market' approaches — maintaining public financing while encouraging competition between service providers.

In the Hungarian health care system, maintaining the dominance of public funding and at the same time increasing the competition between providers of services, together with privatisation can increase the cost-consciousness of suppliers and their efficiency and responsiveness to consumer demand. In the broad meaning of privatisation I include hospitals at present owned by local governments being transformed into rented non-profit private hospitals as well as management agreements concerning only their operation. Well considered privatisation could improve the efficiency of Hungarian health care. That is why it is very unfortunate that the 'family doctor' system was introduced without making all general practitioners self-employed, private enterpreneurs (together with the proper economic and legal conditions).

One of the main question-marks in connection with privatisation is that if it happens without a growth of resources, it would produce results contrary to expectations. A consequence of privatisation would be that in the labour market the monopoly position of the state disappears which could increase the costs of health personnel. What is more, competition between suppliers is not a 'price-competition' but takes place mostly by applying new technologies which can be a further factor increasing the costs of services. If on the other hand strict limitation of total expenditure on health care is the ruling factor, an increase in costs can result in a decrease in the quality and/or quantity of services. So opposite effects can take place: supporting market factors, in certain circumstances, can result in deterioration of the quality of services.

I have tried to draw attention to matters which are usually overlooked in ideological debates about the role of the public and the private sector. But, finally, I would like to emphasize one further basic question: who defines what the proportion of the private and the public sector should be? Theoretically there are three possibilities: spontaneous processes, central orders, and decision-making mechanisms based on the reconciliation of the interests of the main actors of the health care system. So far spontaneous processes have dominated the transformation of the health care system. The 'results' of this are reflected, for example, in the chaos surrounding the general practitioner system and the insurance card, though these are only symptoms of conceptional confusion and the lack of consensus. Consensus is needed not only because of economic points of view or the basis of health care reform. The increase in poverty, unemployment and insecurity affects the conditions of health of wide social groups. Their exclusion from health care (or from most of it) can cause deterioration of physical and mental health to such extent that it becomes impossible for them to return to work or to the labour market. One issue of consensus is whether the emerging new health care system will increase the unequal division of the burdens of the economic transition or, on the contrary, it will become one of those (few) social institutions trying to prevent the growth in inequalities.