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FINANCING THE HEALTH CARE SYSTEM: IS PRIVATE FINANCING AN ALTERNATIVE?

BRIAN NOLAN



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BRIAN NOLAN

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GENERAL SUMMARY

Introduction

The appropriate method of financing the health care system is currently the subject of debate in many developed countries, in the face of an explosion in costs and apparently insatiable demand. The primary objective of the paper is to critically examine one widely-discussed option, which is to rely on *private* funding as the dominant means of financing. Some important issues with respect to financing in the context of systems which are instead dominated by the State are also discussed. While the arguments are dealt with at a general level, they have immediate relevance to the direction in which the Irish health services should develop.

The Case for Private Financing

The main arguments in favour of private financing as the dominant means of funding the health care system appear to be that the consumers of care have control over both the total amount spent and its allocation between providers of care. This, it is argued, maximises competition between providers leading to greater efficiency and control of costs.

It is acknowledged by proponents of such a system that *insurance* is an integral part of a privately-financed system, given the unpredictability of the incidence of the substantial costs which may be associated with illness. Gaps in insurance cover may therefore be a problem, and the need for a limited degree of State intervention is generally accepted. Such a private insurance-based system would, it is argued, avoid the problems inherent in a State-dominated system, of little or no scope for competition, lack of responsiveness to consumer demands, and in some variants a tendency towards under-funding.

The Case Against Private Financing

In critically examining these arguments, the paper suggests that the health care area is inherently unsuitable for the application of the private insurance model. Gaps in coverage may be extremely serious, notably for those on low incomes or those who have a pre-existing illness or are in a high-risk group. Limited State intervention to deal with such groups within a private insurance-based system is likely to result either in critical problems in defining groups to be subsidised, or acceptance of some remaining gaps in coverage.

The other key weakness of private insurance as the main method for funding

health care is the ability to control costs. So-called “third-party payers” problems arise because the “claimant”, without the knowledge of the insurer, is able to affect the size of the claim. Combined with the most common arrangements for remunerating suppliers, on a fee per-service basis, this means that both patient and doctor can act as though health care were free: neither has an incentive to control costs. This tendency is accentuated by the many obstacles to competition on the supply side of the market, between health care providers. As a result, private expenditure on health care has increased very rapidly in the US where private insurance funding is particularly important.

Modified Private Insurance Systems

This cost explosion has led to the development of some modified forms of private insurance, which attempt to alter the traditional systems of delivery of care and payment to providers. In particular, Health Maintenance Organisations (HMOs) accept responsibility for providing comprehensive health care services to the client population for a fixed payment in advance, with a range of methods of remuneration for medical professionals. While these organisations have succeeded in altering incentives to providers of care in a manner which improves cost consciousness, these incentives may also lead to an under-provision of care. In addition, the problems of gaps in coverage remain.

Financing Issues for Predominantly State-Funded Health Care Systems

The paper evaluates the arguments with respect to a number of key financing issues facing health-care systems largely financed by the State. The first is whether raising revenue through a State National Insurance scheme is preferable to financing out of general taxation. It concludes that the advantages of the National Insurance method remain to be proven, while there are disadvantages in terms of the tax base on which contributions are generally levied.

Proposals for financing health care through earmarked taxes and for setting a target level of expenditure as a proportion of national income are also discussed. The paper argues that the particular nature of health-care expenditure is not in itself a sufficient justification for tying the hands of the Exchequer in such a manner.

The contribution which ancillary fund-raising mechanisms, in particular lotteries, might make is examined. While a variety of fund-raising schemes may have their place as supplementary sources of funds, lotteries have a number of disadvantages – generally drawing revenue disproportionately from lower income groups, having an unpredictable yield, and perhaps adversely affecting voluntary activities.

The appropriate role of private insurance within a largely State-funded health care system is one of the most complex and contentious of financing issues. A number of distinct questions arise. Providing additional non-clinical facilities within the State system to privately-insured patients appears a legitimate means

of generating extra revenue, provided of course that the amount charged in fact exceeds the costs. The provision of clinical facilities on such a basis, though, leads to more fundamental questions in terms of equity of access and of quality of treatment.

If private insurance has a role within a State-dominated system, should the State encourage such insurance, for example by tax relief or allowing opting out? Here the extent to which the State itself essentially provides full entitlement to all — as it does in the UK — is obviously a key factor. Where such State entitlement does exist, there appears little justification for encouraging private insurance via tax relief. Even where full cover is not provided by the State, it is questionable whether tax relief is the best method of contributing to the health care expenses of those without full State entitlement. Allowing those who take out private insurance to “opt out” of the State system entirely and on that basis reclaim a proportion of tax paid would result in the State system forgoing substantial revenue while having to provide cover to the less healthy and poorer groups in the population.

Applying user charges for health care is often proposed as both a source of extra revenue and as an incentive towards “responsible” utilisation, in contrast with services free at the point of delivery where over-utilisation may be a problem. Such charges, if carefully structured, may help to channel patients towards appropriate treatment and reduce waste, but applied universally they run the risk of discouraging lower income groups, who may need care most, from obtaining care.

Conclusions

Having examined the case for private funding as the dominant means of financing the health care system, major problems with such an approach have been pointed out. These relate particularly to gaps in coverage and to the inherent difficulty in controlling expenditure. Even with the modifications to the pure private model which have been discussed, it is concluded that predominantly private modes of financing still have very serious weaknesses and do not represent a desirable direction for development.

As far as predominantly State-funded systems are concerned, suggested alternatives to general taxation as the major source of revenue do not appear attractive. The role of private insurance within such State-dominated systems, especially the availability of additional clinical facilities to those who are in a position to pay extra, is particularly contentious. It is clear that in many ways it is not so much the method of financing as the organisation of the delivery of health care and the incentives facing providers of care which are central to the control of costs and the achievement of efficiency.

Chapter 1

INTRODUCTION

A very rapid rise in the costs of health care has been the common experience of many Western countries in recent years. In the on-going and often heated debate about methods of dealing with this cost explosion, the case is frequently put for a reduction in the role of the State in the health area, an opening-up to market forces, and reliance on private funding as the dominant means of financing the health system. This paper critically examines the economic arguments on which the case for relying on private financing rests. While the objective of the paper is to address the issues of health care financing in a general setting, rather than in the specific context of the Irish system as it currently exists, the conclusions have direct relevance to present Irish health policy concerns.

Chapter 2 begins by setting out the case for private funding as a means of dealing with the problems of health care financing. Chapter 3 outlines the major problems inherent in any such system. Possible modifications to the pure private funding model which attempt to take these into account are discussed in Chapter 4. Chapter 5 then discusses some important issues, including the role of private financing, which arise within the context of a financing system dominated by the State in some form. Chapter 6 brings together the main conclusions.

The paper concentrates largely on the financing rather than the delivery of health services, though it is not always possible to separate the two completely. The arguments discussed are for the most part economic and focus on the efficiency aspects of the system, though, in concluding, reference is also made to the ideological, ethical and distributional concerns which are of such importance in this area.

Chapter 2

THE CASE FOR PRIVATE FINANCING

2.1 The Case for Markets

Proponents of a primarily privately-financed health system tend to regard its advantages as rather obvious, and state them only at a very general level. The key elements of the case for private financing are indeed quite general, based on standard economic arguments for the efficiency of markets.

In the health context, it is argued (see, for example, Green, 1988) that private funding would:

1. allow patients to decide the amount they are willing to spend, and thus permit *total expenditure* to be determined directly by consumers' wishes (rather than by, for example, a combination of administrative and political decisions);
2. allow patients to choose between providers of health care, thereby promoting competition between providers, producing efficiency and controlling costs.

The market, it is argued, is the most efficient way for consumers to gain information and allocate their expenditure in such a way as to maximise their satisfaction. It is also the most efficient mechanism for signalling producers as to consumer "needs", leading them to allocate production optimally. Competition between providers will ensure that these needs are satisfied in a cost-effective manner.

2.2 The Role of Insurance

So far, the case is a quite general one, applying to health care or any other commodity. When the specifics of health care are introduced, certain modifications are required, as is recognised by proponents of private financing. First, because (a) there can be great uncertainty for an individual about the expected incidence of ill-health, and (b) the costs of health care may be very substantial, the costs of health care cannot merely be paid for "out of pocket" by individuals as required, in the way that, for example, food or clothing are purchased. The standard market response to such unpredictable and substantial

contingencies is for insurance to be taken out. Arguments for privately-funded health care systems are therefore almost always for *private insurance-based* systems.

Consumers thus choose first between a range of possible insurance schemes: the extent to which, having made this choice, they are then free to choose between providers would depend on the nature of the insurance scheme. At one extreme, the patient could be entirely free to choose between providers of medical care and then be reimbursed by the insurance company. At the other, under some variants of the Health Maintenance Organisations (HMO) model — a modification of the pure private funding model to be discussed in detail in Chapter 4 — consumers can obtain care only from the HMO's own providers.

Clearly there is a wide range of possibilities for consumer freedom within the private provision system. The assumption however would be that competition among providers will still be promoted despite the mediation of this insurance. Since the insurance companies are themselves competing, they will have to minimise costs/maximise benefits to consumers, and in doing so will enforce efficiency among providers of care. This could operate in a number of different ways. For example, the insurance company could either direct insured patients towards particular providers through allowing only its own "panel" to be used, or it could allow freedom of choice of provider but reimburse only to a set scale of expenditure per item/procedure, with any excess to be paid by the patient him/herself. In either case efficiency and cost effectiveness among providers are encouraged. (Modified private funding models such as the HMO are essentially methods of making these links between insurer and provider a great deal closer, as discussed below.)

The consumer would be expected to have a wide range of choice not just of insurance company, but of type and extent of insurance. Those who wish to obtain cover only for amounts over a ceiling, and those who want complete cover, will be catered for automatically as a response to market demand. If many consumers do not have complete cover but opt for cost-sharing in some form (e.g., "co-insurance", "co-payments", "deductibles") then this will also act to promote consumer awareness of the costs of treatment and encourage "shopping-around".

2.3 Gaps in the Insurance System

Most proponents of private insurance-financed health systems recognise two major problems with such systems:

- (1) Insurers will wish to select people who are currently in good health and least likely to fall ill. Under a pure private system, those who are already ill or who are particularly likely to become so (e.g., the elderly) — the people who are most likely to want insurance — may be unable to obtain insurance.

(2) Those on low incomes may not be able to afford insurance.

Various options for dealing with each of these problems have been put forward. The State could simply pay an insurance premium to private insurers for those in either category.¹ The State could alternatively provide the health-care directly to these groups. A variant would be for the State to provide health care to the poor while insisting that insurance companies insure anyone who applied, at a “reasonable” premium. This would involve “open enrolment” — no one can be refused cover due to existing ill-health — plus controls over premium loadings for particular groups to prevent their being priced out of the market. (This could be done, for example, by setting premiums on the basis of average risk for a particular area — “Community Rating” — rather than on the basis of individual risk.)

2.4 Disadvantages of Alternative Systems from the Market Perspective

Proponents of private insurance-financed systems argue that while tax-funded systems along the UK National Health Service (NHS) model can effectively control overall expenditure on health, they do so by setting arbitrary expenditure ceilings in a way which does nothing to promote efficiency. Indeed, some would argue that the NHS-type model has an inherent underfunding problem (Green, 1988), in addition to no or inadequate scope for competition and lack of responsiveness to “customer demands”.

Some State-financed systems operate not through direct tax financing but rather through national insurance schemes with contributions being deducted from earnings and credited to a State supported fund. Proponents of private financing argue that in practice, where these operate, governments have rarely had the discipline to confine health spending to the income raised from contributions. Further funds have been allocated from general taxation, and governments have become involved in detailed control and regulations of providers in a way which has frustrated competitive forces without preventing rapid increases in costs.

1. It would presumably be argued that the appropriate premium for the high-risk individuals in category 1 would then be a matter for negotiation between the State and the companies but competition between the companies should allow the State to drive a “reasonable” bargain.

Chapter 3

THE CASE AGAINST PRIVATE FINANCING

3.1 Introduction

The case against private financing as the dominant means of funding the health services has a number of different strands. Some of these are based not on economic arguments but on ethical or value judgements about the nature of the health service produced by different funding methods. Such perspectives cannot be ignored in considering health care—indeed it is because health care is “different” that gaps in coverage are widely (though not universally) considered to be a problem in the first place. We may be unwilling to accept the consequences of some individuals being denied care — even if through their own failure to insure themselves. Health care is thus a “merit good”, too important to allow individuals pay the penalty for — in this example — their own myopia, or to allow the market to exclude certain categories. While taking this starting point as given, here we will concentrate primarily on the economic issues, attempting to distinguish the various elements in the critique of private financing, which are often presented in a somewhat confusing amalgam.

3.2 Private Financing Abstracting from Insurance

It may be helpful to begin by ignoring the “complications” introduced by the fact that intermediation by insurance is a central component of private financing, and consider the market for health care with only consumers and providers. In this case, the pure “consumer sovereignty”/“efficiency of the market” case breaks down because of critical features of both demand and supply sides of the market:

- (a) On the demand side, consumers do not have sufficient knowledge on which to base independent rational decisions about the nature of their health problems and the care required. When choosing between providers, when assessing their advice and deciding on further action, and even when considering the quality of the care received, patients have insufficient information and expertise to make independent choices. Thus they are dependent on expert advice *from the providers* of care, because there is a critical asymmetry of information between consumers and providers (see Arrow, 1963; Culyer, 1971).

- (b) On the supply side, there are significant departures from the conditions necessary for perfect competition to operate. Partly as a response to the consumer's lack of knowledge and therefore the need for protection through regulation of health care providers, there are usually significant barriers to entry, often effectively controlled by medical professionals themselves. For the same reasons, professional codes of practice are established which also often have the effect of reducing competition — for example bans on advertising and discouragement of the “poaching” of patients and of price competition. Thus, competition between providers is stifled, market failure is inherent on the supply side.

Taken together, the weak position of the consumer *vis-a-vis* the provider and the limitations on competitions between providers lead to a situation where supply can induce its own demand (see Evans, 1974; and in McLachlan and Maynard, 1982). As put by Culyer (1976) in the context of the impact of increased supply on hospital waiting lists,

...the demand for care is mediated by doctors whose perception of need ... is what really decides whether a patient is admitted. Since doctors also control supply the usually convenient separation of resource allocation problems into a demand side and a supply side (the two blades of Alfred Marshall's “scissors”) ceases to be valid, for the factors affecting one side can be no longer be supposed to be independent of the factors affecting the other (p. 99)

Because of both demand and supply side factors, then, the consumer sovereignty/many competing providers model does not apply. As far as the supply side is concerned, the particular institutional arrangements in a country are critical in determining the degree to which there is competition between providers. Such arrangements cannot however get over the demand side imperfections and consequent absence of separation of demand from supplier decisions. It is important to emphasise that while consumers' lack of information and reliance on experts is obviously not confined to the area of health care, there is certainly a difference in degree if not in kind between health care decisions and other consumer decisions. There is little scope for learning by experience, often little useful information may be gleaned from other consumers, and the degree of technical complexity may be very high. Together with the importance of the decision — and the possible costs and irreversibility of a wrong decision — this means that consumers are much more reliant on (“at the mercy of”) experts, less able to make informed independent choices, than in other areas.

3.3 Private Financing with Insurance

If we now introduce the complication of insurance, and assume that all or almost all private financing is in fact channelled through private insurance companies, how does the picture change? The first point to be noted is that the health care area is in fact unsuitable for the pure insurance model in a number of respects (see Barr, 1987; Barr, Glennerster and Le Grand, 1988). As already noted, low-income groups may be unable to afford insurance but cannot be denied medical care, while those who have pre-existing medical problems or who are considered particularly likely to develop them may also not be able to obtain insurance. These gaps in coverage are one major obstacle facing private financing models. The second is that the "third party" payment problem can lead to exploding costs. We will discuss these problems in turn.

3.4 The Problem of the Poor

The problem of low-income groups is readily acknowledged by proponents of private insurance-based financing: while these groups cannot afford insurance, society may be unwilling to deprive them of medical care on this basis (unlike, for example, insurance for loss of property). The obvious solution from the market perspective is that the State pay insurance premia for such individuals, below a specified income cut-off, to private insurers. This could be done directly by transfer from the State to the insurer, or by the State providing vouchers to a particular value to the individuals who are then free to choose between insurers.

Various problems arise with these solutions to the problem of "the poor". First, how is the level of premium payable to be decided on? The State is either negotiating directly with the insurance industry (or taking tenders from individual companies) or deciding on the level of the value of the voucher to be paid to the individuals. The premia cannot merely be set on the basis of those applicable to similar age-sex groups above the poverty line — which have, we presume, been determined by the market — because the poor are known to experience more ill-health. If there is competition among many insurers then the overall expenditure by the State may be limited by such competition, but the pure market model of consumers deciding how much and where to spend on health no longer applies to a substantial share of the market. If we further relax the assumptions to take into account the possibility of collusion between insurers and/or domination of the market by one or a few large companies, then the situation may in fact emerge where for a substantial part of the health insurance market there is a monopoly buyer (the State) dealing with a monopoly or oligopoly of sellers.

At least at the level of theory with a perfectly competitive insurance industry, though, the problem of the poor may not be insurmountable to the proponents of private insurance financing. The other two problems mentioned above are arguably even more serious, though.

3.5 *Other Gaps in Coverage*

As also recognised by those who favour such a system, individuals who (a) have a pre-existing illness or (b) are considered particularly likely to require medical care may not be able to obtain insurance, certainly at a price that many can afford. As far as (a) is concerned, if the expenditure on health care for the known condition is predictable, then the "correct" price for insurance is just the same as this expenditure and there is no point in an individual wanting, or a company offering, such insurance. Even where the expenditure is not perfectly predictable the likelihood is that cover will not in practice be available. As far as (b) is concerned, those groups thought to be high-risk — for example the elderly — may be excluded from cover or, even if an actuarially-fair premium is available, this may be too high for many and they may *choose* to go uninsured.

Pre-existing illnesses or high risks which are known to both the "customer" and the insurer lead to problems of unavailability of cover: pre-existing illnesses or high risks known only to the customer lead to the classic difficulty, from the insurer's point of view, of "adverse selection" (see Barr, 1987). Private insurance can only operate optimally if those who are providing the insurance have as much information as those seeking it about the underlying risk involved, and can therefore calculate an actuarially fair premium. This may often not be the case with medical care: the individual may be able to conceal from the insurer existing or potential medical problems. Since these are the very individuals who will most want insurance, there is inherent "adverse selection" from the insurers' point of view, leading to underestimation of claims and therefore losses.² A monopoly insurer could offset losses from such cases by charging other individuals more than the "fair" price. In a competitive market, though, there will be an incentive for individual companies to offer cover at the lower, "correct" price to low risk groups, while what are seen as categories where adverse selections may be particularly likely may be excluded from cover altogether or effectively discouraged by price. (Not all persons with existing or known (to them) potential problems will fall into easily identifiable categories, of course, so there will still be a problem for insurers in correctly assessing risk.)

3.6 *Response to Gaps in Coverage*

So the problem of adverse selection and the rational response by insurers reinforces the already severe problem of gaps in coverage. The State will be expected to respond, to cater now for (a) the poor, (b) those with pre-existing medical problems, (c) actual high-risk groups, (d) groups thought by the insurance industry to be particularly prone to adverse selection, and (e) those who would, in the absence of compulsion, choose to remain uninsured: all of these categories

2. Assuming insurance is not mandatory, not all individuals in a particular category (e.g., age, sex) will obtain cover. Those who do have in fact a relatively higher risk than average, but to the insurer the group is homogenous. Thus the actual risk is underestimated.

— with clearly some scope for overlap between categories — would be likely to go uninsured in a pure private insurance model. The State response, again, could be to make private insurance mandatory and subsidise it wholly or partly for the individuals concerned, or to provide care directly to the uninsured.

In the former case, though, how is the State now to decide whose insurance to subsidise? Where only the poor were concerned, an income limit could be used — though this would clearly involve other distortions such as reinforcing “poverty traps”. But in the case of the other categories, defining the borderlines between those who will and will not be subsidised could be extremely complex. If all those who decline to take out insurance voluntarily are subsidised, obviously no one will do so: if some minimum level of cover is made mandatory for all those above the poverty line, the extent of the subsidy for different high-risk groups and the definition of these groups remain to be decided. Clearly broad categories such as the elderly can be easily defined: but beyond this, categorisation by either existing or potential medical problem would be extremely difficult.

Rather than attempting — by subsidisation, compulsion or both — to get private insurers to provide insurance for those who, in a pure private insurance market, would remain uninsured, the State could respond by itself paying for or providing health care for those who fall through the insurance net. Again, though, problems of categorisation arise. If the State pays or provides for anyone without private insurance, private insurance must offer something “extra”, in addition to the basic State provision, or no one will pay for it. The State could rather provide treatment for all, irrespective of whether they have insurance or not—which is essentially the NHS model in the UK — with private insurance again offering “extra”. In either case private insurance is then unlikely to be the dominant funding mechanism unless the State-provided care is very poor, in effect forcing people to take out insurance.

If State payment/provision is limited to certain categories, then once again the problems of definition and borderline loom large. Certain groups — for example low income families, the elderly, children — may be relatively easily designated and afforded State provision, and all others left to the private insurance market. This is likely to involve significant remaining gaps in the coverage of the State/private insurance systems, as shown by the US experience. In sum, gaps in coverage provided by the private insurance market are likely to be substantial, making significant State interventions necessary. This State involvement will then entail either providing support for anyone who remains uninsured by the private system, or attempting to define broad groups and accepting remaining gaps between the State and private financing systems.

3.7 Control of Costs and Private Insurance

We now turn to the other critical problem with private insurance, in addition to gaps in coverage, as the main method for funding health care: its ability to control costs. As we have seen, there are crucial market imperfections and failures

on both demand and supply side in the health care area, when considered purely as a private market. When insurance is introduced, how is the picture altered?

On the demand side, individuals are now choosing in the first place not between providers of medical care but between insurance companies/policies — choice between providers may or may not then be subject to limitation by the insurance company. Rather than “the price” of medical care being determined between consumers and providers, it is now determined primarily between insurance companies and providers. Insurance companies may be in a better position to overcome the information imperfections which handicap consumers in the health care market, and thus in a better position to make informed choices between providers. However, in assessing the likelihood that this would lead to effective control of expenditure on medical care, two crucial problems must be taken into account: (1) “third-party payment”, and (2) supply-side barriers to competition.

- (1) So-called “third-party payment” problems arise in insurance where it is possible for the claimant, without the knowledge of the insurance company, to affect the size of the costs being claimed for. In this instance, if treatment is paid in full by insurance and the provider is paid a fee for service, then both patient and doctor can act as though health care were free: neither has any incentive to minimise costs. This is likely to lead to excessive expenditure on health care and exploding costs. In an attempt to deal with this problem, various methods of sharing costs between insurer and consumer are possible — where the consumer is liable up to a certain ceiling or for a proportion of the costs. However these can only partially offset the tendency towards oversupply.
- (2) This tendency towards oversupply of medical services under the private insurance model depends not only on the incentives on the demand side, but also on the supply side. While insurance companies may be in a stronger bargaining position than “automatic consumers”, it is difficult to see that their presence in itself does much to remove the many obstacles to competition on the supply side which have already been outlined. For this reason, advocacy of private insurance *per se* does not, even at a theoretical level, appear to address the critical issues in health care provision and cost. These may in fact be not in the area of *financing* but in *delivery* — its organisation and systems of payment.

The rate of cost explosion in the health area in the US, where “third-party payers” dominate, has been particularly dramatic, with health care spending as a percentage of GNP rising from about 8.5 per cent in 1975 to about 11 per cent in 1987 (see OECD 1987; Prospective Payment Assessment Commission,

1988). Such problems have led to the development — again mostly in the US — of some modified forms of private insurance-based systems, which attempt to retain the insurance element but also alter the traditional systems of delivery of care and payment to providers. These will now be briefly considered.

Chapter 4

MODIFIED PRIVATE INSURANCE SYSTEMS

4.1 The HMO Model

The adaptation of private insurance to the particular features of health care delivery has seen the development of a number of variants of Health Maintenance Organisations (HMOs) (see Green, 1988; Enthoven, 1985 and Tussing, 1985 for example). The key feature of these organisations is that, for an agreed regular fee or premium, consumers are guaranteed health care by the organisation. The care may be provided by employees of the HMO itself or by independent doctors/hospitals under contract, but in either case the relationship between the insurer and provider is very much closer than when cover for health care expenditure is provided by an insurance company in the usual way. This, it is argued, enables HMOs to control costs by altering incentives to providers and provider behaviour, and by directing consumers towards particular providers. Competition between HMOs should ensure maximum effort on their part to meet consumer needs while controlling costs.

Where the providers are actually partners in the HMO, then they have a clear financial incentive to reduce costs since this will contribute to the profit in which they share. In the case where providers are employees, the organisation can still exercise tight control on provider behaviour. Even where some of the care is contracted out, the HMO, it is assumed, has the medical expertise and management systems to monitor and control the behaviour of providers – in terms of type and cost of treatment given – much more effectively than a traditional insurer. By contracting directly with providers, incentives to control costs of treatment can be passed on to these providers. With HMOs, thus, the “third-party payer” problem on the supply side is offset. As far as the consumer is concerned, cost sharing in various forms can be part of the contract with the HMO, thus working to offset the problem on the demand side (though this route is of course also available under the pure insurer model).

4.2 Key Problems with the HMO Model

Some experience has been gained over the past fifteen years or so of the operation of HMOs in the US, which helps in assessing their effectiveness. Before discussing this evidence, though, some likely problems at a theoretical level may be noted. First, the modification of the private insurance model by the

introduction of HMOs does nothing in itself to address the major problem presented by gaps in coverage. The HMOs should be just as reluctant as traditional insurers to take on those with pre-existing illnesses or in high-risk groups, since their profit is derived in just the same way from providing insurance: the fact that they are also involved in delivery of care is in this context irrelevant.

Secondly, while HMOs do alter incentives to providers in such a way as to promote cost control, precisely this feature also represents an incentive towards *under-provision* of care. Since the cost of all care provided will directly reduce profit, not only the minimisation of the cost of any given element of care but also of the extent of care provided will clearly be in the interests of the organisation.

The available evidence from the operation of HMOs in the US bears out the importance of these two problem areas (see Petchley, 1987). While the numbers covered by HMOs have grown rapidly, this has partly been through employers transferring their employee health insurance schemes to HMOs. In their marketing HMOs also appear to concentrate on enrolling such members. This means that HMO recruitment has been disproportionately of younger and healthier individuals — a factor that has to be taken into account in assessing their cost performance. Relatively low costs for those covered by HMOs may thus be at least partly achieved by shifting costs to other parts of the health care system — primarily the State. The same problems which arise when trying to buttress a private insurance-based model through State effort arise when considering methods of dealing with gaps in HMO coverage — either the State ends up with the high-risk/low income groups, HMO coverage is enforced and subsidised, or gaps are allowed to remain. If HMOs are compelled to cover high-risk groups, all the problems already discussed about how to decide who is to be subsidised and to what extent would remain.

The analysis of US experience also suggests that, in addition to covering relatively low-risk groups, HMOs have achieved cost reductions by reducing usage of health care services. (This has been one of the findings of a major RAND corporation research project on HMOs, described in, for example, Petchley, 1987.) This is clearly related to the relatively good health status of the membership group and may obviously represent either unnecessary or necessary care. Given the enormous difficulties in relating health care and health outcomes in any case, the two are very difficult to disentangle. It would appear, though, that while high income groups have not been adversely affected by reduced usage, this is not the case for poorer members. It is suggested that this is because low-income members are less well equipped to overcome the tendency towards under-provision than those in higher socio-economic groups. The HMOs may also tend to be more inaccessible geographically to poorer members (see Ware *et al.*, 1986; Petchley, 1987). These problems have indeed been recognised by some HMOs themselves, leading to internal regulation to try to prevent under-provision and to “outreach” programmes to poorer groups.

It is clear, then, that relying purely on market forces within the HMO framework is not possible because the incentive structure on which HMOs are based has this inherent bias towards under-provision. Nor can the argument that the customer is protected by his ability to "take his money elsewhere" be considered sufficient safeguard: it may be perfectly efficient from their own point of view for competing HMOs to all concentrate on higher income and low risk groups and to under-provide where possible. The minimum size of population necessary for competitive HMOs to operate profitably may also be quite large.

Chapter 5

ISSUES WITHIN A STATE-DOMINATED HEALTH FUNDING SYSTEM

5.1 *Introduction*

Major weaknesses in systems of health-care financing relying primarily on private funding have been outlined in Chapters 3 and 4. This has been based on an assessment primarily in terms of economic efficiency and ability to control costs, though taking as a starting-point the assumed societal value that individuals should not be deprived of health care through lack of resources. We now turn to some important and topical issues relating to funding which arise in the context of a system predominantly financed through the State.

We begin with a brief discussion of some of the problems facing State-dominated health financing systems. While solutions to many of these problems may not lie purely or even largely in the area of *financing*, on which this paper concentrates, the following important issues with respect to funding are considered:

- (i) Within a largely State-financed system, is a national insurance type of scheme preferable to pure tax financing?
- (ii) In a tax-funded State system, is there any argument for a “hypothecated” tax, i.e., a tax earmarked specifically for health funding?
- (iii) Should target levels for State expenditure on the health services — representing both target and ceiling — perhaps in terms of a proportion of GNP be adopted?
- (iv) What should be the role of ancillary fund-raising mechanisms such as lotteries?
- (v) What should be the role of private insurance and the relationship between State and private financing?
- (vi) What should be the role of user charges?

Rather than reaching hard-and-fast conclusions on all these issues, the objective will be to present and evaluate the key arguments in each case.

5.2 *Problems Facing State-Dominated Health Funding Systems*

The central problem currently facing State-dominated health funding systems is not peculiar to such systems. The control of costs in the face of ever-increasing demand and increasingly expensive medical technology has been the major preoccupation of health policy in developed economies irrespective of public/private mix over the past quarter century or so. Highly-centralised State-funded systems such as the NHS have in fact been relatively successful in controlling overall expenditure by the State on health care (see, OECD, 1987). However, even if total expenditure is kept under control — or perhaps especially if this is achieved—the problems of *allocation* and of *incentives* loom large.

Consumers of health care within a publicly-funded system will in general have limited scope for choosing to allocate resources toward a particular area of health care, and treatment will not be primarily allocated to particular consumers on the basis of their demand. This may however be seen as an advantage if we take the view that consumers are not best placed to make such choices because of lack of information. Welfare may in fact be maximised not by responsiveness to consumer preferences but by some alternative “objective” method of allocation on the basis of “need”. Even so, the problem remains that the procedures for allocation may not have build into them incentives towards efficient and cost-effective utilisation and treatment. Incentives facing consumers may lead to over-utilisation by some, if treatment is free or heavily subsidised at point of delivery. Producers may have little or no incentive — or perverse incentives — to keep costs under control, or behave optimally within a given budget constraint if such is imposed.

These problems, as discussed earlier, are not unique to publicly-funded systems and, we have argued, are not effectively tackled by alternative systems based primarily on private financing. Various methods for improving the incentives within publicly-funded systems are possible. Some involve enhancing scope for competition between providers—for example, in the UK there is currently lively interest in the possibility of developing an “internal market” in the NHS. This would involve encouraging district health authorities to “trade” services, to enable greater “production” of care within a given total budget for each district by reducing spare capacity and taking advantage of economies of scale (see, Enthoven, 1985, King’s Fund Institute, 1988). Another widely-canvassed development is the greater involvement of doctors in management and budgeting, so that the link between costs and treatment can be more fully taken into account in resource allocation. What is not clear at present, though, is precisely how such initiatives would alter the *incentives* facing health service managers and medical staff. Some form of performance-related remuneration would appear to be a vital element in providing such incentives towards greater efficiency.

These and other possibilities for improving efficiency in the delivery of health care fall outside the scope of the present paper. In the context of financing, though, the main emphasis tends to be on the relationships between methods of financing and the behaviour of *consumers* of health care. In the context of incentives towards excess utilisation, for example, user charges and earmarked taxes are put forward as possible influences on behaviour. The role of private health insurance, within a system largely financed by the State, is also particularly controversial. We now turn to these issues, dealing first with the question of national-insurance versus pure tax-funded models of State financing.

5.3 *National Insurance or Tax Funding*

It is argued that a national health insurance scheme run by the State, analogous to the social insurance schemes providing support during unemployment, sickness and retirement, is preferable to pure tax financing of health expenditure on a number of grounds. The central argument is that people would be able to identify the direct link between their contributions to this fund and State expenditure on health. Depending on the perspective from which the argument is being put, this is seen as likely to lead to either:

- (a) a greater willingness to pay contributions than to pay general taxation, making it easier to raise funds for the health service; or
- (b) a more binding constraint on health expenditure, keeping it in line with the willingness of contributors to increase their contributions, which will, in turn, be influenced by perceptions of how effectively the system is performing and what "value for money" is being provided.

It is also argued that, when the link between State health expenditure and their own contribution is made clear, people will better perceive the costs of providing health care and be more "responsible" in their utilisation than when the health care appears to be "free".

Finally, it is argued that a separate funding system for State health expenditure, outside of the general government revenue and expenditure system, would help to cushion the health services, provide greater stability and allow better management.

There is some survey evidence that many people express greater willingness to pay tax, or otherwise contribute, to fund health expenditure than other forms of State expenditure. Similarly, surveys have sometimes indicated a greater willingness to pay contributions to social insurance funds than general income taxes. However, the extent to which this actually influences behavioural responses to taxation is very much more difficult to assess. Even if the contribution paid is accurately distinguished from general taxes, the link between an individual's contribution and the overall level of expenditure may be obscured, and appears

unlikely for most people to be a major influence on either willingness to pay or utilisation.

The major disadvantage of national insurance (NI) type arrangements compared with tax funding is the base on which they are usually levied. Most often, NI contributions are levied on those in employment, as some proportion of earnings and often with a ceiling on the earnings level to which they apply. If the contribution is a fixed proportion at all income levels then the system of funding is obviously neither regressive nor progressive: if there is a ceiling, then it is regressive. Even if there is no ceiling and a number of contribution rates increasing with earnings is applied, the system is likely to be much less progressive than an ordinary income tax system levied on *all* income with a sliding rate scale. An income tax system clearly offers much greater *potential* for progressivity, and though this is often eroded in various ways in operation it is thus likely to be more closely related to ability to pay than NI contributions.

Thus, while NI-based health funding does operate in a number of countries, the advantages of such a funding arrangement compared with direct taxation are unproven, while in equity terms the base on which income tax is levied appears preferable.

5.4 "Earmarked" Taxes?

It is argued that, rather than paying for health care out of general revenue, funds raised for such purposes should be clearly identified through a "hypothecated" or "earmarked" tax — that is, the funds raised through a particular tax are pre-committed to health expenditure. Clearly national insurance contributions are one variant of this approach while other possibilities would be a particular indirect tax, or a specified element of income tax — a certain proportion of the standard rate or of the total funds raised, for example.

The advantages perceived for this type of "earmarking" are essentially the same as those already described in the context of the NI alternative — (a) the link between funds raised and health expenditure would be clearly seen and would influence willingness to pay and behaviour, and (b) the funding of the health services would be separated from the rest of the State revenue/expenditure system. We have already dealt with (a) and expressed some scepticism about the advantages in terms of "visibility".

As far as the cushioning of health funding from the rest of the State's operations is concerned, clearly this could have considerable benefits for the management of the health services. An element of stability in funding could be provided — though this would also depend on the precise form of the "earmarking" — allowing longer-term planning and providing a financing framework within which resources could be allocated. However, it is questionable, from the wider perspective of the public finances, whether health expenditure should be distinguished from other forms of public expenditure in this way. Removing a major element of expenditure from the direct control of the overall policy makers

would leave other areas to bear the entire burden of adjusting to either exogenous influences or desired policy changes in the overall revenue/expenditure balance. In any case, it is arguable that State expenditure on the health services should be decided through the political process in a similar manner to expenditure on, for example, social security or education, rather than treated as a quite distinct form of social expenditure: while it obviously has particular features, health care does not appear *a priori* to clearly deserve special consideration compared with other such State expenditures.

5.5 *Should Health Expenditure be Linked to National Income?*

It has been suggested, in the context of largely State-financed health systems, that the level of State expenditure on health should be linked explicitly to the level of national income — GNP or GDP. This, it is argued, would overcome (what some see as) the inherent tendency of highly centralised and tightly controlled State-financed systems of the NHS type towards under-funding. From a different perspective, reflecting the more usual international experience of unsustainable rates of increase in health expenditure, such a target level could also clearly operate as a ceiling, limiting State expenditure in the face of rapidly rising costs. (See for example the discussion in Institute of Health Services Management, 1988 and King's Fund Institute, 1988.)

Similar objections to those facing earmarked taxes may, however, be raised to this proposal. It is not clear that constraining the freedom of the Exchequer in respect of health expenditure either by earmarking or linking with GNP — and thus placing additional burdens of adjustment on other forms of spending — is justified by the special nature of the health sector. Health, it is argued in this context, is unique in that it is (a) costly, (b) important to the whole population, and (c) relevant for the whole of each person's life (Barr, Glennerster and Le Grand, 1988). Demand for health care also rises with income over time, so that a buoyant source of funding is required. However, rather than seeing these special features as justifying a general case for linking State expenditure explicitly to national income, they serve as arguments merely for some broad correspondence between income growth and the level of expenditure, *ceteris paribus*. The case for a specific link may be seen more as a product of particular circumstances such as the current situation in the UK, where it is a widespread perception that the State system is being under-funded.

5.6 *The Role of Ancillary Fund-Raising Mechanisms*

Within the context of State financing, a number of supplementary revenue raising mechanisms in addition to taxation/national insurance have been used or proposed in the health sector. User charges and private insurance raise wider issues and will be discussed separately below: first we focus on revenue-raising through lotteries and other voluntary methods. The advantages put forward for such methods are that they tap the general goodwill which exists specifically

towards the health area of State spending, and allow revenue to be raised with less "resistance" than general taxation. They may also allow people to become more involved and identify with their local health services.

As against this, though, there are major disadvantages with such mechanisms, in particular lotteries:

- (a) The funds raised by lotteries are in general drawn from lower income groups disproportionately relative to income.
- (b) The yield is unpredictable from period to period, and this impedes planning and stability.
- (c) Other voluntary activities — which it is considered *preferable* to leave to the voluntary sphere — may be adversely affected by the State's revenue raising through lotteries or related mechanisms.

These disadvantages appear considerably more substantive than the suggested advantages of such methods of fund raising. In addition, if the State is seen as providing health care for the community as an expression of social solidarity, it is arguably more appropriate that taxation be the source of revenue.

5.7 *The Role of Private Insurance*

The role of private insurance within a largely State-financed health care system has been keenly debated. In general, this is in the context of a situation where the State is closely involved in delivery as well as financing, so a purely private independent sector of provision can be distinguished from a sector dominated, if not wholly run, by the State. It is not the intention to fully cover this ground here — this would require at least a separate paper to itself — but a number of key issues and arguments will be presented. Some critical questions are:

- (a) What "extra" should private insurance (or indeed private resources in general) be able to "buy" within the State system of health-care provision?
 - (b) To what extent should the State encourage private insurance, through tax reliefs or otherwise?
 - (c) Should individuals be permitted to "opt out" of the State system, and what would the relationship of such individuals be to the system?
- We now take these questions in turn.

(a) "Buying Extra"

Within a system where there is full entitlement to health care provided by

the State to all individuals, the questions posed by "topping up" are relatively straightforward. Through private insurance or otherwise, to what extent should people be able to purchase either additional clinical services or better non-clinical conditions *within* the State system (i.e., not from private hospitals completely independent of the State)? Within a system of incomplete State provision — such as Ireland's — where entitlement to care differs across categories, the picture is somewhat more complex but the main arguments in principle remain.

As far as non-clinical services are concerned, it is a widespread practice within State health services to provide better "hotel" facilities at extra cost where desired. This is not acceptable to all: some regard such a two-tier standard within the State system as inequitable and argue that those who wish better conditions should be provided for outside that system. It is also frequently argued that the full cost of providing the higher standard — in terms of capital costs, for example — is often greater than the amount charged, leading to hidden subsidisation. The contrary argument, though, is that it is preferable for the State system to provide the extra facilities and earn the extra revenue from doing so — rather than lose the business to the private sector — and thus be able to use the additional funds to improve standards for all.

In order to be able to fully assess the financial implications for the State system, detailed information on (a) the "true" costs incurred in providing better conditions compared with the revenue raised, and (b) the responsiveness of consumers to price in this respect — i.e., the price elasticity (and indeed income elasticity) of demand, would ideally be available. This would enable the revenue raised minus the cost of provision of better facilities in the State sector to be compared to the savings to the system of not having to treat patients who would shift to the private sector if these facilities were not provided. At this level, the issue is an empirical one and will differ across countries. One universally applicable argument for provision of such facilities within the State sector, though, is that only if the more vocal and articulate consumers are kept within that sector will standards be kept up by consumer pressure, and the willingness of the better-off to support the system through taxation be maintained.

An even more contentious issue is the appropriateness of providing additional clinical facilities within the State sector to those who can afford them. In practice this generally means not more advanced technology or treatment—though this can arise — but higher-grade medical personnel and, most importantly, shorter waiting periods. Here the arguments appear particularly finely balanced. On the one hand, such provision could be considered contrary to the principle of treatment and access according to need rather than income, which is of fundamental importance in most State-financed systems. On the other hand, again the argument may be put that there is a demand for such services on the part of the better-off which will be satisfied outside the State system if not within it, and the extra revenue earned can be used for the benefit of the system as a whole. It is argued that if the State does not provide such extra clinical facilities,

then a two-tier system — private versus public — will be promoted: but the alternative may be two tiers *within* the State sector.

(b) Encouraging Private Insurance

It is commonly argued that the State should encourage private health insurance by tax reliefs on premia or by other mechanisms. Where the State is already providing full entitlement to all — as in the UK, for example — it is difficult to see the merit of this argument. In that context, the advantages of State subsidisation are generally put within the wider case for a move towards a private insurance-based system, away from a pure NHS model. This case has already been discussed in Chapter 3 above.

Where full cover is not provided for all by the State — as in Ireland — it is argued that the State will want to encourage those not fully covered to take out private insurance. This is desirable in order to minimise the extent of gaps in overall coverage — i.e., people who effectively are “uninsured” by either State or private systems. Such gaps are considered unacceptable, as already discussed, because health care expenses can be extremely high and it is a fundamental principle that care should not be denied on the basis of ability to pay.

It is questionable, though, whether tax relief on private health insurance is the best way to accomplish this objective. It raises interesting distributional issues, providing high-income groups with a greater incentive to take out insurance. It also does not achieve the objective of avoiding gaps in coverage, since some people will still choose to remain uninsured, despite fiscal incentives. Finally, it may be seen as State subsidisation of the higher tier in a two-tier system of care.

An alternative might be for the State to provide a core of “disaster relief” for calamitous expenses on medical care for those not fully covered by the State system who choose to be uninsured. Some would still choose to pay for private insurance, even without tax relief, while the remainder would have to pay for other medical expenses out of pocket. Clearly defining which expenses were and were not to be covered by the ‘disaster’ provision would pose difficulties: however, complete gaps in coverage would be avoided.

(c) “Opting Out”

Where the State in effect provides cover (full or partial) for medical care, should those who wish to take out private insurance be allowed to “claim back” their contributions to the financing of this State cover, to “opt out” of the State system entirely? The argument made is that by removing themselves from the State system such people are allowing a saving to be made, and should, therefore, be allowed to “pay for themselves” if they so wish rather than being asked to pay twice.

The main objection to this suggestion is that, harking back to the discussion of Chapter 3, it would produce “adverse selection” from the point of view of the State system. That is, those who opt out will be those who are best able

to obtain private insurance, i.e., those who are most healthy and those with high incomes. The State system will, therefore, forgo relatively high income tax payers with little saving in terms of health care provided, and be left with the less healthy and poorer groups in the population. A two-tier system would undoubtedly emerge. It is also obviously regressive in that the better-off benefit disproportionately from the rebate of tax.

5.8 *User Charges*

Two main arguments are made for user charges at point of delivery within a State-financed health care system:

- (a) They act as an incentive towards "responsible" utilisation whereas over-utilisation is likely where services are free at point of delivery;
- (b) They allow revenue to be raised through the health system to supplement taxation.

While revenue raised in this way may be a useful complement to other financing mechanisms, the problem with the incentives argument is that reducing utilisation is likely to have greatest impact on poorer groups who generally need care more. The savings made may in many cases be short term, leading perhaps to more serious problems for individuals at a later stage. It is, however, difficult to generalise: if charges are structured so as to promote access to primary care while discouraging unnecessary hospital-based care, for example, then discouragement of those who actually need care may be minimised. To assess a particular structure of charges, estimates of the responsiveness of demand for care of those at different income levels are needed and are usually tentative at best. In assessing the impact of charges, the pattern of private insurance cover obviously also needs to be taken into account: if cover is provided in full, including all charges, then those with insurance will not be affected by the incentives argument. This can lead to the paradoxical situation that the impact of charges on utilisation may be greatest on those who need care most, with little or none on those who are in less need of care.

What is critical, clearly, is the *level* of the charges — but this emphasises the inherent conflict between raising revenue and encouraging optimal utilisation. If nominal charges are imposed in a structured way designed to promote effective utilisation, then little revenue may be raised and the costs of administration and collection may be large relative to this revenue. If, however, charges are substantial, revenue may also be substantial but at the expense of discouraging desirable utilisation. More fundamentally, the principle of access to care on the basis of need rather than ability to pay is clearly violated, and selective State subsidy for low income groups in the context of such charges is likely to be considered necessary.

Chapter 6

CONCLUSIONS

Bringing together the main strands of the argument, the paper's primary objective has been to assess, at a general level, the case for private financing as the dominant means of funding health care. The main arguments in favour of such a system appear to be that both the total amount spent on health care and its allocation are under the control of the individual consumer. Thus, the range of choice and consumer satisfaction are likely to be maximised, while competition between providers will be promoted, leading to greater efficiency and cost control. It is acknowledged by proponents of such a system that private insurance will be an integral part, and that gaps in coverage can, therefore, be a problem. Various methods of overcoming this problem have been suggested, involving a limited degree of State intervention.

It has been argued here, though, that the problems posed by gaps in coverage are extremely serious, being produced by the inherent unsuitability of the health care area for the application of the private insurance model. The proposed State interventions are likely either to result in critical problems in attempting to define groups to be subsidised, or to leave significant gaps in coverage.

It was also emphasised that the private financing model is open to serious "third party payer" problems in the health area, leading to inherent difficulty in controlling costs. Modifications to the pure private financing model have been developed to attempt to cope with this, notably the Health Maintenance Organisation, of which there are a number of variants. It was pointed out though that the incentives towards controlling costs in such methods of health care financing and provision are closely associated with an incentive towards under-provision which may affect poorer groups particularly severely. It was therefore concluded that even with such modifications, predominantly private modes of financing still have very serious weaknesses and do not represent a desirable direction for development.

Turning to health care systems financed largely through the State, a number of key funding issues facing such systems were discussed. On some of these issues generalised arguments, abstracting from specific institutional and behavioural situations, do not provide much guidance. However, it was argued that:

- (i) The arguments in favour of a national insurance-type scheme of public funding rather than financing through general taxation do not appear particularly convincing;
- (ii) The particular nature of State expenditure on health care is not a sufficient reason to tie the hands of the Exchequer by earmarking specific taxes for that purpose or to set explicit target levels for expenditure as a proportion of national income;
- (iii) While ancillary fund-raising mechanisms in addition to taxation may have their place, State-run lotteries are not a desirable means of providing significant funding for the health services.
- (iv) The provision of additional non-clinical facilities within the State system to those willing to pay extra appears a legitimate means of raising revenue provided the full cost (including such elements as capital and manpower training costs) plus a profit margin is charged. The provision of clinical facilities on such a basis leads to more fundamental questions, especially of equity and the objectives of the State system.
- (v) Encouraging private health insurance through tax relief does not at a general level appear desirable.
- (vi) Direct user charges, if carefully structured, may have a role in reducing excess utilisation, though they run the risk of discouraging those who need health care most from obtaining such care.

In conclusion, two further points may be made. The first relates to the ideological or value-based arguments which play such a major role in the debate about health service financing. While private modes of financing may allow enhanced consumer choice and freedom, it is clear that, in general, the difference between high and low income groups in medical care received is also greater under such systems. Secondly, the debate on "solutions" to the problems facing health care systems has tended to focus on the method of financing. It is clear, however, that in many ways the organisation of the *delivery* of health care and the incentives facing providers of care are more central to the control of costs and achievement of efficiency.

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