

# Health System Reforms in Industrialized Democracies: An Emerging Paradigm

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**D**URING THE PAST DECADE, HEALTH CARE SYSTEM reform has emerged as a primary concern in industrialized democracies. Australia, Spain, Italy, and Germany introduced major systemic reforms during the 1980s and are now contemplating further change (Scheffler, Rossiter, and Rosa 1990; Hurst 1991; Commonwealth of Australia 1991; Deeble 1991; McClelland 1991; Organization for Economic Cooperation and Development 1992). The United Kingdom, the Netherlands, New Zealand, and Israel have recently proposed or launched health care system reforms (Netherlands Ministry of Health, Welfare and Cultural Affairs 1988; Her Majesty's Stationery Office 1989; State of Israel 1990; Chernichovsky 1991; Day and Klein 1991; Upton 1991). Sweden has also been experimenting with a variety of systemic changes (Twaddle and Hessler 1986; Saltman 1990), and major systemic reform was recently proposed in the United States (White House Domestic Policy Council 1993), but did not succeed in becoming law.

The proposed and implemented reforms differ according to their cultural, social, historical, and political circumstances, and they must take into account both the advantages afforded by existing institutions and political realities. Even so, the economic and organizational issues are the same everywhere: how to contain costs, increase efficiency, satisfy

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consumers and providers, achieve equity, and improve the quality of health care (Organization for Economic Cooperation and Development 1990; Hurst 1991; Kirkman-Liff 1994). The principles guiding the solutions are also common to all.

Indeed, despite the variety of health care systems in the different nations, a universal outline or paradigm for health care financing, organization, and management is evolving. This paradigm cuts across ideological (private versus public) lines and across conceptual (market versus centrally planned) frameworks, as it combines principles of public financing of health care with principles of market competition applied to the organization and management of its consumption and provision. This combination can be at times both conceptually and politically confusing because of the tendency to interpret “public” incorrectly to mean exclusive government involvement, and, similarly, “private” to mean privatization and commercialization.

In this article, I attempt to describe the universal principles and trends in the reform strategies that were developed to address the common issues in the health systems of industrialized democracies. In the first section, I present the background to the reforms of health care systems. In the second, I discuss the emerging paradigm—both its philosophy and its application to the financing, organization, and management of health care systems. I conclude by anticipating the major challenges facing health care systems that operate under the new framework.

## The Old Paradigm

Until recently, scholars and politicians classified health care systems in industrialized democracies along a continuum, ranging from the “private” or “market” (United States) approach at one extreme to the “public” or “state” (United Kingdom) approach at the other (e.g., Cullis and West 1985). This classification was based on a philosophical distinction rather than on a realistic one; no pure system of either kind has existed in either place. Community care in the United Kingdom has been provided mostly by private general practitioners (GPs), but under a public contract; the American system receives more than 40 percent of its financing from public sources.

Some basic features of these two extremes are outlined in table 1. Where health services and health insurance are treated as market goods,

TABLE 1  
Basic Characteristics of the Health Care Systems in the United States  
and the United Kingdom

Market/private-based: United States	Planned/public-based: United Kingdom
Health services and health insurance are market goods; demand is rationed through fees and various limits on private health insurance	Health care is a right; demand is rationed through supply by direct budgeting and management of providers
Fifteen percent of the population is uninsured or underinsured	"Insurance" is universal
Life expectancy at birth (1990) Males: 72.0 Females: 78.8	Life expectancy at birth (1989) Males: 72.8 Females: 78.5
Infant mortality (percent of live births in 1990): 0.91	Infant mortality (percent of live births in 1990): 0.79
Percent of GDP spent on health (1990): 12.1	Percent of GDP spent on health (1990): 6.2
Average annual growth percentage of health in GDP, 1980-90: 2.7	Average annual growth percentage of health in GDP, 1980-90: 0.7
Percent of public share in health expenditure (1990): 42	Percent of public share in health expenditure (1990): 84
Per capita annual spending in U.S. dollars (1990): \$2,566	Per capita annual spending in U.S. dollars (1990): \$972
Average annual growth percentage of per capita spending: 9.2	Average annual growth percentage of per capita spending: 7.4
Main mode of compensation for service: fee-for-service by third-party insurers and consumers	Main modes of compensation for service: capitation and state salaries
Controls/regulations Regulations of investment, mainly in hospitals Prospective payment mechanisms Manpower licensing	Controls/regulations Budgetary rationing
Issues Lack of access because of cost barriers, i.e., equity Rising costs "Social" macroinefficiency	Issues Queues (limiting access) Lack of responsiveness to consumers Internal or production inefficiency

Source: *Health Care Financing Review* (1992): tables 1, 2, 3, 19, 20, 25: pages 4, 5, 53, 55, 65.

as in the United States, demand is rationed either through fees and various limits on private health insurance or by willingness and ability to pay. Where health care is considered a right, as in the United Kingdom, demand is rationed through supply; the system is directly budgeted and sometimes managed by the state. Thus, in the United States, about 15 percent of the population remains uninsured or underinsured, whereas in the United Kingdom all citizens have access to a basic package of care.

Basic mortality statistics for the two systems indicate that the United Kingdom has a marginally healthier population than the United States. Yet the United Kingdom spends about 6.2 percent of its gross domestic product (GDP) on health, whereas the United States spent 12.1 percent in 1990 and has a considerably higher growth rate in spending. The public nature of the British system is reflected in the government's 84 percent share in national health care expenditure, compared with the 42 percent share spent by the U.S. government. Both systems have administrative mechanisms to control costs: the United Kingdom employs rationing; the United States controls cost by regulating investment (mainly in hospitals) and by imposing prospective payment mechanisms (capitation and diagnostic related groups [DRGs]), particularly on patients financed by the public.

The public and policy makers have been unhappy with both systems. Complaints range from a lack of equity and loss of control over the cost of care in countries with "market-oriented" systems, to the lack of responsiveness to consumers and inefficiency in provision or production of care in "state-oriented" systems. Reforms have endeavored to address these issues by combining the relative advantages of both systems.

## Realities and an Emerging Consensus

Realities and an apparent consensus on several fundamental health care issues—access to care, the role of health care, cost, responsiveness to consumers, and regulation of the health care system—are the basis of the emerging paradigm. Regarding access to care, the solidarity principle in health care stipulates "vertical equity"—different treatment of different individuals in the financing of care—and "horizontal equity"—equal treatment of equal individuals or equal need in the provision of care. This operational definition, used by Wagstaff and van Doorslaer (1992a,b), means that each citizen contributes according to ability while receiving

treatment according to need. Systems that probably best exemplify this principle are financed through progressive income taxes and provide individuals with universal access to a socially defined, usually minimal, package of care.

Among industrialized democracies, only the United States has yet to implement the solidarity principle. The United States does recognize, however, that the poor and the elderly are entitled to a care package through their Medicaid and Medicare programs. Nevertheless, based as it is on privately financed care and insurance, the American system denies about 15 percent of its population adequate access to care, despite the rise in medical expenditures to above 12 percent of the GDP, with public financing accounting for 42 percent of these expenditures (table 1).

In other industrialized democracies there is universal, or near universal, access to a basic package of state-regulated care. This is the case in Germany, France, and Japan, whose health care systems "share three major traits with the United States system:

- a. Medical care is provided by private physicians and by private and public hospitals, and patients have free choice of physicians.
- b. Most people receive health insurance coverage through their workplace.
- c. Health insurance is provided by multiple third-party insurers." (U.S. General Accounting Office 1991, 4)

Australia, Spain, Italy, and, recently, Israel, which previously had systems with traits similar to those in Germany, France, and Japan, have now opted for universal insurance administered by the state, so that their systems have come more closely to resemble those in the United Kingdom, Canada, New Zealand, and the Scandinavian countries, where the state is assumed to bear ultimate responsibility for health care, even when that care is provided through private institutions. Hence, although all health systems emphasize equity in health and medical care (McClelland 1991), this is no longer a paramount political issue in developed health care systems.

There is no clear evidence of a positive association between medical expenditure and health status in OECD countries, as is also suggested by the data presented in table 1 (Organization for Economic Cooperation and Development 1990). It is increasingly clear that health problems in modern industrialized societies can no longer be solved solely through

medical care, but rather by a combination of medical care and changes in lifestyle and environment (Contandriopoulos 1991). This realization has produced a shift in attitude toward medical care that has several major implications. First, allocation of public resources to health care must take into account factors that reach beyond medical care. Second, in the absence of a visible return in the form of generally improved health resulting from higher outlays on care, policy makers increasingly tend to see the rising expenditures on medical care as a transfer of income from the public sector to providers, that is, to those who have substantial power to control the level of these expenditures. Third, the role of expert opinion in operating health care systems has declined. What consumers think about resource allocation in health care has grown to be more important than the opinions of medical experts (Kim, Park, and Sohn 1993).

Regarding cost containment and efficiency, it is clear that during the last 20 years governments of all persuasions in industrialized democracies—whether overseeing a market-oriented system (as in the United States), a mixed system (as in Germany), or a public-oriented system (as in the United Kingdom and Sweden)—have been concerned with the rising costs of health care, both in absolute dollar terms and as a percentage of the GDP (Scheiber and Poullier 1988, 1989). Labor markets have suffered as pressure has mounted on employers to increase their contributions to employee health care. Increased expenditures on health have had an adverse effect on the competitiveness of developed economies in international markets, especially in conjunction with the declining economic growth of these economies during the 1970s and 1980s. In this regard, it appears that public-based systems may give more value for the money invested than private-based systems do (table 1); the former are also considered more equitable and better able to control costs. Moreover, it appears that the U.S. market-based systems may be financially unsustainable in the long term (U.S. General Accounting Office 1991).

Although difficult to establish, the assumption nevertheless exists that public operations are less efficient in the provision of care than private ones, and that public systems consume increasing shares of government subsidies (Culyer 1989). This apparent difference, between the so-called internal (micro) efficiency in the production of care and the market (macro) efficiency of the medical care sector at large, merits clarification. One must distinguish between the operations of the entire market and the individual enterprises that constitute it, and between

medical care and the achievement of health. Although private enterprises may have greater incentive to operate more efficiently than their public counterparts, the private system for health care generates monopolies (even at the level of individual provider), may prevent economies of scale, and imposes high information and transaction costs on the consumers, the insurers, and even the care providers. Ultimately, in private- and market-based systems, these costs can yield less value or output on a marketwide basis than in public-based systems. In addition, the free market system may generate more care for cost, but not necessarily more health, partly because technological medical advances in particular specialties do not necessarily prolong overall health and quality of life.

It is presumed that because of consumer ignorance and supplier-induced demand, society or the state is better able than its citizens as individuals to make informed choices about the overall levels of health expenditure and its allocation. Nonetheless, even in systems that are not dependent mainly upon government budgets for health care financing, but in which the government attempts to set overall expenditure targets, health care costs have remained unaffected; in the case of France, Germany, and Australia, spending has continued to increase (e.g., U.S. General Accounting Office 1991; Deeble 1991).

In the matter of responsiveness to clients, although public systems like those in the United Kingdom and Sweden tend to perform comparatively well in terms of equity and cost containment, consumers criticize centrally budgeted health care systems and subsystems (the public hospitals) for their lack of responsiveness, long waiting lists, delays in receiving specialists' attention, limited choice, and internal inefficiency in the production of care. A lack of incentives to improve efficiency, compounded by a lack of accountability—mainly to consumers—on the part of centralized bureaucracies results in consumer dissatisfaction (Enthoven 1989, 1991).

In the United States, consumer satisfaction has been less of an issue for those with access to paid or insured services. It has been of less concern in France and Germany—where providers in the community are paid mainly on a fee-for-service (FFS) basis—than in the United Kingdom—where providers are paid on a capitation basis or are salaried. Systems that rely on FFS to reimburse at least part of community care appear to yield greater consumer satisfaction than systems based on salaries or capitation schemes (Blendon et al. 1990). FFS systems facilitate consumer choice from among competing providers. However, this choice

is associated with rising expenditures for care because the state has been unable to control the volume of care even when fees are set (e.g., France, Germany, and Australia). Fee for service needs to be interpreted broadly in this case. Even in so-called closed insurance systems, usually health maintenance organizations (HMOs), where consumers can link their insurance premiums directly to service, consumers are demanding greater value for their money.

Consumer dissatisfaction can undermine public efforts to control costs and maintain equity. When consumers are dissatisfied with public systems, they create a demand for private care and stimulate the private market, which does not permit equal access to care and which charges higher fees for medical services without necessarily producing obvious improvements in health. Hence, consumer dissatisfaction in a public system may undermine the justification for the system.

As for health care regulation, no country in the world has a completely free market for health care because of fundamental market failures in this area (Arrow 1963). For example, the market-oriented systems of France, Germany, and Japan are extensively regulated (U.S. General Accounting Office 1991); even in the United States, the health care market is regulated, mainly through control of capital investment in hospitals, manpower licensing, and prospective payment mechanisms. Presupposing regulation of health care systems, the consensus breaks apart over the question of how it should be done (Evans 1983). Health care systems may be regulated through financial and structural channels, reimbursement mechanisms, or state directives. Most countries prefer to minimize directives in order to avoid the attendant risk of government "policing," opting instead for channels and mechanisms that tend to be self-sustaining approaches to regulation like those that may predominate under the emerging paradigm.

## The Emerging Paradigm

The paradigm emerging from this consensus offers technocratic rather than ideological solutions. It promotes system efficiency and consumer satisfaction rather than a particular doctrine. Consequently, it denotes efforts to combine the comparative advantages of public systems—equity and social (macro) efficiency—with the comparative advantages of com-



petitive, usually private, systems—consumer satisfaction and internal (micro) efficiency in the provision of care.

This paradigm is based on the fundamental principle that a citizen has a right to a socially guaranteed package of care. Key system functions are separated, at least conceptually, and consist of the following:

1. financing of care
2. organization and management of care consumption (OMCC) that is funded according to public finance principles
3. provision of care

The OMCC function that is most characteristic of the emerging paradigm concerns the range of choice and the nature of access to care made available to consumers. Hence, this function can deal primarily with the “packaging” of particular provisions for, or entitlements to, publicly financed care. Development of the distinct OMCC function can be viewed as a public effort to effect, preferably without direct government involvement, the organization and management of care provision for the benefit of both individual clients and the paying public. Institutions performing the OMCC function seek both to improve client satisfaction and to secure cost-effective care. Conceptually, the OMCC function can be linked to Enthoven’s “managed competition” whereby, within preset budgets, institutions rather than individuals purchase care from providers (Enthoven 1988). These institutions can be financed using public finance principles and, at the same time, purchasing care from competing providers.

Paying for care involves principles of public finance, without necessarily implying that funding derives only from general government revenues. Similarly, OMCC and provision of care utilize aspects of competition, like the resource allocation mechanism and the scope of consumer choice, without necessarily implying privatization, which refers to the ownership of assets and to the manner in which operational surpluses are distributed.

The emergence of the new paradigm from the old may be demonstrated by the movement and convergence of health systems toward the lower left box of figure 1. Financing is increasingly based upon public finance principles, whereas care provision is increasingly based upon competitive principles. The OMCC function facilitates this emerging paradigm, and its dynamic nature should be noted. Mainly during the 1980s,

Provision			
Competitive (possibly private)	Public		
United States		Competitive (private)	Finance
Germany Japan France Australia Netherlands Canada Italy Spain	Israel		
	United Kingdom	Scandinavia	Russia
		Public (principles)	

FIG. 1. Classification of systems by finance and provision functions.

systems have either moved into that position (e.g., Australia, Italy, Spain) or are in the process of doing so (e.g., United Kingdom, Netherlands, Israel).

The three system functions and the associations among them are illustrated in the right-hand panel of figure 2. Where there is complete separation of functions, transactions take place in two internal markets. In the first, OMCC institutions offer citizens different provision contracts for at least the "social package" or "minimal package" financed by the public. The latter group (*viz.*, the public) comprises the buyers; each citizen chooses an OMCC institution ("packager") and endorses to it the allotted public financing for his or her social entitlements. In the second internal market, OMCC institutions buy care on behalf of their constituencies from providers who sell the care.

The financing and OMCC functions may be institutionally integrated under the emerging paradigm. Similarly, the OMCC and care provision may be integrated. The three functions, however, cannot be combined; the financing and provision functions are always separate because different principles (public versus competitive) guide each function. Hence, at least one of the internal markets must exist. In contrast, under the old

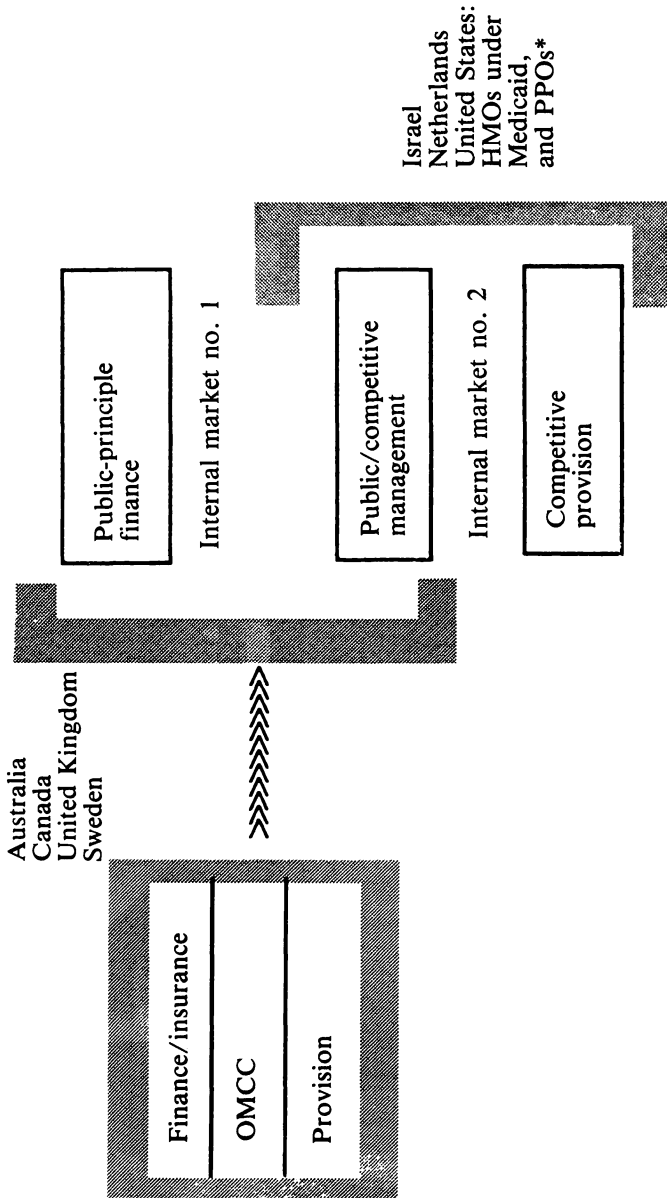


FIG. 2. Schematic design of emerging paradigm.

\*Examples exist within these systems (see text).

paradigm (represented by the left-hand panel of figure 2), all functions could be combined institutionally based on the same—either market or public—principles.

The integration of public finance and the OMCC function leads to publicly financed systems whose pattern of care consumption is organized and managed by public administrations that reimburse or budget the private and other free-standing institutions providing the entitled care to citizens. Examples of such systems can be found in Canada, the United Kingdom, and Sweden. The Medicaid and Medicare arrangements in the United States, which use free-standing providers of all kinds, conform to this type of system.

Integration of the OMCC and the provision function leads to institutions that organize and manage care for consumers while providing care as well—as in the case of an HMO, preferred provider organization (PPO), or the sick fund that is funded or reimbursed by the state in full or in part. Examples of these systems can be found in Israel, the Netherlands, and the United States.

## The Principle of Public Finance

Under the emerging paradigm, health care is financed according to public finance principles. This approach has two main objectives. The first is to provide universal access to a social package of care while still applying the solidarity principle. This principle, which implies paying according to means and receiving care according to need, can be applied only through a system of a public nature that can tax and subsidize. The second objective is to achieve social or macroefficiency, mainly through effective control of expenditure limits or “sitting on the (cost) lid” (Evans 1983, 34); expenditures can be best controlled through the state or a statelike budget. These objectives are supported by several additional features associated with public finance: nondiscriminatory (nonmonopolistic) subscriber selection, low administrative costs, and monopsony buying from providers.

Reform programs that have adopted public finance principles include the establishment of Medicare in Australia in 1984, the changes in the Spanish and Italian systems in the mid-1990s (Fausto 1990; Hurst 1991),

the 1994 Israeli national health insurance legislation (Chernichovsky 1991; Chernichovsky and Chinitz 1995), and the Dutch reform proposal (Netherlands Ministry of Health, Welfare and Cultural Affairs 1988). Alternatively, the government can set national expenditure targets, as France, Germany, and Japan have done. The same principles apply to the Medicare and Medicaid programs in the United States.

There are two basic ways to apply public finance principles to health care. The first, known as the “commonwealth” model (e.g., United Kingdom, Canada, Scandinavia, Italy, and Australia), uses tax-based general revenues. The second, called sometimes the “continental” model (in effect, Germany, France, and Japan), relies on social insurance run by regulated insurance companies or sick funds. These companies and funds may also perform OMCC and care provision functions.

In response to those who may be opposed to incorporating such companies or funds as part of the public finance system, it should be pointed out that—except for the United States—the “insurers” may be regarded as arms of the state. In most instances, enrollment in a scheme, payment of so-called premiums, and entitlement to a basic package are all state regulated and compulsory. Moreover, premiums are income based rather than risk based, and so-called insurers cannot turn away “bad risks.” The German and French systems best exemplify applications, albeit to different degrees and through different means, of public finance principles in the social insurance or continental model. In both countries, sick funds have been granted administrative freedom within a system of heavy government regulation. In France, the funds are in fact part of the social security system. In both cases, the governments attempt to exercise overall expenditure limits. Much the same holds for private insurers and quasi-public sick funds in diverse systems like those in Australia and Israel, respectively.

However, the two modes of applying the principle of public finance differ substantially in their political and economic implications. Social insurance is for most practical purposes a transparent “earmarked tax” on the income of individuals and on the payroll that is not directly associated with government taxation; in principle, this tax can be unequivocally identified with health expenditure. Working within the framework of government regulations, “insurance companies” and other nongovernmental organizations can raise “premiums” to finance care faster than the government can raise taxes and allocate them to health. The govern-

ment, however, can make contributions to social insurance as part of its fiscal outlay.

Social insurance often raises questions of efficiency and equity. In terms of efficiency, social insurance usually provides patchwork coverage and financing. Although many employees will be at least partially covered by their employers and unions (as in Germany, France, Austria, and Japan), other segments of the population—the unemployed and retired, the poor, rural populations, and at times employees' dependents—need alternative arrangements, which inevitably bring in the government and require some financing through general revenues. When social insurance spawns a multitude of collection and administration systems, overhead costs to the system increase. Evans (1990) points out that the costs of insurance and administration in 1987 were about 0.6 percent of the GNP in the United States and only 0.1 percent in Canada. Woolhandler and Himmelstein (1991) point out that administrative costs were 4 to 6 percent of total health spending in the United Kingdom, compared with 22 percent in the United States.

Regarding the employer's contribution, an interesting feature of the Israeli system is that, unlike most continental systems, employers in no way act as intermediaries between their employees and the insurers, sick funds, or providers. In Israel, employers, regardless of size, contribute to a public pool (with the National Insurance Institute) through a tax on the wage bill, rather than paying directly to insurers or providers. This arrangement provides employees with several important options unavailable in systems with direct employer-insurer-provider links. First, because their employers' contributions are not a priori worker- or insurer-specific, employees can choose any insurer-provider they wish. This arrangement also promotes competition among OMCC institutions in the first internal market and between providers in the second internal market; care is thus organized and provided without links to particular employers. Second, employers' contributions can be pooled with other resources and allocated according to a national policy within overall or national expenditure limits. In addition, through mandatory employer contributions that cannot take into account an employee's medical history, the system "frees" employers from having to consider health insurance costs or contributions while hiring particular individuals because their contributions are based on the wage bill rather than the employee's health (insurance) burden. Employees too do not need to form links with employers in order to obtain health benefits.

A system that includes numerous insurers can also be challenged on grounds of equity, especially when arrangements are made locally and the entitlements differ, as might be the case in Germany. This applies particularly to programs where individuals can “opt out” in order to insure themselves and thereby avoid contributing to the public or compulsory system; or alternatively, when households have tax benefits in lieu of private insurance and other health-related payments, as in the United States. For this reason, the Netherlands eliminated opting out, and Sweden cut out pertinent tax benefits in 1988. Challenges to the German system include finding ways to equalize premiums and benefits mandated under state regulation and eliminating the opting out of the very rich who are, in fact, exempt from supporting the “public” system. This can best be achieved when funds are centrally collected and distributed, which is the case when funds are raised through general revenues.

When applying public finance principles in federal systems, it may be necessary to pay particular attention to care that is financed by local sources or by tax bases with regional variations in both socioeconomic conditions and health status. Such cases may require that local or regional authorities work closely with federal or central authorities to eliminate regional inequalities in access. Attention must also be given to containing costs. Regional models and solutions that increase overall costs to the system tend to be discouraged, in part because the public may not tolerate regional disparities in access to care. Financial contributions from a central or federal government to a regional or local government or authority can enforce common policy that includes these objectives. Such an arrangement exists in Sweden, Canada, Australia, and in the U.S. Medicaid and Medicare programs. In Canada, for example, provinces that allow extra billing of patients, beyond local government payments, lose their entitlement to federal grants.

The trend in the emerging paradigm for organizing the financing of care points to efforts to achieve synthesis between the commonwealth (general revenues) and continental (social insurance) models. Although the synthesis reflects both the tradition and the political economy of particular situations, it also mirrors the philosophy guiding the emerging paradigm. For all of these reasons, there is a tendency to bring finance completely under public control, replacing the heavy regulatory frameworks that have evolved in financing health care in the continental-like models. At the same time, efforts continue to carry on the nonbudgetary, earmarked nature of financing, to maintain a multiplicity of sources

(mainly employers' contributions), to keep options open to new earmarked sources such as fees or other levies, and, not least, to retain the ability to pool all sources for public distribution.

The best current examples of this trend, from the perspective of the continental-like model where a change in health care finance is most needed, are the Dutch reform proposal and the recently passed Israeli health insurance legislation. "Alliances" would essentially pool mandatory ("public") funds for low-income beneficiaries, the unemployed, and some employed with private, mandatory "earmarked" contributions in one basic package. Although it is becoming a commonwealth model, Australia has kept some pertinent ambivalence in its health care financing; despite passage of a "nationalized" health financing law in 1984, it kept a "health levy" and retained a wide range of private insurance, heavily regulated in line with public finance principles (Altman and Jackson 1991; Chernichovsky 1994a).

An earmarked "health tax," whose revenues are pooled with employers' contributions where applicable, meets several objectives. First, a clear and direct link is established between the public's expectations and its financial support of the health system. This aids the political debate and process, including the setting of tax rates, by clearly revealing the link between health expenditure and the taxes financing it. Second, the financing of the system is based on taxes that are on a par with other taxes and, consequently, consistent with the equity principles and fiscal policy guiding public finance in the overall economy. Third, barring unexpected disasters, the system operates on a fixed budget. Fourth, there is no link between particular sources of finance and particular consumers and uses of the funds (e.g., employers and employees). This helps the system improve equity, set priorities, promote desired substitution among services, and make certain services (and populations) less vulnerable to fluctuations in particular sources of finance. Last, but not least, everyone who is liable for payment of income taxes also pays into the health system, and does so in the most cost-effective manner.

Economists and ministries of finance dislike earmarking, and with good reason: it restricts fiscal policy (McCleary 1991). However, they must keep in mind that, unlike most other public undertakings, health has other viable alternatives for financing: private insurance and direct out-of-pocket fees. There are worse alternatives from a macroeconomic perspective. When financing of care through general revenues is politically impossible or undesirable, earmarked taxes are the next best alter-



native. They may, in fact, be optimal for the reasons I have discussed above.

## Organization and Management of Care Consumption: Budget- or Fundholding

OMCC has evolved as a distinct function in the emerging paradigm: to help make services more responsive to clients and more efficient, yet governed by principles of public finance. To different degrees in the various systems, the OMCC function aims (1) to help “powerless and ignorant” citizens deal with both public administrations and providers, and (2) to help the public or government deal—not on an individual basis—with citizens’ aspirations and with regulated, but hard to control, providers. Consequently, this function minimizes the role of government wherever feasible and decreases the influence of providers, while increasing the power of consumers.

OMCC institutions are proving to be a systemic solution for the commonwealth and state-oriented models as well as for continental and market-oriented models. For the former, this solution means divesting the government of key systemic functions: OMCC and care provision. For the latter, it means taking advantage of established health insurance companies while introducing or fostering public finance principles. In both cases, the objectives are the same.

Indeed, competing nongovernmental OMCC institutions, operating in a public finance environment, have emerged in distinct health systems. They are the various HMOs that serve Medicare and Medicaid patients in the United States; the Israeli sick funds, which, beginning in 1995, will operate under a public budget (Chernichovsky and Chinitz 1995); the proposed Dutch sick funds (Netherlands Ministry of Health, Welfare and Cultural Affairs 1988); and the emerging British GP groups, which are budget holders (Glennerster et al. 1994).

Conceptually, the institutional separation of the OMCC and financing functions creates the first internal market (fig. 2), withdrawing the government from the organization and management of how citizens acquire their public care entitlements, relinquishing this function to OMCC institutions, which become “budget holders” and normally operate under capitation contracts (Chernichovsky 1994b). This separation aims to promote alternative, decentralized—yet not individualized—

access and provision models or “packages” of social benefits, while serving consumer groups with different (collective) demands. This also relieves the government from dealing with individual demands for access to care.

OMCC institutions that operate in the first market can assume any of the following forms:

1. HMO-type institutions of the kind that provide both primary and secondary care in their own facilities with salaried staff
2. HMO-type institutions that directly provide some or no care and contract for the remaining care
3. PPO-type institutions that primarily coordinate private, solo practices and medical institutions on behalf of their clients, but still leave individuals a wide range of choice for extra, direct out-of-pocket or insurance pay
4. GPs, or groups of GPs, who become budget holders controlling their clients’ entire health budget

Intermediate arrangements are also possible. The different types of OMCC institutions, rather than public administrations, are accountable directly to consumers, who choose among these institutions, and indirectly to the public or government (generically defined), which pays for care but does not make choices for individuals, or rather for groups of individuals.

The separation of OMCC and care provision functions establishes the second internal market, in which OMCC institutions may be buyers from competing providers: individual physicians, hospitals, clinics, or other types of providers. This removes the government from direct or indirect management of care provision. At the same time, it reduces the power of providers, who are accountable directly to OMCC institutions or to the consumer groups that contract care and indirectly to individual clients who choose OMCC institutions. Because OMCC institutions have the right to provide all or some care in their own facilities through salaried staff, they have the prerogative to submit to the second market in order to balance provision efficiency and consumer satisfaction.

Competing OMCC institutions that do not provide all care (e.g., the two internal markets exist) have some advantages over the alternative arrangements in terms of efficiency and quality of care. Working under capitation arrangements for the entire “package of care,” OMCC institutions assume part of the cost risk associated with care provision. As a re-

sult, they are inclined to organize and procure care in the most efficient manner possible. When contracting the entire package, including hospitalization and specialized services, to an OMCC institution, care becomes continuous, less expensive care is substituted for more expensive services, and cost shifting from one service to another is minimized. In addition, an OMCC institution can apply, in principle, monopsony power vis-à-vis providers, thereby serving cost-containment efforts.

By handling a defined population, OMCC institutions have an incentive to, and can, often better than governments, record and monitor outcomes and practices for their cost-effectiveness, efficiency, and quality of care and service. On the basis of such data, OMCC institutions can also develop alternative delivery mechanisms or models. Moreover, these institutions have incentives to invest in preventive care and health promotion, commonly public functions. It should be noted that such incentives often do not apply sufficiently to regular third-party insurers or providers.

Important policy issues regarding the organization and management of care are highlighted by comparison of the model without the first internal market—where the only OMCC institution is the regional administration—to the model with this market—where multiple OMCC institutions are competing, possibly interregional, entities. The provincial administrations in Canada and the local (district) health authorities in the United Kingdom and Sweden are examples of the first model. The American and Israeli “insurers,” HMOs, sick funds, and the like, which operate across regional borders, are examples of the second model.

The regional public administration is well suited to addressing local problems and to serving sparsely populated areas where the scope for competing OMCC institutions and providers is limited at the outset. This model may also be better suited to combat communicable diseases that require heavy outlays for preventive care and health promotion and that may be handled more efficiently by public administrations than by decentralized and private institutions. When the alternative exists, the major drawback of this model is that it tends to preclude experimentation with, and competition among, a variety of OMCC options, some more efficient and attractive to consumers than others. This model is also too heavily regulated to bring to bear issues that are beyond the control of the individual consumer, mainly those concerning need, quality of care, and cost. Inevitably, administrative systems tend to become bureaucratic and insensitive to the public. It should be noted that, even in

the Canadian and Australian public contract and public reimbursement models where consumers have ample choice, OMCC institutions would probably be more cost effective, would provide attractive packaging of preventive, primary, and secondary care, and would monitor quality better than existing arrangements through public administrations.

An interregional or population-based solution, comprising various competing nongovernmental OMCC institutions, is particularly suited for (a) sharing financial risk with public financing institutions; (b) exploiting economies of scale across boundaries; (c) centralizing the purchase of drugs, equipment, and supplies; (d) making national arrangements for highly specialized and expensive care involving national centers; and (e) promoting competition among OMCC institutions, even in small regions. This solution also helps to eliminate regional disparities by allowing patients in one region to select care and services from other regions. A national-scale or interregional OMCC institution can assume some of what are otherwise considered "state" functions. For example, in Israel, the General Sick Fund, which insures about 65 percent of the population, has its own hospitals and national centers of excellence, actively supports medical training, and includes central purchasing organs. To overcome some of the problems the public administration model aims to resolve, OMCC institutions handling lucrative areas could be regulated to handle less privileged areas, thereby transferring resources and technology across borders. This is a most important task that the local civil administration of a poor region cannot handle.

An issue may arise when public funds are allocated regionally while OMCC institutions are interregional. Although such institutions are able to promote equality, they also have the potential to distort the public regional allocation. However, national OMCC institutions that are regionally accountable cost centers can be prevented from shifting funding from one region to another in defiance of national health priorities. At the same time, the national nature of the OMCC institutions is preserved to capitalize on the advantages of large, nationally based entities. Yet, if OMCC institutions become too large, several drawbacks can emerge. A large institution might (a) interfere with setting national health policy, (b) become bureaucratic and too centralized, and (c) eventually encounter financial problems of national magnitude if they are not carefully monitored and regulated. This has been the unhappy legacy of the largest sick fund in Israel.

Under the current British reform, for example, two OMCC institutions are evolving. They are potentially competing and/or potentially complementary: the local district health authority (DHA) and the GP. The DHA is presumably more concerned than is the GP with environmental and other determinants of health and with preventive care. This situation probably best reflects the trade-off and (British) ambivalence about the two options in a given district.

## Provision of Care

Organization of the second market, where providers or producers sell care and where OMCC institutions buy or produce it for their constituencies, is paramount to attainment of the system's objectives, mainly those concerned with client satisfaction and cost control. Once the issues of equity and overall expenditure limits are settled to a substantial degree at the macro level, through revenues based on principles of public finance and (usually) a capitation-based allocation scheme, OMCC institutions need to balance, at the micro level, between efforts to stay cost-effective and contain costs and efforts to promote client satisfaction. Maintaining this balance, while also adhering to regulations concerning quality of care and equity, is the challenge facing OMCC institutions and the key to their success.

Client satisfaction appears closely linked to the range of choice offered to clients in an environment where competing providers are paid on an FFS basis (Blendon et al. 1990). In a paradigm with OMCC institutions, whether public administrations or free-standing and competing entities, such choice is best exemplified by the selection of providers offered to clients by public administrations and HMO-type institutions that do not provide care but contract with multiple providers on an FFS basis. When condoned, the range of choice is widened by mainly PPO-type institutions, which give clients—for extra insurance or out-of-pocket pay—care options in addition to those included in the public basket. Such arrangements, however, particularly the latter, may aggravate efforts to contain costs, to maintain equity, and even to monitor quality of care. These particular efforts are alleviated under a public administration or by “closed shop” HMOs operating both as OMCC institutions and as providers in their own facilities. Nevertheless, by limiting consumer choice

and working mainly with salaried staff, who may have limited incentives to serve, these fully integrated models—the public administration model in particular—may not be as conducive to client satisfaction.

Consequently, pressure to balance between efforts to contain costs and efforts to satisfy clients leads to the tendency (a) to decentralize horizontally the provision of care by having multiple providers in the community, (b) to integrate vertically preventive and primary care in the community, and (c) to decentralize or segregate vertically the ownership and management both of primary care and of more highly specialized, mainly hospital, care. The horizontal decentralization—which can lead to small provider units rather than to comparatively large community clinics and group practices—fosters pluralism, competition, and choice, all of which promote client satisfaction. Moreover, providers in small practices know their patients personally and are in a good position to make decisions on their behalf, which can further improve patient satisfaction.

Clinics or comparatively larger practices, however, have several advantages over small provider units, especially when working under capitation arrangements (Chernichovsky 1994b). First, the former can bear financial risk better than the latter and can reduce administration and overhead costs by sharing support staff and equipment. Consequently, clinics and larger practices are better equipped to save on costs, and hence may be less inclined to exercise adverse selection and cut patient care costs. Second, the larger operations also offer a wider range of services to clients, sometimes in place of expensive hospitalization away from home. Third, such practices can also provide better quality assurance through informal peer review. Fourth, they can offer flexible work arrangements, suiting both physicians (for example, vacations) and patients (for example, special receiving hours for working clients). Hence, the smaller and more numerous the providers, the greater may be the need for specialized management institutions and for the monitoring of potential adverse selection and diminished quality of care. This pressure is apparent in the British system today. The drive to entrust GPs with the entire or larger part of the public per capita care budget, or to turn them into OMCC institutions or budget holders in addition to their role as primary care providers, gives rise to specialized groups whose function is to manage the risk and administration for several GPs. Indeed, systems try to strike a balance between the extreme options. Centralized

provider systems, like those in Sweden, are under apparent pressure to split up in order to foster competition and offer more choice to consumers (Saltman 1990). At the same time, decentralized systems based on solo practices, such as those in the United Kingdom, are under pressure to form group practices (Glennerster et al. 1994).

The vertical integration between preventive and primary service is presumed to make services in the community more efficient and convenient to clients, by promoting substitutions—when cost beneficial—between preventive and curative care and by making both types of care accessible in one location. Cost-benefit considerations derived from prevention and related health promotion reduce the risk of curative care crowding out preventive care when the two are provided by the same institution, especially in a capitation-based environment. In addition, the decline of infectious diseases has rendered people's health progressively less interdependent; this reduces the need to concentrate public efforts on public facilities and to establish aggressive outreach programs that are separate from curative programs in the community (although the spread of AIDS may force analysts to modify this line of reasoning). Discrete community services are also costlier than integrated services and are inconvenient to clients, who increasingly place a high value on their time.

The issue of vertical separation between hospital care and community care revolves around hospital finance. Hospitals—even when nongovernmental but recognized as public—can be directly budgeted either through a public administration performing the OMCC function or through a fully integrated HMO carrying out this service. Alternatively, hospitals may rely entirely on the sale of services for revenues; a combination of these two basic options is also possible.

Systems that have directly budgeted hospitals effectively eliminate market forces (buyer-seller relations) from the interaction between primary care and secondary hospital care, thereby opening up some unattractive possibilities. First, at the level of primary care, hospitalization is cost free to those GPs who refer patients to specialized or hospital care; thus, there is an incentive to “kick the patient up” to more expensive care, rather than treating him or her in the community. The incentive to refer patients to hospitals is particularly strong in the fully (managerially) integrated system because primary care physicians, especially those who are paid salaries, will effectively lower their work load and assume less risk in treatment through such referrals. If paid on a capitation basis,

community physicians will essentially raise their incomes through such behavior. However, where physicians in the community are paid an FFS per activity (e.g., Germany, France, Canada, and Australia), the problem is moderated because sending the patient to the hospital unnecessarily may actually generate less income for those who provide care in the community.

Excessive referral to hospitals by providers in the community also allows hospital managers to maintain high occupancy rates, eventually justifying requests for more resources. Budgeted hospitals tend to fall into an "efficiency trap," whereby those who save money are punished by having their successful efforts translated eventually into budget cuts. Worse, perhaps, is that at the budgeted hospital there is no accountability to primary care physicians (those who refer the patients) or to the patients themselves because hospital revenues are not directly based on decisions of the patients or their family physicians.

In other words, the budgeted hospital, particularly in the fully integrated system, offers no incentives either to be efficient or to be responsive to clients, contrary to the fundamental systemic objectives under the emerging paradigm. Consequently, there has been a growing tendency to promote buyer-seller relations between those who refer patients; that is, they practice in the community in association with OMCC institutions and the hospitals that receive the referrals. This is accomplished by giving OMCC institutions, and possibly practices in the community, the (presumed) hospitalization budget of their patients. In this way, the costs of referrals are borne at least partly by those who create the costs, reducing the incentive to hospitalize. By exposing hospitals to competition and to revenues based on services, hospitals and other specialized institutions become more accountable to those who pay for services on behalf of patients. Moreover, hospitals in a competitive environment will be reluctant to introduce new and expensive technology that is not cost-effective and marketable.

This organization of care provision has a qualitative dimension as well: it aims to foster curative and predominantly preventive community care. It encourages physicians in the community to become gatekeepers, assuming full and continuous responsibility for their patients, even through a period of hospitalization and beyond.

To become sellers of hospital services in a competitive market, hospitals that are not free-standing institutions, but, rather, are state enti-



ties, can be organized through creation of public, self-governing hospital trusts (SGHTs). Such trusts are implemented in the United Kingdom and are being attempted in Israel and the Scandinavian countries. SGHTs are maintained on variable income from the sale of services rather than on fixed budgets based on inputs. Because “money moves with the patients” or with those representing them in the community—but not with those who have no direct vested interest in the hospital—SGHTs must focus their energies on patient care and satisfaction when marketing their services in order to remain viable. Under this system, control of health resources allocation shifts from hospital consultants and bureaucrats to the buyers of hospital services in the community (Glennester et al. 1994).

Organizing buyers of hospital services is a more complex affair, raising the question of who is best suited to manage the hospital budget or to buy appropriate hospital services. Two basic options exist: (a) the OMCC institution, whether or not it is publicly administered, or (b) the community practice. In the first instance, the OMCC institution, which does not provide hospital care, purchases hospital care according to referrals from the community practices that may operate under guidelines of this institution. In the second instance, GPs, or the community practices themselves, become the exclusive managers of the hospital budget.

Because OMCC institutions are larger organizations than GP practices, they have sufficient leverage to negotiate advantageous financial arrangements with hospitals and other specialized providers. These institutions can also challenge monopoly hospitals and other specialized institutions. Faced with the responsibility of procuring care on a fixed budget, OMCC institutions are likely to develop review and approval systems that could improve the quality of care as well. This particular arrangement conflicts, however, with the potential advantages of the budget-holding and gatekeeping function of primary physicians. Here again, comparatively large practices can assume some of the functions normally performed by the OMCC institutions, under arrangements negotiated by the hospitals and the OMCC institutions, and monitored by the latter.

In sum, a system composed of comparatively large group practices or clinics that compete for patients in the community appears to be the most compatible with the emerging paradigm. Such clinics or practices, independent in management and ownership from hospitals, may work with OMCC institutions under capitation or FFS arrangements, or a

combination thereof, depending on the size of the clinics and their ability to be effective budget holders. Such a system may be evolving both in the United Kingdom and Israel.

## The Responsibility of the State (Beyond Public Finance)

Despite the wide scope for competition and private sector involvement in the OMCC arrangement and provision of care under the emerging paradigm, the state shoulders the final responsibility for orderly provision of care, particularly of social benefits. The state needs to secure an environment that safeguards the viability of OMCC institutions and providers from market imperfections while also promoting systemic efficiency, assuring quality, and protecting equal access to social entitlements. These functions are of particular importance in the emerging paradigm because capitation constitutes its primary allocation and compensation system. Capitation ensures control of expenditures by capping costs (predominantly in the first internal market); at the same time, it permits the free allocation of resources by OMCC institutions (in the second internal market) in ways that may be cost effective as well as attractive to clients. However, a capitation system entails risks to equal access and quality of care because OMCC and provider institutions working under this system assume financial risk, and, consequently, are motivated to select patients and administer treatments that can save on costs (van de Ven and van Vliet 1990; Chernichovsky 1994b).

As a result, and more specifically, the state remains primarily responsible for the following:

1. setting policy
2. instituting and regulating standards
3. collecting and disseminating information
4. promoting competition and consumer choice and regulating monopolies and monopsonies
5. establishing allocation criteria primarily for tax-based funds and providing guidelines for contracts, including suggested fees and reimbursement schedules
6. supporting research and training

7. funding unexpected expenditure for health-related events with social consequences, such as various disasters and epidemics
8. regulating access to social benefits

Policy making and safeguarding the standards of care remain the state's key responsibilities. The state must establish national health priorities within the expenditure limits it attempts to control, primarily principles of public finance. Then, it must promote those priorities, including desired regional allocation of human and other medical resources, through appropriate incentives. These incentives can be incorporated in the allocation criteria, such as a capitation system formula set by the state (for the first internal market), and even the reimbursement mechanisms it may develop and suggest, like capitation, DRGs, and regular fee schedules (for the second internal market). The state also remains responsible for policies that have long-term implications for the system, particularly policies concerning medical education and training, research, and the adoption of new technology.

Public information is a fundamental enabling mechanism in the emerging paradigm. The appropriateness of health sector priorities, allocation criteria, and reimbursement schemes must be based on public health and cost data. Because the state also has a prime interest in cost containment and efficiency, it must help identify comparatively efficient methods of providing care and disseminate relevant data, while itself taking into account this information when setting and suggesting allocation and reimbursement techniques. Part of this responsibility entails developing and setting risk-adjusted capitation rates to minimize adverse selection by OMCC institutions and providers, and establishing guidelines for the amount of financial risk that institutions of different sizes can take. For example, GP practices of fewer than 8,000 enrolled participants cannot become budget holders in the United Kingdom.

Health system management information is also important for safeguarding equality of access and quality of care and service. Such safeguards are especially important under a capitation system. Furthermore, the emerging paradigm presumes increasing levels of education and awareness among consumers as a means to foster better health through improved lifestyles and to encourage competition through informed choice. Thus, the public needs to be informed about health behavior and about the nature and quality of services. Pertinent information is presumed to

promote both consumer satisfaction and systemic efficiency. The Dutch reform proposal, for example, views provision of information as a key duty of the government.

The issues of competition, consumer choice, and pertinent imperfect markets are addressed with the aid of figure 3. The figure represents extremes; oligopolies and cartels may exist within these extremes. Preferably, there are many buyers and sellers in the second market; that is, there is genuine competition within the overall budget, and competitive market forces determine the prices and the nature of contracts, subject to comparatively minimum government regulation. In this market, OMCC institutions are regulated so that they cannot turn away citizens who wish to enroll with them, and providers must meet quality assurance standards set by the government. In the case of a combined monopoly (single seller) and monopsony (single buyer) situation (upper left cell in figure 3), contracts are likely to be determined through a bargaining process rather than through competition. In this case, it is in the best interest of each side to secure the viability of the other side, and, as with competition, government involvement may be minimal compared with its participation in the other situations. In both cases the state can be instrumental in establishing and suggesting fee schedules, including capitation and DRG schemes.

		Managing institute/buyers		
		Single	Multiple	
Providers (sellers)	Single	Monopoly/ monopsony	Monopoly	
	Multiple	Monopsony	Competition	

FIG. 3. OMCC and provider institutions: a conceptualization of potential market situations.

Special government intervention may be required to determine the nature of the contracts when either a monopoly or monopsony situation exists, as may be the case in peripheral regions, or as may be justified on efficiency grounds in the case of so-called natural monopolies. This situation involves the risk of exploitation by either the monopoly or monopsony institution, undermining efforts to maintain equal access, efficiency, and quality of care, and the economic viability of the exploited institutions. In this respect, the strict regulatory role of the government in the health system is no different from its role in any other sector. At the extreme, this situation may even call for direct provision of care by the government.

Concerning the financing of research and education in a competitive environment, especially for hospitals, there is a fear that lack of direct state financial support or budgeting would jeopardize medical education and research in care institutions that are not strict research and training facilities under direct government responsibility and control. This fear has not been borne out by the experience of the United States, the leading nation in medical research; indeed, this issue may lie beyond the purview of health care per se. Funds for training and research have often become part of the overall budgeting for care provision in many systems. Worse still, training and research under these circumstances may have often become ends in themselves at the expense of care provision, serving providers' interests rather than the public's, even in the long term, as funds earmarked for care provision are used for training and research. The issue is complex because of the natural synergism between the different functions, mainly in terms of quality of care and client satisfaction. Nonetheless, when medical education and research are practically subsidized in the system at large, as may be the case in hospitals that have such functions in addition to provision of care, the state needs to establish guidelines, and even regulations, protecting patients' interests.

## Conclusion

I have reviewed common objectives and principles underlying health system reforms that have emerged in the search for provision of equitable, efficient, and consumer-oriented health care systems in industrialized

democracies. Implementation and operation of systems along the lines of the paradigm now emerging from this search face many challenges: finding a satisfactory private–public mix; developing appropriate ways to handle investment in expensive new technology; keeping the system flexible while health care becomes increasingly dependent on public finance; and, of course, addressing politically the array of vested interests that could obstruct reform.

Although based on principles of public finance, private finance remains important in the emerging paradigm. In a free society people cannot be prevented from spending their money as they see fit, including expending it on medical care. The question is, therefore, What is the optimal mix of care and control expenditure for a system that is meant to promote equal access to a basic package? Immediately a gray area opens up between what constitutes “basic” care and what constitutes “amenity” care. To take this a step further, given a choice and “consumer ignorance,” will people purchase additional private insurance or pay extra for services that are indeed different from their public entitlement? And if they do, is it at the expense of others who do not hold private insurance or do not pay privately? The issue of the private–public mix underscores the painful trade-off between equity and expenditure control, and consumer satisfaction. Some systems (e.g., Australia and France) allow private and public finance and care provision to function under the same institutions. Others (e.g., the United Kingdom and Canada) discourage and forbid such coexistence, segregating private and public care. The 1994 Israeli health insurance legislation opened up the possibility of such coexistence. The first approach risks declining equity and loss of cost control, while the second approach risks growing client discontent.

Decentralization and competition in the organization, management, and provision of care may leave key issues unresolved, such as how to extend the emerging paradigm to outlying rural areas where competition is not feasible and how to exploit economies of scale, which are most pronounced when new and expensive technology is introduced. As for outlying areas, public administration with the OMCC function, or even the fully integrated system where provision is also public, may be unavoidable. At the same time, as I stressed earlier, a system based on national OMCC institutions can both regulate and offer incentives to such institutions to operate in outlying areas.

As for investment in expensive technology, the challenge is to identify the need and to provide for it in a way that keeps the state from becoming an owner of health facilities or becoming directly involved in the provision of care; this is accomplished mainly through direct budgeting of medical institutions. New, expensive technology cannot be economically efficient unless a large demand for its use is secured. In addition, such technology is likely to “push” the cost of care. Therefore, all governments tend to control large capital investments within their health care systems. Such control may range from requiring a “certificate of need,” as has been done even for private investment in the United States, to establishing a government (central and local) monopoly on such investments, as, for example, in Canada and Sweden. Here the dynamics of the situation must be recognized and managed. Technology is relatively expensive when new; thus, ways should be sought to shift the investment over time from the state to private institutions when costs decline. One such way is for the state to help finance investments to private institutions through lending mechanisms, possibly subsidized when serving appropriate policy objectives, and setting fees that secure the capital cost.

Increasingly dependent on public finance principles, health systems must be able to adjust whenever resources begin to contract in the same way as other public and private sectors of the economy. Under financial stress, and in view of the fact that providers’ wages and income cannot be reduced as easily, health systems face several risks: the infrastructure and equipment may deteriorate; the quality of care may go down with declining supplies and deteriorating equipment; a black market for health care may evolve; and private financing may become prominent. Pooling all financial resources and financing OMCC institutions through capitation under clear policy objectives allows the tightening to be spread equally across the system—regardless of the relative contraction of specific sources of finance—and allows for more consumer say in how service should be reduced. At such times, careful consideration should be given to how to regulate private financing in the system in conjunction with declining public finance.

Reforms are costly in many aspects and are bound to be opposed in some quarters, partially because medical care is a sensitive social issue and public intervention is invariably a controversial political issue. The cooperation of the independent medical profession is crucial in health

system reform, especially in view of the nature of the emerging paradigm that primarily addresses economic and social concerns.

The issues I have discussed here, in addition to others that are sure to emerge, may be most efficiently addressed in an environment where “public and planned” and “private and competitive” can complement each other and perform tasks in which each has a relative advantage under particular circumstances. The challenge is to maintain enough flexibility in the system so that it can be rebalanced with changing circumstances.

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