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CHAPTER

1

HEALTH CARE FINANCING REFORMS: MOVING INTO THE NEW MILLENIUM

INTRODUCTION

During the 1990s, many governments changed their methods of financing health services. These changes have often been, in part, based on political ideology but are also, it is claimed, results of economic or financial pressures. Implicit in many of the changes has been a genuine desire to do better with the health care resources at the disposal of nations. But do these reforms actually work out like this?

Despite involving large amounts of public and private money and resources, as well as potentially affecting the welfare of large numbers of the population, it is often the case that scant regard is paid to the economic principles and economic evidence on the costs and effects of such change. Since publication of the first edition of this book the body of literature on the economics of health care financing has grown even larger but without necessarily becoming any more accessible or easier for any interested person to draw together. Hence, the main aim of this revised edition is the same; that is to allow such individuals to gain easier access to the economic literature and principles on health care financing. A subsidiary aim is to keep up with developments and new empirical findings in this rapidly changing field. In meeting these aims there are four strands. First, we set out the economic principles of markets and market failure which underpin different methods of financing health care. Second, we outline different methods of funding health care and review the efficiency and equity objectives of these methods. In the third part of the book we assess the evidence from economic studies of the different methods in light of efficiency and equity objectives. Finally, we examine some future challenges for research and policy making regarding health care financing.

In introducing the rest of the book, in this chapter, we focus on two issues. First, changes in financing arrangements which have taken place in different regions of the world are highlighted. The reader should note that it is not the intent here to review the arrangements *per se* or to be comprehensive, but, rather, to focus on change. The nature of such change sets an agenda for the remainder of the book. Thereafter, we indicate how each chapter contributes to the overall assessment of the changes that have been, and are, going on.

THE CHANGING WORLD OF HEALTH CARE FINANCING

Western Europe

In Western European health care systems, the basic funding arrangements have traditionally been of two main sorts: directly from tax revenues (such as in Denmark, Norway, Sweden and the UK) and funding from social insurance contributions (such as in France and Germany) (Jonsson, 1989).¹ Some systems, like those in Italy and Spain, use a mixture of the two, although the trend in Spain in recent years has been towards the former (Taroni *et al.*, 1998; Puig-Junoy, 1999). The Dutch system is slightly different again, relying not only on social insurance but also on a large degree of private insurance for routine care for those over a certain level of income.

So, even within a small geographical area of the world, basic funding arrangements differ. In Western Europe these reflect not only economic considerations but also cultural differences and the history of health care financing in the countries involved. Of more recent importance, however, are the changes in financing arrangements which these countries have made and whether these will make things better or worse for their populations.

Some of these changes are at a system level (i.e. changing the funding arrangements by trying to introduce more competition) and can be evaluated with varying degrees of difficulty. Others are at a micro level (e.g. considering different ways of paying providers, but still remaining within the basic system of fund raising). For many micro-level changes, such as patient charges, a great deal of information exists which can help in determining whether or not such changes are for the better.

Regarding basic-system changes, the governments of both Italy and Spain made commitments to move towards systems funded mainly from taxation (Italian Ministry of Justice, 1978; Ministerio de Sanidad y Consumo, 1989). Progress towards this has been made in both countries. About 51 per cent of funding in Italy is still dependent on social insurance, with about 46 per cent of funding coming from general taxation (Taroni *et al.*, 1998). In Spain, about 20 per cent of funding is accounted for by private insurance and charges, with the remainder financed from general taxation (Puig-Junoy, 1999). Meanwhile, although the Greek Government introduced legislation in 1983 in an attempt to expand the role of the public sector, private sector financing has increased in importance there (Liaropoulos and Tragakes, 1998).

Other major reforms, but not involving the basic systems of raising finances, nevertheless included attempts to inject more competitive elements into health care financing and provision, most notably in the Netherlands, Sweden and the UK (van de Ven, 1989; Hakansson, 1994; Secretaries of State, 1989). In these countries, the main reform has been to introduce competition in health care provision rather than in financing. Thus, 'purchasers' (sickness funds in the Netherlands, counties in Sweden, and, until recently, district health authorities in the UK) were encouraged to play the role of contracting for care on behalf of the communities

they serve. Generally, this care could be purchased from either public or private providers, the aim being for providers to compete for funds on the basis of the cost and quality of services they provide. Such reforms have spread to other countries, such as Finland (Linna, 2000), and even Denmark is now proposing to let publicly funded patients choose between public and private providers for surgical procedures (Csillag, 2001). In France, in 1997, regional agencies were given powers to contract with providers, although this reform has still to be implemented in any meaningful way (Segouin and Thayer, 1999). Likewise, the Greek Government has announced, but not yet implemented, a move to a purchaser-provider arrangement for health care (Tountas *et al.*, 2002). Germany, too, now encourages selective contracting since the introduction of competition amongst its sickness funds, the latter being the bodies that administer insurance funds (European Observatory on Health Care Systems, 2002).

Also, in some systems, reforms based on the US health maintenance organisation (HMO) model were introduced. For instance, in the UK, during the 1990s, many general practitioners (GPs) were allocated budgets with which to purchase certain types of hospital care on behalf of those on their lists (Secretaries of State, 1989), a reform which was recently modified by the Labour administration there (Her Majesty's Government, 1999). Meanwhile, the Netherlands has struggled throughout the 1990s to introduce a system of competition amongst the sickness funds whereby consumers pay a flat rate which is risk-adjusted via a government subsidy (van de Ven and Rutten, 1994; van Doorslaer and Schut, 2000). Despite this, other countries, such as Switzerland and Germany, have tried to implement similar reforms (Zweifel, 2000; European Observatory on Health Care Systems, 2002). Of course, the main challenge of such reforms has been to guarantee that the risk-adjustment component can compensate for most of the variation in health expenditures amongst enrolees, thus ensuring a fair distribution of funds and prevention of risk selection.

There are many more micro-level changes which have been taking place in Western European countries. Patient charges for health care are substantial in many countries, such as Spain. In Norway, such charges are levied for visits to GPs, patients paying 100 per cent for a visit of less than 15 minutes without any additional services, with the additional services (e.g. laboratory tests) paid by government. This is similar to Sweden, although in the latter country there is a maximum annual outlay (Kristiansen and Pedersen, 2000). Belgium too has substantial out-of-pocket payments (up to 40 per cent of agreed fees), although some of these (for hospitalisations) can be recovered through private insurance (van Doorslaer and Schut, 2000). In France, about 13 per cent of health care costs are borne directly by patient payments (Poullier and Sandier, 2000). In Germany, there is a small daily charge (of 9 Euros, in 2002 prices) for the first 14 days in hospital, although various exemptions apply (European Observatory on Health Care Systems, 2002). Even in Sweden, perceived as one of the most egalitarian societies, user charges have played an uncontended role in health care financing ever since health care was socialized in 1970, before which patients paid out-of-pocket for a large proportion

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of services (Hjertqvist, 2002). Most countries operate systems of charging patients (at least in part) for GP drug prescriptions as well as other elements (such as medical aids, dental care, physiotherapy and spectacles) which now seem to be regarded as 'supplementary'.

Specifically on payment of doctors, there are various arrangements across Western Europe. In most cases, hospital doctors are salaried, although in France (private hospitals), Belgium and Luxembourg, the system is based on fee-for-service (FFS) (Directorate General for Research, 1988). GPs are reimbursed in a mixture of ways; totally FFS in Germany, but with a recent introduction of a cap on total spending (Henke *et al.*, 1994), some salaried and some FFS, as was the case in Norway (Kristiansen, 1989) before switching to capitation combined with FFS, as exists in countries such as Italy and the UK, sometimes in combination with further allowances for achieving particular objectives (Directorate General for Research, 1988; Donaldson and Gerard, 1989a), and HMO-style arrangements in the UK (now for most practices) and the Netherlands as mentioned above.

Hospital funding also varies and some recent changes have been observed. In Denmark, Italy and Spain, hospitals can receive most of their revenues through a block grant from the central pool of funding, be it taxation or social insurance (Jonsson, 1989). Recent innovations, however, have included more competition between providers to attract funds (as in the Netherlands and the UK), experiments with clinical budgeting (also in the Netherlands and the UK) and the proposals and experiments with diagnosis-related group (DRG) funding in Austria, Germany and Norway (Magnussen and Solstad, 1994; Sommersguter-Reichmann, 2000; Scholkopf, 2000). Once again, in many countries, attempts have been made to cap hospital expenditure by making grants prospective.

In most countries during the 1990s, there have been important moves to curb the growth of drug expenditures. In many cases, for example, France and Germany, this simply involves placing a cap on such expenditures, usually in the general practice setting, whilst introducing an element of financial risk for providers by having overspend (or a proportion of them) deducted from the following year's allocation (Kamke, 1998; Segouin and Thayer, 1999). Reference-based pricing has also been introduced in Germany (Kamke, 1998). Under this scheme, drugs are classified into therapeutic categories, and the sickness funds reimburse pharmacies the cost of the lowest drug price in the respective category. The additional cost of any other drug in the category is the responsibility of the provider or patient, depending on the scheme.

Eastern Europe

Pre-1989, the health care systems of Eastern Europe were based on the principle of 'free' access, financed by monies from general revenues of governments. Since then, however, the health care systems of this region of the world have undergone substantial reforms, in many cases trying to move from tax-based financing to social insurance (Ensor and Thompson, 1998). Pre-reform, general revenues were

devolved to more local levels, and this has largely remained the case under moves to social insurance. Through restructuring and openness it became clear that Eastern European health care faced many problems: perverse incentives (such as hospital funding being based on bed days and, in primary care clinics, on attendances), shortages of supplies and equipment, and duplication of services between primary care clinics and hospitals. With economic restructuring leading to falling government revenues, in many cases, like that of nations comprising the former Soviet Union, the intention was to use social insurance to increase or maintain previous levels of health care funding, along with reforms aimed at increasing the 'flexibility' of the system. In many countries (such as Bulgaria), control of funds remains with the Ministry of Health, whilst in others (such as Georgia), this control is exercised by a body at arms length from the Ministry. Yet other countries, such as Poland, are considering going further, by having sickness funds administered by private insurance companies (Tymowska, 2001). In all cases, payments from taxation (or by top-slicing social insurance monies) still have to be made to sickness funds in order to account for differences in risk levels of enrollees.

In most systems in Eastern Europe, the role of the private sector in financing and provision has increased, as even social insurance has struggled to get off the ground due to economic recession and consequent problems in raising funds from employers (Ensor and Thompson, 1998).

In Poland, recent reforms discussed have included provision of a limited health package by the state plus a system of voluntary health insurance for services beyond the basic package (Indulski *et al.*, 1989). Whilst the state struggles to maintain the basic package, the use of private sources of finance grows, with up to 40 per cent of health care expenditures estimated to come from this source (Tymowska, 2001). Such a phenomenon has also been observed in other countries, such as Bulgaria (Delcheva *et al.*, 1997) and Russia (Twigg, 1999).

In the Russian Federation, an important innovation in the late-1980s was the experiment in primary care clinics (or polyclinics) and hospital funding taking place in St Petersburg, Samara and Kemerovo (Siberia) (Hakansson *et al.*, 1988). Hitherto, hospital budgets went from the Ministry of Health to the hospitals and polyclinics separately. In the experiment, however, polyclinics held the budget, the hospital being paid by the polyclinic for services carried out on the polyclinic's patients. The polyclinics received a fee for each patient registered, and so had an incentive to attract patients. Polyclinics and hospitals retained surpluses. The aim was to achieve greater efficiency in health care, in particular to reduce length of stay which had been rising. Subsequent to economic collapse in the early 1990s, this experiment collapsed, due to difficulties in making payments (Isakova *et al.*, 1995). Further reforms were, however, based on similar principles. Now, each territory in the Federation has its own social insurance plan, the main difference from other countries mentioned above being that territorial governments contract with insurers who then act as intermediaries with providers. Thus, there is an element of competition amongst insurers in attracting public funds. But, similar to most of the other countries using social insurance, there is also an element of competition

on the supply-side, with providers attempting to win contracts from funders (or the intermediaries). The extent to which such reforms have been implemented within the Russian Federation varies, which makes for some interesting comparisons and, thus, assessment of these reforms (Twigg, 1999).

Most of the above reforms also require micro-level change in order to eliminate perverse incentives, thus allowing such reforms to have maximum impact. Therefore, it has been the case, for example, in the Russian Federation, that different schemes for reimbursing hospitals have been tried or are being discussed. These include global budgets and DRG-style forms of reimbursement (Isakova *et al.*, 1995; Twigg, 1999). However, it is fair to say that, generally, such changes have not been fully implemented.

North America

The Canadian health care system has been relatively stable over the last 30 years, since the introduction of public health care insurance. The most frequent debates have been about the introduction or extension of patient charges (Barer *et al.*, 1979; Evans, 2000). The switch in Canada, from a US-type system to public insurance, provides some useful comparisons at the global level, with extremely large sample sizes (about 30 million people in the Canadian group versus about 250 million in the US!). Despite apparent stability, there have been significant micro-level reforms within the Canadian system, the most notable being the move to regionalisation in most of the provinces; now provincial governments, who are responsible for health care in Canada, allocate budgets to geographically defined health authorities on the basis (at least in part) of needs-based formulae (Province of Alberta, 1994). These authorities are meant to plan services for their local populations. Other innovations in the Canadian system have been the introduction of reference-based pricing, notably in British Columbia, and giving health authorities the option of applying to the Minister of Health for permission to contract out services to private providers (Alberta Health and Wellness, 1999). One further trend (rather than reform) which has taken place within Canada has been the growth in the share of total health care spending derived from private sources, having risen from around 25 to 30 per cent over the period 1990 to 1999 (Evans, 2000), although this trend has been reversed slightly in recent years.

The US is one of the few countries in the Organisation for Economic Cooperation and Development (OECD)² which does not have universal (or close to universal) coverage of its population, whether through tax-funded schemes or private health care insurance (see Table 9.4 in Chapter 9). In the US, the public health care system is in two main parts (although this varies slightly from state to state): Medicaid for low-income persons and financed from federal and state general taxation revenue; and Medicare for those aged over 65 years, those on renal dialysis and those who are permanently disabled (financed by a combination of pay-roll taxes on earnings up to a ceiling, premiums paid by elderly people and general revenues) (Ginsburg, 1988). Medicare also requires direct charges from

patients for doctors' bills and hospitalisations (often in the form of a deductible with a percentage user charge thereafter). Within the US Medicare system a prospective pricing system for hospital episodes was introduced in 1983. DRGs have been used to fix prices paid by Medicare for hospitalisation, price being determined by the patient's diagnosis. This innovation has been well studied and has also spread to other countries (see above and below).

The greatest change in the US health care market over the past two decades, however, has been the move in the private sector from domination by private health care insurance to 'managed care', as embodied most notably in the proliferation of HMOs and preferred provider organisations (PPOs) (Churchill, 1999). Managed care embodies several features, such as: greater competitiveness amongst funders in attracting enrollees; more active 'management' of providers by these funders (through the use of protocols and negotiation of lower fees and prices); and some might say, greater restrictions on the range of services, providers and other aspects of care made available. Both Medicare and Medicaid programs have also made substantial use of managed care (Freund and Hurley, 1995). Managed care potentially affects both hospital financing and doctor reimbursement. Payment of doctors in the US, however, remains dominated by FFS and many policies still require substantial out-of-pocket payments from enrollees.

Despite recent developments, mostly aimed at cost containment, the percentage of the non-elderly population uninsured reached a high of 18.4 per cent in 1998 (Gold *et al.*, 2001). This used to lead to calls for a system of universal health care insurance (Enthoven and Kronick, 1989a,b; Navarro, 1989). However, more recently it seems that states are resigned to trying to improve coverage within the current Medicaid system, with some, such as Oregon and Tennessee, having achieved limited success (Gold *et al.*, 2001).

Latin America

Latin America is dominated by social insurance systems (Akin, 1988). Workers usually pay a fixed percentage of wages to the system and most are self-financing. Sixteen Latin American countries use such systems, with varying degrees of success regarding coverage: as high as 87 per cent of the population being covered in Chile and as low as 7 per cent in the Dominican Republic (Pan American Health Organisation, 1998).

Despite good rates of coverage, many governments have aimed to expand this. Combined with fiscal crises during the 1990s and recognition of fragmentation and 'overconsumption' in various systems, many countries have instituted substantial reforms. Two-tier systems exist in all countries, with more wealthy members of society receiving access to better facilities through private health insurance. Generally, however, most funds derived from payroll and other taxes are placed with financial intermediaries (e.g. obras sociales in Argentina). Differing degrees of redistribution from richer to poorer intermediaries takes place, depending on country. In countries such as Argentina, Chile and Colombia,

these intermediaries have been encouraged to compete more with each other to attract enrollees and to, in turn, encourage competition amongst providers (Jack, 2000). This has also led to a range of payment mechanisms for providers. Columbia has the most extensive experience of such managed competition (Hsiao, 1995; Plaza *et al.*, 2001). While the increased enrolment of a large number of poor people is cited as a key achievement of the subsidised system, a series of constraints undermining both utilisation and access were identified (Plaza *et al.*, 2001). Uruguay has also been at the forefront of experimentation with prepaid health care plans, such as HMOs, whilst Brazil has recently introduced a DRG system for funding hospital care.

Australasia

Up to 1990, the stability of the Australian and New Zealand health care systems contrasted greatly. The New Zealand health care system, the first to establish a National Health Service, had remained very stable, whilst the Australian health care system, on the other hand, was (and remains) a constant source of political debate, having been subject to many fundamental changes since 1945.

In 1984, a universal public health insurance system (Medicare) was reintroduced in Australia. A previous version (Medibank) had operated for 12 months in 1975–76, but had been gradually dismantled under Liberal administrations until the return of a Labour Government in 1983. In the system prior to Medicare, private insurance was widespread as was use of patient charges. Elderly people and some poor people were covered by the public sector, but many people remained uninsured (Deeble, 1982; Palmer and Short, 1989). In opposition since 1983, Liberal Party policy had advocated a return to the previous system along with assurances that it would not be more costly and that universal coverage would be maintained. However, since being in government from 1996, the Liberal Party has maintained Medicare with some erosions at the edges, such as the encouragement of private insurance through subsidies and tax incentives in order to arrest the decline in its uptake (Deeble and Smith, 2000), most notably the introduction of ‘lifetime community rating’ insurance to take account of individuals’ life time risks averaged over the lifetime of enrolment (Willcox, 2001). Australia has also become a major user of DRGs (Braithwaite *et al.*, 1998).

It now seems that it is the New Zealand system which is more subject to change. The early 1990s saw the introduction of provider competition, as in the UK and The Netherlands. Four new regional health authorities (RHAs) were created to purchase care on behalf of their populations (about 800 000 people each) from competitors in public, private and voluntary sectors. People could opt out of RHA cover to a private sector plan, taking a weighted cash allocation with them, so there was also some competition in financing. Second, patient charges were introduced for outpatient visits and inpatient stays, thus increasing the proportion of funding which comes from private sources (Hopkins and Cumming, 2001). A change of government in 1996 has resulted in abandonment of the internal-market-style reforms, with the four RHAs amalgamated into one, removal of the profit motive from

public hospitals and greater emphases on longer term contracts, cooperation and openness (Kriebler, 2000). However, the private sector will continue to compete for those wishing to supplement access to public services. Furthermore, out-of-pocket expenditures, largely user charges, have increased and now account for 16 per cent of health care costs (European Observatory on Health Care Systems, 2002).

Lower income countries

Financing reforms in the health sectors of many low- and middle-income countries can be grouped under three broad, and related, themes. The first is the diversification of funding patterns away from tax revenues to fund public health services and the second is the formalisation of relationships between public and private sectors (Mills *et al.*, 2001). A third theme is that of reforming the role of consumers and citizens in the financing and planning of health services. Initiatives under each theme can also be characterised by the actors involved (Mills, 2000).

Poor economic trends in many lower income countries have motivated policy-makers to consider cost recovery in the health sector, a mechanism whereby users pay part or all of the cost of care in a public facility as a means of generating additional funds. A number of innovative schemes have been, and continue to be, explored in low- and middle-income countries. Two reform options available to health care planners include payment by the service users only (e.g. fee for service payment or payment per episode of sickness or risk) and payments based on risk-sharing schemes through the contributions of potential users (Noterman *et al.*, 1995).

User fees have been a very common component of reform packages, especially in Africa (Gilson and Mills, 1995; Mills, 2000; Mills *et al.*, 2001). While they are becoming more widely accepted, there is still a long way to go both in terms of understanding and responding to the welfare implications of this type of cost recovery strategy (Diop *et al.*, 1995) and in delivering the improvements in access and quality that are expected to accompany the introduction of fees (McPake, 1993). In many countries, strengthening the participation of health care users in decision-making has been an important component of health sector reform (Broomberg, 1994; Twaddle, 1996; Mosquera *et al.*, 2001). Such community participation is often cited as a key principle underlying the implementation of user fees. In the case of Zambia, it was argued that under a cost-sharing policy the 'dependency syndrome' would be broken into active involvement and a greater sense of 'ownership of public health care' (van Der Geest *et al.*, 2000).

Risk sharing is based on the assessment of the probability that a particular event or use of an intervention will occur over a given time-span (Noterman *et al.*, 1995). The cost of this intervention will be supported by the contributions of people who subscribe to the scheme. A number of lower income countries have experimented with voluntary risk-sharing strategies in rural areas (Creese and Bennett, 1997; MCPake, 2000).

A variety of public-private mix practices have been implemented in low- and middle-income countries to encourage efficiency. One practice that has received

considerable attention has been the contracting out of clinical and non-clinical services. Experience with managed competition in the developing world is relatively limited (Tollman *et al.*, 1990; Ron, 1999; Mills *et al.*, 2001), the most extensive experience being that in Colombia, referred to above (Hsiao, 1995; Plaza *et al.*, 2001).

Specific hospital reforms include the use of 'cost recovery beds' in public hospitals. Allowing public hospitals to invest in and operate a system of higher charges for commercial beds, enabling them to compete for those users who are willing to pay for better quality hospital amenities, is one recent type of reform in developing countries, Indonesia providing a good example (Suwandono, 2001).

South Africa provides an interesting case, whereby, since democracy was introduced, reforms have involved a mix of the egalitarian (i.e. attempting to differentiate contributions for a package of benefits only on the basis of income) to more regressive financing (such as continued user charges and the introduction of medical savings accounts, or MSAs) aimed at controlling consumer behaviour more directly and giving physicians some freedom as to whom they treat and for what price (van Der Heever, 1998). The last of these reforms, MSAs, have also been introduced in China and in more developed countries such as Singapore and (in a small way) in the US.

As will be seen, there is a growing literature describing and comparing the types of health sector reforms being undertaken in low(er) and middle-income countries. However, the political challenges associated with the adoption and implementation of health reform proposals are greater in these environments. The design and implementation of new health reforms occurs through an interaction between various international lending agencies and national government bodies, each with their own political agenda (Glassman *et al.*, 1999). This makes it difficult to pin down causes and effects.

OUTLINE OF THE BOOK

The first part of the book, Chapters 2 and 3, deals with the economic reasoning behind the health care systems which different countries have. Some commentators have claimed that government intervention in health care financing should be far less than it is today (Logan *et al.*, 1989; Zelder, 2000), with more being left to market forces. Indeed, no matter what system of financing is in operation, market forces will always exist. How they operate will depend on the structure of the basic financing system. Therefore, as market forces can never be ignored in the health care financing debate, in Chapter 2 we deal with the issue of defining 'markets'. Before discussing market failure and building in major modifications, such as government intervention, it is useful to strip markets bare and describe how they would work in ideal conditions.

Towards the end of Chapter 2, and more fully in Chapter 3, the reasons for the failure of markets in health care financing are outlined. It will be seen that government intervention in health care financing is not only inevitable but also to

the benefit of the community. The main problems with which financing systems and, therefore, governments have to deal come to light explicitly in this chapter, devising financing mechanisms which avoid: 'moral hazard', whereby, as a result of being insured (publicly or privately), the attitudes of consumers and providers of health care change so that they have no incentive to moderate 'overuse' of services 'because the insurer will pay'; 'adverse selection' and the problem of ensuring access to care for less-well-off groups in need; judging how much societies care about the access of less-well-off-groups; and problems of asymmetry of information which leads to consumer ignorance of much health care and puts the doctor in a particularly powerful position in the health care market.

Government intervention does not necessarily imply that the form of intervention will be uniform across different countries. The different basic systems of health care financing and their objectives are, therefore, outlined in Part II which encompasses Chapters 4 and 5. It will be seen that within the different systems outlined in Chapter 4 many micro-level type arrangements exist. These arrangements are not exclusive to one type of system; for instance, patient charges can be tried in public as well as privately orientated systems. The objectives of health care systems against which changes in financial arrangements should be measured are outlined in Chapter 5. These objectives cover efficiency and equity, and it will be seen that there is a greater consensus over defining the former rather than the latter type of objectives.

The evidence on different arrangements in dealing with the main problems of financing is dealt with in Part III of the book. As moral hazard is the area of concern here which is most well researched by economists and others, it is dealt with in Chapters 6–8. In Chapter 6 different ways of dealing with moral hazard on the part of the consumer are examined. Chapters 7 and 8 concentrate on the supply side of the market; examining mechanisms for countering moral hazard amongst doctors and in hospitals respectively.

The challenges of adverse selection and achievement of equity are returned to in Chapter 9. Different financing systems obviously have implications for equity as well as efficiency.

Part IV looks to the future. In Chapter 10 we ask 'given the financing arrangements that exist, how can economics techniques be used in the future to improve things?' The chapter is thus about using approaches which take account of costs and benefits in order to set the budget for health care and allocate resources within health care; the approaches are based on principles of economic evaluation and examining determinants of health (of which more details follow later).

Finally in Chapter 11, we conclude on the state of current evidence. No hard and fast answers are given, but much more can be concluded than was the case 12 years ago, when the first edition of this book was published. But, the following questions will be addressed:

- How will funds be raised and what does this mean for the nature of the financial intermediary that stands between the consumer and the provider and the principles on which the 'insurance premium' will be based?

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- What is the role of out-of-pocket payments made by the consumer at the point of use? Can other forms of reliance on consumer preferences, such as MSAs, be used?
- How are professional providers to be paid?
- How are institutions to be reimbursed?
- How will the 'market' be organised and to what degree will competition be used within this?

In answering these questions, financing arrangements are judged in terms of efficiency and equity. Some arrangements are judged less desirable than others and future areas for health economics research identified.



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