

The proper role of public versus private health care financing



by **Mark Stabile**

As part of HEPL's 10th anniversary edition I was asked to comment on an **excellent paper by Tinghog and colleagues** that explored what parts of health care are suitable for private financing. In doing so, I turned the idea around as I believe many countries need to clarify the role and scope of the publicly financed portion of the health care system. That is, we must clearly define what the public benefit will cover and for whom. In the absence of such streamlining the health care system cannot be expected to achieve its goals, and the private system cannot step into an optimally helpful supplementary role. Knowing what health care was used to be easier. Care performed in hospitals or by doctors was considered to be a core benefit available for all. If a doctor didn't do it, it wasn't medicine. The task is considerably more difficult now.

Any framework that tackles this project of evaluating what we want to fund will also have to consider what we do for people who want more, better or faster service. How do we tackle the private side of health care financing? In part, I'd suggest, by getting the public side right. I note in my comment that it is interesting that the U.S. Affordable Care Act, despite its flaws, takes some important steps in this regard. It recognizes that health needs of the population change much more slowly than the technologies to best meet these needs. And in more predictable ways. We have many of the same health problems as 50 years ago but we deal with them much differently. Therefore, we should design the public benefit around these health needs, not around providers, or treatments. The question shouldn't be: should insulin be covered or should services by psychologists be covered. Rather, the system should be framed so that funding is targeted at diabetes and mental health disorders, and the most effective treatments for those conditions. If we agree that chronic conditions such as diabetes and mental health are among our health care needs, then the most effective way of treating them should be publicly financed.

We are then left with dealing with the concept of "most effective". Ongoing advances in both technology assessment and the implementation of "best practices" among physicians offer reasons to be optimistic (examples would include NICE in the UK for technology assessment, Intermountain Health, or the Mayo Clinic as far as best practices implementation among physicians is concerned). And I'm hopeful that the UK will figure out how to take successful models in small settings and scale them up to the system level.

What does all this actually mean for the design of public benefits? It suggests a broad base of coverage – and for most countries this will mean broad universal coverage (although it doesn't need to be). It suggests that it does not make sense to have a system where entire categories of care are left to the private sector. Because the standards of care provided in the public system are established based on the latest expertise and evidence, they should lead to a relatively high level of quality. This needs to include both evaluation of new drugs and technology and greater uniformity over what doctors and other practitioners actually do. The private domain would be defined by treatment for which there are more (cost-) effective options or for items that we do not consider part of the broad essential needs of a population. The goal of promoting the most cost effective method of treatment should not be undermined by the private sector. Therefore, private financing that alters the incentives in the public system (for example, by covering services like essential medications or treatments that complement doctors and hospital services) should be discouraged.

What are the implications for private financing? Technologies, procedures and options not well supported by evidence as cost-effective need to be left to the private domain. Therefore the

private domain will be defined by treatment for which there are more effective options or for items that we do not consider part of the broad essential needs of a population. There will, of course, be some who perceive any private financing as inequitable. But if we get the public system right, privately financed care will only mean the kinds of differences in access that we tolerate in a market society; it will not add to inequalities in health and quality of life.

About the author

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