# T02P02 / Comparing Different Models of the Public/Private Sector Mix in the Delivery of Healthcare Services

**Topic :** T02 / Comparative Public Policy sponsored by Journal of Comparative Policy Analysis

**Chair :** Howard Palley (Sch, of Social Wk, University of Maryland)

## GENERAL OBJECTIVES, RESEARCH QUESTIONS AND SCIENTIFIC RELEVANCE

This panel examines how different models of the public/private sector financing affects the delivery of healthcare service outcomes in different developed nations. For example, the U.S. complex mix of about 50% public and 50% private financing has contributed to the highly fragmented character of healthcare services that serve different population groups. The Canadian model of about 70% public and 30% private financing sometimes labeled "narrow but deep" results in universal access without financial barriers to hosFpital care and ambulatory medical services but greater variation in coverage at the provincial/territorial level for prescription drugs and other long-term healthcare delivery services. The Swiss model of mandated but individual choice of basic health insurance has also resulted in extensive regulated services and some variation in access across Cantons. The Japanese model includes universal insurance for medical and hospital services that is provided by public and private hospitals and physician care in many small physician run clinics. The italian model of overall universal health insurance administered at the regional level includes a significant degree of "contracting out" of delivery of services. In France universal coverage goes hand in hand with significant private options in a complex system. This panel examines how different models , of which I have provided some examples, with a variety of public/private financing arrangements affect the quality of healthcare services and the achievement of social equity.

## CALL FOR PAPERS

The healthcare systems of various nations all utilize a mix of governmental and private services. This mix differs from nation to nation and is related to institutional development, ideology and culture, politics and the disposition to act of political leadership, as well as funding arrangements. This mix encompasses predominantly tax-funded national healthcare delivery systems and social insurance systems. Often in such systems low-income groups lag in healthcare due to a multiplicity of factors that may include social determinants of health as well as the lack of availability of quality healthcare services. A key hypothesis of this session is that different national models of healthcare delivery will produce different outcomes with regard to the delivery of quality health care services and result in differences regarding the achievement of social equity in health care delivery. A second hypothesis is that a vigorous public regulatory framework conscientiously implemented can result in a public/private sector mix which provides a broad base of quality health services in an equitable manner. Various papers are invited that examine national health delivery systems with respect the model of the public/private sector mix developed and which relate to the hypotheses noted.

# T02P02 / Comparing Different Models of the Public/Private Sector Mix in the Delivery of Healthcare Services

**Chair :** Howard Palley (Sch, of Social Wk, University of Maryland)

## Session 1The Public/Private Sector Mix in Health Care Delivery: A Variety of Models

Friday, June 30th 10:30 to 12:30 (Manasseh Meyer MM 2 - 3)

**Discussants**

Marian Palley (University of Delaware)

### Hierarchy, market or network? Analysing governance of the Japanese mixed health care delivery

Ryozo Matsuda (Ritsumeikan University)

Governing healthcare delivery is one of critical challenges in the health care sector for many countries. With different mixes of public and private delivery in different regions, as in Japan, it would be difficult to make a simple regulatory framework on providers to achieve policy goals regions because different kinds of provides have different organizational principles and motivations for their activities under different general regulations correspondent to their legal status. This qualitative study aims to gain insights from an in-depth case study on the governance of the Japanese mixed health care delivery, which has historically developed differences in public/private mix of delivery. First, the paper starts with a brief overall description of the healthcare system, followed by explanation on what obligations and powers the government has to govern healthcare delivery. Second, it analyses the system from perspectives of the three models of governance: hierarchy, market and network. The government has strong influence on the healthcare "market", consisting of public and private providers, but limited hierarchical power to directly control providers, particularly private providers. When market failures arise, different models can be used in different regions with different public/private mixes. Third, the paper describes historical changes of government regulations and interprets as changes in ways of governance. The government tried to expand the healthcare "market" until the middle 1980s, when overall restrictions on number of hospital beds were introduced. Since the 2000, the government has been increasingly engaged in transforming healthcare delivery with slightly enhanced regulatory power. Yet the governance of the system seemingly is shifting from the market model to the network model, not to the hierarchical mode. The paper concludes with general remarks on the governance of mixed healthcare delivery from comparative perspectives.

### How Public/Private Mix in Health Care Financing and Delivery Shape a Health System Structure and Outcomes: a Case of Russia

Tatiana Chubarova (Institute of Economy, Russian Academy of Sciences)

Natalia Grigorieva (Lomonosov Moscow State University)

Health reforms are at the forefront of modern health care systems development for many well-documented reasons. The limits of public funds that can be mobilized and allocate to health care in modern capitalist society give rise to the problem of how to find resources to satisfy raising health needs and how to use the available funds more effectively. One way is to increase the share of private finance and delivery in more or less “socialized” (tax-funded or social insurance) health systems, but this is likely to negatively affect access to health care without significantly improving quality of treatment.

Development of public/private mix in Russia is influenced by both the Soviet history of health system development and societal reforms undertaken during transition period, the general trend however being less state participation and increased private mostly out-of-pocket spending. The paper analyses the existing public-private mix in health finance and delivery in Russia including introduction of fee for services in state

health services and raise of private sector in health care delivery and how it might affect access. The research is based analysis of both literature and official statistical data available on the subject and results of various sociological survey conducted by research groups or commissioned by official bodies, such as Ministry of Health and Federal State statistical agency (Rosstat).

Taking into account the “sustainable” low level of public health expenditures coupled with high inequality, it is suggested that certain groups of low-income people in Russia, first of all low income and living in remote areas are likely to experience problems in obtaining medical care. This situation provides for a new role for the government to control not only public but also private health expenditures as well in strengthening state administrative capacity in the course of public sector reforms with the view of securing people's access to health care.

### Health policy Chile: Ten years after the reform

Oriana Piffre (Universidad Central de Chile)

In Chile, the public health system that emerged in Chile in 1952 following the British NHS model was transformed under the dictatorial Augusto Pinochet regime in 1981, into a segmented system that positioned healthcare as a commodity rather than an entitlement. This system was comprised of both a National Health Fund (FONASA) and Private Health Insurance Funds (ISAPRES), who acted as both insurers and providers (Jimenez and Bossert 1995; Castiglioni 2005). By the end of the authoritarian period, the sector accumulated a number of shortages due to cutbacks in public expenditure, low investment in infrastructure, and a lack of regulation for the private market around the ISAPRES (Barrientos 2002; Taylor 2003). The return to democracy in 1990 marked a turning point to introduce major changes to correct the deficiencies created by the dual system.

Nevertheless, the imbalances and inequities were and are still an enormous problem for Chilean society. By 2000, FONASA covered around 66% of the population, whereas the private sector covered approximately 20% of the population. Although it could be argued that the problems of ISAPRES be restricted to the population who subscribed to private insurance plans, the effects cream skimming had an impact on the entire system. This is particularly true in the case of the health sector where, for instance, women in a fertile age are discriminated when they buy an insurance plan from private insurance companies, paying almost 70% more than men in the same age. While a reform was passed in 2005, with the aim of to provide guarantees and access to health care; some problematic issues remains.

In this context, in 2000 President Lagos sought to address the imbalances between the public and the private system, as well as emphasising citizens’ rights as the foci of the reform to change the individualist approach of the existing model. The two most important areas of the reform proposal were: first, the introduction of a set of laws designed to regulate private sector activities. And, second, making the State a compulsory provider and legal guarantor of a new program to ensure universal access and financial support for a list of conditions prioritised according to the recurrence and costs by the AUGE Plan (Plan AUGE), which is a system of Universal Access with Explicit Guarantees.

In the last decade, many things have changed in Chile: for instance, an increase of civil society mobilization, alternation of political power in the presidency, the judicialisation of political cases of corruption among others, but the financing structure on the health systems remains stable. Therefore, after 11 years of the reform approval, it is worthwhile to ask: Are there any improvements or changes on the healthcare sector? In answering this question, this paper examines critically the process of implementation of this reform; assessing the achievements and difficulties under the administration of Sebastian Piñera (2010-2014) Michelle Bachelet (2014-2018) from various sources of data and indicators.

### Public – private mix in the Brazilian health system: regulation, financing, and interests compromising equity

Ienaura Iobato (Fluminense Federal University)

The paper aims to analyze the relationship between public and private sectors in the Brazilian health care system, and how it impacts equity in access to health.

Brazil has a unique health system with a universal public subsystem, financed by the State, and a large private subsystem, funded by companies and families, that serves 25% of the population. The public subsystem relies heavily on the private sector for the provision of health services.

This dependence compromises equity because 1) Brazil is a federative country, and the subnational units have the autonomy to decide what to contract and how; 2) Private providers are actors with a high capacity

of interference in government choices, either because they control services, or because they control political capital; 3) the public system is underfunded, and many local governments have low technical capacity and funding, which compromises the planning and regulation of contracted services; 4) human resources for the public system are more expensive because they must follow specific contracting rules, which has favored the hiring of private non-profit organizations to provide and manage certain services, causing fragmentation in the service network and segmentation of clienteles; 5) the public subsystem has a public owned primary health care network and contracts private providers for high-level services. But remains a gap in the secondary level, as it is expensive for governments either to invest or to contract private providers.

It is precisely at the secondary level of care where the private subsystem is most useful because it offers a network of providers of reasonable access to the entitled persons. This subsystem consists of health insurance companies hired by families, individuals and mainly by companies for their employees. Most of the population can not pay for these plans, but they are funded by the whole society, as individuals and enterprises can deduct these expenses from taxes. It is a system of scarce equity because access depends on the type of plan contracted, consequently on income. Although the private subsystem is subject to the regulation of a state agency, such control is fragile, and there is a permanent problem of denial of services, as well as many conflicts between health companies and providers. Many of the patients denied by the companies are directed to the public subsystem, usually through the doctors, who operate in both systems.

The complexity of the public-private mix in Brazil can be attributed to fragile regulation, underfinancing of the public subsystem, and private interests with privileged access to government decisions. These three factors are likely to be aggravated by the measures of the government that deposed President-elect Dilma Rousseff. Among the most relevant measures are the drastic reduction of health spending and the proposal of low-cost private plans for the low-income population.

To analyze the public-private mix according to regulation, financing, and interests, we intend to use recent data and research on health services in Brazil and discuss their impacts on equity.

# T02P02 / Comparing Different Models of the Public/Private Sector Mix in the Delivery of Healthcare Services

**Chair :** Howard Palley (Sch, of Social Wk, University of Maryland)

## Session 2Some Comparative Analyses of the Public/Private Sector Mix in a Variety of Health Care Services

Friday, June 30th 13:45 to 15:45 (Manasseh Meyer MM 2 - 3)

**Discussants**

Howard Palley (Sch, of Social Wk, University of Maryland)

### The safeguard of public values and governance structures in health care

Salvador Parrado (UNED- Spanish Distance Learning University)

Anne-Marie Reynaers (Autonomous University Madrid)

The governance of Spanish hospital care has changed during the last decades. As advocated by New Public Management (NPM) that prescribes the implementation of private sector management techniques in the public sector and/or closer collaboration between the public and private sector organizations, several regional governments have transferred operational and/or clinical services to public-private partnerships (PPP).

The introduction of PPPs has caused social and political debates regarding the safeguard of public values such as accountability, quality and transparency. Some suggest that public values are neglected when private companies take over responsibility. Others, on the contrary, advocate the benefits of private sector involvement for the safeguarding of such values, as well as promoting efficiency in service delivery.

The Spanish healthcare sector constitutes a laboratory of international relevance for comparative purposes since it uses at least three different governance models for public hospitals: (1) direct service provision, (2) PPPs for operational services and (3) PPPs for operational and clinical services. Different governance models within one sector and one political jurisdiction allow for comparative empirical research to explain how public values (transparency, accountability, responsibility, responsiveness and quality) are safeguarded against managerial principles of efficiency and economy. This paper focuses on the trade-off between quality and efficiency. In doing so, we will take into account the role of health care professionals. Managerial studies indicate the evolution towards a ‘hybrid’ role of the health professional in which the deontological principles, the trust service delivery model, and their autonomy give way to more choice for patients and performance regimes led by government. Therefore, it is expected that the roles of health professionals in the process of public value safeguarding might be different in each governance structure.

The above results into the following research question that we would like to cover wit the proposed paper: What impact do different governance structures for public hospital care have on the role of professionals and the safeguarding of public values (in particular, quality against other managerial principles)? In order to answer these questions, we compare three hospitals using case study methodology that respond to any of the three governance models. We use quantitative and qualitative data.

Quantitative data includes objective and subjective indicators on the performance of all the hospitals in the last three years obtained from ranking leagues established by the government. A library of indicators that measure the efficiency, effectiveness and the quality of care in all the hospitals is contrasted with the results of semi-structured interviews with project directors, project members and medical staff in the three selected hospitals. The interview protocol is adapted from earlier studies on public values in PPPs (Reynaers and Grimmelinkhuisen 2015; Reynaers 2015; Reynaers and Paanakker 2016; Reynaers & Parrado (2016).

## Regulating Dual Practice in Israel and Canada: A Comparative Policy Analysis

Gregory Marchildon (Institute of Health Policy, Management and Evaluation, University of Toronto)

The controversial issue of physicians simultaneously practicing in both public and private sectors is a policy challenge common in most high-income countries. The rules governing the practice, including its restriction or prohibition, vary considerably among jurisdictions. Israel and Canada provide very different approaches to regulating dual practice. Israel had little in the way of regulation. Dual practice grew over time - at first slowly, then much more quickly. Dual practice now poses a serious threat to quality in the public sector. Regulators have recently woken up to the threat and are starting to put restrictions in place, but it may be too late to get the genie back into the bottle. In contrast, Canada has historically had significant, effective regulation of dual practice. Although dual practice is not prohibited or discouraged under the Canada Health Act, dual practice has been highly restricted at the provincial level. This regulation has taken the form of an understanding between the state and the medical profession, and dual practice has largely been discouraged through the self-regulatory bodies of provincial medical association. In addition, dual practice has different levels of provider and patient support and differing outcomes in Israel and Canada. These differences are examined in order to shed new light on the existing dual practice regimes in each country and draw some policy lessons for the future.

## Conceptualizing oral health care systems for comparative analysis – public, private and statutory

Carmen Huckel Schneider (University of Sydney)

Joerg Eberhard (University of Sydney)

Kate Ruiz (University of Sydney)

Every year worldwide 16,969,600 disability adjusted life years are lost due oral health disorders. Socio-demographics, diets, age profile and oral hygiene habits are all known contributing factors for the most common oral diseases dental decay and gum disease. However, little is known about how oral health policy, including dental health care systems, influence oral health outcomes. This includes factors such as how dental care is financed, preventative oral health policies and practice, the composition and task-mix of the oral healthcare workforce; and workforce education.

In most advanced health care systems medicine and dentistry have remained distinct practices that been treated differently in policy debate. Public provision or subsidy of dental care is frequently (at least partly) run under separate schemes to that of primary, tertiary or allied health care.

In Australia for example, oral health is not included in the public health care system Medicare. Some emergency care is provided in hospital settings and various schemes have been implemented to subsidized dental visits for children and disadvantaged populations. For the vast majority of Australians however, dental care is either paid for by the consumer or purchased as part of a private health insurance package. Although private health insurance is partly subsidized by the Australian government, dental care can be categorized as private oral health insurance system, with some public safety net.

In contrast, in Germany, statutory sickness funds (Krankenkassen) are required to pay fixed rates to providers for most oral health related costs, with additional private insurance as an auxiliary option to cover some items. While the coverage of oral health services within this system is not as comprehensive as other medical services, Germany can be considered as having a statutory oral health insurance system.

The United Kingdom represents a third contrasting model of dental care system. All treatments that in the dentist’s opinion are required to maintain good oral health are available through the National Health Service. Services are provided without consumer contributions for certain populations groups (eg. children, youth and students, low income) and attracts a standardized 3-tier co-payment for most citizens. Providers are obliged to maintain the payment levels. The UK model can thus be categorized as a public oral health care system.

There are clear differences between the oral health status of Australian, German and British citizens. In this paper we explore how these different models of public-private financing can be conceptualized for comparative analysis of oral health care systems and their effects of oral health outcomes. We postulate mid-level theories that link financing with other system characteristics, such as access and workforce composition and practice culture and ultimately service utilization and health outcomes.