Commentary

The Public/Private Mix in the Funding and Delivery of Health Services: An International Survey

VICENTE NAVARRO, MD, DRPH

Abstract: Two recently published international surveys show that industrialized Western countries with the greatest government funding and administration of health services have the greatest population coverage and the lowest administrative costs. Countries with central government administration and fiscal controls have the greatest ability to control health care expenditures. Current United States focus on the private sector may be misplaced. (*Am J Public Health* 1985; 75:1318–1320.)

A main characteristic of current federal health policies implemented by the Reagan Administration and the United States Congress is their focus on the private sector as the sector most capable of resolving the problems of growing costs and inefficiencies that plague much of American medicine. The 1980 Republican Platform stated that "what ails America's medicine is government meddling and the strait jacket of federal programs."[1] A similar position can be found in some sectors of the Democratic Party. *The New York Times* reported, for example, that the 1984 Democratic Platform reflected new awareness by the Democratic Party Leadership of the intrinsic limitations of government intervention in many areas of life, including medicine.[2] This consensus seems to have been reached without fully exploring the experience of other developed industrialized countries with government intervention and the lessons these experiences may provide for the US. Two recently published books help us to understand and shed some light on this experience:

- *Health and Wealth: An International Study of Health Care Spending*[3] is authored by a well known British economist, Robert J. Maxwell, current Secretary of the King Edward's Hospital Fund for London.
- The 1984 Report of the Directorate for Social Affairs, Manpower and Education of the Organization for Economic Cooperation and Development (OECD), the main economic and social association of the top industrialized Western societies, is entitled *Expenditures on Health Under Economic Constraints*.[4] It was the product of a series of studies carried out by the Secretariat of that Association in response to the governments' concern about the remarkable growth of health expenditures at a time when all these governments face economic difficulties.

The Private/Public Mix

Funding of Health Services

Maxwell reports an international survey of health expenditures which shows that the US government allocates proportionately less government funding to health services than any other developed industrialized nation. Government expenditures represent 91.7 per cent of all health care expenditures in Sweden, 92 per cent in the United Kingdom, 75 per cent in Canada, 77 per cent in West Germany, and 75 per cent in France, while they represent only 42.7 per cent in the US.[5] Similarly, among Western developed industrialized countries, the US government health expenditures as a percentage of the GDP (Gross Domestic Product) are the lowest. In 1982, health expenditures by government represented 9 per cent of the GDP in Sweden, 5 per cent in the United Kingdom, 5.9 per cent in Canada, 6.6 per cent in West Germany, and 6.7 per cent in France, while they represented only 4.5 per cent in the US.[6]

A more detailed analysis of the sources of funding for public and private expenditures on health care in the six major Western developed industrialized countries (Table 1) shows that public/social insurance is the main source of funding of health services in France and West Germany, while general taxation is the main source in the United Kingdom, Sweden, and Canada. The US is the only one of these six countries in which the majority of funds for health services comes from private sources, half of this being direct family or individual payments.

Delivery of Health Services

The other side of the coin in the analyses of public versus private funding of health services in Western industrialized nations is to look at the institutional channels through which these funds are being expended. In other words, what proportions of these funds are spent in government-administered institutions, in nonprofit voluntary institutions, and in for-profit institutions. Table 2 provides this information for the same six countries. Sweden and the United Kingdom are the countries where the majority of funds go to government-administered institutions. In West Germany, France, Canada, and the US, the majority of funds are spent in non-government institutions. These are also the countries with larger private, for-profit sectors. It is worth noting that these "large for-profit sector" countries also share the following characteristics:

- *Physicians have higher relative incomes* than those in countries with a small "for-profit" sector. In 1980, for example, the ratio of earnings of physicians to average compensations per employee was 5.1 in West Germany, 4.1 in Canada, 3.8 in the US and 3.3 in France, while it was only 2.8 in the United Kingdom.[7] (No similar information existed for Sweden for 1980.) This ratio, incidentally, was also lower in the United Kingdom and Sweden than in West

Address reprint requests to Vicente Navarro, MD, DMSA, DrPH, Professor of Health Policy, School of Hygiene and Public Health, Johns Hopkins University, 615 North Wolfe Street, Baltimore, MD 21205. This commentary, submitted to the Journal April 11, 1985, was revised and accepted for publication July 10, 1985.

© 1985 American Journal of Public Health 0090-0036/85$1.50

TABLE 1—Health Care Expenditure by Source of Funding, 1975 (percentage of total expenditure)

Source of Funding	United Kingdom	Sweden	Canada	West Germany	France	United States
Public Expenditures						
General Taxation (including payments to public insurance schemes).	87	78	66	14	7	31
Public Insurance	5	13	9	62	69	11
Other	0.3	—	—	—	—	—
Total Public Expenditures	92	91	75	77	76	42
Private Expenditures						
Direct Payment	5	8	20	12	19	27
Private Insurance	1	—	2	5	3	25
Total Private Expenditures	7	8	22	17	22	52
Other	0.4	—	2.6	5.1	1.4	4.6
Total	100	100	100	100	100	100

Adapted from Maxwell RJ, Table 4-1, p. 61.[3]

TABLE 2—Health Care Expenditures by Ownership-Administration of Institution, 1975 (percentage of total expenditure)

	Sweden	United Kingdom	Canada	West Germany	France	United States
Government institutions	82	73	20	20	37	19
Non-government, non-profit	negligible	negligible	37	80* { 33	17	36
Private, for-profit institutions and contractors	17	26	42	47	44**	44**
Other	—	—	—		0.3	—
Total	100	100	100		100	100

Adapted from Maxwell RJ. p 68.[3] ("Private, for-profit institutions and contractors" includes payments to physicians and others in private practice or working as independent contractors, to pharmaceutical companies and to other medical suppliers.)

*The separation profit-nonprofit is unrecorded by the West German government. It has been estimated, however, that not less than 47 per cent of all total expenditures is spent in payments to physicians and other professionals in private practice or working as independent contractors, pharmaceutical companies, and independent contractors and medical suppliers. U. Deppe, *Health Policy in West Germany*, V Congress of the International Association of Health Policy, Barcelona, Spain, 1982.

**The figures for the US and France are the most conservative figures within the size range that R. J. Maxwell calculated for the profit sector. This range was, for the US, 44 to 81 per cent of all health expenditures, and for France, 44 to 60 per cent.

TABLE 3—Coverage and Co-payment Rates by Country, 1981

	Coverage Rates (% of population covered by public programs)			Co-payment Rates (% of total costs paid by public expenditures)		
	Hospital	Ambulatory	Pharmaceutical	Hospital	Ambulatory	Pharmaceutical
United Kingdom	100	100	100	99	94	99
Sweden	100	100	100	100	91	70
West Germany	91	91	91	79	84	70
France	100	99	99	92	58	75
Canada	100	100	33	91	72	23
United States	40	25	2	54	56	9

Adapted from OECD Report, Table 7, p 40.[4]

Germany, Canada, France and the US in 1975, when similar information for all these countries was available.[8]

- *There is a larger expenditure on pharmaceuticals* (as a percentage of total health expenditures) than in those countries with small "for-profit" sectors. France spends 21 per cent, West Germany 17 per cent, and Canada 10 per cent of their total health expenditures on pharmaceutical products, whereas Sweden spends 9 per cent and the United Kingdom 7 per cent. An anomaly, incidentally, is the case of the US, which, in spite of having a very large "for-profit" sector, spends only 8 per cent of its total health expenditures on drugs.[9] This may be due, in part, to government regulation of drugs, government control of market entry, and government supervision in the distribution of drugs and therapies by the US Food and Drug Administration.

- *There are larger administrative costs for health insurance and public agencies* than in those countries with small "for-profit" sectors. Administrative expenditures, for example, represent 9.3 per cent of all health expenditures in

France, 6.0 per cent in West Germany, 4.7 per cent in the US, and 1.7 per cent in Canada, while they represent only 0.9 per cent in the United Kingdom and 0.4 per cent in Sweden.[10]

- *Health coverage of the population is less extensive* than in countries with small "for-profit" sectors. Table 3 shows the percentage of the population covered by public programs for different health services and the percentage of those expenditures covered by public funding. This Table shows that countries with a large "for-profit" sector (Canada, the US, West Germany, and France) offer less coverage for health services than those countries where the "for-profit" sector is small (United Kingdom and Sweden). The US offers the least public coverage of health services to its population and also provides the lowest amount of public funds for hospital, ambulatory, and pharmaceutical services. It is worth noting that these limitations extend to private insurance, as well: 39 million Americans (19 per cent of the total population) did not have any form of public or private health insurance whatsoever.[11,12] In 1982, 6 per cent of US families (4.2 million) reported that they needed medical help during the year, but failed to get it; and 2 per cent of US families (1.4 million) were refused care for financial reasons.[13] Rationing of health care does indeed occur in the US, with the criterion for the allocation of resources being the ability to pay.
- *There is a greater degree of direct payment by users of health services* than in those countries with small "for-profit" sectors. Table 1 shows that countries with large "for-profit" sectors (Canada, the US, West Germany, and France) are also those that require more direct payment from the users of health services.

In brief, those countries that have larger government involvement in the funding and in the administration of health services are also the countries that have health systems with lower "for-profit" sectors, as well as lower relative earnings for physicians, lower expenditures on pharmaceuticals (with the exception of the US), lower administrative costs, greater public coverage of the population, and less direct payment for health services. It is also worth stressing that the reliance on public/social insurance as the system of funding for health services (as in France and West Germany) does not necessarily lead to a small "for-profit" sector. The overall size of this "for-profit" sector (as percentage of total health expenditures) has major consequences in terms of extent of coverage, administrative costs, degree of direct payment, and other factors relevant to the cost-efficiency concerns in the health sector, widely discussed in the US today.

Controlling Health Care Expenditures

Another observation that an international survey allows is that among countries (such as the United Kingdom, Canada, and Sweden) that depend heavily on general taxation for the funding of health services, those with central government control of general funds (Canada* and the United Kingdom) are able to control the overall growth of health expenditures better than those with general tax funds controlled by local governments (Sweden). For example, Canada and the United Kingdom have controlled overall health spending as a percentage of the Gross National Product (GNP) (from 7.1 per cent in 1971 to 7.1 per cent in 1979 in Canada, and from 4.3 per cent in 1971 to 5.2 per cent in 1979 in the United Kingdom) far better than Sweden, where the majority of tax funds are controlled by local government, and where health expenditures have grown from 7.4 per cent of the GNP in 1971 to 10.2 per cent in 1981. Similarly, the United Kingdom and Canada have been able to control the growth of health expenditures better than France and West Germany, where the majority of public funds come from public/social insurance to pay for the privately provided health services, or the US, where the majority of funds and delivery institutions are private. Health care spending as a percentage of the GNP increased between 1970 and 1979, from 6.4 per cent to 8.4 per cent in France, from 6.4 per cent to 9.2 per cent in West Germany, and from 7.6 per cent to 9 per cent in the US.[14,15]

In summary, those countries in which the central government plays a major role in funding health services via general central taxation have been able to control the growth of health expenditures better than those where the central government has played a lesser role. Thus, an active government intervention in the funding and administration of health services does not necessarily mean more inefficient health services with larger administrative costs and lesser coverage. In fact, government intervention leads to a more efficient and supportive health service, one that protects and covers more people and services, than those in which the private "for-profit" sector dominates.

In light of all the evidence presented, one must question whether the current US emphasis on the private "for-profit" sector and the de-emphasis on central government interventions will lead to efficient ways of allocating resources within and outside the health sector.

*Canadian federal government *shares* costs with provinces, but federal policies *influence* level of provincial expenditures.

REFERENCES

1. GOP National Committee: The 1980 Republican Party Platform, 1980.
2. Weaver W: Democratic Platform Shows a Shift from Liberal Position of 1976 and 1980. *The New York Times*, July 22, 1984.
3. Maxwell RJ: *Health and Wealth: An International Study of Health Care Spending*. Lexington, MA: Lexington Books, 1981.
4. Organization for Economic Cooperation and Development: *Expenditures on Health under Economic Constraints*. Report of the Directorate for Social Affairs, Manpower and Education, OECD. Washington, DC: OECD, 1984.
5. Figure 4-1, Sources of Finance for Health Care Expenditures: The Mix between Public and Private in 1975 as a Percentage of Total. *In:* Maxwell RJ, *op. cit.* p 60.
6. Table 4, Share of Total Expenditures on Health in Gross Domestic Product (percent in current prices). *In:* OECD Report, *op. cit.* p 37.
7. Table 13, Relative Earnings of Physicians (Ratio to average compensations per employee). *In:* OECD Report, *op. cit.*
8. Table 4-7, Doctors' Income in Relation to Gross Domestic Product per Capita and Earned Income, 1974 or Near Date. *In:* Maxwell RJ, *op. cit.* p 77.
9. Figure 4-9, Expenditures on Pharmaceuticals (Prescribed and OTC) as a Percentage of Total Health Care Expenditures in 1975. *In:* Maxwell RJ, *op. cit.* p 78.
10. Table 4-12, Health Care Expenditures by Service (Percentage of Total Expenditure. *In:* Maxwell RJ, *op. cit.* p 83.
11. Uninsured Increase, Study Shows. *Washington Report on Medicine and Health* April 30, 1984; 38:3.
12. *Medical Care Review* Summer 1984; 41(2):72.
13. Aday LA, Andersen RM: The national profile of access to medical care: where do we stand? Am J Public Health 1984; 74:1337.
14. Estimated from Table A-1, Total Expenditure on Health (in Millions of National Currency Units) and Table H-4, Gross National Product (in Millions). *In:* OECD Report, *op cit.*
15. Figure 3-9, Trends in Total Health Care Spending as a Percentage of GNP. *In:* Maxwell RJ, *op. cit.* p 45.