

An Overview of Health Sector Reforms in Developed Countries

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Introduction

In many countries all over the world, health sector is undergoing change, often described as health sector reforms. The need for this change or reform is driven to *meet diverse but conflicting pressures* (1). For example, most countries are implementing reforms in face of fiscal crisis and national debt. With technological advancements, health care delivery has become costly and governments perceive a need to control expenditure as well as role of the state in supporting the health care system. However, at the same time there is a growing pressure on the health care systems to meet rising health care needs as well as expectations with availability of better (even though costly) technology. Balancing these conflicting objectives is not easy and governments all over the world have considered health financing reforms as well as reform of service institutions to balance these conflicting demands. Health sector reforms also have to be understood in the context of globalisation, media revolution and access to information about democratic processes (2). Inter-relatedness and interdependence across countries has increased through spread of democracy and speed of communication (3). Many developed countries have implemented very similar market models of reforms in which role of state (and

therefore, cost to the state) has decreased. This suggests that governments and policy makers in different countries have transferred, borrowed and replicated similar principles of reforms from one another. Issue of equity, equality, coverage, choice and access come out as common reasons as to why these countries chose to reform their health care system (4). They appear to have implemented not too dissimilar solutions.

Objectives of health reforms

Health reforms in most developed countries share three objectives for their health care systems.

It is accepted that there should be adequacy and equity of access to minimum health care for all citizens. Most countries have mechanisms to ensure that either minimum health care is accessible to its population or some allowances are made available to the underprivileged for them to have access to minimum health care.

Most countries have concentrated on achieving macro-economic efficiency to control total health care expenditure. Countries have decided what percentage of Gross Domestic Product (GDP) will be devoted to health and then adopted economic models to ensure that cost

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of health care does not exceed this acceptable share of national resources.

An emphasis has been on achieving maximum health care at minimum cost. Some countries have chosen to retain a public health model, other countries have privatised health care, but all countries have adopted micro economic models to gain efficiencies, the goal being to achieve maximum health gains and consumer satisfaction at minimum cost.

Methods

These countries have tried to achieve these objectives by the following methods :

Divergence and regionalisation : Governments have decided to decentralise and regionalise rather than let the national civil servants guide health policy. In Austria, Belgium, Finland, Germany, Spain, Sweden and the United Kingdom, there is a tendency for health policies to be guided by regionally elected politicians (5). This has meant emergence of regional and local delivery systems.

Introduction of competition in the health sector : Most countries that have reformed their health care system have introduced competition in the delivery of health care. This has meant that countries have moved away from the State being a provider of health care to being a facilitator of health care provision. Health care is delivered on basis of contracts for provision of care that are tendered and won. In New Zealand, for example, prior to 1993 there was a regulated health care market. In 1993 the government created a purchaser (Regional Health Authority) that floated contracts on behalf of the people, and provider (Crown Health Enterprises) that contracts for provision of packages of care with the purchaser, the Regional Health Authority. Therefore, providers

have to compete with on another to win health care contracts.

Shift away from public health sector to privatisation.

To decrease their health care spending, governments have found it rather convenient to some how shift the burden of health care to the private sector. To decrease their health care spending governments have decreased the level of health care that is minimum that the State should provide. In reality this has meant that anything other than minimum health care has been picked up by the private sector.

Outcomes

Unfortunately even though one of the aims of new health care reforms was to achieve equity, this has remained impossible to achieve. Some argue that even though health care delivery is now more efficient than before, there has been a decrease in availability and accessibility of health care among the different population groups. This is especially true for expensive technology and health care procedures that are not considered to be the 'core'. Despite competition (and even government regulation of private sector) inequity remains between regions, and between population groups. In most countries that underwent reforms co-payments have been introduced under the guise of encouraging individual responsibility and preventing indiscriminate wastage of expensive health care resources which has meant that the poor are not able to have access to what used to be considered basic health care.

Health care reforms and introduction of market in health care has meant evolution of a new paradigm. Therefore, an army of managers and management consultants took over health care delivery system

resulting in an increase in management costs and overheads. Market oriented health reforms and introduction of contracting was intended to lower costs. It was hoped that providers would become cost-efficient to compete with one another. However, this paradigm shift has meant that health care organisations have become bureaucracies with huge increases in administrative costs to process information for purposes of contracting. Availability and use of health information has become more important than provision of health care itself so that contracting can occur and market mechanisms can take its course. Moreover, improvement in information technology has meant that there is a possibility of capturing the most complex information even though it may not have too much relevance.

There has also been a change in power structures. Government departments are no longer huge bureaucracies. Instead power is in lower level organisations. In countries where health care market is split into purchasers and providers, power is at this level. In other countries, e.g. the US, where there are employer organisations power lies in managed care organisations. With regionalisation, there is more authority and influence of local and regional governments rather than national or Federal governments. Unfortunately, the end user, the consumer, continues not to exert too much power on the system. Some suggest that in fact power of the

consumer has actually diminished. In the past there was some scope for the consumer to negotiate with his/her doctor about health care provision. However, now decisions with regard to provision of health care tend to occur at the level of purchasers and providers, which are too distant from the end user.

Conclusion

Health policy makers in the developed world have tried to address the issue of equity and access in context of financial squeeze by reforming their health care systems. Most countries have implemented very similar reform but whether the consumer has benefits from these reforms, has to be questioned.

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