

The Centre for
International
Public Health Policy



A Return to a public health paradigm

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Goals of a National Health Service

Universal – for all

Comprehensive

Equal access for equal need and not on ability to pay

Free at point of Delivery

Mechanisms

1. Redistribution– fairness of funding , social solidarity
2. Risk pooling – no segmentation of risk pool

Funding

Redistribution through raising of funds

Redistribution through delivery system –resource allocation

Funding

Central Taxation – substitute Grant for poor countries

Local Taxation

Social Insurance Funds

Private Voluntary insurance

Micro–insurance

User Charges

Medical Savings

Service delivery

Population: Area based Population– no exclusion of groups, conditions or treatments

Planning: Needs Based Planning: population based– inputs, processes and outcomes, integration to prevent segmentation

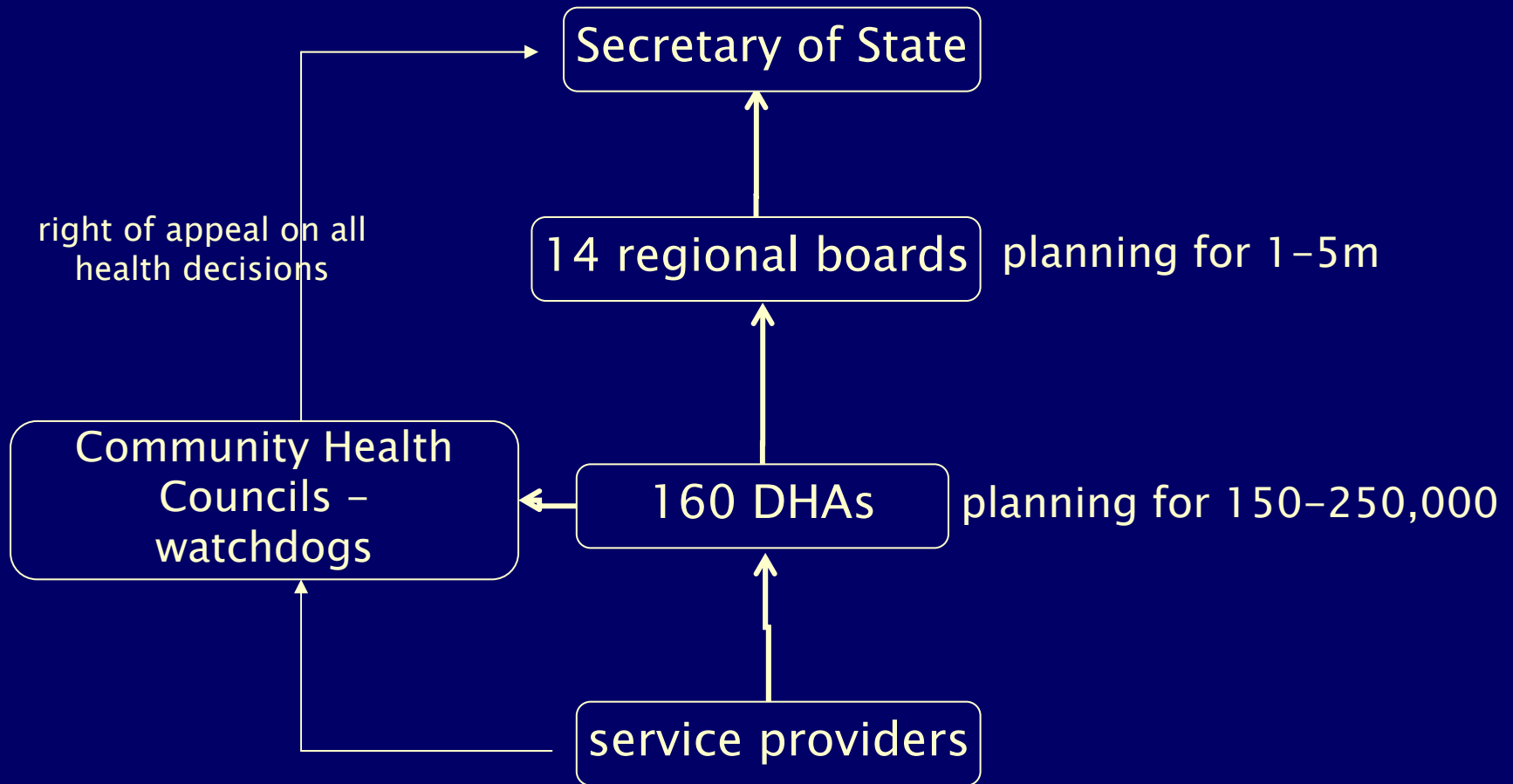
Public accountability for resources and public control either through direct regulation or direct ownership

Model 1: Information–designed to monitor access and fairness

Needs Assessment/ planning Information for public health

- Inputs: staff, services, beds, resources per head of population
- Access: age and sex adjusted referral, consultation, treatments rates per head of population by geographic areas, patient surveys, audits and inspections, complaints
- Outcomes: quality of life, death rates by geographic areas, patient surveys, audits and inspections, complaints

Accountability: case study UK NHS pre 1991



Planning universal population-based services



Public private partnerships

The main principles of PPP are drawn from New Public Management. This encourages:

the decentralisation of management;

the separation of public funding from service delivery– purchaser provider split;

financial incentives as a driver of better performance, demand and supply side controls; and

private sector involvement

Networks with blurred funding and accountability

No evidence base and no data

Model 2: Market forecasting

Providers attempt to predict profitable treatments and care

Providers limit risk

Regulators decide eligibility and range of services through the license to operate

Commissioners allocate and decide supply according to price and performance measures – mechanisms for needs assessment are weak not least because of information asymmetry

Commercial contracts– lack of transparency

Fragmentation

	Universalism Risk pooling and social solidarity	'Non' Universalism 'Targeting' Market mechanisms
Methods of funding	Progressive taxation - Social insurance - Central taxation	Regressive taxation - Private insurance - local taxation - Charges
Resource allocation	Risk pooling - geographic allocations on basis of population needs	Individual - Capitation payments based on risk
Service provision	Cross subsidisation of services and treatments - Block budgets, salaries, state ownership	Service unbundling - Pricing and competition - DRG
Organisation	Planning authorities - 1°, 2°, 3° levels of service within a geographic population - Not- for- profit	Providers/ Companies - enrollees/ members - combine insurance + provider
Accountability	National and local electorate, users, staff	Shareholders, boards

Changes to NHS in England

- Abolition of planning tiers and population based resource allocation mechanisms
- Uncoupling of planning from provision with the introduction of pricing
- Devolution of risk to multiple providers and ultimately patients and carers by establishing financial regimes based on corporations
- Service fragmentation and unbundling of service elements through pricing and charging
- Move from population to individual consumers
- Abolition of public interest accountability structures
- Structures designed to protect the state are now being used to protect the private sector

Diagram 1. Regulatory Framework for Health Care in the United Kingdom

