

Public health classics

This section looks back on a ground-breaking contribution to public health and provides a commentary on its significance from a modern perspective. To complement the theme of this month's issue, Jacky Mathonnat reviews an article by Herbert A Klarman that was published in 1965 in the journal *Medical Care*.¹

The case for public intervention in financing health and medical services

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“THE CASE FOR PUBLIC HEALTH INTERVENTION IN FINANCING HEALTH AND MEDICAL SERVICES

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The market mechanism is neither all pervasive in the health and medical care industry in the United States nor given full sway in the areas it does permeate. The question is: Why do governments and philanthropy play such important roles in the provision and financing of health and medical services?”

For the full text of the paper by HA Klarman,¹ please see:
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Klarman's article “The case for public intervention in financing health and medical services” has aged very well.¹ His main arguments, some of which are derived from an analysis (that has since become a classic) of the inadequacies of the health market, are still current. Although he was writing from the perspective of developed countries, primarily the United States of America, his points can be transposed to the problems developing countries now face. I will select some aspects of Klarman's essay to show how economic analysis – since fuelled by empirical work – has further extended his analyses, without questioning their essence.

There has long been a broad consensus on the need for governments to play a role in health. Philanthropy is also well established in this sphere, from the religious hospices of the Middle Ages to the creation in 1863 – after the Battle of Solferino – of the International Com-

mittee of the Red Cross. Nongovernmental organizations (NGOs) continue to provide solutions where governments are seen to have more or less failed and are credited with being more efficient when it comes to delivering goods and services. NGOs have become a strong partner in health, not only of governments, but also of bilateral aid agencies and international organizations, such as the United Nations and The World Bank. However, we lack the evidence to credit them consistently with clear-cut qualities and results.^{2,3}

Fifteen years ago, private aid for health was quite negligible in terms of its financial importance. It now represents about one billion dollars, mostly coming from foundations, which is about one-quarter of public aid for health in developing countries. Through the examples he quotes, Klarman has pinpointed how the government can offer incentives to encourage philanthropic

contributions to health, in particular by using tax measures.

Studies of mortality determinants over several decades, or even centuries, have highlighted the role of health policies.⁴ However, the relative significance of any particular policy is highly controversial, such as the debate over whether income is the most important determinant of health.⁵ For example, mortality trends in the former Soviet Union suggest that income may not be the primary determinant of early mortality.⁶ Government intervention plays an essential role in most public health actions,⁷ while some can be credited to the private sector and to private initiatives. Nonetheless, the links between public health expenditure and health improvement are tenuous and econometric analyses have yielded widely divergent results,^{8,9} leading us to the highly consensual formula that “it is not enough merely to increase expenditure on health”.

Contemporary analyses back up Klarman's line of argument, for example that the efforts to strengthen health systems or to control neglected diseases are underfunded.¹⁰ His position on medical research has also been vindicated. While research is essentially a public good – albeit largely financed by private resources in certain fields – there are still (as he wrote) “serious questions [that] arise concerning patent policy and regulation of monopolistic practices,” as shown by the licensing of antiretrovirals.

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When he observes that it might be in society's interest to subsidize individuals to encourage immunization, Klarman foresaw current practice. He was also right about what are now called conditional transfers, giving individuals an incentive to change their behaviour to benefit both their health and society's interest. A good example is Oportunidades (formerly called Progresá), an anti-poverty programme established by the Mexican government, that has shown significant reductions in child mortality as well as a lower prevalence of anaemia.¹¹

All countries struggle to justify government intervention in efforts to reduce unit costs of health care. Here Klarman emphasizes the variability of marginal costs in relation to the concentration of care providers. But he does not consider the government's dilemma of choosing between methods of financing public and private providers where competition exists in the health care and health insurance markets.

Klarman's analyses on the efficiency of health systems do not consider countries, such as those in sub-Saharan Africa, where more than half of total expenditure on health care is private (and generally of mediocre standard). Total expenditure on health in almost all countries is insufficient to ensure universal coverage of basic health care alone. Therefore, government intervention, by means of financial and other instruments, is essential to improving the efficacy and efficiency of both public and private sectors.¹²

More recent studies have shown that a certain number of efficacious and reasonably or moderately priced solutions are dramatically underemployed.¹³ If 99% use were made of preventive measures and effective treatments to control childhood illnesses, it would

be possible to reduce child mortality by 63%. If the same use were made of interventions addressing the key causes of maternal mortality, the rate could be reduced by 74%.¹³ These estimates are open to debate but they give an idea of possible progress. Such underutilization can be attributed to many factors affecting supply and demand for health services and it is difficult to see how the private sector alone can correct such deficiencies without financial and regulatory action by governments.

Many studies have since confirmed what Klarman wrote about "assistance to the poor", including the relationship between catastrophic costs and poverty.¹⁴ Other studies have justified government intervention to establish equity in financing, access and consumption of care. We now know that, when they exist, private mechanisms for sharing the burden often operate inefficiently and cannot solve the problem of access to health care for the poor or the consequences of major health problems.¹⁵ We have also learnt that in low-income countries it is often necessary for the government to intervene financially to encourage health-insurance mechanisms and that tax policy is a key element in mobilizing and pooling resources for health.

Klarman rightly points out that choices made by consumers are unreliable. In his view, "consumers need guidance". Many individuals behave in ways that harm their health and consumer pricing policies have been shown to reduce consumption of harmful products such as alcohol and tobacco.¹⁶ Such policies raise the question of individual preferences and whether the government has the right to try to modify them. Demand for health care is also expressed (through the ignorance of patients) in inefficient, costly and even dangerous forms (e.g. large demand for

antibiotics or for injections), which could also have negative consequences beyond the individual (e.g. resistance to antibiotics). On the other hand, government intervention can also be used to encourage demand for preventive services and curative treatment.

Klarman does not address the related issue of agency theory. Many health interventions are marked by an asymmetry between the information available to patients and to providers, resulting in "credence goods." That is, experts are better placed to know what type of goods and services consumers need than consumers themselves.¹⁷ This situation offers a justification for regulatory and financial intervention by the government. Studies have shown that price mechanisms aimed at solving the problem posed by experts abusing patients' trust are unrealistic.¹⁷

Klarman did not tackle the admittedly controversial interrelationship between health production, health, economic policy and growth.^{18,19} When he wrote, he could not take into consideration the basis of the development of public and private aid to health, which aimed to fill part of the funding and knowledge deficit in the national public and private sectors. A growing part of this aid is today motivated by concerns for "global public health".

Klarman also takes the view that increased expenditure on health will be a source of employment for the surplus workforce of the manufacturing sector. It is interesting to note that he is thinking along the same lines as Fogel did in 2004, who considers that the health industry will be the driving force of tomorrow's economy, as the railways and the motor car once were.²⁰ But, without a doubt, this is not the soundest point in an otherwise remarkably prescient article. ■

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