

Public economics in current health policy

Veřejná ekonomie v současné zdravotní politice

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1 Introduction

Currently, the Czech Republic is standing at the crossroads and has to decide which way to go in its health service system. The current trend seems to lead to a sharp weakening of the government and public sector role. This is, of course, “a big topic” and it is not easy to cover it, not to say responsibly analyse it, on a few pages.

Though, it is useful to search and sum up what makes advanced world economies act in a different way in their health services, attribute a system role to the public sector in health service and develop this role in an active and responsible way. This will be dealt with on a theoretical level – we will tackle the role played by the economics of public sector or, in short, public economics in current health policy, and particular spots suitable for its application.

The starting point of this paper is the hypothesis that current health service policy in the Czech Republic leads to the model of passive care for health problems of the population and applying the principles of (quasi)market allocation in health service. Two essential questions follow from this summary hypothesis. First, if this approach is in compliance with the principles of public economics, especially from the viewpoint of a rational allocation in the public sector aimed at the results in health condition of the population. Second, to which extent the discussion on solidarity principles and equivalence is mixed with economic effectiveness. And/or, to which extent the back off from the solidarity in the sense of securing the necessary health care as a public service is accompanied by the signs of market failure and thus also suboptimal solution in allocating private resources. We can see that there are important hidden risks in both questions as regards the rationality and effectiveness of the system and also in its results measured by health condition of the population and other sub-criteria describing its characteristics.

2 The importance of public economics in health policy

A market solution in the field of health service consists in the approximation of health risks through private insurance. Historically, it was applied e.g. in the USA, but even there it resulted in regulating its rules by the government, managing the costs of health care and efforts to utilize economies of scale.

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Private insurance of health risks has, however, a number of properties making it unsuitable as a universal means for practising health policy. They are namely:

- The selection of risks leading to non-insurability, non-insurance and underinsurance of citizens
- Unless a non-profit principle in the sense of allocating the profit “inside” the insurance company is applied, the effort to make profit with the aim of its allocation outside the insurance company can weaken the sense of insurance
- For the insurance company, primarily, the quality of the insurance stock is substantial, not the health condition of the insured from the medical viewpoint
- Administration costs and dependence on economic activity of citizens
- The tendency of more well-off insured not to share the same “group” with the less well-off can theoretically result in the liquidation of the whole insurance market
- A private insurance company is an institution based on actuarial mathematics and aims at maximising the profit, not an institution pursuing the welfare and health condition of its clients – patients

These disadvantages can be found even with other kinds of private insurance. In case of health insurance, however, the problem is that generally, the citizens cannot avoid the costs of health care and thus it is absolutely imperative for them to participate in the insurance. Different situation exist in private life insurance relating to higher income categories and private non-life insurance. Here insurance is based on a voluntary principle and individual relation to risks. We can imagine that if, e.g., insurance policies of engines of higher volumes were expensive the share of such engines would relatively fall. Here the principle of “deadweight costs” known from tax theory can be applied. Just as well, insurance companies may indirectly force the clients not to build their houses in flood areas. In this respect private insurance can have an “educational” effect – it can suppress activities or situations which are obviously risky and thus hardly insurable.

In case of health insurance it is not so because this approach quickly collides with physical and psychical identity of an individual, and also with his or her social position in the economy.² These are objective facts difficult to handle in a short period and, moreover, there exists the principle of freedom, which is fundamental, connected with the very existence of human beings. But there is also the right to life – and as the condition of health is often linked with life and its quality, there is a tight relation between the right to life and the right to health in the sense of health care consumption necessitated by a change of health condition.

So we can see that a market solution through private insurance in health service meets a number of problems. Together with the application of solidarity principle this leads to its limited applicability in practising health policy. However, if it is not possible to apply the principle of private insurance generally, then a second rational approach is using economics of the public sector or, simply said, public economics.

2 *This does not mean, however, that insurance companies could not support the kind of behaviour which is evidently desirable for health condition – prevention or penalties for contrary behaviour. But the practice of health policy and experience of advanced countries show, that such tools have limits in health insurance.*

It is necessary to say that public economics is not self-salvable in the area of health service (or anywhere else). Disadvantages and risks described in the theory of public finance concerning the effectiveness of the public sector also apply to health service.

The principle of public health insurance does not consist in the calculation or individualisation of risks, but in sharing the aggregate health risk of the population. The premium for public health insurance is not a tax (as it is often mistakenly believed to be) indeed, but it is a specific parafiscal revenue – a fund – covering the aggregate risk of the population in a given year economically expressed as costs of health care.

No matter which way we prove the importance and ensure the effectiveness of the public sector even by using purely economic tools (Bénard, 1990), the sense of its existence in the economy is much broader. First of all, it facilitates the consumption of goods and services on the principle of civil rights where the society arrives democratically at a consensus. In case of health service where the right to health is defined by law (Listina základních práv a svobod) it is a very appropriate tool.

Let us point out, however, that the concept “the right to health” itself is only of a declaratory character, undoubtedly, the point is not in the possibility of making claims on health, on reaching good health condition of a concrete individual. Meeting such claims can never be guaranteed, which is given by the character of medicine and human existence, and also by economic constraints. So if we discuss the right to health, it is, in fact, a discussion on real possibilities of consuming health care used by an individual according to his or her health problems. The right to health can thus be interpreted as “equal chances of recovery”. And, of course, so it is with other rights, for instance the right of equality before the law – in practice an ideal application can hardly be achieved.

Another purpose of employing public economics in health service is the wielding of the state power in cases defined by law – in health service the so-called goods under protection (e.g. compulsory vaccination, treatment of contagious diseases), and also in the sense of ensuring the availability of health care for citizens across social groups and regions.

And the last purpose of employing public economics is the fulfilment of those health service dimensions and criteria which – as shown by empirical experience of market oriented health service systems – are not fulfilled by the market spontaneously. It is not only the social dimension of effectiveness (as described below), but also ethical criteria forming an organic part of market relations from where, however, they may be pushed out on the basis of momentary effectiveness preference (Smith, 1958)

3 The classification of goods in health service

Health care is indisputably a scarce good with non-zero production costs. Generally, economic theory classifies scarce goods from economic viewpoint as public and private.³

3 SAMUELSON, P. A. *Pure Theory of Public Expenditure and Taxation*. In: MARGOLIS, J. D. GUITTON, H. (eds.): *Public Economics: An Analysis of Public Production and Consumption and their Relations to the Private Sector*. London, Macmillan, 1969.

The criteria are non-exclusion from consumption, indivisibility of the good and non-rivalry in consumption (the costs of extending the service for another consumer are close to zero). Some economists, e.g. Coase, regard as more important than these criteria the criterion of transaction costs whose increase leads spontaneously to setting up bureaucratic institutions that do not make decisions about the goods on the principle of supply and demand of individuals.⁴

Methodologically it is useful to classify the goods from the institutional viewpoint as done by Bénard who classifies them from the viewpoint of financing to non-market, impurely market and market.⁵

Table 1: General classification of goods according to institutional criterion

Institutional criteria		
Category of goods	Existence of market negotiation and market price	Government discriminatory intervention
Pure market goods	yes	no
Impurely market goods	yes	yes
Non-market goods	no	yes

Source: Bénard, J. *Veřejná ekonomika I. Praha: EÚ ČSAV 1990*

This classification makes it possible to differentiate the character of a good from the viewpoint of financing (allocation) – if there exists a market price resulting from the interaction of supply and demand in a competitive market and financing from private sources, Bénard considers the good to be pure market, in contrary case non-market.

There is a connection between the characteristics of goods in health service and the concept of externalities, both positive and negative. Externalities are a sort of market failure and are the cause of the fact that the participant of an accomplished transaction does not bear the consequences of his activities.⁶

In health service by a positive externality we mean e.g. treatment of contagious diseases, more precisely speaking, its effect on not spreading it on further individuals. A negative externality is e.g. a high consumption of antibiotics based on non lege artis treatment because it may cause a loss of effect of a certain antibiotic on further people.⁷ Nevertheless, it is the character

4 COASE, R. *The Problem of Social Cost. Journal of Law and Economics*, October 1960. Coase suggests solving even the problem of externalities in this way – dealt with below.

5 BÉNARD, J. *Veřejná ekonomika I. Praha: EÚ ČSAV, 1990.*

6 In other words the impacts can be seen even out of the group of participants of a market transaction, so they are not “evaluated” within. By Bénard an externality is defined as a “direct linkage between utility functions or production functions of various economic subjects which does not develop through market”.

7 Viz Czechs score again in taking antibiotics.

<http://aktualne.centrum.cz/zdravi/zpravy/clanek.phtml?id=378360&tro1164_0_5>, [cit. 14. 3. 2008].

of externalities that the quantification of their effect is usually difficult, moreover, there may be different opinions on what may be considered an externality.

Generally, externalities can be solved by

- a) regulation and setting rules for transactions or by providing a good (in case of positive externality) in a non-market way,
- b) internalisation (negotiations between private subjects on condition of perfect information, defined ownership rights and zero transaction costs).⁸

In health service production only few goods being up to the criterion of a public good appear. Their consumption is either automatic (e.g. hygienic service, fighting epidemics, basic research of diseases, creating quality standards) or facultative (e.g. prevention programs). A much higher share of goods (e.g. the most of ambulance and sick-bed care in European systems) is financed publicly or regulated (so they are non-market or impurely market according to Bénard's classification), but not quite up to the criteria of a public good from the viewpoint of consumption. These health service goods (sometimes called mixed goods – see below) are, with some abstraction, divisible as to quantity, but typically, not quality, and technically, we can – ignoring medical or ethical criteria – exclude individuals from their consumption. Moreover, there may appear an effect of overburden, especially above a certain level of consumption of these goods (the case of using up the capacity).⁹

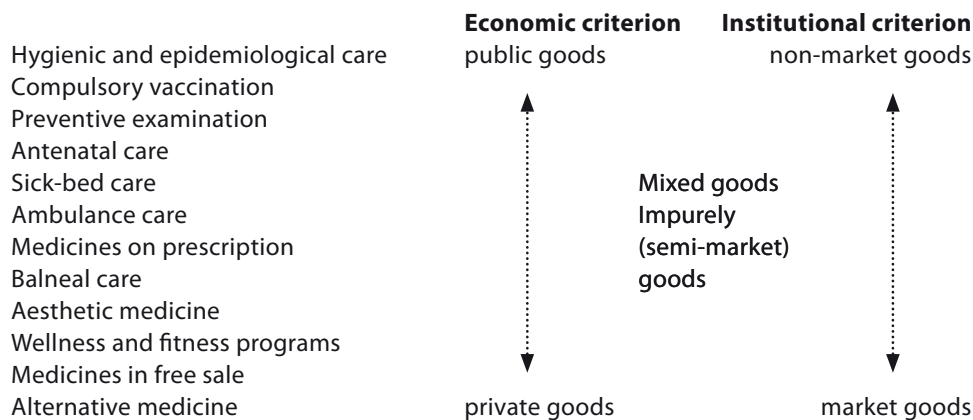
The problem is different if the exclusion is allowed by legislation, then other factors working within society are involved. Methodologically, it is useful to distinguish if it is really difficult to exclude an individual, either technically or by the nature of the good (e.g. from polio vaccination or national prevention program on cancer the exclusion is possible, though, but then the whole good will lose the sense of disease eradication) or if it is only a result of social consensus that there will be no exclusion (e.g. consuming physiotherapy care). Of course, it is not always possible to clearly determine the goods, as marked by connected arrows in the picture. It is also true that in the literature (with Bénard, too) the most of goods in health service are often classified as mixed goods with a combined collective and private element. I believe, however, that such classification is done according to benefits, i.e. who benefits from the consumption of the respective good (then it is obvious that it is both an individual and society, which leads to state intervention). I consider the differentiation used in this chapter more complicated, but more precise. Though it is true as well that if there is a long-term claim guaranteed by legislation on which there is general agreement and a certain capacity is defined by the nature of the good (e.g. salvage and rescue service covering a region) then I would rather classify such a good as public even considering a theoretical possibility of exclusion from consumption. It is a paradox of health service practice that currently, the governments can buy such a good from the private sector (through a public tender for e.g. rapid salvage service), but it is a matter of

8 *This approach is recommended especially by Coase who proves that under the fulfillment of these premises the market will solve the externality problem without a regulation – by including all participating subjects into negotiations and also the balance of the transaction (Coase's theorem).*

9 *As Bénard says to this effect "with a growth of consumed quantity (e.g. traffic congestion, overcrowded exhibition) the quality goes down (the speed and safety of traffic, impression of works of art)" BÉNARD, J. Veřejná ekonomika I. Praha: EU ČSAV, 1990.*

co-called make or buy decision (details by Hamerníková, 2007). It is necessary to say that the conceptions of various economists on the classification of concrete types of goods differ (they also depend on normative approach and public option, particularly as it regards the institutional criterion but also the way of understanding the characteristics of goods). The following scheme shows a model classification of health service in the direction from public goods to private and non-market to market.

Picture 1: Classification of goods in health service



Source: worked up by author

The scheme shows one more important fact, namely that in health service goods of various economic characteristics can be found, which makes the analyses more complicated. The biggest and most expensive group is sick-bed care and ambulance care which is situated in about the centre of the classification. Let me point out that the option of financing individual types of goods from public or private resources may also depend on criteria other than it corresponds to their economic classification and characteristics in achieving Pareto or Walras optimum. This is analysed by e.g. Buchanan coming to the conclusion that the real way of financing goods as a manifestation of their character also depends on the result of the democratic process (Public Choice) within which financing goods can be changed in any way.¹⁰ As said by Hampl in the discussion on approaching public goods in connection with Buchanan's approach, „in a democratic society relevant majority is authorised to make any good public without any regard to its character or economic nature.”¹¹ In Buchanan's conception this is, of course, true also in the other way – in relation to private goods. These shifts, however, describe exclusively the institutional criterion, because the economic nature of goods cannot be changed even by democratic vote.

This analysis of goods shows that from the viewpoint of public economics Bénard's institutional approach is essential beside "intrinsic" characteristics of the good. The reason

10 BUCHANAN, J.M. *Public Finance in Democratic Process, Fiscal Institutions and Individual Choice*, Chapel Hill: The University of North Carolina Press, 1987.

11 HAMPL, M. *Troji přístup k veřejným statkům*. In: *Finance a úvěr*, č. 51, 2/2001, str. 111-125.

is that in different systems the government enters the allocation in different ways and so economic characteristics of goods are only a kind of „a starting point“ for discussions on intervention possibilities. The attitude of the government is an authentic fact according to which the goods are classified in Bénard’s table and thus the rationality of their allocation viewed by public economics is implied.

4 Dimensions of effectiveness in health service

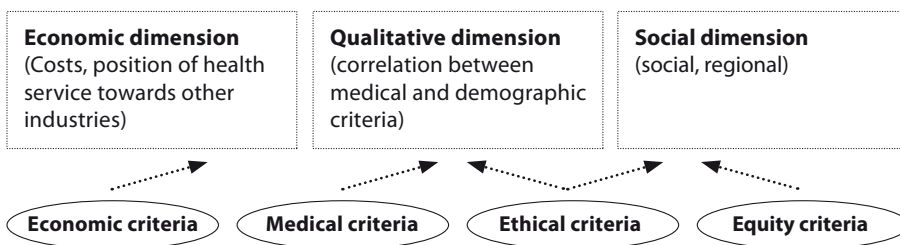
Let us emphasise the essential aspects which are, even on the basis of approaches mentioned in this text, the key to determine effectiveness in health service. The first, inherently present, is a continuous conflict between economic effectiveness and other criteria to be fulfilled by the system of health service. It hides not only the pressure on health service effectiveness per se, but also the pressure of competitive public systems such as education or transport – they want health service to consume more resources than objectively necessary – which means effective.¹² The second aspect is the grouping of sub-criteria into blocks (dimensions) which allow the classification of individual criteria from an analytic viewpoint.

The mentioned approaches lead to dividing criterional effectiveness of health service system into three basic dimensions – economic, qualitative and social dimensions.¹³ The fulfilment of these dimensions of effectiveness can be transposed as being up to

- economic criteria (e.g. expenses, financial stability, economic rationality) contained in the economic dimension
- medical criteria (e.g. the number and rate of success of transplantations, infant mortality) contained in the qualitative dimension
- equity criteria (e.g. availability of health service in social groups and regions) contained in the social dimension
- ethical criteria contained in both qualitative and social dimension

The presented idea is shown in the following scheme in a graphic form:

Picture 2: Scheme of effectiveness dimensions



Source: worked up by author

¹² More to the problem see e.g. MOONEY, G. *Economics, Medicine and Health Care*, second edition, Essex: Prentice Hall 1992 and his simplified analysis of cost of health service versus education.

¹³ Social dimension contains the aspect of non-discrimination according to income, i.e. social aspect, or residence, i.e. regional aspect.

The basic shortcoming is that in these dimensions effectiveness can hardly be achieved at a time. Typically, relative success may be reached easily in two of them, the more two dimensions are fulfilled, the more difficult the fulfilment of the third of them.

If we try to illustrate the above mentioned statement by an example, then, if the health service system fulfils the criteria of the social and qualitative dimension well, there will probably be problems with economic criteria. If economic and qualitative criteria are fulfilled well, there will be a problem with the social dimension. And finally, even if economic and social criteria are fulfilled well, there may be a problem with the quality of universally accessible, though cheap, care.

This implies that in creating health service conceptions the supporters of all mentioned approaches will be in conflict. According to which aspect will be more emphasised, health service may be "bent" to two of the three mentioned dimensions. Achieving overall consensus is a task that might be compared to other similar task in economic policy – and that is pursuing macro-economic objectives in the form of the tops of a magic quadrangle.

The key aspect to determine the effectiveness of health service systems is the identification of criteria influencing the effectiveness of the system in its individual dimensions, which means splitting effectiveness dimensions into a tree of criteria contained in them. It is necessary, no matter how the system may be set in practice, to identify key processes of negotiations on rationality and effectiveness held between the participating subjects – as we could see them in the chapter on individual health service systems.

Mutual contradiction of individual effectiveness dimensions is the factor making health service such a complicated economic sector. In other economic sectors pure market system is a tool which is able to balance the interests of individual subjects to achieve, as a result, a Pareto effective situation. The findings from health service economics show, however, that the system of supply, demand and price needs a number of means of aid and support, from the viewpoint of both economic rationality of chosen solutions, and (here more importantly) of results in improving the patient's health condition.

This requires balanced optimising in the field of health service and non-functioning of the concentration to one or two effectiveness dimensions. It is possible to make simple projections showing what consequences ignoring individual effectiveness dimension in health service leads to.

It is probably most difficult to ignore the problems of qualitative (medical) effectiveness, because it is medical profession itself that guarantees it. It is possible to imagine situations in which other people without medical education on the level required at present will, through various mechanisms, get to positions enabling them to treat. Another factor of decreasing medical effectiveness may appear when individual methods of treatment are no longer evaluated centrally – e.g. for the purpose of proclaimed decreasing costs of such evaluation and making various methods of treatment accessible. This will result in leaving evidence-based medicine and lege artis treatments – treatments will be based on the patient's confidence in his or her rational option only. In other words, this weakening, in spite of positive effects in strengthening competition and developing various treatments

including psychological or placebo effects, may, no doubt, lead to constraining effectiveness in the qualitative (medical) dimension of the system.

The problems of social dimension effectiveness, on the other hand, prompt ignoring. It is easy to transfer the system to the state when fewer performances will be accomplished at the same or larger amount of money – because on leaving social criteria it is not guaranteed that the system must meet all the need for health care. The care which will be materialised in effective demand will, simply, not be realised.¹⁴ Imperfect understanding the social dimension may lead to the fact that those relatively poor will look for health care in the quality corresponding to their economic possibilities, which may further complicate the quantitative dimension of the system towards health care consumed. It may also lead to under-consumption of health care, which can be reflected in health condition, but also in the life quality of patients and their possibilities to tap the services of modern medicine. The way of consuming care “if worst comes to worst” is risky as well – such care is often very expensive, can be urgent and need not guarantee a full recovery if it is practised only in the form of an acute intervention not being followed by a systematic treatment.

As to the economic dimension, that can be ignored as well if care is provided disregarding the availability of resources to cover it. In this respect, public insurance system tends most to ignore the economic dimension. In this system the provided care is specified by law without a guarantee of available resources to cover it. In health service systems financed from the national budget the risk consists in a low budgetary discipline and/or selective allocation of funds to the system disregarding possible factors justifying such exclusive interventions (e.g. epidemics, a sudden increase in sickness-rate). In a market system respecting social criteria the risk is represented by a growth of treatment costs for so-called socially recognised groups of population. The total of private and public expenditure can thus reach a high share of GDP.

Should we answer the question whether it is possible to ignore individual effectiveness dimensions, then the answer is „yes“ – it is a proven fact based on the experience of health service systems. It is not necessary to ignore them completely. It may be enough to leave certain aspects out of account. Hence, ignoring effectiveness dimensions means worsening the criteria in the respective dimension.¹⁵ It is difficult to set such practice right, because if individual subjects get used to it, then it is difficult for them to get rid of the rooted stereotypes.

5 The risk of mixing the social dimension of effectiveness and irrationality of allocation

The fact that in health service the social dimension is a very important phenomenon has been known since long ago. But in modern times there are significant shifts and much confusion in this area. On the one hand, there is a real, objective social problem measured by, let us say, the subsistence minimum, on the other hand, there is the rationality of allocation and fixing rational prices – and these two facts are mixed. Such mixing results

¹⁴ Also see the situation of the system in the USA

¹⁵ For instance, when ignoring the economic dimension the system becomes economically ineffective, because cost and financial stability indices are not objectified

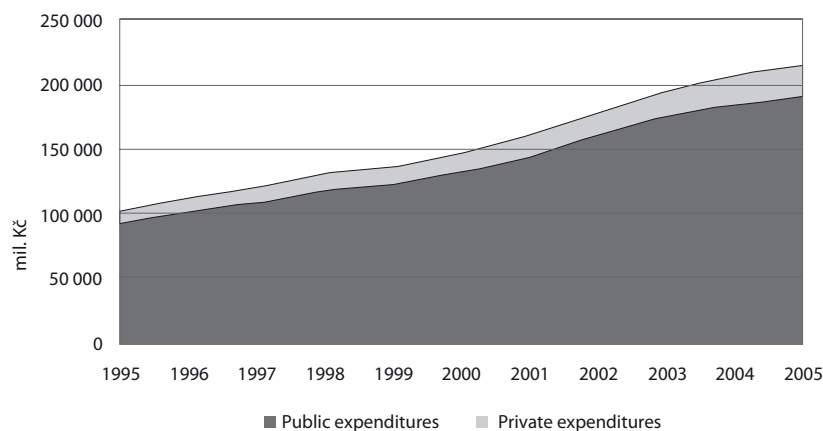
in a simple, but effective trick – the price rationality is assessed according to whether an individual or a household are able to afford a certain kind of health service. If they are, then it is regarded as given, health is not for free, so “if I have money, what to do, I will pay”. Seen economically, this situation implicitly supposes a vertical curve of demand for health care and zero elasticity of demand – the given volume of health care will be consumed by the patient in any case and “at any rate”.

This situation, however, leads to a dangerous phenomenon. The price of health care is considered a given fact, nobody is much interested in the possibility of cutting it while maintaining the effectiveness and quality. Only ways how to ensure financing the ever growing costs are being looked for. This approach in the form of a spiral has no way out, it lacks a limiting factor which in other types of markets returns the prices to a real level corresponding to real preferences of both sides and reflecting the objective situation in competitive markets.

And so, especially in case of private costs of health service, the patient is exposed to statements saying that health care “simply costs something” and thus practically an endless channel is opened through which financial means can be drawn. However, the patients are interested in quite different issues, their demand does not consist in some definite claim for health service, but in maintaining or restoring their health. And here is the core of the conflict which is determined only by the patients’ social situation and their budgetary constraints.

This implies one more task for public economics in health service. Fixing the price in the public sector is, as shown above, of key significance for, at least, partial objectification of costs of health service. It is evident from an international comparison that the higher the share of private resources in financing health care, the higher the prices (e.g. comparing Great Britain–Germany –USA). As shown by the following graph, in the CR this share has been relatively low so far, and that is probably the cause of a relatively low level of costs of health service in proportion to GDP.

Picture 3: The trend of total health service expenditures in CR 1995-2005



Source of data: *Zdravotnictví České republiky ve statistických údajích 2006*. Praha: ÚZIS, 2007

The above mentioned implies a very important conclusion for health policy – it is very misleading if just social acceptability is taken into account in the discussion on health care or health insurance prices. The issue of whether private expenditures on health service are a social problem is just one and, paradoxically, less important aspect viewed from the whole system. Much more important is in which way the prices are calculated, and what they result from, or whether private expenditures make the system more effective in the sense of cheaper achieving a better health condition of the population.

6 Conclusions

The application of public economics in health policy comes out of the nature of private insurance as a tool of solving health risks, objectively given market failure, enforceable laws, the necessity of rational allocation in the public sector and the existence of more effectiveness dimensions in health service. In practice there is a number of models of different intensity of employing the mechanisms of public economics.

The role of the government in the allocation of goods was empirically taken into consideration by Bénard in his formulation of goods classification according to institutional criterion. The possibility of an arbitrary choice of the character of a good on the basis of public choice is the key to allocation rationality. If the government intervenes in the interaction of supply and demand, it must choose tools to ensure the rationality of such intervention. And on the contrary, if the government decides not to intervene in this interaction, it must create conditions for competition and free option by legislation.

The theory and practice of health service systems implies the limits of effectiveness which are, having been worked up into definite indicators, an important guideline for practical implementation of health service. There are differentiated concepts of effectiveness and its criteria. Projecting theoretical principles into the practice of health policy and a follow-up synthesis of findings leads to specifying three basic dimensions of effectiveness in health service, namely economic, qualitative and social. These dimensions form a basis of effectiveness concepts. Their simultaneous fulfilment is a difficult optimisation task, because they eliminate one another in a way. The individual dimensions containing criteria to measure and assess the system of health service are subject to optimising health condition of the population as a fundamental, general target of health service.

The social dimension of effectiveness and social criteria are, indisputably, a significant reason of employing public economics in health service. However, they are not the only reason, and in any case, not the most important one. The discussions on the „social acceptability“ of reforming measures are an inseparable part of any thought of change. It is also substantial to consider if private resources of the citizens (if already taken into account), are being made rational use of to the benefit of improving their health condition. It is also necessary to examine continuously how the price of health care is calculated. A certain risk may be involved in gaining additional resources from patients who worry about correct and quality treatment in case of their illness. Public economics offers a number of tools to objectify the price of health service and optimise the expenditure on the basis of economies of scale. The question to what extent this is compatible with satisfying indi-

vidual needs and priorities of patients depends on the social consensus and civilisation standards.

Abstract

This article focuses on the role of the economics of public sector, shortly said public economics in current health policy and searches for the most important and strongest area for its adoption and application. It is based on the hypothesis, that currently, health policy in the Czech Republic heads to the model of passive solving of emerging health care problems of the population and applying (quasi)market allocation principles. Out of this hypothesis two research questions outcome. First, whether this approach is consistent with the principles of the public sector, rationality of resources allocation and population health condition achievements. Second, how much we mix the problem of social solidarity and economic effectiveness. Moreover, whether the current withdrawal from solidarity is accompanied by risks of market failure and thus suboptimal allocation of newly introduced private resources. In this context the dimensions of effectiveness and risks of mixing social acceptability and rational resource allocation are analyzed.

Keywords

Health, health care, health insurance, effectiveness, ethics, public economics, public sector

Souhrn

Článek se zabývá tím, jakou roli hraje ekonomie veřejného sektoru či zkráceně řečeno veřejná ekonomie v současné zdravotní politice a kde lze vidět nejsilnější místa pro její uplatnění. Východiskem je hypotéza, že současná zdravotní politika v České republice směřuje k modelu pasivní sanace zdravotních problémů obyvatelstva a uplatnění principů (quasi) tržní alokace ve zdravotnictví. Z této souhrnné hypotézy vyplývají dvě zásadní otázky. Za prvé, zda tento přístup je v souladu s principy veřejné ekonomie zejména z pohledu racionální alokace ve veřejném sektoru s cílem výsledků ve zdravotním stavu obyvatelstva. A za druhé, do jaké míry se tak v praxi směřuje diskuse o principu solidarity a ekvivalence s ekonomickou efektivností. Respektive, do jaké míry je ústup ze solidarity ve smyslu zabezpečení potřebné zdravotní péče jako veřejné služby doprovázen projevy selhání trhu, a tudíž také suboptimálním řešením při alokaci soukromých zdrojů. V této souvislosti analyzuje dimenze efektivnosti ve zdravotnictví a rizika směřování sociální únosnosti nastaveného systému financování a racionality alokace zdrojů.

Klíčová slova

zdraví, zdravotnictví, zdravotní pojištění, efektivnost, etika, veřejná ekonomie, veřejný sektor

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