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WHY SHOULD THE STATE HAVE A LEADING ROLE IN THE HEALTHCARE MARKET?

AN EVALUATION ON MARKET FAILURES AND EQUITY IN HEALTHCARE

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Abstract

The basic duties of a state can be expressed as protecting the integrity of the country and democracy, ensuring the welfare and peace of the people, ensuring economic, social and cultural development, making necessary arrangements and taking measures regarding health services, education services and human rights. Health services, which are among these basic responsibilities, are an area that should be particularly emphasized and analyzed since they are decisive on the social and economic future of a country. Recently, in line with the view brought to the literature by endogenous growth theories, it has started to be accepted that the steps to be taken to improve the health status of a country are a prerequisite for sustainable growth and development. In this context, governments have started to pay more attention to assuming various responsibilities in health services and their financing. However, certain risks arising from the unique characteristics of health services necessitate the state to assume a leading role in the health services market. In this context, in this study, the view that the state should have the leading role in the provision and financing of health services is supported with its justifications.

Anahtar Kelimeler: *Asymmetric Information in Healthcare, Inequity in Healthcare, Moral Hazard and Adverse Selection in Healthcare Market.*

SAĞLIK HİZMETLERİ PİYASASINDA NEDEN DEVLET BAŞROLE SAHİP OLMALI?

SAĞLIK HİZMETLERİNDE PİYASA AKSAKLIKLARI VE ADALET ÜZERİNE BİR DEĞERLENDİRME

Öz

Bir devletin temel görevleri ülkenin bütünlüğünü ve demokrasiyi korumak halkın refah ve huzurunu sağlamak, ekonomik, sosyal ve kültürel gelişmeyi sağlamak, sağlık hizmetleri, eğitim hizmetleri ve insan hakları hususunda gerekli düzenlemeleri yapmak ve tedbirleri almak şeklinde ifade edilebilir. Söz konusu temel sorumluluklar arasında yer alan sağlık hizmetleri, bir ülkenin sosyal ve ekonomik geleceği üzerinde belirleyici olması itibariyle özellikle üzerinde durulması ve incelenmesi gereken bir alandır. Son dönemlerde içsel büyüme teorilerinin de literatüre kazandırdığı görüş doğrultusunda bir ülkenin sağlık statüsünün geliştirilmesi için atılacak adımların sürdürülebilir büyüme ve kalkınma için ön koşul olduğu kabul görmeye başlamıştır. Bu kapsamda devletler, sağlık hizmetlerinde ve bu hizmetlerin finansmanında farklı sorumluluklar üstlenme konusuna daha büyük bir önem göstermeye başlamıştır. Bununla birlikte sağlık hizmetlerinin kendine özgü özellikleri itibariyle ortaya çıkan birtakım riskler devletin sağlık hizmetleri piyasasında baş rolü üstlenmesini zorunlu kılmaktadır. Bu kapsamda ortaya konan bu çalışmada sağlık hizmetlerinin sunumunda ve finansmanında devletin baş role sahip olması gerektiğine ilişkin görüş gerekçeleriyle birlikte desteklenmektedir.

Anahtar Kelimeler: *Sağlık Hizmetlerinde Asimetrik Bilgi, Sağlık Hizmetlerinde Adaletsizlik, Sağlık Hizmetleri Piyasasında Ters Seçim ve Ahlaki Tehlike*

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1. INTRODUCTION

Health is the most fundamental right for all living beings that must be protected for the continuity of their species. In the 1946 WHO constitution, it is defined as "the right to the highest attainable standard of health is one of the fundamental rights of every human being, regardless of race, religion, political belief, economic or social status" (WHO, 1946).

In this context, each state has certain responsibilities in relation to the protection of the right to health, including the development of determining factors for the improvement of social health status, health education and information, and ensuring sustainability in health services and financing (Nygren Krug, 2002: 1). The extent to which these responsibilities are fulfilled may vary according to the dynamics of the health system implemented in the country.

Health systems, which are shaped by the cultural, political and socio-economic structure of countries, differ from country to country in terms of the delivery of health services, financing, system needs and organisational structure. The way services are provided affects the financing mechanism and the financing model used in the same way has an impact on service delivery, resource production and management.

In a health system shaped in line with these interactions, the state has different functions. These functions are basically service provision, orientation, planning, regulation, supervision, financing and information dissemination. The extent to which these functions are fulfilled by the state may vary across countries. However, the risks and market failures that arise in line with the specific characteristics of health services support the fact that the most important task in the sector should be undertaken by the public sector. The fact that health is a virtuous good, that it concerns the whole population, that its demand is uncertain, that it cannot be postponed, that it is indivisible and that its outputs cannot be directly expressed in monetary terms are some of its important characteristics. In addition, the fact that the health services market has the characteristics of imperfect competition, asymmetric information, adverse selection and moral hazard are also important factors supporting the implementation of the public-dominated model in the health sector. Because these disruptions may cause much greater grievances in the private health sector than in the public health sector. In addition, the wide service area of the private sector in a health system, the predominance of private expenditures in the financing mechanism and the weak public intervention in the health market lead to inequalities in access to health services. At this point, low-income groups in the society cannot access health services or have to give up some of their compulsory needs for health expenditures. In this case, although health expenditures increase within the scope of profit-oriented policies of the private sector over time, the social health status decreases or cannot improve at the same rate. In this sense, it is important to evaluate both the risks arising from the characteristics of health services and the market failures and social risks that are more valid for the private health sector in order to reveal the necessity of public intervention in the health sector.

2. Health Services and Financing: Conceptual Framework

Health services can be defined as the whole of planned activities carried out in order to protect the health of individuals, to prevent the occurrence of diseases, to apply the necessary treatment when they are ill, to provide opportunities for those with disabilities to meet their needs without being dependent on others, to increase the health status of the society and to ensure that each individual maintains a healthy and long life. As it is understood from the definition, these studies cover all preventive, curative and rehabilitative services (Sargutan, 2004: 68).

According to the definition made by WHO, Health Care Services *are "Health services provided in ways accepted by the general population, with individual participation and at an expenditure that can be met by the country and society. These services, which constitute the core of the country's health services, are an indispensable part of social and economic development in general."*

However, the principles taken into account by different countries for the development of primary health care services are as follows (ALMA ATA, 1978):

- *"Increasing life expectancy at birth: The most basic indicator of a country's health status is life expectancy at birth. Increasing this indicator, which varies in line with the development of health services, is one of the main objectives of the policies implemented to improve health services in every country".*
- *"Realisation of sustainable healthy life: It is necessary to create the necessary conditions to enable individuals to use their physical and mental capacities in the most effective way".*
- *"Ensuring equality in access to health services: In line with this approach, which requires inter-sectoral co-operation, public policies are determined by taking social differences into consideration".*
- *"Encouraging social participation: Ensuring that individuals participate in health services in an informed, highly motivated and active manner is very important for increasing the social health status".*

Within the scope of the definition made by WHO and the principles expressed, it can be said that every state is obliged to ensure that the society has access to basic health services and should assume the dominant role in the provision of services. However, it is important to evaluate some of the characteristics of health services in order to understand why these services should be provided and financed predominantly by the public.

2.1. Characteristics of Health Services and Presentation Methods

The provision of health services, which started with the history of mankind, has changed and developed with the development of scientific thought and has turned into a multifaceted, multidimensional and multisectoral field. However, there is an unchanging and general idea

that health services should be recognised as the most fundamental human right that strengthens social solidarity and supports citizenship, and that everyone should have equal access regardless of socio-economic differences (Alcock et al, 2011: 422). The fact that the social benefit of healthy individuals is high and, on the contrary, it is difficult to estimate the size and cost of the damage incurred makes the role of the public in the provision of health services a priority (Altay, 2007: 36). However, the fact that health services differ from other goods and services that can be bought and sold in the market in terms of their characteristics necessitates public intervention. These characteristics can be summarised as follows (Altay, 2007: 35; Bhattacharya et al, 2014: 434; Preker and Harding, 2000: 192; Musgrove, 1996: 9);

- *It concerns the entire population:* Goods and services of a social nature within the framework of basic human rights.
- *It is not known when and where it will be demanded*: It is uncertain when, where and how the demand for the service will arise and the extent of its cost.
- *Non-substitutable*: Health services cannot be replaced by other goods and services.
- *Health cannot be postponed*: In many cases, health care services are urgent. At this point, delaying the service can cause permanent damage to the person.
- *Health outcomes cannot be directly monetised*: Health services raise the health status of the society. However, it is very difficult to express health status indicators in monetary terms, even indirectly. In this sense, it can be said that health is an element with a more social aspect.
- *They are virtuous goods*: If left to market choice, inadequate production may lead to inefficiency and welfare losses in society.
- *Health services are indivisible*: Needs that are "indivisible" and of interest to the masses, but which the market does not want to produce because they are not profitable, are undertaken by the public sector. Examples include vaccination programmes offered as part of primary health care or protocols in times of epidemics.

In addition to the aforementioned characteristics, the impact of health on human capital is one of the reasons that necessitate public intervention. The "*Productive Time Hypothesis*", which explains the causal relationship between socioeconomic status and health, states that worsening health status due to inequality in access to health services will reduce productive time and the efficiency obtained from human capital. The fact that inequality between income levels poses a threat to the right to health of disadvantaged individuals and reduces the social health status is one of the important factors that necessitate public intervention. In addition, some other characteristics of the health services market cause market failures. The characteristics of imperfect competition, the fact that it is full of externalities and the emergence of adverse selection or moral hazard due to information asymmetry are among the aspects of health services that necessitate public intervention.

2.2. Characteristics of the Health Services Market

Just like the specific characteristics of health, some characteristics of the health services market cause market failures and therefore necessitate government intervention. The fact that the health services market has the characteristics of imperfect competition[1] , the existence of externalities and asymmetric uncertainty are some of the characteristics that pose a risk for the functionality of this market.

According to basic economic theory, it is accepted that markets will function more efficiently in the absence of externalities and asymmetric information. The evaluation of these criteria for the health economy is important in order to clearly express the resulting market failures. At this point, it is necessary to focus on the economics of externalities and asymmetric information problem in health.

2.2.1. The Economics of Externalities in the Health Services Market

In markets, there is an agreement in which both parties (buyer and seller) benefit as a result of a standardised exchange. In these transactions, which are expressed by Pareto optima, it is assumed that the parties concerned are profitable and no one else is harmed. However, when a transaction in the market affects a third party other than the buyer and seller, it is defined as an externality.

Externalities are recognised as one of the most important justifications for public intervention in the market. At this point, if the health services market is evaluated, it can be stated that the provision of health services under free market economy conditions is not correct due to externalities.

One of the most important characteristics of health is that it is highly contagious. At this point, it is accepted that health service markets are also full of externalities. Individual health decisions of individuals may concern the whole society. For this reason, it is possible to prevent social damage caused by negative externalities or to "internalise" behaviours that cause positive externalities by encouraging them through public regulations. At this point, positive externalities include social immunity gained through vaccination and negative externalities include passive smoking. All interventions to internalise these externalities are known in the literature as Pigou Subsidies and Pigou Taxes under the name of British economist Arthur Cecil Pigou. Pigoue subsidies and taxes were developed to internalise externalities by converting them into individual costs or benefits (Bhattacharya et al, 2014: 434). Thanks to the transformation provided by these subsidies and taxes, individuals think that social costs and benefits are private. While inadequate consumption is corrected by subsidies, excessive consumption is restrained by taxes. As a result, the level of "social welfare"[2] is improved.

[1] In this approach, since health is a socially orientated element, it should not be subject to tough competitive conditions as in other markets. This characteristic is predominant in countries where health services are provided entirely by the public sector. However, it is recognised that in these countries, hospitals do not compete as in the private sector market, thus creating the problem of "ineffective quality competition".

[2] It refers to the sum of the welfare levels of individuals in society. As the opposite of individualism, there is a social benefit or cost incurred as a result of actions affecting the level of social welfare.

2.2.2. Asymmetric Information Problem in Health Services Market

Moving away from the efficient allocation of resources is one of the main reasons for the emergence of market failures. One of the most important areas where this situation may arise is the health services and products market. The problem of asymmetric information arises as a result of the fact that the party demanding services in the field of health does not have information about the health service to be received and the party providing services has little or no information about the health status of the individual in front of them. In other words, asymmetric information is the problem arising from the fact that one party has less information than the other. This problem, which arises due to uncertainty, is valid for patients in some cases and for doctors in others. For example, in the health services and products market, the patient does not have as much information about the medicines to be used as health professionals or drug manufacturers. Even when prospectuses are read, most of the information is not clearly understood and expert knowledge is needed. However, uncertainty may cause victimisation for both the patient and the doctor in cases such as failure to detect the disease diagnosis in the early stages. In this context, it can be said that this situation, which can occur in many markets, increases victimisation for the service recipient and may lead to social consequences on the grounds that there may be urgency in health services and there may be problems in terms of information collection compared to other markets.

The problem arising from the fact that the provider determines the scope and size of the service instead of the demander may lead to market failures called adverse selection and moral hazard. Before addressing these market failures, it is useful to evaluate the delivery and financing methods of health services. Because the emergence of these risks and the measures to be taken to minimise them depend on who provides health services.

2.3. Presentation Methods of Health Services

Due to the characteristics of health and the health services market, health services are largely provided by the public sector in most developed countries today. However, especially in countries where financing through social health insurance is preferred, a wide service area is also defined for the private health sector. The development of the private health sector dates back to the mid-1970s. In this period, when privatisation started to intensify in every field, economic and political transformations towards the inclusion of the private sector in the health system led to a change in the practices that the provision of health services should only be carried out by the public sector. The emergence of new products and services in the health sector in line with technological developments and the improvement of diagnosis and treatment methods have a great impact on this change. Due to the increasing demand for new technologies, the public sector's undertaking the financing of the relevant development alone may cause resource allocation problems. Within the scope of sharing such financial risks, it can be said that health services today are provided primarily by the public sector and then by the private sector and by delivery methods in which both elements are intertwined. The prevalence and predominance of public and private health institutions in the system

varies depending on the social and political conditions of the countries from the past. For example, private health institutions play a dominant role in the USA and Japan, while public health institutions play a dominant role in the UK and most Scandinavian countries. At this point, the preferred method of financing services, as well as the predominance of public or private health institutions in service delivery, is important for the functioning of the health services market with minimum disruption.

2.4. Financing Methods of Health Services

Health financing is defined as the creation of the necessary resources to cover the costs incurred as a result of the health services provided (Gottret&Schieber, 2006: 1). The main purpose of health financing, which is one of the two main functions of a health system, is to ensure that all individuals have financial access to health services and to protect individuals from the financial burden of diseases. At this point, it is of great importance to create sufficient and sustainable resources, to use these resources efficiently, to finance services fairly and to prevent the impoverishment of households while collecting resources (WHO, 2004:18).

In the financing models of health systems that are widely used today, a method in which third-party payers act as financiers through funding and allocation is generally followed instead of ensuring a direct financial flow between service providers and service recipients. In this context, financing of health services can basically be defined as the process of resource transfer between service providers and financiers. The uncertainty of when individuals will need health services and the cost that will arise in case of a need, and the fact that the cost arising from the structure of health services is above the level that can be borne by the individual make third party intervention necessary. In the absence of third-party payers in the system, the individual may receive less service than he/she needs or may not receive the service he/she needs. At this point, the third party in question can be the public or private sector. In summary, financing of health services is carried out by allocating the funds obtained by the public and private sectors through various methods to the institutions providing services in the public and private sectors. A common approach has been determined for the classification of these methods and these are public/semi-public and private financing sources (WHO, 2002: 1). Public and semi-public financing sources are basically obtained in two ways. These are premiums collected within the scope of social health insurance and general tax revenues collected specifically for health or allocated from the general budget. Private financing sources are mainly obtained through private health insurance and out-of-pocket payments.

In the social health insurance format of public financing, premiums paid by employees and employers are used to provide health care services to individuals in case they fall ill, while in the tax-based financing method, which is mostly preferred by developed countries, resources are allocated from the general budget for health services. In countries where social health insurance is used, a wide service area is defined for the private sector in the provision

of health services, whereas in countries where the method of financing through taxes is used, health services are provided completely by the state and free of charge to all citizens.

Out-of-pocket payments from private financing sources include out-of-pocket payments made by individuals in return for the health services they receive. In the method of financing through private health insurance, premiums and contributions paid by individuals to insurance companies in order to receive private health services are used.

At this point, it should be noted that while the financing source used in a country mainly consists of public financing, the central role in service delivery may belong to the private sector. However, while the financing of health services is entirely public and the central role in service provision belongs to the public sector, the private sector may also play a limited and optional role. At this point, it is important to evaluate the market failures in the health sector in order for decision makers to make the right choices and to understand the importance of the public sector in the health services market.

3. Market Failures in the Health Services Sector

In the literature, the first study on the failures in the health services market was put forward by Stanford University professor Kenneth Arrow in 1963. According to Arrow (1963), the most important factor that distinguishes health from other goods and causes specific economic problems in the market is uncertainty. Uncertainty about whether the patient will receive a quality health service or not In addition to the uncertainty and unpredictability of health services, the reluctance of human beings towards risk increases the tendency towards health insurance. However, at this point, it should be recognised that insurance markets are unique markets due to information asymmetry. Information asymmetry and the market failures it causes are primarily in question for private health insurance.

In insurance markets, financial flows do not always follow a course from individuals with good health to those with poor health. In this financial flow, some disruptions may arise due to the lack of transparency of individuals about their health status, in other words, due to asymmetric information in the health services market. In this context, contractual cost problems arise especially in the private health insurance market and constitute an obstacle to the predominant use of this financing method in the financing of health services. These twin disruptions caused by information asymmetry are the adverse selection that occurs before the signing of the contract between the patient and the insurer, who are in the position of buyer and seller in the market, and the moral hazard that arises after the contract.

Adverse selection, which is one of the most important problems caused by asymmetric information, occurs mostly in private health insurance. Rothschild&Stiglitz (1976) analysed the concept of adverse selection proposed by Akerlof (1970) based on the health sector. They stated that this problem is based on the ability of customers to measure their own risks better than insurers and to act according to information asymmetry (Bhattacharya, 2014: 187).

When private health insurance providers cannot discriminate between the health risks of the individuals to be insured, those with low risk finance those with high risk. In such a situation, low-risk individuals are forced to pay higher premiums and give up insurance. With the increase in the current premium level due to exits from the system and the fact that only high-risk individuals are included in the insurance system, a market imperfection called adverse selection emerges. However, due to the selection of customers who are against the insurer's interest, the average costs that the insurance can finance may be exceeded. In this respect, the budget of the insurance company deteriorates and an important obstacle to financial sustainability emerges.

Another possible failure that may occur in the system is moral hazard. According to the definition made by Baker (1996), moral hazard is the increase in the tendency to rely on insurance despite the decrease in the tendency to prevent or minimise the cost of loss (Baker, 1996: 1). In the private health system, this situation arises from the view that it is immoral to think that the only purpose of insurance is to obtain money from insurance. The decrease in the efforts of insured persons to protect their health and the determination of the demand for health services according to the status of being insured are considered within the scope of this hazard. In cases where the moral hazard is high, the insurance company may increase costs by adopting a timid attitude. In this case, the consumer may be victimised. However, countries where services are provided by the state and public health insurance is used also face the cost-increasing effect of moral hazard. However, these countries develop different approaches and reduce the impact of disruptions in the health services market within the scope of the regulatory role of the public sector.

Considering these shortcomings, in order to protect both citizens and insurance companies, it is preferred to use private health insurance as a model that supports public financing instead of using it predominantly in the financing of health services.

In line with the characteristics of the health services market, it can be said that public intervention and investments are of great importance in order to prevent destructive social consequences in terms of the risks that arise.

4. The Policy Trilemma in the Health Care Market: Adverse Selection, Moral Hazard and Fairness

In the study, market failures in health services are expressed and it is stated that they are caused by information asymmetry in the sector. Since information, which is a valuable product in all markets, is used by patients, physicians and insurers in the health services market for personal interests, adverse selection or moral hazard problems may arise. In addition, concealed information may lead to higher utilisation of inefficient services. While market failures continue, on the other hand, countries try to determine policies to ensure fairness in access to health services in order to improve social health status. At this point, health policy dilemma is encountered. The policy trilemma in health services can be explained by Arrow's impossibility theorem. According to this theory, there is no optimal

health policy for a country. Decision makers have to make a political choice between adverse selection, moral hazard and injustice in access to services.

Adverse selection and moral hazard risks vary according to the financing mechanism and national health policies adopted in a country. At this point, the weight of the public sector plays a major role in the financing mechanism used in the country. In different applications, decision makers may be in a dilemma between controlling adverse selection and moral hazard and ensuring justice. At this point, the policy choice varies depending on the priorities and constraints in the country. Countries may prefer to provide health services free of charge and ensure justice at the expense of moral hazard[3] or restrict access to services by limiting state participation.

For example, in the USA, Japan and Switzerland, where private insurance is compulsory or employer-sponsored private insurance is used, adverse selection may be reduced and inequitable access to services may be possible. In the UK, Canada and Sweden, where single-payer universal public insurance is used, adverse selection is eliminated and equality is achieved, while the probability of moral hazard increases. In this context, countries where public insurance is the main mechanism tend to use "cost-effectiveness analyses"[4] and "gatekeeping"[5] to reduce the risk of moral hazard. In addition, queues caused by prolonged waiting times are also one of the strategies used to reduce moral hazard in countries where health services are provided by the public[6] . At this point, it can be said that in countries where health services are provided free of charge by the state, market failures can be minimised through different regulations.

On the other hand, market failures are observed much more intensely in countries where the private health sector is dominant. In the USA, the high number of private hospitals under antitrust law limits the participation of the state in services. In addition, the vast majority of the population in the country, which cannot overcome the adverse selection problem, is still not covered by any insurance, which leads to inequitable access to services. In this context, the US example is very important in terms of indicating the risks of the central position of the private sector in the health services market.

On the other hand, Japan is another important example where the private healthcare market is dominant. The majority of hospitals and clinics in the country belong to the private sector. However, unlike in the USA, there is intense public intervention in Japan and governments prevent the private sector from having market power through price determination. At this

[3] The moral hazard arising at this point is based on the understanding of "free of charge", which causes people to consult a physician even in the simplest ailments. The moral hazard arises especially when individuals with full coverage insurance policies demand more health services than they need.

[4] Cost-effectiveness: It is the process of measuring the costs and health gains of different medical treatments and procedures. In general, a cost-benefit comparison is made for a medical device, a new drug or a treatment method and a recommendation is made for decision-makers.

[5] Gatekeeping: General practitioners control patients' utilisation of other stages of the health system (Starfiled, 1998). It is a practice that serves the purpose of reducing costs in health services.

[6] It is assumed that only patients for whom treatment is of primary importance will remain in the queue, as long waiting times will lead patients to be indifferent between receiving treatment and home care (Cullis & Jones, 1986).

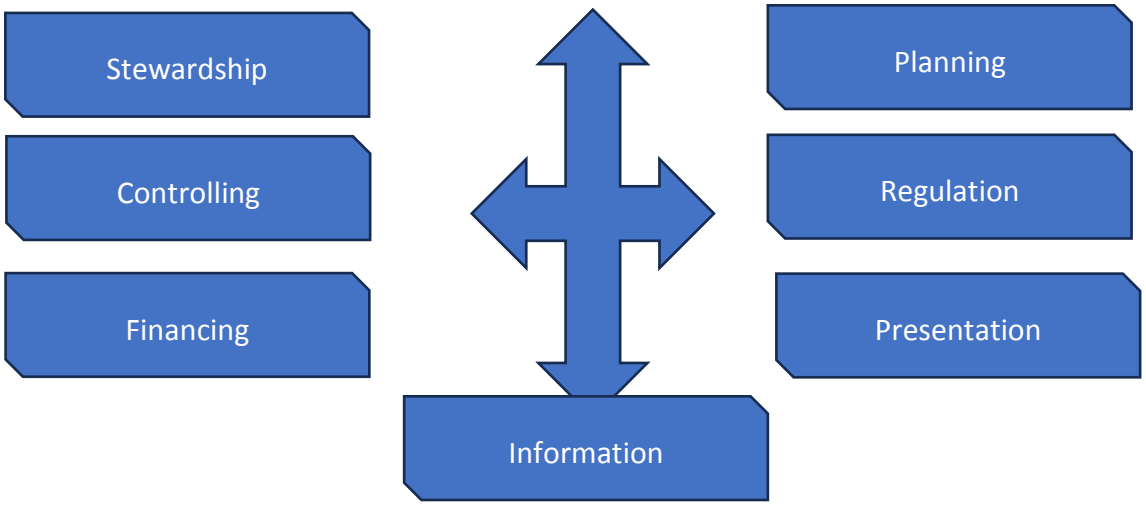
point, it should be noted that while price-setting policy is a practice to ensure fairness in access to health services, services that are not priced correctly may cause perverse incentives. For example, procedures priced below marginal cost may not be offered to patients, while procedures with high profitability may be offered more than necessary. In this context, in markets where the private sector plays a central role in service provision, although public intervention tries to ensure fair access to services, different market failures may be created on the other hand. This example shows that it is not sufficient for the public sector to be dominant only at the point of financing in health services.

In health care markets that focus on fair access to services, both delivery and financing are undertaken by the public. However, in different applications, an approach based on combating adverse selection with an effective method and increasing fairness may cause costs to rise. However, there are also approaches that involve public intervention to control rising costs within the scope of moral hazard. In this context, in conclusion, although it is difficult to find solutions to the problems arising from information asymmetry at the same time, it can be said that the provision and financing of health services should be undertaken predominantly by the public in order to minimise the aforementioned disruptions.

5. The Role of the State in the Health Services Market

The unique characteristics of health, the imperfections in the health services market and the necessity to ensure fairness in access to services are the most important reasons for the state to take the leading role in health service provision. In the context of these justifications, it is necessary to summarise the functions of the state in the health services market before moving on to the reasons why the state should take the leading role in the health market. Figure 1 shows the functions of the state in the health services market.

Figure 1: Functions of the State in the Health Services Market



Source: Aktan, (2017). http://www.canaktan.org/reform/saglik-reform/PDF-aktan/04%20%20devlet-rolu.pdf

The fact that the state plays a role in the provision of health services with the function of directing refers to the directing function, determining national targets by making strategic plans refers to the planning function, supervising the activities of service providers refers to the supervision function, setting regulatory rules in the health sector and designing the relevant institutions refers to the regulatory function, and the fact that the institutions providing services belong to the state refers to the service delivery function. The financing of health services directly by the state, the financing of low-income individuals in the society by high-income individuals in a mechanism using tax revenues or premium payments refers to the financing function of the state, the state informing the public in the field of health services and increasing the efficiency in service delivery by utilising information and communication technologies when necessary refers to the information function. The implementation of all the functions of orientation, planning, supervision, regulation and information is considered as the governing function of the state.

In terms of these functions, the state has important roles both in the provision and financing of health services. While primary health care services are directly financed by the public in most countries, the state plays a supportive role in the financing of curative health services. Today, preventive health services and primary health care services are compulsorily financed by the public, particularly in developed countries. In the provision of services other than preventive health services, it is accepted that the state should participate in the financing of the service to a large extent or completely in order for low-income groups to demand the service.

6. Why Should the State Provide and Finance Health Services?

The directing, planning, supervising, regulating, service provision, financing, information and management functions of the state in the health services market have been emphasised. The importance of these functions in eliminating the failures in the health services market and ensuring justice in the health system can be explained as follows:

- The intervention of the state in the context of its function of supervising and regulating health service providers keeps the prices of health services at an accessible level. Increased access to health services improves the social health status.
- The planning function of the state enables the identification of strategies for improving the health status of the population.
- Making public health insurance compulsory within the scope of service provision and financing functions prevents adverse selection, which is a prominent market imperfection in private health insurance in the provision of health services.
- The service delivery and financing functions of the state ensure the provision of health services with low profitability for the private sector but high social benefits for society. In this way, positive externalities are created, contributing to the improvement of the social health status.

- The information function of the state is the most effective method to raise public awareness and create positive externalities.
- The management function, which combines the functions of direction, planning, supervision, regulation and information, ensures integrity in the health system and minimises the disruptions caused by information asymmetry.

To summarise, the state playing the leading role in the health services market with its different functions primarily ensures justice by making health services accessible. In systems where health services are financed predominantly by the private sector, the access of low-income groups to health services is limited. This situation both contradicts the basic principles defined by WHO and causes the social health status to fail to improve in line with health expenditures. Because if there is no fair access to health services in the society, the social health status does not improve. In addition, adverse selection, which is one of the market failures caused by information asymmetry, is at low levels in health systems where the public sector plays a leading role. The moral hazard problem in these systems can be minimised by the practices used within the scope of the regulatory function of the state. In this direction, in many countries, especially in developed countries, the financing of health services is fully undertaken by the public.

In addition to these, one of the most important issues justifying the state to take the leading role in the provision and financing of health services is the negativities caused by the increase in catastrophic health expenditures. Catastrophic expenditures and impoverishment are among the most important dangers in countries where the state takes a back seat in the provision of health services and out-of-pocket payment rates are high. Although there is no clear definition of catastrophic expenditure, it refers to the situation where the ratio of health expenditure incurred by households to their payment capacity is 40% or more. (TURKSTAT, 2024). At this point, out-of-pocket health expenditures may lead households to waive their compulsory needs, sell their assets or incur debts by depriving them of financial protection. An increase in the rate of out-of-pocket payments in the household budget may lead to impoverishment of individuals, considering the loss of income due to health problems. Poverty, in turn, leads to an increase in crime rates and psycho-social problems. In addition to the social problems caused by the increase in crime, the most important economic effect is on economic growth. The economic growth and development process slows down with increasing crime rates in line with the increase in poverty and injustice in income distribution. With the said slowdown, the decrease in income level and the increase in income injustice create a poverty spiral that is difficult to get out of. According to this view, which is especially valid for developing and underdeveloped countries, it can be said that the marketisation of health services creates a vicious circle in the opposite direction between poverty and economic growth and development. At this point, it is of great importance for the state to assume the leading role in health services and financing with its management function and to ensure justice in order to break this cycle and for the future of the country.

7. EVALUATION AND CONCLUSION

The most important approach to solve the problems of market power and ineffective quality competition is the nationalisation of health services. According to this approach, hospitals and clinics are owned by the state and financed by tax revenues. In developed Scandinavian countries, health systems are financed entirely by the public through tax revenues and all services are provided free of charge by the state. In most developed countries, especially Germany, Japan, the Netherlands and France, a mechanism financed by employer-sponsored premiums is used and it can be said that the public plays a leading role in the financing of services. However, in the USA, the pioneer of private health insurance, the weight of the public sector in financing health services has reached 86%. In other developed countries, the role of the public sector in total health expenditures is 80% and above (OECD, 2024). In this context, it can be said that today, especially in developed countries, the financing of health services is largely undertaken by the public. At this point, important reasons are shown that the state should assume the most important role in the health sector. The impact of the health status of the society on the national economy, market failures caused by asymmetric information in health services, externalities created by health and the risks arising from the specific characteristics of health services are the most important reasons shown at this point.

The health factor has been included in the model as the driving force of growth with endogenous growth theories. One of the most important factors for increasing the productivity of the human capital factor, which is particularly emphasised in the endogenous growth model, is the increase in the level of health. In this context, it can be said that policies aimed at improving the health status of a country will accelerate the economic growth process. For this reason, every state must first determine policies that will increase efficiency in both the provision and financing of health services in order to ensure sustainable improvement in growth and development and assume the leading role.

According to the view that emphasises the importance of the health-economic growth relationship, another important point that supports that the state should play a leading role is the effect of impoverishment caused by the increase in private health expenditures on the economic growth and development process of the country. In addition to the inability to improve the social health status in line with health expenditures as a result of the increase in out-of-pocket payments made by households in health services, the most important risk, especially for developing and underdeveloped countries, is the increase in catastrophic expenditures and the resulting impoverishment. The increase in social exclusion and crime tendency brought about by poverty also leads to negative effects on the basic service areas of the state, especially health. The spiral of poverty and the subsequent transfer of psycho-social health problems lead to an increase in expenditures in health services and other social services. In this context, breaking this vicious circle created in line with the marketisation of health services in terms of the management function of the state is of great importance for the improvement of the economic growth and development process in a country.

In addition, the specific characteristics of the health services market and the disruptions that arise within the scope of these characteristics also support the necessity of public intervention. One of the most important characteristics of the health services market is the existence of uncertainty, in other words, asymmetric information.

Asymmetric information problem is a market failure that can occur in many markets. However, unlike other sectors, it can be said that it increases victimisation for the service recipient and may lead to social consequences on the grounds that there may be urgency in health services and there may be problems in terms of information collection compared to other markets. In this respect, public intervention and investments are of great importance to prevent disruptions. The problem of asymmetric information can be reduced by means of regulations to be made through supreme boards, relevant directives, legislation, encouragement of digital applications and supervision mechanisms at the institutional level. With these regulations, adverse selection and moral hazard, two factors caused by the asymmetric information problem, can also be prevented.

Accordingly, it can be concluded that the state should play a dominant role in both the provision and financing of health services for all the reasons mentioned and functions explained.

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