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Health Systems and Commercialisation
In Search of Good Sense

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Global and Local Dynamics and Policy Responses**

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1. Introduction: health care commercialisation and health policy, whose common sense?

> '.of the various interpretations of public health, the Indian subcontinent is being pushed into choosing a restrictive paradigm, which offers apparently sophisticated methodologies for the collective good, without actually helping the good to materialise' (Qadeer 2001 p.117)

Health policies reflect, and have always reflected, values, culture and policy priorities in different countries. The *analysis* of health policies therefore necessarily brings together sociological and political understanding and more technical evidence with insights from epidemiology, clinical medicine and economics.

However, in the world at present, health policy analysis has come to take a particular predominant form: the analysis of health care as an economic sector of health service provision plus a set of managerial evaluation techniques for analysing health care inputs and outcomes. The fragmentation engendered by this dual approach is often reinforced by a division within the institutions of health policy analysis between those whose interests and expertise lie in health protection and public health policies, and those whose 'lens' is the analysis of health care perceived a market-provided service. This dominant 'common sense'[1] of health policy then perpetuates fragmentation through a policy framework that allocates public health measures to a limited policy sphere of 'public goods' while framing health services as a sector of market trading: these are the 'sophisticated methodologies' Imrana Qadeer is referring to above.

We argue below, drawing on both new research and existing evidence, that this dominant common sense in health policy is in certain ways both incoherent and damaging. However our aim is primarily constructive rather than destructive. It is well understood that a properly functioning health system is essential to an effective market economy. To make a health system *work* in a market economy, however, does not imply simply the commercialisation of the health care sector itself. It requires rather a different starting point for health policy.

This alternative starting point has traditionally been articulated as part of a health systems approach. It recognises the importance of values. It also acknowledges the existence of market failures in health systems. It draws on economic analysis of health care financing and economic assessment of health care systems as a whole. But it draws also on public health and medical knowledge concerning the needs and problems that health systems have to deal with. Our ambition with this paper and the project to which it relates is nothing less than to provide the outline of such an improved 'common sense', as a foundation for better analysis and practice in health systems and health policy design.

[1] We define this concept in Section 5.

This alternative starting point has traditionally been articulated as part of a health systems approach. It recognises the importance of values and ethically based objectives. It draws on economic analysis of health care financing and economic assessment of health care systems as a whole. But it draws also on public health and medical knowledge concerning the needs and problems that health systems have to deal with. Our ambition with this paper and the project to which it relates is nothing less than to provide the outline of such an improved 'common sense', as a foundation for better analysis and practice in health systems and health policy design, and some basis for it in evidence.

We begin in Section 2 by discussing the concept of 'health system': creating a definition and discussing the ways in which the definition of health systems employed makes a difference, helping or hindering our analysis and understanding of processes and change in health systems as well as understanding of their role and purpose in a society. We also examine the economic ideas associated with this concept of health system. We contrast these concepts with the dominant model of health sector reform and *its* economic presuppositions.

The values at the centre of health systems have today to be pursued in a rapidly changing context of health service commercialisation, both within countries and in integrating international markets. In Section 3 we seek to contribute to a better understanding of the nature and consequences of this commercialisation, by examining cross-country and case-based evidence different 'paths' of health care commercialisation.

In Section 4 we offer some evaluation of the current commercialisation of health care. We argue that the cross-sectional and qualitative evidence available contains no comfort for the commercialisers. On the contrary, commercialisation, on many indicators, is positively associated with ill health and exclusion. And some patterns of commercialisation appear particularly damaging.

In Section 5 we set our to define the basis for a new 'common sense', explaining in more detail what we mean by this term. We argue that to build effective and decent health systems, some elements and patterns of commercialisation have been and will have to be blocked – not merely 'regulated' – in the interests of public health and effectively functioning market economies.

2. Health systems, health policies and economic suppositions: two contrasting views

2.1 Health systems, redistribution and industrial change

Defining health systems

Our working definition of health policies and health systems in this paper is grounded in the understanding that public policies and health policies form part of the broader public policy framework in a society. Health policies tend to be discussed in the context of broader social policies of a country. However, while choices of health policies are often in line of the values and emphasis of broader social policies, decision-making on health policy often differs greatly from social policy. The role of service provision is substantially larger in health and the impact of labour markets more limited than in the context of social policies. Health policies are also part of normative policy-making within a society, and embedded in legal rights and commitments made as part of public policies. While analysis of health policies may need to cover processes and stakeholders, these relate more to politics of health than health policies. In practice health policies are rarely defined explicitly in a society unless a process of reform or policy change is suggested.

Health policies are fundamentally based on values, but many aspects of policies are based on evidence, experience and more technical aspects of decision-making. Health systems are the institutional basis and expression of health policies. The way in which the health system is structured, organised and governed has fundamental implications to how health policies can be implemented and on what cost. Health policies define the direction towards which health systems are geared, how health systems are resourced and on what basis these operate. We argue that health system should be exist to fulfil a purpose, and that their functions, structures, financing and priorities are, and should be based on aims which are health- and health policy-related.

Health systems are thus based in the expectations and priorities of a society. The basic reference for health systems remains at national level, but in practice health systems, especially in many federal countries, operate at the sub-national level. National level decisions do however have importance also at sub-national level and thus provide the last resort in terms of accountability.

This definition of health systems contrasts with recent very broad usage: from the corporate providers of 'health systems' to all-embracing definitions covering education or what individuals do at home. Internet search on the phrase ‘health system’ brings a large share of corporate health care plans, which are referred to as ‘health systems’. In this paper we have wanted to put the emphasis on national level as still many core decisions are made at national level and have implications for the ways in which regional or local levels function. Health systems have also a global dimension, which is set in the global regulatory context and has major importance, for example, with respect to the ways in which standard setting is based, diagnostic criteria are defined and many regulatory measures operate.

In order to define health systems, it helps to specify some crucial aspects of health systems that are usually assumed but rarely discussed in practice. These include the following:

1) Focus and scope: health systems cover areas and functions in which health is a first priority and have broader than individual or health services focus: Health systems are population-based and cover public health policies, health promotion and assessment of health implications of other policies. It is known that driving forces/determinants of health status are defined often by other sectors than health. However, while food or education policies may be of crucial importance to health it is not meaningful to extend the definition of health system to cover everything that is of relevance to health. Health systems may thus cover institutions, capacities and ways in which 'healthy' food and educational policies are promoted and ensured in the context of health policies and priorities, but not food or educational policies as such.

2) Legitimation and accountability: health systems are response to political commitments made towards citizens: The accountability and responsibility for proper functioning of health systems thus lies in the domain of public policies and cannot be left merely to consumer choice and action.

3) Groundedness and universalism: the organisation and functions of a health system reflect the culture, resources and values of a country. This is often taken as granted or ignored, but is of substantial relevance to how health system can be organised. While the way health systems are organised may have largely the same elements in any country, the emphasis on different aspects of care differ substantially. The case is perhaps clearest with respect to family planning and abortion, but exists also in other aspects of care.

We have previously proposed that health systems exist to fulfil a purpose and this purpose is often defined through the definition of objectives. The WHO World Health report in 2000 defined three fundamental objectives for health systems: improving the health of the population they serve, responding to people's expectations, and providing financial protection against the costs of ill-health. (WHO 2000). We would define the aims rather differently, and with more explicit focus on what health systems *do*, as this is often in danger of becoming lost in management terminology or mere emphasis on health services. We would claim that the aims of health systems should generally cover the following areas:

1) Protection and promotion of population health and provision of preventive services and emergency preparedness ("public health")

2) Provision of health services and care for all according to need, and financing these according of ability to pay ("health services")

3) Ensuring training, surveillance and research for maintenance and improving of population health and health services and availability of skilled labour force ("human resources and knowledge")

4) Ensuring ethical integrity and professionalism, mechanisms of accountability, citizen rights, participation and involvement of users and respect of confidentiality and dignity in provision of services ("ethics and accountability")

The first aim covers traditional public health aspects of health systems, covering the necessities to ensure traditional public health policies, preventive measures as well as health promotion and the notion of healthy public policies and assessment of health implications of other policies. The aim of these functions is to maintain and improve health, and reduce structural aspects of disparities in health. It also deals with general regulatory means in the field of health protection (e.g. drinking water quality), health promotion (advertising of products hazardous to health) and broader health efforts (campaigns and health impacts of other policies).

The second aim defines the principles of universality in access according to need and solidarity in provision and financing of health services and care. This covers also the protection of people against costs due to illness, cost-containment in the context of the whole health system and the distributional matters in health care financing. It also relates to regulatory and organisational aspects of quality of care and health technology, pharmaceutical policies and other so called supporting functions in health systems.

The third aim states human resource and knowledge- and evaluation -based aspects of health care systems. It deals with data, but also evaluation and regulatory aspects of quality of care and standards of medical treatment. This is often neglected in analysis of health systems, and is an issue which cannot be left merely to the markets to fulfil. The knowledge-based functions also provide a basis for the development of capacities and resources to ensure data and surveillance functions as well as procedures of quality of care.

The fourth covers political and ethical commitments of health systems. These include the ways in which citizens social rights are set and met, the accountability of the health system and services providers, and ethical issues covering such areas as confidentiality, malpractice and non-health related client aspects of health care. These cover also matters concerning public health and preventive measures as well as ensuring citizen trust on public policies and in relation to health protection. However, we have set these principles more in the context of rights of public services provision and citizen rights than of more consumerist models emphasising responding to expectations and ensuring choice.

We have, through our definition of health systems, wanted to combine and ground the analysis of health systems more closely in the health and public policy priorities.

Economics of health systems: redistribution and industrial change

Health systems understood as based on these values are rooted in a concept of the economy which accepts that some elements of that economy are inherently 'social'. By this we mean, health care is perceived in this framework, not as a commodity like any other, but as inherently a social and public responsibility, an element of the public sphere of concern. The economic perspectives underpinning this concept of health system necessarily include:

1. an acceptance that benefits from health care can be compared between individuals, as a basis for evaluating redistribution through the health system;

2. a concept of the economics of health which draws on macroeconomics as well as microeconomics, understanding its redistributive function as inherent in economic evaluation of outcomes;

3. an analysis of the processes of change in industrial production and marketing of goods and services that shape the possibilities and constraints of the health system;

4. an institutional understanding of the non-market patterns of incentives, exchange and caring that sustain professionalism and effective care in a health system.

None of these economic perspectives are new or, in analytical terms, particularly controversial. Redistribution was identified as a standard function of macroeconomic management of the economy after 1945, and the option of provision of services 'in kind' to ensure that all had access to certain 'merit goods' such as education and health care was included for decades in macroeconomic and fiscal policy texts even in the United States (Musgrave and Musgrave 1984). In almost all rich countries, health care forms one of the least controversial elements of macroeconomic redistribution (Barr 1998). The economic analysis of inequality and equity routinely treats individual benefits as commensurable (Atkinson and Stiglitz 1987).

The analysis of firms and the dynamics of industrial change is a major branch of economic analysis (Simonetti et al 1998). Only the analysis of non-market behaviour is less familiar, and even that is increasingly an element of government economic policy, for example in the analysis of gender impacts of budgets (Elson 1998). However, as a set of perspectives, they are not currently brought to bear on health systems, and we intend this project and conference to assist in repairing this gap.

Health systems as just noted are a major sphere for economic redistribution. Health has thus served, in many different countries and epochs, as a political and social platform for addressing social inequality and exclusion. In most rich countries today, health systems are highly redistributive in economic terms: the combination of proportional, mildly progressive or somewhat regressive financing with services which approach (though they do not generally achieve) equity in the face of need, has a very large progressive impact

on the income distribution that emerges from market activity (Wagstaff et al 1999, Besley and Gouveia 1994). Only one rich country, the United States, does not achieve – and does not aim to achieve – universal near-equitable inclusion in health care.

Redistributive health care based on universalist objectives is also found in some low and middle income countries, including upper middle income countries such as Costa Rica, Taiwan and Korea (Kwon and Tchoe 2004 *this conference*); low income countries such as many African states in the early independence period which rapidly expanded public provision of primary care as a way of responding rapidly to social need (Mackintosh 2001); socialist states such as China up to the 1990s and Cuba to date; and Sri Lanka before the 1980s (Drèze and Sen 1989). Even the African public expenditure patterns on health care, so often characterised as 'regressive' or 'pro-rich', are generally having a progressive impact on the market-derived income distributions, as indeed the IMF acknowledges (Davoodi et al 2003, Kida and Mackintosh 2004 *this conference*).

To estimate the extent of redistribution through health care we need to assume that benefits to individuals from health care provision can be compared. This does not sound particularly controversial: we assume that the benefit of an appendicectomy, or the treatment of a fracture, or immunisation against polio – or more generally benefit from the availability of such services in case of need - is the same for each person who requires the service, and can or may one day benefit from it. Indeed, in the economics of inequality literature this is *not* controversial: we cannot analyse the extent of inequality and redistribution without making assumptions of this kind.

There are good reasons why health care is an excellent sphere for redistributive economic policy. Health care systems address one of the major forms of social risk people face, and there is a widely held view that it is not ethically acceptable that access to care when ill should depend on ability to pay. Inclusive health systems in most rich countries combine in one health system insurance against the costs of ill-health and treatment, cost control in health services, and insurance against one major source of severe impoverishment (Barr 1998).

An appropriately functioning health system is also important for economic policy in terms of ensuring healthier citizens, provision of basic social security, limiting impact of epidemics and public health scares and in containing the overall costs of health care to the individual and indirectly to the productivity of the economic sectors of the society as whole. Whatever the institutional form, and whatever the mix of types of provider and pattern of social insurance or tax financing, health policy can be seen, in economic terms, as part of a country's macroeconomic policy framework as well as a major sector of the economy.

However, in order to understand aspects of commercialisation it is also necessary to treat and understand health sector also in the context of microeconomic activity. Health systems are influenced and reshaped by industrial innovation, interests and investment. In the context of health promotion and public health policies, the nature and ways in which industrial innovation, products and markets operate have always been highly influential. However, the role and relevance of industrial change has become increasingly influential

in the organisation and costs of health services and health systems. Health systems have been transformed in the last fifty years, in terms of what they can do, by industrial innovation in pharmaceuticals and medical technology. Industrial innovation, interests and developments in the services industry are also becoming more evident in the sphere of health services provision, through both direct and indirect influence on how health services are financed and organised.

In the OECD countries market driven processes in health systems have in practice been associated with rising costs of care. According to the most recent OECD assessment the main reason and driving force behind increasing costs of health care is health technology (OECD 2003). In low and middle income countries too, health care has long been a field for industrial and service sector investment, as this paper and this conference explores (Chaudhuri 2004, Altenstetter 2004, Jasso et al 2004, Lethbridge 2004 *this conference*). The pattern of investment behaviour and the emerging market structure including patterns of monopoly and competition and the profitability of different market segments, shape the constraints and options open to public authorities in the design of health systems. Where there is a commitment to the design of an inclusive and effective health system, an economic understanding of industrial change is a key working tool for health policy makers: the regulatory aspect of health policy needs to be rooted in an understanding of what market incentives are driving change, and how patterns of private investment can be harnessed and constrained to serve public purposes more effectively? An economics of solidarity requires an economics of industrial change.

Finally, health policy requires an effective institutional economic understanding of non-market working relationships in the public sector, in the nongovernmental sector (notably the role of value-based provision in the religious-owned facilities), and outside the health system in care provided by relatives, friends and neighbours. Health policy makes strong yet unexamined assumptions about the nature of non-market behaviour in health care, and most of those assumptions appear to be wrong (Mackintosh and Gilson 2002). Without an improved understanding of non-market working relationships, policy makers may inadvertently undermine – or fail to construct – acceptable incentives and conditions for professional working behaviour, and may effectively misunderstand the extent to which health system functioning depends on limited care resources outside the home.

2.2 Health services as a market sector

The definition we have put forward above of health systems is neither universally agreed, nor currently the dominant view in international health policy thinking, though the tide of international opinion may be shifting. The view of health systems implicit in the highly influential models of health sector reform defines a health system ostensively: the phrase indicates the totality of the health facilities and public health activities there happen to be in any country at a given moment. This empirical definition appears to be value-free but it is not: the implied redefinition of a health system as a set of health services forming a sector of a market economy is based in some strong value-based assumptions. Like our definition above, it is also rooted in a particular form of economic analysis.

Health sector reform and health systems.

The international literature on health systems has been dominated during the last two decades by the literature on health care reform. The processes of health sector reform have been seen also as an element of globalisation process, propagated by epistemic communities and managerial and consultants' networks (Lee 2002; Moran and Wood 1996). While deploring the 'blueprints' of the past, the health sector reform (HSR) literature has peddled new universal 'blueprints' for the management of health services. The 'new public management' structures and mechanisms have become embedded in the proposals for health care reform and for broader public sector reform, presented as technical rather than political measures (Mills et al 2001).

The outlines of the HSR model as promoted for middle and low income countries have been endlessly rehearsed (World Bank 1987; World Bank 1993; WHO 1997; OECD 2003; WHO 2000; Gwatkin 2003; World Bank 1997; Preker and Harding 2003). They include in various combinations the following changes:

- provision of health services by a 'mix' of public, private and voluntary providers;
- liberalisation of private clinical provision and pharmaceutical sales;
- retreat of government to a mainly regulatory role, with responsibility for direct provision of services in public health and primary care for the poorest ;
- the emphasis on "government steering, not rowing"
- decentralisation of health systems and emphasis on local resource gathering
- user charges for remaining government health services and for government-provided drugs and supplies;
- the use of contracting-out where possible when governments continue to finance provision;
- autonomisation and corporatisation in the hospital sector;
- liberalisation of insurance provision for health care, and a shift towards insurance rather than tax-based financing mechanisms including mutual insurance schemes; the introduction of concepts of pre-paid care or even more direct emphasis on prepaid plans (managed care)
- encouraging competition between insurers as well as providers and distancing social insurance mechanisms from government, including the abolition of compulsory elements of social insurance and the contracting out of insurance management.

The emphasis within the 'package' has differed between 'clients' of HSR advice, and the proposals have also been allied with donors' demands for broader government sector decentralisation and reform. The role of international organisations, such as the OECD and World Bank, in the process and implementation of reforms has been important in practice (Lee 2002). The elements of the HSR package are reflected more broadly in public sector reform models promoted for lower income contexts that promote a residual provider role for the state through means-tested funds.

This model has been summarised as a reliance on private provision and insurance where possible, with public finance – and as a final fall back public provision – for the poorest:

'market commodities and poor relief' (Laurell and López Arellano 1996). The huge critical and evaluative literature on HSR in developing countries focuses in particular on the consequences for inequity and exclusion, and also for quality, of particular aspects of reforms such as user charges and cost sharing[2]. The reforms have been energetically proposed and indeed ensured by various international organisations, such as the OECD and World Bank. The complexity of the model in relation to the institutional capabilities in the developing world have also been criticised in internal evaluations undertaken the international agencies. The core concept of a shift to a more formally commercial health system has been widely questioned, and the rest of this paper addresses this aspect in more depth. We argue below that while the institutional environment of health systems has changed in many countries in the developing world, the evidence base to suggest that further commercialisation would improve outcomes is scarce if not largely non-existent.

The WHO 2000 report on health systems claimed to have changed from ideological stands of health for all policies to more evidence-based approches, however, it is clear that many of the claims and also ways of measurement and ranking were based more on ideological preferences and values (Ollila and Koivusalo 2001). An example of this is that the United States was given the first rank in responsiveness of health care in spite of known problems of uninsured persons without sufficient access to health care. This was possible due to the weighting of the measures and in practice the inclusion of share of private sector providers as part of this weighting process (WHO 2000, Ollila and Koivusalo 2001). The most recent World Health Report, however, has actually returned to the recognition of Health for All policies and the importance of the more integrated primary health care approach to the development of health systems (WHO 2003).

Health policies and health systems are fundamentally based on values and these need to be explicit and guide the way how health systems are governed organised. Worse than explicit blueprints are such implicit blueprints which are maintained and implemented without broader contextualisation to the health system as whole and within the local context of service provision.

The question of the appropriateness of the HSR model is sharpened by the new emphasis in the international development literature and donor policies on pro-poor policies. International interest and support for poverty reduction and for services for those who are poor ('pro-poor services') has become more outspoken (Gwatkin 2003, World Bank 2003, OECD 2003). As proposals for pro-poor policies become more defined, the values underlying HSR have come to be more openly questioned.

First, there is increasing recognition that the ways reformed health systems are financed may lead to poverty. People may be willing to pay and invest in health care much more than they are able to afford, driving themselves into chronic poverty. There is thus a need to separate ways of coping with costs related to illness from the impact in terms of loss of capacities and costs of care. Health sector reform models, by treating health care as, at

[2] See the reference list in Mills et al (2001); recent papers include Stierle et al (1999), Fabricant et al (1999), Gilson and Mills (1995)

root, a market sector, obscure the ways in which the systems re-distribute resources in the short and long run.

Second, the HSR model generates a response to poverty that focuses on the provision of basic services for those poor. The problem is not about being pro-poor or putting emphasis on basic services, but rather in forgetting the existence of the rest of the health system and the rest of the population and the impacts of this on the aims of provision of basic services to those poor in the long-run and the implicit residual model of health policies and role of public policies merely as provider of last resort.

One crucial aspect with respect to basic services for those poor is what is understood as 'basic'. The danger is that basic becomes too basic and selective to address actual health services needs of people. In segmented systems services for those poor are likely to remain poor services. In this respect three issues need to be raised, first, the capacity to ensure quality of services and limits of participatory mechanisms; second the problem of professional work-force and education; and third, the problem of more long-term financing of services. Hospitals are an important part of a health system and teaching hospitals have a specific broader value to a national health system and training of professionals. There is no evidence that those poor suffer from less problematic diseases which would be more treatable purely in the context of basic services. The difference between poor and 'non-poor' is not always sharp or stable, since a substantial part of the non-poor is vulnerable to becoming poor due to health care costs.

Third, and in some ways ironically, poverty policy in the context of HSR generates a focus almost exclusively on public sector budgets. The model diverts attention from the assessment of the overall costs of poverty policy generated by particular health system design; the focus merely on targeting of public funds or organising particular services, treating the public sector as a separable sector, obscures interactions between public and private that may change the scope of the public itself (Baru 2004 *this conference*). The focus on basic services for those who are poor, and the targeting of public funds, is in the context of the promotion of commercialisation for the more affluent, and pressure for privatisation of hospitals, that between then create an inbuilt bias against risk sharing and resource pooling.

Pro-poor policies which exclude those more affluent and healthy are a bad basis for building up a health system with cross-subsidisation and risk pooling. A crucial issue for poverty policy is how to make the rich and healthy pay more than their share for the services, and to ensure that a skilful workforce and good quality of services for those poor is maintained or built up. Proposals to 'off-load' the better off need to explain how redistribution will be achieved without a common pool of health service funding. The danger is that the quality of the services for those poor is so bad that they are driven to use the services of (low quality, for the poor) the private sector. The HSR schemes pay insufficient attention to the nature of poverty and the ability to pay for health care costs of the so-called 'non-poor' (Kida and Mackintosh 2004 *this conference*).

Finally, there are consequences for poverty policy of the impact of HSR and associated commercialisation *within* the public sector and as part of public finances. Contracts and collaboration with private sector and especially non-profit actors in many countries long predate the emergence of more managerial approaches. However, under the pressures of commercialisation and technical emphasis on 'steering' rather than 'rowing' (Osborne and Gabler 1991), the public sector is itself commercialising, as are some of the ways in which non-profit agencies operate. This commercialisation of the public sector from within is an important aspect of health sector reforms. Management models and contractual arrangements stimulate the entry of private sector firms into publicly funded or reimbursed service provision, but leave the responsibility for service provision still with the public sector, which also acts as the last resort financier in case problems emerge.

There are also tasks which become easily 'underserved' in a more commercially oriented mode of service provision and which are more difficult to ensure in the contractual arrangements. The most important is provision of emergency services and emergency preparedeness. Health systems do have firefighting functions, which cannot be assessed merely in terms of commercialised services, which are hard to assess and which require substantial resources. During epidemics it is usually the ultimate responsibility of the public services' staff to take a frontline position, however they may be denigrated at other moments. The bearing of risks and accountability in health systems is a crucial question which needs to be addressed when services are contracted out, but can rarely be addressed as part of contracts. Another problem is related to the capacities of Ministries of Health to manage and steer, and the access to and availability of data for purposes of evaluation and analysis of the functioning of the health services. Given the prevailing view that the state has failed in the direct provision of health care, it is not clear why there is greater faith in its ability to regulate, especially the more sophisticated forms of regulating that seek to avoid the 'command and control' mode (Mills 2000).

Finally, the more commercialised context of health systems creates options and prospects for many such commercial activities which are of problematic ethical nature. This can be exemplified by the trade in human body parts and the options of malpractice and quackery as personal economic career choices in a poorly regulated and commercialised context of service provision. The more traditional emphasis on professionalism, trust and ethics in health systems is also challenged by the incentives towards more consumer oriented and demand-based context of service provision which encourages more entrepreneuralism.

The underlying economics: health care as competitive market exchange

The economic model underpinning HSR is the competitive-market model of health care as market exchange, rooted in 'neo-classical' microeconomic theory. Two key values implicit in this model – which as a 'welfare' model *does* embody explicit values – are key to understanding both its influence and the opposition it arouses.

1. The model assumes that individuals are incommensurable: islands unto themselves. The value of health services to one person cannot be compared to the value to others. Our valuation of services is expressed by market purchase, and hence freedom to choose what to purchase is the basis of expression of individual valuations.

2. The model assumes that all products and services are marketable. Health care can be divided into units of service for efficient individual purchase.

This framework of thought is the 'common sense' of much current microeconomics of health care: the taken-for-granted set of assumptions which are true until demonstrated false[3]. It is an individualist methodology that provides the ethical (not merely the empirical) basis for much current research. Consumption of health care by individuals is the key variable for analysis; individual experiences and preferences the key values; choice (e.g. of health care provider) a core concern. Hence, this is often called a 'choice-theoretic' framework of economic analysis of health care, and it motivates an analysis of health care interactions that starts by conceptualising them as atomistic exchange among individuals.

This health economics literature also contains however a very substantial demonstration that the second key assumption above *is* frequently false in health care markets. It identifies a long list of perverse incentives (that is, incentives for inefficient market behaviour) generated in principle and practice by market incentives in health care and health insurance (Barr 1998). The most important of these 'market failures' are poor information in the hands of patients, and resultant incentives and opportunities for providers to over-treat and offer poor quality treatment, and for the uncontrolled escalation of costs of provision to the benefit of providers' incomes and the detriment of patients; also the exclusion even of some who would have been able to pay through the inefficient operation of private insurance markets in health care. The literature also analyses at length the (limited) extent to which health care can be regarded as a 'public good' that cannot (technically) be divided into pieces to be sold on a market, hence must necessarily be provided by public action. And it recognises, of course, that in a market system people who cannot pay will be excluded.

The literature on public goods and 'global' public goods in health (Smith et al 2003) accepts this residual definition of 'public goods' as those items the market cannot provide (*not* those items to which all should have access) and tries to expand its reach a little. These are the working assumptions that underpin – almost uniquely – health policy in the United States. The current World Development report on services characteristically treats the broad framework of thought as of universal applicability while characterising critics as bound by national preconceptions[4].

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[3] See for example current US health economics texts and journals; however, even much more institutionally focused UK texts, such as Donaldson and Gerard 1993, start (Chapters 2 and 3) with an exposition of a standard market model of the economics of health care.

[4] For example: 'For instance, British and Nordic advisers are familiar with a free clinic-based free health service and so prefer to support these systems in low income countries too' (World Bank 2003 p.217. Note the 'so'; there is no equivalent recognition in the report that the relentless promotion of competition might be the result of United States 'familiarity' with that system.

This framework of thought is also widely referred to by proponents of international market liberalisation in health care. A WTO official's informal contribution at a seminar in 2002[5] put it neatly: his view was that other services benefited from liberalisation and that he could not see why this could not also be true of health services. As discussed below, the impact of GATS (the General Agreement on Trade in Services) in health care has so far been limited, though the liberalisation of insurance markets may be increasingly important in health, as are some of the implications of TRIPS (WHO 1997; Correa 2002ab; Chaudhuri 2004 *this conference*).

There is substantial evidence that market failures in health care can interact cumulatively to reinforce exclusion from care because of inability to pay, at all levels of income. The effect is generated by rising costs of both insurance and services that worsen levels of access by those on low incomes. 'Catastrophic' health costs – the consequence of unpredictable severe illness – then become a key cause of impoverishment in many low income countries where most health care is paid for – when the money can be found – from people's pockets (Stierle et al 1997, Mackintosh and Tibandebage 2002 World Bank 2000/2001). By contrast, there is remarkably little available systematic evidence on the benefits of competition in health care provision and insurance.

This economic model of health care obscures, as noted above, the redistributive processes within the health system as a whole. Rather, this framework of thought carries a presumption against cross-subsidy within health care as a means of redistribution. Instead, redistribution through cash income transfers is typically proposed, or direct 'delivery' by the public sector if needed for those unable to pay. While reducing the public sector to a residual actor, and generating a strong critique of government agency, the model thus puts the whole weight of redistribution within the system onto public expenditure, while promoting a highly regressive predominant mode of private financing of access to provision. The burden on a weak public sector is enormous: the HSR model in effect rejects the redistributive processes within health systems, typical of most inclusive health systems with a high level of legitimacy, in favour or redistribution *around* a regressive system .

As a market model, these economic assumptions tell is little, however, about what makes for an effective public sector: by definition it has little to offer on how to make the public sector work. The public sector is a *residual,* and treated as a wholly separate sector, not an inherent part of an interactive system. The framework has, by definition rather little to offer about the analysis of the 'meso' level of institutional processes and interventions at which policies to regulate, constrain and supplement private care necessarily operate (Mwabu 2001).

Yet the model also puts an enormous weight onto government in its demands for regulation of the private sector. Especially in the context of developing countries it is not clear why there is at the same time recognition of the failure of the state to provide services and at the same time sunstantial faith in the abilities of the state to undertake

[5] where the authors were present

sophisticated regulatory measures. The model of government stewardship or steering of private provision implicitly assumes that it has the capacity and skills to regulate the services, to ensure (or at least promote) equity, quality and cost-containment. However, the regulation of a strong commercially oriented private sector or a multitude of small actors is a highly demanding process. Large private institutions have their own interests and constraints. A large share of the non-governmental organisations associated with health services provision are connected with a religious institution. This implies that provision of reproductive health services and sexual health care may face substantial problems. Some corporate actors in the fields of pharmaceuticals and health technology, which are directly associated with health related products, are interested in moving into provision of health services, and conflicts of interest can be severe. Information problems, and issues of relative power arise. Regulation of entrepreneurial behaviour has been shown to be complex even in the developed countries with good information and management structures (Saltman et al 2001), and much of private provision in low and middle income countries is effectively unregulated.

As capacities to regulate remain often weak, the longer-term risks of non-regulation are relatively large. Two examples may be raised: the control of epidemics and antibiotic resistance. The control of epidemics and prevention of diseases cannot be separated from the provision of services. The separation of personal health services from the 'public goods' conceptof public health services and regulatory functions is to a large extent artificial. The human and economic costs of epidemics are substantial and require a cooperative, not competitive, relationship between health services providers. In the pharmaceutical sector antibiotic resistance is a serious concern and has potentially extensive public health implications of global relevance. In the more commercialised context of health systems various mechanisms at different levels pave way to an increasing risk of antibiotic resistance. First, through inappropriate demand-based practices in treatment of disease in a more commercialised context of care, second through liberalised markets in distribution of pharmaceuticals and inbuilt incentives towards selling more highly priced drugs, third through increasing direct purchasing of pharmaceuticals due to increased cost-sharing and costs of care.

3. Commercialisation and globalisation: is there an economic transition in health care?

3.1 Defining commercialisation and globalisation

The key focus of this project and this paper is the nature and implications of commercialisation in health care. We define the concept of 'commercialised' health care to mean:

- the provision of health care services through market relationships to those able to pay;
- the associated investment in and production of those services for cash income or profit;
- and health care finance derived from payment systems based in individual payment or private insurance.

This definition is wider than simply the 'private sector' of provision and finance, and encompasses the nature and implications of differentiated market structures and processes. It is also broader than 'liberalisation' and 'marketisation', each of which refers to a shift to market-led provision from state-led or state constrained systems; it is also broader than 'privatisation', which refers to the sale or transfer of state-owned assets into private hands. We explore in this paper some indicators of the *extent* of such commercialisation of health care, and also of its *direction.*

The concept of economic globalisation is also a narrower concept than 'commercialisation'. 'Globalisation' of the economy is something that happens *within* as well as between countries: that is, two economic processes, both in principle measurable, operate to create the experience of 'globalisation':

- individual economies become more 'open', that is, their internal economic structure and dynamics become increasingly driven by the nature of their insertion into the international economy;
- particular international markets become more integrated, so that firms supplying those markets treat them increasingly as a single market.

Commercialisation of health care in the sense just defined long predates in many countries the current wave of globalisation. Indeed the history of health care in many countries could be written in terms of waves of commercialisation followed by resistance to commercial practice and a turn to decommodification. By 'commodification' (discussed further below) we mean the creation of health services in the form of units that can be and are sold on markets; decommodification implies a turn to non-market patterns of supply. This retreat to non-market provision has then been followed in some countries – and, at present, internationally – by renewed pressures for commercialisation of service provision, as policies and economic pressures have shifted.

It follows from this set of definitions that globalisation presupposes commercialisation, but not *vice versa.* We therefore treat commercialisation as the focus of our analysis in this project, and globalisation as a set of pressures among others that drive, embed and

restructure commercialisation. We set out to understand from the perspective of middle- and low-income countries the nature and effects of these pressures.

Finally there is another sense of 'globalisation' in the literature: globalisation not as a set of observable economic and social phenomena but as a *policy project.* In the 'policy project' sense, the current literature includes within 'globalisation' not only policy pressure from multilateral organisations and bilateral donors to open economies to the international trade and investment, including the policies associated with health sector reform, but also pressure for internal liberalisation of economies, including liberalisation of supply of health and education services (Lee et al 2002). Internal and cross-border liberalisation are closely intertwined, but should not be taken to imply that all liberalisation is driven by globalisation.

3.2 Is health care commercialised? Data analysis of the 'public/private mix'

To analyse the extent of commercialisation we need a model or framework of analysis to allow us to interpret available evidence. There are two available. The currently dominant framework of thought – part of current common sense in the international literature – is the concept of the 'public/private mix' (Bennett et al 1997a, 1997b, Bennett and Tangcharoensathien 1994, Bhat 1993, Ngalande Banda and Walt 1995, Bloom 1998, Leonard 2000b, Segall et al 2000, Najandra et al 2001). Like all models this is in essence a metaphor: an image of a (cake) mix where one can have more of one ingredient and less of another along a continuum. We employ this metaphor initially to analyse the available cross-country data on extent and patterns of commercialisation, and identify its limitations in creating policy relevant concepts of commercialisation. In the following sub-section, we employ an alternative economic metaphor for analysing commercialisation, with stronger roots in economic theory. We employ cross-country comparative data in this section *not* as a means to analyse causality, but rather in exploratory mode: it see what they can tell us about different patterns of commercialisation world wide.

In the 'public-private mix' framework, the appropriate indicators of commercialisation are the public and private proportions of health expenditure or supply of health services. Expenditure data can give us estimates of the proportion of health spending that is done by private individuals buying services or private insurance, as compared to the proportion of the money for health care spent by governments or by compulsory social security funds. We use here comparative health care expenditure data and other indicators from the WHO (www.who.int/whosis) and World Bank (World Development Indicators online www.worldbank.org).

Alternatively we can look at data on provision: who owns the capacity to provide the health care? Oddly, however, there are virtually no comparative data sets routinely collected on this topic. The multilateral data collection effort would appear to have been driven by the assumption (or perhaps the principle) that while the public/private financing split is a key policy variable, the public/ private/ voluntary pattern of ownership is not. This, we will argue, is a mistake. It is indeed a curious feature of the current literature

that the now quite substantial case study literature on the 'public-private mix' in provision has not been associated with systematic cross-country data collection.

In part no doubt this lack is because of the conceptual and practical difficulties of collecting data on ownership of health services supply. We employ below two indicators. One is the proportion of hospital beds in the public and private sectors, drawn country by country from a wide variety of sources. (We have been unable systematically to distinguish non-profit from other private beds in these data). We could find no comparable direct indicator of ownership of primary care capacity, so we have used an intermediate one: the public/private split in use of ambulatory care. We draw below on data from the Demographic and Health Surveys, undertaken since 1990 in 44 largely low and lower-middle income countries (www.worldbank.org), showing the public/private division in use of facilities for specified childhood illnesses.

Findings

From the expenditure side, we use as our indicator of commercialisation the proportion of total health care spending that is spent by individuals directly or via private insurance. A key characteristic of such private spending is that it is in principle unrelated to ability to pay. Conversely, government or social insurance spending may (or may not) be income-related. Private spending is not of course only spent in the private sector; much private spending now goes on fees for religious, NGO and government-provided care as well as to private providers. The data show the following patterns of commercialisation.

1. Commercialisation, measured by the share of private in total health spending, tends to be higher in lower income countries.

Commercialised health care (on this indicator) is not a system preferred by the better off; rather it appears more as an affliction of the poor. Levels of commercialisation as measure in this way are significantly and negatively associated with average incomes, across the world, though there is considerable dispersion (Figure 1). Rich countries have almost universally established social insurance or government-based health financing systems: only the United States and Singapore have private shares over 50%. All but one of the twelve countries in Figure 1 that have private health expenditure shares over 70% have national incomes per head under $1000 per year.

2. The poorer a country, the more likely the population is to face the most regressive form of health finance, out of pocket expenditure.

Private health finance is likely to be – and generally is found to be – regressive, that is, where it is a predominant means of access to health care across the social scale, it weighs most heavily on those on lower incomes and excludes the very poor. Its most regressive form of all is out-of-pocket spending, and it is the population of some low and middle income countries, including India and China, who face most severely this barrier to health care access. Not only is the proportion of health spending that is out of pocket strongly negatively associated with income per head by country (Figure 2); even worse,

large numbers of low and middle income countries – and *no* rich countries except Singapore – finance over 40% of health care out of pocket and/or spend over 3.5% of GDP out of pocket on health care (Figure 3).

3. Health care appears highly valued, since at higher average incomes, proportionately more is spent on health care in total and through government/social security expenditure; however private health spending is ***not*** *apparently valued in this same way.*

Strikingly there is no correlation whatsoever between average incomes per head and the share of GDP spent privately on health care. Health care appears a valued good in the sense that the richer countries not only spend more than poorer countries, they spend *relatively* more, a significantly higher share of their total income, and they generally do this through a higher share of government/social security health spending in GDP (Figure 4). These relationships are strong and significant: economists call goods that are bought proportionately more at higher incomes 'luxury goods'; the usual examples include yachts (Begg Dornbusch and Fisher 2000), but ironically government/socially-purchased health care seems to fit the definition. Equally striking, private spending on health care does not: it is *not* a luxury good in this sense, since its share in GDP is completely uncorrelated with income per head (Figure 5). The irony lies in the frequent casual association drawn in the economic literature between privately purchased health care and quality.

4. Higher spending in total on health as a percentage of GDP is associated not only with higher incomes per head but also, independently, with higher private health spending relative to GDP: is the extra private spending producing more care or just higher costs?

The data show that countries with highly commercialised health systems in the sense of a high ratio of private health spending/GDP also spend more of their GDP in *total* on health care independent of income per head (Figure 6). (This is not the case for government health spending/GDP.) This suggests that countries with commercialised health care in this sense tend to have either more health care or higher cost health systems than would be expected for their income level (or both).

5. Regionally, Asian health systems are the most commercialised, as measured by private as % of total health expenditure, and high income OECD countries the least.

Only Asian (low and middle income) economies have a median level of private/ total health expenditure, by country, over 50%. Only high income OECD countries (treated as a 'region' apart) have a median below 30% (Figure 7). The pattern suggests – as do historians of social provision, and common sense – that local economic, political and cultural strands are important determinants of health care commercialisation. Japan however has a low rate of commercialisation on both measures even by rich country standards.

Interpreting expenditure data – and assessing its quality – is not easy, but the problems are worse when we turn to ownership of health facilities and the employers of health care

staff. Here there are no reliable indicators or accessible cross-country data at all. Using the data referred to above, these are the findings.

6. Hospital provision has a generally low level of commercialisation.

To explore secondary care commercialisation we have collected data (of variable quality[6]) on the public/private 'mix' in ownership of hospital beds. Beds data provide a better indicator than ownership of facilities, since they remove what can be dramatic bias in the indicator as a measure of commercialisation of provision if public hospitals are (as they tend to be) larger than private ones. The data show that in most countries, less than fifty percent of hospital beds are in non-government sectors (Figure 7); the median percentage is 23.5, and only four of 32 countries have over 50% non-government beds. Government hospitals thus still appear to provide the bulk of hospital based in-patient care.

7. Conversely, primary care provision in low and middle income countries is highly commercialised.

Primary care commercialisation can only really be assessed comparatively by data on usage. Ownership of facilities is a problematic indicators, because of the very different sizes and levels of service provided. The DHS data (see details above) give us one indicator of primary care commercialisation: the proportion of children who, when ill with acute respiratory infection or with diarrhoea and taken for treatment, were taken to a private facility or provider as opposed to a government provider. The data include information on children ill but not taken for treatment. In almost all countries, the percentage of children treated for ARI and for diarrhoea who were treated privately was over 50%, and this percentage was unrelated to GNI per head. Figure 8 shows ARI data; the pattern for child diarrhoea is very similar. This image of highly commercialised lower income primary care is well supported by qualitative evidence (see below) and has serious and increasingly debated consequences for public health.

8. Deliveries outside the home, however, in low and middle income countries, are less commercialised than primary care for children.

A rather different indicator of commercialisation can be drawn from the same data set, on deliveries. Deliveries are recorded as supported by a trained attendant or unsupported, and as deliveries at home or as a private or government inpatient. For the DHS set of countries, the proportion of deliveries outside the home as a percentage of the total varies very widely, for example from 5 % in Bangladesh to 99% in the Kyrgyz Republic at similar recorded income levels; both the percentage of deliveries outside the home and the percentage of attended deliveries in the total tend to be higher at higher income levels but the associations are not strong. In no country was the proportion of total deliveries in private facilities over 25%; in most it was much lower. The percentage of deliveries

[6] The data are from a variety of sources; we have sought to cross-check with researchers in the relevant country where possible. We owe some of this data collection to Seife Ayele.

outside the home that were in private facilities was generally well below 50% (Figure 6), and in only one country were more than 15% of all deliveries attended privately.

9. Commercialisation as measured by expenditure indicators is unrelated to commercialisation in terms of ownership of provision

The data show that the pattern of publicly and privately owned provision does not map onto the public/private 'mix' in expenditure. This conclusion is robust, and is consistent with earlier research on 1980s data. As Hanson and Berman (1998 p.208) explain:

> 'The public-private mix in finance is unrelated [in their data] to the mix in provision: this suggests that a simple segmented model of public and private health care may be very misleading.'

There is thus no significant association in our 1990s data, between the percentage of health expenditure which is private, and the proportion of hospital beds in the private sector. Nor is there any significant association between the proportion of children taken to the private sector when ill, or the percentage of deliveries in the private sector, in the data set of low and middle income countries, and the proportion of health care spending that is private.

Interpreting the findings

There is, then, no straightforward way to create an index of health care commercialisation by bringing together indicators of commercialisation of expenditure and of ownership of provision, given the lack of association between the two. This is because existing health care systems are not generally segmented into a 'private' sector funded privately and a 'public' sector funded by the government. That model is a strong policy aspiration for some multilateral commentators, national policymakers and economists; as David Gwatkin puts it: (Gwatkin 2003)

> 'A more radical approach would be to get the better-off out of government facilities altogether …by, say, using government regulatory powers to foster the establishment of a fully self-financing private commercial health sector serving the better off.'

However the model bears no relation to current reality.

Nor, conversely, do the data represent a 'demand and supply' pattern of health service markets, where the all expenditure goes via the patient or 'insurer' to pay for a range of services. This too represents an aspiration in some policy circles but is again in no way a description of reality. On the contrary the pattern of public health activity and service provision is, in lower and higher income countries alike, a system of mixed funding of mixed provision, where much public spending goes on direct provision as does some private funding (e.g. company clinics), and 'private' funds are spent in all sectors by ownership: government, NGO and private.

Responses to this apparent confusion have included proposals to tidy it up by 'separating financing and provision' (in rich and middle income countries) and by segmenting the

system into private (for the well off) and public (for the poor) in the low and middle income countries. Neither of these are helpful as universal nostrums, in part because the image of semi-commercialised health care systems on which they are constructed is too thin. To design policy that can create more inclusive systems we need 'thicker' models that allow us to understand the implications of different *kinds* of commercialisation, notably in the sense of understand the behaviour of different kinds of firms and providers. To inform policy effectively, our models need to distinguish the corporate supplier from the informal drug shop: to draw, in other words, on industrial rather than market economics.

3.3 How is health care commercialised? Alternative paths at different income levels.

Our economic approach to explanation therefore focuses on seeking to explain *behaviour* of suppliers, funders and those seeking care. We draw on institutional and industrial economics, and frame our understanding of commercialisation in dynamic terms.

In practice this means:

- *not all markets are alike and history matters* : we can treating markets as instituted processes that can be empirically classified according to observed patterns of interactive market behaviour that involve have involved learning and feedback and that tend to lock in particular outcomes ('path dependency'):
- *private ownership is a complex category:* size, national or international ownership, sector of activity, historical evolution of the company, profit seeking or not, all these aspects influence the kind of private sector that emerges over time; policy can influence the kind of private sector as well as its scale;
- *public sector behaviour is diverse and market-influenced:* public providers that charge fees take on some of the behavioural characteristics of private providers – this is one reason why the 'public-private mix' model is so misleading;
- *response to policy incentives is diverse* : there can be no single model for 'regulating' commercial provision, response to incentives depends strongly on prior experience and professional cultures.

On that basis, here are three stylised 'paths' through commercialisation of health care, drawn from both the above data and large amounts of qualitative and case study evidence. We concentrate here on commercialisation of services; the next sub-section considers inputs such as drugs.

1. The informal commercialisation of low income primary care

In many low income countries, the predominant form of health care commercialisation is the informalisation of primary care, through the creation, expansion or reinforcement of private small scale, largely unregulated primary provision. In *most* low income countries, urban primary care is delivered to a substantial or predominant extent by private individuals for fees. These countries include many Sub-Saharan African countries, South Asia, and also the currently low and (now) middle income transition economies such as

Vietnam and China (Hanson and Berman 1998). Based in household sample surveys, recent data for India locate over 80% of outpatient consultations in the private sector in both urban and rural areas (Narayana 2003). In Vietnam there has been rapid growth of independent provision at primary level, with a strong bias towards urban areas, and the attendant problem of widespread unlicensed practice (Nguyen Hong Tu *et al* 2003). The Vietnamese studies emphasise the particular dangers of very widespread purchase of drugs including antibiotics without prescription, including self-medication. The poor as well as the somewhat better off use private services and unlicensed drug sellers in Vietnam, as in China and across Sub-Saharan Africa (Segall *et al* 2000).

In these countries fee levels in private practice necessarily interact with user fees in government primary care (Tibandebage 1999). The Asian transition economies went into the marketisation process with a substantial and well distributed primary care network; many sub-Saharan African countries created government primary care provision as a key political element of nation-building. The organisation and scope of this publicly funded sector is now at issue in all these countries. Most, especially low income African countries, have seen the rise of informal charging in government health care, coinciding with economic crisis and a resultant severe fiscal squeeze on public sector wages and supplies. The subsequent introduction in many countries of official fees for access to government primary care has interacted in complex ways with existing informal charges, and many public sector health workers also work informally in the private sector.

The implication is that the population in low income countries is now are generally faced with heavy out-of-pocket spending for health care, whether for public sector fees (formal and informal) or access to private providers and commercial medicines. The predominant form of commercialisation at low average incomes has thus tended to be a largely informalised, small scale private practice market for health services paid on the spot, much of it unlicensed and uninspected, involving widespread sale of drugs off prescription. There is a negligible development of private insurance, few forms of private risk pooling, and social insurance restricted to the formally employed and sometimes to the public sector.

Private sector suppliers are generally individuals and small firms, and operate particularly in urban markets; the market is too small for corporate capital. The poor depend heavily on this informalised primary care and generally spend a much larger proportion of their incomes on health care than the better off, and there is widespread exclusion of those unable to pay (Jowett et al 2003, Tibandebage and Mackintosh 2001, Nandraj 2001, Baru 1998). This informalised marketisation undermines public health measures, leading to an emerging literature on how private providers can be given incentives to respond to public health needs. Furthermore, hospitals remain predominantly public or government-supported religious foundations in many low income countries; proposals to privatise them need to take into account the implications in the context of commercialisation of primary care.

2. Polarisation and corporatisation in middle income countries

A quite different pattern of commercialisation can be seen in some particularly middle income countries: the development of private medicine, funded through private insurance for the well off, and reliance by the poor on public services. South Africa is an example of this pattern, built up during the apartheid era. Wadee *et al* (2003) show that the majority low income African population still rely heavily on public sector health care, though there is a shift over time to more use of private provision even by the poorest quintile of the population. The system remains extremely polarised between the well off, including most of the white population, belonging to private 'medical aid' insurance schemes, and the rest. The private sector is subject to cost escalation and is itself financially fragile.

The pattern of private insurance for the well off alone is found among mainly middle income developing countries. India, however, while a low income country in terms of average incomes, is a huge country that in absolute terms has a large, prosperous middle class. Hence the Indian economy can support, in addition to the small scale informalised marketisation just described, a private formal commercial hospital and clinic sector, associated with private insurance, alongside small scale private providers and some (in most states, very patchy) public provision for the poor (Baru 1998, Narayana 2003).

It is particularly in middle income countries, because of the attractiveness of their markets to corporate investors in health care and health finance, that the sharpest battles are occurring over commercialisation of secondary care. Many middle income countries, in Latin America, Asia and transitional Europe, have a history of social insurance provision that includes health care, and also of direct public health care provision. Many also have a recent history of rising levels of private insurance and increasing corporate investment (Londoño and Frenk 1997, Stocker et al 1999), and face external demands from donors to break up social security funds.

If social insurance mechanisms for health care are broken up in this way, and replaced with (or come into competition with) individual risk rating in private insurance, the effect is to increase pressure for social and economic polarisation. This is because the private insurers will seek to sign up the well, young and cheap, leaving bad risks to the social system and undermining cross-subsidy. If private individual insurance for the well off becomes established, associated with expensive for-profit provision, this helps to build inequality into the social institutions of a country, making it hard to move over time towards the kind of universal risk-pooling systems most high income countries have achieved and many middle income country populations aspire to.

3. High income regulated commercialisation

High income health care systems have strong commercial elements on the supply side in many countries, but are typically very highly regulated, and normally exclude commercial finance except at the margins. Most high income OECD countries have health care systems dominated on the expenditure side by social insurance or tax-based

universal provision, and private providers work either for those systems, or as supplementary providers. Where private insurance is compulsory for the better off, as in the Netherlands, it is very closely regulated to ensure wide risk pooling and inclusion. Proportions of private providers financed vary greatly – and are increasing in some countries – but all providers within these countries are very strongly regulated (Saltman et al 2002). Only the US tolerates high levels of inequity in health care access; levels of inequity are fairly low elsewhere and overall most high income health care systems are strongly redistributive (Wagstaff et al 1999, van Doorslaer et al 2000). However, the USA too spends substantial sums from government funds to support health care access by some categories of the population, notably the elderly.

3.4 Globalisation and health care: evolving international market integration and the role of global regulation

Discussion of globalisation in health care has tended to focus on the extent of observed service trade: activities such as 'health tourism', that is, export of services such as surgery for high income patients. One ambition of this project was to shift this focus from the concerns of the rich world to the experiences and perspectives of developing countries. The project work has produced three robust generalisations about the nature, extent and consequences of international market integration and associated international/ multilateral policy pressure.

1. The predominant form of globalisation in health is on the input side

In medical technology and pharmaceuticals, where MNCs operate increasingly in integrated markets; actively seek scope for further integration; and are having considerable success. Their role in shaping of public policies has been substantial, for example, in the context of European Community policies (Greenwood 1997; Altenstetter 2004 *this conference*). At the global level the role of MNCs has been and still is substantial in protection of corporate interests through international agreements, such as the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). TRIPS is an example of an agreement with substantial indirect implications to health and health systems (Koivusalo 2003; Correa 2002ab; CIPR 2002). The most important of these implications are mediated through pharmaceutical and research policies and technology transfer. The role of industry in negotiating and promoting the TRIPS Agreement is well established (Drahos 1995; Drahos 1997). TRIPS is not about liberalisation of services, but essentially about protection of commercial interests and rights.

This emphasis in TRIPS has been reflected in the debates on access to pharmaceuticals in developing countries in the context of Doha declaration and Cancun decision on the matter, during which the interests of US and European based pharmaceutical industry were set against presented public health interests in the developing countries. It is likely that from a health policy perspective the interests of the US and Europe could have been more in line with the positions of developing countries, but the issue was carefully kept aside from the debates.

These patterns of integration of drugs and technology markets have enormous implications for low income countries' health service costs, and for their ability to respond to rising expectations in middle class patients. The potential of these technologies is enormous, but slanted to the historical concerns of the wealthy countries. In the corporate sector, research and development expenditures are predominantly geared to larger markets and to the diseases of more affluent populations. These account for about 95% of investments, and just 5% goes toward diseases of major importance to developing countries (CIPR 2002). Another concern has been raised with respect to antibiotics as research lines on antibiotics have been closed due to insufficient profit margins (Nelson 2003). On the other hand the focus and emphasis on access to pharmaceuticals ignores the problems of inappropriate use of pharmaceuticals, including the threat of increasing antibiotic resistance. The risk to industrial development and health care access from the import of some of these drugs into unregulated low income contexts is enormous.

As a result, the national ownership of productive and technological capacity emerges in this project as a key issue. The case study on pharmaceutical policies in India has shown the importance of local production to costs of pharmaceuticals (Chaudhuri 2004 *this conference*). It has also shown the ways in which international commitments in the context of TRIPS and associated political pressures undermine the product development capacity of developing and transition countries. This international restructuring of industrial capacity in health inputs – and the slanted technological developments associated with it – promise to create new problems for the viability of developing countries' health care systems.

2. ***The second key form of international market integration in health care is in the labour market*** .

It has long been forcibly argued that, because health care is a labour intensive system, its costs are substantially lower than in high income countries, hence health care is more affordable than may at first appear (Drèze and Sen 1989, Sen 2001). This argument is losing its bite, as active recruitment of doctors and nurses from low income contexts to work in higher income systems proceeds. Increasingly, the cost of health care staff is influenced by international market conditions and international recruitment firms' behaviour.

The increasing migration of health care staff to better conditions of work and pay is thus leaching the health care systems in low income countries of professional staff. A paper for this project (Mensah 2004 *this conference*) proposes that this situation should NOT draw from concerned policy makers a response that undermines the human rights of professional staff from low income countries by preventing migration, but rather be responded to by policies to rebuild the health care systems in which they work.

3. International market integration in services is patchy and fragile

As compared to the above, a much less robust, more faltering form of globalisation is that in the market for health service provision: cross-border investment in services for sale to individual (privately insured) high income patients wherever found. This has had a lot of air time, but papers for this project find that corporatisation and international market integration in health services provision is hard to achieve profitably, and it is limping. Many MNCs have considered this form of FDI to be in their longer term interest, only to change their mind in a few years (Jasso and Waitzkin 2004 *this conference*).

There has nevertheless been great pressure put on middle income countries by some donors, by multilateral initiatives and from large firms with home government support, to permit risk rating and the breaking up of compulsory social security schemes to support this form of commercialisation. In effect, this is a process of 'market making' (Chan 2004 *this conference*); creating new markets through changing regulation and marketing as well as liberalisation. The underlying problem facing multinational companies in health services such as hospitals appears to be that corporate provision of health care tends to be high cost, low profit and high risk: the US system, in constant crisis and unable to incorporate all its citizens, is the paradigm case. No other rich country, for good reason, permits this form of commercialisation to dominate its provision. As a result, many large firms in this sector prefer to keep risk under control through management contracts rather than asset ownership; through joint ventures; and through contracts that reduce their exposure to risk.

Some WTO Agreements are of importance in promoting all three of these patterns of international market integration, notably the General Agreement on Trade in Services (GATS) and the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). The GATS agreement deals with international trade in services, and the regulation of service takes the agreement much further into the sphere of domestic regulation than the predecessor agreement GATT (General Agreement on Tariffsand Trade) had gone (Mattoo and Sauve 2003). The role of GATS is to promote liberalisation of trade in services; however, its role in current processes of commercialisation of health care is probably far smaller than it is usually assumed. The opening of markets and ensuring regulatory framework for the operation of commercial actors may currently be more easily achieved in practice through bilateral treaties and regulatory reforms than directly through multilateral GATS negotiations.

This lack of impact is not due to the fundamental structure of GATS: to the extent that commitments are made, the Treaty 'locks them in' when committments are made. The flexibility of the Treaty thus ends at the moment a Member State commits a services sector. However, in terms of current state of committments sectors, GATS commitments in health sector have been limited (Adlung and Carzaniga 2001). Furthermore some crucial parts of the Treaty, which are of more relevance to health systems, such as approaches to subsidies, issues of domestic regulation, necessity tests and future of activities with respect to several of the so called Singapore issues, competition, investments and government procurement, remain still to be negotiated.

Finally, it is often emphasised that GATS does not influence health policy aims or priorities. However, this notion is not explicit in the sense that GATS has a broad importance in setting the international commercial legal framework in which policies take place and thus how services are organised. The relevance of GATS also increases the more the provision of health care is open to commercial providers. The emphasis on aims of policy priorities thus obscures the important ways how GATS influences *how* health systems function and address the aims of health policy. The inbuilt emphasis on least trade restrictiveness in the context of GATS then becomes more important as it easily indirectly pushes towards a more individualised and market-based models of health care provision and regulation as these tend to be less restrictive to market opportunities and commercial rights.

4. Evaluating health care commercialisation

4.1 Cross country evidence: no comfort for the commercialisers

So do these patterns of commercialisation matter? How are they associated with health outcomes and inequality? Given the assurance with which the concept of health care as a 'private good' – a 'default' policy of marketisation of health care – has been promoted, this is a very important question. This section explores the cross-country evidence for associations between health outcomes and patterns of commercialisation. We are well aware that drawing causal implications from such cross-country regressions is intensely problematic, because health care systems evolve, as we argue further below, on their own politically and culturally embedded tracks, over time, and one richer country's experience will not represent the future of a poorer developing country.

Nevertheless, cross-country comparisons are widely used as an input to multilateral and bilateral policy advice. We therefore use these data in this section to argue that, strikingly, the evidence on health outcomes contains no comfort for the commercialisers. Very much the contrary.

To make this point, we offer here five 'stylised facts' drawn from the same cross-country data as was used in Section 3.2.

*Stylised fact 1: countries with longer healthy life expectancy at birth and lower under-5 mortality have a significantly **lower** percentage of private in total health expenditure.*

Healthy life expectancy (HALE) tends to be lower, across countries in 2000, in countries with higher ratios of private to total health expenditure (Figure 10). HALE is also strongly influenced, especially in sub-Saharan Africa, by the AIDS pandemic. A regression of HALE on both the private share of health spending and a dummy variable for sub-Saharan Africa shows a large negative coefficient for SSA, but the negative relationship between health life expectancy and share of private in total health spending remains significant (Figure 11 shows the partial regression plots). Commercialisation, on this indicator, (to put the point contentiously) appears bad for your health.

A similar result is found for child mortality. The probability of dying before five years is positively related to commercialisation in this sense: a higher share of private spending is associated with a higher probability of death before 5 years.

Behind this conclusion lies one of our findings above. Higher income countries have higher healthy life expectancy and lower child mortality; they also (as shown above) have lower private shares in total health spending. If we allow for the association of higher average incomes with longer healthy lives, using regression analysis, then we still find no comfort for commercialisers. A regression of HALE on GNI/head and on the share of private in total health spending produces a strong and significant effect of income per head and turns the effect of the private share of health spending insignificant. There is still no positive relationship to be found between the share of private health care spending

and healthy life expectancy. Similarly for child mortality, allowing for the effect of higher incomes in a regression reduces the effect of the commercialisation indicator to insignificance, but the coefficient remains positive: there is no mortality benefit associated with a higher private share of total health spending.

*Stylised fact 2: countries with longer healthy life expectancy and lower under-5 mortality spend significantly **higher** shares of their GDP in the form of government (including social insurance) expenditure on health care.*

We explained above that government/social insurance expenditure on health care is a 'luxury' good in economic terms: the richer countries buy proportionately more (Figure 4). The data make it appear money well spent.

There is a strong and significant positive association of HALE with the share of GDP spent by government on health (Figure 12), and a negative association of child mortality with the same variable. The relationships are weak in AIDS-devastated Africa, but strong elsewhere. An additional dummy variable for Sub-Saharan Africa in the regressions has a significant coefficient, while the relationship between the outcome variables (HALE and child mortality) and the share of GDP spent by government on health remains strong.

A pattern thus emerges: richer countries spend relatively more on health care via the government and they enjoy better outcomes. No statistically significant effect of the share of government spending *independent* of income per head can be found in the data – additional relative spending by government does not consistently improve outcomes further.

*Stylised fact 3: however healthy life expectancy and child mortality have **no** significant cross-country association at all with the share of GDP spent privately on health care.*

Spending more of your GDP privately on health care is associated with no observable benefit at all in terms of the two health outcome indicators studied here. Figure 13 shows this result for child mortality, that is, the probability of dying under five; note that a decline in this indicator is beneficial. The plot for HALE is similarly patterned.

This result is rather strengthened if one allows for the associations between HALE and child mortality on the one hand and income per head on the other; there are still no additional health benefits from additional spending per head. Figure 14 shows the partial regression plots for the regression of child mortality on: income per head, a dummy variable for Sub-Saharan Africa, and the share of private health spending in GDP. The last is quite strongly positive, though not significant: to the extent there is any association it is with *higher* child mortality (strongly influenced by a few country observations). The regression result for healthy life expectancy is precisely comparable and the coefficient is

also not significant: private health spending as % of GDP is associated with, if anything, lower life expectancy. There is no comfort for commercialisers here.

*Stylised fact 4: across a set of low and middle income countries, better care at birth is associated with a higher share of GDP spent on government-financed health care. There is however **no** significant association with the private health spending/GDP ratio.*

This evidence is drawn from data from the 44 countries' *Demographic and Health Surveys*, made available on the World Bank web site. As in the bigger data set above, GNI/head and government health expenditure as a share of GDP are strongly correlated with each other. Both are positively associated with the share of births that occur with a trained attendant.

However private health spending as a share of GDP has no significant relation to any of these variables. There is no evidence here that higher private spending is associated with better care at birth. Figure 15 shows the partial regression plots from a cross-country regression of the percentage of births attended by a trained person on public and private spending on health as percentages of GDP. The public spending coefficient is strongly positive and significant, the private spending coefficient is positive but insignificant.

Stylised fact 5: for a set of low and middle income countries, the percentage of children treated for acute respiratory infection is negatively associated with the percentage treated privately.

We proposed in Section 3.2 that the percentage of children who, when taken for treatment for acute respiratory infection (ARI) or diarrhoea, are seen privately, can be thought of as a proxy for commercialisation. Across countries in the DHLS data set, the higher is this percentage, the lower is the percentage of children who are taken to any facility for diagnosis and treatment when ill with ARI. Figure 15 shows this (significant) negative relationship for ARI. The higher the share of private in total consultations, the lower the rate of consultation. The data thus suggest that commercialisation in this sense is associated with higher levels of exclusion from access to care.

It follows that the percentage going public is positively correlated with treatment rates. In this data set, income per head has no significant association with the rate of treatment for childhood ARI, nor do any of the government and private health care spending variables. Only the proportions of public and private treatment are significantly associated, positively and negatively, with overall treatment rates.

4.2 A global health care transition?

A second way of assessing commercialisation is to ask: where is it going? What is the direction of change and to what extent can it be understood as a transition to a globally

commercialised health care system? The concept of e*conomic transition* has been widely used since the 1990s to refer to a change in economic regime in currently and formerly communist-governed countries, from extensive direct allocation of economic resources and planned, state-owned production, to a much more market-led system of production and exchange of goods and services. Several contributors to this project are working in countries where such processes of transition are a key aspect of economic experience and policy. To what extent is health care sharing in that transition in 'transitional' countries? And more broadly, can one see the current period of change in health care world wide as a step change of this kind from more state-controlled to more market-led systems of health care?

To answer this question in economic terms we need some way of modelling it, and evolutionary models in economic analysis of industrial and institutional change offer a way to do this. Evolutionary modelling asks, how are the directions of change determined by the starting points, the incentives within the system, and the feedback of current actions (such as investment decisions and technological discoveries) on future change? Evolutionary models do not imply that change cannot be reversed, but they look for ways to model cumulative causation and change.

These ideas of incentives and feedback give us a way of examining the question of transition. 'Transition' in economic terms refers to a major change in economic institutions, and, centrally, in the type of economic incentives facing people and firms. It specifies a shift from non-market allocations of resources to production in response to opportunities to make profits, and a shift to access to goods and services via market exchange. This kind of change has clearly been occurring in the last two decades in health care in a number of countries – and for much longer in some.

The concept of transition (to a market system) contains however a strong implication of irreversibility – or at least great difficulty in going into reverse. Investment decisions - in factories, say, or hospitals, or training schemes - shift into private hands, and the investments made begin to build market incentives into steel and concrete… and into skills in writing software or using high-tech medical equipment. Institutional and industrial economists call this effect 'path dependency': early decisions shape later opportunities, hence constrain later actions. The system becomes physically different in terms of the types of assets available and goods and services consumed, as well as the ownership patterns. Once this has happened on a substantial scale, any road back to a more planned system has to undertake major investments in a different direction. It is not that the process *cannot* be reversed: but it is difficult and expensive. Any reversal of direction faces strong vested interests from new asset owners.

This notion of a one-way process, not a reversible choice, characterises much economic writing on the broad processes of transition in the Eastern European, Russian and East and South East Asian contexts. The economic transition is understood as the dismantling of one set of institutions and the creation of set of market processes and institutions which once established have a life of their own. If we were to find that we could apply to health care commercialisation world wide the concept of transition in just this sense, a

profound institutional and economic transformation generating its own logic of behaviour and operation, then in principle health care commercialisation will only be reversible through another sharp break, as when some European systems were redirected via nationalisation.

Indicators of transition

How would we know if such a process was occurring? Possible indicators of transition that might be drawn from the analysis of commercialisation in Section 3 include the following.

*1. The commercialisation of the **public** sector*

If the logic of public sector operation – both the incentive structures and they way in which people respond to them – becomes marketised, then the *capability* of public sector institutions to create (socially defined) public goods will be permanently undermined. There is, as already suggested, a failure of logic at the heart of current reform models in that they rely on public interest behaviour by the government sector, for 'residual' safety net provision and for regulation, while both denying (at times) its possibility and proposing to undermine it in practice. Empirically, the marketisation of the public sector can be observed and the cultural changes researched (Baru 2004, Kida and Mackintosh 2004). There is considerable evidence of public sector commercialisation in low income contexts, predating health sector reform. There is also some indication in rich-country work that importing material incentives into public sector professional contexts can undermine established public benefit behaviour that can then be very hard to re-establish.

2. Instituting risk rating in health insurance

A key institutional shift, which is very hard to reverse, is the breaking of risk pooling in health care finance – for example by privatising social insurance systems or liberalising private health insurance as a competitor to socialised insurance - and the resultant shift to risk rating. The more this happens, the more expensive and exclusionary the health care system and the harder to reform in a more inclusive direction, since reinstituting wider risk pooling then faces opposition from entrenched interests. A strong alliance between private insurers and corporate hospital provision may be the most important driver of extreme social polarisation of provision and access in middle income countries. Some middle income countries, notably in Latin America, may be shifting in that direction, but in others there is a strong movement to institute social insurance; a number of papers for this project explore aspects of this issue (Sun Qiang 2004, Iriart 2004, Kwon and Tchoe 2004, Datzova 2004, Blam and Kovalev 2004 *this conference*).

3. Privatisation of public hospitals

Substantially privatised health care systems, in the sense of systems dominated by private facility ownership, vary a great deal in terms of accessibility and quality. It may be that one of the most important factors blocking public health deterioration in some countries

is the existence of a decent and functioning, even if over-stretched, public hospital system. The public hospitals act as 'beneficial competitors'[7], putting a floor on the quality that can be got away with elsewhere, providing a benchmark for public expectations. One of the most serious consequences of the current 'reform' model of moving resources away from hospitals, and marketising their operation, may have been to remove this underpinning from the broader health care system.

Access to primary care is relatively more affordable and it is in the context of hospital care where larger costs incur. The privatisation or decay of public hospitals may also lead to impoverishment of those non-poor due to higher costs of care. The role of public hospitals gains importance also in the context of government action in emergencies and epidemics.

4. *Blocking public sector asset creation*

This point follows from the one above. There is a lot of discussion of the need for 'regulation' in the current health care literature, but little of it is convincing on methods and incentives. In a personal service sector of this kind, rule making alone is a poor basis for regulatory influence. To regulate effectively, the public sector needs expertise and leverage, it needs to be a *player* (Ayres and Braithwaite 2002; Tibandebage and Mackintosh 2002). This implies investment in public assets to support public sector delivery and intervention. To the extent that 'reform' models prevent that, regulation will have little effect on market dynamics.

5. The segmentation of basic services according to ability to pay

The segmentation of primary health care into public health interventions and preventive measures ('public goods') and the lossof effective hospital referral capacity can be seen as indicators of shift from primary health care-based health systems towards mere provision of basic services. The danger of this lies in the incremental return to the selective vertical programmes approach in the public sphere, in contrast to a more comprehensive primary health care, an issue which has raised already concern in the context of emphasis on three diseases and the establishment of Global Fund to fight against HVI/AIDS, tuberculosis and Malaria (Segall 2003; Unger et al 2003a; Buve et al 2003; Mahendradhata et al 2003; Unger et al 2003b). The debate between selective and comprehensive primary health care is not new (Koivusalo and Ollila 1997). It is also known that when pilots of selective approaches to service provision were tested, patients were reluctant to use these facilities because they realised that these facilities could not cover the broad spectrum of their complaints and that they would need to visit another health post for complementary treatment (Prost and Jancloes 1993). It can thus be argued that the more selective and basic primary care services become, the more prone they are to become part of a vicious circle increasing commercialisation in health care as people will by pass public facilities.

[7] The phrase is from Mackintosh and Tibandebage 2002, and originates from discussions with D. Narayana, an economist working in Kerala where public hospitals appear to play a role of this kind in the increasingly privatised Keralan health care system.

6. Regulation with 'one way valves'

Finally, transition may be, not only facilitated but also locked in by regulatory intervention. This is one of the main worries of the critics of GATS and NAFTA in terms of public health implications: that the agreements may create 'one way valves' (Commission on the Future of Health Care in Canada 2002 p.238) locking in policy changes which turn out to be detrimental. Worries include the difficulty of excluding for-profit suppliers of clinical services once admitted, and of facing legal challenges to expansion of the scope of public financing monopolies in Canada under NAFTA.

At present, the survey of the extent of commercialisation in this paper suggests that transition is partial. The regulatory structures do not enforce it, and the resistance to the dominance of risk rating – and associated emphasis on building social insurance – is probably growing. But policies towards the scope, scale and culture of the public sector – shrinking and commercialising it, and undermining its capacity to operate on the basis of non-market incentives – form the most serious set of pressures for such a transition to a market led system; the further this goes, the harder retreat would be.

5. A better common sense for health policy: in search of good sense

We have argued that there has been for the last two decades a 'common sense' embedded in the dominant models of health care reform relentlessly propagated by multilateral agencies and some donors. The 'common sense' is embedded in the fall-back assumptions, presented as indisputable because technical, of health care as a 'private good' that should be sold commercially unless this was technically inefficient. And we have argued that this has silenced, excluded from dominant discourse, a set of issues that health policy makers and users of health services have continued to be concerned with, notably the redistributiveness of health systems and the importance of an effective public sector.

We intended this project, from the start, to explore the outlines of an alternative common sense. Before we outline our tentative conclusions, we want to reflect briefly on the nature of this idea of 'common sense' and its political and policy importance.

'Common sense' and 'good sense'

The use of the concept of 'common sense' in not new in health policy writing. We are building upon recent critical writing on multinational investment in health and insurance services in Latin America which examines US and multilateral efforts to bring about a change in health policy 'common sense' (Waitzkin et 2003).

This notion of 'common sense', as we develop it further here, is a Gramscian one. In the *Prison Notebooks* (Gramsci 1929-35 [edition 1971: pp.323-33]) the innovative Italian Marxist philosopher Antonio Gramsci defined 'common sense' as 'a generic form of thought common to a particular period and a particular popular environment' (ibid 330). He drew a distinction between popular common sense, which encompassed a necessarily somewhat incoherent set of assumptions and generally held beliefs, and a core of 'good sense' within it, rooted in experience and systematic thought. This 'good sense' he characterised as a 'conception of necessity which gives a conscious direction to one's activity' (328).

Gramsci furthermore linked this idea of good sense to the concept of an elaborated 'philosophy', that is, a coherent system of ideas that may typically become the common sense of intellectuals in a given place and period (330). And he noted that just as there are different philosophies, so also 'common sense is a collective noun' (324): there are many versions of common sense, each a product of a different history.

These notions of 'common sense', 'good sense' and 'philosophy' – or 'theory' –have shaped the way we have drafted this paper. We have understood the health care reform frameworks of thought, and the repeated appeal in policy papers to a very elementary version of neo-classical micro-economic theory, as a deliberative exercise in shifting the dominant 'philosophy' in health policy, especially in international arenas, in such a way as to influence the day to day common sense of national health policy makers, in favour of the concept that an economic transition in health care was inevitable. That political

power has been at times exercised internationally to impose these reform frameworks is part of the process, but only a part of the rather dramatic change in working assumptions that these initiatives have sought to impose. There seems no doubt that, over a number of years, the more macroeconomic and public sector-based concepts of redistribution and primary health care have been supplanted in dominant discourses by the more individualist and market-oriented frame of thought outlined in Section 2.2. This has been made to seem even 'good sense' by a popular experience of a deteriorated and even abusive public sector in many developing countries, systematically undermined by periods of severe economic crisis. Furthermore this changing common sense has been associated in a number of contexts – including sub-Saharan Africa from the 1980s, the transitional economies from around 1990 or before, and also many Latin American countries since the 1970s – with a real increase in the levels of health care commercialisation (as defined in Section 3.1) as compared to the mid-20th Century.

We have argued that this current health policy common sense is, however, resting on a remarkably small evidence base. On the contrary, better health and higher health care activity by governments are strongly associated across the world; historically, success in address ill health at low income levels is strongly (not of course uniquely) associated with public expenditure based initatives. The analysis of social policy approaches behind the 'success' cases (Costa Rica, Chile, Cuba, Kerala and Sri Lanka) in the 1990s in terms of superior educational and health performance concluded that the overall social approach to social policy and the pattern of public expenditure and provision of services that mattered. The single most important common feature of their experience is the pursuit of social policies according to priority to primary health care, adult literacy, basic education and sanitary and environmental improvements. These programmes are not too costly in terms of finance and skills. But they do require an efective public sector which can reach the entire population with these services (Ghai 2000).

Furthermore, when democratic countries can afford higher levels of spending, they turn predominantly to public initiatives and inclusive projects. This has been true in virtually all now-high income countries, and growing upper middle income countries such as Korea and Taiwan have experienced political movements and 'advocacy coalitions' for universalising health care. Social insurance initiatives are widespread. And the discourse of risk pooling and cost control is returning to international policy documents (OECD 2003; EC 2002; WHO 2003). One could see these responses as a re-emerging of a popular and intellectual 'good sense' in favour of concepts of health policy rooted more in the notions of health systems and redistributive economics we outlined in Section 2.1.

A better common sense in health policy

So how might a better common sense in health policy, rooted in this (re)emerging good sense, be summarised? The main aspects appear to be:

- a concept of 'health systems' that unites value-based objectives for the health system and health policy and evidence combining the fields of public health, medical care and economics, rooted in ethical principles and reflecting a broad understanding of

the requirements for the medical, epidemiological, political and social construction of public health in the context of public policies;

- an economics of health care that focuses on redistribution, and understanding of industrial and service sector investment patterns and technical change and their regulatory implications, and the importance of professional and caring non-market relationships to effective health care,
- a recognition that effective health policy requires, as its absolute precondition, an effective public sector of an appropriate form for the national context, able to exert leverage over the system as a whole; and hence a policy focus on the (re)construction of government and public sector capacity.
- a recognition of conflicts between global commercial regulation and health policy interests. Ensuring global support to the normative and legislative functions in health systems and in the field of public health, equity and regulation and assessesment and containment of quality and costs of services.

In economic terms, the change in 'default' assumptions is needed, away from market exchange as the paradigm unless proved inefficient. Revised 'default' assumption include the promotion of cross-subsidy within the health care system; the sustaining of non-market professional relationships and incentives within facilities and relations with users; the valuing and promoting of the public sector, including public hospitals as a valuable part of the system; a regulatory process that values and tries to shape appropriate patterns of private investment and technical change.

Taken together, these elements provide the basis for a better common sense: a revised 'philosophy' and a better set of taken-for-granted assumptions that could frame market processes and regulatory structures within a value-based understanding of health systems and of non-market relationships. Such a revised international common sense must be rooted in the variety of local common sense: for example, it would build on existing and long standing (intellectual and popular) conceptions of public health and the public good; on widely held understandings of health care and of ethical and professional behaviour; and on the central role that health care has repeatedly played, across the world, in inclusive and redistributive politics and nation building.

Blocking and shaping commercialisation

Most fundamentally, the switch in common sense for which we are arguing requires an acceptance that the extent of commodification of health care – what is and is not shaped into market commodities for sale - is an essentially social (not technical) matter and a proper concern of public policy makers. We need to know, in different contexts, which current forms of commercialisation need to be *blocked*, in the interest of current and future health care access by those on low incomes. It would be good to see less general discussion of regulation, and more systematic identification of the most seriously perverse market incentives in the current system, and what is to be done to circumvent them. Which are the most damaging forms of commercialisation and why? Our list would probably include liberalisation of drugs supply, widespread privatisation of public

hospitals, and the attempt to resolve public sector inefficiency by tolerating and reinforcing individual materialist behaviour.

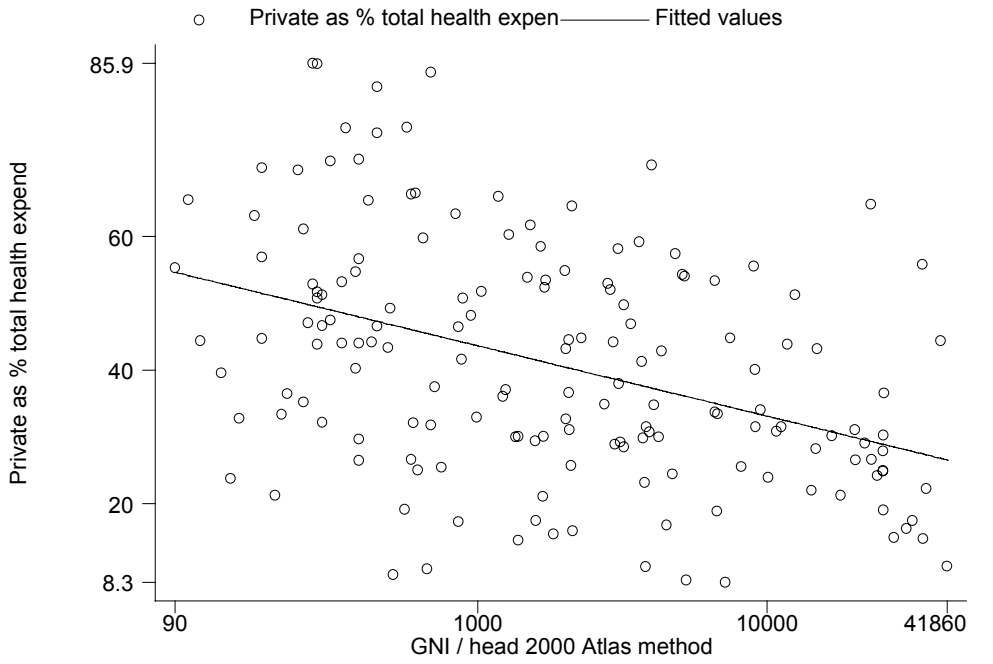
Others would have a different list: we simply aim to get this question more centrally into the health policy agenda. We could put our point a different way. *Some* 'mixed economies' of health care work. Many reasonably equitable health care systems rely on strongly commercialised supply systems. All truly inclusive health care systems avoid significant individual payment at the point of use. All health care systems that contain costs successfully unite funding and provision in a form that is not corporate/ commercial. All inclusive health care systems rely on some form of social risk pooling. None of these statements is controversial.

What are controversial are the implications for low and middle income countries' health policies. Consider the evidence gaps, excluded from research by dominant policy frameworks. For example, which types of markets generate socially beneficial innovation and which are most perverse? How do market structure and political economy of policy formation interact, e.g. to influence public expenditure allocation? How can cross-subsidy be sustained in a partially commercialised system? What parts of the health care system can a country shape into a 'public good' associated with rights of access? What types of commercialisation are disastrous for inclusive health care? How can a *culture* of effective contracting be built up in a mixed health care system?[8] Which types of regulation most effectively sustain the continuing existence of low-cost pharmaceutical production in developing countries? Most generally: what kind of health system best serves the purpose of achieving universal access to decent health care?

[8] There is an industrial literature on contracting cultures barely referred to in the health contracting literature (Sabel and Prokov 1996, Burcell and Wilkinson 1997, Deakin and Michie 1997)

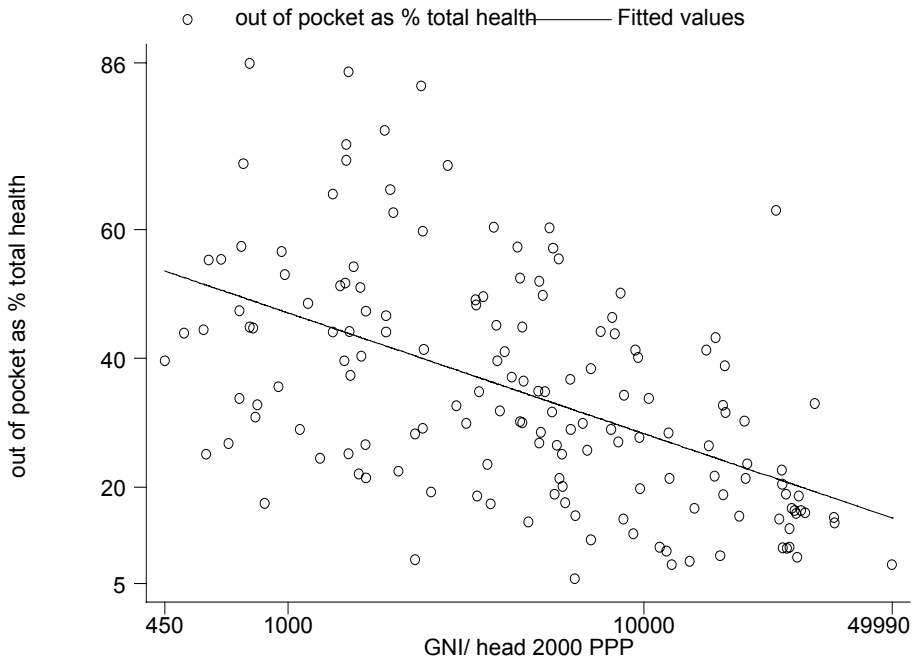
Figures

Figure 1: Private as a percentage of total expenditure on health, by log GNI/ head 2000



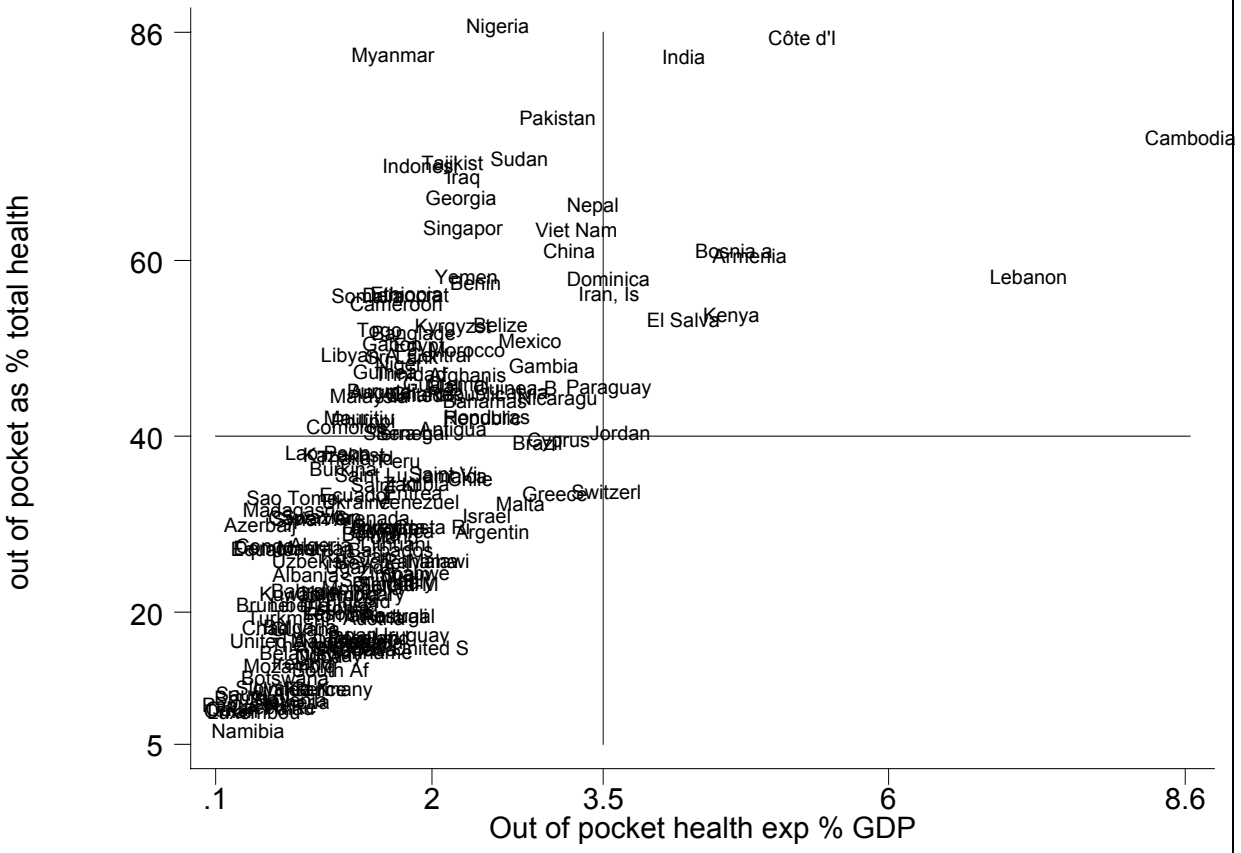
Notes: 163 countries (intersection of WHO and World Bank full data set less Pacific islands.) Regression is significant at 1% level. Horizontal axis is log scale; regression *x* variable is log GNI per head; the association is considerably *strengthened* using PPP data for GNI/head.

Figure 2: out-of-pocket as % of total health expenditure plotted against GNI per head (PPP basis) log scale.



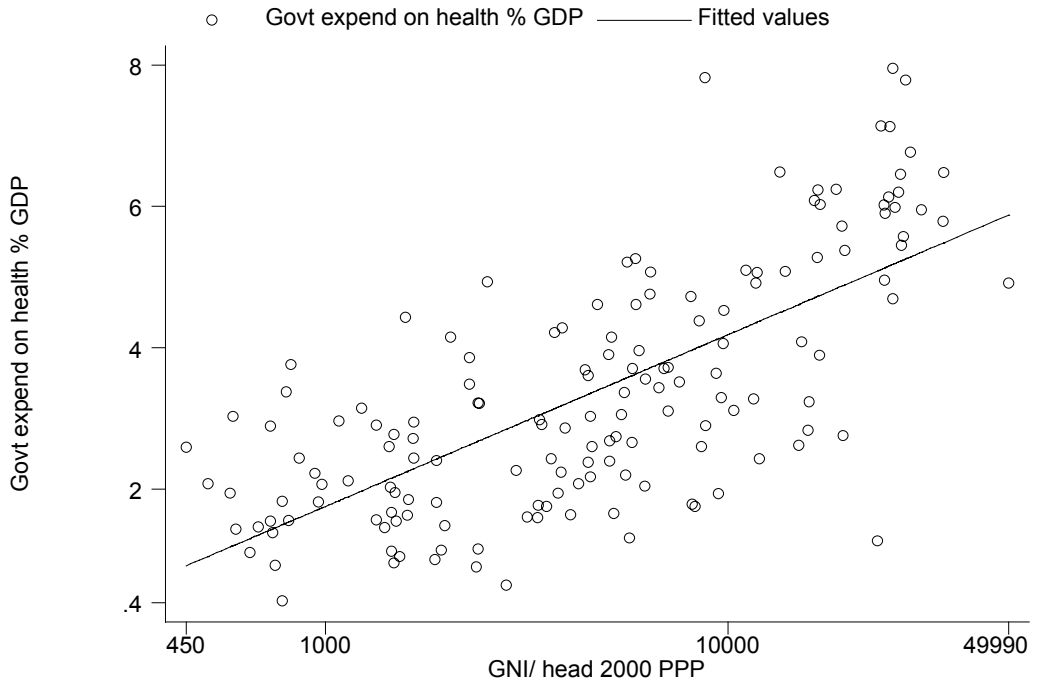
Notes: Notes: 155 countries (intersection of WHO and World Bank full data set less Pacific islands.) Regression is significant at 1% level. Horizontal axis is log scale; regression *x* variable is log GNI per head (purchasing power parity); the association is also strong and significant as the same level using Atlas method exchange rate data for GNI/head. The outlier among the high income countries (upper right) is Singapore.

Figure 3: out of pocket as % total health expenditure plotted against out of pocket health expenditure as % of GDP 2000



Notes: All rich countries (>$20000 per head Atlas method) except Singapore lie in bottom left quadrant. Though hard to read, this figure identifies the countries with strikingly high scores on each variable.

Figure 4: government expenditure on health as % GDP and log GNI per head (PPP basis) 2000



Notes: 155 countries; the relationship is highly significant on both measures of GNI/head. Note that the rich countries lie predominantly above the regression line; an additional variable in the form of a dummy variable for rich countries is significant at the 1% level.

Figure 5: private expenditure on health as % of GDP and log GNI per head (PPP basis) 2000



Notes: 155 countries; there is no significant relationship between the variables. The use of GNI/head (Atlas method) data produces the same result.

Figure 6 : partial regression plots for the regression of total health spending as % of GDP on log GNI/head (Atlas method) and on private health spending as % GDP, 2000

Model:

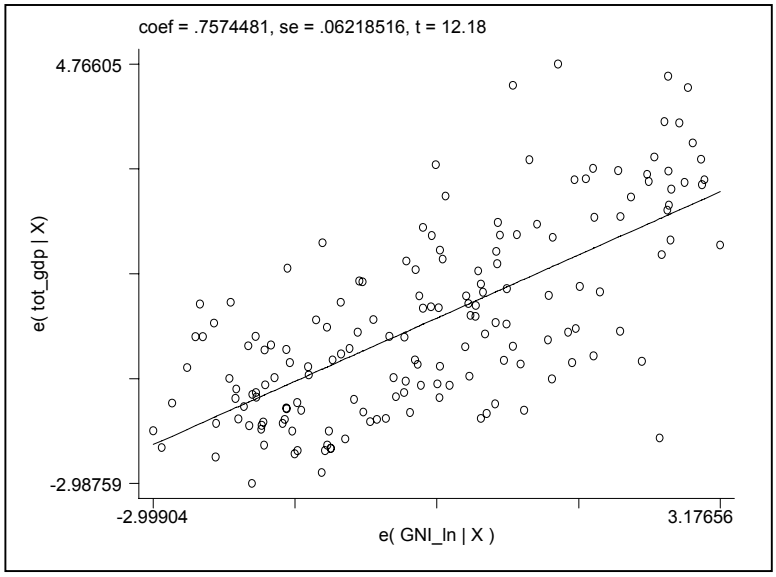
Predicted (total health spending as % GDP) = -2.124046 + .7574481 (log GNI/head) + .9368991 (private health spending as % GDP)

R^2 0.686 Observations: 163

Both independent variables significant at 1% level.

The countries exerting a particularly high leverage on the right in plot (b) are Cambodia, the Lebanon, the United States and Kenya.

(a) Partial regression of total health care spending as % GDP and log GNI/head



(b) Partial regression of total health care spending as % GDP and private health care spending as % GDP

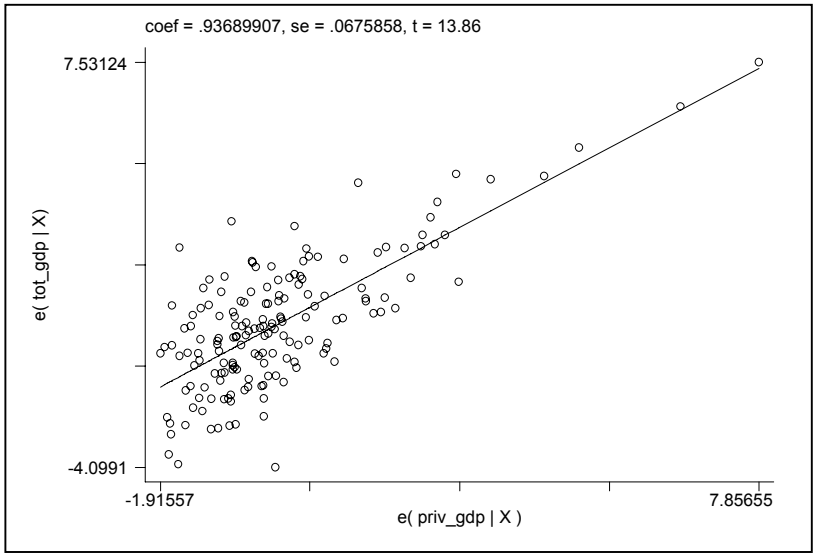


Figure 7: box and whisker plot: private as % of total health spending by region (low and middle income countries) and high income countries, 2000

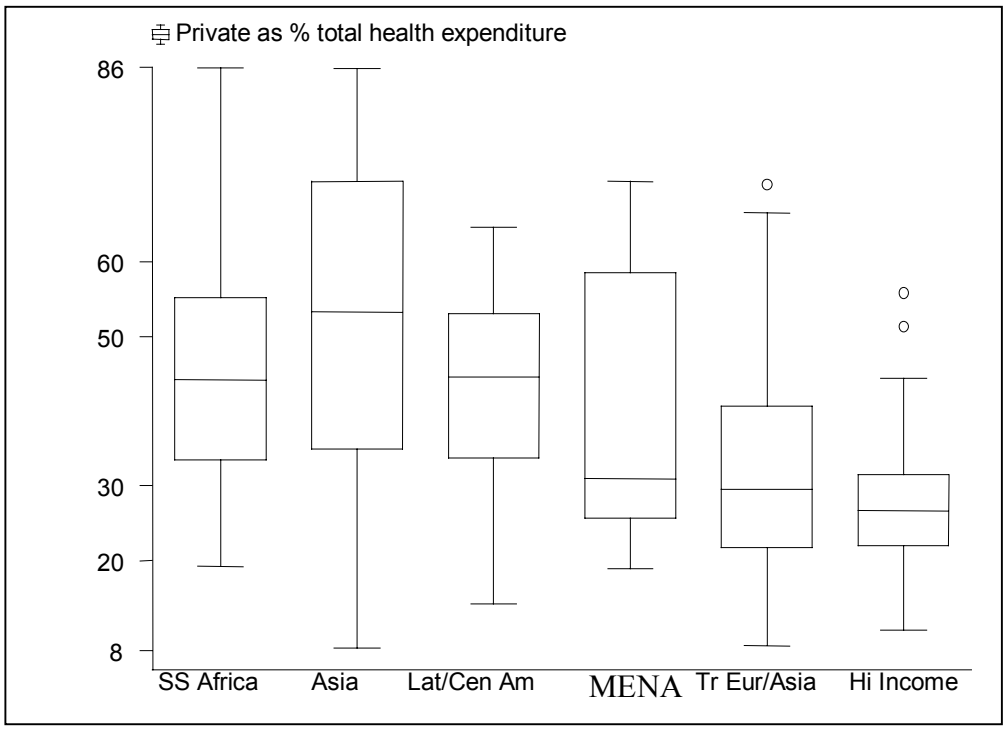
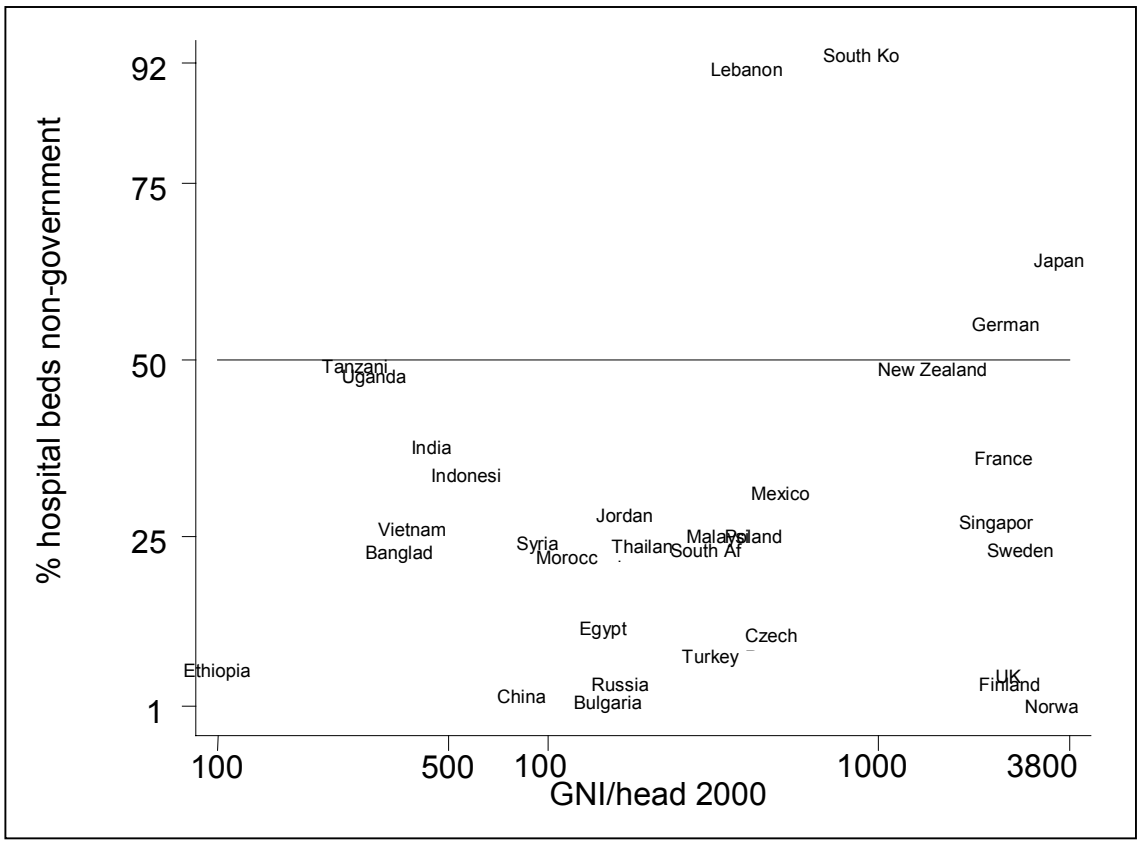


Figure 8 Percentage of hospital beds not government owned by GNI/ head 2000 (US$ Atlas method)



Note: 32 countries, data for various years 1990-2002

Figure 8 Percentage of children taken for treatment for ARI who were taken to private facilities, by GNI per head (log scale)

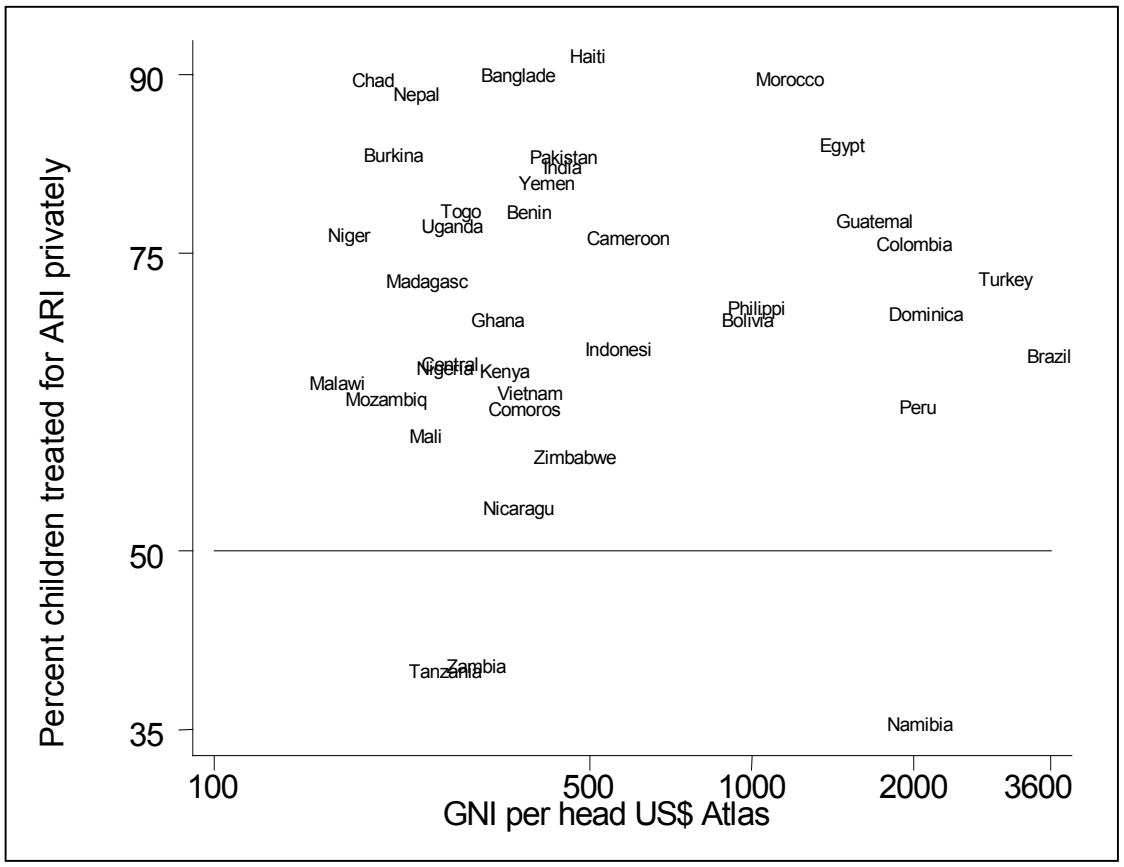
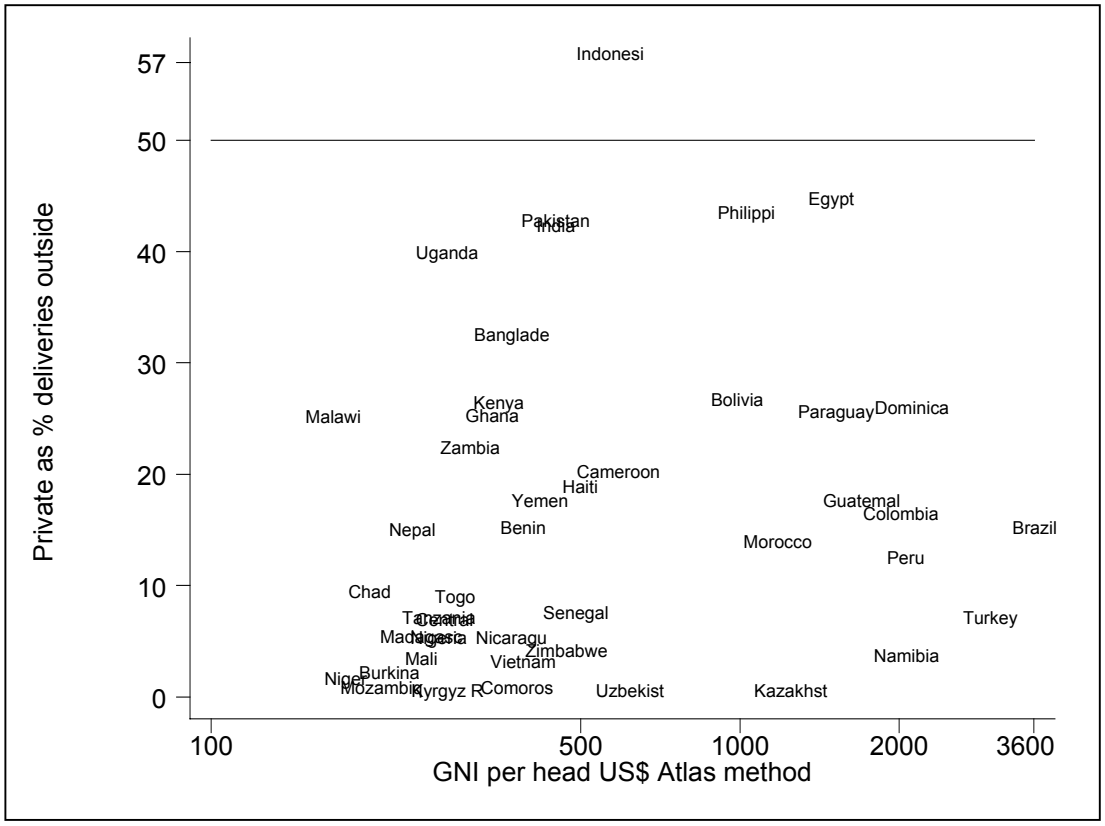
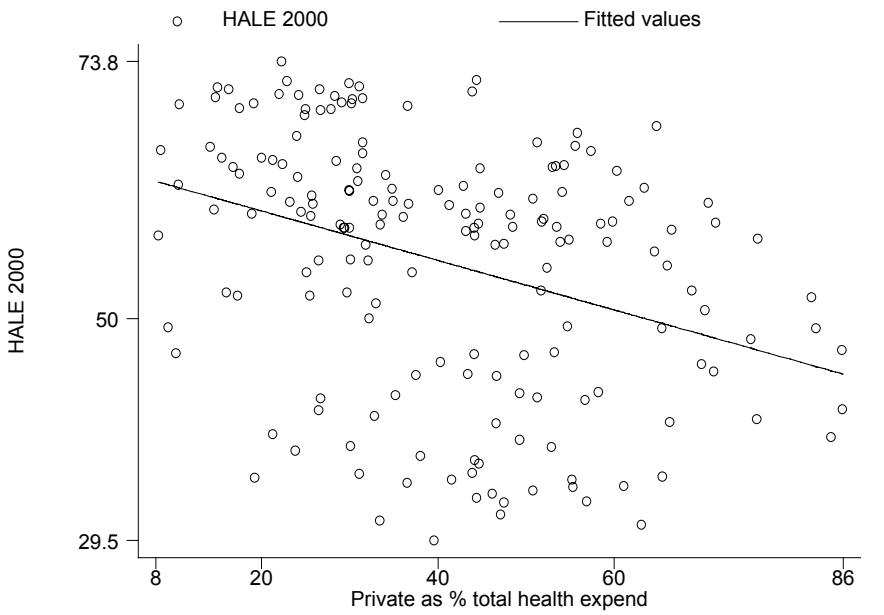


Figure 9 Private deliveries as % of all deliveries outside the home, by GNI/head (log scale) various years 1990-2002



Note 44 countries, all low and middle income.

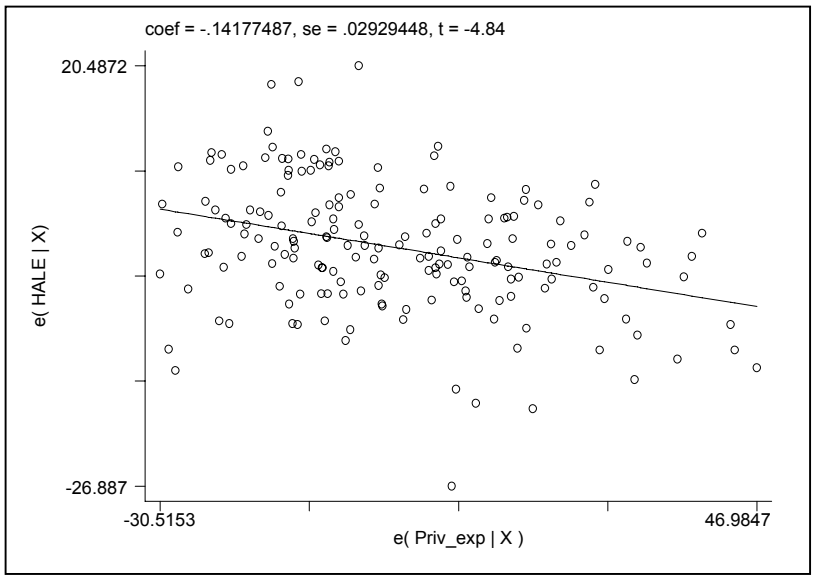
Figure 10 Healthy life expectancy and private as % of total health spending, 2000



Notes: 178 countries. Significant at the 1% level.

Figure 11

(a) Partial regression plot, HALE and private as % of total health expenditure 2000



(b) Partial regression plot, HALE 2000 and dummy variable for sub-Saharan Africa

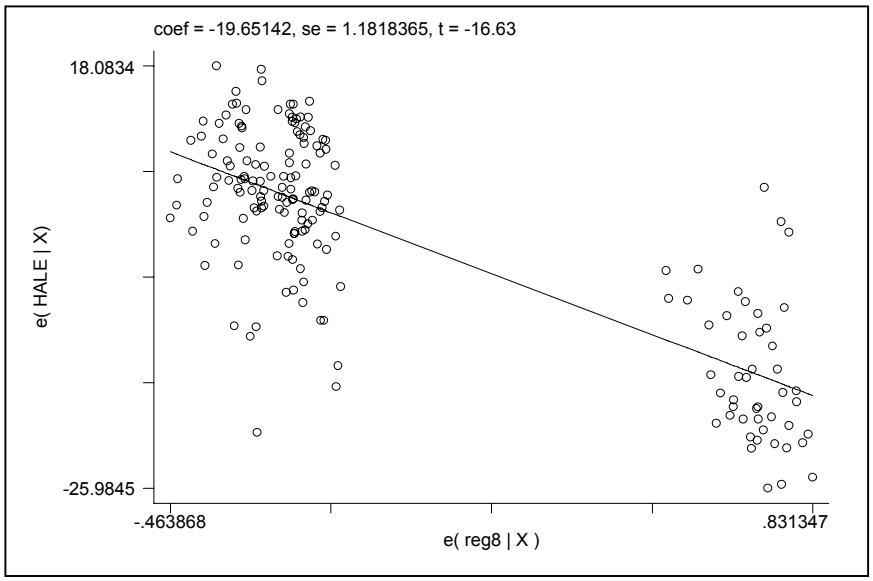
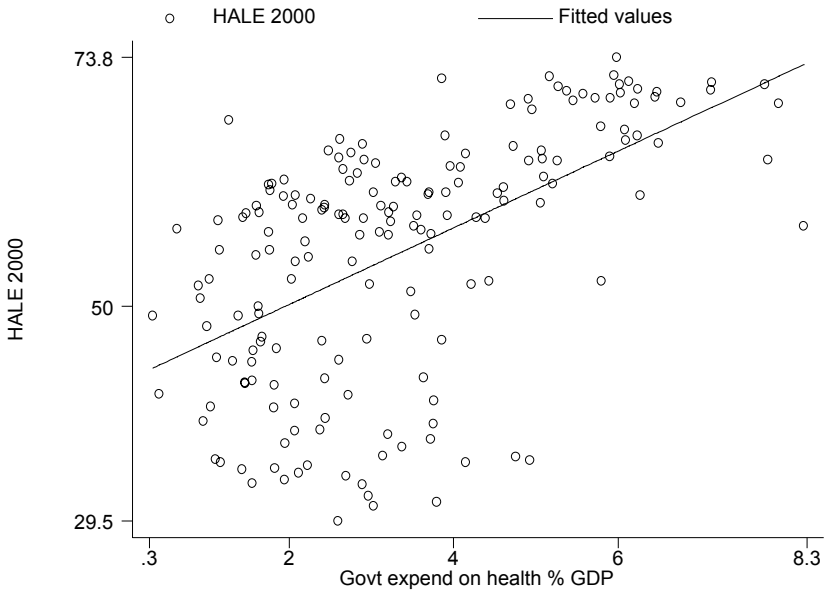
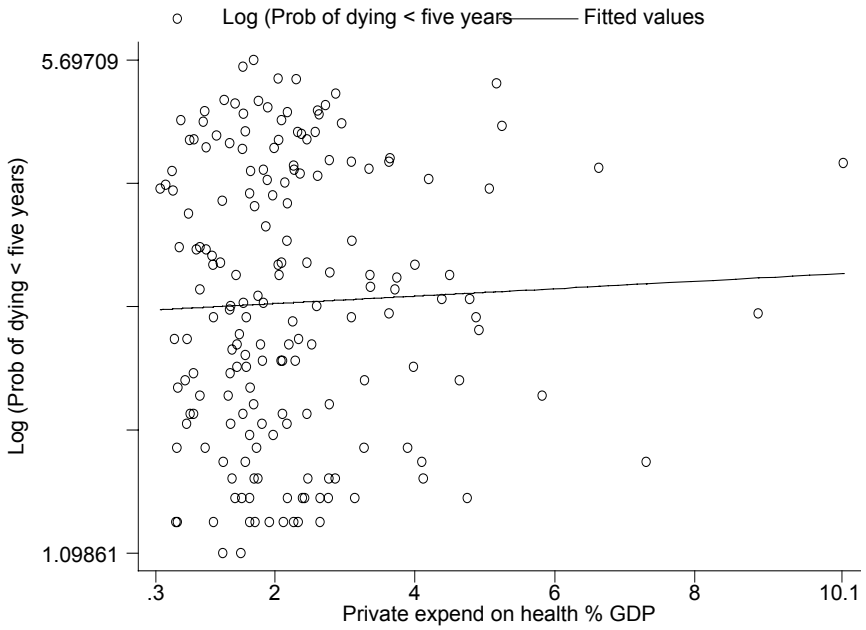


Figure 12 Healthy life expectancy (HALE) and government expenditure on health as % of GDP 2000



Notes: 173 countries.

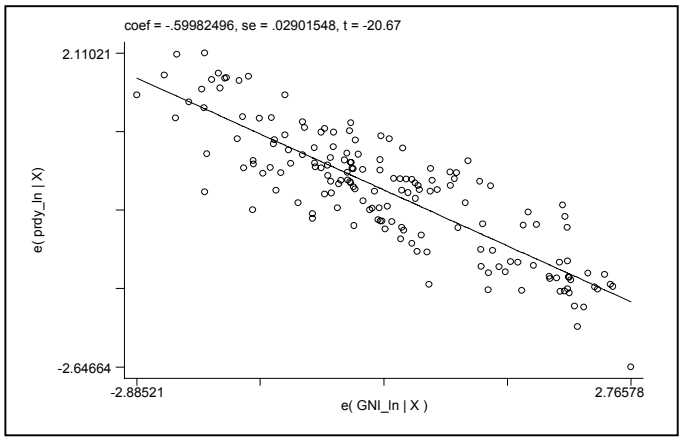
Figure 13 Log of probability of dying before five years and private expenditure on health as % of GDP, 2000



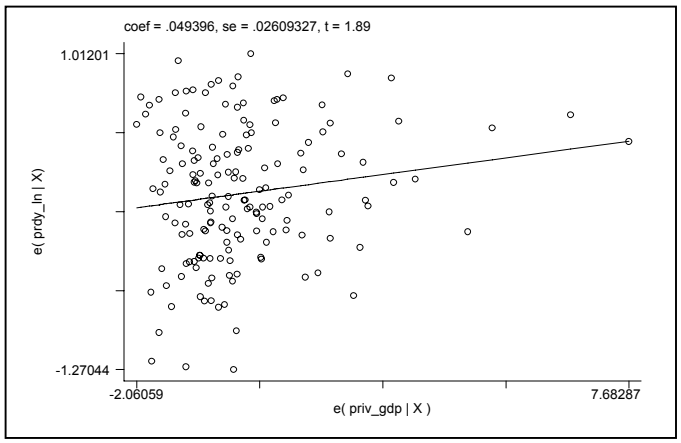
Notes: 178 countries. The indicator of child mortality is strongly skewed, hence the fit is (mildly) improved by using the log of the indicator variable. The coefficient on the independent variable is insignificant. R^2 is 0.0001

Figure 14 Partial regression plots from the regression of log (probability of dying before 5 years) on log (GNI/head Atlas method), the share of private health spending in GDP (%) and a dummy variable for Sub-Saharan Africa

(a) Partial regression plot of log (probability of dying before 5 years) and log (GNI/head Atlas method) 2000



(b) Partial regression plot of log (probability of dying before 5 years) and private spending on health care as % GDP 2000



(b) Partial regression plot of log (probability of dying before 5 years) 2000 and a dummy variable for Sub-Saharan Africa

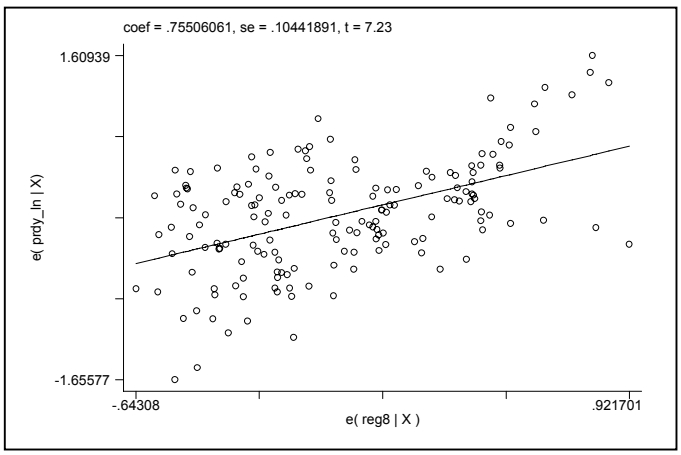
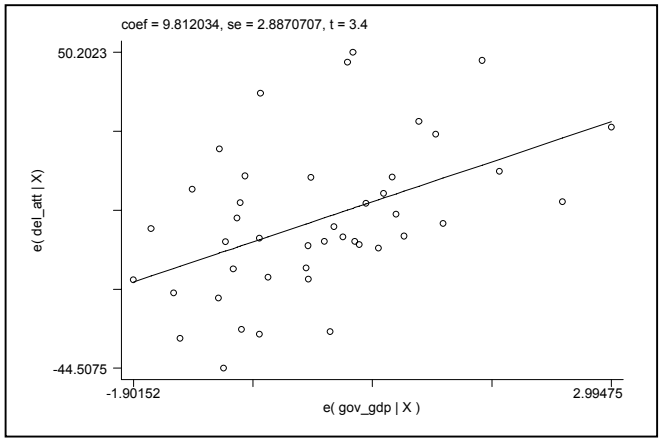


Figure 15: Regression of percentage of deliveries with a trained attendant on government and private health expenditure as percentages of GDP. (44 low and middle income countries, various years 1990-2002)

(a) partial regression plot of percentage of deliveries with a trained attendant on government health expenditure as a percentage of GDP.



(b) partial regression plot of percentage of deliveries with a trained attendant on private health expenditure as a percentage of GDP.

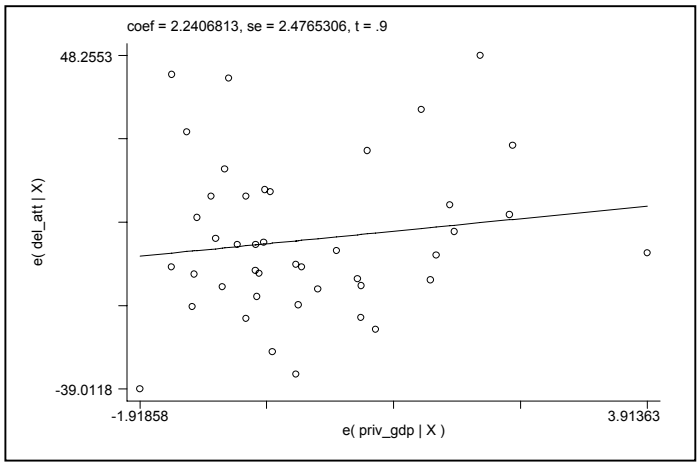
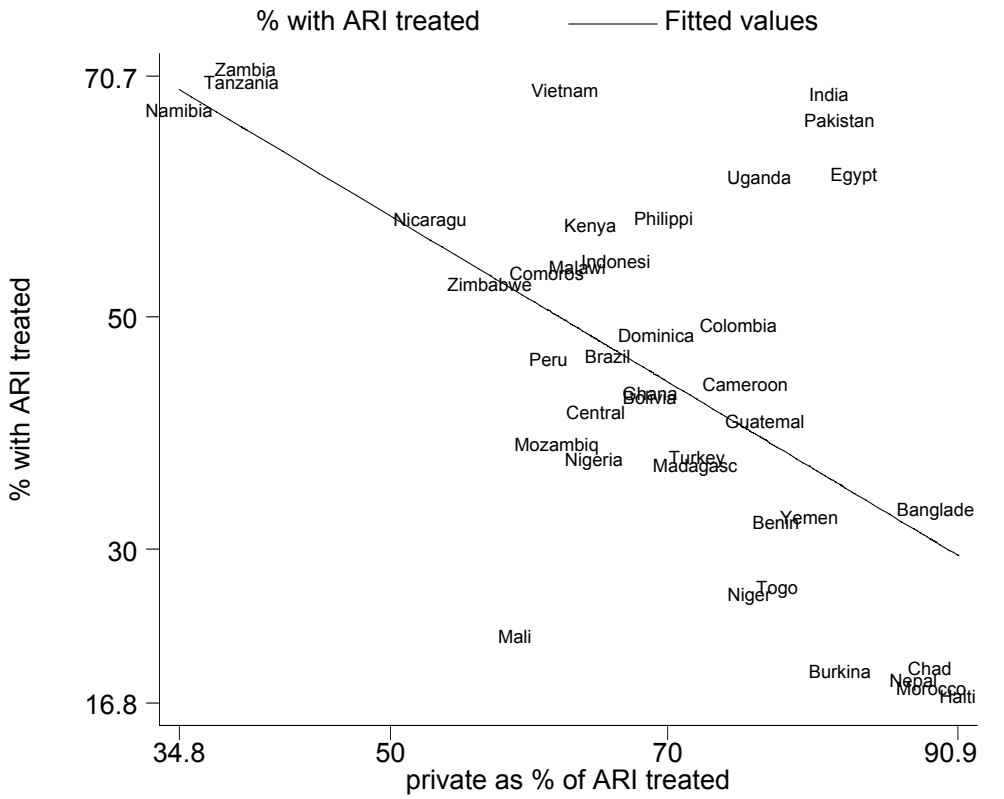


Figure 15 Percentage of children with ARI taken for treatment, and percentage of those taken for treatment seen privately, various year 1990-2002



Note : 44 countries.

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