

Health

Wrong questions: wrong answers The global 'health reform' agenda

John Lister

Whatever the advocates of market-driven reforms may claim, there is no evidence from recent experience, either in the wealthiest or the poorest countries, that greater reliance upon the private sector and competition reduces costs, enhances efficiency, or does anything but widen inequalities in access for the poor.

Health care systems in rich and poor countries are crying out for the right package of reforms – structural changes and an injection of sufficient resources to enhance equity and access, accountability, professional skills, effectiveness and standards of treatment, and empowered service users. Governments and their advisors, and all of the main groups and organisations proposing health system reform, are working to a very different agenda, however, driven not by patient needs or by the quest for efficiency and equity, but by very different concerns – ideological and economic.

One thing is very clear: while some of the earliest so-called ‘reforms’ are clearly driven by cash constraints and the drive to cut spending and hold down taxes, the most recent school of reforms – policies which seek to treat health care as a commodity and to establish some form of market mechanism in the purchasing and provision of health services – have the effect of *increasing* costs, and actually *reduce* efficiency.

These ‘market-style’ reforms are clearly driven by ideological conviction rather than economic necessity. Policies involving attempts to restructure health care systems to embody some or all of the features of a market (whether ‘internal’ within the public sector, or, more

commonly, a ‘mixed economy’ public-private market) in health services, are relatively recent, having largely emerged in the 1990s. This chapter will briefly examine each type of ‘reform’ and the experiences of their impact in health care systems.

Cost-driven reforms: cash limits

Market-driven (or *cost-driven*) reforms date back at least to the 1970s and attempt to limit public spending. Measures such as global cash limits to hold down spending on health care are a part of the stock neo-liberal policy agenda of ‘small government.’ They do not involve substantial restructuring of the health care system: services may be rationalised, rationed or restricted, and subordinate elements of the service may be privatised, but the main driver is *cost* rather than *policy*. High-spending health services, however, generate high levels of popular expectation of prompt, modern and appropriate treatment. So while the *rate of increase* in spending can be slowed, any substantial real terms *cutback* in the public sector in the wealthier countries is fraught with political problems.

Such policies tend to be more readily recommended

for, and imposed upon, the governments of developing countries by agencies such as the IMF and World Bank, while the richest nations in general seek other means to unload the burden of public sector funding for health care.

Levels of spending on health care also have to be viewed in the correct context. From the free market point of view, and the standpoint of for-profit health care providers, the runaway expansion of *private* spending on health care in the USA or anywhere else is no problem at all – merely a reflection of the choices made by individuals and the play of market forces, and an opportunity for an entrepreneurial industry to accumulate profits.

The only ‘principle’ for neo-liberals and their pro-market fellow-travellers is that none of the private spending on health care by those able to afford it should actually be used to subsidise health services for those who cannot afford them: the poor should be confined to their own exclusive sphere of low budget and minimal services, while the rich exercise their choices as consumers.

While the countries that are members of the Organisation for Economic Co-operation and Development (OECD) have in general witnessed an upward curve of health care spending since 1945, the imposition of austerity policies has been far more rigorously applied in poor and ‘middle income’ countries, especially those under the discipline of IMF Structural Adjustment Programmes. Health spending in Zimbabwe, for example, was slashed by more than half in the years following IMF and World Bank advice in 1988. Zimbabwe also agreed to introduce user fees, which rose four-fold over five years. The spending cuts brought shortages of medicines, a lack of functioning equipment and the closure of some rural hospitals: the user fees brought a sharp decline in hospitalisation, but also deterred poor people from seeking treatment for venereal diseases, thus contributing to Zimbabwe’s disastrous HIV epidemic. The ‘Country Assistance Strategy’ for Ecuador endorsed by the World Bank in 2000 involved slashing health spending to *half* the 1995 level (of just USD 71 per head per year, compared with an OECD average of more than USD 1,800).

When health care spending is already well below the minimal targets (USD 12 per head per year) set by the World Bank and the WHO for a ‘basic package’ of primary and preventive health services, further cuts in spending are likely to have an exceptionally heavy impact: the WHO argued in 2000 that countries spend-

ing less than USD 60 per head would not be able to provide even a reasonable minimum of services.

Rationalisation: reductions in bed numbers

Hospital beds can be extremely expensive to run, both in the wealthier countries and in many developing countries: in sub-Saharan Africa public hospitals absorb between 45 percent and 69 percent of government health spending. Reforms aimed at capping spending will therefore inevitably seek to reduce spending on excess numbers of hospital beds in the drive for ‘efficiency.’ Driven by advances such as the development of day surgery and minimally invasive techniques, together with improved anaesthetics and dressings, substantial reductions in average lengths of stay for surgical treatment can legitimately reduce the need for surgical beds.

Medical specialties, however, have not achieved the same reductions in lengths of stay. For good reasons: most medical admissions are for emergency treatment, often for older patients. This means that in any programme of bed reductions, a proper balance must be maintained between medical and surgical beds. In England, where thousands of beds closed in the 1980s, a government-commissioned beds inquiry at the end of the 1990s found a shortfall in available beds. Total acute bed provision over a 23-country OECD average fell by over 20 percent, from around 5.7 per thousand population in 1980 to around 4.4 in 1998 (OECD, 2003). Sweden and Finland, however, cut over 40 percent, while bed numbers dropped by just 14 percent in Germany, and by even less in some countries, while Japan expanded bed capacity. The proper objective of rationalisation is not simply to close surplus capacity, but to ensure that the remaining beds are used more intensively and efficiently. This often requires additional investment in equipment and training of staff.

Market mechanisms do not help: according to OECD data, US hospitals apparently became *less* efficient at treating and discharging patients in the ten years 1982-1992, when ‘throughput’ per bed dropped. Over the next five years (1992-1997) – the period in which ‘managed care’ was seeking to regulate and tame the market however, it did manage almost a 10 percent increase in throughput, however. Most of the dramatic 76 percent increase in throughput in British hospital beds in 1982-1997 had already been achieved *before* the market-style reforms, which came into effect from 1991.

Rationalisation may be advocated for a variety of rea-



sons. Centralising specialist services into fewer, larger units, to improve the training of medical and other staff and focus skills, may represent an advance in clinical terms at the expense of user-friendliness: but the efficiencies of such changes are debateable. Unit costs may well be higher in larger hospitals, and the new hospital may even act as a monopoly, preventing any wider competition.

The scope for substantial rationalisation of hospital services in many poorer countries is restricted by the inadequate infrastructure of hospital and primary care, and the lack of the technology to implement modern techniques. World Bank figures offer a single total for 'hospital beds' of all types – including acute beds, long-stay beds, maternity beds, psychiatric beds and those in specialist facilities – and have to be viewed with caution. They also combine the totals of publicly-funded beds with those of private beds, which are not available to the majority of the population. However, the figures show a substantial (around 25 percent) reduction in beds in the 'low income' countries over the last decade. Given the mounting HIV/AIDS epidemic in sub-Saharan Africa, we can assume that the loss of these beds represents an absolute cut in health care provision, unrelated to health needs.

Market-driven user fees

A different approach to reducing public spending is to impose user fees, which bring in some additional income as well as squeezing down demand for health care. The main claim that user fees help improve 'efficiency' revolves around their effectiveness in discouraging 'unnecessary' demand, or in some cases in generating additional revenue for funding health care when alternative funds are not available.

The most common user fees are co-payments for pharmaceuticals – covering as much as 35 percent of the drug cost in Hungary – while nine EU countries have imposed charges for general practitioner consultations, and most EU countries impose co-payments for specialist consultations. Sweden levies extensive user charges, including for children's outpatient services. Only Greece, Italy and Portugal, however, rely upon user charges to raise more than 20 percent of health care funding.

Many of the post-1989 countries of Eastern Europe and the former Soviet Union now levy user charges as part of new health insurance schemes. But while total revenue from user charges rarely exceeds 5 percent of

total health revenue, the charges have strongly reduced utilisation, and thus worsened equity of provision, having a heavier impact upon the poor.

In the poorest countries, Creese (1997) argues that *"the higher the proportion of user payments in the total mix of financing for health, the greater the relative share of the financing burden falling on poor people."* User fees are often suggested as a means to reduce 'unnecessary' demand for services, but may also act as a *market-style* reform, a lever in creating a new system of private or social insurance for the wealthy and middle classes.

Market-style (ideologically-driven) reforms

Health reforms and the 'New Public Management'

Much of the discourse promoting health care reforms since the early 1990s has embraced key terms and concepts from the mish-mash of theories which have become known as 'New Public Management' (NPM). However, there is little evidence that NPM delivers economies or increased efficiencies in the operation of the public sector, while as a pro-market approach NPM ignores considerations of equity in access to services for the poor.

The marriage of NPM with health system reforms (see Osborne and Gaebler, 1992) has brought references to such stock panaceas as:

- public-private partnerships;
- contracting out and various forms of increased local autonomy ('steering, not rowing');
- competition ('managed' or otherwise);
- user choice and user empowerment;
- and the introduction of internal or 'quasi-markets'

Overview: limits to the health care market

Within a free market system, the main drivers are competition and private and corporate gain. In private sector enterprises, these gains generally take the form of profits and shareholder dividends. Where market-style competition is introduced within a public sector framework the gains take the form of increased revenues for providers, resulting in surpluses and the possibility of enhanced rewards for executives and other sections of staff – at the expense of the less successful providers, which may face loss of contracts, budget reductions, redundancies or even closure. While heightened prestige may also be a by-product for the most successful public sector providers, it is clear that the introduction of a market mechanism

focuses strongly on the exchange-value (money) element of health care, rather than on the use values delivered: health care is effectively commodified through market measures.

Despite claims that competition necessarily leads to lower prices, and improved efficiency and cost-effectiveness, the opposite is often true. Markets encourage the many perverse incentives visible in what passes for a health care system in the USA, where costs are far higher than in publicly-financed Canada.

Even neo-liberal policy proposals for the reform of health care systems generally accept that the outright privatisation of existing health care systems, to replicate the dominance of private provision in the US model, is not desirable. Indeed, the US system itself – despite the failure of the Clinton reforms, which aimed to bring in a greater degree of control – evolved some time ago away from a largely unrestricted free market in health care, exhibiting what Enthoven (1997) describes as “*profound and multifaceted market failure*” towards more regulated regimes of “*managed care*.”

It is these devices intended to *regulate* the market, rather than the extravagant, fraud-ridden, bureaucratic and socially exclusive US system itself, which governments elsewhere have sought to emulate. It is ironic that many of the health system reforms that have been implemented in the last fifteen years have *begun* with neo-liberal ideology – of small government, low taxes, decentralisation, competition, privatisation and consumer power. But in many cases – perhaps all – the end result of such reforms has been *increased* state spending, and *more* bureaucracy.

The most fundamental contradiction that ensures health care creates inevitable ‘market failures’ under capitalism is the inherent class division between rich and poor. While wealthier people can (and obviously do) also get ill, the main burdens of ill-health and illness are directly related to poverty. Health care is therefore a commodity the exchange value of which is least likely to be affordable to many of those who need it most. These tend to be the very old, and the very young, most of whom also tend to be among the poorest groups. So the vast potential ‘market’ for health care services in the developing world is largely composed of individuals and countries least able to pay for them.

Health care in many poorer countries and poorer areas is correspondingly less likely to attract sustained investment by hospital corporations or by drug compa-

nies which follow purely market criteria. The remainder of this chapter will explore some of the market-style measures that have been brought forward as part of the international reform agenda.

Decentralisation

The call for ‘decentralisation’ is a theme running through most studies and reports advocating health system reform, in wealthy and poor countries alike. It is a key element in the New Public Management (NPM) agenda. Even so, support for some form of decentralisation spans the political spectrum. It has been accepted both by socialists and by the new right, by the left-leaning governments of Tanzania and Nicaragua, and by Chile’s Pinochet dictatorship, as well as the World Bank and USAID. However, the results can prove very different from those intended:

- Control over service provision may be captured at local level by elites who are even less responsive than central government to the needs of the poor.
- Decentralisation may also offer new openings for local-level corruption.
- The new system may find itself struggling in the face of a lack of local managerial skills and expertise.
- Decentralisation may also mean smaller scale and less well-resourced providers, which wind up delivering less training and skills for staff and lower quality care.
- And smaller-scale, more local structures almost inevitably offer less scope to tackle inequalities in the terms and conditions of health workers.

Internal market reforms which emphasise the development of autonomous and competing local hospital units in countries like Britain and Sweden can result in duplication of effort, wasted resources and high transaction costs. Strengthened local control can also obstruct national-level planning and any possible rationalisation of services, and restricts the ability of a health care system to offer a wider range of career options as a means to retain qualified staff. As with other facets of the New Public Management, enthusiasm for decentralisation appears to have developed and survived despite the lack of evidence to show it can deliver improvements to efficiency, equity, quality or accountability.

Contracts between purchasers and providers

Once the chain of command of a centralised system has been broken, a new system of contracts must be put in place in order to establish the responsibilities and



accountability of service providers. Contracts drafted in terms of cash, inputs and outputs, represent a first step away from notions of public service and social solidarity, and towards the establishment of health care as a commodity to be bought and sold. Contracts can in theory be used to regulate any part of the health care system, covering not only support services, but also clinical care – again from public or private sector providers. They may be enforced either positively, through incentives for providers to meet targets, or (less frequently) negatively through the imposition of sanctions in the case of failure.

The ongoing battle over hygiene standards in Britain's hospitals 20 years after many cleaning services were first contracted out to private companies underlines the problems of quality control. The 'contract culture' that emerged from the 'new managerialism' of the 1980s leaves a number of unresolved problems: they require expertise in drawing up precise specifications, and constant monitoring if they are to be upheld.

While the ideological commitment to market-style measures may be strong, and the market-driven pressures on health care systems may press in the direction of tighter contracts, the progress has not been even. Nor is the mere existence of a contract sufficient to ensure control and the delivery of targets. One study, examining the working of these systems in Latin America, identifies a number of issues that show a need for more precision and monitoring if the contract is to deliver the intended results. Examples show that:

- 'Fee for service' contracts with no volume restriction carry no incentive to keep costs down: in Uruguay high tech services were 20-25 percent more expensive from private facilities rather than public units.
- 'Fee for service' contracts with volume restrictions give an incentive to claim for treatments not delivered: in Brazil in 1995 an estimated 28 percent of hospital inpatient services that were claimed for were not delivered.
- A 'fee for service' contract with volume restrictions that was not properly monitored led to increasing numbers of treatments and an overexpenditure of more than USD 1 billion in Colombia in 1998 (Slack and Savedoff, 2001).

Provider autonomy /corporatisation

The notion of going beyond decentralisation to establish local health care providers as autonomous, free-standing corporate bodies in their own right has been gathering

momentum among the advocates of market-style reforms. This is not new: the British Conservative government's marketising measures split provider units from purchasers, and encouraged the creation of 'self-governing Trusts', the first of which were launched in 1991. New Zealand's government also experimented with 'Crown Health Enterprises' in the early 1990s, with profoundly mixed results (including massive private sector borrowing by CHEs, requiring later government intervention). By the mid 1990s all NHS providers in the UK had taken Trust status, defined in the initial White Paper as 'public corporations.' Their budget was constrained by their ability – in competition with other providers – to secure contracts from NHS purchasers, together with income from private patients and 'income generation.'

Competition, therefore, impacted primarily in the form of a downward pressure on prices. Any efficiencies that may have been secured through improved management in Trusts were obscured by the substantial increases in transaction costs, administration and management created by the introduction of the 'purchaser-provider split' into the British NHS. In some countries the level of local autonomy has been taken further than NHS Trusts. 'Foundation Hospitals' in Spain and in Sweden, and 'hospital companies' in Portugal have gone further in floating the hospital as a free-standing enterprise, 'corporatised', with their own discretion to borrow funds and conduct deals with private sector.

Britain's New Labour government has begun to copy this model in England, despite vociferous opposition from Labour backbenchers, health unions, academics and campaigners. In the UK, Foundation Trusts are now accountable only to an 'independent regulator' (Monitor), which in its first year spent two thirds of its budget on private consultancy – from US management consultants McKinsey.

This type of autonomy may prove, as with one major Swedish hospital, simply a transition point to full-scale privatisation – although, in response, the Swedish government has recently enacted legislation to forbid any further privatisation of health services. Spain's four foundation hospitals have been accused of making staff work longer hours and of 'cream skimming' the more lucrative treatments, leaving other hospitals to pick up the remainder (Nash, 2003).

The enthusiasm for this type of reform from the World Bank's Preker and Harding (2003) cannot hide the poor results of the limited experiments that have taken

place with hospital autonomy in the poorest countries. They cite a handful of examples from Latin America and Tunisia, not all of which have succeeded, and Indonesia, where the autonomous hospitals failed to improve financing, access for the poor, personnel management, service quality or patient satisfaction, but *did* succeed in raising fees and increasing revenues from patients.

While the intended broad progressive effects of autonomisation were 'largely absent', a negative impact on equity is much more common. "*The empirical evidence shows that autonomous hospitals start giving priority to paying patients, and that waivers and exemptions of user fees have been rather ineffective in reducing access barriers to services by the poor*" (Castano et al 2004).

Reforming provider payments

While Beveridge-style tax-funded systems offer governments the opportunity to restrict individual hospital budgets through a single centralised policy decision, in Bismarck-style systems decentralised payment mechanisms have always involved a form of 'contract' between the insurance funds and the providers of care. Theoretically, this separation of functions offers more scope to constrain the increase in costs: but in practice it has been hard to control the various purchasers of health services, and even harder to control the prices charged by what is often a mix of private and public sector providers.

Insurance-based systems, including France, Germany, Korea and Japan, have seen funds facing huge deficits and recent attempts to restrain spending. One argument for introducing a market-style system to countries which had centrally-controlled health care systems was that a combination of competition and contracts would offer new mechanisms to ensure that, in the famous words of the Thatcher NHS reforms, the 'cash follows the patient.' Market-style methods might suggest the need for systems which pay hospitals only for the episodes of treatment they deliver (case-based) or the catchment population they agree to cover (capitation-based).

Case-based payment can be seen as giving an incentive to respond positively to local demand – or even to compete with other hospitals for patients – while capitation-based contracts encourage hospitals to hold down costs, but create an incentive to cut costs at the expense of quality, to supply as little treatment as possible, and even to ration care for the catchment population. Case-based contracts on the other hand can generate a perverse incentive to treat larger numbers of less serious

cases, and to increase the numbers of cases treated – again possibly at the expense of quality. In the UK, New Labour is bringing in a new fixed price system of 'payment by results': already it seems set to increase levels of hospitalisation.

While some health system reformers have seen adjustments to provider payment mechanisms as one way of reducing perverse incentives and inefficiency, others have drawn the conclusion that each system creates a mixture of adverse and beneficial effects.

Purchasing from the private sector

Bismarck-style health care systems, which have always had some separation between purchasers and providers, have also long accommodated a private sector in the provision of health care: in France 29 percent of beds are in the private 'for profit' sector, while in Japan 80 percent of hospitals are in the private sector.

The announcement in 2000 by British Health Secretary Alan Milburn of a Concordat under which the NHS would purchase treatment for non-emergency treatment from private sector hospitals drew an angry response from public sector trade unions. The unions argued staff shortages in the public sector would be worsened by any expansion in private sector capacity – with NHS providers losing both funding and the staff required to sustain the full range of services (including emergency services) provided only by the public sector.

Further 'modernising' reforms create new ways in which public funds can be used to buy services from private providers. The British government is introducing a nation-wide 'patient choice' programme, which will eventually offer every NHS patient the right to choose from at least four hospitals – in either the public or private sector, and already this is leading to a drain of resources from the public sector into private hospitals. And plans for chains of new privately-run Diagnostic and Treatment Centres (DTCs) have generated fresh controversy, not least because of the financial impact of 'cream skimming' lucrative elective work from NHS units, which will be left with reduced budgets but the responsibility for the more complex and costly cases. The limited evidence so far available shows that the unit costs of the private sector providers will be higher than could be achieved by expanding NHS capacity, and that doctors and consultants in the private units will be paid several times the comparable NHS salary.

Developing countries face pressure from global bod-



ies and powerful donors (notably the World Bank and USAID) which are ideologically committed to privatisation and the expansion of the private sector, which is thought to be more responsive and efficient. The evidence to support this presumption is weak, however. In many of the poorest countries, privatisation or the purchase of services from the private sector is easier proposed than done, since there is little in the way of a developed private sector, especially if this is seen narrowly as private for-profit health care provision, operating on a scale which might compete with or even replace publicly-provided services. The availability of potential providers may, as with other services, be largely confined to urban areas, with little or no provision in the rural districts. There may also be a shortage of capacity to formulate explicit specifications and contracts, and to monitor them adequately: the process may also incur heavy transaction costs without any compensating advantages.

In much of the literature on health system reform the definition of the private sector is widened to embrace a wide variety of non-profit providers, notably NGOs and church groups, which stand outside the funding network of the public health care system. One extensive survey for USAID on the extent of collaboration with the private sector in Africa, Asia, Eastern Europe and Latin America, revealed that of 65 schemes identified, only three schemes clearly involved 'for profit' companies. Nevertheless, despite a severe absence of evidence that private provision offers improvements in quality and efficiency, the World Bank, in a website briefing on Private and Public Initiatives, confusingly mingles all the different 'private' spending together, and concludes approvingly that *"an estimated 50 percent of all global spending for health comes from the private sector."*

Since the evidence shows that purchasing care from the private sector serves to increase costs and thus drain resources from limited public sector budgets, any such a strategy must worsen the crisis of health care in developing countries.

Competition

The World Bank's advice for health care reform, displayed on its own website, hinges on the assumption that competitive markets offer the best of all possible arrangements. *"After more than a half-century of experiments with alternative forms of economic development, the evidence strongly favours the proposition that competitive markets are the best and most efficient way yet known to*

organise the production and distribution of goods and services" (World Bank, 2000).

There is little evidence of the effectiveness of markets as a means to govern health care systems. But competition is central to the full operation of the various market-style reforms, since it represents the greatest break from traditional public service notions of planning and centralised state provision and control. Competition brings with it very large overheads in the form of transaction costs. Any efficiency savings that may be generated have to be offset against the overall cost increases.

Even in the wealthiest and highest-spending countries full-scale competition in a free unregulated health-care market is unknown. While the World Bank sees competitive market systems as a general formula, applying to all countries and circumstances, the possibilities for establishing genuine competition between health care providers, or even 'managed competition' between rival health funds is largely restricted to the wealthier countries, where budgets are sufficiently large to allow the possibility of surplus capacity, and where there are a sufficient number of properly-resourced competitors to create the semblance of a 'market'.

One USAID-funded study of Tanzania notes with approval that the public sector is now obliged to compete with private providers on an unusually wide front. Yet the same report also notes the profoundly unequal provision of competitive for-profit private health care in the rural areas. Private provision is concentrated in the capital, so if the private sector emerges the 'winner', the end result will be to leave the public sector shouldering the costs of care for the poorest and the rural population (Munishi, 1995).

Privatisation

Privatisation does not necessarily have to follow from decentralisation, but as another facet of the New Public Management, it comes from the same neo-liberal school of policy. Private providers are not bound to serve the public interest, and are unlikely to deliver any more than is required under a formal contract. However, the extent to which full-scale privatisation of health care facilities and services has been carried through in more advanced economies is very limited – even in the transition economies of the former Soviet Union and Eastern Europe, where there has been a concerted drive towards privatisation in other sectors.

In the UK – despite the reforming zeal and neo-liber-

al credentials of Margaret Thatcher, and a Conservative government that privatised so many state-owned utilities – only a part of the non-clinical support services and (later) long term care for the elderly were privatised in the hospital sector, until the current privatisation drive by New Labour, which is even threatening to privatise primary and community health care. By contrast, New Zealand and Sweden have each moved along the path of neo-liberal reform in health care, only to hesitate and stop well short of wholesale privatisation.

The model aspired to by many neo-liberals was the situation in Chile, in which wholesale privatisation of the economy was driven through by the extreme right wing Pinochet junta after the 1973 coup, with advice from neo-liberal guru Milton Friedman and his ‘Chicago Boys.’ The Pinochet regime did drastically cut health care spending and increased the proportion of private beds from 10 percent to 25 percent between 1981 and 1992. But such policies could only be sustained under a military dictatorship. The new government from 1990 was obliged to implement substantial increases in public spending on health care. By 2000 the private sector collected two thirds of Chile’s health insurance contributions, controlling 46 percent of total health spending, but covered just 23 percent of the population. Even at its peak of ‘authoritarian neo-liberalism’, Pinochet’s regime pulled back from privatising the entire system, however, leaving 75 percent of hospital beds in the public sector.

Privatisation in developing countries is driven on by global agencies, notably the World Bank and USAID. The ‘inefficiency’ of publicly provided services in these and other countries is a stock assertion made by neo-liberals, while the inherent ‘efficiency’ of private health providers is also assumed, despite abundant evidence that the costs of the private sector are much higher than publicly-funded systems, and the fact that only publicly-funded systems have shown themselves able to deliver universal services offering equal access.

Indeed, if there are problems managing a publicly-funded service, logic suggests the same weak and poorly resourced government would have just as many – if not more – problems seeking to ‘regulate’ the activities of a relatively powerful and autonomous private health care sector – a task which has so far eluded the administration of the world’s largest and wealthiest capitalist nation. The World Bank insists that publicly-funded services are ‘inequitable’ because the wealthy find ways to seize more than their share. But there is more than ample evidence

to demonstrate that *privatised* systems, especially those involving user fees, are even more skewed, and exclude the poor.

User fees and other policies to expand private insurance

European health care systems, which generally offer universal coverage, leave little room for a substantial private health insurance market. In general private insurance has been squeezed out by publicly-funded schemes. Some EU governments have attempted to pump-prime private health insurance through offering tax relief: in Ireland the government spends over EUR 79 million each year on what is effectively a subsidy that reduces the cost of premiums by 32 percent – though most subscribers to voluntary health insurance are high earners.

Australia too has heavily subsidised private health insurance (and simultaneously fostered the expansion of a private sector that is far more expensive than public sector health care). The European Health Management Association has concluded that: *“In essence, the Medicare system was proving too good for the private sector, so the government subsidised the private sector to allow it to compete better with the public sector”* (EHMA, 2000). Despite economic logic, even the danger of catastrophic bills for hospital treatment may not always induce people to opt for private medical insurance: in Greece, despite the high level of charges faced by those who fall ill, voluntary schemes cover only 10 percent of the population.

In Eastern and Central Europe and in many developing countries, the World Bank and other agencies have pressed for the introduction of user fees not as a means to raise serious resources, but precisely as a way of persuading the middle classes to seek out insurance schemes, and a device to open up a private sector. The World Bank’s International Finance Corporation has focused on developing private insurance schemes targeted at the ‘lower middle and middle classes in countries without risk pooling’, which is seen as contributing ‘to the strengthening of the middle class.’ The extent of poverty in many developing countries, however, has meant that attempts to launch self-sufficient insurance schemes have been largely doomed to remain as small-scale experiments.

Patient choice and ‘Consumerism’

Enthoven (1997) showed how consumerism could be utilised by the private sector to drive up costs (and thus



profits), arguing that a free choice of provider ‘destroys the bargaining power of insurers.’ It was to forestall this and similar destabilising factors that health maintenance organisations and managed care were introduced in the USA: they aimed both to contain costs and improve quality by *restricting* the level of patient choice.

In publicly-funded services, already struggling to supply sufficient care for a rising level of demand, the apparently innocuous suggestion of ‘patient choice’ can prove an impossible target, or a potentially open-ended commitment to fund private sector treatment. Canadian cancer patients who travel from Ontario to US hospitals to avoid long waiting lists can incur bills six times higher than the cost of treating them at home. To offer all patients a choice as to where to seek treatment requires an expansion of capacity to ensure that a surplus is always available within any provider to accommodate those who ‘choose’ to transfer from a competitor – or a potentially substantial and open-ended increase in budget.

Yet the public sector – increasingly as a result of market-style reforms – tends to receive revenue funding only on the basis of the workload it treats, leaving little if any room for prospective investment. Patient choice breaks down boundaries between public and private sectors: any patient choosing treatment from a private provider will take with them the funding to pay for their treatment.

As the epitome of consumerism and the opposite of planning, patient choice counterposes the choices of individual ‘consumers’ to the stability of a system that has an obligation to care for the whole population: the public sector is stuck with the more expensive or complex cases, as the private sector pockets the profits.

PFI/PPP and its extension internationally

The financing of new hospital and health care projects through the Private Finance Initiative (PFI) has become a major contentious issue in the ‘modernisation’ of the British NHS, but PFI hospital schemes are also taking shape or already operational in Canada, Australia, South Africa, Italy, and Portugal.

PFI first emerged in Britain in 1992 in the aftermath of the Conservative government’s market-style reforms, which established the principle of NHS hospital Trusts paying ‘capital charges’ on the value of their property assets, and on any new capital borrowing from the Treasury. This policy introduced the notion of hospital Trusts as *tenant* rather than landlord, occupying build-

ings for which they had to pay, rather than simply regard as a ‘free good.’

Conservative chancellors began a two-pronged approach, imposing a steep reduction in the annual allocation of capital to the NHS with the requirement that any substantial development (initially GBP 5 million or more) had to be ‘tested’ in the market to investigate whether any private consortium might bid to put up the capital, build and operate the hospital, and lease it back to the NHS on a long-term (25-30 year) contract. The private sector could not be convinced to sign such contracts until after the change of government in 1997, when New Labour, having first denounced PFI as ‘the thin end of the wedge of privatisation’, came to office pledging to ‘rescue PFI’, as ‘a key part of the government’s 10-year programme for modernisation.’

Twenty-one PFI-funded hospitals have now been completed in Britain, with a total value of around GBP 1.5 billion. The next ten are in the process of construction, at a capital value of GBP 1.9 billion, and the government aims to have established GBP 7 billion worth of PFI hospitals by 2010. 85 percent of all new capital investment in the NHS now comes via PFI, with public funding largely restricted to smaller scale and refurbishment schemes. As a result, an ever-growing share of NHS funding is flowing straight out of the public sector to private sector shareholders, for whom (despite the rhetoric claiming a ‘transfer of risk’) completed PFI hospitals are seen as a virtually risk-free income-stream.

NHS Trusts leasing hospitals under PFI normally only retain financial control over clinical services and the payroll for nurses, doctors and other professionals – services excluded from PFI. No spending cuts can be made without hitting patient care. PFI maintains the appearance of a publicly-funded, publicly-provided service while in practice diverting huge capital assets and revenue resources into the private sector. The notion that PFI hospitals represent ‘value for money’ despite their inflated costs has been questioned. The experience of poor quality, poorly-designed and inadequately-sized buildings, with poor quality privately-provided support services has been highlighted in many brand new PFI hospitals: a number have been obliged to begin extensions to add extra beds and facilities not properly planned into the original building (Lister, 2003a, 2003b). But with soaring capital costs, the question of value for money has been overtaken in some of the larger PFI schemes by the issue of affordability.

Conclusion

Whatever the neo-liberals may claim, there is no evidence from recent experience, either in the wealthiest or the poorest countries, that market mechanisms or greater reliance upon the private sector – the main content of most so-called ‘reform’ measures – reduce costs, enhance efficiency, or do anything but widen inequalities in access

for the poorest population.

The pattern of reform is flawed: the answers lie not in rolling back the wheel of history to re-impose a failed market system, but moving forward to new models based on the widest possible risk-sharing, collective funding, and progressive taxation to fund services run for need rather than profit.

References

- Castano, R., R. Bitran and U. Giedion** (2004) *Monitoring and evaluation of hospital autonomization and its effects on priority health services*. Bethesda, MD: The Partners for Health Reformplus Project, Abt Associates Inc.
- Creese, A** (1997) ‘User fees: they don’t reduce costs, and they increase inequity’, *British Medical Journal* 315.
- EHMA** (2000) *The impact of market forces on health systems. A review of evidence in the 15 European member states*. Dublin: European Health Management Association (EHMA).
- Enthoven, A.C.** (1997) ‘Market-based reform of US health care financing and delivery: managed care and managed competition’, in G.J. Schieber (ed.) *Innovations in Health care Financing*. World Bank Discussion Paper 365. Washington DC: World Bank.
- Lister, J.** (2003a) *The PFI Experience, Voices from the frontline*. London: UNISON.
- Lister, J.** (2003b) *Not So Great: voices from the frontline at Swindon’s Great Western Hospital*. London: UNISON.
- Lister, J.** (2005) *Health Policy Reform: Driving the Wrong Way?* Middlesex: University Press.
- Munishi G.K.** (1995) ‘Private sector delivery of health care in Tanzania’, *Major Applied Research Paper* 14. Bethesda, MD: Abt Associates Inc.
- Nash E.** (2003, May 14) ‘The Spanish prototype: efficient, but controversial’, *The Independent*.
- OECD** (2000) *Health Data 2000* (CD). Paris: Organisation for Economic Co-operation and Development (OECD).
- Osborne, D. and T. Gaebler** (1992) *Reinventing government: how the entrepreneurial spirit is transforming the public sector*. New York: Addison-Wesley.
- Slack, K. and W.D. Savedoff** (2001) ‘Public purchaser-private contracting for health services.’ Washington D.C.: Inter-American Development Bank (IADB).
- World Bank** (2000) ‘The role of the World Bank.’ Retrieved from the World Bank’s Public and Private Initiatives website: <<http://www.worldbank.org/html/extdr/hnp/health/ppi/contents.htm>>.