Preface

The Globalization Knowledge Network (GKN) was formed in 2005 with the purpose of examining how contemporary globalization was influencing social determinants of health. It was one of nine Knowledge Networks providing evidence-informed guidance to the work of the World Health Organization’s Commission on Social Determinants of Health (2005-2008): like most of the Knowledge Networks, its operations were financed by an external funder (in this case, the International Affairs Directorate of Health Canada, Canada’s national ministry of health). The GKN conducted two face-to-face meetings to debate, discuss, outline and review its work, and produced thirteen background papers and a Final Report. These papers and the Final Report underwent extensive internal and external peer review to ensure that their findings and policy inferences accurately reflected available evidence and scholarship.

This GKN publication series was prepared under the general editorship of Ronald Labonté, with assistance from Vivien Runnels and copy-editing provided by Wayne Harding. All views expressed are exclusively those of the authors. A complete list of titles in the publication series appears on the inside back cover of this monograph.
Globalization and Health Systems Change

WHO Commission on Social Determinants of Health

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<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
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<tr>
<td>ANC</td>
<td>African National Congress</td>
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<td>ART</td>
<td>Anti Retroviral Therapy</td>
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<td>CMS</td>
<td>Cooperative Medical System</td>
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<td>COSATU</td>
<td>Congress of South African Trade Unions</td>
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<td>DDM</td>
<td>Data for Decision Making</td>
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<td>DFID</td>
<td>UK Department for International Development</td>
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<td>EHMA</td>
<td>European Health Management Association</td>
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<td>EPS</td>
<td>Empresa Promotora de Salud - Health Promoting Enterprises</td>
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<td>EU</td>
<td>European Union</td>
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<td>FONASA</td>
<td>Fondo Nacional de Salud</td>
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<td>GATS</td>
<td>General Agreement on Trade in Services</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GFATM</td>
<td>Global Fund to Fight AIDS, TB, and Malaria</td>
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<td>GKN</td>
<td>Globalization Knowledge Network</td>
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<tr>
<td>GNP</td>
<td>Gross National Product</td>
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<td>GPPPs</td>
<td>Global Public-Private Partnerships</td>
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<tr>
<td>GTZ/GmbH</td>
<td>Gesellschaft für Technische Zusammenarbeit/German Agency for Technical Cooperation</td>
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<td>HFS</td>
<td>Health Financing and Sustainability</td>
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<td>HIPC</td>
<td>Heavily Indebted Poor Countries</td>
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<tr>
<td>HIV/AIDS</td>
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<td>HMO</td>
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<td>HNP</td>
<td>Health, Nutrition and Population</td>
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<td>IADB</td>
<td>Inter-American Development Bank</td>
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<td>International Bank for Reconstruction and Development</td>
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<td>IDB</td>
<td>International Development Bank</td>
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<td>IFC</td>
<td>International Finance Corporation</td>
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<td>International Labour Organisation</td>
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<td>IMF</td>
<td>International Monetary Fund</td>
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<td>IMSS</td>
<td>Instituto Mexicano del Seguro</td>
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<td>ISAPRE</td>
<td>Institucion de Salud Previsional</td>
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<td>ISTC</td>
<td>Independent Sector Treatment Centers</td>
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<td>LIC</td>
<td>Low-Income Country</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MIC</td>
<td>Middle-Income Country</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MRI</td>
<td>Magnetic Resonance Imaging</td>
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<td>MSH</td>
<td>Management Solutions for Health</td>
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<td>NEPAD</td>
<td>New Partnership for Africa's Development</td>
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<td>NGO</td>
<td>Non-Governmental Organization</td>
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<td>NHB</td>
<td>National Health Bill</td>
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<td>NHIF</td>
<td>National Hospital Insurance Fund</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NHISIF</td>
<td>National Hospital Social Insurance Fund</td>
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<td>NiDs</td>
<td>National Immunization Days</td>
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<td>NPM</td>
<td>New Public Management</td>
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<td>OECD</td>
<td>Organization for Economic Cooperation and Development</td>
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<td>PAHO</td>
<td>Pan American Health Organization</td>
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<td>PEPPAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<td>PHR</td>
<td>Partnerships for Health Reform</td>
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<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>POS-S</td>
<td>Plan Obligatorio de Salud Subsidiado</td>
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<td>PRSP</td>
<td>Poverty Reduction Strategy Paper</td>
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<td>PSIA</td>
<td>Poverty and Social Impact Analysis</td>
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<td>PSP</td>
<td>Private Sector Partnerships</td>
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<td>SAP</td>
<td>Structural Adjustment Program</td>
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<td>SSA</td>
<td>Sub-Saharan Africa</td>
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<td>SWOT</td>
<td>Strengths, Weaknesses, Opportunities, and Threats</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>THPHS</td>
<td>Towards High-Performing Health Systems</td>
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<td>UK</td>
<td>United Kingdom</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>UNITAID</td>
<td>United Nations International Drug Purchase Facility</td>
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<td>UNRISD</td>
<td>UN Research Institute for Social Development</td>
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<td>US</td>
<td>United States</td>
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<td>USAID</td>
<td>US Agency for International Development</td>
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<td>WDR</td>
<td>World Development Report</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WHR</td>
<td>World Health Report</td>
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The last 30 years of globalization have had an uneven and unequal impact not only on the economies and living standards of the developed and developing countries, but also on their health systems and on the possibilities of establishing universal and comprehensive health services alongside public health policies. Inequalities in access to health care and in the resourcing of health systems have widened.

A breakdown in the predominant post-war consensus since 1980 has brought the re-emergence in global bodies of ideology and policy linked to neo-liberalism – with its preference for markets, competition and maximizing private provision regardless of its higher overhead costs – in place of social solidarity, planning, equitable allocation of resources and public provision. This same dynamic has led to a waning in the influence of the World Health Organization (WHO) and its commitment to health as a human right, universalism, and Health For All on the basis of extending primary health care.

The dominant policy role in shaping health systems since the 1990s has been played by the World Bank as lender and as sponsor of research, and more recently by powerful new multilateral and bilateral donors. As a result, policies that are costly, inefficient and inequitable have been promoted and adopted or imposed in many low-income countries (LICs) and middle-income countries (MICs) despite mounting evidence that they can have a negative impact on access to care among the poorest.

This paper analyzes 11 of the most commonly applied “reform” measures, reviewing the evidence of their impact, and finds that they consistently increase overhead costs while creating less efficient and effective health systems. The World Bank itself has conceded that some of the countries most successful at improving health have been those which have systematically ignored most or all of its proposed reforms. The Bank lacks any equivalent examples of successes for its own policies. Its favoured combination of an “essential package” of care, user fees, purchaser-provider split, competition, decentralization and maximizing private sector provision has proved expensive, unpopular and ineffective.

The paper looks at a number of case studies and common lessons from success and failure, noting an increased emphasis in reports from WHO, the World
Bank, the UK Department for International Development (DFID), leading non-governmental organizations (NGOs) and academic studies on the need for government intervention, the elimination of the profit motive, the scrapping of user fees and the need for a universal health service rather than one seeking to “target the poor”.

The paper offers five positive policy conclusions:

• First, do no harm – stop adding to the list of failures by dropping the Bank’s reform program of user fees alongside market-style and privatizing reforms.

• Second, explore and analyze alternative models that have worked – following up, for example the Equitap survey of 16 Asian countries¹ which came up with a very different line of approach from that of the Bank, urging universal, publicly provided health care.

• Third, explore alternative sources and mechanisms for funding. The Bank has opened up debate on possible sources of funding, including a tax on airline tickets, a carbon tax, a Tobin tax on currency transactions, and IMF gold reserve sales. Other options also exist.

• Fourth, invest in human capital – noting that the key to Cuban successes in health has been a combination of public health measures and the training of doctors who are now a major resource for developing countries.

• Fifth, revive the values of universalism – scrap existing user fees, and work towards a new type of partnership between NGOs and not-for-profit organizations and governments in LICs in which the developing countries are put firmly in the driver’s seat, deciding priorities and setting the terms for any involvement of the private sector.

¹ (Equity in Asia-Pacific Health Systems is a collaborative effort of more than fifteen research teams in Asia and Europe...” http://www.equitap.org/. See also footnote 44, page 84 below)
The last 30 years of globalization have had an uneven and unequal impact not only on the economies and living standards of the developed and developing countries, but also on their health systems and on the possibilities of establishing universal and comprehensive health services alongside public health policies.

Inequalities in access to health care and in the resourcing of health systems have widened, with the US alone, with just 5 per cent of the world’s population, now spending 40 per cent of the world health budget on a costly, inefficient, exclusionary and bureaucratic system. By contrast many of the poorest countries, facing the greatest burden of disease, spend a tiny share of their much lower GDP on health care. Yet much of even this limited spending is unequally allocated and shared, resulting in the exclusion of many of the poorest who have the greatest health needs. In the poorest countries even as many as 40 per cent of the rich lack access to health care in addition to the urban and rural poor. Many of these countries also face the highest levels of private sector provision and out-of-pocket payments.

A breakdown in the predominant post-war welfarist consensus in most high income countries has brought the re-emergence of ideology and policy linked to neoliberalism – with its preference for markets, competition and maximizing private provision regardless of its higher overhead costs – in place of social solidarity, planning, equitable allocation of resources and public provision. This same dynamic has led to a waning in the influence of the WHO and its commitment to health as a human right, universalism, and its project of establishing Health For All on the basis of extending primary health care. Instead the dominant policy role in shaping health systems has since the 1990s been played by the World Bank both as lender and as sponsor of extensive research, and more recently by powerful new multilateral and bilateral donors.

The Bank, together with the International Monetary Fund (IMF) and the US State Department, as part of the so-called Washington Consensus, has been the driving force behind the Bank’s policy prescriptions. These prescriptions are characterized not by a focus on low-spending, low-cost health systems in the low
income countries (LICs) but by a more complex mix of policies. For most of the last 20 years these have focused on development of the private sector and the imposition of user fees, regardless of the lack of any evidence that such policies can be equitable, efficient or cost-effective.

The dominance of neo-liberal and market-style approaches within the global bodies shaping health policy has been sufficient to ensure that policies which are costly, inefficient and inequitable have been promoted and adopted or imposed in many LICs and MICs despite mounting evidence that they can have a negative impact on access to care among the poorest.

The “menu” of reforms which the Bank and others within the policy elites have attempted to generalize in LICs includes policies tried and rejected in some high-income countries, and questioned by current research of the Organisation for Economic Co-operation and Development (OECD), with only the United Kingdom (primarily in England) and Portugal of the 30 wealthiest countries presently pursuing most of the main proposals.

This paper looks at the common elements of globally driven health sector reforms and explores their impact on health systems. It also examines the evolution of the main global organizations driving health policy – the World Bank and its sections, the IMF (through Structural Adjustment Programmes), the OECD, the WHO and the new global donor agencies – and a policy-making elite of academics and technical advisors. It explores their effect on health systems and reforms, and analyzes 11 of the most commonly applied “reform” measures that these organizations and influential individuals have promoted, reviewing the evidence of their impact. It notes that:

- Two-tier systems along the lines of the World Bank’s influential 1993 World Development Report (WDR) policy Investing in Health, which offer only a minimum package of care for the poorest, are more expensive and less inclusive than some universal systems
- User fees consistently serve to deter the poor, without raising significant revenue
- Health insurance schemes in LICs have largely proven unsuccessful
- Reforms based on contracts for care represent a step towards commodification of health services, while enforcement and regulation of private providers remain unresolved problems in many LICs
- In many of the poorest countries the private sector is too small – and often unwilling – to play any significant role in public health provision or delivering services to deprived and rural communities
- The World Bank’s focus on building up private sector provision centres on strengthening of the “middle class” and fostering a two-tier health system
- The drive towards privatizing existing public sector health provision ignores the widening inequalities and inefficiencies which have followed such policies in practice – most notably in Chile under the Pinochet regime
- The policy of “public-private partnerships” has to be seen as misguided, especially in the context of less than satisfactory or equitable “partnerships” between the relatively weak WHO and LIC governments on the one hand, and powerful, well-resourced global pharmaceutical companies on the other
- Systems based on competition between rival service providers (or insurers) generate larger overheads and inefficiencies, and may also compound geographical and other inequalities
- Decentralization has been embraced as a policy by very different parties and governments, but there is little evidence that decentralization in the absence of other policies creating a framework for equity brings any improvement in health care
- Corporatization or autonomization of local health providers also carries risks of declining accountability, and lacks convincing evidence to show it improves health care.

While the “reforms” take place against a backdrop of globalization of the world economy, the policy prescriptions themselves are not directly driven by competitive pressures. In fact they consistently increase overhead costs while creating less efficient and effective health systems. Nor are they a logical response to the burden of disease and health needs. The reform package not only compounds inequalities but it also
significantly ignores the growing issues of mental health and the health needs of a rapidly increasing global population of older people.

The roots of the main reforms have to be sought in the ideology of global bodies and powerful institutions rather than deriving from any imperative of objective economic or other forces within globalization. The World Bank itself has conceded that some of the governments most successful at improving health – Costa Rica, Brazil, Kerala in India, Sri Lanka, Thailand, and Cuba – have been those which consistently ignored most or all of its proposed reforms. The Bank lacks any equivalent examples of successes for its own policies.

The paper continues with a number of case studies\(^2\) which look at the reform process and health system changes in a variety of settings, followed by a section which formulates a strengths, weaknesses, opportunities and threats (SWOT) analysis of the issues facing health systems in the context of globalization and the ideological pressures exerted by global bodies.

In conclusion, the paper looks at common lessons from success and failure, noting an increased emphasis in reports from WHO, World Bank and DFID on the need for government intervention, and for the elimination of the profit motive, the scrapping of user fees and the need for a universal health service rather than reformed systems which seek to ‘target the poor’. In contrast to these reports, the Bank’s favoured combination of an “essential package” of care, user fees, purchaser-provider split, competition, decentralization and maximizing private sector provision has proved expensive, unpopular and ineffective.

A turn from competition to collaboration and from markets to planning and government intervention also appears to be taking place. This is being reinforced in Latin America where Brazil’s “unified health system” has achieved dramatic successes in combating HIV/AIDS, and where Venezuela’s president Hugo Chavez and Bolivia’s president Evo Morales have recently led the way, spending some of their country’s energy wealth on programs which have brought in Cuban doctors to deliver free health care to poor neighbourhoods.

The paper offers five positive policy conclusions:

- First, do no harm – stop adding to the list of failures by dropping the Bank’s reform programme of market-style and privatizing reforms.
- Second, explore and analyse alternatives that have worked – following up, for example the Equitap survey of 16 Asian countries which came up with a very different line of approach from that of the Bank. Other examples are also cited of reports identifying useful and effective models for improving health systems.
- Third, explore alternative sources and mechanisms for funding, which have tended to be sidelined by the focus on organizational changes, private sector involvement and user fees. The World Bank (Gottret and Schieber 2006) has opened up some fresh debates on possible sources of funding including a tax on airline tickets (such as UNITAID), a carbon tax, a Tobin tax on currency transactions, and IMF gold reserve sales or new Special Drawing Rights.
- Fourth, invest in human capital – noting that the key to Cuban successes in health has been a combination of public health measures and the training of doctors who are now a major resource for developing countries.
- Fifth, revive the values of universalism – scrap user fees, and work towards a new type of partnership between NGOs and not for profit organisations and governments in LICs in which the developing countries are put firmly in the driver’s seat, deciding priorities and setting the terms for any involvement of the private sector.

\(^2\) Kenya, Zambia, South Africa, Mexico, Chile, India, China, Viet Nam, with shorter studies of Russia, Hungary, Czech Republic and Poland.
Introduction

Health care is probably the world’s largest single industry, with a combined turnover in excess of US$3.2 trillion annually, equivalent to a tenth of global GDP, and employing in excess of 59 million staff (Gottret & Schieber 2006, WHO 2006). It should therefore be no surprise that the various processes and structures of globalization inevitably impact upon the health systems of countries rich and poor – or that these impacts should be as distinctive and unequal as the health systems and countries themselves.

The policy context within which this contest for a slice of the growing global health budget takes place is very different from the general consensus that prevailed 30 years ago. That common approach was marked by the overwhelming vote of the WHO’s World Health Assembly to embrace the 1978 Alma Ata declaration and the objective of ensuring “Health for All” by 2000. The three principles at the centre of the Alma Ata policies were simple and clear:

- Health, defined as “a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity”, was proclaimed to be “a fundamental human right”: this has subsequently been criticized as over ambitious or idealistic, but has the strength of clearly locating health and health care in a public health context rather than adopting a narrower, less effective curative focus or “medical model”.
- Universalism reflected the drive to include the whole population of every country within a protective network of health care and health services, available on the basis of clinical need rather than the ability to pay. This led inevitably to opposition to user fees and charges which exclude the poor.
- Primary health care was defined as “essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to
individuals and families in the community through their full participation and at a cost that the community and country can afford.” This should combine local, flexible and responsive primary care incorporating physicians, nurses, midwives and other health professionals and support staff with the availability of accessible hospital and secondary care services for those who need them. Primary health care also requires systematic promotion and enhancement of public health through preventive measures, education, immunization, and provision of clean water, nutrition and sanitation.

The strong consensus around these values represented the high point of the post-war welfarist consensus in western Europe and the OECD countries, but already being undermined by a growing economic crisis. It was soon challenged by political developments which changed the dominant ideological paradigm of the capitalist countries. This began in earnest with the election of Margaret Thatcher in the United Kingdom in 1979 and Ronald Reagan as US President in 1980. The economics of monetarism accompanied the revitalized ideology of neo-liberalism and the politics of deregulation and privatization. This powerful political shift helped shape the emerging Washington Consensus in which the leading global financial institutions, the International Monetary Fund (IMF) and the World Bank more openly embraced the political and ideological agenda of the US Administration.

The 1990s saw a further fracturing of the common vision of 1978 as the experiments aimed at containing the runaway costs of the largely private US health care market led to notions of “managed care” and “managed competition” and pressure to restructure planned and centralized health care systems into competitive markets, most of which were subsequently abandoned as costly failures (New Zealand, the UK, Sweden, the Netherlands).

However, the ideological pressure from the US and UK governments and the global institutions has continued into the 21st century, with more governments, and agencies such as USAID also committed to promoting market-style, managerialist policies and increased private sector involvement in the provision of health care. This commitment developed despite the lack of any
convincing evidence that such systems could achieve the desired objective of increasing efficiency and controlling costs, let alone achieving professed objectives of equity and accessibility.

Pressure from the World Bank and other agencies has helped ensure that a majority of sub-Saharan African countries have adopted and still maintain user fees for health care services, despite overwhelming evidence that this policy unreasonably excludes the poor. By contrast the organization tasked with driving forward the principles and values of Alma Ata, the World Health Organization (WHO) has been in retreat for most of the last 10 years, unable to challenge the resources and the ideological weight of the Bank.

The Bank’s vast budget for projects and research has sponsored a largely one-sided line of enquiry and debate, while the WHO has found its budget frozen in real terms, and been driven to seek compromises and “partnership” with the Bank and increasingly with the private sector. These have served to undermine the WHO’s commitment to the goals and methods agreed at Alma Ata. The WHO’s relative lack of economic knowledge and clout was one of the factors which led to a top-level recruitment of World Bank health economists to the WHO, many of whom brought with them their World Bank assumptions and policy framework, resulting in the conflicts over the WHO’s 2000 World Health Report. This specifically changed WHO policy on such key issues as universalism, criticized the policy of primary health care as a failure, condemned the Alma Ata declaration for its omission of references to the private sector, and diluted the WHO’s historic opposition to user fees for health care and its commitment to the concept of a basic human right to health.

The examination of globalization and its impact on health systems is therefore in part an examination of the consequences of policies which have broken from the Alma Ata principles, and embraced free market values and methods in place of the goal of health care systems based on primary health care, equity, accessibility for the poor, collective risk-sharing, and public services planned to meet social needs. The result is what Unger et al. (2006) describe as “disintegrated care”.

Globalization

The dynamics of the various aspects of globalization often drive in different ways towards changes – sometimes proactive, but more often reactive – in health systems. The eventual impact on health systems may flow more from the policies and ideological prescriptions of global bodies and institutions – or from the traditionally powerful countries and corporate interests within them – than from any necessary logic of globalization itself or the new world order it has ushered in. For instance:

- The scale and speed of cross-border movement of goods, services and finance capital leaves many national economies and their governments potentially vulnerable to short-term movements of capital, and might therefore be seen as a driving force towards more frugal and cost-effective health systems that could keep levels of taxation low in order to attract and retain inward investment. Yet there is relatively little evidence to demonstrate this effect (Gough 2000).

- Most governments appear to be committed to work towards further economic integration, and to policies of labour market flexibility, low taxes and tariffs, privatization and minimal regulation. But the consensus is stronger in theory than in practice. While there have been sustained and continuing attempts to apply market-style reforms to health systems in developing countries, very few of the wealthier OECD countries have opted to do the same. Indeed, with the notable exception of the unique ongoing and unresolved situation in the US, most OECD countries have retained welfare state protection and social solidarity on health and some (Mexico, Turkey) have even begun to extend it. Some early moves towards more extreme market reforms have been

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3 The US healthcare system is by far the most expensive in the world, consuming 16 percent of GDP (almost $2 trillion) in 2005 (Tanne 2007), and spending upwards of $400 billion on administration (Woolhandler et al 2003), while leaving 45-50 million Americans without full insurance cover (Cohen et al 2006). US government spending as a share of GDP was equivalent to the UK in 2003, leaving the bulk of additional spending to the private sector and out of pocket payments (Hsiao and Heller 2007).

4 Even while a number of countries have seen an erosion of entitlements to social security, pensions, and benefits for people with physical disabilities.
halted and reversed in the light of negative experience (New Zealand). Within the OECD only the United Kingdom (primarily in England) and Portugal have remained firmly committed to the implementation of market-style reforms in health systems, regardless of their cost, their political unpopularity, and the lack of any evidence that they deliver the promised improvements, while Australia and Ireland have been exceptional in pursuing the expensive option of encouraging greater use of private medical insurance.

The establishment of binding rules through the WTO and other bilateral and regional treaties may constrain the policy flexibilities of governments to expand publicly provided services and – particularly regarding extended patent rights – their access to new medicines, vaccines and potentially life-enhancing science.

Globalization therefore does have an impact on health systems, although in general the policies for change come not directly from the powerful forces of the global economy. More often they come through the ideology and policy prescriptions – the “hidden politics” – of the Washington Consensus (Deacon 2001) and related approaches and assumptions (Third Way, New Public Management) which look to market mechanisms, competition, choice and the supposed efficiencies of the private sector rather than to the previous social democratic/social solidarity consensus focused on proactive planning and allocation of resources to meet health needs and achieve goals of equity, universalism, access and inclusion.

The “globalization of the social policy process” is described (Yeates 2001:28) as centred on “general agreements reached by participants in international fora, such as the UN or G7 summits”. Yet, while these bodies (though very different) can be seen as gatherings of equals, most health system reforms appear to have been transmitted from the wealthier countries to the poorest. This has been not through voluntary engagement, partnership or agreement, but through the pressure and even through the intervention of less egalitarian global organizations. While the basic menu of reforms may be similar everywhere – the “one size fits all” derided by Stiglitz (2002) and other critics – the policies adopted are not by any means identical. Few governments with any room for choice have opted to push through systematic market-style reforms in health care.

Another important factor that has impacted on health systems has been the emergence of new and extremely well resourced multilateral and bilateral donors, often starting up with an explicitly global objective of combating particular health problems. Examples are the Bill and Melinda Gates Foundation, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and George W. Bush’s Presidential Emergency Plan For AIDS Relief (PEPFAR). Each of these donors requires various levels of technical, practical and human resource support in the recipient countries, and in some cases impose sweeping and controversial conditions, impacting on existing systems, and posing new problems (Hsiao and Heller 2007).

**Health systems**

It is important first to address the significance and interpretation of the term “health system”, which can itself be one of the range of social determinants of health (Irwin et al. 2006). Other social determinants not directly linked with a narrow definition of health systems, but linked with public health, would include access to clean water and sanitation, diet and environmental factors. The Pan American Health Organization (PAHO) argues that various levels of definition of health system are possible, ranging from the narrowest notion of the ‘activities organized or controlled by the Ministry of Health’, through to a wide-ranging definition that includes all kinds of non-health activity that might possibly have a bearing on health (PAHO 2001b: 4).

The WHO defines a health system as:

“All the organisations, institutions and resources that are devoted to producing health actions. A health action is defined as any effort, whether in personal health care, public health services, or through intersectoral initiatives, whose primary purpose is to improve health.” (World Health Report 2000).

There are clearly problems of focus and definition in a concept this wide-ranging. WHR 2000 went on to identify four key functions of a health system – stewardship, financing, securing human and physical
resources, and organization and management of services. The notion of “stewardship” or even “stewardship/steering” (PAHO 2001a) has itself been defined in new ways by the WHO since 2000 to incorporate the WHO’s relatively recent acceptance of a new and expanded role for the private sector alongside its traditional adherence to public provision, and effectively downplay the significance of government action (Saltman and Busse 2002, De Groote et al. 2005, PHRplus 2006).

While the wider dimensions are important in determining health status, for the purposes of this study of health systems Roemer’s 1991 definition seems most accurate:

“...the combination of organisation, financing and management that culminate in the delivery of health services to the population” (cited in World Bank Group 2005).

Health systems in different countries will combine varying proportions and roles of public and private providers in finance and provision of services. Some are mainly public, others mostly private, many are mixed, although the mixture varies. Another factor that will affect the health system is how care is paid for, whether through taxes (public funding), insurance (social or private), or through payments by consumers.

In each case the mix of public and private finance and provision results in a health system. The extent to which this works effectively, fairly and consistently can make a real difference to the health of the country’s population. One recent analysis of 16 Asian health systems concludes:

“Ultimately it is health systems that matter. Even at low income levels and with low levels of public spending it is possible for health systems to ensure some equality of access to services...and to largely protect the poor from impoverishment as a result of illness” (Rannan-Eliya and Somanathan 2005:11).

The global pattern of stark inequalities in health spending and access to affordable, effective health care between richer and poorer countries can also be seen at national level, with hugely unequal access to care between rich and poor in the poorest countries/ According to World Bank figures in 2002, just $350 billion – a mere 12 per cent of the $3.2 trillion global health care budget – was spent in low and middle income countries comprising 84 per cent of the global population, but suffering 90 per cent of the global disease burden (Gotttret and Schieber 2006).

In addition, health systems must address the issue of the distribution of health services, which in turn can restrict access, especially in services dependent on any measure of private sector provision. Private health providers, especially the for-profit sector, tend to congregate in the urban centres (Palmer 2000), leaving rural populations with a “choice” of long journeys to access treatment, or going without. But the exclusion of a large section of the population from such a health care “system” also limits the scale and quality of the services that can be developed – impacting even on the middle class and the rich. A World Bank website points out that:

“...In Côte d’Ivoire less than one quarter of the rural poor who were sick received any form of medical care, as compared with half the urban rich. In Peru only 20% of the poor received care, versus 57% of the rich”. (World Bank 2000).
What appears to have escaped the World Bank in this instance is that the systems in place in the poorest countries are so inadequately resourced that in some cases, like Côte d’Ivoire and Peru, even half the rich people cannot get the treatment they need.

It is clear that the level of resources available is an important factor distinguishing health systems. In cash terms, the high-income countries spend about 100 times as much per head of population on health as do low-income countries. Even if differential costs of living are factored in, there is still a 30:1 difference (Gottret and Schieber 2006). These differences in resources mean that the options and possibilities for short- and medium-term changes are also very different in Kenya, Cambodia or Colombia from those in the wealthiest countries. With so much less money to spend, the low- and middle-income countries are limited in what drugs they can buy, how many professional staff they can recruit and train, how much they can pay them – and whether they can retain their services in the face of growing competition in the growing global labour market and “brain drain” of nursing and medical staff (Nduru 2006, McVeigh 2006). Thirty-eight of the 47 countries in Sub-Saharan Africa fall below the WHO recommended level of 20 physicians per 100,000 population – 13 countries have five or fewer, and 17 have less than half the recommended level of nursing staff (Physicians for Human Rights 2004, Clemens and Pettersson 2006). These issues are studied in much more detail in the Globalization Knowledge Network paper on Health Human Resources as well as papers from other Knowledge Networks.

The second major difference between the health systems in most low- and middle-income countries and those in OECD countries is the much higher level of private out-of-pocket spending, and higher proportion of the health care budget that comes from private sources (Gottret and Schieber 2006). The low-income developing countries are more dependent on private health expenditures, with only a small fraction of this covered by any form of prepayment or insurance. India is the most privatized of the developing countries, with 82 per cent of health spending coming privately. Other countries with over 70 per cent of spending from private sources, mostly out of pocket, include Kenya (79 per cent), Nigeria (77 per cent), Pakistan (76 per cent), Indonesia (75 per cent) and Viet Nam (71 per cent) (Gottret and Schieber 2006, citing WHO 2004). Some of these countries are discussed in greater detail in Section 5 of the paper.

The conventional wisdom of neo-liberalism has been that governments in low-income countries lack the tax base to roll out or sustain publicly funded health care, and therefore they are required to levy charges for treatment with few if any exemptions. This assumption is strongly contested by Rannan-Eliya and Somanathan (2005), drawing conclusions from a systematic survey of 16 Asian countries. They argue that user fees could be reduced or eliminated by government spending as little as 2 per cent of GDP on a universal health system that would give most benefit to the poor.

Where fees have been imposed, those on the lowest incomes – notably women, children and the elderly – have been deterred from accessing treatment. Nevertheless, user fees have been relentlessly advocated and sometimes effectively imposed on debt-ridden poor countries by global bodies such as the World Bank and IMF – despite the evidence of the damage they do to health care and equity for the poorest (Oxfam 2006, Human Rights Watch 2006, Save the Children 2005, Hutton 2004, Rannan-Eliya et al. 1996, Reddy and Vandermoortele 1996).

**Burundi**

In Burundi, the government announced in May that maternal health care and care for children under five would be free of charge – but other forms of hospital care will continue to be subject to substantial charges in one of the world’s poorest countries with an average income of just $1 per day. Hundreds of patients have been detained in hospital in the last four years because they could not pay medical bills: some have been held for weeks, many for months, and have been kept under guard in wards without food unless brought by charities, family or friends (Human Rights Watch 2006).
Out-of-pocket fees and charges and individual user fees are major obstacles to access for the poor, and therefore widen inequalities. But they also constrain the growth of any comprehensive health system. Global pressures that promote such policies therefore generate distorted health systems which exclude large numbers of people with the most serious health needs.

In summary, the common elements of globally driven change or health sector reform in the last 15-20 years are:

1. Promotion of a model which aims at minimal government provision and spending on publicly funded health care, restricting such services to a “minimum” or “essential” package, with any additional services provided privately and subject to user fees.
2. Imposition of user fees for most health care services, with minimal exemptions
3. Encouragement of the establishment of various forms of health insurance – even where this is restricted to the middle class and the rich and is shown to deliver few if any benefits to the poorest.
4. Encouragement contracts as a means to commission private sector or NGO bodies to deliver publicly-funded health services (“steering rather than rowing”).
5. Maximum involvement of the private sector that includes privatization of existing public sector services and “Public Private Partnerships” as another way of enabling the private sector to play an extended role in the provision of public (and publicly funded) services. Competition between rival service providers seen as a means to improve efficiency, despite the lack of any evidence to support this view.
6. Decentralization of health systems advocated as a universal reform, irrespective of the political and social context.
7. Corporatization of health care providers to ensure that even public sector hospitals and organisations function in “entrepreneurial” fashion, more along the lines of a private company.
8. In high- and middle-income countries, advocating consumerist policies such as “patient choice” – although examples of full implementation are extremely limited (Thomson and Dixon 2006).
Section 2. The main drivers and policies in health sector reform

Introduction

The policies identified above, which are characteristic of many market-style reform packages, do not arise spontaneously at the national level in developing countries. Still less are they a direct or inevitable response to the pressures of globalization on national economies.

Instead the transmission belt which carries these policies from the academic circles and policy élite of the wealthiest countries into the health ministries of the poorest developing countries involves major global agencies which subscribe to the so-called Washington Consensus of neo-liberal economic and social policies.

This section will therefore look at the process through which the World Bank, the International Monetary Fund, regional subdivisions of the World Bank, USAID, and the rich nations’ club, the Organisation for Economic Co-operation and Development (OECD), have to varying degrees embraced and promoted the main menu of market-style reforms, and created conditions for political adaptation by the World Health Organization. It will look at the impact on health systems of large-scale donor organizations with their own very specific areas of interest, preferred methods of organization, ideological views and relationships with the profitable and powerful pharmaceutical industry.

It will also look briefly at the emergence in the last 20 to 30 years of a distinct and influential if little known and unaccountable policy élite of First World academics and researchers, many of them funded by the Bank or other policy drivers. This “epistemic community” can be seen as a crucial factor in translating the economic and managerial nostrums of markets and competition into policies to restructure and constrain health care systems.
Globalization and Health Knowledge Network

World Bank and International Monetary Fund (IMF)

Historical origins

The World Bank, like the IMF, was established in 1944 as one of the institutions charged with stabilizing and assisting the development of world capitalism after World War II. As Williams (1994:111) notes:

“The World Bank has never pretended to be anything other than a capitalist enterprise with a commitment to free trade, the optimisation of investment flows and the support of free enterprise.”

While the IMF’s task was to extend loans to relieve balance of payments’ deficits and ensure stable currencies and economies, the Bank’s role was originally to lend for long-term development, beginning with the reconstruction of war-torn Europe, and then to focus on industrialization. Only since the 1980s has the Bank’s focus (and influence) concentrated on the poorest developing countries. More recently the Bank has embraced poverty reduction as its overarching goal, emerging as “the world’s foremost development agency” (Williams 1994:101).6 It now covers 184 member countries, although its internal structure has left it vulnerable to veto by the US or policy capture by the most powerful of the wealthy countries. Its governance arrangements continue to reflect the reality when the Bank was first established when it depended on the wealthy industrialized countries for funding. However, funds from these donor countries now represent only a small share of the Bank’s lending,7 much of which is raised through loans on the financial markets and from interest payments on the billions already extended in long-term loans (Christian Aid 2003).8 According to a major report from Social Watch,9 multinational financial agencies “are increasingly becoming a burden” to the poorest countries. For the last 15 years “net transfers (disbursements minus repayments minus interest payments) from the World Bank’s International Bank for Reconstruction and Development (IBRD) have been negative.”

“Taken as a whole the IBRD is not making any contribution to development finance other than providing finance to service its outstanding claims.” (Social Watch 2006:14)

The institutional imbalance of power between rich and poor countries within the World Bank/IMF is intensified by the fact that all of the major emerging market economies, with the sole exception of Turkey, have now paid off their loans to the IMF and the Bank, leaving only the poorest countries behind and dependent upon loans and credit guarantees, and the wealthiest countries in control. The US alone has 17 per cent of the votes, while just 15 per cent is required to block a decision by either the World Bank or IMF boards. Five of the world’s richest G7 countries, none of which borrows from the Bank any more, share over 20 per cent of the votes, while the world’s 80 poorest countries have a combined voting strength of just 10 per cent on the Bank’s board, and the combined voting strength of 50 African countries is less than half that of the US.10 Only European members and the US can nominate candidates for the two top jobs in both Bank and the IMF. To some extent even this summary gives an exaggerated view of the level of accountability and democracy in the Bank. In practice the influence of executive directors in the operational running of the Bank has been marginalized since 1947, while all of the Bank’s presidents have been US citizens (Williams 1994). The structure and working of the Bank and IMF have been explored in more detail in a separate paper (Woodward 2006).

Alongside the Bank, the other Bretton Woods global body, the IMF, has also acquired a reputation for

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6 In fact the Bank consists of a Group of five linked institutions: the International Bank for Reconstruction and Development (IBRD), the International Development Association, the International Finance Corporation (IFC), the Multilateral Investment Guarantee Agency, and the International Centre for the Settlement of Investment Disputes. The first three of these are the most relevant to the development and implementation of health care reforms.
7 The Bank loaned $18.5 billion to more than 100 developing countries in 2003 (WDR 2004).
8 This dependency on the private sector, requiring it to maintain its “triple A” credit rating, has preserved its essential character as a bank, rather than a donor agency.
9 An organization linking over 300 civil society groups across more than 60 countries.
10 In the IMF, which describes its 184 member states as shareholders, just five countries – the US, Japan, Germany, France and the UK – hold 29% of the votes (IMF 2003).
imposing its will on developing countries without reference to the views (often involving active protests) of their populations, and failing to play a useful or progressive role in providing multilateral finance (Development GAP 1999, Tan 2006).

The Bank and IMF deploy large-scale human and financial resources. In 2001 the World Bank employed 10,587 people originating from 160 countries, made loans totalling $17.3 billion and guaranteed investments in 28 countries worth another $2 billion (Pincus and Winters 2002). By the late 1990s the Bank was spending around $100 million each year on research, commissioning work from hundreds of academics and professionals, and publishing hundreds of reports each year on a wide range of social policy issues, including health care (Caufield 1997).

In addition, to develop its policy influence and input into the reorganization of health systems around the world, the Bank has consciously fostered an image of itself as a “knowledge bank” (Pincus & Winters 2002). Notably it runs a “Flagship Program”, a project for training the top managers and civil servants running health services in developing countries and Eastern Europe on the assumptions and values the Bank wishes to promote. Trainees receive an intensive, four-week course in Washington, at the end of which participants are expected to be able to “speak a common language about dimensions of health care reform and sustainable financing options” (World Bank 2004). It is clear that in the context of the Bank’s lack of track record in promoting strong and independent critique and analysis, such programs will tend to reinforce views that cohere with the prevailing policies of the Bank itself, and thus to train and elevate policy-makers and leaders in developing countries who also share the Bank’s predominant ideological and policy preferences.

However, the Bank’s influence is far from restricted to policy and ideology. These have been reinforced by the discretion to grant or withhold loans to enable LICs to implement health programs. Though its first lending for health services was not until 1980, the expansion of the Bank’s role in this area was rapid. By the end of that decade it was the largest funder of health sector activities, having overtaken the WHO, and lending an average of $1.5 billion per annum in the early 1990s (Walt 1994).11

The Bank adopts a health policy

In 1985 the Bank published a major document, “Paying for health services in developing countries: an overview”. This argued the case for user fees for health care (de Ferranti 1985). This was followed by a more developed neo-liberal policy in an official Bank document, “Financing health care: an agenda for reform”, which combined arguments for user fees with a concerted argument for a reduced role for the state and increased reliance on market mechanisms and the private sector (World Bank 1987).

Perhaps the most influential policy document shaping health policy for developing countries in the 1990s was the Bank’s 1993 World Development Report (WDR). This effectively proposed the consolidation of a two-tier global health system, in which the wealthy countries would remain free to spend as much as they wish, but publicly funded hospital care in developing countries would be reduced to a rudimentary minimum, or privatized. The same report itemizes and estimates the costs of a “minimum package” of public health and essential clinical services (discussed in greater detail below), designed for the poorest developing countries.

The estimated cost of this minimal – largely educational rather than health care – package was put at $12 per head of population per annum in 1990 prices for the low-income countries. However, the Bank was concerned to restrict the range of health care services provided, again stipulating a “minimum package of clinical services”. It warned that government-run health systems in many developing countries are overextended and need to be scaled back.” (1993:108).

Despite increasingly critical reports on the failure of the 1993 policies to deliver even the “essential package” (Colgan 2002) and mounting evidence of the

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11 Since 1990 the Bank has lent over $34 billion for health and social services and in the six years since 2000, annual Bank lending for health related projects has ranged from $1.5 to $3.4 billion, averaging $2.5 billion – 13% of Bank lending (World Bank Annual Report 2005).
negative impact on equity and access flowing from the imposition of user fees (Creese 1997, England et al. 2001, Nanda 2002), the World Bank continued to press low- and middle-income countries in this same direction throughout the 1990s.12

By 1999, however, amid growing signs of system failure in key areas, the Bank’s annual report argued that its task was to work with countries “to help protect public expenditures in crucial areas in the social sectors; protect access to basic social services especially for the poor, improve social insurance …” (cited in Petchesky 2003: 145). In 2000 a group of US NGOs managed to press Congress to threaten a withdrawal of US funding if either the IMF or World Bank continued to make user fees for health or for education a condition of loans to developing countries (Weisbrot 2001). While this was not fully or immediately acted upon,13 it has secured a shift from a full-scale policy of proposing user fees towards attention on exemption schemes. One result of this was the declaration in the 2004 WDR that the Bank now has “no blanket policy” on user fees (Hutton 2004) while a recent letter from Paul Wolfowitz to 60 NGOs agrees that user fees may pose a barrier to poor people seeking essential services and stresses the readiness of the Bank to help find alternative financing to compensate for lost revenue if fees are abolished (Wolfowitz 2007); another has been the recognition in WDR 2004 of the gains that have been made by health systems that do not apply fees, such as Cuba’s.

The year 2000 also saw the Bank launch a new policy of Poverty Reduction Strategy Papers (PRSPs), which are planning frameworks for the lowest-income countries to replace the Structural Adjustment Programs (SAPs), the bulk of which had had a negative impact on health. A 2001 review of 76 articles studying the effects of structural adjustment programs on health found 45 per cent drew negative conclusions and 20 per cent neutral while just 8 per cent recorded positive results and 27 per cent were ambiguous (Breman and Shelton 2001).

The WDR 2001 Attacking Poverty admitted openly that “markets do not work well for poor people” and praised countries such as Costa Rica, Mauritius and Morocco that had spent less on debt servicing and more on health, education and infrastructure. It singled out the health gains made in an earlier period by different policies in the Indian state of Kerala (cited in Petchesky 2003: 147–9).

It is also important to recognize that the role the Bank sees for the public sector is to fill the voids left by a private sector rather than ensuring universal, publicly funded and provided health care freely available and virtually free of charge to all.

Since 1999 the World Bank has been fully involved in PRSPs. By 2003, 32 countries had produced full PRSPs, which are often prepared with the active involvement and assistants of consultants from the Bank or IMF. A 2004 WHO survey of 21 PRSPs found that 18 argued explicitly that improving health assists with economic growth. All of them featured health in their strategies and all provided some national health data. Fifteen discussed financial barriers, such as user fees which prevent the poorest from accessing health care, but most assume that some form of exemption system is the solution. Few discussed the barriers obstructing poor women from accessing reproductive health care (Dodd et al. 2004). There is also less reference to government spending cuts and privatization that were more central to earlier structural adjustment conditionalities. However, conditionalities and the drive to privatization are still very much alive in the Bank/IMF negotiations over the cancellation of debts for 23 Heavily Indebted Poor Countries (HIPC), which should see their debt service payments reduce by an average of 1.9 per cent of GDP (Gupta et al. 2001).

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12 As Weisbrot (2001:6 and 2006) points out, the key economic policies imposed on the same countries by the World Bank/IMF under the rubric of structural adjustment have also proved to be an unquestionable failure: growth in GDP per capita in Latin America has been about 7% in the last two decades of neo-liberal policies, whereas the 20-year period 1960–80 saw growth of 75%: in Africa income per head has fallen by 15% since 1980, compared with 34% growth 1960–80. A background paper assessing the evidence on the impact of these policies on health outcomes, prepared for the Commission on Macroeconomics and Health, found mixed results, although a preponderance of empirical studies were negative, and almost singularly so for Africa (Breman and Shelton, 2001). Breman, A., Shelton, C. 2001. Structural Adjustment and Health: A literature review of the debate, its role-players and presented empirical evidence. Paper No. WG66. Cambridge, MA: Commission on Macroeconomics and Health, June; http://www.cmhealth.org/docs/wg66_paper6.pdf (accessed May 27, 2003).

13 According to Stiglitz (2002:52) the President signed the law requiring the US to oppose proposals for user fees “but the US executive director [at the IMF] simply ignored the law and the secrecy of the institutions [IMF and World Bank] made it difficult for Congress – or anyone else – to see what was going on.”
Significantly HIPC countries are required to make improvements in immunization and health care delivery, including steps to slow the spread of AIDS, before they receive the promised financial reward. Many are kept waiting. In the case of Malawi, the process dragged on for years from 2000, with the IMF accusing the government of “overspending” – despite the fact that it was attempting to compensate for the loss of donor support. Malawi also fell victim to limits on the proportion of public spending that could be used to pay public employees (Fontana 2005). Recently the British government, which provided the Bank with £1.3 billion in 2005, has been critical on the strategies outlined by the Bank’s then president, Paul Wolfowitz, threatening to withhold its promised payments unless the Bank drops its requirement that poor countries liberalize their economies and privatize public sector enterprises (Elliot 2006).

These signs of division over Bank policy come at a time when the authority and the economic power of the IMF are also under threat. The IMF’s long-awaited promise of reforms to the voting strengths of different countries may be attributable to an eagerness by the US to divert attention and discussion away from possibly more serious economic questions. These could include the massive expansion in the US current account deficit, standing at $900 billion or 6.5 per cent of US GDP, while the Chinese economy is just one of a number in Asia that have accumulated huge surpluses. China’s is likely to reach 10 per cent of GDP in 2007 (Guha 2006). In any event the IMF itself is facing a mounting financial crisis as a growing number of countries pay off their outstanding loans with many of them vowing never again to borrow from the IMF, with its punitive strings attached to loans.14 The Fund’s level of lending has fallen to the lowest level for 25 years and within the next three years the level of income from repayments will fall below the Fund’s rising annual expenditure (Wolf 2006).

With most emerging market economies running surpluses, the first low-income countries released from long-standing debts, and new potential lenders emerging on the world market, the power of the IMF to dictate policies has been drastically reduced.15

Other organizations offering the same menu of market reform

The World Bank’s favoured package of market-style health system reforms is echoed by the regional banks like the Asian Development Bank (ADB) and the Inter-American Development Bank (IADB). The IDB has specifically endorsed a principle of fee-for-service payment for health care funded through its loans (IADB 1994), while the ADB has stressed its commitment to expanding the private sector (ADB 1995).

In the European Union, despite the very different circumstances and the near universal prevalence of welfare states, social insurance and tax-funded health care, the European Central Bank, charged with the stability of the Euro, has gone on record advocating a cap on health care spending. It has also called for greater use of private finance, coupled with the use of “market forces” to move towards “efficient solutions”, and the restriction of public health care to “core services” for health care and prevention, leaving individuals to provide for “non-essential health expenditure”. The European Central Bank has also proposed greater private involvement in the funding of health care and the introduction of co-payments (2003).

Another very significant global force in market-oriented economic reform has been the US Agency for International Development (USAID), with a budget of almost $1.5 billion for health development projects

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14 For example, Thailand’s then Prime Minister Thaksin Shinawatra, repaying the final instalment of a $17.2 billion IMF loan two years early in 2003 declared in a live TV broadcast that Thailand would “never again fall prey to world capitalism” (Giles et al 2006).

15 Brazil in December 2005 paid off its entire $15.6 billion debt to the IMF: Bolivia too has let its agreements with the IMF expire. Venezuela, riding high on oil revenues, has $30 billion of reserves from which it is able to offer loans and support to other Latin American countries, and China has massive reserves that could be offered to developing countries at low interest and without the strings of IMF deals (Weisbrot 2006).
in 2003 (Michaud 2003). Since its establishment as a subdivision of the State Department in 1961 – in the midst of the Cold War – USAID has been explicitly tied to the US administration of the day, and to its foreign policy objectives. Its most recent Strategy Document (2004-2009) proclaims as a core principle USAID’s “Loyalty: Commitment to the United States and the American people”. The organization and the work it sponsors are not primarily concerned with health, but in all its policies USAID demonstrates a consistent bias towards privatization, economic liberalization, private sector involvement and socially conservative policies (Ollila 2005, USAID 2003, 2006). In the Philippines a June 2005 USAID document proclaims that “USAID is developing the private sector as an alternative source of health services.”

USAID funding has underwritten projects and services, but also research and consultancy work in many developing countries, much of it carried out via such organizations as the Data for Decision Making project, the Health Financing and Sustainability (HFS) project, Partnerships for Health Reform (PHR and more recently PHRplus), and Management Solutions for Health (MSH). Many of these consultancies are undertaken by private, for-profit firms which advise on health system reforms compatible with the US system and interests (see Box below). On a worldwide scale consultancy firms such as McKinsey’s also promote the drive towards more private sector and market-style policies, as indeed do the large-scale corporations involved in health care – the drug companies, US and other insurers and private hospital chains and corporations such as South Africa’s Netcare.

The British equivalent to USAID is the Department for International Development (DFID), which also has a network of academics drawn towards its considerable budget for commissioning research and sponsoring consultancy and projects. DFID has been one of the international organizations accused of attaching conditionality to loans and assistance to developing countries, and which for many years evaded taking a clear policy line on user fees (Hutton 2004). Even now the doubt persists. In 2005 the British government issued a policy paper which focused on “partnership” with governments in developing countries rather than conditionality. It pointed in particular to the pressures that had been put on developing countries to adopt policies of privatization, often with embarrassing results for all involved with the policy (DFID 2005:6).

The new “tenets for the Ministry of Health”, published on the Internet, introduced co-payments with few exemptions, competition, provider autonomy, “patient choice” and the use of public funds to commission private sector organizations. The meetings to discuss the policy were reportedly attended by just 150 people in total (Abt 2003a). So whether the proposals reflect any of the aspirations of Iraqi people is as yet unknown.

16 A major USAID policy document in 2002 is boldly titled “Foreign Aid in the National Interest”.
17 Interestingly DFID itself was challenged in 2004 by members of Parliament over its “privatisation” of its own research and consultancy work, handing over contracts for the conduct of projects worth a total of almost £38m to the free market neo-liberals of the Adam Smith Institute.

Consultants at work

Much of the research and consultancy work procured by USAID is carried out by Abt Associates Inc., one of the largest for-profit consultancies in the US, based in Cambridge Massachusetts. Abt received a $42 million contract from USAID to supervise the reconstruction of health care services in Iraq from 2003-4. However, this involves the imposition of a new system and structure much more akin to that of the US.

During that process Abt convened meetings to agree on a policy document “Iraq Healthy and Free” which focused on breaking from Iraq’s pre-invasion model of centralized, state-funded service that (prior to the prolonged UN sanctions) had once been one of the best health systems in the Middle East (UNICEF 2007).

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The new UK government policy also discusses measures to ensure money is spent in ways which do not jeopardise human rights, and which strengthen financial management and combat corruption. While the underlying intentions may be laudable, here too it seems that the conditionality of previous negotiations is simply translated into the less confrontational language of “partnership”. A critique of the new policy commissioned by DFID from consultants Mokoro Ltd. found that neither the new conditions for accessing aid nor the milestones countries are expected to reach were clearly enough defined. It also raised real doubts over the procedure where countries are deemed by a lender to have fallen short of a “partnership deal” midway through a project (Mokoro 2005).

OECD researchers advise member states: Don’t try this at home

Policies for health systems for the world’s poorest countries are debated in multinational institutions, NGOs and aid agencies elsewhere.

But policies for the 30 wealthiest countries are debated and promoted through the Organisation of Economic Co-operation and Development. Interestingly OECD researchers have become more critical of market-style reforms in the last few years, and this has allowed an examination of the weaknesses of many of the favoured lines of reform.

In 2004, after its Health Project had run for four years, the OECD produced its most comprehensive report to date on health. The findings were published in May 2004 at a first-ever meeting of OECD Health Ministers, in the report ambitiously titled Towards High-Performing Health Systems (THPHS).

The report does not address whether markets are an appropriate mechanism to govern the allocation of health care resources, or capable of securing equity in access to health care for the most deprived, vulnerable and socially excluded. Nor does it consider the possibility that governments could raise additional resources through progressive taxation to meet financing challenges.

While the report notes the isolated examples of Ireland and Australia, in which there have been big expansions of private health insurance, it does not explore or criticize the substantial tax subsidies which have driven this process in Ireland. Nor does it criticize the even larger (£1 billion a year) government tax subsidies and penalties which drove better-paid workers in Australia towards the private sector. The new Australian system has also brought very substantial increased costs, and undermined the viability of public sector hospitals (Hall and Maynard 2005, Zinn 2003, Birrel et al. 2003). However, OECD researchers did note that insurance companies in Australia made more profits by attracting low-risk individuals to cheaper, less comprehensive policies. This makes good market sense for insurance company shareholders, but does little for equitable or universal health coverage.

The OECD study also discusses user fees. But it does not properly explore the weight of evidence that shows how charges serve to deter the low paid from proper access to treatment while raising insignificant sums of additional funding. Nevertheless, a box on Korea concedes that the hefty co-payments there, which mean out-of-pocket payments account for 40 per cent of health spending, have done nothing to curb runaway growth in health spending – led, as in so many instances, by private sector providers.

The final chapter in THPHS looks at increasing “value for money in health systems”. The report dismisses many of the stock neo-liberal policies. Cost sharing, the purchaser-provider split, decentralization, payment by results (activity based systems of payment), and competition between providers are all found wanting. Contracting out (privatization) of support services is given only the most fleeting and uncritical attention, ignoring considerations of quality.

The section on private insurance and efficiency underlines that, although in theory private insurance schemes could employ market power to secure cost-effective health care delivery, in practice most of the evidence, especially from the US, suggests they do not, and can not be relied upon to do so.

In summary, the OECD researchers provide a thoughtful, restrained approach to assessing health system reform. Their findings question the model of care that OECD-trained economists have been recommending for several decades to the low- and middle-income countries.

But while OECD member states may be in a position to politely refuse the invitation to embrace market-style reforms, no such freedom exists for many of the poorest countries that depend on external donors for a large portion of their health care budgets and economic survival.
The attitude of the UK and US to aid and development are strikingly similar in their eagerness to use economic levers to achieve policy change, and also very different from equivalent programs from other countries. For example, Australia made only the most fleeting reference to the possible use of private providers in its 1998 document on health aid (Dowser 1998) and continues to place little emphasis on this aspect of health reform (Barraclough 2005, AusAID 2006). Denmark’s government’s aid agency, Danida, in an extensive policy document, accepts the need to encourage human rights but makes no suggestion of conditionality or other political preconditions for the aid program (Danida 2003). Danida has also explicitly criticized the impact of user fees (Danida 2005: 27). A 2005 strategy paper on the fight against HIV/AIDS discusses in detail Denmark’s eagerness to influence final outcomes, but never goes further than “co-funding important programmes and participating actively in government-donor fora” (Tomaes 2005: 6). The programs for young people significantly make no reference to religious calls for sexual “abstinence” and the Danish definition of the private sector is an extended one that includes trade unions.

Germany’s equivalent organization, the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ GmbH – German Agency for Technical Cooperation), also follows a markedly different agenda from USAID. In December 2005 it jointly organized a major international conference in Berlin with the International Labour Organization (ILO) and the WHO around the theme of social health insurance in developing countries. A central focus of the conference was on establishing universal coverage and solidarity-based financing schemes, and an accompanying critique of the “considerable and negative impacts” of policies based on the Washington Consensus. The GTZ guidelines submitted to the conference stress the principles of “universality, solidarity, social responsibility, subsidiarity, independent administration and pluralism, negotiation and consensus-building” (Schwefel et al. 2005: 6).

The policy-making élite

Many of the most influential academics in the sphere of health policy and health economics are attached to universities and institutes in the richest G7 countries, especially the US and the UK. They constitute the core of a small and “tightly integrated network of policy-makers, technical advisors and scholars” who have largely shaped and driven the policy reforms promoted by global bodies (Lee and Goodman 2002). Lee and Goodman argue that a small policy élite, an “epistemic community”, has effectively been imposing its view with the backing of the ideological – but also considerable financial and economic – weight of the World Bank, the International Monetary Fund and the WHO:

“Analysis of policy changes over time suggests that the process of policy initiation and formulation has been largely top-down, developed and supported through the Washington and London hubs (Lee and Goodman 2002: 116).”

This analysis follows the established critique of Walt (1994) which charts the rising influence of the World Bank on health issues since the early 1980s, enhanced by the powers of patronage flowing from its generous research budget.

In Britain a network collaborating with the WHO emerged around the London School of Economics and the London School of Hygiene and Tropical Medicine. In the US the lead was taken by USAID, which brought in consultants John Snow Inc, and Abt Associates. By the mid 1990s the World Bank had moved to centre stage, promoting the importance of health economics, and effectively eclipsing the WHO which employed just one health economist.

Stone (2001: 352) also refers to epistemic communities, and notes the role of a transnational network of “élite, technical and scientific cliques” that have been able to effect change in policy and policy agendas and become “entrenched in bodies such as the IMF, WTO, OECD and World Bank”. The influence can also work in other ways. Many of the main architects of the WHO’s controversial WHR 2000 were former or current employees of the Bank, some also involved in drawing up the Bank’s 1993 Investing in Health WDR. Indeed, in addition to Bank employees, among those drafting WHR 2000 only two were from health ministries of member states, but others came from
health insurance companies, universities, the OECD and private health organizations (Ollila and Koivusalo 2002).

The Bank has successfully networked on a global level to establish “a consensus across different institutions and national settings defining the ‘problem’ of health care financing reform and potential solutions” (Lee and Goodman 2002: 116): but the “consensus” often reaches no further than the elite community of policy-shapers themselves. Even PAHO has voiced criticisms of the narrow circle that has had any voice in health policy:

“It is simply unacceptable for health policy to be researched and conducted in small, closed circles of consultants and policy-makers…It is in the very definition of good governance that people have a right to a meaningful say in the decisions that govern their lives” (PAHO et al. 2001, Foreword).

It would be a mistake to see all such problems as simply flowing from the World Bank/IMF. Market-style policies and ideological pressures flow also from adaptation to the global market itself and the prevailing ideas and policy frameworks elsewhere in the market system. Seeking to re-enter the global market system, the Chinese government opted to implement policies including privatization of health care and user fees, without facing any explicit pressure from the Bank or IMF. The same is also true of South Africa. Other governments (such as Sri Lanka, Ghana, Thailand, Costa Rica) have withstood pressures and retained more progressive and equitable policies, delivering improved health outcomes for their population. Globalization provides a context, but there is still a political choice in response.
Section 3. Global pressures for “reform”: the market prescriptions examined

Despite occasional ambiguities (Deacon 2001), the fixed menu of policies and health sector reforms proposed by the World Bank and the associated epistemic community overlaps strongly in many areas with neo-liberal economic policies.

It is much easier to trace the connections between these policies and the ideology of the free market than it is to show evidence that the policies are in any way a rational response to the actual situation and pressures facing health systems. As Armada and Muntaner (2004) conclude from their literature review, such policies have mostly originated as theoretical proposals lacking any serious evidence of their effectiveness. In many cases evaluative studies years later (examples of which are cited below) have confirmed the fears of critics that the policies have produced very different, sometimes quite opposite, results from those intended.

If space is to be opened for the implementation of progressive and soundly based reforms, it is necessary first to dispel illusions in the menu of measures already established as the “norm”. In this section these main policy proposals are examined and some general conclusions drawn. We then move to a final section that assesses the impacts of the reform process on health and health systems, case studies from various parts of the world, and an analysis of the strengths, weaknesses, opportunities and threats facing policy makers and governments in the ongoing processes of health system reform.

1. A minimum package of care

The World Bank’s Investing in Health in 1993 estimated that delivery of an “essential clinical package” would cost an average of about $8 per person each year in low-income countries, and $15 in middle-income countries such as those in Latin America, rising to $12 and $22 per capita respectively when selected public health interventions were added (1993:116 – see table below). This was then (and in many cases still)\(^\text{18}\) well above the levels of spending in many low-income countries.

\(^{18}\) The latest WHO estimate is that a minimum spend of $34 per person per year is required (Spinaci et al 2006, Emmett 2006, Ooms 2006) – well above the levels that can be afforded by the low-income countries.
But there was another warning:

“The case for government financing of discretionary clinical health care – services outside the essential package – is far less compelling. In fact, governments can promote both efficiency and equity by reducing – or when possible eliminating – public funding for these services.” (1993:119).

The equity of such a system is limited, since the wealthy few will continue to gain access to services not available to the vast majority. The imposition of user fees, as advocated by the Bank – i.e., with few if any exemptions – could also lead in the opposite direction, even if services were subsidized to make them more affordable to the poorest:

“If the wealthy are willing to pay but the poor are not, then this policy could lead to a reallocation of public subsidies from the poor to the wealthy” (Gertler and Hammer 1997:21).

The ability of governments to go it alone, work outside the framework of the Bank’s 1993 policy and compensate for the chronic and inevitable failure of the market are limited by their extreme and continuing lack of resources. Even raising the level of health provision to supply the World Bank’s essential “minimum package” was estimated to require a quadrupling of poorer countries’ spending on public health from $5 billion to $20 billion a year in 1993 prices, requiring

### Table 1: Estimated costs and health benefits of the minimum package of public health and essential clinical services in low and middle-income countries (1990).

<table>
<thead>
<tr>
<th>Group</th>
<th>Cost (dollars per capita per year)</th>
<th>Cost as a percentage of income per capita</th>
<th>Approximate reduction in burden of disease (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low-income countries (income per capita = $350)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Health</td>
<td>4.2</td>
<td>1.2</td>
<td>8</td>
</tr>
<tr>
<td>Essential clinical services</td>
<td>7.8</td>
<td>2.2</td>
<td>24</td>
</tr>
<tr>
<td>Total</td>
<td>12.0</td>
<td>3.4</td>
<td>32</td>
</tr>
<tr>
<td>Middle-income countries (Income per capita = $2,500)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Health</td>
<td>6.8</td>
<td>0.3</td>
<td>4</td>
</tr>
<tr>
<td>Essential clinical services*</td>
<td>14.7</td>
<td>0.6</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>21.5</td>
<td>0.9</td>
<td>15</td>
</tr>
</tbody>
</table>

* The estimated costs and benefits are for a minimum essential package of clinical services, as defined in the text. Many countries may wish, if they have the resources, to define their essential clinical package more broadly.

Source: World Bank calculations. Table reproduced from World Bank 1993:10
some unspecified “combination of increased expenditures by governments, donor agencies and patients and some reorientation of current public spending for health” (World Bank 1993:11).

For slightly wealthier countries – those “with the financial resources and political will to go beyond the minimum package” – the Bank proposed more scope to offer additional interventions, such as treating diabetes, medical treatment for mental illness, screening and treatment for breast and cervical cancer and “inexpensive management of angina and heart attacks”. Other possible additional treatments could include hernia repair, treatment of meningitis in children and cataract operations.

The World Bank conception of a minimum or essential package, set out in this 1993 policy statement, achieved an extremely wide currency. Indeed what began as a “minimum” provision became increasingly perceived as a target, effectively a “maximum” for organizations such as the WHO, in a context in which

**Colombia: the limitations of the reform package**

Held up as a shining example of health reforms by the WHO in its WHR 2000, Colombia was the Latin American country which followed the Bank’s 1993 policy most closely (Homedes and Ugalde 2005b).

The scheme that has since evolved entails the government paying insurance companies to provide a “managed care” system for the poor, while those in formal employment pay into a contributory system. This has required a substantial increase in government spending on health. But the private health insurance companies that administer the basic benefit package now warn it faces a crisis and public hospitals and clinics are running out of money. The government lacks the funds to achieve its target of enrolling another 7 million members to the subsidized health system POSS, (Plan Obligatorio de Salud Subsidiado) which would create universal health care coverage. The spending gap seems to be upwards of $600 million. (Global Insight 2006b).

“Universal” coverage is not quite as universal as might appear. Some research shows that by 1999 the new system covered just 66 per cent of the population compared with 75 per cent who had access to some form of health services before the reforms. However, it still leaves more than 40 per cent of the poorest population uninsured, and that the largest proportion of the uninsured is in the lowest income groups. By contrast the richest 20 per cent of the population has actually seen its contribution to health spending reduced by 40 per cent (Homedes and Ugalde 2005b). Immunization rates against both TB and polio actually declined in Colombia between 1993 and 1998.

With the entitlements from the subsidized health insurance package fixed at just one-fifth the value of those of formal sector workers affiliated to the full package (an estimated value of $20 compared with $100 per year) substantial co-payments can also deter and exclude the poor (Flores 2006).

The insurers (Health Promotion Enterprises, EPSs) have found ways to evade their theoretical obligation to cover the indigent and poor. A 2002 survey of specialist doctors showed 62 per cent considered the quality of care had worsened and two-thirds believed that health promotion and immunization services had not improved or had declined (Homedes and Ugalde 2005b).

Blas (2004) found that the separation of purchaser from provider and the referral of the same patient to more than one provider could lead to delays in diagnosis and treatment, and impede proper follow-up. Information systems were driven by billing, and each patient-provider encounter often resulted in more than one transaction – inflating overhead costs and bureaucracy.

The combination of this inefficient system with even the limited expansion of coverage to the poor has resulted in a dramatic increase in Colombia’s health care spending to 10.5 per cent of GDP, questioning its sustainability (Flores 2006). By contrast publicly provided, universal services are delivered on a more equitable basis in Sri Lanka for less than 2 per cent of GDP (Rannan-Eliya and Somanthan 2005).
many of the poorest countries were spending substantially less than the $12 per head per year (Laurell and Arellano 1996). With the additional impetus of the transfer of several leading World Bank health economists to the WHO, the same Bank policy helped shape WHO and other policies for the remainder of the 1990s, and remains as a factor into the 21st century (Pearson 2000, Navarro 2000).

While some would argue that the Bank has become more sophisticated and changed some of its policy prescriptions since 1993, the WDR framework for policies in the lowest income countries based on a “minimum package” has persisted An example is in the form of the limited health aspirations of the Millennium Development Goals (MDGs), and also in the narrow focus of vertical programs funded by the Bill and Melinda Gates Foundation, PEPFAR and other donor funds, which do nothing to address the wider and ongoing health needs of the populations of LICs.

The scale of the failure to trigger the required increases in spending on health care in the lowest-income countries to finance even these minimum packages is underlined by the enormous (up to $66 billion) gap in resources that stands in the way of achieving the similarly essential health package embedded in the MDGs. Some countries have worked to introduce social health insurance schemes in which the subsidized enrolment of the poor comes with a reduced entitlement to a “minimum package” of care – as in Colombia (where it is equivalent to just 20 per cent of the value of the full insurance package) and Mexico (Flores 2006).

2. Imposition of user fees

Despite an apparent rethink following the vote by the US Congress to oppose the imposition of user fees on health in both IMF and World Bank, and evidence that they not only deter the poorest, but also discriminate most heavily against women (Nanda 2002), this policy appears to be one of the most deeply ingrained in the thinking of those responsible for policy in developing countries. A recent survey of 30 African countries found 27 still imposing fees (Oxfam 2006). The Bank’s 2004 WDR actually argues that “paying for services confers power”, claiming that “modest co-payments can also provide an entry ticket to clinical services for poor people by reducing capture of supposedly free services by richer groups” (WDR 2004: 143). 19

This claim assumes – without evidence – both that the poor can afford and will pay a “modest co-payment”, and that the rich will not, even though they are better able to afford it. It does not explain what “power” is derived from paying for treatment rather than being entitled to receive it as of right. Any illusions that patients might be “empowered” by fees should be dispelled by the revelations in recent reports of patients being forcibly detained in Burundi for weeks or months for failure to pay hospital bills, following the introduction of a “cost recovery” system in 2002 to make the system more “financially efficient” (Human Rights Watch 2006). Similar confrontations are also reported in Ghana, where newborn babies have been held in hospital in a bid to force mothers to pay maternity bills (Amanfo 2006, UN Office 2005).

The argument that user fees can be used to create free or freer access to the poor does not correspond to the experience of countries implementing fees, especially in sub-Saharan Africa. Although they deter poor people from accessing care and cause real problems to those struggling to pay, the fees do not bring in significant income. Health care cost recovery experiences in African countries show that average fees yield only around 5 per cent of operating costs, meaning that the net yields are lower – or even negative – when collection costs are factored in. For example, a Harvard University study in Tanzania found that the administration of the user fee program cost more than the user fees brought in (Kessler 2003). Similar experiences apply elsewhere. In Honduras, despite minimal exemptions, the fees raised less than 2 per cent of the Ministry of Health’s income, but two-thirds of the funds collected were used to administer the fee system itself (cited in Flores 2006).

19 A 2001 DFID manual, discussing the objectives of introducing user fees does not even mention the most common motivation and impact of the policy – effecting an immediate reduction in demand – but suggests euphemistically that it “encourages more efficient use of resources” and “creates greater accountability to the consumer” It goes on to claim that the “almost universally negative” effects of fees on the poor are almost always due to a technical glitch – “the result of poor design, planning and implementation” (Bennett & Gilson 2001:1, 11).
User fees imposed largely through Bank pressure in the 1990s mostly remain in place, although there have been some “astounding” successes where they have subsequently been abolished – notably in Uganda (Hutton 2004). Another 2004 study of 24 priority countries supported by DFID revealed that 20 of them had user fees at primary care level, and two-thirds of health spending in developing countries comes from out-of-pocket payments rather than from governments. (Save the Children 2005). The fact that both Save the Children and Oxfam have felt the need to publish recent new research arguing the case against them also underlines the fact that user fees remain a pervasive and enduring feature of health systems in many developing countries, and in newly independent states of the former Soviet Union (Emmett 2006).

In promoting the policy the Bank has argued that imposing a price on certain forms of care brings a series of benefits because charges:

- Deter unnecessary or frivolous use of services
- Encourage appropriate use of first contact and referral services
- Encourage the use of important services by exempting them from charges
- Encourage providers to limit over-supply
- Act as an incentive for providers to improve quality
- Contribute to resources for spending on health care.

(Schieber 1997, Wang’ombe 1997)

Schieber (1997) further suggests that cost sharing is a means to combat “moral hazard”, while Wang’ombe optimistically suggests that the “right” people are deterred and that “frivolous demand” is affected (Wang’ombe 1997:151). However, there is little evidence of frivolous demand in developing countries or in other contexts (Deber 2000). And reducing demand does nothing to reduce the need for health care. Those most likely to be deterred from accessing health care are the poorest – and especially women. In fact this effect is the most consistent and predictable result from any cost-recovery program (Creese and Kutzin 1995).

The Bank played a crucial role in generalizing the imposition of user fees. By 1998 about 40 per cent of the Bank’s Health Nutrition and Population projects – and almost 75 per cent of those projects in Sub-Saharan Africa – included the introduction or increased use of user fees (Dunne 2000).

The minimal health system available to the poor in Peru offers drugs and medical inputs that are charged to the user at full cost plus a mark-up, yet fewer than one in five of the poor is exempt from payments (Collar 2000). The validity of claims that user fees can actually lead to an increase in utilization if they are accompanied by an improvement in the quality of services and availability of drugs has been questioned by research from Nigeria which suggests that poor users who are deterred or excluded by the fees are replaced by wealthier sections of the population who can afford to pay – a backward step for equity (Blas 2004:19).

All of the empirical evidence appears to confirm the initial assumption that the imposition of charges will reduce the utilization of services. The scale of the reductions observed ranges from 52 per cent in Kenya (Mwabu et al. 1995) to 64 per cent in Zambia (Kaheny and Lake 1994). Other countries where the same effect has been observed include Ghana, and the former Zaire (Shaw 1995). High levels of user fees “which exclude the poor” have been seen by donor groups as a problem in Mozambique (Brown 2000a) and Uganda (Brown 2000b). The UN Research Institute for Social Development (UNRISD) has concluded that: “Of all measures proposed for raising revenue for local people, this [user fees] is probably the most ill advised. One study of 39 developing countries found that the introduction of user fees had increased revenues only slightly, while significantly reducing the access of low-income people to basic social services” (Unrisd 2000, cited in Whitehead et al. 2001).

A variant model of user fees has been the Bamako Initiative (BI), largely restricted to countries of Francophone West Africa, in which the fees go into community-owned “revolving funds”, to be spent and controlled locally. This model is still running in Benin,

The Bank itself has in recent years backed away from its more overt promotion of the policy, to take refuge in the formula that there should be “no blanket policy on user fees” (World Bank WDR 2004). However, this policy has left fees firmly in place in most countries where they have been imposed.

User fees have little or nothing to do with equity: even supporters of the policy admit that of the 31 African countries that had been persuaded to implement user fees, only four had claimed that either “efficiency” or “equity” was an objective (Leighton and Wouters 1995).

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Mali and Guinea. And the World Bank (WDR 2004: 76-77) claims that it has contributed to improved health outcomes, dramatic improvements in immunization rates, a narrowing of the gap between rich and poor, and a tenfold increase in use of health services by children. However, on closer examination it becomes clear that immunization is provided free of charge and the user fees have been held down below the price of alternative traditional healers. However, even at this level they are still seen as a barrier and, despite attempts to allow for exemptions, few were permitted and “a large proportion of the poor still do not use key health services in all three countries”. In some instances Bamako Initiative health centres have become a service for the affluent22 (Blas 2004). After 12 years, government subsidies to the BI system in Guinea still benefit richer groups rather than the poorest, and there is still an unresolved question of how to subsidize and protect the poor.

The Bank recognizes that user fees deter the poorest from even such basic health care as immunization, but this has not prevented the policy being applied in some countries. Indeed some Bank-sponsored research in the 1990s led towards precisely such a policy (Shaw and Ainsworth 1995). By contrast a major WHO report on user fees in immunization services in 2001 concluded that it raised little money but had many disadvantages, and offered a blunt three-point summary:

- User fees discourage people from seeking vaccination
- Public funding is the most equitable way to finance essential immunization
- Essential immunization services should be free of charge.

(England et al. 2001:6)

Any immunization program the fees for which deter a section of the poor is going to be less effective – and thus less efficient – than one that erects no such barriers (Segall 2003). The exclusions always hit the weakest of the poor. Among the poorest social groups, those most likely to be excluded from treatment by user fees are women, children and the elderly. Nanda (2002) explores the additional barriers that limit women from accessing the funds to pay for care, and the additional informal and hidden costs faced by women, while also highlighting the overall lack of gender-disaggregated data on the implementation of user fees. Not only do the fees create a differential impact on utilization of health services by men compared with women, but they also affect the utilization of key services by women themselves. The fall-off in utilization of prenatal and maternal health care services is often dramatic when fees are introduced. And fees are often supplemented by informal or hidden costs that can mean that an expectant mother, for example may receive minimal if any care in childbirth even if she has paid the user fee (Nanda 2002: 131).

**Georgia**

One of the newly independent states after the break-up of the Soviet Union, Georgia has experienced the abject failure of neo-liberal reforms on both the economy and the health system. About 40 per cent of the population lives below the poverty line of just $50 per month, with state health insurance in 2001 as admitted by the health minister to be adequate for only 20 per cent or so of health needs.

Georgia’s economy was subjected to World Bank-driven shock treatment, and opened up to market forces. The socialized system of centrally funded health care was dismantled, with the health system decentralized and the closure of 60 per cent of its hospitals (most of them small) (Lister 2005).

Heavy user fees were imposed, which effectively excluded 30 per cent of the population, leaving another 20 per cent able to access only limited services. Collins (2003) reports that a staggering 96 per cent of Georgians often avoided visiting a doctor when sick, opting to self-medicate instead, despite widespread ignorance of the appropriate treatment and doses.

The impact of the market-style reforms on Georgia’s health system has delivered “no improvements in terms of the quality, efficiency and access to the system” (Collins 2003).

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22 A similar phenomenon has been reported in Peru, where user fees led to reduced use of hospital services by the lowest and also the middle-income groups, while higher income group usage increased by around 50% (cited in Flores 2006).
A recent three-year UK government-funded comprehensive and systematic survey of health systems in 16 countries of Asia concluded that the most pro-poor systems were those offering universal services that were free or almost free of charge, and mainly dependent upon public sector delivery (Rannan-Eliya and Somanathan 2005).

It is clear that, however marginal their contribution to the finances of health systems, the abolition of fees would carry significant additional costs in the short and medium term, since not only would any revenue stream be lost, but also a large body of pent-up demand potentially would be released.

Experiences from Uganda, Zambia and South Africa (see case studies below and Gilson and McIntyre 2005) show there are real dangers. If the abolition of fees is not properly prepared and resourced, and if there are not appropriate increases in staffing, equipment and other supplies, the result could be the inundation of local services. For such a change of policy to be seriously contemplated in the poorest developing countries, therefore, requires much more commitment from the Bank and other donors in terms of policy guidance and practical and material/financial support than the general statement that there is “no blanket policy” on user fees. Anything less than a positive, proactive and overt campaign by the Bank to ensure countries remove existing fees is likely to leave the present system in place.

Ooms (2006) goes further and challenges the whole “illusion” of sustainability as a criterion for planning services for the poor. He complains that the argument logically leads to rationing of care and the imposition – or continued acceptance – of user fees that discriminate against the poor. His paper shows that it is impossible for the poorest countries to sustain adequate levels of health care services from their own resources and emphasizes the need for more long-term and guaranteed assistance from the wealthiest countries. It is necessary to reject the status quo and fight for more resources, he argues.

3. Encourage health insurance

One of the reasons the World Bank and other agencies have promoted user fees has been to nurture the emergence of insurance schemes even in the poorest countries. Among the key conclusions from a major USAID-funded workshop in Zimbabwe analyzing “lessons learned” on health care funding was that “user fees are vital to the introduction of any type of insurance system” (McEuen and McGaugh 1997:11).23 The rationale for the ensuing two-tier system, in which the wealthy use one health service, and the poor get equal access to another state-funded safety-net, is that “A sensibly designed insurance system, even if targeted to the richest 10-20% of the population, will almost certainly improve equity if only by ushering the rich into a system that they, rather than the rural poor, support financially” (Griffin and Shaw, 1995). But another less equity-oriented reason is that “private health insurance is virtually the only practical instrument through which governments can get out of the expensive business of across the board subsidies for hospital care, and thus release funds for public health, preventive and primary services that benefit the poor” (Griffin and Shaw 1995). Extensive surveys by Data for Decision Making, however, found only limited evidence of success in such health insurance schemes operating in developing countries24:

“DDM research…indicated that only small percentages of the populations studied had any kind of health insurance, and that insurance schemes currently do not contribute significant resources to total health financing. Current insurance schemes also tend to cover mainly the more wealthy income groups or the formally employed, limiting the reach of such schemes into the lower income or rural populations” (McEuen 1997:16).

Moreover a crucial factor limiting the scope for any European-style insurance system are conditionalities associated with World Bank/IMF Structural Adjustment Programs, which have in almost all cases resulted

23 Mark McEuen is described as a ‘Research Analyst, Abt Associates, PHR Project’, and his 1997 report with Jhana McGaugh (Program Officer Development Associates, PHR Project) was written under the direction of Harvard University’s Peter Berman and other leading academics from the DDM and PHR projects.
24 The workshop included participation of government representatives, health staff, academics, NGOs and donor agencies from Botswana, Ghana, Malawi, Mozambique, South Africa, Zambia and Zimbabwe, with additional representatives from Ethiopia, Kenya and Uganda (McEuen 1997: xi).
Private insurance in Africa

Thirty-four of the world’s 49 least developed countries are in Africa, which faces a $19 billion gap in health financing to provide the most basic care, according to WHO estimates (Dare and Buch 2005).

Private health insurance markets in Africa include South Africa, Namibia and Zimbabwe (over 20 per cent of health spending in 2000 but covering only 6 per cent of population) but also include Botswana, Côte d’Ivoire, Kenya, Madagascar and Mali (Sekhri and Savedoff 2004).

The Kenyan insurance market was hit hard by the collapse of major insurance firms that were unable to sustain their debts (Global Insight 2006a). There are fears that the application of new GATS (General Agreement on Trade in Services) rules could encourage a greater involvement of US and other transnational Health Maintenance Organizations (HMOs) for wealthy Kenyans seeking insurance cover: GATS would allow the full repatriation of any profits from such schemes, effectively siphoning resources out of Kenyan health care (Wemos 2003).

Social insurance versus user fees

African governments launching social health insurance schemes include Nigeria, Kenya and Ghana. Nigeria is at an early stage, while Ghana is facing very slow take-up, probably as a result of the relatively high contribution which deters the low-paid (Global Insight 2006a).

The scheme to cover the poor, elderly and children with both parents subscribing, was introduced in 2003, and premiums come out at $17 for a family of five with two parents (Sulzbach et al. 2005). But the scheme only reimburses care in the lower-cost district hospitals and not the much higher costs in the capital’s big teaching hospitals. As a result there have been high profile incidents in which poor women have seen the newborn babies detained in intensive care units until outstanding bills have been paid (UN Office 2005).

“Microinsurance” brings small benefits

The Netherlands government has announced the launch of a $128 million fund to subsidize private health insurance in Africa, underwriting premiums by up to 95 per cent in Nigeria, Uganda, Namibia and Rwanda (Global Insight 2006a). “A growing phenomenon” is microinsurance, which according to Global Insight has signed up “more than 200,000 people” across 11 countries in schemes involving units of fewer than 100 members. This raises the question of to what extent this is really insurance—since the risk pool is so small—rather than simply a community savings scheme. Countries involved include Benin, Burkina Faso, Cameroon, Côte d’Ivoire, Ghana, Guinea, Mali, Nigeria, Senegal, Tanzania, Togo and Uganda (Global Insight 2006a).

The experience so far is not very positive. A supportive 1999 PHR study of three small “community-based health insurance” schemes in East Africa revealed that these were extremely small scale and precarious projects. The one in Uganda required “urgent attention” to financial viability. The Kenyan scheme had failed to make itself known to more than a handful of people and had failed to involve the local community. And the Tanzanian scheme faced a financial threat from “over-utilisation” of services by members, while some poor people were being deterred from seeking treatment by the introduction of user fees (Musau 1999).

A much more enthusiastic and superficial article in the Abt Associates newsletter in 2002 claimed that “community organizations that provide some form of health care insurance are becoming popular in Africa”, citing research from West and Central Africa indicating a growth to 827 “mutual health organizations” in 2000. However, even this picture is clouded by Abt admissions that four-fifths of MHOs for which data were available “reported significant dues arrears of varying times and amounts” (Abt 2002).
in a reduction in size of the formal employment sector and cut the incomes of the rural and urban poor along with public employees (Türshen 1999:61, Simon et al. 1995).

In the absence of any viable basis for large scale private health insurance schemes, academics working with the World Bank have been keen to promote the notion of community-based health insurance schemes which would target the poor. But in Kenya the only scheme investigated by Partnerships for Health Reform, centred on Chogoria Hospital, had managed to enlist only 1,400 persons, just 0.3 per cent of its target population, and by 1998 had only the hospital’s staff as members. Other such schemes surveyed by Musau in Uganda, Tanzania and the Democratic Republic of Congo had either targeted very small communities or failed to achieve any significant wider support (Musau 1999). A prepayment scheme in Rwanda managed to recruit just 4.6 per cent of the target population, while the user fee system reduced attendance at health centres and thus drove up their costs (Schneider et al. 2000).

There are no serious grounds to believe that such schemes in low-income countries will ever be much more than token exercises to cover over the lack of public health provision for the majority of the country’s population. By 1997 there was sufficient evidence of the failure of policies along these lines for the World Bank’s Health Nutrition and Population Sector Strategy to conclude that:

“Because of cost and the pronounced market failure that occurs in private health insurance, this is not a viable option for risk-pooling at the

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**Slovakia**

Six years after Slovakia’s health insurance system had been introduced the insurance companies were facing debts totalling over 12 per cent of their total resources. All but five of them collapsed (EHMA 2000: 57). The switch from tax funding to payroll-based insurance suffered as a result of the economic downturn in which many employers closed down without paying off contributions owing, and by a decision of the government to cut its share of contributions to just one-tenth of the amount indicated in the Act on Health Insurance (Hlavacka and Skackova 2000).

The proliferation of health insurance funds, far from improving efficiency, led to an increase in transaction costs. The aim of a shift towards primary care was not achieved. And health care providers responded to the competitive element of “patient choice” by by prescribing more and more expensive drugs in their efforts to compete for patients and their subscriptions.

Hlavacka and Skackova conclude that a “pluralist” health insurance market may be affordable in the wealthier countries with more advanced economies, but is a model requiring “a great deal of financial resources” and offering few incentives for efficient behaviour by hospitals. They also note that, workplace insurance as implemented in Slovakia with contributions proportionate to income but with a ceiling limiting the contributions of the highest earners, is a regressive method of funding health care. The new system has left health workers on very low pay while not delivering on the promised cost containment or cost-effectiveness. (op.cit 69-70).

Competition has again been introduced to Slovakia’s health insurance business, with up to 600,000 Slovaks expected to change insurers in 2006. Meanwhile, legislation enacted in June 2006 forbids insurance companies from retaining profits if any patients are still waiting for treatment, and ministers plan to limit the funds’ operating costs to a maximum of 4 per cent of the mandatory premiums they collect (Orogvanyiova 2006).

The newly elected social democrat government led by former populist Robert Fico more than doubled its vote in June’s general election as voters rejected the free market reforms of ousted Prime Minister Dzurinda (Anderson 2006). The new government has promised to abolish fees for consultations (€0.5), hospital stays (€1.20 per day) and prescriptions (€0.5), halt the privatization of hospitals and increase health workers’ pay. There are also plans to increase the payroll tax for health care from 4 to 5 per cent of the average wage. (Orogvanyiova 2006).
national level in low and middle income countries” (World Bank Group 1997:8).

Nonetheless eight years later, together with its most commercial, pro-private sector wing the International Finance Corporation (IFC), the Bank was again collaborating with leading neo-liberal academics and executives from major health insurance companies and HMOs in a Wharton Impact Conference (March 15-16, 2005). Participants were discussing the economics of voluntary health insurance at low-income levels and the implications for health financing in Africa and South Asia (Wharton School 2005).

4. **Promote contracts with the private sectors or NGOs**

Enthusiasm for a policy of promoting contracts with the private sector or NGOs in low- and middle-income countries appears to flow predominantly from the desire to transfer “reforms” from the developed to the developing countries, regardless of the managerial and other problems that inevitably arise.

Its link to globalization is that contracting out services (“steering rather than rowing”) is part of the economic and new public management philosophy dominating much global policy discourse, which aims for a minimal public sector and maximum private sector involvement. Moreover, the recipients of the contracts are likely to be multinational corporations or their subsidiaries whose interests in global services provision has underpinned, in part, the European Union’s push for further liberalization commitments by developing countries under the WTO General Agreement on Trade in Services (GATS). The liberalization has been largely a one-way process in which only the wealthy countries stand to make any serious gains. Significantly the much vaunted Doha “breakthrough” which was supposed to open up more affordable access to generic versions of high-cost drugs has just passed its fifth anniversary. Yet not a single developing country without its own pharmaceutical manufacturing capability has been able to invoke its full provisions to obtain supplies of cheaper drugs (Bridges Weekly 2006).

On a wider view, 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, and a market in which these transactions can take place (Leys 2001).

For market mechanisms to come into play, a market has to be created through the separation – where they have been linked in a common centralized system – of purchasers and providers. Once the chain of command of a centralized system has been broken in this way, a new system of contracts must be put in place to establish the responsibilities and accountability of service providers.

Contracts can in theory be used to regulate any part of the health 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. In many cases (including England) the “contracts” are better described as planning agreements, since they have not had the legal force of a normal commercial contract, and the purchasers lack any effective sanction in the case of failure, other than to seek an alternative provider (Palmer 2000).  

However the contract culture that emerged from the ‘new managerialism’ of the 1980s leaves a number of unresolved problems, notably:

> “how to be sure that when an organisation or individual is recruited to pursue the interests of the purchaser, they do not use it as an opportunity to pursue their own interests. Contracts always have ‘gaps’, performance indicators can always be manipulated or used perversely, and even worse, as ‘contract culture’ takes over from trust and good will, every one looks to exploit these opportunities more forcefully.” (Ling 2000:99).

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25 In Britain new regulations making contracts between Hospital Trusts and Primary Care Trusts legally binding began in the spring of 2004, amid warnings that the new system would “throw up even bigger risks and challenges” (Plumridge and Kemp 2004).
Neo-liberalism and New Public Management (NPM)

The policy prescriptions of neo-liberalism are the most obvious response to the pressures and challenges of globalization. But they also correspond closely to the combination of theories that have become collectively known as “new public management” (NPM), which itself draws heavily on (initially US) private sector assumptions, theories and practices (Hood 1991, Osborne and Gaebler 1992, Osborne and Plastrik 1997, Newman 2000, Preker and Harding 2003). However, as Pollitt (2000, 2003) points out, NPM remains desperately thin on evidence of its effectiveness.

Few partial attempts have been made to evaluate NPM policies and methods where they have been introduced, and these studies have been severely limited (Pollitt 2000:187). While there is little to support the assumption that NPM delivers economies or increased efficiencies in the operation of the public sector (Pollitt 2000; Manning 2000), the pro-market assumptions of the NPM approach often sit uneasily in policy documents alongside professions of concern for “equity” and maximum access to services for the poor.

For the purposes of this investigation it is useful to note that the marriage of NPM with health system reforms has brought a steadily increasing reliance upon relatively new stock panaceas such as:

- Public-private partnerships [few of which attempt any examination of the potential conflict of interest between public and private sectors – such as the vexed issue of appropriately skilled human resources].
- Contracting out and various forms of increased local autonomy (“steering, not rowing”) – often linked to various forms of privatisation.
- Competition (“managed” or otherwise) [but with little discussion of the surplus of capacity that needs to be in place to enable unfettered patient choice, or the potential cost of this much additional (under-used) capacity].
- User choice and user empowerment [concepts which could fit more appropriately into an agenda for a collaborative, cooperative system than one in which policy decisions of purchasers and providers are shaped by market pressures and competition].
- And the introduction of internal or quasi-markets [again with little debate over the potentially inflated overhead and administrative costs involved, or the resultant lost opportunity for local, regional or national government to plan the allocation of resources according to social and health needs].

(Osborne and Gaebler 1992:25.310).

The policy package is of dubious value for the wealthier countries, but can be even more wasteful and disruptive in the context of resource-poor developing countries. By 1998 one of the most eager advocates of NPM, Allen Schick, was urging low-income countries not to attempt reforms based on NPM (Schick 1998).

5. Purchasing from private providers in developing countries

The notion of “steering rather than rowing” which has become so central to market-style reforms and contracting out of non-clinical and clinical services in the high-income countries has also been promoted as part of a standard package of reforms in the middle-and low-income developing countries. Developing countries can face pressure from global bodies and from powerful donors (notably the World Bank and USAID) which are ideologically committed to privatization and the expansion of the private sector (World Bank 1987, 1993, Skaar 1998 Mudyarabikwa 2000, IFC 2002).

Among the alleged attractions of the policy in the eyes of its enthusiasts is that it facilitates “using the private sector’s greater flexibility and generally better morale” and “using competition to increase effectiveness and efficiency” (Loevinsohn and Harding 2005).

As long ago as 1996 an extensive USAID-funded literature review noted that “contracting health services to
the private sector is a policy that is frequently recommended, but evidence of its effectiveness is lacking” (Rannan Eliya et al. 1996:9). Nor have subsequent years yielded evidence that contracting-out and privatization deliver the promised results. However this lack of supporting evidence has not deterred USAID, which has recently launched new initiatives (notably Private Sector Partnerships (PSP)) aimed at expanding the level of private sector provision. The USAID/PSP website notes with approval the changes in Indonesia which it claims had:

“successfully shifted market share from predominant reliance on the public sector to reliance on the private sector. The Indonesian case study examines the policies and programs implemented to incentivize the private sector to enter the Reproductive Health/Family Planning marketplace.” (PSP 2006).

Information on the scale and character of private sector activity in health care in poorer countries is hard to find. In 1998 Hanson and Berman attempted an analysis of private health provision in developing countries, only to conclude that the “paucity of available information” made it impossible to generate meaningful findings on more than 25 to 35 countries, compared with 114 countries for which the World Bank had figures on health spending in 1993. Most of the information they collated was drawn from 1980s documents (Hanson and Berman 1998:210-11). As a consequence, in much of the literature of health system reform the definition of 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 system. Traditional healers, people selling pharmaceuticals (often illegally) and unqualified people who are paid privately in the absence of accessible health care may also be included as a part of the “private sector” by advocates of further expansion along the line of private provision rather than the development of public health services (Brugha and Zwi 2002). In general, however, relatively little “private” activity is “for profit” other than at the level of individual practitioners (Skaar 1998).26

The World Bank’s 2004 WDR highlighted the use in Cambodia of “contracts to improve health services – quickly”. However, on closer examination it becomes clear that the organizations receiving the contracts are NGOs. Indeed the source cited by the 2004 WDR makes it quite clear that the success and popularity of the contracted-out services was linked to the fact that they were non-profit organizations that did not charge user fees, and that they paid staff on a higher scale to prevent them imposing “unofficial” fees (Bhushan, Keller and Schwartz 2002). Either or both of these policies could of course be adopted by a public sector provider.

For organizations and researchers eager to demonstrate the importance of increased private sector involvement, there is an advantage in combining together all the aspects of existing health systems that can be regarded as “private”. These include the out-of-pocket fees-for-service paid by the poor in countries where primary care providers are largely private. While this clearly demonstrates the burden of unfunded health care on the poorest, it does nothing to show the superiority of such systems over public provision. Nor indeed does it answer concerns over the uneven and often questionable quality of privately provided services (Brugha and Zwi 2002). Indeed private health care can combine higher costs beyond the reach of poorer households and very low quality treatment. Even in the technologically advanced US health care system, quality is a problem. High-priced treatment runs alongside a massive toll of avoidable deaths and injuries, with official figures showing more Americans were killed by medical errors in 2000 than by car accidents or breast cancer, and almost three times as many as died of AIDS (Mills et al. 2002, Walker 2004).

Another aspect of privatization is spending on pharmaceuticals – the majority of it private and out-of-pocket – which accounts for 30 to 50 per cent of total health care spending in developing countries, compared with less than 15 per cent in developed economies (Whitehead et al. 2001). In many cases the drug vendors are unqualified and target their products at people too poor to consult health professionals.

26 One exception appears to be Tanzania where historically voluntary agencies have controlled around half of the country’s hospital beds. Munishi (1995) reports a rapid expansion of for-profit hospital care, albeit largely concentrated in the capital, where 83% of private hospitals and 57% of private hospital beds were for-profit.
The situation is different in MICs, but some of the same ambiguities remain. In a survey for the Inter-American Development Bank, Slack and Savedoff (2001) have identified five distinct types of contractual arrangement between public and private sectors in MICs of Latin America, giving varying degrees of control on the level of financial commitment. But, of their 27 case studies, more than a third involve contracts with NGOs, community groups or no-for-profit providers rather than conventional for-profit private companies.

Importantly with respect to health systems’ role in contributing to policies and programs influencing the social determinants of health, McPake and Mills (2000:813) find that private-for-profit providers seldom offer services “of a public health nature”, even immunization. Instead they “over-prescribe in general” and tend to use excessive, unnecessary technology. Again the US Comptroller General’s report from 2004 underlines the fact that this problem is endemic in all private sector provision. In the US the system means that Medicare beneficiaries are less likely to receive recommended treatments and procedures for such conditions as heart disease, diabetes, breast cancer and stroke, while those with insurance were likely to receive unnecessary treatment involving surgical intervention or excessive use of antibiotics (Walker 2004:43).

There is a considerable body of evidence from developed economies and from Thailand (Brugha and Zwi 2002) that purchasing care from the private sector serves to increase costs and thus draw resources out of limited public sector budgets. Thus, it must be at least questionable whether such a strategy could do other than worsen the crisis in health care in developing countries (Palmer 2000:826).

6. Maximum involvement of the private sector

Both the World Bank and USAID share the goal of promoting greater collaboration with the private sector (Axelsson et al. 2003). In the case of USAID this flows from an explicit – yet evidence-free – “presumption” of “greater cost effectiveness of the private sector compared to the public sector”, and the superior “efficiency” of the for-profit private sector (Skaar 1998). Since 1997 the Bank has been calling for more nuanced “quasi-market mechanisms” that would “encourage quality participation by the private sector” (World Bank Group 1997:18), relying on governments to purchase, regulate, and in some cases subsidize, private sector services.

A Strategic Directions document drawn up in 2002 by the division of the Bank that lends at commercial rates, the International Finance Corporation (IFC), appears to revert to the original hard-line privatization stance. It notes approvingly that a majority of health expenditures in most low-income countries is private, compared with less than a third in the wealthiest countries (p8), and welcomes the opportunity for “developing clear country and regional World Bank Group strategies that successfully promote the integration of the private health sector”:

“The reliance solely on the public sector to address these major challenges appears to be no longer a viable or sustainable option in the long term because of fiscal constraints…Many governments are rethinking the respective roles of private and public agents in the health sector, and are beginning to turn to market instruments to enhance the efficiency and quality of health care provision. The aim of much of recent health care reforms in several countries has been to increase the role of the private sector as the provider (rather than the financier) of care.” (IFC 2002:3).

Peru

In 1997 Peru’s government was pressed by the IMF into imposing a decree opening up health services for private sector providers as a condition of IMF financial support. Most loans to Latin American and Caribbean countries from the World Bank and IDB favoured private financing and provision of health systems in place of public sector provision: one 1998 loan to Nicaragua involved “modernising” public hospitals by creating private wards for fee-paying patients (Armada and Muntaner 2004:31-32).

While admitting that there is no supporting evidence, the IFC strategy argues that the expansion of the private sector helps develop health services for the poor by “producing extra capacity in the sector as a whole”,...
leaving the public sector to “redirect its scarce resources to those most in need” (2002:35).

The IFC focus will be on financially viable projects, delivering a profit close to the IFC average of about 5 per cent, and therefore its strategy will be primarily centred in urban areas where (especially in poorer countries) the private market is “most mature” (2002:36). Significantly the IFC argues it wants to “contribute to the financial protection against ill health and to the strengthening of the middle class”, and evinces little interest in the health of the poorest, advocating an almost completely evidence-free and ideological formula:

“increased involvement in private health insurance, to benefit the lower-middle and middle classes in countries without universal risk-pooling and to support growing supplementary insurance in many of our client countries” (IFC 2002).

However, a rather different and more ambiguous note is struck by the Bank’s WDR 2004, which breaks completely new ground with a largely positive appraisal of the previously ignored health system in Cuba" and, in contrast with the 1997 Health, Nutrition and Population (HNP) Strategy and its emphasis on private sector solutions, declares that “There is no presumption that one type of provider – public, for-profit, or not-for-profit – is likely to be any better than any other.” (World Bank 2003b:151) The chapter on health includes a number of passages highlighting market failure and the shortcomings of private sector providers as well as criticizing examples of poor public provision. Another section offers a far less assertive defence of the imposition of user fees, claiming once again that these can “reduce capture of supposedly free services by richer groups” (2003b: 143), but noting that such policies also risk excluding the poor.

The chapter concludes by explicitly rejecting any “one size fits all” system of accountability to ensure the best allocation of health care resources, and offers six possible variant models for health systems. Most of these include contracting with private providers, but place little emphasis on decentralization, competition, privatization, user fees and market-style mechanisms. As such, they bear little relation to the policies advocated in the 1990s. While USAID and its sponsored projects and researchers forge ahead regardless along an unreformed line of privatization, WDR 2004 suggests that at least some researchers at the World Bank may now be beginning to recognize the extent to which previous reform packages have failed.

7. Privatization of existing public sector services

Any form of decentralization may lead to or include a further more radical additional element, which is the privatization of services hitherto provided by publicly owned agencies. It may be linked with moves to decentralization or corporatization (Sein 2001, Preker and Harding 2000), or may flow from other aspects of New Public Management and policy reform. Public Service International, the international organization of public sector trade unions, distinguishes between a number of levels and forms of privatization:

- Privatization of ownership [of health facilities and service units]
- Privatization of responsibility [management of public services privatized, or state provision withdrawn in favour of private sector]
- Privatization of provision [health care services contracted out, or even publicly-owned facilities leased, to the private sector]
- Privatization of finance [the use of Public Private Partnerships, Public Finance Initiatives, borrowing private capital for public health schemes, charging higher fees for health care treatment and services, or shifting from public funding of health care to private health insurance]
- Privatization through markets – creating conditions where the private sector can competes with the public sector for government or social insurance scheme funds – where necessary splitting purchasers and providers.

(Public Service International 1999:9).

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27 “Experience from Brazil, Chile, Costa Rica and Cuba, Iran, Nepal, Matlab in Bangladesh, Tanzania and various West African countries shows that health services, if delivered well, can improve outcomes even for the poorest groups” (World Bank 2003b: 134). A two-page “spotlight” feature on Cuba (157-8) shows that the foundations of its success have been the 1961 nationalisation of health services with the government as sole provider, centralized control, tight monitoring and evaluation, and motivated doctors and medical staff.
Leading World Bank economists Preker and Harding, promoting “greater private sector participation in generating inputs and providing health services,” see privatization as following naturally from the autonomization and corporatization of hospitals (Preker and Harding 2000). Discussing decentralization of health care services in various Asian countries, Sein (2001:2) includes privatization as part of a general “transfer of functions” from government to “nongovernmental organisations, including private for-profit enterprises and NGOs in the established sense of the term.” However, the extent to which full-scale privatization 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 privatization in other sectors.

Bulgaria
Bulgaria plans to privatize state-run hospitals that cannot balance their books, as part of a “reform” package which will also include the imposition of strict cash limits after hospitals ran up debts totalling $120 million (AP 2005).

Slovenia
Slovenia aims to speed up its privatization of health care delivery, aiming to hive off at least 50 per cent of primary care (twice as much as previously proposed) within three years (Albreht 2006).

There have been attempts to press home a more thoroughgoing privatized model, especially in poorer countries. In Chile the Pinochet regime drastically cut health care spending after the 1973 coup, slashing per capita public health spending by more than a third by 1979, and to 34 per cent of its 1974 level by 1990 (Taylor 2003). The proportion of private beds increased from 10 per cent to 25 per cent between 1981 and 1992. But such policies could only be sustained under a military dictatorship.

The new democratic government from 1990 implemented substantial increases in government spending on health care (Fleury 2001). However, this has not completely reversed the expansion of the private sector. By 2000 it collected two-thirds of Chile’s health insurance contributions, consumed 46 per cent of total health spending, but covered just 23 per cent of the population, and maintained a rigorous system of risk-adjusted contributions that excluded those most likely to require health treatment (Taylor 2003). The system also imposed substantial co-payments for the public sector service, with some subsidy for the poorest. Yet even at its peak of “authoritarian neoliberalism”, Pinochet’s regime pulled back from privatizing the entire system, and left 75 per cent of hospital beds in the public sector (Taylor 2003).

Costa Rica
Costa Rica has been under pressure from the Bank to privatize its health system, the most successful in the region, which provides comprehensive care to 90 per cent of the population. However, its experiments with non-profit provider cooperatives in the early 1990s showed them to be more expensive, less efficient and no better in quality than the mainstream public sector services. The co-ops also had a negative impact on the efficiency and costs of the public clinics. (Homedes and Ugalde 2005b:85).

Seeking a pragmatic rather than an overtly ideological argument for promoting privatization, the World Bank argues that it is a response to the fact that in many poorer countries the state itself is desperately short of the resources required to run a publicly funded service.28 (World Bank 2000). But while the Bank’s criticism of publicly provided services in cash-strapped countries has an element of truth, it is not sufficient to establish a case for privatization as the solution.

8. Public Private Partnerships

A different adaptation to the pressures of the market can be found in the emerging UN and WHO concept of Global Public Private Partnerships (GPPPs) (Buse and Walt 2000a). By 2001 around 70 such partnerships were identified, many of them involving drug companies and research projects (Buse and Waxman 2001).

28 Of course one might conclude, as Deber (2000a) argues, that if a single payer public service cannot be afforded, a privatized service is also financially out of reach.
This stance has been controversial among NGOs and within the WHO’s own structures. Critics point out that the WHO, with its global budget of $1.7 billion, is potentially vulnerable to political and economic pressure from much wealthier drug companies and private corporations, making any “partnership” profoundly unequal. (HAI 2000) They question the altruism of the corporations concerned, and point to the potentially valuable commercial, political and public relations advantages that could be secured by large private companies that are seen to be working alongside the UN, the WHO and health NGOs.

Critics argue that policies emerging from such “partnerships” are more likely to revolve around the use of more costly, modern (patented) drugs and vaccines than cheaper generic alternatives. In the case of immunisation campaigns, in a context where immunisation coverage in many of the poorest countries has fallen back to 75% or below, GPPPs are more likely to concentrate on applying new drugs in areas of proven success – the 74% of the target population already covered by immunisation – rather than attempting to penetrate the more needy areas, the 20-30% who do not yet receive any preventative treatment. There are also fears that the privately-backed campaigns may result in a reduced local capacity to produce vaccines and a rejection of local generic products by a sceptical public convinced that the cheaper product is inferior. (Hardon 2001).

The ethics – and the longer term effectiveness – of the immunization and other programs promoted by the WHO, alongside UNICEF and the World Bank have occasionally been challenged by angry critics, often from bitter experiences in developing countries (Banerji 1999, Schreuder and Kostermans 2001, Tan-Torres Edejer 1999). Banerji decries global programs on immunization, AIDS and tuberculosis in Asian countries, which he describes as “astonishingly defective” in concept, design and implementation. In a study of Southern Africa, Schreuder and Kostermans (2001) argue that the WHO’s technique of organizing national immunization days (NIDs) has served to divert resources from routine work on immunization coverage. They warn that the extension of immunization to reach the most deprived and distant sections of the population who are often those at greatest risk could be unaffordable from the resources of some individual countries.

Tan-Torres Edejer highlights concerns over the future treatment of Guatemalan AIDS patients who took part in a Merck drug trial once the trial was completed and the supplies of drugs involved were running out. She noted that, “despite the good intentions of the North-South partners, clashing agendas and values persist”, and the benefits of such research are still unequally shared. Ncayiyana (2002) is also critical of the way Africans have been used to test drugs from which they will never benefit, “either because the drugs are too costly, or because they are designed to treat conditions that largely affect industrialised nations”.

Any attempt to extend to developing countries the modern medical techniques that have enabled health gains in the advanced economies would also require the additional development of modern, well equipped hospitals and specialist staff. Persuading developing countries to set their sights no higher than a primary care system – with even this minimal provision possibly underwritten through user-fees and “cost recovery” – can be seen as a means of consolidating a global two-tier system for health care, in which whole populations and sub-continents are denied access to comprehensive services.

If this were to become the accepted model, it would mean that in developing countries, any modern and complex treatment – whether medical or surgical – would for the foreseeable future be available only to the wealthy and educated who were able to access treatment in the advanced health services abroad. For the WHO such a policy would represent not just a retreat, but also effectively an abandonment of the underlying values of social solidarity and the principles of equity and access which were at the root of Health For All 2000.

9. Competition between rival service providers

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 organize the production and distribution of goods and services”.

“Consensus is also forming that a market-oriented approach to development – complemented by a transparent legal and regulatory framework and government that steps in only where markets fail – can yield spectacular results.” (World Bank 2000)

Even though the effectiveness of markets as a means to govern health systems is less categorical than the Bank’s assertions suggest, 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 centralized state provision and control. To create conditions for competition – and thus open up the possibility of ‘patient choice’ and consumerism – centralized systems must be broken up and decentralized. A variety of options can be attempted individually or in combination:

* Restructuring centralized systems to separate purchasers from providers
* Moves to enhance the autonomy and encouraging “entrepreneurialism” and competition between public sector providers
* The deregulation of public purchasers (or other measures to permit, encourage or compel them to buy services from private rather than public sector providers)
* The privatization of publicly run services.

However competition brings with it new overheads in the form of transaction costs. Modern health care systems are complex. The requirement to formulate precise specifications and standards, and then to administer and monitor the resulting contract means that any efficiency savings that may be generated through competition have to be offset against the overall cost increases. These are among the factors that help push the costs of administering the US health care system to over 30 per cent of its spending (Light 2003).

The Bank sees competitive market systems as a general formula, applying to all countries and circumstances. However, 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”.

In developing countries, where incomes are chronically low, competition appears to be closely linked with the imposition or retention of user fees. Pro-market reformers fear that competition between providers would be eliminated if publicly-provided services were available free of charge to all, including the wealthiest service users. This, they argue, would deter the wealthy and middle classes from either paying into private insurance schemes, or paying to use alternative private hospitals (Shaw 1995).

Even where a degree of competition exists, it by no means guarantees a positive long-term outcome for health care services to the poor. 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 “in providing a full range of curative services at all levels of care in hospitals, health centres and dispensaries, and also in providing preventive and other high-priority public health services” (Munishi 1995:xvii). Yet the same report also notes the profoundly unequal lack of provision of competitive for-profit private health care in the rural areas. Private provision is concentrated in urban Dar es Salaam. It is clear that if the private sector emerges the “winner” in this type of competition, the end result will be to leave the public sector shouldering the costs of care for the poorest and the rural population.

Competition between public and private sectors for scarce qualified staff frequently works to the detriment of the public sector and the poor who depend on it. The issue is equally difficult in middle- and high-income countries. Waitzkin (1997) notes the failure of “managed care” and competition to hold down costs or ensure universal coverage in the US, and warns that attempts to extend it into Latin America, with the prospect of competition between large private companies, are likely

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28 Conspicuously, the promotion of competition comes as the first of the 10 principles of the New Public Management as outlined by Osborne and Gaebler (1992:25,310)
Managed care

Originating in the US as a debate on organizational and financial mechanisms to squeeze down on the soaring costs of the health care system in exchange for some limitation of patient choice of provider, “managed care” is a term that gained in currency in the 1980s with the re-emergence of neo-liberalism and commitment to free markets and competition.

The basic ideas behind managed care go back to the work of US economist Alain Enthoven in the 1960s, and his 1977 proposal for a health plan based on “regulated competition in the private sector”.

Enthoven subsequently advised governments in the United Kingdom, the Netherlands, Sweden and elsewhere on market-style reforms to health care systems. The notable form of managed care is Health Maintenance Organizations (HMOs) which offer reduced premium insurance coverage in exchange for policyholders accepting a restricted list of service providers with whom specific contracts had been negotiated. HMOs succeeded briefly in stemming the upward tide of health care costs and insurance premiums in the US in the mid 1990s (Mercer Consulting 2006). However, similar policies in other high-income countries have served to increase overhead costs and have largely been abandoned.

In the US there is some evidence that reduced costs of HMO coverage were only achieved alongside reduced access to family doctors, and pressure on these doctors to reduce referrals for tests and hospital treatment. More recently new competition for subscribers has begun to erode the “managed care” system (Enthoven 1997, 2003, Lister 2005). The guarded optimism of Robinson and Steiner’s study identifying positive aspects of managed care while warning of the danger of extrapolating from different contexts and cultures has been overtaken by events and experience. This has led even one of the foremost advocates of the system to question its future (Enthoven 2003, Robinson and Steiner 1998).

While managed care began life as a trade-off between limited patient choice and attempts to hold down the soaring costs of US medicine (Enthoven 1997), a number of other provider payment reforms have been proposed on a much wider basis. Mostly these have been advocated as methods of cutting costs or stimulating competition, although all of them involve the creation of perverse incentives (Barnum et al. 1995). The alternatives include:

- Replacing fee-for-service payments by capitation-based funding for covering a designated population (prospective payment)
- Replacing flexible fee-for-service payments by fixed price payments for particular treatments, on the basis of Diagnostic Related Groups or the equivalent
- Payment per diem for inpatient treatment
- Payment for designated specialist services, with fixed targets.

Market-style methods might suggest the need for systems that pay hospitals only for the episodes of treatment they deliver (case-based) or the catchment

30 The weaknesses of the managed care model were also exposed by the barrage of correspondence to the BMJ in 2002, eager to refute claims by Richard Feachem and colleagues that California HMO Kaiser Permanente represented better value for money than the universal service provided by the British National Health Service, and noting how many specific factors and differences had to be ignored by Feachem et al. to contrive an apparent comparison (BMJ 324: 1332-1335).
population they agree to cover (capitation-based). The British government has largely implemented a controversial “payment by results” system which no longer guarantees hospitals a core contract income. It also therefore facilitates removing a portion of the public sector (National Health Service) funding in order to purchase care from private sector providers.\textsuperscript{31}

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. The downside to a capitation-based system is that it can 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. Citing examples in both Colombia and China, Blas (2004) argues that the cost-per-case payment system for providers and for front line staff can have an adverse and measurable effect on the treatment and follow-up of TB patients.

Similar pluses and minuses can be identified for systems that fund hospitals to deliver specific designated care (i.e. setting targets for cardiac or cancer treatment, accompanied by ring-fenced allocations of revenue). While it may be possible to achieve improvements in the designated service, this may well be at the expense of diverting management and staff resources from other areas of care – and reducing any local management flexibility in achieving a balanced service.

A 1998 survey of European health systems found that governments seeking to pay by results were in the minority. Ten of the 16 countries examined use prospective funding systems to set budgets for hospital inpatient services, mostly of them global budgets, although Germany allocates prospective flexible budgets, and Sweden combines prospective payments with a further payment linked to numbers treated (Maceira 1998).\textsuperscript{32}

Despite the strenuous efforts of reformers in Europe (Saltman et al. 1998), and in Latin America and Asia (Bitran and Yip 1998), it seems clear that tinkering with provider payment mechanisms can consume large amounts of managerial time and resources without offering any guaranteed solution to perverse incentives.

In most developing countries, public sector health centres and hospitals are funded according to historic budgets, or even on the basis of numbers of staff in post (Bitran and Yip 1998, Blas 2004). A similar pattern prevails in the payment of government subsidies in China (Eggleston et al. 2006). Not only does this replicate each year the chronic underlying lack of resources but, as the authors point out, from a management point of view the system almost inevitably promotes inefficiency, containing no incentive to alter staffing levels, reduce costs or respond to local demand for services.

10. Decentralization - does one size fit all?

The call for decentralization is a theme running through most studies and reports advocating health system reform in wealthy and poor countries alike. It is “generally recognised as a major strategy for health reform” (Rannan-Eliya et al. 1996:5, Valentine 1998). In abstract the notion of “transferring power from unconcerned and inefficient central bureaucrats to the people” is hard to oppose (Homedes and Ugale 2005). Yet as much as any element of the generic health reform prescription, decentralization needs to be geared to the specific needs and political/social realities in each country. In some instances decentralization may put power in the hands of social conservatives or religious fundamentalists who may restrict access to sexual and reproductive health services – with serious consequences for women, especially young women (Ostlin 2005).

\textsuperscript{31} Interestingly the ‘payment by results’ system and the financial insecurity both apply only to the public sector hospital provision: the new private sector “Independent Sector Treatment Centres” are given preferential 5-year contracts at higher cost per case than the NHS, but on a “play or pay” basis that ensures they receive full funding regardless of numbers treated. The contracts for ISTCs specifically exclude NHS hospitals from applying, ensuring that the only competition is between rival private sector for-profit providers (Lister 2005, Nunns 2007).

\textsuperscript{32} The six countries allocating budgets on a service-based system also differed widely in the system employed: they were Austria (which paid on the basis of length of stay in hospital); England (in which payments related to service level agreements between local purchaser and provider); Finland (with local-level service-based reimbursement); Hungary, with a performance related payment system; and Slovakia, which paid hospitals by the bed-day for inpatients.
Support for some form of decentralization spans the political spectrum. Even as they highlight the policy’s negative implications in some developing countries, Collins and Green point out that 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. They go on to argue that “the value we place on decentralisation will depend upon the way we define it and its political use” (Collins and Green 1994:460). The general assumption made by advocates of decentralization is that by breaking down centralized systems, and bringing decision making closer to local people, both as providers and consumers of health care, the reform process will improve equity of access for the poor (who can be more influential at local than at national level), improve efficiency and improve quality, since more local service providers will feel more answerable to local consumers.

However, the decentralization of a previously centralized service also assumes an availability of resources. These include a developed planning and management infrastructure and human resources in the form of skilled health managers at local level, which may well not be available in many countries (Rannan-Eliya et al. 1996, Berman and Bossert 2000, Homedes and Ugalde 2005a). Indeed, the results of decentralization can also prove very different from those intended, as Rannan-Eliya and colleagues found in their extensive literature review for USAID-funded Partnership for Health Reform:

- control over service provision may be captured at local level by élites who are even less responsive than central government to the needs of the poor
- urban populations are often more politically influential than rural populations and therefore better placed to keep a larger share of resources
- decentralization 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
- decentralization may also mean smaller scale and less well-resourced providers, which wind up delivering less training and skills for staff and lower quality care
- smaller organizations also lose potential bargaining power and economies of scale in negotiation with major suppliers
- and smaller-scale, more local structures almost inevitably offer less scope to tackle inequalities in the terms and conditions of health workers (Rannan-Eliya et al. 1996:5-6).

In countries with marked social inequalities between town and country and between rich and poor, decentralization of services can also increase problems of equity, unless it is firmly underpinned by guarantees of adequate needs-related funding. If not, granting local hospitals and health services powers to raise local funds may liberate local entrepreneurial talent in a wealthy area, but condemn poorer inner-city and rural health services to permanent under-funding and second class status (Mackintosh 2001, Homedes and Ugalde 2005). In Mexico an IDB report found that decentralization led to a serious decline in the quality and quantity of primary and hospital services for the poor (Homedes and Ugalde 2005b: 87).

Evidence to show that decentralization improves health care remains stubbornly hard to find. Bossert’s comparison of three countries, Chile, Colombia and Bolivia for Data for Decision Making and Harvard School of Public Health, argues that though decentralization and health finance reform have been “touted” by the World Bank through much of the 1990s, “the preliminary data from the field indicate that the results have been mixed, at best.” In some cases the backlash has generated moves to recentralize services. (Bossert 2000: 3) Decentralization of the control over hospital services also raises difficult questions about the capacity of management both at national and at local level. (Mills et al. 2001, Homedes and Ugalde 2005).

11. Corporatization and “entrepreneurialism”

The notion of going beyond decentralization 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 (Preker and Harding 2003). In the developed countries this is not new. The British Conservative government’s marketizing measures separated 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 along the same lines in the early 1990s, with profoundly mixed results (Lovelace 2003).

By the mid 1990s almost all British NHS providers had taken Trust status, defined in the initial White Paper as “public corporations”. Their level of local discretion and accountability was limited, and, though Trusts were in theory permitted to fix pay and conditions of their staff at local level, few did more than increase bonuses and payments to top executives. 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.

In some countries the level of local autonomy has been taken further than NHS Trusts. “Foundation Hospitals” in Spain and Sweden have gone further in floating the hospital as a free-standing enterprise, “corporatized”, with their own discretion to borrow funds and conduct deals with the private sector. This type of autonomy may prove, as with one major Swedish hospital, simply a transition point to full-scale privatization (Busse et al. 2002). The Swedish government later enacted legislation to forbid any further privatization of health services. Spain’s experiment came to a halt with the formation of just four foundation hospitals. These 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).

In developing countries the corporatization of hospitals has taken the form of the establishment of major teaching hospitals as “parastatal” organizations (Kenya’s Kenyatta National Hospital), and autonomous “self governing” bodies (Ghana’s Korle Bu and Komfo Anokye hospitals) (Govindaraj et al. 1996). One immediate difficulty in these circumstances is the disproportionate share of resources already allocated to these hospitals, which also tend to be a power-base for some of the country’s most powerful medical professionals, making it very difficult for governments to scale them down. On four evaluative criteria of efficiency, equity, public accountability and quality of care, research by Govindaraj and colleagues in Ghana (1996) concluded that the experiment had not delivered many of the hoped for benefits “although there have been some isolated successes”.

In other developing countries the corporatization of providers has yet taken place in Western Europe.

33 Saltman (2002) disagrees, claiming that the majority shareholder control of this hospital is still in the hands of public sector organisations, and argues that no substantial privatization of providers has yet taken place in Western Europe.
So far this study has examined the prevailing pattern of change or “reform” to health systems in high-, middle- and low-income countries and one common feature emerges. Whether the reform process has stalled or been driven forward at pace, and whether the changes have arisen from the aspiration of national leaders and policy makers to match global trends or been imposed by global bodies, none of the main menu of policies arises directly from globalization as such.

Of course a country’s level of indebtedness and resultant level of dependency and limited (or enhanced) level of political decision space and autonomy in relation to global bodies may be the product of economic globalisation, and the predominance of neoliberalism reflects the economic domination of transnational corporations and the wealthiest OECD countries. This also applies in a wider sense to the political pressure on middle and low income countries.

But the policies that feature most prominently in the checklist of health system reforms associated with World Bank advice are not a logical or necessary response to external global pressures. They do not result in leaner and more cost-effective government. They do not reduce but increase costs; they do not increase but impede efficiency.

Nor are they an appropriate response to the burden of disease and health needs. For example, the neglect of mental health provision, and the rapidly growing issue of the health needs of older people (Lloyd Sherlock 2005), are constant and abiding features of all but a tiny handful of Bank documents, studies and projects, despite the appalling lack of resources for mental health highlighted by Beeharry et al. (2002) and WHO (WHR 2001).

Rather the packaged set of reforms are drawn from an ideological “one size fits all” menu, and applied with various degrees of commitment and conviction by national governments that have had no hand in devising them.

So if globalization itself is not the direct wellspring of reforms and policies to reshape health systems, how can its influence and impact on health care best be understood?
While recognizing new factors in the world in the 21st century, Petchesky essentially rejects the notion of globalization and falls back on the use of the term “global capitalism” implying continuity with previous periods. Her summary reduces the new elements to seven themes common to most analyses of globalization:

- “Hypermobility” of capital
- Liberalization of trade
- A uni-polar world dominated by the US since the fall of the Berlin Wall
- Explosion in the use of electronic communication
- Looser national and regional boundaries
- Weaker nation states in the face of corporate and financial multinationals

Stiglitz, a latter-day Keynesian critic of the IMF and World Bank, defines globalization as:

“the closer integration of the countries and peoples of the world which has been brought about by the enormous reduction in costs of transportation and communication, and the breaking down of artificial barriers to the flows of goods, services, capital, knowledge and (to a lesser extent) people across borders.” (2002:9)

To understand what has gone wrong with globalization, Stiglitz focuses attention on “the three main institutions that govern globalization: the IMF, the World Bank and the WTO”. Stiglitz also points to the abrupt change of emphasis in the World Bank following a “purge” of its top officials in the early 1980s, to be replaced by neo-liberals appointed under Ronald Reagan. An organization which had once investigated the failure of markets in developing countries and focused on government action to reduce poverty was transformed into one which saw “government as the problem”. There was a similar sea change in the IMF (Stiglitz 2002:13-14). These changes at the top level of two global bodies have had a major and lasting impact on the health systems of the developing countries.

Following the Stiglitz approach, it is in analyzing the impact of global institutions – including the WHO and the new global donor bodies (The Bill and Melinda Gates Foundation, the Global Fund to Fight AIDS, TB and Malaria (GFATM), PEPFAR) on dependent governments – that the effects of globalization on health systems can be most clearly identified in the low- and middle-income countries. By contrast the OECD countries, whose governments generally enjoy greater scope for autonomy in decision making, within the context of well-developed health systems, but which also face generally greater political pressures arising from public expectations, have charted paths of reform more closely related to their own dominant political parties and ideological preferences.

Where is the counterfactual?

It is becoming possible to analyze the impact of the prevailing line of health system reforms – with an increasing body of increasingly critical and independent literature questioning assumptions that have stood unproven at the centre of World Bank/IMF orthodoxy since the early 1980s. The most recent examples include the debunking of five common “myths” on health systems including the notion that private providers are more efficient than the public sector (Hsiao and Heller 2007), and Wagstaff’s critical review of Social Health Insurance (2007). However, it is less easy to find evidence to support a counterfactual analysis, since few countries have had the combination of political will and material/human resources to pursue an alternative course.

Some counterfactuals have been estimated on an economic basis, although largely hypothetical. In Sri Lanka an estimate has been made of the economic benefit that would have accrued if a malaria eradication program had been in place over the 30 years 1947-1977, and calculated that national revenues would have increased by $7.4 billion at a cost of just $52 million (Sabri 2000).

Such projections can be dramatic and help focus on the wastefulness of existing systems. But as calculations and cash equivalents they lack the human scale. However, we have a good idea what many countries of sub-Saharan Africa would have aspired to in the way of health services in the absence of pressure from the World Bank and IMF Structural Adjustment Programs, since a number of them took the opportunity immediately after achieving independence to establish publicly funded health care, free at point of use, and
supported by substantial economic expansion in the 1960s and early 1970s. Most of these – such as Kenya, Uganda and Zimbabwe, and post 1979 Nicaragua – registered substantial gains in life expectancy and reductions in child mortality (Colgan 2002, Gatheru and Shaw 1998, Birn et al. 2000).

By contrast health outcomes have fallen back in almost every country since the 1980s and into the 1990s, following the implementation of SAPs which sharply reduced state spending on health care, and Bank/IMF-dictated policies of user fees. However, it must be recognized this is also the period of sharp economic decline, and the start of the HIV/AIDS epidemic, which weakened health systems were in no position to confront. Not all of the responsibility to demonstrate a convincing counterfactual, however, should fall on those critical of market-oriented health sector reform. Among others Yeates (2001:29) notes the limited range of policies promoted by the Bank and IMF, and the “marked absence” of any international institution with equivalent influence and economic power to the Bank or IMF “advancing a social democratic or redistributive agenda”. The various UN bodies, the WHO and the ILO have a certain global reach, but can more easily be ignored by governments preoccupied with the conditionalities of loans and credit ratings from the international financial institutions, or securing USAID funding for a project.

However, while there is absence of solid evidence to support a “counterfactual” model, the Bank itself acknowledged in its 2004 WDR the striking success of the Cuban government’s health system, despite Cuba’s very obvious rejection of every one of the Bank’s main lines of health care reform. A health system that has remained centralized, nationalized and free to all at point of use (with the exception of co-payments for prescriptions) and funded from state revenues has managed to combine an extensive and effective network of primary care and public health together with high-tech hospital treatment. In the absence of significant economic growth, and despite over 40 years of US economic blockade and 16 years after losing Soviet economic support, Cuba has managed to continue spending 6.6 per cent of GDP on health care, increasing life expectancy and reducing child mortality to levels comparable to Canada, and better than the US. The unique political context of Cuba suggests that it could not be read across as a “counterfactual” to other developing countries, few of which have had sufficiently enlightened leadership willing to remain as committed for over four decades to such a radical set of policies and priorities, which also required economic sacrifices in other sectors.

Perhaps partly due to the abrupt exit from the island of thousands of supporters of the old regime including many rightward leaning doctors in the immediate aftermath of the 1959 revolution, and the consequent need to build a new system virtually from scratch, one unique factor in the Cuban success has been its remarkable level of social equality. This has been coupled with the absence of a powerful lobby of medical professionals or wealthy individuals demanding the “right” to private health care. The ongoing US embargo, forcing Cuba’s exclusion from the mainstream of world trade and market pressures, and its alignment with countries willing to defy US pressure have also allowed an enlarged “policy space,” permitting a very different line of policy from indebted African countries dependent on IMF loans.

However, the success of policies contrary to those prescribed by the World Bank/IMF appears to be as consistent as the failure of the neo-liberal policies to improve health or deliver equitable health systems (Unger et al. 2006); the Bank’s 2004 WDR is strikingly short of positive examples to illustrate the usefulness of the policies it had prescribed for over 15 years.
Kenya achieved independence in 1964, and now has a rising population of 30 million, 42 per cent of whom are aged 14 or under, with fewer than 3 per cent aged over 65. UN statistics suggest that as many as 15 per cent of the population have AIDS or HIV, and 500 to 700 will die from AIDS-related causes each day in 2003. Around 50 per cent of hospital beds are occupied by AIDS sufferers. In 2001 Kenya had half of the East African total of 4.2 million HIV-infected population, with 500 more contracting the disease each day (Achieng 2001).

The new government elected at the end of 2002 announced a change of policy towards prevention of the further spread of the virus, centred on a mass distribution of 300 million free condoms, to be funded through the World Bank (Wax 2003).

Kenya’s total GDP was $46 billion in 2000, but the very large informal economy and low levels of earnings resulted in total government revenue of just $2.9 billion per year, and external debts of over $6 billion. Debt service charges have run at more than 15 per cent of the country’s export earnings throughout the 1980s and 1990s> These payments are prioritized by the government above spending on health care (Kimalu 2001). Seventy per cent of the labour force is unemployed, and government estimates suggest that 56 per cent live on less than $1 per day. Only 50 per cent of health spending in Kenya is publicly financed, while 42 per cent is paid privately, and the remaining 8 per cent comes from international donors and NGOs (Kimalu 2001:7).

In the period immediately after independence, Kenya’s economy grew rapidly – averaging just over 6 per cent a
year for the first decade, a rate exceeding Malaysia and Indonesia – and the government began to implement its 1963 election pledge to develop a health care system offering free basic treatment, introducing free outpatient care in 1965. It achieved reductions of almost 50 per cent in mortality among the under-5s in the years to 1993. Life expectancy increased from 40 to 60 years (Colgan 2002, Gatheru and Shaw 1998). Rural health centres were set up and there was an expansion of the renamed Kenyatta National Hospital, which enabled the launch of a program for training Kenyan doctors.

But during the 1970s the emerging system was swamped by the demands of a rising population while the economic growth faltered, stretching resources. Although bed numbers have grown more than four-fold since 1963, they have not kept pace with the rapid growth of the population. It is common for beds to be shared by patients, and for patients to sleep on the floor (Kimalu 2001).

The service was never able to grow on sufficient scale to confront the major endemic threats to health. Diseases that could be prevented or contained are still among the major causes of illness and death. Malaria (23 per cent; respiratory tract disease (26 per cent) skin diseases (7 per cent) diarrhoea (5 per cent) and intestinal worms (4 per cent), could all be tackled through improved primary care, preventive health policies, clean water supplies and enhanced nutrition (Gatheru and Shaw 1998).

Another aspect of the decline in Kenya’s health care system has been the reduction in coverage for immunization from 79 per cent in 1993 to just 65 per cent in 1998 (Kimalu 2001:11). Despite the prevalence of disease, Kenya still spends 75 per cent of its health budget on curative (mainly hospital) care (Kirigia et al. 2002), and just 11 per cent on health promotion and preventive health measures.

The 1980s brought the end of economic growth and, with it, pressure from the IMF and World Bank to implement “structural adjustment” programmes, including cuts in public spending. (Amrith 2001) Government health spending fell sharply in the 1990s, from $10 per capita in 1990 to just $2.90 in 2000 (Heaton 2001, Achieng 2001).

Infant and child mortality rates which fell so dramatically in Kenya’s first 20 years both rose by around 50 per cent in the years 1992-1998, bringing fears that many of the gains recorded in 25 years after independence could rapidly be lost (Kimalu 2001:10). Maternal mortality rates also doubled in the period 1993 to 2000 (IFC 2002).

The public hospital sector is dominated by the Kenyatta National Hospital in Nairobi, which in 1993-4 received no less than 13 per cent of the entire Kenyan government health budget and treated up to 30,000 in-patients, while just 26 per cent of the budget was allocated to primary care services for the remainder of Kenya’s population (Hsiao 2000). A strategic plan designed to shift more government resources towards primary care (Wang’ombe 1997) has not been implemented. As in the case of Zambia’s University Teaching Hospital (Purvis 1997), the Kenyatta is too visible and politically sensitive for major cutbacks to be politically acceptable. Funding for primary care has increased, but not in real terms (McEuen 1997).

Kenyan government spending on health care has not kept pace with the growing population and the need for preventive medicine and health promotion, which with rural health care receives less than 20 per cent of the budget. Kenya is caught in the classic bind of a poor capitalist economy in a harsh global market. The major constraint on government spending is that “devoting more resources to health would compromise overall growth and employment goals” (Kimalu 2001:18). However, constraints also apply to the private sector. High domestic interest rates exceed the margins of the not-for-profit hospitals, making it impossible to borrow money for investment in new technology or improved capacity (Stenton 2002).

**User fees**

Since 1989 the government has – largely at the behest of the World Bank – imposed user charges on health services, despite the immediate evidence that it reduced access and service use for the poorest. The policies include:

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36 The most recent official figures show a slow increase in numbers but uneven distribution of hospital beds, ranging from just 14.2 per 100,000 population in Northeastern Province, to 21.6 in Nairobi and 31.4 in Coast (Central Bureau of Statistics 2003).
• User fees in government health facilities
• Health insurance schemes to draw in extra resources for health care
• Encouraging the private sector and non-governmental providers including NGOs to develop services for which patients would be prepared to pay
• Decentralisation of planning, budgeting, purchasing and management of government health services (World Bank 1987).

In the run-up to the 2002 election the government agreed under heavy public pressure to lift fees and charges for treatment and tests in three highland areas subject to an especially virulent malaria outbreak, but stressed that this was an exceptional measure that was “too expensive” to apply to other districts (Omanga 2002).

Fees are levied for all treatment. A hernia operation could cost £500-£800 depending on the hospital and the surgeon, while setting a broken leg could cost £50-£120. The state-run National Hospital Insurance Fund gives partial coverage to at most 25 per cent of the population, all in formal employment, who pay premiums of up to £3.20 per month from their salaries. The fund will reimburse only the bed costs of hospital treatment, paying up to £14 per day for an in-patient, but nothing towards costs of outpatient care (Njeru et al. 2005). This would leave the hernia patient receiving a subsidy of £28-£42 towards a total bill of £500-£800 (Stenton 2002). Even the cheapest reasonable standard of hospital bed costs £15-£20 per night, with additional charges for consultation with doctors, drugs, bandages and other consumables, most of which have to be imported and paid for at world market prices. Government hospitals also operate on a “cost-sharing” basis, leaving the patient to cover around 70 per cent of the costs of health care. Many people have to sell their houses to pay for medical care. (Stenton 2002, Gatheru and Shaw 1998)

In outpatient centres the user fees of US$0.33 for visits brought initial drops in attendances averaging 37 per cent and as high as 52 per cent. When the fees were suspended, visits rose by 41 per cent (Ugwumba 2000). Fees at Nairobi’s clinic for sexually transmitted diseases brought a reduction in attendances of 40 per cent among men and 65 per cent of women in nine months. But here, even after the fees were abolished, attendance levels never fully recovered (Brugha and Zwi 2002).

Moreover, as in many African countries, the fees failed to generated the expected contribution towards the health budget, yielding just 2.1 per cent of Ministry of Health spending by 1993 – well below the 10 to 20 percent forecast by the World Bank, even before the cost of administering the charges was taken into account. Kenya has also attempted to “cascade” charges in such a way as to encourage patients to go first to the lowest appropriate level of care, but by implication imposing financial penalties on those who have more serious illness (Creese and Kutzin 1995).

A 1998 survey showed that 9 per cent of the population had chosen not to visit a government health facility because they could not afford the fees: but 76 per cent had decided they could not afford to visit a private medical facility. Just over a third (37 per cent) of Kenyan mothers gave birth in a hospital. Seventy per cent of the rural poor and 81 per cent of the urban poor cannot afford private health charges, while 20 per cent of urban and 8 per cent of rural poor cannot afford the lower costs of government-funded health care (Kimalu 2001:11).

However, such problems have not deterred external agencies such as Management Sciences for Health offering their assistance to tighten and enforce the imposition of charges. A new system of networked cash registers was installed by MSH in the Coast Provincial Hospital in Mombasa, the country’s second largest. “Within four months the cost of the cash registers was recovered”, primarily through “efficiency measures” but also by “modest increases in patient fees” (MSH 2001). Thus new technology has been employed to remove more money more systematically from the pockets of Kenya’s poor to “increase financial resources for health and family planning services”.

As Arhin-Tenkorang (2000:14) argues, the reality is that systems which hinge on payments only by sick people and their families “do not equate to additional sources of funds for the health sectors of developing countries.” This could only come from sharing risk among both the sick and the healthy. This is why user fee systems have generated negligible – if any – funds
for fresh investment in primary care or more local hospital facilities. More recent studies have shown that the system of user fees, coupled with systematic under-funding of health care facilities by the Ministry of Health, generates a degree of dependence on even the small sums of money generated, so that the system of waivers that should exempt the very poorest from payment of all or part of the fees has often not been fully implemented (Korir 2003).

**Regulating drug costs**

Donor funding has focused largely on HIV/AIDS and on health promotion and prevention. But in 1999, according to UN figures, Kenya was spending just US$0.76 per capita on AIDS. The country cannot afford modern anti-retroviral drugs, and has been among the African countries seeking to import cheaper generic drugs. The cost of the branded products has been as high as $15,000 per patient per year, compared with an average Kenyan annual income of just $270 (Achieng 2001).

By September 2004 concerns were growing that even some of the patients being treated in Nairobi with donated anti-retroviral drugs through Médecins Sans Frontières, and others receiving treatment at Kenyatta National Hospital, were dropping out of treatment because they could not afford the Ksh500 (less than £4) monthly fees for tests and drugs (Okwemba 2004).

NGOs and the Global Fund to Fight Aids, Tuberculosis and Malaria have pressed the government to ensure that fees are waived where they could prevent the poorest patients accessing the treatment they need. The Fund supplies drugs free to governments, and expects governments to pass them on free of charge to patients. A high dropout rate from treatment could trigger a halt to Fund support.

These problems underline the fact that even when AIDS drugs are donated, there are problems in arranging the effective distribution to those in greatest need. A study by German development agency GTZ found that the value of donated drugs to prevent mother-to-child transmission of the HIV virus in East Africa would amount to just 1.2 per cent of the total cost of the program – with the remaining costs falling to local services (Heaton 2001).

With malaria a major cause of death killing 750,000 children in Africa each year, affordable treatment and prevention is vital for Kenya. But the more modern drugs such, as Larium and Malarone, costing $80 per fortnight, are also far too expensive for most Kenyans to afford (Rocco 2003).

Even the donation of a million doses of Malarone by GlaxoSmithKline has brought serious problems, raising questions over the sustainability of any application of the drug, and carrying restrictive “strings” on its use which meant that by December 2000 only 223 patients had been treated with it, while research indicates that up to 500,000 children would benefit from treatment (Heaton 2001). By contrast quinine hydrochloride, derived from cinchona trees grown in Congo, can be produced for just US$1 per course (Rocco 2003).

**Market-style reforms**

Attempts at decentralization, creating more district level planning, have also failed to deliver many of the expected improvements, especially in the context of limited resources for information systems and appropriate training of staff (Owino et al 2000, Owino et al. 2001).

Senior health officers have continued to promise decentralization, Most recently Health Permanent Secretary Patrick Khaemba told The Nation on March 20, 2005 that public hospitals would be given greater local decision making powers, but admitted that no funds had been allocated to finance any such changes.

Kenya’s government took the advice of the World Bank and others and in 1987 turned Nairobi’s Kenyatta hospital into a parastatal, a state corporation with a degree of autonomy from the Ministry of Health. However, the results of this reform have not been an unambiguous success. Impatient at the slow progress, the government attempted to contract out the management of the hospital to a European company in 1991, only to retreat in 1992 in the face of opposition. But chronic and unresolved shortages of financial and other resources, compounded by the need to compete for professional staff with private sector hospitals paying higher rates, have limited the extent to which the Board has been able to demonstrate im-
Govindaraj and Chawla, whose study includes the Kenyatta and autonomous hospitals in four other countries, are more categoric in their warnings that corporatization and autonomy are no panacea for under-resourced public sector hospitals:

“An incontrovertible overall conclusion of the five case studies [India, Zimbabwe, Ghana, Indonesia and Kenya] is that autonomy in public sector hospitals has not yielded many of the hoped-for benefits in terms of efficiency, quality of care and public accountability… It would seem that a flawed conceptual basis for hospital autonomy in the public sector as much as the poor implementation of the autonomy measures is to be held responsible for this failure” (Govindaraj and Chawla 1996:3-4).

Among the failures, the authors point to “an inability to successfully transplant private sector structures and incentives to the public sector hospitals”. And to make matters worse, far from leading towards the World Bank goals of a smaller state and public sector, the result from exercises in corporatization have “increased the government expenditures on public hospitals – both in absolute terms and as a share of government health expenditures” (op. cit: 25).

In what might seem to be heresy among some World Bank and USAID researchers, Govindaraj and Chawla conclude that in the context of developing countries:

“It is not implausible that introducing autonomy and private sector measures in the public sector might actually increase inequity without significantly increasing efficiency. … Therefore in our opinion what is required in order to ensure that public hospitals discharge their functions effectively…is not a blind emulation of the private sector. Instead we would recommend a hybrid institutional system, consisting of participative, decentralised decision making and goal-setting, performance and outcome based management structures and processes, and appropriate incentive systems” (op.cit:26).

The expansion of the private sector has been hampered by the lack of insurance cover and the inability of most of the population to pay a viable fee for treatment, especially in the rural areas (Wang’ombe 1997). Despite a rapid growth of non-government providers since 1990, Berman and colleagues (1995) found “very limited” evidence on the quality and efficiency of the services they provide, and that regulation is weak. There is no substantial for-profit private hospital sector in Kenya. But in 2001 only 600 of the country’s 5,000 doctors were practising in the public sector. The World Bank’s subsidiary, the International Finance Corporation (IFC) reports with approval:

“[the] Private health sector is vibrant and the government is supportive of it. Half of all the hospitals are private. Recently, quality of public health has been declining. Population is accustomed to user fees at public facilities” (IFC 2002:49).

All of the substantial private sector hospitals are run as “not-for-profit” enterprises, though this still requires them to balance their books and generate a margin within their fees to cover maintenance and investment in stocks and new equipment. There are also many mission hospitals, which receive over 90 per cent of their funds from USAID or international religious organizations, and are thus as dependent on them for survival as the public sector hospitals are on state support (Amrith 2001).

The chronic lack of resources has led to shortages of even the most basic supplies in public sector health facilities, and not surprisingly brought low levels of satisfaction among service users. One survey found that 54 per cent of Kenyans who used private rather than public health care did so because of the non-availability of drugs (Kimalu 2001). This makes it appear as if private services and those provided by NGOs or the private sector rather than the state are necessarily and by definition “more efficient”. This type of statistical data reinforces the World Bank and USAID’s largely...
ideological preference for working through NGOs rather than lending support to public sector services. By 1994 no less than 95 per cent of USAID’s funds for Kenya were paid to NGOs and private companies (Amrith 2001).

There is little doubt that the efficiency of Kenya’s public sector hospitals is inadequate, although factors driving this include insufficient numbers of professional staff, shortages of consumables or breakdowns of equipment leading to non-functioning theatres and laboratories, and problems importing or paying for drugs and supplies (Owino and Korir 1997). However, many private facilities are also under-resourced, and offer questionable quality of care. A 1998 survey found that less than a third of Kenya’s private clinics offered laboratory services (ICHRSI 1998). A study in 1994 by DDM found that

“there is no clear evidence that the private sector is more efficient than the public sector” (Berman et al. 1995).

One of the reasons the World Bank and other agencies have insisted on the need for user fees has been to nurture the emergence of insurance schemes even in the poorest countries. “[U]ser fees are vital to the introduction of any type of insurance system” (McEuen 1997:11).

However, it appears that this dogmatic approach represents a triumph of hope over experience. Extensive surveys of developing countries by researchers for the USAID-funded Data for Decision Making found limited evidence of success:

“DDM research...indicated that only small percentages of the populations studied had any kind of health insurance, and that insurance schemes currently do not contribute significant resources to total health financing. Current insurance schemes also tend to cover mainly the more wealthy income groups or the formally employed, limiting the reach of such schemes into the lower income or rural populations” (McEuen 1997:16).

It may be World Bank policy, but the chances of establishing health insurance in low-income countries have been and are undermined by the World Bank/IMF Structural Adjustment Programs, which in almost all cases result in a reduction in size of the formal employment sector, and cut the incomes of the rural and urban poor along with public employees (Simon et al. 1995). Only a small proportion of Kenya’s workforce – and less than 10 per cent of the entire African labour force – is employed in the formal sector, and many more are on extremely low rates of pay, limiting the scope for any European-style insurance system (Turshen 1999:61). In fact the IFC makes clear that its target audience for such schemes is not Kenya’s poor. Rather it is aimed at facilitating the use of private health care by Kenya’s (far from numerous) “middle class” (IFC 2002).

However, less than 12 per cent of the population has private health insurance, and the largest private insurer has an annual turnover of just $12.6 million a year, covering 200,000 subscribers. Other schemes are so small that they were threatened with extinction by a provision in the government’s Insurance Act which, after years of little or no regulation or supervision of the private insurance sector, would have required them to maintain a capital base of $1.3 million (Kimani 2002).

National Health Insurance

Plans by the National Rainbow Coalition government to transform the limited National Hospital Insurance Fund into a new universal health care scheme were first drawn up in 2003. And they have come under heavy fire from private sector critics, large employers and by trade unions concerned that workplace taxes would be used to subsidise a system that will cover all Kenyans (Munaita 2003).

The scheme could mean that employers’ and employees’ contributions increase by up to 135 per cent, while the already established National Hospital Insurance Fund (NHIF) and its assets, until now an institution financed and benefiting the best organized formal sector workers, would be absorbed into the new wider scheme. From the beginning there have been doubts and unanswered questions about the costs and viability of the scheme, which had at first proposed monthly contributions of Ksh400-600 (US $5.80-$8.80) from each worker, and twice as much
from employers, who would for the first time be liable to contribute to the health care of all their staff.

Running costs of the scheme have been optimistically estimated at around US$580m per year, and government measures to cover the extra costs of covering the 56 per cent of Kenyans who live in absolute poverty include the use of value added tax, levying contributions from those working in the informal sector, a new airport tax on foreigners travelling to Kenya, donations and grants (Munaita 2003). The opposition has been led by an angry private sector, which has stressed the unrealistically low cost estimates for the scheme, in which a maximum of 1.5 million Kenyans employed in the formal sector will, together with increased taxes on business, effectively support the health care for 30 million.

A survey by Njeru and colleagues (2005) highlights a series of concerns over the ability of public sector services to deliver the planned new National Social Health Insurance Fund (NHSIF), and the low level of public confidence in existing public health services. They conclude that there is little option but a much more gradual process of change:

“Kenya lacks the key prerequisites for introducing and sustaining a universal social health scheme. The scheme can hardly be supported by the current status of the economy and health care infrastructure” (Njeru et al. 2005:3).

By the autumn of 2004 business lobbies stepped up the pressure against the new scheme, proposing instead a merger of the National Hospital Insurance Fund and the existing National Social Security Fund, along lines implemented in Tanzania and Ghana. Another alternative plan is to establish separate schemes for different sectors of the population: one for those in formal employment, another for the rural population, and so on. One key objective of these proposals (much of which had already been conceded by the government by September 2004) is a reduction in the share of the Fund to be paid by the employers compared with their workforce, from the original 2:1 to closer to 1:1. The contradictions of a divided coalition seeking a progressive reform in the teeth of such powerful opposition on the basis of such a weak infrastructure remain unresolved (Opiyo 2005).

ZAMBIA

Zambia, which in 1999 spent $14 million more on debt servicing than on its health system, is one of a number of African countries to have its debts cancelled by the World Bank and IMF after the G8 summit in Gleneagles in 2005. As a result, on April 1, 2006 it scrapped user fees and introduced free health care for people in rural areas. (Loyn 2006, Oxfam 2006, Penda 2006)

A recent USAID-funded study found that complex arrangements to exempt the very poorest from charges through a voucher system had failed to deliver any significant improvement, and concluded that “the identification of the most vulnerable remains a challenge in a resource-poor setting (Kafue team 2006).

Those who suffered most from the user fees imposed from the early 1990s were women and especially young girls (Oxfam 2006, Atkinson et al. 1999). But the introduction of free care will raise the need to expand the health workforce to meet a sharp rise in demand, especially in rural districts where staff numbers are already inadequate. There is also a danger that under pressure of a large number of patients the quality of care will decline. The country has just 600 doctors for a population of 11 million – and not a single psychiatrist (Penda 2006).

Prior to these recent changes Zambia’s health system had been described by Abt Associates Project Director Marty Makinen (1998) as possibly “the world’s most aggressive reformer”. As with many other sub-Saharan African (SSA) countries, the World Bank-style reforms followed a worsening of health outcomes beginning in the late 1970s, despite initial gains after independence, which had brought the nationalization of health services (Nwuke and Bekele 1995).

Among the features of Zambia’s “reforms” was an explicit commitment to work in partnership with the private sector. In 1994 it brought in the Harvard-based DDM to advise on further measures. A National Conference on Public/Private Partnerships for Health was financed in 1995 by USAID. Despite the “nascent” stage of development of private medicine in Zambia (most private provision coming from church-affiliated institutions) the agenda was fairly explicit in its direction:
“To provide a forum for the government to express its commitment to forging partnerships with the private sector
To offer various components of the private sector the opportunity to communicate with government
To define the contractual relationship between government (as purchaser) and private sector (as sellers) of care
To identify constraints to the development of the private sector and explore feasible solutions
To recommend appropriate policy reform for maximising private sector (provider) participation in the public health agenda
To identify critical next steps in the development of public/private sector partnership.”
(Nwuke and Bekele 1995:13).

The conference heard not only Zambia’s health minister, but also the acting director of USAID, who was much more categorical in stressing the need for “private provision of health care services”. With total health spending running at just $12 per capita annually, half or more of this already coming from service users and out-of-pocket payments, of course it was clear from the outset that the scope for private sector expansion would hinge on capturing a growing share of an increasing government health budget. However, the emphasis on the private sector comes in a context of wholesale privatization of much of the Zambian economy during the 1990s, under the watchful eyes of the IMF. Two hundred and twenty-four non-mining public enterprises out of a target list of 282 had been privatized between 1991 and 1998, with fresh efforts to privatize the mines, the power industry, the National Bank, the State Insurance Company and the National Savings and Credit Bank by 2000. The civil service and remaining public sector jobs were to be further scaled down, reducing the share of wages of national wealth, while the IMF urged a widening of pay differentials between management and staff (IMF 1999a).

The Zambian reform package that so impressed Abt’s Dr. Makinen reflected a similar approach. It included a substantial decentralization of health management to 72 districts, the creation of a professionally led Central Board of Health to allocate funds to districts, excluding government health workers from public service status, contracting out a wide range of non-clinical services to the private sector, restricting public funding to a basic package of “cost effective” service, introducing user fees, and establishing a voluntary insurance system for residents of two main cities. The system of user fees, introduced in 1991, involved fees set by each government facility, varying from 10 to 20 per cent of the cost. Children under 5 and adults over 65 would be exempt, (although it appears that only about two-thirds were able to escape payment) and the poor could apply for “certificates of indigency” (Makinen 1998, Nwuke and Bekele 1995). The theory is that the user fees “free up” resources from the hospital sector that can then be reallocated to expand alternative systems of primary and community health care.

A 1996 survey by PHR found that utilization of services was “equitable across income groups”, since around 40 per cent of people in each income group sought health care when ill. It also showed that almost half of the richest 20 per cent choose private health providers, while 70 per cent of the poorest choose a government health centre (Makinen 1998, 1999). But since the poor get no exemptions at private facilities, while the private sector employs more doctors and specialists, this is no great surprise.

The PHR survey also showed that the probability of getting care for a sick child – at just 52 per cent, was better than the general average (43 per cent). But the elderly face a much lower (36 per cent) probability of care. Nor is it surprising that the “risk sharing” insurance scheme has mainly been patronized by the rich, who accounted for over 70 per cent of those in the scheme, since they were best able to afford the premium payments. Since there is little else in the way of health insurance available in Zambia, leaving out-of-pocket payment as the source of a majority of health funding, it makes sense for the rich to cover themselves against possible costs.

The PHR survey confirmed the general picture of inequality: the richest 20 per cent spend about 1.3 per cent of their income on health, compared with more than double this percentage among the poorest 40 per cent. Yet the richest also spend five times more on drugs and three to six times more on other forms of health care, with greater use of outpatient services than the poorest. In other words the user fees and “reforms”
in Zambia have simply institutionalized and perpetuated the inequalities. Life expectancy in Zambia had fallen since 1990 by about 10 years to just 43, while infant mortality had risen by a third (Wynne 2000). While welcoming a new promise of cheaper drugs for the poorest in society from a Western pharmaceutical corporation, by the summer of 2003 The Times of Zambia noted that:

“Ten years down the line of liberalisation, the ordinary citizen had borne the brunt of medical costs.” (Editorial 2003).

Even top DDM consultants have been forced to conclude that the package of reform in Zambia has not delivered what it promised:

“Zambia’s local districts are receiving less funding than before the reform, and user fees may be limiting access. In most countries insurance reforms have been associated with shifting of resources from the general ‘solidarity pool’ to private insurance and private providers who attend wealthier patients…” (Berman and Bossert 2000:10).

As in many other low-income countries, the moves towards health system reform came at a time of financial pressure, forcing a reduction in government spending. Health spending in Zambia also fell as a share of government spending 1994-97. Nevertheless the same years saw a substantial (“unprecedented”) shift of spending from (largely urban) hospitals to local districts (Makinen 1999).

But the drain of resources had an impact on hospitals. The main one, the UTH, has suffered a sustained reduction in budget, from a colossal 25 per cent of the Ministry budget, to 17 per cent in 1994 and 11 per cent in 1997 (Purvis 1997). The IMF noted a deterioration of facilities and equipment, shortages of drugs and a poorly staffed system that was still predominantly publicly owned.

Nevertheless, it endorsed the government’s ‘goal’ of siphoning even more cash from hospital care to provide by 2001 a range of health services well below the World Bank’s “essential package” that had been costed at $12 per head per year six years previously, in 1993:

“a package of essential services (costing about US$7 per person) to all Zambians, compared with an allocation of about US$3.20 in 1997. This increase will be financed by the reallocation of resources from lower-priority ministry and hospital expenditures” (IMF 1999a).

SOUTH AFRICA

South Africa is the most prosperous of the SSA countries, classified by the World Bank as an “upper middle income” country, with a GNP of $113 billion in 2001 and a population of 43 million. However, more than half the population can be classified as poor, in many cases still reflecting the stark racial inequalities inherited from the apartheid regime, with poverty concentrated among black people and the rural areas (McIntyre et al, 1998).

Despite high comparative and absolute levels of health spending in South Africa, life expectancy fell from 62 to just 48 years during the 1990s, largely as a result of the raging HIV/AIDS epidemic, which had infected almost 5 million adults by 2005 (almost 20 per cent of the adult population) with 84,000 infants born with HIV in 2001 (World Bank HNPstats 2003).

Apartheid South Africa’s health policies were regressive in every way, with more than 75 per cent of public health spending allocated to hospitals, most of which are in urban areas, with academic and specialist hospitals taking 44 per cent. Just 11 per cent was allocated to primary care. A burgeoning private sector employed the majority of health staff, and controlled 61 per cent of the country’s health spending.

The allocation of hospital beds and every other aspect of health care resources was consistently focused on the richest districts (and therefore the white minority of the population) which enjoyed almost double the allocation of hospital beds, almost seven times as many doctors, double the number of nurses and nearly four times the health budget per head compared with the poorest (Gilson et al. 1999).

37 (Equivalent to around half the entire health budget for all the SSA countries: see Appendix A below)
However, despite the overwhelming mandate for change secured by the new African National Congress (ANC) government after the end of apartheid, there has been no South African equivalent of the dramatic post-independence upturn in health investment and outcomes seen in most SSA countries. Instead the general line of policy had already been established as one of collaboration with the private sector. This is in the very nature of the ANC as a cross-class liberation movement, and Lucy Gilson and colleagues trace the roots of this policy at least as far back as a 1991 speech by Nelson Mandela in the US, where he declared that:

“The private sector must and will play the central and decisive role in the struggle to achieve many of these [ANC] objectives….The rates of economic growth we seek cannot be achieved without important flows of foreign capital.” (Cited in Gilson et al. 1999:25).

The ANC government has therefore effectively followed a variant of the World Bank model for health sector reform, without being compelled to do so by external pressure. But, on a wider level, the same approach has informed the ANC government’s leading role in promoting the New Partnership for Africa’s Development (NEPAD) – a continent-wide initiative launched in Abuja in 2001, aiming to resolve Africa’s chronic problems of under-development and dependency through encouraging additional direct investment from the main centres of capital. NEPAD is at pains to present itself as an African-owned and led initiative. But its objectives are clearly to reform and strengthen African states to encourage and facilitate a major injection of foreign direct investment.

Like the IMF, NEPAD sees the solution to Africa’s under-development and exclusion from the world’s economy as “private sector-led growth” (Calamitsis 1999). The founding document identifies “an annual resource gap of US$64 billion” and states, “The bulk of the needed resources will have to be obtained from outside the continent.”

Partly because of this, the limited goals for health improvement are tied not to any commitment for long term government investment, but to appeals for a $10 billion per annum increase in external donor assistance. Even if it were forthcoming, it would still leave health services dependent on the benevolence of the advanced economies into the indefinite future. NEPAD’s quest for foreign investment and the resulting reluctance to raise or even impose taxes on transnational corporations operating in African countries cuts off one possible alternative mechanism to secure the necessary resources from within the continent. But it does so without any corresponding guarantee that the high-income countries will establish or maintain the necessary level of external support to expand and sustain health services to provide care for those who need it (Ooms 2006).

Ten years after the end of apartheid, leading medical experts point to the disappointing progress, both within South Africa itself and in its contribution to health care in the continent:

“We have provided 80% coverage to prevent mother-to-child transmission of AIDS. South Africa leads the world in this. But I still don’t see the political commitment yet to rolling out the programme of treatment with anti-retrovirals. We see the Director General’s post is still vacant, and now we have a vacancy for the head of the AIDS programme” (Coovadia 2004).

Indeed the planned roll-out of the Anti Retroviral Therapy (ART) program faced real problems, with far fewer than the target figure of 53,000 receiving the drugs in 2004, while researchers argued that the £37 million budget for ARV drugs would be enough for just 7 per cent of South Africa’s AIDS patients (Kamaldien 2004). By the end of 2006, 235,000 people were benefiting from ARV treatment. But, despite this being hailed by ministers as the “fastest growing treatment in the world”, it was covering just under 5 per cent of South Africa’s 5 million-plus infected with the virus, while an estimated 800 people were dying each day from HIV/AIDS and 1,400 more each day are becoming infected (Biles 2006). By contrast the much more ambitious and proactive anti-retroviral (ARV) program in Brazil, combined with preventive

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38 ART drugs administered to women in labour in Gauteng have saved an estimated 58,000 babies from contracting AIDS in the last three years, according to researchers – restricting incidence of the virus from 33% of babies to just 8% (Park 2004).
measures including free condoms for prostitutes and needle hand-outs to drug users, has halved deaths from HIV/AIDS and reduced incidence to 0.6 per cent of the population. Successful use of ARV drug treatment has drastically reduced the pressure on hospitals, cutting hospitalizations by 80 per cent last year, and helping to save $1.7 billion in hospital costs over 10 years (Lakshmanan 2007).

The political and economic policies of the ANC in government have also meant that the much-promised National Health Bill (NHB), which after its first appearance as a draft in 1995, and years of debate and delay, only passed through Parliament in 2004, and was further held up awaiting the Presidential signature that would make it law. This process has been further impeded by threats from the private sector and other political opponents of the ANC that they would go to court to challenge central aspects of the legislation, most notably the powers of the Minister of Health to grant – or refuse – any health care facility a Certificate of Need, without which it will be illegal to continue to practise (Kane-Berman 2004).

Although these same regulations would also apply to public sector hospitals – some of which are predicted not to survive scrutiny – they are widely interpreted as an attack on the private sector, which has continued to show itself reluctant to direct resources to poorer and more rural areas, where less income can be generated (Pillay Y 2004). However the ANC has established itself as a keen proponent of public-private partnerships, and the bill itself stresses from the very outset its objective of “establishing a national health system which encompasses the public and private providers of health services” (Pillay Y 2004).

Indeed the NHB does not, as its name might suggest, focus on funding a health care system to allow the elimination of user fees. Rather it seeks to regulate the private sector and establish a more equitable allocation of resources and more decentralized structure, while retaining full powers at government level in the hands of the minister. Its supporters argue that the bill does represent a real step forward for some of South Africa’s most vulnerable people (Pillay K 2002).

For example, it does seek to ensure that all South Africans have access to a package of free primary health care, although even where such services are provided free of charge, many people face physical and financial problems travelling to and accessing them (Connolly 2002). There is no specific health insurance system for the whole population, and the main trade union confederation, COSATU (Congress of South African Trade Unions), in its initial response to the bill strongly urged that further measures should be brought forward to establish a system of National Health Insurance, which would ensure universal access to comprehensive health care, and allow all health services to be incorporated into the public sector (COSATU 2002).

The Health Minister has been quoted describing the public sector provision as “in a shambles”. Chronic shortages of resources in the more isolated rural areas have contributed to an exodus of doctors, dentists and other trained professionals. They have gone to the cities, to the private sector, or often overseas to work in developed countries for higher salaries – creating an atmosphere of growing crisis in South African public sector health care (Cullinan 2003).

Even in the midst of an AIDS epidemic some public sector hospitals have been struggling with low levels of bed occupancy, with only two provinces exceeding 75 per cent. Reformers are pressing for a rationalization, with the closure of surplus beds and hospitals and resources redirected into primary care (Boulle et al. 2000). However, the more fundamental problem remains – the unequal distribution of hospital and other services, which can only be addressed by the injection of serious new resources as part of a planned reform aimed at equity of access.

Many hospitals still show the scars of neglect during the apartheid years. Many are in the wrong places, while other areas lack access. An audit in 1996 found a third (by value) need to be replaced or repaired, with a growing backlog and ongoing deterioration of the building stock, and equipment maintenance requirements of over R1 billion a year – well above current spending (Boulle et al. 2000:12). Problems included a third of buildings with unreliable supplies of water or electricity. The most neglected buildings, often again in the poorest rural areas, also have underpaid, neglected and depleted numbers of staff (Mtsashali 2003).
From 1994 the new South African government confined itself initially to two substantial changes, bringing in free health care to pregnant women and children under six, and instituting free primary care for all. These policies appear to have increased the attendances at public sector clinics, but did little to ensure that the required services would be available where required, and retained hospital fees for those other than indigent patients (Gilson et al. 1999).

Estimates of the scale of revenue that would be generated if the government carried out its pledge to introduce social health insurance show that it could raise around double the current amount collected in fees. But, as COSATU has pointed out, in pressing the case for the alternative policy of national health insurance, the cover would only be for those in formal sector employment and their families, and leave the larger share of resources in the private sector.

Raising what amounts to a workplace tax would leave the wealthiest minority paying little or nothing into the system, and would make the poor pay for the poorest. However, in the absence of either this or a national health insurance system, the government share of health spending has actually fallen back, with social sector spending increasing at a lower rate than general public spending since 2000.

As a result the largest share of the increases in health spending have come from households (out-of-pocket payments for fees, drugs and private medical insurance), the least equitable source (Doherty et al. 2002).

While health spending seems set to continue increasing, the expansion seems likely to be greatest in the private sector, which is still expanding, and larger as a share of GDP than public health services, though less than 20 per cent of the total population makes use of it. One reason for restricted use has been cost escalation which has affected private medicine in South Africa – especially the for-profit sector – just as it does everywhere, making it more difficult for those other than the wealthy and the top-paid workers to afford the premiums and charges. In 1998/9 medical schemes spent almost six times more per head of beneficiaries than national and local health spending per public sector dependent, and the gap is widening (Doherty et al. 2002, Connolly 2002).

In a lop-sided competition for patients and fee income with a private sector that currently has the advantage, public sector hospitals have responded by fitting out plush new private wards designed to compete head to head with private hospitals for insurance-funded patients, who will be able to choose which hospital to use under new regulations scheduled to take effect in 2004. Government hopes were that this would enable the public hospitals to draw in new funds – and create competitive pressure to hold down private sector charges (Jacobson 2003).

South African private health care providers are expanding into other countries, including the contract to fly in doctors and nurses from South Africa to Oxfordshire (one of the most prosperous counties in England) to perform elective cataract operations in a new treatment centre (Timmins 2004, Carvel 2004).

More than 7 million South Africans – 18 per cent of the population – are members of some 200 “medical schemes”, voluntary, non-profit funds (though administered by for-profit companies) which offer a range of benefits packages that can reimburse anything from primary care costs to hospital care costs. Schemes allow members to use public or private hospitals — most go private (McIntyre et al. 1998).

An attempt to transplant the US model of “managed care” (even as it showed itself unable to control costs in the US) proved an embarrassing disaster for United Health Care, whose Southern HealthCare venture wound up adrift with “many enemies, few friends, and no market” (Gould 2001).

**LATIN AMERICA**

**OVERVIEW**

Neo-liberal reforms in Latin America have had largely negative impact on the health care workforce. (Homedes and Ugalde 2005a). The privatization of hospitals in Latin America has led to large investments in improving financial information, estimating costs and developing contract and payment systems, but there is no evidence of an improvement in quality of care (Homedes and Ugalde 2005b). With the exception of Chile, Colombia and Brazil, which have contracted much tertiary care to private hospitals, most Latin American countries have had difficulties implementing the neo-liberal reform
package and most have only implemented aspects of it, such as decentralization or some form of privatization.

The prime beneficiaries of neo-liberal policies have been the HMOs which have expanded their operations in a number of Latin American countries (Iriart et al. 2001), private insurance firms, and the rich, while other beneficiaries include consultancy firms, universities – and World Bank staff. (Homedes and Ugalde 2005b). Another extensive survey has also concluded that reforms carried out in Latin America between 1995 and 2005 resulted in a “lost decade” in the search for equity in health care provision: in some countries reforms had actually deepened inequity, and run alongside a reduction in public spending on health care (Flores 2006).

In a survey of Andean countries, Rivas-Loria and colleagues (2002) found “limited” evidence of the success of health reforms in improving equity, effectiveness or quality.

Another PAHO report notes that while the health sector reforms in Latin America were resourced by “outside funding agencies”, the Bank/IMF structural adjustment programs had previously had “negative impacts on the health sector in many countries”. Its reported results “demonstrate that health reforms appear not to have had an aggregate positive impact on the health sector throughout the region.”

Despite increased health spending in many countries, “many of these same countries indicated that social exclusion from the health sector was still rampant in many areas…A couple of countries provided data indicating that a large percentage of the public is dissatisfied with the public health services provided” (Rivas-Loria and Shelton 2004).

The authors conclude that health reforms have not only failed to deliver on the promise of improved equity, but privatization has opened up a new danger that those with serious illness could be plunged into poverty by the cost of care.

**MEXICO**

Mexico has been widely promoted as a model of progressive health sector reforms, with its high profile Health Minister Julio Frenk contributing articles alongside other academics to a major series in the Lancet in October 2006.39 Many of the authors of these articles declared an interest as a result of their direct involvement with government reforms, which have been running since 2001, although the main legislation was only passed in 2003 (Gakidou et al. 2006).

The extension of health insurance coverage to millions of the poorest people in Mexico who previously had no cover – with the enrolment levels especially high in previously neglected rural areas and among indigenous communities – clearly represents an important progressive move to change the previously inequitable system. But the extensive and somewhat repetitive series of Lancet articles does not provide all of the information necessary to assess the scope and limitations of the Mexican reforms.

By contrast the OECD briefing paper on Mexico for its Health Data 2006 stresses Mexico’s continued low level of health spending (more than 2 per cent lower than the OECD average in 2004) and its low level of per capita spending (just $662 per head, around a quarter of the OECD average). Along with the US, Mexico remains one of just two OECD countries in which public spending is less than half of all health spending. According to the most recent forecasts even after three years of the reforms, public funding will make up just 46.4 per cent of the Mexican health spending in 2006, with public spending not expected to account for more than half of health spending until 2010 (Frenk et al. 2006).

The level of health provision has also remained very low. Numbers of doctors per capita are just over half the OECD average, while Mexico has a quarter of the proportion of nurses per capita and a quarter of the availability of hospital beds per head. And health services are poorly resourced, with the OECD’s second lowest provision of MRI scanners (around a fifth of the OECD average) and just over a sixth of the OECD average provision of CT scanners. Infant mortality is the second highest in the OECD, well over three times the average (OECD 2006).

Whatever has been achieved by the reforms since 2001, there are clearly serious weaknesses and problems in the

provision and accessibility of health care for much of Mexico’s population. Strangely neither issue is square-
ly addressed by Frenk and colleagues in the Lancet series.

By 2000, when Mexican President Vicente Fox took
office and appointed Frenk as Health Minister, there
was clearly a need for reform. Health and education
had been the two social programs most affected by the
massive cut in public expenditure as a share of Mexi-
co’s GNP in the prolonged financial crisis that struck
during the 1980s. Health spending had been halved
as a share of GNP in the six years to 1988, in a period
of rapid population growth (up by 20 per cent in the
decade (Laurell 1991).

The health care system took its modern shape back in
the 1940s and 1950s, as a result of government moves
to tie the most powerful groups of workers (the mili-
tary, civil and public service workers and some sectors
of the working class) to the state and the ruling party
(Tamez and Molina 2000).

This divided the Mexican population into three un-
equal groups:

- Around 50 million workers in formal sector
  employment, and their families, covered
  by six government-run social security
  institutions which provide comprehensive
  health cover. The largest of these, the IMSS,
  covered almost 40 per cent of Mexico’s
  100 million population in 2000.
- Upwards of 40 million people who are
  unemployed, self employed or in informal
  employment which leaves them outside the
  social security net, who have been obliged to
  fend for themselves through out-of-pocket
  payments for private sector care, and more
  recently dependent on limited insurance
  cover from the Ministry of Health.
- A small group of 2 to 4 million who have
  private health insurance (Burki et al. 1999,
  Frenk et al. 2006) – a relatively small
  number despite the entry to the health
  care market of a number of managed
  care organisations (Laurell 2001).

More than a third (36 per cent) of Mexico’s hospitals
are private, many of them offering relatively high-tech
services, “funded entirely by out of pocket expendi-
tures” (Ernst and Young 2003). This is largely due to
the weakness of the insurance market, although man-
aged care organizations have been entering the market
since the late 1990s, forging links with some of the
larger private hospitals (Laurell 2001).

Fifty-two per cent of the funding for the public sec-
tor hospitals comes from payroll taxes on employers,
while the federal government contributes 39 per cent,
and the remaining 9 per cent comes from workers’
contributions to the funds. The sectors of the publicly
funded health care system work separately from each
other, and each remains bureaucratic and centralized,
with each social security insurer having its own fund-
ing arrangements, facilities, doctors, nurses and other
staff (Anderson 2006, Ernst and Young 2003). The
system thus generates duplication and inefficiencies at
the same time as inequality:

“In short, the health care system features in-
complete coverage, stratification by population
group, and excessive centralisation, as well as
serious problems of duplication, poor quality
and inefficiency” (Tamez and Molina 2000:4).

The reform package brought forward by the govern-
ment in 1995 set out to extend a minimum package
of health care protection to some 10 million Mexicans
who were excluded from the previous schemes (Tamez

Critics argued that the potentially progressive element
of that reform would inevitably be undermined by the
inclusion of another ostensibly positive move – the in-

troduction of user choice in the social security system.
The “patient choice” policy opened the way for low-

risk, relatively high-paid workers earning more than
three times the minimum wage (and therefore pay-
ing an additional contribution), to transfer to private
insurance plans, while the high-risk, low-paid section
would inevitably gravitate to the protection of pub-
licly funded services. There were fears that this could
lead to a reduction of up to 50 per cent in the income
to the social security system, while leaving over 70 per

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40 Public spending decreased from 10.1% to just 4.3% of GNP between 1980 and 1989 (Tamez and Molina 2000).
percent of the existing contributors on its books. The new scheme also reduced the levels of social security contributions from both workers and employers, requiring a seven-fold increase in government funding (Tamez and Molina 2000:10-13).

In the extended provision to include new sections of the poor, an essential package of basic services was agreed by the government to be affordable through a combination of federal and World Bank resources as well as contributions at state level. It was intended that the whole responsibility for funding the package would be devolved to the state governments. The package included 12 interventions in the area of primary care and public health.41 (Gonzalez Block and Frenk 1997:14).

The Ministry of Health reported that the package covered 6 million people by 1996, and had led to an expansion in numbers of physicians and nurses delivering these basic services (op.cit: 15). However, it was clear that this limited list of treatments would leave many sections of Mexico’s poor at risk of catastrophic expenses in the event of serious illness or accident. Barraza-Llorens and colleagues (2002) stress the minimal extent of this coverage for the poorest, arguing that half of the country’s 100 million citizens were effectively “uninsured”, while more than half of the country’s annual health spending was out-of-pocket (more than three times the level in the US and 16 times the level in the UK).

They pointed to continued inequalities that gave a tenfold difference between infant mortality rates in the poorest areas compared with the richest:

“For persons at the top of the socio-economic spectrum, Mexico’s multiple, parallel health care subsystems provide excellent care as assessed by any standard. But for those at the bottom of the distribution, the system provides little more than vaccination” (Barraza-Llorens et al. 2002:48).

Meanwhile the private sector has continued to offer comprehensive health insurance to those able to afford it, and this is expected to “make private medical practice function more as a corporation”. The private sector remains largely unregulated, offering variable quality of care at varying prices, often in small hospitals. Forty-eight per cent of private beds were in facilities with fewer than 15 beds, which clearly offer no scope for delivering emergency medicine or many modern high-tech treatments (PAHO 2002:ii, 6).

In this context the reforms proposed by Frenk represented a significant step forward for the poorest and excluded. Legislation established a new Seguro Popular (Popular Health Insurance) which offered free access at point of delivery to an “explicit set of healthcare interventions” (Frenk et al. 2006). The bulk of the funding for this insurance cover, which is expected to increase public spending on health care from 3.1 per cent of GDP in 2003 to 3.9 to 4.1 per cent over seven years (Gakidou et al. 2006) was to come through federal taxes with additional contributions from the states. But there were also to be means-tested charges for families who enrolled in the scheme, with the poorest 20 per cent paying no fees, but expected to participate in health promotion schemes. Those who are offered some form of health coverage under this arrangement are the self-employed, unemployed and those who are for whatever reasons, outside of the formal sector workforce:

“Poverty and labour market status are no longer barriers to participating in public institutions for health insurance. The law establishing the new system was passed in April 2003 and came into effect on January 1 2004, with the goal of achieving universal health insurance coverage by 2010.” (Frenk et al. 2006)

However, the reform of the insurance system has not been linked to any reform of the health care system itself. Its chronic shortages and unequal distribution of facilities, services and staff remain as an obstacle to equitable policies. Nor does the reform process confront the substantial problem of the private sector, which remains largely unregulated and grossly inefficient. As far back as the late 1990s its efficiency lagged way behind public sector hospitals on such measures as the

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41 Basic household sanitation, family planning, prenatal, delivery and postpartum care, nutrition and growth monitoring, immunizations, oral rehydration therapy for diarrhoea, anti-parasite treatment, treatment of acute respiratory infections, TB prevention and control, prevention and control of hypertension, accident prevention and first aid, and community participation for self-care.
productivity of outpatient services, throughput per bed, efficient use of operating theatres and delivery of maternity care (Laurell 2001: 309-10). The private sector has also remained far more expensive than the public sector, paying much higher wages to its doctors and consuming half the country’s health budget while delivering just 30 per cent of the beds and 32 per cent of consultations (Anderson 2006). Many of the larger private hospitals and clinics are located close to the US border and in big cities, and the private sector is under no obligation to offer services to poor people covered by Seguro Popular or social security insurance, or to target resources on areas of greatest health need.

One key issue is to expand public sector facilities and Frenk and colleagues refer to three “master plans” to expand the infrastructure, re-equip and staff new health facilities, but their report is remarkably vague on the scope of this expansion. We are told that “1,792 health units had been built” by 2006, including four specialist regional hospitals, but nothing on the size and capacity of these new buildings or whether they would replace or augment existing services (Frenk et al. 2006:7).

The plan to extend public sector health coverage is concentrated primarily on insurance coverage, with little reference to the provision of additional hospitals, clinics and other facilities in the states and areas previously lacking access to services. Frenk and colleagues stress that the “essential package” of services now covered in the new extended Seguro Popular has been substantially widened to cover “about 95 per cent of all causes of hospital admissions” (Frenk et al. 2006:9) However, there is no related guarantee that poor people requiring care will be able to find a doctor, a hospital or a bed close enough to deliver the treatment they are entitled to. The long tradition of many Mexican citizens enjoying a theoretical “right” to health care without actually being able to access it seems set to continue.

The inequalities remain very significant. While the average provision of doctors per head is two per 1,000 population, some states such as Chiapas and Mexico have less than half this (0.9, 0.8), while Mexico City has well above average provision, with 3.2. The same semi-privatized and fragmented system remains in place, and the Seguro Popular is “unlikely to reach down” to the regions most affected by disease. In place of equitable policies the government seeks to justify inequalities, resorting to market-style notions of “competition” and “consumer choice” while access to care for the poorest is still inadequate (Anderson 2006).

The official “interim report card” on the first five years of the reforms notes an increased use of hospitals and health care in the areas that have enrolled in the new system, but does not question why some areas – such as Chiapas – should have been so dramatically more reluctant to sign up than others. And it does not address issues of ensuring local access to high quality public hospitals (Gakidou et al. 2006). Nor is there any discussion of compliance rates among better paid workers, despite World Bank findings that a mere 8 per cent of the richest 60 per cent of the population actually contributed to the Seguro Popular, while those who did pay put in an average of less than half their proper contribution (Scott 2006, cited in Wagstaff 2007:14). With evasion of payment on this level, it is questionable whether the resources required will ever be secured for full implementation of the reform program.

Alternative suggestions on how health reform could have been more effectively carried through include removing the tax exemption for private health care. This would affect only the richest 30 per cent of the population but generate additional resources equivalent to 0.48 per cent of GDP. Another suggestion is switching from a system which offers privileged access to workers who remain employed in certain sectors of formal employment to one which breaks down the three-tier structure and offers universal care on the basis of citizenship. The estimated $9 billion cost of expanding this provision could have been found by a government which bailed out bankrupt freeways and banks to the tune of $130 billion in the 1990s (Laurell 2001).

As Mexico City health secretary from 2000, Asa Cristina Laurell was able to test out a number of the policies that had previously been argued as alternatives to those of the federal government. Exploiting local autonomy, her ministry implemented a program focused on Food Support and Free Health Services and Drugs which involved a substantial (67 per cent) increase in health spending, achieved through...
“an austerity program that cut superfluous government spending with a 15 per cent salary reduction for top officials, a reduction of their staff, elimination of certain expenditures…” This yielded $200 million in 2001 and $300 million in 2002 for social programs, while an attack on corruption cut 10 per cent from health department’s bills (Laurell 2003).

CHILE

Chile’s health system was “reformed” by the Pinochet dictatorship in the early 1980s, with the primary objective of expanding the role of the private sector in both provision and financing, as well as improving resources allocation and promoting decentralization (Barrientos and Lloyd Sherlock 2000:418).

The old Bismarck-style social security system that had been in place for the best organized workers since the 1920s (de la Jara and Bossert 1995, Fleury 2001:7) was replaced by a new one that gave priority to the best paid workers, who were encouraged to “opt out” of the publicly funded FONASA health fund, and pay instead for private insurance (ISAPREs). Substantial resources were also transferred from the budgets of state-run clinics and hospitals to the ISAPREs (Vergara 1997).

Per capita spending on health fell from $29 annually in 1973 to $11 in 1988 (Petras and Vieux 1992). By 1989, 44 per cent of Chileans were living in poverty (Vergara 1997). In 1990 the elected government of President Patricio Aylwin pronounced a new policy of “growth with equity” – in sharp contrast to the neoliberal policies and widening inequality of the previous 17 years. Taxes were increased to help fund increased social spending, which by 1993 had risen to 15 per cent of GDP – although still below 1970 levels in per capita terms (Vergara 1997:209).

Until 1981 the government health system had provided 90 per cent of all hospital beds. By 1992, as a result of private sector expansion, almost a quarter of beds were in private hospitals (Bitran et al. 2000:173). The trend to privatization continued after the dictatorship had ended and by 1999 the private sector ran more than one bed in three (PAHO 2002:163). The system brought new inequalities and the right to health care was still limited by the purchasing power of the individual.

In 1991 private insurance covered only 19 per cent of Chile’s population, but spent 50 per cent of total health expenditure. Subsequent investments by democratic governments have reduced the public-private sector differential to 2:3 (Fleury 2001). However, the significance of the additional spending by the private system is enhanced by the fact that it covers largely higher-income groups and the young – those at least risk of serious illness – while the poor and elderly are reliant on the publicly funded scheme.

Bertranou (1999:24) notes that more than 70 per cent of ISAPRE subscribers were under 40 years old, with less than 2 per cent over 65, and the ISAPREs focus on providing insurance cover for “high frequency, low cost services for high income, low health risk groups” (Barrientos and Lloyd Sherlock 2000:421).

Nor is there any evidence that the private sector offers enhanced efficiency. Administrative costs consumed 18 per cent of ISAPRE budgets in 1997, compared with just 1.8 per cent in the public sector (Fleury 2001:17). On top of this profit margins have been as high as 20 per cent (Homedes and Ugalde 2005b).

By 2003 Chile’s Minister of Health acknowledged that the health system was “extremely inequitable”, ranking 168 out of 191 WHO countries in accessibility of services in terms of cost. A new program set out to improve access for 56 catastrophic conditions and capped the potential maximum fee payable, at no more than one month of family income (Homedes and Ugalde 2005b).

ASIA

INDIA

Indian government investment in the health system has dropped 30 per cent from just 1.3 per cent of GDP in the 1990s to 0.9 per cent – equivalent to just $4.49 per head – leaving the public sector desperately short of resources and the private sector dominant. Life expectancy is just 66. Over 40 per cent of Indians who receive hospital treatment have to borrow heavily or sell off assets to pay for treatment (Johnson 2006) and 38 per cent of Indians cannot afford or access basic medicines (Dabade 2006). India’s cumulative borrowing of $60 billion since 1949 makes it the largest “customer” of the World Bank, and the country’s total external debt now amounts to $120 billion. Debt
repayment and military expenditure consume 60 per cent of the annual budget.

Nayar (1998) as well as Srinivasan and Sukumar (2004) argue that World Bank influence has forced cuts in public spending on health and the introduction of user fees in public hospitals. Investment in health care has been centred on family planning services which have been the main growth sector. Now the Bank is trying to press the Indian government to spend more on preventive interventions to stem the spread of HIV/AIDS, pointing out that this is much cheaper than buying even cut-price drugs to treat those who have already contracted the virus. A prevention program could cost as little as $24 per case prevented, and would involve an increase in spending of just $37 million a year (“less than one tenth of the government’s revenue expenditure on medical and public health”) (World Bank 2006).

Many seeking a more positive model for health care to counterpose India’s poor performance at the national level have pointed to the spectacular achievements in the state of Kerala. There until the early 1990s health status reached US levels while spending just $10 per capita compared to the US figure of $3500, buoyed up in a not especially prosperous state by a combination of policies and factors, including especially high levels of female literacy.

However, Ekbal (2000) warns that this model was faced with mounting pressures, notably a decline in the quality and popularity of public sector health services, and a runaway expansion of the private sector, which by 1996 had almost twice as many hospital beds as the public sector, twice as many doctors and vastly more technical equipment.

One consequence of this rapid expansion of the private sector was a rapid five-fold increase in out-of-pocket expenditure on health care. On average the poorest were spending up to 40 per cent of their income on health care, with 9 per cent spending more than 100 per cent of their annual income.

But another consequence was a lack of facilities willing to offer suitable treatment to poor people suffering from HIV/AIDS, since the private sector proved unwilling to offer such services (Srinivasan and Sukumar 2004). By contrast, Harvard’s Peter Berman argues in defence of India’s private sector and presses for reformers to abandon as “infeasible and inefficient” any objective of establishing a universal public health service (1998).

CHINA

China’s system provided one of the models of primary health care which inspired the WHO’s Alma Ata declaration and its Health for All 2000 campaign (Hesketh 1997a). But, while 71 per cent of Chinese had access to state health care in 1981, by 1993 this had fallen to 21 per cent (Lampton 2003). In 2005 Health Minister Gao Qiang publicly blamed the 2003 SARS epidemic on the inequity and weakness of the rural health system (Kauffman 2005). The government’s own third survey of health services found 50 per cent of the population unable to afford medical care when they are ill. Just 34 per cent of the population has some form of health insurance, with hospitals offering three differing levels of care, catering for patients on different levels of income and ability to pay (Cannaby 2006).

An official national survey in 2003 found that nearly 49 per cent of patients needing treatment did not go to doctors and nearly 30 per cent of patients needing hospitalization did not receive it because of cost. But another problem is accessibility of care. A quarter of China’s health spending is focused in just four of China’s wealthiest cities and provinces, while half of all hospital beds and personnel are in urban areas. A survey of recent data for the World Bank found China’s health care in need of reform, with up to a third of all drug prescriptions deemed unnecessary, waning efficiency in hospitals and rising costs. But the team rejected as inappropriate the stock answers of more privatization and more competition – instead calling on government to intervene more strongly in a failing market (Egglestone et al. 2006).

The chaotic system appears to have generated a wide consensus that more public spending is required and greater responsibility must be taken by the central government, although there are unresolved issues over the form this involvement should take (Bloom 2001, Jing and Qiongfen 2001, Bloom et al. 2002, Liu et al. 2002, Lampton 2003).
Globalization and Health Knowledge Network

Liu and colleagues (2002) point out that, for all the local-level schemes that have developed across the country since 1949, there is not one example of a scheme totally initiated and sustainably run by a non-government organization without government support. Revolutionary China once led the world in the eradication of disease, the provision of universal access to basic health care, the training of a million “barefoot doctors” and the emphasis on prevention of ill health. Using techniques very different from the hospital-based Semashko model that had been introduced by Soviet communists, Mao Zedong’s party developed an inherently decentralized and rural-focused health system which, alongside improvements in general nutrition and living standards, delivered some remarkable improvements. Mortality rates from infectious disease in Chinese cities fell from 128 per 100,000 in 1957 to 4.6 in 1998. Immunization levels exceeded 95 per cent in the 1990s, helping to eliminate polio by 2000. Smallpox had been eradicated as early as 1961 (Li et al. 2001).

But by the mid 1990s many of the key progressive policies had been abandoned or reversed. Privatization and the market had replaced socialist provision. The communal agriculture system was dropped and the collective provision for health in the rural areas embodied in the CMS largely collapsed with it. The ageing of the population has also left many older people with little or no cover, and growing numbers unable to afford the care they need. There were fewer doctors per head and fewer hospital beds in 1999 than in 1980 (Liu et al. 2002). The situation is even worse for the large migrant population of 80 million rural workers in the cities, and for the unemployed (Bloom et al. 2002).

The spending pattern also tends to widen growing social inequalities. The poorest 25 per cent accounted for just 4 per cent of all health spending in 1993 and suffered infant mortality levels 2.4 times higher than the wealthiest and almost three times more infectious disease (Bhushan 2001). The central government had virtually ceased funding health services, spending just 0.7 per cent of GDP on health, devolving responsibility to local government, while private sources delivered 76 per cent of spending (Saadah and Knowles 2000:11). Sixty per cent of hospital revenues are from patient fees paid out-of-pocket, with just 20 per cent from insurance funds (Egglestone et al. 2006).

The decentralization of health services has also had negative consequences, cutting off provincial-level funding for Epidemic Prevention Services, and leaving services including TB control subject to user fees. Preventive care has been supplanted by fee-for-service activities, with prenatal care and hospital births among the services that have declined as a result (Jing and Qiongfen 2001:14).

In June 2001 China’s then health minister stunned the world when he announced that the real level of HIV/AIDS infection was 600,000, compared with previous reports of fewer than 23,000. The disease finds China with no organized public health system and few doctors with the necessary training. Unaffordable fees for treatment are compounded by the enormous costs of imported drugs – meaning that only the wealthiest can access the care that might prolong their lives.

Though health spending as a share of GDP increased from 3.17 per cent to 4.82 per cent between 1980 and 1998, the government share of this spending fell by more than half, from 36.4 per cent to just 15.5 per cent (Liu et al. 2002). Public funding was left to provincial and county governments, which can raise money from taxes. However, as a result, poorer areas are least likely to have funds for health care. By 1998 an estimated 700 million rural Chinese had no insurance or prepayment system to cover health care costs, and were obliged to pay out-of-pocket for any treatment or drugs they may require. A mere 10 per cent were covered by remnants of the Cooperative Medical System (CMS) (Liu et al. 2002). A big problem following the privatization of many rural clinics and hospitals is that neither they nor the public clinics will provide preventive care without reimbursement (Meng et al. 2004). Even in the cities, only half of the population was covered by health insurance, and that number has been falling. As well, insurance policies offer highly uneven entitlements (Hesketh 1997b, Liu et al. 2002, Li et al. 2001, Yip and Hsiao 2001).

The country that sacrificed its universal health system to embark on the road to globalization and the free market now finds itself unable to afford the prices demanded by the western pharmaceutical companies. Nonetheless, it is unwilling to jeopardise its relations
with the leading global powers by breaking patents and manufacturing its own generic drugs, especially having just joined the WTO (Ewing 2001). It is clear that in the case of China decentralization has served primarily to weaken the regulatory power of the central government to the extent that the same amount of money delivers less in the way of health care. It could even result in a worsening of township (formerly commune) hospitals. As with poor countries elsewhere, the solution to the health problems of China’s 900 million rural poor cannot be solved within the poor areas themselves (Jing and Qiongfen 2001).

The collapse of the public sector brought a mass defection of doctors and professionals to private practice. By 1994 almost half the village clinics were private. A visit to a village clinic could cost a third of a week’s income, with township hospitals charging twice as much. A quarter of the people surveyed who had incurred health bills had had to borrow or sell items to pay them, and the long-term impact of health costs are now seen as a major cause of poverty (Bloom 1998:243, Jing and Qiongfeng 2001, Liu et al. 2002). By 1997 individuals were paying a massive 85 per cent of total health spending in most rural areas (Bloom 2001).

There have been some moves to improve the system, but they have been piecemeal and covering relatively small numbers. In December 1998 the government established a new social insurance program for urban workers, but it was to cover only those employed, and not their dependents (Yip and Hsiao 2001). This followed a decision earlier in the year to “streamline a health care network” to deliver a basic package of care to rural workers (People’s Daily 2002b). More recently, according to the World Bank’s HNP website, teams of Bank and other advisors have been working with the Chinese government to address the problem of resourcing rural health services.

**VIET NAM**

The Vietnamese government was obliged to seek support from the IMF and World Bank in the mid 1980s: and the strings attached to this support involved wide-reaching free market reforms, including the introduction of user fees at district hospitals and commune level centres that had distributed health care and pharmaceuticals free of charge (Hong 2000).

The infant mortality rate had been halved between 1979 and 1989, and progress had been made on many preventable health problems. The 1989 reforms changed all that. User fees ran alongside deregulation of pharmaceuticals, the legalization of private practice and a halt to government funding for local level facilities. A World Bank report a few years later surveys the aftermath of a devastating collapse in what had been an effective and localized system:

- Deaths from malaria had reached the highest ever level in 1991, not least as a result of the under-funding of the National Malaria Control Program.
- District hospitals were running out of medical and surgical equipment, while “a large proportion of commune health facilities have become dilapidated to the point of being unusable.”
- Outpatient attendances had halved, along with hospital admissions.
- Service users at public health facilities were paying twice as much as the government in health spending, and even more was being spent by patients buying drugs from private practitioners or as self-medication: in total the state budget paid just 16 per cent of health spending in 1993.
- Steps to revitalize and further extend the public health network was “essential”, since “without government intervention the commune health centres will turn to fee for service arrangements…or wither away”. This would endanger TB control, disease surveillance and other community services. (World Bank 1995)

The situation worsened further in the 1990s. By 1998 another World Bank analysis, which regarded Viet Nam as “a not uninteresting case study”, noted that 80 per cent of health spending was paid out-of-pocket. User fees for hospital care had risen 1,000 per cent in real terms between 1993 and 1998, while fees for private clinics and doctors had risen 600 per cent. There were also charges for commune health centres “even though these were still supposed to be free in 1998” (Wagstaff and van Doorslaer 2001).
The government budget, accounting for 58 per cent of health spending, increased only marginally from 1995 to 1998, and the health system remained dependent on foreign aid (an “unsustainable resource”) for 13 per cent of its resources (Trong Hai and Schuftan 2001). A report for the UN Viet Nam country team concludes that “allocation for health is not a government priority, as shown by the low government health budget: less than US$4 per capita per year in 2001 (less than 1 per cent of GDP). This figure includes central, provincial and commune budgets.” (Brudon 2003).

Viet Nam’s social health insurance scheme, introduced in 1993, covered only 12 per cent of the population, mainly among the higher income groups, falling to less than 10 per cent by 1998 (Trong Hai and Schuftan 2001). Lonroth and colleagues note that in 1998 there were no health insurance schemes covering private health care provision, despite the fact that a majority of physicians were practising in private clinics, many with limited facilities and equipment (Lonroth et al 1998).

Under-utilization of services by the poor has created problems in sustaining the network of community health stations. The government has tried to shift the balance of spending, to allocate greater resources in areas of greatest need, such as the impoverished mountain communities which suffer the greatest burden of disease – and therefore incur the greatest cost. The mountain areas currently receive 1.8 times the per capita budget allocated to the more prosperous areas, but this is not enough to compensate for the additional spending required. Given the differentials in income, and the lack of insurance coverage, spending in the rural areas has to be predominantly financed from government budgets. (Trong Hai and Schuftan 2001).

TRANSITION COUNTRIES
RUSSIA

Russia appears to be experimenting with a variant of the market-style reforms that have failed elsewhere. Between 1991 and 1998 public spending on health shrank in real terms by 33 per cent, while levels of contributions raised by the workplace insurance scheme were just over a third the amount required to fund its basic entitlements. The decision to institute a health insurance system was made in 1992-93, as a way to pump additional resources into health care at a time when the slump in GDP was putting a huge strain on government resources. But, as critics of the reform pointed out, introducing a payroll tax at a time when many businesses were struggling even to pay wages moved the problem from one part of the economy to another. (Ingram 1995) Many employers failed to pay the contributions; others were already filing for bankruptcy.

By 1998 many regions were facing a collapse of investment in new equipment and seeking cash savings through wholesale closures of local hospitals and beds. There are few up-to-date overviews of the evolution of the Russian health system, but it seems that the chaos continues. Dmitriev and colleagues (2000) reported to the IMF that in the absence of sufficient money to pay for the promised benefits there was a choice between cutting the cost of health care services or imposing “co-payments” from patients, breaching the long-standing state guarantee of free care.

One of the arguments for an insurance-based system was to separate funding (purchasing) from service provision and to open up competition. But, as Danishevski and McKee (2005) point out, previous Soviet central planning had avoided any duplication of facilities, so hospitals were generally local monopolies. This in turn raises real problems for those advocating privatization, since these large private monopolies could dominate health care over large areas. Early in 2003 a World Bank document summed up the situation in Russia’s health sector:

“a complex picture of weak governance at the federation level, inefficient allocation of resources despite financial constraints at the regional level, inequities across and within regions, as well as underperformance in terms of aggregate health status.” (World Bank 2003:5).

While an unstable economy limits government funds and limits possibilities for increased public or private financing of health care, Russia faces a dual epidemic of drug-resistant TB and HIV/AIDS
which if left unchecked could reduce GDP by over 4 per cent by 2010 and by over 10 per cent by 2020 (Cullinan 2001, World Bank 2003d).

The reforms were drawn aiming to preserve universal access to a basic package of care. But the expected efficiency savings have not been achieved, and “a de facto rationing now takes place without scrutiny”. Increasing out-of-pocket payments mean that equity is “clearly being compromised” (Tragakes and Lessof 2003). Osborn (2004) reported an attempt at a “root and branch reform” of the health care system “that could see half the country’s medical professionals given the sack”, close upwards of 500,000 hospital beds and axe 300,000 doctors and health workers.

A new draft strategy paper, On improvement of structural efficiency in health care in Russia, was awaiting approval in 2005 by the Russian Duma. This indeed proposed big cuts in hospital capacity along with the strengthening of primary care services, and new systems of provider payment, while additional legislation would establish autonomy for hospitals and primary care organizations. However, this had raised fears of privatization (Danishevski and McKee 2005).

Up to now the abolition of the power of central bodies to plan and set targets for local and regional health care provision appears to have been the signal not for a constructive development of decentralised planning but for a chaotic descent into localism, with growing levels of inequality. The expected market discipline arising from competition between insurance companies and providers has either not developed at all, or failed to deliver the expected advantages (Tchernjavski 1998).

Extremely low levels of spending on health care (estimated by the WHO at just 2.2 per cent of GDP in 1997), and the context of rapid economic decline during much of the 1990s has left little scope for the expansion of a private sector even while the state-run system has been increasingly discredited. By 1998 hospitals were still “exclusively” owned by the public sector, while privatization had been largely restricted to the usual front-runners: pharmacies, dentistry and ophthalmology (Tchernjavski 1998).

**HUNGARY**

Hungary’s Prime Minister Ferenc Gyurcsany has promised to cut the country’s budget deficit by fighting “waste” in the public sector, raising taxes – and increasing the role of the private sector and introducing co-payments in health care (Condon 2006) with a fixed fee of around $1.50 to see a doctor or for a day in hospital.

Hungary, which slashed spending on health from 5.5% of GDP in 1990 to just 4.3% in 1999 has recently been under pressure from the IMF, which appeared less than convinced that the promised package tax increases would deliver the promised result, and has pressed for bigger cuts in public spending (Guha and Condon 2006). Successive governments have been faced with the chronic deficit of a health system that originated in the old “state socialist” system on the principle of universal and comprehensive coverage. There is a strong body of opinion against higher co-payments (Gaal 2005).

**CZECH REPUBLIC**

After 1989 the Czech Republic’s healthcare system was decentralized to create a partly privatized Bismarck-style social insurance system with competing sickness funds, each bidding for subscribers on the basis of offering more generous benefits, and with subscribers allowed to change funds as often as every three months.

Primary care was privatized, as were ambulatory specialists, and later some hospitals.

Patients were free to choose any provider, who would then be reimbursed on a fee-for-service basis. As the European Health Management Association (EHMA) points out, this, perhaps the most extreme marketizing reform in Eastern European health care, soon led to a crisis of provider-led demand, which forced all but nine of the 27 new sickness funds into bankruptcy – and this in turn rebounded on hospitals and providers who were not paid for services delivered.
The government was forced to step in and restrict competition between providers, imposing a uniform list of benefits. The reform also changed the system of provider payment to introduce prospective capitation-based payments (EHMA 2000:57).

The Czech reforms, including decentralization and privatization, have nevertheless forced up spending on health care, to above 9 per cent of GDP in 2001 (Medicover 2002a) The four-fold increase in spending and the substantial increase in the share of GDP spent on health (from 5.2 per cent in 1990) have run alongside a reduction in the proportion funded publicly, although the public share of Czech health spending is still higher than almost every EU country (Busse 2000).

The ruling Social Democrats succeeded in the dying days before the 2006 general election in pushing through controversial legislation to roll back privatization, forming a new network of 146 not-for-profit hospitals, and to revamp the health system.

Hospitals that refused to become non-profit could lose out on contracts with the republic’s insurance companies, which have also been brought under stronger government control. Critics claim that “140 hospitals will be nationalized and 80 will be liquidated”.

Health Minister David Rath insisted that the reforms were intended to prevent regional governments, controlled by the right wing Civic Democrats, from privatizing “practically all the hospitals”. Twenty per cent of those transferred to regional control in 2003 have been turned into joint stock companies, and almost 70 hospitals have been privatized over the last six years, with another 20 closed. He pledged to keep all health care free of charge if the Social Democrats won the election.

Private sector doctors called protest demonstrations against the reforms which were carried through with the support of the Communists, whose backing was key to overriding a presidential veto. (Lopatha 2006)

POLAND

Poland has switched in less than 20 years from a tax-funded and centrally run health service to an internal market system of 16 regional sickness funds (1999) and since 2003 to a single National Health Fund and a separation of purchaser and provider involving competitive tendering (Kuszewski and Gericke 2005).

Early moves towards decentralisation of health care in the early 1990s left catchment populations of less than a million, which were too small to sustain the planned network of tertiary level specialist hospitals. The World Bank pointed out that such “extreme decentralization” had therefore created new inefficiencies (World Bank 1993:163).

The controversial 1999 reforms also involved a rationalization of hospital services, with the loss of up to 30,000 jobs. They were intended to open the way for private health insurance to compete for subscribers against the regional funds. But this scheme was delayed as a result of public opposition. The regional funds ran up deficits in 1999 and 2000, forcing the government to increase the payroll tax, while the funds imposed limits on outpatient treatment, creating waiting lists, and squeezed payments for hospital care.

This prompted the hospitals to establish a two-tier system, with preferential care for those prepared to pay an additional fee over and above the scale paid by the insurance funds. This has helped create a market for private health care and insurance (Tapay 2001, Oresa Ventures 2003).

The privatization of health care provision is still on course to reach levels higher than anywhere else in Europe. By 1999 an estimated 90 per cent of dentists and two-thirds of doctors were working privately. Fifty-eight per cent of ambulatory care is also delivered privately though most hospitals are still in the public sector. The expansion of private medicine has been held back by the generally low levels of incomes (Kuszewski and Gericke 2005).

42 Meanwhile Polish doctors have been existing on salaries averaging just £4,200 per year. Poland’s accession to the EU in 2004 is widely expected to trigger an exodus by doctors and health professionals in search of higher pay and better resources elsewhere in Europe (Burgermeister 2004b)
Health spending, at 6.1 per cent of GDP ($650 per head) in 2002, well below the EU average, has been seen by the private sector as evidence that “healthcare in Poland is underfunded and is likely to remain under strong budget pressure for years to come” (Oresa Ventures 2003).

The World Bank subsidiary, the International Finance Corporation, has funded efforts by the private company Medicover to expand its operations in Poland, though Medicover insists it wants to work alongside the public hospitals (D’Amato 2000).

The private sector claims to “promote cost-consciousness and better care”, but laments the residual opposition to privatized services in countries used to care free at point of use, and the widespread suspicion that such services “lead to improperly unequal outcomes” (D’Amato 2000).
The last two decades have seen the emergence of a menu of market-style reforms for health systems. The most striking feature of these reforms is that they neither flow from health needs nor from popular political pressure among health workers, service users and the wider public. Nor do they save money or generate proven efficiencies or more equitable patterns of service delivery. On the contrary, they force up bureaucratic and overhead costs, increase bureaucracy, undermine existing public sector services, and still lack any systematic evidence that they can deliver any of the promised improvements.

Reforms which increase costs and hold back efficiency are clearly not directly driven by the process of globalization. Instead they flow from the neo-liberal ideology of the US, EU and OECD as reflected in the most influential global institutions – the World Bank, IMF and WTO – and agencies (notably USAID). The power and influence of these organizations have appeared to be enhanced in a global economic context in which low- and middle-income countries have been dependent on external loans and donor aid, and therefore more likely to accept loan conditions including external proposals on the restructuring of health systems.

The success in imposing the model has not meant that the Bank’s policies have delivered much in the way of positive results. The Bank’s own 1997 HNP Strategy noted that out of 120 ongoing projects from 1970-1995:

- Only 17 per cent of completed HNP projects were classified as contributing substantially to institutional development
- Only 44 per cent of completed HNP projects were rated as likely to be sustainable
- Only 59 per cent of 68 recently completed HNP projects were rated as satisfactory, compared with 81 per cent in education (World Bank Group 1997:15).

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43 SWOT - strengths, weaknesses, opportunities and threats
The general lesson might be that, if there are problems managing a publicly funded service, logic suggests the same weak and poorly resourced governments would have just as many – if not more – problems seeking to “regulate” the activities of a relatively powerful and autonomous private health care sector.

The same global balance of forces has also weakened any political resistance that might have been expected from the WHO to policies which have cut across the universalist values and primary health care ambitions embraced since Alma Ata. Instead the WHO has itself adapted to take on some of the new market-style reforms:

• Opening up to close working links with private sector organizations
• Diluting its traditional opposition to user fees
• Dropping the focus on universalism and equity in favour of the World Bank’s notion of an “essential package” of care for the poor, with private sector provision for those who can afford to pay.

While the developing countries have been subject to heavy pressure to adopt reforms from the neo-liberal menu, the organization of the 30 richest nations, the OECD, has researched these policies and largely concluded that they come with a price tag of complications, contradictions and increased costs. With few exceptions (the UK and Portugal) most OECD countries have steered well clear of the reforms that global bodies have been seeking to impose on developing countries.

This study has examined the links between globalization and the program of health sector reform promoted by the World Bank/IMF and the varied ways in which a common ‘one size fits all’ prescription has impacted upon health systems in a wide range of countries – high, middle and low income.

Responding to these policies and to the health needs and pressures of the world’s population requires an evaluation of the successes and failures of the interventions and reforms adopted so far – and a balance sheet of the strengths and weaknesses of an increasingly globalized and profoundly unequal world economy. The world has the wealth and technology to prolong and improve the lives of billions. But to do so it first requires the political will to break from the present pattern and from systems that have consistently been shown to fail and to compound the problem of ill health, compounded by social inequalities which further exclude the poorest and most vulnerable from treatment.

**STRENGTHS**

Healthcare is probably the world’s single largest industry, with spending of $3.2 trillion in 2003 (10 per cent of global GDP). Because of this, it has a high political profile, making it easy to promote debate and very hard for politicians to ignore, especially in the wealthiest countries which account for the lion’s share of health spending.

Large experienced and active networks of NGOs and CSOs add an additional voice in policy debate on a national and international level. In many countries with well-developed health systems, health workers – 59 million of them worldwide – are strongly organized in trade unions and professional bodies to stand up for them. These organizations are almost all committed to the defence and improvement of health services, and in many cases to the notion of health as a public service and a building block of social solidarity.

The size of the health care workforce and the specific weight of health in national economies make it difficult for governments to scale back spending and investment, or impose radical reorganization, especially where this is in any way contentious with health care professionals.

Meanwhile, on a world scale and especially since the Seattle meeting of the WTO in 1999, the political and financial stranglehold of the neo-liberal global bodies, the IMF and World Bank, is being undermined and challenged. NGOs, civil society organizations and campaigners are forming their own international links, with regular meetings of the European and World Social Forums, while others liaise over issues including fair trade, climate change and the foreign policy of the big powers.

Pressure groups for various areas of health care are also organizing at national and international levels, pressing the case for services for older people (HelpAge
Globalization and Health Knowledge Network

International) as well as those suffering from diseases such as HIV/AIDS. Within the health sector there are examples of this type of link-up involving non-commercial global partnerships (notably Cuban doctors in Pakistan, Indonesia, etc., Médecins Sans Frontières and other NGOs which combine practical and physical support with political activism).

The continued rise in health spending in the wealthiest countries has fuelled research and increased the global pool of medical knowledge and expertise. And the ever expanding scientific knowledge offers means to treat and cure more illnesses, prolong lives, reduce suffering, while an active media industry immediately publicizes every advance and development, generating public pressure for the latest and most effective drugs and treatments.

Globalization and global communications (notably the internet, telephony, television and radio.) have brought the potential for the internationalization of medical science. Only the stark contrast in the availability of resources and the desperate lack of the most basic facilities and infrastructure in the poorest countries stands in the way of medical interventions that could save millions of lives each year.

In the last 28 years a strong lobby for public health and cost-effective primary health care has built up around the ideals of the WHO’s Alma Ata declaration. Those active in this movement embrace far-reaching notions of equity and access which make them critical of any policies which seem to undermine these values.

There is evidence of projects that have successfully reformed health systems – and there is also evidence of failed policies that if taken seriously can ensure mistakes are not repeated.

WEAKNESSES

The biggest weakness that confronts health systems in this epoch of globalization is the hugely unequal division of health care resources. The poorest countries with 84 per cent of the population and 90 per cent of the disease burden share just 12 per cent of health spending. The US alone, with just 5 per cent of the world’s population, spends at least $400 billion a year simply on administration of a grossly inefficient and socially exclusive system (Woolhandler et al. 2003).

The other striking imbalance is between the preponderant influence of market-style health system “reforms” proposed or imposed by the key influential global bodies and the abject track record of failure of these policies to deliver the promised results.

The phenomenon branded by Hart (1971) as the “inverse care law” can also be observed in the major inequalities in access to health care that persist within all countries (high, middle and low income). The best-resourced health services (and most private for-profit provision) tend to be concentrated in localities inhabited by the affluent and influential, while services in rural areas and for the urban poor, women, elderly, and people with mental health problems tend to be seriously lacking in facilities, resources and staff.

As noted in another paper for the Globalization Knowledge Network, shortages of skilled and trained medical and nursing staff in many developing countries are exacerbated by the “brain drain” of staff to wealthy countries or to more modern and better-resourced facilities.

In many developing countries this problem is compounded by the fact that governments are insufficiently accountable to populations as a whole, and especially to poor and vulnerable groups who lack either economic or political voice and power. But on a global level too the international bodies tasked with assisting development are dominated by richest countries and by neo-liberal ideology.

A major weakness in confronting the issue of health system reform is that the world’s leading economic and military power, the US, has the most costly and one of the least inclusive and least efficient health systems. US health insurers recognised more than a decade ago that they had largely exhausted their own profitable market, and have since been looking for market opportunities outside the US. A 1996 conference of leaders of managed health care in Mexico City discussed prospects in Israel, Korea, Venezuela, Canada, Mexico, Russia, France, Singapore, Brazil, New Zealand, Australia, Puerto Rico, South Africa and Argentina. (Smith R 1996). Significantly these captains of the private medi-
cal industry were not drawn to many of the countries with the greatest unmet health needs – since most of these LICs would not be in a position to pay a profitable rate for the services of expansionist HMOs.

However, scarce resources in LICs and MICs as well as OECD countries have been squandered on more expensive, bureaucratic market-style systems and “reforms” which have been promoted by global bodies and international policy-formers without any base of supporting evidence.

One common feature of such reforms is that they lead to the notion of health care as an economic transaction, a form of commodity, rather than as a public good or a product and component of social solidarity. Commodities are customarily traded and exchanged in a market, and the creation of a market in health care serves to break down notions of resource allocation and planning of services according to objectives of equity and efficiency.

This creates additional space for profit-seeking private sector providers, which everywhere prioritize contracts that “cherry pick” the most simple and low-risk treatments, for which caseloads are predictable and profit margins most generous. Expanding companies, many of them multinational corporations, have begun in some countries (notably the UK) to secure a growing share of the public sector health budget to supplement the more limited income that can be made through traditional means of marketing private health insurance and pay-as-you-go treatment to those who can afford it.

As a result the public sector becomes a provider of last resort, delivering services the private sector does not wish to offer, and carrying responsibility for the more complex, costly and risky caseload, but with reduced income and capacity, and reduced volume of routine cases to facilitate the training of new staff or research.

OPPORTUNITIES

The growing body of experience of various lines of health system reform offers governments and health system managers a real opportunity to learn lessons from successes, analyze failures, and avoid repeating them. A more systematic review could highlight the key role of the public sector in providing comprehensive care and support – and not only in those areas or on those health issues where the private sector sees no chance of profit.

This would logically lead to a halt to privatization, market-style reforms and the imposition of user fees. Instead global bodies (notably WHO), backed by NGOs, could embrace policies that encourage national governments to take responsibility for planning and shaping health systems, and to direct resources to areas and communities in greatest need – a possibility excluded by most “market-style” mechanisms.

Funding is already available from existing global partnerships to help strengthen health systems. There is an opportunity for this to be spent effectively, not least by building new, explicitly non-commercial global partnerships to train health professionals (as the Cuban government has begun to do), tackle specific diseases with a combination of preventive and curative intervention, offer relief, and at the same time help design and build up responsive, accountable health systems.

It already seems clear that political pressure, government regulation or donor funding can be used to force big pharmaceutical corporations to focus research on major world health issues, such as communicable and water- and vector-borne disease. The opportunity is there to develop the means to save millions of lives.

A new focus on strengthening health systems in developing countries to build a sustainable health care system gives a fresh opportunity to revisit and revive commitment to the objectives of the WHO’s 1978 Health For All initiative, focusing resources on evidence-based systems, and building an infrastructure of primary health care services and public health measures. The recent WHO focus on workforce issues gives a new opportunity for governments to recognize the need to recruit, train and retain a dedicated health care work force, with appropriate improvements in pay and reward systems.

The growing recognition that systems have to change, and need alternative ways of obtaining resources offers a new opportunity for debate on the merits and potential pitfalls of more equitable models of financing,
as discussed briefly below. The commonplace argument that health systems are generally in need of “reform” also opens the potential space for a discussion of alternative, non-market models for health systems based on:

- Universalism – comprehensive services free for all at point of use
- User empowerment
- Democratic participation
- Cooperation and collaboration in place of competition
- Planning and needs-based allocation in place of market forces
- Accountability
- Social solidarity.

**THREATS**

Perhaps the biggest threat to progress is that things could stay as they are, with health care resources profoundly unequal, and development funds and loans in the hands of global bodies whose policies have already been shown to have failed. No change would leave the poorest countries denied access to the resources they require to establish access, availability, affordability and quality in health systems.

No change would leave gaps in care and uphold wrong priorities which already leave billions of the world’s poorest people – especially women and rural populations – at risk of preventable disease or suffering from conditions for which support should be available.

In this largely dysfunctional global system, another threat would be that epidemics — including HIV/AIDS, avian flu and other diseases — could gather pace and overwhelm poorer countries, but also spread into middle- and high-income countries.

Some fragile health systems in developing countries could collapse under a combination of resource constraints and the loss of skilled staff to fill health care job vacancies in other countries.

A further threat would flow from the process of commodification, privatization and commercialization of health care, not only in developing countries but also in MICs and OECD countries, which again would have greatest impact on the old, the poor and the socially excluded.

If governments and international agencies continue to ignore evidence, but instead allow ideology to skew research and follow the bias of global bodies and the epistemic community, wasteful and counterproductive policies for health system “reform” will continue to be imposed.

There is the related threat of a new “Microsoft medicine” in which the priorities and billions of the Bill and Melinda Gates Foundation and other well-funded First-World technocrat philanthropists hijack the health policy reform agenda. This would leave the poorest countries with a patchwork of vertical programs reliant on high-cost high-tech medicines and vaccines rather than using donor support to help develop sustainable, accessible and equitable health systems.

The long-term threat from one-sided “partnerships” with the private sector – GPPPs – would deny the public sector any genuine control over policy and implementation, but oblige governments to pick up the bill and lay on ancillary support for initiatives and projects owned and controlled elsewhere.
Conclusions: Action to make systems and people better

Glimpses of an alternative: current experience of successful reform

Recent studies from the WHO and the Bank have highlighted the success stories of health system reforms in a number of countries.

Costa Rica and Brazil in Latin America, and Kerala in India were favourably discussed in WDR 2004 (157, 201-2, 44-5), but these success stories are not the fruit of market-style reforms and privatization. They are examples of national and/or regional government intervention, public spending and reduction or elimination of user fees. Indeed a whole chapter of WDR 2004 is entitled “Governments should make services work”, conceding that a market mechanism on its own is not able to deliver.

Sri Lanka and Thailand have also been identified by the Bank as examples of successful health policies (WDR 2006). Yet again both of these are examples of governmental policy, with services largely financed through public spending. Indeed the Thai system is criticized for leaving insufficient incentives for private providers to participate (WDR 2006:147).

Sri Lanka is also singled out by Oxfam (Emmett 2006) for reducing its maternal mortality rate to one of the lowest in the world, despite a third of the population living on £1 per day. The Oxfam report points to free health care and public provision as key factors in this success. Rannan-Eliya and Sonamathan (2005) also conclude that Sri Lanka and Thailand have succeeded in reaching the poor most effectively because their national policies stress universalism with little or no user charges and “do not explicitly target the poor, either through user fee exemptions or specially-targeted programmes” (2005:11).

The 2006 WDR acknowledges the achievement of Uganda which, having suffered almost two decades of user fees and plunging health outcomes, decided to scrap the fees in 2001, with the government increasing its health budget to compensate for the resulting loss of income and increased demand for care. “The
result was a significant increase in health care use, lower probability of sickness, and better anthropometric measures, especially for the poor” (WDR 2006: 146).

The Uganda example is also discussed, along with the lifting of user fees in South Africa by Gilson and McIntyre (2005), who echo the need for such policies to be carefully planned and resourced if local services are not to be overwhelmed and unable to cope with increased pent-up demand for health care services concealed by the charges.

A recent WHO report, Tough Choices: Investing in Health for Development (Spinaci et al. 2006), explicitly rejects the notion of applying a fixed “blueprint” for health systems and problem solving, emphasizing instead the need for local involvement and a “bottom up” approach.

The chapter on policy implications returns repeatedly to the need for greater government intervention and public funding, whether in China to ensure affordable and quality health care is available to the poor, or in Mexico to fund a universal health insurance scheme – and ensure the implementation of a “master plan” for expanded public sector hospital and other services (Frenk et al. 2006). In India, attempts at collaboration with the private sector have proved unsatisfactory, while non-profit NGOs have been “able to provide quality care at low cost or free to poor patients”. Where policy proposals include the private sector, it is not in the context of a competitive market, but seeking “collaborative efforts” to improve access to the most vulnerable groups.

Common lessons from success and failure

If recent DFID, WHO and World Bank reports are to be believed, the consistent themes of successful health reforms appear to be:

- elimination of the profit motive (and the resultant margin scooped out of health care budgets to benefit proprietors or shareholders)
- scrapping of user fees
- commitment to a universal service rather than seeking to “target the poor”
- replacement of competition with collaboration
- planning and coordination.

In other words the policy prescription imposed so dogmatically by the Bank and the IMF, which forced concessions and retreats from the WHO, has led developing countries down a blind alley: as Harvard University’s expert on the Chinese health system, William Hsiao, said recently:

“The world realises they have been following the wrong path. African nations are changing their course, India is waking up…Chinese people do not necessarily follow the mistakes made by other countries.” (Chan 2006).

Evidence is lacking to support market-style reforms: discussing public health in Haiti and Cuba, Farmer and Castro (2004: 17) conclude that

“It is difficult to support the assertion, widespread in international financial institutions, that the neoliberal economic policies now in favour will ever serve the interests of those living with HIV.”

However as Armada and Muntaner (2004: 38) argue, in many parts of Latin America at least, neo-liberal reforms of welfare states “are not inevitable”.

They are still the result of choices made by national governments, albeit under pressure to conform to the prevailing global ideology. “There is room for national governments to define and carry out redistributive, social democratic policies.” A similar theme is echoed by Muntaner and colleagues, reviewing the new health care reforms in Venezuela which buck the neo-liberal trend (2006).

With the new political alignments, including the defeat of US-backed presidential candidates in Peru and Nicaragua, strong energy prices and the emergence of new alliances around a more radical platform of domestic and international policies, it seems clear that much of Latin America does have significantly new choices.

Some new lines of approach are already well established. Venezuela’s President Hugo Chavez has been making use of Cuban doctors and teachers to deliver free health care to poor neighbourhoods and offering to lend money to other countries from the vast surplus from oil exports. Bolivia’s President
Evo Morales has been reaping the political rewards of a deal to bring in Cuban doctors to run the country’s first-ever free hospital. And, with many of the continent’s major countries now free from any commitment to the Bank or the IMF, new policy horizons could be opened up.

It is less clear how many new options will be opened up for heavily indebted and smaller countries in Central America (Nicaragua), the Caribbean (Haiti) or for HIPCs in sub-Saharan Africa which are still servicing extensive debts to the International Monetary Fund and the World Bank and dependent upon donor funds. There is scope and political space for other countries too to break away from the failed neo-liberal model: only this type of change in policy can open up real chances of success.

Wherever health systems have attempted to implement the stock formulae of reducing the poor to a minimal “essential package of care”, user fees, separating purchasers from providers, maximizing private sector provision and financing, competition, decentralisation and corporatisation of providers, these policies have proved expensive, unpopular and ineffective. This has proven true whether the setting be the richer OECD countries, the transition economies, the middle- and low-income countries of Latin America and the Caribbean, or the largely low income countries of Sub-Saharan Africa.

FIVE POSITIVE CONCLUSIONS

From these common lessons flow five positive conclusions to shape health policy.

First: do no harm

The evidence is still being gathered, but virtually all of the initial findings point in one direction. The neo-liberal menu of marketisation, privatization and health sector reform are all costly failures. That’s why virtually every OECD country and the OECD itself have backed away from them, leaving only the British and the Portuguese rushing towards privatization and market-style measures and the United States already living with them and counting the cost.

So a very first, relatively simple but very progressive step that could be taken right away would be to stop adding to the list of failures and call a halt to any further implementation of the key policies on the market-driven menu.

Obviously a rejection of failed approaches does not mean that potentially useful and progressive policies such as decentralization have to be discarded altogether, especially if combined with steps towards broad and democratic participation, such as the process pioneered in Porto Alegre in Brazil (Bruce 2004). But it does mean that any such policies must be critically analyzed to ensure that they are appropriate, and any necessary safeguards for the poor and any necessary mechanism to ensure transparency must be put in place.

Second: explore and analyze alternatives that have worked

The narrow focus on the fixed menu of neo-liberal reforms and the widespread lack of political commitment and resources to facilitate alternatives have severely limited the development of positive and progressive models, especially in developing countries.

More recently a detailed analysis and comparison of the health systems of 16 Asian countries and their health outcomes have noted the limited impact of local projects and initiatives, arguing that, “Ultimately it is health systems that matter.” The authors identify the systems that appear to have delivered positive results for the poor as Sri Lanka, Thailand since 2000 and Malaysia. What do they have in common? Their national policies reject targeting in favour of universalism: “the only poor countries where the poor are effectively reached are those where policies do not explicitly target the poor.” (Rannan-Eliya and Somanathan 2005: 11). By contrast countries did worse where they levy user fees for health services or allow a high incidence of “informal” fees:

“It is a legitimate question given this experience, whether any pro-poor health strategy can be considered realistic as long as official policy continues to maintain user charges for health
spending.” (Rannan-Eliya and Somanathan 2005:11)

The most equitable Asian services also rejected the neo-liberal approach of providing only an “essential package” of health services centred on primary care, and allocated a much larger share of spending to hospital and inpatient services to provide substantial risk protection (op.cit: 12). Indeed Rannan-Eliya and Somanathan stress their emphatic conclusion that no low-income developing countries have been able to achieve good health incomes without establishing high levels of access and use of medical services. They argue the controversial view that these medical interventions are “responsible for the bulk of health improvement in the developing world in the past fifty years”. However, far from rejecting the notion of Primary Health Care, the mix of services that they propose, and their focus on universal coverage and access effectively revive the key values and objectives of the Alma Ata declaration.

A major Oxfam study reviewing the literature and experience on public services in developing countries echoes another of the findings of Rannan-Eliya and Somanathan by highlighting the contribution that can be made by well organized and properly resourced universal public services They also point to the gaps and failings that are common occurrences when profit-driven private services are involved in the delivery of services intended to benefit poor people (Emmett 2006). Unger and colleagues (2006) press the case for integration of health care in place of failed “disintegrated” medical models based on disease control, commodification and privatization of health care. Other examples of initiatives and projects that can be regarded as successful can be found in recent WHO (Spinaci et al. 2006) and World Bank (WDR 2004, 2006) studies. None revolves centrally around the neoliberal/market-driven policy menu, and most involve only non-profit NGOs if they use any private sector input at all.

In an extensive book of articles studying the impact in Asia, Africa, Latin America and the Caribbean of the standard reform menu from the standpoint of sexual and reproductive health, De Pinho (2005:334) points to four guiding principles in seeking out the “right reforms”:

- Strengthening state legitimacy and reinforcing good governance
- Building political will and commitment to a discourse of equity and rights that ensure an inclusive health system
- Strengthening health systems
- Developing constructive accountability and participative mechanisms.

De Pinho goes on to argue that reforms to be successful have to be “context-specific” rather than centrally driven by agencies and donors, and calls for more research to identify some of the information required to ensure services – especially those for sexual and reproductive health – are correctly focused (2005:338-9).

Alternative sources of expertise can also be brought in to assist a genuine effort to help the poor. Venezuela has brought in thousands of Cuban doctors and health workers to deliver care in deprived districts that Venezuelan doctors have historically neglected: Bolivia too has made use of Cuban expertise to deliver free cataract operations, and a Cuban medical team arriving in Pakistan in the aftermath of the Kashmir earthquake in 2005 treated 1.5 million patients free of charge, earning thanks from Pakistan President Pervez Musharraf (Lakshmanan 2005, Ospina 2006).

Another general lesson from the experience of health sector reform is that competition has largely failed to deliver its promised improvement in efficiency or value for money, while cooperation, collaboration and genuine partnership can generate real gains in efficiency effectiveness and quality (Berwick 2004).

The authors point out that many of the approaches used in this Equitap report “were originally developed by UK researchers (Adam Wagstaff, Julian Le Grand) in the ECuity project, a 15-year ongoing collaboration of European researchers examining equity in European health systems (van Doorslaer, 1993)” The Equitap project involve “the application of standardised methods and tools for assessment of equity in all participating countries, to enable reliable comparison of health system performance.” The dimensions of equity that have been examined “include equity in payments, delivery of health services, protection against catastrophic impacts and health status.” The authors state that “The work of the Equitap study represents the most comprehensive and systematic assessment to date of the available empirical evidence of health system equity performance in Asia” (2005:2)
Third: explore alternative sources and mechanisms of funding

The World Bank and WHO have always tended to be rather evasive over the possibilities of governments raising additional revenue for health care, but there are far wider options than simply taxing workers in the formal economy or levying generalized taxation which again tend to land most heavily on formal sector employees.

The amounts needed just to do the minimum in developing countries are massive. In 2001 the Bush administration was disconcerted to find the UN campaigning to raise $7 billion annually simply to fight AIDS in Africa, while the US had pledged just $200 million. As a Time Magazine commentary noted, “To a problem that will kill more than 2 million Africans this year…the US contributed the annual budget of a Midwestern hospital” (Ramo 2001).

More recently Bush has initiated the President’s Emergency Plan (PEPFAR), while the US has also increased its allocation to the Global Fund to Fight AIDS, Tuberculosis and Malaria. The Global Fund’s Fact sheets spell out the scale of the resources that have been mobilised:

“Raising New Resources – The Global Fund has raised in excess of US$ 9.7 billion to date from public and private donors, driving a dramatic increase in international funding to fight the three diseases over the last four years.

“Rapid Scale-up – US$ 7 billion has already been committed to more than 450 programs in 136 countries, making the Global Fund the largest international financier of TB and malaria control and among the three largest funders of AIDS programs.” (Global Fund 2007a)

However, the totals still fall well short of the amounts required simply to cope with AIDS (estimated as high as $9.2 billion a year in 2004, in addition to running costs of services and infrastructure) let alone build and sustain health systems offering a range of services. The total pledged for 2007 is just $2.6 billion, and for 2008 so far only $540m has been promised (Global Fund 2007b). To bring all of sub-Saharan Africa up to the per capita spending of South Africa on health would require an annual expenditure of $72 billion, compared with total current government and donor funding of just $8.5 billion (England 2004).45

Among the options discussed by Gottret and Schieber (2006: 128-130) to raise funds in the developed countries that could be channelled into donor funds towards the Millennium Development Goals, including those for health, are:

• A tax on airline tickets, projected to raise around $12 billion a year.46
• Establishing a specific international finance facility that would pool the funds of donor countries (no projected total).
• A ‘Tobin tax’ on currency transactions, which if applied at no more than 0.01-0.02 per cent to exchange market turnover of $300 trillion would raise $15-$28 billion per year.
• A carbon tax that could raise as much as $60 billion a year from high-income countries alone and encourage environmentally sound energy policies.
• IMF gold reserve sales – noting that IMF gold stocks are hugely under-valued at $30 per ounce, but that large scale sales would force down the market price.
• Create a new system of Special Drawing Rights which might generate resources for investment totalling $25-$30 billion.

The authors express no preference between these possible taxes, stressing only the complexity of persuading the key member states of the Bank and IMF to agree a common course of action.

While all these options require concerted action by the wealthiest nations, other options to raise substantial

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45 In 2003 the Commission on Macroeconomics and Health confidently predicted that “Assistance from developed nations should increase from the current levels of about US$ 6 billion per year globally to US$ 27 billion by 2007 and US$ 38 billion by 2015” (Global Fund website).
46 The UNITAID scheme has been launched as a mechanism to channel income from a levy on airfares into bulk purchases of drugs for low-income countries, although only France and Chile of the five founding countries (France, Chile, Brazil, United Kingdom and Norway) have so far established the levy. The French system was legislated in December 2005 and took effect from July 2006 and is expected to generate €200m a year. Côte d’Ivoire, Gabon and Mauritius have also brought in the levy, with another 15 countries pledging voluntary contributions to UNITAID (www.unitaid.eu)
funding for health care at the national level include levying a turnover tax on multinational corporation activities – since few of these companies pay significant tax, concentrating on repatriating profits. Steeply progressive taxation aimed at ensuring the wealthy and landowners are taxed in the same way as formal sector workers would also be widely popular and productive, although this is virtually never even discussed in World Bank and IMF documents.

One of the stock responses to such suggestions is to argue that progressive taxation would simply trigger massive flight of capital and a wave of disinvestment, triggering economic chaos. This type of response is regarded as an effective veto on the policy rather than leading on to any constructive proposals on how the system could be tightened to ensure that those with most wealth pay the most tax. Indeed recent studies indicate that the international finance system in its present form has already facilitated the extraction of trillions of dollars from developing and developed countries to tax havens. The Tax Justice Network has calculated that the amount held in this way by individuals alone is estimated to be $11.5 trillion, resulting in a loss of tax revenue equivalent to $255 billion worldwide each year – equal to the amount needed to fund the UN’s Millennium Development Goals (Spencer 2006).

The United Nations has denounced capital flight, but little has been done to stop it. The global institutions (IMF-OECD-World Bank) have dragged their feet on commitments made in 2002 to help developing countries improve the effectiveness of their tax régimes. As well, the OECD and its member countries have also failed to lift the veil of bank secrecy that protects tax evaders and capital flight. Action on these and other proposals already tabled and agreed would facilitate real progress and open up fresh options for developing countries to raise funds themselves and reduce their dependence on donor finance.

In any event a draconian level of tax on the wealthy is not necessarily required to open up the possibility of a much more equitable health system. Equitap’s survey of Asian health systems found that publicly funded health care sufficient to mitigate the worst inequalities could be provided in Sri Lanka, Thailand and Philippines for less than 2 per cent of GDP, funded through taxation (Rannan-Eliya and Soman than 2005:11).

However, there may also be ways in which countries can tap into large existing pools of funding. The World Bank has begun to recognize that global initiatives to fight TB, HIV/AIDS, malaria and other diseases cannot succeed in the absence of adequate health systems in developing countries. As a result, substantial resources are now in theory available to help build and strengthen health systems. “[T]his is a period of great opportunity to channel donor funds for health into strengthening health systems in countries” (World Bank Group 2005).

Proposals for Venezuela to establish a new Bank of the South using some of its $30 billion reserves may indicate another source of low-cost and unconditional borrowing for developing countries in Latin America. Also there is still a possibility that an increasingly influential Chinese government might see even a 0 per cent return on lending to developing countries preferable to watching the depreciation of its billions in US Treasury bonds and devalued dollars (Weisbrot 2006).

Fourth: invest in human capital

The crucial factor in the emergence of Cuba as a reservoir of medical expertise was the decision at an early stage of the Cuban revolution – influenced by Che Guevara, a physician by training –to establish a medical school to train Cuba’s own doctors (Bernal 2001). As a result, a country that lost 3,000 doctors in the immediate aftermath of the revolution now has more doctors per head of population than the US and can now deploy more doctors around the world than the WHO. In March 2006, 25,000 Cuban health professionals were at work in 68 countries (Ospina 2006).

Cuba has also become a major centre for training doctors, especially from developing countries, with hundreds of scholarships available giving free training, food, accommodation and equipment. In 2005 the first 1,600 Latin American students graduated.

47 The wider issue of brain drain is discussed in more detail in another paper from this Knowledge Network.
But even if dispatching students to Havana is not seen as desirable, the example of Cuban investment in self-sufficiency in health care, and in training doctors versed in the principles of public health alongside modern high-tech medicine is one which other – more prosperous – middle-income countries would benefit from following.

The brain drain of qualified medical, nursing and professional staff to higher pay and more developed health systems in the high-income countries also demands a radical policy. This includes many of the proposals outlined above in this section – to tackle the frustrations and under-investment which “push” staff to look elsewhere and make them more vulnerable to the “pull” of higher pay and better resources (Physicians for Human Rights 2004, Nduru 2006, McVeigh 2006 Clemens and Pettersson 2006).

Fifth: revive the values of universalism and tear down obstacles to the poor 48

The single most regressive policy to apply in the context of reaching the poorest and most vulnerable communities is user fees, especially for hospital inpatient services. Where fees have been abolished, as in Uganda and more recently in Zambia, a tide of pent-up demand was unleashed that gives further proof of their negative effect, especially on women, children and older people who have less access to and discretion over money.

Services for poor people tend to be poor services, not least because those which exclude the more affluent and healthy wind up with limited risk sharing, as well as excluding those with greater political leverage to force improvements and challenge abuses (Koivusalo and Mackintosh 2004).

The wider the risk pool, the lower the general level of risk, the more cost-effective the risk pooling and the greater potential social solidarity.

But fees are not the only obstacles to the poor. The distribution of health services – primary and secondary care – the availability and cost of transport, suitable translation services where required, cultural sensitivity in the treatment of patients and the appropriate mix of services to meet health needs of vulnerable groups all play a vital role.

Civil society organizations that share these goals and can contribute skills or other resources on a non-profit basis should be welcomed into a partnership to deliver a new, universal service, and play a role in a health system geared to the needs of the poor as well as the rich. Equitable, universal and sustainable health systems could begin to take shape within a framework that puts developing countries in the driver’s seat, aided and advised by not-for-profit organizations including the WHO, and enlisting the assistance and resources where appropriate of the private sector and the governments of high-income countries. An inversion of this process, which leaves the poorest country governments subordinate to a hierarchy of external donors, policy-makers and commercial interests, is likely to fail on all the important measures.

48 And also in developed countries: similar scenes and issues were noted at the launch of the National Health Service in Britain in 1948.
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