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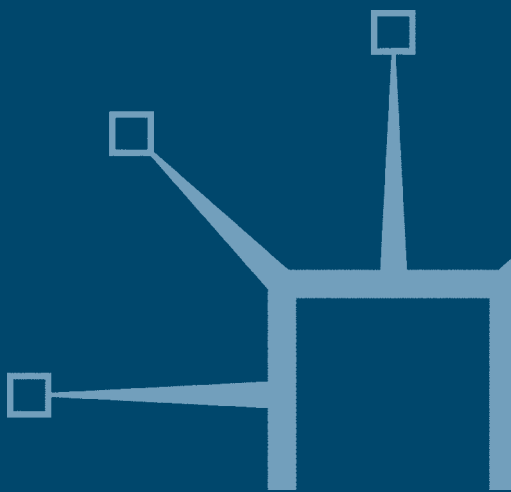
Commercialization of Health Care

Global and Local Dynamics and Policy Responses

Edited by
Maureen Mackintosh and
Meri Koivusalo



Commercialization of Health Care

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General Editors: **Thandika Mkandawire and Huck-Ju Kwon**, both at UNRISD

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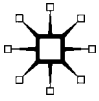

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Foreword

In the struggle for more developmental, inclusive and democratically rooted social policy, health policy is a key battleground. Health poses some of the most serious challenges, and offers some of the greatest opportunities. This book brings together the results of a major research effort in this field, supported by the United Nations Research Institute for Social Development (UNRISD) as part of its research project on *Social Policy in a Development Context*.

When UNRISD initially designed the *Social Policy in a Development Context* project in 2000, we realized that 'globalization' and its impact on the scope and nature of social policy-making in developing countries would be an important topic of research. Maureen Mackintosh and Meri Koivusalo took on the challenge of coordinating collaborative research on health policy with particular reference to globalization. To understand globalization and its impact on health, we need first to locate aspects of globalization, such as international integration of markets, knowledge and policy pressures, within a deeper analysis of the commercialization of health care.

This book brings together closely argued and summarized results from most of the research undertaken for the project. The researchers as a group intend to create a better understanding of the extent of commercialization that has been occurring in health care, its implications, and effective and ineffective policy responses. The research examines the interconnections between global and local commercialization processes, with the intention of empowering policy-makers to tackle the challenge of creating inclusive, integrated health systems in this context. Inclusive, decent, effective health care cannot be created without a democratically informed policy focus on how commercialization should be managed, framed and limited for public benefit – a far more demanding agenda than most discussions of 'regulation' of the sector currently allow. The authors aim to influence the 'common sense' of health policy towards a better policy framework that is rooted in a public commitment to integrated, effective and inclusive health systems.

The papers in this volume were presented at a conference in Helsinki, Finland in March 2004. UNRISD would like to take this opportunity to thank the National Research and Development Centre for Welfare and Health (STAKES) for hosting this conference. UNRISD is grateful to the Government of Finland, the Geneva International Academic Network (GIAN), the Swedish International Development Cooperation Agency (Sida) and the United Kingdom Department for International Development (DFID) for their financial support to this component of the project. As is the case with all UNRISD projects, work on the Social Policy in a Development Context project would

not have been possible without the core funding provided by the governments of Denmark, Finland, Mexico, Norway, Sweden, Switzerland and the United Kingdom. Let me once again take this opportunity to express our gratitude.

Thandika Mkandawire, Director, UNRISD

Preface and Acknowledgements

This book is an outcome of UNRISD's innovative programme of research in Social Policy and Development, at the heart of which lies a commitment to demonstrate that inclusive social policy in low and middle income countries is and can be both economically developmental and democratically rooted. The aim of the programme is nothing less than to rebuild, through detailed primary research, the historical record, the political concepts, the economic frameworks and the understood case for democratic, inclusive and developmental institutions of social welfare in developing countries.

In this intellectual and political task, health care is a key international battleground, on which competing visions of the ethical and political basis of society, and of the nature of the economy, are fought out. Health systems are powerful drivers of social exclusion or inclusion: key markers of a country's public ethics that play a central role in nation building and in response to national crisis. Internationally, the (patchy) international integration of health care markets and its consequences form a contested aspect of 'globalization', associated with intense political pressure on developing countries to adopt – intellectually and in policy terms – a market-led model of health care to which there is widespread local resistance. We analyse the extent to which, globally and locally, health care is becoming a commercialized sector of the economy, and explore the scope for creating good quality, inclusive health systems in that context. We very much hope that this book will contribute to a shift in the international 'common sense' in health policy, towards a more humane, inclusive, egalitarian and ethical framework for policy formulation.

As co-ordinators and editors of the project, we would like to thank UNRISD, and specifically Thandika Mkandawire, for the intellectual and funding support that has made all this new primary research possible; also at UNRISD, Cynthia Hewitt de Alcàntara, Huck-Ju Kwon, Shahra Razavi, and Josephine GrinYates and Wendy Salvo; without the efficiency, hard work and warmth of Wendy and Jo, the project would simply never have happened. For support for the final project conference in Helsinki we also wish to thank Pertti Majanen, Matti Jaskari and Taisto Huimasalo from the Finnish Ministry for Foreign Affairs, and Kimmo Leppo from the Finnish Ministry for Social Welfare and Health; also Minna Ilva, Alexandre Peyre Dutrey, and Lorraine Telfer-Taivainen. Our thanks also to Avis Lexton for assembling and formatting the book manuscript. For further funding and material support we thank RUIG, the Réseau Universitaire International de Genève, STAKES in Finland and the Finnish Ministry for Foreign Affairs and also the Open University, UK.

We also thank all our project participants and contributors, and also all those people to whom we have written over the two years of the project for help and advice, and who have responded so patiently and supportively. We learned a lot from participants and commentators in workshops in Geneva and at the Helsinki conference, including (from UN organizations) Ellen Rosskam, Tony Shorrocks, Mikko Vienonen, Mary Collins, Nick Drager and Orvill Adams, and UN Under-Secretary General Anawarul Chowdhury; also Juan Rovira, John Hilary, Anil Bhattarai, Rogatien Biaou, Manuel Montes, Rene Lowenson, Mike Rowson and Viroj Tangcharoensathien. This book is, however, the sole responsibility of editors and authors. As editors we have enormously enjoyed the intellectual engagement with our project colleagues over the last two years, and have also learned a lot from working with each other across exactly that intellectual divide – between health policy analysts and economists – that we hope to bridge in this book.

Maureen Mackintosh and Meri Koivusalo
November 2004

Notes on Contributors

Christa Altenstetter (PhD) is Professor of Political Science at the Graduate School of the City University of New York (CUNY), and Queens College of CUNY. Her current research interests are the regulation of medical devices and the medical technology industry, national and transnational public policy-making processes, and comparative health care reform in Europe. Among her publications are *Health Policy Reform, National Variations and Globalization* (Macmillan 1997), and numerous book chapters and articles published in refereed journals.

Rama Baru is an Associate Professor at the Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi. Her research interests include privatization of health, international health policy, comparative studies in health systems and disease control programmes. She has published a book entitled *Private Health Care in India: Social Characteristics and Trends* (Sage Publications) and has contributed chapters to several edited volumes.

Inna Blam is Research Fellow at Novosibirsk Institute of Economics and Industrial Engineering. Her major research interests and publications are in applied econometrics and social economics. She is conducting research on Russian households' demand for higher environmental quality, under the umbrella of the Economic Education and Research Consortium, Russia and CIS.

Sudip Chaudhuri is a Professor of Economics at the Indian Institute of Management Calcutta. His main research interests are problems of industrialization in developing countries, the role of the state in economic change, globalization and liberalization in developing countries. His recent work includes a book on *The WTO and India's Pharmaceuticals Industry: Patent Protection, TRIPS and Developing Countries* (Oxford University Press 2005).

Lucy Gilson holds a joint appointment between the Centre for Health Policy, University of Witwatersrand and the London School of Hygiene and Tropical Medicine. She is involved both in health policy and systems research, with a particular interest in health and health system equity, and in capacity building in this field. Her recent work includes investigation of public/private interactions in the South African health system and work on primary health worker motivation.

Celia Iriart is Assistant Professor, Department of Family and Community Medicine, Masters in Public Health Program, University of New Mexico. Her fields of research are the impact of globalization on medical practice in the US; global trade and mental health services; health care system reforms in Latin America; and health care service organization and community participation. Her recent publications include (with H. Waitzkin) 'How the United States Exports Managed Care to Developing Countries' in V. Navarro and C. Muntaner (eds), *Political and Economic Determinants of Population Health and Well-Being: Controversies and Developments* (Baywood Publishing Company, Inc. 2004).

Rebeca Jasso-Aguilar is a graduate student in the Department of Sociology at the University of New Mexico. Her current research interests are in globalization and health care, and anti-privatization social movements in Latin America. Her publications include (with H. Waitzkin, A. Landwehr and C. Mountain), 'Global trade, public health, and health services: stakeholders' constructions of the key issues', *Social Science and Medicine* (forthcoming); and (with E.R. Shaffer, H. Waitzkin and J., Brenner), 'Global trade and public health', *American Journal of Public Health* (forthcoming)

Mamadou Kani Konaté is a sociologist, and Executive Director and Senior Researcher at the Centre for Research and Training Support (CAREF) in Bamako, Mali. His main interests are behaviour changes in health, reproductive health and education. He is a qualitative researcher, whose most recent publication is (with Mouhamadou Gueye and Sarah Castle) 'Timing of first intercourse among Malian adolescents: implications for contraceptive use' in Yanyi K. Djamba (ed.), *Sexual Behaviour of Adolescents in Contemporary Sub-Saharan Africa* (in French), Studies in African Health and Medicine Number 11 (Edwin Mellen Press 2004).

Bakary Kanté is a rural development specialist, with the World Bank Office in Bamako, Mali. He is an agri-business economist with experience of research in food security, poverty alleviation and sustainable development. Since 1992 he has worked as an independent consultant with international organizations including FAO, UNIDO, UNDP/ILO, the International Red Cross and the Red Crescent, on topics including institutional reform in rural areas, rural infrastructures, water control management, and income diversification

Tausi Mbaga Kida is a researcher for the Economic and Social Research Foundation (ESRF), Tanzania, and also contributes to a joint Postgraduate Diploma Programme in Poverty Analysis delivered by ESRF, Research on Poverty Alleviation (REPOA), Tanzania, and Institute of Social Studies (ISS), Netherlands. Her main research interests are in health policy (access to health

care, health care financing, HIV/AIDS) and in rural development and poverty analysis.

Meri Koivusalo is senior researcher in the Globalism and Social Policy Programme at the National Research and Development Centre for Welfare and Health. Her research interests and publications are in the fields of health policy, globalization and the impact of international agreements and organizations on national health policy and health systems.

Sergey Kovalev is Senior Lecturer in Economics, Novosibirsk State University where he teaches courses on economics of transition and on health policy reform in Russia. His major research interests and publications are in the economics of transition. He is completing a research project on reform in the oil and gas sector in Russia, under the umbrella of Economic Education and Research Consortium, Russia and CIS.

Huck-Ju Kwon is Research Coordinator at the United Nations Research Institute for Social Development (UNRISD), while on leave from the Sung Kyun Kwan University, Korea. He has worked on comparative social policy in East Asia and the politics of public policy. His publications include the edited book *Transforming the Developmental Welfare State in East Asia* (Palgrave 2005).

Angela Koury Menescal Landwehr obtained her medical degree at the School of Medicine, University of Brasilia, Brazil, and her MPH from the University of New Mexico, where she focused on public health policies in Brazil and contributed to the Fulbright New Century Scholars Program's project on 'Impacts of International Trade on Public Health Policies'. She works for Brazil's national health programme as a primary care physician and has coordinated public health initiatives to prevent and to treat hypertension, diabetes and leprosy; currently she is focusing on smoking cessation programmes.

Asa Cristina Laurell has been Secretary of Health in Mexico City since 2000. She was previously a professor at the Autonomous Metropolitan University in Mexico City. She has published extensively on social epidemiology and social and health policies since 1975.

Jane Lethbridge is Senior Research Fellow, Public Services International Research Unit (PSIRU) at the Business School, University of Greenwich, London UK. Her main research interests are commercialization of health care, social dialogue and trade union responses to liberalization. She has recently published 'Public sector reform and demand for human resources for health', *Human Resources for Health* (2004) November 23: 2(1): 15 and 'Combining

users' and workers' interests in the health-sector trade unions and NGOs', *Development in Practice* 14(1&2) (2004).

Maureen Mackintosh is Professor of Economics at the Open University, UK. Her research interests are in the economics of markets in 'social' goods such as health care and social care, both in the UK and in African contexts. Her recent writings include 'The market shaping of charges, trust and abuse: health care transactions in Tanzania' (with Paula Tibandebage) forthcoming in *Social Science and Medicine* and *Making the International* (edited with Simon Bromley and others, Pluto Press 2004).

Abla Mehio-Sibai is Associate Professor at the Department of Epidemiology and Population Health, Faculty of Health Sciences, American University of Beirut. She has been involved in a number of major research projects on population health, and was the scientific coordinator of the multi-centre European Commission-funded research on 'The Impact upon Families and State of Traumatic Injury Related Disability' (1996–2000). She has been on several advisory committees, national and international, to support the establishment of a database structure for the reporting of morbidity and for policy formulation for the elderly population in Lebanon.

Kwadwo Mensah is a Human Resource Management consultant. Originally trained as a medical practitioner, his main research interests are in the internal and external migration of health workers. His recent research work was on 'Attracting and Retaining Health Staff: a Critical Analysis of the Factors Influencing the Retention of Health Workers in Deprived/Hardship Areas' funded by the Ministry of Health, Ghana.

Luisa Mussot is a sociologist and works as an Assistant at the Health Ministry of Mexico City. Her main research interests are in social and health market reforms in Mexican social development. Her publications include 'La reforma de la seguridad social', in *Agravios a la Nación* (Mexico, Galileo 2000), 49–74, and 'México: La estrategia social del nuevo milenio', in *Geopolítica de América Latina y el Caribe. Latinoamérica Fin de Milenio* (Mexico, Fondo de Cultura Económica e Instituto Panamericano de Geografía e Historia, 1999), 161–92.

Eeva Ollila is senior researcher in the Globalism and Social Policy Programme (GASPP) at the Finnish National Research and Development Centre for Welfare and Health (Stakes). She has published research on population, pharmaceutical and health policies. Her most recent work has been on health promotion policies and on health care policies, as well as on the health policy implications of global level public–private partnerships.

Kasturi Sen is an independent researcher based in Oxford, UK. She is completing a book on patterns of health care utilization in three states in India with a focus on the commercialization of public health. The research was funded by the European Commission, where she has acted as an adviser on health and social projects for the past decade. She has also recently advised the WHO and the United Nations on the training needs for ageing in the developing world and has published on the global restructuring of health services as well as on health services in South Asia and the Middle East.

Sun Qiang works in the Center for Health Management and Policy, Shandong University, Jinan, Shandong, P.R. China. His main research fields are economic evaluation of disease control, and the impact of economic globalization on health. Current research projects include a study of the compliance of TB patients on DOTS, funded by WHO/TDR, a study of public health planning in a western part of China funded by the World Bank, and a study on the impact of TRIPS on access to medicine, a multi-country comparative study funded by WHO.

Byongho Tchoe is a Director of the Social Insurance Division of the Korea Institute for Health and Social Affairs (KIHASA). His main research interest is in advancing social health insurance within broader health policy and health markets, in pursuit of equity and efficiency. He recently participated in several research projects, including: an evaluation of equity of access to health care under the National Health Insurance, determinants of national health expenditures, and reform of the provider payment system.

Haroon Wadee is a researcher at the Centre for Health Policy, University of Witwatersrand. He has undertaken research in health financing reform, primary care contracting and public–private interactions. He is currently a doctoral candidate at the University of Witwatersrand studying the implications of market-style reform in public hospitals. In addition he is involved in postgraduate teaching in health policy and health financing and is currently developing training in the area of trade and health systems.

Howard Waitzkin, MD, PhD, is Professor of Family and Community Medicine, Internal Medicine, and Sociology, University of New Mexico. His work has focused on health policy in comparative international perspective and on psychosocial issues in primary care. His books include *The Second Sickness: Contradictions of Capitalist Health Care* (Rowman and Littlefield, updated edition, 2000), and *At the Front Lines of Medicine: How the Health Care System Alienates Doctors and Mistreats Patients . . . and What We Can Do About It* (Rowman and Littlefield, 2001, paperback edition, 2004).

Eduardo Zepeda is an employment specialist at the UNDP International Poverty Centre. His recent publications include (with Kevin Middlebrook editors), *Confronting Development: Asssessing Mexico's Economic and Social Policy Challenges* (Stanford University Press and Center for US–Mexcian Studies UCSD 2003) and (with Diana Alarcon) 'Economic reform or social development? The challenges of a period of reform in Latin America: case study of Mexico', *Journal of Social Development Studies* (Spring, 2004)

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Part I
Commercialization: Nature, Causes and Effects

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1
Health Systems and Commercialization: In Search of Good Sense

Maureen Mackintosh and Meri Koivusalo[1]

1.1 Introduction: health systems' objectives and health care commercialization

It is the argument of this book that health systems exist to fulfil purposes, including protecting and improving health and the provision of professional, ethical, accountable and accessible health care for all. Therefore policies that influence the nature and extent of health care commercialization should be designed to further those purposes. To achieve this, better economic, social and technical analysis of health care commercialization is required as a foundation for effective health policy.

Based on original research, the book's contributors, predominantly researchers based outside the high income countries, build up an analysis of the growing scale of commercialization of health care worldwide, its sources and consequences, and examine more and less effective policy responses across the world. Commercialization, this research demonstrates, is a powerful force for change in health systems, and one that is currently being actively promoted; we argue that it should instead be reshaped, directed, and in part blocked, in the interests of better health.

We employ the concept of 'commercialization' to encompass, and to allow us to examine within a single framework, a number of related processes. By 'commercialized' health care we mean: the provision of health care services through market relationships to those able to pay; investment in, and production of, those services, and of inputs to them, for cash income or profit, including private contracting and supply to publicly financed health care; and health care finance derived from individual payment and private insurance.

This concept of commercialization is thus wider than the 'private sector' of provision and finance, encompassing, for example, commercial behaviour by publicly owned bodies. It is also broader than 'liberalization' and 'marketization', each of which refers to a shift to market-led provision from state-led or state-constrained systems, and broader than 'privatization', which refers to the sale or transfer of state-owned assets into private hands.

It has been well understood for many years that markets in health services and health insurance are problematic: bedevilled by incentives for overtreatment, withholding of information and inefficient exclusion from access to insurance (Barr 1998). It is also well understood that redistribution towards those unable to pay is an essential element of health system design. In the current context of expanding commercialization, the challenge is therefore to develop an institutionally and contextually differentiated understanding of the evolution and effects of commercialization in input supply and health service provision, in countries at different levels of national income per head, and in global markets, as an essential basis for health policy. This book is a response to that challenge.

Pressures for health care commercialization, we argue throughout, stem from an interactive mix of policy (and policy failures) and of private responses to shifting economic opportunities and incentives. Globally, corporate restructuring to take advantage of international market integration and new incentives for international investment have influenced local patterns of commercialization (Chapters 2–4). So have international and regional regulatory changes and commitments, that open up these investment and trade opportunities, and associated national regulatory accommodation (Koivusalo 2003; Chapters 6, 10, 11, this volume).

Commercialization of national health systems has interacted with changing international health policies, including public–private partnerships that take commercial firms into new policy roles (Chapter 12). The rapid integration and commercialization of the international labour market for health care professionals have been driven by broader health system commercialization and by changing global hiring processes across the world (Chapter 13).

A different set of commercializing pressures have been constituted by acute economic crisis in some countries and periods, associated with public sector deterioration and collapse. In sub-Saharan Africa the 'health sector reform' requirements of liberalized clinical provision and public sector commercialization have generated and legitimated high levels of out-of-pocket health spending by the poor as well as the better off (Gilson and Mills 1995; Mackintosh 2001; Chapters 9, 17, this volume). In middle income contexts of economic and social crisis, greater reliance on private health finance and provision has generated high cost, socially polarizing health systems (Chapters 4, 5). The pressures exerted by widespread health system commercialization can alter the values and operation of the public sector, and may undermine national health insurance (Chapters 7, 8).

Effective policy responses generally have to move away from the 'health sector reform' framework, towards policies that influence and constrain the impact of commercialization. Examples in this book include national health insurance in a context of highly commercialized service provision (Chapter 15), and rebuilding public sector provision to guarantee universal access in a context of mixed finance and provision (Chapter 14). Less ambitious restructuring, such as private wards in public hospitals, has to be very carefully designed if it is to generate redistribution against the grain of commercial pressure (Chapter 16), while fee-charging primary care can undermine efforts to achieve redistributive tax-based finance (Chapter 17).

Commercialization of health care is therefore *both* a powerful, self-generating economic process and *also* a process that responds to effective policies and political choices. In health policy terms, it is a means not an end, its promotion a policy direction to be judged on its merits, not a premise on which policy can be built.

In the rest of this chapter we explain what we mean by health systems and their purposes; survey the extent and nature of commercialization in health care; and present a critical examination of the extent to which cross-country evidence can legitimate the promotion of commercialization. Our ambition, as the final section explains, is that this book should contribute to the emergence of a better 'common sense' in international and national health policy, focused on the construction of ethical and inclusive health systems, rooted in evidence and expertise, and drawing on more effective collaboration between economists and health policy analysts to underpin effective public policy for health.

1.2 Health systems and commercialization

Health policy is part of normative policy-making within a society, and is therefore embedded in legal rights and commitments made as part of public policies. Health policies are typically based both on values (not always made explicit) and also on evidence, experience, knowledge and technical expertise which are key aspects of health policies. Health systems are the institutional basis and expression of health policies, since the structure of health systems, their organization and governance, have fundamental implications for methods and costs of policy implementation.

Health systems cover more than health services for individuals. They include functions for which health is the first priority, and are essentially population-based, including public health, health promotion and assessment of health implications of other policies. The legitimacy of health systems is derived from political commitments made to citizens, so that accountability and responsibility for their proper functioning lie in the public domain and cannot be left solely to consumer choice and action. Crucially, the organization and functioning of health systems are grounded

in and constrained by the culture, resources and values of a country, yet operate in a field of medical care and normative policies which is open to international exchange and learning.

The continuing support for the World Health Organization's *Health for All* strategy and principles of primary health care has shown that values such as universal, equitable access to services have been adopted, and continue to be acknowledged, in very different countries (WHO 2003a; WHA 1998; WHA 2003). While the WHO took a different approach to health systems in the *World Health Report 2000*, it seems that the WHO has changed course. In the *World Health Report 2003* the WHO returned to an emphasis on integrated health systems and called for the reinforcement of health systems to be based on the core principles of primary health care as outlined at Alma-Ata in 1978: universal access and coverage on the basis of need; health equity as part of development oriented to social justice; community participation in defining and implementing health agendas; and inter-sectoral approaches to health.

Our definition builds on the same principles of primary health care, but also focuses on what health systems *do*. This can become lost in management terminology or over-emphasis on health services. Health systems we believe should address:

- Protection and promotion of population health and provision of preventive services, inter-sectoral action and emergency preparedness ('public health').
- Provision of health services and care for all according to need, and financing of these according to ability to pay ('health services').
- Ensuring training, surveillance and research for the maintenance and improvement of population health and health services and availability of a skilled labour force ('human resources and knowledge').
- Ensuring ethical integrity and professionalism, mechanisms of policy development, planning and accountability, citizen rights, participation and involvement of users and respect of confidentiality and dignity in provision of services ('ethics, accountability and policy').

Embedded in this definition is an understanding that health services must aim for universality of access according to need, and solidarity in provision and financing, and that health systems should be judged against these objectives. Solidarity here is about robust redistribution and cross-subsidy to sustain access on the basis of need. This implies that health system performance should not be exclusively defined in terms of health outcomes. Health systems do promote health, but they should also invest resources in chronically and terminally ill people. This is a fundamental matter of human dignity: health systems are not only about improving health and curing illness, but also about care, rehabilitation and alleviation of pain and disability. To assess these aspects requires attention to how systems

function, including the balance with home care which is a burden largely carried by women.

Commercialization has not only influenced health systems' operation, but has also influenced how health systems are defined. While health systems do cover different functions, the strong separation frequently made between public health measures ('public good') and health services ('private good') is not useful in the context of health systems functions. A narrow economic definition of public goods limits the scope of public health measures and provides an insufficiently explored presumption of an expanding role for markets in health services. This retreat from the traditional broader concept of public health has been found problematic in terms of logic, ethics and effectiveness of services, since there is no clear boundary between aspects of public health such as immunization, prevention of epidemics and environmental health, and personal health services that must also have the capacity to respond to emergencies (Qadeer 2001).

Health systems have been too readily reimagined as a collection of cost-effective interventions and strategic purchasing. Rather, sustaining effective health services requires a balancing of the different requirements of primary and outpatient and hospital care. Regulatory and organizational effectiveness is needed not only in relation to quality of care, but also for health technology and pharmaceuticals (Chapters 10, 11). These are too often treated separately from health services, even though they are of increasing importance to costs and quality of care in all countries, not only in the developing world (OECD 2003). Health systems have been transformed in the last fifty years, in terms of what they can do, by industrial innovation and investment in pharmaceuticals and medical technology. Yet more interventions do not always imply better care. The *laissez-faire* approach too often proposed at present for the commercial 'sector' should be replaced by active policies to direct research and development more towards public health needs, and to conserve scarce resources through rational use of drugs and technology.

Too close a focus on interventions and outcomes, furthermore, obscures the importance for evidence-based health systems of local gathering and evaluation of information. Data collection and surveillance functions rely on traditional aspects of medical care such as accurate diagnosis, pathology departments and undertaking obductions, crucial aspects of health systems rarely contributing directly to health outcomes. A health systems perspective brings into view the needs of the human resource base of the health system, including sustained training of nurses, auxiliaries and medical doctors, and capacities in management, research and the legal expertise for regulatory measures.

Health systems should aim to meet political and ethical commitments in the context of a legal framework of social rights of citizens. These commitments include forms of accountability and principles such as confidentiality, respect and communication, and response to malpractice. The emphasis on

rights overlaps with, but is distinct from, consumerist models that emphasize response to expectations and ensuring choice. Citizens' capacity to act as informed consumers is always constrained, most severely when ill; professionalism is essential to address the limits of consumerism in health care.

1.3 The extent of commercialization in health systems

Commercialization of health care long predates the current wave of international market integration, or 'globalization'. To measure the extent of commercialization we need a framework within which to interpret evidence. This section uses the currently dominant approach, part of the common sense in the international literature, of the 'public/private mix' (Bennett *et al*. 1997a, 1997b). Section 4 takes an alternative approach.

The 'public/private mix' is a metaphor: it places each health system along an imagined continuum between more 'public' and less 'private' expenditure and provision. One indicator of commercialization in this framework is therefore the percentage of a country's total health *expenditure* spent directly by private individuals (out of pocket or through private insurance). We examine this here using health expenditure data and other economic indicators for 2000, from the WHO and World Bank.[2] 'Private expenditure' is not of course spent only in the private sector; much also goes on fees for religious, other NGO- and government-provided care.

Three findings stand out from the cross-country data analysis. First, commercialized health care, on this expenditure measure of commercialization, is not a choice of the better-off countries; it is better described as an affliction of the poor. Higher shares of private in total health spending are strongly associated, across countries, with lower average incomes per head. Among rich countries, only the United States and Singapore have private expenditure shares over 50 per cent, while all but one of the countries with private health expenditure shares over 70 per cent have national incomes per head under $1000 per year.[3]

Worse, the poorer a country, the more likely the population is to face the most regressive form of health finance: out-of-pocket expenditure (Figure 1.1).[4] Where this is a predominant means of access to health care across the social scale it weighs most heavily on those on lower incomes and excludes the very poor. In many low and middle income countries, including India and China, but in no rich countries except Singapore, over 40 per cent of health care spending is out of pocket and/or over 3.5 per cent of Gross Domestic Product (GDP) is spent out of pocket on health care.

Third, 'socialized medicine' – health care financed through tax-based public expenditure and social insurance – is a 'luxury good' in economic terms, that is, it is purchased proportionately more *relative to GDP* in countries with higher incomes per head (Figure 1.2).[5] Economists' usual examples of

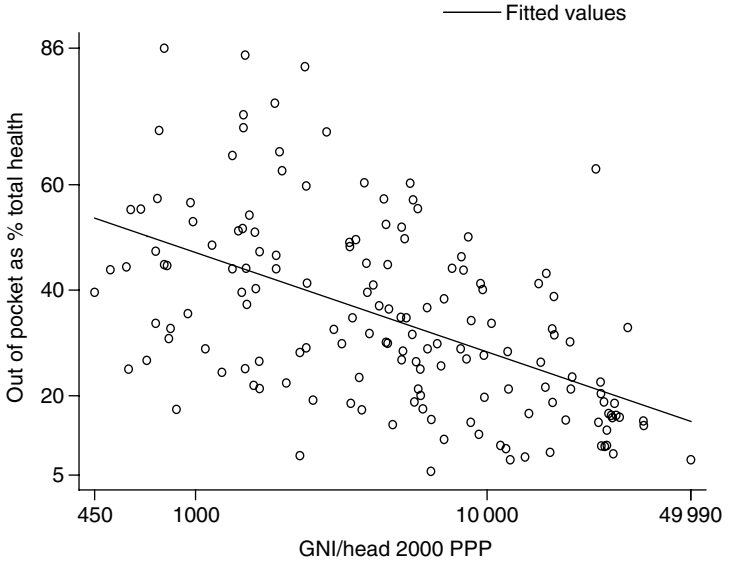

Figure 1.1: Out-of-pocket as percentage of total health expenditure and log GNI per head (PPP) 2000

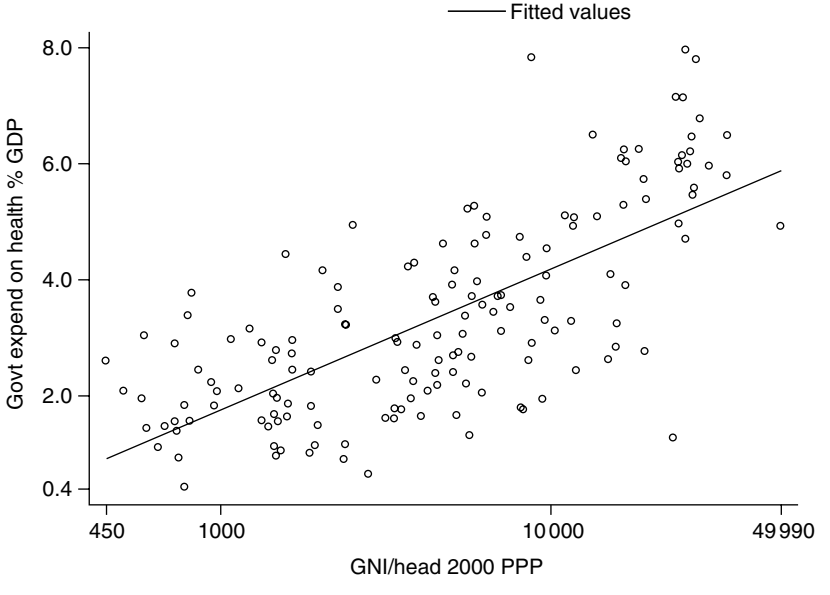

Figure 1.2: Government expenditure on health as percentage of GDP and log GNI per head (PPP basis) 2000

'luxury goods', on which more is spent relative to income at higher incomes, are things such as expensive cars (Begg, Dornbusch and Fisher 2000: 66), but ironically government/socially purchased health care fits the definition well at a national level. The irony lies in the association frequently drawn between privately purchased health care and quality of provision, since, strikingly, private spending on health care is *not* a luxury good in this sense; its share in GDP is completely uncorrelated with countries' income per head (Figure 1.3).[6]

The public/private mix in health care *provision* is much harder to measure. The multilateral data collection effort has concentrated on expenditure, and there are also conceptual and practical difficulties in collecting data on ownership of health services. We use two indicators: the proportion of hospital beds in the public and private sectors[7] and an intermediate indicator of primary care commercialization, the public/private split in use of ambulatory care for specified illnesses of children in forty-four low and middle income countries for which there have been Demographic and Health Surveys (DHS).[8] Both data sets refer to a range of dates in the 1990s and early 2000s. In each case 'private' includes all non-government provision.

These indicators show that in developing countries, primary care provision is in general highly commercialized, while hospital, and more generally

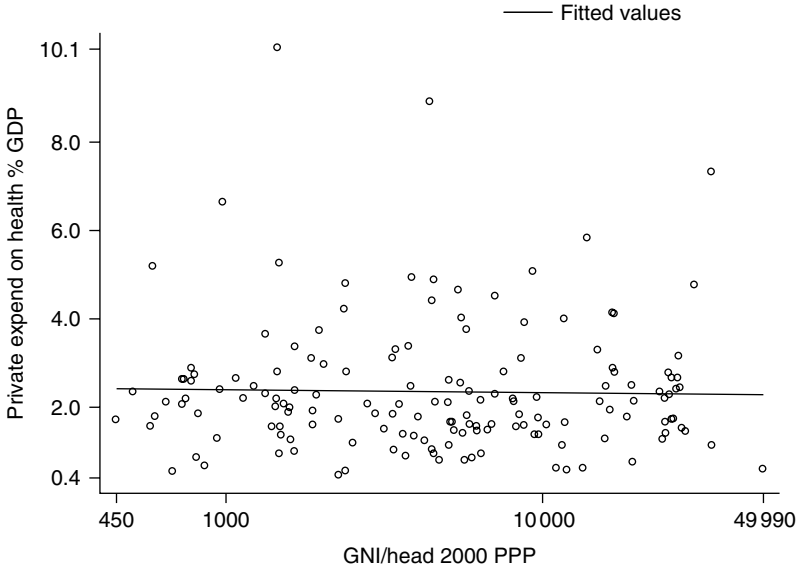

Figure 1.3: Private expenditure on health as percentage of GDP and log GNI per head (PPP basis) 2000

in-patient care is not. In almost all[9] of forty-four largely low income countries, over 50 per cent of children treated for acute respiratory infection (ARI) or diarrhoea were treated privately, and the percentage was unrelated to GNI per head. This finding of quite highly commercialized low income primary care is well supported by qualitative evidence (see Section 4), and has serious implications for public health.

Conversely, in none of the forty-four countries did deliveries of babies in private facilities make up over 25 per cent of total deliveries. Further evidence of lower commercialization of in-patient care is provided by the data on private share of hospital beds. Of thirty-two countries for which we have data, only four (two rich countries, Germany and Japan, and two middle income) have more than 50 per cent of hospital beds in non-government sectors; the middle income countries, South Korea and Lebanon, stand out very sharply as highly commercialized on this indicator, with around 90 per cent of beds non-government owned; the median is 23.5 per cent. Government hospitals thus provide, in this subset of countries, the bulk of hospital-based in-patient care.

Finally, and strikingly, there is *no* correlation between the public/private mix of provision and of finance: existing health care systems are not generally segmented into a 'private' sector funded privately and a 'public' sector funded by the government. In the 1980s (Hanson and Berman 1998), as today, health systems in low and middle income countries display mixed funding of mixed provision. Much public and some private expenditure goes on direct provision (government hospitals, company clinics) while private spending goes on purchase of services in all sectors: government, NGO and private.

1.4 Paths of commercialization: informalization, corporatization and globalization

An alternative policy-relevant approach to assessing the extent of commercialization in health care would replace the 'mix' concept with a model of different 'paths' of institutional change in health care. The metaphor in this case is an evolutionary one, inviting attention to feedback and cumulative change in the commercialization process over time. We sketch here three widely observed paths of health care commercialization within countries and across national borders, drawing on evidence of characteristics of the firms and other actors involved, and market characteristics such as the level and nature of competition and the payment processes. Each of these 'paths' is policy-influenced but not policy-determined. Each has an economic life of its own, driven by market dynamics, profitability and incentives, the costs of information, trading and job search, levels of income and changing patterns of competition.

Informal commercialization in low income primary care

In most low income countries in sub-Saharan Africa and South Asia, and in the Asian transitional economies, this is the predominant form of health care commercialization. Private, small-scale, largely unregulated provision has come to play an important role in urban primary care, for the poor and slightly less poor, in much of Africa (Chapters 9, 17). In India, 80 per cent of outpatient consultations are in the private sector in both urban and rural areas, and there is no effective licensing of practitioners (Narayana 2003). Vietnam has seen rapid growth of independent provision at primary level, with a strong bias towards urban areas, and widespread unlicensed practice (Nguyen Hong Tu *et al*. 2003). Unlicensed and off-prescription sale of drugs is widespread in all these areas. Payment is largely out of pocket, generating exclusion and impoverishment, and price-focused competition and repeated financial failure strengthen incentives for unethical practice (Tibandebage and Mackintosh 2002).

Corporatization and segmentation in middle income hospital care

Corporatization of hospital care, in the sense of hospitals run by quoted corporations for privately paying patients, has a higher policy profile than its extent within developing countries yet warrants. Lethbridge, Jasso-Aguilar *et al*. and Iriart (Chapters 2, 3, 4) document the reluctance of corporations to sustain ownership and provision of hospital care, and the extensive profit taking, risk shedding and corporate exit the sector has experienced in recent years. The high profile is in part the result of the active promotion by the World Bank of corporatization of hospitals, in the broader sense including more commercial behaviour by public hospitals (Preker and Harding 2003). The Bank has also promoted 'managed care' initiatives whereby corporate insurers commission privately provided care, and there is pressure on developing countries to open markets to private insurers (Chapters 3, 6). The development of a fully separate high income segment of commercial health care in developing countries is a strong aspiration for some multilateral commentators (Gwatkin 2003). In practice, however, these private high income market segments in middle income contexts tend to be financially fragile, with firms constantly in search of public subsidy and public contracting opportunities.

Globalization in input supply and labour markets in the health sector

While globalization in the sense of corporate investment across national borders associated with rising cross-border trade is fragile and patchy in hospital services, it has long been strong and is increasingly dominant in medical technology and pharmaceuticals. Multinational companies (MNCs) operate in increasingly integrated markets and their role in shaping global and

regional norm-setting on trade in goods and intellectual property rights has been substantial (Greenwood 1997; Chapters 10, 11, this volume). Trade and industrial policies including plurilateral and bilateral trade agreements and trade-related agreements on trade in services, investments and competition, profoundly influence health care. At the global level US and European-based MNCs actively pursue protection of corporate interests through international agreements, such as the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), which have substantial implications for health (Drahos 1995; Drahos 1997, Koivusalo 2003; Correa 2002; CIPR 2003). TRIPS, as Chaudhuri shows (Chapter 10), has little to do with market liberalization but may rather increase the monopoly power of currently dominant firms, with severe consequences for access to drugs for the low income majority of the world's population.

It has long been argued that, because health care is a labour-intensive system, its costs are substantially lower in developing than in high income countries (Drèze and Sen 1989; Sen 2001). However, as the migration of doctors and nurses from low income contexts to work in higher income systems accelerates, globalization of the health professional labour market – so far largely independent of international regulatory changes under the General Agreement on Trade in Services (GATS) – is undermining the staffing and financing of low income health systems. Mensah (Chapter 13) argues that policy responses should not undermine the human rights of professional staff from low income countries by preventing migration, but address the problem by rebuilding low income health care systems.

1.5 Evaluating health care commercialization: no comfort for commercializers

Health care commercialization needs to be evaluated in terms of stated objectives and values. In this section, we examine further the cross-country data used in Section 3 and ask to what extent higher levels of commercialization of expenditure and provision, in the public/private mix sense, are observed to be associated with better health outcomes. As measures of health outcomes we use two widely employed indicators: healthy life expectancy and child mortality (the probability of dying before five years).

We present our findings in the form of six 'stylized facts' about the associations between commercialization and these health outcomes. Stylized facts are empirical generalizations, sometimes invoked by economic theorists to underpin model-building: observed regularities that require explanation or explanation-away. Cross-country regressions such as these are not unproblematic, and the observed relationships vary in strength; we do not draw conclusions about causality. Rather, we simply seek to demonstrate that the cross-country evidence carries *no* comfort for those promoting commercialization as a generally beneficial process.

Countries with better health outcomes have significantly lower commercialization of health expenditure

Healthy life expectancy (HALE) was significantly higher and child mortality significantly lower, in 2000, in countries with lower ratios of private to total health expenditure (Figure 1.4 shows the plot for HALE), and this remains the case if we allow separately for the strong influence of the AIDS pandemic on life expectancy in sub-Saharan Africa.[10] Commercialization of expenditure is thus significantly associated with worse health outcomes. Higher income countries have, as noted above, relatively less commercialized health spending; higher income and less commercialized health expenditure are each associated with better health outcomes.

Countries that spend more of their GDP on private health expenditure do not display better health outcomes

Spending more of a country's total income privately on health care is *not* associated with better health life expectancy or lower child mortality, whether or not one allows separately for the effect of higher incomes on health outcomes. Higher commercialization in the sense of more of GDP spent on private care is very mildly associated with worse outcomes, but the association is not significant (Figure 1.5 shows the plot for child mortality).[11]

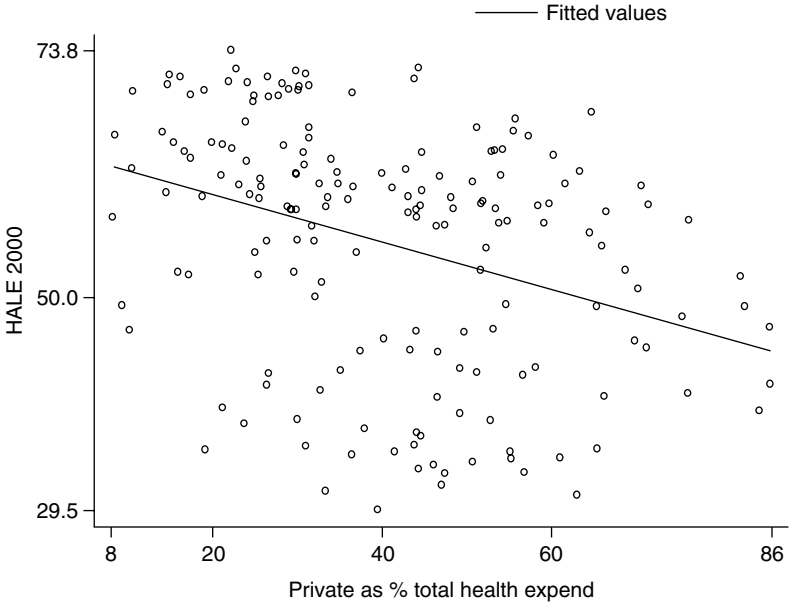

Figure 1.4: Healthy life expectancy (HALE) and private as percentage of total health spending, 2000

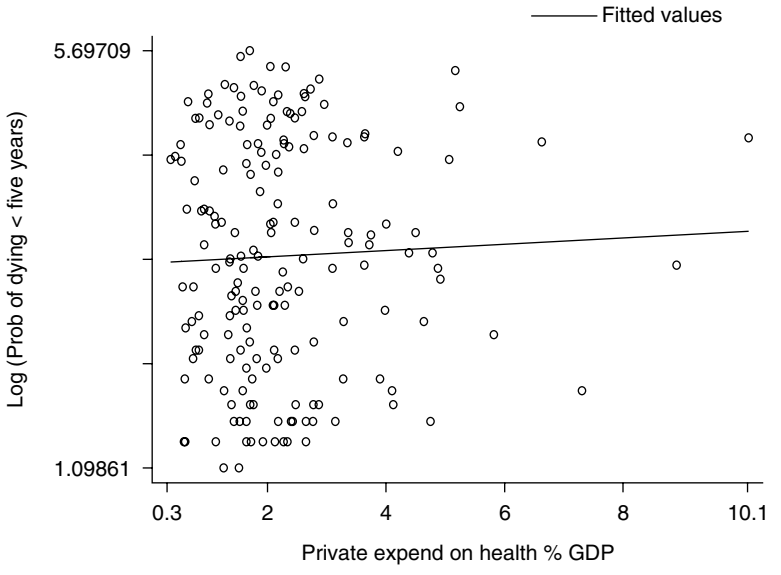

Figure 1.5: Log of probability of dying before five years and private expenditure on health as percentage of GDP, 2000

Countries that spend more of their GDP on health through public expenditure or social insurance do, however, have significantly better health outcomes

Healthy life expectancy is significantly higher and child mortality significantly lower in countries that spend more of their GDP on health care through government and social insurance funding (Figure 1.6 shows the plot for health life expectancy).[12] Health outcomes in richer countries are positively associated with both higher incomes, and more public and social health expenditure relative to GDP.

The last three stylized facts link indicators of commercialization to indicators of health care access in forty-four low and middle income countries in the Demographic and Health Survey (DHS) data set.

Better care at birth is associated with more of GDP spent by government or social insurance funds on health care, but not *with more private health spending/GDP*

This finding supports the last two: among forty-four DHS countries, the share of births that occur with a trained attendant is strongly associated with government health expenditure as a share of GDP, but has no significant association with private health spending as a share of GDP.[13]

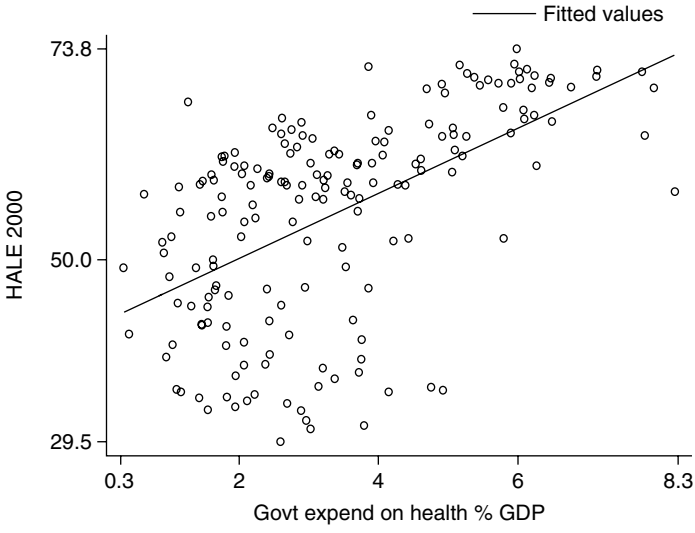

Figure 1.6: Healthy life expectancy (HALE) and government expenditure on health as percentage of GDP, 2000

Higher primary care commercialization is associated with greater exclusion of children from treatment when ill

The percentage of children who, when taken for treatment for acute respiratory infection (ARI) or diarrhoea, were seen privately can be used as a proxy for health care commercialization. In the DHS data set, a higher percentage of children with ARI or diarrhoea seen privately is significantly associated with a lower percentage of children who are treated at all. Figure 1.7 shows the plot for ARI.[14] Greater commercialization on this measure appears to be associated with higher levels of exclusion from access to care.

Commercialization of primary care is associated with greater inequality in rates of consultation for children when ill

In the DHS data set one measure of equality of access to health care can be constructed from the ratio of the percentage of children with ARI or diarrhoea in the bottom asset quintile[15] who were taken for treatment to the percentage of children in the top quintile who were treated. The higher this measure the more *equal* the treatment rates. For ARI this measure of inequality is negatively and significantly associated with primary care commercialization as measured by the proportion of children treated who are seen privately (Figure 1.8).[16] However, for diarrhoea the association, though also negative, is not significant.

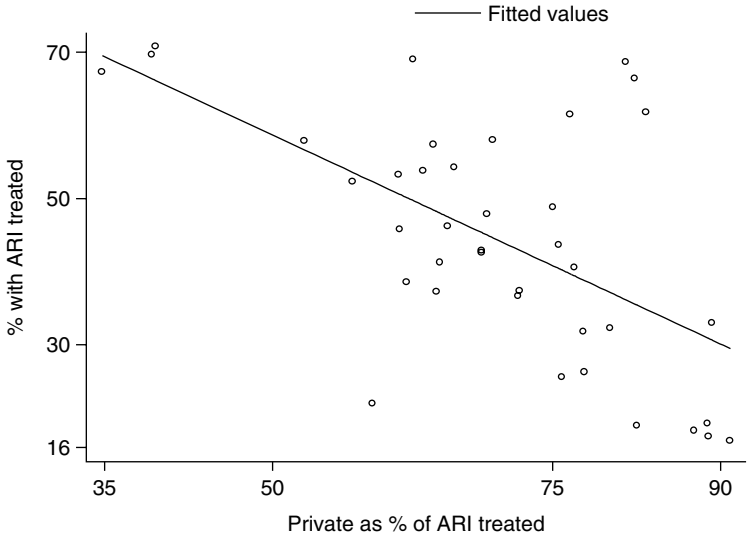

Figure 1.7: Percentage of children with ARI taken for treatment, and percentage of those taken for treatment seen privately, various years 1990–2002

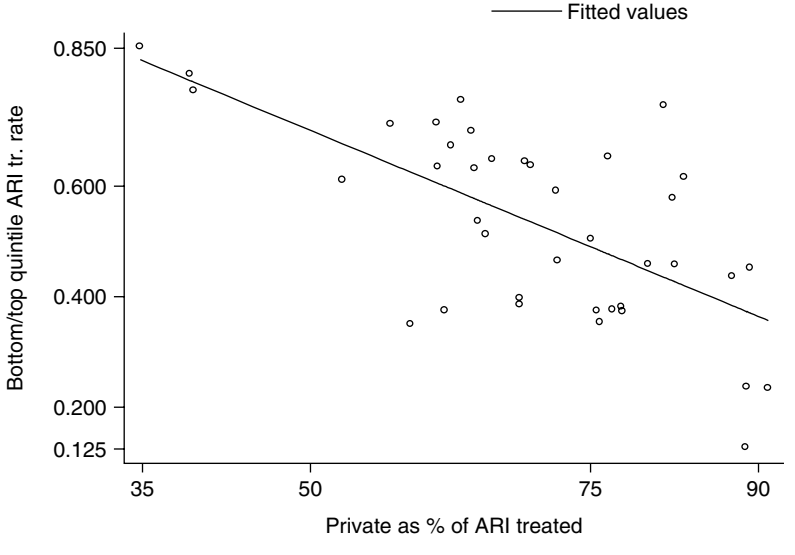

Figure 1.8: Ratio of percentage children with ARI from the bottom quintile taken for treatment to percentage from the top quintile, and percentage of all those taken for treatment seen privately, various years 1990–2002

Our aim in presenting these stylized facts is modest: to generate some empirically founded doubt about the assumed benefits of commercialization. The stylized facts illustrate the striking lack of evidence, in very widely used comparative data sets, for positive benefits from commercialization.

1.6 Conclusion: a better common sense for health policy: in search of good sense

Health care systems are thus quite highly, though unevenly, commercialized in developing countries. Further commercialization has been relentlessly promoted by international financial institutions, pushing to the margins of dominant health policy debate a set of issues that national health policy-makers and users of health services continue to be concerned with, notably health system integration and effectiveness and redistributive health finance. Yet the evidence base for the benefits of system-wide commercialization of health systems is largely lacking. We therefore end this chapter with some propositions, rooted in the research presented in the book, that can contribute to a better 'common sense' for international and national health policy.

'Common sense' and 'good sense' in health policy and politics

First a brief reflection on our concepts of 'common sense' and 'good sense'. In the *Prison Notebooks* (Gramsci [1929–35] 1971: 323–33), the innovative Italian Marxist philosopher Antonio Gramsci defined 'common sense' as 'a generic form of thought common to a particular period and a particular popular environment' (ibid.: 330), and identified within it a core of 'good sense', rooted in experience and systematic thought. A 'philosophy' he characterized as a coherent system of ideas that may become the common sense of intellectuals in a given place and period (ibid.).

The promotion of commercialization in the 1980s and 1990s, supported as it was by repeated appeal to elementary economic models of competitive markets, can be understood as a deliberative exercise in influencing the intellectual common sense, or philosophy, of national health policy-makers (Iriart *et al*. 2001). The pro-commercialization arguments even came to seem 'good sense' in many contexts, because of popular experience of deteriorated and even abusive public sectors. A presumption of commercialization as a basis for policy came to obscure the extent to which health success stories in developing countries relied on effective public sector initiatives in primary care, adult literacy and public health, and the reasons why many democratic countries turn to public initiatives and public and social insurance forms of health care finance (Ghai 2000; Chapters 14, 15, this volume).

We aim therefore in this book to contribute to what we believe is a re-emergence of a more effective and inclusive common sense in health policy, that links up with popular and political 'good sense' for health. The shift is visible for example in the WHO's *World Health Report 2003*, which returns to the integrated primary health care approach to the development of health systems. We summarize here key policy-related aspects of this emerging good sense.

A better common sense for health

First, commercialization is an important element of many health systems, but health systems should not be market-*led*. They should be governed on the basis of public priorities and accountability. The roles and limits of commercial activity in health are core decisions for national and local health policy-makers, and the capacity to make those decisions therefore needs to be safeguarded for democratic arenas. This implies the active protection of policy autonomy, avoiding too much 'lock-in' by international economic integration and global and regional regulatory constraint. It also implies the maintenance of the technical, institutional, research and resource base in health systems for decision-making.

It follows that the public sector itself should not be allowed to become commercialized, that is, driven by market incentives, whether by policy or by default. Public, non-market health care provision works in many countries as part of a 'mixed' health system. But failure to protect the public sector from the erosion of public values and purpose undermines its capacity to work for public benefit (Chapters 7, 8, 9, 17). Public provision or publicly managed health finance can only play their role in universalizing health systems if their principle of operation is non-commercial (Chapters 14, 15).

Second, do not allow the health care system to be segmented by creating a high income segment of private insurance for private provision. Such a strategy will raise health system costs and tend to leach resources from other parts of the health system, driving out cross-subsidy and undermining the finances of both private and government segments (Chapters 4, 5). If health care provision is highly commercialized, then universalization will rely on keeping commercial insurance at bay. Conversely, with substantial private finance, effective public services are required as a low cost basis for social insurance and for universalizing access by direct provision; and social insurance will have to be legally protected from 'cherry picking' by private insurers (Chapters 6, 14, 15).

Treat health systems, therefore, as a sphere of redistribution. Reducing risk pooling increases the burden on public financing, since 'buying' access for low income and seriously ill people to private provision becomes increasingly expensive. Instead, recognize that redistribution *within* health systems is widely regarded as politically legitimate and ethically desirable. It is also economically efficient to embed redistribution in national insurance against

health risk (Barr 1998). Developing greater cross-subsidy *can* be done effectively in partially commercialized systems (Chapters 14, 15, 16).

Third, use public and non-profit provision to influence the health system as a whole in the direction of integrated and accessible care. The proper role of the public and non-governmental non-profit service providers is *not* (despite the private companies' negotiating stance) to compete on a 'level playing field' with private providers; rather it is to create regulatory leverage over the operation of the system as a whole by influencing the incentives faced by the private sector. This argument implies a retreat from the mind-set that separates public provision – or 'interventions' to address specific diseases – wholly from the regulatory and planning roles; in very low-resource contexts, this separation can collapse capacity for policy implementation (Mackintosh and Tibandebage 2002). It re-emphasizes the importance of public action to ensure the infrastructural aspects of systems such as training and research.

Finally, integrate health policy priorities into trade and industrial policy decisions. Commitments made in bilateral and multilateral trade agreements, and national industrial and regulatory decisions, affect many aspects of health policies from public health measures and standard setting to service provision and pricing of pharmaceuticals (Luff 2003; Koivusalo 2003; Fidler 2003). Decisions on health-related aspects of trade treaties need to be made on health grounds, and where flexibilities exist these should be utilized (Chapters 10, 11). And health policy-makers therefore need to recognize as part of their concerns the industrial and market behaviour of large and small firms in health care supply and services. Understanding private firms' behaviour is essential to avoid, for example, public–private interactions and partnerships draining public resources, or regulatory changes in pharmaceuticals generating higher prices for poor patients (Chapters 2, 3, 10, 11, 12).

Countries' health systems, we noted at the beginning, reflect strongly their different history, resources, culture and administrative traditions and capacities. They also reflect the particular evolution of commercialization and industrial investment in each country and region. 'Globalization' has brought new forms of international market integration and new policy pressures, with widely differing effects in different regions and at different income levels (Chapters 2, 3, 4, 10, 11, 13). In this context, the construction of ethical and inclusive health systems remains possible. Policy needs to be rooted in a concept of health systems, in evidence and expertise, and also in appropriate economic analysis capable of underpinning effective industrial and regulatory policy for health. Our central theme is that health systems are part of the public policy sphere and that policies towards commercialization within health systems should and can be within national and local democratic control.

Notes

1. We are grateful to all the participants in a workshop in Geneva, March 2003, and in the Helsinki conference, March 2004, for comments and debate; the views expressed are solely our own.
2. WHO data online for 2000 (www.who.int/whosis), and *World Development Indicators* online (www.worldbank.org). For more detail see Koivusalo and Mackintosh (2004).
3. 163 countries; regression of private as percentage of total health expenditure on GNI/head (Atlas method); coefficient is negative and significant at 1 per cent level; the negative association is considerably *strengthened* using PPP data for GNI/head.
4. 155 countries; coefficient is significant at 1 per cent level; horizontal axis log scale; regression *x* variable is log GNI per head (PPP); result unchanged using Atlas method exchange rate data for GNI/head.
5. 155 countries; the coefficient is highly significant on both measures of GNI/head; note that the rich countries lie predominantly above the regression line; an additional dummy variable for rich countries is also significant.
6. 155 countries; no significant relationship between the variables; the use of GNI/head (Atlas method) data does not change the result.
7. New data set drawn from a wide variety of sources; our thanks to Seife Ayele for research assistance. Beds data provide a less biased indicator than ownership of facilities, since private hospitals tend to be smaller than government hospitals.
8. Source: Demographic and Health Surveys; data accessed online at www.worldbank.org. This analysis was done in 2003 before a 45th country was added to the online data.
9. 43/44 countries in the case of diarrhoea, 41/44 for ARI.
10. 178 countries. In a regression of HALE on private as percentage of health expenditure and on a dummy variable for sub-Saharan Africa both coefficients are negative and significant.
11. 178 countries. The indicator of child mortality is strongly skewed, hence fit is (mildly) improved by using the log of the dependent variable. The coefficient on the independent variable is insignificant. R^2 is 0.0001.
12. 178 countries; coefficient is significant at 1 per cent level.
13. Regression of percentage of deliveries with a trained attendant on both government and private health expenditure as percentage of GDP, 44 countries; only the first coefficient is both positive and significant.
14. 39 countries; coefficient is negative and significant at 1 per cent level, R^2 0.34.
15. The bottom 20 per cent of the population in terms of asset ownership.
16. 39 countries; coefficient is negative and significant at 1 per cent level, R^2 0.43.

2

Strategies of Multinational Health Care Companies in Europe and Asia

Jane Lethbridge

2.1 Introduction: understanding MNC strategies in a difficult health care market

'Health care is one of the most difficult markets to penetrate.'[1]

Multinational companies (MNCs) exert influence over the rate of commercialization and corporatization of health care worldwide, through direct investment and through their influence on regulatory decision-making. However, multinational health care companies have shown an uneven process of expansion in the last five years in what they perceive as risky and highly politicized markets. Health policy needs to be informed by a good understanding of MNCs' strategies of market development and regulatory influence.

This chapter presents findings from ten key informant interviews in five multinational health care companies and four interviews with trade unions, supported by analysis of company publications and evidence from market research reports, published academic research on aspects of contracting, regulation and pricing at a global and national level, and the press. The companies originate in Denmark, Sweden, the United Kingdom, Germany and Singapore, and the research explored some of the differences in MNC strategy between Europe and Asia. An interview schedule covered questions about the development of company marketing strategies, the relationships between companies and public health care systems, company approaches to pricing, and company attitudes to regulation and health insurance. This was sent to key informants before the interview.

The chapter has two central themes. The first theme is the interaction that can be observed between the changing characteristics of public sector and social insurance-financed health care in both Europe and Asia and the strategies and behaviour of the multinational companies analysed here. Company strategy is strongly influenced by both the historical background of the companies and the current market context. Conversely, multinational companies are becoming skilful players in influencing national markets and political environments in their own interests.

In Europe, national private health care sectors are shaped by market-dominant public health care and social insurance systems, and the specific context of national health system development. The presence of private sector companies in public health care systems is increasing because of policies favouring public–private partnerships, private finance initiatives, contracting out of services, including cleaning, catering, facilities management, and the corporatization of public sector institutions, plus restrictions on government provision of services (Sen 2003). In many countries the private sector has expanded in the past two decades into the provision of residential and home care for older people, people with mental health problems and people with disabilities.

In the process, the financing of the private European health care sector is changing, with a small group of companies floated on the stock market within the last five years as publicly quoted companies. Private equity firms have also started to invest in private health care companies, suggesting that they expect a rapid rate of return. However, despite these trends, in Europe multinational health care company expansion has been relatively slow (www.psiru.org/database). This chapter shows that European-based companies' strategies include further expansion into public sector markets and reshaping the opportunities in those markets.

Company strategies also include investment and market development in Asia. In South-east Asia there is a highly competitive health care market with private health care companies and government hospitals competing for fee-paying patients. In Singapore there is a system of public health insurance but private providers deliver 80 per cent of primary care services while public providers deliver the majority of acute care. Malaysia has a tax-based health care system with a parallel private health insurance sector, which has expanded in the last decade due to the Employees' Provident Fund, which gave its members the option of using their savings for a risk-rated health insurance scheme (Chee 2004). There are currently plans to introduce a new national health financing scheme. As part of a strategy to improve the health care available to the majority of the population in Malaysia, the coordination between the public and private sectors is to be enhanced so that more people can gain access to the private sector (Market Watch Malaysia 2004).

Trade union interviews in Malaysia show that the interactions between public and private sectors operate also in the health labour market. Corporatization of public hospitals, in the context of competition with the private

sector, has had immediate effects on the workforce through efforts to control labour costs by contracting out services, sacking staff and increasing workloads. An illustration of the public/private interface is the requirement for staff to work in both the public sector part of the hospital and the private patients' wing, resulting in health workers in the public sector wards covering for colleagues in the private sector wing or health workers working double shifts. Types of contracts have been changed to make staff more flexible, and staff reductions are affecting particularly those aged over 45. Within hospitals operating under business principles, divisions emerge between high income and low income departments. Performance-related pay also breaks down national pay agreements into individually negotiated contracts. The result is deepening divisions between different groups of health workers and different hospital departments in what is already a highly stratified sector.

Both Asian and overseas-based MNCs are seeking to contribute to pressures to segment the health systems into private care for the better-off, alongside government provision for others. In BUPA's words:

> *'. . . we do want to provide good quality care but to do that, you need a funding base that can afford that care . . . in Asia, we can only be in places where there is a certain standard of living that can afford private care.'*

This chapter analyses the approaches of European and Asian multinational health care companies to influencing government policy and regulation in South-east Asia.

The second theme in the chapter is the companies' response to the perceived high level of risk in private health care markets. The BUPA interviewee quoted at the beginning of the chapter went on to explain that the markets are difficult because health care affects the lives of most people and governments are cautious. There is also a strong nationalist sentiment involved. The result at present is unstable markets especially in developing countries: in Asia, companies are moving in and out all the time.

> *'The American companies came and established their base but over time they have their priorities back home and they left.'*

This perception, and the relevance of both themes to understanding multinational strategy, is confirmed by the analysis of US health care multinationals in Chapter 3.

2.2 The companies

The four European and one Asian multinationals analysed here illustrate a range of types of company in these markets. The companies were chosen according to three criteria: operations in one region (Capio and Parkway);

fully international operations (BUPA and Fresenius); health care companies set up by a parent multinational company (ISS).

Two companies, Capio and ISS, illustrate the influence of Nordic contracting experience on companies' strategy. Bure, a Swedish government-funded investment company, set up in 1994 a health care division which took advantage of the contracting out of public health care and social care services in Sweden and subsequently in Norway and Finland. The successful health care division was floated on the Swedish stock exchange in 2000 and the new company was called Capio. Capio defines its mission as *'to serve the public sector'*, and says it doesn't *'define itself as a private healthcare provider'*. It was the first private company in Sweden to manage a public hospital, it now owns that formerly public hospital company, and it is a major contractor delivering health care in the public sector. Capio is playing an active part in the new wave of private contractors delivering care to the public sector in the UK.

ISS, a Danish multinational facility services company, has developed through the Nordic governments' contracting out of ancillary services. Its health care goals are shaped by the position of the company in relation to public contracting. The ISS Healthcare division has evolved from health and social care investments made in the 1990s to become a focus of growth within a large global company delivering facilities management services. It provides services for both the public sector and private sector in Nordic countries, seeing an opportunity in governments' search for *'more efficiency and more effective ways of running the health care sector, trying to get inspiration from private operators'*.

That is also a theme in UK policy, and BUPA, a UK-based non-profit company providing both health insurance and health care, has benefited from the contracting out of social care for older people and child care in the UK, the basis of its expansion over the past decade. However BUPA's expansion of acute care has been limited by its focus on providing privately financed private care in a context where the UK National Health Service (NHS) is dominant. In the last fifteen years the company has expanded into both insurance and provision in Europe, Asia and the Middle East, and can see opportunities to provide services for the public sector in the UK and Asia.

The German company, Fresenius, whose main activity is the manufacture of equipment and products for renal care and a firm which is a key player in the global medical devices industry, provides a contrast. The global medical devices industry is highly competitive, as Chapter 11 shows, and manufacturing of kidney dialysis equipment has currently little scope for innovation. Fresenius therefore views health care delivery as an area of potential expansion. In 1997 it began to run renal dialysis clinics, and health care activities are now its largest division; it aims to *'become a large international health care company'* arguing that globally *'due to the expected privatization of health systems we will have good opportunities to build up a company that*

can command a leading position in the hospital field'.[2] This chapter analyses the market strategies of the company in Singapore and Malaysia, showing the subsidiaries to be sensitive to national government priorities as well as seeking to influence them.

Finally, Parkway Holdings is a multinational company based in Singapore, that operates hospitals, health care centres and laboratories in Singapore, Malaysia, Indonesia and India. It is a regionally based multinational in the same sense as Capio is regionally based in Europe, though until three years ago Parkway had a hospital in London. The corporatization of public hospitals in Singapore and Malaysia has led to increasingly intense competition between public hospitals and private sector providers for private patients. Parkway's strategy is distinctive in that it sees government services as potential competition in its priority niche providing for high income private patients, though it is also taking advantage of the Singapore government's policy of out-sourcing some clinical services.

This chapter analyses companies' strategic objectives and behaviour, and briefly reflects at the end on the implied challenges for regulatory frameworks and strategic behaviour by policy-makers.

2.3 Health insurance and health care market development

A key strategic issue facing policy-makers and large companies alike is the role of private health insurance and its relationship to the provision of health services by private firms. Company views of private health insurance can be seen as an indicator of how they see the future of health care, and in particular their positioning in relation to the public health care sector. There are significant differences between the European and Asian markets in terms of companies' approaches to health insurance.

In many European countries the market for private health insurance is slow-moving, and the European companies agreed that this was a difficult field for market development. One Swedish company made clear that they did not want a major development of private insurance in Europe: *'I hope not . . . – should have the French solution – should use it as a top up'*, so that the private insurance is supplementary and public and private coexist. The other Nordic company considered that an increase in private health insurance in Europe had encouraged private providers to invest, but that it takes five to ten years to get a return from insured patients; the business would only be attractive if insurance *'breaks through into hospitals'*, which they thought might happen. These firms both recognized, however, that if European public authorities can reduce waiting lists, the market for private health insurance will be squeezed.

Capio and BUPA are both aware of the potential impact that reduced waiting lists will have on the private health care sector in the UK. In the UK

there had been an initial expansion of private health insurance taken out by individuals after the 'internal market' was introduced into the NHS in 1990. However, since 1997, when tax relief on personal premiums was abolished, any expansion of health insurance has taken place in policies paid for by companies for their employees. In Denmark, too, companies have bought insurance policies, but if waiting lists are significantly reduced companies may no longer feel it necessary to guarantee access to health care for employees. *'A lot of companies are paying health insurance for their employees, because of cost of illness to the company if an employee is ill.'*

The 'self-pay' market, where people pay out of pocket for an operation rather using health insurance, also illustrates the influence of hospital waiting lists on the private sector. In the United Kingdom, self-pay operations have grown to 20 per cent of the private health care market in seven years. This might also decline if public sector capacity were increased.

Multinational health care companies are also aware that if they develop a larger role as health care providers for the public sector they may play a significant role in eliminating waiting lists, thus undercutting their own insurance market. If the development of new treatment centres in the UK is successful, then Capio considers that there will no longer be a need for private insurance at a service level. As the recent recipient of one of the largest contracts to run a treatment centre, the company is playing an active role in this process. BUPA has recently put ten of its smallest hospitals up for sale, stating that it wants to concentrate on providing for the public sector. The companies therefore appear to see contracting to the public sector as a larger and more desirable market than provision of private insurance and providing for privately funded patients.

In Asian countries health insurance plays an important and expanding role in enabling middle-class groups to access private health care. Companies are strongly aware of the relationship between the provision of health insurance and the growth of markets for their health care products, although they are still at an early stage of understanding the dynamics of success in Asian markets. Parkway, the Asian regional health care company studied, started to run its own managed care programme (combining insurance with provision of care[3]) in a joint venture with Allianz, a large European insurance company, three years ago. Parkway now has 40 000 members in Singapore and is hoping to expand this programme to Malaysia and Indonesia in the future. It is currently finding out how many members are needed to break even, and is targeting *'high end'* patients. Parkway views the expansion of private health insurance and private health services as complementary market processes.

With the experience of running its own managed care programme, Parkway also considers that it is in competition with insurance companies and will be able to compete away part of their business. Insurance companies will also, it believes, have to out-source work to Parkway because it is one of the largest private operators, including a GP chain, laboratories, hospital beds and its own specialists. Currently, Parkway works mostly

with the companies AIA, Aetna and Malaysia British Assurance. This suggests that as a health care provider and health insurer, the company will benefit from any aspect of private health care expansion, and could play a role in consolidating a private provision sector based in private health insurance.

Interestingly, in Asia the experience of BUPA, which in the UK is both a provider and insurer, has been up to now as a health care provider rather than an insurer. The company argues that in India and China new insurance laws are needed to create the conditions for multinational entry, and BUPA would agree to tougher legislation if necessary. BUPA has been in discussion with Chinese health insurance companies and stated that *'I think that in the next several years you will see BUPA entering the health insurance market in China.'* This is partly because it considered that rising income levels and a developing middle class in China will provide a large enough market for its products. India is felt to be over-cautious in its approach to the private health insurance market because of the requirement of a minimum level of capital investment for each foreign company wanting to operate, but there are signs that when the Indian market becomes more accessible, BUPA will be ready to move in there too. (The growth of the Chinese private health insurance market is described in Chapter 6.)

2.4 Relationships with the public sector: companies, contracting and regulation

Governments are frequently urged, in the health policy literature, to 'retreat' from active provision to 'purchasing' services (especially for those on low incomes) and a regulatory role. Governments regulate private sector activity in two main ways: by setting the rules for public sector contracting and purchasing, and by setting regulatory requirements such as licensing and quality standards for private sector providers. These forms of rule-making thus control entry into a market or profession and seek to control the quality of services being provided. A regulatory body can operate through inspections, complaints systems and other forms of review. Regulation of the health sector is by national agencies, which are often, but not always, separate from Ministries of Health. There are mixed views among health policy-makers about whether existing systems of regulation are strong enough to control private sector providers, especially with a growing private sector presence in public health care. The multinational companies interviewed generally sought increased contracting for clinical services while having strong and consistent views on the types of regulation that they did and did not favour.

Private firms will tend to seek regulatory and contracting frameworks that limit competition while expanding potential market share. In Europe the evolution of contracting has been part of the process of introducing market principles to the public health care sector, and in the Nordic region there

has been a decade of experience built up between public commissioners and private providers (Hortsberg and Ghatnekar 2001). This has led to companies in this region viewing their relationships with the public sector as mutually dependent, and to well-developed company positions on desirable regulation. In Asia, the European companies are adapting these positions to the different market environment.

All of the companies dislike regulation that restricts activity on the basis of ownership, and companies that view publicly funded health services as potential growth markets fear regulations that prevent privately owned companies from supplying parts of them. In Asia, the companies are critical of restrictions on foreign investment in health care (as in other sectors) that prevent foreign capital entering a country, or frequently permit it only as part of a joint venture with domestic capital. Both BUPA and Fresenius have to deal with these restrictions when entering countries in South-east Asia. BUPA takes a pragmatic approach to the different systems of regulation, especially in fragmented markets.

> *'Malaysia has a tough foreign investment policy and health care is always a sensitive area. You figure out how best to be in the country, meet the regulation of the country and yet to be able to manage it successfully, it's always a sort of balance.'*

The company believes that these types of restrictions may be changed, particularly in relation to investment in the higher income Asian countries, as the General Agreement on Trade in Services (GATS) Mode 3 starts to liberalize foreign investment: *'With WTO, these barriers will be lifted and we will enter the market.'*

Companies' attitudes to regulation of standards are quite different: they see these regulations as potentially opening up markets and restricting undesirable competition, and seek to influence their design. The private sector views regulation of health care delivery as a positive force for helping the private sector to become an integrated part of a national health system. Parkway, like many European multinational health care companies, welcomes systems of accreditation that allow private and public sector providers to be considered on an equal basis. One of its hospitals in Malaysia was the first hospital to be accredited, even before government hospitals.

Fresenius' operations in Asia, involved in the delivering of kidney dialysis, have also experienced the limitations of too little regulation in the delivery of health care. Production of kidney dialysis equipment is part of a highly competitive global industry. Fresenius, a well-established company with higher prices and higher standards of delivery than some of its competitors, is vulnerable to undercutting in unregulated national markets by companies setting up dialysis centres operating with low standards. The company therefore actively prefers a more highly regulated market environment, where

both distributors and manufacturers of medical devices have to register and show proof of quality and reliability:

> *'this helps us as a company which has already implemented these processes . . . it helps us differentiate ourselves from other potential companies that do not have such capabilities but still intend to sell in the country.'*

There are similar issues in the attitude to regulation of laboratory testing facilities, which is an area of growth for many multinational health care companies. Large firms prefer a regulated environment with minimum qualification standards and standards for laboratory licensing to an unregulated environment where anyone is free to set up a laboratory.

This distinction between attitudes of multinational health care companies to different types of regulation is illustrated in the European context by Capio's reaction to a report on the future of health care regulation in Sweden. As one of the first northern European governments to contract health care to the private sector, the Swedish government set up a commission in 2002 to look at future health care regulation so that it could safeguard priorities and basic principles in Swedish health care (SOU 2002). Capio welcomed the interim report and was supportive about increased regulation and central supervision under the National Board for Health and Welfare. It also welcomed the proposed system of compulsory certification of health care providers.

However, the company opposed legislation that excluded certain forms of ownership from operating emergency hospitals or highly specialized health care units or which would prohibit health care providers from accepting patients regardless of who pays for the care. Drawing on its own recent experience of working in the UK, it recommended dialogue between central government, county councils and private health care providers to establish long-term cooperation. The company's fears about ownership regulation were confirmed in 2004 by a subsequent 'memorandum' presented in the Swedish Parliament by the Social Democratic Minister for Health and Social Affairs, with support from the Green Party and the Left Party, which proposed a change in Swedish hospital law. It would mean that hospitals run by private companies – for example, St Goran's Hospital, Stockholm, which is owned and managed by Capio – could not continue to operate in their present form (Capio press release, June 2004).

In South-east Asia, the relationships between companies and governments are generally less close than in Europe because contracting is less developed as an activity. In Asia, there is also the added dimension of corporatized public sector institutions competing with private sector providers. Parkway argues that the government should be providing for the *'basic healthcare needs of the population'*. The company sees a conflict of interest in the behaviour of doctors in public hospitals who should be treating public patients but are increasingly treating private patients as well.

'For all private health care, you should go to the private sector. For those who need basic healthcare, the government must provide.'

The company's views on regulation in the South-east Asian context were particularly influenced by this preferred role for the government, which Parkway argues should be *'the regulator rather than the competitor'*. The company feels that for the government to be both a health care provider competing with private providers and a regulator demonstrates a conflict of interest.

In countries where publicly funded health care services are limited, companies are lobbying governments to make certain types of treatment more widely available, e.g. kidney dialysis treatment, so that they can become major providers of specialized care. Companies are also aware of new business opportunities arising in countries where governments are just beginning to out-source clinical services. Even Parkway, after arguing for a clear difference between the roles of public and private providers, is starting to be a service provider for Singapore General Hospital. The company presents this move as part of the response to the SARS epidemic, which created a backlog of cases, and so is being done in the national interest. However, the company is also viewing this contractual arrangement as a new business venture and only covering variable costs in its initial pricing arrangements.

There is thus considerable consistency between companies in their approach to government regulation. The MNCs' regulatory objectives include a regulatory system which subjects all providers of whatever ownership to the same regulatory standards, restricting undercutting from small firms and opening up public sector markets to competition on the basis of equal standards. At the same time, firms are generally opposed to public sector competition for privately paying patients. Despite regional differences, all see the market possibilities in opening or further developing clinical services contracting, and look to regulatory frameworks to open up market opportunities and reduce some forms of competition. All, inevitably, oppose regulatory rules that restrict markets for private providers, while regulation in relation to professional standards is a less important concern, perhaps because the companies adhere to national pay standards and conditions.

2.5 Pricing systems as infrastructure for market development

Parkway's move into public sector contracting on the basis of marginal rather than full costs, just described, points to the importance of pricing strategies for multinational objectives of market development and profitability. This research demonstrates two key aspects of pricing strategies by health care multinationals: constant efforts by the companies to reduce public sector price competition in both public contracting and private markets, and some price discrimination among market segments.

The companies frame the pricing issues in a particular way. They argue consistently that they are subject to unfair public sector competition – notably in the market for public sector contracts, because public providers price below full cost. The firms are repeatedly critical of what they see as a slow process of identifying the total costs of public health care treatments. The private sector argues that public health care systems are often unaware of their costs, implying that until the public sector is more realistic about its own costing and pricing the private sector will not be able to compete effectively. This suggests that European private companies aim for an envisaged 'ideal' level of competition with public sector providers.

It is hard to establish stable market pricing systems for health care because of its personal nature, yet the private companies' concern with pricing issues illustrates the extent to which a standardized pricing system is an essential form of 'infrastructure' necessary for the emergence and development of health care markets. Companies focus on establishing pricing systems they feel will suit their objectives, and several multinational companies view pricing based on Diagnostic Related Groups (DRGs) as a system that facilitates better engagement of the private health care sector with the public sector, although with some reservations.

DRGs provide a system of categorizing patients based on diagnosis, treatment/procedures, age and length of stay. Categories allow providers to calculate average cost of each category and commissioners to set maximum prices for reimbursement. Medicare, the United States government health insurance programme for the elderly, originally introduced DRGs in 1983 as a way of trying to control the Medicare budget. The system is now being promoted and refined in many countries (Mikkola *et al*. 2001). Throughout Europe and in Singapore DRGs are the main system of pricing currently being introduced by governments. The two Nordic companies, Capio and ISS, argued that although DRGs could potentially mean that public and private providers were treated on equal terms, several European governments still discriminate against the private sector by weighting the DRG system towards public sector operators.

Where companies are providing health care directly to the public sector, pricing based on DRGs can be significant in determining market share. For example, Capio has been contracted to manage St Goran's Hospital in Stockholm, Sweden's second biggest hospital, since 1994 (Lofgren 2002). The costs per DRG for health care at St Goran's are cheaper than in other public sector hospitals because they do not bear the costs of training personnel. As an indication of how public sector commissioners are operating in a price-sensitive way, the County Council tends to buy more health care from St Goran's Hospital at the end of the financial year when resources are more limited (Svemen and Essinger 2001).

International companies delivering standard packages of care in South-east Asia have also had to adjust to markets where public, private and non-profit

providers charge patients differing amounts for care, resulting in severe financial pressures on lower income patients. In these contexts, companies may charge different prices in different sectors, and depend on subsidy to expand their markets. For example, a Fresenius renal dialysis treatment costs between $1200 and $2500. In Singapore, Medisave, the public system of health insurance, can contribute up to $450 but will not cover the whole cost of dialysis. Patients have to pay for themselves or seek a subsidy from the Kidney Foundation, whose contribution varies from patient to patient. In Malaysia, pricing per dialysis treatment includes the costs of bloodlines, needles and concentrates. Three sectors provide treatments at different prices for the patient. Government hospital patients pay RM1 to register themselves and the treatment is free. Non-governmental organizations charge RM110–120 or RM60 if the government subsidizes the treatment. The private sector charges RM150–250. Fresenius also operates some price discrimination in its sale of dialysis equipment to public and private health care providers, and lowers prices in markets such as Malaysia in the face of competitors entering the market.

Multinational companies are developing sophisticated approaches to pricing as a way of influencing their potential markets. Parkway uses pricing as a market development tool: in addition to growing its contracting activity for the Singapore government by charging prices covering only variable costs such as drugs, laboratory tests and radiology but not fixed costs, the company also prices basic health care *'sensitively'* because it constitutes a large part of company business and cash flow. More specialized *'high end'* work is priced at a higher level because people have no other option but to pay for the treatment. *'The cream comes from these top 10%.'*

2.6 Reducing market risk

As noted earlier, companies see health services, internationally, as a difficult market. Companies identified the market risks as, first, the extent of competition. As Parkway put it, the problem in Asia is:

> *'intense competition, not only from the government but from other affluent companies moving up the ladder, they will compete with the same target patients.'*

This is exacerbated by the Asian recession of the late 1990s and the impact of SARS. Second, there is a problem of capacity to pay by all but an affluent minority in many Asian countries, implying the importance of public sector contracting markets. Third, cost escalation is pervasive in private and in public health care, resulting from an ageing society and new technological treatments and this puts pressure on health care financing budgets – public and private – if increased taxation is not considered viable. All the companies interviewed had adopted explicit strategies to manage and reduce risk.

Getting out of asset ownership

There are growing signs that health care companies are becoming reluctant to invest in long-term ownership of hospital buildings. Several companies have developed lease-back arrangements with newly acquired hospitals that enable them to focus on the delivery of care rather than on the management of buildings and land. In 2000, Capio bought the Community Hospitals Group in the UK but sold the buildings to an investment company shortly afterwards. Although Capio now owns 100 per cent of the shares of this investment company, it has kept property ownership separate from the process of managing health care services. The Capio CEO commented that

> *'To ensure that we maintain our focus, we are separating the business and management of the new company from the operational side of our business. Capio's core operations will continue to focus on health and medical care, areas in which there is excellent scope for continued expansion.'* (Capio press release, 17 June 2003)

This approach to risk reduction is influenced by Capio's experience of operating in the context of Sweden, a country that creates few barriers to the entry of private operators into the health care market because companies can lease hospitals rather than having to own health care facilities. This reduces the finance a company needs to raise to acquire and manage assets.

Other companies were actively considering how to reduce their existing assets in the form of hospital buildings. In South-east Asia, the experience of SARS has made health care companies more aware of the limitations of health care facilities because of the transmission of hospital infections. The focus on trying to anticipate new trends in health care treatments, influenced both by new technologies but also by the demands of patients to avoid hospitalization, is leading to more investments by companies in home-based treatments. This can also be seen as a type of investment designed to minimize risk that reflects the changing nature of health care: companies are investing in high technology equipment that they are in a better position to acquire than government health care providers, while divesting themselves of buildings. Fresenius, for example, is involved in developing peritoneal dialysis, a home-based form of kidney dialysis, which will mean more limited use of dialysis clinics.

Changing employment relations

Further insights into risk minimization strategies can be gained by studying the relationships that companies have with doctors. Doctors play a key role in the delivery of acute private health care and consequently in the development of multinational health care products, and employment relations with doctors are perceived by companies as a restriction on their operations in the health care sector. In many Asian countries, doctors are self-employed

even when working in a private hospital. This puts companies in a position of relative uncertainty about their costs and the prices that patients can bear. Companies often do not know the fees which doctors are charging patients because they are determined by the nature of the consultation and the doctor involved. However, the doctors need the hospitals to deliver the supporting care for patients.

A regional multinational health care company such as Parkway, has access to 900 specialists in Singapore but none of them is directly employed by the company. This arrangement allows the company to minimize the risks of expansion and contraction, a model also followed in Kuala Lumpur, Malaysia where a Parkway subsidiary, Gleneagles Intan, sold off its medical centre suite to practising doctors and so no longer employs doctors.

In contrast, some companies in Europe, such as Capio in Sweden, employ doctors directly and argue that this gives companies more control over how and when their doctors work, especially consultants. Capio feels that this contributes to improving the efficiency of its hospitals because it can plan workloads and schedule operations during non-peak times. It contrasts with difficulties Capio has experienced in France, where doctors working within hospitals are self-employed. The French government temporarily closed one of its clinics because of a complaint against a doctor. The company was unable to challenge this action because it did not have access to the medical records of the patient, which were held by the self-employed doctor. Capio sold this clinic in December 2003 to a locally based health care company, which was felt to be better suited to managing it (Capio press release, 30 December 2003).

Companies are thus strongly influenced by the prevailing system within which doctors operate. Many adopt nationally agreed pay and conditions of the countries where the company operates. In this sense, companies adhere to existing systems of regulation for staffing issues. In South-east Asia, when Parkway does employ staff directly it pays according to the country with its standards and benchmarks. Expatriates are not paid more than local staff and so the company does not employ expatriates. Fresenius Singapore also pays according to what the market pays in each country. It does not hire expatriates unless they have special skills.

Health care is a labour-intensive industry, and for multinational companies to expand their markets they have to have access to supplies of labour. There is a global shortage of nurses, and in South-east Asia multinational companies are addressing this by setting up their own schools of nursing. Parkway has set up the Gleneagles College of Nursing in Kuala Lumpur to train staff nurses for its own hospitals. Students will be drawn from Malaysia, Burma, Indonesia and Singapore. The college is recognized by the Ministry of Health in Malaysia, and once the nurses are trained they will be placed in Gleneagles Group hospitals and medical centres.

In Europe, both BUPA and ISS are setting up their own universities to train their own staff, at the same time that public health care systems are also

improving training and continuous staff development. The ISS University aims to build up education plans for staff, including nurses and administrators. Significantly, this company is always interested in using its facilities for research and development and sees training and education as a potential area of collaboration with the public sector provided there is adequate public funding.

2.7 Conclusion: MNC strategies and the challenge for health policy

Multinational expansion through cross-border investment in the provision of health services is continuing to expand. Health policy-makers need to understand the strategies of the large companies they are seeking to influence through regulation and contracting. Regulation is too often understood simply as rule-making in pursuit of minimum quality standards; it is better defined as an interactive relationship between governments and companies both seeking to influence market development. Ayres and Braithwaite (1992) develop a concept of *responsive regulation* that is particularly appropriate in this context, arguing that the regulatory strategies of government intervention should respond to the behaviour of firms, and take into account that firms also seek to shape regulation to their own ends.

This chapter has shown that the multinational health care companies considered in this study are all strongly influenced by changes in the government sector, both in their country of origin and in the countries in which they operate. Governments need to be more aware of how MNC objectives and behaviour are shaped.

Companies in both regions aim to expand contracting with the public sector, and are seeking to adapt public sector pricing and costing systems to improve their competitive position *vis-à-vis* public providers. They frame this objective in terms of working effectively with the public sector and being treated on an equal footing with public providers. In Asia, the MNCs are all competing to serve an expanding middle-class segment of privately financed hospital-based and technologically advanced health care. Companies describe this strategy in terms of a division of activity between governments serving those on low incomes and providing 'basic' care, and private companies providing for the better-off. The development of this strategy is dependent on the creation of a market for private insurance, and its integration with private provision.

Companies' strategy towards private market regulation therefore focuses on establishing the right of entry for privately owned and foreign-based companies, resisting regulations that restrict activity on the basis of ownership, and supporting regulation of standards that reduce market competition from smaller companies. Companies also seek to shift risk by avoiding ownership of facilities and weakening commitments to employees, making market

exit easier. Health policy-makers need to base regulation in explicit policy towards the level and type of commercialization in the health system, and seek to influence the behaviour of the private companies operating within it.

Notes

1. Interview with a BUPA manager. Italicized quotations are all from interviews with company managers or trades unionists, undertaken by the author and by Loh Foon Fong.
2. Statement by retiring President Gerd Krick at the Fresenius Annual General Meeting, 28 May 2004. www.fresenius.de.
3. 'Managed care' is defined more precisely in Chapter 3.

3

Multinational Corporations and Health Care in the United States and Latin America: Strategies, Actions and Effects

Rebeca Jasso-Aguilar, Howard Waitzkin and Angela Landwehr[1]

3.1 Introduction

The process of globalization raises several problems regarding health care and public health. Influenced by public policy-makers in the United States, such organizations as the World Bank, International Monetary Fund (IMF) and World Trade Organization (WTO) have advocated policies that encourage reduction and privatization of health care and public health services previously provided in the public sector (Stocker *et al*. 1999; Iriart *et al*. 2001; Rao 1999; Turshen 1999; WHO 2000). International financial institutions and multinational corporations have influenced reforms that, while favourable to corporate interests, have worsened access to needed services and have strained the remaining public sector institutions.

In this chapter, we present evidence that multinational corporations, based in the United States and focusing on health care, have expanded worldwide, especially in Latin America. Managed care organizations (MCOs), health care consulting firms and pharmaceutical and medical equipment companies have entered foreign markets. As MCOs have faced declining rates of profit in US markets, they have entered foreign markets in Latin America and worldwide, usually seeking access to public social security funds designated for health care and retirement benefits (Iriart *et al*. 2001). At the same time large health care corporations have abandoned large numbers of unprofitable patients in the United States. Health policy reforms in Latin American and other less developed countries, supported by international financial institutions, have facilitated corporations' entry into these markets. Such strategies

have culminated in a marked expansion of corporations' access to social security and related public sector funds for the support of privatized health services. Later, as profitability in Latin America has decreased, the same corporations have begun to abandon those markets. We focus especially on two corporations, Aetna and CIGNA, for two reasons: they are major MCOs in the United States, and until recently they have maintained a large presence in markets abroad.

3.2 Methods

We reviewed the research and archival literature, published and unpublished, with the purpose of tracing the actions and strategies of multinational corporations in the United States and in the Latin American health care market. The search included professional journals, business journals, newspapers and magazines, and corporate records in the public sphere, such as filings with the US Security and Exchange Commission (SEC). Although we focused primarily on multinational corporations such as Aetna and CIGNA, we also investigated documents and reports that could shed light on the role of international financial institutions such as the IMF and the World Bank in facilitating the penetration of Latin American markets by multinational corporations. Two of us (RJ-A, HW) conducted research in Mexico during January through March 2003, while the other (AL) carried out research in Brazil during 2002–3, including structured interviews with health professionals, to investigate specific practices of corporations and respondents' perceptions of these practices.

3.3 The rise and fall of managed care profitability in the United States

For this work, we have defined 'managed care' operationally as health care services under the administrative control of large private organizations, with prepaid, capitated financing. In general, managed care seeks to separate financial administration from the delivery of services, requiring an intermediary (a state, private, or mixed entity) between providers and users. This intermediary administers financing under the concept of shared risk (with the same fee for each insured person, the so-called 'capitation') (Merhy *et al*. cited in Iriart *et al*. 2001: 1245). Through managed care, insurance companies hoped to control the rapidly increasing health care costs generated by traditional payments practices such as fee-for-service. By the late 1980s, managed care was favoured in US health policy decisions. Insurers formed their own MCOs, in an effort to respond to employers' demands for a choice of benefit plans (Loos 1987; Graham 1986).

The MCOs reaped major earnings initially by paying hospitals a fixed capitation for each patient at a low negotiated rate (Freudenheim and

Krauss 1999). However, the rate of profit fell as the market became increasingly saturated (Stocker *et al*. 1999). By 1996 private health insurance premiums were rising at a much lower rate than MCO costs. The managed care industry struggled with higher medical costs, insufficient premiums, heavier than expected Medicare[2] costs, and an increasingly competitive market (Bennett 2001; Pulliam and Winslow 1997; Scism 1997a, 1997b; Winslow 1997; Anders and Winslow 1997).

Despite MCO strategies such as large mergers to enhance their bargaining position, the managed care industry's problems persisted. The organizations failed to bridge the tensions between cost control and patient choice, the same issue that had contributed to the failure of President Bill Clinton's proposed national health plan in 1994. At that time, private sector advocates argued that they could do a better job than a government-dominated plan in holding down costs by steering patients to cost-effective doctors and hospitals, thereby curbing wasteful expenditures. But by 1998, health plans began to raise premiums several points above the 2.5 per cent inflation rate, citing an inability to control medical costs as much as predicted. This increase proved dramatic when compared to the premium increases of 1 per cent or less offered in the mid-1990s (Anders and Winslow 1997).

The main government health care funding programmes, Medicare and Medicaid, also proved less lucrative than industry officials had anticipated. The initial profits from Medicare had been large because federal payments for Medicare MCO members had risen as much as 10.5 per cent per year. But in 1997 Congress limited premium increases to just 2 per cent annually in future years. Concern grew about MCOs' ability to manage costs within these stipulated premium increases. In the Medicaid market, many states ratcheted down their payments to MCOs (Anders and Winslow 1997).

Changes in the value of company stocks reflected the financial difficulties of the managed care industry. From 1990–5, MCO stocks surged an average of 33 per cent a year, far ahead of the overall market. By 1997, worsening stock market values – including those of large MCOs – disappointed analysts and investors (Anders and Winslow 1997). This weaker position in the stock market persisted subsequently, and it only began showing signs of recovery in early 2004 (Levick 2004).

3.4 US MCOs' international expansion and exit from US markets

Two major MCOs, Aetna and CIGNA, greatly expanded in Medicare and commercial markets in the United States during the mid-to-late 1990s. This expansion, however, took place despite a falling rate of profit overall. Therefore it is not surprising that eventually they began to leave these markets.

According to its 2000 Securities and Exchange Commission (SEC) report (p. 6), Aetna exited certain unprofitable Medicare markets during 1999, yet

the membership by the end of the year was larger than the previous year's. This increase indicated that the company dropped members in unprofitable markets and acquired new members in more profitable areas. Subsequently, Aetna continued to exit from unprofitable Medicare as well as commercial markets, a fact reflected in declining membership. For CIGNA, increases in both commercial membership and Medicare for the period 1994–8 contrasted with a decline in Medicare and Medicaid membership thereafter.

MCOs exited from managed care programmes in multiple geographical regions. The American Association of Health Plans (AAHP) estimated that at least 711 000 Medicare beneficiaries would be affected starting 1 January 2001. According to these estimates, Aetna's pull-out affected 355 000 members in eleven states, while CIGNA's pull-out affected 104 000 members in thirteen states (Fisher 2000; McGinley and Winslow 2000). By the end of 2001, Aetna's exit from numerous Medicare markets affected an additional 105 000 members – a number equivalent to 38 per cent of its Medicare membership. Several other companies, including PacifiCare Health Systems and Health Net, were also exiting selected Medicare plans across the country, leaving approximately 500 000 subscribers to seek new medical coverage (Rundle 2001). According to Lankarge (2001), the total number of beneficiaries who lost their plans during 1999–2001 rose to more than 1.7 million.

MCO withdrawals from Medicaid markets also occurred in multiple states, including both urban and rural areas. MCOs dropped about 1.2 million enrolees during 1997–9. Dropped subscribers faced the burden of selecting a new health plan and discontinuity of care if required to change providers (Felt-Lisk *et al*. 2001: ii, 5, 7, 17).

Managed care has remained a troubled industry. According to an administrator at HCFA (Health Care Financing Administration, currently the Centers for Medicare and Medicaid Services or CMS), private sector Medicare MCOs received more than enough federal payments to provide the basic Medicare benefits. However, the formula set by law did not always pay enough to cover the extra benefits provided and to produce profits. MCOs also complained that the Balanced Budget Act of 1997 capped reimbursement increases at 2 per cent annually, a rate which did not keep pace with rising medical costs (Bennett and McGinley 2000). MCOs like Aetna tried to address their high costs by increasing premiums when renewing contracts and by evaluating markets and products with the goal of exiting when financial or strategic purposes were not met.

As MCOs faced declining rates of profit in US markets, they entered foreign markets, seeking access to public social security funds designated for health care and retirement benefits (Stocker *et al*. 1999). Aetna's rapid expansion into foreign markets, especially Latin America, occurred during the period 1996–9. In 1997 CIGNA expanded into Brazil, a market that other US companies such as American International Group and Liberty Mutual Fund Group had just entered. The timing of these expansions coincided

with ongoing or imminent reforms to privatize health services and pensions in the targeted countries. Aetna highlighted these reforms as important steps in the company's strategy to expand in emergent markets (Aetna Inc. 22 July 1996; 3 February 1997; 15 January 1998; 13 January 1999; 3 February 1999; 17 May 1999).

3.5 Corporations and international health care markets

Corporate expansion into international markets

As the US domestic market became more contentious and less attractive, a transition from national to multinational managed care thus emerged. Multinational corporations, including pharmaceutical companies, long-term care corporations and MCOs, turned to the international service sector as an alternative source of profits (Price *et al*. 1999). US-based corporations exported managed care as the main organizational format, rather than other forms of commercial insurance, because managed care had become the dominant form of health care organization in the United States and had emerged as the most profitable framework for commercial organizations to provide health insurance.

The Latin American health care market presented very lucrative opportunities at the time (Swafford 1996; Cisneros 1997; *Financial Times* 1997). Still untouched by the privatization wave that had swept the region in the previous years, the health care sector was about to undergo reforms that would open the door to private capital (Swafford 1996). After implementation of reforms, favourable economic conditions under this scenario would fuel a long-term boom for investors. By 1999, Latin America had become ripe for US companies' investments and operations (Freudenheim and Krauss 1999).

Corporate strategies in international expansion

One strategy followed by corporations to export managed care is investment in joint ventures with local companies. The joint ventures provide an already established clientele and help corporations circumvent national laws that restrict foreign ownership. These arrangements include some degree of financing from social security funds and the private management or ownership of previously public programmes (Stocker *et al*. 1999; Iriart *et al*. 2000; Iriart, this volume).

Between 1996 and 2000, Aetna entered into joint ventures with domestic companies in Mexico, Brazil, Venezuela, Argentina and Colombia. The strategy encompassed not only expansion but also exiting from certain international markets – such as Canada and some European countries – that had become inconsistent with the company's focus on the high growth potential of the world's emerging markets (Aetna Inc. 28 September 1998; 13 April 1999). Aetna's SEC reports often emphasized the company's

intentions to invest in emerging and other selected markets outside the US that showed the potential for favourable long-term returns.

The main international operations of CIGNA have focused on Japan, although from the late 1990s it began expanding operations in Latin America and other Asian countries. In 1997 and 1998, CIGNA invested in Brazilian health care operations, which included the acquisition of an MCO serving approximately 337 000 members. CIGNA made several acquisitions in Chile and Mexico and established offices in selected emerging markets, such as China and India (CIGNA Corp. 1998: 16–18).

A second corporate strategy is a 'trade show' approach. Corporations organize conventions or presentations at professional meetings to build interest in managed care principles (Stocker *et al*. 1999). Attendees at such meetings have included Latin American health care leaders who have received financial assistance from corporations, the World Bank, or both. The World Bank and IMF have required reforms favouring the privatization of health services in developing countries that have benefited US and European corporations (McMichael and Beaglehole 2000; Armada *et al*. 2001; Sen and Koivusalo 1998; Iriart *et al*. 2000, 2001; Stocker *et al*. 1999; Freudenheim and Krauss 1999). International organizations like PAHO and WHO also have favoured these programmes and reforms (Armada *et al*. 2001).

A third strategy for corporations to expand in international markets involves the use of their own governments to influence international trade organizations such as WTO. Governments exert this influence by setting agendas at meetings of trade organizations and ensuring commitments from other countries that benefit corporations, usually based in the United States and Europe. The US and European governments exert disproportionate influence on WTO policies to advance their own economic agendas, in comparison to the governments of smaller or less developed countries (Pollock and Price 2000; Lipson 2001; Zarrilli 2002).

Under the General Agreement on Trade in Services (GATS), for instance, the United States and European Union have proposed that country members of the WTO grant greater market access in financial services, by eliminating or lowering restrictions on investments by foreign companies. These proposals run counter to national legislation needed to prevent, for example, 'cherry-picking', which involves corporate decisions to provide services to young, healthy and financially advantaged segments of the population while excluding older people, sick people, and the poor (Zarrilli 2002).

US corporate withdrawal from international markets

By 1999 Aetna was experiencing problems of corporate instability and declining stock value. Although SEC reports showed international operations to be profitable, Aetna began selling its joint ventures. In December 2000 the company sold Aetna International and Global Financial Services to Amsterdam-based ING Group NV. Aetna's officers emphasized that the sale aimed at

consolidating the corporation's activities in the US health care market, which had become relatively inefficient and unprofitable, and at enhancing stockholders' confidence and stock value (Aetna Inc. 13 December 2000). Substantial additional assets derived from the sale of Aetna's foreign subsidiaries (Aetna Inc. 18 December 2000).

CIGNA withdrew in 1999 from its traditional health care operations while continuing in the managed care business (CIGNA Corp. 1999, 2003: 24). CIGNA's profits in Brazil's private health care markets decreased in 2001–2 (Panorama Brasil 2002). In January 2003, citing growth potential below the company's long-term expectations, CIGNA sold its remaining health care operations to a Brazilian company, Amil (Panorama Brasil 2003; CIGNA Corp. 2003: 24), after extracting substantial revenues from prepaid capitation fees.

The behaviour of these corporations, which rapidly entered and then began to exit foreign markets, remains somewhat puzzling, though the level of profitability clearly contributed to these corporate decisions. The wealth in Latin American social security funds was created with contributions from the government, employers and employees during decades of job growth and economic expansion. Privatization in Latin America was accompanied by massive unemployment, which drastically reduced contributions. Health care reforms further diminished these contributions (as described in the following sections). From this perspective, the social security funds represented an initially lucrative opportunity; later Latin America proved not 'the goldmine that it looked like it would be during the heady days of policy reforms at the beginning of the 1990s' (Strategy + Choice 2002: 7).

The domestic US market has also played a role in withdrawal from Latin American markets. In the case of Aetna, stockholder pressure directed the company to focus its attention on the US market. As the new Medicare legislation was being formulated in 2003, it became clear that changes in the law would benefit health insurance companies. The legislation approved in December 2003 will transfer approximately $46 billion to private insurance companies and managed care organizations, partly through higher payments to attract more seniors into private health plans (Kemper 2004). Anticipated annual premium increases have reached 10.6 per cent, the level at which managed care made its highest profits in the early and mid-1990s (Physician Business Week 2004). Not surprisingly, Aetna has strongly advocated Medicare reform (Aetna Inc. 8 September 2003; 17 November 2003).

3.6 The role of international financial institutions and health policy reform

Armada *et al.* (2001) have documented how international financial institutions (IFIs) intervene in social policy-making by requiring major health care and social security reforms. Loan conditions and renegotiation of external

debt payments have comprised the major tools of political leverage used by IFIs. 'Letters of Intent' that debtor countries submit to the IMF provide evidence of how health and pension reforms become embedded in major economic policies, as the following excerpt from a Letter from the Mexican government of 15 June 1999 shows:

> The Government intends to continue with the process of structural reforms, particularly in the areas of banking and social security . . . The Government is studying various options to strengthen further the recent reforms to the social security and health care systems. The Government plans to relax investment restrictions . . . With regard to health care, the most immediate objective is to ensure the efficient operation of the public health care reform implemented in 1997–1998. (IMF 1999a: paragraphs 19, 27)

Reform in Mexico

Mexico's health care system contains two subsystems, the social security system and the Ministry of Health. Social security is mandatory for workers in the formal labour sector, both rural and urban; participants pay according to income but receive services according to need (Laurell, 2001a: 298, 303). The Mexican Institute of Social Security (IMSS) covers private sector workers (and to some extent their families), while the Institute of Security and Social Services for Workers of the State (ISSSTE) covers the public sector. The Ministry of Health, in theory, is responsible for the health care of the uninsurable or open population. Although the Ministry traditionally has provided a variety of services, comprehensive health care has not reached the entire eligible population. During recent years, for instance, about 10 million Mexicans have lacked access to any type of health care (in Chapter 14, this volume, Laurell *et al*. examine the Mexico City government's efforts to tackle this lack of access).

The Mexican government presented the basic characteristics of its planned reform to the World Bank in June 1995 – five months before presenting it to Congress (Laurell 2001b). The reform included the following proposals: (a) change from progressive, mandatory, employee–employer contribution rates to flat rates; (b) allow employers to opt out of the social security system, provided that the employers provide access to MCOs for their employees; and (c) permit uninsured people with regular incomes to buy into social security. The final goal of the reform was 'to have the public social security institutions finance but not provide services' (World Bank 1995: 6), in other words, to use the public funds collected by social security to finance managed care A new social security law, enacted in July 1997, made this transition. The reform's proposals opened the door to multinationals because now MCOs

could compete for IMSS-insured clients, receive funds from the Social Security Health Fund, and purchase services from IMSS specialty hospitals or the public National Health Institutes (Laurell 2001a: 307).

Interviews with Mexican respondents revealed a perception that the reform moved public resources into the private sector in several ways: (a) by allowing unequal competition between the private and the public sectors, where the former can select healthy and younger patients while the latter continues to be responsible for chronically ill, more expensive patients; (b) by allowing tax exemptions for employers who offer private health insurance to employees (in this fashion the government forsakes tax revenues that could be used to strengthen social security but that instead subsidize private companies); and (c) by requiring that the IMSS return contributions made by employees when they choose to receive health care elsewhere. Interviewees also suggested that the private sector possessed insufficient capacity to provide care for large numbers of people.

Reform in Brazil

In Brazil, pressure from IFIs and particularly the IMF forced the government to reduce social spending. A broad package of controversial measures, for instance, reduced the 1999 health budget by $854 million (Hensley 1999). In Letters of Intent to the IMF, the government committed itself to seek alternatives that permitted multinational corporations to gain access to public social security funds (IMF 1999b: paragraph 15).

The Brazilian health system has functioned as a mixed public–private system. The public system both finances publicly provided services and – where no public services and/or facilities are available – reimburses services provided by private entities. The private system is called a supplementary system, with services financed and provided in the private sector (Médici 1997). About 24.5 per cent of the Brazilian population holds private health insurance.

A large proportion of the services in the public system are provided by reimbursing private entities under contract with the government. Most inpatient services are provided under this system, since about 80 per cent of hospitals that deliver services to the public system are private. In contrast, public establishments provide about 75 per cent of outpatient care (PAHO 2001). Because health care is a constitutional right – guaranteed by the state – for all Brazilians (Brazil 1988: Art. 196), about 43 per cent of the privately insured population have also utilized the public system, particularly for more complex and costly procedures (Hensley 1999). Despite the large proportion of the population that has obtained services from the public system, this sector gradually has become more fragmented and underfunded (Almeida *et al*. 2000).

Brazil's 1988 Federal Constitution sought to implement the Unified Health System (*Sistema Único de Saúde*, SUS). The SUS was promoted throughout the country, partly as a criticism of the prior model that financed the

private sector with public resources while undermining the public sector (Campos 1997). Under the 1988 Constitution, private enterprises could participate in the SUS, but only in a supplementary manner and by means of public contracts and agreements. Such enterprises were to provide services free of charge to the population when services were financed by the SUS. Allocation of public funds to aid or to subsidize profit-oriented private institutions was forbidden (Brazil 1988: Art. 199, paragraphs 1, 2).

Measures to establish the mechanisms of funding allocation and to define the managerial model for the SUS emerged during the 1990s through ministerial regulations such as the Basic Operational Norms (*Normas Operacionais Básicas* – NOB 91, 93, 96). NOB 96 proposed implementation of the Family Health Programme as a condition to transfer financial resources from the federal government to municipalities. The programme was compatible with the basic health services packet for the poor which the World Bank had actively promoted in developing countries (World Bank 1993; Merhy and Bueno 1998). NOB 96 also allowed for large public hospitals to be managed as Social Organizations (*Organizações Sociais*), a model which dissociated public institutions from municipal governments and facilitated implementation of managed care in the public sector (Brazil 1996). The introduction of competitive managed care to capture financial resources in the Brazilian public sector, however, conflicted with the principles of universality and integrity enacted through the 1988 constitution (Merhy and Bueno 1998).

IFIs such as the World Bank and IMF, in summary, have taken active roles in promoting policies that favour the penetration of international health care markets by multinational corporations based largely in the United States and Europe. In particular, IFIs have advocated reforms that have privatized public sector services and have opened them to corporate ownership and/or administration. Policies of IFIs have fostered reform decisions in Mexico and Brazil that have supported an expanded role for multinational corporations in those countries' social security systems.

3.7 Effects of health policy reform and the opening of international markets

Effects of reform in Mexico

As noted above, IFIs play crucial roles in the reforms that take place in debtor countries, where multinational corporations often benefit from these reforms. In Mexico, the World Bank supported health reform with loans of $700 and $25 million (Armada *et al.* 2001). The reform facilitated the penetration of multinationals into the social security system by allowing patients to 'opt out' of coverage by the social security system and into coverage by private MCOs. The World Bank itself pointed out the reform's potential to weaken the social security system's financial underpinnings due to adverse selection and 'cream skimming'. These tendencies involved

moving 'good risks' from the social security system to MCOs, while leaving the social security system with the relatively 'bad risks', who contribute less to the system but make more use of it (World Bank 1998). In spite of these concerns, one of the World Bank's conditions for awarding the loan was that some MCOs would be operating by the year 2000 (Laurell 2001a: 307).

Mexican health reform included a free package for the 'uninsurable' population in rural or poor urban areas. Although proponents portrayed the measure as an 'essential health package' which would provide universal coverage, the package in reality contained fewer services than those traditionally provided to the poor by the Ministry of Health. In concrete terms, this gap in coverage meant that all services not included in the package would be charged directly to the patient or financed by state governments with limited capacity to make independent decisions and to collect taxes. Services not included in the package had to be contracted through public or private insurance (Laurell 2001a, 2001b). This essential health package closely resembled the basic packages promoted by the World Bank in developing countries.

Effects of reform in Brazil

Health corporations in Brazil implemented several classic features of managed care. For instance, they employed mechanisms to restrict utilization, such as denial of care, refusal to reimburse physicians for certain procedures, arbitrary termination of contracts with physicians, and preferred private provider networks. Private health insurance plans increased, as did the number of patients' complaints due to service denials (Silva 2001). The 1998 Health Plans Law – *Lei 9,656* – was introduced to protect consumers from the arbitrary practices of insurance companies, yet issues about rising premiums, restrictions on physician visits and hospitalizations, and contracts not conforming to the legislation continued. New contracts frequently did not cover the minimum services required by legislation. At the same time, insurance companies reported high profits.

By late 2000 a special commission appointed by Congress initiated financial investigations concerning the practices of these companies (Prates 2000; Miranda 2000). Legislation eventually caught up, forcing companies to comply with lawful insurance plans and curtailing 'cream-skimming' and 'cherry-picking' practices. This change increased costs for companies – which may have played a role in CIGNA's exit – and the companies then raised premiums to maintain profits. A decrease in the number of privately insured people from 41 million in 1998 to about 35.1 million in 2003 reflected the inability of many clients to afford these higher premiums and the public system's financial difficulty in absorbing them (IBGE 1998, 2002; ANS 2003).

Disinvestment in the public sector led to inadequate service provision. Paradoxically, specialized and expensive medical procedures still took place largely in the public sector, and those covered by private insurance utilized public facilities when they needed such services (Almeida *et al*. 2000).

The increasing mix of private–public financing in public hospitals, according to our respondents, led to reduced access for those who depend only on the public sector.

Privatization and the opening of public sector services to corporate participation therefore have exerted major effects. IFIs and multinational corporations have promoted continuing reforms that, while favourable to corporate interests, worsened access to needed services and strained the few remaining public sector institutions, despite research verifying predictions of worsening access and health care outcomes among the most vulnerable populations. Reforms supported by the World Bank and other IFIs threatened the social security system while providing 'packages' of basic services that left many needs unmet.

3.8 Conclusion: the beginnings of a theory and praxis

Globalization and 'silent reform'

Linkages between economic globalization and health deserve more critical attention. A growing network of professionals and advocates has drawn attention to the new policies affecting health and health services that derive from new conditions of global trade. In most Latin American countries, privatization policies, decided after consultation with IFIs, reach implementation usually through executive decrees or changes in regulations rather than through new laws debated in the legislative branch. These policy changes receive little attention among law-makers, in the public media, or in professional associations and consumer groups. The political process that accompanies such reforms therefore is usually a silent one, restricted to the executive branch of government (see also Iriart, Chapter 4, this volume).

Through 'economism', Pierre Bourdieu (1998, 2003) argues, policy-makers choose reforms based on technocratic assumptions that market processes – the 'confidence of the markets' – achieve the broadest good across social classes in both economically developed and less developed countries. From this view, technical experts in IFIs and corporations call upon political leaders to take their advice, rather than relying on democratic, consensus-building processes to evaluate policy reforms. The economism that accompanies globalization has led to increasing acceptance that – to the extent that it interferes with trade both within and across national boundaries – the state must be dismantled (Bourdieu 1998). This dismantling involves cutbacks of public sector services and reversals of laws and regulations that restrict trade in health services within the private marketplace.

Praxis

Action informed by theory, or praxis, has focused on the detrimental effects of economic globalization on health and health care, as well as alternative projects that aim towards improvements in health conditions

(cf. Waitzkin 2000, 2001). Opposition to policies which generate adverse effects on health and health services has increased worldwide. Specific examples of organized resistance have shown that such policies can be blocked or reversed. For instance, a campaign to eliminate users' fees in public sector health services and education led to a major change in the World Bank's policies of enhancing privatization and corporate trade in services. Through a series of protests, a coalition of health professionals, non-professional health workers, and patients who use public hospitals in El Salvador have blocked, at least temporarily, the privatization of those institutions.

Alternative projects favouring international collaboration have countered some effects of globalization on health and health services. For instance, the Brazilian Workers Party, which won the presidency in late 2002, has emphasized the expansion of public hospitals and clinics at the municipal level. Adopting the principle of community participation in municipal budgets, the new government has encouraged the strengthening of municipal public services and has tried to limit the participation of multinational corporations in health. Such efforts have occurred in the context of a global network of advocacy organizations, political parties, labour unions, and organizations of professional and non-professional workers. This network aims to develop alternative models of service delivery that emphasize a strengthened public sector, and to counter the corporate dominance in health care that globalization encourages.

Notes

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2. Medicare is the US federal programme initiated in 1965 to help pay the medical costs of the elderly. Medicaid is the major government programme for poor people, also established in 1965. It is the largest public medical programme for low-income mothers and children. Medicaid is funded by federal and state governments.

4
The Transnationalization of the Health Care System in Argentina

Celia Iriart[1]

4.1 Introduction: the health crisis in Argentina and economic reform

> *If privatization is the cure, why is Argentina dying?*
> (Graffito on a wall in Quito, Ecuador, May 2002)

That question well expresses popular perplexity at the scale of the Argentinian crisis at the end of 2001. Argentina, considered a model economy by the International Monetary Fund (IMF) and World Bank, pursued the prescribed policies of deregulation and opening its economy to participation by transnational capital in the privatization process. Argentina privatized, totally or partially, all state companies (oil, chemical, airline, merchant fleet, communications, water and electricity) and the management of pension funds, public health care services and the medical social security system. Yet after ten years of structural adjustment policies, Argentina's economy collapsed, pulling down social institutions such as the health care system, education, and retirement funds.

This chapter examines one aspect of this disaster: the role of multinational corporations in the privatization process in health care. The chapter begins by establishing the severity of the decline in health of the Argentinian population through the period of 'reforms': that is, the privatization process. It then demonstrates that the multilateral agencies effectively enforced their preferred reforms of the health care system, based on a concept of health care

as a commodity that represented a major ideological shift in the 'common sense' of health policy. The reforms opened the way for multinational financial capital to transform Argentinian social insurance funds, moving them towards private insurance models of managed care, while public provision deteriorated. Despite the documented health consequences, the dominant policy discourses continue to promote managed care; only social movements offer a better, alternative common sense.

Research for this chapter drew on secondary sources and new interviews to update evidence collected between 1996–9 for an earlier project (Stocker *et al*. 1999, Iriart *et al*. 2001). The chapter draws on official documents and statistical information from national and private databases (National Institute of Statistics and Census, Ministry of Health, Ministry of Economy, Superintendent of Health Service, professional and corporate associations); searches of Argentinian newspaper databases and web sources; and interviews with government officials, legislators, international agency officials, managers and executives of the national and multinational private sector, and union and political leaders.

4.2 The health crisis in Argentina

The economic reforms implemented in Argentina after 1991, and related health system reform, were associated with a sharp deterioration in health indicators and public health provision, worsened by the dramatic impoverishment of Argentinian society from 2001. Even during the economic growth period up to 1998, vaccination coverage in children under 6 years old decreased in Buenos Province, the richest province in Argentina. Polio vaccination coverage fell from 87.7 per cent in 1992 to 64.4 per cent in 1998 while DPT vaccination (Diphtheria, Pertussis and Tetanus) coverage decreased from 86.5 to 62.1 per cent coverage in the same period. The decline was caused by a cutback in government funds to buy vaccinations for free provision in public hospitals and clinics and increasing privatization of the vaccination services. Pulmonary TB in children under 5 years old increased 153 per cent between 1991 and 1996. Child diarrhoea increased 41 per cent during the same period and 13 per cent of the children born in public hospitals weighed less than 2500 grams or 5.5 pounds (López 2000).

A World Bank report (Uribe and Schwab 2002) also found a deterioration in basic health care. An analysis of a World Bank-financed project (PROMIN) showed that between July 2000 and September 2001 the coverage and quality of maternal and child services decreased substantially for a set of community clinics in poor neighbourhoods. The data show: a 43 per cent decrease in visits to primary care centres by pregnant women; a 23 per cent decrease in early detection of pregnancies; a deterioration of the quality of prenatal care, especially for poor women, because of a lack of supplies to test for toxoplasmosis and syphilis; and a 20 per cent fall in the number of

children receiving the nationally recommended number of first-year check-ups. Argentinian surveillance system data cited in the report showed that in August 2002, as compared with August 2001, there was an increase in notified cases of 21 per cent for HIV, 113 per cent for Chagas by vector, 24 per cent for congenital Chagas and 480 per cent for Leishmaniasis.

The deterioration is difficult to understand in a country that until 2001, before the fall of the convertibility plan (1 peso = 1 dollar), spent 8.5 per cent of its GDP or US$653 per capita on health (Tobar 2002), had an extensive health care network and high technical development in health care. In 2001, however, the economic collapse sent all health care sectors into shock and decreased people's capacity to pay out of pocket. In 2002, total health expenditure per capita decreased dramatically to US$184, and the services that could be purchased with this sum also fell because devaluation of the currency (of around 300 per cent) increased the costs of medication and technological supplies, most of which were imported. Drugs prices rose on average at 170 per cent of the inflation rate. Total health expenditures decreased by 9 per cent between 2000 and 2001, and continued to fall in 2002 (Tobar 2002). The National Ministry of Economy reported that between 2001 and 2002, taxes related to medical social security institutions (called *obras sociales*) decreased 15.5 per cent and that employers evaded contributions to the system for 15 per cent of their declared workers (Uribe and Shwab 2002).

4.3 Problems in Argentinian health care before reform

The Argentinian health care system has always exhibited a deep fragmentation, which has persisted despite several government attempts to unify it (Iriart *et al*. 1994). From the 1940s, three sectors became legally and financially differentiated. The public sector provided open access, tax-financed and publicly provided. The medical social security sector restricted access to people in formal employment, was financed by obligatory contributions, and paid for care by private providers. In this sector each trade union organized its own *obra social*, based on a specific occupational branch, and the workers were obligated to affiliate. By 1990 there were 370 national and 24 provincial *obras sociales*. Finally, the private sector restricted access to people with a prepaid plan or able to pay private fees.

This fragmented structure relied heavily on private providers and generated very high costs. All three sectors were oriented towards curative practices, emphasizing expensive diagnoses and treatments that constantly incorporated new technology, high consumption of medications, and specialized medical consultations. Evaluations focused on costs, not quality or appropriateness of procedures to patients' needs. Providers' wide autonomy resulted in costs of health care services that spiralled out of control during the 1970s and 1980s.

The 1980s in Argentina were marked by the beginning of severe structural unemployment, declining purchasing power of wages and salaries, and changes in labour laws that decreased the employers' contributions to the social security institutions. Together with rising medical costs, this brought on a huge financial crisis among the *obras sociales*. During the 1980s, more and more people who had enrolled in small *obras sociales* began to require health care in the public sector because their *obras sociales* had cut contracts with the private providers or had applied co-payments in response to the financial crisis. In effect, giant yet hidden subsidies from the public health care system, also in crisis, moved to the *obras sociales*.

High and middle-income people turned to private insurance, and the number of companies providing prepaid plans rose from 25 in 1974 to over 200 in 1989 (Lloyd-Sherlock 2002). Some contributors remained legally required to contribute also to the *obras sociales*, but were not satisfied with the services provided and paid to obtain better services (especially comfort and speed). By 1990, the state sector formally covered around 30 per cent of the population, the *obras sociales* 63 per cent, and the private sector 7 per cent through prepaid plans. However, both social security enrollees and the privately insured also used public health care facilities, for their recognized quality and free access. Of health expenditure, approximately 22 per cent came from state administrations (86 per cent from provinces and 14 per cent from national and municipal administrations), 36 per cent from social security institutions, and 42 per cent was out-of-pocket expenditure (including medication, co-payments, payments to prepaid plans and private health care services) (Lloyd-Sherlock and Novick 2001).

In 1970, state regulation strengthened the *obras sociales* by establishing a fixed obligatory salary percentage at a time of very low unemployment, and these funds were at the root of a huge rise in private health care provision. The public hospital infrastructure had expanded spectacularly in the 1940s and 1950s, but then the number of hospital beds began to decline, falling from 97 319 to 94 883 between 1958 and 1980. The number of private beds increased from 17 903 to 47 048 over the same period. Private health care services are concentrated in urban areas where higher socio-economic groups and those covered by social security or with access to private coverage live. The capital city of Buenos Aires is an example: 94.6 per cent of the outpatient facilities and 67.8 per cent of the inpatient health care services are private (Ministerio de Salud 1995).

4.4 Official discourses about health care system reform

By 1990 there was therefore an undoubted need for reform. However, the Argentinian government used this moment to introduce into the health care system the neoliberal 'common sense' that characterized health care as just another commodity.

This concept of 'common sense' is an important one for this book as a whole. It refers to core ideas that underlie official discourses on health (the evaluations and proposals promoted by government, multilateral lending agencies and representatives of private sector interests) and also are reflected in the experiences of the population. Ideas become 'common sense' to the extent they become real, shared meanings providing direction for society, and acting as social cement that fills gaps and artificially softens social contradictions. Common sense shapes the subjective assessment of a shared situation by people in different places in the social structure (Benasayag and Charlton 1993).

In Argentina, the shift in common sense reconceptualized health care services as no longer a universal right for which the state is responsible but rather a commodity that individuals could acquire. This is a fundamental redefinition of health care from a public good to a private good (Laurell 1995b), according to which the health care sector should be transformed into a market where public and social security institutions compete with the private sector for resources, in a process promoted as natural and irreversible, rather than social and political and driven by powerful interests.

Policy was based on the claim that market competition would improve efficiency and quality of the *obras sociales*. Deregulation therefore allowed those in formal employment to choose their *obra social* regardless of occupation. The implication was that the contributions that employees and employers had to send to the specified *obra social* became understood as the 'property' of each worker, facilitating the breakdown of the concept of group solidarity (from each according to his/her salary, to each according to his/her needs) that is central to social security.

The reforms, modelled on the US 'managed care' model of the 1980s and 1990s (see Chapter 2), introduced private companies to manage the funds of the *obras sociales*. The official discourse argued that these companies would reduce costs and manage financial resources more efficiently, controlling excessive prescriptions and specialized consultations and sharing risk with the most qualified providers. The core idea, promoted globally in these years, was that a shift from a 'supply subsidy' (to providers) to 'demand subsidy' (to the poor) (Londoño and Frenk 2002) would allow people to become 'natural' regulators of health costs through their market choice of managed care organization and provider. Official discourse also began accusing worker union leaders of corruption and using the *obras sociales* for political purposes. The deregulation of the *obras sociales*, forcing them to compete with each other for members, was justified as neutralizing their power.

The reforms were associated with a sustained attack on public hospitals and clinics as bureaucratic and inefficient, with workers (professionals and non-professionals) unmotivated to improve the services because of job security and lack of performance incentives. The official discourse was silent on the shortage of human resources, subsequently worsened by adjustment

policies that also further ran down physical infrastructure and equipment. Decentralization, implemented by the national Ministry of Health, transferred hospitals to provincial ministries but failed to transfer the operating budgets, worsening pressure on under-financed provincial public health systems.

The political process accompanying these reforms was a 'silent' one in that it was restricted to the executive branch of government, segmenting the policy-making process and thereby reducing political conflict. Interviewees, including an official of the World Bank's delegation to Argentina and a senior official of the Ministry of Health and Social Action, stated that implementation of reform was sequenced and fragmented, avoiding a unified approach to the whole health care system. Policy implementation largely bypassed discussion in the legislative branch, and multinational and national financial capital took advantage of loopholes in the reform regulations to take over management of public health care and social security funds despite legal and regulatory prohibitions (López Delgado 2001).

4.5 Health care reform: commercializing the public hospitals

The health care reforms of the 1990s also brought market logic into the heart of the public health care system. The government aimed for an agreement that would permit public hospitals to receive payments for patients covered by the *obras sociales*, removing the hidden subsidy to the social security funds when their insured members obtained public health care services without payment. Federal and provincial governments also sought to introduce direct payments by those patients who had the ability to pay but were without private or social security coverage. The state budget would then cover only basic health care packages provided free of charge to the poor. These packages exclude health care services previously covered by the public sector but for which people now had to pay, increasing health costs for poor families. Public hospitals and clinics implemented so-called 'voluntary' fees that were a significant disincentive for the poorest and most vulnerable groups (Lloyd-Sherlock and Novick, 2001).

In 1991 the Menem government reactivated several projects financed by the World Bank and the Inter-American Development Bank, including the creation of Self-Managed Hospitals (SMH, *Hospitales de Autogestión*) through national decree law 578 in 1993. However, in 1991 all nationally managed hospitals had been transferred to the provinces, over which the national decree law did not automatically apply in Argentina's federal system. The government's plan to induce provincial governments to accept the decree, as high-level officials at the Ministry of Health and World Bank informed us in interviews during 1998, is described below.

The SMH were key to the conceptual change away from health care as a guaranteed right. Public institutions competed for funds and people had

to pay for public sector health care services with their insurance (private or social) or from their pockets. Applicants for exemptions from fees for inability to pay faced a difficult bureaucratic process, and most were denied their rights. Hospitals gained more autonomy to determine priorities for services offered, networking with other public or private hospitals, and population covered. Each public hospital competed with private and other public hospitals for the state budget and social security and private funds. The budget requested each year from the state administration had to be based on demand as measured by types and amounts of services used, not on needs as expressed by epidemiological assessment.

The SMH was implemented through the 'Project of Health Sector Reform, Component 2, Self-Managed Hospitals'[2] partially funded by a World Bank loan. This introduced specific economic and business concepts into hospital administration: costing of procedures, comparison with benchmarks, and budgeting according to financial results. The reform was also associated with a major shift in the concept of equity underpinning health policy. Previously, 'equity' meant payment according to income and services according to needs. Now a new concept of 'financial equity' was explicitly defined to mean a separation of health accounts for types of beneficiaries ('voluntary members, trades union members, the poor, among others') 'in order to avoid cross-subsidy . . . to the poor' (IADB 1999). Provinces that formally enrolled their hospitals in a Register of Self-managed Hospitals received a World Bank loan. In 1995, 516 hospitals were registered and in 1996, 800 outpatient and inpatient health care services, representing 75 000 of the 84 094 beds in the public sector at the time. Cash-strapped provinces had a strong incentive to register because the *obras sociales* were then obligated to pay for public hospital services, and hospitals were also permitted to charge patients without coverage.

This new financing system did not, however, function as designed. A World Bank report (Uribe and Schwab 2002) found that only 9 per cent of the 1600 hospitals enrolled in 2002 billed the *obras sociales*, which in turn had, in the first half of that year, paid just 44 per cent of the bills; in 2000 they had paid 86 per cent. According to our interviewees, the *obras sociales* faced their own financial crisis and increasingly refused to pay the public hospital bills, justifying refusal on the grounds that the public hospitals did not obtain authorization for the treatments. The *obras sociales* also claimed that public hospitals charged more than the private sector. In reply, public hospital staff said that the *obras sociales* established complex administrative procedures in order to avoid paying. Public hospitals cannot, by law, refuse to see patients, and rising paperwork for claims was worsening their financial crisis. Hence, the hospitals turned to relying on 'voluntary' fees collected through private foundations and civil associations (*cooperadoras*) installed in the hospital, creating more barriers for poor people demanding health care (Lloyd-Sherlock and Novick 2001). Public hospitals in Argentina have

become increasingly hospitals for the impoverished middle classes, who can pay the fees that poor people are unable to find.

These reforms installed a private market logic inside the Argentinian public hospitals. There was a dramatic expansion of income-generating activities such as diagnoses or treatments using high technology and high cost supplies. These profitable activities resolved the health problems of only a limited number of people, and were quickly privatized through foundations, while less profitable activities were squeezed. Interviews with leaders of the Health Professional Association of Buenos Aires Province (CICOP) reported that since 2000 financial restrictions had worsened in the hospitals of Buenos Aires province. The Secretary of the Health Professional Association of the Mar del Plata Regional Hospital said that *'restrictions imposed by the provincial government caused strategic areas of several hospitals to close (surgery rooms, and entire wards due to the lack of nurses and cleaning staff, among other reasons). Also, pharmacy shelves were empty and people who required attention needed to buy medication and other important supplies and carry them to the hospitals'* (Dr Carlos Trotta, June 2002).

4.6 Medical social security reform and trade union responses

The reform of the *obras sociales* required a long and complex negotiation process, during which the most important objective of the government and its allies was to break the power accumulated during the previous fifty years by physician associations and worker union leaders. The government's stated motivation for establishing control over the *obras sociales* was to avoid corruption. However, the true objective – of opening the social security funds to management by national and multinational financial capital – actually opened new opportunities for corruption as negotiations proceeded between worker unions managing *obras sociales* and those seeking to manage the funds (Hawley 2000).

The government sought to divide the opposition to reform. In 1991, the decree law 2284 opened the entire Argentinian economy to deregulation and structural transformation, including the medical profession and the social security system. Medical associations were prohibited from acting as their members' representatives, obliging physicians to contract individually with *obras sociales* or private prepaid plans. This prohibition broke the previously strong negotiating power of the professional groups over remuneration and other conditions, based in collective withdrawal of services. This process was applauded by the worker unions and other groups on the grounds that it would lower costs and increase quality, allowing major cost reductions through a shift to managed care, and renegotiation of the giant debt that the *obras sociales* had accumulated with private providers.

However, deregulation of the *obras sociales* also gradually undermined the negotiating power of the powerful worker union leaders. The decree law

9 (approved in 1993) was followed by numerous decrees and ministerial resolutions that repeated the same reforms, notably three decree laws and several ministerial resolutions permitting employees a free choice among *obras sociales*. The repetition was used to exert pressure on union leaders to approve other reforms: if they did so, the deregulation was not applied. Free choice among *obras sociales* was only finally applied in 1997.

Union leaders used these delays to exploit new opportunities. The more powerful union leaders organized their own managed care organizations (*gerenciadoras*) to act as financial intermediaries between the *obra social* and the providers, or negotiated with the multinational-managed care organizations to participate in managing social security funds.

Probably the most important tool weakening union resistance was a project approved in 1994, partially funded by the World Bank, named 'Program to Reform the *Obras Sociales*' (*Programa de Reconversión de Obras Sociales – PROS*). An *obra social* that signed the contract would be loaned up to three months of regularly collected funds, the loan to be repaid over fifteen years, beginning three years after the loan was received and with an annual interest rate of 3.75 per cent. Each contracting *obra social* had to select one of 160 international consulting companies approved by the World Bank (including Arthur Andersen, later involved in the Enron scandal) to present its financial reports to a government agency. The agency in turn sent the report to another international consulting company which made the final decision whether to approve the reform plan of each *obra social*. Although the project had minority World Bank financial participation (US $150 000 versus US $210 000 from the government), it was the Bank which established the reform guidelines and chose the international consulting companies responsible for institutional analyses, reform plans, and final decision-making.

It is difficult to understand why the worker union leaders accepted these loans, given the requirement to allow a foreign group access to well-kept secret information. The loan conditions also required them to dismiss workers, and to sell hotels and other recreational facilities and the health care facilities which a few *obras sociales* still owned. All of these assets were sources of union power. The imposed conditions obliged *obras sociales* to spend 80 per cent of their funds on contracting medical services. The only explanation provided by interviews and analysis of the Argentinian context (as well as observing the reformed health care system ten years later) is related to corrupt practices involving politicians, union leaders, and multinational groups that congressional investigators later documented (Comisión de la Honorable Cámara de Diputados de la Nación 2001).

The reforms also reduced the number of *obras sociales* and private prepaid plans. The consulting companies analysed the financial viability of each institution and in some cases recommended that medium or small *obras sociales* needed to transfer their members to, or merge with, others in order

to achieve economies of scale. To hasten this market concentration process, the government approved, in 1995, the first Obligatory Medical Programme (*Programa Médico Obligatorio*, PMO). This programme required the *obras sociales* and prepaid plans to offer a diversity of services that most of them were not financially able to cover. Those unable to provide the services had to merge with others or close down completely.

This mix of regulation and deregulation successfully achieved the market concentration sought by the government and the lending agencies. According to the agency that regulates the social security institutions, the number of national *obras sociales* fell from 361 in January 1994 to 290 in February 1999. Currently, most *obras sociales* are administered by local or foreign managed care organizations. Prepaid plans were sold or incorporated into joint ventures with transnational insurance companies or investment fund administrators. Before the 1990s prepaid plans were owned by physicians; now most are in the hands of financial groups which bought them as a strategic move towards management of social security funds and public health care services. The resultant concentration of the prepaid plan market was accelerated by renewed selling of plans during the Argentinian economic crisis in late 2000 and through 2001. Then in 2002 the executive branch of the government approved a new PMO, called Emergency PMO (*Resolución 202/2002 Ministerio de Salud*), that decreased the health care services that had to be offered and the percentage to be covered by social security institutions and prepaid plans. It appears that, while the first PMO achieved the intended market concentration, offering all of the health services included in the earlier programme was, however, not profitable for the local and multinational financial companies that had moved in.

4.7 The role of the managed care organizations (MCOs) in the reform

A feature of the so-called globalization era has been a shift in the nature of multinational capital investing in health care from predominantly industrial and service companies, in pharmaceuticals and health services, towards financial corporations operating in insurance and pensions. Argentina is one of the Latin American countries where the penetration by multinational financial capital has advanced most rapidly, playing a central role in transforming the health care system. Its entry was facilitated by the health reform process just described, which by changing the relationships among the private, public and social security sectors allowed multinational finance capital to position itself in prepaid insurance, administering medical social security funds and state-supported health services. Some corporations have also operated as providers of services, with the vertical integration characteristic of managed care organizations in the United States.

The three main ways that multinational corporations have invested in the Argentinian health system are through: (a) purchase of established companies selling indemnity insurance or prepaid health plans; (b) association with other companies in the framework of a ' joint venture' ; and/or (c) agreements to manage social security and public sector institutions (Stocker *et al*. 1999).

Many of the companies investing in Argentina are subsidiaries of large US and European insurance corporations; others are mutual and pension funds that manage the capital invested by universities, foundations and corporations of First World countries. The main multinational companies that have operated in the Argentinian health care system are: Aetna, the Exxel Group, the American International Group (AIG), International Medical Group (IMG), Prudential, International Managed Care Advisors (IMCA), and Swiss Medical Group. Interviews and review of publications by US corporations showed that an explicit objective of these firms in Latin America, and in Argentina in particular, is to expand their business operations in the medical social security and public sectors, since the scope of the private market is limited (Iriart *et al*. 2001).

In 1997, the government put into effect the legislation that permitted employees to move their obligatory contributions from one *obra social* to another that they consider offers better services. This was the moment when the prepaid plans, mainly owned by financial corporations, moved into the management of social security funds. The legal framework did not permit contributors to an *obra social* to move to a private plan, so the firms turned instead to agreements with some *obras sociales* to manage their funds on a 'capitated' basis, that is, agreeing a specified payment to obtain health services for a specified number of people.

This was the route taken by Aetna, owner at that moment of the largest prepaid plan for the middle class (*Asistencia Médica Social Argentina* – AMSA), which advertised to recruit contributors to a list of ten *obras sociales*, through which people would then receive services through their prepaid plan. This was also the strategy of Managed Care Advisors, an investment fund from New York that established a joint venture with a provincial state bank that managed several *obras sociales*, and of Medical Group Latin America Inc. (IMG) that signed agreements with five *obras sociales* which merged into a consortium during the reforms in order to survive. Other companies such as Exxel Group and Bank Roberts (later sold to HSBC bank) preferred to purchase *obras sociales*. Exxel bought Witcel, an *obra social* that had offered coverage to workers of a paper company that had ceased operations, and Bank Roberts, owner of a prepaid plan directed to upper-middle-class people, bought OSDO, the *obra social* of two closed chemical companies. Witcel, before it was purchased, had 300 beneficiaries; during the transfer in May and June 1997, it gained almost 10 000 additional members. OSDO, managed by Bank Roberts and its prepaid plan, Dochtos, received 40 000 new members (ANSES 1997).

The free choice of *obra social* thus consolidated market-oriented criteria in the operation of the social security sector. The new criteria were visible in companies' advertising for contributors. Most television, radio and printed advertising was by the prepaid plans, not by the *obras sociales*, despite that not being legally permitted, and promoted the benefits of having private coverage through the *obras sociales*. Phone, mail and personal promotions were directed to people with the following characteristics: young, high income, smaller number of family members, and employees in companies that contributed reliably to the system.

Representatives of the prepaid plans and associations that represent these companies, interviewed during June 2003, characterized the deregulation of the social security system as partial, so that the prepaid plans, in the words of the President of Swiss Medical Group (SMG), 'entered through the window, not through the door'. He emphasized that the SMG only accepts from *obras sociales* people whose money contribution is sufficient to cover the premium that the group requires from its enrollees, whether from salary alone or supplemented by extra money paid by employers or employees. Belocopitt, the SMG President, considered that this cream-skimming process by the prepaid plans, recruiting only young, healthy, and better salaried people from the *obras sociales*, necessarily prejudiced the financial situation of the social security system.

4.8 Exxel Group – a paradigmatic company

The Exxel Group manages Argentinian and foreign mutual and pension funds. Its headquarters are in the Cayman Islands, a location attractive to US corporations that invest outside the jurisdiction of US regulatory agencies (Stocker *et al*. 1999). The group began its activities in 1992, when the US investment company, Oppenhemier & Co., chose Exxel to administer its investments in Argentina. Later, other investment funds followed (Arce 1997). Each investment fund had to make a minimum contribution of about 8 million dollars, and invest for at least ten years; investors were also required to renounce the right to oppose acquisitions by the Group. The Exxel Group is thus a long-term investment corporation, and one which is paradigmatic of financial corporations moving into multinational investment in health, extracting income for investment elsewhere, pursuing profit in a manner that restricted access to health care services, and worsening the financial crisis in the sector.

In ten years of operation, the Exxel Group grew until it figured among the ten largest corporations in Argentina. From its long list of investors, the better known included Aetna, Columbia University, General Electric Pension Trust, Massachusetts Institute of Technology, Oppenheimer & Co., Princeton University, Rockefeller & Co. and the Ford Foundation. The US institutions whom we consulted were unaware that their employee pension

funds, invested in a US company such as Oppenheimer & Co., had been reinvested in the Exxel Group. Exxel invested very widely in Argentina, including energy distribution, restaurant chains, credit card services, music store chains, construction materials, private mail companies, airport storage, duty-free shops and cargo transport.

In health care, Exxel positioned itself in all three sectors: private, medical social security, and public. In the private sector, it bought three of the most prestigious prepaid health plans that had approximately 190 000 insured members and annual billings of almost US $260 million. It also purchased three large inpatient facilities. Exxel unified these enterprises under the name of *Sistema de Protección Médica* (System of Medical Protection), now the second largest prepaid health plan in Argentina.

In social security, as described above, Exxel acquired a small *obra social*, Witcel. Exxel then obtained approval from the federal agency that regulates the activities of social security funds (*Superintendencia de Servicios de Salud*) for Witcel to act as an 'open' fund to receive affiliate members of other *obras sociales*. Witcel is currently managed by the *Sistema de Protección Médica*.

Finally, the company moved into the public sector by contracting with the provincial government of San Luis to manage the billings of twenty-seven of its public hospitals to the social security system and the provincial government. In this province the billing procedures in the contract with Exxel had some novel features. Exxel billed the government and the *obras sociales* for patients seen at its hospitals and retained 20 per cent of the payments received. Meanwhile, the physical hospital infrastructure, part of the utilities consumed such as electricity, and the majority of hospital workers were paid by the provincial government.[3]

In 1998, the Exxel Group had 73 companies, 40 000 employees, assets worth US $4500 million, and an operational capital movement of US $4800 billon per year, an extraordinary expansion for a company that started with US $47 million invested by Oppenheimer & Co. in 1992 (Guerrero 2003). The financial model that Juan Navarro, President of Exxel, said that the Group used to achieve this growth was the 'leveraged buyout', meaning the takeover of a company using a significant amount of borrowed money, usually 70 per cent or more of the total purchase price (Brea 2002). The Exxel Group's purchases of local companies were financed by short-term loans from foreign banks. The loans were repaid by the issue of bonds sold in external markets as 'junk bonds'. During the good times the Group offered up to 50 per cent interest rates on the invested capital. It operated in Argentina, Chile and Uruguay.

Companies purchased using this financial mechanism had high levels of debt and stopped paying income taxes since the tax laws permit deduction of interest payments and losses. As a result of such manoeuvres, the National Treasury in Argentina lost millions of dollars. The consequences were increased fiscal deficits and cutbacks in the public social expenditures,

such as health care and education. Worse still, by 2003 most of the companies bought by the Exxel Group had gone into bankruptcy. The Group sold on the bankrupt firms or lost them to creditor banks. In 2003 the Group owned just seven companies, with assets that did not surpass US$500 million (Álvarez Guerrero 2003).

The Exxel Group operation caused a huge transfer of capital from Argentina to foreign private accounts, in the form of interest on the 'junk bonds' and payments to the foreign lenders, the banks and pension and investment funds that provided the initial loans. In 2001, a National Committee of Senators and Deputies investigated Exxel Group for activities linked to movements of capital outside of the country, and from the legal to the illegal capital market in the sense of capital outside the taxation process (Comisión de la Honorable Cámara de Diputados de la Nación 2001). Argentinian society also lost thousands of jobs because, when Exxel Group purchased companies, their first move was to cut jobs and reduce the salary bill (Naishtat and Maas 2002).

According to market analysts, the decline of the Exxel Group implies that the leveraged buy-out mechanism and the associated tax deductions are ending. However, the mechanism may have restarted. In 2002, the Exxel Group's prepaid plan was sold to an Argentinian physician, Julio Framoeni, owner of other prepaid plans. He also purchased AMSA, a prepaid plan owned by a Dutch company called ING which in 1999 had purchased it from Aetna. After these purchases, this physician merged the large prepaid plans. The method of buying these companies was, again, through international short-term loans.

4.9 Conclusion

Argentina is an extreme case of a country that accepted the multilateral lending agencies' recipes for economic management, including opening up to the globalized world, privatizing, and allowing national or multinational finance capital to play a fundamental role in many areas of the economy, including the health care system. In health, this was accompanied by a major ideological shift in people's 'common sense' about health care: that health services are not a right but a commodity to be obtained on the market by individuals according to their ability to pay. And health system restructuring was facilitated by the fragmented and silent process of reform, avoiding public debate.

The health system reform created struggles between poor people: on the one hand, the workers of the underfinanced public hospitals and the social security systems, and on the other, the poor population trying to obtain health care services in public hospitals or through their social security institutions. The winners were multinational firms that extracted profits and then left the country, and local mutual and pension fund administrators, as

well as political and trade union leaders who were involved in corruption and movements of capital outside of the health system and the country.

However, after ten years of these policies that impoverished the Argentinian people, the technocrats of the World Bank, International Monetary Fund, and other agencies, as well as the interested agents of the US government, argue that the problem lies not in the model of reform but in poor implementation and in local corruption that made health care reform impossible. This assessment concentrates on those taking bribes, not on those paying them, and also ignores the implications of the multinational companies' extractive strategies described above. The multilateral policy proposals are, in essence, more of the same.

The health system in Argentina needs to be reformed, but not by a private financial sector that extracts money from the health system to make profits elsewhere. To change the health system to benefit people requires a transformation of the health care model. The curative, individualist, mercantilist, and biological model cannot resolve the health care of the majority of people, and no managerial reform can stop the increasing costs of the health care system that are inevitable in this model. The only hope is that some governments and especially some social movements are questioning the globalization process that has underpinned the disastrous policies just described, and are trying to develop alliances that could be the seed bed for developing a more just world for millions of suffering people.

Notes

1. I am grateful to Ana González, who participated in the data collection, and to Maureen Mackintosh for excellent editing.
2. *Proyecto de Reforma del Sector Salud – PRESSAL – Componente 2. Hospital Público de Autogestión*.
3. Source: interviews with workers unions and documentation.

5
The Dynamics of Commercial Health Care in the Lebanon

Kasturi Sen and Abla Mehio-Sibai[1]

5.1 Introduction: the interaction of commercialization with social and political inequality

Public health systems worldwide have experienced rapid commercialization conflicting with the socially based values of public provision. The ideological rationale underpinning these changes combines claims of market efficiency with a notion of 'consumer' interests that may be better served by markets than state health services (World Bank 1993; Newbrander 1997). This neoliberal paradigm has to a considerable extent usurped and transformed the notion of 'the public' and of 'civil society' into a collection of individual consumers and providers.

Nowhere is this global paradigm of health services commodification better observed in operation than in a country such as Lebanon, which witnessed, through war and civil strife between 1975 and 1991, a systematic erosion of centralized authority. This chapter documents the predominance of private health care in the country, which has relegated the role of the state to financing some private care, with few controls over cost and quality, and has raised major issues of access and equity. The central aim of the chapter is to trace the interaction between the evolving predominance of private health services and a pattern of social relations and of power distribution historically geared to reproducing social and geographical inequality. We trace the historical roots of the Lebanese health care system in charitable and private provision, and explore how a natural alliance has evolved between the extreme commodification of health services and the politics of 'confessionalism' which is reflected both in the composition of state power and in

health service provision. The result, we suggest, is an ad hoc and fragmented system which, relative to GDP, is one of the most expensive in the world.

5.2 Lebanon: political background

A brief explanation of the political constituents of the Lebanese state provides useful background for understanding the evolution of health care. Historically the leading merchants and financiers of Lebanon belonged to Christian and Sunni Muslim communities or confessions. According to Johnson (2001) confessional identity was built into the judicial and administrative system during the Ottoman period and under the French mandate (1920–43). Each community was allowed to manage its affairs on the basis of family and kin, located within confessional groups, especially in relation to personal law and welfare provision.

After independence (1943) Lebanon was reshaped into a state characterized by *laissez-faire* ideology, yet dominated by semi-feudal social relations manifested in a struggle for territorial sovereignty between competing confessionalisms. The presidency of the republic was reserved for a Maronite Catholic, the then largest sect according to the last and only census ever undertaken in the Lebanon, in 1932 (Hourani 1946). The premiership was reserved for a Sunni and the office of the speaker for a person of Shiite origin. Seats in the elected Parliament were divided on a ratio of six Christian to five Muslim deputies in rough proportion to the supposed size of the various confessional groupings (Johnson 2001: 4).

There are currently three major Muslim confessional groups constituting around 57 per cent of the Lebanese population, according to the most recent estimate in 1984, paralleled by some twelve Christian confessional groups (Johnson 2001). Post-independence there was an implicit agreement between the different confessional groups with regard to power sharing, based upon territorial segregation (Harik 1994). An alliance between the commercial and financial bourgeoisie and rural landlords dominated the state and promoted the trading, banking and insurance sectors of the economy, while political leaders also developed sophisticated political machines to distribute patronage and control their clients (Johnson 1986).

The civil war of 1975 played a key role in the current state of fragmentation of health and social sectors, consolidating para-legal public and social services. According to Johnson (2001) the civil war was very much influenced by 'external' elements within Lebanon, among whom are the Palestinian refugees who live mainly in camps and who fell outside of the confessional system and thus of the system of patronage. As Harik (1994) explains, 'with their government helpless to affect the spiralling violence and to perform the essentials of public services, the Lebanese caught in the crossfire of conflict turned for assistance to those who militarily controlled their areas – the armed fighters of local parties'. There ensued several experiments in the

provision of public services and social assistance which served to further the autonomy of the areas concerned and the state's territorial disintegration (Harik 1994).

5.3 Origins of Lebanon's private-dominated health sector

Public health provision in Lebanon has a chequered and fragile history. The colonial power limited state paternalism to water and sanitation measures to protect the poor from carrying 'contagious' diseases. Post-independence, Lebanon briefly built up some public provision under the rubric of national social development, predominant throughout the Arab world during the 1950s. Between 1943 and 1958, the state built a network of district and rural hospitals operating within a referral system but focused on servicing the underprivileged. Patients were required to prove hardship in order to be admitted for care. This legacy of stigma associated with public provision remains today.

The civil war that lasted between 1975 and 1991 was worsened by frequent Israeli invasion, occupation and bombing. The war wholly weakened the institutional and financial capacity of the government, bringing the almost total disintegration of the Ministry of Health and its associated services. Political and social fragmentation was reinforced and consolidated by protracted war. As a result, there was no clear health policy, no means to implement it and no information database to work from – a classic situation of a country at war. The few public health programmes that had existed, such as vaccinations, mother and child health, were donor-driven and pushed further into the hands of local and international non-governmental organizations, further weakening the already minimal role of the state.

The result was that non-governmental groups and the private sector rapidly increased in numbers and capacity to fill the vacuum. While ensuring the continuation of basic minimal services, this rapid expansion also brought long-term consequences: an escalation of costs and coverage through private health financing mechanisms, and the expansion of an exclusive curative health system with a focus on hospitals and centres for high technology services (Ammar *et al.* 2000). One effect was to create health services that were led by private for-profit provision with much supplier-induced demand (Ammar 2003).

The public sector shrank dramatically in quantity and quality. Public sector hospital beds declined from 1870 before the war to less than 700 or from 26 per cent to 10 per cent of the total (Mechbel 1997). Conversely more than 56 per cent of the private sector bed capacity was created during the war, much of this expansion focusing on high-cost curative care. Concurrently, the war period (1975–91) also witnessed the rapid expansion of non-governmental not-for-profit health centres, dispensaries and hospitals.[2] International NGOs increased service coverage throughout the country

from 28 to 171 services (Mechbel 1997). Small-scale national NGOs also multiplied, working in underserved rural and urban communities, notably in Mount Lebanon and Beirut. A study in the late 1990s showed, for example, fifty-six NGOs working solely on issues of disability and rehabilitation, in a country with a population of no more than 3.5 million (Sibai and Sen 1999). Access to the services of NGOs was linked to geographic location and political allegiance. These services also functioned often on a reactive rather than a proactive basis and were poorly coordinated in terms of the needs of disabled adults and children.

Post-war, government provision was therefore reduced to some secondary and tertiary care for civil servants, plus targeting where feasible of the most disadvantaged. The private sector has remained the main secondary and tertiary provider, with primary care largely relegated to national and international NGOs. Public provision retained its stigmatized status as 'last resort' for the poor, yet even within the public element of provision one needs to be linked to a politico-religious association in order to have ease of access to most services, whether health care or essential utilities such as electricity.

The private for-profit sector continued to expand, with a concomitant proliferation in modern diagnostic techniques, equipment and services disproportionate to the size of the population, in an extreme version of trends encouraged by the global restructuring of public health and welfare provision during the past two decades (Table 5.1). As elsewhere, the predominance of demand for curative health services only for those able to pay skews the health system away from the needs of the majority and tends to prevent the expansion of preventive and promotive care.

Once established, this process has been difficult to reverse because of vested interests embedded in the political and economic structure of health

Table 5.1: Number and growth of high technology centres in Lebanon, 1997–1998

	Number of centres 1997	*Number of centres 1998*
Open heart surgery	12	16
Cardiac lab	19	24
Linear accelerator	6	6
Bone marrow transplant	2	2
Lithotripsy	27	27
Dialysis centres	39	45
Kidney transplant	3	3
Specialized centre for burns	2	2
In vitro fertilization	12	12
CT scan	54	60
MRI	12	16
Total	**188**	**213**

Source: Ammar *et al*. 2000.

provision. The powerful syndicates, professional associations such as the Order of Physicians and Pharmacists, and the predominance of confessional political parties have played key roles in maintaining the predominance of private providers (Ammar 2003). The system allows a minority of the better-off to transcend the confessional route by paying their way out of the system of patronage. However, it is now widely recognized that the health sector in Lebanon faces a major crisis, with inefficient services of uneven quality that display gross inequality in distribution and access to care despite high cost and substantial public funding (Mechbel 1997).

5.4 Demography, morbidity and social inequality

Geographically and administratively Lebanon is divided into six provinces or *Mohafazats*, including the capital Beirut, Mount Lebanon, the North, the Beka'a, the South and Nabatieh. The provinces are further subdivided into twenty-four districts or *Qadas* following geographic, political, social and historical lines of confessional division. The health care system was further fragmented in 1983 by devolution and decentralization to these political subdivisions.

Morbidity and mortality

In Lebanon, there are considerable gaps in demographic and epidemiological knowledge for most indicators and diseases. Data at the national level are scarce; the last census was in 1932. Since independence, efforts to collect demographic data and population statistics have been politically unwelcome. Registration of deaths is unreliable, while government statistical surveys and health statistics were, until recently, non-existent. The following discussion draws on several recent population-based nationwide surveys. They include the Population and Housing Survey (PHS, 1995), covering around 10 per cent of the population; the National Household Health Expenditures and Utilization Survey (NHHEUS) and the National Health Accounts (NHA), both undertaken during 1998–9. For the first time in Lebanon, these surveys provided information on out-of-pocket expenditures, insurance coverage, information on health financing agencies as well as on the expansion of the pharmaceutical sector.

Data available suggest that the Lebanese population is witnessing a continuing demographic transition, with falling fertility rates, and a rising proportion of the elderly (over 65) from 5 per cent in 1970 to 7 per cent in 1996 (NHHEUS 2001; PHS data, 1996). There is a marked excess of females in the young adult population (30–44 years) and this may reflect earlier male war-related deaths or emigration of the male labour force outside the country. Life expectancy has been rising, the total fertility rate is considered one of the lowest in the region, and other basic and health indicators such as vaccination coverage and infant mortality rate appear to indicate an overall adequate health status (Table 5.2).

Table 5.2: Selected demographic indicators for Lebanon

Demographic indicator	
Crude birth rate	22 per 1000
Total fertility rate	2.5%
Crude death rate	6 per 1000
Death due to diarrhoea under 5 yrs	3.75%
Deaths due to accidents <15 yrs	4.6%
Low birth weight	19% of births
Vaccination coverage <1 yr	97% OPV/DPT, 85% Measles

Source: Kronfol (2003) adapted.

However, national level data often conflict with local level reports, especially in relation to infant mortality rates and levels of literacy (Deeb 1997). Epidemiological measures such as incidence, prevalence and mortality statistics are lacking for most diseases. A comprehensive, detailed and reliable epidemiological assessment of the major health conditions in the country is urgently needed.

The absence in Lebanon of a reliable vital registration system of the number and causes of death by age, sex and region may be attributed to a lack of incentive to register a death, particularly for neonatal and infant deaths, and to difficulties in registering a death in a governorate other than that where the deceased was originally counted and registered (as indicated on the identity card) (Sibai *et al*. 2002). Shortage of doctors in rural areas is one among a number of other reasons for limited registration of deaths outside of the capital. Small-scale studies, which are considered a better representation of mortality in Lebanon, suggest a crude mortality rate of around 6–7 per thousand individuals (Zurayk and Armenian 1985; Deeb 1997).

There are important variations across the country, in terms of demography, morbidity and mortality, reflecting socio-economic inequalities. The North, the Beka'a and Nabatieh are demographically and economically disadvantaged (PHS 1996; Sibai *et al*. 2004), are more rural, and have higher mortality and morbidity rates and hence lower life expectancies (Table 5.3). Beirut city and some areas in Mount Lebanon which contain more than half of the population have a concentration of health services, both of preventive and curative care, and higher levels of employment.

Kronfol (2003) suggests that despite a protracted war, the health of the Lebanese population has shown continuing improvement. Life expectancy at birth rose from 64 years in 1970 to 71 years in 1996, while ad hoc surveys show falling infant and child mortality rates throughout the country. Noncommunicable diseases and risk factors for cardiovascular diseases constitute most of the burden of disease (Table 5.4).

Table 5.3: Selected demographic and socio-economic indicators for the six *Mohafazat*

	Beirut	*Mount Lebanon*	*North*	*South*	*Beka'a*	*Nabatieh*	*Lebanon*
Population (%)	13.1	36.8	21.6	9.1	12.9	6.6	100
Per cent urban	100.0	92.5	64.9	72.4	65.6	70.4	80.8
Per cent elderly (60+)	13.7	10.8	8.8	8.3	8.9	11.0	10.3
Infant mortality rate (number /1000)	19.6	27.6	48.1	27.2	39.8	17.2	28
Life expectancy at birth (yrs)	75	74	69	73	70	71	71
Illiteracy							
Males (%)	6.2	10.4	15.6	9.8	9.8	10.8	9.3
Females (%)	12.2	13.5	24.3	18.3	22.6	25.1	17.8
Employed							
Males (%)	74.8	74.4	78.7	79.0	74.5	75.6	77.3
Females (%)	35.1	23.7	17.4	18.7	12.1	15.0	21.7
Average income/ family/month (1 000 LL)	2 067	1 946	1 235	1 135	1 264	1 089	1 540
Average income/ person/month (1 000 LL)	481	442	229	277	253	248	328

Note: \$1 = 1500 LL
Source: Adapted from Sibai 2001; Kronfol 2003; Ammar 2003.

Table 5.4: Selected morbidity estimates in population

Variable	
Diabetes	13% of the adult population
Hypertension	26% of the adult population
Obesity	55% (Males), 67% (Females)
Cancer	4 000 new cases/yr
Handicapped children	200 000
Episodes of diarrhoea	3.6 per child
Malnutrition <5 years	3% of children
Prevalence of smoking	54% of population above the age of 15

Source: Adapted from Kronfol 2003.

Social inequality and poverty

The considerable regional variation within Lebanon, in health indicators and income levels, shown in Table 5.3, masks further intra-regional variations, for example, pockets of severe poverty and deprivation within the Beirut

suburbs. The average monthly income required for basic needs was calculated at $500 in 1998, while average incomes are less than half of those in parts of the country. In addition, most published data exclude the Palestinian refugee population who continue to live in camps, largely reliant upon their own services funded in an ad hoc manner by donor agencies (UNRWA). The quality of these services is increasingly affected by limited resources, and the population suffers from high levels of poverty and deprivation, with more than half of households reported to be headed by women. At least 10 per cent of the total population of Lebanon is composed of such refugees who are concentrated in Beirut and southern Lebanon.

The socio-economic data suggest that up to 40 per cent of families are living on the margins of poverty, with the 1998 ESCWA survey suggesting a much higher proportion of up to 60 per cent living on the minimum required for sustenance. Between 1997 and 2000 there has been a worsening of general economic conditions with rising public debt and household incomes falling. The costs of access to health care and basic social services are therefore a major burden upon families and carers, especially among the underprivileged and the poor. There are persistently high levels of child mortality in pockets of poverty (Mechbel 1997). Survey data show that low-income groups use the health services relatively more, which is likely to reflect poorer health status or a greater number of sickness episodes. Yet 51.5 per cent of Lebanese are not covered by any health insurance scheme, creating a very significant burden upon household expenditure.

5.5 The crisis in Lebanese health finance

Public and private expenditure on health services in Lebanon escalated dramatically and is now among the highest in the region relative to GDP. In 1992 the reported total expenditure was US$300 million or about $100 per capita and 9.4 per cent of GDP; by 1998 it was almost $2 billion and $499 per head, far outstripping inflation (Table 5.5).

Total expenditure on health care of some 12.3 per cent of GDP is far higher than most countries of the region and more than most OECD countries (Table 5.6; see also Chapter 1). The 6.5 per cent share of the government budget allocated to the health sector represents only 18 per cent of total expenditure on health care (Ammar *et al.* 2000). Seventy per cent of the remaining burden falls on households and 10 per cent on employers (Table 5.5).

This burden is unequally distributed. The National Household Expenditure Survey (1999) revealed that, on average, a Lebanese household spent some 2 609 000 LL ($1740) per annum on health care, constituting 14 per cent of their income; 97 per cent of this was spent in the private sector, 22 per cent on buying drugs and pharmaceuticals. Two per cent was spent on the NGO sector and only 1 per cent on the public sector (Ammar *et al.* 2000). As Table 5.7 shows, the low-income households spent a much higher share of household income than the wealthy on health services.

Table 5.5: Lebanese health expenditure (National Health Accounts), 1998

Total population	4 000 000
Total health expenditures	US$1 996 millions
Per capita health expenditures	US$499
GDP	US$16.2 millions
Health expenditures as per cent of GDP	12.32%
Government budget allocated to health	6.6%
Funding sources of health care finance	
Public	17.98%
Private	
Households	69.74%
Employers	10.32%
Donors	1.96%
Distribution of expenditures	
Public hospitals	1.7%
Private hospitals	22.8%
Private non-institutional providers	41.0%
Pharmaceuticals	25.4%
Others	9.1%

Source: Ammar *et al.* 2000.

Table 5.6: International comparison of health expenditures

Country of origin	*GDP per capita (US$)*	*Health expenditures per capita (US$)*	*Health expenditures as percentage of GDP*		
			Total	*Public sources*	*Private sources*
Yemen	449	19	5.0	1.5	3.5
Egypt	1016	38	3.7	1.6	2.1
Morocco	1241	49	4.0	1.3	2.7
Jordan	1475	136	9.1	5.2	3.8
Iran	1776	101	5.7	2.4	3.3
Tunisia	2001	105	5.9	3.0	2.9
Lebanon	**4045**	**499**	**12.3**	**2.3**	**9.9**
Middle East & N. Africa	5608	116	4.8	2.6	2.2
OECD	24930	1827	8.3	6.5	1.8

Source: Ammar 2003.

Sources of rising expenditure

Table 5.8, one of few currently available showing trends in health expenditure by the Ministry of Public Health, shows fairly steady expenditure growth since 1994. Over an eight-year period most expenditure headings have

Table 5.7: Proportion of household expenditures spent on health by level of income

Income category (in 1000 LL)	*%*
Less than 300	19.9
300–500	18.0
500–800	16.1
800–1200	14.8
1200–1600	14.0
1600–2400	14.1
2400–3200	11.4
3200–5000	10.7
5000 and over	8.1
All households	**14.1**

Source: Adapted from Ammar *et al.* 2000.

doubled, but the cost of drugs increased fourfold, perhaps because of over-prescription and high levels of self medication because of the high cost of consultations. The largest expenditure heading is payments to private hospitals, which more than doubled in nominal dollars between 1994 and 2001 despite numerous attempts to cap expenditure through flat rate payments for specific interventions. This pattern of state health expenditure reflects the provision of health services in the Lebanon mainly by private providers, with few supply-side controls. An MOH study showed that hospitals receiving most of their income from public funds tended to perform a large number of investigations and prescribed multiple drugs per episode, in order to maximize revenues (Ammar 2003). The resultant rising costs are associated with a substantial degree of fragmentation and unequal distribution and access to provision, by locality and socio-economic background.

Fragmentation of health finance

The 'indirect' role of the Lebanese state in financing health care is associated with a complex and fragmented set of health-financing mechanisms in the Lebanon. There are five important public financing schemes. All except the direct MOPH financing are tied to employment, with levels of contribution dependent upon both employer and employee resources (Table 5.9). According to the NHHEUS, while the largest share of public expenditure on private sector health services stems from the Ministry of Health and NSSF budgets (Table 5.10), payments per beneficiary vary across the financing agencies with the largest being granted to those employed in the security forces.

Whilst access to insurance coverage is better than no coverage at all, there are numerous problems with a system that covers mostly those in formal employment, even though in theory it covers the bulk of health care costs.

Table 5.8: Ministry of Public Health recurrent expenses (*). Accrual accounting (1994–2001)

Budget items (in millions LP)	*1994*	*1995*	*1996*	*1997*	*1998*	*1999*	*2000*	*2001*
Salaries and indemnities	11 623	13 141	15 521	14 252	15 600	18 504	18 465	26 248
Drugs	7 494	12 560	14 659	20 300	21 150	22 042	23 042	29 326
Contributions and support to NGOs	4 252	5 240	4 723	11 520	9 654	7 491	7 641	9 117
Hospital care (short and long stay)	106 133	131 767	162 360	195 414	187 000	186 258	205 335	226 000
Others	10 567	19 717	13 818	9 288	17 184	10 582	21 369	20 238
Total	**140 069**	**182 425**	**211 081**	**250 774**	**250 588**	**244 877**	**275 852**	**310 929**
Total (in thousands of US$)	**83 375**	**112 539**	**134 361**	**162 946**	**165 295**	**162 439**	**179 669**	**206 254**

**Note*: Part 1 of the budget excluding the Central Laboratory budget.
Source: Ammar 2003.

Table 5.9: Tutelage and coverage of public health care funding agencies

Fund	*Tutelage*	*Coverage*
National Social Security Fund (NSSF)	Ministry of Labour	Ambulatory care (85% reimbursement to user) Hospital care (90% direct payment to hospitals)
Civil Servants Cooperative (CSC) Fund	Presidency of the Council of Ministries	Ambulatory and dental care (75% reimbursement for employee, 50% for family members) Hospital care (direct payment to hospitals 90% for the employee, 75% for the family members)
Army Medical Brigade (AF)	Ministry of Defence	Ambulatory and hospital care (100% for the member, 75% for the spouse and children, 50% for dependent parents)
Interior, General and State Security Forces (ISF, GSF, SSF) Departments	Ministry of Interior	Same as the army coverage
MOPH	Ministry of Public Health	Hospital care (85% direct payment to hospitals, 15% co-payment with some exemptions) Dispensing expensive drugs for catastrophic illnesses Providing vaccines and essential drugs to public and NGOs health centres

Source: Adapted from Ammar 2003.

Furthermore, top-up payments are required for any major health interventions, since the full cost is rarely covered except for particular interventions through the MOPH funds. In addition, eligibility for cover is fragmented between different ministries, creating complexity in claims. There are also problems of duplication, compounded by the complexities of eligibility criteria. This means that people are forced to fall back upon MOH funds alone (Ammar 2003). Ironically, coverage through the NSSF ceases upon retirement. Subsequently elderly people and poorer sections of the population have to rely upon the Ministry of Health 'welfare funds' in order to obtain coverage. More recently, the NSSF has been refusing to pay fees to private hospitals over a particular capped limit, due to a major crisis in the financing of health care since 2001. This patchwork of funding mechanisms, including in theory coverage for those not insured, creates serious burdens on out-of-pocket expenditure of households.

Table 5.10: Public expenditures on health services provided by the private sector (1998) (US$1 = 1516 LP)

Financing agency[a]	*Number of beneficiaries*[c]	*Expenditures*[d] *(in millions LP)*	*Expenses per beneficiary*[e]	
			LP (in thousands)	*US$*
MOPH[b]	1 934 415	208 150(137.30)	108	71
NSSF	712 890	197 400(130.2)	277	183
CSC	180 225	44 511(29.4)	247	163
AF	260 000	58 467(38.6)	225	148
ISF	53 000	37 000(24.4)	698	460
GSF	9 000	5 600(3.7)	622	410
SSF	2 405	2 288(1.5)	951	627
Total	**3 151 935**	**553 416 (365.1)**	**176**	**116**

Notes: Financing agencies for expenditures, NHHEUS for beneficiaries numbers.
(a) Palestinian refugees and other non-Lebanese population are excluded as well as adherents to private insurance.
(b) For the MOPH; uncovered Lebanese are considered beneficiaries, expenditures include drugs and hospital care.
(c) NHHEUS: The number of beneficiaries includes adherents and their dependants.
(d) Covering hospital and ambulatory care except for MOPH-paid coverage.
(e) Administrative costs excluded.
Source: Ammar 2003.

The public health funding dilemma

There is much debate over health coverage in Lebanon. According to Ammar and others responsible for Ministry of Health studies (1998 and 1999) only 49.5 per cent of the population reported having any insurance (Table 5.11). Of those, 62 per cent were covered in 1999 by various public financing mechanisms; the remaining 38 per cent were covered by an assortment of private for-profit and not-for–profit schemes (Table 5.11). There is considerable geographic variation, with the highest proportion of the population covered by any type of public or private insurance in Beirut city (59.2 per cent) and the lowest in more remote areas such as the Beka'a (37.5 per cent) and Nabatieh in the south (39.4 per cent), reflecting availability and purchasing power in the different regions. Insurance also varies by income level: 75 per cent of the highest income category are insured, against 24 per cent in the lowest income category (Ammar 2003).

The remaining 50.5 per cent, with no insurance cover at all, represents the most vulnerable population, such as the unemployed, seasonal workers, the poor, housewives and elderly people. They claim from various Ministry of Health schemes, and are also as a result dependent upon confessional parties, on non-governmental provision, and ultimately upon out-of-pocket expenditures for one-off episodes of care.

The Ministry of Health acts as 'the insurer of last resort' since, in theory, it finances the hospitalization costs for any citizen, whatever their income or

Table 5.11: Percentage of population covered by various financing agencies (1998)

Financing agency	*Figures obtained from agency*		*Figures obtained from household surveys*	
	% of total population	*% of those covered*	*% of total population*	*% of those covered*
Public				
NSSF	26.1	46.8	17.8	36.0
CSC	4.4	7.9	4.6	9.3
Army	8.8	15.8	8.1	16.4
GS + SS + IS	2.3	4.1	NA	NA
Private				
Private insurance*	12.6	22.6	8.3	16.8
Mutual funds	1.6	2.8	NA	NA
Other types of insurance†	NA	NA	10.7	21.6
Total	55.8	100.0	49.5	100.0

* Includes both complete coverage and gap insurance

† Complementary insurance, insurance at work, group insurance and insurance provided by municipalities

Source: Adapted from Ammar *et al*. 2000.

asset status, who is not covered by an insurance plan. However, the nature and organization of health services means that as much as 84 per cent of expenditure of the Ministry of Health is allocated for curative care, with hardly any support for preventive or promotive health care (Ammar 2003). Furthermore, claiming is often complex, and is compounded by long waiting lists, often excluding those with real need.

The Ministry contracts most of its hospital care from private hospitals, and has little control on the type of health interventions they undertake (Ammar *et al*. 2000). Despite attempts at capping payments for types of interventions, hospitalization costs have continuously increased. The Ministry also provides population-wide coverage for three curative services: kidney dialysis, open-heart surgery and cancer treatment. In 1998–9 a disproportionate 75 per cent of the Ministry's health budget was spent on supporting these and other special programmes, addressing a small section of the population's needs. Increasingly this kind of subsidy and the inability of the Ministry to influence costs leads to budget deficits. In 1997, for example, the inability of the MOH to curb hospital costs led to a crisis in repayments to insurers (Ammar *et al*. 2000; MEDNET, personal communication December 2002).

Given the separation between financing and the provision of health care, the loss of control by agencies of the state is almost inevitable. This kind of dilemma typifies a market-led and corporatizing health care system where private profits rely on public subsidy. In the Lebanon, the situation

is compounded by the close links between a process of private investment and the confessional mode of governance. This situation heightens inequality by linking access to health care to political allegiance, and by cream-skimming through limited coverage of the formally employed and the better-off. There are growing foreign shareholdings within tertiary sector provision, in the form of ownership by non-resident Lebanese and non-Lebanese shareholdings.

Private insurance coverage

The private insurance market has expanded fast in recent years in both coverage and type of insurance company. In 2000, the Ministry of Economy registered 91 private insurance companies of whom the majority (67) were Lebanese, 10 were foreign subsidiaries, 10 were not operational, while 4 could not be traced (Kronfol 2003: 23; Ministry of Economy). Total private insurance premiums were $355 million by 1996, up sixfold from $57 million in five years. In 1996, it was estimated that only some 440 000 Lebanese were either partially or fully covered through private insurance; Table 5.11 shows 1998 estimates. 'Cream skimming' is observed in Lebanon, with older people and those with chronic ailments unable to afford the premiums or simply being refused.

The private insurance market is highly fragmented, providing both complementary and comprehensive coverage and making it hard for citizens to choose packages and to claim when needed. In 2000 for example, only 8 per cent of the population were estimated to have comprehensive private coverage (Ammar *et al.* 2000). Policies typically cover inpatient care, whilst outpatient services require additional premiums and co-payments. There is evidence that private insurance companies increasingly transfer the burden of high cost cases to the Ministry of Health, which is unable to verify whether applicants have other insurance.

The past twelve years have also witnessed a rapid increase in occupational mutual funds. By 1999 there were 64 179 beneficiaries.[3] The law permits any group of fifty persons or more to form a mutual fund and gain tax-free status. Groups may be professional or faith-led or community based, and constitute something of a threat to the private insurance sector in an otherwise 'captive' market.

5.6 Confessional allegiance and health care in Lebanon

The case of hospitals

The complexities of claiming from insurers – particularly public schemes – means that the population are discouraged from utilizing outpatient or any form of preventive care, since the onus for reclaiming expenditure lies with the patient (personal communication, Kronfol, Beirut, December 2002). This

encourages greater hospital use, since once admitted, the onus falls on the providing agency. Public expenditure on hospital care is high (Table 5.8), while expenditure on primary health care services and non-institutionalized health care providers accounts for less than 5 per cent of public health expenditure. According to Ammar *et al*. (2000), the Ministry of Health has been unable to disburse even the small amounts allotted to primary health care and as a result in some cases these have had to be diverted to curative care services.

There are 167 hospitals with 11 533 beds in Lebanon; only 12 per cent of hospitals and 10 per cent of the beds are in the public sector. Lebanon has 2.9 hospital beds per 1000 population, mainly in the private sector, giving it one of the highest population/bed ratios in the region. There is regional inequality, with Mount Lebanon having 6.55 beds per 1000 population and south Lebanon and Nabatieh having only 0.86 beds. Whilst during the past five years there has been a distinct shift towards large multi-speciality hospitals,[4] currently more than two-thirds of hospitals in Lebanon consist of 70 beds or less, often offering only a few specialist interventions.

The majority of hospitals (other than the small handful of teaching hospitals) are linked to faith-led groups that have contractual arrangements with the state (usually the Ministry of Health) for the provision of subsidized care. This is the legacy of the civil war when the majority of public hospitals were destroyed either through internecine strife or Israeli bombing (Mechbel 1997; personal communication Dar al Ajaza al Islamia, Beirut, December 2002). This has led to special financing arrangements between the state and numerous private hospitals, which, according to some observers, strengthened and reinforced confessional relations. Hence it was during this period that the hospitals became a powerful political lobby, with considerable influence on public health expenditures.

Non-governmental organizations

As with other non-public agencies, NGOs grew in prominence during the war. Their constituents are mainly the poor and the uninsured, and it is likely that the skeleton services provided account for a large share of ambulatory health care. The National Health and Household Expenditure Survey of 1998 indicated that 78 per cent of outpatient visits took place in the private sector, 9 per cent in the public sector and 12 per cent through NGOs. To a large extent, usage is linked to availability and cost, rather than being a matter solely of choice as argued by some donor agencies such as the World Bank (1993).

However, since the end of the war in 1991, NGOs have found it increasingly difficult to retain donor or public sector funding and have begun to rely upon charitable donations, when the lending agencies began to support the post-war state. The redirection of funding to the state has supported the public subsidy of private provision. In this process it is unclear how

essential services such as mother and child health (MCH) and vaccination programmes provided by NGOs are being sustained.

In general, NGOs play a limited role for inpatient care. The exceptions are organizations such as Hizbollah, whose network of health centres and hospitals has been expanding rapidly over the past fifteen years. Between 1996 and 2001, for example, contributions to the social fund of Hizbollah, collected almost entirely from private donations, increased threefold. The NGO sector appears to concentrate on activities that are unprofitable for private providers, such as prevention and health promotion, and the community-based health activities of Hizbollah are considered to be exceptional. These include vaccination programmes, MCH activities, and regular organization of lectures on health education for the people spread across different regions. This has been undertaken in addition to preventive programmes for chronic diseases such as cancer, diabetes and osteoporosis (Islamic Health Society 2002).

Hizbollah is one of the larger NGOs and appears to command substantial credibility among ordinary people. It remains faith-led though not exclusive as to access, and charged a minimal fee of $15 per month (2001) for immediate access to any of its services. During interviews in Beirut, the head of its social services claimed that their involvement as a provider had been essentially accidental, due to the prolonged nature of war and the loss of alternative provision. They also suggested to us that the provision of health care should properly only be a matter for the state, to ensure equity of access and quality of care. This was due to the fact that despite their success in filling the gap, in reality they were unable to cope either with the demand for health care or with the range of services requested, mostly from among the vulnerable sections of the population who had access to little else.[5]

Most NGOs are finding it increasingly difficult to raise funds for needed health services. Many have been forced to operate, therefore, as semi-private organizations and are increasingly charging for their services or renting out their facilities to private doctors. A process of cost recovery is initiated, whereby proceeds are split between the part-time physician (who rents the establishment) and the NGO. When not functioning through the NGO, the private practitioners function as individual entrepreneurs, with a specialist label but often without registration through local or national authorities, and thus without much control or regulation in the quality of care provided mostly in rural areas. According to Mechbel (1997), not only does this affect quality of care, it also leads to a continuum between health centres and ad hoc private practice such that the NGO centres are commercialized, with *de facto* norm-setting for behaviour by other NGOs and private providers.

5.7 Concluding comments

Despite widely expressed concern, this is a very difficult health system to reform. The endemic problems are fragmentation, high costs, limited preventive or promotive care, over-usage of drugs, lack of continuity of care

and severe inequality of access. In this context, confessional allegiance does not diminish financial burdens, but does ensure some essential rights to citizenship, which operate within an affective and communal locality. Only a wealthy minority can transcend the route of confessional group support and seek health care through private insurance mechanisms alone.

The ideological climate in Lebanon continues to favour private sector development. The inequities and cost of the system, however, constitute a rationale for state intervention and an important signal to other countries pursuing commercialization. The Lebanese state's inability to replace its contractors weakens attempts to curb the most irrational features of the market-led health system, including the cost of surgery and medication and high administrative charges, which ultimately benefit political allegiances carefully sustained at the level of the state. Change may depend in the long run not only upon the class dynamics of Lebanese society but on pressure from civil society to move away from confessional ties towards a more egalitarian and secular polity.

Notes

1. This chapter is based upon the authors' empirical research in Lebanon during 1996–2003, funded by the European Commission and UNRISD. The authors are grateful to Dr Nabil Kronfol for his invaluable help during fieldwork for this paper
2. Interviews with NGOs, Beirut, December 2002.
3. Personal communication, Kronfol, Beirut, December 2002.
4. Personal communication al Makassed Hospital and MEDNET Beirut, December 2002.
5. Personal communication, Hizbollah, Beirut, 14 December 2002.

6

The Interactions between Social and Commercial Health Insurance after China's Entry into the World Trade Organization

Qiang Sun[1]

6.1 Introduction: social and commercial health insurance in urban China

Like many other developing countries undertaking health sector reform, China puts health insurance reform high on its policy agenda (Naylor 1999; Phua 1999). Since the 1980s, China has implemented a series of health insurance reforms, culminating in the government's major policy decision in December 1998 to establish a social health insurance system for all urban employees. The key policy, 'The Decision to Establish an Urban Employee Basic Health Insurance System' (hereafter called *The Decision*) is to set up the Urban Employee Basic Health Insurance Scheme (UEBHIS) which pools some elements of risk for all urban workers, including both public and private sector employees, at the city level. By the end of 2003, most cities had established the UEBHIS, covering at that time about 100 million people (Yao 2004). The urban workers covered by the UEBHIS receive only a basic set of health services as defined by an Essential Services List and Essential Drug List issued by the government.

At the same time, the Chinese government has been positively encouraging the development of commercial health insurance, defined as playing a major complementary role in building up a multilevel health insurance system. Currently the commercial health insurance market is China is growing rapidly. In 2002, about 112 million people were covered by different kinds of commercial health insurance products, or about 8.6 per cent of

the population. It is anticipated that the commercial health insurance market will generate profits of more than 200 billion Chinese RMB in 2008 (Wu 2003). These profits are expected to come from meeting the demand for complementary health insurance for urban employees, for catastrophic inpatient health insurance, for non-urban residents and for group health insurance for students. It is widely reported that foreign and domestic insurers expect the Chinese health insurance market to grow rapidly: 'ING and other European insurers are looking to cash in as China cuts back on government welfare benefits, forcing hundreds of millions of workers to shoulder more of their own health insurance and pension cost' (newspaper report cited in Pollock and Price 2000).

China joined the World Trade Organization (WTO) in 2001. The resultant opening-up of the domestic health insurance market to international investment is likely to increase the rate of market development in commercial health insurance. According to its commitments on entry to the WTO, China will gradually open up its health insurance market to the world. The main commitments and conditions are the following. First, China committed itself to further enhance the scope for insurance business of foreign life insurers, allowing them to set up health insurance companies, but in a joint-venture format. Second, China proposed to eliminate geographical limitations on foreign life insurance companies, so that if they operate for three years in China they can expand their provision of health insurance services to most Chinese cities, rather than being limited to certain big cities such as Beijing and Shanghai. Third, foreign life insurers will be permitted to provide health insurance services to Chinese people from 2004, three years after Chinese WTO entry (Liu Penglong 2002). Combined with the push for social health insurance reform, the process of commercialization of health insurance provision after China joined the WTO would be accelerated by these commitments.

Important policy questions include the extent to which social health insurance and the commercial health sector interact; whether they complement each other by serving different insurance needs or different people; and what problems may arise. This chapter draws on primary research and aims to provide a systematic analysis of these interactions in China. The research included a literature review, reanalysing secondary data, key informant interviews and a structured questionnaire survey.

6.2 The development of the Urban Employee Basic Health Insurance Scheme

Over the past four decades, the Government Health Insurance Scheme (GIS) and Labour Health Insurance Scheme (LIS) have played an important role in providing China's urban working population with health protection. However, the two schemes were judged also to have contributed to China's rapid

health care cost inflation and inefficient resource allocation. Policy-makers took the view that the type of third-party insurance represented by GIS and LIS gave the urban insured no incentive to seek the most cost-effective health care, since they imposed limited financial responsibility on consumers for the health services they utilized. Policy-makers believed that unless these problems were addressed, excessive health care cost escalation would exceed China's ability to pay, jeopardizing continuing improvement of urban residents' health status and affecting social stability.

As a result, in the 1980s, China implemented a series of reforms to the urban health insurance system. The UEBHIS replaces the GIS and LIS as the dominant part of the multilevel social health insurance system managed by the Ministry of Labour and Social Security. The new programme aims to provide a basic benefit package to all urban workers including employees of both public and private enterprises.

The population covered

As compared to the former GIS and LIS, the UEBHIS expands coverage to private enterprises. All urban employees in public and private enterprises, civil servants and the retired employees are compulsorily enrolled. Self-employed and rural industrial workers may buy into the programme, but are not required to enrol. Workers' dependants, including their children, used to receive partial coverage by GIS and LIS, but are now excluded. The main reason for this exclusion is financial constraint, plus the intention to control rapid health care cost inflation. At the end of 2002, the UEBHIS covered about 94 million people, approximately 19 per cent of the Chinese urban population of 502 million.

Funding and benefit design

The UEBHIS programme is financed by compulsory premium contributions from employers (6 per cent of the employee's annual wage) and employees (2 per cent of their annual wage). Currently the rate of premium is uniform for all employees regardless of their income level. Retired workers are exempt from premium contribution, while their former employers are responsible for contributing 8 per cent of the employee's wage.

As shown in Figure 6.1, total premium contributions are divided into two parts: the individual medical account, and social risk pooling. The individual medical account was introduced with the intention of increasing individual patients' cost-consciousness when utilizing health care. The social risk pooling in the UEBHIS was designed to strengthen the capacity of social insurance to spread the risk of catastrophic medical expenses. From the employee's wage, 3.8 per cent goes into the individual medical account, which enrollees can use only to pay for outpatient health care expenses in public hospitals or for purchasing drugs in drug stores selected by government. The enrollees themselves therefore hold these individual accounts like

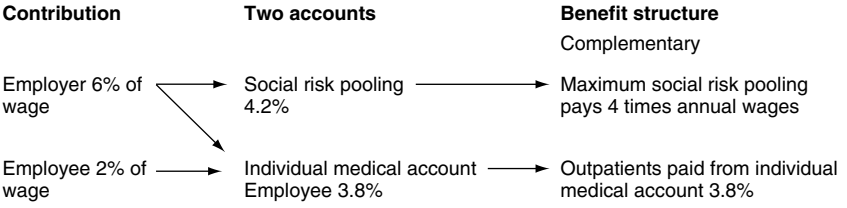

Figure 6.1: Funding and benefit structure of the UEBHIS programme

a savings account, and the amount of the money in the individual account depends on the level of the employee's wage. If the enrollee has used up the money saved in the individual medical account in one year, they have to pay subsequent bills out of pocket; if money remains at the end of the year it automatically transfers to the next financial year. The remaining 4.2 per cent of the wage goes into the social risk pooling, which covers part or all of inpatient medical expenses. The social risk pooling limits payment for each enrollee to four times the average annual wage of workers in that city. Expenses exceeding the ceiling can be covered by complementary insurance schemes, or have to be paid by the patient out of pocket or by purchasing commercial health insurance.

However, some problems emerged in the process of establishing the UEBHIS, because *The Decision* lacks sufficient legal backing and authority. One problem concerns enrolment. According to regulations issued with *The Decision*, all urban workers who meet the enrolment conditions should join the UEBHIS. However, in practice, especially in the early stages of the reform, the greatest difficulty, according to an interviewee at the Department of Labour and Social Security, has been to persuade all qualified organizations and enterprises to join the scheme. Officials from the Shandong Labour and Social Security Bureau said that enterprises with many retired employees are willing to join the scheme, but that some enterprises, such as telecommunications, the electric power department and banks, which have mostly young staff, are reluctant to join it because they do not currently face a high risk of ill health. Another serious problem is to ensure collection of premiums. Although *The Decision* provides clear government regulations on the level of premium that all enrollees should contribute, in reality there are considerable problems of refusal or delay in handing in the premiums.

Management

To help control the costs of the social insurance scheme, Essential Drug Lists and Essential Services Lists have also been developed. These lists specify which drugs and services are covered and not covered by the scheme. The two lists can be updated periodically by central government. The Essential Drug Lists is divided into two parts: Drug List A and Drug List B. Drug

List A is established by central government, and the local government does not have the power to adjust it. The medical expenditure of enrollees who use the drugs in Drug List A is paid by the UEBHIS. The local government has the right to expand or reduce the items in Drug List B by up to 15 per cent. The medical expenditure generated in Drug List B is divided proportionately between the enrollee and the scheme. In the Essential Services Lists, the central government first defines a standard set of basic medical diagnostic and treatment services, and then identifies those medical services excluded from payment by the UEBHIS and those services for which the UEBHIS will pay part of the expense.

Each city has established a social insurance bureau, which has the responsibility of collecting the premiums, contracting with hospitals and drug stores, and paying for the patients. At present only public hospitals can be contracted, but both public and private drug stores can be selected and contracted. Everyone covered by UEBHIS must go to these contracted health providers in order to get reimbursement through the scheme. Meanwhile, the social insurance bureau, in cooperation with the health authorities, will monitor the behaviour of these contracted health providers and drug stores.

6.3 The development of commercial health insurance in China

In China, the history of commercial health insurance is only fifty years old. As an official in the China Life Insurance Company, Shandong Branch, said, the development of commercial health insurance is just starting, but now faces its best opportunities for development.

The structure of commercial health insurance in China

By the end of 2001 there were fifty-two commercial insurance companies operating in China, including five wholly state-owned insurance companies, fifteen insurance companies that issued shares, nineteen joint venture companies, and thirteen branches of foreign insurance companies. Among the fifty-two insurance companies, seventeen commercial life insurance companies also sold health insurance, including two state-owned companies (China Life Insurance Company and Xinjiang Corps Property Insurance Company), five companies issuing shares, three branches of foreign insurance companies, and seven joint-venture companies. Table 6.1 lists the main companies. At present the state-owned and single-funded and stock life insurance companies are dominant in the Chinese health insurance market. A few of the property insurance companies are also in the health insurance business. Up to now, there are no specific health insurance companies in China.

In 1992, the American International Assurance Co. Ltd (AIA) came into China, and its arrival marked the opening-up of the Chinese insurance market to the world. After China's entry to the WTO, increasing numbers of

Table 6.1: Business statistics of life insurance companies in 2001 (1 million Chinese RMB)

Name and ownership characteristics of companies	*Total premium income*	*Premium income*					
		Personal insurance			*Group insurance*		
		Life insurance	*Personal accident insurance*	*Health insurance*	*Life insurance*	*Personal accident insurance*	*Health insurance*
China Life Insurance Company	81 313.57	64 382.21	1.71	1 099.22	8 583.90	5 460.83	1 785.70
China Pacific Insurance Co., Ltd	15 682	8 753	61	223	5 590	605	450
Ping An Insurance Company of China, Ltd	39 699	30 658	566	501	7 274	448	252
New China Life Insurance Company, Ltd	2 298.30	1 040.50	24.89	242.44	654.38	10.29	325.90
Tai Kang Life Insurance Company Co., Ltd	1 696.32	549.71	11.03	192.20	862.84	40.48	40.06
Xinjiang Corps Property Insurance Company	82	14		3	23	42	
Tianan Insurance Company Limited of China	11.62	1.29	0.1	1.19	4.52	4.52	
American International Assurance Co., Ltd (AIA), Shanghai Branch	1 406	1 239	87	80			
American International Assurance Co., Ltd (AIA), Guangzhou Branch	598	468.70	54.80	74.8			
American International Assurance Co., Ltd (AIA), Shenzhen Branch	65.8	46.70	8.80	10.30			
Manulife-Sinochem Life Insurance Co., Ltd	275	264	11	0			
Pacific-Aetna Life Insurance Co., Ltd	210	170	8	32			
Allianz Dazhong Life Insurance Co., Ltd	55.3	50.23	3.04	2.03			
AXA-Minmetals Assurance Co., Ltd	64	48	4	12			
China Life-CMG Life Assurance Co., Ltd	6.69	4.42	1.71	0.56			
CITIC-Prudential Life Insurance Company Ltd	120.98	102.3	7.36	11.32			
John Hancock Tianan Life Insurance Company	5.26	4.27	0.60	0.39			
Total	**143 590.2**	**107 999.56**	**1 013.04**	**2 485.45**	**22 992.64**	**6 611.12**	**2 853.66**

Source: *Statistical Yearbook of Insurance* 2002.

foreign health insurers took a greater interest in the Chinese health insurance market. The official interviewed in the Ministry of Labour and Social Security said they were extremely busy dealing with the increase in applications from other countries including the United States, Germany, Australia and Japan to engage in the health insurance business in China.

The cost and coverage of commercial health insurance in China

At present, the development of commercial health insurance in China is at an early stage, but displaying a rapid growth. In 1996, the national premium income of commercial health insurance was about 1.3 billion Chinese RMB, representing only 0.019 per cent of GDP. In 2001, the income has increased to about 5.3 billion Chinese RMB, an average rate of increase of about 32 per cent. However, compared to the total premium income from life insurance in 2001, health insurance is still a very small business – only 3.71 per cent of the total of 143.6 billion Chinese RMB paid for life insurance. An analysis of the data from the National Health Service Surveys of 1993 and 1998 showed that the percentage of the population in urban and rural areas covered by commercial health insurance had risen from 0.58 per cent in 1993 to 4.58 per cent in 1998.

However, compared with the need for health coverage and the demand in China's insurance market, the role of the commercial health insurance sector is still very limited. Commercial health insurance contributes little to guarantee people's health. In 2001, commercial health insurance income represented about 1.03 per cent of total health expenditure in China of 515 billion Chinese RMB. The average health insurance expenditure per capita was about 4.08 Chinese RMB, but at the same period, the average urban individual health expenditure was 343 Chinese RMB per year. Most health care expenditure was direct out-of-pocket payment. Personal health expenditure was about 300 billion Chinese RMB, or over 60 per cent of total health expenditure. There are serious questions about how much of this expenditure could be transferred to commercial health insurance

Services and benefit design of commercial health insurance in China

In 2001, there were seventeen commercial life insurance companies in China that also offered health insurance products (Table 6.1). Those products can be summarized into three categories. The first category is catastrophic disease insurance. When the insured suffer from one or several stated catastrophic diseases, they can get reimbursement from the insurance company according to the contracted insurance level. Each disease has a different premium level. The second category is indemnity insurance, based on medical expenditure: the insurance company pays the patient a certain proportion of actual

medical expenditure. The third category is workers' compensation. When the income of the insured is decreased because of work-related illness, they can gain a certain level of reimbursement, according to their contract. Among the three categories, the first is dominant, but the diseases accepted for the insurance contract are mainly cancer and kidney transplants, small-probability events that often entail catastrophic medical expenses.

The insurance premium depends on the age and health status of the insured as well as on the health insurance products they purchase. The insurance companies ask all the insured to accept a physical examination and to sign the health declaration statement. The companies use the results of health examination of the insured as the basis for individual risk rating. And in general the insurance companies do not accept individuals for insurance whose age is over 65 years.

Most of the commercial health insurance products are offered as additional to life insurance services. Table 6.2 summarizes the health insurance products provided by some insurance companies. After the rapid development of commercial life insurance and the introduction of foreign advanced health insurance technology, some commercial life insurance companies went on to offer more health insurance products. The informants from the China Life Insurance Company, Shandong branch, explained that in 1999 China Life Insurance Company, the biggest life insurance company in China, introduced the 'Life Green-Shade' health insurance product. This covered 581 kinds of disease and operation, and was the first health insurance policy with wide disease coverage. In 1999 Ping An Life Insurance Company also started to offer medical expenditure insurance in some cities such as Shanghai, Jinan and Chengdu.

However, in general, some officials in commercial life insurance companies explained that at present the design and development of commercial health insurance products are not rational. They mainly represent individual health insurance products, with high rates of premium and a limited function in safeguarding the insured. They gave two reasons for these limitations: the first is that the health insurance products were mainly designed by using the theory of life insurance for reference, because there is a lack of systematic health insurance experience and no database of the population; and second, there is a shortage of health insurance professionals.

6.4 The interactions between social and commercial health insurance market

The main aim of UEBHIS is to ensure that urban employees get basic health care. This places the emphasis on equity rather than on efficiency. The social health insurance provides only a basic benefit package, with a ceiling capped at four times of the average annual wage as described above. The health

Table 6.2: The major commercial health insurance products provided by commercial companies

Name of selected companies	*Major commercial health insurance products*
China Life Insurance Company	'Life Green-Shade' health insurance Health insurance for life
China Pacific Insurance Co., Ltd	Safety health insurance for mother and children Anaesthesia safety insurance Children's immunization health insurance Additional inpatient insurance Group catastrophic disease insurance Additional group catastrophic disease inpatient insurance
Ping An Insurance Company of China, Ltd	Inpatient insurance Additional catastrophic disease insurance for life Additional inpatient insurance Group catastrophic disease insurance Group inpatient insurance Children's health insurance Catastrophic disease insurance for children and infants
New China Life Insurance Company, Ltd	Individual inpatient insurance Catastrophic disease insurance Group inpatient insurance Complementary inpatient insurance General medical insurance
Tai Kang Life Insurance Company Co, Ltd	Health insurance for life Special arranged inpatient insurance Health insurance for woman Special arranged medical insurance Catastrophic disease insurance

expenditure over the ceiling can be covered by complementary health insurance. What is not clear is how to develop complementary health insurance, and who should play the main role in providing these health insurance services. During the survey, many officials and experts considered that the commercial insurance companies should play dominant roles in the provision of complementary health insurance, while the social health insurance sector should focus on assuring all the population access to basic health care. Even when the social insurance scheme is fully established in China, private insurance would therefore still play, in their opinion, an important role in several areas.

Providing complementary health insurance

At present, commercial insurance companies can provide individual and group health insurance as described above. However, in the Chinese commercial health insurance market, the individual risk rating system is particularly problematic because of a lack of health insurance databases and weak controls over health providers. So commercial insurance companies find it even more difficult than is normally the case to control their costs effectively and to assess risk. They therefore prefer to develop group insurance, since this can decrease the business risk and management costs, and they have been particularly interested in developing group health insurance for the population also covered by the UEBHIS.

The commercial insurance companies have two possible models for complementary health insurance in this context. One is to engage in complementary health insurance in cooperation with government. The Department of Labour and Social Security, as the representative of all enrollees covered by UEBHIS, can purchase for them group complementary health insurance from commercial insurance companies. During the survey, the officials from commercial insurance companies told us that some companies have started to become involved in the urban employee complementary health insurance business. They include the China Pacific Insurance Company, Xiamen Branch, which provided the Xiamei employee complementary health insurance in cooperation with the Social Health Insurance Bureau.

The funding for this complementary insurance comes from the basic social health insurance contribution. The Social Health Insurance Bureau picks up each year 6 Chinese RMB per capita from the social risk pooling and 18 Chinese RMB per capita from individual accounts (total 24 Chinese RMB per year per worker), and uses that fund as the premium to purchase commercial complementary health insurance. The commercial insurance mainly covers that part of medical expenditure, over and above the ceiling of basic health insurance, spent in the selected public hospitals. The commercial insurance company covered 90 per cent of the medical expenditure per year of the insured over the ceiling, while the other 10 per cent was paid by employees out of pocket.

In this manner each enrollee can be given complementary insurance by a payment of about 0.19 million Chinese RMB, which can reimburse many catastrophic medical expenditures. There are two advantages to this model: one is that this model can ensure all that enrollees get full-scale health insurance from basic medical care to higher level health insurance. Another advantage is that in this model the premium is low but insurance levels are higher, while the problems of individual risk rating can be avoided. These features facilitate the development of the commercial insurance companies. However, there are also disadvantages: it is argued that using the social insurance funding to purchase complementary health insurance in this way

will weaken its capacity for social risk pooling for the insured, by reducing funding levels.

Another model for complementary health insurance is an entirely commercial style, operated solely by commercial insurance companies. This is in fact the main direction of development of complementary health insurance in China, but it faces great challenges. The most serious difficulties are the lack of appropriate regulatory and legal frameworks, the absence of any effective individual risk rating system, and the lack of any effective control of health providers' behaviour. The insurance companies respond to these problems by imposing very strict enrolment conditions, and setting ever higher premium rates. These in turn limit the market, operating as the main constraints on people's willingness to purchase commercial health insurance products.

Providing comprehensive commercial health insurance

In addition to providing complementary health insurance, commercial insurers can in principle provide comprehensive insurance to those currently without insurance from any health insurance scheme. They can also offer to cover services which are not covered by the social insurance schemes. These may include deductibles and co-payments, as well as services or drugs that are not on the official list of essential services and drugs. Table 6.3 compares social with commercial health insurance in China at present.

6.5 Determinants of the interactions between the two systems

As described above, some Chinese insurance companies have started to provide complementary health insurance services in cooperation with the social health insurance scheme. It is therefore an important policy question to ask what determines the manner in which the social insurance and private insurance sectors interact with each other. To what extent do they serve different insurance needs of different people, and to what extent do they compete?

Strengthening the role of government in directing the development of the health insurance market

In the survey, many officials and experts pointed out that commercial insurance can expand its role in providing complementary health insurance services, but that clear policy guidelines are still lacking. They stated that regulations identifying the respective roles and responsibilities of social and commercial health insurers, and clarifying the business development expected in health insurance services, would be helpful in supporting the development of the commercial health insurance market. Such markets require

Table 6.3: Comparison of the UEBHIS and commercial health insurance

	The UEBHIS scheme	*Commercial health insurance*
Role and function	The main component of social health security system	Playing complementary role in meeting health demand at different levels
	Providing basic health insurance	
	Compulsory	Voluntary
The covered population	Civil servants	The population who voluntarily purchase it
	All urban employees in public and private enterprises	
The source of contribution	Government	Premium from the enrollees covered by it
	Employer Employee	
Premium income	60.78 billion Chinese RMB in 2002	5.3 billion Chinese RMB in 2001
Management	The Department of Labour and Social Security	Commercial life insurance company
The provision of health insurance services	Basic medical services including both outpatient and inpatient	Medical insurance for diseases causing high expenditure
	Drugs	Inpatient medical insurance Some special medical insurance such as intervention diagnosis and therapy
Payment method	Fee for service	Based on medical expenditure
	Fee per capita	Fixed compensation

effective regulation in order to operate effectively. The government, informants argued, should therefore play an active role in regulating the health insurance market, setting out relevant policies to support the development of health insurance markets.

Creating an effective mechanism for cooperation

Currently there is an absence of operational government policies of this kind, so that commercial insurance plays a complementary role, rather than competing with social health insurance. The officials from the Departments

of Labour and Public Health still lack sufficient guidance and understanding of the role and function of commercial health insurance in relation to the establishment of the whole social health insurance system, just treating the issue simply as a matter of commercial market behaviour.

The current relationship among patients, hospitals and insurance companies therefore does not lead to the most desirable development of the health care system. One deputy manager of Ping An Insurance Company of China Ltd, Shandong branch, interviewed during the survey, said that health insurance would not be developed robustly unless the three parties all win. That is, the insured want to get the best medical services through health insurance, while the insurers and the hospitals want profit. However, the current situation is that the insurance companies find it difficult to control the behaviour of patients and health services providers. In a few cases, patients may collude with the health service providers in order to get more compensation from insurance companies.

Building the health insurance database

As noted, there is no systematic health insurance database in China. The official from the China Life Insurance Company, Shandong branch, pointed to several factors that impeded the development of health insurance. One was the complexity of management of health insurance; another was the problem of cost escalation and mistaken risk assessment resulting from the lack of a database and the difficulty of controlling the professional ethics of health care providers.

When commercial life insurance companies identify the medical insurance service items they will provide and the rate of premium, they need a series of data about people's demand for and utilization of medical services, the incidence rate of illnesses, the mortality rate and so on. However, in practice it is very difficult for them to get such systematic information in China. The Department of Public Health does not provide these data. The Chinese government has now issued some regulations on standardizing and monitoring the behaviour of selected hospitals, as a contribution to supporting the development of social health insurance, but the commercial health insurance companies cannot apply these regulations at present. One manager from the Ping An Insurance Company of China, Shandong Branch, complained that the institutions that are responsible for the social health insurance had the right to ask a hospital to provide information on the insured's medical expenditure, but the commercial company had no such right, so the hospital can reject the company's requirement at any time. Meanwhile the commercial life insurance companies lack any effective strategy to control and monitor the behaviour of health care providers.

A health insurance database is also the basis for pricing by the commercial and social health insurance sector, and is the basis for professional operation of commercial health insurance. However, at present these kinds of health

information about the population are spread across different government departments. The Department of Health, the Department of Social Security and commercial insurance companies would need to cooperate with each other to build up a systematic health insurance database and share and update the database periodically.

Other influential factors

In addition, there also exist other influential factors that shape the interaction between the two types of insurance. One is that insurance companies have very restricted options for investing premium funds. The main vehicles for investment of the funds are savings in banks, purchasing government bonds, and investing in social security funds. Another is that the business of commercial health insurance needs advanced technology and has high operating costs, which implies that the price of commercial health insurance products is too high for the financial capacity of most of the population. Finally, health insurance businesses are not exempt from tax nor are tax discounts made available by the government.

6.6 Concluding discussion

The international experience

Many developing and developed countries have had policy debates on the design of mixed systems of health insurance (Besley *et al.* 1998; Blomqvist and Johansson 1997). In some industrialized countries the structure of mixed health insurance system design is based on compulsory social health insurance covering a major part of essential services required, and funded by a specified element of health expenditure, plus complementary private health insurance which tops up remaining services and which requires co-payments by patients.

In this way health expenditure is divided into three parts: the first covered by social insurance, the second by private health insurance and the third by out-of-pocket spending. Examples include the US Medicare plan, for which private insurers offer complementary health insurance services, and Australian Medicare, for which complementary private insurance contracts are offered by Registered Private Health Funds (Petretto 1999). A comparable situation exists in the UK (Timothy *et al.* 1998) where in 1998 around 12 per cent of households had members who purchased private insurance, either through their employers or individually. The key determinant of private insurance demand appeared to be the length of waiting lists for treatment in the National Health Service (see also Chapter 2). Private insurance in the UK is mostly used to cover certain kinds of elective surgery where waiting lists have been notoriously long. Private health insurance gives individuals an alternative to a subset of the treatment that they receive in the NHS and

a method to supplement the overall level of health insurance coverage that they receive through the NHS.

In China some researchers have suggested it is an important policy question how the social insurance and private insurance sectors interact with each other to serve different insurance needs of different people (Liu 2002). Following the further development of commercial insurance, especially after China's WTO entry, the large potential profits from the health insurance market will bring in more and more foreign insurers, so that competition in the insurance market will increase. Currently, domestic commercial insurance companies are planning to expand commercial health insurance services as a new source of profit. Some of those companies saw provision of commercial complementary health insurance services to enrollees covered by the UEBHIS as their jumping-off point for greater cooperation with the social health insurance sector. They have explored from their point of view some methods for creating more effective interactions between the two sectors (Zhou 2000; Yan and Zhangyi 2003).

In this study we have also found this developing pattern of cooperation. The main characteristic of the currently emerging system reflects some aspects of the mixed health insurance design in some developed countries mentioned above. The focus, however, is on the identification of an individual's contribution and right to treatment. The medical expenditure for a contributor to UEBHIS is divided into three parts: the first covered by the UEBHIS, the second by commercial complementary health insurance (if available), and the third out of pocket. However, this emerging model is just the market behaviour of some insurance companies in response to market opportunities, and the collaborative behaviour of the companies and the Department of Social Health Insurance. It is not supported or guaranteed by the regulations or laws from government.

Equity and efficiency issues

A mixed health insurance system in which the consumers have complementary commercial health insurance in addition to the social health insurance scheme is desirable for several reasons. On the one hand, the compulsory or tax-financed social health insurance scheme is focused on equity, on inclusion of all employees, and on avoidance of high administration costs. People are compelled to enrol in the social health insurance scheme, which does not discriminate according to risk of illness. For this reason, such schemes are equitable in the sense that they reduce the significance of inequity in real income for the response to risk of illness. On the other hand, it is suggested that the involvement of commercial health insurance can be helpful for solving problems that can characterize the social health insurance sector, such as the bureaucratic inefficiency and lack of choice in government monopoly plans.

However, some researchers dispute the efficiency of mixed health insurance systems (Blomqvist and Johansson 1997). In China the commercial

insurance sector has just begun to involve itself in the construction of the social health insurance system. The mixed health insurance system is not already shaped; rather, an awareness of the potential inefficiencies in such systems is relevant when considering the question how such mixed systems should be designed. Although this study did not directly explore the issue, it is a really important one to be examined during the deeper development of China's health insurance reform.

Setting down essential regulations or laws

Although in *The Decision* it is clearly stated that China will establish a multilevel health insurance system and will actively improve the development of commercial health insurance, the central government has not issued specific operable guidelines on how to do it, especially on how to regulate commercial insurance to ensure that it provides complementary health insurance. At present, there is no national social health insurance law in China. *The Decision* issued by the State Council is the only regulation that directs and regulates the reform of the social health insurance system. It is urgent and important for developing the social health insurance system that a social health insurance law is rapidly put in place in China.

Setting down essential regulations and laws can, first, ensure the authority and validity of the social health insurance scheme to collect and spend the health premium. It should create regulations to ensure that all urban employees enrol in the social health insurance scheme and contribute to the total premium income collected, so that the young, well-off and healthy are not allowed to 'opt-out' of social health insurance.

Second, the regulations or laws should identify the roles of commercial insurance in the development of the health insurance system. In the long term, China will establish a mixed health insurance market in which the social health insurance scheme will be dominant, but the supplementary role of commercial health insurance will be strengthened. So regulations should be created to ensure that the sectors cooperate rather than compete. Regulations setting out a minimum benefit package for commercial insurance companies are also needed in order to avoid individual risk rating, and especially the selection only of profitable targeted populations. It has frequently been suggested that the government should specify premium and coverage of a standard contract and oblige all commercial insurance companies to offer this contract and to accept all applicants for it. As long as a firm offers the standard contract, it would then be free to supply any other contracts too (Werner and Podczeck 1996). As an alternative to a standard contract, the government can also require a minimum insurance benefit package; this is a feature of almost all recent reform proposals. Compared to standard contacts, regulating a minimum insurance benefit package at least can avoid the destabilizing effect of skimming low risks: commercial insurance companies can no longer attract only low risks by reducing coverage.

Meanwhile, some other regulations are also needed in order to ensure desirable interactions between commercial and social health sectors. For example the government can allow commercial insurance companies to become involved in health service pricing reform, aimed at controlling the cost of medical services and increasing the efficiency of medical services provision. And the commercial insurance sector can also play an important role in the process of establishing an effective health insurance monitoring mechanism.

In conclusion, the UEBHIS plays the dominant role in guaranteeing people's access to basic health care, while the commercial insurers could further contribute to the development of complementary health insurance, and the role of commercial health insurance is likely to be further strengthened. The commercial insurance sector and social health insurance sector can interact with each other in different ways; it is striking that the provision of complementary health insurance in cooperation with the social health insurance sector is the priority choice of commercial insurance companies. However, in order to ensure desirable interactions, some measures should be taken in terms of developing essential regulations and laws, establishing an effective cooperative mechanism, setting up a health insurance database and sharing health information. In addition, attention should be paid to the equity issue following the development of mixed health insurance system in China.

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7
Commercialization and the Public Sector in India: Implications for Values and Aspirations

Rama V. Baru[1]

7.1 Introduction

This chapter explores the implication of commercialization of medical services for values and aspirations of doctors in public hospitals in India. Based on in-depth interviews with retired doctors from a premier public institution, it delineates the complex interaction between the growth of commercial medical services, the public sector and the changes in the Indian economy and society over the last four decades. The chapter examines the linkages between socio-economic development, its influence on organizational culture, and the effects on the values, norms and aspirations of doctors. Based on a review of available studies, it begins with an overview of the structure and characteristics of the mixed economy in medical care in India. This is the backdrop within which an exploration is conducted of the extent and nature of shifts in the values and aspirations of doctors in public hospitals.

7.2 Structure and characteristics of private health services in India

At the time of Independence the leadership of the Indian Nationalist movement had committed itself to building a welfare state which would provide health services to all its citizens irrespective of the ability to pay. The Bhore Committee report, which provided the framework for health services development in India, envisaged a comprehensive and universal service to be

funded largely by the state. The private sector was dominated by individual practitioners who formed about 78 per cent of allopathic practitioners. This committee recognized the large presence of private practitioners and also private practice by government doctors. While it called for the abolition of the latter within the health services, a softer stance was adopted vis-à-vis the former. Thus private interests were accommodated in the public health services at the time of Independence and these grew in an unregulated manner during the post-Independence period. As a result the health sector assumed the characteristics of a mixed economy, and because of paucity of funds and inadequacies of the public sector the private sector was given legitimacy in the government's health policy during the early 1980s (GOI 1983).

The Indian private health sector continues to be dominated by individual practitioners, both trained and untrained, at the primary level. The secondary and tertiary levels of care consist of nursing homes and hospitals which provide inpatient care with bed strength ranging from five to a thousand beds. In a large and diverse country like India the growth of the private sector at the secondary and tertiary levels during the last five decades presents regional variations, with the more prosperous states having a higher proportion of total beds in the private sector (Baru 1996).

Across rural and urban areas, the private sector at the secondary and tertiary levels is dominated by sole proprietors and partnerships, mostly doctor entrepreneurs, while the tertiary level is dominated by big business groups and non-resident Indian doctors who belong to the middle and upper middle classes. In the Indian context, as elsewhere, the growth of the private sector is not independent of the public sector but is interrelated with it in several ways. These include government subsidies in the form of public insurance, concessions for infrastructure and technology, and allowing 'pay beds' in public hospitals and private practice by government doctors; also state-subsidized medical and paramedical education that feeds into the private sector. This rather complex set of interrelationships can be termed a mixed economy in medical care which has serious policy consequences for the nature of growth, quality and accountability of both the sectors (Baru 1998).

7.3 Commercialization of medical services and implications for the public sector

The nature and extent of the interrelationships of the public and private sectors have not really received the kind of scrutiny that they deserve. These are in the form of private practice by government doctors; pharmaceutical and medical equipment companies supplying drugs and technology to public hospitals; emergence of private medical and paramedical colleges; research funding and priorities being influenced by private interests such as pharmaceutical, medical technology corporations and international funding agencies. While private practice by government doctors has often been discussed as a form of 'rent-seeking behaviour' that reduces the 'efficiency' of

public systems in developing countries, it has not been examined in terms of the extent and nature of engagement of government doctors with the private sector and vice versa.

Some studies have commented on how the accommodation of private interests devalues the public sector (Gish 1975) but this has not been adequately researched. In the Indian context private interests are well established and have grown over the last three decades. The engagement of government doctors with the private sector has become much more complex and is no longer restricted to individual private practice but is deeply entrenched in the private sector at the secondary and tertiary levels. Government doctors act as consultants to private hospitals and in some situations are also owners of private nursing homes. Two studies in Hyderabad, by Devi (1985) and Baru (1998), illustrated the changes in private practice. During the 1960s and 1970s private practice by hospital doctors was largely restricted to consultations after working hours at the residence of the doctors. With the proliferation of nursing homes and hospitals, reciprocal relationships emerged. Government doctors encouraged patients to get treated in the private hospitals in which they were consultants, while the private facilities were dependent on government doctors for patient supply.

The importance of understanding the accommodation of private interests in the public sector is in highlighting how it affects the effectiveness and quality of public services. Public sector doctors do recognize that private practice affects quality of patient care, teaching and research. While they were unanimous about allowing private practice in the form of consultations outside working hours, they felt that it was undesirable for government doctors to act as consultants in private hospitals because they would be 'unable to devote adequate time for patients, their teaching commitments, conduct research or keep up with the latest development in their respective fields. Their involvement with the private nursing home sector diverts patients to private nursing homes and, as a result, the poor will be forced to pay for medical care' (Baru 1998: 145–6).

In the Indian context the growth of the private sector has been dependent on the public sector. The former has used the inadequacies of the latter to further consolidate its position in the delivery of medical care. The reasons for the public sector's inadequacies have been widely debated, including under-funding, shortage of drugs, lack of personnel, few diagnostic facilities, heavy patient loads and unresponsive behaviour of medical and paramedical staff. There has been a stagnation of public health spending from the late 1970s, and even a decline during the 1980s in some states in India, while costs of medical care were rising rapidly. The under-funding affected basic infrastructure of the public sector like buildings, drugs and equipment that are necessary for medical and paramedical staff to respond to and treat patients. The poor quality infrastructure is a major source of frustration for public personnel who often have to treat patients without the required drugs,

necessary diagnostic tests and other supportive interventions. This creates dissatisfaction among patients and becomes an important reason why they 'choose' to go to the private sector.

The large private hospitals are able to pay higher salaries than the public sector. This has resulted in huge and possibly widening differentials in incomes from private practice relative to salaries in the public system. The better qualified public sector personnel and those belonging to upper-income families found it easier to move into private practice, thereby leaving the public sector with those disadvantaged on both grounds. This has resulted in increased frustration among doctors in the public sector. The state has also been proactive in promoting private sector growth, especially at the secondary and tertiary levels of care. Through a variety of subsidies and concessions in the form of land and reduced custom duties for the import of high-technology equipment, it has fostered the growth of the private sector.

Most studies on the public and private sectors have focused on structural issues, the advantages and constraints faced by each. What has not been adequately explored is how private interests, both within and outside the public health services, have affected values and aspirations of doctors employed in the public sector. Values and aspirations are not merely shaped by institutional factors but also by changes in the larger society. The larger socio-economic changes in society find reflection in the changed values and aspirations across different strata and this has affected doctors as well. We chose to focus on doctors because they occupy the highest rung of the occupational and social hierarchy in the health services, a position that gives them status and power, both clinical and administrative, within medical care institutions (Madan 1980).

The study was conducted among doctors who have retired and those who are currently employed in a premier teaching hospital, the All India Institute of Medical Sciences (AIIMS) in New Delhi. The Institute was established in 1958 as an autonomous research-cum-teaching institution. We chose to study doctors in AIIMS because it has the attributes of an 'ideal public hospital'. These include generous funding, selection of academically competent staff and students, prohibition on private practice by doctors, and a reputation as a model institution for teaching, research and clinical care. In a sense the Institute is a symbol of a well-functioning public institution that is seen as a place that has the best clinical, teaching and research expertise in the country. It symbolizes the best among public institutions in terms of working conditions for its staff and remains committed to values like excellence, ethical practice and equity that are still viewed as positive attributes of public systems. Therefore researching the perceptions of doctors who were associated with and continue to work in it can serve as a 'marker' for shifts in values and the reasons for them. It could serve as a benchmark in relation to other public hospitals where funding has been poor, doctors have been allowed private practice and there has been an increase in commercial medical services over the last four decades.

Fifteen senior doctors, who have retired from the Institute after having served at least three decades, were interviewed. The doctors were asked to recollect the evolution of the Institute, its work culture, the organizational strengths and weaknesses, the growth of commercial medical services and the shifts in values and aspirations of doctors over time. These in-depth interviews were not merely an exercise in recollecting their experiences but also in eliciting the reasons for the changes in values and aspirations. It was possible to discern pathways through which the growth of private interests, both within and outside public institutions, have influenced and changed values and aspirations of providers during the last four decades.

A questionnaire was also given to fifty-seven doctors, professors, associate professors and assistant professors across five departments: oncology, general medicine, obstetrics and gynaecology, paediatrics and ophthalmology. We chose these five because these are some of the specializations the private sector has focused on. With repeated written and personal reminders we were able to gain responses from thirty-seven doctors.

7.4 Shift in values and aspirations: the complex interplay of organizational and societal factors

These interviews and questionnaire responses demonstrate the complex relationship between organizational and societal factors. They provide a historical overview of the development of the Institution, and the factors that contributed to changes in the work culture and values of doctors.

The doctors recognized and mentioned the special status and regard that the Institute had, and continues to enjoy, both nationally and globally. They discern three phases: the early period, roughly from the 1950s to the mid-1960s; the middle years to the late 1970s; and the later phase from the 1980s to the present. All spoke at length about the changes in the values, norms and aspirations among doctors, and the reasons for these changes. A senior professor who spent close to thirty years at the Institute recalled the history of the institution:

> AIIMS was formed with the goal of producing medical practitioners of the highest order. While research and training was the primary focus, patient care was also undertaken. It was a young institution when I had joined it. The Institute was constantly on the rise in the initial years, middle years as well as the earlier part of the later years. However, during the later years AIIMS saw a gradual devaluation of the environment. Commitment to work went down and so did excellence in work. As a result institutional pride became diluted . . . Initial people remained loyal. (30 July 2003)

There was great deal of institutional pride when these doctors describe the early years and also gave insights into the work culture of the institution.

> The Institute was infrastructurally superior to any other in the country at that time. It provided a great deal of academic freedom, even though the authorities made most of the administrative decisions. The admissions to the postgraduate course were purely on the basis of merit. No timescale promotions were given, candidates had to compete for promotions at all levels. The cases brought to AIIMS provided an opportunity for great exposure and learning. At that time AIIMS was the place where all sorts of problems of people from all sections of society were handled, from the most simple to the most complicated. (19 July 2003)

> When I came to the Institute, overnight it offered me the opportunity to get into a very good group of like-minded people ... it was a big thing for me. Earlier, I always used to tell myself, someday I will get to the Institute. I always had a desire to be at the premier Institute of our country. The first thing that struck me about the Institute was that there were so many like-minded and highly academic people with open minds towards research. You met so many colleagues and seniors who had such big names in the field of medicine. At that time I was young, and it felt great to be able to communicate and exchange ideas with them. That itself is so important for academic growth and personal growth, and I found it at AIIMS ... The other thing, which I realized when I retired, is that the most invaluable gift the Institute gave to its people, was to be themselves ... to be their own people. It gave you a certain kind of freedom where even the junior-most faculty members could apply for research grants. (5 November 2003)

What really motivated many of the senior doctors was the reputation that the Institute enjoyed for excellence in teaching, research and clinical practice. It was also seen as a place where there was both academic and clinical freedom, and therefore money was not the major motivation for those who worked here. As a senior doctor opined:

> I was not motivated by money. I think this was true for most doctors of my generation. Probably, this was an individual characteristic which was seen in most other doctors at the Institute. I was motivated by the desire to gain name and fame. Being the premier Institute of the country, the most difficult of cases, the most variety of cases came there, which you won't find anywhere else in any other hospital. So, you had the opportunity to continue to learn and to grow ... to see medicine in its full spectrum. That's something outstanding about AIIMS. If one is able to generate research grants both within India and outside India; it was just perfect. A lot of what I have achieved in my profession was due to the fact that I was at the Institute. (5 November 2003)

The Institute attracted some of the finest minds both as students and teachers during the early years. Since it was well-funded it also managed to get the 'state of the art' technology and research. Most of the doctors saw the middle years as the beginning of 'challenges and difficulties' arising out of a number of factors, both organizational and socio-economic. These included factors such as greater political interference challenging the autonomy of the institution; interference in selections and promotions; increase in patient loads; the beginnings of private capital in medical care; and growth of consumerism. The loss of autonomy due to greater political and bureaucratic interference was cited as an important reason for the gradual decline of the Institute. This was firmly articulated by all the doctors interviewed.

> In the initial years of the Institute's growth there was no political interference at all in AIIMS. The President of the Institute was the then Health Minister, Rajkumari Amrit Kaur. She was the one who came down to the Institute to meet the Director, the opposite was never the norm. Gradually, the self-interests of senior doctors in terms of promotions and selections created a situation where outside authorities started dictating to AIIMS. (26 July 2003)

This was also the period of expansion of the Institute. Most of the doctors felt that this expansion eroded the 'we' feeling that existed in the Institute during the early years.

> In the later years major expansion of AIIMS took place wherein other people who were trained at various other institutes with different values were recruited to the Institute. This is when problems started as the quality of doctors as well as ancillary staff gradually fell . . . With such an expansion, the 'sense of collective' and 'we-feeling' gradually eroded. A slow erosion of the values of the doctors set in. But the doctors from outside cannot be held solely responsible for this phenomenon, as it is connected with devaluation of social and moral values of society in general. The aims of the doctors changed, rather than thinking of the overall good of the institution, self became their focus. In the early phase the 'self' was subordinated to the institution. Later the self took over. Doctors wanted more for themselves – visits abroad, more money, etc. Political connections became more important. Unhealthy practices crept in. (30 July 2003)

> I think that as the Institute grew unwieldy, people related less to each other. Each one was for himself or herself. I think it was a reflection of what was happening in the entire country. It was not just limited to the Institute, you see the world as it has moved, it's not a kind world, it is not a considerate world. It doesn't care for people. And this is what is happening all around us, all the time. People are just different. I think

> what was happening to the Institute was a general sociological change. (5 November 2003)

Two important reasons for changes in the work culture of the Institute were related to organizational issues. These included a lack of vertical mobility and increase in patient loads. This did produce a conflict in the aspirations for doctors who were at the mid-career level and was an important source of frustration and demotivation. This sentiment was well articulated by the senior doctors as well as those who are presently working at the Institute.

> In the late 70s, the Institute was also reaching a saturation point. Promotions became bleak, there were hardly any positions. Channels for promotion were squeezed. This is when frustrations started setting in. There was little money and poor opportunities for mobility. Lateral entries were allowed at the Assistant Professor and Professor level, this added to frustrations. (26 July 2003)

The doctors currently employed at the Institute have been witnessing a slow movement to the private sector. Nearly half the respondents claimed that about 10–15 per cent of doctors had moved into the private sector during the last decade. Some departments, including cardiology, oncology and ophthalmology, have lost a larger proportion of senior and middle level doctors. Higher salaries, minimal administrative interference, availability of high technology and lighter patient load were ranked as the most important reasons for moving to private hospitals.

According to the available statistics there has been a dramatic increase in patient load over time. When AIIMS was first established it had the status of a referral hospital but over the years the demands for both general and specialist services increased. Recent data show that AIIMS treats 22 lakh patients per year. The amount of time and energy that doctors were able to devote to patients was severely compromised.

> The number of patients has grown at an alarming rate. Huge numbers visit AIIMS and obviously a lot of them require investigations. Patient load is very high and they have to be given later appointments; this is where the discomfiture of the patients starts. (13 September 2003)

> I felt harassed at AIIMS due to lack of facilities and the sheer load of patients. This posed obstacles to my ability to take care of patients. It is normal to suffer fatigue after having seen 20–25 patients in a day. Is the doctor to blame if he makes a mistake in clinical judgement in such a state of fatigue? (28 August 2003)

The reason for the heavy patient load is a consequence of the near collapse of referral systems in and around Delhi. This has stressed the system very heavily, affecting quality of care.

> The Institute lost its referral character, and started sliding to becoming a general hospital. This situation was somehow out of the control of the people at the Institute because you cannot and you do not refuse patients. So, it kept happening and the doctors kept coping. But, then there does come a point when it just becomes too much. You read in the newspapers that doctors were accused of not speaking nicely to their patients. I am not saying that it is a good excuse for doctors to behave like that but when things progress in such a manner . . . I think the doctors were not left untouched by what was happening outside. (5 November 2003)

> Patient care which is our primary concern has deteriorated. Not because of the quality of people (doctors) there but probably due to overcrowding. I think it is wrong to think that people (doctors) are less competent now than they were earlier. People (doctors) are still committed, there are groups of people (doctors) who are committed even now and working very hard to maintain the reputation of the Institution. (1 February 2004)

7.5 Growth of commercial medicine and its influence on values and aspirations of doctors

The growth of private sector at the tertiary level also challenged the 'hegemony' that the Institute enjoyed in terms of technology and clinical care. During the period of growth of private medical care at the secondary and tertiary levels in the 1980s and 1990s, the state offered subsidies to the private sector for technology and infrastructural inputs, causing a substantial increase in imports of medical equipment by private hospitals. This created direct 'competition' between the public and private sectors.

> Take Delhi for example, the medical scenario in Delhi in private sector was zero in 1974. In 1974, the Institute had the latest, sophisticated and state-of-the-art technology. But, in the private sector it was just preliminary. Only basic investigations were possible and everyone who mattered used to go to the Institute. There was a lot of satisfaction for the people who worked in the Institute because that was the best place to work, facilities-wise, atmosphere-wise and professional satisfaction-wise. (4 November 2003)

> In the early years the private sector was not developed and the application of advances in medicine and research was mainly going on in AIIMS. It was that way an exciting time to work at AIIMS . . . even though

> the salary was only Rs. 30 000, the perks they gave you, attending conferences, going out, interacting with other scientists, was much more. (18 November 2003)

> The deterioration of the rest of the public sector hospitals happened faster than AIIMS. Their downfall began in the early 1970s itself. Before this doctors in public hospitals where private practice was permitted maintained a strict separation between the space and time for their public and private practice so that their teaching and government duties do not get affected. However, with the growing private sector in the 1970s this changed. Corruption became rampant. But private practice has never been permitted in AIIMS. (19 July 2003)

The growth of the tertiary private sector produced stark differences in working conditions, patient load and salaries as compared to the public sector. The higher salaries in the private sector were attractive. For some, money was an issue because of changing lifestyles, and for others frustrations arising out of lack of promotional avenues and recognition provided the context for questioning and even undervaluing the public sector.

> Some doctors left to go to the Middle East in the 1970s ... This was almost twenty years back that the trend started. I saw people who were not getting promotions who said, let me go and make money for some time till an opportunity comes along. So, I would not say that money was never an issue with the Institute doctors; it would be incorrect to say that. Only the nature of frustrations for a person might have been different. Not all youngsters left, only some left, so they were clearly different from those who did. These are personal decisions based on how motivated they are in life, what they actually want out of their life, what they want for their families, what their circumstances otherwise are. So, a lot of other factors also affect one's decision. (5 November 2003)

> Sometime, in early 1970s there was a group of medical specialists who had visited the Institute and they were discussing at that time the income of the private practitioners outside compared to those in the public sector. And their income was five to ten times more. In 1974 I used to get 1200 to 1300 rupees as an Associate Professor in AIIMS, later it got revised. But, even within that I was the happiest man. That money was enough to run my requirements. House was provided on campus, there was no expenditure on transport. We were pretty happy in that much amount. So, it was not the money consideration at all. We were very conscious of the fact that people outside were making much more money. A general practitioner outside was making 10 times more than that amount. Though the change happened much faster in other government hospitals, in the Institute it was much less. In other government medical colleges

at the state level, private practice was allowed. Those are the people who were making enough money, and getting a lot of satisfaction in treating patients in the medical colleges. (4 November 2003)

7.6 Private market, the middle classes and consumerist culture

In the 1960s and 1970s, the public sector was the dominant form of provisioning and avenue of employment for medical and paramedical personnel. The private sector was largely restricted to the primary level of care and there were very few institutions at the secondary level. The tertiary sector was the hegemony of the public sector and therefore the incentive to move to private hospitals was a non-issue. This, however, changed with the growth of private markets in medical care at the secondary and tertiary levels during the 1980s and 1990s.

When I was at AIIMS, people were happy living in their little houses on the campus, getting the salaries that they were, but discussing their research projects, their work, publications in the corridors. They were just a happy bunch of people. To be at the Institute became like an addiction. The thought that one can make ten times more money outside wasn't an issue with that generation. We were quite happy doing what we were and it was such a kick if you got invited to international meetings or to other national meetings and to serve on task forces of research bodies. All these were academic things, which we valued a lot. (5 November 2003)

The coming up of state-of-the-art hospitals in the private sector provided an outlet to the younger people, earlier there were no opportunities outside of the government institutions, they had to stay on, frustrated as they were. But, as the private sector came up, some very fine hospitals emerged, which provided the ease of practising evidence-based medicine effectively . . . However, the older people, you see, left the Institute only when they retired. People who took premature retirement were very few and far between. They simply said, I have only these many years to go, I am doing good work, why leave it now. I'll try private institutions when I retire. (5 November 2003)

Not only did the values, aspirations and norms of the doctors seem to have changed but they largely reflected the changing aspirations and expectations of the middle classes.

the coming in of globalization and consumerism . . . Consumerism and the desire and the availability to people has also added a materialistic approach. Society is now wanting much more than what they were. Doctors are not left behind. Their salary structure has not grown with

> the time. Consumerism is one reason; the other reason lies in what has happened to medical education. Nowadays, about 30 per cent of students go to private medical colleges where they pay capitation fees of Rs. 10 lakh, 15 lakh, 20 lakh and then when they want to specialize they pay another 25 to 30 lakh. The parents want returns and the person also says I want to make that money. They want to make fast money. People in every sector of society want to make fast money and doctors coming from the society are no different. Still, I would say, that out of all professionals doctors are still a better lot compared to advocates, chartered accountants, etc., in terms of compassion, in terms of commercialization of their profession. A large proportion is still dedicated. (4 November 2003)

The interviews highlighted the changes in the economy and society during the late 1970s onwards which was marked by growth of markets and consumerism, resulting in changing aspirations and a redefinition of status among the middle classes.

> Lifestyles of people in the private sector appeared to be better. Lifestyle differences became glaring. Changing values of doctors were reflecting the shift in societal values in general. With the opening up of markets and increasing consumerism, people's aspirations and expectations were changing. Commercial interests started affecting values. (19 July 2003)

> The world around you was growing, India was growing, money was coming in a big way. The younger people especially found that their counterparts in the business world, say MBAs, were making such huge amounts of money. That's when they thought to themselves, well I cannot live this lifestyle . . . However good a doctor, involved a doctor, busy a doctor you may be, if you have a family, you want to educate your children in good schools, you want to send them out, and you find that those who are actually not doctors at the Institute but working somewhere else were making big bucks and could afford all these things. When it came to interest of the family, then people who were good doctors started realizing that of course they need the money. They felt that maybe I am not being fair to my family. So, that set in dissatisfaction. At the senior level, lack of promotional avenues was the biggest cause of dissatisfaction and amongst the younger people, I think money was an issue. Doctors put in such long hours and they worked so hard and they felt that their remunerations were like zilch compared to what the others are getting. (5 November 2003)

> Lifestyles of people in the private sector started appearing to be better. This is the time that saw the rise of corporate hospitals such as Apollo and Escorts. The benefit that doctors saw in these hospitals that doctors were placed here in key positions on full-time jobs unlike other places

where they went as visiting consultant. At this time not just doctors but also technical staff shifted from AIIMS to Escorts. They also sought lifestyle change. The 1980s were also the time when some of the most renowned doctors at AIIMS reached retirement age. These were absorbed by corporate hospitals as they had the potential of drawing patients just by their name. (5 November 2003)

7.7 Contrasts in work culture: public and private hospitals

Increasing commercialization affected the values and aspirations of the doctors and therefore had an impact on the work culture of public hospitals. The in-depth interviews tried to elicit contrasts in the work culture of public and private practice. These include the recruitment process, the level of job security, criteria for remuneration, consultative clinical decision-making, the role and use of medical technology, and the type of research and the notions of equity and universality.

The private sector is more individually driven, both in terms of doctors and patients.

> In private hospitals, everybody is for himself or herself. There is a tendency to monopolize the patient. If a case is referred to me and I am asked to do a test I don't question but I just do it whether it is ordered correctly or not. Because, if I don't , then the doctor thinks that I am trying to disprove him, so that in the patient's eyes he becomes little by saying this fellow's judgement is not right. He doesn't send me another patient. You see, the whole system works on this. So, you fall in line and you keep doing whatever the system is doing. A lot of extra tests have to be done because of the fear of litigation. (18 November 2003)

> In private hospitals, the patient comes on my name, saying I want to see Dr X . . . Because they are paying they want to see the best . . . That's why juniors cannot take off well in the private sector. A patient coming for operation to Gangaram, will say I want operation by Dr Y, that's it and will not let anybody else operate. That is one reason why they come to the private sector, they can get service from the person they want but not in the public sector. You cannot go and demand that I want to be operated by the professor because there is a team that says okay, you are admitted in Unit 1, so you will be treated by Unit 1 but nobody will guarantee you that you will be operated by the big man or the other people. (18 November 2003)

> In other businesses the organization is bigger than the individual, but in medicine, the organization has to depend greatly on the reputation of individual doctors. Therefore individual doctors with long clinical experience can be deemed and compared to 'branded products'. Therefore, it is

> the doctor's name rather than the hospital that attracts patients. This gives individual doctors a great deal of power and prestige. (22 August 2003)

In contrast, the public hospital has much more of a collective approach to patient care. In public hospitals there is far greater consultation and discussion among doctors leading to clinical decisions, while in private hospitals there is greater competition between doctors. This stems from remuneration of individual doctors on a per case basis, so that sharing of cases is difficult, if not detrimental, to their practice.

> There is greater possibility of teamwork (in public hospitals) and the assurance that someone is looking over your shoulder. In the private sector you are on your own, most doctors take decisions single-handedly. (19 July 2003)

Those who are presently employed at the Institute valued it for similar things. Consultative clinical decisions, equity in treatment and teamwork were the three most important strengths of the work culture of the Institute. The major strengths of the Institute included the status and prestige that it enjoys as a premier institution, exposure in terms of clinical practice, and job security. The weaknesses, on the other hand, were largely institutional – administrative hurdles, high patient loads, unfair selections and promotions, low salaries (compared to the private sector), and poor accountability. The increasing avenues for individually driven medical practice in the private sector and the glaring salary differentials as well as lower patient loads added to the lure of working in private hospitals, especially in a liberalizing socio-economic scenario. The gradual devaluation of the public sector was affected by increasing privatization and consumerism that characterized this period.

7.8 Conclusion

The shaping of values and aspirations is indeed a complex social process. The responses of doctors clearly spell out the complex interaction between class background, organizational and socio-cultural factors that are responsible for the changing values and aspirations of doctors in the public sector over roughly four decades. These shifts are a reflection of the changing organizational and socio-political scenario in the country.

The phases in institutional growth reflect the three eras in the socio-political history of India: Nehruvian socialist, post-Nehruvian and the liberalization eras. The values that guided state policy during the Nehruvian era were self-reliance, building indigenous technical competence through state support and welfarism. This was the growth period of public institutions for the delivery of health services, training of medical and paramedical personnel, public funding of research and investment in production of drugs and

medical equipment. The role of the private sector was relegated to primary level care delivered by individual practitioners.

The decline in public investments during the post-Nehruvian period stunted the growth of the public sector, affecting accessibility, availability and quality of care. Despite its inadequacies, the public sector continued to be the major provider of services across most states. The rise of private hospitals was a result of the growth of a middle class in both rural and urban areas, who were both the 'suppliers and consumers' of services. As a class they were 'not substantial property owners, but rather were dependent on educational and cultural capital and the professional careers that these promised' (Misra 1961). Studies on the social background of doctors in both public and private sectors show that they belong primarily to these middle classes.

The 1980s' liberalization policies had direct consequences for shifts in value orientation at the personal level amongst the middle classes, broadly reflecting the movement from collective welfarism to more individualism during the post-Nehruvian era. The growth and differentiation of the private hospital sector 'challenged' the monopoly of the public sector in terms of technology, infrastructure and working conditions for specialists. The increasing attractiveness of the private sector, contrasted with the inadequacies faced by doctors in public hospitals, examined in detail above, constituted economic and institutional processes which had a deep impact at the intangible level also, affecting the values and aspirations of doctors.

These intangible processes were expressed by senior doctors in terms of frustration with the public sector, erosion of the status and pride that the doctors enjoyed by belonging to a premier public institution, and a sense of inferiority to their peers in the private sector in terms of working conditions and lifestyles. Aspirations regarding professional success and mobility have been redefined in terms of more lucrative options in the private sector. For the present generation of government doctors, the motivation to serve in the public sector during the initial years in their career is fuelled by aspirations for mobility into the senior positions in the private sector. This kind of a desire stems from the very redefinition of success, status and what is a suitable lifestyle for a doctor, by the middle class in present times.

Even with the ideological onslaught on the public sector, the interviews with doctors who are presently employed in the Institute highlight the areas of strength. The government doctors were unanimous that public hospitals were indispensable, especially in a developing country, and especially for the poor. The strengths of the public sector derive from a comprehensive view of teaching, research and patient care. In private hospitals the focus is largely on curative care and only marginally on research. There has been a spurt in private medical colleges and they are poaching from public teaching institutions for manpower and infrastructure for training. All this is going to further undermine public institutions in the future.

It would be erroneous to conclude that there is a lack of skill or commitment among doctors who are currently serving in public institutions.

The doctors recognize that constant pressure to make profits in the private sector leads to unethical practices. Therefore most preferred hospitals that are 'non-profit', and which invest in research and maintain a culture where ethical medical practice is possible. The Institute still represents the ideal public institution, especially for professionals who trained and worked there. Increasing commercialization has eroded the work culture of public institutions in very important ways. However, commitment to some basic values like equity, consultative work and dedication towards research have not been entirely lost and seem to guide doctors' motivations and actions who have spent long years at the Institute, even while working in the private sector.

Note

1. I thank all the doctors and administrators of the Sitaram Bhartia Hospital, Gangaram Hospital and All India Institute of Medical Sciences, New Delhi for sparing their valuable time for the interviews and responding to the questionnaires. I would also like to thank Ms Ujala Dhaka for research assistance, and Dr Rakesh Thakur for his help with administering the questionnaire to doctors in AIIMS. For comments and suggestions on an earlier draft of this paper, my thanks to Maureen Mackintosh, Meri Koivusalo and Imrana Qadeer.

8

On Shadow Commercialization of Health Care in Russia

Inna Blam and Sergey Kovalev

8.1 Introduction: the sources of shadow commercialization

The current state of organization and financing of public health care provision in Russia complies neither with the declared constitutional guarantee of free-of-charge comprehensive coverage nor with the realities of ongoing market reform in the wider economy. It is a rudiment of incoherent reforms conceived and decided upon in the times of *perestroika* in a country with a different social structure and by people with a now obsolete view of how the economy works.

Most market transactions for publicly provided health services and goods in Russia have taken routes and forms not envisaged by the designers of the system. Meanwhile, the routes and forms originally prescribed for the system either still wait to be taken or have been significantly perverted. Commercialization of the Russian health care system has a 'shadow' character. While most authors who write on the topic (Boikov *et al*. 1998; Satarov 2001; Shishkin 1999; Shishkin *et al*. 2002) concentrate mainly on the problem of informal payments by patients of public facilities, the concept of 'shadow commercialization' includes other types of trading relations such as supply-side deals by the third-tier hospitals, financial and barter deals between regional authorities and providers of health care, and dubious medical insurance schemes.

Most politico-economic structures created in the final days of the Soviet Union did not survive the stormy reforms of the 1990s when the new government of Russia started building a modern society based on private property, market economy and democratic political system.

However, the market socialism version of the public health care system that was introduced just before the collapse of the USSR has been kept alive (with minor changes in 1993) as a temporary compromise. Therefore, the shadow commercialization phenomenon so characteristic of the *perestroika* period has been kept alive as well.

The main source of shadow commercialization is the pronounced imbalance between the constitutional guarantee of free-of-charge high quality public health care and the capacity of public financing at all levels of authority. Estimates of the overall deficit in public health care financing vary from 11–25 per cent (Shishkin *et al*. 2002) to 40–65 per cent (Makarova 2000). A more precise figure is difficult to obtain because health care-related expenditures are hidden between the lines of public spending of a more general nature. A respectable business periodical estimates the total annual social obligations of Russian federal, regional and municipal governments at 6.5 trillion roubles and their total consolidated budget only at 3.5 trillion roubles (*Vedomosti* 2003). These figures include health care-related expenses, social security payments and retirement-age pensions.

The term 'shadow' does not necessarily mean 'illegal'. There is enough vagueness in the Russian public health care legislation to allow for creative interpretations. When the total amount of available resources cannot match the guaranteed benefits, clear delineation of responsibilities between different government bodies becomes impossible. The original design of the reform drew very blurred boundaries between the spheres of responsibility and revenue sources assigned to different levels of authority, as well as between the public and the private in general. Usually both sides of a questionable transaction succeed in assigning it a legal status.

Shadow commercialization means that today's nominal constitutional guarantee of a comprehensive universal coverage does not prevent *de facto* segregation of citizens on the basis of their place of residence and work. The insurance element is almost absent from the official mandatory health insurance system while creative soliciting of money from the patients of public health care facilities is socially accepted and organized at a governmental level.

8.2 Mandatory health insurance and radical decentralization of provision

The Russian Mandatory Health Insurance (MHI) system was established in the summer of 1991, when the dissolution of the Soviet Union was going full speed. The governments of the USSR and the component republics were engaged in a kind of 'war of attrition' over the distribution of political and economic authority. Seeking political support from lower-level bureaucracy, they were taking turns offering state-owned labour-ruled industrial enterprises better terms for administering public cash flows. While the management of enterprises took hold of more cash revenues than they were ever

allowed during the Soviet rule, both the union and the republican budgets experienced severe deficits. Facing rapid deterioration of the centrally financed health care system, a natural decision by the top Russian authorities was to transfer a part of the financing responsibility to the labour collectives.

A parallel system of health care financing was created on the basis of a newly introduced 3.6 per cent payroll tax on employers. In order to collect and manage the tax revenues, an independent regional network of intermediaries was formed. In the general vogue for 'introduction of market elements in the socialist economic mechanism', the intermediaries were named MHI funds (MHIFs). They were supposed to redistribute the money collected on a per capita basis to independent third-party payers, who then would contract for care with providers.

The role of third-party payers was reserved for independent insurance companies, which did not exist at the time but were expected to emerge in the future. In the meantime, MHIFs were allowed to play the role.

The novelty of the MHI reform for a communist-ruled country was the separation of those who provide medical services from those who pay for them. While the former remained subordinated to the All-Union Ministry of Health, the latter were to be supervised and regulated by the MHI system. The reformers put much effort in convincing the society that the introduction of the purchaser-provider relationship would promote supply-side competition among medical care providers and, hence, better quality and efficiency of services, while the demand-side competition among the insurance companies would support better intermediation between citizens and medical institutions.

A more attractive feature of the reform for the Russian government was that the burden of financing the health care of the working population was shifted downwards to the labour collectives of enterprises, while the health care provision for the non-working population remained the responsibility of the All-Union government.

One would think that the quick collapse of the USSR in the end of 1991 denied the Russian government the right to such a convenient position of side observer. Indeed, having declared itself the political assignee of the Soviet Union, the Russian Federation's inheritance included the vague constitutional guarantee of free high-quality health care to every citizen, as well as the general belief that the health care system should be centred on need rather than ability to pay. However, the federal authorities managed to shift most health care-related liabilities towards the regional level of government.

Although the legislation is vague concerning the precise delineation of responsibilities of the federal level towards the regional, today it is the regional government that contributes to the MHI system on behalf of the non-working population, that owns most of the country's public health care facilities and *de facto* carries the burden of maintenance and investment

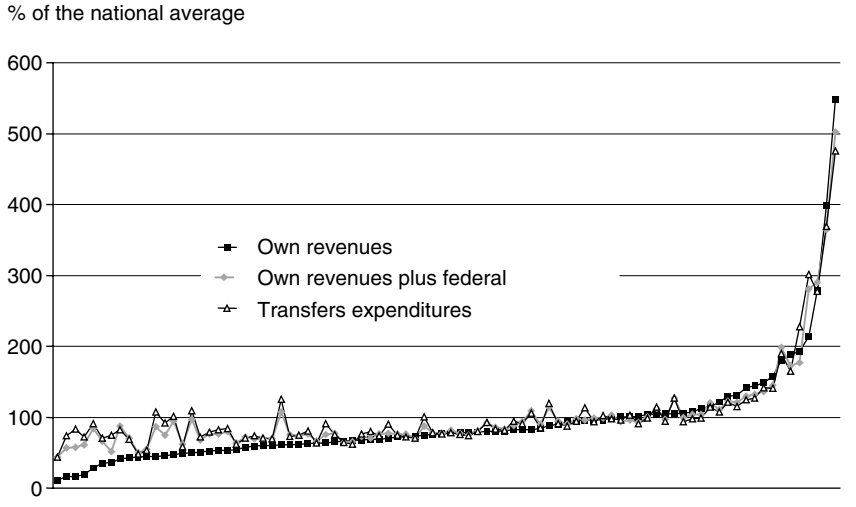
decisions, that controls roughly two-thirds of public financial flows related to health care, and so retains a significant role in system management. The regional authorities are to determine levels of health care funding and provision subject to certain minimum federal standards. While regional MHI funds are nominally subordinated to the federal MHI fund, their boards are typically controlled by top officials of regional governments. A vice-governor in charge of social issues usually chairs the governing board of a fund.

Although the federal Ministry of Health is assigned the core functions of health policy formulation, training, research, and definition of public health standards, it currently controls only a small portion of total public health care resources, estimated to be about 5 per cent (Tragakes and Lessof 2003).

There exists an inherent contradiction between the constitutional declaration of universal coverage across the country and the significant variation in real tax-collecting abilities of regional budgets. In large regions with diversified economic structures, per capita tax collection may be twenty to thirty times higher than in less-developed rural areas. Obviously, not all regions are able to meet the health care standards affordable for the few rich. Nevertheless, the federal government stipulates that coverage is to be universal. In a typical official interview, a deputy director of the federal MHIF said: 'The government of every region in the Russian Federation has to develop and approve its own territorial MHI program. However, this program in no case can be narrower than the basic one. That is, the volume of services offered free of charge cannot be reduced. This volume should not depend on the actual amount of the MHI contribution . . . Let me emphasize the importance of the MHI system. It allows the insured citizens to receive the guaranteed additional volume of free-of-charge medical service . . . in every region, in every corner of the Russian Federation' (Kryukov 1998).

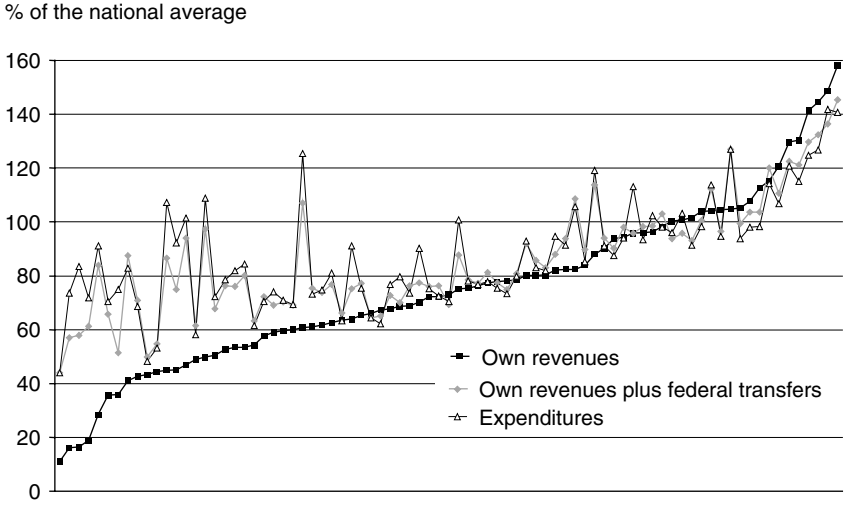
In order to ensure 'federal entitlements,' the federal centre is supposed to pay matching contributions to regional budgets. It has not been clear, however, which federal transfers to regions play the role of matching contributions. The only mechanism of federal financial help to regions that has been based on some kind of objective calculation is the Federal Fund for Financial Help to the Subjects of the Russian Federation. Its sources of financing and the shares of different regions in the total volume of transfers have been subject to annual endorsement as a part of the federal budget adoption procedure.

The calculation method has been changed several times in an attempt to find a balance between the equalizing role of the transfers and the creation of perverse incentives for regional governments in tax collection. The efficacy of these transfers as an equalizing tool is illustrated by Figures 8.1 and 8.2. In Figure 8.1, the eighty-eight regions of the Russian Federation are ranked according to their per capita tax-collecting capacities measured as



Source: East–West Institute 1999.

Figure 8.1: 1998 per capita regional budget revenue



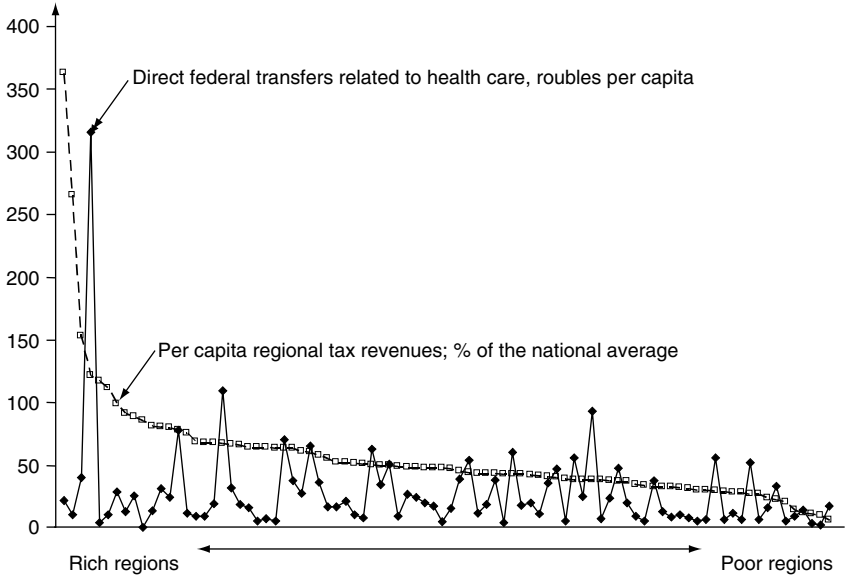
Source: East–West Institute 1999.

Figure 8.2: 1998 per capita regional budget revenue (excluding seven richest regions)

percentages of the national average. It can be seen that the federal transfers do reduce the regional spread in per capita budget sizes. This effect is more clearly demonstrated by Figure 8.2 where seven observations that correspond to the seven richest regions (the city of Moscow and six oil-producing territories) are dropped from the sample.

What makes the equalizing role of the transfers from the Financial Help Fund questionable is that they contribute only about one-quarter of the total expenditures by the federal government in the territories. The rest is mainly so-called direct expenditures by different branches and departments of the federal government. The direct expenditures include the financing of those inpatient and outpatient treatment facilities that are subordinated directly to federal authorities including the Ministry of Health. Since most such facilities are located in well-to-do regions, the direct expenditures actually worsen the health care provision disparities within the country. Figure 8.3 illustrates this point plotting regional own tax bases against the amounts of direct federal transfers related to health care.

One may conclude that the present MHI system constitutes radical decentralization of the public health care in a form that is both contradictory and inegalitarian, and as a result generates a variety of types of commercialization.



Source: East–West Institute 1999.

Figure 8.3: 1998 per capita regional budget revenues vs. direct federal care-related transfers

8.3 Adjustment to the contradictions: some examples

During the 1990s, the matching contributions have become an object of many political struggles between the federal centre and regional governments. Chronic federal budget deficits and consequent irregularities in federal transfers created incentives for regional governments to blame all health care system problems on the lack of federal funding. Regional MHI funds would refuse to pay for a treatment received in a different region or in a federal facility. Consequently, treatment facilities would deny free-of-charge services to patients with MHI policies issued in another region.

Even within regions, the authorities now tend to assign a patient to a treatment facility on the basis of the place of residence. For instance, the 2001 Novosibirsk Regional Government Programme of Free Medical Care Guarantees states that 'the chaotic movement of patients among the polyclinics must be stopped' (Dumler 2001). While differential pricing patterns have become common everywhere, the capital city of Moscow was the first to openly challenge the federal law.

Since the introduction of the MHI system, the Moscow city government has emphasized that the vague constitutional declaration of universal national health care coverage would not work without taking into account the realities of the federalist state:

> The residents of other territories of Russia already have the right to obtain an insurance policy from the governments of the territories where they reside. Hence, while the citizens of Russia who happens to be Moscow residents have the right to just one MHI policy, the residents of other regions now have the right to the second MHI policy, issued by the Moscow city MHI fund, should they just visit the capital city and register at their place of stay. This contradicts the norms of Chapter 6 and Chapter 19 of the Constitution of Russian Federation according to which all the citizens of Russia are guaranteed equal rights and equal responsibilities that exclude any discrimination on the basis of the place of residence and the occupation. (Government of Moscow 2001)

The chief of the Moscow city MHIF Law Department put this in a simpler form:

> Should any newly-arrived person be able to receive a Moscow city policy, a colossal outflow of means from the city budget would happen. Let's assume that a person from Tver' stays for one day in Moscow, receives a policy, and then our fund must pay for his or her health care forever, wherever he or she resides! (Veretennikova 2001)

The Moscow city government uses a complicated system of mandatory residence permits as an effective tool of restricting the access of newcomers

to the city health care facilities. Although top juridical authorities of Russia several times pronounced Moscow residential registration procedures anti-constitutional, the city government feels independent enough essentially to ignore their decisions. Recently, a top-ranking official of President Putin's administration emphasized in a public interview that Moscow's semi-formal limits and quotas are 'a very complex issue' that 'cannot be solved in a week' while attempts to change them in order to satisfy the requirements of the federal law 'would violate the rights of the 8.5 million Muscovites because they will not be able to receive an adequate medical care' (Chernega 2000).

The *de facto* regionalization of public health care has caused a distorted form of commercialization of the federal third-tier facilities, that is, the leading federal treatment and research facilities specializing in, for example, oncology, heart diseases and traumatology. Most are located in Moscow, St Petersburg and several other big cities. Dr Karpeev, a top Ministry of Health official, admits that their financing 'covers only 5 to 10 per cent of the real needs'. Moreover, in 1996, only about one-half of these already insufficient sums were actually provided. Therefore, 'it happens commonly that according to the documents a treatment is provided for free but in fact, it is paid for by the patient' (Latynina 1997; Karpeev 2000).

In the second half of 1996, the Moscow Bakulev Centre for Heart Surgery received from the Ministry only money for wages. Chronic under-financing caused the Centre to use a part of this for the purchase of therapeutic materials. This fact allowed the Moscow city MHI fund to stop financing expensive surgery in the facility. The Centre was forced to look for a legal way to provide services on a commercial basis. It signed several direct agreements with big corporate clients in Moscow for treatment of their employees, and offered paid surgeries for non-citizens of Russia. Altogether, 17 per cent of the surgeries performed in the Centre in 1996 were on a paid basis.

The need for spare cash was exacerbated because the Bakulev Centre had to operate according to the distorted rules of the transitional market economy. When it received two international loans for the purchase of medical equipment guaranteed by the Russian government, this equipment was held at customs for several months. On the one hand, the Centre could not find the money to pay the 5 per cent customs duty covered neither by the loans nor by the government budget. On the other hand, the customs officials considered every item imported at the preferentially low customs duty subject to formal and informal negotiations because, indeed, it was common practice to title any imported consumer goods 'medical equipment' in order to get the low rate. The Centre therefore had to pay extra for so-called shipping and handling services of private firms associated with the customs officials (Latynina 1997).

In the federal Diagnostics Centre for Children, according to its chief medical officer, they 'have two price lists for the same services. One is for Russian children from any region or republic. The other is for children from former-Soviet countries and Moscow. The prices in the first list are two times lower

than in the second.' We were told by the Moscow city MHI fund that they would not provide for the treatment of Moscow children because they are already financed by the Ministry of Health. 'Of course, we may switch to the financing by the Moscow city MHI fund, which today provides more favorable terms, but in that case we will lose the Ministry of Health financing and will be ordered to close the doors in front of the children from the province, and that would be unacceptable' (Politkovskaia 1997).

Dr Mitrofanova, a senior officer of the Moscow Region administration, permits herself to declare openly: 'We don't need our local children to be treated in a federal clinic. Let "our" money go to "our" clinics and diagnostic centres . . . Recently, we received a 16 million ruble invoice from the Burdenko Neurosurgery Institute. This federal facility did not let us know beforehand that they were going to operate on a boy from the region!' (Politkovskaia 1997).

In federal facilities, the decision to provide a service on a paid basis is often determined by the character of a health problem. Typically, a patient with a disease on which the facility is conducting research is treated free of charge while other patients must pay. Another principle is to treat free of charge only the main health problem (for example, a nephrosis); the treatment of side-effects is done for an extra payment.

The regional quotas for free-of-charge treatment in federal medical facilities were first published by the Ministry of Health only in 2000. The quotas are based on the indicators of regional morbidity statistics. The 2000 resolution also defined for the first time the full list of the types of expensive treatment to be provided within the quotas. The Ministry admitted that 'the quotas would not provide fully for the needs in expensive types of treatment. They only would make transparent the process of patients' transfer and budget expenditures' use. They would also help to realize the real volume of paid services offered by the medical centers of federal subordination.' The Director of the Bakulev Centre considered this order to be 'a step forward from the chaos we were in before' and 'more fair with respect to the patients' (Karpeev 2000).

8.4 Private insurers as perverse intermediaries

The role of insurance organizations was defined in the original MHI law in such broad terms that their development could take many routes. The legislation did not prevent them from becoming health maintenance organizations, or preferred provider organizations, or budget-holding general practitioners who control their patients' health budget. They also were permitted to provide voluntary insurance. However, the majority of the insurance companies that now operate in the MHI system are reduced to commission-taking intermediaries facing perverse incentives to raise the cost of the service.

Two types of entities have been legally allowed to be insurance carriers: private health insurance companies and territorial MHI branch funds. The federal Health Development Concept has always implied, however, that private insurers should be responsible for health care purchasing for the MHI system, while the MHI branch funds might act as substitute insurers mainly in remote low-populated areas.

In spite of the original intent of the system creators, regional authorities have not supported independent insurers' involvement in health care planning. They have been very reluctant to tolerate local employers paying per capita MHI contributions directly to insurance companies, leaving out the government budgets. In most regions, this practice was discontinued on the grounds that private insurers tended to engage in too speculative investments. Indeed, in the early 1990s several insurance companies were involved in a series of financial pyramids. Another commonly used argument has been that operational costs of independent insurance companies are too high, while their efficacy is doubtful.

Private companies negotiate contracts with providers on a case payment basis (although they do not set limits to the volume of care to be purchased) and then pay the hospital case by case, invoicing the territorial fund for each item covered. They charge a percentage on each invoice processed, in effect a commission. This tends to undermine the insurance element of the scheme. Although it was never the intention of the reform to set limits to the care available under the basic package, the new interpretation of the model removes any incentives for the insurance company to encourage providers to contain costs. For instance, the insurance companies' remuneration from the Moscow MHI fund until 2000 was based on the amount of money they handled, and only recently was it made proportional to the number of insured citizens (Neimysheva 2000). Hence, the companies are inclined to accept high costs of medical treatment, to receive more funds at their disposal and live on their commission. A typical commission supposed to cover costs of administration amounts to 15–30 per cent of the cash flow (Tzelms 1999).

The director of the Novosibirsk regional MHI fund complains: 'Our fund strongly objects the practice when hospital services are resold or provide the degree of profitability in excess of 10 to 12 per cent. Today, it is a common practice when intermediaries act between an ill person and a treatment facility. As a result, the profitability can reach 30 to 40 per cent at the stage of resale. Nowhere in the world would such a practice be tolerated' (Aseev 2001).

Many regional governments chose to eliminate private insurers from their territorial MHI systems. In the regions where private insurers are still a part of the MHI system, formal terms of contracts entered into by an insurer, an insured, and a medical institution are, to a great extent, supplemented with informal terms and agreements that involve regional authorities. In Moscow, where about twenty private insurance companies were originally involved

in the MHI operations, only four survived the pressure from the regional authorities by 2000 (Joganssen 2000).

Neither visible competition between insurers nor the optimization of health care structure and higher efficiency of resource utilization through sophisticated management of patient and cash flows have been achieved. Instead, the companies mainly have become mere translators of cash flows for regional administrations. On the one hand, regional government agencies commonly force insurers to finance their treatment facilities in order to keep them running regardless of quality and effectiveness of care they provide. On the other hand, the companies have a demonstrated tendency to overload medical personnel of public polyclinics with extra bureaucratic work.

In the 1990s, public health care providers were transformed from budget organizations into treatment-providing facilities, i.e. state enterprises with little autonomy in managing resources but with additional tax liabilities. Federal requirements for the design of payment systems used by a regional government and/or a territorial MHI fund to pay a treatment-providing facility were poorly specified, so in practice, the design of new payment methods was left to the discretion of regional authorities. In most of the payment schemes introduced to replace or run alongside the former line-item budgets, it was the sick patient who was chosen as the basis for cost calculation. Thus, introduction of new methods usually created perverse incentives making providers economically interested in sick, not healthy patients. For instance, the preventative services listed in the basic MHI package are paid dozens or even hundreds times less than therapeutic, surgical and other interventions for critically ill patients or confirmed invalids (Makarova 2000). The doctors have to write long monthly reports and service registers, and then engage in long arguments on seeming discrepancies the companies are keen to find between these reports and medical case histories.

The notorious role of private insurers in dealing with the MHI money has become so evident that both the left and the right in the State *Duma* (the country's parliament) several times attempted to vote for their complete exclusion from the MHI system (Joganssen 2000).

Indirect evidence that regional authorities often use friendly private insurance companies as a means to gain more discretion with respect to the MHI money can be seen in the tendency for every change of a regional administration all over the country to be typically followed by an MHI corruption scandal, resulting in the exclusion of old private insurers from the MHI system and invitations to new ones. A multitude of direct evidence was provided, for instance, by the General Prosecutor's office that audited regional MHI funds in February 1997 (Latynina 1997; Politkovskaia 1997).

Sometimes, the freedom of manipulating the medical insurance money by the regional governments has gone so far that they were attempting

direct financing of medical treatment facilities, bypassing the MHI fund. In 1999, such a system of direct financing, called the 'incomplete model of medical insurance' was introduced in the Novosibirsk region (Aseev 2000).

In practice, the overwhelming majority of the population of Russia knows neither the identity of the insurance companies that process their MHI money nor their own rights as these companies' clients. Moreover, a significant share of currently active MHI policies was issued by the companies that have ceased to exist or lost their MHI licences (Tarnovskiy 2000).

8.5 Barter and quasi-money

A nice illustration of how the symbiosis of private insurers and regional authorities works is the popular practice of offsetting mutual claims using in-kind payments. In the mid-1990s, the MHI system experienced a critical decline of the payroll tax revenues caused by the structural transition of the Russian economy. Large obsolete industrial enterprises that employed the majority of the workforce in the country were making chronic losses while waiting for new owners who would invest in their restructuring. Although they were accumulating astronomic wage arrears and tax debts, the government, fearing a surge in unemployment, was not eager to start massive close-downs. The employers' contributions to the MHI funds were dropping to naught.

An interim but very widespread solution to this problem was found in the expansion of mutual offsetting of claims and barter. Regional MHI funds would accept in-kind payments from enterprises as the MHI contributions. After a long chain of barter transactions, these goods would then be exchanged for some kind of medical materials or equipment, which would be distributed among the medical treatment facilities. Since there was very little cash exchange involved, the MHI funds were free to manipulate the nominal prices such that all their obligations with respect to the clinics and hospitals looked fulfilled. Essentially, regional governments used the MHI contribution as a means to emit their own quasi-money to distribute among the insurers according to the number of insured citizens. Since the rate of exchange of this quasi-money for cash depended on how good a relationship its holder had with regional authorities, this practice created a lot of arbitrage opportunities for profiteering. The enterprises were getting advice from the MHI authorities on the intermediaries to contract for barter schemes, and on the insurers to choose for their employees. In 1999, one-half of the MHI payments in the Vladimir region in central Russia were made via mutual claim-offsetting schemes. In the city of Murom, these led to a homicidal criminal conflict between the insurance companies associated with the regional authorities and the insurers associated with the city government (Brusnikina 2001).

In 1997–8, the government of the Novosibirsk region signed an agreement with the regional MHI fund that legalized the use of promissory notes issued by enterprises as a means of the MHI contributions from the budget for non-working citizens. The director of the Novosibirsk regional MHI fund recalls:

> The government contributions that were supposed to cover the wage payments to the medical personnel were made with promissory notes at their nominal value while their market value was only 30 to 60 per cent of that. At the same time, we paid the wage bills of treatment facilities 100 per cent. The fund had to compensate the difference with money taken from other expense items. (Aseev 2000)

In 1999, after a complaint lodged by the regional association of medical doctors, a six-months-long inspection organized by the federal Ministry of Finance found that the practice of payments with promissory notes was completely legal. They took into account that, while the MHI fund was supposedly an independent body, the representatives of the regional government had the decisive majority on its Board. The vice-governor in charge of social issues had the position of the Board chairman; the chief medical officer headed the tariff commission; the chief financial officer and his deputies determined the financial decisions. The inspection concluded that the fund's chief executive officer who was the main target of the inspection 'only carried out orders while the Board determined the goals, the objectives, and the directions of the fund spending' (Aseev 2000).

The Novosibirsk inspection demonstrated a quite paradoxical but typical feature of the MHI financing. In the words of the executive director of the regional MHI fund: 'The fund budget comes from the two sources, the contributions of the enterprises and organizations, and the regional budget contributions for non-working population. While we have never had any problem with the former source, one cannot say the same about the latter' (Aseev 2000). In other words, the MHI fund, essentially a subdivision of the regional government, has always been better financed by regional private businesses than by the regional government itself.

8.6 Charging for health care and social inequality

No official data on the spread of shadow commercialization within Russia's public health care system are available. The Minister of Health Care admitted in a 1999 interview: 'It is a pity that within the Ministry, the statistical monitoring of different types of services has not been organized and I can tell you no official data on the proportion between paid and free-of-charge medical services. Nevertheless, according to different estimates, in the Moscow clinics subordinated to the Ministry, 40 per cent of the services are paid, and

60 per cent are free of charge. In the Ministry clinics in Russia as a whole the free-of-charge treatment constitutes 30 per cent while 70 per cent of services are paid' (Kozhahmetova 1999).

An alternative source is an excellent study by Shishkin *et al*. (2002), which presents a comparative analysis of commercial vs. non-commercial medical services at twenty outpatient care treatment facilities in Moscow and St Petersburg, and a provincial city, Saratov. The services are grouped in two categories: free services financed from public sources (including the budgets of different levels of the government and the MHI funds), and paid services financed from private sources (patients' own money, patients' employers' money paid directly to a treatment facility). Officially, services cannot fall between or into both categories, because mixed funding is not allowed. At present formal cost sharing is not considered by the Ministry of Health as a method to make up for the shortfall in public resources. Until June 2001, even the term 'cost sharing' was never used by the Ministry. It seems that health authorities are afraid of any public discussion of this issue since it would lead to the politically dangerous question of necessary downward revision of the guaranteed benefits.

The authors find that the volume of funding from private sources is roughly equal to the total amount of financing from public sources. However, the number of patients financed from public sources is much larger. Hence, on average, the treatment of one patient financed from public sources costs much less than the treatment of one patient financed from private sources. The authors also find differences in the combinations of medical services that public treatment facilities provide on commercial and non-commercial bases. While the federal MHI standard prescribes a typical combination of services provided free-of-charge to include an appointment with a general practitioner or a specialist and two or three lab diagnostic procedures or functional diagnostic procedures, in practice such combinations are available only for extra payments. The authors estimate that only 20–30 per cent of non-commercial patients, but the majority of commercial patients, receive MHI-guaranteed service combinations. The authors conclude that the patients are forced to purchase commercial services because of their shortage in the system of free-of-charge health care provision.

The demand-side view on shadow commercialization is presented by various studies on household expenditures. The estimates differ greatly, probably because of differences in the way the corresponding questions in public opinion polls and interviews are formulated. One widely cited source is Satarov (2001). He reports that 22 per cent of those who seek services in a government polyclinic have to offer a bribe. His data are based on respondents whose relatives have had health problems during the year preceding the poll. On the basis of the nationally representative Russian Longitudinal Monitoring Survey (RLMS) primary data, we estimate a smaller number of 5 per cent (see Table 8.1). Note that the RLMS data reflect only the responses of

Table 8.1: Percentage of visitors who reported paying out-of-pocket payments while visiting a medical institution in 2000

	Officially in the cashier's office	*With money or gifts to the personnel*	*No out-of-pocket payments*
For a preventive check-up	17.3	6.7	77.3
For additional test or procedures	11.4	5.7	82.9
For the visit itself	5.6	5.0	90.0

Source: RLMS Individual Questionnaire Data.

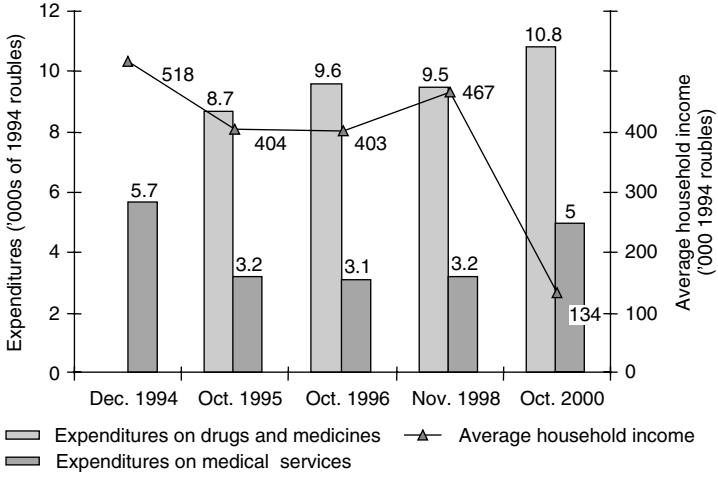
those respondents who actually had a medical treatment during the month that preceded the poll. The Satarov (2001) estimate of the degree of bribery in public hospitals is 26 per cent. Again, our estimate based on the RLMS data is only 10 per cent. Altogether, Satarov (2001) reports that 36 per cent of Russian citizens pay shadow money or gifts to medical personnel in order to solve health problems of their own or of a family member.

The RLMS data suggest that most health care-related out-of-pocket payments go, officially or unofficially, for services provided in public sector facilities. The data also demonstrate that the amount of these payments has been surprisingly stable (in real terms) during the period 1994–2000. Hence, as real incomes collapsed after the 1998 financial crisis, the overall burden rose dramatically.

An average Russian household has been spending monthly about 10 000 1994 roubles on drugs, and roughly 5000 1994 roubles on medical services, and these numbers did not depend on the fluctuations in the average household income. To account for inflation, we use two alternative price deflators: the consumer price index and the rouble/US$ exchange rate – see Figures 8.4 and 8.5.

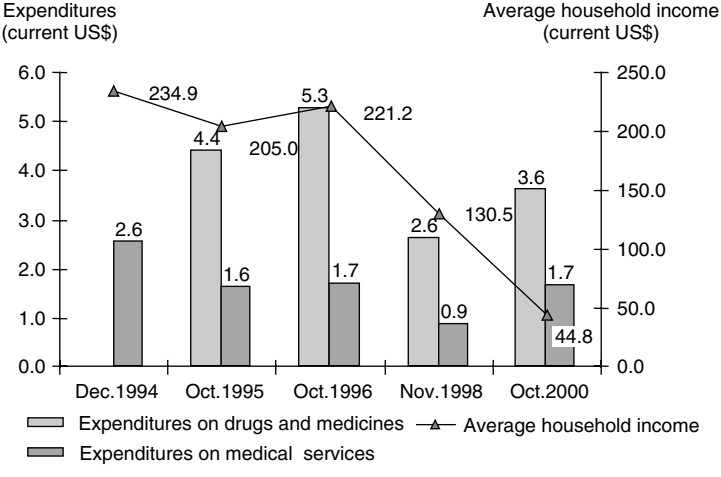
Since there were considerable fluctuations in the average household income in the period of 1994–2000, the share of the health care expenditures in the income went up and down too (Figure 8.6).

The data also suggest that health care expenditures pose a heavier burden on lower income groups. Figure 8.7 plots the 2000 expenditures against quintiles of households grouped according to their per capita income. The chart shows a J-shaped picture where the bottom quintile spends more than each of the three middle quintiles, the three middle quintiles spend about equal amounts, and the top quintile spends the most. This shape is typical for every year of the 1994–2000 RLMS data. Figure 8.8 presents the same data in terms of percentages. One can see a steady decline of the health care expenditure as a percentage of a household income with the growth of the income. Alternative but qualitatively similar estimates of household expenditures are presented by Street *et al.* (1997) and Boikov *et al.* (1998).



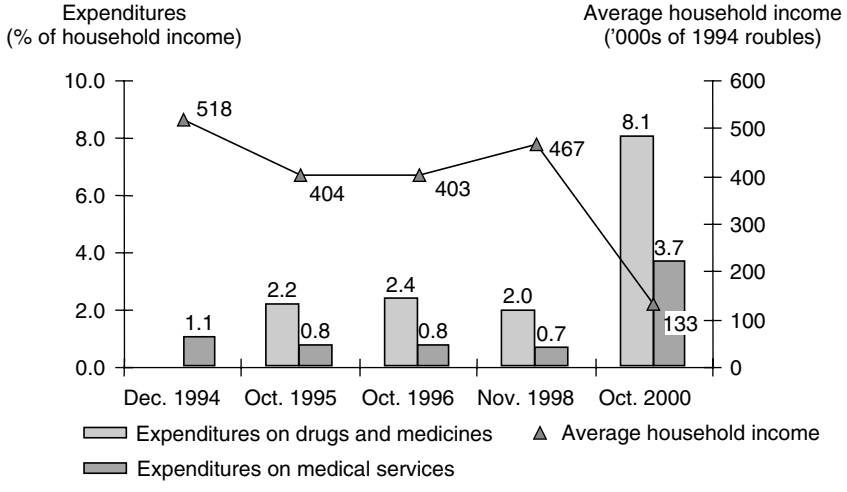
Source: RLMS Household Questionnaire Data.

Figure 8.4: Average household expenditure on health care, 1994–2000
Note: In the 1994 questionnaire, expenditures on drugs were combined with other expenditure items such as the costs of gym exercises. Hence, we did not consider them.



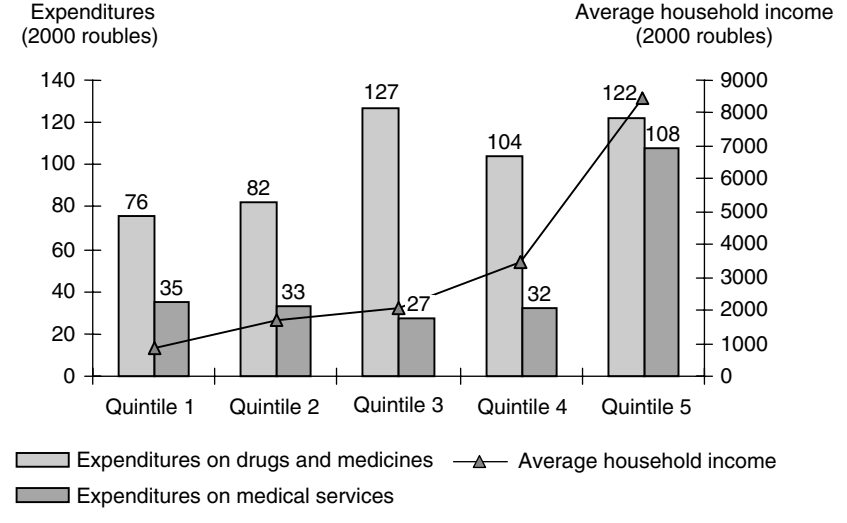
Source: RLMS Household Questionnaire Data.

Figure 8.5: Average household expenditure on health care, 1994–2000
Note: In the 1994 questionnaire, expenditures on drugs were combined with other expenditure items such as the costs of gym exercises. Hence, we did not consider them.



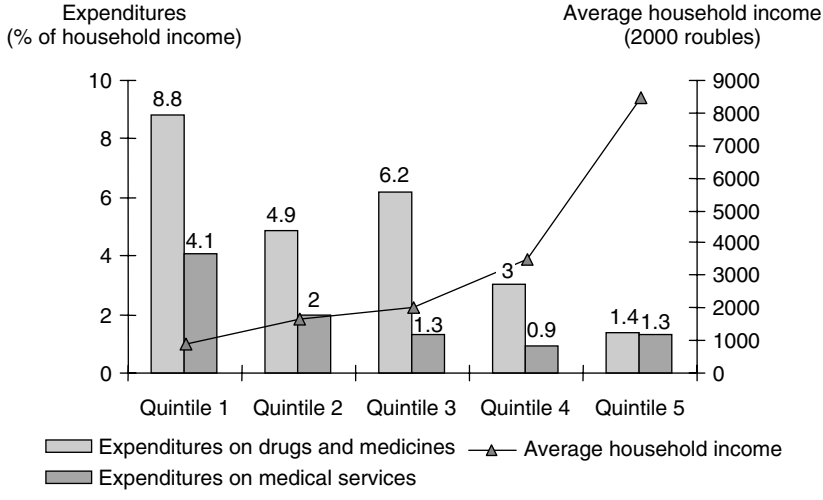
Source: RLMS Household Questionnaire Data.

Figure 8.6: Average household expenditure on health care, 1994–2000



Source: RLMS Household Questionnaire Data.

Figure 8.7: Average household expenditure on health care, October 2000



Source: RLMS Household Questionnaire Data.

Figure 8.8: Average household expenditure on health care, October 2000

8.7 The private sector

Commercialization of health care in Russia has not yet led to a booming development of a large-scale private sector. Only 1 per cent of treatment facilities is private, and of those, nine-tenths are small medical centres specializing in ophthalmology, urology, dentistry, plastic surgery, etc. Private dental clinics and officially registered private practitioners supply about one-half of dental services in money terms. There are also a few large private multi-purpose clinics built mainly by large corporations for their employees (Moskalenko 2003). The relative role of these private facilities is almost negligible in terms of the number of patients treated. However, since the services provided in these facilities are considerably more expensive than the ones provided in the public sector, their share in the money spent on medical care is far more pronounced. According to the RLMS data, while private outpatient treatment facilities serve less than 3.7 per cent of the total number of patients, they accumulate one-third of the total household expenditures on outpatient care. Private inpatient treatment facilities provide services to less than 4.5 per cent of the patients but account for 15.4 per cent of the total household expenditures on this type of medical care.

Ownership of hospitals remains almost exclusively in the public sector. Legal uncertainty on the security of leases has discouraged a mass shift to private ownership (Malginov 1996). The option of creating not-for-profit or 'trust' status hospitals is also problematic because of considerable uncer-

tainty about the taxation of charitable institutions and general hostility from governmental bodies towards the encroachment of non-governmental organizations into their traditional spheres of activity (Shishkin 1996).

The RLMS data suggest that commercial health care in Russia is a luxury good available mainly for the rich. In 2000, only 3.4 per cent of the patients from the lowest income quintile chose to go to a commercial treatment facility or a private practitioner, while among the patients from the highest income quintile, 10.5 per cent did so.

8.8 Conclusion

'The transition towards a paid health care system will be the slowest part of the reform conducted by the government' said Russia's Minister of Labour in August 2000, 'of course, the rich, who have the money for medical care, must pay. Another matter is less affluent people, who should not be hurt . . . '(Neimysheva 2000). The twelve-year experience of the MHI system demonstrates that such declarations remain just declarations if not properly supported by a solid system of public financing. Since public funds have been insufficient to meet the commitments to free health care, the shortfall in resources has been made up by informal charges and charges for privately provided services by the regions. Shadow commercialization of provision by government-owned providers is the reality of today's health care in Russia. It has highly inegalitarian consequences regionally and by social groups. The problem is that the federal government prefers to let the problem build up rather than to acknowledge its own failure in organizing comprehensive services provision as guaranteed by the Constitution.

9

Commercialization of Health Care in Mali: Community Health Centres, Fees for Service and the Rise of Private Providers

Mamadou Kani Konaté and Bakary Kanté[1]

9.1 Introduction: generalised poverty and community health care in Mali

Mali is one of the world's poorest countries, with an estimated income per head of US$250, as compared to an average of US$480 for sub-Saharan Africa in 2000.[2] It falls into the category of Highly Indebted Poor Countries in the World Bank's debt relief programme. Geographically, it is a landlocked country in the semi-arid Sahel in West Africa, with an estimated population in 1999[3] of just 10.5 million people. The underlying rate of population increase of around 3 per cent a year coexists with very considerable emigration, leaving a net rate of increase of around 2.2 per cent. The population remains predominantly farmers, with about 7.6 million people living outside cities despite strong flows of internal migration that are constituting a rural exodus and rapid urbanization as well as other migratory movements within the country.

The Malian capital, Bamako, is known in international health policy circles for having hosted the WHO meeting that established the highly influential 'Bamako Initiative' in African health sector reform, bringing together the principles of cost recovery and community participation in managing local health services (McPake *et al*. 1992; Ridde and Girard 2004). Domestically, Mali has a history of health and health policy which has involved substantial community initiative in developing local health services, and the country

is therefore an important test-bed for the viability of community-based care in conditions of severe poverty.

This chapter examines the viability and mode of operation of Mali's community health centres, and contrasts them to an emerging urban private health care sector. It begins by sketching the origins of the community health movement in Mali, in relation to broader international policy initiatives. Then, after an outline of the current situation of poverty and health care in Mali drawing on existing sources, the chapter presents the results of two small exploratory surveys, of community health centres in urban and rural areas and of private health care providers in the Bamako urban area. It draws on the survey data to explore perceptions and behaviour of the various health providers, and the views of their patients and local communities. The chapter shows that both community health centres and the private sector are operating rather similarly, as financially fragile fee-charging institutions, but that they serve distinct elements of the population. We suggest that this fragile dual structure of commercialized and semi-commercialized health provision is reinforcing inequality while undermining the broader public health activity which was at the core of the community health movement's vision for health.

9.2 The roots of the community health centre movement in Mali

Mali's commitment to a policy of expanding access to basic health care began in 1964, reflecting policy trends at the time in a number of other African countries. Between 1996 and 1998, a First Ten-Year Plan for Health Services (*1er plan Décennal des Services de Santé*) aimed 'to develop a public health pyramid of services running from the village health team right up to the top professionals' (FENASCOM 1996). It has as its primary objectives preventative care, public education on health and hygiene, sanitation, and essential curative care.

These policies were echoed and propagated at the international health policy level when the Alma Ata Conference in 1978 adopted the policy of primary health care.[4] In this national and international context, Mali pursued a number of initiatives, including a health programme for Southern Mali, and Rural Heath Projects in Koro, Yélimané, Mopti and other areas. All of these efforts were based on the training and support of village health workers, who constituted the team of health promoters on whom the health system, envisaged as a pyramid, was to be built.

Despite huge constraints, Mali thus decided in the late 1970s to pursue the strategy of primary health care, bringing together the range of services required. The strategy was based on the principles of social justice and equity in access to health care. Unfortunately, however, it did not succeed in meeting these objectives. The problems included insufficient funding and a high

level of centralization of the health programmes, and the reforms did not improve the health situation of the population.

Towards the end of the 1980s another political and health policy issue facing Mali was unemployment of young doctors. That problem caused a number of new ideas to germinate in the soil of the accumulated experience in the health sector (FENASCOM 1996). The problem of poor quality health care was addressed by sending these young doctors to work in the areas of the country remote from the towns.

During the mid-1980s, furthermore, communities in Mali began making clear their own determination to create community associations which could take charge of addressing their health care problems. These community associations were faced with huge public health problems; the most important included access to essential medicines and the complete inadequacy of the public health services. The search for solutions to these problems was the origin of the popular community health movement in Mali, of which the pioneer remains the Community Health Association of Banconi (*l'Association Santé Communautaire de Banconi (ASACOBA)*). This, like other early community health initiatives in Mali, began before 1987; ASACOBA was established on a formal basis in 1989.

This was the context in which the thirty-seventh regional committee meeting of the World Health Organization was held in Bamako in 1987. The African Ministers of Health voted to adopt a resolution proposing to redynamize the primary health care policy through strengthening popular participation in health care. The redynamizing was to be built on two pillars: primary health care services were to be supported by a policy to ensure the supply of essential medicines, and a system of management of the health services was to be created with the participation of local communities and local government. It was these two pillars for relaunching primary health care that became known as the Bamako Initiative. James Grant, the Executive Director of UNICEF, in a speech when the initiative was announced, emphasized the aspect of cost recovery to ensure supply of essential drugs (Ridde and Girard 2004).

The popular movement in Mali to create Centres for Community Health (*Centres de Santé Communautaires*) (CSCOM) had begun as an urban phenomenon. It then spread progressively to the rural areas, in an unprecedented flowering of local initiative in Mali. In the space of a decade the numbers of CSCOM grew rapidly, from 10 in 1993, to 123 in 1996, and 285 in 1999, demonstrating, if demonstration is still needed, the scale of the phenomenon. The population took this system of health care so strongly to their hearts, and made it such a focus of popular initiative, that the state was really forced, from 1991 onwards, to take this initiative forward as a key driving force of its new health policies.

Following official recognition of the initiatives, new larger-scale structures were created to develop a new Health, Sanitation and Population Programme

for the Rural Areas (*Programme Santé Population et l'Hydraulique des Populations Rurales*) (PSPHR), and to implement and co-ordinate the programme at the national level. This was made possible by funding from the World Bank and USAID, among other development partners. The core objective of the new health system was to reduce maternal and infant mortality.

In pursuit of its objectives the PSPHR supported the creation of new CSCOMs, by providing funding, constructing or renovating buildings for literacy teaching, and providing to each CSCOM inputs for a 'minimum bundle of activities' (*Paquet Minimum d'Activités*) (PMA) that included essential generic medicines and other supplies. The PSPHR also encouraged autonomous management of the centres, and pushed for the local population to take responsibility for the financial cost of running them. The method of financial devolution to local communities was the introduction of a system of user fees for the services rendered. This entire formula, the objective of which was to adapt the costs of service provision to the low levels of income of the Malian population, was an approach that sought to take into account the poverty of the beneficiaries of the services.

9.3 Poverty and the viability of the community health centres

There are no reliable indicators of the differing level of incomes and rates of economic growth in the regions of Mali where the CSCOMs have been established. We therefore begin with a summary of available information on the general level of poverty and its implications for inequality of access to essential services such as health care. The main sources for the information provided here are two reports: from the Observatory for Sustainable Human Development (*l'Observatoire du Développement Humain Durable*) (ODHD 1999) and a joint publication by the World Bank and the Government of the Republic of Mali (Banque Mondiale et Gouvernement de la République du Mali 2002) setting out a strategic framework for the struggle against poverty.

The Malian population faces generalized and extreme poverty. Studies by the ODHD in 1999 and in 2002 (ODHD 1999; Ministère du Développement Social *et al*. 2001) showed 63.8 per cent of the population living in poverty, and 21 per cent in extreme poverty: and these figures are based on a low poverty line (see also Chapter 17). The poverty is above all rural, but it nevertheless also touches the big towns, where poverty is worsened by a collapsing labour market and by in-migration. The Ministry of Health, in research done in the context of revisions of the Ten-Year Plan for Health (PRODESS), also found that poverty remained a predominantly rural phenomenon. The Ministry's data showed that 80 per cent of the poor were concentrated in four major regions of Mali: Mopti, Sikasso, Ségou and Koulikoro. The consequences of this generalized poverty are very poor health indicators.

The health-seeking and health-related behaviour of the poorest households is strongly constrained by mothers' low levels of education, by poor geographical access to needed good quality services, and a lack of information. There is almost no information on the effect of charges for services and transport costs on health-seeking behaviour. It is notably the case in Mali that most health services are used less by the poor than by the rest of the population, and less by those in rural areas than by urban residents. Household expenditures on health care of the poor are of a completely different order than the expenditure by the better-off. Dubious practices, injurious to health, continue and HIV/AIDS is a fearsome epidemic.

In this context, a very low capacity to pay leads the poor to reduce to a strict minimum their consultations for preventative care, and to look for alternative responses to ill health: self-medication, traditional healers and recourse to religious leaders. A low ability to pay reduces opportunities for people to make extensive use of the community health centres. For example, the price of a consultation at a community health centre, supposedly fixed at a level affordable for the majority of the population varies between 300 and 600 francs CFA.[5] The cost of a prescription for generic medicines will be more than the equivalent of one US dollar. This sum may simply be unaffordable by the section of the population considered poor, that is, 69 per cent of the total, since their daily income is often less than this amount.

In these circumstances, the viability of the community health centres (CSCOMs) is undermined by poverty, especially in the rural areas. While the number of visits to many CSCOMs remains low, below a necessary threshold for financial viability, these CSCOMs will fail to generate sufficient resources to cover their running costs and allow investment. The study reported in the next two sections suggests that there is a cause for real concern. There are two possible responses. One is a policy of greater subsidy, which runs counter to the spirit in which the CSCOMs were created. The other, for the better-off, is recourse to private medicine, which has been developing in Mali since 1985.[6]

9.4 The community health centres as seen by the population and their staff

The study

This section is based on a small exploratory study undertaken in 2002, of the financing and activity of four CSCOMs (Konaté *et al*. 2003). The aim of the study was to explore how and to what extent key elements of Malian health policy were being realized in the CSCOMs studied. Two urban CSCOMs were chosen in two economically distinct urban districts in Bamako, one categorized as 'average', and one as 'poor'. Two rural sites were each about 30 kilometres from Bamako, there too one is less poor than the other. Interviews for this exploratory study were undertaken with

thirty-nine respondents from three groups: the population using the services, the staff and members of the Community Health Associations (described below) that manage the centres. In addition, financial data were collected and management processes explored.

The study showed that in these four areas, the staff of the CSCOMs and the population benefiting from their services had some differing perceptions of the community health structures.

The growth and local management of the community health centres

The CSCOMs have evolved rapidly, as noted above, in response to unsatisfied need for health care in the population. According to the official definition,[7] the community health centre is a primary health care unit, created on the basis of the involvement of a defined population. It is organized within a Community Health Association (*Association de Santé Communautaire*) (ASACO), with the aim of responding effectively to the population's health problems.

Furthermore, the CSCOMs are key elements in national health policy. Their results are an indication of what one may hope to achieve as outcomes of the new policies of institutional decentralization which are being pursued in Mali as in many other parts of Africa (Gilson and Travis 1997). The CSCOMs are regarded in Mali as key examples of institutional innovation that can shift responsibility for local development towards decentralized community structures, in partnership with the state, NGOs and other partners.

In general, the CSCOMs' mission is to undertake social and public health initiatives which address the health problems of both individuals and the community. In practice, their activity consists in providing curative services, ensuring the availability of essential drugs, promoting community development activities and actively seeking to create participation by the community in managing the CSCOM. For a unit to be recognized as a CSCOM, it should undertake the full range of curative, preventative and health promotional activities.

On the basis of the decrees that provided for the creation and management of the CSCOMs, the state began to devolve the management of the primary health services to the community health associations (ASACOs). This process moved quite quickly, rapidly increasing the numbers of health centres. The movement is quite geographically concentrated: the Sikasso region has 99, the largest number of CSCOMs, followed by Ségou region with 73 and Kayes with 63. The rest of the regions of Mali have less than 50 CSCOMs each, some many fewer. This inequality is rooted in economic divergence and diversity within Mali. Sikasso and Ségou are the two economically better-off regions of Mali; while in Kayes, the number of CSCOMs is largely the result of investments made by emigrants who come from the region.

According to data from the National Directorate of Health (*Direction Nationale de la Santé*), Community Health Division, the public health plan envisages 1110 health centres for the whole country. By the end of 2002, there were 404 CSCOMs, and 214 restructured local health centres that were moving towards CSCOM status; the latter have also grown rapidly in number from three in 1993 to forty-six in 1996.

The community health centre movement in Mali is therefore something of a test case for the viability of this widely promoted mix of local finance and local management in primary health care in contexts of generalized poverty. Our study aimed to investigate experiences of four of the centres.

Differing perceptions of the services provided by the CSCOMs

The interviews with staff, health association members and local residents identified two aspects of the services provided that were widely regarded as problematic, and one positive element. The first widely identified problem was that the health promotional activity was not being done effectively by the CSCOMs. Health promotion is, as noted above, one of the three vocations that the community health centres have to pursue, yet it appears to be one of the least understood, being overshadowed by other activities.

The local residents interviewed were largely unaware of health promotional activities such as information, education and communication being undertaken by the CSCOMs. No local resident interviewed had participated in any such activity since the start of the CSCOM, and the members of the community health associations concurred with the view that these services were poorly provided. This is a worrying finding, suggesting that the CSCOM staff, who generally stated that they were providing the service, are finding it hard to extend their efforts effectively to the population at large.

The second problem concerned the preventative services, which do not appear to be reaching a sufficient proportion of the population to achieve the desired effect in improving access of the community to better health. The preventative services particularly sought by the population were, according to the interviewees, antenatal care, vaccinations and child welfare. Most interviewees (81 per cent) agreed that the CSCOMs were doing antenatal care effectively, while only a minority were aware of the existence of the other services. More than two-thirds of residents interviewed stated that child welfare monitoring for children who are not ill was not provided, and a third of the staff and most association members interviewed agreed. In one of the rural centres, Tamina, the staff stated that during the national vaccination campaigns, large numbers of people came to the centre, but for the rest of the year vaccination was an activity that was virtually unknown. The staff interviewed stated that the urban CSCOMs all undertook vaccinations, but not all the rural centres.

The number of interviewees is small, but this remains another worrying finding, suggesting that public understanding of the CSCOM services is

limited, and the preventative activity weak especially in rural areas. It may be that an apparent lack of information is one reason why some potential users of the CSCOMs go instead to higher level health facilities run centrally or (in the urban areas) to private facilities.

Opinions, and public information, were much more positive as regards the curative activity. The services most sought after by the population were medical consultations and attendance at births. Most people interviewed (80 per cent) agreed that these services were provided by the CSCOMs, in both urban and rural areas. Most association members and local residents interviewed said, however, that there were problems with supply of essential medicines, while some of the staff disagreed.

The centres studied were quite well staffed relative to the required minimum staffing of two or three people; those studied had an average of six professionals in each centre. In each of the urban centres there was a general medical doctor, while the rural centres are generally run by nurses. In the poorer of the two urban centres, Sabalibougou, however, the staff expressed the view that because of poverty a substantial element of the population came to the CSCOM only when faced with serious illness or to give birth. This assessment is supported by other research in Mali which found that a willingness to pay for care was not matched for many by ability to pay, except at very substantial personal sacrifice in cases of severe illness (Ridde and Girard 2004: 42).

9.5 The community health centres: financial fragility

The CSCOMs were conceived as autonomous institutions: this is one of the fundamental concepts underlying their creation. The state provides at the start 90 per cent of the construction costs, and most of the equipment costs; it also provides an initial fund for medicines of 1–2 million francs CFA. The centres can also receive support from NGOs, but in the centres studied that had been limited to some support for transport in urban areas. The state can provide some qualified staff from the national Health Ministry budget. For example at Magnambougou, at an urban CSCOM, the doctor said:

> *All the centre staff are on contract to the centre except the midwife, who is a state employee. This arrangement began in 2002, when the Regional Directorate for health decided that the midwives employed by the state should undertake rotations of three months in the CSCOMs.*

Those running the CSCOMs increasingly take the view that decentralization brings the health centres under the tutelage of local government: the mayor and the local councillors. Hence the local council should support the health centres in their search for NGOs and other donors, and indeed should pay for some of the running costs.

Otherwise, the autonomy and financial viability of the CSCOMs depend on the income they can generate. The financial data collected from the four centres studied demonstrates rather sharply that the main income-generating activity, especially in the urban centres, is the sale of medicines. However, frequent gaps in the supply of drugs and an insufficient stock reduce the income performance of the CSCOMs from this activity.

Figures 9.1 and 9.2 show two years' data on income (2000 and 2001) for one of the most successful CSCOMs in Bamako. The three main sources of CSCOM funds have been graphed separately (omitting smaller sources of funds): sale of drugs, income from consultations by members of the CSCOM, and income from consultations by non-members. When local residents join a CSCOM, they pay a fee for a membership card, and thereafter pay a lower fee than non-members for each consultation.

The predominance of the sale of drugs within total income stands out. In addition, in these two years the income from consultations by members remained relatively low, never reaching 200 000 francs CFA (about US$365) a month, while the fees of non-members were in certain months as high as 600 000 francs CFA (rather more than US$1000). In 1999 the income from drugs reached 1 400 000 francs CFA, and then fell slightly in the subsequent years. These three sources of funds dominate the accounts; much smaller sums are generated by payments for minor operations, diagnostic tests, maternity care fees and (smallest of all) payments for membership cards.

For this CSCOM, a comparison of costs and income was also possible for 1995–2001, from the accounts. This showed that the centre had slipped from a small operating surplus in 1995–7, into just breaking even and then into an operating deficit in 2000 and 2001.

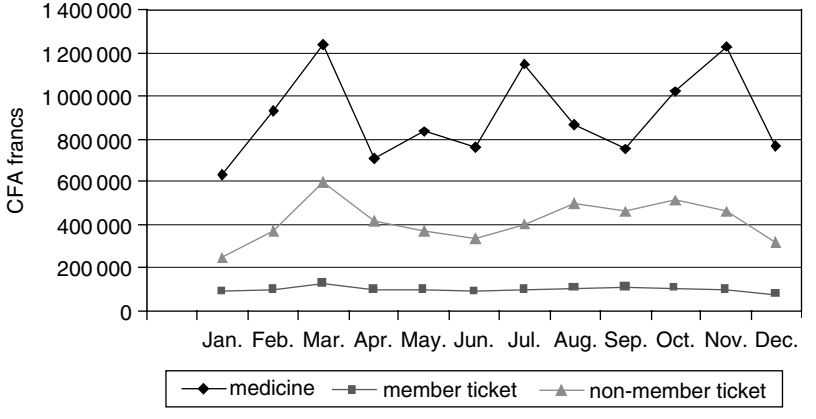


Figure 9.1: Income of an urban CSCOM (ASACOMA) 2000

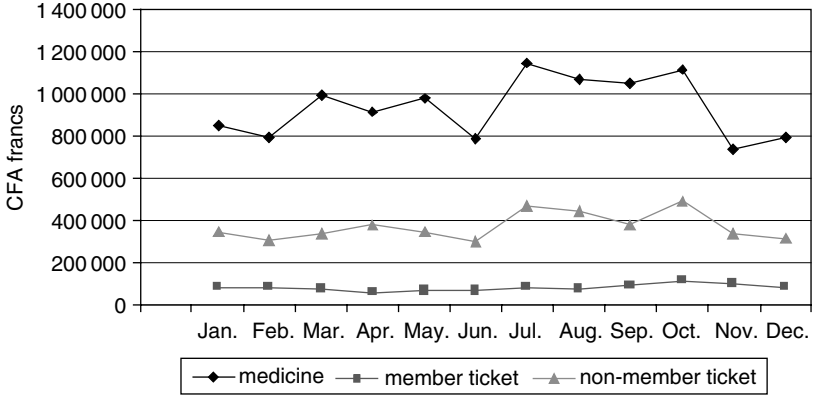


Figure 9.2: Income of an urban CSCOM (ASCOMA) 2001

Financial data for the rural CSCOMs is less detailed, and members and non-members' fees cannot be separated. Figure 9.3 shows combined data for the two rural CSCOMs for 2001, showing that sales of medicines are a somewhat less dominant source of income.

The interviews and data suggest a number of reasons why the finances of the CSCOM are precarious. One difficulty is with the payment of salaries, which are a considerable burden on health care fees. The ASACOMA accountant, at the Magnambougou centre, asked about payments to staff, said: *'It is the centre that has to take responsibility for everything; it is we who pay the salaries, training costs, cost of security for the centre.'*

In Sabalibougou, a rural CSCOM, the person in charge of the pharmacy said: *'I deposit the money received with the accountant of the ASACO twice a week. The money we receive for drugs is deposited at the Bank of Africa, while the money received from consultations and other services is kept in a savings bank in the market, and our salaries come from that.'*

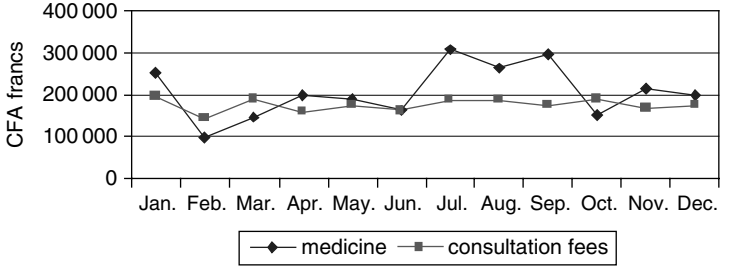


Figure 9.3: Income from fees and sale of medicines, two rural CSCOMs, 2001

In the urban areas, the predominance of non-members' consultations is striking. The urban CSCOMs, especially in the better-off areas, are operating more like small commercial health centres than membership-based community organizations. Nor do they appear to be operating very successfully as such. They appear relatively unsuccessful at recruiting new clients, and do not 'market' their activities very effectively to raise their activity rates.

Furthermore in the urban areas the health care environment has changed. Private medical practice in private dispensaries is now permitted, and these facilities, as the next section explores, are highly competitive with urban CSCOMs. They are close to many potential users. They offer similar services, and succeed in gaining the loyalty of patients by a more flexible and human approach. Patients associate private practice with better quality, and so are willing to pay more – the next section examines these attitudes in more detail. When one looks closely at the private sector, the competitors of the CSCOMs are not large clinics. It is rather the small primary care dispensaries, offering consultations and treatment, midwives' consultations, or care by nurses that are creating fierce competition for the CSCOMs. Here, the issue is as much comparison of quality of service and accessibility, as differences in price. The lower end of the private sector provides accessible services at critical times, including remaining open during the night.

To this emerging private sector explored below, we can compare the image of the CSCOMs that emerges from the exploratory study: health centres, in urban and rural areas, that are doing relatively little preventative and promotional activity, concentrating rather on the income-generating activities of consultations and the sale of drugs – precisely the main services sought by the population in time of need. In that sense, the CSCOMs too are semi-commercial facilities, reliant on fee-for-service activity. In rural and poor urban areas their financial fragility is the result of poverty. In better-off urban areas, where income generation possibilities are greater, the competition from the private sector is more severe. In this context of poverty and private sector competition, the collective, preventative and local developmental activities at the heart of the CSCOM idea are, this small study suggests, seriously under threat.

9.6 Private providers in Bamako, and interactions with the community health centres

The study, the types of private facilities and their location

The main types of facility registered to practise private health care in Mali are doctors' surgeries, consultation rooms of midwives and nurses, physiotherapists, and also private hospitals. Nurses can offer services that include treatment of wounds and prescribing, e.g. for malaria. Since the law was passed permitting private medical and other health care practice, these facilities have been established almost solely in urban areas. In 2001 there were

338 private facilities of all types registered in Bamako urban district, the capital city.

A study of a small sample of these facilities and practitioners was undertaken in February 2004 in Bamako. Two clinics or dispensaries were chosen in each of five sub-districts (*communes*) in Bamako urban district, and one in a sixth.[8] A total of thirty-three users of these facilities were interviewed on exit from a consultation, including men and women, of a variety of ages, and even some Malians living abroad and visiting. In addition, those who owned and/or managed the private health facilities were interviewed about the characteristics of the facility and the services and products sold. They were also asked about the prices charged, and also their sources and management of their stocks of drugs.

The owners and practitioners interviewed in the private facilities said that the most important reason for locating the facility in a particular place was ease of access by patients. More than half said location was a key determinant of the number of clients coming to the facility. Otherwise, a key determinant of location was ownership of the structure; this in turn influenced costs. Only one-fifth of facility owners and managers interviewed thought that the skills and training of the staff were a major influence on the number of people coming to the facility.

Those running the facilities were also asked what were their problems in terms of achieving profitability in private health care in Mali. The main problems cited included taxes, the cost of supplies, and the general running costs of the facility. The financial viability of the private facilities visited seemed no more secure than that of the CSCOMs. As a result, interviewees focused strongly on the need for lower taxes and access to bank credit.

Reasons for going to private facilities rather than to the CSCOMs

Clients interviewed in the private health care facilities expressed a number of complaints about the CSCOMs. The leading complaint was about poor equipment and supplies. The poorly equipped CSCOM facilities did not give clients confidence, and when people could afford it they preferred to seek private treatment.

The second most common complaint was about the general level of service provided at the CSCOM, and very particularly about the kind of welcome patients received on arrival. According to a number of interviewees, the CSCOM staff have a bad reputation for not attending to patients properly, and for frequently sending them away with instructions to return the following day. This behaviour discourages people from going to the CSCOMs, and creates incentives for people to pay more than they can afford to seek treatment. The following interviewee makes the point: *'It's because, when you go to the CSCOM, say at a particular time such as 9 or 10 o'clock, someone comes to say that today, they cannot work any longer during the day. But someone who is ill cannot wait.'*

The third factor which tarnishes the image of the CSCOMs, in terms of their quality of service, is the level of qualifications of the doctors and other health care staff working there. Patients interviewed in private facilities asserted that students from the health care training schools were working in the CSCOMs: *'There [in the CSCOM] there are a lot of young people seeking patients, and for this reason the person that I was accompanying, she would never have accepted to be treated by these children had I not insisted. But I said to her, they are doctors.'*

People drew invidious comparisons between well-qualified doctors who work in private clinics and the young doctors who are practising for the first time in the CSCOMs, and the community health centres suffer in urban areas from an image of cut-price care.

In contrast to the complaints about CSCOMs, the private patients interviewed expressed appreciation of the warm welcome and in particular the good working environment in the private facilities. As compared to the CSCOMs, said one: *'There is a great difference. I came to this clinic because it is clean, and you do not have to expend a great deal of time waiting, while at the CSCOM you sit around whether you want to or not. Also [in the CSCOM] once you are on the treatment table, you find other people next to you and I do not like that.'*

In summary, the CSCOMs are not seen as centres with specialized staff. They are seen as community facilities whose principal vocation is to provide a minimum of basic care to the majority of the population at a manageable price. Given the low income of most of the population, the CSCOMs are their only resort, and most have no means to go for treatment to the private clinics: *'People go generally to the CSCOMs because it is cheaper there. It is not because they want to go there, but because they can afford it. It is cheaper for most people.'*

The charges at private facilities are higher than the charges at the CSCOMs. Therefore most of the population goes to the CSCOMs for treatment when ill because the CSCOMs are cheaper, more affordable and can be accessible (though with a struggle) to the poorest part of the population: *'It is at the level of the CSCOMs where you find more patients, because people are not equal, they do not all have the same ability to pay. If you do not have enough money, you are forced to go to the cheaper place.'*

Prices in private facilities and comparisons with the CSCOMs

The main constraint for potential clients on access to private clinics and doctors' surgeries is the cost of the services, rather than the distance to be travelled. The following response in a private clinic is representative of a number:

> *There is a great difference [in comparison with the CSCOM] because not everyone has the means to cover the clinic charges. Everyone can afford the*

> *charge for consultation at the CSCOM, but not everyone can afford to be treated at the clinic. This is because the clinics have good doctors. I'm not saying the doctors in the CSCOM are not good, but the fact is that here the doctors treat patients well, they are intelligent and competent. It's for that reason above all that I am here.*

Despite the high charges, people may make a major effort to find the money for private treatment because they are seeking better care: *'I think it is better to go to the place that offers the best services, because at least you may get well more quickly.'*

There is thus a widely expressed view that the higher charges in the private clinics reflect a markedly better level of services than those provided by the CSCOMs. The quality of the services depends in good part on the quality of the health care staff, and also on the equipment and supplies available in the facility.

Private practice is thus seen as in the interests of people who have a high enough income to afford a certain type of service. The high charges for treatment in the private facilities are assessed in different ways by the interviewees. Some of the private clients, when interviewed, expressed the view that the charges of private clinics and surgeries were reasonable. For example: *'I think that the fees charged for consultations at this clinic, where you have met me – I think they are acceptable. I pay 5000 francs CFA for the consultation, and this is a fee which is typical of most of the private clinics.'*

Some, however, are not at all accepting of the high charges because they believe that the private providers charge differently according to whether the client is rich or poor.

> *The costs of treatment in the CSCOMs are much more affordable, because they are set at a level that matches the funds of the people who go to those centres. But unfortunately in the private facilities, I would say that there is a tendency to provide prescriptions and treatment according to the type of person who is being treated. This is deplorable however, because in the CSCOMs you are prescribed generic drugs; these are the same drugs as you find in the private sector, but you are prescribed lots of different drugs for the same illness.*

And another client said: *'I think it is best to go to the clinics rather than the CSCOMs in order to be well treated, because in the clinics you can be treated with a single drug, while in the CSCOMs you may pay for three different drugs without getting better.'*

These interviewees suggest over-prescribing is widespread. The first argues that private doctors tend to over-prescribe to the well-off in order to make money. The second suggests that CSCOM staff tend to over-prescribe through inexperience, using a variety of drugs to treat an ailment in the hope of including the right one.

Some interviewees felt that on reflection they were satisfied, even if they had paid a high price: *'One does not pay too much attention to that: but people say that when you go there [to the CSCOM] you pay a lot without being satisfied, so it is better to go somewhere where you can be treated satisfactorily, whatever it costs. I think that in the CSCOM, the medicines cost less, while in the clinics the costs of consultations are much higher and the medicines are more expensive.'*

Most people interviewed explained the differences between the costs of treatment in the private and community sectors in two ways. First, people attributed the difference to the quality of service, as described above. The second reason given was the cost of the investments made by the private facilities. Many people attributed both low cost and poor quality in the public sector to the fact that community health centres received a state subsidy and that they sold generic drugs. It is generally said in this part of the world, and particularly in Mali, that people take little care of things which are in the public sector. A culture of caring for the public good still remains to be created in the population at large; however, a culture of private property has rapidly become integrated into urban life, responding particularly to the changes in family structure.

9.7 Conclusion

The economic situation is at the root of the dual health care system that can now be observed in Mali. The national health policy embeds and rigidifies the state of affairs inherited from the second and third republics in Mali, and has not reduced the gap between the health care available to the majority of people living in poverty and the smaller numbers of the better-off. This is a health care system with two distinct levels. There is a growing and diverse private sector, interacting with state and community sectors. The community sector is more affordable than the private provision, but remains a comparably curative-focused, fee-for-service system of provision that struggles to undertake the broader public health and community activities that are its vocation. And there is substantial exclusion from access to needed care. As the Malians put it, whatever the sector, *'health, which is priceless, always has a cost'*.[9]

Notes

1. The opinions expressed are those of the authors alone, and do not reflect the views or policies of any organization. We are grateful to UNRISD and to RUIG for funding support from the UNRISD programme of research on Social Policy and Development and the RUIG/UNRISD project on *Globalization, Inequality and Health Care*. We thank Dr Fatoumata Djènèpo and Issa Daffé for research collaboration, and Maureen Mackintosh for translation.

2. Based on the Atlas exchange rate method. Source: *World Development Indicators*, online at www.worldbank.org.
3. *Source*: 1999 Census of Population and Housing Conditions.
4. Alma Ata declaration, World Health Organization, accessed online at http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf, November 2004.
5. US$1 = 550 francs CFA.
6. The law which permitted private medical practice was the *Loi N°85-41/AN.RM portant autorisation de l'exercice privé des professions sanitaires*.
7. Article 3 of the *Arrêté ministériel N°94/MSSPA-MATS-MP, 21 Août 1994*.
8. Only one private facility was identified there.
9. Quotation from a participant in an organized group discussion as part of a study of reproductive health care in Mali (CERPOD 1996: 29).

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Part II
Policy Issues and Responses

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10
Indian Pharmaceutical Companies and Accessibility of Drugs under TRIPS

Sudip Chaudhuri[1]

10.1 Introduction

Before the creation of the World Trade Organization (WTO) as the new permanent international trade organization, individual countries had the freedom to have their own patent laws. India was one of the countries which introduced a new patent law: the British Patents and Designs Act, 1911 was replaced by the Patents Act, 1970. The most striking feature of the new law was that it abolished product patents in drugs (and food). India had a long tradition of drug manufacturing. But the full potential could not be realized because of the constraints imposed by the Patents Act of 1911. The multinational corporations (MNCs) holding the drug patents used the then existing patent law to prevent the Indian generic companies from producing the new drugs.

The elimination of product patents, supported by other favourable industrial policies, brought about significant changes in the pharmaceutical industry in India. The industry witnessed remarkable growth of production and exports. The technological skills developed by the Indian generic companies and the government laboratories under the Council of Scientific and Industrial Research, were used to generate processes for manufacturing the latest drugs, introducing them at a fraction of the international prices and dislodging the MNCs from their position of dominance. India also emerged as a major player in the global pharmaceutical industry, and has received worldwide recognition as a low-cost producer of high-quality drugs (Chaudhuri 2004).

The pharmaceutical industry in India now faces a radically changed environment. Under the Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS), all member countries are required to grant product patents in all products including pharmaceuticals. To comply with the TRIPS requirement, the Patents Act, 1970 has been amended and India is in the process of introducing product patents in drugs by 2005. After a fully fledged product patent regime is introduced in India, generic companies will no longer be able to reverse-engineer and produce the new drugs invented abroad and protected by product patents. So far as the new drugs are concerned, the options for the Indian generic companies in the post-2005 scenario are: (i) to produce these under compulsory (or voluntary) licensing arrangements,[2] or (ii) to develop new drugs themselves. The Indian companies can of course continue to produce the existing generic drugs in India and abroad. They can also start production of the new drugs after the expiry of the patents. With a number of blockbuster drugs going off-patent in the near future, the prospect of generic exports from India has attracted wide attention.

This chapter examines the responses of Indian generic companies to TRIPS and the policy options as regards accessibility of drugs.

The Indian generic companies, particularly the larger ones have basically responded to the new regime by investing in R&D for new drugs and promoting generic exports particularly to the major developed country markets. Section 10.2 discusses the status and prospects of these activities. The Indian generic companies have demonstrated their strength in developing cost-efficient processes to manufacture bulk drugs (i.e. the active pharmaceutical ingredients present in the drugs) and formulations (i.e. processing of these ingredients into finished dosage forms such as tablets and capsules) at competitive prices. If these companies are given licences to produce new drugs patented abroad on payment of royalty, then competition would drive down prices, but the royalty paid to the innovators would continue to provide funds and the incentive for R&D (Commission on Intellectual Property Rights 2002: 42; Correa 2000: 91). Not only will this help consumers in India: exports of these drugs to other countries with no or insufficient manufacturing capacities will also contribute to accessibility of drugs in these countries. As WHO and WTO (2001: 99) pointed out, compulsory licensing is one of the ways in which TRIPS attempts to strike a balance between promoting access to existing drugs and supporting R&D into new drugs. In section 10.3, we will discuss the progress and the prospects of implementing a proper compulsory licensing regime.

10.2 Responses of the Indian companies to TRIPS

R&D for new drugs

One of the major problems of the structure of the pharmaceutical industry dominated by the MNCs is that diseases of the poor countries are often

neglected.[3] There are a number of diseases (for example, dengue, malaria, measles, leprosy, diarrhoeal diseases) for which 99 per cent or more of the burden falls on the low- and middle-income countries.[4] The MNCs involved in the business of developing and marketing new drugs do not find these diseases attractive enough for R&D investments because of the small size of the markets. People in the poor countries who suffer from such diseases do not constitute a profitable market because of their poverty. Private R&D is driven by market considerations. Hence efforts of the MNCs are primarily directed towards developing new drugs for the large developed country markets (Correa 2001: 19). During the TRIPS negotiations, the MNCs argued that the developing countries, too, would benefit from stronger patent protection (Lanjouw and Cockburn 2001: 266). It has been claimed that grant of patents on pharmaceutical products will lead to an increase in resources devoted to R&D by local companies in developing countries for the development of new drugs more suited to their needs.[5]

Since the mid-1990s, the Indian private sector has started investing in R&D for new drugs. Until then R&D basically related to developing processes for manufacturing. New drug R&D was started by Dr Reddy's Laboratories and Ranbaxy Laboratories. Since then some other companies have joined in and at present there are about fifteen Indian companies which do R&D for new drugs. Though the amount spent on R&D by these companies is still meagre,[6] nine companies have reported some successes. These nine companies have developed about thirty-five new chemical entities (NCEs), which are at different stages of development.[7] None of these has yet been approved for marketing, but seventeen have successfully completed the preclinical stages.

It is important to note that none of these companies is engaged in the entire process of drug development. As an Indian pharmaceutical company, Glenmark Pharmaceuticals, has pointed out in its Annual Report, 2001–2, Indian pharmaceutical companies are not yet ready for a start-to-finish model in NCE research because they do not yet have all the skills and the funds required. The model that the Indian companies have adopted is to develop new molecules and license out the molecules to the MNCs in the early phase of clinical development. This was initiated by Dr Reddy's Laboratories when it developed a molecule for treating diabetes in 1997 and licensed it out to Novo Nordisk.[8] Since then the other companies which have made some progress in new drug development, for example Ranbaxy, Kopran, Torrent and Glenmark, have essentially followed the same model.[9]

When a company licenses out a molecule, the subsequent expenditure is incurred by the licensee and the licensor gets milestone and other payments depending on the stages through which the molecule passes. The later the stage at which the molecule is licensed out, the higher is the cost incurred by the Indian company and hence higher the risk – the entire cost incurred would be lost if the product fails. However, the return is also higher – they

will get higher payments for the licensed product.[10] The company which has been most active in licensing out, is Dr Reddy's – the company which started it all. Licensing of compounds by Dr Reddy's Laboratories and the milestone payments (for example, $55 million in 2001 and $344 million in 2001–2 from Novartis[11]) received widespread publicity and is believed to have lured other smaller Indian companies into new drug development.

Such licensing is not unknown in the international pharmaceutical industry. In fact a number of blockbuster drugs, for example Lipitor, Procrit and Paxil, have been in-licensed molecules.[12] But if the Indian companies want to license out molecules, as they are trying to do, then naturally, the molecules should be those which the MNCs are keen to develop further. As mentioned, the MNCs are keen to develop drugs which cater to their main markets in the developed countries. Not surprisingly, Indian companies are targeting not the neglected diseases of the poor countries, but diseases which interest the MNCs. NCEs being developed by the Indian companies are related primarily to diabetes, cancer, respiratory, urology and cardiovascular conditions for which the main markets are in the developed countries.[13] There are only two exceptions – malaria and tuberculosis. But the NCEs developed (by Ranbaxy and Lupin) are still at the pre-clinical stages. Unlike malaria, there is a sizeable market in developed countries, too, for anti-tuberculosis drugs (Kettler and Collins 2002: 29).

The NCE R&D pattern is unlikely to change in the foreseeable future. As Glenmark mentions, the criteria adopted by the Indian companies are to target areas of global potential in terms of growth and value, which are of interest to the international pharmaceutical industry.[14]

Generic exports

After the introduction of a fully fledged product patent system in pharmaceuticals by 2005 in India, the generic companies will be prevented from producing the new patented drugs and this will have an adverse effect on their space of operations. An easy-to-use compulsory licensing system could have sustained some growth in new drugs. The assessment of the Indian generic companies appears to be that the prospects of liberal use of compulsory licensing are not good.

The Indian generic companies are responding to such loss of domestic markets, arising out of product patent regime under TRIPS, by a conscious strategy of developing exports. This is particularly true for the larger and more successful companies. As a senior official of Ranbaxy (Raizada 2002) explained, during the Uruguay round of multilateral negotiations it was clear to them that a product patent regime would soon be introduced and the global trading rules would change. Entering and growing in developed country markets was an important aspect of the restructuring exercise that was undertaken in response to such changes.

Major export expansion schemes have been initiated by a number of Indian companies and these are reflected in the export growth in recent years. Table 10.1 lists fifteen major Indian exporters which account for about 44 per cent of India's total pharmaceutical exports. These include some of the large Indian companies in the domestic formulations market, for example, Ranbaxy, Dr Reddy's, Cipla, Lupin and Wockhardt. They also include some of the specialized bulk drugs manufacturers, such as Aurobindo Pharma, Shasun, Orchid, Hetero, Matrix, Neuland, Divis and Ind-Swift. Exports have become the major/dominant market for most of them. The largest two (Ranbaxy and Dr Reddy's) earn more than half of their revenues from exports, and the third largest (Cipla) more than a third. Exports account for 83.4 per cent of Orchid's sales, 58.6 per cent of Shasun, 52.4 per cent of Ipca, 49.9 per cent of Aurobindo and so on. Even for those companies for which exports are not yet that important, it has been identified as a thrust area and exports are increasingly relatively and rapidly.[15]

The export market can be broadly classified as either regulated or unregulated. In the regulated markets, there are regulatory barriers in the sense that the exporters to the market are required to follow an elaborate registration and, in some countries, inspection procedure to satisfy the drug control authorities about the quality of the medicines. Such requirements are absent or are not so important in the unregulated markets. The stricter the regulations, the higher are the entry barriers and accordingly the higher the prices realized. The regulated markets include North America, Western

Table 10.1: Export intensity of selected Indian companies, 2001–2

Company	*Exports (in Rs.million)*	*Exports as % of sales*	*Exports as % of total exports*
Ranbaxy	10 290.8	50.1	9.8
Dr Reddy's Laboratories	9 254.3	59.4	8.8
Cipla	4 941.7	35.7	4.7
Aurobindo Pharma	4 865.4	49.9	4.6
Orchid Chemicals & Pharmaceuticals	3 537.0	83.4	3.4
Lupin	3 022.7	31.6	2.9
Ipca Laboratories	2 312.6	52.4	2.2
Wockhardt	1 573.9	24.2	1.5
Sun Pharmaceuticals	1 337.2	17.9	1.3
Shasun Chemicals and Drugs	1 287.3	58.6	1.2
J. B. Chemicals & Pharmaceuticals	1 242.0	45.0	1.2
Alembic	926.9	18.6	0.9
Cadila Healthcare	848.3	14.4	0.8
Morepen Laboratories	627.8	12.5	0.6
USV	618.1	16.8	0.6
Total	**46 686.0**	**43.1**	**44.5**

Source: Annual reports of companies and company websites.

Europe, Japan, Australia and New Zealand. Within the regulated markets, the USA has the strictest norms.

The growth of the pharmaceutical industry in India has basically followed the following sequence:

- production for the domestic market
- exports to unregulated markets
- exports to regulated markets other than USA
- exports to USA.

The motivation for moving up these stages has been larger markets and higher price realizations. Within each market again, the tendency has been to move up the value chain and target higher value-added market segments. Because of the tough entry barriers, only a small minority of the companies have been able to undergo the full transition to exports to the US market. We highlight here the US market because it is by far the largest and the most lucrative and naturally, the Indian generic companies are very keen to enter and grow there. To enter the US generics market, companies are required to submit a Drug Master File (DMF) for bulk drugs, and file an Abbreviated New Drug Application (ANDA) for formulations, and also set up dedicated plants at huge costs. Table 10.2 lists the Indian companies quite active in the US generics market, as of 30 September 2003.[16] A few others, such as Aurobindo and Glenmark, have recently initiated major programmes for entering the US market.

The outward thrust is not only providing the Indian generic companies a larger space of operations. It is also making drugs more affordable and accessible overseas. Indian companies compete strongly among themselves, resulting in lower prices. Success of an Indian company in a field often induces the entry of other Indian companies. Out of the 383 bulk drugs and intermediates for which the Indian companies have filed drug master files (DMFs) as of 30 September 2003, there is more than one exporter for eighty-eight bulk drugs. There are thirty-six bulk drugs for which the number of Indian companies with DMFs is three or more. Ten Indian companies have filed DMFs for cefuroxime, nine for ranitidine, eight for fluconazole, six for ibuprofen, four for enalapril maleate, three for cephalexin and so on.[17]

In formulations too, Indian companies compete among themselves. Consider the three companies – Ranbaxy, Dr Reddy's and Wockhardt – which are most active in formulations exports. All are involved in exporting ranitidine and enalapril maleate formulations. Two of them compete in nefazodone, fluoxetine, famotidine and cefuroxime.[18]

Most of the Indian companies operate at the lower end of the market. These are products at the later stages of the product cycle where barriers are less and the number of competitors is greater. Prices here are lower than in the value-added segments. But in the US, the returns are still attractive. A few Indian companies have lately started targeting the value-added segments

Table 10.2: DMFs and ANDAs filed by Indian companies in the USA as of 30 September 2003

Company	*No. of DMFs*	*No. of ANDAs*
Ranbaxy Lab Ltd	43	37 (110)
Dr Reddy,s Laboratories Ltd	41	9 (25)
Cipla Ltd	33	
Wockhardt Ltd	31	6 (17)
Neuland Laboratories Ltd	15	
Ipca Laboratories Ltd	13	
Lupin Ltd	13	3 (9)
Shasun Chemicals and Drugs Ltd	12	
Divis Laboratories Ltd	10	
Sun Pharmaceutical Industries Ltd	10	
FDC Ltd	8	
Unichem Laboratories Ltd	8	
Biocon India Ltd	8	
Cadila Pharmaceuicals Ltd	7	
Matrix Laboratories Ltd	7	
Banyan Chemicals Ltd	7	
Hetero Drugs Ltd	7	
Sekhsaria Chemicals Ltd	6	
Granules India Ltd	6	
UAV Ltd	6	
Unique Chemicals	5	
Jubilant Organosys Ltd	5	
Alembic Ltd	5	
Orchid Chemicals and Pharmaceuticals Ltd	5	

Sources: Information on DMFs has been obtained from the website of US FDA (http://www.fda.gov/cder/dmf/xls/3Q2003ACTIVETYPE2EXCEL.xls) and on ANDAs from the Electronic Orange Book accessible at the US FDA website (http://www.fda.gov/cder/ob/default.htm).

in different ways. These are markets where due to some entry barriers, the number of players is limited. Ability to introduce products in the relatively early stages of the product cycle has a significant impact on the price realized. The generic company which is the first to launch (or among the first few to launch) a product, gets a much better price than in the case of matured products.

In the process of targeting the value-added segments, the Indian generic companies are facilitating early entry of generics and thereby contributing to accessibility of drugs in the US market.

An innovator company usually does not only have a patent on the new chemical entity (NCE) involved in a new drug. Other possible secondary patents relating to the same NCE are: (i) for specific formulations covering physical composition or delivery mechanism of the drug product, for example a coated tablet or a once-a-day capsule, (ii) for methods of use to

treat certain health problems such as asthma or depression, and (iii) for the process of manufacturing the active ingredient. Most of the drugs with high sales have multiple patents.[19] These secondary patents are obtained later and hence expire typically after the basic patent on the NCE expires. Thus by taking such patents, the innovator companies can delay the entry of generics. Several studies have shown that they do so as a matter of strategy to maintain their market dominance (e.g. Federal Trade Commission 2002). In fact with a number of drugs scheduled to go off-patent, they have intensified their efforts in recent years to extend the period of patent protection and protect the sales of their branded drugs (NIHCM 2000: 3). Generic products are not available for a number of drugs with substantial sales despite the expiry of the patents on NCEs.[20]

Thus generics do not enter the market necessarily and immediately after the expiry of the patent on the NCE. Entry depends on whether companies can successfully challenge the secondary patents. Under the US Food and Drug Administration (FDA) rules, any generic company which successfully contests a patent by filing a Para IV ANDA,[21] gets a market exclusivity of 180 days, i.e. no other generic company is permitted to enter during this period.

A number of Indian companies, such as Dr Reddy's and Ranbaxy, have lately been very active in patent challenges.[22] Dr Reddy's was the first Indian company to get 180-day exclusivity for marketing fluoxetine (Eli Lilly's Prozac) 40 mg capsule on 3 August 2001.[23] Ranbaxy has obtained a Para IV approval for ibuprofen over-the-counter (OTC) tablets. Another way in which a generic company can be the first to enter is to directly challenge the existing patents. Consider antibiotics. Patents on antibiotics are not required to be listed with FDA and hence Para IV certification and 180-day exclusivity are not applicable. Ranbaxy successfully challenged GlaxoSmithKline's patent for cefuroxime axetel and received manufacturing and marketing approval for the product from the US FDA.[24]

10.3 Making compulsory licensing work for those who need drugs

TRIPS not only provides for compulsory licences. Article 31 of TRIPS, dealing with compulsory licensing,[25] does not place any restriction on the grounds under which a compulsory licence can be given. In case there were any doubt, the Doha Declaration[26] has made it clear that 'Each member has the right to grant compulsory licence and the freedom to determine the grounds upon which such licences are granted.' The problem is that certain conditions listed in Article 31 will have to be satisfied. These include: (i) that authorization of such use will have to be considered on its individual merits, (ii) that before permitting such use (except in such cases as situations of

national emergencies, extreme urgency, public non-commercial use), the proposed user will have to make efforts over a reasonable period of time to get a voluntary licence on reasonable commercial terms, (iii) that the legal validity of the compulsory licensing decision and the remuneration will be subject to judicial or other independent review, and (iv) the compulsory licences can be terminated if and when the circumstances which led to it cease to exist and are unlikely to recur. However, as several commentators including Watal (2001) and Love (2001) have argued, the grounds and the procedure can be so specified as to make these conditions less onerous than they appear.

However, developing countries have not been able to take advantage of compulsory licensing as provided under TRIPS. In late 2001, when there were a series of anthrax attacks, the government of the US did not hesitate to initiate action to make the drug more affordable to tackle the crisis. A German MNC, Bayer, held the product patent for the antibiotic ciprofloxacin (Bayer's brand, Cipro) prescribed for treating patients. Bayer was threatened with compulsory licences unless it reduced its price. The threat worked and Bayer reduced its price substantially. Neither the German government nor the EU issued any warning of trade sanctions on the US if it granted a compulsory licence on the Bayer patent. Naturally the MNCs, Bayer in particular, were against the grant of any compulsory licence, but the opposition was measured and non-threatening (Abbott 2002: 55–6).

The situation is totally different in developing countries. MNCs are actually very much opposed to widespread, easy and systematic use of compulsory licences. They see this as a threat to their monopoly power provided by product patents. Compulsory licensing according to them should be used as an option of last resort.[27] Whereas NGOs highlight the pro-competitive effects of compulsory licensing in making medicines more affordable, the International Federation of Pharmaceutical Manufacturers Associations thinks that 'compulsory licensing is a threat to good public health by denying patients around the world the future benefits of R&D capabilities of the research based industry from which new therapies come'.[28] The developed country governments, particularly the US, intervene in favour of the MNCs. In contrast to its actions in the anthrax crisis, the US government has been aggressively indulging in activities which deny the same freedom to the developing countries to tackle their health crisis, which is much more severe.

The WTO Ministerial Conference at Doha clarified and confirmed that the member countries have the right under TRIPS to take appropriate measures to protect public health. That member countries can take measures to protect public health or prevent abuse of IPRs are well recognized in Article 8. The problem is with the condition imposed in the same Article that these measures will have to be consistent with TRIPS. The problem really is that in case of a conflict between IPR and public health, can the latter override the former? What the developing countries sought was a recognition that

under TRIPS they have the right to take some pro-competitive measures such as compulsory licensing, and parallel importation to enhance access to health care without being harassed as in the cases of South Africa and Brazil. The Doha Declaration is of immense help to developing countries in that it acknowledges that a conflict may exist between IPR standards and public health concerns and indicates that the former should not be an obstacle to the realization of the latter (Correa 2002, 2003).

India amended her patent law in 2002 (after the Doha Declaration) to introduce an elaborate system of compulsory licensing for all products including pharmaceuticals. But the entire process is excessively legalistic and provides the patentees with the opportunity to manipulate by litigation. The huge expenses involved in fighting the MNCs holding the patents may dissuade the generic companies from applying for licences in the first place, and if they do, it will take years before they get compulsory licences, if at all (Chaudhuri 2002).

The MNCs and developed country governments have been putting pressure on the developing countries not only to prevent them from using the TRIPS flexibilities, but actually to adopt 'TRIPS-plus' measures which would limit the ability to implement the Doha Declaration. TRIPS-plus refers to efforts to go beyond the minimum intellectual property standards specified in TRIPS, for example to extend patent life beyond twenty years or limiting the grant of compulsory licenses in ways not required by TRIPS (t'Hoen 2003: 45).

The pressure is exerted in different ways. The MNCs use the vast resources at their disposal to lobby and to conduct massive publicity campaigns to influence the opinions and actions of the decision-makers in developing countries and undermine the use of TRIPS flexibilities (Musungu *et al*. 2004: 30). But often what has been more effective is pressure emanating from developed country governments, particularly the US government. Despite endorsing the Doha Declaration, the US government continues to indulge in activities which essentially contravene their commitments at Doha. The basic objective of the US is to seek harmonization of intellectual protection standards in all countries to the US's level. The US has the highest intellectual property protection in the world and hence such harmonization efforts boil down to TRIPS-plus measures.

The US, for example, has been pursuing a number of regional and bilateral free trade agreements (FTAs) which would in effect deprive the developing countries from benefiting from the TRIPS flexibilities. The countries joining the FTAs are being provided access to the huge US market in exchange for accepting higher intellectual property standards as desired by the US. The lure of the economic growth expected to result from higher market access is forcing these countries to accept higher standards. The US has recently concluded FTAs with Jordan, Singapore, Chile, Central America, Australia and Morocco (Abbott 2004). The US–Singapore Free Trade Agreement, among

others, places limits on the use of two important flexibilities provided in TRIPS and specifically mentioned in the Doha Declaration, viz., compulsory licensing and parallel imports. Similar agreements are being negotiated with several other countries in Latin America, Africa and Asia with similar aims. The US has actually announced its intention to use the intellectual property chapter in the Singapore agreement as the model for other FTAs (Oxfam 2003: 17–20). Among the FTAs being negotiated, the most significant is the Free Trade Area of the Americas (FTAA) involving thirty-four countries in North, Central and South America and the Caribbean, except Cuba. If implemented, this will be the largest 'free trade zone' in the world with a US$13 trillion market covering more than 800 million people (MSF 2003: 3).

Under TRIPS, governments have complete freedom to determine the grounds for issuing compulsory licences. But the FTAA agreement being negotiated effectively limits the use of compulsory licences to national emergencies and to the public sector. Thus the countries would not be able to issue compulsory licences to enhance competition in the private sector, reduce prices and increase access.

Another form of pressure is threat. The threat can be in the form of a complaint to the WTO. But the threat is often issued through diplomatic and other channels informing the developing country governments what the US does not want. In Thailand recently when health ministry officials were pursuing the idea of issuing a compulsory licence to make the price of antiretroviral drugs more affordable, a US Embassy official intervened and had to be reassured that compulsory licensing was not actually on the Thai agenda. As a health ministry official pointed out, Thailand was too frightened of the US to take any action against the latter's wishes (Mayne and Bailey 2002: 10). Developing countries fear that they might lose foreign direct investment; even that sanctions might be imposed bilaterally or multilaterally (Commission on Intellectual Property Rights 2002: 42; UNDP 2001: 107).

The US has systematized the threat of unilateral trade pressures through Section 301 of the United States Trade Act of 1974. Under Section 301, United States Trade Representative (USTR) issues a yearly report threatening foreign countries with trade sanctions for not adequately protecting the intellectual property rights of US companies. The Pharmaceutical Research Manufacturers Association (PhRMA), located in Washington, DC, a trade association representing the drug MNCs, keeps careful track of the intellectual property protection environment throughout the world and annually notifies the USTR about the outcome of its review and what action needs to be taken by USTR in countries deficient in providing adequate protection (Tancer and Josyula 1999: 3). USTR actions are highly influenced by the recommendations of the pharmaceutical lobby. In fact a comparison of the aims of USTR and PhRMA shows that their views are remarkably similar – more often than not, identical.[29]

Developed countries, particularly the US, have also been opposed to a simple and effective solution to the Doha Paragraph 6 problem. The problem

is basically that a country with no or insufficient manufacturing capacity cannot effectively resort to compulsory licensing to import drugs. This is because compulsory licence cannot be granted in countries with manufacturing capacities exclusively or mainly to export to countries with no manufacturing capacities.[30] The Doha Declaration recognized this major lacuna of TRIPS (in Paragraph 6) and instructed the TRIPS Council to find an expeditious solution to this problem.

Even after several rounds of formal meetings and informal discussions, a consensus could not be arrived at by the deadline of December 2002. The delay was basically because of differences between the developed and the developing countries over the scope of the solution, including the diseases and the medicines to be covered, the countries to be eligible to import, and the procedures to be followed. Ultimately a compromise was reached on 30 August 2003. This took the form of a temporary waiver (pending the amendment) of the obligation under Article 31(f) of TRIPS that compulsory licence can be granted predominantly for the supply of the domestic market. The decision permits countries producing patented drugs under compulsory licence to export these to countries with no manufacturing capacities.[31]

The developed countries negotiated fiercely and introduced unnecessary procedural complications and limitations, which will make it extremely difficult for countries without manufacturing companies to use compulsory licensing and import medicines for tackling their health crises. For example, it has been stipulated that two compulsory licences will have to be issued, one in the importing and another in the exporting countries for specified drugs and specific quantities. While granting compulsory licences, the procedures specified in Article 31 of TRIPS, for example that the applicants must first try for a voluntary licence, will be applicable. It is not only that the procedure is complex and burdensome. It will have to be followed each time a country exports or imports and thus acts as a serious disincentive for the parties involved in the system, particularly the generic suppliers.

It is important to note that in the initial negotiations, the US tried to impose the restriction that the decision would not be used for 'commercial gain', an obvious attempt to exclude the private generic manufacturers from getting compulsory licences to export. Ultimately the US was successful in inserting the clause that it will not be for pursuing industrial policy objectives. The problem with such a clause is that it can be used by the US or other developed countries to create obstacles for private generic manufacturers to export. And if they do that, and if the generic manufacturers are uncertain about the extent to which they can produce for exports, then naturally they may not be willing to invest in facilities to make such exports possible. The uncertainty and inconvenience of being required to apply for a compulsory licence each time they produce for exports will also discourage generic manufacturers from investing and producing for exports. Thus even when some countries want to import, such supplies may not be available.

10.4 Conclusion

The prices of drugs depend on the market structure. If there are a number of producers, then competition among them tends to reduce prices. But if patents are granted for the new drugs, then the patentees can prevent others from producing the drugs and charge higher prices.

By abolishing product patents in pharmaceuticals in 1970, India was able to ensure a very competitive pharmaceutical industry with prices of new drugs being among the lowest in the world. India became a source of low-cost quality drugs to the entire world.

But to comply with the TRIPS agreement, India is introducing product patents in pharmaceuticals by 2005. This chapter discussed how the Indian pharmaceutical companies are responding and what implications it has for accessibility of drugs.

The Indian generic companies, particularly the larger ones, have basically responded to the new regime by investing in R&D for new drugs and promoting generic exports, particularly to the major developed country markets. Since the mid-1990s, some Indian companies have started R&D for new drugs, but the Indian companies are basically targeting not the neglected diseases but the diseases of the developed countries.

The outward thrust of the Indian pharmaceutical companies is making drugs more affordable in developed country markets, because of competition among the Indian companies and some Indian companies successfully contesting MNC patents and entering the market in the US.

TRIPS also provides opportunities to generic companies to make new drugs more affordable in developing countries. If compulsory licences are given to Indian pharmaceutical companies, which have demonstrated their strength in developing cost-efficient processes to manufacture drugs, then competition among them would drive down prices, but the royalty paid to the innovators would continue to provide funds and incentive for R&D. However, India and other the developing countries have not been able to take advantage of compulsory licensing as provided under TRIPS, because of MNC opposition to its widespread, easy and systematic use. The developed countries, particularly the US, have been intervening in favour of MNCs and preventing the developing countries from ensuring a more competitive pharmaceutical industry and making drugs more affordable.

Notes

1. I would like to thank the participants in workshops at Geneva (3–5 March 2003) and Helsinki (15–17 March 2004) for helpful discussions; also Meri Koivusalo and particularly Maureen Mackintosh for detailed comments on earlier versions of this paper.
2. Patent laws provide for compulsory licences, i.e. an authorization by the government to non-patentees to use the subject matter of a patent

without or against the consent of the patentee usually on payment of royalty.

3. This section draws heavily from a draft of Chaudhuri 2005: chapter 5.
4. World Health Organization (WHO), quoted in Lanjouw and Cockburn (2001: 270).
5. See WHO (1999: 37), for a reference to such views.
6. Twelve out of these fourteen companies spent Rs. 10 021 million (approximately US$220 million) on R&D during 2003–4 (7.73 per cent of their total turnover). See Table 5.2 of Chaudhuri 2005.
7. See Table 5.3 of Chaudhuri 2005.
8. See Dr Reddy's Laboratories Ltd, Annual Report, 2001–2.
9. For example, Torrent has entered into an agreement with Novartis for the development of its AGE breaker compound (www.torrent-india.com).
10. See 'Indian Pharma Sector: Manual of Risks for Growth Opportunities', Industry Report, Salomon Smith Barney, September 2002.
11. Dr Reddy's Laboratories Ltd, Annual Report, 2001–2.
12. See Glenmark Pharmaceuticals Ltd, Annual Report, 2001–2, p. 22.
13. See Table 5.3 of Chaudhuri 2005.
14. See company website: www.glenmarkpharma.com.
15. For USV Ltd, for example, export share increased from 16.8 per cent in 2001–2 to 24.7 per cent in 2002–3 (see its Annual Report, 2002–3).
16. As of 30 September 2003, sixty-seven Indian companies filed 383 DMFs for bulk drugs and intermediates. In this table we have listed the twenty-four companies each of which individually have more than four DMFs and together have 311 DMFS, i.e. over 80 per cent of the total. The figures within brackets are the number of dosage form/route and strength.
17. Source of data: as in Table 10.2.
18. Computed from the Electronic Orange Book accessible at the US FDA website (http://www.fda.gov/cder/ob/default.htm).
19. See Chaudhuri (2003). GlaxoSmithKline's largest selling drug, Paxil (active ingredient: paroxetine hydrochloride) with global sales in 2001 of $2.67 billion, for example, has twenty-two patents, of which the earliest expires on 29 December 2006 and the latest on 13 October 2019.
20. See Chaudhuri (2003). For fourteen out of the twenty-seven top selling drugs for which NCE patents have expired during 2000–2, generic versions were not available by mid-2003 in the US.
21. When an ANDA is filed, the application must contain a certification with respect to the patents held by the innovator company and listed with FDA. A Paragraph IV certification states that the patent is invalid or will not be infringed by the generic drug for which the ANDA applicant seeks approval.
22. Ranbaxy has filed, up to 31 December 2002, twenty-four Para IV ANDAs. They are the first one to file in nine of these ANDAs. Hence, if successful, they will get 180-day exclusivity for these nine products (see the

company website: www.ranbaxy.com). Out of the fourteen ANDAs filed by Dr Reddy's in 2002–3, ten are Para IV applications. It has eight first-to-file Para IV applications pending with the US FDA (see Dr Reddy's Laboratories Ltd, Presentation at Bear Stearns Healthcare Conference, 8 September 2003 (www. drreddys.com).

23. Dr Reddy's Laboratories Ltd, Annual Report, 2001–2.
24. 'US Federal Circuit vacates injunction against Ranbaxy Laboratories in patent infringement matter', in www.wptn.com.
25. As Scherer and Watal (2002: 915) point out, compulsory licences can be also be granted under Article 40 of TRIPS in case of an adverse impact on competition in the relevant market.
26. The special declaration adopted by the WTO Ministerial Conference in November 2001 at Doha on issues related to TRIPS and public health.
27. See, for example, the presentation of David Earnshaw representing an MNC (SmithKlineBeecham) at the MSF/HAI/CPT Conference in Amsterdam, 26 November 1999.
28. Quoted in t'Hoen (2003: 56).
29. See Oxfam (2003: 27) for the argument that 'US government is pursuing this pro-patent agenda on behalf of its powerful pharmaceutical lobby, PhRMA' (p. 2).
30. Under Article 31(f) of TRIPS, production will have to be 'predominantly for the supply of the domestic market of the member authorizing such use', unless the compulsory licence were issued to remedy anti-competitive practices under Article 31(k).
31. For the 30 August decision, see Matthews (2004: 95–8); Correa (2003: 2–3); Velasquez (2003).

11

International Collaboration on Medical Device Regulation: Issues, Problems and Stakeholders

Christa Altenstetter[1]

11.1 Introduction

Commercialization of health care around the globe manifests itself in the liberalization of markets and global trade and health care reform measures, including competition and privatization, generating a shift in the balance of power away from the stewardship of the state to free markets. These transformations are especially important for medical devices which carry special risks when unregulated or inappropriately regulated. They may be wrongly classified, dumped on foreign markets where regulatory requirements may be lower, or can even be fraudulent products. The key issue for public health is whether recent trade in medical products, as well as the global and regional harmonization of product and diagnostic standards, have encouraged a widening gap between patients and providers. Conversely, has commercialization produced some tangible (if indirect) benefits to some patient groups and providers?

Two streams of research – the politics of regulation and the delivery of health care – are typically undertaken by different research communities with different disciplinary traditions (Baldwin *et al.* 1998: 38–9). Analysts interested in regulation tend to look at the relations between firms and regulators; those interested in the delivery to patients of health care and the use of medical devices look at the local provision of health care. However, in order to fully understand regulatory policy implementation, our analysis needs to be linked to global and regional developments.

Regulation raises complex issues which require highly specialized scientific and technological knowledge and skills that often surpass the capability of

national regulators. The pooling of resources, knowledge and expertise at the global and regional levels is seen as producing the most appropriate regulatory solutions based on the latest state-of-the-art medical technology in a host of different disciplines. While the pooling of resources has benefits, it also carries a heavy price. That price is dependence on the knowledge and expertise of a small number of industry scientists, clinical innovators, and regulatory affairs specialists of multinational companies with little accountability.

The US and the EU have the largest share of global trade, control the largest markets, and are the most important importers and exporters of these products. International and European standards are formulated and agreed upon by medical device experts from EU-based and US companies, national standards organizations, and representatives of national regulators. Understanding their approaches to regulation is thus of importance for the understanding of expected international developments in medical device regulation.

With the widening scope and potential of medical technology, the need for best practices and best available technologies in manufacturing, design controls and marketing is more urgent than ever before. Consequently, global and regional rules, principles and standards have grown quantitatively and qualitatively.

The chapter begins with an overview of the economic significance of medical technologies in the OECD countries and an overview of the medical device industry. This is followed by an analysis of the evolution of medical device regulation, comparing the EU regulatory regime with the global regulatory context, and discussing the implications from a public health perspective.

11.2 Medical devices and medical technology

These two terms are used for many different products and processes. For simplicity's sake, and because EU legal language gives preference to the term 'device', we follow the same usage. Medical devices are often confused with pharmaceuticals but reasoning by analogy can be misleading for three reasons.

First, unlike prescription drugs, medical devices come in different sizes, shapes and forms, are far more heterogeneous than prescription drugs, and undergo different mechanisms for innovation, clinical evaluation, access to markets, as well as clinical practice (Altenstetter 2003). The revolutionary pace of medical-technological innovations has necessitated the reassessment and sometimes reauthorization of drugs, medical devices and in vitro products,[2] which were previously approved for the market.

Second, unlike drugs and IVD-products, over 95 per cent of devices are incremental improvements over pre-existing products or medical and surgical procedures (Rozynski 2000). Only 5 per cent are genuinely innovations

and medical advances (about 4000 per year) which may result from an incrementally altered product as much as from the use of a device in a new medical-surgical procedure. Unlike pharmaceuticals and IVD products, the lifetime of a medical device for exploiting a patent is relatively short (except for medical equipment): three to five years as opposed to five to twenty years for pharmaceuticals. This difference in patenting time and in marketing procedures may explain why innovators of borderline products such as drug-device or device-biologics combination products prefer their product to be classified as medical device rather than as drug or biologics. The differences are considerable in terms of the number of trials, review time, user fees and additional documentation. However, in 2003, the Council of Ministers decided that combination products will no longer be subject to the medical device regime in the future. Instead, they will be reviewed under the EU pharmaceutical regime, with its centralized European and a decentralized national market approval procedure.

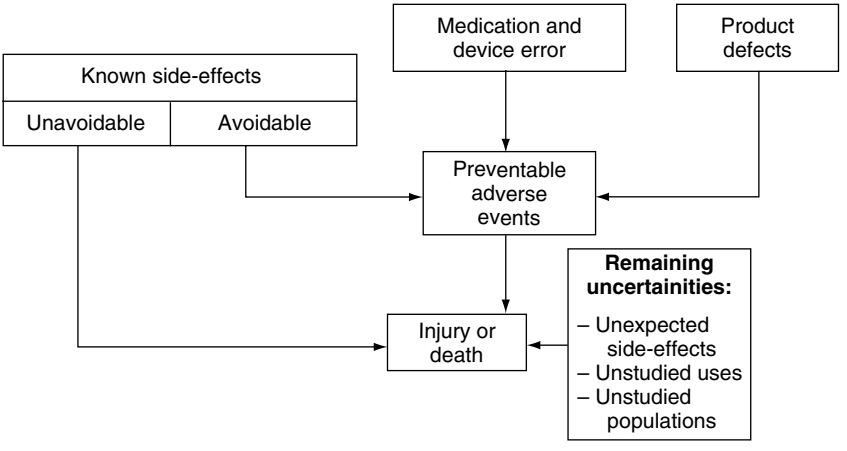
Third, the two regulatory regimes were established at different times. The pharmaceutical regime has evolved over three decades and is embedded in well-established global regulatory practices and protocols.

The institutional arrangements and regulatory mechanisms thus differ for medical devices and pharmaceuticals and involve a distinct group of stakeholders. However, the centrality of the health care system is undisputed. Both product types are unusual consumer products with a potential to harm humans and therefore justify stricter regulatory requirements than average consumer goods.

Why regulation matters

The purpose of regulating medical devices is not only to regulate products, companies and markets, but, above all, to reduce risks to health that arise from their use in clinical practice. While products can be safe, using them on patients may entail serious risks. For this reason, risk analysis and design controls are increasingly critical goals for companies and regulators everywhere.

In the context of commercialization, industry regulation is also important for the development of markets, assessment of cost-effectiveness, and providing patient protection. Standard setting needs thus to be seen also in the context of industrial and market-oriented strategies. Regulating for patient safety and regulating products for cross-border trade, access to new markets, and facilitating market dominance in high-, medium- and low-income countries, are controversial but must not be mutually exclusive. To reach compromises on the most effective technocratic solutions requires balancing the interests of patients and the financial sustainability of the health care system on the one hand and, on the other, the interests of an array of private sector interest groups, professionals and decision-makers who are loosely linked in fluid, overlapping and ever-changing networks of generalist and specialist players. The different stakeholders in this process have different



Source: Food and Drug Administration 1999.

Figure 11.1: Sources of risk from medical products

interests and priorities and their influence is contingent upon the governmental, economic, political and professional circumstances in each country.

There are five clusters of ideas and practices, concerning quality, safety, performance, clinical evaluation and clinical trials, that constitute the core agenda around which the global, regional and national regulatory discourse, decision-making, and conflict management over the prevention of risks take place. These clusters speak to very different activities and knowledge imperatives in quite different circumstances (Witkin 1998).

Knowledge of medical devices arises typically, but not exclusively, from the medical, natural science and bio-engineering side. In terms of power and influence, the privileged players in regulatory policy are regulators, medical technology industry representatives, scientists and clinical innovators abiding by the scientific rationality of their respective disciplines. In sum, all risks, irrespective of level or source, can lead to adverse events in clinical practice and may harm patients or, more importantly, may lead to injury or death (see Figure 11.1).

11.3 Patenting and intellectual property rights

In theory, patents are barriers to trade; in practice, they are instruments for market dominance and creating inequities as side-effects. Intellectual property rights (IPR) are part of a broader regulatory framework. Unlike pharmaceutical patents, the patenting of medical technology has received scant attention. This is striking in light of the contentious debate in the pharmaceutical sector and the rising costs of drugs resulting from patent protection.

There are two approaches. A lawyer might insist that existing patent law and trademarks fully apply to medical devices and IVD-products. S/he might argue further that the TRIPS agreement obliges all countries to respect each other's patents despite perverse effects. For example, exporters who may wish to export medical products to the US which were manufactured outside the US but patented there must pay patent royalties to the patent holders, overwhelmingly American and European firms and innovators. Applications for patenting medical products have been increasing in the EU over the last three years (Blatt fűr PMZ, 2001–3). Undoubtedly, the payment of royalties for patented medical technology is a hindrance to accessing innovative care in resource-poor countries.

The second approach emphasizes the importance of national patent laws in this context. It can be illustrated by a cursory look at EU patent law which distinguishes between patenting products and patenting medical-surgical procedures (Schulte 2001). While devices fall under EU patent law, and some (though not all) IVD-products under the EU pharmaceutical regime, medical treatments are not patentable (§5 PatG). Medicine comprises surgery, diagnosis and therapy and these should be protected against patenting. 'Illness must not be commercialized', states §5 PatG. A physician must not be restricted in his/her treatment decisions or diagnoses by patent considerations. By contrast, medical devices and procedures are said to be patentable in the US. According to the WTO TRIPS Agreement, governments can refuse to issue a patent for an invention if its commercial exploitation is prohibited for reasons of public order or morality. They can also exclude diagnostic, therapeutic and surgical methods, plants and animals (other than micro-organizations), and biological processes for the product of plants or animals (other than microbiological processes) (www.wto.org/English/thewto-e/what is-e-tif-e-utw-ch.2-e.pdf, accessed 8 July 2004, p. 41).

One frequently asked question is whether the advantages for innovators of patent protection generate pressures for regulating and classifying medical devices as pharmaceuticals. Keeping in mind the heterogeneous nature of medical devices and the fact that many are obsolete within a few years, reasoning by comparison about patenting issues may be indefinite. The evidence at hand is ambivalent. Patent protection and fast access to the market is a balancing act between two competing objectives.

In the last decade, medical technology manufacturers have preferred the EU medical device regime over the FDA counterpart. There is also, however, contrary evidence. First, the FDA recently has relaxed its procedure for medical devices. Second, the preferences of innovators of drug-delivery systems (for example, insulin pumps or asthma inhalers) for medical device regulation have been replaced by the preferences of national regulators through an EU Council decision to treat all borderline products and combination products as drugs. Although not addressed in this chapter, the situation for

tissue engineered products is similar, and they will come under the pharmaceutical regime. Whether efforts to bring therapeutic and surgical procedures onto the patenting agenda is a good thing remains an open question. Certainly such initiatives will find supporters and strong opponents. Given the flexibility of international trade agreements in public health matters, much will depend on the position national policy-makers will adopt.

Health care reform and global harmonization

Two developments impact upon the industry and trade in medical devices. The first crossroads involves the political and institutional transformations under way in the relation of global to regional (especially EU) to domestic regulation. The imperatives of adapting to international and European norms, rules and standards, and the pressures of global harmonization and international competitiveness are well known (Egan 2002: 40–109).

The second crossroads is domestic health care reform. The cost of medical devices has attracted the attention of payers of health care, buyers of medical services, budget cutters in the treasuries, and cost reformers who promote health technology assessment and evidence-based medicine as a cost containment remedy. The actual proportion of public spending on medical devices in the world is hard to pin down. Even OECD data on health care expenditure, which are the best available, provide only a general impression of the proportion of the total health care budget represented by expenditure on medical technologies (Table 11.1). They do not begin to deconstruct public and private spending on medical technology in meaningful ways. Except for a few countries, public spending figures for medical devices are suspiciously low (Eucomed 2000: 28).

The medical device industry

Interest representation in the political arena counts in domestic, transnational and international politics but until recently has been highly segmented. Compared to the power of the pharmaceutical industry, the medical device industry has had limited influence and low political status in most countries, except for the national champions. Over time, the industry slowly overcame segmentation and fragmentation for purposes of interest representation and mediation in the European Union (Altenstetter 1998a, 1998b) and in the US (Duesterberg *et al*. 1994; Bartlett Foote 1992). Collective action of the European and US industry was effectively and successfully co-ordinated and supported by the European Commission, which has energetically promoted product innovation and cutting edge biomedical and technological research to increase the competitiveness of the European industry in the global market (Steg and Thumm 2001). It has a strategic interest in restoring and maintaining the international visibility of European leaders in scientific medicine, biomaterials and biocompatibility and has promoted computer and information technology, including telemedicine.

Table 11.1: Total health care expenditure (THE) and expenditure on medical technologies (EMT) in %

Country	*THE % GDP*	*EMT % THE*
Austria	8.0	7.8
Belgium	8.6	5.2
Denmark	8.3	4.6
France	9.4	7.2
Germany	10.3	7.2
Hungary	6.8	11.1
Italy	8.2	6.0
Netherlands	8.7	8.8
Norway	9.4	7.7
Portugal	7.7	7.8
Slovakia	6.5	7.1
Spain	7.0	8.1
Sweden	7.9	10.5
Switzerland	10.4	4.4
UK	6.8	4.2
USA	12.9	6.4

Note: Total Health Expenditure = total personal expenditure on health + total expenditure on collective services + investment into medical facilities. OECD data on THE may deviate from nationally reported figures, due to differing national definitions. Data adapted by OECD to allow cross-country comparisons.
Source: Eucomed 2000.

The industry is made up of different segments. Multinational corporations have three outlets for exercising pressure and political influence through direct access to regulatory authorities and political decision-makers; membership in trade associations that matter domestically; and in regional and global negotiations. In contrast, small and medium-sized firms, 90–95 per cent of the industry, rely on national trade associations which are members of European (con)federations. Under pressure from domestic health care reforms, as well as fierce international competition for new markets, the US AdvaMed and the European Eucomed have joined forces. Continued success in lobbying and successful requests for hearings is secured by membership in the respective European trade associations and by a permanent presence in Brussels of multinational corporations, including US companies, which small and medium-sized enterprises cannot afford. All leading US corporations are on board.

The world market for medical devices

Medical products, whether authorized for the market in the EU, Japan and the US, or manufactured locally, are sold on all markets around the globe and used in clinical practice.

Table 11.2: World market by region

Americas	56.6% (41.5%US)
Western Europe	21.7%
Eastern Europe	2.6%
Asia/Pacific	16.8%
Middle East/North Africa	1.9%
Africa	0.5%

Source: EBI 2003: 28, data reproduced with permission.

The world market is broken down by region as shown in (Table 11.2).[3] The US, EU and Japan manufacture the bulk of medical devices, invest in R&D, and conduct clinical evaluations and trials. In the European Union, a few countries dominate the export business, led by Germany and followed by Ireland, Italy and the United Kingdom. However, dependence on export business varies: UK (20 per cent of domestic production), Germany (17 per cent) and Ireland (35 per cent).

Medical devices are used in the high- and medium-income countries more than in the low-income countries. Moreover, their use is greater in the old European Union of the fifteen than in the ten new EU member states. Information about medical devices is scarce, crude and highly commercialized, and often absorbed in statistical categories reporting on the pharmaceutical and chemical sectors.[4] Yet the links between wealth, resources and affordability are obvious. The higher the income, the more the countries can afford.

Table 11.3 shows an array of products used in patient care on a daily basis around the world. Half the world's trade in medical devices involves medical equipment. The potential for internationalizing and globalizing risks to health is as serious as for heavy machinery. For example, surgical and medical instruments, heart and hip transplants, breast implants, and diagnostic products raise far more salient regulatory issues than machinery, with dire consequences for life and death, and profits are considerable.

The manufacture of medical products does not generate high numbers of jobs. The industry is relatively small, with more than 15 000 manufacturers employing over 600 000 highly skilled and specialized workers worldwide who command higher than average salaries. About 5000 manufacturers are located in European countries employing around 351 000 persons, with another 350 000 in the US (Eucomed, 2001: 4). The bulk of manufacturers are US companies. Without drawing a distinction between producer groups, fifteen multinational manufacturers are in the world league (Table 11.4).

The industry is highly sectorized and fragmented. Producers are subdivided into four sectors: electro-medical devices and equipment; non-electrical products; implantables; and diagnostic products. Despite a frenzy of takeovers and mergers in the late 1990s, the structural profile of the industry has

Table 11.3: World market by type of device

Device	*Percentage of total market*	
Bandages & other medical supplies	8.4	
Medical X-ray film	2.6	
Rubber surgical gloves	2.6	
Medical, surgical or laboratory sterilizers	0.4	
Wheelchairs	0.9	
Contact lenses	2.6	
Medical equipment	49.4	
Electro-medical		10.7
Syringes, needles & catheters		12.4
Dental instruments & appliances		2.2
Ophthalmic instruments and		1.7
Other instruments and appliances		22.4
Therapy apparatus		4.4
Orthopedic/prosthetic goods		16.8
X-ray apparatus		10.8
Medical furniture		1.3

Source: EBI 2003: 29, data reproduced with permission.

Table 11.4: Industry leaders

1. Johnson & Johnson (USA)
2. General Electrics (USA)
3. Baxter International (USA)
4. Tyco International (USA)
5. Siemens (Germany)
6. Medtronic (USA)
7. Fresenius (Germany)
8. Philips (NL)
9. Becton Dickinson (USA)
10. Abbott Laboratories (USA)
11. 3M (USA)
12. Guidant (USA)
13. Boston Scientific (USA)
14. Gambro (Sweden)
15. Stryker (USA)

Source: EBI 2003: 11. Data reproduced with permission.

remained stable: the industry is dominated by multinational companies operating globally, while 90–95 per cent of all firms are small and medium-sized. The electro-medical equipment sector has long been dominated by Hewlett Packard, Toshiba, Siemens, Philips and GE-Thompson. In the implant sector, Boston Scientific, Guidant and Medtronic supply most implants in the

world and seven or eight global companies control 75–80 per cent of the world market in in vitro diagnostic products. About eight to ten US and European corporations provide a vast spectrum of highly diverse products.

Finally, a new industry, the home health care industry, is a fast-growing industrial sector comprised of a few of the industry leaders mentioned above, among others, selling to regional or national markets. This, too, is characterized by high product segmentation; products range from infusion therapy and home monitoring, to telemedicine and home dialysis, to diabetes management and respiratory devices.

11.4 EU regulation and medical devices

EU regulation of medical devices has been shaped by three separate but mutually reinforcing developments. First is the internationalization and globalization of production, technology and trade. Second, by accepting the historic project of creating a single European market in 1985, the member states have accepted the delegation of regulatory functions to the EU. However, member states retain full authority over implementation. Third, the European Court of Justice has legitimized a new regulatory strategy that allows addressing non-tariff barriers; this is particularly consequential in the social model of health care prevailing in the old EU fifteen member states, but much less in the new EU ten member states.

Historically and cross-nationally, the regulation of medical devices was the responsibility of public health authorities of nation-states. At the EU level pharmaceuticals were regulated prior to the creation of the single European market in 1985 and extended thereafter (Permanand 2002) prior to its overhaul in 2003 (Mossialos *et al*. 2004). By contrast, medical device regulation, which now covers IVD-devices, is entirely embedded in the creation of the single European market and is centrally connected with market building rather than market correction. The EU case study can thus be seen also in the context of regulatory needs of market building and its relationship to health and safety concerns.

The EU regulatory regime for medical devices is complete but continuously evolving along the fundamentals set in place by single market legislation, the *new approach* to technical harmonization. The first EU-level regulatory measure specific to medical devices was a directive passed in 1990 on heart transplants (AIMD, 90/385/EEC), the second medical devices directive more generally was adopted in 1993 (93/42/EEC), and by 1998 the third adopted directive included all diagnostic products and laboratory systems (98/79/EC). In addition, between 1998 and 2003 a series of amendments were adopted that further raised health and safety standards moving up technical and diagnostic standards (Kent and Faulkner 2002).

The essence of EU medical device regulation is compliance with essential requirements and standards (Cutler 1999a) as the basis for assessing

safety and performance and the issuance of the CE-mark. By contrast, the US model relies on a comparison with currently satisfactory devices as a basis for safety and effectiveness. Unlike the FDA, which retains full control over market approval, the EU approach relies on private organizations – firms, so-called notified bodies and providers – for implementation while domestic public authorities retain oversight functions as a national competency. Public regulatory functions are not privatized and deregulated; yet these functions are separated from health care services functions and organized outside the traditional Ministry of Health, assigned to a quasi-public regulatory agency. In 2002, this process was followed by the UK when medical devices were merged with pharmaceuticals into the new Medicinal and Healthcare Product Regulatory Agency.

In Europe, the regulatory agencies of the 'big three' (France, Germany and the UK) are central players and strong competitors for approving devices and diagnostic products for access to the market. They, like their counterparts in other countries, monitor the EU-mandated medical vigilance system designed to monitor unexpected failures and adverse incidents involving medical devices. They can recall medical products from the market, and monitor the safety of human subjects in clinical investigations. Finally, they can audit and inspect manufacturing and health sites. However, in monitoring and enforcing compliance they depend on the co-operation of other players, which is not always forthcoming. State capacities for enforcement and implementation are very uneven and have become more uneven with enlargement. While advocates of regulation push for rules, statutes and procedures, it takes more to turn regulatory goals into effective practice. It takes knowledge, manpower capacities and financial means to monitor post-market surveillance, which are not always available, even in rich countries.

Of major concern for transition countries are the missing operational capabilities to implement rules and enforce medical vigilance. For the CEE countries after enlargement the key issue is this: how extensively and effectively can they monitor risks, adverse effects and events given their limited resources? The new members face a major challenge in creating national capacities while adapting to the EU regulatory regime, a novel situation in that prior to joining the EU, none of them differentiated between a certification body and a competent authority. In some countries, medical devices were regulated separately from pharmaceuticals; in others they were regulated as part of pharmaceutical regulation (Van Gruting 1994).

In the multilevel governance system of the EU governance is divided between competence of the member states and the Union (Table 11.5). This has resulted in a situation in which politically sensitive health and safety issues must be approved by the Council of Ministers and by the European Parliament while regulatory details are worked out by experts from national offices, academia and multinational companies under the umbrella of 'comitology' (shorthand for national bureaucratic influence, lack of transparency and accountability of industry, academic and bureaucratic experts).

Table 11.5: EU power sharing arrangements regarding medical devices

Policy issues within EU jurisdiction	*Policy issues within sole member state jurisdiction*
• Trade	• Health care
• Commerce	• Health and safety
• International competitiveness	• Professional and lay users
• AIMD, MDD, IVD	• Coverage
• Blood safety and other directives	• Pricing
• Pharmaceutical regime	• Reimbursement
• Data Protection Directive (95/46/EEC)	• Clinical investigation/evaluation
• Cross-border health care	• Laws on labelling
• Professional mobility	• Medical institutions & health facilities
• Requirements on instructions for use/leaflets	• Post-market controls & surveillance
• Packaging requirements	• Distribution
• Advertisements	• Installation
• EU product licensing through the CE mark	• Vigilance
• Conformity with standards	• Notification/registration for market access
• Patent protection	• Unregulated medical devices
• Parallel trade	
• Wholesale distribution	
• Other potentially applicable EU directives*:	
• Biocidal products	
• Dangerous substances and preparations	
• Electromagnetic compatability	
• General product safety	
• Low voltage	
• Medicinal products	
• Packaging and packaging waste	
• Personal protective equipment	
• Electric and electronic equipment waste, etc.	

Source: Pieced together by author.
* *Source*: L. Morisset, Medpass, Paris, 2003.

A similar characterization fits the process of standard-setting by the European standardization organizations, CEN and CENELEC. A separate research effort is required to discern who is representing whom in committees convened by the Commission or by CEN or CENELEC, and who from which multinational company serves on which of the numerous working groups dealing with issue-specific matters.

Although the single market legislation was adopted as a package, in the early 1990s a major disagreement flared up concerning about 10 per cent of

medium-risk and high-risk devices. France, with the support of the UK, was able to introduce tougher requirements for evaluation and efficacy of medical devices on clinical outcomes. Political changes can further strengthen public health interests. When Sweden, Finland and Austria joined, the power relationships were redrawn in the Medical Device Expert Group (MDEG) and the pendulum swung in favour of public health. Public health concerns were strengthened in the Treaty of Amsterdam.

Finally, in spite of the EU regulatory measures towards a single market on medical devices, there is no functioning single market in medical devices. This is mostly because conditions for selling, purchasing and using medical devices and IVD-products in European and CEE health care systems differ considerably. Medical devices reimbursement takes four forms:

- Product reimbursement (Fr, Be, Ge, Italy, Spain)
- Physician reimbursement (Fr, Be, Ge, NL)
- Surgical intervention reimbursement (Fr, Be, Ge)
- DRG-like total reimbursement package (Ge, Italy, US)

Each payment type has influence on the medical device market and affects sales volume, market growth and profits. Considerable price differentials and differences in value added tax (VAT) on medical devices exist across the member states. The institutionalization of a regulatory regime on medical devices in the European Union has been a long, drawn-out process over the past decade and is still intimately linked to global harmonization although it remains a distinct regional regime. It was also an exercise in trial and error; learning from the first two directives and from overseas regulators and then, later on, incorporating tougher regulatory requirements.

Developing regulatory requirements can be described as a 'race to the top' while implementation of those requirements qualifies as a 'race to the bottom'. Strong national legal and administrative traditions persist in each member state as well as strong traditions as to how to manage capitalism, government and corporate relationships. Despite the dramatic changes at the international and EU levels, in almost all countries path-dependent regulatory mechanisms remain strong and shielded from major changes in the governance of public affairs.

11.5 The 'global approach': universal safety and quality standards

The industry prefers a single regulatory window, which ideally would use universal norms of safety and quality standards for patient care. These norms would be supplemented by safety, quality and performance standards of medical products secured through the entire lifetime of a medical product. In practice only a few universal norms and standards are available (for example, the building blocks of ISO 9001 and 9002 series as amended) and the 'global dossier' on technical documents.

Why are international or regional regulatory solutions necessary, desirable and beneficial? The approval of an allegedly improved new silicon breast implant by the FDA in October 2003 is welcome. In contrast, the long-term effects can only be proven in twenty or thirty years. Stents are, but should not be, sold when the damage to patients is greater than the benefits. US-manufactured and CE-marked implants are sold in Europe and elsewhere but have not always had FDA approval. Non-CE-marked devices are also traded. The interested public should have access to information on what medical devices have been approved by which regional regulatory regime, and made available on which markets, and which potentially harmful or counterfeit products are available.

If global harmonization were about optimizing knowledge through epistemic communities (Haas 1992) to discover 'best manufacturing practices' and 'best medical practices', using 'best available technology' and 'best materials', patients and policy analysts would have nothing to be concerned about. If global harmonization incorporated 'learning', 'pooling resources and knowledge', 'exchanging information', 'transparency' and 'accountability', there would be even less to be concerned about. What gets into the 'global dossier', however, is a result of a struggle for commercial and professional dominance and trade and profits. Global networks of industry representatives and coalitions of national regulators compete for influence in realizing their own vision of scientific and diagnostic criteria and standards.

Global Harmonization Task Force (GHTF)

In response to trade liberalization since the early 1990s, national regulators from the advanced industrialized countries have worked together through GHTF, a voluntary consortium of regulators and industry representatives (www.ghtf.org). The consortium aims to achieve global harmonization by reducing differences among regulatory systems.

GHTF is composed of a small circle of key players, up to four from medical device regulatory authorities and up to four trade associations (nominated by the most influential multinational companies in specific product sectors). The original impetus for GHTF is said to have come from two US trade associations, the Advanced Technology Association (AdvaMed, previously HIMA) and the National Electrical Manufacturers Association (NEMA). In the late 1980s and early 1990s they began to bring together specialists from around the world. The formal request for the formation of the GHTF came from the FDA (Higson 1997). GHTF mirrors a pattern of geographic representation set by the original founding members: Europe, the US, Canada, Australia and Japan. Each of the three major geographic areas was entitled to eight seats, with observers and advisers from the founding members.

Is GHTF for medical devices the functional equivalent of the International Pharmaceutical Manufacturers Association (IFPMA), which under pressure from WHO established its own codes of conduct and ethics? This is difficult

to say. During the 1990s until 2000 the medical device industry met in tandem with GHTF. Thereafter, due to various events beyond the control of the industry (9/11, the Iraq war, SARS), all scheduled meetings were cancelled. The industry has found new forms of communication through e-mail and e-commerce.

GHTF is a relative newcomer to the international standards system. It is playing an important role and bases much of its work on existing ISO and IEC standards and regulatory practices in the EU and the US. GHFT's activities are clearer, more transparent and more accessible than they were in the early 1990s, ending a rather obscure, highly Byzantine style of decision-making (Higson 1997). GHTF's chair and four Study Groups (SGs) rotate among the national regulatory authorities of the three geographic areas. The term of office extends to three years or the time period covering two GHTF conferences, whichever is longest.

ISO, CEN/CENELEC and WHO have observer status at the meetings of GHTF. Representatives from South Korea, China, Brazil, Argentina, Cuba, Poland, and later Israel and Switzerland attended the meetings of the SGs as observers, in addition to the representatives of the founding members. The representation of WHO through the Division of Drug, Management and Policies mirrors a legacy of treating medical devices largely as pharmaceuticals. However, the absence of a WHO representative in meetings of the SGs (including SG 2 on Medical Devices Vigilance) is striking.

Beyond GHTF, international collaboration has gone through the signing of bilateral mutual recognition agreements (MRAs) and the development of ISO standards for testing, certification and labelling. An industry insider remarked: 'there is … a confusion of documents …' from the three regulatory regions (Cutler 1999b: 2–3).

MRAs are binding legal instruments and impose rights and obligations on the signatories. The EU has signed medical device MRAs with the US, Canada, Australia and New Zealand, Israel, Japan and Switzerland. Each MRA was negotiated separately and differs from the others in substance and rules. Except for the US and Japanese regulatory regimes, the other countries are closer to the EU approach than to the FDA.

For a good part of the 1990s, the EU and the FDA made little progress towards resolving their differences. The FDA criticized several features of the EU system: (1) the delegation of regulatory authority to notified bodies outside a public regulatory agency; (2) the sloppy oversight of aftersales responsibilities; (3) the payment of fees for the CE-mark compared to the use of general tax revenues in the US (until 2003, when Congress mandated a user charge to be levied on manufacturers); (4) disagreement concerning the classification of medical devices by risks, notably high-risk products in the US, and more stringent requirements for clinical investigations as a precondition for market approval in the US. A final controversy concerned the length of time for market approval (three years) in the US as compared

to roughly eighteen months in the EU. Clearly, US firms favored the EU approach over that of the FDA. Differences continue to exist.

The EU response was supported by a shift of opinion within ministries of health and industry in some EU member states. In turn, the US modernized the role and responsibilities of the FDA (Chai 2000: 60). Restructuring is ongoing. Recently, the two sides have moved closer to each other. The EU has up-classified some products (for example, breast, knee and hip implants) and single-use devices into the high-risk class. In turn, the US has down-classified some devices. Confidence-building processes between the EU and the US began and several Certification Assessment Bodies (CABs) were appointed to certify devices for sale in the US and in EU markets.

11.6 Conclusion

Global regulatory harmonization is a minimalist solution from a public health perspective. The industry's intent to maintain a share of already existing markets and gain access to new markets under a single regulatory window is the key to regulatory integration of the medical device sector, as well as other health care sectors such as the pharmaceutical and biotechnology industries.

Which international and regional forum is most important for international collaboration on medical devices? Does a tacit tripartite division of labour exist between the WTO TBT (the most important arena for the negotiation of international agreements on barriers to trade), GHTF (for technical issues) and WHO (as credible leader for public health)? This is one scenario. Another derives from EU experience. One of the reasons it took more than seven years before public health and patient safety concerns were fully discussed in the EU has to do with the composition of the national delegations to the negotiations about the single market, the *new approach*, and the formulation of sectoral rules governing medical devices at the highest political level, the Council of Ministers. With few exceptions, the negotiators were diplomats and representatives of the ministries in charge of trade, the economy or industry. The absence of the ministry of health in the initial stages of negotiations is striking but systemic. Public health concerns emerged much later in sectoral negotiations lower down the hierarchy.

The institutionalization of a global regulatory regime is a fantasy. A model regime for an effective regulatory programme is available for the international community (Eccleston 2001). However, the model stresses the importance of formal, that is, legal, aspects of regulation and downplays the informal influences, rules and behaviour, often more important in the respective countries than formal frameworks. In the global context, it would be important to keep track of the differences in regulatory stringencies among the three regional regulatory regimes. Despite efforts at convergence of global rules and regulatory instruments, there is no convergence of

regional rules and instruments, nor is there convergence in national implementation. On the contrary, the variations in practices and activities across the member states are many and significant and may increase in the future.

The lesson from the Global Harmonization Task Force is clear. Once the issues are framed as trade first and public health issues second, it is difficult to reverse provisions harmful to patients and users but exclusively beneficial to trade. What can and should be done to strike a balance between trade and public health interests in the delegations to international and regional negotiations? Unmistakably, public health interests must be present from the beginning to avoid the probability that international agreements will only work for shareholders to the detriment of patients.

Notes

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2. The 1998 IVD directive covers any medical device which is a (i) reagent, reagent product, (ii) calibrator, control material, or test kit, and (iii) instrument, apparatus, equipment, or system whether used alone or in combination, intended by the manufacturer for use in laboratory medicine. All single-use devices such as self-test devices for a pregnancy test or urine test are also included.
3. Data in Tables 11.2–11.4 reproduced with permission of Espicom Inc, 116 Village Blvd, Suite 2000, Princeton Forrestal Village, Princeton, NJ 088640-5799, USA.
4. The most comprehensive market report is *World Medical Market Report 2003*, which draws on a variety of commercial and non-commercial sources such as the African Development Bank (www.afdb.org); Asian Development Bank (www.adb.org); International Monetary Fund (www.imf.org); and PC-TAS trade data, published by the International Trade Centre; UNCTAD/WTO, United Nations Statistics (www.un.org). Among non-commercial data sources are OECD Health Data (www.sourceoecd.org), the Pan American Health Organization (www.paho.org) and WHO's World Health Statistics (www.who.org).

12
Restructuring Global Health Policy-Making: the Role of Global Public–Private Partnerships

Eeva Ollila[1]

12.1 Introduction

The last two decades have seen major shifts in global health policy-making, in terms of actors and agendas and in underlying broader policies and ideologies. First there was a shift from the UN agencies towards financial institutions, then increased influence of private interests in the UN system, and finally global legally independent entities were constructed as public–private partnerships and became important health policy-makers at the global level and at developing country national level.

This change can be seen as a reverticalization of health policy-making, including the founding of new organizations for each health issue. It has also meant substantial change in the content of health policy rhetoric, shifting the emphasis from holistic policies based on universal social rights to policies that emphasize results-based interventions aiming at maximizing health gains and ultimately gains in the productiveness of populations. Faith in technologies and technological development as solutions for global health and development problems re-emerged. The new international health policy actors, the legally independent global health-related public–private partnerships (GHPPPs) reconstruct global and national health policy-making to include industry and other private sector actors at all levels of public health policy-making, with a consequent blurring of the roles and interests of the public and the business actors.

This chapter briefly describes the evolution of global health policy-making and then examines the GHPPPs and their implications. It draws conclusions about the effects of increased private sector involvement in policy-making

on the content of the policies and on the role of the public and private sectors.

12.2 International health policy, from 'Health for All' to commercialization and selective technology driven interventions

International agencies influence strongly the scope and nature of developing countries' health policies and systems through drafting policies and interventions at the global and national levels. In the 1970s the two major global health actors were the World Health Organization (WHO) and United Nations Children's Fund (UNICEF). The Health for All by the Year 2000 Declaration had the broad ideal of social justice and equality as its point of departure. Health was defined broadly as important in its own right. Gross health inequalities were socially and politically unacceptable and economic and social development, based on a New International Economic Order, was important. Health for All arose from the realization that in the absence of sustainable horizontal health systems, vertical approaches to prevent or treat individual diseases failed (Koivusalo and Ollila 1997; WHO and UNICEF 1978). However, implementation stalled, partly because of continued emphasis in development aid policies on selective targeted measures (Ollila and Koivusalo 2002). The predominance of vertical programmes continued in the 1980s.

Starting from the 1980s the World Bank became by the mid-1990s the major global actor in health sector policies, emphasizing health sector reforms and private sector and non-governmental actors in two key *World Development Reports* (World Bank 1987, 1993). Aspects of health care reforms such as decentralization and user charges have been part of conditionalities for loans in the context of structural adjustment programmes (see also Chapters 3 and 4). The Bank's influence on commercialization has been mediated through its work on regulatory reform, user cost-sharing and promotion of private practice, partnerships and private provision of services. This has in some fields and countries been complemented by the International Finance Corporation's promotion of private investments in health.

The WHO picked up much of the World Bank thinking, most notably under the directorship of Gro Harlem Brundtland. In her era, the organization shifted towards a more private sector focus in analysis of the responsiveness of health systems and emphasis on 'strategic purchasing', as part of the contested *World Health Report 2000* on health systems (Ollila and Koivusalo 2002). Increased corporation influence was also seen in some of WHO's norm- and standard-setting activities (Kopp 2000; Utting 2000), in the emphasis on supporting intellectual property rights in public statements, as well as in the work of the Commission on Macroeconomics and Health (CMH) (Brundtland 1998, 2001; CMH 2001; Motchane 2002).

Similarly, corporate influence has increased in the whole UN (Ollila 2003; Richter 2003a, 2003b; Zammit 2003). UNICEF, having earlier emphasized the role of the citizens in fund collection, has increasingly emphasized corporate sponsorship and traded its name and logo to companies like McDonald's and Coca Cola for fundraising assistance. The United Nations Population Fund (UNFPA) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) have also increased their attention to corporate sponsorship and collaboration. Examining the interactions between the UN agencies and the corporations at the turn of the millennium, it is clear that the atmosphere changed from a more cautious approach to one emphasizing the importance and desirability of collaboration with the private sector, often at the expense of good health policies (Ollila 2003; Richter 2003a, 2003b).

International health policy interventions by the United States, and to a large extent other rich countries, are mostly driven by perceptions of their own interests: the threats of disease and economic and trade interests. From about the 1970s population growth in developing countries was seen as a major threat to the industrialized world. With the International Conference on Population and Development (ICPD) in 1994, the approach to birth control changed (at least in rhetoric) to one emphasizing reproductive health (Ollila *et al*. 2000). Since the mid-1990s the arguments for greater US involvement in global health have increasingly been expressed in terms of national interests or enlightened self-interest. In 1996, emerging infectious diseases and HIV/AIDS became defined as foreign policy issues and national security challenges of the United States rather than simply matters of foreign assistance (Kickbusch 2003).

By the end of the 1990s, HIV/AIDS gained its current emphasis as the leading development and health problem, which led to substantial global efforts and new structures to address it. The Joint United Nations Programme on HIV/AIDS (UNAIDS) was founded in the mid-1990s. In 2000, HIV/AIDS became the first health-related theme to be discussed by the Security Council in its history; the G77, the G8 and the World Economic Forum discussed health, including HIV/AIDS, tuberculosis and malaria. The United Nation's General Assembly held a Special Session on HIV/AIDS in June 2001. The Global Fund to Fight AIDS, tuberculosis and malaria (GFATM) was founded in 2001.

The Millennium Development Goals (MDGs), agreed by international agencies, including UN agencies, the World Bank, the IMF and the OECD, and subsequently recognized by the General Assembly as part of the road map for implementing the substantially broader Millennium Declaration,[2] have become a tool to steer and redirect global-level development work. Three are health-focused: namely to reduce child mortality, improve maternal health, and combat HIV/AIDS, malaria and other diseases. The eighth goal is to develop global partnerships for development, including developing an open trading and financial system, rule-based and non-discriminatory,

and in co-operation with the private sector to provide access to affordable medicines and to the benefits of new technologies.

The MDGs steer UN agencies towards a narrower agenda with more emphasis on selective interventions and country presence. The UN-led Millennium Project is forcing the whole UN system to revise its work programme to address the MDGs, and to report to the Secretary General on their achievements (Horton 2002). For health policies, this has meant, for example, pressures from some member states, such as the UK, for the WHO to refocus its work on, notably, the goal regarding HIV/AIDS, malaria and tuberculosis, while its wider mandate as the normative health organization that sets standards and promotes the building of health systems, would be ignored (DFID 2002; Horton 2002).

This selective emphasis was further iterated by the economist-dominated Commission on Macroeconomics and Health (CMH), led by Jeffrey Sachs (subsequently leader of the Millennium Project). It recommended focusing development aid for health and developing country public funds on communicable diseases, on malnutrition that exacerbates infections in children, and on reproductive health, using selective cost-effective interventions in which technologies would play a major role. The CMH strongly endorsed public–private partnerships (PPPs), including private sector incentives for research and development and no challenge to intellectual property rights. Non-communicable diseases, the majority of the disease burden even in most developing countries outside sub-Saharan Africa (WHO 2002), would be left without both public sector resources, whether originating from external or domestic sources.

Development aid to health has continued to grow substantially since 1992 despite the fall in total official development assistance (ODA) since that time (OECD 2000). The health problems that have been identified as global priorities by donors and various international forums – infectious disease control, sexually transmitted disease control including HIV/AIDS, reproductive health care and family planning – have received a major share of global development aid funding (OECD 2000; Yach *et al*. 2004). Recognizing that national priorities often differ from global priorities and that single-country ODA is often used to address global issues, it has been suggested that conditionalities or 'joint' teams may be used to ensure that bilateral aid programmes help to address global priorities (Stansfield *et al*. 2002). Currently USAID's funding for global health focuses almost entirely on the above priorities (USAID 2004). The Global Health Programme of the BMGF has become a very significant funder of development aid for health. According to the BMGF, its grants focus on innovative solutions, including discovery, product development and research trials of new products, while recurrent costs or chronic conditions are not financed. Together with USAID, the Bill and Melinda Gates Foundation (BMGF) is the single most important financer of GHPPPs, while GHPPPs and other partnership arrangements comprise a significant proportion of total development funding for health.

12.3 Global health-related public–private partnerships

Partnerships between public and private actors are promoted as an innovative tool for fund-raising, policy-making and implementation. In health, PPPs have become immensely influential in shaping health policies, their priorities, content and mode of action. At the global level, PPPs are situated both within the UN system (Buse and Walt 2000a, 2000b; Zammit 2003; Tesner with Kell 2000) and outside. While the term 'partnership' is used loosely to describe any type of interaction, according to a UN Secretary-General's report (UN 2003) partnerships are commonly defined as voluntary and collaborative relationships between state and non-state participants who agree to work together to achieve a common purpose or undertake a specific task, and to share risks, responsibilities, resources, competencies and benefits.

This chapter examines the global public–private partnerships that have been established as legally independent bodies outside the UN system to deal with health-related issues: global health-related public–private partnerships (GHPPPs). The focus is not on the projects GHPPPs fund but on their founding premises, their structure and their implications for global health policy-making including equity and sustainability. The GHPPPs focus on technological solutions for central public health issues. The first, Global Alliance for Vaccines and Immunization (GAVI), was launched at the 2000 World Economic Forum meeting in Davos, with a substantial contribution from the BMGF. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) followed in 2001, and the Global Alliance for Improved Nutrition (GAIN) was announced at the UN Special Session on Children in 2002. GFATM and GAIN used GAVI as a model for their structure. The following discussion concentrates on GAVI and GFATM (better documented than GAIN).

Integrating business into health policy-making

The GHPPPs were founded on the premise that the private sector is an integral part of public health policy-making at all levels. Therefore the corporations have voting representatives on the boards as well as in other major working bodies. Board membership is divided between representatives of bilateral donors, developing countries, private industry, NGOs, multilateral agencies including UN agencies, and other possible constituencies depending on the GHPPP.

The GHPPPs expect private sector involvement also in national policy-making, through a national-level co-ordinating body involving public and private sectors. This body prepares the funding proposal. In GFATM, the co-ordinating body is explicitly expected to include representatives of private business and three-quarters of the Country Co-ordinating Mechanisms submitting proposals have done so (GFATM 2004). GAIN's 'Request for Proposal

Guidelines' suggests that the National Food Fortification Alliances should include, among others, the food industry as well as public regulatory institutions for food quality and safety, and also those who implement pertinent policy and tax reforms (GAIN 2004). For its country-level inter-agency collaborating committee, ICC, GAVI does not explicitly expect private industry participation.

The UN agencies have been marginalized from global health policy-making on these central public health matters, while retaining various servicing roles. In GAVI, WHO, UNICEF and the World Bank have voting seats on the board, but in GFATM, WHO, UNAIDS and the World Bank have non-voting seats, while in GAIN only one UN or one other multilateral agency representative has a seat on the board. The GHPPPs stress the independence from the UN system, yet their secretariats are hosted by UN agencies[3] so GHPPP staff have UN privileges. The UN agencies provide substantial technical assistance to the GHPPPs, and are sometimes paid by GHPPPs for performing administrative tasks.

Management of conflicts of interests in GHPPPs has generally been poor or non-existent. Initially, written conflict of interest policies did not exist for the decision-making bodies in GFATM or GAVI, although GAVI had one for its technical body dealing with individual applications. A GFATM official interviewed in 2002 identified no need for a conflict of interest policy. The official argued that the corporation representatives were sitting in their personal capacity only. However, the amended GFATM by-laws from October 2003 (GFATM 2003) clearly state that board members serve as representatives of their constituencies. The official also expressed concern that raising conflict of interest issues might 'alienate' the industry. More recently GFATM has established a conflict of interest policy, yet in a 2003 interview all examples given of problems with conflict of interest focused on public sector multiple roles at country level. No problem was seen still in having the pharmaceutical industry in the working group preparing procurement policy, despite pharmaceutical industry vested interests in the policy and more specifically the continuing debate between generic and patented products.

The GHPPPs have been put into the international health policy arena with high expectations of substantial new funding for global health problems, notably from the private sector. To date, the BMGF has been an essential funder for both GAVI and GAIN. Other private money has been scarce. GFATM and GAVI have set (unofficial or official) preconditions for board membership in terms of minimum in-cash contributions for some members or member coalitions. The unofficial amounts for industrial country representatives of their constituencies have been US$70 million for GFATM, with discussions about raising the sum to US$120–130 million.[4] GAVI has a 'board member due', a fee of US$300 000 for all industrial country-based constituencies (including industry and foundations).[5]

Both GAVI and GFATM accept contribution in-kind from the industry. According to a private sector briefing paper for GFATM, the potential for in-cash contributions from the corporate sector is limited, while in-kind contributions could offer more scope.[6] A subsequent information sheet for corporations,[7] stresses in-kind opportunities to contribute, such as donation of health technologies, and co-branding campaigns that would provide a financial opportunity for corporations partly through discounted advertising rates. With these arrangements, there is an obvious risk of steering countries to choose a particular company's product against its own judgement of the best pharmaceuticals or vaccines for the purpose, thus affecting national prevention, treatment and care protocols. These strings tied to aid are likely to increase the costs of the programmes in the short[8] and especially longer term. The Global Fund has also encouraged transnational companies to apply for money from the Global Fund to expand their HIV/AIDS prevention and treatment programmes in the communities where they operate.[9]

The GHPPPs offer an attractive opportunity for corporations to increase their influence in public affairs, enhance their image and market their products. The industry is provided the opportunity to decide over public policy-making and the use of public money, with minimal or no financial contribution and with opportunities to tie the programmes to its own products. This raises problems in terms of democratic decision-making, rational use of public resources and conflict of interest.

Targeted approaches and problems of sustainability

The GHPPP framework is more conducive to vertical, technology-intensive interventions than, for example, multi-sectoral development strategies. Emphasis on innovations and innovative approaches encourages the use of new technologies and the building of new structures. The relative focus on new technologies may, of course, also result from the interests of the corporations producing these technologies in new markets accompanied by secured funding.

GHPPPs stress performance-based management of funds and more business management-oriented mechanisms for action. GAVI and GFATM aim to implement performance-based monitoring and incentive systems, but construction of workable practices has been difficult. GFATM has put substantial emphasis on monitoring the use of the funds and has recruited 'Local Fund Agents' (LFAs), organizations hired by the Secretariat to assess the principal recipients' capacity to administer funds and provide ongoing oversight and verification of reported data on financial and programmatic progress. The LFAs have been hired through a global tender, and the winners of the tenders have been multinational companies.

A need to demonstrate efficiency may lead to less than optimal choices in policies and their implementation, and to problems of sustainability

and equity. Yamey (2002) has called the GHPPPs' imperative for demonstrable quick results, rather than building up wider systems, 'picking the low hanging fruits'. The requirement of technical efficiency has also been conducive to directing donations to targets which have a high absorptive capacity and to which expensive solutions are applicable. This may disadvantage the poorest countries and regions, and also more wide-ranging solutions whose implementation takes more time and fewer funds (Hardon 2000; Starling *et al*. 2001). The BMGF contribution to GAVI is primarily targeted to financing the procurement of new technologies and only countries with at least 50 per cent basic vaccine coverage are eligible for such funding. (GAVI 1999, 2000)

A record of good banking efficiency may be facilitated by the disbursement of large grants. According to a GFATM official (interviewed in 2003), GFATM has not discussed financing ceilings in terms of percentages of total national health budgets, nor the effects in terms of sustainability of the efforts in the long term; an amount as large as 30 per cent of a total national health budget has been granted. There has, however, been some discussion over 'floors': which amounts would be considered too small for its funding.

The high levels of funding of the GHPPPs, as well as their very aim to 'catalyse', 'spearhead' and 'innovate', directly threaten the sustainability of the GHPPPs themselves as funds and even more critically the results they achieve at the national level and the structures they create. The GHPPPs are reliant on the short-term commitments of their funders who have high interests regarding the policy directions taken in the GHPPPs. The sustainability of the results at the country level may be put at risk by the heavy reliance of the GHPPPs on new health technology, unaffordable by the developing countries themselves. Both GAVI and GFATM expected to limit their funding to a five-year period, after which new sources were expected to be found to cover the costs. It seems, however, that both have reconsidered this policy, and they may provide funding for a longer period. In the case of GAVI, the immunization programmes have become substantially more expensive with the addition of the new vaccines introduced (Brugha and Walt 2001). Currently, countries would be facing serious problems in financing the new immunization programmes without extended GAVI support.[10] In the case of GFATM, the problem is even more serious. Once the treatment for HIV/AIDS has been started, it should continue for a lifetime, as the disease itself cannot yet be cured. Interruption in the medications for the infectious diseases increases the risk of developing drug-resistant forms of the pathogens.

So far the GHPPPs have not paid adequate attention to strengthening health systems (Hardon 2000; Starling *et al*. 2001; Poore 2004). Poore (2004) has pointed out the obvious risk that well-funded projects can distort the more comprehensive provision of care, by attracting staff and other resources to the project area. This big flow of money through the GHPPPs can have a very negative impact on the sustainability of whole health systems. For

instance, the GFATM framework does mention training of personnel and community health workers, and GFATM has provided funding for educating health personnel to deal with HIV/AIDS but has so far not considered basic education of health personnel,[11] even though HIV/AIDS has had a devastating effect on the personnel as a whole. However, in Mozambique the GFATM will be providing funding to the sector-wide health budget. This is a pilot in one country only, but it may prove to be an important step in increasing country ownership and decreasing fragmentation of health systems at country level.

Substantial funding through the GHPPPs to national health budgets challenges the World Bank and IMF macroeconomic framework as regards to the size of the public health sector. In some countries, such as Uganda, it has been difficult for ministries of finance to approve such increases in health budgets, even from a source such as GFATM. There is also a risk that this increased flexibility in health spending will be reflected in reducing the budgets of other public social sectors. The CMH concluded that investment in the health sectors of developing countries should be increased to a level many times greater than today, a change requiring considerable outside funding (CMH 2001) The follow-up work of the CMH has facilitated discussions between the ministries of health and finance at the country level.

The fact that GHPPPs rely largely on the same sources of funding as other development aid increases the risk that in the longer term the GHPPP funding takes resources away from other development aid, especially from the social sectors. There is also a risk that GHPPP funding reduces funding through more traditional channels such as bilateral aid and aid through the UN system, and that even aid through these channels is mainstreamed to the same narrow priorities (see also Yach *et al*. 2004). The original aim of attracting new funding that would not otherwise be channelled to development aid has also become obscured by calculations estimating and asking for the 'assessed contributions' of each bilateral donor, presented by lobbying groups for GFATM.

PPPs as industry-friendly solutions to problems of access to expensive but essential medicinal products

The GHPPPs can be seen as industry-friendly answers to the debates that have arisen from the detrimental effects of strengthened patent rights on access to pharmaceutical products. The GHPPPs can be seen as an ideal funding mechanism for new technologies. The debates have shifted from prices of essential medicinal products to issues of fund-raising and larger questions of implementation of health interventions. Describing the construction of GAVI, Muraskin (2002) noted that the industry gave importance to this refocusing away from prices. While increases in volumes were considered necessary for the reduction of prices of new vaccines, increased demand combined with secure funding has made prices higher rather than lower.[12] Prices

of pharmaceuticals for HIV/AIDS treatment have fallen more substantially. These reductions are, however, more likely a result of debates on flexibility within trade-related intellectual property rights (TRIPS) and negotiations on tiered pricing than a result of increased volumes of production or the benevolence of the pharmaceutical companies (see also Smith 2004).

In the context of GHPPPs the protection of intellectual property rights has been a starting point (Muraskin 2002; CMH 2001; Koivusalo and Ollila 2001), and the emphasis has been on securing funding for products. Subsequently attention has also been paid to price reduction through mechanisms such as tiered-pricing. After vigorous debates in GFATM, it was concluded that generics were not excluded; rather, policies stress national and international law as well as the best prices. Nevertheless, the founding of GFATM can be largely seen in the context of perceived need to divert debates away from intellectual property rights and their implications towards access to essential medicines.

NGOs working in support of HIV-positive people campaigned for the availability of HIV medicines. The fundamental human rights of people who needed certain essential medicines were, it was argued, being violated, because a narrow interpretation of TRIPS made prices excessively high (Chapter 10). The NGOs' arguments for a broader interpretation of flexibilities under TRIPS and for an exception to patents in these cases, were supported by the actions of a number of countries such as Thailand, Brazil and South Africa, but vigorously objected to by others including the US. These protests against patents were, of course, in conflict with the interests of firms that produce patented medicines. There were also pressures within the UN system to tackle the catastrophic dimensions of the HIV/AIDS situation. The founding of GFATM seems to solve many of these conflicts, but it may have also served to weaken the pressures for applying broad TRIPS flexibilities.

The PPPs are also portrayed as a way of increasing public financing for research and development (R&D) on diseases of the poor. The CMH recommended public financing of basic research, and private financing of applications R&D, accompanied by patent protection for the applications and pre-commitments by the public sector to purchase the targeted technologies. To establish research priorities jointly with industry, CMH (2001) recommended the establishment of a Global Fund for Health Research, which would itself be a PPP. This approach can be seen as a continuation of the 'global public goods' debates, which started from the premise that the market provides the most effective incentive for producing private goods, but recognized the need for public goods with effects spreading beyond individual buyers (Kaul *et al*. 1999): in the sphere of health these are traditionally identified as control of communicable diseases (Chen *et al*. 1999). The GHPPPs are seen as a mechanism to fund the development of new technologies largely unaffordable at current prices in the developing countries. So far GHPPPs'

contribution on R&D has been limited and it has concentrated on providing funding for buying technologies that otherwise would be too expensive for the developing countries.

Partnerships are defined by a common purpose and sharing of the benefits and the risks by all parties (UN 2003). However, in practice PPPs are often structured so that the public sector absorbs the lion's share of the risk and costs, while the private sector absorbs a disproportionate share of the profit (Stansfield *et al*. 2002). Indeed, the role of the private sector has in some cases been to do product development based on basic research done by the public sector with a public sector commitment to building the delivery infrastructure, conducting the intervention research, diminishing the regulatory barriers and paying for the product (Stansfield *et al*. 2002; see also UNFPA 1999). Furthermore, the sustainability of the national programmes and structures, and ultimately the public, may be put at risk by disproportionately high volumes of money given for limited time periods for expensive technologies that either use new delivery channels or crowd-out the existing ones.

GHPPPs as tools in restructuring global health policy-making

The GHPPPs have increased global funding for a number of important health problems. Increased attention to HIV, malaria and tuberculosis in sub-Saharan Africa is long overdue and welcome. At the same time, they undermine the UN, weaken the role of the public sector in norm- and standard-setting at all levels, and ignore the importance of strengthening of health systems as a whole as well as many other pressing health problems.

GHPPPs are nevertheless only one kind of player in the restructuring of global health policy-making. Their existence reflects a shift in general policy paradigm towards a neoliberal agenda rooted in commercialization, as well as a tool to enhance such policy. The GHPPPs reflect the aims and goals of their partners, including bilateral donors and corporate actors who often largely share the same vision. There have, however, been many heated debates over policy decisions such as those concerning the role of generic drugs in GFATM, reminding us that the content of these endeavours is by no means totally determined by their structure, but also by the individuals who are actively participating in shaping the policies and approaches.

The side-tracking of the UN from policy-making on essential public health issues now run by the GHPPPs did not happen accidentally. GHPPPs have been seen as a way to get distance from the UN, which is governed by its member states and has had limitations on its involvement with the private sector. The cautious approach of the WHO to integrating private industry into its activities has been reported to be one of the main reasons for GAVI's construction as an independent legal body. Problems were encountered, for example, when issues of intellectual property rights arose and were dealt

with by the WHO legal advisers (Muraskin 2002). According to Phillips, the US opposed the running of GFATM by either the UN or the World Bank. The US also demanded that the fund be set up as a worldwide aid-delivery system instead of relying on established agencies, such as the UN and the World Bank (Phillips 2002). The private sector has not only been perceived as more effective, but according to Stansfield *et al*. (2002: 16) it has even postulated that the 'private sector has the comparative advantage of being less constrained only to nation-identities and interests', and 'might report to a truly global constituency', while multilateral agencies were said to remain accountable only to nation-states (Stansfield *et al*. 2002).

GHPPPs provide an ideal opportunity for venture philanthropy, a form of charity investment. While getting valuable public relations credit for their charity investments, private investors can also deduct these investments from their taxes. Typically, investors demand seats on the decision-making bodies, and business-like management, including performance goals and exit strategies (Richter 2004; Piore 2002).

From the perspective of ensuring public interests, inclusion of companies with vested interests in bodies which make public policy and set priorities for the use of public money constitutes a structural conflict of interest. This poses important questions about global democratic decision-making, due process, and undue industry influence in public affairs (Richter 2004). Why is this not seen as a problem in GHPPPs? Is it because the objective of GHPPPs is not primarily to look after the public interest but to reconcile private and public interests in 'a common purpose'? Among the 'equal partners with common interests', the interest of private industry in furthering its aims when pursuing policies, strategies and other decisions that could affect its business is seen as just as legitimate as the public sector's interest in furthering public aims. Conflict of interest policies focus on eliminating possible individual gains, while failing to address institutional conflict of interest issues. The public and the private sector certainly do have common interests. But it should be a matter of particular concern that global health policy should not turn into trade and industry policy as a result of seeing health policies from the perspective of multinational companies in health technology industry, health services and management services.

12.4 Conclusions

The content of health policies in developing countries is being narrowed to those aspects of ill-health in the developing world that have been defined as threats for the industrialized countries: the same priorities that have also emerged in the MDGs, the CMH and in the framework of global public goods. There have been demands that both bilateral development aid (CMH 2001; Stansfield *et al*. 2002) and also public developing country funds for health (CMH 2001) should all be steered towards these same priorities.

While these strategies do reflect important health problems, especially in Southern Africa, they exclude the majority of health problems of most developing countries (Yach *et al*. 2004). Even though development aid policies emphasize rhetorically national priority setting over aid policies and sectoral policies, the globally set health priorities seem to override national ones.

The GHPPPs tend to propose industry-friendly solutions for the contentious issue of patent rights and the high prices for medicinal products. The conflict over the patent protection of essential medicinal products is often perceived as a conflict between the North and South. However, it is primarily a conflict between private and public interests, and between trade and industry policies on the one hand and health and development policies on the other. The pharmaceutical and health technology costs in Northern health care are rising considerably faster than other health care costs (OECD 2003). While the benefits of new products are in many cases at best marginal, the rising cost of pharmaceuticals threatens the sustainability of health care financing in the North too. Meanwhile the pharmaceutical industry remains among the most profitable industrial sectors in the world (Light and Lexchin 2004; see also Chapter 10). In the debates around health technology research in the context of PPPs, it has been stressed that the public sector should increase its funding for basic research that leads to development of medicinal products, for the infrastructure needed for the product implementation, and for securing funding for the patented products.

In the globalizing world, rules are increasingly being made from the perspective of business and trade policies, with emphasis on competition, rather than from the perspective of well-being and health (Koivusalo 1999). Utting (2000) has noted that increased business involvement in policy-making risks reducing the use of regulation and norm-setting in policy-making while emphasizing weaker voluntary mechanisms. The various PPP arrangements serve to weaken public sector capacity to regulate and set norms and standards at global and national levels.

Since the Alma Ata Declaration 1978, health has travelled from a social right to become mainly an expenditure, a perquisite for prosperity, and an attractive market in terms of technologies, and health, management and consultancy services. The ways in which the programmes and projects are managed provide a fruitful soil for corporations and business-oriented NGOs. We may have entered into an era of a new international economic order, but not quite the same one that was postulated in the Health for All strategy.

Notes

1. Judith Richter provided information and insights on public–private partnerships, as well as useful detailed comments on earlier versions. With Meri Koivusalo I have worked on global health policy issues, and I owe Meri much for insights on the linkages between health policy and industrial and trade policies. Outi Hakkarainen researched sources of and targets

for development aid. Maureen Mackintosh provided important comments on the draft and improved the text substantially with her editing. My thanks to all of them. However, the responsibility for the final product rests solely on me.

2. United Nations Millennium Declaration (A/RES/55/2).
3. The GAVI is hosted by UNICEF, GFATM by WHO and GAIN by UNDP.
4. Interview with a GFATM civil servant in 2003.
5. GAVI workplan 2004–5, p. vii, GAVI board meeting, 13 December 2003; and Annex 6, GAVI Secretariat: progress, plans, income, expenditures and budget for 2001–2, GAVI board meeting, 19 November 2000, both available from GAVI website, http://www.vaccinealliance.org/, form under board documentation.
6. Private sector delegation briefing paper for the board, mobilizing corporate sector resources, 21 May 2003, confidential draft, fifth board meeting, document number GF/B5/18, online at http://www.theglobalfund.org/.
7. The Global Fund to Fight AIDS, Tuberculosis and Malaria. Opportunities for Partnerships with Corporations. January 2004. Downloadable from the Global Fund's web site www.theglobalfund.org.
8. For the short-term consequences, see for example, Health Action International. HAI to the Global Fund, 'Say no to medicines donations', A position statement, July 2003, online at http://www.haiweb.org/.
9. 'Nine Major Companies Commit to Co-Investment to Expand Community HIV/AIDS Programs Using Corporate Infrastructure', Global Fund press release, 3 December 2003.
10. Proposal for Bridge Financing, GAVI board meeting, 6–7 July 2004, available from http://www.vaccinealliance.org/.
11. Interview with a GFATM official in 2003.
12. Proposal for Bridge Financing, GAVI board meeting, 6–7 July 2004, available from http://www.vaccinealliance.org/.

13

International Migration of Health Care Staff: Extent and Policy Responses, with Illustrations from Ghana

Kwadwo Mensah

13.1 Introduction: economic motivations and migration

> '... the government should not waste time and effort trying to get us to return but concentrate on improving conditions for those remaining at home so that they stay'. (Young Ghanaian doctor now working in the USA)[1]

International health care staff migration, and appropriate global and local policy responses, are major topics of international health policy debate (Stilwell *et al*. 2004; WHO 2004a, 2004b; Buchan and Sochalski 2004). The research literature on migration focuses strongly on economic motivations of both migrant and employer, as well as the costs to low income countries of origin, while being largely silent on the role of broader health services commercialization and trade in driving health professionals' migration (Wibulpolprasert *et al*. 2004). This chapter examines health care staff migration from a mainly developing country perspective, drawing examples from Ghana, a country which has lost a high proportion of its doctors and nurses and in which there is active debate about local and international response (Sagoe 2001; Ghana Health Service 2002).

Cross-border migration, as evidenced by multicultural societies globally, dates back centuries. Documentation of migration is, however, relatively recent. In the US, for example, accurate recording of immigrants started in

1820 and by 1950 had recorded 39 325 000 immigrants (Thompson 1957), the largest movement of immigrants into any country known at that time. Economic motives have been generally dominant, although not of equal importance in all movements. 'Economic migration' is often characterized as the movement of people 'from countries where there is a labour surplus to countries where there is a labour shortage' (Nayyar 2000: 8); the implication is that migration responds to opportunities for profit and output (by employers) and employment (for uncoerced migrants).

Viewed from this perspective, international economic migration on a large scale began with the obnoxious slave trade in the mid-sixteenth century, when fifteen million people were forcibly moved from Africa to Europe, North America and the Caribbean to work in households and plantations (Nayyar 2000) until its abolition in 1833 (British Empire) and 1865 (USA). Economic depression reduces migration: large-scale international migration ended temporarily between the two world wars in response to mass unemployment in Europe and North America, blocked by passport controls and opposition by labour interests. Post-1945, people moved in large numbers towards employment opportunities; the 1970s and 1980s saw a slowdown and rising immigration controls; latterly, migration rates are rising and skilled professionals are being actively recruited (Nayyar 2000; Stilwell *et al*. 2004).

Nayyar (2000) classified five modes of migration, all rooted in but not limited to economic needs and pressures: *emigrants* (who move to a country to settle permanently); *refugees* (who leave their homes because of famine, ethnic strife, civil war or political persecution to seek a home or asylum in other countries); *guest workers* (who move on a temporary basis for a specified purpose and limited duration); *illegal immigrants* (who enter a country without a visa, take up employment on a tourist visa or simply stay on after their visa has expired); and *professionals* (with high levels of education, experience and qualifications who typically face less restrictive immigration laws). These distinctions are neither mutually exclusive nor exhaustive and the status of an individual may change after some time.

Skilled emigration from developing countries has mixed economic effects. It can stimulate economic growth through return migrants bringing back skills and work experience from abroad, and through remittances from those who remain abroad. Indeed 'brain exchanges' between countries characterize all advanced economies. However, it can also undermine economic development: Eastern Europe's economic growth, for example, was slowed by skilled emigration during the 1990s (Wong and Yip 1999; Straubhaar and Wolburg 1997–8, cited in Lowell and Findlay 2001).

Migration of health professionals

Migration of skilled health workers from developing to developed countries fits the general pattern of rising professional migration, but this 'brain

drain' has very specific costs to patients and health systems. Concern over the impact of health worker migration on the health systems and economies of poor countries was expressed as long ago as 1965 at the Edinburgh Commonwealth Medical Conference (Martineau *et al*. 2002). In Africa alone, where health needs and problems are greatest, around 23 000 qualified academic professionals are estimated to emigrate annually. Information from South African medical schools suggests that a third to a half of their graduates migrate to the developed world (Pang *et al*. 2002). The crisis of health service staffing in Africa is large and growing (Liese *et al*. 2003), and the Director General of WHO, Dr Lee Jong-wook, acknowledged that 'the brain drain from Africa is severely limiting the ability of health workers to combat the HIV/AIDS epidemic and achieve any substantial progress towards the millennium development goals'.[2]

Yet this emigration has recently been driven by large-scale, targeted international recruitment by developed countries to address domestic health staff shortages. For example, in Ghana, agents from the industrialized countries, especially the UK, US and Canada, use very attractive reward packages and aggressive strategies to poach nurses, to the extent that some health workers are issued with work permits by recruiting agents when they have not even applied for work in the host country (Sagoe 2001). As the consequences of the health professional brain drain on developing countries are appreciated, the ethics of policies which allow richer countries to recruit from poorer countries at no cost or penalty to themselves are now being questioned (Martineau *et al*. 2002).

This chapter examines two aspects of this global policy issue: the sources and motives for migration, and local and global policy responses. It argues that policy needs to grasp the implication of the interaction between commercialization of both health systems and labour markets, and migration patterns; to recognize that coercive measures do not work; and to look for positive measures to tackle the deterioration of health care in low-income countries that it creates.

13.2 Why health professionals migrate

Wage and salary differentials

Differences in wage levels and employment opportunities between source and receiving countries, and perceived differences in income and the quality of life, are the main reasons for economic migration (Dovlo 1999; Nayyar 2000). An opinion survey in early 2002 of 1119 foreign nurses who were UK Royal College of Nursing (RCN) members found that 'more than half intended to stay in the UK on a long-term basis, citing pay and professional development as the two most preferred aspects of working in the UK' (Buchan 2002b). Table 13.1 highlights the low salary levels for doctors in many African countries.

Table 13.1: Average monthly salary for junior doctors in US$ equivalent, 1999

Sierra Leone	*Ghana*	*Zambia*	*Lesotho*	*Namibia*	*South Africa*
$50	$199	$200	$1058	$1161	$1242

Source: Dovlo 1999.

When compared with their counterparts in developed countries, the difference is startling. For example an anaesthesiologist in the USA would earn $18 000–20 000 a month (Upadhyay 2003). The picture is similar for nurses. In the Ghana Health Service, the average monthly salary of a professional nurse rages between US$50 and US$95 depending on grade (Sagoe 2001). This situation has led to increasing agitation for adequate compensation for work overload. There were five national nursing strikes in Ghana between January 2000 and October 2001. The fallout from all this is the migration of doctors and nurses to seek 'greener pastures'.[3]

While pay and conditions in the UK act as 'pull' factors for many developing country nurses, they appear not to be adequate to retain UK nurses (WHO 2003a) who are moving abroad mainly to Ireland, Canada and Australia for more attractive reward packages (Buchan 2002b). Similarly, the NHS (UK) is losing 15 per cent of its doctors by three years after graduation, rising to 18–20 per cent after 10–20 years (Goldacre *et al*. 2001). The main migration direction remains from developing to developed countries.

Other professional influences on migration

The dissatisfaction of government-employed professional medical workers is well documented internationally. In the late 1970s and early 1990s some African countries including Ghana, Uganda, Zambia and Tanzania had to accommodate IMF/World Bank pressures for market-based reform programmes which often resulted in deterioration in working and living conditions and led to migration of health workers (and workers in other sectors). Hardill and Macdonald (2002) found that in the UK it was particularly stress, hours worked and disillusionment with the NHS rather than remuneration that caused nurses to leave. Martineau *et al*. (2002) observed that in some countries, people who have lived or worked abroad are more respected, and that this alone might drive people to migrate.

In Ghana, the documented pressures on nurses include overwork, in part from non-nursing duties such as revenue collection, accounting, and running errands to the laboratory and pharmacy (Sagoe 2001). There is also much resentment of insensitive administrative behaviour; for example staff who acquire higher academic qualifications are not rewarded through promotion or compensation (MOH 2002). It can take twelve months or more between appointment and payment of the first salary, and frustrations around recruitment procedures often cause departure (GHS 2002).

Table 13.2: Reasons given by Ghanaian doctors for migration

Women	*Men*
To specialize (6)	To specialize (9)
Disillusioned (1)	To obtain better salary (6)
No job satisfaction (1)	Poor working conditions (3)
Poor working conditions (1)	No job satisfaction (1)
Influence of relatives abroad (1)	
For better salary (1)	

Source: Mensah 2004.

Ghana's pay system does not recognize workload variations nor compensate unfavourable work locations (Dovlo and Nyonator 1999). Finally, there is inefficient allocation of resources: Ghana's Ministry of Health headquarters spends about 40 per cent of the national recurrent health budget, two teaching hospitals spend 25 per cent, while the 84 district hospitals and 500 health centres and clinics share the remaining 35 per cent (Sagoe 2001), resulting in poor working conditions in these institutions.

Interviews in 2003 with Ghanaian doctors about reasons for wanting to migrate illustrate this mix of factors, including the importance of career progression (see Table 13.2).

The World Health Organization has noted (WHO 2003a) that there is still a lack of qualitative policy-relevant evidence on why individual migrants depart. The destination country of a migrant appears to be influenced not only by financial gain but also by the linkage between the two countries (for example, migration from Ghana to Britain is shaped by post-colonial ties), and 'by geographical proximity and accessibility, and by the existence of an immigrant community with the same language and culture' (Nayyar 2000).

Two studies of migration of Ghanaian doctors showed the UK and US to be their preferred destination. Dovlo and Nyonator (1999) found 90.3 per cent of doctors trained between 1985 and 1994 migrated to the UK and the US, while Mensah (2004) found 90.8 per cent trained between 1998 and 2002 did so. In the earlier period more went to the UK; in the later period the USA. Interviews with twenty doctors who intended to migrate from Ghana by the end of 2005 (Mensah 2004) also showed the UK and US as the preferred countries, with the US predominating; the main reasons given were better salary, better academic opportunities and better working conditions.

13.3 An integrating and expanding global labour market

Labour market integration and commercialization

The international labour market for health service staff is becoming more integrated. The Internet, easier international communication generally, and the rise

of commercial agencies organizing health care staff migration have all greatly increased access to information about means, costs and consequences of migration. Informed comparisons of wages and conditions and informed decisions on migration have become easier, notably for nurses.

In Ghana, migration by doctors to the UK and the US has long been an individualized, well-understood process of passing examinations (some of which for the US can be taken in Ghana) and visa application, though the real cost has risen over time. As a result, the rate of migration of Ghanaian doctors after qualification was already approaching 100 per cent in the 1970s (although many have returned) and remains equally high today, with the whole class that graduated in 2002 having left or planning to leave.[4]

For nurses, however, the migration process has changed greatly. Nurses have generally required a personal or an organizational intermediary in order to migrate. Nurse migrants to the US often get themselves to the US, then rely on support from a commercial agency while they take the required professional exams. Most Ghanaian-trained nurse migrants, however, headed for the UK in 2004, at least initially. Before the 1980s, all that the Ghanaian nurse had to do was to pay a fee and register with UKCC (now NMC) as the professional qualification for nurses in Ghana was accepted for registration; from the 1980s, a period of supervised practice (known as 'adaptation') was also required. Until the brain drain became a UK policy issue, the NMC supplied the Ghanaian nurse with a list of hospitals to which s/he could apply for supervised practice.

However, since the late 1990s the onus has been on the Ghanaian nurse to find the UK hospital willing to take her/him. This difficulty in finding a place for supervised practice has stimulated the setting up of private recruitment agencies in Ghana. The agents arrange for a work permit including the period of supervised practice, and assist with the visa application. The agents charged in 2004 between £2500 and £3500 which excludes accommodation, visa fees and air fare, and may loan part of the funds.[5]

The broad effect of the restrictions on hiring from low-income shortage countries ('ethical recruitment' policies) has thus been, in Ghana, to raise the cost of migration, and support a shift to commercial intermediaries. In some ways this has simplified the procedure for migrants by depersonalizing it. What it has *not* done is to slow out-migration.

This is in part because other commercial processes are contributing to the availability of the option to migrate. Total applications for nursing training are also rising, and the proportion of men is increasing. Better qualified applicants are going into nursing, seeing it explicitly as an investment in leaving the country.[6] A shift in the social composition of nurse trainees appears to be associated with a higher capacity to pay; loans are also now more easily available, and it is becoming easier to raise extra money, since there are now more opportunities to work for private health practitioners in formalized locum systems and via local agencies for nurses. Relatives

and partners abroad also support nurses to train and to join them. This facilitation of migration by the general commercialization of the health care system in Ghana echoes findings of Thai researchers about health professional migration from Thailand (Wibulpolprasert *et al*. 2004).

Finally, in other countries, and embryonically in Ghana, there has been private investment in nursing training to 'feed' the requirements of those aiming to migrate to work elsewhere. Some missions and private sector investors in Ghana have responded to demand by starting new nursing schools where students pay fees, but even this has not absorbed the excess demand.

Increasing migration: the scale of the problem

Controversy about migrating health workers is not new. Buchan (2002b) refers to a complaint by the executive secretary of the ICN in 1948 to the Chief Nurse in England concerning the recruitment of Dutch nurses to England. Although doctors and nurses currently constitute a small proportion of all migrating professionals, their loss for developing countries 'represents reduced capacity of the health system to deliver health care equitably' (WHO 2003a). Ultimately, unless governments in developing countries find innovative strategies to reverse the brain drain, the health systems in these countries could collapse from lack of human resources.

Rising migration is driven by an acute global shortage of nurses. Migration of nurses has been facilitated by nursing skills being 'portable' (Hardill and Macdonald 2000) so they can work almost anywhere regionally and internationally with minimal adaptation training. In rich countries shifts from acute to primary care, shorter hospital stays, and ageing populations, plus the effects of advanced technology on demand for nurses, have met a decrease in supply of nurses arising from wider career choices for women, an ageing nursing workforce, a poor image of the profession and reduction in student numbers (RCN 2002). An estimated 27 per cent of student nurses in the UK never complete the training (Hardill and Macdonald 2000). In Ghana 520 nurses are required annually, but intake into nursing schools has been only 375 annually due to budgetary constraints (MOH/HRDD 1999; Sagoe 2001).

It is difficult to estimate the exact extent of migration. There is no international system for recording skilled migration (Lowell and Findlay 2001) and this has contributed to difficulties in planning human resources for health (Dovlo and Nyonator 1999). In some countries migration data is very limited and categories are inconsistent (Martineau *et al*. 2002; WHO 2003a). In other countries migrants are no longer recorded as such when they change nationality to that of the host country (Vila 2002). Finally a comparison of data from the sending and receiving countries shows inconsistencies. Some receiving country records show higher immigration totals than departures

registered by the source countries (WHO 2003a). South Africa's emigration estimates, for example, are well below the totals from countries receiving their migrants (WHO 2003a).

However, it is known that migration is extensive, rising, and increasingly propping up health care in countries of destination. In 2002 over 5000 doctors trained in sub-Saharan African medical schools were working in the US (Hagopian *et al*. 2004). The numbers of internationally recruited nurses working in the UK has climbed fast since 1993; and about 42 000 were employed in 2002, apparently more than double the numbers three years before (Buchan 2004). In 2002/3 alone, of more than 12 000 non-EU nurses registering in the UK, 3199 were from sub-Saharan Africa, including 256 from Ghana.[7] One in four of all non-EU overseas nurses recruited was from a country identified by Department of Health as not to be targeted by NHS recruitment because of damaging shortage of skilled staff at home. Numbers of overseas doctors recruited are also rising.

One useful proxy indicator of Ghanaian nurse migration is verification requests. When Ghanaian nurses or midwives want to migrate, the employing country requires verification of their qualification by the Nurses and Midwives Council of Ghana; requests for verification thus reflect migration and intent to migrate. This is not an accurate measure, but verification attracts a relatively high fee so it is unlikely that nurses who have no intention to migrate would want to pay the fee. Table 13.3 shows an alarming increase in verification requests between 1999 and 2001.

Recent research suggests that 40 per cent of doctors graduating from the University of Ghana Medical School would have migrated by four years after graduation (Mensah 2004). This is consistent with the finding that 50 and 75 per cent of each batch of medical graduates emigrate in 4.5 and 9.5 years respectively (Dovlo and Nyonator 1999). Migration of both doctors and nurses has created severe shortages in many countries of origin, notably African countries such as Zimbabwe and Ghana which have absolute shortages of nurses and doctors. This contrasts with a few countries,

Table 13.3: Verification requests for qualifications of nurses and midwives

	1999			*2001*		
	Male	*Female*	*Total*	*Male*	*Female*	*Total*
Jan.–Mar.	8	68	76	21	194	215
Apr.–Jun.	11	64	75	24	158	182
July–Sept.	8	86	94	29	263	292
Oct.–Dec.	13	89	102	27	199	226
Total	**40**	**307**	**347**	**101**	**814**	**915**

Source: Compiled by author from data from the Nurses and Midwives Council of Ghana.

including the Philippines, which have long 'exported' some of their skilled health professionals (WHO 2003a). In Ghana nurses form the backbone of the health services, the ratio of doctors to professional nurses in 2001 being 1:13.5 (MOH 2002; Mensah 2002); thus migration of nurses has serious consequences at all levels of care and especially in rural areas (Mensah 2002).

There are data gaps (Dovlo and Nyonator 1999), but all indicators suggest that migration from Ghana is extensive and increasing; the result is declining staff numbers in the Ghana Health Service (the government sector that dominates delivery), low staff/patient ratios, and rising vacancies. Table 13.4 shows an overall drop in health staff numbers despite the output from medical and nursing schools. The increase in the midwives is less than the loss of 2309 nurses.

Costs of migration for health care in countries of origin

The costs of this type of staff shortage are very great in terms of health service provision. Recent fieldwork[8] found 40 per cent of a sample of districts with two Ghanaian doctors or fewer to serve the whole district population, and strong reliance on Cuban volunteer doctors. Professional nurses are simply not replaced. Some district hospitals at any one time are unable to do surgery at all. One hospital doctor, asked how many people were turned away because of inability to treat said, *'too many to recount'*.

A story from outside Ghana well illustrates the grim cumulative decline migration can trigger. The Centre for Spinal Injuries in Boxburg, South Africa was the referral centre for the whole region but was closed down in 2000 when a Canadian institution recruited the two anaesthetists at the centre (Martineau *et al*. 2002).

The brain drain thus deprives many developing countries of essential qualified personnel whose education and training were at considerable expense to their countries. In the 1980s, a wave of migration of Ghanaian doctors to the Middle East also severely depleted teaching capacity in medical and nursing schools, and this was partially restored at the expense of service delivery (Martineau *et al*. 2002). There is now again an acute shortage of medical and nursing academics.

Table 13.4: Staffing situation in the Ghana Health Service in 1999 and 2001

	Aux. nurse		*Prof. nurse*		**Midwife*		*Medical officer*	
	1999	*2001*	*1999*	*2001*	*1999*	*2001*	*1999*	*2001*
Total	**6388**	**4718**	**5168**	**4529**	**1257**	**1997**	**1115**	**828**
Change	16% drop		12% drop		29% increase		16% drop	

Source: Ghana Health Service 2002.

* In Ghana auxiliary or professional nurses go for additional training to become midwives.

One method of costing this brain drain is to calculate the cost of training lost to the country. One much-quoted estimate of the cost of training a doctor in a developing country is $60 000, implying that developing countries are subsidizing North America, Western Europe and South Asia an estimated $500 million annually in training costs of doctors alone (IOM 2003). With 600 South African medical graduates registered in New Zealand, the training cost saved by New Zealand was estimated at $37 m (Pang *et al*. 2002). UNCTAD has estimated a loss of US$184 000 for each migrating African professional (Pang *et al*. 2002), while it is estimated that Ghana has lost US$60 million in investment in the training of health professionals (Martineau *et al*. 2002). The foundation of these calculations is weak, but the implication that there is a large and growing perverse subsidy flowing from developing to developed countries in the form of training costs of essential medical staff appears correct. Furthermore training represents only a fraction of the real costs of out-migration in this context, which include the loss of a lifetime's provision of needed health care services to a predominantly low-income population.[9]

Abuse of migrant health workers versus benefits from migration

A number of reports in the UK cite abuse of migrant health workers by private sector employers, including poor accommodation, undervaluing of skills in terms of pay rates, misleading information about employment contracts, and payment of commissions to recruitment agencies, all of which have raised concerns at the UKCC (Buchan 2002b; RCN 2002). Health professionals face numerous hurdles in establishing whether qualifications are recognized, coping with lengthy procedures to gain employment, and working in jobs well below their levels of expertise. Migrants often face isolation and discrimination abroad, and the social costs for women migrants and their families can be particularly high (PSI 2004). The 'hidden' costs of migration are difficult to calculate in monetary terms, and include splitting families, with attendant social consequences, interference with children's education, and loss of earnings of those who provided various services for the migrants in the home country.

One motive for migration is the intention to send money home to help the family. Of twenty-four doctors and nurses interviewed who were planning to migrate, all intended to remit money to relations in Ghana (Mensah 2004). Remittances are an important source of foreign exchange, and the World Bank has suggested that developing countries might benefit from temporarily sending their health personnel abroad (World Bank 2001). According to the Bank (cited in Buchan and Sochalski 2004) remittances wired by migrant workers through the banking system alone totalled US$90 billion in 2003, up from some US$88 billion in 2002 and US$72.3 billion in 2001. The International Organization for Migration estimates that at least as much again

is remitted outside the banking system (Buchan and Sochalski 2004). There is a lack of evidence, however, about the remitting behaviour of the highly skilled; they are likely to travel with their families which may reduce the amount they remit (Lowell and Findlay 2001).

Critics argue that remittances are spent on consumption, do not improve local production or investment and also increase inequality. Furthermore, however important the general economic impact, little of the remittance income goes back into the local health service, to stem the effects of cumulative staff loss and decline as out-migration accelerates (WHO 2004).

13.4 Policy responses to migration of health workers

Policy responses to migration reflect the perspectives of the relevant actors – the source country, the recipient country or the migrating individual (Meija 1978; Mutizwa-Mangiza 1998; Castles 2000; WHO 2003a). The core policy problem is the conflict of interest between source and receiving countries each wanting the same health workers for better functioning health systems.

From the point of view of the migrating individual, denying individuals their rights to migrate purely on the grounds of profession and country of origin is unacceptable (Mejia 1978). It is discriminatory in creating two categories of people with unequal human rights. The RCN (UK) has policies based on this perspective, supporting nurses' rights to travel, and recommending that employers should consider all unsolicited applications to work in the UK from nurses trained abroad (RCN 2002). At the same time the RCN supports guidelines that ban NHS recruitment in low-income contexts where the health system damage is severe. It encourages employers to contact the professional nursing association in the source country for their views on whether large-scale, targeted recruitment would undermine local health care delivery. This dilemma is not the RCN's alone: there are serious conflicts of interest and principle here.

Government chief nurses and other delegates from sixty-six countries met in October 2001 to discuss how best to deal with the challenge of international nursing shortage (Buchan 2002a). The UK, US, Australia and Canada have sought to address the shortage through improving retention; recruiting ethnic minorities, mature and less qualified entrants into nursing; attracting returnees from the pool of former nurses; and importing nurses from other countries. The last option seems to be seen as the easiest (Buchan 2002b).

The policy dilemma is constantly debated internationally. The Durban Declaration (1997) recommended in part that:

- governments of countries experiencing damaging brain drain be encouraged to seek the reasons why and ensure at least a 'living wage' and adequate basic equipment for adequate medical services; and conversely

- governments and medical councils that rely on doctors from other countries be encouraged to consider the effects of their policies on the disadvantaged countries, and take appropriate action.

More recently, a World Health Assembly resolution in May 2004 (WHO 2004) called on WHO's 192 member states to manage the migration of health workers better in order to avoid damaging health services in poor countries.

The receiving countries

Having the upper hand, receiving countries can manipulate migration by imposing or removing barriers such as examinations and 'adaptation' (Martineau *et al*. 2002). In general, receiving country policies protect their own need to recruit, to get their health services to work. However, there have been attempts to restrict immigration from the countries most vulnerable to skill losses, enforcing the terms of fixed-term contracts, making recruitment agencies and employers more accountable for their behaviour, establishing best practices for the employment of foreign professionals, and facilitating return migration (Lowell and Findlay 2001).

The Department of Health (England) in November 1999 reacted to the brain drain by issuing guidelines to NHS employers to avoid direct recruitment from South Africa and the Caribbean. They did not cover non-NHS employers, and had very limited initial effect on recruitment. The Department recognized these limitations and in September 2001 introduced a new Code of Practice, requiring NHS employers to target only developing countries whose governments formally agreed. In the same breath, however, the code made it clear that international recruitment should continue as a sound legitimate contribution to the NHS workforce; part of a broader opening to speedier access to work permits especially by skilled migrants (Migration Watch UK 2002).

In the US, hospitals hire about 5000 foreign medical graduates yearly to fill first-year residency positions while simultaneously US medical schools reject thousands of well-qualified US applicants (Martineau *et al*. 2002). Cynical as is seems, some receiving countries take such a stand because they benefit by savings on training and education of health professionals (Martineau *et al*. 2002).

The source countries and the Ghanaian policy debate

Low income source countries are generally the losers. Vacancy levels in the public health sector range between 7.6 per cent for doctors in Lesotho and 72.9 per cent for specialists in Ghana (Dovlo 1999), threatening health outcomes (Mutizwa-Mangiza 1998). Policies tried in a number of developing countries include efforts to stimulate more involvement, knowledge transfer, remittances and investment by their nationals abroad ('diaspora'

options); strengthening local educational institutions in an effort to encourage people to stay (Lowell and Findlay 2001); and conversely bonding health workers to try to force them to stay a given number of years.

In some countries, migration and health system collapse is low on the policy agenda. Nigeria claimed it could afford to pay its medical professors $50 a month while spending $1 million a day to fight in Sierra Leone – an amount that could pay sixteen professors 5000 dollars a month (100 times the current salary) for one year to entice them to stay (Emeagwali 2002). Conversely, some countries have successfully invested resources in effecting a 'brain gain' by attracting back medical professionals. Thailand, for example, has a reverse brain drain programme offering generous research funding, monetary incentives, services and assistance.

The Ghana government, too, has tried a mix of pressure and incentives, with little effect to date. The medical and nursing school intake has been increased but raising enrolment is expensive and slow (MOH 2002). The Ministry of Health planned in 2004 to collaborate with the Ministry of Education to further increase training of doctors and pharmacists, and to raise training of nurses and auxiliaries by about 50 per cent. Tutor recruitment poses a problem, however, for planned new Nurses' Training Colleges and Community Health Nurses' Training Schools. There is, of course, no guarantee the new trainees will stay.

Hence, more punitive approaches have been tried, too. A proposal to require payment of full cost medical school fees was dropped before implementation as it might have reinforced income disparities and reduced medical school intake (Dovlo and Nyonator 1999; MOH/HRDD 1999). Bonding was instituted, but has been ineffective as currency depreciation makes bonds lose their value and deterrent effect (Dovlo and Nyonator 1999). Attempts by the University of Ghana Medical School and the Medical and Dental Council of Ghana to delay migration require doctors who do not start their housemanship in the first six months after graduation to rewrite their final examination, and much higher fees are charged for academic transcripts for use abroad ($500 in the first year, $120 after four years of service in Ghana) as compared to $6 for local service. These schemes are unpopular with the doctors and have not reduced migration appreciably.

More positively, the Ghana Medical Association called in 1999 for the establishment of a Postgraduate Medical College as a means of arresting the brain drain because few specialists trained abroad return. The proposed college would keep the doctors in the system at least during the training period (Plange-Rhule 1999) as well as ensure a progressive career structure (Nyame 2002). This became operational in 2004, with a novel system whereby doctors can stay at post and enrol in the programme. The government has also made arrangements with organizations such as IOM to assist in recruiting experienced specialists (especially Ghanaians abroad) for short-term appointments, and contract appointments for those who reach

compulsory retiring age. Recruiting abroad is extremely expensive and in practice has focused on low-cost Cuban doctors.

Finally, the Ministry of Health has braced itself to tackle the problem of migration and local maldistribution of health staff through incentives.[10] Starting with salary top-ups for workers in deprived areas, free accommodation for staff, and prioritizing staff in deprived areas for further training, there have been efforts to improve working conditions, remuneration and career opportunities. The previous delay of twelve months between appointment and initial salary has been shortened to three months. Promotion of health workers has been improved and delays shortened. Proposals include a revolving fund for a mortgage scheme to allow critical staff (ultimately all staff) to own their homes, and collaborate with District Assemblies to provide good schools in deprived areas.

The question now is whether these measures address the concerns of the migrating health workers. They do not address the top concerns expressed by doctors intending to migrate, of unrealistic salaries and poor working conditions, though they do address home ownership (Mensah 2004). The junior doctors and nurses who form the majority of migrating health workers who are the target of government efforts are still not effectively part of the policy process. What the government sees as appropriate is very different from migrating health workers' requirements. The way forward is not to treat the intending migrants as 'unpatriotic deserters' and other derogatory adjectives, nor to use high-handed measures, but to communicate with the junior health workers, listen to their needs and negotiate before the situation gets out of hand.

13.5 Conclusion

This chapter has argued that health profession migration is driven by economic motives and opportunities generated by active recruitment and integration and commercialization of the health care labour market. Health profession migration from low-income staff-short economies is accelerating, creating hugely damaging effects in source countries and providing a perverse subsidy to high-income health systems. Punitive and exclusionary responses are discriminatory and ineffective; their costs are borne by the migrating health workers. Only rebuilding source country health systems in order to provide a decent wage and working conditions represents a response that is ethically acceptable and also has a chance of working. The vast majority of migrant nurses interviewed for the PSI (2004) said they would prefer to work in their home countries if they could at least earn a living wage. Compensating low-income source countries for the costs of trained health workers' out-migration is not only more likely to preserve individual freedom than policies to restrict migration, but is also just and more likely to contribute to creating incentives for health professionals to stay and to return (WHO 2004a; Bundred and Levitt 2000; Pang *et al*. 2002).

Notes

1. Information from email exchange 2004.
2. Speech in Johannesburg, 1 September 2003, accessed online 11 November 2004, http://www.afro.who.int/press/2003/regionalcommittee/pr2003090103.html.
3. A phrase used repeatedly by interviewees in Ghana.
4. Author's interviews, 2003.
5. Author's interviews, 2003. Given pressures and local disapproval of nurses' departure, it is not easy to research these processes.
6. Author's interviews.
7. Compiled from Nursing and Midwifery Council data.
8. Drawn from current research with Richard Biritwum and Maureen Mackintosh, supported by WHO and UNRISD.
9. The research referred to in note 8, based at the University of Ghana Medical School, is seeking to improve these cost estimates for Ghana.
10. Interview with the Deputy Director of Human Resources, Ministry of Health, Ghana, February 2004.

14

Eliminating Economic Barriers in Health Care: the Mexico City Government's Experience

Asa Cristina Laurell, Eduardo Zepeda and Luisa Mussot[1]

14.1 Introduction: health care as a social right in a difficult context

Assuring universal access to comprehensive health care in highly unequal societies with partially commercialized health systems is difficult. However, the Mexico City government's social programmes implemented since December 2000, aimed at ensuring adequate access to health care and food support for the elderly, provide one example of what is possible. We describe and evaluate these policies which are based on the principle of health as a social right and on public provision of health care, and represent a sharp break from previous Mexican pro-market, small-scale and tightly targeted programmes.

The context of the Mexico City initiative

Health protection is a constitutional right in Mexico, which suggests that it is socially recognized as a basic need of the population. However, the Constitution does not specify who is obliged to grant this protection, meaning that in practice it is more a normative conception than an enforceable right. The principal health services are public, but are provided through different institutions: mainly, the national and sectoral social security institutions and by those belonging to the federal and state ministries of health. Social security is mandatory for formally employed workers and should provide integrated health services to about 50 per cent of the population. The two main

institutions have their own facilities and salaried staff (*Programa Nacional de Salud* 2001–6, 2001).

The federal Ministry of Health decentralized health services to states in the 1980s and 1990s; since then, state ministries are responsible for public health actions directed to the whole population, including a free Basic Health Package (thirteen individual medical interventions and nineteen drugs) for the uninsured population. States also offer a variety of other subsidized services that are charged to the patient, but these do not include the required drugs. Health care facilities in most states are insufficient, and in nine out of thirty-two there are serious shortages (Laurell and Ruiz 1996). The population living in these areas faces significant obstacles in accessing sufficient and needed medical care.

Private providers are of two major types. First, there are many private units, mainly independent doctors and small clinics. Second, there is a large and profitable section that emerged during the last decade with private health insurance and large business-oriented hospitals (Laurell 2001a). In fact, the term 'private health providers' is partially a misnomer since private health services are tax deductible, so that these large for-profit hospitals benefit from an invisible public subsidy estimated to be 0.5–0.7 per cent of GDP (Laurell and Ruiz 1996).

Total national spending on health represents about 5.6 per cent of GDP; 3.0 per cent is private spending, despite low private sector coverage; and 2.6 per cent is public spending divided into 1.9 per cent for social security and 0.72 for the uninsured population (Secretaría de Salud, 2001). Some state governments channel local funds to health, but given the centralized taxation system, most states, particularly the poor ones, can do little to improve the financing of health services.

Total per capita expenditures under the different programmes and institutions of the public health system are today below the 1982 levels (Laurell 2001b). This underfunding of health services is an effect of the successive structural adjustment programmes that involved budget cuts and wage retrenchment (Salas and Zepeda 2003). Financial macro constraints hit the social security system particularly hard. Not surprisingly, its services, historically the best in Mexico, have deteriorated steadily over the last twenty years, while services for the uninsured have stagnated. Ironically, the wide recognition of these facts has been turned against the public health system by the twisting this historical deterioration into an intrinsic characteristic of public institutions.

The decisive involvement of supranational financial agencies, such as the World Bank and the IMF, in these structural adjustment programmes explains to a large extent the policy profile of the health reform. Its main components are a market-driven system – external and internal competition – for those who can afford to pay for their own health care or have access to health insurance through mandatory social security, and a decentralized system of publicly provided basic, collective and individual, services

for the poor and uninsured (Laurell 2001b; see also Chapter 3). However, the implementation of this reform has faced wide opposition, including from leftist political parties, professional organizations, trade unions, NGOs and academic experts, who, recognizing the serious problems affecting public health services, propose an alternative reform based on strengthening public institutions in order to grant the universal right to health protection stated by the Mexican Constitution (Laurell 1995a). This social and political dispute has delayed the implementation of the reform, despite its being one of the 'conditionalities' of the adjustment loans to the Mexican government (World Bank 1998).

The financial difficulties of health care during the last two decades have not caused a general deterioration in health conditions, as these are susceptible to specific low-cost technologies. However, very great inequality in health conditions remains.

The challenges of health conditions and health care in Mexico City

Health conditions and health services in Mexico City are similar to the country at large, but with some peculiarities. For example, life expectancy is only one year more than the national average, but mortality of children under five is the lowest in the country. Health inequality is smaller than in the country as a whole, yet disparities in mortality between sections of the city range as high as four times (*Programa de Salud del Gobierno del Distrito Federal*, 2002).

Mexico City's health care system is highly segmented. There are five public social security institutes, several decentralized federal hospitals, the primary health care facilities and hospitals of Mexico City's government (MCG) and a sizeable private sector. The public health sector of the city has shared the lack of resources, the corruption that pervades in the rest of the country, as well as the erosion of services and facilities.

The health infrastructure, developed during the 1960s and 1970s, displays a striking geographic, demographic and epidemiological misfit between health resources and current health needs of the population. The main health facilities are concentrated in the centre and northern part of the city and not in the eastern, southern and western periphery where most poor communities settled during the last twenty years. The number of children has decreased while the population over 65 is rapidly increasing. Furthermore, the most common childhood diseases have been successfully fought and chronic diseases now predominate.

This segmented, obsolete and deteriorated health care system has provoked a large inequality in access to health services between a small wealthy minority that can afford private insurance and services, those that have access to some kind of public social security (60 per cent), and the poor uninsured (35 per cent) that only have access to MCG health facilities and inexpensive

private doctors and clinics. To them the most important obstacle to required health care is lack of money.

This was the balance sheet of structural adjustment and a decade of reforms for Mexico City. Taking office in December 2000, the new administration of the city set itself to an ambitious programme that can be summarized in four goals: (1) to decrease inequality in health conditions between groups and geographic areas and to improve general health conditions; (2) to ensure 'public health security' to the city, as it is vulnerable to social and natural contingencies; (3) to provide timely access to required treatment and decrease inequality in access to sufficient services; (4) to implement a system of sufficient, sustainable, equitable and solidarity-based financing.

14.2 The Mexico City health and social policies

The social, economic and political background

Mexico is a highly centralized country despite being a federation. This historically turned Mexico City[2] into the political and economic centre of the nation. During the last two decades the city has stagnated in economic and demographic terms since the new economic policy imposed on the country favours the growth of export industries in areas close to the US border. Mexico City, with its 8.5 million inhabitants, nevertheless produces 23 per cent of GDP but local taxation is very limited and federal transfers are not proportional to the volume of taxes paid in the city.

The gradual decline of productive economic activities has caused a precarious social situation. Although the city has the highest median education, informal employment is particularly large and the city also shares the countrywide growing polarization between a large majority of impoverished people and a small minority of extremely rich people. Using the method 'integrated measurement of poverty',[3] it has been concluded that 3.3 million (38 per cent) live in critical poverty and another 2.3 million (27 per cent) moderate poverty (Boltvinik 2000). This means that the Federal District is the second state in Mexico in terms of the number of poor people.

Given its political strength, the government of Mexico City used to be appointed directly by the president, to avoid a competing powerful governor. In the 1980s the population of Mexico City started a struggle to obtain complete citizens' rights and full political representation as a federated state. This battle was originally started by opposition parties but was spurred by social and civic movements. In 1996 Mexico City was given a new legal status as a limited federated state, gaining the right to elect its head of government and a local congress. Like many large Latin American cities the 1997 elections brought a progressive political party (*Partido de la Revolución Democrática* – PRD) into power with a policy agenda of social rights and redistribution.

The year 2000 marked a historical turning point in Mexico since the 'state' party (*Partido Revolucionario Institucional* – PRI), that ruled the country for seventy years, lost both the country's presidential and Mexico City's head of government elections. However, while the presidency was conquered by the PAN (*Partido de Acción Nacional*), a right party, the government of Mexico City went to the PRD, a left party, but neither of these two parties obtained an absolute party majority in their respective congresses.

The two most important political positions in the country are thus occupied by governments with opposite views on the role of public policies. The national government has embraced, by and large, a neoliberal policy; meanwhile Mexico City's government has given high priority to a comprehensive social policy. In health this translates into a continuation of pro-market health reform in national policies, in contrast to the adoption of a comprehensive and progressive policy by the government of Mexico City.

The MCG social policy

The conception behind MCG's social policy is that the satisfaction of basic social needs should be considered as a right of all citizens and, therefore, should be universal. The practical translation of this principle is that social programmes – be they cash transfers, free social services or low interest loans – should be implemented on a large scale. This is in sharp contrast with the former emphasis on small-scale programmes, restricted to selected groups and with little impact on the living conditions of the population. Only with large-scale programmes, that require strong redistributive measures, can social policy effectively address the needs of the population and significantly widen access to basic human entitlements.

When feasible, programmes have been regionalized to the 1352 city sections in order to facilitate social participation and monitoring by the population. The main integrated social programme (*Programa Integrado Territorial*) comprises: housing and neighbourhood renewal; scholarships for children of single mothers; breakfasts in public schools; compensation for the increased milk price; economic aid for the disabled; scholarships for job training; micro credits for household production; funds for rural development; a pension and health care for senior citizens.

Most programme components have been designed according to the poverty incidence of each of the city sections, to attend preferentially those classified as of very high or high marginality. The reasons for territorial targeting are to: use incontrovertible criteria; avoid individual means-testing to diminish stigma and administrative expenditures; eliminate discretional decisions that facilitate political patronage; and avoid divisions within the community.

The MCG health policy: values, principles and strategies

Following the premise that no public action can be defined independently of social values,[4] MCG explicitly holds that all men and women are

intrinsically of equal value, hence governments have the obligation to honour and protect alike the life of all human beings. The concrete expression of this is to approach health as a social right and, thereby, as a responsibility of governments as guardians of the collective or common interest.

On this basis, the MCG's health policy pursues eight major goals:[5] (a) to democratize health, reducing inequality in disease and death; (b) to promote the development of bio-psychological capacities and potentialities; (c) to remove economic, social and cultural obstacles to access; (d) to strengthen public institutions to grant equal and universal access to health protection; (e) to attain universal health coverage, diminishing exclusion and dissolving the link between access and capacity to pay or labour market position; (f) to broaden services for the uninsured population; (g) to achieve equality in access to existing services facing the same necessity; (h) to procure solidarity through fiscal funding and the distribution of the costs of disease among the sick and the healthy.

To achieve these goals one would need a smoothly running health system, which is notoriously absent. Therefore, the MCG's strategies aim to restructure the highly deteriorated system and to expand services according to the needs of the population. The key strategy is the removal of the link between payment and access to health. This is done through the Programme of Free Health Services and Drugs (PFHSD) that provides the required health care to the uninsured local population free of charge at the health facilities of the MCG. This strategy applies to all collective public health activities offered to the whole population, and potentially provides free individual health care and drugs to 800 000–850 000 families or 3.5 million people. This programme complements social health insurance, and the two taken together will ensure universal coverage of health services in Mexico City.

A second strategy addresses how to set health priorities. Rather than taking decisions based on, as has become customary, a simplistic cost-efficiency formula, the strategy starts from the principle of equity with the aim of reducing inequality in access to health services (Sen 1998). MCG allocates resources according to specific health needs and according to the geographical distribution of the population of Mexico City deprived of health services.[6] After equity is considered, then efficacy and efficiency are brought in, in order to provide the best and most appropriate treatment at the lowest possible cost to address existing needs and demands.

A third strategy is to strengthen public health services, through the MCG's Broadened Health Care Model (MAS is the acronym in Spanish) of service provision. The model includes interventions to grant public health security, including health promotion, epidemiological surveillance, emergency plans in case of disasters, as well as preventive actions with community participation based on public health teams with geographically defined responsibilities. In addition, individual preventive care is based on integrated interventions according to age groups. All uninsured families that enrol in

the PFHSD are assigned to a health centre that keeps their records and refers them to a MCG hospital if necessary. The orientation of each MCG hospital is also being redefined into nodes of a network of hospitals, rather than self-contained units. A special effort is being made to set up a co-ordinated system to respond to emergencies that, hopefully, will include all health institutions, public and private, in Mexico City.

A fourth strategy is to improve the quality of services, on both technical and interpersonal dimensions. Actions to address this problem include significant improvements in the provision of drugs and supplies and the establishing of scientifically based guidelines to ensure proper treatment and update the therapeutic skills of nurses and physicians. An extensive training programme for all health workers was accompanied by an effort to provide maintenance for buildings and equipment, and a programme directed to building a new culture of public service.

Critical for all these strategies is a strong political and financial commitment to health. In 2001 the health budget increased 67 per cent, so that 12.2 per cent of Mexico City expenditure was dedicated that year to health, up from 8.0 per cent the year before. This large increase was permitted by sharp reductions in conspicuous expenditure and by reducing corruption (Section 14.5).

A final strategy hinges on intensifying popular participation and social control managed by the MCG. The basic concept is that there is a reciprocal relationship of rights and obligations between the government and the population. The government is obliged to grant the right to health protection, and to promote popular participation in the definition of the concrete content of this right given the available scientific and material resources, including provision of information. In return the population is obliged to contribute to efficacy in, and control of, the use of public (its own) resources. This 'contract' between government and society makes the difference between 'populism' and a socially responsible government.

Participation would occur through 1352 neighbourhood assemblies that would then form local Health Committees to deal with health matters. If this scheme comes to fruition it would amount to an effective mechanism of popular participation and informed social control on health matters that would also ensure transparency of government action.

14.3 Implementing the strategy of free health services in Mexico City

Mexico has been living on the verge of a serious political crisis for a decade, as low economic growth, crisis, inequality and a high incidence of poverty, worsened by neoliberal policies, threaten the social fabric. It was therefore of the utmost importance for Mexico City's new government to have policies in place quickly and obtain tangible results. The whole approach to health

as a social right was at stake. In this section we will review the two major programmes implemented by the Ministry of Health, but special attention will be give to the Programme of Free Health Services and Drugs.

Senior citizen pension

The first large-scale social programme implemented by the MCG was the Programme of Food Support and Free Health Services and Drugs directed to senior citizens, aged 70 years or more, who live permanently in Mexico City. The programme addresses the critical fact that only 30 per cent of Mexican senior citizens had an old age pension. This was the first step towards a universal citizen's pension granted by a social institution. The programme began with 141 000 recipients in March of 2001; by October 250 000 had been included; and a year later 325 000, an estimated 98 per cent of the eligible population.

Its geographical targeting proved successful. Eighty-eight per cent of those living at city sections classified as of very high and high marginality received their pension in 2001 while 64 per cent of those living in areas classified as of very low marginality got it in 2002.

In late 2003 the local congress approved the law granting the universal right to a food pension for the population aged 70 or more living permanently in Mexico City.

Improving access to health services in Mexico City

The new MCG programmes have been implemented for two years or even less, which means we can evaluate progress but not really assess their health impacts. Nevertheless, it should be recognized that some of the implemented programmes have a value in themselves. For instance, the fact of having access to health services or to a pension, when elderly, increases welfare and life security for a person, which is an issue that has often been overlooked by cost effectiveness-driven health interventions (Hammer and Berman 1995).

The twofold challenge of reforming the provision of health services of Mexico City towards a rights-oriented system and the necessary reconstruction of health infrastructure and practices has been successful during its first two years. Comparing them to the last year before this administration took office, the health service activity increased by 9 per cent (see Table 14.1). This is well above the expected natural increase in the demand of health services, allowing us to say that the overall strategy is reaching out to population groups not attended before.

The pattern of increase reflects the variation that accompanies every innovative strategy. The largest increases over the two years occurred in early detection of diseases (50 per cent), surgical interventions (41 per cent), and supervised deliveries (34 per cent). In the emerging institutional context of free health services, it is not surprising that the most expensive services are

Table 14.1: Delivered health services, Mexico City Health Ministry, 2000–2 (thousands of actions and interventions delivered)

Service	*2000*	*2001*	*2002*	*Per cent increase 2000–2*	*Absolute increase 2000–2*
Total	**14 129**	**15 314**	**15 480**	**9.6**	**1 352**
Consultations	**4 818**	**4 957**	**5 212**	**8.2**	**394**
General medicine	3 488	3 575	3 731	7.0	243
Specialities[1]	655	669	745	13.7	90
Dentistry	675	713	736	9.1	61
Hospital services	**735**	**824**	**964**	**31.1**	**229**
Emergencies	572	646	754	31.9	182
Hospitalized persons	90	92	108	20.5	18
Surgical interventions	43	50	60	40.8	17
Deliveries	31	35	42	34.3	11
Normal	24	27	31	32.0	8
Caesarean section	7	8	10	42.3	3
Ancillary Services	**4 751**	**5 256**	**4 931**	**3.8**	**180**
X-ray	405	452	469	15.9	64
Laboratory	4 346	4 803	4 461	2.7	115
Promotion & prevention	**3 825**	**4 277**	**4 374**	**14.4**	**549**
Prevention & disease control	836	827	924	10.5	88
Early detection of diseases	187	227	288	54.2	101
Vaccination[2]	2 802	3 223	3 162	12.9	360

[1] Includes specialized and mental health consultations. [2] Campaigns and permanent programme.
Source: Sistema de Información en Salud para Población Abierta (SISPA). Mexico City Ministry of Health.

the fastest growing ones. Most likely, we are witnessing here a shifting pattern in patients' preferences from private or public non-free services towards the hospitals of the MCG, in search of access to better services. Thus, the population seems to be using the services offered by the MCG with more confidence and not only as a last resort.

Programme of Free Health Services and Drugs

The strategy to diminish economic obstacles to access is implemented through the Programme of Free Health Services and Drugs (PFHSD) using the MCG health facilities. The PFHSD began in June 2001 at the 210 health

centres and twenty-six hospitals of the MCG, aiming gradually to incorporate the entire eligible population. The prerequisites to enrol in the programme are simply to prove residency in Mexico City and to state that one does not belong to any social security programme. Once a family is signed up, and an identification card issued, the family has full access to services and prescribed drugs, free of charge. The programme grants beneficiaries access to primary health care, to the four basic specialities (surgery, internal medicine, paediatrics, gynaecology and obstetrics) and to subspecialities such as traumatology, orthopaedics, neurosurgery, ophthalmology, otorhinology, infectology (including AIDS) and others. The MCG does not offer advanced technology interventions in oncology, cardiology, endocrinology or neurology. These are offered by the (federal) National Institutes of Health located in Mexico City; however, in spite of these being public hospitals, fees are charged.

According to the principle of equity, understood as equal access to existing services for the same need, the programme includes *all* available services and authorized drugs,[7] rather than a 'package' of free services and drugs. This approach also has advantages in efficacy and efficiency, since its wide coverage favours the timely provision of required treatment, which in turn prevents progression of disease and complications. In former health programmes for the poor in Mexico City, fees were imposed, so health care only acquired some priority in the family budget when the disease was perceived as serious or very serious. The choice of health services and treatments should be based on needs and the best scientific knowledge, not on short-term budgetary decisions within families subject to strict income constraints.

The performance of the new PFHSD programme has been remarkable. Eighteen months after it was launched, 375 000 households had been signed up, or 45 per cent of eligible families. However, not all members of the subscribing families have become members of the programme. Individuals tend to sign up for the programme only when there is a specific health problem calling for attention.

Excluding promotion and prevention and emergencies, out of the 10 million interventions in 2002, the PFHSD accounts for one-third of consultations and hospitalization and one-sixth of ancillary services (see Table 14.2).

The opening of a free health care option does not appear to have distorted the demand for health services, as pro-market reformers would argue, since the structure of demand revealed by the service delivered conforms well to the pattern one would expect given the current health conditions, particularly among the poor. The highest proportion of services provided under the PFHSD is deliveries (41 per cent), followed by visits to general doctors (36 per cent). The proportion of ancillary services that are provided free (16 per cent) is significantly low, which might be an indication that PFHSD patients do not get the same care as those who pay. If this were the case, it would be a negative aspect of the programme that the Ministry of

Table 14.2: Services delivered by Mexico City government's hospitals and health centres to the population as a whole and to beneficiaries of the PFHSD, 2002 (thousands of actions and interventions)

Services	*Total*	*Traditional services*	*PFHSD*	*% PFHSD services*
Total	**10 363**	**7 731**	**2 632**	**25.4**
Consultations	**5 212**	**3 422**	**1 790**	**34.3**
General medicine	3 731	2 380	1 351	36.2
Specialities[1]	745	544	201	26.9
Dentistry	736	517	238	31.5
Hospital services	**210**	**138**	**72**	**34.2**
Hospitalized persons	108	71	37	34.4
Surgical interventions	60	43	17	29.0
Deliveries	42	24	17	41.1
Ancillary services	**4 941**	**4 171**	**770**	**15.6**
X-ray	469	407	62	13.2
Tomography	10	9	1	8.1
Laboratory	4 461	3 754	707	15.9
Free drugs[2]			**1 053**	

[1] Includes mental health. [2] The drugs for hospitalized persons of the PFHSD are all free.
Source: *Sistema de Información en Salud para Población Abierta* (SISPA). Mexico City Ministry of Health.

Health needs to correct. Finally, more than 1 million people, or 62 per cent of those receiving free services, got prescribed free drugs.

14.4 Evaluating the free health programme

In order to have more specific information on the socio-economic characteristics, access, services provided, and perception of quality and satisfaction from PFHSD families a survey was conducted in April of 2003 of a random sample of 924 households from the database of enrolled families.

The impact on the vulnerable population

The sectors of the population that have signed up to the PFHSD include the most vulnerable groups. Table 14.3 shows that the reported income is much lower among the PFHSD households than among the economically active population as a whole.

As expected, a larger proportion of PFHSD households work in the informal sector, hence are not eligible for public social security. About 57 per cent of the PFHSD head-households are wage workers, 37 per cent are self-employed and 5 per cent are employers, while the corresponding data for Mexico City at large are 73 per cent, 19 per cent, and 4 per cent (INEGI 2003).

Table 14.3: Comparison between reported income among PFHSD households and general Mexico City population, 2003

Reported income *	*PFHSD household* [1]	*Mexico City* [2]
Below 1	25.6	7.2
1 to 2	24.8	29.3
Above 2 to 5	24.8	42.4
Above 5	12.2	14.6
No data	12.2	6.2

* Measured in number of minimum wages. [1] *Source*: Survey data head of family. [2] *Source*: National Survey of Urban Employment, INEGI, April 2003.

Education attainment is much lower among the head of PFHSD households than in the general population (Table 14.4). Table 14.5 shows that enrolment is concentrated in sections of the city where marginality indexes are very high.

In sum, compared to Mexico City's population PFHSD households have lower income, less education, and more frequently live in city sections with higher levels of marginality. This conforms to the expected pattern and refutes a commonly held view that middle-class families are more likely to take advantage of programmes that offer free social services in the absence of means-testing.

Access to the programme and services

The rapid expansion of the programme has depended on ease of access. Of those interviewed, 98 per cent described enrolment and compliance with required documentation as easy. It is relatively rapid, since 88 per cent spent

Table 14.4: Comparison between level of instruction of head of PFHSD households and Mexico City population

Instruction	*PFHSD households* [1]	*Mexico City* [2]
None	7.5	3.6
Incomplete primary school	12.1	8.6
Primary school	27.1	15.5
High school*	39.2	26.6
Preparatory school	11.8	24.4
University	2.1	20.0
No data	0.3	1.3

* Includes technical training 6.9 per cent. [1] *Source*: Survey of head of family. [2] *Source*: Population aged 15 years or more, Censo de Población 2000, INEGI.

Table 14.5: Distribution of PFHSD households and general Mexico City households according to marginality of city section, 2003

Level of marginality *	*PFHSD households* [1]	*Mexico City households* [2]
Very high	31.2	13.0
High	24.1	21.0
Middle	26.5	30.1
Low	10.0	13.7
Very low	4.3	21.8
No data	3.9	0.4

* The level of marginality was estimated by COPLADE, MCG, using socio-economic data from the 2000 Census and direct observation, Censo de Población 2000, INEGI. [1] *Source*: Survey data. [2] *Source*: COPLADA, MCG, 2003.

less than one hour. Although corruption has not been fully eradicated, it has been reduced significantly. Only 0.7 per cent indicated that they were asked to pay some money to get enrolled.

Table 14.6 shows the medical services that were demanded by the interviewed PFHSD households and those that were received. Outpatient services are by far the most requested services, followed by laboratory and radiology services. Hospital care was requested by 17 per cent of families and deliveries by 13 per cent, higher than the expected rates of 8.5 and 6 per cent respectively. This indicates that the inscription is frequently precipitated by these events to deal with their costs. It is interesting to note that only 52 per

Table 14.6: Services demanded and delivered, PFHSD, 2002–3

Services	*Percentage of households that requested the service*	*Percentage of the requesting households that received the service*
Outpatient services		
Medical consultation	78.0	97.4
Dentistry consultation	22.6	56.5
Hospital services		
Emergencies	21.5	95.5
Hospital care	16.8	60.0
Delivery	12.7	96.6
Laboratory & radiology		
Laboratory	38.5	97.2
X-ray	24.6	93.0
Other services	7.5	100.0
Drugs	51.9	92.1

Source: Survey data.

cent expected to get drugs, given the conventional view that medical care without prescription is a failure.

The ability of the PFHSD to respond to the health needs of those enrolled appears to be good. In over 90 per cent of the cases in which members of households requested most services, these were provided (Table 14.6). The low rate of non-response is consistent with rejection solely on technical grounds, although administrative failure cannot be fully ruled out.

The response rate for hospitalizations is much lower, in part no doubt because of a gap between medical criteria and patients' wishes. A similarly low rate of response, 57 per cent, in the area of dental care can most plausibly be explained by the omission from the programme of reconstructive dental care.

Only twelve families reported that they had been asked to 'contribute' to their treatment. Four were asked to pay – three less than 100 pesos and one 840 pesos; three were asked to bring drugs with a cost of between 120 and 550 pesos; and five consumables. These data confirm that the programme is conducted according to the new rules; leaving behind the practice of requesting monetary or in-kind contributions as a prerequisite to receiving health services.

Opinions of the programme

The survey included a set of questions to explore beneficiaries' perceptions of the quality of services. Since the vast majority had used the MCG health facilities before enrolling in the programme, they were asked to compare service delivery before and after the programme. Rather less than two-thirds of respondents considered that there has been no change in the overall quality of health services; a significant one-third indicated that most service delivery had improved; and only about 5 per cent thought that services were now worse than before (Table 14.7).

Table 14.7: Opinion of changes in service delivery after enrolling in the programme

Topic	*Better*	*Similar*	*Worse*
Waiting time	26.6	65.9	7.5
'Quality'	35.3	60.6	4.1
Attitude to patient	33.3	61.4	5.3
Variety of services	19.7	65.0	15.3
Access to drugs	21.9	62.6	15.6
Integrated services	35.8	59.1	5.1
Health information	32.9	61.8	5.3
Explanation of disease	33.2	61.6	5.2

Source: Survey data.

Sixteen per cent said access to drugs had worsened. The programme may have created the expectation that drugs would be prescribed without proper surveillance. However, as it should, the programme aimed to regulate former inadequate practices in the prescription and use of drugs: only MCG doctors trained in pharmacological therapy can now prescribe drugs.

The survey also explored the impact of the programme upon living means and conditions. Having access to a physician (medical care) in case of need is the most frequently mentioned benefit, followed by improved health and the feeling of having some protection (Table 14.8). It is revealing that the three aspects that received the highest ranking are those related to the feeling of uncertainty that is experienced by people in the face of the possible misfortunes of life such as disease and death. Seventy per cent of respondents indicated that the programme has helped to 'free' scarce monetary resources from health expenditures. These two perceptions intersect and, interestingly enough, correspond to the core of a welfare society: security, redistribution and state responsibility.

We also explored perceptions of MCG's motives and beneficiaries' concept of social rights and government responsibilities (Table 14.9). More specifically, we wanted to see to what extent it was true that the population of Mexico City that enrolled in the programme had no sense of their social rights and shared the misconception that what you get for free is inferior to what is paid for. Furthermore, we wanted to explore perceptions of the programme as being an exercise in clientelism.

The answers of respondents are quite revealing. Large majorities are aware that health protection is a constitutional right, and consider that taxes should be used to improve health and that health is government's responsibility. On the other hand, half thinks that the government is not concerned with overuse of resources by the population and a significant one-third of the respondents believes that the programme is a device to obtain votes.

Table 14.8: Opinions on benefits of the programme

Topic	*Agree*	*No opinion*
Visit a doctor when needed	91.3	2.7
Obtain the necessary drugs	73.3	2.9
Improves health	85.9	3.1
Integrated care	37.9	13.7
Feels protected	83.3	2.8
Can satisfy other needs	70.1	15.9

Source: Survey data.

Table 14.9: Reasons attributed to MGC for offering free services and drugs at government health facilities, 2003

Reason	*Agree*	*No opinion*
People's health is a government responsibility	78.1	2.7
Taxes should be used to improve health	87.6	2.7
It is a constitutional right of citizens	83.1	3.1
The government considers people's needs	79.5	5.7
The government is not afraid that people use services too much	49.7	5.4
The government uses it to get votes	34.0	3.1

Source: Survey data.

14.5 Financing and the fight against corruption

Public services were eroded by the protracted underfinancing suffered for two decades. In addition, health institutions have not escaped the corruption that plagues public and private establishments. The Mexico City government sought to counteract institutional poverty through a substantial budget increase for priority programmes, a programme to reduce unnecessary expenses – republican austerity – and a decisive attack on corruption.

The annual local budget for the Ministry of Health increased sharply (Table 14.10). The bulk of the growth went to social programmes, mainly to the universal pension. The increase in health expenditure was mainly

Table 14.10: Health Ministry budget according to source, Mexico City, 2000–2 (thousands of pesos*)

	2000		*2001*		*2002*	
	Pesos	*%*	*Pesos*	*%*	*Pesos*	*%*
Local government						
Health	2 201 086	63.1	2 687 689	48.2	3 039 650	43.4
Social programmes[1]	75 023	2.2	1 365 991	24.5	2 320 661	33.1
Subtotal	2 276 109	65.3	4 053 680	72.7	5 360 311	76.6
Federal government						
Health	1 210 928	34.7	1 523 430	27.3	1 640 720	23.4
Total	**3 487 037**	**100.0**	**5 577 110**	**100.0**	**7 001 031**	**100.0**

* 1US dollar = 9.3–9.5 pesos. 1. Universal pensions and the milk compensation programme.
Source: Cent Publican, Ministry of Finance, Mexico City Government, 2000–2.

devoted to drugs, medical supplies, maintenance of buildings and equipment, and replacing equipment. Furthermore, the Ministry of Health achieved a strong increase in direct expenditures in social programmes without proportional increases in administrative items.

The increased expenditure on health and social programmes was mainly financed by local sources, and federal financing decreased relatively. Since local taxation is quite limited, there is a need for redistribution or the recovery of local fiscal resources.

The two major measures in this regard were cutbacks in unnecessary expenditures and savings from reduced corruption. Significant resources now devoted to social programmes came from the reduction of the salaries of high government officials, that had skyrocketed to among the highest in the world, and the elimination of superfluous expenditures from central government funds. Just these two actions produced savings of US$200 million in 2001 and US$300 million in 2002.

The struggle against corruption is a complex task since corruption takes on many different forms, some unperceived. The MCG appointed scrupulously honest people to leading positions and made transparent the use of public resources to facilitate public scrutiny. A critical area is the acquisition of goods: to get the best price and to buy the right things require competent and transparent planning. At the Ministry of Health about US$13 million were saved in the planned purchases in 2002.

14.6 Conclusion

Shortly after coming to office, the Mexico City's government launched an ambitious strategy to construct a new approach to the public provision of health care, to ensure adequate access to health services for the uninsured and to provide food support to the elderly. Looking at health as a social right that should be enforceable by everyone, the large-scale programmes meant a radical departure from former pro-market policies that had introduced co-payments and fees for health services and concentrated on restrictive, small-scale and tightly targeted programmes.

After only three years of implementation, programmes show tangible progress though there is still a long way to go. The food support programme for the elderly has grown to almost full coverage, and the programme has been legislated as a pension law, attesting to its wide acceptance. The Programme of Free Health Services and Drugs reached 65 per cent coverage at the end 2003. The programme has enlarged access to health services to the poor. Despite the fact that inscription is not means-tested, the socio-economic profile of the PFHSD households is poorer, less educated and more marginalized than the Mexico City population at large. These findings refute the belief that middle-class households are the disproportionate beneficiaries of universal public programmes.

Although exclusion of the poor from health services in Mexico City was not absolute, access was linked to severe economic strain and delay. The PFHSD is removing the economic obstacle to timely access to required care. In addition, the PFHSD has broad acceptance among beneficiaries who, contrary to conventional wisdom, consider it and the senior citizen pension as rights of the population and as obligations of the government. This suggests that there is a broad popular support for tax-financed social programmes as a priority of the government.

The analysis of the Mexico City social policy experience shows that it is feasible to implement comprehensive social programmes and finance them, so long as they receive strong political support. However, it is easier to put into operation new programmes such as the citizen pension than to change existing institutions. The problems in the implementation of the PFHSD are related to the difficulties of changing existing health institutions and the prevailing institutional culture. In this context the fight against corruption is a means both to increase available resources and to dignify public service.

Notes

1. For valuable assistance with the survey we thank Elsa Veites, Ricardo Gallardo, Omar Grados and Baruch Ramirez; also Diana Alarcon and Jan Vandemoortele for comments and suggestions. All remaining errors are the authors'.
2. The denomination 'Mexico City' referrs to the Federal District that does not include the counties of the metropolitan area.
3. This is a composed measure that includes consumption, education, health, housing, etc.
4. Sen (1999) argues that even markets are built upon and act according to specific social values.
5. See, *Programa de Salud del Gobierno del Distrito Federal*, 2002–6.
6. The tracking is done through a system – RUTA – that uses census track data to classify the city sections according to their level of marginality and links them to systematic health information on morbidity and mortality and existing health service resources.
7. About 300 drugs decided by groups of experts.

15
The Political Economy of National Health Insurance in Korea

Huck-Ju Kwon and Byongho Tchoe

15.1 Introduction

National Health Insurance (NHI) is one of the main contours of the Korean welfare state. It was introduced in 1977 and extended to cover the whole population in 1988/9. In fact, the history of NHI goes back to 1962 when it was first considered by the military government. In 2000, the fragmented health funds within NHI were integrated into the National Health Insurance Corporation as a single insurer. This integration was an important *volte-face* in the social policy paradigm after the long period of the economy-first approach in which the 'productive workers' were the priority of social protection rather than vulnerable people. The integration reform aims not only to widen the risk pool of health insurance but also to enhance equity by redistributing financial responsibility for NHI.

This change in policy direction and its consequences for equity are of particular international relevance for policy analysts because the delivery of Korean health care was and remains highly commercialized. Hospitals and clinics are mostly privately owned, and the delivery of health care thus mostly private, though there is an extensive network of public hospitals, clinics and health centres (see also Chapter 1). This chapter analyses the political rationale of this policy change, and the redistributional impacts of the reform of NHI in this context.

The chapter therefore begins by analysing the policy debates over NHI, where a deep political tension over equity has been manifested. In particular, it examines the policy debates over NHI since the 1960s with special attention to the financing arrangements of the programme from the perspective of the advocacy coalition (Sabatier 1986). The chapter argues that the advocacy coalition for equity in health care that emerged over the course of the policy

debate since the 1960s was able to develop its position on equity only after losing the debates on a number of occasions, and successfully produced the policy output when they seized strategic points of policy-making under the Kim Dae-jung government.

The chapter then goes on to analyse the redistributive impacts of the integration of NHI in 2000, at a concluding point in the long-running policy debate. The chapter uses micro data sets from the National Health Insurance Corporation and the National Survey of Family Income and Expenditure for this assessment. This analysis is an attempt to understand whether the reform has achieved its aim, and it sheds light on the directions for future policy agendas.

15.2 The politics of National Health Insurance under the authoritarian regimes

Although policy debates on NHI have taken place in Korea since the 1960s, there were a number of occasions that held more significant implications than others for policy change. The first occasion occurred in the early 1960s just after the military *coup d'état* of 1961. The military government announced its intention to introduce social programmes at a news conference in January 1962. This announcement was an effort to appeal directly to people with substantial policy ideas, after the military government had consolidated its position during its first six months in power. The task of preparing a policy programme went to the Committee for Social Security (CSS) (Ministry of Labour 1981: 25), which was at the time a private study group of experts including bureaucrats from the Ministry of Health and Social Affairs, doctors and academics who were concerned with social policy. CSS came up with a proposal for an insurance programme in which employees and employers would pay contributions to a fund that in turn would pay hospitals and clinics for their health services, although they had found that low-income families most needed a public health care programme. CSS put forward such proposal mainly because of considerations of financing the health care programmes. As Mills (1985) explained this was not, however, a unique case since health insurance programmes in many developing countries often start with those who can afford it, rather than those who need it most.

The CSS recommendations went to the Supreme Council for National Reconstruction, the highest decision-making body under the military government. The health insurance proposal faced serious opposition in the Supreme Council. The argument against the recommendation was an objection to extra financial burden other than taxation. The proposal for health insurance was perceived as too idealistic, and was consequently rejected. The CSS failure in the introduction of health insurance was clearly related to the highly disciplined institutional hierarchy under the military government,

which did not allow voices other than the official stance. Nevertheless, CSS planted a seed for policy debate in the future.

The second policy debate took place after the introduction of NHI in 1977. The Korean government implemented in that year compulsory health insurance for the large-scale companies with more than 500 employees, which was almost exactly what the CSS had recommended. A separate health insurance fund was launched for public sector employees under the same law in 1979. This time National Health Insurance for workers in large-scale companies was perceived as an instrument for economic policy. In contrast, equity in the health care system was not on the agenda for debate, except for the introduction of the Medical Assistance Programme in 1977 providing subsidies for the poorest households' medical expenses.

Within the umbrella of NHI, separate health funds were set up based on workplaces. Employers and employees contributed to their own funds. These funds then paid hospitals through the national co-ordination agency for the treatment of their members, but there was no mechanism for financial transfers between health insurance funds within NHI. There was no subvention from the government to health funds, except for administrative costs at the initial stage. This structure was convenient for the expansion of the programme because any further expansion would not disturb the existing financing arrangements. However, it became clear that it would be difficult for the programme with such a structure to be extended to those without employers, such as farmers, self-employed people and urban informal sector workers.

A significant debate took place in 1980 when the Ministry of Health and Social Affairs (MoHS) launched a plan to integrate health insurance funds for private sector employees and for public sector employees, as a part of long-term strategy for universal coverage by NHI. MoHS wanted to integrate the separately managed health funds into one insurer for administration and financing. This plan was seen as an essential step in the extension of the programme to the entire population. This plan was prepared by CSS and was supported by key officials within the MoHS. The minister of the MoHS was convinced that the plan should go ahead. They submitted the plan for integration of health funds to the Presidential Office for approval. It was then reviewed by the policy staff at the Presidential Office, who recommended that it should be returned to the Ministry for further research. Effectively this was a rejection of the proposal.

The brief by the policy advisers of the President gave four reasons for the rejection (Kim 1992: 59):

- Integration of health insurance funds would lead to a situation in which the state would take all responsibility for financing National Health Insurance.
- The citizens and the state would confront each other directly over the level of insurance contribution, especially if it was necessary to raise it.

- Parties involved in insurance were likely to abuse the system if the insurer was too big.
- Farmers and self-employed would ask the state to pay for half of their contributions as an equivalent of employers' contribution for employees.

It is clear from reading this brief that the Presidential Office's main concern was the political stability of the authoritarian government headed by President Chun, who had taken over power by a military coup in 1979. It suggested that the government should not opt for health policy that might lead to political confrontations, nor should it make any financial commitment to the health insurance programme. Effectively it opposed the idea of expanding health insurance to those outside the programme because of political and financial concerns. President Chun decided to reject the proposal for the integration of health insurance funds as his advisers at the Presidential Office suggested. Considering that the Chun government was a highly authoritarian regime, failure to have presidential blessing was effectively the end of the policy proposal.

Once again, the CSS and officials in the MoHS failed to carry through their policy agenda. This failure mainly stemmed from the authoritarian politics, which did not allow people to speak in voices different from the official line. It was also because the CSS and other officials within the government were not yet able to form an effective advocacy coalition pursuing this policy agenda. They might have needed support from outside the government, but they never tried to get such support, which seemed impossible for them under the authoritarian government. Despite such caution, CSS was abolished by the new minister of the MoHS, and the officials who had argued for the integration plan were forced to resign from the government after this debate (Kim 1992: 62). It should be noted that CSS and people involved in health debates in the authoritarian governments had not yet developed a coherent belief system on equality in health. There were concerned with the extension of health insurance to those outside of the programme, which had an important implication for equity and redistribution, but they did not articulate their position or try to pursue the policy vigorously. Nevertheless, this second debate set the main issues for NHI in the following years: integration of health funds and financial transfers between them.

Let us note here that Korean politics in the 1980s was largely dominated by the political conflict between the authoritarian government and the civil movements for democracy. Health policy had not been at the centre of political debate, but remained inside the government. Because of the nature of this politics, the group of policy experts who argued for universal health care was not able to develop into a fully fledged advocacy coalition in this period.

Yet, despite its obscurity in the political domain, NHI grew rapidly during this period. It was extended to cover employees in the medium-sized firms in this period. Those without employers who might have paid half a

contribution were left out until 1988/9, when NHI became a universal programme. As the coverage of NHI increased, those outside the programme felt increasingly isolated from the rest of the population. These people shared a common characteristic in that they were not salaried employees: farmers, self-employed, urban informal workers, unemployed and elderly people. There were growing grievances about this exclusion.

15.3 Democratization and the advocacy coalition for NHI integration

After 1986 the Chun government examined policy options for the extension of NHI to cover the entire population, recognizing people's grievance about exclusion from NHI in the run-up to the presidential election at the end of 1987, the first democratic election for two decades. The contentious issue was whether to create a single insurer that would manage the administration and finance of NHI, or to stick to the existing structure of separate funds that had operated health insurance since the introduction of NHI. The Chun government chose the second option.

In December 1987, Roh Tae-woo, the government candidate, was elected President. As politics underwent a democratization process, debates on social policy moved to the political domain. It was a clear contrast to the previous debates in which discussion took place only within the government. Those who had argued previously for NHI integration at CSS and the MoHS now left the government and spearheaded the advocacy coalitions, which emerged at this time. Some of them moved to universities and provided expertise to the advocacy coalitions. A number of grassroots organizations, in particular those based on farmers and the urban poor, joined the advocacy coalitions, giving them a network of mass mobilization (Lee 1997: 70–2). Opposition parties were also in favour of integration. There began to emerge an advocacy coalition for equity in health with a clearer shape in terms of belief, participants and institutional networks.

The Association of Social Security Studies was established, and it presented the case for integration to the public. The idea of equity and redistribution was put forward as an argument for integration, in contrast to the previous inclination towards administrative argument. The main points in their argument were the following (Kim 1992: 67):

- To integrate all health funds within National Health Insurance into one National Fund, in order to widen the pooling of risk.
- To ensure the access of low income group of people to health service.
- To increase horizontal equity of health insurance contributions.
- To increase efficiency of health insurance administration.

The line of thinking was basically the same as before, but the emphasis was shifted from administrative concern to social equity. The experience of NHI

since its introduction in 1977 showed that there were rich health funds which had a surplus in their finance, while other funds were struggling to balance their books. Because of varying financial situations, people with the same level of income paid different amounts as contributions to their health funds. This raised the issue of horizontal equity. A more serious concern raised was about the financial viability of health funds for farmers, the self-employed and others who were classified as residence-based members. Their funds were small and had fluctuating revenue. Given their fragmented structure, it was argued, the health funds for these residence-based members would be faced with financial difficulties, which would then threaten the programme itself. The integration of all funds within National Health Insurance would widen the pooling of risks, facilitate redistribution of financing and secure the future of the programme.

The general election for the National Assembly in 1988 gave a big boost to the advocacy coalition. The governing party failed to secure a majority of seats at the National Assembly, and three opposition parties started to form a policy alliance for certain issues. In particular, the opposition parties were united on the integration of NHI. In March 1988, the opposition parties tabled an amendment bill for NHI. It was certain that the bill would be passed in the National Assembly.

Those who opposed the integration of NHI also put forward their arguments in public. In particular, a group of economists who specialized in health insurance put forward an argument against the idea of integration. They argued that the integration of health insurance would weaken the idea of self-reliance among citizens. In a smaller, separated insurance fund, they argued, people tended to use health services prudently since excessive use would lead to increase in their contribution. In the case of a nationwide health fund, according to them, people would not care much about the finance of the health fund since their prudence would make no difference. This logic of rational choice was contentious, because the size of the small health insurance funds that had been operating was large enough for members to behave 'irresponsibly'. The stronger objection to integration, however, stemmed from the inadequacy of the Korean tax system.

One of the important premises on which support for integration was based was the idea of equity through redistribution: pooling together all different income groups into one national fund, charging contributions according to their levels of income, and protecting those in need irrespective of their levels of contributions. The necessary condition for this redistributive mechanism hinged on whether the government or the National Health Insurance Corporation would be able to gauge the precise levels of people's incomes, in order to charge them according to their ability to pay. For it would not be difficult to know the exact incomes of wage and salary earners. As in most countries, however, it would be difficult to obtain precise information on the self-employed. The latter tend to underreport their levels of income,

and Korea was no exception. In Korea, however, the number of people and businesses exempt from filing tax documents is exceptionally large, because of the antiquated tax system. Only 17 per cent of businesses pay tax based on their bookkeeping (National Tax Service 2000).

This problem became the main objection to integration aimed at equity by redistribution. If those with higher levels of income paid less than lower-income people, redistribution would take place in a regressive direction. In particular, wage and salary earners would lose out to the self-employed. This led business interest groups such as the Korean Chamber of Commerce and the Korean Federation of Business to oppose the integration of NHI.

For the first time, an issue of social policy occupied the centre stage of public debate. In 1988 the opposition parties passed the bill for integration, and in an attempt to avoid the presidential veto, the opposition parties revised the original bill to allow the integration to take place in a step-by-step manner and tightened the conditions for financial transfers between funds during the transitional period. President Roh, however, vetoed the bill when it arrived in the government. He feared that he would lose support from the upper- and middle-income classes who were thought to lose out in an integrated system. He did not want to impose concessions on his supporters in confrontation with the National Assembly. Government ministries such as the MoF and the MoHS (now deprived of the supporters of integration) also advised the President to veto the bill. Because of this veto, NHI was only extended to the whole population under the existing structure of separate funds. The health funds of those without employers, who were classified as residence-based members, were organized along the lines of administrative districts, and their contributions were set based on multiple factors such as their dwellings, cars and farmlands among others. Table 15.1 documents the process of extension of NHI across the population.

During this debate a well-equipped advocacy coalition emerged after the frustrating experiences of CSS and of people who had argued for

Table 15.1: Coverage of National Health Insurance 1977–1989 (% of the whole population)

	Industrial	*Government*	*Self-employed*	*Residential*	*Others*	*Total*
1977	10.33	–	–	–	–	10.33
1978	10.34	10.15	–	–	–	20.49
1981	18.70	10.27	0.06	0.47	0.19	29.69
1984	28.75	10.11	2.02	0.97	0.53	42.38
1987	36.01	10.50	3.17	0.76	0.69	51.13
1988	38.76	9.67	2.58	16.15	0.64	67.48
1989	38.96	10.55	0.00	44.69	0.00	94.2

Note: Figures include contribution paying members and their families.
Source: National Health Insurance Corporation, *Health Insurance Statistical Yearbook* (1990).

universalization and integration of NHI. Their policy goals and instruments began to take coherent shape. Equity in health insurance became a major goal and the policy mechanism was clear-cut: pooling different income groups into one national fund. In terms of its network of supporters, the advocacy coalition made a link with grassroots organizations and political parties. Despite all these advantages, the advocacy coalition failed to achieve what it sought. It could not carry its policy agenda through the institutional bottleneck, the presidential veto. More importantly, a serious weakness was exposed in their proposed mechanism: due to the deficiency in the tax system, the proposed contribution mechanism did not guarantee a fair system of burden sharing.

15.4 Integration of NHI

In 1994, the Korean Confederation of Trade Unions and the Citizens' Coalition for Participatory Democracy spearheaded the formation of a Coalition for the Integration of NHI, which included seventy-seven social pressure groups and maintained close contact with the opposition party. It had a clear link to the previous Association of Social Security Studies in terms of core members. This coalition also represented a considerable part of the progressive political forces in Korea, and placed strong pressure on the government. The advocacy coalition concentrated its efforts on building social support for integration, which it now saw as hanging only upon a political decision, since the pros and cons of integration were well exposed (Lee 2000: 86).

The situation dragged on without a breakthrough until 1997, when the political parties at the National Assembly were able to agree a compromise on the health insurance bill. The bill, however, proposed integration of the health funds only for the public sector employees and the regional members, while leaving the health funds for employees as they were. The incumbent Kim Young-sam government considered whether it should veto the bill, but did not do so, and the bill became law.

At the presidential election in December 1997, Kim Dae-jung was elected to the presidency. This was in the middle of the economic crisis of 1997–8. Kim convened a tripartite committee of the government, business and trade unions to push ahead economic reform with social consensus (Kwon 2001). The advocacy coalition which wanted full NHI integration put the issue on the agenda of the tripartite committee. Some members of the coalition also participated in the Transition Committee for the New Government. President Kim appointed a former bureaucrat who was dismissed by the Chun government because of his support for integration to be the Minister of Welfare. This meant that the advocacy coalition for equity took a hold on key decision points.

The Kim government was able to push through the new law that would integrate all the health funds into NHI in 2000. In this period, health care

suppliers such as hospitals and pharmaceutical companies took no particular stance against the reform, since most of their patients were already within NHI after the universalization of 1988–9. Integration of NHI funds did not make much difference to them. The Kim government was, however, able to integrate fully only the administration of health insurance, and reorganized the financing structure into two separate accounts according to job categories: one for the employees in public and private sectors and the other for residence-based members. This was because the government did not find a solution to the problem of establishing a fair contribution system: information about the levels of the incomes of the self-employed still remained elusive.

By July 2003, a wave of reform policies was implemented, resulting in a single-insurer structure with two operating funds: the NHI Corporation manages two health insurance funds internally, one for wage and salary earners and the other for residence-based members of NHI. The Corporation has 227 branches across the nation, responsible for membership and collecting contributions and for reimbursing fees to clinics and hospitals. NHI has three funding sources: contributions imposed on taxable incomes of wage and salary earners; contributions from residence-based members (the self-employed, farmers and temporary workers who are not categorized as wage and salary earners) calculated on the basis of factors such as their property, sex, age and the number of family members; and government subsidies. A special tax on cigarettes was introduced in 2002 to finance government subsidies for NHI. The revenue of NHI in 2002 accounted for the equivalent of 2.4 per cent of GDP.

On the expenditure side, NHI applies the fee-for-service system for the reimbursement for clinics and hospitals for their services, although other methods have been experimented with such as the DRGs (Diagnosis Related Groups) to curb the practice of overtreatments. As noted above, most providers remain privately owned, with some implications for equity outcomes of NHI explored below.

15.5 The redistributive impact of NHI integration

The core premise of the integration reform of NHI is that integration will widen the risk pool of health insurance, and enhance equity by redistributing financial responsibility. The risk pooling was widened through the integration of fragmented funds. The question immediately arises as to the effects on social equity: was it enhanced by the reform? The rest of this chapter will look into the redistributive impact of the integration of NHI, with particular attention to changes in insurance contributions by income groups. Since the separation of the finance between wage and salaried members and residence-based members remains, the analysis of redistribution will be carried out according to that line of separation.

We will examine the redistributive impact of the integration through analysis of NHI data and of National Survey of Family Income and Expenditure

(NSFE) data. The former data include the contributions and incomes of all insurance participants in 1999 and 2000, and were used to analyse the equity of the contribution burden by income class. With respect to the NSFE, we used 1996 and 2000 survey data, and we compare health care expenditure across households before and after integration. The sample size for the household expenditure survey data is 24 274 in 1996 and 23 710 in 2000.

Redistributive structure before the integration

Before the integration, the financial condition of the health insurance funds differed significantly. While some funds managed to accumulate a considerable reserve, others, mostly regional funds, were financially weak if not showing a deficit. In 1991, the government introduced redistributive mechanisms in two different ways to ease the financial conditions of those health insurance funds in difficulties. First, a sharing fund was established in order to allow cross-subsidy across different health insurance funds. In all, 373 health insurance funds under the umbrella of NHI transferred 5 per cent of their revenue to this sharing fund in 1991 (10 per cent in 1992, 20 per cent in 1994, and 25 per cent in 1995). The sharing fund was then distributed to health funds according to the size of catastrophic care cost and the medical cost for the elderly of each fund. Most residence-based funds in rural areas were among the beneficiaries of this cross-subsidy.

Second, the government provided subsidies directly to the residence-based funds according to the number of their members, their level of income and the proportion of the elderly among their members. The Roh government (in office 1988–93) promised that half the financing of the residence-based health insurance would come from public expenditure when the residence-based members, that is, the self-employed, farmers, informal sector workers and the elderly, were included in NHI in 1988–9. The subsidy from the government decreased over the years, although it still accounted for a good proportion of the financing of residence-based funds (see Table 15.2). Despite these subsidy mechanisms, a sharply increasing number of residence-based health funds were in deficit. In 1992 only seven funds were in deficit, but by 1996 that number had risen to 147. However, the number fell to 59 in 1997, mainly because the government allowed the health insurance funds for the residence-based members to raise their rates of contribution to correct their balance sheets. The government wanted the finance of the residence-based funds to look better in the context of the policy debate on integration, but the effect of this modest rise in contribution was short-lived.

Redistributive structure after the integration

As explained, the NHI Corporation became the sole administrator for NHI after the integration, but maintains two separate financial accounts, one for the wage and salary earners including public sector employees, and the other for the residence-based members. All wage and salary earners now

Table 15.2: Subsidies to the residence-based health funds

	1989	*1990*	*1991*	*1992*	*1993*	*1994*	*1995*	*1996*	*1997*	*1998*	*1999*	*2000*	*2001*
Government subsidy/ Expenditure(%) (A)	50.8	36.1	50.8	42.4	38.3	36.6	31.0	28.6	27.5	26.1	24.9	29.7	40.6
Cross subsidy/ Expenditure(%) (B)	–	–	1.5	1.7	2.0	1.2	4.7	5.0	6.9	5.9	4.1	2.1	–
A+B	50.8	36.1	52.3	44.1	40.3	38.8	35.7	33.6	34.4	32.0	29.0	31.8	40.6

Source: Ministry of Health and Social Affairs.

pay 3.94 per cent (2002) of their basic income, while the residence-based members pay contributions according to their taxable incomes, assets, automobiles and the number of household members. In other words, there are two risk-pooling groups. In principle, any redistribution effect is taking place within a risk-pooling group. Nevertheless, the risk-pooling was now much wider than before, and redistributive effects should take place after integration. In the following section we examine the extent of the redistribution effect of the integration reform within two groups.

15.6 Redistribution among the wage and salary earners

Before the integration, there were numerous health insurance funds for wage and salary earners. At one time the number reached 253 at its highest. The government did not impose the level of contributions, and each fund decided the contribution rate and the basic income to which the contribution rate was applied. What constituted the basic income differed significantly across the funds. Some funds included only regular income whilst others included irregular payments of different kinds, from payments related to working overtime to performance-related payments. Since the integration, the contribution rate has been the same wherever members may work, and the income base was expanded to cover all sorts of regular payments and applied to all members uniformly. This change of the system inevitably brought about redistributive effects in terms of financial responsibility.

Table 15.3 shows that the integration had a clear redistributive impact. The lower income groups began to pay much less than before, while the higher income groups paid more. In terms of the relative rate of change,

Table 15.3: Changes in contributions of wage and salary earners after the integration

Wage deciles	*Changes in contribution (monthly mean, Korean Won)*	*Percentage changes in contribution*
1 (lowest)	−6902	−33.61
2	−5588	−24.20
3	−5143	−18.39
4	−4800	−16.01
5	−3999	−11.50
6	−2688	−6.80
7	−342	−1.03
8	1489	3.20
9	5852	10.29
10	21099	26.14

Source: National Health Insurance Corporation (data points: 1999 and 2000).

the lowest income group had the greatest reduction, and the highest group experienced the highest increase in their contributions.

Nevertheless the picture is not so simple as one might expect, since Table 15.3 only takes into consideration contributions to NHI. Under the current system, the patients also need to pay out-of-pocket payments to hospitals and clinics when they receive treatments. They pay in general 20 per cent of inpatient care expenses and 30–55 per cent of outpatient care costs. There is also a range of medical tests and treatments not covered by NHI, such as MRI (Magnetic Resonance Imaging), brand name medicines and upper standard hospital rooms. Patients also need to pay extra fees if they want to see certain specialists.

Table 15.4, based on the National Household Expenditure Survey, shows that out-of-pocket health care expenditure in fact increased relative to income for the two lowest income groups in 2000 as compared to 1996, while it was reduced relative to income for other income groups. This is due both to an increase in out-of-pocket health expenditure during the period, and to a rise in income of the two lowest income groups which was slower than that for other groups. In fact, income inequality, measured by the income of the highest quintile relative to the lowest quintile, deteriorated from 4.52 in 1996 to 5.66 in 2000. This suggests that the redistributive impact of integration and related reforms had mixed results with regards to the wage and salary earners, although the integration by itself has a strong redistributive impact.

Table 15.4: Out-of-pocket health expenditures by income class of wage and salary earner households

Income deciles	*Health expenditure/ income (%)*		*Health expenditure (Korean won per month*)*		*Income (Korean won per month*)*	
	Year 1996	*Year 2000*	*Year 1996*	*Year 2000*	*Year 1996*	*Year 2000*
1	5.01	5.70	30 142	43 874	602 133	770 041
2	4.08	4.14	38 688	50 791	948 790	1 226 210
3	4.69	3.76	55 783	59 005	1 188 482	1 570 070
4	4.04	3.32	56 748	62 289	1 404 450	1 878 690
5	3.41	3.16	54 555	69 054	1 601 023	2 188 400
6	3.38	2.85	61 343	72 586	1 816 778	2 549 260
7	3.38	2.69	69 700	80 282	2 062 506	2 985 520
8	2.91	2.58	69 025	90 462	2 373 963	3 512 920
9	2.43	2.31	69 151	99 012	2 845 802	4 282 940
10	2.40	1.72	100 272	120 483	4 170 351	7 019 340
Average	3.18	2.67	60 540	74 783	1 901 427	2 798 339

*nominal

Source: National Survey of Family Income and Expenditure.

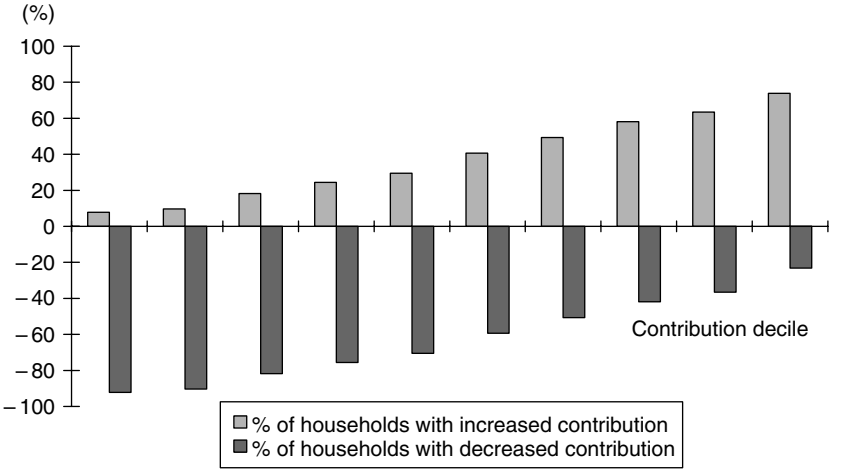
15.7 Redistribution among the residence-based members

The financial situation of those health funds for the residence-based members was very weak before integration. Since the residence-based members were the self-employed, farmers, informal sector workers, the elderly and others who did not have formal employers, it was difficult to know the level of their incomes and it was also more difficult to collect contributions from them than from the wage and salary earners. In general, the level of incomes of the residence-members was lower than that of the wage and salary earners, so that their contributions were smaller. Some members who were considered to have high levels of income, such as small business owners, lawyers and other independent professionals, paid less than they should have because of the underreporting of their income. All of these characteristics made the financial conditions precarious for the residence-based health insurance funds.

Although the integration pooled all those health funds, the fundamental weakness in the financing therefore remains. To tackle such weakness, the National Health Insurance Corporation reviewed its information on income and modified the formula that decides the level of contributions of residence-based members, such as taking into consideration the real estate, automobiles and the number and age–sex composition of household members. High-value real estate and luxurious cars are thought to represent higher income. Households headed by women, or with infants and the elderly are considered to be less well-off. In principle, this new system of asset and income evaluation aimed at raising contributions levied on the wealthier households while reducing those of the lower income groups.

Figure 15.1 shows changes in insurance contribution by deciles. It should be noted that we use contribution deciles, that is, decile groups according to the level of contributions, since the NHI data set only has information on contributions. Across all deciles, there are some households who experienced a rise in contributions and others who saw a decrease. However, the lower deciles have far more households whose contributions decreased, while the higher deciles have far more households whose contributions increased. This suggests that the integration had a strong impact on the redistribution of financial responsibility for NHI.

On the other hand, we can look into the out-of-pocket health expenditures of households using National Survey of Family Income and Expenditure data. Table 15.5 shows that health care expenditures relative to income decreased across the income groups. This is partly because the range of treatments within NHI has been rapidly extended since 1996. Patients need not pay for some treatments which used to be outside the coverage and therefore had to be paid for. Even though the relative burden of out-of-pocket expenditure is higher in the lowest income group than the two highest groups, the



Source: National Health Insurance Corporation.

Figure 15.1: Changes in insurance contribution by deciles: residence-based members' households

Table 15.5: Health expenditures by income class of self-employed households

Income deciles	*Health expenditure/ income (%)*		*Health expenditure* (Korean won per month)*		*Income* (Korean won per month)*	
	Year 1996	*Year 2000*	*Year 1996*	*Year 2000*	*Year 1996*	*Year 2000*
1	13.98	7.92	34 345	59 713	245 752	753 502
2	8.89	4.56	50 181	60 015	564 630	1 317 260
3	6.65	4.34	61 963	74 730	931 538	1 722 720
4	4.86	3.29	62 710	67 789	1 265 583	2 058 360
5	3.57	2.77	55 921	65 806	1 566 448	2 373 580
6	3.67	2.54	68 838	69 075	1 875 088	2 723 720
7	3.48	2.30	74 819	72 151	2 147 428	3 133 710
8	2.78	2.58	71 018	95 091	2 555 897	3 690 850
9	2.60	2.11	81 797	97 561	3 145 523	4 624 470
10	1.87	1.27	102 357	134 347	5 474 191	10 598 240
Average	3.36	2.41	66 394	79 627	1 977 207	3 299 641

*nominal.
Source: National Survey of Family Income and Expenditure.

relative burden of health care expenditure fell more sharply among the lower income groups than among the higher. However, it is important to note that such positive effects cannot entirely be attributed to the integration. The major effect derives from the fact that the incomes of the lower deciles have increased more rapidly than those of the higher deciles. The income distribution ratio was 10.6 in 1996 and was reduced to 7.4 in 2000.

15.8 Conclusion

The integration reform of NHI in 2000 aimed at widening the risk-pool of health insurance and enhancing equity by redistributing financial responsibility. This is an important shift in policy paradigm for NHI in Korea. This chapter has examined the political dynamics and rationale behind the reform through the advocacy coalition approach, and evaluated its redistributive impact, using NHI and National Survey of Family Income and Expenditure data sets.

Under the authoritarian government, policy experts and bureaucrats who were concerned with equity in health care were not allowed to make their voice heard and were even purged because of their policy proposals. Economic development and political security were the first priority in the policy paradigm of the authoritarian governments, and any other policy agenda not in line with this paradigm was effectively rejected. Once democratization took place, the advocacy coalition for equity in health care emerged and was able to connect with the wider alliance including the opposition parties. The advocacy coalition, however, failed to push through the health care reform during the debate in 1988 because it still lacked institutional strength in policy-making. In the wake of the economic crisis of 1997–8, and the change of government, the advocacy coalition was able to seize a number of effective points of decision within government and successfully carried out the health care reform. In a nutshell, this chapter has argued that the health care reform in 2000 was an outcome of the long-term efforts of the advocacy coalition for equity in health care, a result of preceding policy debates.

The final integration reform was, however, a watered-down version, since a fully fledged integration would not produce the intended effect due to the deficiency of the tax system, a problem identified during the debates in the late 1980s and 1990s. For this reason, this chapter has evaluated redistributive effects within two separate groups: one for wage and salary earners and the other for residence-based members of NHI, comparing changes in contributions to NHI by income groups before and after the reform. It also analysed changes in out-of-pocket health expenditure since this expenditure still accounted for a good proportion of health expenditure. Within the wage and salary earners group, the integration reform showed clear redistributive effects in that lower income groups pay less and the richer pay more. However, with respect to out-of-pocket payments, the two poorest groups still pay

the largest proportion of their income as out-of-pocket health expenditure. The situation worsened between 1996 and 2000, because of a combination of a higher rate of increase in health expenditure and a lower increase in the income of the poorer income groups.

This chapter has also found similar but different changes with respect to the residence-based members group. The integration reform had redistributive effects in that those with lower incomes pay lower contributions after the integration reform. In terms of out-of-pocket expenditure, unlike the wage and salary earners group, the situation has been improved, since out-of-pocket health expenditure as a proportion of income decreased in the lower income groups, most sharply in the poorest three income groups. This is also due to a combination of health expenditure and income effects. However, the poorest groups' relative burden of out-of-pocket health expenditure remains much higher than that of the other groups. We concluded that the health care reform achieved its first-order goal, i.e. equitable burden sharing in NHI, but it could not much improve equity in overall burden sharing in health care. This is because NHI share in total health expenditure is only 54.7 per cent at the national level (OECD 2003), while the rest is mostly borne by households. This is why the poorest households only benefited only a limited extend by the 2000 NHI reform and they still suffer from a higher relative health care burden. This conclusion points to the future direction of NHI reform, which should seek to reduce the overall health care burden of the poorest households and increase their ability to gain access to the health care system.

16

The Search for Cross Subsidy in Segmented Health Systems: Can Private Wards in Public Hospitals Secure Equity Gains?

Haroon Wadee and Lucy Gilson[1]

16.1 Introduction

The commercialization of health care presents a series of challenges for policy-makers concerned about improving access to health care for poorer groups. Health care tends to be used most by the richer groups of a population, even though they, in general, have better health and are likely to live longer than poorer people. This pattern is only reinforced by the market mechanisms associated with commercialization, such as user fees or private insurance. These entrench ability to pay, rather than health need, as the primary criterion on which resources and health care use are distributed within a population, and so disadvantage the poor. In addition, those health system actors that benefit from commercialization (such as insurers, private providers, the richer users) are likely to oppose any actions that threaten their privileges.

Nonetheless, one strand of health policy debate has argued that some forms of commercialization can be turned to the advantage of the poor. Revenue generation through user fees at public facilities has, for example, been seen as a means of supporting quality gains for lower income users (Russell and Gilson 1997). Some public hospitals have, therefore, established special wards targeting fee-paying, higher-income users, from whom revenue can be generated both to relieve the budgetary pressures they face and improve quality throughout the hospital (Harding and Preker 2003).

To contribute to debates on health care commercialization, this chapter explores the emerging South African experience of establishing private wards in public hospitals, considering their potential to promote equity. This focus is appropriate because the South African government has, since 1994, clearly established equity as an important driver of general health policy as well as a specific objective for public–private interactions. The chapter draws on data collected as part of a wider study[2] that sought to map the range and nature of, and rationales for developing, public–private interactions within the South African health sector. It also uses wider international evidence about similar arrangements. The chapter is intentionally exploratory, both raising questions and issues that need to be considered in the further development of private ward arrangements, and offering insights into the challenges of promoting equity within commercialized health systems.

The rest of the chapter is structured as follows. Section 16.2 presents the framework for analysis used in the chapter, and clarifies some of the key terms used in this analysis. Section 16.3 then provides a brief contextual background to South Africa. Section 16.4 describes the key elements of policy design across the three forms of private ward arrangements developing within South Africa and Section 16.5 considers the potential equity impacts of these wards, together with key influencing factors. Finally, the broad lessons of this analysis are considered in Section 16.6.

16.2 Framework of analysis

Assessing the potential of private wards to promote equity must begin with detailed consideration of the design of this policy mechanism. This section outlines the key issues that need to be considered in assessing design, and clarifies the main terms used in these discussions.

The *equity impacts* of any health system intervention are linked to how they affect the pattern of who benefits from, and who pays for, health care. Equity gains are associated with some combination of greater benefits and lower costs for lower income and less healthy users in comparison to higher income and more healthy users. Although health status improvements are the ultimate benefit offered by health care, health policy analysis often focuses on benefits in terms of access to health care or the receipt of good quality clinical care.

For there to be any possibility of promoting equity gains through private wards it is necessary that higher income patients are attracted to use these wards and that they are charged fee levels that generate a net surplus. Attracting high-income customers is usually achieved by offering higher levels of quality in private wards compared to other wards. From an equity perspective it is important that such differences are only in terms of hotel amenities (quality of food, number of beds per ward, presence of television, etc). Any differences in the clinical quality of care provided would undermine equity

because they are unlikely to reflect underlying differences in health need. In order to attract users, it may also be possible to price private wards in public hospitals below that of competitors in the private sector. Nonetheless, the fees charged in private wards must be high enough both to cover the full costs (including initial investment costs) of providing care in these wards, and to generate a surplus that can then be used to benefit public ward users. Fees below total cost levels impose the risk that resources used elsewhere in the hospital will be channelled to support the provision of care to private ward patients.

Given these starting points, Table 16.1 identifies the pattern of benefits and payments that must, in principle, be generated to ensure that private wards in public hospitals generate equity gains. This pattern is influenced by two main factors.

The first influence is the extent to which the surplus generated in the private wards is used to *subsidize* improved care in the public wards. In other words, whether the surplus is used to fund the provision of either amenities (such as better linen, fewer beds per room, radios or televisions in the room) or, preferably, inputs that would improve clinical quality of care in the public wards. Such inputs might cover a higher number of staff, a wider range of drugs or more use of laboratory or other interventions to

Table 16.1: Conditions for achieving equity gains for private wards in public hospitals

	Public ward users (low income)	*Private ward users (high income)*
Who benefits	Revenue generated in private wards used to	Revenue generated in private wards used to
	(a) improve quality of amenity care to basic standards (but remaining below that of private wards)	(a) support better amenity care than public wards (to encourage use)
	(b) support sustained improvements in quality of clinical care e.g. improve staff availability, improve equipment	(b) support levels of clinical quality of care comparable with that received by public ward users
Who pays	No fees or fees lower than those paid by private ward users	Fees higher than for public ward users and greater than total cost of providing services
	Revenue generated in private wards used to support price reductions for public ward users, e.g. reduced transport expenditure through better ambulance services	

allow better diagnostic practice. As noted, whilst it may be acceptable, from an equity perspective, for the amenities of private wards to remain above the level offered in public wards, equity would be undermined if clinical quality of care were better in the private wards. In addition, an important problem to look out for in the operation of private wards is whether there is a *reverse subsidy* flow. In other words, whether the existing budgetary resources received by the hospital from the government are used to support the provision of care in the private wards, perhaps even generating clinical quality of care differentials between private and other wards. With a reverse subsidy flow, the public budget is effectively channelled towards supporting care in the private wards at the expense of care offered in other wards.

The pattern of benefits and payments resulting from private wards is also influenced by the extent to which revenue raised from the higher income users of private wards is used to *cross-subsidize* the costs of care borne by the lower-income users of public wards. In other words, whether the activities funded by the revenue generated from the higher payments of higher-income users in the private wards lower the prices faced by the lower-income users of other wards. Relevant activities might include, as noted in Table 16.1, better ambulance services; or reallocating resources to strengthen the primary care services that are both more easily accessible than hospitals and, for many conditions, offer equally effective treatment.

Given these requirements, Table 16.1 indicates that achieving equity gains from private ward arrangements will require careful planning of charging practices and of how to use the revenue generated through private wards. Efforts should also be made to prevent limited government resources being used to fund care for private patients.

A final factor influencing the impacts of private wards on equity is the nature of the health care financing mechanisms supporting hospital use, particularly by the higher-income group. Simple fee systems may limit the level of revenue generation possible from private wards. In contrast, by allowing the risks of the high cost burdens associated with hospital use to be shared among a wider population, insurance mechanisms can, in principle, sustain higher levels of revenue generation (Barnum and Kutzin 1993). However, the size of the population covered by such insurance mechanisms and their detailed design will directly influence the level of *cross-subsidy* achieved through the mechanisms. As only a relatively small pool of people is easily insurable in lower-income countries, those in formal employment, the level of revenue generation and extent of cross-subsidy that can be achieved is probably limited.

Overall, therefore, assessing the equity gains likely from private wards must encompass consideration both of the cross-subsidy generated through the provision of care, as well as how financing mechanisms shape cross-subsidy patterns.

16.3 The South African context

The South African health system provides a stark example of a commercialized and segmented health system, within which to consider the emergence of private wards in public hospitals. Public providers serve the lower-income and largely Black African majority of the population, and private providers serve the minority high-income and largely White population. The public sector is predominantly tax-funded, although user fees are levied at hospital level. Private sector users finance their care primarily through private insurance (there are a range of different schemes), and some out-of-pocket payments.

Since 1994, much has been done within the South African public sector to promote greater health system equity. The policy changes include removing user fees for primary care, improving geographic access to facilities, implementing rational drug policies and reallocating resources geographically to reflect population need (McIntyre and Gilson 2002). However, the central equity problem of the health system has remained largely untouched by policy: the expenditure of over 50 per cent of the total pool of national health resources on the users of the private sector, who represent less than one-fifth of the population (Doherty *et al*. 2002).

Three factors underlie the failure to tackle this major inequity. First, the new policy frameworks introduced since 1994 have provided only weak support for an explicit and strategic approach to the private health sector (McIntyre and Gilson 2002), in part due to the ambivalence of some policymakers towards the private sector. The piecemeal approach adopted instead has led to a range of regulatory measures that have either been ineffective (such as efforts to contain the sector's growth by placing a moratorium on private hospital construction) or mired in controversy (such as efforts to restrict dispensing by private practitioners). Second, stagnating public health spending has encouraged public sector managers to look for alternative sources of funding, particularly public hospital managers whose budgets have been squeezed in the effort to reallocate resources to primary care. Total public health sector spending levels fell by 2.5 per cent between 1997/8 and 1998/9 (Doherty *et al*. 2002) and it is expected that real per capita public health expenditure will have declined by 0.5 per cent per year between 1997/98 and 2005/6 (National Department of Health 2003). Third, across sectors and in line with overall macro-economic policy, the national Treasury has strongly encouraged moves towards the greater involvement of private agents in public sector activity. Some provincial health departments have quite enthusiastically responded to this encouragement.

In addition, there are pressures from private sector agents wanting to enter into partnerships with government. One set of agents are those who have for a long time been involved in public health care provision (ranging from private hospital companies to groups offering non-clinical services). In 1995, the value of government contracts with such organizations was estimated as equivalent to 9.4 per cent of the total public hospital budget

(Monitor Company *et al*. 1996). Although private hospital companies see themselves as in competition with the public sector, some forms of public–private interactions (such as the co-location model of private wards in public hospitals) may allow them to expand their market base.

Private insurers also see arrangements with the public sector as a mechanism to extend their market. Given an environment where new regulatory frameworks are having an impact on their business, membership levels are stagnating and private provider costs are escalating, insurers must enhance the affordability of their benefit packages both for existing and potential new and lower-income members (Macleod 2003). Engaging public hospitals as preferred providers offers important cost advantages to the insurance industry. It may also provide the basis for them to play a continued role within the keenly awaited Social Health Insurance scheme that is likely to offer public hospital care to the currently uninsured, but formally employed, population (McIntyre *et al*. 2003).

In response to these pressures, various forms of interactions with the private health sector are emerging within South Africa. They include the extension of longstanding contracts for non-clinical care, a few private finance initiatives for equipment and facility management, and 'joint ventures', including the establishment of private wards in public hospitals (Wadee *et al*. 2003a). Treasury guidelines on public–private partnerships strongly emphasize the pursuit of efficiency through such arrangements (National Treasury 2000). However, health policy documents express concern about the need to balance efficiency considerations with those of equity and sustainability (National Department of Health 2001). They also suggest that in some instances public–private interactions may have potential to generate 'community benefit', understood to mean gains such as better access for disadvantaged population groups, health personnel retention or new models of service delivery (National Department of Health 2000).

Although the scale of private wards is currently quite limited, it is growing. Three out of the nine provinces are developing such arrangements; in one, the number of public hospitals considering or offering private beds has risen from one in 2002 to four in 2004. In another, around ten hospitals offer 250 such beds in 2004, from a zero base in 2000. As there is little evidence yet on the operation or impacts of such wards, early reflection on these matters is important in planning and evaluating future developments.

16.4 The design of private wards in public hospitals

Three different approaches to instituting private wards within public hospitals are developing within South Africa: co-location, the private ward network (PWN) and differentiated amenities (DA). Each is discussed here across the range of issues identified in Section 16.2 as influencing equity impacts, and summarized in Table 16.2. The PWN and DA options are both similar to each

Table 16.2: Three options for establishing private wards in public hospitals: key elements in South Africa

	Co-location	*Private ward network (PWN)*	*Differentiated amenities (DA)*
Private ward ownership & Investment	• Publicly owned but leased to private hospital company for specific period, which makes initial investment	• Public	• Public
Quality differentials between private and public wards	• Hotel facilities of private wards improved • Some services & equipment shared between public & private patients • Private doctors treat private patients	• No clinical quality differentials intended • Public doctors treat private patients.	• No clinical quality differentials intended • Public doctors treat private patients.
Pricing practices	• Fee set at private sector rates • Fee-for-service pricing basis	• Fee set slightly above existing public sector fee rates, but lower than recommended private sector rates	• Fee set slightly above existing public sector fee rates, but lower than recommended private sector rates
Revenue generation	• Rent, under lease agreement • Share of private provider profits • Charging private patients for use of public services	• Revenue from patient fees	• Revenue from patient fees

Table 16.2: (Continued)

	Co-location	*Private bed network (PWN)*	*Differentiated amenities (DA)*
Revenue retention & revenue use decision-making	• Portion of revenue retained at hospital level	• Portion of revenue added to provincial department of health & hospital budgets	• Portion of revenue retained at hospital level
	• Revenue use intended to improve quality in public wards	• Revenue use intended to improve service delivery for all population	• Revenue use in hospital to maintain private ward amenity standards & improve quality in public wards
	• Portion of revenue returned to provincial Treasury (for redistribution in provincial health system)	• Decisions on revenue use made at provincial level & by hospital managers	• Portion of revenue returned to provincial health department to improve referral networks
User financing mechanisms	• Private patients: private insurance or out-of-pocket payments	• Private patients: low-cost private insurance schemes (government hospitals as preferred provider) and/or out-of-pocket payments	• Private patients: low-cost private insurance schemes (government hospitals as preferred provider) and/or out-of-pocket payments
	• Public patients: normal user fees (graduated by level of income); plus tax-funded budgets		

other, and most like the type of arrangement introduced in other countries. Co-location is, however, unusual. Where relevant, the following discussion compares the design of the South African private wards with similar arrangements in Indonesia (Lieberman and Alkatari 2003; Suwandono *et al*. 2001), Singapore (Puah 2003) and Zambia (Blas and Limbambala 2001; Hanson *et al*. 2002; Nakamba *et al*. 2002a, 2002b).

Private ward ownership/investment, and quality differentials with public wards

Some differences between the models can be seen in ownership and initial investment patterns. In co-location agreements, unused publicly owned hospital bed capacity is leased to a private hospital company for a set period, after which time the lease is either renewed or the bed capacity is returned to public management. The private company both makes the initial capital investments and manages the wards for the duration of the lease period. In contrast, the initial investment in publicly owned and operated wards is made by the public sector under both the PWN and DA options. Across options, these initial investments build in a quality differential in hotel amenities in comparison to public wards. Like the United Kingdom (Fattore 1999) and Zambia, but unlike Indonesia and Singapore, only two tiers have been introduced, with single and double private wards offering amenities such as air-conditioning, television and private bathrooms. Under the co-location agreement it is possible that clinical quality of care differentials may also emerge between public and private wards, although there is an explicit intention *not* to allow such differentials under the PWN and DA options.

Pricing practices

Across all options prices for private wards are set on a fee-for-service basis. Private sector billing practices and guidelines are used in setting fees for the co-location option, presumably allowing for a profit margin. For the PWN and DA options, the public sector's uniform patient fee schedule has informed price-setting. Prices are also set below private sector rates to make private wards attractive, relative to private hospitals, for health care users and insurers. However, it is unclear whether these prices, and those set for use of public facilities by private patients under the co-location option, are high enough to recover full costs.

Revenue generation, retention and use

The key differences between the options are rooted in the intended practices of revenue generation, retention and use.

Under the co-location agreement the main revenue source for the public sector is the rental paid as part of the lease. In addition, a proportion of the private agent's turnover is shared with the public sector and the public

sector charges private patients on a fee-for-service basis for services used within the public wing of the hospital (such as radiology). A portion of the revenue is then retained at hospital level for use, in principle, in improving general hospital quality, and a portion is returned to the provincial Treasury for redistribution within the health system.

In contrast, under both the PWN and DA options revenue is generated primarily via fee-for-service billing of private patients. In addition, insurance schemes pay initial deposits under the PWN scheme to reserve beds for their members. In both cases, under agreement with the provincial Treasury, a portion of the revenue is effectively retained by the facility if the actual levels of revenue exceed forecast levels for the financial year. Hospital managers then determine how to use this revenue. With the DA option, for example, there is an understanding that the revenue will be used to maintain amenity standards in the private wards as well as, over time, to improve amenity care throughout the hospital. In addition, it is intended that some of revenue retained at provincial level will be used to strengthen health facility referral networks.

Across options, therefore, hospital managers' influence over revenue use is limited to the portion of revenue retained at facility level. Other countries often provide specific guidelines on revenue generation and use, to shape managerial decision-making. These include caps on: the proportion of revenue that can be generated from private wards (Singapore); the proportion of private beds allowed within a hospital (Indonesia); the proportion of revenue that can be used for personnel incentives (Indonesia); and the types of other items that can be purchased with the revenue (Indonesia and Singapore).

User financing mechanisms

In South Africa, like some other middle-income countries, the dominant financing mechanism for users of private wards across all three options is private insurance, although some users may also pay out of pocket. However, whereas co-location arrangements target the higher-income end of the market, the PWN and DA options target the lower-income and currently uninsured population. Public wards, as in other countries, are financed primarily through a combination of general taxation and user fees that are lower than those for private wards, with care provided at no cost to those uninsured and unable to afford charges.

16.5 Potential equity impacts: considering design and wider influences

Although few data are yet available with which to assess the equity impacts of private wards in South Africa, experience from, in particular, Indonesia, Singapore and Zambia indicates that there are many obstacles to achieving such gains. These reflect problems of design, as well as wider influences over private ward operations.

Revenue generation

A study of three facilities in Indonesia found that although revenue generation increased as a result of the private ward arrangements, cost-recovery rates ranged from only 0.44 to 0.72. Indonesia's cost-recovery efforts are particularly constrained by physicians' retention of their portion of the fees charged, which amounts to 48–60 per cent of total revenue raised. In Singapore, the cap on revenue generation levels affects all facilities, although tertiary hospitals achieve higher cost-recovery rates than community hospitals. Analysts also suggest that cost-recovery levels are weak in Zambia and Uganda.

In some cases low cost-recovery levels may be explained by weak public sector capacity. For example, as cost data did not appear to be used in setting prices in Zambia, it is not surprising that revenue generation was limited. In other countries, weak government capacity to negotiate with key groups can undermine revenue generation (Hawkins and Ham 2003). Interested actors include private sector agents (providers or insurers), the potential users of private wards, the potential opponents of the arrangements (such as trades unions in South Africa) and health professionals (see below).

Although the South African public sector's uniform patient fee schedule has been used as the basis for pricing in both the PWN and DA models, it is unclear whether these prices reflect the costs of provision, as well as the initial capital investments. Some public sector officials, as well as private insurers and private hospital managers, raise concerns about the capacity of the public sector to set private ward prices appropriately. Few cost data for public hospitals are available. There is also debate about whether public hospital prices should allow for the costs of activities provided by other public agents (for instance, maintenance undertaken by public works departments), as well as what portion of hospital overheads should be included in the price of private wards.

Routine collection of cost data and careful decision-making around private ward prices are required as a basis for revenue generation under the PWN and DA options. For co-location, the concerns are that the public sector must not only set appropriate prices for the specific services used by private patients but also, and even more difficult, establish fair profit-sharing arrangements. Private providers are likely to be tough negotiators, seeking an agreement that benefits them over the public sector. Based on wider experiences in the South African health sector, public sector managers are likely to require support in conducting such negotiations.

Another factor influencing revenue generation levels will be the utilization levels of private wards. Given alternative suppliers, setting private ward prices too high may encourage demand shifts towards private hospitals, a concern also raised in Indonesia. It is unclear whether the population groups targeted by new low-cost insurance packages in South Africa will find the public sector sufficiently attractive. The country has a well-established private hospital

market, and there is emerging evidence of a shift towards use of private services since 1994, perhaps because of public perceptions of poor public hospital care, even amongst those without medical aid (Wadee *et al*. 2003b). There is already some concern among insurers about the limited take-up of existing low-cost insurance options and there are one or two examples of failure with private ward type arrangements as a result of lower than expected utilization levels.

To mobilize patient demand, a better understanding of the market context is likely to be a necessary foundation for all options – again requiring new forms of public sector management capacity. Such understanding could, for example, provide the basis for marketing public hospitals in ways that address users' current concerns, and sell their strengths (such as excellent clinical care quality). The co-location arrangement may be less risky in this regard because it is not linked to low-cost insurance schemes and can be marketed as a privately managed hospital ward without the potentially negative connotations of 'public hospital'. However, as noted, its revenue generation potential for the public sector is subject to probably difficult negotiations with the private sector.

Subsidy and cross-subsidy

Low levels of revenue generation inevitably limit the possibilities of securing subsidy or cross-subsidy from private wards. Even where a net surplus is raised, the way it is used may not generate the benefits anticipated. For example, system-wide efforts to contain costs in Singapore were undermined by purchasing new medical technology with the revenue generated from private wards. At the same time, the financial incentives for medical personnel funded through the revenue were insufficient to ensure personnel retention, and caused conflict between medical staff because they were only allocated to some personnel categories.

Another key concern about the impacts of private ward arrangements is that their existence may generate a private ward bias in resource allocation patterns at hospital level, which may even have the potential to undermine the clinical quality of care offered in public wards (Hakkinen 1999; Hanson *et al*. 2002; Theurl 1999). There is clear international evidence of such a resource allocation bias. In Singapore, the general budgetary funds available to hospitals are used to fund the care provided to patients in private wards. In Indonesia, the proportion of public sector beds in hospitals has fallen despite a cap on private bed numbers. Finally, analysis of experience in two Zambian hospitals also demonstrates that overall resource use favoured private ward patients. These patients were more likely to be provided with drugs prescribed, and benefited from disproportionate amounts of surgical time and higher allocations of clinical and non-clinical staff, than patients in public wards.

Four key features of policy design and implementation practices in South Africa suggest that there is a strong potential for similar problems to result from the new private ward arrangements.

First, the fee-for-service mechanism through which providers are paid throughout the private sector offers incentives for providers to overservice their patients, as evidenced by the high levels of cost inflation in the private sector (Macleod 2003). Under the DA and PWN options there is, therefore, a danger that private ward patients will receive more drugs or a greater number of diagnostic tests than public ward patients, or that the number of private beds will increase, at the expense of services within public wards. Current efforts to explore alternative reimbursement mechanisms identify ways of limiting this danger. The co-location option may, anyway, be less affected by this problem because of the clear management separation between public and private wards in the same hospital.

Second, it is unclear whether specific procedures are in place to guide decision-making in South Africa. Guidelines can at least provide some guidance on revenue use (though may be ineffective, as with the Indonesian cap on private beds, or create their own problems, as with the Singaporean support of medical technology purchase). Also important are the routine monitoring and evaluation procedures that identify problems before they become entrenched and support remedial action. Little or no effort has yet been made to build such capacity in South Africa, for any form of public–private interaction (Wadee *et al*. 2003a). Monitoring quality gains/losses may be especially tricky with respect to the co-location option, unless agreements clearly specify quality indicators and reporting practices.

Third, only limited consideration has apparently been given to the governance mechanisms required to support implementation in the public interest. In Singapore, for example, a holding company was specifically established to oversee the reform and supervise reforming hospitals; albeit leading to some increase in administrative costs. In South Africa, accountability mechanisms, particularly for revenue use, are unclear. Co-location contracts should offer a mechanism for accountability in private ward operation, and agreements with the Treasury may offer some accountability in relation to revenue generation under each option.

Fourth, government capacity to negotiate effectively with key actors and to manage implementation processes is relatively weak, yet Indonesian and Singaporean experience demonstrates its importance. In both countries, initial physician support for private wards may have been influenced by the decision to allow them to retain a portion of the fee charged. However, this design element both lowered overall revenue generation levels and led to friction with the specialists who received no incentive. It also proved difficult to change in the face of resistance from the benefiting physicians. As the dominant practice within the private sector in South Africa, it seems likely that medical professionals will try to secure at least a portion of the physician

fee component of prices for themselves. In addition, concerns have already been expressed about the potential for the differential distribution of incentives resulting from private ward arrangements to generate conflict among staff. The initial efforts to consider alternative reimbursement mechanisms under the PWN option are important to note in this regard.

One other noteworthy design point of all three South African options is that at least some portion of revenue is returned to the provincial Treasury for redistribution within the health system. This link between revenue mobilization and resource allocation may have some potential to support positive policy impacts. For example, if the returned revenue is used to increase budget allocations to lower levels of health care then this might be seen positively, given the recognized importance of primary care in treating common health problems. However, this impact is linked both to how much revenue is returned and how it is allocated within the sector. Historical health sector expenditure patterns indicate that it has so far been difficult to move expenditure out of hospitals and towards primary care levels (Doherty *et al*. 2002).

Overall, therefore, with current designs, only the largely separate management of private wards under a co-location agreement seems likely to constrain a reverse cross-subsidy. However, with co-location, the extent of reverse cross-subsidy may be determined by the extent of shared resources. For instance, with senior clinicians treating patients in both public and private wards, there is the potential to spend disproportionate amounts of time in private revenue-generating ward activities, at the expense of quality in the public.

The final factor that will influence cross-subsidy patterns is the nature of the broader health care financing mechanism. Little international evidence is available on this issue. In South Africa the dominance of private insurance in financing the use of private wards is likely to limit the potential for cross-subsidy from high- to low-income population groups across options.

Only around 16 per cent of the population has medical insurance (Doherty *et al*. 2002), and there are currently no mechanisms to channel financial flows from the insured to the uninsured. Policy debates suggest there is likely to be little change to this situation in the near future. Whilst current (2004) proposals to implement a risk equalization mechanism within the insurance sector may allow the more wealthy to cross-subsidize the less wealthy amongst the insured population, they will not tackle the broader divide between the insured and the uninsured. In addition, even if insurance was extended to the currently uninsured but formally employed population, through social health insurance, the pool of insured would remain quite small, limiting the extent of cross-subsidy (McIntyre *et al*. 2003). Perhaps most important, however, is the recent decision *not* to alter tax subsidies for medical insurance (Roux 2004), which sustains a tax privilege captured only by the wealthy. In 2002 the value of the tax subsidy per insured beneficiary

was estimated to be greater than the amount spent from government funds per public sector beneficiary (Macleod 2003). This tax subsidy is particularly controversial as those with the highest incomes receive the greatest subsidy. Significant reform of the current insurance environment is, thus, required to promote cross-subsidy at the population level throughout the health system.

16.6 Conclusion

Private wards in public hospitals are being developed in South Africa as a mechanism of generating revenue and benefits, such as improved quality and the retention of personnel, for the broad pool of lower-income public hospital users. However, this exploratory analysis suggests that achieving such gains will be very difficult. Instead, there is real potential for the operation of these wards to benefit the rich at the expense of the poor.

This analysis suggests that the design and management issues most likely to influence the impacts of private ward arrangements are whether:

- cost data and knowledge of the market are used in establishing the prices and benefits of these wards;
- the incentives for overservicing associated with paying providers on a fee-for-service basis can be countered by introducing alternative reimbursement mechanisms and/or guidance on revenue generation and use;
- government actors can develop the capacity to negotiate effectively with private sector actors, particularly under the co-location option;
- governance structures are established that act to promote the interests of poorer patients;
- the impacts of private wards are evaluated and monitored over time, allowing problems to be picked up early and addressed;
- the overall health sector financing system is supportive of cross-subsidy at the population level.

More generally, this exploration of experience with private ward arrangements highlights the peculiar and difficult management challenges of working within commercialized health systems.

In such systems public sector managers have to think explicitly and carefully about the market in which they operate, and the incentives driving professional and managerial practices. They must not only understand their own businesses but also that of their competitors. They have to be able to negotiate with these actors, as well as with powerful professional groups. They have to make realistic decisions about the possible returns on this new business strategy, and how to set prices to support the achievement of these returns. Yet at the same time, and unlike those working in the private sector, public sector managers have constantly to make decisions that try to protect the interests of their primary user group, the poor population.

The rules and procedures that represent the core of current public sector management practices are inadequate tools with which to manage within commercialized systems. However, simply importing management practices from the business sector will also fail to support the achievement of public sector goals as the task of management in the public sector is more complex. New approaches to public sector management are required that balance commercial practices with concern for equity.

Notes

1. We thank the people interviewed for the study that underpins this chapter, and the colleagues involved in that study (Duane Blaauw, Ermin Erasmus, Okore Okorafor and Michael Thiede). We are particularly grateful to Di McIntyre and Maureen Mackintosh for their support. Funding for this work was received from UNRISD, the Health Systems Trust of South Africa, and The Wellcome Trust. All views expressed in this chapter are the authors' own.
2. The study involved analysis of policy documents, interviews with key informants (selected for their knowledge and involvement in policy processes around PPIs), and a review of media reporting on the subject. A fuller report of the study is available (Wadee *et al*. 2003a).

17

Public Expenditure Allocation and Incidence under Health Care Market Liberalization: a Tanzanian Case Study

Tausi Mbaga Kida and Maureen Mackintosh[1]

17.1 Introduction: public expenditure and health care commercialization

The arguments for health care commercialization in the international policy literature have been strongly reliant on the premise that promotion of the private sector 'frees' public sector resources for the poor (World Bank 1993). Concurrently, policies to address poverty, including those of the Tanzanian government, actively seek to shift public expenditure on health in a more 'pro-poor' direction (URT 2000, 2003b). Potential conflicts between health care commercialization (promoted through health sector reform policies) and poverty-focused public expenditure policies are widely remarked upon by African policy analysts (Mackintosh 2001), yet are insufficiently researched.

This chapter aims to contribute to identifying and addressing that gap in the international health policy debate. The Tanzanian health policy context is one of widespread and severe poverty and an extensively commercialized health care system (URT 2002b; Tibandebage and Mackintosh forthcoming). This chapter first contributes evidence of commercialization of health care at all income levels in Tanzania, drawing on data on the utilization of private health care facilities in urban and rural areas. It then examines available evidence on the allocation and incidence of public expenditure on health in this context, in particular the benefits for the poorest part of the population. Since all income groups use private as well as public care, and since people's

capacity to benefit from public subsidy to health care in this commercialized system depends upon ability to pay the fees and other associated costs of publicly subsidized care, people face a barrier to accessing the subsidy. We conclude that policies that encourage commercialization should be evaluated carefully for conflicts with policies that attempt to improve the extent to which the poorest benefit from public expenditure on health.

17.2 Commercialization of Tanzanian health care and public expenditure policies

Tanzania went through severe economic crisis in the 1980s, which adversely affected financing of basic social services including health services (Wangwe *et al*. 1998). Underfunding of the public health care delivery system at all levels led to quality decline and a fall in provision, including shortage of drugs and medical supplies, overall deterioration of the physical health infrastructure and low wages for health workers resulting in low staff morale and increasing resort to informal charging. In response, since the early 1990s, the government has promoted health sector reforms with the primary objective of increasing funding for the sector. In 1991 the government legalized private clinical practice after a period from 1977 when it had been banned. The outcome was a rapid increase in the number of private facilities (Table 17.1). By 2001, 21 per cent of registered dispensaries were in the commercial sector, and this is likely to be an underestimate (Tibandebage *et al*. 2001). The rise of

Table 17.1: Mainland Tanzania: health facilities and bed numbers, 1992 and 2001

Year and level	*Ownership*				
	Government	*Voluntary*	*Parastatal*	*Private**	*Total*
1992					
Hospital	77	84	9	4	174
Health centre	265	8	2	1	276
Dispensary	2218	585	175	36	3014
Hospital beds	12015	11437	568	110	24130
Health centre beds	5598	124	18		5740
2001					
Hospital	85	81	13	29	208
Health centre	292	69	5	36	402
Dispensary	2683	598	187	912	4380
Hospital beds	15464	12395	1030	893	29782
Health centre beds	6184	2222	83	492	8981

Note: *In 1992 'other' has been put in this column. No privately owned facilities were licensed before 1991.
Sources: URT 1993, 2002c.

private facilities was accompanied by the introduction of user fees for access to public hospitals and later to urban and rural government dispensaries. The result by the late 1990s was a health care system where almost all consultations and treatments required payment (Mackintosh and Tibandebage 2002).

Health is one of the priority sectors in Tanzanian poverty reduction efforts (URT 2000). In the Poverty Reduction Strategy, health sector funding by government is expected to increase both absolutely and as a share of the budget, and this shift has been managed in practice through a Sector Wide Approach (SWAp).[2] A SWAp entails pooling of donor funds into one basket with the aim of providing budgetary support allocated according to government priorities. Some donor agencies have agreed to use a joint funding mechanism known as the Health Sector Basket Fund (HSBF), or joint disbursement mechanism, to finance the Ministry of Health annual Plan of Action. These changes are associated with a decentralization programme that allocates health care funding through the local government structures (URT 2002d).

Spending on the health sector appears to have increased, and the allocation to primary health care has also improved. Both allocation to and expenditure on the health sector as a whole have grown substantially since fiscal year (FY) 2000, with increases coming from both government and basket funds (Table 17.2). The nominal spending on the health sector for 2001/2 showed a large above-inflation increase over the previous year,[3] and budgeted spending for 2002/3 showed further large increases, particularly in on-budget and recurrent spending, based on a planned increase of over 80 per cent in the donor basket fund (URT 2003a). Furthermore, in line with the decentralization programme, the health funds allocated to the local government level rose (Table 17.2), with implications for the needs of the majority of the poor who live in the rural areas. Decentralization is expected to enhance service delivery at the most accessible level for the majority of health service beneficiaries. Table 17.2 also shows the continuing importance of off-budget donor-financed spending within the total health budget (URT 2003a).

Tanzanian policies therefore encompass a shift to higher and more progressive public expenditure allocation for health care, and also rising commercialization of the health system investigated in Section 17.3

17.3 Use of private health care facilities

There is a widely proposed view that the liberalization of health services can be expected to create a move of the better-off towards the private facilities, 'freeing' the public health facilities for use by the poor, and that this is desirable. The point has been repeatedly made in World Bank documents, and continues to be promoted, for example:

> A more radical approach would be to get the better-off out of government facilities altogether . . . by, say, using government regulatory powers

Table 17.2: Total public health expenditure in Tanzania (billions of shillings)

	1998/99	*1999/2000*	*2000/2001*	*2001/2002*	*2002/2003*
	Actual	*Actual*	*Actual*	*Actual*	*Budget*
Recurrent expenditure					
Ministry of Health	37.15	32.39	44.25	58.99	86.94
Regions	8.68	9.01	5.61	6.58	7.60
Local govt.	16.34	17.95	35.67	46.28	57.66
Total recurrent	62.18	59.34	85.53	111.86	152.20
Development expenditure					
Ministry of Health	17.27	10.19	14.84	21.12	33.78
Regions	0.67	0.79	1.39	1.28	4.75
Local govt.	–	1.06	1.52	–	2.04
Total development	17.94	12.03	17.74	22.40	40.57
Total on-budget	**80.11**	**71.38**	**103.27**	**134.26**	**192.77**
Off-budget expenditure					
Cost sharing	1.09	1.49	1.86	1.37	1.20
Other foreign funds	42.76	60.04	75.00	79.37	49.25
Total off-budget	**43.85**	**61.53**	**76.86**	**80.74**	**50.45**
Grand total	**123.96**	**132.91**	**180.13**	**215.01**	**243.23**

Note: US$1=1106 Tshs, mean exchange rate November 2004 (*source*: Bank of Tanzania website).
Source: URT 2003a.

> to foster the establishment of a fully self-financing private commercial health sector serving the better off. (Gwatkin 2003)

This proposition assumes both that 'government regulatory powers' can determine health seeking behaviour, and that, once liberalized, the market can and will segment in the manner proposed.

We show in this section, based on Tanzanian household survey data, that these expectations are not fulfilled in this very low-income context. The data on utilization of private health care facilities are drawn the database of the *Household Budget Survey* (HBS) 2000/1.[4] The HBS provides evidence on the utilization of public and private health facilities by the population by income quintiles and geographical location. The geographical division is between urban and rural settings. The HBS categorized urban areas into two: the capital, Dar es Salaam, and 'other urban'. This division was seen as important given the wide income gap between Dar es Salaam and other urban areas. The survey confirmed that Dar es Salaam is substantially better

off than the rest of the country, and found the rural households to be much poorer than their urban equivalents by almost any indicator (URT 2002a).

The HBS collected information on household members reporting illness during the previous four weeks, and sources of consultation including public and private facilities, mission facilities, pharmacies and traditional healers. Table 17.3 shows the rate of consultation of private dispensaries, health centres and hospitals by income quintile,[5] and the share of each quintile in all consultations. The column labelled '% private' shows, for each area, the percentage of those reporting that they sought treatment for illness in the previous four weeks who consulted private facilities. (These figures do not include the small numbers registered as consulting 'private doctors and dentists', nor consultations in pharmacies and with traditional healers.) We find that the rate of consultation of the private sector is lower in the lower income quintiles in urban areas, including the capital Dar es Salaam, but surprisingly, the data show a quite similar rate of consultation of the private sector across quintiles in rural areas.[6]

Table 17.3 also shows that overall in the Tanzania mainland, and in rural areas in particular, a more than proportionate share of all consultations undertaken with private health facilities were by people from the poorest quintile (see the column labelled '% of total private'). In the urban areas, however, the share of total recorded visits to private facilities is weighted toward the top end of the income distribution.

These results reinforce other evidence showing that despite continuing subsidy of public facilities, poor people also use private health care provision extensively (Gwatkin *et al*. 2000). The private facilities are not in general the

Table 17.3: Percentage of those seeking treatment for illness who went to private facilities, and percentage of total private consultations, each by quintile and geographical area

*Quintiles**	*Dar es Salaam*		*Other urban*		*Rural*		*Tanzania mainland*	
	% private	*% of total private*	*% private*	*% of total private*	*% private*	*% of total private*	*% private*	*% of total private*
1	33	8	27	15	20	29	21	24
2	43	15	26	15	17	21	19	19
3	35	13	30	18	16	17	18	17
4	53	21	34	25	19	18	23	19
5	54	44	36	27	22	15	29	20
All quintiles	46	100	31	100	18	100	22	100

*Quintiles of the population by income from the lowest 20 per cent (1) to the highest 20 per cent (5) by income levels.
Source: National Bureau of Statistics (NBS), based on HBS 2000/1 database.

sole preserve of the better-off – though for the expensive private hospitals in Dar es Salaam this will of course be the case. The vast majority of private facilities are small dispensaries (Table 17.1), and are often more geographically accessible, especially in Dar es Salaam, than government facilities. Table 17.3 indicates that of those using private facilities in Dar es Salaam, 44 per cent are from the highest quintile compared to only 8 per cent from the lowest quintile. This is in part because the Dar es Salaam population includes a more than proportionate share of the people in the country in the top income quintile. It is also the case that the mean income level of people in the highest quintile who are resident in Dar es Salaam is considerably higher than the mean income of people in the top quintile in the rest of the country (see Table 17.9 below).

17.4 The incidence of district-level public health expenditure in Tanzania

In this context, how are the benefits from public expenditure on health at district level in Tanzania distributed? In particular, to what extent does this public expenditure benefit the poorest part of the population in urban and rural areas? This section investigates the incidence of public expenditure on health care at district level, in so far as the available data allow, in three stages (Demery n.d.; Davoodi *et al*. 2003). First, we analyse the utilization of public health care facilities, again using data from the database of the *Household Budget Survey* (HBS) 2000/1. Second, we analyse the public expenditure allocation on health by level of the health care system using *Health Sector Public Expenditure Review* (PER) update 2003 (URT 2003a), and findings of the Tanzanian *Census* 2002 (URT 2003c). Third, we bring together these results to analyse the benefit incidence of the public subsidy to health care by income group and by geographical location.

Utilization of public health care facilities

In obtaining information concerning consultation of public health facilities, the HBS 2001 questionnaire unfortunately lumped together responses for public hospitals, health centres and dispensaries. Therefore in this analysis we are unable to separate the utilization of these levels. Table 17.4 shows the number of people consulting any provider in the previous four weeks, and the percentage of those who consulted a public hospital, health centre or dispensary by income quintile and geographical location. The 'public facilities' category does not include visits to 'community health centres'[7] nor regional hospital visits.[8]

The relatively low variation across quintiles and geographical areas in the percentage consulting public facilities is striking, demonstrating widespread reliance upon the public sector for health care in all income groups and geographical areas. In urban areas it is quintile 2 (the second lowest) which

Table 17.4: Number consulting any provider, and percentage of those who consulted public hospitals and dispensaries, by income quintile and geographical area

Quintiles	*DSM*		*Other urban*		*Rural*		*Tanzania mainland*	
	All consult.	*% public*	*All consult.*	*% public*	*All consult.*	*% public*	*All consult.*	*% public*
1	32 367	40	140 904	37	1 357 186	40	1 530 457	40
2	49 933	50	144 992	47	1 151 796	43	1 346 720	43
3	51 660	45	152 405	39	1 039 160	44	1 243 225	43
4	55 647	37	186 719	34	870 094	45	1 112 460	43
5	115 334	38	189 354	35	621 857	42	926 545	40
All quintiles	304 942	41	814 374	38	5 040 093	43	6 159 408	42

Source: National Bureau of Statistics (NBS), data provided based on HBS 2000/1 database.

displays the highest rates of public health services utilization among those consulting; nationally, the variation is particularly low.

Table 17.5 shows the distribution of the total of these consultations in public facilities (district hospitals, health centres and dispensaries) by quintile for each geographical area.[9]

Tanzania is predominantly rural. Therefore the rural area findings dominate the national results. Of the total of those who consulted public health care facilities in rural areas and nationally, a more than proportionate share came from the lowest two quintiles, and the share in total use of the public sector falls as income rises. In the urban areas – and strikingly in Dar es Salaam – the situation is different; in urban areas outside the capital there is rather little variation, while in Dar es Salaam, 35 per cent of users of public facilities were from the highest income quintile.

Table 17.5: Consultations in public health facilities: percentage of total consultations by quintile

Quintiles	*Dar es Salaam*	*Other urban*	*Rural*	*Tanzania mainland*
1	10	17	25	23
2	20	22	23	23
3	19	19	21	21
4	16	21	18	19
5	35	22	12	14
Total consultations in public facilities	100	100	100	100

Source: National Bureau of Statistics (NBS), data provided based on HBS 2000/1 database.

Considering these two tables together suggests that the utilization of public health facilities, like private facilities, in different geographical areas is strongly influenced by the geographical distribution of income. That is, the top income quintile is disproportionately concentrated in Dar es Salaam, which has relatively few members of the lowest quintiles as compared to the rest of the country. The pattern of consultations in Table 17.5 may also influenced by different rates of consultation when ill by income quintiles (see Section 17.5 below).

Public health expenditure allocation at the local government and district levels

The district level has been identified by government as the priority level of health care delivery. One measure of district level public health expenditure used here is therefore the expenditure allocation to Local Government Authorities (LGAs) as reported in the PER 2003. As explained above, these allocations have been increased by decentralization policies, and are destined in principle for district hospitals, health centres and dispensaries rather than regional or referral hospitals.[10] We also present a second measure, based on the allocation of total recurrent health care spending by level of the health care system as reported by the Ministry of Health statisticians in the PER 2003. We have included in our second measure estimates of district level spending on primary and preventive care, including donor provision of primary health care kits.

On the first measure, the government allocated Tshs 35.48 billion for health expenditure by LGAs in FY 2002. The PER 2003 indicates that out of these, Tshs 7.06 billion were allocated to urban and 28.42 billion to rural districts. These data should be interpreted with caution because the analysis of total government subventions on health to LGAs is incomplete; it does not include a complete breakdown of centrally produced drugs and supplies nor the amount of money allocated to LGAs through the basket funds. Problems include a lack of up-to-date and accurate data on allocation of centrally produced supplies, and the fact that basket funds have been allocated only to those districts which have qualified as reforming districts in Phase 1 or 2.

Furthermore, the urban/rural breakdown of the PER LGA data does not separate the allocation to Dar es Salaam. We estimated the allocation to Dar es Salaam by employing the figure given in the PER for the per capita allocation of Tsh 887 to Dar es Salaam (URT 2003a: 27) multiplied by the population of Dar es Salaam as given in the 2002 Census estimates (URT 2003c). This gave an estimate of Tsh 1.73 billion public expenditure on health allocated to Dar es Salaam region at LGA level. Subtracting this from the total allocation to urban areas gave an estimated allocation to 'other urban' areas of Tsh 5.33 billion.

The second measure is substantially larger, but cannot be broken down into rural and urban. Total recurrent health care spending to the district level

is estimated at Tsh 62.31 billion. This figure has been obtained by adding up recurrent spending to all district hospitals, designated district hospitals (that is, government-funded district hospitals run by religious missions) and preventive/primary health care, as they are reported in PER (2003: 11).[11] The figure has further been adjusted by adding Tshs 5 billion as an estimate of misclassified funds for essential drugs, including drug kits supported by Danida Health Sector Support Programme, that were included within the Development Budget rather than the Recurrent Budget for the Ministry of Health (URT 2003a: 11). These data should also be treated with caution, as some data are missing; again drugs and supplies data by level are incomplete (URT 2003a: 11). The data include both 'preventive' and 'curative' spending estimates and the PER 2003 notes that there are difficulties in clearly distinguishing between these two, particularly at the point of entry into the formal public health system

Table 17.6 reports these two measures in column 1; the first four rows show the first measure broken down by geographical region and for the mainland as a whole; the final row shows the second measure. In Table 17.6 we also report our estimates of the number of annual consultations at public health care facilities in the different geographical locations, using the HBS 2000/1 data. The HBS collected information on consultations at different health care facilities in the preceding four-week period. We have multiplied this up to fifty-two weeks. This estimate of annual consultations is likely to be low since the HBS 2000/1 did not record multiple visits to a single type of provider within the specified period of time. Based on these figures, the final column provides estimates of the amount of subsidy per consultation in the different areas. Recall that we are unable to further disaggregate the

Table 17.6: Estimates of public health expenditure allocation to district level health care (district hospitals, preventive/primary health care), fiscal year 2002

	Expenditure allocation	*Annual consultation numbers*	*Average subsidy per consultation (Tshs)*
Dar es Salaam*	1 727 793 692	1 632 750	1 058
Other Urban*	5 332 206 308	4 016 247	1 328
Rural*	28 420 000 000	27 883 159	1 019
LGAs			
Mainland Tanzania 1*	35 480 000 000	33 532 157	1 058
Districts Preventive/ PHC allocation			
Mainland Tanzania 2**	62 310 000 000	33 532 157	1 858

*subvention to Local Government Authorities
**total estimated allocation at district level, Tanzanian mainland
Source: URT 2003a and HBS database.

district level subsidy by hospital/ dispensary visits since the HBS data do not permit it.

Benefit incidence analysis

We now bring these findings together to create an estimate of the benefit incidence of public health expenditure allocation to district level in Tanzania; that is, we examine what can be learned from the data available about who is benefiting most from the public expenditure, by geographical location and income quintiles. Table 17.7 applies the percentages of total utilization in Table 17.5 to the expenditure totals in Table 17.6, to estimate total subsidy by income quintile.

Tables 17.5 and 17.7 indicate that overall the public health expenditure allocation at the district level is 'pro-poor', that is, it is enjoyed more than proportionately by the lowest income quintile of the population. The data show that, nationally, 46 per cent of the public health expenditure at district level benefits the two lowest income quintiles of the population; in the rural areas it is 48 per cent. This is encouraging since it suggests that public health expenditure allocation is in line with the Tanzanian government's PRS objectives. Only in urban areas, and particularly in Dar es Salaam, does the public health care subsidy go disproportionately to the upper quintiles.

This finding for urban areas, and the conclusion of Section 17.3 about the rate of use of private facilities in all areas by the lower quintiles, raise many questions about the provision of public health care services. We suggest in the next section that the cost of accessing the subsidy may be too high in public health care facilities, especially in Dar es Salaam, so the poor opt for largely unsubsidized private health care provision which may not appear in total more expensive. The high cost of accessing the public subsidy can be caused by many factors including long distance, demands for unofficial charges (bribes), unavailability of adequate services and poor attitudes of health care workers. Dar es Salaam, in particular, may also lack adequate numbers of public health facilities, so the poor have no choice but also to go to private health facilities.

17.5 Benefit incidence, commercialization and poverty

The implications of government expenditure allocation decisions for the incidence of benefits to those needing health care depend upon the particular form of commercialization of health care in the country. We have shown that the benefit from public subsidy to district level public health facilities appears slightly weighted towards the lower income quintiles nationally and in rural areas, but not in urban areas, especially Dar es Salaam. We recognize that the results might have shown a different picture had we been able to separate hospital from dispensary visits, if it is the case that the poorest rely

Table 17.7: Benefit incidence analysis at the district level (district hospitals, preventive/primary health care): distribution of the subsidy by income quintiles (Tshs)

Quintiles	*Dar es Salaam**	*Other urban**	*Rural**	*Tanzania mainland 1**	*Tanzania mainland 2***
1	179 205 187	890 100 493	7 164 885 970	8 326 440 087	14 622 899 712
2	345 581 574	1 167 526 717	6 524 936 817	8 049 561 934	14 136 646 113
3	319 999 457	1 015 373 842	6 064 841 510	7 425 097 396	13 039 961 069
4	280 998 529	1 109 317 408	5 221 776 857	6 585 782 969	11 565 956 505
5	602 008 944	1 149 887 849	3 443 558 846	5 093 117 615	8 944 536 600
Total	**1 727 793 692**	**5 332 206 308**	**28 420 000 000**	**35 480 000 000**	**62 310 000 000**

*subvention to Local Government Authorities
**total estimated allocation at district level, Tanzanian mainland
Sources: National Bureau of Statistics (NBS), based on HBS 2000/01 database, and URT 2003a.

disproportionately on dispensaries, but we do not have data to explore this point. The data we have, however, imply that benefit incidence of district level public health care spending is progressive in the country as a whole and in rural areas in two senses. It is progressive in the strong sense that the lowest quintile benefits disproportionately (it is 'pro-poor'[12]), and it is *highly* progressive in the standard sense that it is distributed much more equally than the underlying income distribution.

However, this finding does not take into account the cost of accessing government facilities. This cost includes user fees, informal charges and other related cost such as transport, time and lost income. Virtually all government facilities at all levels make some charge, formal or informal. These fees are regressive in that they take no account to ability to pay; those on lowest incomes must either pay more, or receive less service than those able to afford higher charges. The HBS 2000/1 questionnaire did collect data on medical expenses at household level but unfortunately we do not have these data by income quintile, so we are unable to do an 'affordability' analysis by income level (Demery n.d.).

We do, however, have mean medical expenditure in the previous twenty-eight days by geographical area and we can compare these with mean and median consumption expenditure and declared income (Table 17.8). Mean medical expenditure was 2.9 per cent of mean consumption expenditure in Dar es Salaam, and rather less in other urban and rural areas. Table 17.8 also shows the absolute level of income and consumption expenditures recorded. Since 1US$ was worth approximately Tshs 800 in 2000, the median income per head recorded was (on an exchange rate basis) approximately US$10 per

Table 17.8: Medical expenditure, consumption expenditure and income per head, 28 days, by area, 2000/1

	DSM	*Other urban*	*Rural*	*Mainland Tanzania*
Mean medical expenditure per head (Tshs)	569	338	190	232
Mean total consumption expenditure per head (Tshs)	21 949	14 377	8 538	10 120
Median total consumption expenditure per head (Tshs)	16 349	11 561	6 860	7 523
% share of mean medical expenditure in mean total consumption expenditure	2.9 %	2.4 %	2.1 %	2.2 %
Mean income per head (Tshs)	40 767	30 426	14 134	17 928
Median income per head (Tshs)	16 473	13 810	7 513	8 328

Source: URT 2002a: 68, 70, 71, 103.

month – much less than US$1 per day. Poverty in Tanzania is thus extremely widespread: the person at the mid-point of incomes in Tanzania cannot, by any international standards, be categorized as 'not poor' (despite the use of this categorization in the HBS published report (URT 2002a) to describe all those above a very low poverty threshold). *Most* people in Tanzania are poor, and are vulnerable to falling into very severe poverty when illness or other crises occur.

To analyse affordability we can also compare this average expenditure to total expenditure by quintile (Table 17.9). The data again show how severe poverty extends across income quintiles. Comparing Tables 17.8 and 17.9 suggests just how hard it is for people in the lower income quintiles to afford medical services.

The medical expenditures per head registered in Table 17.8 include both public and private fees. We have shown that the poor, including those in the poorest quintile, make a lot of private dispensary visits, in both urban and rural areas. This can indicate either that the availability of public dispensaries in urban and rural areas is insufficient or that the public facilities are not sufficiently cheap relative to private facilities, taking into account the presence of other charges required for accessing the subsidy available from public provision and given the very low levels of income.

The opening of private commercial facilities has been very strongly biased towards the urban areas, with the bulk of private facilities in Dar es Salaam (Tibandebage *et al*. 2001). However, small towns in rural areas may have one or more private dispensaries, and there has also been a huge expansion in drug shops and pharmacies. Mission-owned facilities are more spread out geographically, but tend to be in the better off parts of the country, with rather few low charging mission facilities in Dar es Salaam (Tibandebage and Mackintosh 2002).

The result is that in urban areas the reliance on the private sector for medical consultation and treatment is particularly high. In Dar es Salaam, 46 per cent of all those consulting a health provider went to the private

Table 17.9: Mean total expenditure by quintile, by area, 28 days, Tshs

Quintile	*Dar es Salaam*	*Other urban*	*Rural*	*Mainland Tanzania*
1	3279	3009	3014	3015
2	5116	5004	5001	5003
3	7108	6900	6799	6819
4	9796	9855	9593	9649
5	23717	19867	17795	19359

Source: URT 2002a: 153.

sector, falling to 18 per cent in rural areas (Table 17.3, bottom row). Furthermore, 10 per cent of those seeking treatment in rural areas went to mission facilities, and 17 per cent to traditional healers, who also charge fees. Consulting a pharmacy or drug shop can result in high charges for ill-informed prescription.

We would expect, therefore, that those on the lowest incomes would be disproportionately discouraged from seeking treatment when ill. Table 17.10 shows some evidence of this effect in that the rate of non-consultation is consistently lower in the top quintile; however, the data contain a lot of variation.

The barrier of costs may be rather severe across almost all income levels. Table 17.11 shows the percentage of those not consulting who gave 'too expensive' as the reason; this is higher in the lower quintiles but substantial throughout. Furthermore, this reason for self-exclusion from care is more frequently given by those in the lower quintiles in urban areas, consistent with the higher charges observed across the system in urban as opposed to

Table 17.10: Percentage of those reporting illness in the last 28 days who did not consult a health provider, by quintile and geographical area

Quintile	*Dar es Salaam*	*Other urban*	*Rural*	*Tanzania mainland*
1	21	33	35	34
2	20	23	37	35
3	13	23	30	28
4	34	21	35	31
5	13	21	22	22
All quintiles	20	24	33	31

Source: National Bureau of Statistics 2004 (based on HBS 2000/1 database).

Table 17.11: Percentage of those not consulting a health provider who gave the reason 'too expensive', by quintile and geographical area

Quintile	*Dar es Salaam*	*Other urban*	*Rural*	*Tanzania mainland*
1	39	43	34	34
2	41	41	25	26
3	22	38	25	26
4	28	41	23	25
5	25	27	24	24
All quintiles	30	38	27	28

Source: National Bureau of Statistics 2004 (based on HBS 2000/1 database).

rural facilities (government and private) (Tibandebage and Mackintosh 2002; Tibandebage and Mackintosh forthcoming).

Finally, published data from the HBS (URT 2002a: 96) break down attendance at different facilities, nationally, by different income categories: the 'very poor' (those living below the food poverty line, a sub-set of the lowest quintile), the 'poor' (those below the basic needs poverty line, the top end of the first quintile and part of the second), and the rest, the so-called 'not poor'. These data confirm the reliance of the 'very poor' and 'poor' on the private sector for a substantial element of care, and also that they are less likely than others to benefit from mission-based care, while being more likely to go to traditional healers.

The poor who benefit from public subsidy thus face a considerable financial hurdle in the form of fees: the net benefit could be considered to be the subsidy less the fee, a calculation we do not have the data to make. Furthermore, many poor people appear to find the private sector no more expensive than the public. Liberalization and commercialization, in association with user fees, far from 'freeing' public subsidy for 'the poor', has created a situation where poor people right across much of the income distribution have to struggle to find the funds to access both public and private sectors.

Interpretation of these findings should also take into account the point made above: that most people in Tanzania are in fact poor. People in the second, third and fourth quintiles live on very low incomes and are highly vulnerable to sliding into worsening poverty as a result of health care costs. Policy to further improve the redistributiveness of public expenditure needs to consider carefully how to lower the barrier public sector charges impose on the accessibility and net benefit of the subsidy provided.

17.6 Conclusion

Our purpose in this chapter has been to analyse some key aspects of the allocation of public expenditure on health care in Tanzania, in the context of an extensively commercialized health care system and widespread poverty, and to suggest some policy implications.

Our main findings are the following. There is relatively high dependence on private health care across the income spectrum; although the type of private facilities accessed is likely to differ sharply by income, there is no segmentation between private facilities for the better off and public for the poor. The benefit incidence of public health spending at local government and district level in this context appears to be both progressive and pro-poor for the Tanzanian mainland as a whole and in the rural areas, but the benefits are not weighted towards the lower quintiles in urban areas and especially not in Dar es Salaam. However, the cost of accessing the subsidy is likely to be regressive, since the fees charged and other associated cost in accessing the subsidy take no account to ability to pay. People on low incomes risk being

impoverished, or discouraged from treatment, or receiving worse treatment, or all three of these, in the face of severe or chronic ailments.

People's ability to benefit from public subsidy to health care in a commercialized system depends upon ability to pay. In other words, it depends not only on the fees charged by the government sector, but also the cost of initial consultation and treatment in the private and mission sector which may use up funds before patients arrive at government hospitals. The distribution of public subsidy is, in other words, a function of the nature of the commercialization process in health care.

Our findings cast some doubt on repeated claims that the public expenditure on health throughout sub-Saharan Africa is 'poorly targeted' and 'pro-rich' (Davoodi *et al*. 2003: 1, 24).We are aware that higher-level public spending on regional and third-tier hospitals would display a different pattern from that shown here for the district level. But we do not find for the district level allocations as a whole a pattern that reflects statements such as those of Davoodi *et al*. (2003: 24, 33) that: 'Spending on primary health care is poorly targeted ... the poorest quintile receives the lowest [share] in Sub-Saharan Africa', nor that 'the middle class captures most of the gain from ... primary health care, particularly in sub-Saharan Africa'. Our data include district hospital spending and use, but we know from case studies that government hospitals are important resorts for the poor in the face of severe illness. It is important not to allow repetition of generalizations about sub-Saharan Africa as a whole to obscure evidence of the progressive and indeed relatively 'pro-poor' incidence of public health expenditure at district level (before allowance for fees) in particular countries.

There are two broad policy implications. First, policy should consider the health system as a whole, examining, for example, the interactions between policies to allocate public funds, charging policies, and policies to encourage commercialization, rather than treating public expenditure policy as if it were a separable policy issue from generalized health sector commercialization. The implications of commercialization for use of facilities across income classes should be investigated empirically, without presumptions about the preferences and actions of the 'better-off' and the 'middle class' especially in very low-income contexts where those groups in any internationally comparative sense are both small and economically vulnerable. It would then be recognized that 'pro-poor' public expenditure objectives may be undermined by commercialization.

Second, the dominant international voice of critique of the distribution of public expenditure on health care in sub-Saharan Africa as 'poorly targeted', should be tempered by a more open and effective recognition of the *progressiveness* of much existing spending. As Demery (n.d: 2–17) comments for the case of Ghana, 'governments would be hard pressed to find another commodity [other than public spending on health centres] where consumption by the poorest quintile approaches such a large share of total

consumption'. In Africa, as in other unequal societies, public expenditures are driven by competing political pressures. There are good reasons why progressive African governments have repeatedly tried to build and rebuild district-level public health care systems: they are not only needed, they are also a robust method to redistribute resources in a manner that, rather than 'targeting' a desperate minority, provides support for the broad majority of the poor and the vulnerable in very low income countries.

Notes

1. Our thanks to participants in the Helsinki Conference and to Marc Wuyts for helpful comments; the views expressed are solely the responsibility of the authors.
2. SWAps are seen by donor agencies and their country partners as a means of translating the goals of Poverty Reduction Strategy Papers (PRSPs) into operational plans facilitating a transition from project aid to forms of budget support (Land *et al*. 2003).
3. Inflation was estimated at about 5 per cent (URT 2004).
4. We are most grateful to Mr Karugendo, of the National Bureau of Statistics in Dar es Salaam for his expert assistance and patient response to our requests and enquiries.
5. A 'quintile' is here defined as one-fifth of the population, as ordered by income from lowest to highest.
6. The HBS 2001 surveyed a relatively small rural sample, so the results should be treated cautiously.
7. We were unable to aggregate visits to these two categories.
8. The HBS questionnaire contains in fact a lack of clarity on this point: available responses for public consultations include public hospital/dispensaries as one category and regional hospitals as another, and respondents may not have understood this distinction. It is therefore not clear where in practice consultations in public referral hospitals (likely, however, to be a small number in the survey) have been recorded.
9. These percentages of total public sector visits are thus directly comparable to the private sector results in the columns labelled '% of total private' in Table 17.3.
10. As public expenditure tracking studies have shown (REPOA and ESRF 2001) there is a variable relationship between allocations and expenditure at district level, so these data should be interpreted cautiously.
11. The local government level comprises four sub-votes, all of which are included in the PRS priority level: curative; preventive; health centres; and dispensaries and clinics.
12. It may, of course, not be sufficiently 'pro-poor' to respond to relatively high rates of morbidity among the poorest – rates that may be underreported in self-report questionnaires such as the HBS.

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