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1

Health Systems and Commercialization: In Search of Good Sense

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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 over-treatment, 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

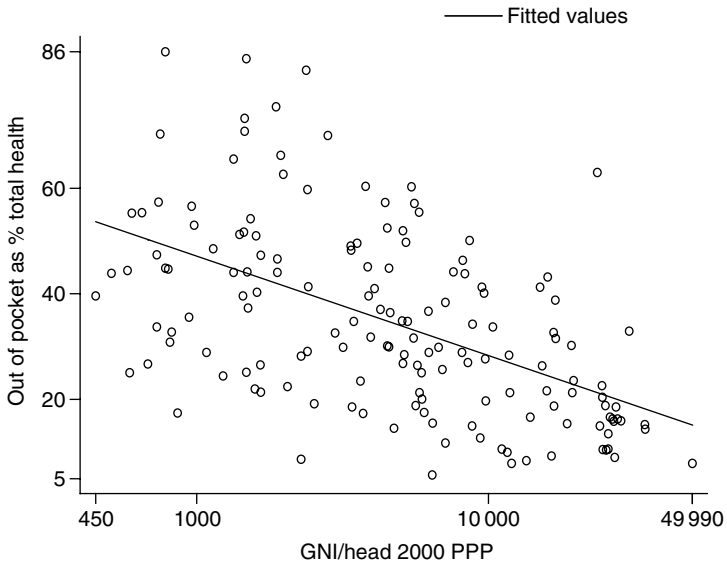


Figure 1.1: Out-of-pocket as percentage of total health expenditure and log GNI per head (PPP) 2000

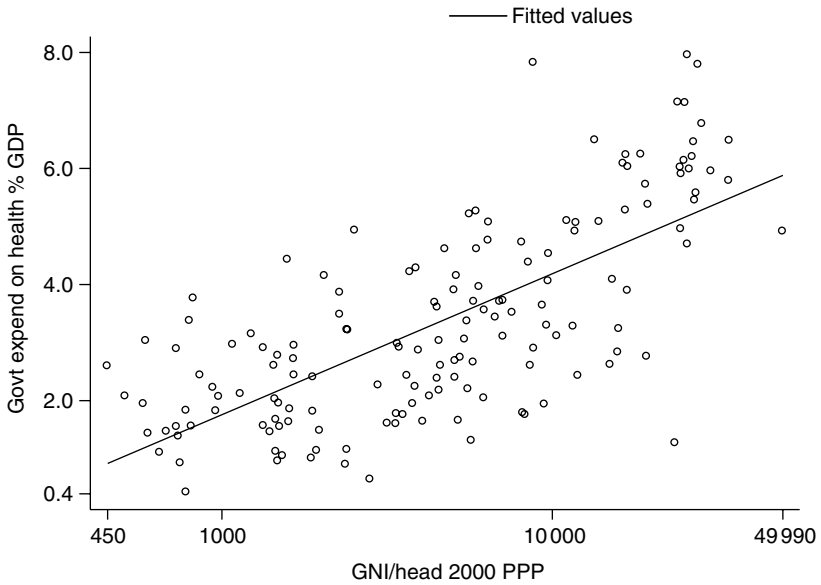


Figure 1.2: Government expenditure on health as percentage of GDP and log GNI per head (PPP basis) 2000

'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 sectors⁷ 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

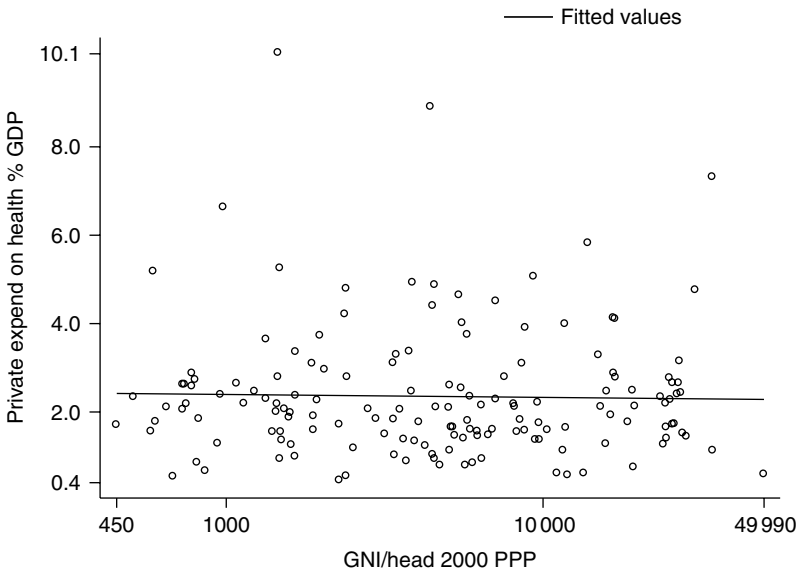


Figure 1.3: Private expenditure on health as percentage of GDP and log GNI per head (PPP basis) 2000

in-patient care is not. In almost all⁹ 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 (Drahoš 1995; Drahoš 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

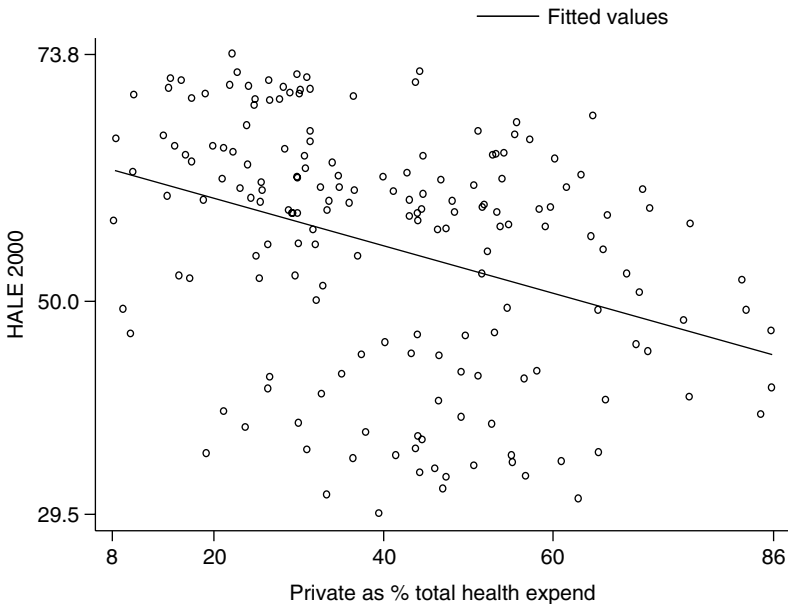


Figure 1.4: Healthy life expectancy (HALE) and private as percentage of total health spending, 2000

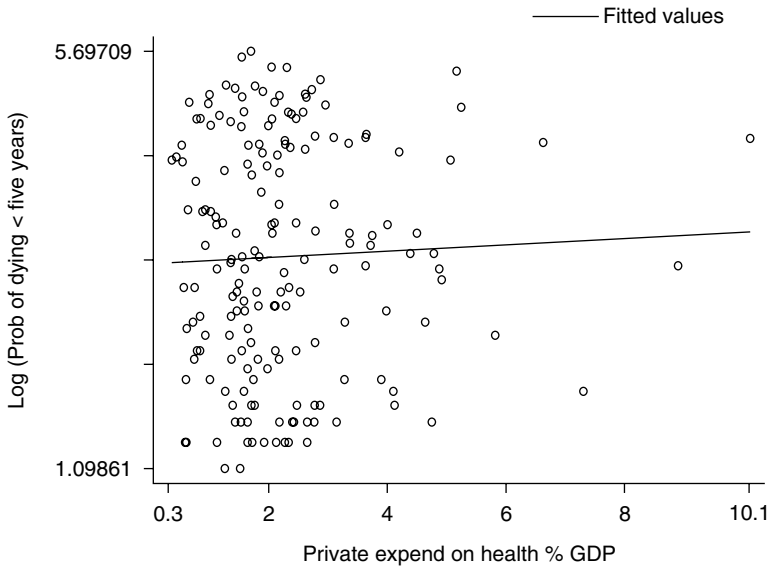


Figure 1.5: Log of probability of dying before five years and private expenditure on health as percentage of GDP, 2000

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

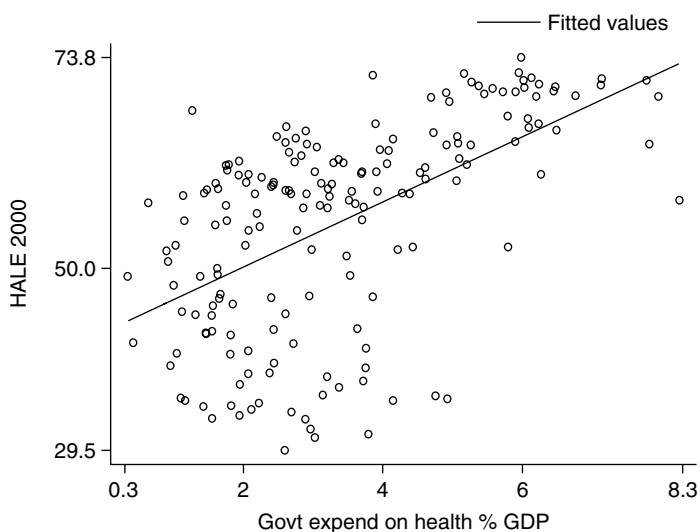


Figure 1.6: Healthy life expectancy (HALE) and government expenditure on health as percentage of GDP, 2000

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 quintile¹⁵ 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.

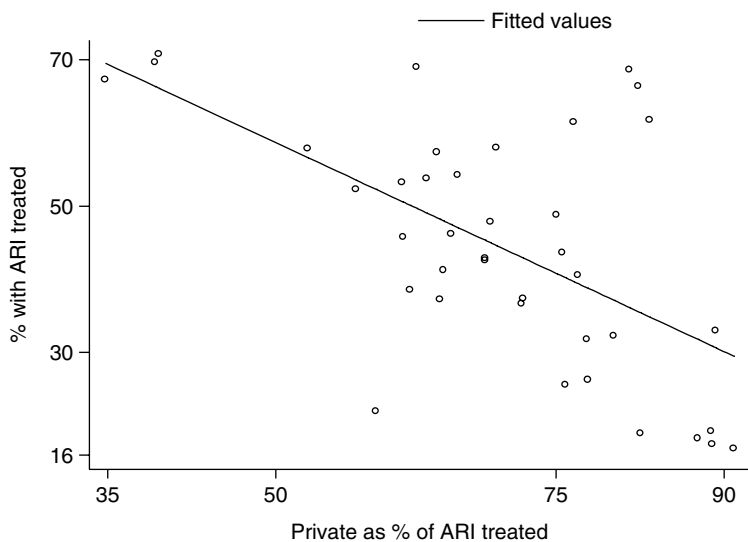


Figure 1.7: Percentage of children with ARI taken for treatment, and percentage of those taken for treatment seen privately, various years 1990–2002

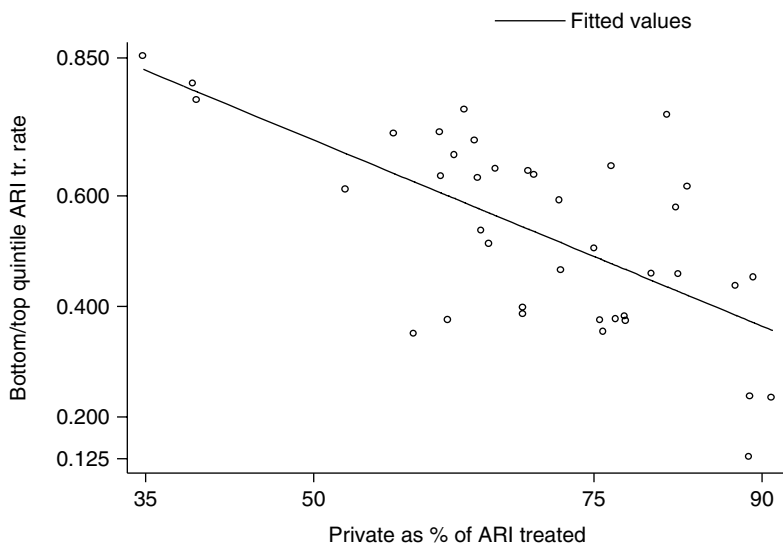


Figure 1.8: Ratio of percentage children with ARI from the bottom quintile taken for treatment to percentage from the top quintile, and percentage of all those taken for treatment seen privately, various years 1990–2002

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.

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