

**HEALTH CARE COMMERCIALISATION AND
THE EMBEDDING OF INEQUALITY
RUIG / UNRISD HEALTH PROJECT
SYNTHESIS PAPER**

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Abstract

Health care systems can embed and reinforce inequality within societies – or, conversely, can be a platform for the public combatting of poverty and inequality. The objective of the paper is to argue that the process of health care commercialisation - a marked trend across the world since the 1970s for reasons that are explored - and the associated process of globalisation of both health care and health policy, changes the terms of these interactions. Commercialisation – sometimes, discredibly, ‘sold’ as a policy for increasingly equity – has generally acted to embed inequality in new forms.

This paper examines the pressures for commercialisation in health care; proposes analytical categories of analysis of commercialisation that can be used for empirical work; explores some available data on the extent of commercialisation and examines its interaction with other aspects of inequality. It argues that health care is a key site on which the social challenge of globalisation is played out: an area where commercialisation has to be at least partially blocked if socially inclusive development is to be possible, and also a policy arena within which – because of the ethical importance of health care to society – that blocking is possible. Linking this paper to that of Comelieu (2003), overall co-ordinator for this collaborative research project, I draw on the work of Karl Polanyi on the economic and social impact of market mechanisms in ‘social’ goods to underpin the argument that commercialisation in health care is particularly destructive of social cohesion, as well as a key site for the social and political framing of more egalitarian development processes.

1. Introduction: health care, commercialisation and inequality

To what extent is commercialisation of health care a driver of inequality and poverty? To what extent is health care commercialisation driven by globalisation? If our objective is a more just as well as a healthier society, what policy responses to health care-driven impoverishment are available?

This paper addresses these three questions, drawing on existing data and literature, and on five country case studies supported by the RUIG research programme. The RUIG programme as a whole had as its *research objective*:

- to contribute new research findings on the effects of globalisation on inequality, poverty and systems of social protection;

and as its *policy objective*:

- to contribute to the search for policy coherence between, on the one hand, the struggle against poverty and exclusion, and on the other hand, macroeconomic policies and national and international governance.

Case studies were undertaken in five countries – Mali, Vietnam, Bulgaria, South Africa and Switzerland – of a number of aspects of the globalisation-inequality nexus: economic development and income inequality, education, health, social protection (notably pensions) and social development and political economy.

In contributing to these broad objectives, the health component of the programme concentrated on the three specific questions outlined above. This paper explains why the questions were chosen, and sets the research in the context of existing understanding of the role of health care in influencing health inequality and broader social inequality and poverty. It then outlines an interdisciplinary framework of analysis of health care commercialisation and globalisation, and examines the implications for policy. This synthesis paper does not summarise the rich detail of the country papers produced for the project, and should be read in conjunction with them.

Commercialisation of health care – the suppressed term in the debate

The qualitative and country-based literature on health care ‘reform’ since the 1980s returns repeatedly to the effect of the often-enforced reforms in increasing and reshaping health care commercialisation (Mills et al 2001, Baru 1999, Mackintosh 2001). By ‘commercialisation’ of health care I mean:

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

This definition brings together a number of aspects of a transition towards health care systems increasingly dominated by market incentives that has been experienced (though unevenly and far from universally) across the world, and which is still continuing. The definition incorporates what is generally called ‘marketisation’, that is, the creation of market payment and incentive systems in public provision as well as private provider contexts. It includes ‘privatisation’, that is the sale or transfer of public assets to private ownership. It also encompasses the shift over time in the

balance of assets between public and private, through investment, that characteristically results from health care market liberalisation (Semboja and Thirkildsen 1995a). Finally, it includes the rise of private insurance, sometimes through the sale or breaking up of social insurance funds, so that the balance of access patterns shifts towards private payment, ability to pay and individual risk rating. I use ‘commercialisation’ as the shorthand for this diversity of market changes because it most effectively summarises the key mix of private initiative, market incentives and private payment that characterises them.

The pressures for commercialisation in health care, and sources of resistance, are discussed below. Here I note the curious relative absence of commercialisation from current analytical work and data collection on health care. Despite the extensive case based research and publication in recent years on markets in health care and the rise of the private sector (Bennett *et al* 1997a, 1997b, Bennett and Tangcharoensathien 1994, Bhat 1993, Ngalande Banda and Walt 1995, Bloom 1998, Leonard 2000, Segall *et al* 2000, Najandra *et al* 2001, Turshen 1998) it is surprisingly difficult to find systematic comparative evidence on ownership patterns in health care. Current cross-country data collection appears to be driven by the (in my view, incorrect) assumption that it is only the mix of *financing* that is key to understanding the public/private relationships in health care, and not ownership of provision¹. And case study research on the private sector rarely creates analytical categories satisfactorily linking finance and provision in distinct patterns of commercialisation. I attempt here to begin to fill this gap, arguing that both financing and provision matter, and that, hence, the current multilateral policy focus on finance in data collection obscures the role of the corporate and small scale private sectors in provision and the interaction between corporate finance and corporate provision.

Globalisation: a key aspect of commercialisation

The concept of *globalisation* presupposes commercialisation. All definitions of globalisation, however broad, include:

- the closer integration of international markets for goods and services;
- rising cross-border investment in production of goods and services; and
- international governance frameworks and policies that seek to sustain both trends.

Other frequently cited aspects of globalisation – such as cultural and political networking, and multilateral policy pressure – depend upon this economic foundation, including the diving price of communications and transport (Cairncross 1997).

Globalisation in the sense of market integration affects health and health care by two routes: via the general ‘opening’ of the economy to trade and investment, and via specific changes in the health care and health finance sectors themselves. Opening the economy can introduce new health problems (Hong Tu *et al* 2003) and disrupt health care systems (if for example employers cease to provide health care to employees).

The direct impact of globalisation within the health care and finance sectors, in the form of foreign direct investment and international trade in services and health-related

¹ I owe this systematic observation, and the cross-country data drawn upon in this paper, to Seife Ayele.

goods, is to create a specific change in market structure, towards corporatisation. For globalisation in this sense to occur, it is not enough to have health care markets, the health care sector must be *corporatised*. It is health care corporations that invest overseas, and that have the marketing expertise to export services. The reasons why this is so are that large quoted companies can raise the finance and exert the leverage necessary to break into overseas markets and to create new patterns of international trade.

Once established, in health care as in every industrial and service sector, large multinational companies restructure every aspect of their markets: pricing, marketing, market segmentation, the nature of the goods and services on offer, and the technology of production. We appear to be in the relatively early stages – compared, for example, with retail food marketing or insurance among service sectors – of corporate restructuring of international health care markets.

The concept of globalisation is also widely used, as noted above, to refer to the extent to which economies are subject to international *policy pressures* to liberalise exchanges and capital flows. Indeed, there is, in the literature, a fair amount of confusion between such policy pressure and actual observed international economic integration, and it may be that this confusion is particularly relevant to the health care sector where profitable foreign direct investment in developing countries appears quite hard to sustain². What is not in doubt is the scale of the policy pressures over the last two decades from, particularly, multilateral donors to commercialise health care. The World Bank has been particularly influential in promoting the concept of health care as a largely ‘private good’ (World Bank 1993, 1996, 1997), hence deliverable through the market. This promotion of commercialisation as part of an international policy package led to the downplaying for much of this period of the well understood perverse incentives structures in health care markets (Barr 1998, Preker and Feacham 1994 discuss the incentive problems). The question of whether health care is a good like any other, for which market liberalisation is no more or less appropriate than for any other good or service (a point of view that has been strongly propounded by WTO officials) is a central issue for this paper.

The embedding of inequality through health care commercialisation

I argue below that health care commercialisation acts to (re)embed inequality in societies in new and often more extreme forms. Commercialisation restructures health care itself, reworking its internal hierarchies and the pattern of those it treats and excludes. It thus also directly influences socio-economic inequality and poverty. The renewed emphasis on poverty and poverty alleviation in international development debate has led to the renewed recognition that exclusion from health care is one of key aspects of poverty as it is lived in poor countries – and to a recognition of the value the poor, like the well off, place on access to care and treatment (World Bank 2001). There is renewed exploration in the international literature of the link between access to health care and poverty, and a recognition that the poor become trapped in a vicious two-way interaction: poverty shuts people out of health care, reinforcing the

² These paragraphs draw on a related UNRISD project on health care commercialisation, involving a larger set of countries; see www.unrisd.org for this and the UNRISD Social Policy and Development research programme of which this contribution to the RUIG project also forms a part.

ill health that is associated with very low income; struggling to gain access to health care further impoverishes, using up assets and informal credit sources, and reducing earning power (Tibandebage and Mackintosh 2001 lists references for Africa).

Furthermore, the interaction between inequitable health care and wider social inequality is two-way. Inequitable and expensive health care impoverishes those on low incomes, and reinforces social inequality; wider social inequality feeds back in turn into health care organisation, reinforcing polarisation and stratification. Health care in any society carries very considerable ethical weight: that is, the extent to which health care institutions reject or mistreat people at their most vulnerable is widely understood to be one of the markers of how a society sees itself. To build an exclusionary health service is to legitimise broader social exclusion. Effective health care is fundamentally about *relationships* between populations and institutions (Londoño and Frenk 1997, Gilson 2003). These institutions centrally involve government, and therefore the attempt to universalise access to health care systems has been a key aspect of post-Independence nation-building and of democratic debate and electioneering as countries have grown richer, across the world (Mackintosh 2001, Chiang 1997, Timmins 1995).

Health care systems thus embody a society's inequalities and *also* provide a platform for challenging them; not just 'illness services', they are also a major site for redistribution and fighting poverty, one which has worked very effectively in many parts of the world. Hence the contestation of health care commercialisation that is visible across the world today.

The rest of this paper is organised as follows. The next section sets the discussion in the context of the current literature on health inequality, income inequality and the role of health care in impoverishment and health improvement. Section 3 examines several stylised patterns of commercialisation, in the context of evidence from existing sources and the project country studies, and discusses the globalisation/commercialisation links. Section 4 then considers the roots of contestation of health care commercialisation, arguing that the commodification of health care that underlies it is inherently problematic. The final section elaborates the argument that health care is a key public 'site' where the social challenge of development is played out and responded to.

2. Inequality in health and health care

Health and inequality

Health is a core aspect of human well being. The capability to achieve a long life in good health is one of the key determinants of quality of life (Sen 1987, 1993, 1997). Ill health and lost years of potential life create a great dividing line between poor and rich, within as well as between countries (Gwatkin 2001). The links between health and socio-economic inequality continue however to be strongly debated; the key findings and issues relevant to this paper are the following.

First, on average, people in poor countries have worse health and shorter life expectancy than the average citizen in high income countries (Prichett and Summers 1997, World Bank 2001). Higher average incomes are strongly associated, on cross-country basis, with lower average mortality, longer life expectancy at birth and lower average morbidity. Figures 1 and 2 illustrate, using World Bank and WHO data, the relationship repeatedly demonstrated in the literature (van Doorslaer 1998). Figure 1 shows life expectancy at birth (male and female) by income per head; the association is quite strong and non-linear.

Figure 2 allows the inspection of the lower end of the distribution³ by plotting healthy life expectancy against the logarithm of income per head: it shows that the association is weak at low levels of life expectancy. The points are labelled by region, and all the low life expectancy countries (HALE below 50 years) are African (Af); the data reflect the very severe impact of HIV/Aids in reducing life expectancies in Eastern and Southern Africa as well as (in all but two countries) the effect of very low average incomes. The countries studied have been picked out: all but the African countries are towards the high end of their income range for healthy life expectancy; South Africa has a shockingly low HALE for its average income. The vertical line in each figure is at \$10000 per head (exchange rate basis): all the developing countries including the richest in the set (South Korea) are below this level. The figures also illustrate another common observation – the income/health relationship appears to become weak or non-existent *among* high income countries (van Doorslaer 1998).

³ The data in this paper reflect work in progress; further exploration (with Seife Ayele) of data for a larger sample of countries is underway.

Figure 1 Life expectancy at birth (years) by Gross National Income per head (current US \$), selected countries 2001

Source: World Development Indicators online 25 June 2003

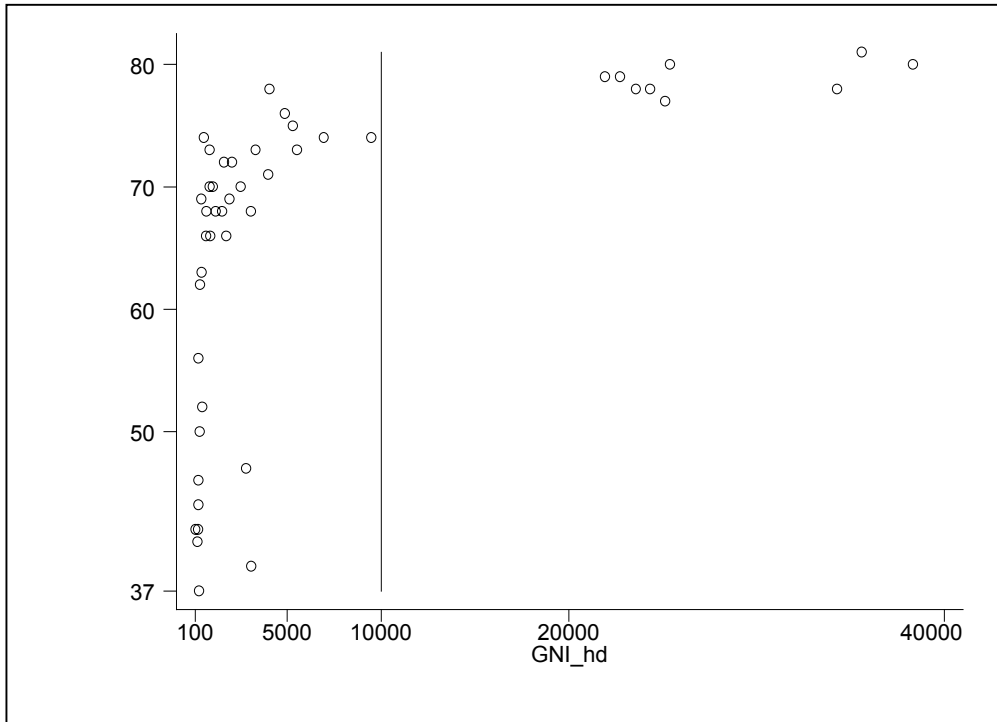
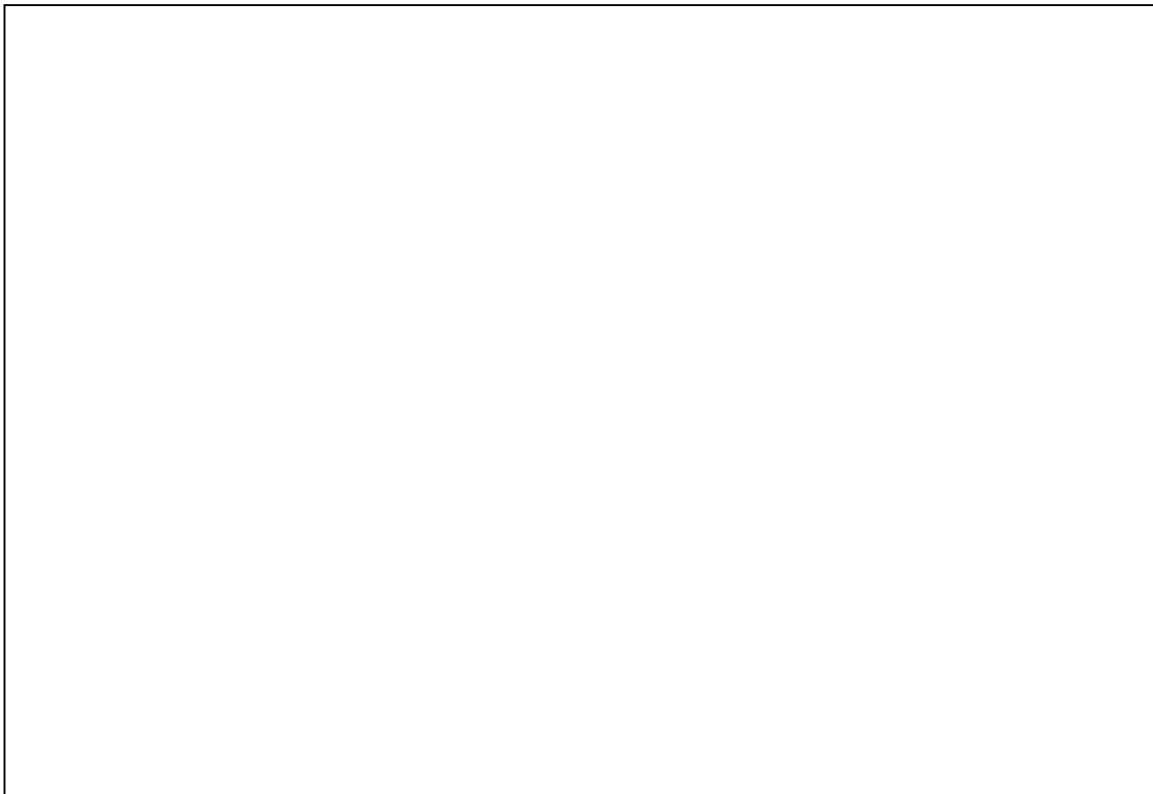


Figure 2 Healthy Life Expectancy (HALE) and logarithm of GNI/head, selected countries, 2001.

Source: WDI online 25.6.03 and *World Health Report 2003* data accessed online 25 6 03



ME Middle and low income Middle East
LA Latin and Central America
TE Transitional Europe/Central Asia
HI High income countries

The determinants of this association, and the variation within it, are understood to be complex. Higher average incomes are associated on average with better nutrition, housing, working conditions, and environment. They are also associated with better health care. Anand and Ravallion (1993) found that for a sample of 22 developing countries, the cross-country correlation between life expectancy and GNP/head was strong and was largely explained by two other variables: the incidence of absolute poverty (proportion of the population living on less than \$1 per day) and public sector spending on health care per head.

The impact of health care on health is itself however a matter of contention. In the literature on health in rich countries, the association is often downplayed (Leon and Walt 2001a). Conversely, the outstanding performance of some low income countries and Indian states, such as Sri Lanka and Kerala, in increasing average life expectancy to a level higher than would be expected from international experience over all, is widely (though not universally) attributed to a wide range of influences that include good public health provision (Drèze and Sen 1989).

Second, the association between health/lower mortality and income also generally holds *within* as well as between countries. In the now-rich countries it has long been extensively researched (Acheson 1998, Whitehead 2000, Leon 2001). The research is much less extensive in low and middle income contexts (Gwatkin 2001), but identifies the same general result: the well off live longer than the poor and are in better health. Among rich countries the differences are particularly dramatic in the United States, where the life expectancy of African American men is lower than that of men in China (Sen 1999).

However, the reasons for this association are the subject of sharp debate. Gwatkin (2001) summarises a range of evidence that shows that most morbidity and mortality indicators are worse for the poor than the well off, across a wide range of developing countries, and that occupation is one influence, farming households among the poor having particularly poor relative health status. However, there exists little evidence on trends over time. Within rich countries, health inequalities are associated with inequalities in nutrition, living conditions, education and working conditions as well as relative income and social status and individual risk behaviour. Some current work focuses on individual risk behaviour and medical history, and contests the existence of a direct effect of socio-economic status on health (Murray et al 2001, WHO 2003, Adams et al 2003, Adda et al 2003). Holly and Benkassmi's (2003) paper for this project reviews the evidence for Switzerland, a rich country with relatively low inequality in health status.

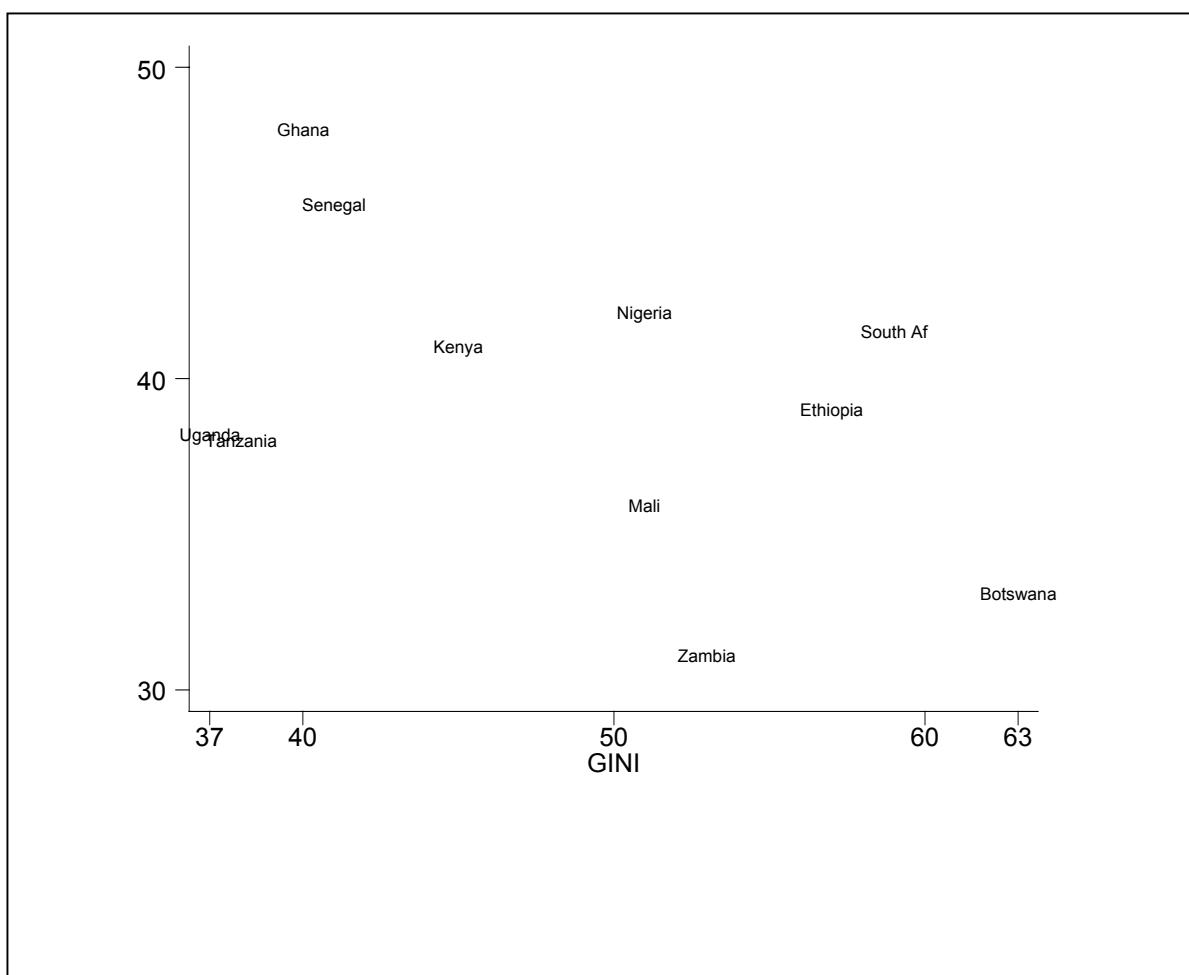
Third, it has been argued that there is an independent association across rich countries between inequality and *average* mortality and morbidity; that is, more unequal countries in income terms have less good health and life expectancy on *average* (Wilkinson 1996). This conclusion, and its implication, that lower relative poverty would raise average health status, have been intensively investigated and debated

(Kawachi et al 1997, Machenbach et al 1997). High income countries as a set display a distinct negative association between healthy life expectancy and inequality of incomes as measured by the Gini coefficient; the effect is strongly influenced by the high levels of both variables in the USA and their low levels in Japan.

We find a similar pattern in data on developing countries but not very strongly. A negative association between income inequality and average healthy life expectancy was however found for particular regions, including Africa (Figure 3), Latin/Central America and Transitional Europe, but strikingly not in Asia. It seems likely that the interconnections between inequality and health are highly geographically specific, with history (of individuals and countries) playing an important role. The data on which the inequality measures are based are also of limited quality and may (notably in the transition countries) be out of date.

Figure 3 Healthy life expectancy (HALE) and income inequality (GINI coefficient), selected African countries

Source WDI online 25 6 03 and WHO World Health Report 2003 online 25 6 03



health inequality? Among rich countries, this continues to be debated, with research evidence on both sides (van Doorslaer 1998). Holly and Benkassmi (2003) show that Switzerland appears to achieve relatively low levels of health inequality in comparison with other rich countries.

Among developing countries there is an increasing quantity of research on this topic (Evans *et al* 2001), including the creation of a variety of indicators of health inequality (Anand *et al* 2001). A recent study (Wagstaff 2002) using a cross-section of developing countries and data on child health and mortality found no significant association between income inequality and health inequality within those developing countries (that is, it did not find that countries with more equal incomes had significantly more equal health outcomes), but did find a strong association between higher average incomes and greater health *inequality* within countries.

Health care and inequality

The role of health care in redressing inequality – or in reinforcing it – is contentious. The broad improvements in population health as incomes rose in now-rich countries are widely attributed to improvements in broadly defined public health: clean water, improved living environments, improved nutrition and child care especially in infancy, better ante-natal care and conditions of birth, prevention of disease transmission, public health education, as well as improved treatment. The current economic and health policy literature varies sharply in the assumptions it makes about the impact of health care on health status, with some playing it down in relation to other effects such as improved nutrition, while, for example, a recent World Bank paper on sources of health inequality models health as produced by solely by ‘medical care’ and *traded off* against higher consumption (Wagstaff 2002).

Two other debates in the recent literature are of particular relevance to this paper. One is the debates around the concepts of public health and primary care. World Bank work in particular in the 1980s and 1990s sought to make a sharp distinction between preventative and ‘curative’ care, characterising only the first as a public good, and placing strong emphasis on narrowly conceived packages of preventative and primary care, that excluded widely valued treatments (World Bank 1997, 1996). This approach contrasted with – indeed attacked – the broader concept of primary care adopted in the Alma Alta declaration of 1977 (La Fond 1995). These simplifications have been abandoned to some extent in the face of the resurgence of communicable disease (or, perhaps more accurately, the widespread acceptance that these diseases threaten rich country populations as well as the rest of the world) and the acknowledged importance of offering care and treatment if prevention is to be improved (Commission on Macroeconomics and Health 2001).

The second debate is over equity in health care. The health care reform package of the 1980s and 1990s was widely presented as promoting ‘equity’. In the health care literature, when equity is distinguished from equality, the former is commonly defined as ‘equal treatment for equal need’ – sometimes called ‘horizontal equity’. It implies that the poor – typically sicker – require more health care than the better off.

‘Equity’ and ‘equality’ concepts are closely related, so that any equity concept has an underlying notion of equality of something. In the case of horizontal equity, the equality concept is equal *access* to health care for equal need, and this is the most commonly used concept of equitable health care – hard though it may be to operationalise in practice. What this concept of equity does *not* encompass is active use of health care as a redistributive force to *redress* health inequalities, a concept summed up by Mooney and Jan (1997) as ‘vertical equity’.

McIntyre and Gilson (2000) discuss the relevance of this latter concept to the extremely unequal health legacy of apartheid in South Africa. The underlying concept of equality here is not equal access at the moment of need, but equal chances at decent health over the life span, so that a health care system seeking to contribute to vertical equity would actively redistribute resources towards the disadvantaged, with particular emphasis on early life chances at good health including the support for child carers.

When health care reform has been promoted as beneficial for equity, it has been always in the horizontal sense, and generally on the grounds:

- (a) that liberalisation of health provision, by allowing the better off to choose the private sector, 'frees' public sector resources for the poor; and
- (b) that fee charging associated with retention of the funds at local level improves access to drugs and supplies, encouraging the poor (if not the poorest) to make more use of the services.

The former assumption has been widely criticised by health policy makers, on the grounds that there is little reason to suppose that liberalisation reduces political pressure for inegalitarian allocation of public funds, and is to my knowledge unsupported so far by any systematic research evidence. The Malian paper for this project (Konaté *et al* 2003) identifies the fragility of this latter effect in poor rural areas in low income Africa.

More broadly, there has been much criticism of the prevalence of 'equity talk' in the essentially disqualifying context of health care liberalisation. In principle, charging for health care implies delivery in response to ability to pay, hence formal liberalisation and official fee charging *legitimise* unequal access (Mackintosh 2001). Imrana Qadeer and colleagues (2001 p.30) have described as the 'sanitization of equity' the slogan of equity through a multiplicity of providers, with the public sector reduced to 'a mere partner'. In a recent literature review written with Lucy Gilson, she and I concluded:

..in the health policy literature the focus on equity as an objective can obscure the exercise of power as a practice.....a presentational and policy emphasis on equity, often reinforced by donors' requirements, disguises regressive and exclusionary behaviour. (Mackintosh and Gilson, 2002)

To create a progressive health care policy it is probably best – given this debasing of equity concepts – to go back to the underlying objectives of equality of some relevant capability, and to judge interventions on the basis on their contribution to a move in a direction of less inequality.

3. Commercialisation and globalisation of health care

The pressures for increasingly commercialisation in health care are well documented. They include economic crisis and severe fiscal squeeze in many countries especially in the 1980s, associated with immense policy pressure from, especially, multilateral agencies, for health care reforms that included market liberalisation of supply, the introduction of out of pocket payment for public health services, and the introduction or expansion of private health care insurance where incomes were high enough. However, measuring and comparing the *extent* of commercialisation in health care in current systems across countries is far from easy. This section seeks to contribute to this endeavour by sketching some ‘stylised patterns’ – ideal types illustrating the different paths commercialisation is taking in different contexts. The patterns pick up the three aspects defined above: market provision, private investment, private finance, drawing on existing literature (such as Hsiao 2000) and data as well as country studies. I locate the countries in this study within this categorisation.

Three stylised patterns of commercialisation

1. The informal commercialisation of low income primary care

In low income countries, one of the most striking aspects of health care commercialisation is the informalisation of primary care, through the creation, expansion or reinforcement of private small scale, largely unregulated primary provision. In many low income countries, urban primary care is delivered to a substantial extent by private individuals for fees. These countries include many Sub-Saharan African countries, South Asia, and also the currently low and (now) middle income transition economies such as Vietnam and China (Hanson and Berman 1998). Based in household sample surveys, recent data for India locate over 80% of outpatient consultations in the private sector in both urban and rural areas (Narayana 2003). Nguyen Hong Tu *et al* (2003) chart for this project for the case of Vietnam the rapid growth of independent provision at primary level, with a strong bias towards urban areas, and the problem of widespread unlicensed practice. The authors emphasise the particular dangers of very widespread purchase of drugs including antibiotics without prescription, including self-medication. The poor as well as the somewhat better off use private services and unlicensed drug sellers in Vietnam, as in China and across Sub-Saharan Africa (Segall *et al* 2000).

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

The implication is that the population in low income countries is now are generally faced with heavy out-of-pocket spending for health care, whether for public sector fees (formal and informal) or access to private providers and commercial medicines. The predominant form of commercialisation at low average incomes has thus tended to be a largely informalised, small scale private practice market for health services paid on the spot, much of it unlicensed and uninspected, involving widespread sale of drugs off prescription. There is a negligible development of private insurance, few forms of private risk pooling, and social insurance restricted to the formally employed and sometimes to the public sector. Private sector suppliers are generally individuals and small firms; the market is too small for corporate capital. The poor generally spend a much larger proportion of their incomes on health care than the better off, and there is widespread exclusion of those unable to pay (Jowett et al 2003, Tibandebage and Mackintosh 2001, Nandraj 2001, Baru 1998).

In this study, Mali and Vietnam display this type of low income commercialisation. Both have low average incomes, and a ratio of government/private expenditure on health care below 1 (Table 1), despite extreme and generalised poverty in Mali (Konaté *et al* 2003). Vietnam has a particularly large proportion of private in total health care expenditure. Both countries have a large percentage of out-of-pocket in total health care spending, and few established insurance mechanisms (Table 2), though Vietnam is in the process of developing social insurance for the formally employed (Hong Tu et al 2003). Data on out of pocket payment are of doubtful quality in informalised contexts, but the impression from Table 2 is supported by other evidence.

Table 1 Expenditure on health care (2000)

<i>Countries</i>	Total expenditure on health			
	US\$ / head at average exchange rate	per cent of GDP	government expenditure as % of total	private expenditure as % of total
Mali	10	4.9	45.5	54.5
South Africa	255	8.8	42.2	57.8
Vietnam	21	5.2	25.8	72.4
Bulgaria	59	3.9	77.6	22.4
Switzerland	3573	10.7	55.6	44.4

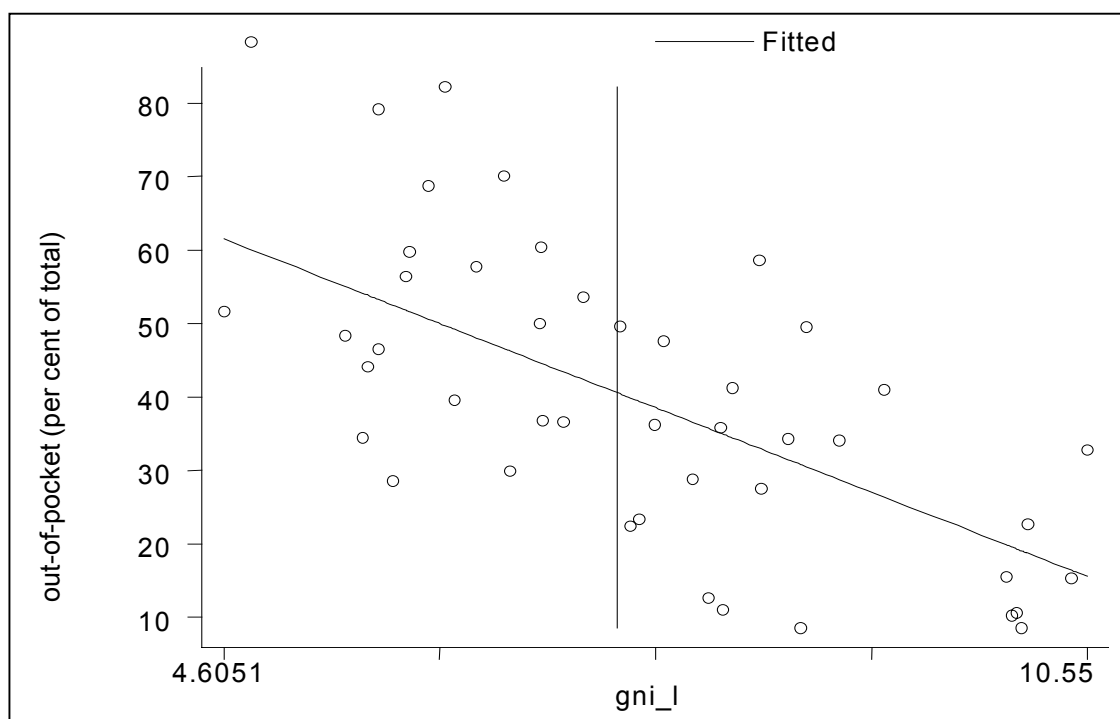
Source: WHO 2003 www.who.int/whosis January/February 2003

Table 2: Selected sources of health care expenditure (2000)

Countries	government expenditure		private expenditure	total health expenditure
	social security (per cent)	external resources (per cent)	pre-paid plans (per cent)	out-of-pocket (per cent)
Mali	0.0	27.3	0.0	48.3
South Africa	0.0	0.2	76.6	12.6
Vietnam	1.5	12.3	0.0	68.7
Bulgaria	16.0	18.0	0.0	22.4
Switzerland	72.7	0.0	42.4	32.8

Given this pattern of informalised private primary care, one would expect to find that a substantial part of expenditure on health care in low income countries would now be private expenditure, predominantly out of pocket. Figure 4 shows that there is indeed a cross-country negative association between income per head (shown here on a log scale) and out of pocket spending as a percentage of total health expenditure. No country in this data set below \$1500 income per head (exchange rate basis, shown as the vertical line on Figure 4) has out of pocket spending less than 28% of the total. Vietnam has an unusually high percentage even for low income countries (Table 2) while Mali falls in the middle of the low income countries range. Since fees are generally paid across all income groups and formal exemption mechanisms work for the poor work badly if at all in many countries – and certainly do not extend to the private sector, these fees are a source of impoverishment for the already vulnerable.

Figure 4 Out of pocket spending on health care as a share of total health care spending, by log GNI/head.



2. Polarisation and corporatisation

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

South Africa is the only country in this project that displays this kind of polarisation, but the pattern of private insurance only for the well off is found elsewhere among developing countries. India, for example, while a low income country in terms of average incomes, is a huge country that in absolute terms has a large, prosperous middle class. Hence the Indian economy can support, in addition to the small scale marketisation just described, a private commercial health care sector, including provision and insurance, alongside small scale private providers and (in most states, very patchy) public provision for the poor (Baru 1998, Narayana 2003).

It is mainly in middle income countries, because of the attractiveness of their markets to corporate investors in health care and health finance, that the sharpest battles are occurring over processes of commercialisation. Many middle income countries, in Latin America, Asia and transitional Europe have a history of social insurance provision that includes health care, and also public health care provision. Many also have a recent history of rising levels of private insurance and increasing corporate investment (Londoño and Frenk 1997, Stocker *et al* 1999). Where social insurance mechanisms for health care are broken up and replaced with individual risk rating in private insurance, this creates a real force for social and economic polarisation. In the transition countries, there is a choice of paths. If private insurance for the well off becomes established, associated with expensive for-profit provision, this may greatly reinforce social and economic polarisation, making it hard to move over time towards the kind of universal risk-pooling systems most high income countries have achieved.

Bulgaria, a lower middle income transitional economy, faces difficult choices. As Datzova for this project (2003) explains, the government is seeking to move rapidly from a government tax-based to a social insurance system. Privatisation is so far very limited, as is private investment in the health care system. It appears to be hard to make private investment pay in the hospital sector, because of low purchasing power in the economy, and the main form of private initiative is the partly fee-based practice of primary practitioners who are also supported by social insurance capitation payments. A large proportion of the population finds it hard to find the money for health care costs.

3. High income regulated commercialisation

High income health care systems have strong commercial elements on the supply side in many countries, but are typically very highly regulated, and normally exclude

commercial finance except at the margins. Most high income OECD countries have health care systems dominated on the expenditure side by social insurance or tax-based universal provision, and private providers work either for those systems, or as supplementary providers. Where private insurance is compulsory for the better off, as in the Netherlands, it is very closely regulated to ensure wide risk pooling and inclusion. Proportions of private providers financed vary greatly – and are increasing in some countries – but all providers within these countries are very strongly regulated (Saltman et al 2002). Only the US tolerates high levels of inequity in health care access; levels of inequity are fairly low elsewhere and overall most high income health care systems are strongly redistributive (Wagstaff et al 1999, van Doorslaer et al 2000).

Switzerland is unusual among European countries in that its universalist system is based on compulsory individual insurance; sickness funds are however very tightly regulated, and must charge a common premium for the required basic insurance (which provides a high level of benefits) (Holly and Benkassmi, this project). The government subsidises the premia of those unable to pay, though the conditions vary by canton. Private supplementary insurance can be taken out, and is quite widespread.

The Swiss system thus combines – uniquely among rich countries – private individual insurance (non-profit and for-profit) with a high level of inclusion. Holly and Benkassmi (2003) raise however a question mark over its inclusiveness, noting that the system requires high co-payments that may in practice reduce the access of those on low incomes. In international comparisons, Switzerland has the highest out of pocket payments, relative to total health expenditure and to GNI, of any rich country. The health system is highly regulated, and it is expensive: the second most expensive system per head after the USA, among high income OECD countries. The key differences from the USA – the most commercialised high income system – are the compulsory nature of the insurance coverage, and the prohibition on individual risk-rating in the universal elements of the system. Only the USA among high income OECD countries does not achieve universal coverage for access to a large range of treatments. Like Switzerland, however, it spends substantial sums from government funds to support health care access by some categories of the population, notably the elderly.

Commercialisation: issues of incentives and behaviour

These three sketches extract patterns from commercialisation processes that involve both expenditure and supply sides. Commercialisation inherently involves supply for income and/or profit – though this may be done by the government as well as the independent sectors. What marks out and distinguishes commercialisation is changing patterns of *behaviour*: the nature of the market incentives, and the extent to which suppliers respond to them on the basis of income and profit-focused objectives. Ownership is relevant to this – for-profit suppliers are expected to behave commercially – but not determining. Government suppliers may well display highly commercial behaviour, as may non-profit organisations – but they will not always do so.

The behaviour of suppliers is, as we know, influenced very strongly by the incentives created by the payment mechanism in health care. An understanding of commercialisation in different contexts – and predictions of its effect on inequality – must therefore consider both expenditure and supply sides of emerging markets. It must include commercial behaviour in the government sector, and extent of access to government facilities via private insurance. Markets – price setting on markets, production for market exchange, a search for care via individual payment – are the defining feature of commercialised systems, but markets also differ in their effects. The more market dynamics dominate health care access and provision, the more ‘commercialised’ they are, and that is likely to include a shift to commercial behaviour by government facilities.

The only easily accessible cross-country comparable data relevant to health care commercialisation are on the expenditure side. Some relevant patterns in these data on a cross-country basis are the following. First, government spending (including social insurance) on health care as a percentage of GDP rises strongly with income: wealthier countries spend a higher percentage of their income on health care through socialised expenditure systems. However, there is no correlation between private spending on health care as a proportion of GDP and income per head. The resultant ratio of private to government spending on health (one possible measure of the commercialisation of health care displays the pattern shown in Figure 5. There is a mild tendency for the ratio to fall as income rises, but in particular there are some striking outliers: a small number of low and middle income countries, including Vietnam, India and Indonesia, are highly commercialised on this indicator relative to other countries. Finally, there is no positive relationship across countries between life expectancy and the ratio of private to total expenditure on health care. On the contrary, Figure 6 displays a negative relationship between healthy life expectancy and the proportion of health care expenditure that is private; the plot shows all the countries in the data set; the regression line is plotted for non-African countries only, and still has a significant negative slope.

Figure 5 Ratio of private to government expenditure on health care, by GNI/head (log scale).

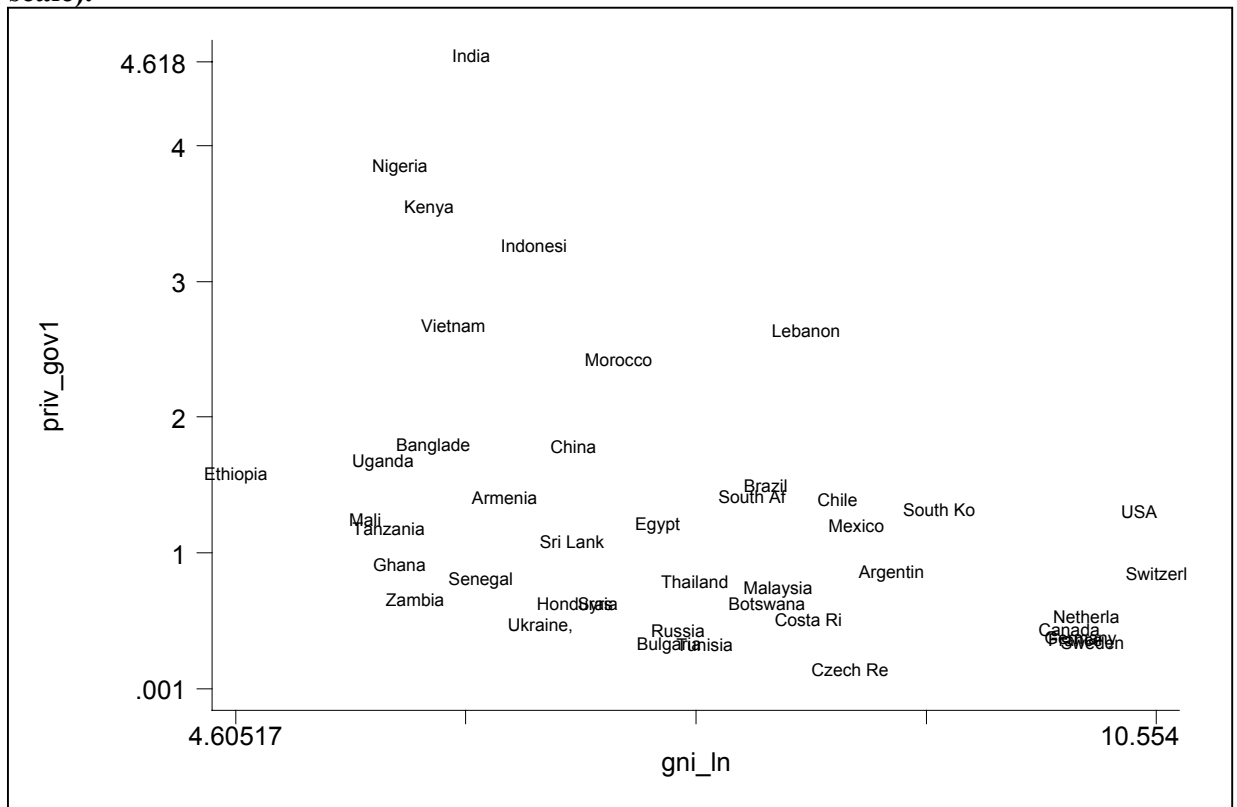
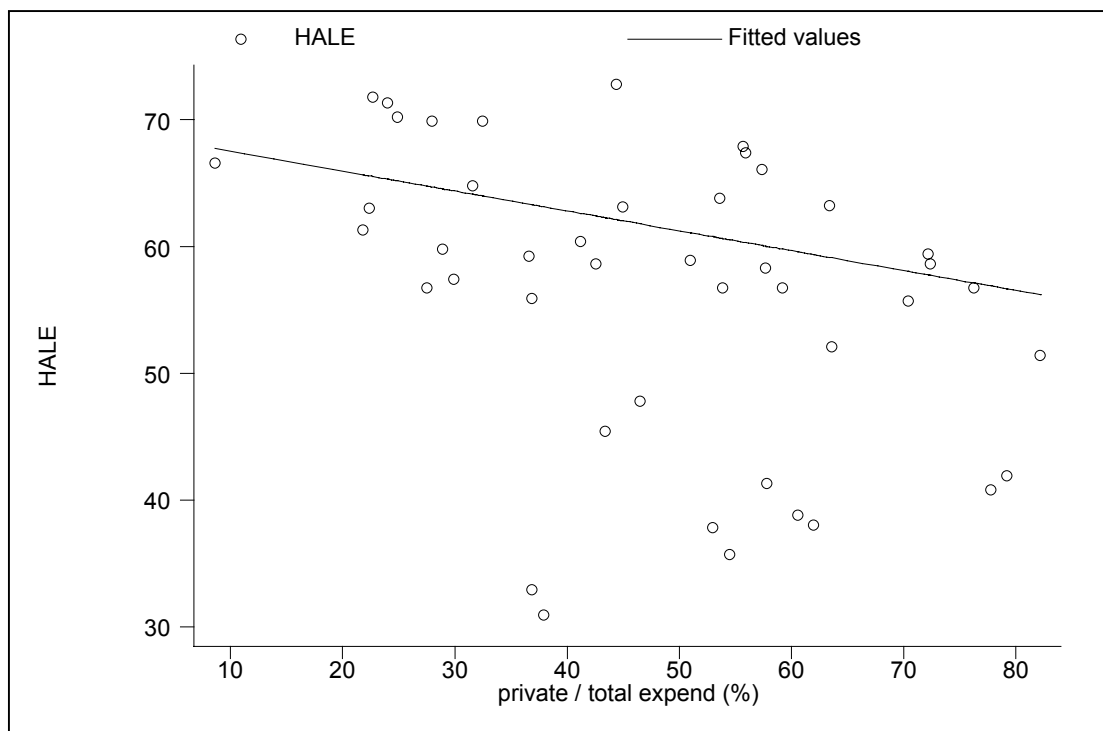


Figure 6 Healthy life expectancy (HALE) by the ratio of private to total expenditure on health care.



On the supply side, recent literature on the role of the private sector in health care employs the concept of the ‘public/private mix’ (Bennett *et al* 1997a). This concept

presupposes a sharp distinction between public and private sectors that the sketches above question. It would suggest as indicators of commercialisation the proportions of health care provision that is under public or private ownership, and the proportions accessed through public or private finance. There are however, as noted above, no systematic publicly accessible data based on this split.

This is in part because no doubt because indicators are hard to compile. The simplest, perhaps is hospital beds in public and private sectors, and proportion of primary facilities publicly and privately owned. The proportion of staff working in the two sectors (or three, if the non-profit sector is distinguished, as it should be) is another possible indicator, but hard to assemble because of the prevalence of informal private practice by government staff. It is not easy to find reliable data on ownership, and those collecting and assembling data for case studies choose their ownership categories to fit their purposes: for example, some sources treat NGO providers as 'private' or part of an 'independent' sector; others treat religious-owned and other NGO providers as a separate sector. One systematic study, extracting 1980s data from country studies (Hansen and Burman 1998) found no correlation between the public/private split measured by the private/public expenditure division and any measure of the public/private mix in supply.

Alternative intermediate indicators of commercialisation are based on transactions. This approach is widely used in country studies (including some referenced above), though the data are hard to compare across countries. Examples are the proportion of health care transactions that are paid cash at the point of delivery; the proportion of the population accessing care through private insurance; the proportion using employer-based private insurance or social insurance for health care. Transaction-based indicators that picked up market behaviour, indicating to what extent markets are liberalised – that is, operate without regulatory constraint and across all ownership sectors in a manner that also commercialises the behaviour of the *public* sector – might include the proportion of transactions requiring formal or informal out of pocket payment; the extent of unregulated price setting in the health sector and the extent of price segmentation in services and medicines and its sources (e.g. active price discrimination; crowding of low income people into certain sectors?). It would also be useful to compare the extent to which regulations on licensing of practitioners and minimum standards exist and are operative, and the extent of unqualified practice.

Again, there is extensive case study evidence on these topics, but little comparative work. To illustrate from recent research in East Africa the kinds of results these indicators generate: in Tanzania in the late 1990s less than 9% of health care transactions studied were free of charge, mainly in some rural dispensaries; systems for exempting the indigent did not work; non-government prices were unregulated, and informal charging quite widespread; there were high levels of market segmentation; minimum standards were largely inoperative and unqualified drug selling very common (Tibandebage and Mackintosh 2001a, 2001b; Mackintosh and Tibandebage 2002). This gives a picture of a health care system that is quite strongly commercialised – formally and informally - across all sectors, despite a relatively weak private sector largely located in urban areas.

It is that the *type* of commercialisation, defined by market behaviour, that structures its social impact. We know that unregulated market incentives in health care are

strongly perverse. Information is dominated by providers, who therefore have strong incentives to over-supply. Third party payment increases these incentives and lead to high levels of administrative costs in private health care. Private risk-rated insurers exclude the chronically or predictably ill and also some who are insurable – as well of course as those who cannot pay. The highly centralised high income health care systems have operated in a reasonably stable way because they combine cost control and universal access into a single framework, essentially by capping total expenditure and redistributing strongly within the systems themselves between rich and poor as well as between healthy and ill.

Private supply that is tightly regulated, and paid through a social insurance or tax-based system, is compatible with high levels of inclusiveness and equity, as in some high income systems; less regulated systems such as the US model generate inequity and are extremely expensive. Among developing countries, low income informalised commercialisation tends to drive down quality: as poor people seek the cheapest care the incentives for providers to cheat rise. The polarised situation with commercialisation of insurance and provision for the better off tends to drive up costs rapidly: the effect is evident in case studies including the South African study for this project. We return to the implications for policy having first considered the impact of globalisation on the commercialisation process.

Globalisation and health care

Corporatisation and globalisation in health care

The literature on the extent of globalisation, and associated corporate restructuring, in health care is still thin, in part because the process of corporatisation is not very advanced beyond the high income countries. Three dimensions of globalisation can potentially be measured are the extent of foreign direct investment in health care; the extent of international trade in health care services and inputs; and the extent of international migration of staff. Of these, the first two depend upon and are structured by corporatisation of the health care industry.

One can sketch the pattern of corporatisation in health care from existing evidence. The USA – the major corporatised high income market on both the supply and finance sides – dominates as we would expect in the list of large health care corporations. The big US firms are very actively seeking to move out of their US base, and establish ‘managed care’ operations and private insurance in middle income markets, notably Latin America, Eastern Europe and Russia, and middle income Asia (Waitzkin and Iriart 2001). The main exception to US corporate dominance is in health care supplies, notably pharmaceuticals and also some medical technology. The European pharmaceutical multinationals have flourished within regulated markets for treatment, and there are non-European companies too that are international players, notably Indian and Brazilian.

Evidence on the changing pattern and extent of foreign direct investment (FDI) in health care is patchy because health care investment is hard to split out from other service sector FDI (Arkell 2002, Fujita 2002). Informed commentary asserts rising investment but the evidence is largely anecdotal (Chanda 2001, Warner 1998). What systematic use of data bases on mergers, acquisitions and direct investment has been attempted indicates, in summary:

- substantial activity, largely cross-investment between industrialised countries, but with investment from Europe and especially the US into middle income countries in Latin America, Asia and higher income transition countries (Fujita 2002, Waitzkin and Iriart 2001);
- the emergence of Asian based MNCs such as Singapore-based Parkway (Hall 2003, Lethbridge 2002)
- difficulty of sustaining profitability in the sector, with high rates of selling on of investments in middle income contexts.

Similarly, empirical research published so far on globalisation and trade in health services focuses on a few items of interest to high income countries: telemedicine and the ‘export’ of cold surgical procedures through ‘medical tourism’, particularly by India, Cuba and South Africa (Chanda 2002, Mandil 1998, Butkeviciene et al 2002). An estimate of the percentage of travel expenditure worldwide that was for the purpose of health care from a curious set of 12 countries who happen to report this in their balance of payments statistics, put it at 1.3% of the total or about \$6.5 billion in 1999, a figure dominated by travel from the US, Canada, two Western European countries, Mexico and Croatia (Karsenty 2002).

This evidence suggests that, to the extent that trade and FDI in health services and health finance is rising in developing country contexts, it is likely to be contributing strongly to health care market segmentation and polarisation (Woodward 2002). Globalisation in this sense is strongly concentrated in high cost, higher income segments of markets, and depends on blocking or breaking up risk pooling between high income and lower income users.

Globalisation as policy project

A second widely used concept of globalisation refers to the extent to which economies are subject to international *policy pressures* to liberalise exchanges and capital flows. There is, in the literature, a fair amount of confusion between such policy pressure and observed international economic integration.

Much of the health and globalisation literature to date is concerned with international regulatory and policy aspects, notably the likely extent of the impact of the General Agreement on Trade in Services (GATS) (WTO 1998, WHO 2002; Lipson 2002). Two aspects of countries’ GATS commitments are key for health care: (1) commitments on medical and dental services, hospital services, and nurses and midwives’ services; and (2) financial services commitments that may strongly affect private health insurance provision. Of the RUIG countries, none have made hospital services commitments, and only Switzerland and Bulgaria Medical and Dental Services commitments; Switzerland, Bulgaria and South Africa have all made insurance services commitments (www.wto.org 18.2.03).

There is a large and inconclusive literature on the extent to which GATS commitments will tend to spill over into pressure for market liberalisation in domestic health care sectors. Much of this concern is being expressed in the high income countries – notably Europe and Canada; Canadian policy analysts point to the dangers of the interaction between NAFTA and WTO commitments in blocking expansion of Canadian Medicare (Pollock and Price 2000, Sanger and Sinclair 2002, Sexton 2003).

The existence of strongly organised industrial lobbies joining in with the other political and economic pressures for market opening and cross-border investment in health care, and drawing on GATS as an opportunity (Vesten 2002), have increased anxieties about the possible social consequences of poorly thought-through trade commitments, and provoked calls for much more integration of social and trade policy.

The WTO strongly rejects arguments that GATS constrains countries to open their public services unless they wish to do so (Adlung and Carzaniga 2001). Critics point however to the process of reciprocal requests within the WTO; the stated objectives of strengthening the commitments; and the irreversibility of commitments, as pressures moving countries towards liberalisation and the weakening of regulation (Koivusalo 1999, Price et al 1999). Furthermore, the high income countries are putting in requests for lower income members to open up their markets to European and US-based investors. There is also a large literature on TRIPS and the extent to which it constrains low income countries' efforts to achieve access to affordable drugs (Chaudhuri 2002). Government reaction in the South to the GATS agenda in health care has been mixed, and responses are still evolving (Drager and Beaglehole 2001).

Assessing the globalisation of local economies in health care

'Globalisation' is, as implied above, something that happens *within* countries, not just between them. As a result an emphasis on measuring cross-border flows misses much of the point. The central issue for economic policy is the nature and effects of 'openness' of diverse national economies: the extent to which leverage is exercised by international economic decisions over the evolution of the domestic economy. The literature on international market integration recognises this effect of openness – and of the developing regulatory framework of the WTO and GATS – through the concept of 'deep integration' (Birdsall and Lawrence 1999)

There is a huge literature on the impact of general globalisation in this sense – the openness of economies to the international markets – on growth and inequality (Lindert and Williamson 2001). I take from this literature one well established conclusion: that openness has very different implications according to:

- the export success of an economy, and
- the extent of internal inequality and redistributive mechanisms within a country.

Many African countries are thus very open to trade, but lack investment and growth and the capacity to diversify exports into expanding markets (UNCTAD 2002). Some transition and Latin American countries have found that economic openness reinforces inequality.

This conclusion re-emerges in research on globalisation and health. The broad economic processes of opening up to international trade and investment strongly influence economic structure and hence feed back onto health and health care. One can distinguish two issues: the extent to which changing patterns of employment, incomes and inequality affect health, and the impact on the delivery of health care as, for example, employers drop obligations to provide employees with services such as health care.

On the first issue, there are some optimistic pronouncements (Dollar 2001, Feacham 2001) but disaggregated analysis by country suggests, as one would expect, that countries where incomes have risen quite widely in the economy as it has opened up have seen health improvements (Vietnam is often cited as one of these). Conversely, countries where greater openness has been associated with economic stagnation and/or rising social and economic inequality the converse has occurred, as in substantial parts of Latin America, Eastern Europe and Africa (Cornia 2001). On the second issue, country by country studies pick up the impact of economic structural change on occupational health and workplace health care (Doyal 2002).

In the health care sector, one can ask, to what extent is ‘extraversion’ occurring: that is, the situation where international rather than national decisions are structuring health care provision and finance? Here is another sketch.

The economic effect of openness to trade and investment is at its sharpest in some middle income countries, where the role of foreign corporate capital in privatising social security funds and pension funds, and developing a private corporate sector is driving market segmentation; examples are a number of Latin American countries (Waitzkin and Iriart 2001, Plaza et al 2001), some transition countries, and some Asian countries such as (potentially) Malaysia.

In these countries the impact is strongest of what has been called the ‘pure globalisation effect’⁴ in health care markets: the spread of the impact of technological change on drugs and medical technology, through market integration, to the higher income groups in middle and lower income countries. This has driven up both the capabilities of medical intervention and (generally) its costs. That this technical change has focused on the health concerns of the well off is well documented (Commission on Macroeconomics and Health 2001). Its effects in liberalising health care systems are to raise the aspirations of the better off, and the costs of delivering a level of care and treatment perceived as satisfactory, and providing private suppliers in those markets with an incentive to over-capitalise. The ‘medical arms race’ – the over-supply of high-tech equipment – in health care systems undersupplied with the basics was visible even in Tanzania in the late 1990s; much more so in countries with a large middle class.

At the bottom of the income scale, for example in low income Africa, ‘openness’ in health care however mainly takes another form, already indicated: extreme vulnerability to the latest health sector reform package from the multilateral and bilateral donors. Furthermore, many such countries face extensive out-migration of health care staff (Mehmet 2002, WHO 2002b ILO 2003). Health care markets in these countries are largely local, but policy is extraordinarily ‘globalised’.

The country papers for this project sought to indicate the main aspects of globalisation influencing health care. One might summarise this findings, along with other relevant literature, as follows.

Mali is very little ‘globalised’ in terms of health care markets, although health care relies on imported inputs and there is likely to be out-migration of health care staff.

⁴ I owe this phrase to Alberto Holly.

The main impact of globalisation in Mali is a policy impact: initially a country that experimented with the primary care approach in its earlier guise, it later hosted the meeting that generated the ‘Bamako initiative’ proposals for rotating drugs funds at local level. The country is very heavily reliant on aid (Table 1) for health care delivery.

Vietnam is somewhat less subject to external policy pressure, though it has liberalised its health care system. There is rather little foreign investment in health care so far. The main impact in Vietnam of globalisation on health care, discussed in detail in Hong Tu *et al* (this project), is through the rise in industrial production for export, and the opening of the country to higher levels of imports e.g. of agricultural inputs. This has introduced new health and safety problems in production, and weakened provision for care at enterprise level.

Neither of the middle income countries in this project, Bulgaria and South Africa, are among the main ‘targets’ for foreign direct investment. Neither have a large enough higher income market. Dacova (this project) identifies in Bulgaria an important impact of globalisation in the sense of international market integration in potentially undermining local pharmaceutical production. South Africa has seen a major impact in the out-migration of health care staff at a time when the health care system is strongly affected by the consequences of HIV/Aids (Equinet www.equinetafrica.org 16.6.03). Finally, the Swiss paper for this project identifies in-migration, and the need to integrate asylum seekers and other migrants into the health care system, as a challenge to inclusiveness raised by globalisation.

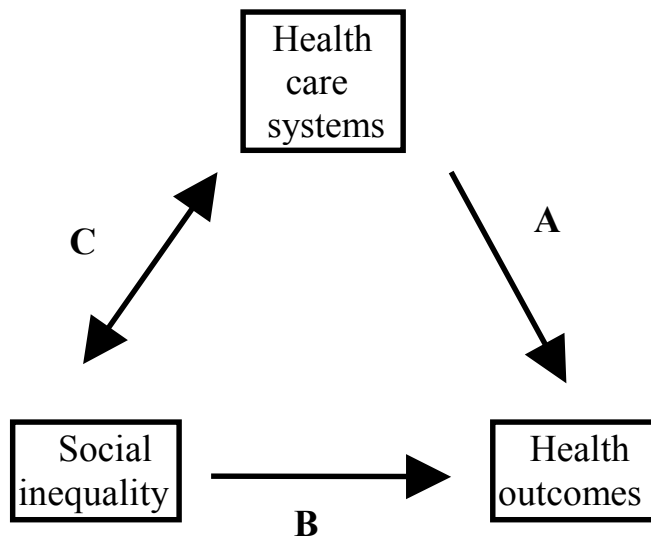
Commercialisation, inequality and health care

These effects of globalisation, in driving corporatisation of health care and (through policy conditions) broader health care commercialisation, potentially play an important role in embedding social and economic inequality within countries at all levels of income. By ‘embedding’ inequality, I mean to indicate the effect of commercialised health care in a series of feedback loops that *can* reinforce and solidify the mechanisms that reproduce social and economic inequality. These include (drawing on the above discussion):

- highly regressive fee payment systems push households into poverty, particularly through forced asset sales and loss of income-earners because of exclusion from care, worsening economic inequality;
- institutionalisation of segregated health care provision that reinforces social division while worsening health differentials among the population;
- social divisions that feed back into the social hierarchies and assumptions of those working in health care;
- policy-led denial of commitments to universal access, weakening the basis of claims and aspirations by low income people to decent care;
- an abandonment of people to face the search for health care without guides, as primary care gateways and referral systems do not function;
- the loss of public sector capacity as an – at least potential – competitor or ‘floor’ under the worst forms of abuse and exclusion;
- informal charging in the public sector as linked to abuse, exclusion and impoverishment, part of a general deterioration of professional good conduct.

Through mechanisms such as these, health care finance and provision and create direct effects on social and economic inequality. One can think of the interconnections as in Figure 7. Most policy and research attention is paid to causal effects of the type A and B (Wagstaff 2002); far too little thought is given to direct intersections of type C, which run in both directions. The final section of this paper outlines a policy framework that takes more of these direct intersections into account in the context of commercialised systems. Before that, I consider in Section 5 a question raised earlier: why the commercialisation of health care is so widely contested, as compared to commercialisation of many other goods and services. What is special about health care?

Figure 7 Health / inequality interactions



5. Contested commodification in health care

‘Market commodities and poor relief: the World Bank’s proposal for health’
Laurell and López Arellano 1996

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

The impact on inequality of globalisation and commercialisation pressures in health care depends on policy responses. I make three arguments in this section.

- First, the theoretical core of current arguments about health care policy can be understood as a debate about the nature of health care: is it a private ‘good’ like any other, or does it have to be shaped, actively and with difficulty, into a commodity if it is to be sold?
- Second, internationally dominant discourses of ‘health sector reform’ and the ‘new international public health’ conceal the extent to which the history of health care policy internationally is characterised by repeated contestation and rolling back of health care commodification.
- And third, health policy is a key public space for constraining and contesting inequality and exclusion, and to do that, health care commodification has to be partially blocked; ‘regulation’, as so widely prescribed, is not enough.

Public or private services: competing intellectual frameworks

There is an economic framework of analysis for health care that is very widely proposed by economists in multilateral agencies as a proper basis for health policy and health sector reform⁵, based in the concept of health care as a ‘private good’. That is, health services are understood as generally divisible into items for sale on markets: consultations, treatments, days in hospital. There are acknowledged problems of actually selling such services efficiently on markets – notably the difficulty ‘consumers’ have in knowing what they are buying and why – but this does not alter the technical character of the good. Only a few aspects of health care, on this analysis, lack this ‘private’ character, notably those such as vaccinations which benefit others in addition to the recipients, or ‘public goods’ such as public health education, training of staff and research, all which, it is accepted, will be under-provided without public subsidy or provision.

There is also an alternative economic framework of analysis of the characteristics of health care that is found rather in historical research and political economy. This argues that the ‘public’ or ‘private’ nature of health care is to be understood not as a technical but as a social set of characteristics. The ‘publicness’ of health care, including public health, was on this view, constructed through political and social

⁵ For example, World Bank 1993, 1996, 1997. This is also the standard text book treatment of health care, especially in US economics teaching, and underpins, for example, the new writing on international public goods in health.

processes in Europe and elsewhere. Public health provision (such as universal access to clean water in large English cities) was for example the result of a mix of social campaigning, changes in medical information on the sources of epidemics, notably the transmission of cholera; changes in proximity and hence mutual knowledge, as the cities became dense, with poor areas in inner cities alongside wealthy quarters; and declining in marginal costs of public hygiene for the poor, such as clean water supplies, once most of the city was connected to pipes De Swaan (1988) Municipalities across Europe, for example, effectively turned water supplies into a public good, making it universally available by decision and providing sufficient infrastructure so that consumption was possible for all.

These two frameworks of economic thought are not, in truth, incompatible. It is possible to hold that many health care services are technically ‘private goods’ yet are socially constructed in many countries as open to universal access. Yet the two frameworks of thought do in practice generate competing policy prescriptions. The first, with its presumption that health is –mainly – a commodity, has been used to underpin multilateral prescriptions for health care reform and health care market liberalisation over two decades. The second framework of thought underpins arguments for the *possibility* and importance of sustaining commitment to decent inclusive social provision including health care at all levels of income (Qadeer 2001, 2003).

Promoting and contesting commodification

One could recount the history of health care over more than a century as a recurrent political struggle over the extent of its commodification. This is by no means a one-way story: commercial health care has expanded, been constrained, and promoted anew in countries at all levels of development. Examples are the near-universalisation of health care access across Western Europe in the decades after 1945, the attempts to reintroduce commodification in the 1980s and the high level of resistance to it; the high profile role played by expansion of public sector health care in post-Independence Africa; the decline of public sector health care in the ex-Soviet and Eastern European transition countries (beginning before 1990), and the initiation of social insurance systems by the turn of the century; and the privatisation of social security systems in Latin America, followed by projects in a number of countries to widen access to primary care. Indeed, countries and periods where inequality of health care access exists but is *not* a subject of open political contestation in democratic polities (such as India at the national government level, as Jeffrey 1988 notes, and the United States with brief exceptions such as the Clinton reform plans) are worthy of note and demand explanation.

At the beginning of the 21st century, the stakes involved in this political struggle over health care commodification have been driven upwards by a number of the factors already discussed: rising incomes (generating opportunities for higher profits from commercial health care); the huge rise in the technical capacities of health care (increasing the ‘product content’ of health services in terms of the drugs and other inputs available); the expanding role of corporate capital in health care, very particularly in the post-war United States; and the involvement of multilateral agencies in the promotion of health care commercialisation.

Health care is in fact not easy to turn into profitable production of marketable commodities. The economic reasons include patients' lack information and the perverse incentives noted above for low quality provision. Furthermore the caring/nursing side of health care is labour intensive, making it hard to increase productivity, again creating incentives to lower quality; some key health care goods are not necessarily desired by their recipients (vaccinations, finishing courses of drugs); and low incomes and spiralling costs constrain health care market size. There are social and ethical reasons too: the relationships of professionally ethical behaviour, trust and information flows that make health care effective can be corrupted by too strong an organisational emphasis on individual material incentives (Gilson 2003, Mackintosh 1999). And there are political reasons: selling health care goods and services (drugs, surgical treatments, advice) allocates them by preference to the better off, which may be contested in democratic polities.

Health economists and policy makers are frequently exasperated the high political profile of health care commodification. They point out that bread is allocated on markets, and no one suggests decommodifying it. This is not universally true – wartime, famines, and widespread subsidies to food production or purchase, are counter examples. But the general point – that health care seems somehow to carry with it political and ethical 'weight' in the form of demands for equal access that make market sale controversial – is correct. Why is this so?

Explaining health care decommodification: a Polanyian framework

I propose that something can be learned about health care from the ideas on commodification of Karl Polanyi, an Austrian historian writing in exile in Britain and the USA during the Second World War, trying to understand the roots of fascism in the economic and social devastation of the 1930s. In *The Great Transformation* (1944) Polanyi argued – among much detailed economic history – the following general points about the industrial revolution of the 18th and 19th centuries and its continuation in his times.

First, he argued that the nineteenth century saw the conscious creation, through extensive government intervention to break down barriers to trade (including colonial expropriation and exploitation) of 'free markets' in a huge range of goods and services, both within countries and across borders. Or, as he put it,

'The road to the free market was opened and kept open by an enormous increase in continuous, centrally organised and controlled interventionism ... *Laissez faire* was planned' (pp 140-1)

Second, as markets (and production for markets) increasingly became self-reproducing, or 'self-regulating', society itself was transformed:

'Instead of economy being embedded in social relations, social relations are embedded in the economic system' (p.57)

Separate institutions of the economy were created, and with them the discipline of political economy – later economics – could emerge to analyse the behaviour of markets.

Third, it became necessary, to sustain 'market society' to create 'fictional commodities': notably land, labour and money. These were not true commodities, Polanyi suggested: two were not 'produced' for sale, one was not sold for its own

intrinsic value. Yet such markets were organised, and in the Industrial Revolution ‘the effects on the lives of people were awful beyond description’ (p. 76), just as were the result later of widespread unemployment and hyperinflation.

The result was what Polanyi calls a ‘double movement’: the creation of markets in labour, land and money and simultaneous and repeated political contestation: efforts to restrict and manage their operation, through social legislation, unemployment insurance, and constraints on trade in land and the creation of money.

Polanyi’s specific history of the industrial revolution is not my concern here. Rather, I want to reflect on the question: is there a sense in which health care operates as a Polanyian ‘fictional commodity’ subject to a ‘double movement’ of contestation? I think we can. Here are some reasons.

The social relations generated by health care markets when healthcare transactions ‘escape’ from social and professional constraints are particularly unpleasant – as anyone who has been close to bad private dispensaries for poor people can testify. Furthermore, because of the relational and personalised nature of health care, the exploitation of the vulnerable is personalised and deeply resented. Surveys constantly reiterate the emphasis clients put on respect, information, honesty and proper care, as well as effective treatment. That private health care is better in some countries than dreadful public sector provision does not change the consequences of market supply that is not socially constrained.

Conversely, non-market supply is observed, in some places, to work. That is, first, the mix provided in high income countries by universalist systems of: insurance, cost control, access free at the point of use, and effective cross-subsidy from the better off well to the ill poor, is popular and perceived to be efficient. Despite great political debate, its persistence is evidence of the effectiveness of non-market organisational forms. At lower levels of income also there are to my knowledge no effective forms of health care provision that do not depend strongly on non-market as well as market activity (Mackintosh and Gilson 2002). What this means is that the argument that health care services are *inherently* private goods stands up badly to evidence and experience.

And finally, concepts of health and illness, and commitments to care for the sick, are deeply embedded within our cultures. To be abused and rejected when ill is to be excluded in a very key sense from society. Some of this carries over into the politics of provision of health care, underpinning instinctive rejections of ‘market commodity’ assumptions.

Blocking commodification

All health care systems that work depends strongly on public interest and professionalised non-market behaviour and relationships. There is no escaping this conclusion once non-market activity is brought into the public gaze. They depend on, for example on the following forms of non-market activity:

1. Effective public provision; we may note that many health care reform prescriptions and commentaries simply assume that the residual health care

needed to ‘fill gaps’ in markets can simply be ‘delivered’ whatever the rest of the reform process has done to the public sector as a professional body;

2. Caring by relatives and caring behaviour from, in particular, nurses; when these two break down in low income contexts people lose access to decent care;
3. Credible and progressive allocative behaviour by public sector budget holders; the possibility that reform will undermine this is discussed below;
4. Professional commitment by staff in all sectors to do their jobs properly when not monitored and even when they could make more money otherwise; health care cannot by definition be monitored continually (though it can and must be supervised and audited), and there are widespread temptations; no professionalism implies no decent system of care and treatment;
5. Willingness by the public to pay taxes and contributions; again, individuals can be caught, but collectively the payments are ‘voluntary’ as illustrated when taxation systems break down.

These public benefit mechanisms in health care *have* to be sustained or rebuilt. There are no decent *free* markets in health care; the only decent markets are strongly socially constrained. To construct decent outcomes means constraining aspects of commodification, and rebuilding or sustaining a social and public commitment to health care as a right and contribution to health care as a duty. The fact that constraints on commodification of health care are at the same time efficient, politically effective and ethically justified has been the foundation of effective health policy repeatedly across the world and historically over the last century and more. Current health care reform discourses are disguising that fact.

6. Concluding reflections: policy implications

Health care both reflects the inequalities of society and is a platform for addressing those inequalities. Given that the health care system provides such a frequent and effective political platform, what are the key elements of policy that, in specific contexts, can contest the most unequalising impacts of health care commercialisation? The following seem to be the general implications of the evidence discussed in this paper.

1. Institutionalising effective alternatives to fee-for-service primary care

Access to primary care via fee-for service payment can generate impoverishment through unaffordable expenditure, undermine preventative activity, create exclusionary processes at entry to health care, break referral mechanisms and subject poor people to poor quality and unqualified care. The most widely proposed alternative in the international literature is a local insurance mechanism. These schemes can improve access, but have well recognised limitations, notably inefficiently limited risk pooling and typically regressive flat fee structures that disadvantage or exclude the poorest. It is very unlikely that effective primary care for the poor can be reconstituted where it has broken down without some direct public sector provision of decent quality, to put a ‘floor’ in quality and price terms under what is provided elsewhere. The primary care system requires – as is widely agreed – a strong redistributive process towards those who require primary care which is free at the point of access. The policy question – which will have different answers in different contexts – is what institutional structure will create and sustain such a redistributive mechanism? The challenge of rebuilding – or retaining – decent public sector primary care is likely to be an element of the answer in many contexts.

2. Reinstating or creating cross-subsidy

Inclusive health care systems generally operate on the basis of substantial cross-subsidy within the health care system itself between the better off and the poor and between the healthy and the sick. Commercialising health care tends to drive out that cross-subsidy, in order to focus provision on profitable transactions. In the extreme, commercial provision can engineer a major shift from serving the poor and ill towards serving the well off and (relatively) healthy. The mechanisms by which this occurs include a decline in risk pooling and rise in risk-rating, if health care insurance systems move towards more private profit seeking and reduced regulation; the exclusion of low income users through a shift from tax-based to flat rate or service-based fee systems for primary and secondary care; and the creation of incentives to exclude the expensive-to-treat, through capitation-based payment systems to clinicians.

These effects are typically generated by commercialisation, and in some countries have been jump-started by the entry of foreign private insurers or private providers, or the insistence by donors on fee-based payment systems. This is not to imply, of course, that public sector necessarily serves the poor better: that in itself is a political and institutional challenge. It is rather to say that in some way, the operation of this circle of incentives for exclusion and impoverishment needs to be broken by

government, or more generally by public action involving government. A government that is not able to create credible public provision is likely to have equal difficulty regulating effectively.

Reconstituting – or defending – cross-subsidy is thus an important element of inclusive health policy. History of the high income countries' systems suggests, first that inclusive health care systems are highly redistributive (when finance and provision are considered together), and second, that redistribution through the health care system itself is politically easier – because socially more legitimate, and usually cheaper – than direct subsidy to individuals or specific elements of a commercial system. The implication of this in turn is that the loss of cross subsidy where it does occur may make it less rather than more likely that public funds will go to the poor. Not all public sector provision cross-subsidises the poor by any means, but it may well be the case that an attempt to increase cross-subsidy is a better response than commercialisation to regressive behaviour of public sector health facilities.

3. Preserving some public hospitals

A good example of the above proposition is the need to increase the access of the poor to public hospitals in many countries. The widespread privatisation and corporatisation of secondary care is likely to create, in addition to the social segmentation already referred to, other unequalising processes, such as driving up costs and driving down overall health system quality and integration. There are substantial joint products in health care systems, generated in the interaction between primary and secondary care: the secondary care system generates training, skill development, treatment of referred patients, and technical backup to the primary system; the primary system generates prevention, first level care and primary diagnosis. The cost of disaggregation is the loss of a number of efficiencies in the use of resources in the system as a whole; a cost of the disaggregation resulting from secondary care privatisation is the loss of referral systems (which have collapsed completely in some countries where they did previously function) and declining effectiveness of both primary and secondary provision. It has been associated in some countries with the detachment of health care from employment rights. The detaching of secondary care access from employment rights reinforces exclusion, and the loss of corporate support can bring wholesale closure.

A necessary response may lie in the preservation of some public hospitals with strong links to primary and community provision. It seems likely that the public hospitals in Kerala have played a role in sustaining the quality and inclusiveness of the system as it has privatised. Like public provision in primary care, they can increase inclusiveness and put a floor under quality for those with low capability to pay. Public hospitals are the lifeline for the poor faced with severe illness in very many developing countries, including low income Africa, and their quality is one key to the behaviour of the system as a whole.

4. Creating incentives for progressive public finance

The political economy of progressive public finance is an essential element of health care provision, but poorly documented and analysed. The policy-project face of globalisation – enforced marketisation of health care – tends to treat the allocation of public expenditure as a technical matter (as indeed, in part, it must be). But marketisation also sets up pressures for the subsidy of struggling (but flagship) projects, and the support of (sometimes ineffective) regulatory structures: as a result it may not ‘release’ funds, or create political and institutional incentives for progressive allocation of funds.

Public expenditure is subject – in all countries – to two major types of political and economic ‘shaping’:

- at the political level it is shaped by interest groups, political programmes and bargaining, private lobbying, bureaucratic processes, institutional claims and theories and assumptions about how things should be done;
- once ‘allocated’ to institutions, the resources generated by public spending are further employed, diverted, charged for and wasted before they come – if they do – to benefit those in need of health care.

The danger with, particularly, the polarised form of commercialisation is that by legitimising unequal provision it encourages regressive finance. A lot more thinking about the converse effect – how to create political rewards and institutional sustaining of redistributive allocations – is needed in the face of health care commercialisation. This is true whether or not the allocation process was regressive before health care market liberalisation. The papers for this project on Bulgaria, Vietnam and South Africa all note the difficulties involved in establishing effective social insurance in the (very different) semi-commercialised environments in these countries, and it may well be that the political economy of effective social insurance is an important topic for further work.

5. Blocking individual private insurance

Health care systems – like other institutions – have very strong elements of path dependency. This implies that in a process of transformation – such as is happening in transition countries and in some other countries in health care – from government dominated to mixed or private-led systems, the early stages (the initial conditions of the system) matter enormously to the later evolution. A good example is private individual insurance: where individual risk rating becomes strongly established, particularly if associated with fee-for-service payment systems, the health care system tends to evolve towards high tech/ high administrative costs / high exclusion path. The costs of universalisation – and the scale of the political lobbies against it – then become hard for even wealthy countries to address: the classic case is the United States, but other middle income countries risk an evolution into a trap of this kind. Where health insurance becomes partially privatised, a determined effort to ensure community rating and prevent rejection of higher risk individuals is both possible and essential from the start. Alternatively, if some private initiative is required, create private management of social insurance systems with income-related payment mechanisms and strong regulation. As argued above, it is the payment mechanism that drives behaviour in the system as a whole. While social insurance mechanisms

may not include the poor, their early establishment or recreation may be key to creating a system that can eventually move towards universalisation.

Can a government act?

Part of the broader globalisation literature argues that globalisation may undermine the scope for government to act, by increasing the difficulty of raising taxes and creating new pressures to undermine social spending by firms, for example, and by undermining government political commitment (Rudra 2002). Conversely, there is an economic literature that points out the countries which successfully open their economies tend to institute larger welfare programmes to protect citizens and encourage economic flexibility (Rodrik 1998).

There is no settling that debate in general, only scope for looking for particular political and economic opportunities. Public health campaigners across the world point out the gap at present between remaining and reiterated political commitments to health care access as a right, and the exclusionary effects of commercialisation. As a group of Brazilian researchers put it:

‘a saúde como direito e como serviço, elementos contrapostos no nossa realidade o que é instituído como direito no nível institucional acaba sendo negado pela prática cotidiana da implementação das políticas de saúde’ [health as a right and as a service, contradictory aspects in our reality that which is established as a right at the institutional level comes to be negated in the daily practice of implementation of health policy] Cohn et al 1999 p.11)

Just so, in many countries, the aspiration that health care should be available as a right, and the experience of its market sale, rub against each other.

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