

Commercialization and Globalization of Health Care: Lessons from UNRISD Research

Using market mechanisms in the provision of health services and seeing health care as a private good are approaches that have featured prominently in health sector reforms across the world. UNRISD research on global and local experiences of health care commercialization challenges this framework. It calls for reclaiming public policies that promote the purposes that health systems are set up to serve: population health and the provision of care for all according to need.

The Issue

In the struggle for developmental, inclusive and democratically rooted social policy, health is a battleground on which competing visions of the ethical and political basis of society are fought out. Health systems act as powerful drivers of social exclusion or inclusion: key markers of a country's public ethics and state-society relations.

Health care is also an important “test case” for proponents of market-led policy in the social spheres, since it was an early field for the promotion of liberalization and the development of private sector supply. Yet the commercialization of health care is highly contested, because of well-understood market failures and because of ethical commitments to access to care that emphasize universal service provision and government engagement in health care. Hence, policy toward health care commercialization focuses attention on a widely contested market/non-market boundary in social policy.

UNRISD research on health care commercialization began from an understanding of health policy as part

of broader social and public policies. Health systems are the institutional expression of these policies, rooted in legal rights, values and political commitments. Health care forms part of wider health systems, which also encompass public health, health promotion and assessment of health implications of other policies. Health services must aim for universal access to care according to need, and solidarity in provision and financing—and have to be judged against these aims. In this framework, commercialization should be evaluated as a means to these ends.

“Commercialized” health care means the provision of health care through market relationships to those able to pay; investment in and production of services, and of inputs to them, for cash income or profit, including private contracting and supply to publicly financed health services; and health care finance by individual payment and private insurance. Commercialization thus encompasses and provides a single framework of analysis for understanding a number of intersecting processes such as private sector expansion, market liberalization and privatization of state assets. Commercialization of health care in this sense has

UNRISD Research on Commercialization of Health Care, 2003–2005

This Research and Policy Brief summarizes findings from two UNRISD projects: *Commercialization of Health Care: Global and Local Dynamics and Policy Responses*, and the health-related research for a broader project, *The Social Challenge of Development: Globalization and Inequality*. These interlinked projects brought together researchers from 20 mainly developing and transitional countries to undertake primary research on the extent and differentiated nature of health care commercialization and globalization, its implications for access and inequality, and the scope for effective policy responses to create inclusive, effective and accountable health systems.

Within these themes, topics included the strategies of multinational companies and the health implications of global industrial regulation; the impact of transnationalization of health care corporations on middle-income country health systems; commercialization of the public sector of health care itself and its consequences; international migration of health care staff; public-private interactions and health equity; and experiences of universalization of care in commercializing health systems. Primary research was undertaken in Argentina, Brazil, Bulgaria, China, Ghana, India, Lebanon, Malaysia, Mali, Mexico, the Republic of Korea, the Russian Federation, Singapore, South Africa, Switzerland, Tanzania, the United States and Viet Nam. The projects demonstrated that economists and health policy experts can work effectively together within a conceptual framework that treats commercialization of health care as a process to be judged on its merits, rather than a premise on which health policy is built.

been promoted directly and indirectly by economic pressures and international policy leverage since the 1980s, and has been the precondition of international market integration, or “globalization”, in health.

Research Findings

No comfort for commercializers: Commercialization is associated with worse access and outcomes

There is a striking lack of evidence from cross-country comparative data that health care commercialization has a positive impact on health care access and health outcomes. Yet commercialization has come to dominate most low-income countries’ primary care. The lower a country’s average incomes, the more likely a population will face the most poverty-inducing form of health finance: out-of-pocket payment. Health care largely free at the point of use, financed by general taxation or social insurance, is both the choice and the privilege of wealthier countries: higher “social” expenditure on health relative to gross domestic product (GDP) is closely associated with both higher average incomes and better health outcomes.

Within the health markets of a set of mainly low-income countries for which we have data, furthermore, the poorest people were more likely than the better-off to depend on private rather than public care: the opposite to the usual supposition. The greater the commercialization of primary care, the greater was the exclusion of children from treatment when ill, and also the greater the inequality in rates of consultation for children when ill and rates of immunization. The relationship was particularly strong for sub-Saharan African countries.

Of all the types of commercialization studied, it was fee-for-service provision in conditions of generalized poverty that had the strongest association with low-quality care, exclusion and neglect. The deterioration of care and working conditions in low-income health services was also the underlying driver of health professionals’ migration, notably from sub-Saharan Africa, to work in higher-income systems.

Commercialization of the public sector undermines its effectiveness

Even in low-income Africa, public expenditure on health is progressive: the poorest groups gain more benefits, proportionally, than their share in cash income. And more public spending is better: governments that spend more relative to GDP have better, and better distributed, health outcomes. In Asia, universalist public health systems free at the point of use, such as in Sri Lanka, not only have above-average outcomes even at low incomes, but are also more redistributive.

However, commercialization of the public sector itself threatens its core role in health systems. For example, the study in Mali showed how public and community health centres that charge fees in conditions of generalized poverty tend to lose their public health vocation and become “semi-commercial facilities” that rely on the sale of consultations and drugs. In transitional Russia, “spontaneous commercialization” within a health sector moving nominally from public to social insurance funding, and offering nominally universalist provision, was shown to have hugely exacerbated inequality of access by associating

better-quality care with payment. The separation of health finance from health care provision in conditions of underfunding has distorted incentives and generated fraud in a system where private medical insurance intermediaries extract profits without improving access to care.

The public sector of health care can play its redistributive and public health role only if its principles of operation differ from those of commercialized services. Policy pressures to commercialize operations, accommodate private interests and shift to material incentives have altered behaviour in the public health sector, while private sector provision in many developing countries relies heavily on public resources, from equipment to trained staff. Research in India underlined the impact of commercialization on the values and aspirations of professional staff, as the more individualized culture of private sector medical careers has come into conflict with a public sector culture that continues to be more consultative and public-interest-based. Such changes in professional values are profound and long term: in the current era of nascent international acceptance of the need to rebuild public provision and trust, a precondition of success will be combating the devaluation of public commitment and ethics.

Health care is a risky and unstable sector for private investment, and multinational firms’ risk-reduction strategies can be damaging and divisive

In middle-income countries, commercialization in the health care sector has been strongly influenced by the increased entry of large health care corporations, and by foreign private investment in provision and insurance. Such manifestations of globalization in health care are, however, patchy and unstable: health care is a risky sector for private investment, and multinational investors focus closely on risk-containment. In the research, European and Asian multinationals were found to display distinctly different investment strategies from those of US-based firms. European and Asian multinationals in health care, which operate in quite strongly regulated environments on their home continents, focused on lobbying for the creation of economic “infrastructure” for private investment, including charging and tendering systems that would allow them to compete; on limiting their risk exposure by reducing asset ownership; and on undertaking a mix of public contracting and growing provision for “high-end” acute patients with an eye to long-term involvement.

US multinationals were perceived in developing countries as more unstable investors in the health sector, aiming at short-term profits. This instability appears rooted in the troubled industry of US “managed care”: a private financing-and-provision format the corporations actively export. The late 1990s saw a wave of US corporate investment in Latin American health care, associated with corporate lobbying of multilateral organizations in favour of reforms that opened health care markets to private investment. In Brazil and Argentina, US firms invested, then quite rapidly sold on. In Argentina, which like Russia was going through economic reform and severe economic collapse in the 1990s and 2000s, and which had an established private sector of health care provision for socially insured employees, the research showed that foreign corporate investors participated in the transformation of social security funds into a private managed

care format, and engaged in leveraged buyouts, closures and resale across the sector.

Globalized commercial supply industries will not respond to public health priorities without regulatory changes

The industries supplying health care inputs, notably pharmaceuticals, medical equipment and supplies, are increasingly operating in internationally integrated markets, with rising exports and developing country firms that are becoming multinational in their turn. Prices of drugs for patients and health systems depend on market structure and competition, and commercial operators' behaviour also responds to the regulatory environment. The research showed that new pharmaceutical research and development (R&D) by Indian firms, for example, is strongly oriented toward the needs of wealthy countries' markets; but if medicines are to be affordable in developing countries, it is essential to sustain competition from generic producers.

Access to medicines and medical technologies is influenced by international industrial and trade policies and regulatory activities, including patent protection and standard setting. But supply industries are increasingly vocal and influential advocates of their own interests, and regulation is shaped by their initiatives and lobbying. The medical device industry, for example (largely US, European and Japanese) has been strengthening its international policy influence, exerting pressure to bring "borderline" items, such as drug delivery systems and procedures, under the pharmaceutical patent regime. European and US policy makers seek to support innovation by and the profitability of their industrial base, and while industrial regulation is crucial to health system safety and effectiveness, industrial policy rarely weighs health policy considerations effectively.

Policy Implications

Conceive of health systems as core social institutions

Health systems should be understood *both* as the institutional expression of ethically framed policy commitments *and* as social institutions embedded in each society's structure and values. This focus on ethics and accountability should warn policy makers against allowing commercialization of the public sphere to contribute to or, worse, legitimize exclusion from health care.

Health systems are an important means of redistribution and solidarity, in which the healthy and rich must cross-subsidize the ill and the poor. In times of crisis, moving toward universalization of access to health care can contribute to nation building. This is illustrated by government health policies in the Republic of Korea in the wake of the 1997 economic crash: democratization had strengthened an "advocacy coalition" pressing for universal national health insurance which, when implemented after 1997, brought significant redistribution toward those on low incomes suffering from the impact of recession.

Establish a coherent policy toward commercialization

Commercialization of health care is *both* a market-driven economic process *and* one that responds to policy decisions. At

present, commercialized health systems in developing countries are largely unregulated, and formal regulation is very hard to achieve in liberalized markets. A more effective policy framework would focus on defining and enforcing the form and limits of commercialization appropriate to health system objectives at different levels of economic development and in diverse political contexts.

Key policy tools for this purpose include national health financing mechanisms and public sector provision. At higher middle incomes, the experience of the Republic of Korea demonstrates that even with a highly commercialized supply side, health care access can be broadened, and its redistributiveness improved, as long as health financing is via social—not individual private—insurance and is increasingly extended to the whole population. At lower income levels, countries can finance a substantial health service through a mix of tax funding, aid funding and nationally mandated insurance mechanisms. Such social funding mechanisms can be powerful tools for accrediting and regulating the behaviour of private sector suppliers.

Rebuilding public sector provision reshapes the market and competitive framework for the private sector at both middle and low income levels. This is illustrated by the experience of Mexico City, where the city government sought to universalize access to health care by first establishing rights of the poor to make claims on the public sector that matched the rights of the socially and privately insured to health care, and then rebuilding public sector provision to respond to those claims. The approach has the beneficial effect of legitimizing universalist claims to care—in contrast to the delegitimizing effect of marketization—in a characteristically stratified Latin American system. In many parts of low-income Africa, there is growing democratic pressure to find alternatives to fee-for-service health care; this reflects a recognition that individual fees undermine claims to access.

Ensure that health policies are not undermined by industrial and trade policy at the international and national levels

Trade and industrial policies profoundly affect the cost and effectiveness of health systems worldwide, yet they are largely conducted without reference to the requirements of health policy. A move to place health policy needs at the centre of industrial and trade regulation is essential for several reasons. First, it would challenge the "reverticalization" of international health policy—the move to technology-driven vertical interventions at the global level through public-private partnerships. Second, it would provide pressure against the expanding leverage of industry interests over global policy frameworks. Third, it would emphasize the importance of democratic decision making when policy priorities are being set, and refocus attention on policies to support health system integration within developing countries. As demonstrated by the study of medical device regulation, public health interests should be present in regulatory forums from the start to avoid the probability that international agreements will work only for shareholders to the detriment of patients. Research findings also suggest that there may be fewer differences in policy priorities between countries of the North and South than there are global differences between the priorities expressed by health and trade policy makers, or between the interests of public and commercial sectors.

Developing countries can also assert much more effective regulatory control over private investment. Corporations may actively seek regulatory frameworks that restrict low-cost competitors. Clear understanding of firms' objectives, and a focus on regulating quality rather than merely offering firms protection from market competition, can shape the role of private corporate providers toward health system goals of cross-subsidy and inclusion. Inclusive health policy is particularly likely to require strong constraints on private health insurers. In China, for example, the research documented a lively debate about how the government might ensure that private insurers play only a complementary and not a dominant role in urban health finance.

Reclaim the "common sense" in health policy for public health priorities and needs

In the 1990s, international health policy actors sought to shape a common-sense view of health care as a private market good. Resistance to this view has been profound, and is increasingly evidence-based. Health systems will continue to be "mixed", with very substantial commercial participation. But if health systems are to play their essential role in providing strong social underpinnings for functioning market economies, they cannot themselves be market-led. On the contrary, they must serve social, ethical and professional objectives, and health policy must shape the commercial elements of the system to serve those objectives effectively.

A better common sense in international health policy will recognize that effective, ethical and inclusive health systems are both relevant to framing broader social and economic policies and global regulatory measures, and also impose certain requirements. International policies toward, and frameworks of support for, national health systems must be reoriented to support equity and inclusion. National, regional and global policy measures in other areas, such as trade and industrial policies, must avoid placing limitations on the policy space available for national health policies. In the current context of commercialization and corporate involvement in global policy agendas, this reassertion of public policy space will require rethinking regulatory approaches and frameworks, including questioning the role of public-private partnerships and the current emphasis on selective technology-driven interventions in global health.

Publications and Further Reading

Project books

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