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Health Systems and Commercialisation
In Search of Good Sense

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1. Introduction: health care commercialisation and health policy, whose common sense?

> '.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)

Health policies reflect, and have always reflected, values, culture and policy priorities in different countries. The *analysis* of health policies therefore necessarily brings together sociological and political understanding and more technical evidence with insights from epidemiology, clinical medicine and economics.

However, in the world at present, health policy analysis has come to take a particular predominant form: the analysis of health care as an economic sector of health service provision plus a set of managerial evaluation techniques for analysing health care inputs and outcomes. The fragmentation engendered by this dual approach is often reinforced by a division within the institutions of health policy analysis between those whose interests and expertise lie in health protection and public health policies, and those whose 'lens' is the analysis of health care perceived a market-provided service. This dominant 'common sense'[1] of health policy then perpetuates fragmentation through a policy framework that allocates public health measures to a limited policy sphere of 'public goods' while framing health services as a sector of market trading: these are the 'sophisticated methodologies' Imrana Qadeer is referring to above.

We argue below, drawing on both new research and existing evidence, that this dominant common sense in health policy is in certain ways both incoherent and damaging. However our aim is primarily constructive rather than destructive. It is well understood that a properly functioning health system is essential to an effective market economy. To make a health system *work* in a market economy, however, does not imply simply the commercialisation of the health care sector itself. It requires rather a different starting point for health policy.

This alternative starting point has traditionally been articulated as part of a health systems approach. It recognises the importance of values. It also acknowledges the existence of market failures in health systems. It draws on economic analysis of health care financing and economic assessment of health care systems as a whole. But it draws also on public health and medical knowledge concerning the needs and problems that health systems have to deal with. Our ambition with this paper and the project to which it relates is nothing less than to provide the outline of such an improved 'common sense', as a foundation for better analysis and practice in health systems and health policy design.

[1] We define this concept in Section 5.

This alternative starting point has traditionally been articulated as part of a health systems approach. It recognises the importance of values and ethically based objectives. It draws on economic analysis of health care financing and economic assessment of health care systems as a whole. But it draws also on public health and medical knowledge concerning the needs and problems that health systems have to deal with. Our ambition with this paper and the project to which it relates is nothing less than to provide the outline of such an improved 'common sense', as a foundation for better analysis and practice in health systems and health policy design, and some basis for it in evidence.

We begin in Section 2 by discussing the concept of 'health system': creating a definition and discussing the ways in which the definition of health systems employed makes a difference, helping or hindering our analysis and understanding of processes and change in health systems as well as understanding of their role and purpose in a society. We also examine the economic ideas associated with this concept of health system. We contrast these concepts with the dominant model of health sector reform and *its* economic presuppositions.

The values at the centre of health systems have today to be pursued in a rapidly changing context of health service commercialisation, both within countries and in integrating international markets. In Section 3 we seek to contribute to a better understanding of the nature and consequences of this commercialisation, by examining cross-country and case-based evidence different 'paths' of health care commercialisation.

In Section 4 we offer some evaluation of the current commercialisation of health care. We argue that the cross-sectional and qualitative evidence available contains no comfort for the commercialisers. On the contrary, commercialisation, on many indicators, is positively associated with ill health and exclusion. And some patterns of commercialisation appear particularly damaging.

In Section 5 we set our to define the basis for a new 'common sense', explaining in more detail what we mean by this term. We argue that to build effective and decent health systems, some elements and patterns of commercialisation have been and will have to be blocked – not merely 'regulated' – in the interests of public health and effectively functioning market economies.

2. Health systems, health policies and economic suppositions: two contrasting views

2.1 Health systems, redistribution and industrial change

Defining health systems

Our working definition of health policies and health systems in this paper is grounded in the understanding that public policies and health policies form part of the broader public policy framework in a society. Health policies tend to be discussed in the context of broader social policies of a country. However, while choices of health policies are often in line of the values and emphasis of broader social policies, decision-making on health policy often differs greatly from social policy. The role of service provision is substantially larger in health and the impact of labour markets more limited than in the context of social policies. Health policies are also part of normative policy-making within a society, and embedded in legal rights and commitments made as part of public policies. While analysis of health policies may need to cover processes and stakeholders, these relate more to politics of health than health policies. In practice health policies are rarely defined explicitly in a society unless a process of reform or policy change is suggested.

Health policies are fundamentally based on values, but many aspects of policies are based on evidence, experience and more technical aspects of decision-making. Health systems are the institutional basis and expression of health policies. The way in which the health system is structured, organised and governed has fundamental implications to how health policies can be implemented and on what cost. Health policies define the direction towards which health systems are geared, how health systems are resourced and on what basis these operate. We argue that health system should be exist to fulfil a purpose, and that their functions, structures, financing and priorities are, and should be based on aims which are health- and health policy-related.

Health systems are thus based in the expectations and priorities of a society. The basic reference for health systems remains at national level, but in practice health systems, especially in many federal countries, operate at the sub-national level. National level decisions do however have importance also at sub-national level and thus provide the last resort in terms of accountability.

This definition of health systems contrasts with recent very broad usage: from the corporate providers of 'health systems' to all-embracing definitions covering education or what individuals do at home. Internet search on the phrase ‘health system’ brings a large share of corporate health care plans, which are referred to as ‘health systems’. In this paper we have wanted to put the emphasis on national level as still many core decisions are made at national level and have implications for the ways in which regional or local levels function. Health systems have also a global dimension, which is set in the global regulatory context and has major importance, for example, with respect to the ways in which standard setting is based, diagnostic criteria are defined and many regulatory measures operate.

In order to define health systems, it helps to specify some crucial aspects of health systems that are usually assumed but rarely discussed in practice. These include the following:

1) Focus and scope: health systems cover areas and functions in which health is a first priority and have broader than individual or health services focus: Health systems are population-based and cover public health policies, health promotion and assessment of health implications of other policies. It is known that driving forces/determinants of health status are defined often by other sectors than health. However, while food or education policies may be of crucial importance to health it is not meaningful to extend the definition of health system to cover everything that is of relevance to health. Health systems may thus cover institutions, capacities and ways in which 'healthy' food and educational policies are promoted and ensured in the context of health policies and priorities, but not food or educational policies as such.

2) Legitimation and accountability: health systems are response to political commitments made towards citizens: The accountability and responsibility for proper functioning of health systems thus lies in the domain of public policies and cannot be left merely to consumer choice and action.

3) Groundedness and universalism: the organisation and functions of a health system reflect the culture, resources and values of a country. This is often taken as granted or ignored, but is of substantial relevance to how health system can be organised. While the way health systems are organised may have largely the same elements in any country, the emphasis on different aspects of care differ substantially. The case is perhaps clearest with respect to family planning and abortion, but exists also in other aspects of care.

We have previously proposed that health systems exist to fulfil a purpose and this purpose is often defined through the definition of objectives. The WHO World Health report in 2000 defined three fundamental objectives for health systems: improving the health of the population they serve, responding to people's expectations, and providing financial protection against the costs of ill-health. (WHO 2000). We would define the aims rather differently, and with more explicit focus on what health systems *do*, as this is often in danger of becoming lost in management terminology or mere emphasis on health services. We would claim that the aims of health systems should generally cover the following areas:

1) Protection and promotion of population health and provision of preventive services and emergency preparedness ("public health")

2) Provision of health services and care for all according to need, and financing these according of ability to pay ("health services")

3) Ensuring training, surveillance and research for maintenance and improving of population health and health services and availability of skilled labour force ("human resources and knowledge")

4) Ensuring ethical integrity and professionalism, mechanisms of accountability, citizen rights, participation and involvement of users and respect of confidentiality and dignity in provision of services ("ethics and accountability")

The first aim covers traditional public health aspects of health systems, covering the necessities to ensure traditional public health policies, preventive measures as well as health promotion and the notion of healthy public policies and assessment of health implications of other policies. The aim of these functions is to maintain and improve health, and reduce structural aspects of disparities in health. It also deals with general regulatory means in the field of health protection (e.g. drinking water quality), health promotion (advertising of products hazardous to health) and broader health efforts (campaigns and health impacts of other policies).

The second aim defines the principles of universality in access according to need and solidarity in provision and financing of health services and care. This covers also the protection of people against costs due to illness, cost-containment in the context of the whole health system and the distributional matters in health care financing. It also relates to regulatory and organisational aspects of quality of care and health technology, pharmaceutical policies and other so called supporting functions in health systems.

The third aim states human resource and knowledge- and evaluation -based aspects of health care systems. It deals with data, but also evaluation and regulatory aspects of quality of care and standards of medical treatment. This is often neglected in analysis of health systems, and is an issue which cannot be left merely to the markets to fulfil. The knowledge-based functions also provide a basis for the development of capacities and resources to ensure data and surveillance functions as well as procedures of quality of care.

The fourth covers political and ethical commitments of health systems. These include the ways in which citizens social rights are set and met, the accountability of the health system and services providers, and ethical issues covering such areas as confidentiality, malpractice and non-health related client aspects of health care. These cover also matters concerning public health and preventive measures as well as ensuring citizen trust on public policies and in relation to health protection. However, we have set these principles more in the context of rights of public services provision and citizen rights than of more consumerist models emphasising responding to expectations and ensuring choice.

We have, through our definition of health systems, wanted to combine and ground the analysis of health systems more closely in the health and public policy priorities.

Economics of health systems: redistribution and industrial change

Health systems understood as based on these values are rooted in a concept of the economy which accepts that some elements of that economy are inherently 'social'. By this we mean, health care is perceived in this framework, not as a commodity like any other, but as inherently a social and public responsibility, an element of the public sphere of concern. The economic perspectives underpinning this concept of health system necessarily include:

1. an acceptance that benefits from health care can be compared between individuals, as a basis for evaluating redistribution through the health system;

2. a concept of the economics of health which draws on macroeconomics as well as microeconomics, understanding its redistributive function as inherent in economic evaluation of outcomes;

3. an analysis of the processes of change in industrial production and marketing of goods and services that shape the possibilities and constraints of the health system;

4. an institutional understanding of the non-market patterns of incentives, exchange and caring that sustain professionalism and effective care in a health system.

None of these economic perspectives are new or, in analytical terms, particularly controversial. Redistribution was identified as a standard function of macroeconomic management of the economy after 1945, and the option of provision of services 'in kind' to ensure that all had access to certain 'merit goods' such as education and health care was included for decades in macroeconomic and fiscal policy texts even in the United States (Musgrave and Musgrave 1984). In almost all rich countries, health care forms one of the least controversial elements of macroeconomic redistribution (Barr 1998). The economic analysis of inequality and equity routinely treats individual benefits as commensurable (Atkinson and Stiglitz 1987).

The analysis of firms and the dynamics of industrial change is a major branch of economic analysis (Simonetti et al 1998). Only the analysis of non-market behaviour is