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, discreditably, '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 Comeliau (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 provision[1]. 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 by *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 sustain[2]. 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 past-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 distribution[3] 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).