Financing health care: False Profits and the Public Good

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The Public Services International Research Unit (PSIRU) investigates the impact of privatisation and liberalisation on public services, with a specific focus on water, energy, waste management, health and social care sectors. Other research topics include the function and structure of public services, the strategies of multinational companies and influence of international finance institutions on public services. PSIRU is based in the Business Faculty, University of Greenwich, London, UK. Researchers: Prof. Steve Thomas, Jane Lethbridge (Director), Emanuele Lobina, Prof.David Hall, Sandra Van Niekerk, Dr. Jeff Powell, Dr Yuliya Yurchencko

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Executive Summary

Fiscal consolidation, escalating health care costs and demographic changes are placing universal public health care under increasing pressure. In this environment the idea that the private sector is more efficient, effective and better able to fund health care than the public sector has been promoted.

After almost thirty years of privatisation in the health care sector the evidence shows that these claims do not reflect the evidence. Comparisons of total health spending at national level show that countries with higher private spending on health spend more on health care and achieve worse results in key indicators of national health.

Countries such as the UK and Sweden spend less than 10% of GDP on health care, of which over 80% is public expenditure. By comparison the USA spends almost 18% of GDP on health care, of which less than 50% is public, but has lower life expectancy and higher infant mortality rates. France which has very high life expectancy and low infant mortality rates spends 11.4% of GDP on health of which 76.7% is public.

The reasons for the efficiency and effectiveness of the public provision of health are not complex. Administrative costs of public insurers are routinely and dramatically lower than private insurers. Public systems, with a single payer system in the form of a government or state run agency, produce efficiencies of scale and are better able to control costs.

Public systems better control over-servicing and ensure the most appropriate form of treatment. Several studies show that the incentive structure in private systems distort the types of treatments provided towards those that are more profitable for the provider even where they are less appropriate and more costly.

Studies of USA healthcare provision show that most of the $750 Billion in inefficiencies annually are from unnecessary services ($210 Billion), excessive administrative costs ($190 Billion) and inefficient delivery of care ($130 billion).

Private providers also pay more to borrow, exploding the myth that they bring more and cheaper financing to health care.

And nor are Public Private Partnerships, often introduced simply to shift debt of the balance sheet, any more efficient. In 2012, the first Public Finance Initiative hospital in England to be completed in 2001, was declared an 'unsustainable provider' and placed in administration.

Tragically the effects of out of pocket costs cause untold hardship. Surveys in 89 countries, both high and low income, covering 89% of the world's population suggest that 150 million people globally suffer financial ruin annually because they have to pay for health services. There is also significant evidence that introducing user fees influences weather people access needed care.

Attempts to supplement public systems with private providers fared no better. The ensuing two tiered system tends to starve the public system and slide towards the inefficiencies of a substantially private system.

Despite widely held beliefs to the contrary, funding universal public healthcare systems through general taxation is more efficient, creates better health care outcomes and is more equitable than the private alternatives.

Research questions:

1. To review the literature on financing of universal health care provision internationally;
2. To identify and profile efficient and inefficient health care systems and their financing;
3. To identify the claims of those promoting private sector involvement in the financing and provision of health care and assess their merits
4. To review the impact of co-payments, supplementary private healthcare insurance and other forms of patient payments;
5. To review the claims and likelihood of success of the so-called innovative financing methods in the financing of health care in developing countries
6. To identify key principles for financing efficient and effective public health care system.

1. Debates on efficiency and effectiveness of health care provision

This paper presents evidence to show the best way of financing and providing health care for citizens. It starts by examining the claims of effectiveness and efficiency of the private sector versus the public sector. Many countries have introduced healthcare privatisation in the last two decades, often without any evidence to show that healthcare privatisation is more effective and efficient.

1.1 Health outcomes

The most important measure of a health care system is health outcomes as seen through reductions in infant mortality, maternal mortality and adult mortality. A study of European countries found that the rate of infant mortality was immediately reduced after the introduction of universal health coverage. [1] Government expenditure on healthcare is a significant factor in improving infant mortality and maternal mortality and is as an important a factor in improving health as economic growth. [2] A study of Italian healthcare privatisation from 1993-2003, found that public sector delivery resulted in a faster reduction in avoidable adult mortality, whereas private sector delivery did not have any effect on avoidable adult mortality rates.[3] Public healthcare expenditure and provision leads to improved health outcomes.

Several studies that compare healthcare in Canada, which has a publicly funded healthcare system, to the United States, which has private healthcare provision, show that Canadian not-for- profit hospital providers have better health outcomes in renal care. [4] Earlier studies of renal care in public, mixed and private healthcare systems showed that public systems provided the most varied and flexible treatments, with more renal transplants. [5] Private healthcare providers do not benefit from renal transplants because in the long term they reduce the demand for dialysis services. In Australia, where there has been an increase in private health care provision of renal care, a recent study found that the public sector provided more renal dialysis sessions for more hours per week than the private sector for patients under 75 years. [6] Private, for-profit companies are driven by business goals rather than the public good.

The difference between health outcomes in a public and private system can be seen in the following table which shows differences between public health expenditure in countries with long established welfare states and countries with either new or low levels of welfare provision. South Africa, Chile, and the United States have rates of between 46% and 48% of total health care expenditure covered by public health care expenditure. Canada, Germany, France and Poland have levels of over 70% with the UK and Sweden having levels of over 80%.

Life expectancy rates reflect the effectiveness of public health expenditure. The United States, as a high income country, has a life expectancy rate of 79 years which is lower than most high income countries and a lower rate of public health expenditure (46.4%). Several Asian countries, which have lower levels of public health expenditure, have life expectancy rates of between 70 and 80. South Africa has a much lower level because of the impact of HIV/AIDS.

Similarly, infant mortality rates (under age of 5), show that the United States, a high income country with a low level of public health expenditure, has an infant mortality rate of 7/000 live births as compared to other high income countries, such as Sweden, UK, France, Germany, Australia, which have rates of 4/000 or below.

Table 1: Public health expenditure and health outcomes

Country	% GDP spent on health	Health expenditure, public (% of total health expenditure)	Life expectancy at birth total years	Infant mortality under 5s (per 000 live births)
Australia	9.1	66.9	82	4
Brazil	9.3	46.4	74	14
Canada	10.9	70.1	81	5
Chile	7.2	48.6	80	8
China	5.4	56.0	75	13
France	11.4	76.9	**83**	4
Germany	11.3	76.3	81	4

Greece	9.3	67.5	81	4
Malaysia	3.9	55.0	75	9
Poland	6.7	70.1	77	5
South Africa	8.8	47.9	56	44
Sri Lanka	3.1	39.8	74	10
Thailand	3.9	76.4	74	13
Sweden	9.6	81.7	82	**3**
UK	9.4	**82.5**	82	5
US	**17.9**	46.4	79	7

Source: World Bank http://data.worldbank.org/indicator/ Highest rates in **bold** Lowest rates underlined

1.2 Efficiency

Public health care is more efficient than private health care. An increase in public funds is significantly correlated with a lower infant mortality and is also more efficient in reducing mortality than private healthcare. [7] Overall, private healthcare was associated with no change in the infant mortality rate. [8]

A study of private healthcare delivery in low and middle income countries found that the quality of private healthcare provision was low and was not associated with improved health outcomes. Diagnostic and medical management standards were lower than in the public sector. There was poor adherence to prescribing practices and unnecessary drugs and medications were prescribed. Privatisation of healthcare services led to increased costs of drugs. [9]

One significant difference between public and private healthcare providers is that private healthcare providers are primarily accountable to shareholders and investors and not to patients. This can lead to unnecessary or poor quality treatments. In Latin America, there has been an increase in the number of caesarean sections in several countries since the introduction of healthcare reforms and the growth of the private healthcare sector. In Chile, changes in the systems of financing had an impact on the choices of care received by pregnant women because private health insurance stipulated that an obstetrician had to provide primary maternity care. Obstetricians saw private practice as a good source of income but they had to attend the births in person. The demands of a range of private patients meant that an obstetrician tried to schedule births at prearranged times. It was easier to plan for caesarean sections than for either natural or induced births. In 2000, the rate of elective caesarean sections was 30-68% in the private sector and 12-14 % in the public or university sectors. [10] In Australia, recent research has shown that women giving birth in private hospitals are more likely to have surgical interventions and that babies born in private hospitals were more likely to suffer health problems and readmissions to hospitals in their first month than babies born in public hospitals. [11]

A review of 33 studies of NHS services in the UK examined the evidence on outsourcing of cleaning, facilities management, 'out of hour' medical services, treatment centres, clinical services and IT. It found negative impacts of outsourcing on service quality in 18 cases and positive impacts in 4 cases. The survey concluded that much of the evidence shows the negative impacts of outsourcing and there is a lack of evidence to show that outsourcing leads to improved quality of care. [12]

Individual countries which have recently introduced universal coverage show that government investment results in better health outcomes. Thailand introduced a '30 baht health card' that allowed low income, previously uninsured groups, to use public facilities without charge. Public

health facilities were funded so that they could deal with increased demand for health services. More people changed from private to public healthcare and most importantly, rates of infant mortality were reduced. [13] This provides further evidence that government investment in public healthcare services results in improved health outcomes.

1.3 Organisation

Public health systems have another important advantage over the private sector because of the way in which they are organised. Public health is based on the 'systematic application of best practice technologies applied at population scale and systematic monitoring and data collection'. [14] Interventions, such as vaccination campaigns, can be implemented across the population, which not only give widespread immunity but also demonstrate economies of scale. The mass provision of emergency services or public awareness campaigns are more effectively delivered through public programmes rather than a more fragmented private sector provision. [15] A review of 317 econometric studies found that publicly owned organisations outperform both not-for-profit and for–profit providers. Although there are many difficulties in comparing efficiency and productivity in different organisations and in the public and for-profit sectors, this is an important study. [16]

Although the level of GDP spend on health is often considered an indicator of how much a country invests in health care, it can hide differences between the level of administration costs between the public and private sectors, as in the case of the United States. Table 2 shows some dramatic differences between the administrative costs of the public and private sectors in a range of high and medium income countries from across the world.

Table 2: A comparison of administrative costs among private and public insurers

Country	Private (% of premium income)	Public (% of public expenditure on health)
Australia	10.1-13.6 (2000-2006) (SHA/NHA)	Medicare admin costs?
Canada	13.3-17.8 (1999-2007 SHA/NHA)	
Chile	14-20% (Iriart, 2001, Mossialos, 2002, Rao, 2005	
France	18.2-18.6% (SHA/NHA)	5.1-5.7% (2003-07 SHA data)
Germany	15.0-17.2% (SHA/NHA)	5.8-6.2% (2001-7)
Greece	15%-18% (commercial life insurers)	5.1%
Malaysia	44.1% (Min of Health, 2006)	2.2 (NHA 2006)
Sri Lanka	11.9 (2002)	
Thailand	40.3%, 37.8% 2000,2001	
United Kingdom	c. 47.5% (1999)	
United States	c. 14.1% (2005) (NHA/SHA)	3-5% (2000-2005 Angrisano, 2007 and Zycher 2007 6.1% Collins, 2009

Source: WHO (2010) [17]

All countries in table 2 show higher levels of administrative costs in the private sector than in the public sectors. Even countries which have mutual insurers have higher administrative costs than the public sector. The United States reports levels of 14.1% of administrative costs as a

percentage of premium. One of the advantages of public sector systems, with a single payer system (called a monopsony) in the form of a government or state run agency, is that they produce efficiencies of scale and control costs. Australia, the Nordic countries and Canada are examples of countries with a monopsony or single payer arrangement. The introduction of competition between insurers causes increases in costs and administration. [18] [19]

Marmor and Wendt (2011) in a study of recent health reforms found that there was a negative correlation between public health care funding and total health care expenditure. Higher levels of public health care spending do not lead to a higher total health care expenditure. Containing costs is easier when health care facilities are owned by the state and providers are paid on a salary basis. Countries where decisions about health care funding are the responsibility of the individual are no better and, may often be worse, at controlling health care costs than when the state has overall responsibilities. The United States illustrates this scenario because studies of USA healthcare provision show that most of the $750 billion inefficiencies annually are from unnecessary services ($210 billion), excessive administrative costs ($190 billion) and inefficient delivery of care ($130 billion). [20] Health care reforms have not resulted in increased efficiency in health care delivery. Innovation at a micro- level does not form the basis of making the overall health care system more effective and efficient. [21]

Private healthcare results in worse health outcomes and is less efficient and effective than public healthcare. This evidence is emerging in large studies of a wide range of countries as well as more specific country studies. Private health companies have to meet the needs of their shareholders or investors rather than the immediate healthcare needs of the public. Public health care is more effective and efficient in meeting the health care needs of the whole population. It has lower administrative costs. Investments in public health care result in better health outcomes then similar investments in the private sector. The next chapter will discuss the challenges facing universal health care systems.

2. Threats to universal health care provision

The basic foundations of a welfare state are made up of social solidarity, shared and pooled risks, universal provision and a national system of provision. These principles of universal health services are threatened from several directions. The provision of publicly funded health care, which is free at the point of access, was established in many high income countries after the Second World War. Health sector reforms, as part of neo-liberalism, introduced corporatisation of public health institutions, making public health care systems work to business principles. The introduction of market mechanisms to the public healthcare sector resulted in the direct contracting-out of catering, cleaning and clinical services to the private sector, leading to increased private sector involvement in the provision of public healthcare services. Public-private partnerships have been encouraged which involve public and private sectors working together over a long period on terms that are disadvantageous to the public sector. The terms of the contracts between public and private sectors often minimise the risks for the private companies, placing the financial responsibility on the public sector if the private company is unable to deliver.

More widely, the growing role of the private sector in public healthcare provision is starting to undermine the sharing of information, experience and expertise that has been one of the major strengths of collective public healthcare provision. Together with the unequal basis of public-private partnerships and the in-built bias of reducing risk for the private sector, many public healthcare sectors have an increasingly uncertain future.

For low income countries, reductions in publicly-funded health care services started to intensify after the IMF forced countries to introduce structural adjustment policies in exchange for loans in the 1980s. Privatisation and reductions in public expenditure have continued as part of loan conditionality. International financial institutions have put pressures on national governments to reform the public sector. Characterised by financial decentralisation, downsizing of public sector workforces, the introduction of market mechanisms and user fees, this has led to the under-investment in healthcare services and restricted people's access to healthcare services.

Lack of investment in public healthcare services has led to an increase in the migration of health workers, from low to high income countries, in search of better paid jobs and improved working conditions. This results in a loss of skills and expertise in public healthcare systems in low income countries. Lack of qualified and experienced health workers is reducing the scope of public healthcare services to deliver basic services for HIV/AIDS, malaria and TB.

Austerity policies, introduced as a way of reducing government expenditure following the 2008/9 global financial crisis and the bailing out of private sector banks, have led to reductions in health care expenditure.[22] The negotiation of both multi-lateral and bi-lateral free trade agreements form a potential threat to the power of governments to deliver existing public services as well as any new forms of public services in the future. [23] For the health care sector, where new technology and other forms of medical treatment as constantly changing the scope of health care, any restrictions on future health care services provides a major threat to the delivery of high quality health care.

2.1 Definitions

With the introduction of health care reforms, where some health services may be contracted out to a not-for-profit or for-profit provider, there is a lack of clarity about what is a public health care service. For example, the terms 'universal health services' and 'universal health care coverage' mask two different approaches to public health care provision. This paper will now provide some definitions of terms used to describe all or part of public health care services.

Table 3: Definitions

Term	Definition or key features
Universal health services / Universal health care provision	Publicly funded health services provided to all the population according to need and funded through taxation
Universal health care coverage	Health financing system based on pooling of funds to provide health care coverage for the whole population often as a 'basic package' of services made available through health insurance and a growing private sector. [24]
Publicly funded health care/ Public health care services	Health care funded by the public sector, usually through taxation, but delivered through public, for-profit and not-for profit providers.
Contracted/ outsourced health care services	Health services which have been contracted out to for-profit/ not-for- profit providers for periods of several years. They might be provided under the logo/ branding of the public health care sector. Workers are employed by the companies not the public sector.

Social Impact Bonds	Social Impact Bonds aim to improve social outcomes of publicly funded services by making funding conditional on achieving results
Public-private partnerships	'A contractual arrangement between a public body (often, though not always a service provider) and a private sector entity (ranging in size from a small individual company to a large consortium). The contractual agreement is used to deliver facilities, infrastructure and services designed to meet the needs of a population, whilst at the same time sharing the costs and risks of delivery and operation' [25]

Table 4: From Universal Health Services to Private Health Care Services

	Universal health services	**Universal health care coverage**	**Public health care services**	**Vouchers**	**Public-private partner-ships**	**Social Impact Bonds (SIB)**	**Private health care services**
Publicly funded from taxation	YES	Several potential sources of funding – community / social insurance	Publicly funded	Publicly funded	NO – capital raised by private sector	NO – capital from private/ not for profit sources	NO
Publicly delivered	YES	Delivered by public, for-profit and not-for-profit	Delivered by public, for-profit and not-for-profit	May be delivered by public, for-profit and not-for-profit	Delivered by public, for-profit and not-for-profit	NO - Delivered by for-profit and not-for-profit providers with capital invested returned if key perform-ance indicators met	NO
Free at the point of access	YES	Usually although co-payments may be introduced	Usually although co-payments may be introduced	Usually although co-payments may be introduced	Usually although co-payments may be introduced	Projects often testing new approaches to delivering public services	NO – unless private health insurance premiums paid

There is a continuum from universal health services, where health services are publicly funded from taxation and delivered by public health services providers, to private health care services, which are provided on the basis of payment by the patient, either through a health insurance premium or through direct payment. There are an increasing number of variations between these two types which show that the public and the private health care sectors are becoming increasingly linked through contracting and outsourcing of services. What appear to be public health care services might actually be delivered and managed by the private sector but still paid for by the public sector. This is having a damaging effect on the public health care sector and in some countries is creating a two-tier health care system where low income groups can only access a poorly funded public health care system. As Chapter 1 has shown, public health care systems delivers better health outcomes and are more effective than the private sector. The

private sector is driven by the interests of shareholders or investors rather than the public good.

1.3 Financing of universal health provision

There are several basic arrangements for the financing of health care but there are a growing number of variations, particularly influenced by health sector reforms.

Table 5: Basic arrangements for financing of health care

Form of funding	Sources
Public funding	General taxation, national insurance, specific sales tax, hypothecated taxes
Social insurance	Funded by contribution from employees and employers to a social insurance health fund – dependent on individuals being employed
Private health insurance	Individuals pay health insurance premiums for either individual health insurance policies or through employer/ corporate health insurance policies – dependent on employment.
Direct private payments	Individuals pay directly for screening, diagnosis, treatment and rehabilitation

Wendt (2009) developed a typology of health systems which focused more on the changing role of the state following health reforms rather than specific types of national health service systems (taxation, social insurance, private). This typology brought together indicators such as different aspects of levels of overall health expenditure, public health expenditure and levels of out-of-pocket payments, which grouped countries into three clusters of health care systems in Europe. These indicators are useful for analysing health care systems, especially the relative importance of public health spending and out-of-pocket spending.

Table 6: Different models of public health expenditure

Cluster countries	Characteristics
1. Social insurance countries - Austria, Germany, Belgium, The Netherlands, Luxembourg, Australia	High level of social insurance funding High level of total health care expenditure and High share of public funding Moderate share of private out of pocket spending. Moderate level of in-patient care High level of outpatient care Doctors are self-employed and have high levels of autonomy. Patients have a high level of freedom of choice.
2. National health systems - Denmark, UK, Sweden, Italy, Ireland, Canada, New Zealand	Medium level of total health expenditure High level of public health funding Moderate level of out of pocket spending Low level of outpatient providers Access to doctors is highly regulated.
3. Newly developed NHS systems and Finland	Low levels of total health expenditure High levels out of pocket expenditure Low levels out-patient and in-patient care GPs on fixed salaries

Source: Wendt, 2009:438-9 adapted

The percentage of GDP spend on health care had been considered an indicator of a country's investment in health care but it can also show the relative expense of administering a health system and is not necessarily the most efficient or effective way of investing in health care. For example, the United States has the highest percentage of GDP spent on health care (17.9%) but over 45 million people (14% of the population) are uninsured. Canada, France and Germany spend over 10% of GDP on health care and other groups of high income countries such as UK, Australia, Sweden, and Greece spend about 9% of their GDP on healthcare, but achieve a much higher coverage of the population. A group of Asian countries, China, Malaysia, Thailand and Sri Lanka, have lower levels ranging from 3.9% to 5.4%.

Demographic changes are taking place in many regions of the world that will influence the demand for healthcare services and the size of the workforce in future. In Europe, North America and other high income countries, the population is ageing which may result in changes in demand for health and social care services. It will also lead to large numbers of the current healthcare workforce retiring, leaving a shortage of healthcare workers. In low income countries, where there is a large and growing young population, there is growing pressure on healthcare services. In many countries of Africa, the impact of HIV/AIDs has led to reductions in the size of the healthcare workforce, which undermines the ability of healthcare services to deliver adequate treatment and care.

The OECD predicts that across OECD countries the combined public health and long term care expenditure will increase from about 6% of GDP annually to 9.5% in 2060, assuming costs are contained through more effective public health policies. A second scenario where there is less effective policy action, the GDP expenditure will increase to 14%. These increases will not be evenly spread across OECD countries. For example, middle income countries such as Korea, Chile, Turkey and Mexico are expected to have higher than average increases whereas Nordic countries, UK and US will have lower than average increases. [26] This study supports the view that health expenditure will have to increase in the future.

A series of research papers and organisations challenge the assumption that an ageing population results in a higher demand for health care and so increased health care spending. A recent study of health care expenditure between 1998 and 2007 found that there was no consensus or empirical evidence which shows that an ageing population is one of the main determinants of heath care expenditure. Instead, technological progress, closeness to death and decentralisation of health care do influence health care expenditure.[27] There is a growing focus on the increase in expenditure within a few months of death rather than assuming that an ageing population will increase health care expenditure. This supports the needs for prevention and rehabilitation policies for older people when diagnosed with limiting long term conditions.

Predictions for high health care spending in future put additional pressure on governments which are already reducing public health care spending as a result of either austerity measures or IMF conditionalities. Political arguments are often used to question whether a country can 'afford' publicly funded health care, assuming that increases in taxation would be unacceptable to citizens. In addition, the effective forms of tax avoidance, pursued by many multinational companies, are reducing government revenues available for use in public health care systems. WHO (2010) recommended that governments improve the efficiency of tax collection and make their health budgets a higher priority.[28] More action is needed to challenge some of the assumptions made about how future health spending can be financed. This series of threats can be found in countries across the world and constitute a global threat to universal health care provision.

3. Problems with alternatives forms of health care provision

Health reforms have introduced alternative forms of health care provision which exist alongside the public health care system. These forms of part-privatisation create problems for service users and for the public health care system as a whole.

3.1 A two tier system

Many countries have privatised healthcare facilities, encouraged the expansion of the private healthcare sector and reduced public healthcare investment. This creates a two-tier healthcare system where high income groups use the private healthcare services and low income groups use the deteriorating public healthcare system. Private healthcare provision of healthcare is often accompanied by inflated prices, constant lobbying to meet middle-class demands and a lack of evidence based practice. [29]

The long term effects of a two-tier system can be seen in Chile, where privatisation of the public healthcare insurance system was introduced over thirty years ago. Individuals could choose whether their health insurance contributions went to the public system or to a private health insurer. Changes in demand for healthcare by an ageing population are causing people, previously covered by private healthcare insurance, to return to the public sector. The private healthcare sector is refusing to insure them because of their age and expected higher demand for care. [30] The private healthcare sector is motivated by profits and not by the healthcare needs of the population.

Malaysia introduced health care privatisation in the 1980s and the private healthcare sector has expanded with government encouragement. Poor people rely more on government healthcare but healthcare privatisation has resulted in low income groups using the increasingly restricted public facilities and higher income groups using both public and private healthcare. [31] Access by low income groups to government services is now threatened because of the migration of government health workers to the private sector and the introduction of user fees for public healthcare, introduced by the government. [32] 'Out of pocket' spending on healthcare has risen to 76.8% of private expenditure on healthcare and 33% of total healthcare expenditure by 2009.[33]

3.2 Out of pocket payments

Throughout the world, countries have increased the share of 'out-of-pocket' spending in total health expenditures. The 2000 World Health Report set out to measure the efficiency of national health systems in terms of the resources put into each health system and the resulting outcomes.[34] In reviewing evidence of financing health care across the world, the damage that out-of-pocket payments make to the goals of universal coverage was clear as well as the impact of illness on lost income. Out-of the pocket payments, which may be the cost of pharmaceuticals or fees for consultations, influence whether people have enough money to access health care. [35] Only very small increases in fees can result in a decrease in service use by poor households. This reduced access to healthcare results in worsening levels of ill-health and higher mortality rates. [36]

Surveys in eighty nine countries, both low and high income, covering 89% of the world's population, suggest that 150 million people globally suffer financial ruin annually because they have to pay for health services. [37] Households may have to pay for initial consultation fees, diagnostics costs, drugs and hospital costs. It is only when 'out of pocket' payments fall to below

15-20% of total health expenditures that the rates of financial catastrophes and the subsequent impoverishment falls to low levels. [38]

Ill health contributes to poverty because people are unable to work and have to pay for health care. Countries with higher rates of inequalities between households are associated with higher rates of financial catastrophe. Governments that do not try and reduce income inequalities are also less likely to try and reduce the risks of financial catastrophe. [39] However, the type of government intervention has an impact on how effectively people can be protected from financial catastrophe as a result of paying for healthcare services. Insurance schemes that cover medicines and out-patient care rather than just hospital costs are more effective in reducing the number of people falling further into poverty. [40]

Out-of-pocket spending can also impact strongly on women and their health. [41] The introduction of user fees, which many African countries introduced in the 1980s and 1990s, affected take up of health services. This resulted in women not attending health services when ill or not continuing with treatment. Women are responsible for their own and their families' health. They also have greater needs for health care because of their reproductive health needs. Women may not have control over money to pay for healthcare if household income is controlled by men. If household members are unable to access health services, this will also impact on poor women because they will have to care for them when they are ill.[42] When women have to pay out of pocket fees for health care, they may have to set these costs against food, fuel or they may use traditional health care which may not address their own health needs.[43] Patel *et al* (2007) found that mental health problems (depressive disorders) had a particularly strong impact on women in terms of higher healthcare costs, loss of time and risk of catastrophic health expenditure.[44]

3.3 Supplementary private health insurance

A study of private health care funding in Western Europe provides a critique of different types of private health insurance and evidence to show that private sources of health care funding are often regressive and limit access to health care. They do not help to limit costs but often contribute to increasing costs. [45] Supplementary private health insurance may cover the same range of services as statutory health insurance but is used to increases the choice of health care provider and access treatment faster. Finland, Greece, Portugal, Spain, Sweden and the United Kingdom use supplementary health insurance as the main form of private health insurance. The study concluded that supplementary health insurance often increases health inequalities of access, especially if the barriers between public and private health care provision are unclear. [46] Rates of subscriptions to supplementary health insurance often increase during periods when there are long waiting lists for national health service treatment.

3.4 Public-Private Partnerships (PPPs)

Public-private partnerships (PPPs) in the health care sector have been used to provide new hospitals. PPPs are long term and provide infrastructure or services through the private sector, with the aim of the private sector taking on the risks of investment, design, construction, or operation. The contract may change over time moving from finance, to construction to operation. [47] There is growing evidence that PPPs are loading the public sector with payments over several decades. One of the arguments in favour of PPPs emphasises the ability of PPPs to access funding for infrastructure and public services faster than the public sector in times of austerity and cuts in government funding. [48] A major reason why governments use PPPs is that the money borrowed does not feature in the government accounts, thus reducing perceived

government debt. However, PPPs do not provide access to new sources of capital. Money is borrowed from the same institutions, e.g. banks, pension funds and other investors as the government would borrow from, so there is no obvious benefit from using the private sector. In the longer term, the government will pay more for the infrastructure project because it pays back to the private sector partners the cost of building and then managing the service. [49]

Public-private partnerships have been introduced in both high and low income countries. In the UK, the Private Finance Initiative (PFI) was introduced by the United Kingdom central government in 1992 for public services to access capital from the private sector to modernise and improve public service infrastructure. [50] The Conservative government, at the time, wanted to limit the public sector borrowing requirement so it could keep tax increases low. [51] [52] Partnerships with the private sector were considered a way for the public sector to access capital funding for infrastructure improvements without the increased capital borrowing appearing as public sector debt, so they were 'off-balance sheet'. However, although PFI contracts did not appear on national accounts, there were still costs to be made by government over the length of the contract, which are often between 30 and 60 years. [53] A growing number of PFI hospitals are experiencing financial difficulties in paying for the PFI charges, especially when having to operate in an increasingly marketised system. In 2012, the first PFI hospital in England to be completed in 2001, was declared an 'unsustainable provider' and placed in administration.[54] Other PFI hospitals are also operating with deficits caused by high PFI payments. As health care changes, so the needs of hospitals are changing and the contractual arrangements for PFI hospitals are too inflexible to deal with the changes needed in health care delivery.

The World Bank continues to promote PPPs through the International Finance Corporation and the Multi-lateral Investment Guarantee Agency (MIGA). The experience of Lesotho shows how a PPP project can distort public spending and increase public sector liabilities. In 2011, the government of Lesotho agreed that a payment of 34% of the health budget was 'affordable' . In 2012, the costs had risen to 41% of the total health budget and by 2013, it was 51%. The cost of the new hospital was 3 times as much as the old public hospitals would have cost. [55] Once again, the private sector is less efficient than the public sector.

3.5 Vouchers

Vouchers are one of the instruments of a public sector reform strategy which transfer the delivery of public services away from public providers to for-profit or not-for-profit providers. Individuals are given vouchers which can be used to access care at any type of provider. It is a way of individualising service provision and eliminates the principles of social solidarity and universal provision by providing each individual with their own voucher, which can be exchanged for care at a range of providers.

In health care, there is extensive use of vouchers to increase the use of maternity and reproductive care in low income countries. There are several studies which show that the use of vouchers for maternity and reproductive health care has increased service take-up. A systematic review of studies of voucher programmes in Bangladesh, Cambodia, China, Kenya, Korea, India, Indonesia, Nicaragua, Taiwan, and Uganda, found that all the evaluations reported increased use of reproductive health services, improved quality of care, and improved health outcomes. However, the study concluded that there was a need for better study designs, especially measuring cost effectiveness and health impacts. [56]

3.6 Social Impact Bonds (SIBs)

A Social Impact Bond (SIB) is a form of financial investment which invests in a social intervention to obtain specific social outcomes. SIBs are another example of how the for-profit sector is using the public health and social sectors as a means to generate profits. SIBs are a complex set of transactions which involve government, service providers, investors, evaluators and programme manager/coordinator. The experience of SIBs so far shows extensive risks and limitations. Programme managers are more often motivated by the success of the project rather than any objective evaluation and this influences any evaluation design. The transaction costs of setting a SIB up are large and these resources could be used more effectively by the public sector. Investors want a return on their investments so will only choose projects where change can easily be measured. This will limit any degree of innovation because social change is highly complex and difficult to measure in the short term.

SIBs have been driven by a critique of public spending and its inability to deliver value for money that underpins public sector reform. Encouraging private investment in social interventions and services is providing new opportunities for the for-profit sector to generate profits. SIBs are part of new strategy by private investors to seek new investment opportunities and to change their image so that they are associated with social gain as well as profit.[57] Increasingly the not-for-profit sector will be vulnerable to changes in legislation that undermine their not-for- profit status so that any for-profit provider can start operating within the social sector.[58]

3.7 Conclusion

The forms of part-privatisation which coexist in many public health care systems result in long term damage to public health care systems. They create a two-tier system where low income groups have to use an underfunded public health care system. High income users can access private health facilities but the principles of universal provision, social solidarity, shared and pooled risks and a national system of provision are undermined. This has implications for the long term health of the population. In many countries, citizens can no longer access health services free at the point of access and are having to use out of pocket payments to access health care. The private for-profit sector is making profits from contracts, outsourcing and PPPs which are reducing resources available for public health care in the short and long term. Investors are being encouraged to invest in innovative social projects which are designed to generate profits for investors rather than dealing with complex social benefits.

4. Lessons for the future

1. There are growing threats to universal health care but there is growing evidence to show that effective universal health services contribute to improved health outcomes.

2. Health care delivered free at the point of access is essential to reduce household spending on health care. It is only when 'out of pocket' payments fall to below 15-20% of total health expenditures that the rates of financial catastrophes and the subsequent impoverishment falls to low levels. [59]

3. Universal health services have to be funded by government revenues generated through taxation. This requires governments to have a strong political commitment to raising income through taxation and to allocate resources to eliminate tax avoidance schemes. Increasingly, this will have to be done through national government and international action.

4. Mechanisms that allow the pooling of resources and consequent sharing of risks need to underpin the national system of health funding. Higher income groups have to contribute more to tax revenues through a progressive tax system. Tax relief should not be given to individuals for private health insurance because this takes resources away from the public health care sector.

5. Public health expenditure is more effective and efficient because higher levels of public healthcare funds are invested in healthcare infrastructure as compared to private healthcare investment.[60] These results have implications for health investment policy decisions because they show that investment in the public sector is more effective that investment in the private sector.

6. Public health care systems must release themselves from long-term, inflexible contracts with the private sector, which syphon off public health resources and are unable to respond to changing health care needs.

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