Health Care Reforms and the Rise of Global Multinational Health Care Companies

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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, Dr. Jeff Powell, Sandra Van Niekerk; Dr. Yuliya Yurchenko

Contents

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Executive Summary

The 2008/9 global financial crisis has had an impact on the funding and delivery of health and social care. Until 2010, government spending on health care in OECD countries had been expanding, but following the adoption of austerity policies, several years of zero growth have been recorded. [1] *This has restricted access to both health and social care services.*

From 2000/1, annual rates of development assistance for health were about 10% per year but had dropped to 3.9% by 2012-3. Contributions by bi-lateral aid agencies and the World Bank International Bank for Reconstruction and Development have declined. However, the contributions by the public-private partnerships of GAVI Alliance and Global Fund to fight AIDS, TB and Malaria have continued to grow. Overall, the contribution of public-private partnerships and NGOs has started to overtake contributions by governments. [2]

Trade agreements
Two major trade agreements, Transatlantic Trade and Investment Partnership (TTIP) and Trade in Services (TiSA), currently being negotiated, form a threat to the future of public health and social care services by treating them as part of the services sector. The definition used for public services is "supplied in the exercise of governmental authority", which "means any service which is supplied neither on a commercial basis, nor in competition with one or more service suppliers"(GATS Article 1.3). After twenty years of public sector reform and the marketization of public services, very few public services operate on a completely non-commercial basis without any form of competition.[3] *This will make them subject to inclusion within the terms of these trade treaties and so open to competition from global services companies.*

Players
The global health care market is expanding but investors are not always moving from North America/Europe to Asia, Africa or Latin America. Instead, there is a trend to move into Europe from Africa (Netcare), Australia (Ramsay Healthcare) and Singapore (Parkway Holdings). This may be partly explained by the reforms taking place in what were strong European public health care systems, which are encouraging for-profit private sector providers to become providers of

publicly funded health care. In social care, the expansion of multinational companies has been slower because social care requires a local system of delivery.

Family capital is still a source of capital for Asian healthcare companies. State investors play a role in for-profit health care companies. Institutional investors retain a significant influence. In Europe and North America, private equity investors are the majority investors in holding companies, which are health care chains. The International Finance Corporation (IFC) has invested in several health care companies which have become global companies.

There is some diversity in company strategies. There are four basic models which have been successful:

1. *Vertical integration of products and services, e.g. Fresenius;*
2. *Expansion of hospital provision, e.g. The Ramsay Group;*
3. *Gradual creation of a health care conglomerate through acquisitions, e.g. IHH Berhad;*
4. *High technology expansion with later specialisation, e.g. Euromedic International;*

The nature of social care as a locally based activity has, until now, meant that multi-national company expansion has been limited. In some countries, for-profit companies may dominate the provision of social care but do not necessarily expand into other countries. There are some signs that this might be changing in Europe, where multi-national companies are involved in care services in several ways, for examples, homecare, residential services. Some companies are exploring the market for social care in East Asia.

The expansion of high technology and medical devices to treat cancer, end-stage renal disease, and other non-communicable diseases is a rapidly growing market. The health care systems of Asian countries with medium income levels are another growth area. Private equity investors have identified several areas of investments: health services in Africa; in other regions, diagnostic equipment, medical devices and cancer and cardiovascular care centres; some aspects of social care, for example rehabilitation services, nursing/ retirement homes. There are also some more tentative moves into IT medical services and health data processing.

The World Bank and other regional banks are investing in a strong 'pro-private sector' approach, with a specific approach to results-based financial management. Global Investment Banks invest in health care and, in a more limited form, social care through private equity investments. University Teaching Hospitals and Academic Health Services Centres are developing a range of public-private partnerships as vehicles for teaching and research into medical technologies.

Management

The introduction of business principles to the management of public health and social care services, as part of health sector reform, has resulted in public services operating more like businesses with a focus on income generation, in preparation for privatisation. Decentralisation policies have transferred responsibility for management and funding from national/ central government to local level, which has often led to a reduction of resources for health services and increased inequities between regions.

Delivery

The results of a survey of PSI health and social services affiliates showed that many health and social care services, including core and support services, are now outsourced. International companies have won at least a quarter of contracts in health services and if national subsidiary companies are included, the influence of international companies on public health and social care systems is increasing rapidly. Outsourcing has an immediate impact on pay, working conditions and union membership.

Health and social care workers

Marketisation and privatisation have directly affected health workers, by increasing workloads, changing terms and conditions, and making health workers work towards targets and other aspects of a managerial agenda. This has resulted in changes in the relationship with patients. The status and integrity of health workers is directly affected by decentralisation and other health reforms. Cutting costs of labour intensive activities, such as health and social care, results in cuts in the labour force or reductions in salaries, which affects the quality of care.

Reductions in salaries and irregularly paid salaries forces health workers to secure alternative sources of income. Workers experience much greater job insecurity. This affects the 'ethos' of public health care services in ways that are detrimental to both health workers and service users because health workers put their own financial survival before the delivery of a public health care service.

There are other issues that face governments when planning for an adequate workforce. There are already shortages of health workers and more are anticipated. The health care workforce is ageing in many countries, which will affect the overall supply of health workers. There are widespread problems of recruitment and retention. It is recognised that health workers need to be kept motivated 'in an enabling environment'. [4] *Some of these problems have been the results of health care reforms.*

The nature of social care delivery is different, with many social care tasks are considered as unskilled work, delivered by workers with little or no training. Changes in the way that care is funded have also led to the expansion of types of care worker.[5] *'Personal assistant' carers, are recruited by the care recipient or recipient's family, and may be permanent, short term or live-in. Once again, the pay and terms and conditions of 'personal assistants' are often poor.*[6] *Long term care for older people is faced with major problems in securing a sustainable workforce. Although the health and social care sector is fast growing in terms of social and economic value and job creation, the long term future of the workforce is unclear with an ageing, low paid, mainly female workforce with high rates of turnover.*

Conclusion

Unions are responding to these changes in positive ways and recognise the potential for organising in both the public and private sectors. The challenges of organising in private and 'mixed' public systems are significant and growing and many unions do not have the experience to be as successful as they need to be. This will have to be addressed through strategies which increase the capacity of affiliates at both the individual and regional levels.

Health care reforms and the rise of global health care companies

A report to inform PSI organising strategies in the health and social care sectors

This report was commissioned by Public Services International (PSI) to supports its work to increase union density and leverage in the health and social care sectors, through an analysis of factors which are shaping the industry, particularly in relation to dynamics and trends in the financing, management and delivery of health care.

It seeks to answer a series of questions about:

- Who currently finances health and social care provision (public, private, individual, other)?
- What are the key models of finance?
- How do the key models affect management and service delivery and outcomes?
- Who are the main players in the corporate finance, management and delivery of health and social care services?
- What are the main models of health and social care management and how are they changing?
- Has the regulatory environment (including trade agreements) in the provision of health and social care affected the structure and trends in health care and social care provision?
- What are the key institutions in the sector and what areas do they influence, Who are they influenced by?
- How has delivery of health services changed?

The report is structured in four sections:

1. Finance and players
2. Management
3. Delivery
4. Conclusion

1. Finance

This section will discuss the main arrangements for financing health and social care, highlighting changes since the 2008/9 global financial crisis.

1.1 Health care

There are several arrangements for financing of health care:

1. Public funding from general taxation;
2. Social insurance funds;
3. Private healthcare insurance;
4. Supplementary health insurance;
5. Self financing.

1. Public funding

Public funding for public health services, paid from general taxation, provided free at the point of access, is considered the most effective in redistributing resources from high to low income groups, if measured by the improvements in health and impact on economic growth. Many national health care systems have been established through public funding. The underlying principle is that a system of universal health care provision funding through taxation allows the risks to be shared across the population. Some people use health services more at certain times in their lives than at others. People from high income groups generally live longer in better health than those from low income groups, who have a shorter life expectancy and higher levels of morbidity. Other individuals have certain conditions which need a high level of health treatment.

The allocation of funds reflects some the factors that influence demand for health care and are part of a process of allocating risk, for example, regions with a high proportion of older people or high levels of unemployment and socio-economic disadvantage. Governments have developed different methods of calculating how much health care to fund, with many governments introducing new payment systems over the last 20 years. These have changed from redistributive systems to more market-based pricing systems within health care systems, which pay for treatment per person according to a specific type of diagnosis (diagnostic related groups). Although the principle of a tax based health care system is that it is free at the point of access, some governments have made care more restricted or subject to user fees.

The disadvantage of tax based health care is that it may be subject to changes in government spending priorities. Austerity policies have affected health care spending. Hypothecated taxes on specific products, for example, tobacco, alcohol, can also be used to fund public health care, which will not be influenced as much by changes in government spending priorities.

Publicly funded health care is more efficient, effective and more equitable than privately funded systems. They enable people to access health care when they need it rather than when they can afford it. Publicly funded health services contribute to redistribution of income than privately funded services.

2. Social insurance

Social insurance funds originate from Bismarckian reforms introduced to provide coverage for unexpected life events experienced by individuals, whether sickness, unemployment, disability.

For health care, employees and employers contribute to a central social insurance fund, which may cover all or part of their health care needs. Government may also make contributions. These schemes depend on employed people contributing to a central social insurance fund but this leaves people who are unemployed or outside the wage economy uncovered. Governments may establish a minimum public system of health care for these groups. An advantage of social insurance funds is that they are not subject to changes in government spending but they are dependent on high levels of employment to maintain funds.

Many countries were required to introduce a system of social insurance as part of entry into the European Union, but reforms in health care financing have been adopted at different times and are subject to political struggles. There are several defining characteristics of social insurance systems that affect the control that governments have over the whole health care system. There is growing evidence that if the government is the single payer for health care, it is more likely to be able to influence the health care system. If there are several insurance companies paying for health care, this introduces a level of competition into the system. In addition, if the government retains the power to set fee levels for health care reimbursements, then this provides some level of control for the government.

Bulgaria
The success of a social insurance scheme is dependent on effective methods to collect contributions. Several countries, have found that collection methods were inadequate to secure regular incomes from insurance funds. In Bulgaria, the 1998 National Health Insurance Act, (and 28 regional health funds) introduced compulsory membership, which aimed to introduce risk pooling and medical care purchasing for the whole population. However, the National Health Insurance Fund (NHIF) has not become fully operational because of delays in the collection of contributions and widespread poverty. Out-of-pocket payments also contributed to the failure of the NHIF to achieve risk pooling because people were unable to afford both contributions and out of pocket payments.[7] Bulgaria has a high percentage of out-of-pocket payments as a proportion of private health care.

3. Private health insurance

Funding for healthcare costs can be provided through individual or corporate health insurance schemes, where premium payments are made to cover the costs of health care in the future. Policies often have exemptions which make them less comprehensive than either health care provided through general taxation or social insurance funds. Individuals may take out their own policies or individuals may be covered through policies paid for by their employer. Although the principle of shared risk still informs the organisation of health insurance, the aim of an insurance company is to make profits from the payments of premiums and so limit the payments that have to be made for the provision of health care. Hence, insurance companies are interested in recruiting young, healthy people to health insurance policies so that they make a minimal call on the policies. Older people, who become more susceptible to needing health care over time, are less likely to be eligible for health insurance policies. People with long term conditions will not be considered a good 'risk' for a health insurance policy because they will need continual care. Private health insurance is not an adequate arrangement to meet the health care needs of whole populations.

Some of the limitations of the privatisation of a public health care insurance systems can be seen in the case of Chile, where the part-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 now 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. The private healthcare sector is motivated by profits and not by the healthcare needs of the population.

4. Supplementary health insurance

Supplementary health insurance is sometimes used in national health care systems where national taxation or social insurance funds do not cover all types of health care costs. An individual may take out supplementary health insurance to cover the costs of some drugs/ pharmaceuticals, semi-private hospital accommodation, specialist nursing services or health care obtained outside the home country. [8]

5. Self-financing

Although the four types of health care financing set out in the previous section remain the main types of health care financing, reforms to public health care systems have led to a greater level of household expenditure on health care. Reforms have taken the form of limiting access to public health care services, which results in people having to pay for treatment and care which would previously have been free at the point of access. In other countries, people have been given tax incentives to take out private health care insurance.

1.2 Global trends in health spending

Global trends in public health care expenditure, out of pocket spending and percentage of Gross Domestic Product (GDP) spent on health show that over the last 20 years there have been some both positive and negative changes. Table 1 shows the percentage of public health expenditure as a % of total health expenditure for a group of high and medium income countries over the period 1994-2013.

Table 1: Public health expenditure as % total expenditure (Significant changes in bold)

Country	1994-98	1999-2003	2004-2008	2009-13	Change (+/- 2%)
Australia	**68.5**	**67.8**	**68.4**	**66.9**	**Down**
Brazil	*43.6*	*47.0*	*45.7*	*46.4*	**Up**
Bulgaria		55.7	55.3	56.3	Up
Canada	70.9	70.8	70.4	70.1	Down
Chile	47.9	48.1	48.4	48.6	Up
China	*52.5*	*54.3*	*55.9*	*56.0*	**Up**
France	77.0	76.9	76.5	76.3	Down
Germany	76.8	76.7	76.5	76.3	Down
Greece	**69.5**	**67.9**	**66.1**	**67.5**	**Down**
Malaysia	**59.0**	**57.4**	**55.2**	**55.0**	**Down**
Poland	71.8	71.6	70.6	70.1	Down
South Africa	46.7	46.6	47.7	47.9	Up
Sri Lanka	**45.1**	**45.3**	**37.8**	**39.3**	**Down**
Thailand	*74.2*	*74.6*	*77.7*	*76.4*	**Up**
Sweden	81.5	81.5	81.6	81.7	Up
UK	82.6	83.5	92.8	82.5	Down
US	47.2	47.6	47.8	46.4	Down

Source: World Bank http://data.worldbank.org/indicator/

Countries can be grouped according to different levels of public health expenditure, which relate to long established welfare states and countries with either new or low levels of welfare provision. South Africa, Chile and Sri Lanka, which can all be described as middle income countries have rates between 46% and 48%. The United States has a similar rate but as a high income country, this reflects the lack of an accessible public health care system. Canada, Germany, France and Poland have levels of over 70% with the UK and Sweden having levels of over 80%. Over the last 20 years, Brazil, China and Thailand increased public health expenditure (as % total health expenditure) and Australia, Greece, Malaysia and Sri Lanka decreased public health expenditure (as a % of total health expenditure).

Table 2: Out of pocket spending as % private health expenditure

Country	1994-98	1999-2003	2004-2008	2009-13	Change (+/- 2%)
Australia	**59.0**	**59.9**	**57.8**	**56.0**	**Down**
Brazil	57.2	57.8	57.8	57.8	
Bulgaria		96.8	96.8	96.8	
Canada	49.0	48.6	48.5	50.1	
Chile	**63.4**	**63.6**	**48.6**	**50.1**	**Down**
China	78.9	77.2	78.8	78.0	
France	32.3	32.2	32.1	32.1	
Germany	51.1	51.2	50.8	50.8	
Greece	**93.2**	**91.0**	**91.3**	**91.3**	**Down**
Malaysia	*77.3*	*75.8*	*78.1*	*84.7*	*Up*
Poland	*77.3*	*75.8*	*78.1*	*84.7*	*Up*
South Africa	14.6	13.9	13.8	13.8	
Sri Lanka	*80.8*	*81.9*	*83.0*	*83.0*	*Up*
Thailand	**59.6**	**55.9**	**55.8**	**55.8**	**Down**
Sweden	88.7	88.4	88.1	88.1	
UK	56.8	56.8	56.8	56.8	
US	**22.7**	**22.4**	**22.0**	**20.7**	**Down**

Source: World Bank http://data.worldbank.org/indicator/

Out of pocket spending as a % of private health expenditure has to be understood in relation to overall private sector overall spending and public health spending. For countries with high levels of public health expenditure, a high level of out of pocket spending, which is likely to cover the cost of pharmaceuticals, shows that there is a small private health care sector, e.g. Sweden. It is in medium income countries, where there have been decreases in public health spending but high levels of out of pocket spending, e.g. Sri Lanka, Malaysia, where households will be strongly affected by these changes. In Bulgaria, although the level of public health care expenditure has not changed, there is a very high level of out-of-pocket spending. Individual households have to pay more directly for medicines and healthcare treatments.

For individuals or households who are unable to afford the costs of health insurance and are unable to access publicly funded healthcare, their only option may be to pay for health care when they need it. This may involve paying a private practitioner or a public facility. This has important implications for households because a decision whether to access healthcare will be determined by whether they have enough money to pay rather than their healthcare need.[9] Individuals may leave treatment until a condition is more serious. It can lead to higher rates of catastrophic healthcare expenditure, which can devastate household income. 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. [10]

The surprising example is the United States which has a relatively low level of public expenditure but also low levels of out of pocket spending. This can be explained by the dominance of the expensive private health insurance system, which covers the major part of private health care spending.

The % GDP spent on health is considered an indication of a country's commitment to maintaining a national health system, although not necessarily a publicly funded one. As with the levels of public health expenditure, there are links to the type of welfare state system and level of country income. The UK, Sweden, Australia, France, Germany, and Greece all spend over 9% of the GDP on health. Brazil now spends 9.3% of its GDP on health. The outlier is the United States which spends 17% of GDP on health but has 45 million people who are uninsured. This reflects the cost of a private health care system. Medium income countries spend between 4 and 9% except for Sri Lanka which spends only 3.1%, which has declined in the last 20 years. Germany, Greece and Poland all reduced the % of GDP spending on health in the last 20 years.

Table 3: Health spending as a % of GDP

Country	1994-98	1999-2003	2004-2008	2009-13	Change (+/- 0.5)
Australia	9.0	8.9	9.2	9.1	
Brazil	**8.8**	**9.0**	**8.9**	**9.3**	**Up**
Bulgaria		7.6	7.3	7.4	
Canada	**11.4**	**11.4**	**10.9**	**10.9**	**Down**
Chile	7.5	7.1	7.1	7.2	
China	5.1	5.0	5.1	5.4	
France	11.7	11.7	11.6	11.7	
Germany	**11.8**	**11.5**	**11.3**	**11.3**	**Down**
Greece	**10.0**	**9.4**	**9.0**	**9.3**	**Down**
Malaysia	3.9	4.0	3.8	3.9	
Poland	**7.2**	**7.0**	**6.8**	**6.7**	**Down**
South Africa	8.7	8.7	8.7	8.8	
Sri Lanka	3.3	3.4	3.3	3.1	
Thailand	4.1	3.8	4.1	3.9	
Sweden	9.9	9.6	9.4	9.4	**Down**
UK	9.9	9.6	9.4	9.4	**Down**
US	17.7	17.7	17.7	17.9	

Source: World Bank http://data.worldbank.org/indicator/

Brazil

Health services in Brazil are provided by a mix of public and private providers, which are mainly financed through private funds. There are three main sectors:

- The public sector, the SUS, finances and provides services through federal, state and municipal levels, including the military health services;
- The private (for profit and non-profit) sector financed through public and private funds and:
- The private health insurance sector financed through health insurance plans.

The private sector has traditionally been protected by the government, which has encouraged the privatisation of medical practices.[11]

Brazil has a national health policy, which is part of the 1988 Constitution. The federal government has overall responsibility for national health policy although implementation is the responsibility of municipal governments. The public provision of health care services, through the SUS, does not meet the needs of the whole population. There is growing evidence that the private sector is playing an increasing role in the provision of health care, especially in different clinical specialties. There has been an increase in out-of-pocket spending for all income groups. Private sector provision, whether as health services or health insurance, is concentrated in the south-east of the country, which is the most economically prosperous.

1.3 Social care

The arrangements for financing of social care reflect a different history of social care provision. Whereas the funding of health care either through general taxation or social insurance has been considered by many countries as a significant development in the 20th century because of the value that good health contributes to social well-being and economic growth, public funding for social care is more contested. In the last 20 years, new arrangements for social care funding have been introduced by several countries, which recognise that an ageing population needs to access adequate social care. This period has also seen the move from institutional forms of social care to more household/ community based care.

There are several types of social care, which are found in many high income countries. These are child care, care for older people and care for people with disabilities. These three care groups have care delivered both at home, in the community and through residential arrangements.

Table 4: Types of social care

	Home	**Community**	**Residential**
Child care	Child minders	Kindergartens, nurseries	For children 'looked after' by the state
Older people	Support for living at home – home care workers	Day centres and other community centres providing services to older people	Residential care – by for-profit, not for profit and public providers
People with disabilities	Support for independent living – personal assistants	Community centres and disability support services	Residential care – most often in small homes but some countries larger institutional arrangements still exist

In many medium income countries, there has been a strong tradition of extended family care but with increasing urbanisation, families are becoming more dispersed and so families can no

longer care for older people. There are a growing number of initiatives to develop different types of care for older people, with the for-profit sector exploring residential developments.

Financing

The demands for social care are changing. With populations living longer, an older person may need some form of social care for several years. The costs of this care are not always offered as a universal service. One difference between health care and social care is that public funding for social care is often the responsibility of local/ regional government authorities. However, the main forms of financing for social care are similar to health care in that they include: Public funding from general taxation; Social insurance fund; Private insurance; Self-funding. Although services are still funded by taxation in many countries, some countries have introduced new systems of long term care insurance and co-payments. Funding of long term care is a major political issue in many countries. For countries that have introduced new funding arrangements, there is concern about the long term financial sustainability of services.

1. Public funding

The public funding for social care paid from general taxation may be in the form of an allowance for care or the direct provision of care services, through both institutions and home care. Social care is often means-tested by central or municipal authorities. For people whose incomes are initially too high to be eligible for social care, many become eligible when all their savings are used up.

Most social care systems depend on unpaid carers in the family to provide different levels of care, from a few hours a week to full- time care to older relatives. The majority of carers are women. Carers have often been recognised for the first time in new social care legislation. The UK introduced an 'attendance allowances' as payment for carers who previously would have provided unpaid, informal care. Ireland has introduced a Carer's Allowance. In Hungary, payments are made to informal carers at a level of the basic minimum pension. Although the recognition of caring responsibilities through an allowance is an important development, in some countries the allowance is used to employ a migrant worker to provide care and live with the family. These are often informal arrangements, with no contract or form of income or employment security. Migrant workers may be trained social work/ health care workers from countries where pay is low and who then move to work as unqualified and often informal care workers in higher income countries.

2. Social insurance

Many countries use a Social Insurance Care Fund to fund social care. Individuals make contributions to fund the costs of end of life caring. A major political issue is whether contributions should be mandatory. Some countries have introduced new statutory schemes, e.g. Germany, where a reform of long term care insurance was introduced in 1994, which established a social long term care insurance (LTCI) and a mandatory private LTC covering the whole population. All insurance products are capped so there are private co-payments and means tested assistance, especially for nursing home care. LTCI beneficiaries can choose between home care (in kind or cash), day and night care and nursing care. All providers, not-for-profit, for-profit and public, must have a contract with LTCI funds. [12]

3. Private insurance

People who are not eligible for state provided care, have to depend initially on private insurance but it is expensive to deliver adequate care and not all insurance companies offer widespread coverage. In the United States, only 10% of people aged 50+ have any long- term care insurance. [13]

4. Self-funding

Self-funding for social care is based on an individual's existing savings. When savings are used up then they have to access basic public provision. In the United States, many older people are dependent on self-payment and with high costs of nursing homes, they often use up their savings and become dependent on the public system. In 2010, it was estimated that per person expenditures for nursing homes costs were five times as high as for community services. For national expenditure, three times as much was spent on nursing home care as community based care. [14] If the local state system is inadequate, then people become dependent on family, most often women, who have to stop full time paid work and whose health may be affected by long term informal care. [15]

1.4 Changes since 2008/9

The 2008/9 global financial crisis has had an impact on the funding and delivery of health care. Until 2010, government spending on health care in OECD countries had been expanding, but following the adoption of austerity policies, several years of zero growth have been recorded.

Governments used several instruments to limit public spending on health care:

1. Limiting the level of financial resources or making changes in public spending through cutting doctor's fees, reducing health worker pay, cuts in pharmaceutical reimbursements and cuts in payment rates to hospitals. In some countries, health care providers have been allowed to accumulate debts. [16]
2. Regulating the demand for services by changing health care coverage, through direct rationing of services and treatment and changes in health care benefit packages.[17]
3. Controlling the cost of care through the introduction of co-payments and increases in patient costs.[18]

Although the overall OECD rate of growth in health care had dropped to zero, this masked some large country variations. Greece registered the highest fall in health spending of 11% in 2010-2011. Ireland, Iceland, Estonia, Portugal, Spain, Denmark, UK, Slovenia and the Czech Republic also recorded negative growth rates. A few OECD countries recorded positive rates of growth in 2009-2011, for example Chile, Israel, Japan and South Korea. [19]

Although the contribution of private financing for health varies between OECD countries, this has also shown a reduced rate of growth. Out-of pocket spending grew more slowly, falling from 3.6% in 2008 to 1.4% in 2011. This slower increase may be explained by moving some health expenditure from public to household expenditure, for example, with the introduction of co-payments or user fees. However, overall reductions in household incomes as a result of the economic crisis may have had negative effect on private health insurance and direct payments for healthcare. People with reduced income are more likely to postpone their use of health care services.

One of the most frequent cuts in health care expenditure is made to preventive and public health services, although preventive health campaigns can help to reduce demand for health services. Increased rates of unemployment are linked to increased rates of physical and mental health problems. At a time of economic crisis, preventive and public health strategies can help to protect mental health and improve workplace health, which contribute to easing the effects of reduced economic growth. [20]

Austerity policies have had an impact on social care. One of the major changes has been a more limited access to services without means testing. Countries that have had to access IMF loans, e.g. Ireland, Greece, have experienced more limited access to government delivered social care.

1.5 Development assistance for health

Development assistance for health from OECD countries was $31.1 billion in 2013. From 2000/1, annual rates of development assistance for health were about 10% per year. Between 2012-2013, the rate dropped to 3.9%. Bi-lateral aid agencies have decreased their contributions to development assistance for health recently. The contributions by the World Bank International Bank for Reconstruction and Development reached their highest point in 2010 and have declined since then. The contributions by the public-private partnerships of GAVI Alliance and Global Fund to fight AIDS, TB and Malaria have continued to grow. NGO contributions have also continued to expand. Overall, the contribution of public-private partnerships and NGOs has started to overtake contributions by governments. [21]

There are imbalances between the disease burden and health investments. Non-communicable diseases are a growing cause of ill-health in developing countries. Although development assistance for health for NCDs has expanded since 2010, it still forms a small percentage of total development assistance for health spending. In contrast, there was an increase in spending on maternal and child health. Expenditures on HIV/AIDS, TB and Malaria were reduced.[22]

National government in developing countries also spend domestic funding on health care. Countries spent 20 times more of their own resources on health than they received in assistance. This grew 7.2% between 2010-2011. The percentage of development assistance for health funding as a total of government spending on health, for many governments, was less than 10%. However, there are countries in Asia, Western and Southern Africa, where development assistance for health makes up half of total government health expenditure. [23] It is the terms and conditions of these large contributions to government spending that have an influence on how resources are spent.

1.6 Universal health coverage

The policy of universal health coverage has been promoted by the World Health Organization and the World Bank as a way of giving people access to adequate health care. It is significant that the 'problem' is seen as a financial one rather than one of delivery of care, free at the point of use. Universal health coverage requires a health financing system, which pools funds to provide services to the population, often as a basic package of health care services.[24] In this sense, it separates the financing from the provision of services and allows the entry of private insurance companies and private providers to become involved in universal health coverage. Governments may only partially be involved. It complements many of the changes that have been introduced through health sector reforms, which have increased the role of the private sector in health care provision.

1.7 Players

The global healthcare market is made up of companies involved in different aspects of health care. The pharmaceutical sector is one of the largest sub-sectors but will not be dealt with in this paper. Instead, the paper will focus on healthcare companies which deliver healthcare

services, including general clinical care, renal care, pathology and high technology diagnostic services.

As the previous section on finance shows, there are several mechanisms used to finance public healthcare services. There are also differences between the levels of public and private sector provision in many countries. Until the introduction of health sector reforms in the 1980s, when systems which were previously publicly-financed and publicly-delivered, were opened up to contracting out and outsourcing, some countries did not have a private health care sector. In other countries, there had been a longer, more established private health care sector, which operated alongside the public sector. Health sector reforms introduced changes in legislation, which allowed private health care providers to enter the healthcare market, which has resulted in an increase in the number and types of health companies which have become global players entering public healthcare systems.

Health sector reform, as part of neo-liberal reforms, has been promoted by international agencies, such as the IMF, the World Bank, the Regional Development Banks, OECD. Global accounting and consultant companies have also played a key role in promoting health sector reform by supporting governments to introduce internal markets to public health care systems and in some cases privatising health care facilities. Changes in legislation have allowed private sector providers to enter health care systems. The conditions imposed by IMF loans have forced governments to either privatise or limit the scope of public health care systems, which are then reinforced by loans from the World Bank and some regional investment banks which support the creation of new health care financial infrastructure.

The International Finance Corporation (IFC), a member of the World Bank Group, has played an important role in the creation of investment alliances between national and global capital, which have contributed to the expansion of a global for-profit healthcare sector. In addition, over the last decade, the global healthcare industry has been the target of private equity investments, with investors identifying potential growth areas in health and social care.

There are several trends emerging in the investments of healthcare companies and private equity investors in healthcare. This section outlines the strategies of some of the main for-profit players in the provision of health care services.

1.8 Trends

Appendix 1 shows the key players in the global health care market by region. Perhaps one of the most surprising observations about the growth of the global health care market is that investors are not always moving from North America/Europe to Asia, Africa or Latin America. Instead there is a trend to move into Europe from both Africa (Netcare), Australia (Ramsay Healthcare) and Singapore (Parkway Holdings). Similarly, two companies set up to work in Eastern/ Central Europe have expanded into Western Europe (Medicover, Euromedic International). This may be partly explained by the reforms taking place in what were strong European public health care systems, which are encouraging for-profit private sector providers to become providers of publicly funded health care.

In contrast, two US companies, HCA and United Health Group, have attempted to expand into Europe over the last 10 years but have not been very successful. HCA had hospitals in the UK and Switzerland but has retreated to the UK. It is currently buying into an Australian healthcare company, Healthscope. which is active in Australia, New Zealand, Indonesia and Malaysia. United Health Group has also spent over 10 years trying to enter one or more European countries but has withdrawn, although it is expected to bid for UK NHS

commissioning contracts in the near future.[25] In 2012, UHG bought Amil, a Brazilian health care company, which provides health insurance and health care services, which will enable the company to expand into a rapidly growing economy. [26]

In social care, the expansion of multinational companies has been slower. A group of French social care companies, which own both care homes and psychiatric services, have expanded into neighbouring countries, for example Italy, Spain, Belgium and Germany. In the Nordic region, multinational companies are active in Norway, Sweden, Denmark and Finland, delivering primary health care and social care.

There are signs of tentative expansion of multinational social care companies into Eastern and Central Europe but there is no clearly defined market or sources of financing for private social care in most countries. There is also an exploration of Asian social care markets by European companies such as BUPA, a UK non-profit company, and EQT, a private equity investor.

1.9 Sources of capital

Family capital is still a source of capital for Asian healthcare companies. Apollo Hospitals, Fortis Healthcare and Ramsay healthcare all have family investors, often founding families, but not necessarily majority investors. The Ramsay family still holds 36% of shares of Ramsay Health Care but other institutional investors hold 64%. Fresenius has 27% shares owned by Else Kroner Fresenius Stifung, a large charitable foundation set up by Else Kroner, who took over the Fresenius company after the Second World War. [27]

State investors also play a role in for-profit health care companies. IHH Berdad has Malaysia Khazanah, the Malaysian Strategic Investment Fund, as a majority investor. The Public Investment Corporation Ltd, owned by the South African government, owns 20.40% of Netcare shares. Swedfund, wholly owned by the Swedish government, has invested in AAR Health care.[28]

Institutional investors hold 45% of Apollo Hospitals. Private investment companies own over 60% of United Health Group and a proportion of Netcare (South Africa). 61% of Fresenius shares are held by institutional investors.

In Europe and North America, private equity investors are the majority investors in holding companies which are health care chains, such as Capio, Euromedic, HCA and Medicover Holdings.

The International Finance Corporation has invested in several health care companies which have become global companies. They include Euromedic and Medicover, both originally set up to operate in Eastern and Central Europe. Current investments cover Apollo Hospitals, IHH Berdad and Fortis Healthcare.

1.10 Corporate strategies and growth models

An analysis of the strategies of a group of global health care companies shows the relative diversity in company strategies. There are four main models that have been successful:

- Vertical integration of products and services, e.g. Fresenius;
- Expansion of hospital provision, e.g. The Ramsay Group;
- Gradual creation of a health care conglomerate through acquisitions, e.g. IHH Berhad;
- High technology expansion with later specialisation, e.g. Euromedic International;

Fresenius – vertical integration of products and services

Fresenius, originally a German company but now a global healthcare company, has built up a vertical integration of renal care services, which involves dialysis equipment, dialysis products and dialysis clinics. However, it is also active in several other areas, which complement this core business. These are: medicines and technologies for critically and chronically ill patients; hospital management and; international healthcare consultancy involving public-private partnerships.

The Fresenius Chairman in 2004 observed that opportunities for hospital privatisation were increasing in Germany. [29] Fresenius then started a process of acquiring German hospital groups, which culminated in 2014 in the purchase of Rhon Kliniken. Fresenius is now the largest private hospital provider in Europe.

Its position in Asia and Latin American markets has been slow growing but with increases in the incidence of non-communicable diseases, including end-stage renal care, there is still potential for growth. This also depends on a secure system of payments for treatment, either private health insurance for middle class groups or universal health care coverage.

The Ramsay Group – expansion of hospital provision

The Ramsay Group is an Australian company, set up in 1964, which has become a global hospital group operating in Australia, the United Kingdom, France and Indonesia. This is one of the global companies that have expanded from Asia into Europe. It has focused on France and the UK in the last seven years, since it bought Capio UK and its portfolio of hospitals in England. In March 2010, Ramsay Health Care purchased a 57% interest in Group Proclif SAS (Proclif), a leading private hospital operator based in France. Proclif changed its name to Ramsay Santé. Ramsay Santé is now one of the leading operators of private hospitals in the greater Paris region, with eight acute hospitals with approximately 1000 beds and day places. In 2014, Ramsay Healthcare bought General de Santé. the largest private hospital group in France, thus consolidating its position in the French health care market . It is aiming to expand further in Asia and Europe.

IHH Berhad – creation of health care conglomerate through acquisitions

Previously known as Integrated Healthcare Holdings Berhad, IHH Berhad was launched as a publicly listed company in 2012 in both the Malaysian and Singapore Stock Exchanges. It owns 100% of Parkway Pantai and 100% of IMU Malaysia (International Medical University), 60% of Acibadem (a Turkish health care company) and 10% of the Apollo Group. This consolidation was the result of several years of acquisitions, which were followed by financial reorganisations, which included de-listing and setting up joint ventures. It has brought together four companies which all operated independently and are now divisions of IHH Berhad. Khazanah, the Malaysian sovereign wealth fund has been the main investor in IHH Berhad.

Parkway Holdings, a Singapore health care company, expanded its activities over the last 15 years from hospitals to primary care services to laboratories. It attempted to expand into several Asian countries by setting up joint ventures. The corporatisation of public hospitals in Singapore and Malaysia has led to increasingly intense competition between public hospitals and private sector providers for private patients although Parkway saw opportunities in the Singaporean government's policy of outsourcing clinical services. [30]

In 2005, Parkway acquired a 31.0% share of Pantai, a group of 7 hospitals in Malaysia. The following year, 2006, Parkway swapped its direct 31.0% equity interest in Pantai and formed a 40:60 joint venture company with Khazanah, the Malaysia sovereign wealth fund, called Pantai

Irama, which controlled Pantai. In 2010, Khazanah transferred its 60.0% equity interest in Pantai Irama and its 23.8% equity interest in Parkway to IHH Berhad.[31]

In 2007, Parkway entered into lease and leaseback arrangements for each of its three Singapore hospital properties with a real estate investment trust, PLife REIT, which has been listed on the Main Board of SGX-ST since August 2007, and subsequently held a 35.8% equity interest in PLife REIT. [32]

In 2010, IHH Berhad made an offer for Parkway Holdings and subsequently delisted the company. It has a 100% equity interest in Parkway and Pantai Irama.[33] The International Medical University, Malaysia (IMU Health), set up in 1992, became a 100.0% subsidiary of IHH Berdad in 2010. IHH owns 100.0% of Parkway Trust Management, the manager of PLife REIT. [34]

The aim of IHH Berhad is to grow its business in Central and Eastern Europe, the Middle East and North Africa, India and China in 2014. This will be done through joint venture opportunities and acquisitions.

Euromedic International – high technology expansion with later specialisation

Euromedic International is a pan-European health care company which now specialises in diagnostics investigations, clinical laboratories and cancer treatment services.[35] For more than a decade, Euromedic International built and operated imaging diagnostic centres and dialysis centres in Eastern and Central Europe. The company used public-private partnership arrangements as a way of expanding its business. Euromedic International invested in the new high technology centres and the public healthcare system paid for the service.

By 2008, Merrill Lynch Global Private Equity (MLGPE), Ares Life Sciences, Montagu Private Equity and Management jointly acquired Euromedic International from Warburg Pincus and GE Capital Equity Investments. Since then, the company has expanded into Western Europe, including Italy, Portugal, Ireland and the United Kingdom. In July 2012, Ares Life Sciences and Montagu Private Equity bought out Merrill Lynch Global Private Equity.

Between 2010 and 2013, Euromedic International sold its dialysis operations in Russia to Fresenius (2011). It expanded into new Central and Eastern Europe countries and extended its services to include cancer treatments. In 2012, Euromedic International signed a formal agreement with Methodist International (MI), a subsidiary of The Methodist Hospital (TMH) in Houston, Texas, US. Methodist International will train Euromedic Cancer Treatment Centres in operational and quality standards for radiation cancer treatment. [36] This will consolidate Euromedic International position as a provider of cancer treatment in Europe.

1.11 Social care corporate strategies

The nature of social care as a locally based activity has until now meant that multi-national company expansion have been more limited. In some countries, for-profit companies may dominate the provision of social care but not necessarily expand into other countries. There are some signs that this might be changing in Europe, where multi-national companies are involved in care services in several ways. A group of French multinational care companies own a mix of care homes and clinical services, most usually mental health services, in countries bordering France. Facilities management MNCs are involved in the delivery of homecare services, for example, Sodexho. Some companies, not always involved directly in care, provide retirement apartments with a range of services (assisted care) which may include care as well as

recreational activities for people on higher incomes. This is an area of potential expansion in the East Asia market.

The for-profit sector is becoming increasingly involved in care provision but there is uncertainty about the future of these types of investments in some countries. There are examples of care homes operating in national markets going bankrupt (Austria/ Germany/UK) and also scandals about the poor quality of care delivered (Sweden/ Germany/ UK). This is partly because the business model for many care homes, until the financial crisis of 2008/9, was based on a sale / leaseback arrangement, which gave companies greater flexibility to respond to the changes in demand for places but without large-scale property investments. However after the crisis, borrowing capital became more expensive and the austerity measures introduced by national governments have put pressure on the payments that governments, as funders of individual care places, will pay. In Germany and France, government funding and regulation for care homes have become more rigorous and the effect on for-profit care homes companies is unclear.

Nordic care companies continue to benefit from the outsourcing of care services at municipal level, and operate within a regional market. However, Sweden reported a decline in care home places but an increase in domiciliary services in 2011. [37] There are examples of private equity companies investing in domiciliary services and the three largest home care companies in Sweden all have private equity investors (Humana (ArganCapital) [38]; Frosunda (HG Capital)[39]; and Olivia (Procuritas)[40]. There are signs that some private equity investors are sensitive to the criticisms of the quality of care. Attendo has been put up for sale by its owners IK Investment Partners.

Private equity continues to invest in care services. Several nordic multinational care companies have private equity investors. The recent patterns of investment by HG Capital show that care continues to be a priority investment in Europe (Table4).

Table 4: HG Capital care investments 2006-2011

Year of acquisition	Company	Activity	Country
2006	Voyage Group	Homes for people with learning disabilities and in 2011 (5,507 workers)	UK
2008	Casa Reha	Care homes	Germany
2010	Frosunda	Personal assistants for people with disabilities (also psychiatry & school 'business') (3,700 workers)	Sweden
2011	Mainio Vive	27 care homes (1,150 workers)	Finland

Sources: http://www.hgcapital.com/; http://www.worksmart.org.uk/

In the United States, the for-profit sector has used Real Estate Investment Trusts (REITS) to invest in health and social care but this trend has been slower to take off in Europe. Confinimmo, one of the largest REITs in Belgium has health care investments in Belgium and France which include nursing homes, psychiatric care and rehabilitation clinics. [41] [42] An analysis of Confinimmo's health / care home investments in France show that both Korian and Medica France run care homes are owned by Confinimmo. [43] In November 2011, Confinimmo

signed a joint venture agreement with ORPEA, the French care company, which would be managed by ORPEA. Their first clinic acquisition was in April 2012.[44] The joint venture is governed by French law in which Cofinimmo holds a 51% stake and the ORPEA Group 49%. Cofinea I SAS receives tax benefits through the *Société d'Investissement Immobilier Cotée* (SIIC) regime or French listed real estate investment company.[45] This example shows how multi-national company investment in social care can be not only through direct care provision but through more opaque property investment.

1.12 Opportunities for growth

The four case studies outlined in the previous section give some strong indications of where the opportunities for growth in the global health care market lie. In addition, investments made by private equity investors present insights into areas of health and social care which are considered likely to expand. A third source of health investment knowledge is the investments made by the International Finance Corporation, a member of the World Bank Group.

The expansion of high technology and medical devices to treat cancer, end-stage renal disease, and other non-communicable diseases is a rapidly growing market. This is significant in that the investments made by development assisted funding do not recognise the growth of non-communicable diseases in low and medium countries. The provision of these diagnostic and treatment services, which are expensive, is dependent on funding either from the public sector or private insurance. Euromedic International has addressed this problem by working in public-public partnerships and getting the public sector to fund the services. In Asia and Latin America, the funding is not always available and so companies have to set up their own health insurance company. In 2000, Parkway formed a partnership with Allianz, the global insurance company in order to private managed care to its patients. One of IHH Berhad's recent acquisitions has been a Turkish health insurance company, which will also enable it to provide health insurance for patients.

The health care systems of Asian countries with medium income levels are another growth area. The expansion and consolidation of IHH Berhad shows that the integration of hospitals, primary care services, laboratories, medical universities and real estate investment trusts is considered a sound business opportunity. In the short term, expansion is established through joint venture partnerships with other private companies. However, the important element of IHH Berhad's expansion is its dependence on the Malaysian sovereign wealth fund, Kazaniah.

Another way of identifying opportunities for growth is to analyse investments made by private equity investors (Appendices 2 and 3). Health services are a strong focus of investments in Africa but other regions show a more diverse set of priorities. Diagnostic equipment, medical devices and cancer and cardiovascular care centres are a growing type of investment in many regions, reflecting the strategies of the multinational companies. There are also investments in aspects of social care, for example rehabilitation services, nursing/ retirement homes, services for people with autism. There are also some more tentative moves into IT medical services and health data processing.

The third source of information is recent IFC investments. The majority of IFC investments are for hospitals but there have been some investments in diagnostic/ outpatient services (China Concord Medical 2013 $40m; India Super Religare Lab $24.53m; Euromedic 2001 and 2004 $33m). The IFC hospital investments are for for-profit hospitals targeting high and medium income groups.

1.13 Other investors

The World Bank Group, the Asia Development Bank, Africa Development Bank and the Inter-American Bank make regular investments in health and social care. Many have contributed to the growth of private sector provision in low and medium income countries. An analysis of recent health projects made by the World Bank and the three Regional Development Banks follows. Overall, it shows that although many projects aim to address some wider public health problems, such as communicable and non-communicable diseases, there is a strong 'pro-private sector' approach, with a specific approach to financial management.

World Bank health projects

The World Bank has been promoting health sector reform for over two decades by implementing decentralisation and new forms of financial management. It works with other multi-lateral agencies, for example, the Public-Private Infrastructure Advisory Facility *(*PPIAF) and national development agencies, for example UK Department for International Development (DFID) to promote these agendas.

Many of the projects funded over the last two years show that 'payment by results' or 'performance based financing' are being introduced to make health services more efficient. Funding is made available using these mechanisms, so that health facilities will only be given funding if they provide services which have an impact on health status. The underlying assumption is that health workers need incentives if they are to deliver services efficiently and effectively. A recently approved project on improving maternal and child health services for the Democratic Republic of Congo (DCR) is using 'results based financing' which pays for outcomes and results rather than inputs. Income from performance based financing is used by health facilities and health administration to buy inputs and performance bonuses. This introduces a competitive element into the health care system. Performance based financing is an integral part of World Bank projects in Chad, Cameroon, Moldova, Zambia, Ethiopia, Nigeria.

Public-private partnerships (PPPs) have also been integral to many World Bank projects. A recently funded project in India (Uttar Pradesh) included the creation of a public-private partnership unit in the Ministry of Health as well as contracting with the private sector for diagnostic services and non-clinical support services. In Liberia, the World Bank produced a report on how to expand the number of PPPs to inform the development of the Liberia Poverty Reduction Strategy. The World Bank also advised on changes in legislation necessary to facilitate an increase in PPPs in Liberia.[46] This advice shows that in order for PPPs to be introduced in low and medium income countries, new legislation is needed to provide appropriate legal and institutional structures to facilitate the setting up and management of PPPs. The prime interests of the Liberia population are not considered.

Part of financial reforms introduced by World Bank funding have involved the introduced of contracting or outsourcing of health or support services. Rationalisation of health services has been a part of health systems reforms. In Romania, a new health sector reform project will include hospital rationalisation as a part of a programme to improve access, quality and efficiency of health services.

The solution to improving access to services is often the creation of a social insurance system. The Kosovo Health Project aims to improve financial protection and reduce household spending on health through a new health insurance law, a payroll tax and a basic package of health services. These are considered solutions to a poorly resourced health care system. Countries are being encouraged to set up social insurance systems to prove universal health coverage,

where health services can be provided by public or for-profit providers, rather than solely public provision.

Asian Development Bank health projects [47]
Some of the same themes that are evident in World Bank projects also emerge in health projects funded by the Asian Development Bank. 'Results based lending' is a form of 'payment by results' and is part of technical support for the India National Urban Health Mission. Public-private partnerships (PPPs) are also part of ADB funding projects. A project in Thailand is explicitly aiming to improve the capacity of the Public Health Ministry to 'identify, develop and implement PPPs projects and to draw more private sector funding into the health sector'. In Mongolia, a project is aiming to improve the social insurance system through institutional strengthening.

Africa Development Bank – health projects [48]
The emphasis of Africa Development Bank health projects is more on ways of addressing communicable diseases, e.g. HIV/AIDS and tropical diseases, and providing basic health services. The underlying approach to the provision of basic health services is through the provision of a 'safety net'. For example, the Africa Development Bank has funded a project in Morocco which supports the 'universal coverage of the social safety net'. It will focus on the management and financing of the reforms, the extension of medical coverage and the regulation and provision of care. It is also investing in a network of high quality tertiary care and education centres in East Africa, which will stimulate social economic development. Upgrading and improving nursing and other forms of health worker training is another priority of Africa DB health projects, for example, Egypt.

Inter-American Development bank – health projects [49]
The health projects funded by the Inter-American Development Bank (IADB) share some similarities with those of the Asia and African Development Banks. A project to improve primary health care in improve primary health care in Panama, includes the 'analysis of mechanisms to setup PPPs'. A project to improve maternal and child care in the Western Highlands of Guatemala is using a franchising model to support a network of private health care sector providers. In Paraguay, a project to improve health care for mothers and new born babies, will disseminate details of a new legal and institutional framework for administration of public and private funds. Overall, the emphasis is on improving the efficiency of health management systems and the establishment of information systems.

1.14 Global Investment Banks

Global Investment Banks invest in health care and, in a more limited form, social care. Private equity investments seem to be most often used form of investment. Standard Chartered Private Equity has invested in Fortis Health care, [50] an Indian health care company, the sale and lease back of Spire hospitals,[51] a UK hospital company and more recently in Emtek Indonesia hospital business.[52] Morgan Stanley private equity has invested in Sinophi Healthcare Limited,[53] a company working with older care in China, which is an indication of how social care investments in Asia are becoming viable investments.

1.15 Other players

Higher education is becoming commercialised and this is reflected in the development of public-private partnerships and other joint arrangements with the for-profit sector. The John Hopkins School of Medicine entered into a public-private partnerships with the Malaysian government to set up a new medical school called the Perdana University Graduate School of Medicine, or

PUGSOM, which opened in 2011, and the Perdana University Hospital (PUH).[54] In 2013, John Hopkins International and the Pacífico S.A. Entidad Prestadora de Salud (Pacífico Salud), a Lima, Peru-based subsidiary of Credicorp Ltd, an insurance company, started to work together to improve care in a network of hospitals just bought by Pacifico Salud. These are two examples of how academic health care institutions are also expanding into global health care through partnerships with the for-profit sector.

Table 5: John Hopkins International partnerships

Region	Hospitals
North America	Amcare Labs International, Inc. (United States) Medcan Clinic (Canada)
Europe	Anadolu Medical Center (Turkey)
Middle East	Al Rahba Hospital (United Arab Emirates) Clemenceau Medical Center (Lebanon) Johns Hopkins Aramco Healthcare (Saudi Arabia) King Khaled Eye Specialist Hospital (Saudi Arabia) Tawam Hospital (United Arab Emirates) Tawam Molecular Imaging Centre (United Arab Emirates)
Asia	HCL Avitas (India) Johns Hopkins Singapore (Singapore) Sun Yat-sen University (China) Tokyo Midtown Medical Center (Japan)
Latin America/ Caribbean	Clínica Las Condes (Chile) Fundación Santa Fe de Bogotá (Colombia) Hospital Moinhos de Vento (Brazil) Hospital Punta Pacífica (Panama) Instituto Tecnológico y de Estudios Superiores de Monterrey (Mexico) Pacífico Salud (Peru) Trinidad and Tobago Health Sciences Initiative (Trinidad & Tobago)

Source: John Hopkins Medicine International [55]

The creation of Academic Health Sciences Centres in the UK, US, Sweden, Canada, The Netherlands and Singapore, has brought together universities, medical schools, teaching hospitals and other medical research facilities. Although initially a form of public-public partnership, these centres have large budgets and are creating partnerships with the for-profit centre to expand opportunities for research. In the UK, the NHS published a report in 2013 on the potential of health technology campuses to collaborate with industry to 'accelerate the development of innovative medical technology solutions and their adoption by hospitals'. [56] The lines between public and for –profit sectors are becoming increasingly blurred.

2. Management

As the section above has outlined, the World Bank and Regional Development Banks play an important role in the promotion of health sector reforms. There have been several significant changes in the management of health services in the last three decades which have had an impact on the way in which public health care services are delivered. The main processes are:

1. Marketisation
2. Decentralisation
3. Corporatisation
4. User fees
5. Privatisation
6. Trade agreements

2.1 Marketisation

Marketisation is defined as the introduction of a public health care system to market forces. In the case of many health care systems, they have been re-organised into quasi-markets. The for-profit sector is encouraged to provide services to the public sector in competition with public sector providers. New ways of pricing health care, which make some of the costs of running services more transparent, are introduced so that public and private providers can operate 'on a level playing field'. What this means for the universal health system is that resources are channelled into the administration of a quasi- market system rather than patient care.

The marketisation of public health care systems is part of a long process, which is not necessarily clearly set out or understood at the beginning. Public policy plays an important role in creating internal markets and changing public health care systems. There are recognisable steps in the process of moving from a state/ government run health care system to a marketised and privatised system but this can take place over many years. It is a more complex process than the privatisation of public utilities.

2.2 Decentralisation

One of the most significant changes is the introduction of decentralisation policies which transfer responsibility for management and funding from national/ central government to local level, whether local government or hospital and institutional levels. Decentralisation is presented as benefiting local people because it gives greater control over decision making. When it is linked to reduced resource allocation from government with no balancing powers of local taxation, the result is often a reduction in resources, leading to cuts in services. The impact of decentralisation can be seen throughout the world.

Within Europe, there are different gradations of decentralisation policies. In some countries of Central and Eastern Europe, decentralisation was a radical policy which resulted in large cuts in budgets. In Western Europe, a more gradual transfer of power to local authorities has occurred with reductions from central government funding. Decentralisation has been introduced in many regions with different administrative systems, for example, Africa, Latin America, Central/East Europe, China.

A relatively early study of evidence from decentralisation reforms showed that equity across regions is often reduced after the introduction of decentralisation. [57] Leaving decision making to local groups can result in greater variations in the types of services and service quality across a country. In the long term this will result in greater health inequalities. Unless central government has powers to introduce minimum standards of services, it will be difficult for any government to address health inequities. [58]

2.3 Corporatisation

Corporatisation is a term which covers the introduction of business principles to the management of hospitals (or other parts of the public sector). Rather than central government giving a hospital an annual budget, after corporatisation, the hospital has to develop a business plan, explain how income will be spent and how new income will be generated. As the same time as hospitals become corporatized, the health system is re-organised into a quasi-market so that health services are bought from health care providers (hospitals) by health commissioning agencies.

Corporatisation or self-management of hospitals accompanied by reduced central funding change the ways in which a public health care institution operates. Corporatisation involves adopting private sector ways of operating, with business plans, targets and cost centres. These measures begin to alter the way in which public health care services operate. Hospitals become more concerned with reducing the costs of service delivery than with delivering improved quality of care.

Several policies, such as decentralisation, create changes in the way in which hospitals operate that lead to strategies of income generation and self-management. Health care institutions start to function as private companies. Legislation is often introduced to enable them to have direct control over their assets and to be able to borrow money. This has implications for the future because whilst hospitals remain as part of a national health service, the risks of going bankrupt are safeguarded by central government. When hospitals operate as private companies, the prospect of failure becomes more likely. This opens the prospect of private companies taking over and potentially asset stripping what were public sector assets.

Another development that results from the corporatisation of hospitals in both the public and for-profit sectors is the 'hospital chain', which links together a number of hospitals, which are run together as a business. The for-profit sector has been running hospital chains for several years. Examples include, Apollo Hospitals, India, Fortis Healthcare, India, Tenet Corporation, US, Helios, Germany. More recently, in the UK, the term has been introduced into the 'language' of the NHS. In autumn 2014, a taskforce that had been asked to look at new, more efficient organisational structures for the NHS began to consider the 'hospital chain', in order to bring together a number of hospitals in the same region or across England. [59] There are already difficulties with the concept of managing a large number of hospitals in the same country as a single entity. [60] Bringing together public sector, NHS hospitals into a chain, sounds as though this will be a way of making them more manageable for takeover by the for-profit sector.

2.4 User fees

In many countries, the last two decades have seen an increase in the amount of out-of-pocket spending on health care in both low and high income countries. Co-payments or user fees are introduced for services that were previously free at the point of use. In some countries, the information about user fees is provided in a transparent way. In many countries, where health workers have had reductions in wages or are paid erratically, patients may have to pay informal payments to obtain access to health care. Although there are some national traditions of providing health professionals with a gift after treatment, this has become more widespread since budget reforms. This is a form of corruption in that health workers are using public facilities for individual private gain.

User fees or informal payments may follow the legal introduction of fees or they may result from the low pay of health care workers. In Central and Eastern Europe, there has been an increase in the use of informal payments and co-payments for health care since the introduction

of health sector reforms after 1990. Several factors influence the introduction of informal payments and user fees. Reduction of funding for government health care may result in health workers being paid erratically. The introduction of legislation that makes it legal for health care practitioners to operate as private practitioners and charge fees introduces the concept of fees into the health care system.

User fees in Africa were introduced as a result of structural adjustment policies in the 1980s. The research over several decades shows that user fees affected access to services as well as the attitude of service users to public health care services in general. [61] As with informal payments in former socialist countries, user fees were a mix of official policy and a result of low pay for health workers. Historically, public health services had been free in many countries but mission hospitals often charged a small fee. This was often accepted because mission hospitals were considered to provide better quality services.

In many African countries, which introduced user fees in the 1980s, governments have started to deliver free health care, often as a way of achieving the Millennium Development Goals. A recent review of literature on the abolition of user fees shows that the elimination of user fees has to be implemented carefully if it is to increase access to services. [62] This is another indication that once user charges are introduced, this can change the balance of relationships within health care services. There has to be a political will, coordination between government departments, adequate human resources to deal with increased demand for services, and incentives to increase the support of health workers . [63]

2.5 Privatisation of hospitals

Many countries have introduced specific policies which have led to the privatisation of healthcare facilities and the expansion of the private healthcare sector. These are often accompanied by a reduction in 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. [64] 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.

Malaysia
Malaysia introduced health care privatisation in the 1980s and the private healthcare sector has expanded with government encouragement. Lower income groups are more likely to use government health services than higher income groups and the gap between these two groups has widened in the last two decades. The higher income groups tend to use government facilities for in-patient care rather than out-patient care. 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. 'Out of pocket' spending on healthcare has risen to 76.8% of private expenditure on healthcare and 33% of total healthcare expenditure by 2009. [65]

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. [66] A more recent study in Peru, also found that the influence of private health insurers on the type of delivery led to higher rates of caesarean sections in the private sector. Rates in the public sector have remained unchanged during the last 15 years. [67]

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. [68] 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.[69] Private healthcare providers do not benefit from renal transplants because in the long term they reduce the demand for dialysis services.

2.6 Social care provision

Care services for older people in many high income countries are diverse and range from institutional care to home care, with some significant changes taking place over the past two decades. There is a growing demand for services to be delivered at home, moving away from institutional care. In Europe, the health and social care sector is one of the fastest growing sectors with increases in both economic and social value as well as the percentage of jobs created. [70]

Across Europe, several countries have adopted and implemented reforms in the provision of care services for older people, which, in some cases, have resulted in a shift from public to for-profit and not-for-profit providers of services. National policies, for the financing of care, have a strong influence on the type of care services provided by the for-profit and not-for-profit sectors.

The expansion of home care services is related to the new systems where money is paid directly to service users so that they can purchase their own personal care services. Older people and people with disabilities, in some countries, are being given cash benefits, which are publicly funded, to purchase the care services that they require. Austria, Germany, France, Belgium, Spain, Greece, UK, Denmark and Finland have introduced these types of arrangements for people needing care. In Denmark, changes in the home help services have taken place since the late 1970s, characterised by the introduction of 24 hour care which involved both home help workers and home nurses.[71] New national legislation, which was designed to eliminate the black market in domestic services, now allocates subsidies for home service or housekeeping activities. [72] Private firms, employing as few as two people, can register to receive these subsidies. The rising demand for home care has also brought increased opportunities for for-profit companies to enter the sector.

In the United States, long term care services are dominated by the for–profit sector. There is evidence that the levels of staffing and quality of care are lower in for-profit companies, which own one or more facilities, than in government services. As these form over 50% of nursing home provision, this highlights one of the major problems of the sector. The cost of nursing home care is higher than community based care. The overall supply of nursing home beds is

almost twice the size of assisted living/ residential care but there are regional differences in the distribution of these different types of facilities. Although, there are state variations in availability of long term care services, in most areas, the supply of residential care beds is greater than for other types long term care services, for example, day care. Assisted care / residential care beds have been increasing over the last decade. [73]

The US home care sector is made up of home health care services companies, non-medical home care companies and private households directly employing home care and personal assistance aides. For-profit franchise chains are one of the fastest growing players in home care, which provide non-medical personal assistance services, for example Comfort Keepers, Home Helpers, Visiting Angels and Home Instead. The expansion of this type of franchise has only taken place in the last decade. [74]

2.7 Trade agreements

At the same time as health care companies and other for- profit companies are expanding globally into public services, there are a series of trade agreements being negotiated which pose a very specific threat to public health and social care services. The Coalition of Services Industries (CSI) is a powerful lobby group for global services companies, which has been trying to open up national public service systems to trade so that they can expand the markets in which they operate.

The Transatlantic Trade and Investment Partnership (TTIP) is a bilateral trade agreement currently being negotiated between the USA and the European Commission (EC) on behalf of the European Union (EU). The Trade in Services Agreement (TiSA) is the outcome of talks that go back to early 2012 and a result of negotiations that began in early 2013 among 23 World Trade Organisation (WTO) members parties: Australia, Canada, Chile, Chinese Taipei, Colombia, Costa Rica, European Union (representing its 28 Member States), Hong Kong, Iceland, Israel, Japan, Liechtenstein, Mexico, New Zealand, Norway, Pakistan, Panama, Paraguay, Peru, Republic of Korea, Switzerland, Turkey and the United States. With the EU accounting for 28 member states, TiSA will include 50 WTO members who account for some 70% of all global trade in services. More WTO members are planned to be included in the future.[75] The Agreement is an extension of the WTO General Agreement on Trade in Services (GATS) negotiations, which are part of the Doha Round negotiations, operating since 2000.

The TTIP and TiSA negotiations have been using many of the same terms as the Global Agreement on Trade in Services (GATS). This poses threats to public services because public services are defined in a narrow way. The definition used for public services is "supplied in the exercise of governmental authority", which "means any service which is supplied neither on a commercial basis, nor in competition with one or more service suppliers"(GATS Article 1.3). After twenty years of public sector reform and the marketization of public services, very few public services operate on a completely non-commercial basis without any form of competition.[76] This will make them subject to inclusion within the terms of these trade treaties and so open to competition from global services companies.

The incorporation of public services into a global trade agreement threatens the existence of public health and social care services in the future. Governments will have to open up public health services to the demands of the TTIP and TiSA. The liberalisation of the trade in services will extend the control that for –profit companies already have over some parts of health and social care services. As public services are dynamic and evolve over time according to the needs of the population, the inflexibility of TTIP and TiSA will make it difficult for governments to use new technologies and other innovations as new public health and social care services.

In 2015, a leaked paper, 'A concept paper on health care services within TiSA negotiations' (2015), presented a detailed view of how health care is seen in the TiSA negotiations. Applying a model of comparative advantage to health care, the paper argues that some countries have a demand for health care which cannot be met because of waiting lists and other countries have a comparative advantage in supply through price and efficiency gains (and lower regulatory and structural barriers). The countries which are unable to meet the demand for health care services could allow their citizens to access health care in another country and this would form the basis for a system of trade in health services. [77]

3. Delivery

3.1 Health care workforce

Marketisation and privatisation have directly affected health workers, by increasing workloads, changing terms and conditions, and making health workers work towards targets and other aspects of a managerial agenda. This has resulted in changes in the relationship with patients. Afford (2003) provides one of the most detailed accounts of how health workers have been affected by health sector reforms in countries of Central and Eastern Europe. Looking at all aspects of workers' security, the study shows that low pay and unpaid overtime were characteristic of almost all countries. Low pay was the result of falling wages, which were often paid late. There was a loss of actual benefits, for example redundancy pay or pensions. Although workers technically still were eligible for sick pay and holiday pay, many were afraid of losing their jobs so were unwilling to take time off. [78]

A physically deteriorating environment in many hospitals led to health workers being put at greater risk of accidents. In addition, violence at work is a symptom of a health care system with reduced resources which means health workers are unable to provide patients with adequate care.

The status and integrity of health workers is directly affected by decentralisation and other health reforms. Cutting costs of labour intensive activities, such as health and social care, results in cuts in the labour force or reductions in salaries. This affects the quality of care. For health workers, reductions in salaries and irregularly paid salaries, forces them to secure alternative sources of income. Reductions in wages lead to corruption as workers struggle to make a living. Workers experience much greater job insecurity. This affects the 'ethos' of public health care services in ways that are detrimental to both health workers and service users because health workers put their own financial survival before the delivery of a public health care service.

Health workers affected by falling wages and late or non-payment wages have to adopt strategies to deal with loss of income. Migrating to another country to find a better paid job is one solution which has been reflected in high rates of health care worker migration from countries with limited health care resources to countries with countries with a demand for health care workers. This has led to a depletion of skilled health care workers in countries that are already experiencing a weakening of health care systems. The Global Health Care Alliance identified mobility as having an impact on the availability of health workers for national health care systems. [79]

Another solution to falling levels of pay, which also affects the quality of health care, is that health workers either find a second job, often in the private sector. Attempting to do two jobs

affects the quality of health care delivered. It can contribute to the poor distribution of health workers in a country. [80]

There are other issues that face governments when planning for an adequate workforce. There are already shortages of health workers and more are anticipated. The health care workforce is ageing in many countries, which will affect the overall supply of health workers. There are widespread problems of recruitment and retention. It is recognised that health workers need to be kept motivated 'in an enabling environment'. [81] Some of these problems have been influenced by effects of health care reforms.

3.2 Social care workforce

The nature of social care delivery is different, with many social care tasks are considered as unskilled work, delivered by workers with little or no training. Changes in the way that care is funded have also led to the expansion of types of care worker.[82] As well as care workers employed by the public, for-profit/ not-for-profit sectors, there are 'independent' formal carers, who are registered with an employment agency, for short term placements. Job security and wages are often inadequate. A third category, called 'personal assistant' carers, are recruited by the care recipient or recipient's family, and may be permanent, short term or live-in. Once again, the pay and terms and conditions of 'personal assistants' are often poor.[83]

A report commissioned by EPSU (2010) presented the results of a survey of health and social care workers in 8 European countries. In the majority of European countries, care workers for older people are low paid, even though their jobs are emotionally and physically demanding. Care work is often considered a low status career. The workforce is predominantly female with 80% of employees in the health and social care sectors in Europe are women. [84] Pay is traditionally higher in public sector services than in private and not for profit services. Improving wages in this sector would help to reduce the gender pay gap. Recent research into the impact of austerity policies on public sector jobs has shown that women are being affected particularly strongly. [85] [86]

Care for older people is beginning to be recognised as an important policy issue at national and European level but there a lack of clarity about how it should be funded and delivered. The use of public procurement processes in the social services sector is making collective bargaining more difficult. In Austria, as a result of the public procurement process and the role of the state in the payment of social services, the state is only willing to pay for the cheapest wages. This restricts the capacity of the social partners (employers/ employees) to negotiate. In Scotland, the absence of a regulatory framework for public procurement, combined with cuts to budgets makes negotiations between public sector employers and trade unions problematic.[87]

The social services sector is directly affected by the austerity programmes that have been introduced in response to the financial crisis in Europe. In both Germany and the Netherlands, budget cuts contribute to making negotiations about collective agreements difficult to resolve. In Ireland, social partners are disaffected with the existing collective agreement. In Spain, new labour reforms are threatening the existence of national collective bargaining agreements with a possible move towards company level collective bargaining. [88]

Long term care for older people is faced with major problems in securing a sustainable workforce. Although the health and social care sector is fast growing in terms of social and economic value and in terms of job creation, the long term future of the workforce is unclear with an ageing, low paid, mainly female workforce that has high rates of turnover.

In other high income countries, the care workforce is also largely female. In the United States, social care jobs makes up 3% of total US jobs. Home care and personal assistance workers are one of the fastest growing occupational groups as a result of a growing demand for home and community long-term services. There are problems with recruitment and retention. Low pay and health and safety injuries are major problems for the sector. Assisted living/ residential care as well as nursing homes depend on low paid aides to deliver the majority of care.

In the United States, the creation of public authorities or 'Home Care Authorities', with responsibility for collective bargaining for home care workers, took place as a result of union (SEIU) campaigning in the 1990s for improved pay and working conditions for thousands of home care workers. Over ten states are now required, through legislation, to set up a public authority, which acts as the employer for home care workers who work for individuals receiving government funded personal home care. Previously, each home care worker was employed by the individual service user and there was no employer who could be involved in collective bargaining. The home care authority functions as the employer in collective bargaining negotiations. This has led to improvements in pay and terms and conditions for home care workers. [89] [90]

In the US, a study found that staffing levels at for-profit, non-profit and government nursing homes were influenced by the type of ownership and the number of 'deficiencies' identified.[91] If a nursing home did not meet the requirements for Medicare/Medicaid reimbursement, it was issued with one or more 'deficiencies' or faults. These can be used as measures of quality. The study found that the largest for-profit chains (companies that owned two or more nursing home facilities) had lower numbers of registered nurses and total nurse staffing hours even though there were legal minimum staffing levels. They also received 36% higher 'deficiencies' and 41% higher serious 'deficiencies' than government facilities.[92] By 2008, nursing chains made up 54% of the 16,000 nursing homes. [93] Other for- profit facilities also had lower levels of staffing and high levels of 'deficiencies' than government facilities. The nursing home companies which had been bought by private equity investors, showed little change in staffing levels but an increase in 'deficiencies' and 'serious deficiencies' after the change to private equity ownership. [94]

3.3 Child care workforce

In all countries, the child care workforce is predominantly female. Although child care services have often been developed as a way of increasing the participation of women in the labour market, the child care sector remains gender segregated. Low pay and poor working conditions in many countries has led to high rates of staff turnover and problems in recruitment. Migrant workers also work in many areas of child care services, particularly unregulated services.

Informal care continues to be the dominant form of care in most countries. Changes in types of funding are having an influence on the types of child care worker. Workers involved in childcare services that are part of the educational sector are generally better qualified and better paid than child care workers for the younger 0-3 year age group. The separation of responsibility for child care services for these two age groups between education and welfare departments has also made it more difficult for workers to move between different services.

3.4 Delivery of services

Marketization and corporatisation of health and social care, as well as investment policies of both public and private financial institutions have contributed to the acceleration of outsourcing and contracting out of core clinical, diagnostic services and support services. In order to assess

the extent of these changes, PSI affiliates in health and social services were surveyed about their experiences of outsourcing and its impact on union membership and organising.

There were 110 responses from PSI affiliates. The responses come from a wide range of countries, with different health and social care systems, in all major regions, including North and South America, Europe, Africa and Asia. They provide an important account of how workers in health and social services have been affected by outsourcing and how unions are already beginning to organise in response to this new threat.

3.5 Outsourcing

Over two thirds of respondents reported that outsourcing of health and social care services had taken place in the last five years. Cleaning services, food services and laundry services were most likely to have been outsourced. However, a range of other more direct health services, including clinical, high technology diagnostic services and laboratory services had also been outsourced along with home-based services. Affiliates reported that almost half of contracts had gone to national companies. Depending on how it is counted, between a quarter and forty percent had gone to international companies. There are also signs that some of the 'national' companies may in fact be subsidiaries of international companies, which shows how the influence of international companies on health and social care services is increasing. Over 77% of all respondents reported that outsourcing and privatisation has had an impact on pay and terms and conditions of employment. Over 67% of respondents reported that it had affected union membership.

3.6 Collective agreements

The majority of respondents reported that over 60% of workers in public health and social care services were covered by a collective agreement and a slightly lower proportion of respondents reported that over 60% of workers in the private health and social care services were covered by a collective agreement. However, a much smaller number of respondents reported that over 60% of workers were covered by a collective agreement in mixed public and private health and or social care services. This shows that the mixed provision arrangements often lead to a weakening of collective bargaining agreements.

3.7 Union membership

The majority of respondents reported that their unions organise health and social care workers alongside other public sector workers. A quarter of respondents reported that they organise only health workers, with a much smaller percentage only organising social care workers. 15% organise both health and social care workers. This shows that the majority of affiliates are unions which combines the interests of several types of public sector workers, a sign of strength.

Union membership reflects the coverage by collective bargaining agreements. Public health and social care services workers had the highest levels of unionisation, private sector workers had lower membership levels and 'mixed' public and private health and social care services had the lowest levels of unionisation.

3.8 Organising

43% of respondents reported that they were mainly actively organising new health and social care workers in the public sector but only 2% were mainly actively organising in the private sector. However, 48% of respondents were actively organising in both the public and private sectors.

Almost 60% of respondents felt that the potential for growth in union membership with public employers was good or very good but less than half of respondents felt that there was a potential for growth in union membership with private employers. Much lower levels of potential (33%) were recorded for mixed public and private employers.

These results show that unions are already organising both public and private sector health and social care workers and the levels of coverage by collective agreements reflect this. However, health and social care systems, with a mix of public and private employers, show lower levels of unionisation and lower coverage by collective agreements. Anecdotal evidence indicates the low confidence regarding mixed and private sector growth which reflects the difficulty and lack of private sector organising experience of PSI affiliates.

3.9 Changes in public health and social care services

Almost half of respondents felt that spending on health and social care had increased in the last 5 years but a quarter felt that spending had decreased. Health and social services are often the most protected services in times of austerity and there is some recognition by governments of the importance of these services. However, this is not the view of all governments and so some decreases in spending were reported.

Part of the processes of corporatisation and marketization involve the creation of systems of accreditation and regulation so that health and social care services can be delivered to similar standards in both public and private sectors. There may be problems in measuring quality of services but new accreditation and regulatory bodies are characteristic of a marketised public system.

The existence of an accreditation system was more widely reported than regulatory bodies. Over 50% of respondents reported that there was an accreditation system for public providers, with 34% reporting an accreditation system for private providers and 31% identified accreditation systems for both public and private providers. Only a quarter of respondents reported that there was no accreditation system in place for either the public or private sector. Although the majority of respondents reported that no new regulatory bodies had been set up since 2009, a quarter of respondents reported the establishment of some new regulatory bodies. The majority of health and social care systems have some form of accreditation and regulation in place.

The delivery of health and social care services has undergone significant changes in the last five years. A wide range of services, both core and support services, is now outsourced. International companies have won at least a quarter of contracts and if national subsidiary companies are included, the influence of international companies on public health and social care systems is increasing. There is an immediate impact of outsourcing on pay, working conditions and union membership. Unions are responding to these changes in positive ways and recognise the potential for organising in both the public and private sectors. The challenges of organising in private and 'mixed' public systems are significant and growing.

These will have to be addressed through strategies which increase the capacity of affiliates at both the individual and regional levels.

4. Conclusion

There have been changes in the mix of different forms of health care financing, with some countries recording higher rates of out-of-pocket payments and a decline in the contribution of public health care expenditure to overall health care expenditure.

Health care multinational companies are entering the European and Asia markets with a variety of strategies, which sometimes concentrate on general hospital care, specialised care, high technology diagnosis and treatment. The most surprising are companies moving from the 'periphery' (Africa/ Australia/ Singapore) to the 'centre' (Europe).

Social care multinational companies have been slower to expand into different global regions because social care is usually a locally delivered service but there are signs that companies are interested in exploring opportunities in East Asia and Europe. Middle income countries are starting to need social care for older people because urbanisation has contributed to the fragmentation of the family and the population is ageing.

The World Bank, IFC and Regional Development Banks promote financial and management reforms of national health care systems. The processes of marketisation, decentralisation and corporatisation of the public sector provide more opportunities for multinational companies to enter the public health care sector. Although global multinational companies are dependent on health sector reforms to create new health care markets, state investment agencies also contribute to company expansion. The increased commercialisation of public health and social care services makes them subject to inclusion in trade treaties which will open up these services up to competition from global services companies.

There has been extensive outsourcing of health and social care services in the last five years. Although cleaning services, food services and laundry services were most likely to have been outsourced, clinical, high technology diagnostic services and laboratory services are also being outsourced along with home-based services. Increasingly, services are being outsourced to international companies. Outsourcing has an immediate impact on pay and terms and conditions of employment and union membership.

Health and social care workers in many countries have been affected by reforms to both health and social care which lead to lower pay, poorer terms and conditions and greater economic insecurity. These changes have led to increased migration of health and social care workers, resulting in shortages of skilled workers in low and medium income countries.

Unions are responding to these changes in positive ways and recognise the potential for organising in both the public and private sectors. The challenges of organising in private and 'mixed' public systems are significant and growing and many unions do not have the experience to be as successful as they need to be. This will have to be addressed through strategies which increase the capacity of affiliates at both the individual and regional levels.

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Appendix A1: Main healthcare companies with international activities

Company	Revenues 2011-12 /operating profit	Revenues 2012-13/ operating profit	Number of employees	Investors	Activities, segments	Comments on recent changes
Asia						
Apollo hospitals	28,279 m /3,375 m	33,488 m /4,079 m	35,000	Individuals/ Hindu Undivided Family 17% Bodies Corporate 18% Foreign Institutional investors 45% (including Oppenheimer Developing Markets Fund 8%; Integrated (Mauritius) Healthcare Holdings Ltd 11%)	India – hospitals and other healthcare services	No investments in other Asian countries although involved in health tourism IFC loan
IHH Berhad	RM 6,756.50/ RM1,658	6,962.50	24,000	Malaysia Khazanah, Japanese Mitsui, Turkish Aydiniar family	Singapore, Malaysia, Investments in China, Hong Kong, India, Vietnam, Brunei, Turkey Segments: Parkway Pantai; Acibadem Holdings; IMU Health – medical education; PLife REIT Other.	Recent movement into Turkey Aiming to move into Middle East and Central & Eastern Europe. IFC loan
Fortis Healthcare	27,995 m crore/ 5,188	53,910 m crore / 14,637	?	Singh Family	Hong Kong, Australia, New Zealand, Vietnam, Sri Lanka	Fortis International split from Fortis in 2013 IFC loan

Ramsay Healthcare	Aust$3.9 bn/$562	Aust $4.2bn/$599	30,000	Ramsay family 36%, FIL Investment Management (Australia) 3% and other institutional investors	Australia, France, UK (bought Capio hospitals), Indonesia	Australian company moved to Europe in 2007 – bought hospitals in UK. Currently bidding for large French hospital company Générale de Santé.
Healthscope	Aust				Australia, New Zealand, Malaysia, Singapore	Being launched as an IPO July 2014

Africa						
Netcare	25,174 m Rand/ 113.2 m	27,801 m Rand/ 142m	? (53% unionised)	Public Investment Corp Ltd. 248,130,668 16.8% Netcare Ltd. 9.89% Elvenwood Investments Pty Ltd. 4.88% Old Mutual Investment Group (South Africa) (Pty) Ltd. 4.64% Allan Gray Unit Trust Management (RF) (PTY) Ltd. 4.35% Netcare Fund 3.69%	South Africa (58%), UK (General Hospital Group & BMI group) (42%) UK and South Africa, public –private partnerships	South African company that moved to UK (10 years ago) as part of contracting out of clinical services by NHS. Then bought two UK private healthcare groups.
AAR Healthcare				IFC $4 million Swedfund Investment Fund for Health in Africa), an IFC portfolio fund established in 2007 dedicated to private healthcare companies in Africa.[95]	Kenya, Tanzania,Uganda Health insurance (individual and corporate plans) and health care facilities	
Americas						

United Health Group	$122,489m /$5,625	$110,618m/ $5,526	156,000 (2013)	FMR LLP 11% Wellington Management Co LLP 7% Price Rowe Associates 14% Bank of New York Mellon Corporation 15% Dodge & Cox 15.5%	US, UK, Brazil (Amil 90% - insurance and hospitals) Health insurance, healthcare provision, pharmacies, health and wellbeing services	Attempted expansion into UK and Europe – failed to expand
HCA	$34,182 bn /$2,946 m	$33,013 bn/ $1,605 m	215,000 (2013)	HCA Holding Co (previously Bain Capital Partners, Kohlberg Kravis Partners, BAML Capital Partners, Dr. Thomas Frist (founder))	US and UK – hospitals	Attempted expansion into Australia to buy Healthscope July 2014 [96]

Europe						
Capio	12,420 MSEK/ 610 MSEK	10,417 MSEK/ 547 MSEK	11,875 (2013)	Capio is owned by Ygeia TopHolding AB which is owned by Cidra SARL which is jointly owned by Apax Partners Worldwide LLP (45%), Nordic Capital (44%) and Apax Partners SA (11%)	Sweden, Germany, Norway, France, UK -	Originally a Swedish company but expanded in last 10 years to European healthcare company in European market
Fresenius	€19,290m/ €3,888 (EBITDA)	€20,331 m/ €3,851m (EBITDA)	178,337 (2013)	Institutional investors 61% Else Kroner Fresenius Stifung 27%	42% North America 40% Europe 10% Asia-Pacific 8% Latin America Fresenius Medical Care Fresenius Kabi Fresenius Helios Fresenius Vamed	Global renal care company – also active in healthcare management. Last 10 years invested in German hospital groups – now largest healthcare providers in Europe.
BUPA	£9.1 bn/ £638m	£8.4 bn/609.5	70,000	Not for profit	Australia & New Zealand, UK, Spain & Latin America, International (insurance) - hospitals,	Recent acquisitions in Poland and Chile

					residential care/ home care, health insurance.	
Euromedic	n/a	n/a	3,000	Ares Life Sciences (Swiss) and Montagu Private Equity	15 European countries – Ireland, Portugal, Switzerland, Hungary, Poland, Czech Republic, Lithuania, Russia, Romania, Bulgaria, Greece, Italy , Turkey - diagnostic centres, laboratories, cancer treatment	Originally based in Central/ Eastern Europe – expanding into Western Europe – use of public-private partnerships
Medicover	n/a	n/a	5,000 medical professionals & 2,000 assoc partners	Medicover Holdings SA	Poland, Germany, Romania, Turkey, Hungary, Ukraine, Belarus, Moldova, Bulgaria and Georgia – clinics, insurance, laboratories.	Move into Germany from Central /Eastern Europe

Appendix A2: Trends in private equity healthcare investment

Global trends	**Asia/ Pacific**	**North America**	**Europe**
Provider and services investments strongest but influenced by pressure to cut healthcare budgets/ costs	Growing interest especially China (bio-tech) with local funds India (provider services) – with global capital funds Some expansion from Singapore to other Asian countries Australia – point for investments	Provider and services companies – dominate Changing regulatory environment results in focus on cost and outcomes	Bio-tech, med-tech, provider and services – equal distribution Budget cuts and continued health care reforms – create uncertain environment for investors Some cross border expansion

Source: Bain Capital Global Healthcare Private Equity report 2012-3

Appendix A3: Main private equity healthcare investors

Investor	Main investments	Comments
Abraaj Group (formed in 2012, when Abraaj Capital bought Aureos Capital) – invests in Middle East & Africa	**Health care** **Ghana -Aniniwah Medical Centre** – largest private healthcare institutions in N.Ghana **Ghana - C&J Medicare** (C&J) private provider of healthcare services to individual and corporate clients **Kenya - Avenue Group** health services and managed-healthcare provider **Togo - Lome - Biasa Clinic** – general healthcare services **Kenya – Nairobi Women's Hospital** **Africa – Revital Healthcare** manufactures a range of medical equipment **Middle East - Integrated Diagnostics Holdings** **India - Bhilai Scan and Research (BSR) group** - healthcare services chain in central India **Sri Lanka - Central Hospital (CH)** is an advanced private tertiary care hospital with 256 beds. It is promoted by Asiri Hospital Group **Health and social care** **Costa Rica - Pacific Plaza** a continuing care retirement community development with integrated medical complex	Large number of Africa healthcare investments – unusual focus for many private equity investors
Advent International	**Health care** **Netherlands - Mediq** is an international company delivering pharmaceuticals, medical devices and related care services. **USA - Connolly Inc. - l**eading technology-enabled provider of recovery audit services **India - CARE Hospital** - a multi-speciality hospital chain **Poland - American Heart of Poland** operator of cardiovascular treatment units healthcare **Ukraine - ISIDA-** medical treatment and healthcare providers healthcare Ukraine Exited in 2014 **Romania - Regina Maria (formerly Centrul Medical Unirea "CMU")** is the largest private healthcare network in Romania **US - Business Services Financial Services Healthcare** USA - Boston **American Radiology Services** - regional provider of diagnostic imaging services acquired by CML Healthcare Income Fund **Business Services Healthcare ,** Boston, USA **Esaote Biomedica** - research, production and marketing of imaging and non-imaging medical diagnostic equipment IPO on Milan Stock Exchange; subsequently acquired by Bracco Group **Independent Care Ltd.,** builder and operator of private hospitals, UK (Exited in1997)	Investments in health and social care in US, UK, Germany, Poland, Ukraine, Romania – testing different aspects of health care, especially in Central/ Eastern Europe

	Social care **UK - The Priory Group** - leading independent provider of mental health and specialist care services **Germany - MEDIAN Kliniken** Leading independent rehabilitation care provider **US - Craegmoor** - UK independent provider of specialist care for adults and younger people (acquired by Priory Group 2011) **Germany - Casa Reha** - nursing home group Germany acquired by HG Capital **Long Term Care Group -** leading provider of outsourced services to the long-term-care insurance industry - acquired by Genstar Capital **UK Greenacre Group plc** - Publicly held owner and operator of residential care facilities and nursing homes Acquired by Court Cavendish Group plc	
B**ridgepoint Capital**	**Health care** **2011 France Compagnie Stéphanoise de Santé ('C2S')** - independent operator of clinics in the Rhône-Alpes region of France, operating polyclinics - general and specialist medicine and surgery. **2007 Sweden - Diaverum** - largest independent dialysis clinic operator in Europe with ancillary businesses in South America and Australia. Headquartered in Sweden, it has over 274 clinics in 18 countries serving over 22,600 patients. **2011 Médipôle Sud Santé** - a private hospital group in France specialising in general medicine, surgery and obstetrics, operating twelve private hospitals in the Languedoc-Roussillon region of Southern France, with over 1,500 beds, 500 healthcare professionals and 2,300 employees. **Social care** **2008 Ansel** focuses on the assessment, treatment and rehabilitation of adults with a wide range of mental disorders, including individuals with a personality disorder and learning disabilities. **2010 Care UK** is a leading provider of health and social care services, working with local authorities and the UK's National Health Service to provide a range of outsourced services including residential, community, specialist, primary and secondary healthcare. €480m **2010 Sweden - Delhaga** is the leading provider in the full responsibility high acuity autism market in Sweden, providing high quality, individually tailored care programmes, to municipalities seeking to provide proper care. Care services such as group/assisted living, daily activities, diagnostics, schools and leisure activities through 70 facilities across the country. **2005 UK Tunstall** European market leader in the provision of telecare systems, principally for use by the elderly and infirm. $191 m	Focus on buying hospitals in France, social care services with dialysis
Cinven	**Health care** **2007 UK Bought BUPA** hospitals $2,130m	Long term investments in

	2010 Fr Sebia – protein testing for disease**s** **2012 UK AmCo Niche** (off patent) **pharmaceuticals $832m** **2014 US Medpace** - Contract research organisation (drug trials) US$915m **Social . mental health care** **2005 UK Partnerships in Care** – secure psychiatric hospitals - $800m	healthcare – interesting new investment in clinical drug trials
EQT	**Health care** **2011 Sweden Atos medical** – medical devices for voice and pulmonary rehabilitation **2012 Germany BSN Medical** – medical devices for wound care **2012 Singapore Econ Healthcare** is one of the leading elderly care providers in Singapore and Malaysia and operates 10 nursing homes, senior citizen centers, as well as provides professional care services in home care, rehabilitation, ambulance and traditional Chinese medicine. The company also owns West Point Hospital, the only private hospital in Western Singapore. Econ also has services in China. **2014 Australia - I-MED** is one of the world's leading diagnostic imaging ("DI") providers. **2005 ISS** – facilities management **2010 Germany - Roeser Group** - value-add, manufacturer-neutral distributor of medical supplies to hospitals **2013 - Terveystalo** – private healthcare service provider in Finland, serving private consumers, companies and organizations, insurance companies and the public sector.	Nordic investor expanding from Nordic region to Australia, Singapore – health and social care
KKR	**Health care** **2010 Ambea AB Sweden** - one of the largest healthcare and care providers in the Nordic region, with strong positions in both Sweden and Finland **2007 Biomet, Inc. US** - designs and manufactures orthopedic medical devices and other products used primarily by surgeons and medical specialists, with distribution in over 70 countries **2012 - China Cord Blood Corporation, China** - first and largest umbilical cord blood banking operator in China **2012 – GenesisCare, Australia** - cancer and cardiovascular care centres **2007 – HCA, US** – hospitals in US and England **2014 Panasonic Healthcare, Japan** - providers of diabetes monitoring systems, specialized laboratory equipment, and clinical healthcare IT systems in Japan and worldwide.	US investor – including hospitals and range of other healthcare activities

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