Health, a commodity?
The risks of commercialisation in health care

SOCIAL PROTECTION FOR EVERYONE
COLOPHON

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A high quality health care system is one of the pillars of social protection and is a *sine qua non* condition for a global population with better health. According to ILO Recommendation 202 on social protection floors¹, the minimum requirements in the area of social protection must include:

- access to a nationally defined set of goods and services, constituting essential health care and including maternity care, that meets the criteria of availability, accessibility, acceptability and quality;
- basic income security (especially in cases of sickness, unemployment, maternity or disability).

These two pillars of social protection demonstrate a clear link between individuals’ state of health and their access to health care.

**FRATERNITY IS MERELY A HUMAN IDEA, SOLIDARITY IS A UNIVERSAL IDEA.**

**VICTOR HUGO, “PHILOSOPHICAL PROSE, THE SOUL”, 1860-1865**

If a person who has social protection becomes ill, the social protection will offer at least partial protection against the potential losses in income that he or she might face because of the health condition. Income protection in the event of illness is essential for avoiding what scientific literature calls the “medical poverty trap”. For some, the harmful consequences of a sickness episode could spill over into the long term. If the costs of a doctor, a hospital stay, a medicine or transport to a health care service provider are too high, some households could be forced to sell off their
productive assets, especially their working tools or animals, which would allow them to generate income. These expenses then force them into a vicious circle which keeps them in poverty well into the long term.

Access to high quality health care is equally crucial. Insufficient access to health care is a major cause of global poverty. It is currently estimated that 1.3 billion people do not have access to affordable and good quality health care in the world. The problem undoubtedly lies with distribution between richer countries and poorer countries, the countries with low and medium incomes having to bear the brunt of 90% of the burden of sickness at global level but only account for 12% of global spending on health care. At the same time, however, we are seeing rapidly growing wealth inequality within these same countries, between rich and poor, which often goes hand in hand with inequalities in medical status and access to health care. Consequently, the most vulnerable people who have the greatest needs in the area of health care have extremely limited, or even practically non-existent, access to health care services and yet health is a human right.

Over 160 countries are steadily making progress with the right to health care by having incorporated it into their own constitution. This means that these States have a responsibility and a legal obligation to respect, protect and promote the right to health care. Nevertheless, all too often the right to health care remains a theoretical right. States failing to respect their commitments is often considered the inevitable outcome of "under-development". The human rights perspective nevertheless contests this explanation by demonstrating that when they are the consequences of governmental policy or result from the governments' capacity to act, the ensuing deprivation linked to poverty does in fact constitute a human rights violation.

Work is urgently needed to make the right to health a reality for all. The process of commercialising health which is being seen in many countries to varying degrees is one of the processes which, in many ways, runs counter to achieving this right. Why? This is the question our report attempts to respond to. We will therefore examine the effects of commercialisation on the various components of a health care system as identified by the World Health Organisation, i.e. policies on medicines, delivery of health care services, human resources management in the domain of health care, financing of health care, governance and information systems. The first four headings are dealt with specifically, whereas the question of governance and information are considered as cross-cutting themes.

The aim of this document is therefore to examine the negative effects of policies that promote private and commercial initiatives, opening up of markets and budgetary austerity, especially in terms of accessing health care. We also propose some avenues for reflection and put forward some alternatives to this model by examining the health systems that appear best equipped to guarantee the fundamental right to health.
2. THE RIGHT TO HEALTH AND UNIVERSAL HEALTH CARE

2.1. WHAT WE ARE DEFENDING: THE RIGHT TO HEALTH!

Health is a fundamental human right that is indispensable for the exercise of other human rights. It is enshrined in the Universal Declaration of Human Rights of 1948 (Art.25) and in the International Covenant on Economic, Social and Cultural Rights of 1966. For the World Health Organisation (WHO), the right to health contains both freedoms and rights: the right to control one’s own health and one’s own body (for example sexual and reproductive rights) and the right to physical integrity (for example the right not to be subject to torture and not to be subject to any medical experimentation without consent); the right to access a health protection system which guarantees equal possibilities to all to enjoy the best possible state of health.

2.2. HEALTH AS A HUMAN RIGHT: WHAT DOES THAT MEAN?

In 2000, the United Nations Committee on Economic, Social and Cultural Rights adopted its General Comment number 14 on the right to the highest attainable standard of health.

A. A HEALTH SYSTEM THAT FUNCTIONS PROPERLY

According to this General Comment, the key to health is a functional health care system i.e. one that is available, accessible and acceptable to all without any form of discrimination and of high quality.

• **Availability:** the facilities, goods, public health programmes and health care services are functional and in sufficient supply.
• **Accessibility:** the facilities, goods and health care services are accessible to all without any form of discrimination. Accessibility is made up of four interdependent dimensions: non-discrimination, physical accessibility, economic accessibility or being sufficiently affordable, accessibility of information.
• **Acceptability:** all facilities, goods and services in the domain of health care must respect medical and appropriate ethics from a cultural point of view, in other words, should respect the culture of individuals, minorities, people and communities, be receptive to the specific requirements linked to sex and stages of life and must be designed so as to respect confidentiality and improve people’s state of health.
• **Quality:** as well as having to be acceptable from a cultural point of view, installations, goods and services in the domain of health care must also be scientifically and medically appropriate and of a high quality.

B. ACTING ON OTHER DETERMINANTS OF HEALTH

The right to health nevertheless extends beyond the health care system. It includes an array of factors which may help individuals to live a healthy lifestyle and improve the way in which health is promoted. The Committee on Economic, Social and Cultural Rights refers to this using the term “underlying determinants of health”. These comprise: drinking water and adequate living conditions; nutritiously safe food and appropriate housing conditions; healthy environmental and working conditions; health education and information, including information relating to sexual and reproductive health; gender equality.
The importance of non-medical factors is largely recognised as being a key predictor of health. The WHO Committee on Social Determinants of Health concluded a 2008 report by stating that “social injustice is killing people on a grand scale and constitutes a greater threat to public health than a lack of doctors, medicines or health care services”\(^6\). The general conditions in which people live and work have a major impact on health outcomes. These “social determinants of health” comprise, among others, socioeconomic development, working conditions, education, housing, sex and high-risk behaviour\(^7\). Health care is just one of the factors to influence health and can therefore only constitute part of the solution.

### 2.3. THE NEED FOR STRONG HEALTH SYSTEMS

There is broad recognition, however, that the health care system constitutes an important determining factor for health, mainly due to its ability to increase or reduce inequalities in terms of health and exert a positive influence on the broader socioeconomic and political context. Polarised debates have taken place on what the appropriate strategy is for designing health care systems and putting them into practice during the 20th century. In the international sphere, health strategies were divided into two approaches, known as “horizontal” and “vertical”.

Before 1960, the international health community concentrated its work on the “vertical programmes” in less developed countries, essentially focusing on treating specific diseases, such as eradicating malaria. After 1960, it became abundantly clear that disease-specific intervention could only work if it were backed up by the widest possible provision of basic health care. Even in 1966, Halfdan Mahler (who went on to become Director General of the World Health Organisation) declared that all communicable disease campaigns have overwhelmingly demonstrated that only through falling back on strong basic health services in developing countries is it possible to achieve an effective consolidation of these campaigns\(^8\). Within the main global institution for health in the United Nations, the WHO, awareness has been growing due to the fact that the population’s health did not seem to be improving significantly through parallel programmes which were all independent from one another\(^9\).

### 2.4. THE ALMA-ATA DECLARATION

The calls for a more horizontal approach, i.e. one more focused on bolstering the health care system, led in 1978 to the “Alma-Ata Declaration on Health for All by 2000”\(^10\). The Alma-Ata participants identified
primary health care as the cornerstone of better-integrated health care systems. Leaders from across the whole world also agreed on the fact that improving the community’s participation and developing intersectoral collaboration formed the necessary basis for dealing with social determinants on health in an effective manner. The WHO attempted to promote the Alma-Ata Declaration. At the beginning of the 1980s, however, the institution became mired in financial crisis due to the freezing of financial contributions paid by its members from high-income countries. The WHO’s budget then became more dependent on funds raised through private donors, thereby creating a return to the focus on vertical and disease-specific intervention.

During this time, throughout the 1980s, international financial institutions (the World Bank and International Monetary Fund) were implementing their structural adjustment programmes. These turned out to be “a cure worse than the disease” by bringing about the privatisation of public services and health systems in developing countries. Towards the end of the 1980s, the World Bank began engaging more and more in health reforms that were “profitable” and market-oriented, as clearly announced in the 1993 world development report entitled “Investing in Health”. These institutions did not adhere to the principles of Alma-Ata, which they quickly qualified as “unrealistic” and “costly”. They promised a stricter interpretation of the Alma-Ata Declaration (more “down-to-earth” in their view), paving the way for the notion of “selective primary health care”. This was characterised by a more pronounced shift towards the notion of “profitability” and promoting of specific interventions mainly focusing on children and women, named “the whole range of essential services”.

Efforts to reform the health system made by low and medium income countries during the 1980s and 1990s led to massive cuts to public health spending, and at the turn of the new millennium the majority of health systems in developing countries lay in tatters, with poor infrastructure, unmotivated health workers, a decrease in resources and increased penetration of the private sector. Several governments decided to implement a programme of reforms which served to increase the costs shouldered directly by the patient for the services (out of pocket payments), thus exposing the population to a greater risk of financial impoverishment when accessing health services (see the following chapters for further information). It is generally accepted today that this programme of reforms had terrible consequences in terms of health equity.

2.5. UNIVERSAL HEALTH COVERAGE (UHC)

At this point in time, universal health coverage is considered the concept of public health with the greatest potential to redress the balance within health care systems. The WHO defines UHC as “access to health services, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship”. UHC is a “concept that is deeply rooted in its 1946 Constitution, which declares health to be a fundamental human right”.

The World Health Report in 2010, “Health systems financing, the path towards universal health coverage”, illustrates the concept of the “UHC cube” (see illustration). UHC is designed as a three-dimensional system that progressively moves towards: i) the coverage of the entire population by a package of services, ii) inclusion of an increasing range of services, and iii) a rising share of pooled funds as the main source of funding for healthcare, and thereby a decrease in co-payments.

This model is gaining in popularity and the current discourse on UHC is dominating the majority of international discussions on health care. UHC is presented as the response to urgent needs in health in low and medium income countries. Some enthusiastic backers have named it the “third great transition” in health, by changing the way in which services and the organisation of systems are financed. Increasingly, it is being heralded as “an affordable dream” with the potential
to make a significant impact on people's individual and collective well-being.

This consensus translates into the words of Margaret Chan, Director-General of the WHO when she describes UHC as “the most powerful unifying single concept that public health has to offer, because you can realise the dream and the aspiration of health for every person irrespective of what class you belong to, whether you are a woman, or whether you are poor”18.

Another sign of the growing momentum: since 2010, over 80 countries have requested technical assistance from the WHO in their attempts to achieve this goal. The emerging economies of Brazil, Russia, India, China and South Africa (the “BRICS”, representing almost half of the global population) have all undertaken UHC measures. In 2012, the UN General Assembly adopted a historic resolution19 calling upon Member States to adopt policies to support UHC and, more recently, the International Labour Organisation (ILO) has joined the movement20. In September 2015, global leaders signed up to achieving 17 sustainable development goals during the next 15 years. UHC is a key target (target 3.8) in achieving the third global goal: “ensure healthy lives and promote well-being for all at all ages”21.

This is all good news. We do, however, see a danger in the dominant interpretation of the UHC concept. Does UHC mean universal health insurance coverage? Or does it mean providing high quality health care for all? What role should the State play? Should we count on the private sector? On the international stage, in the first instance, the focus was placed on “sustainable financing” for UHC22. UHC is not primarily focused on the way in which health care services have to be provided, but on the way in which these services have to be financed. The fundamental principle seems to indicate that if the finances are guaranteed, the health care services could well be provided by a variety of combinations involving both the public and private sectors.

The overarching concept of UHC seems to recommend a pooling of finances for health; the same is not suggested for the provision of services. In other words, there is no proposal for a unified system of public provision. The importance of reinforcing public health care services is not part of the dominant discourse23. And we believe that it should be. As Vivian Lin, Director for the Division of Health Systems in the WHO’s regional bureau for the Western Pacific, reported in The Lancet, “Financial risk protection alone is not enough. Early national discussion on quality, approachable compassionate care, cost of services, and user-friendliness are all crucial – without which UHC is meaningless”24.
2.6. A GLOBAL TREND: THE COMMERCIALISATION OF HEALTH CARE

With the majority of public systems in complete disarray (due in part to structural adjustment programmes), an attractive option for governments consists of choosing not to rebuild public systems but to outsource the provision of health care and to resort increasingly to private /for profit providers. The logic is that the catastrophic impact of direct payments made by the user (so called “out of pocket payments”) requires an immediate solution and, given that the public system is too weak to respond, it is more strategic to turn to the private sector. The UHC model therefore offers the possibility of choosing to open up a country’s health system to private providers rather than considering the public provision of services as a pillar of its health care system.

Despite the facts clearly indicating that the market is not succeeding in offering equitable provision of health care services (see the chapter on services), the commercialisation of health care services has become a global trend. Commercialisation is now an integral part of the policies of several (developing) countries and international institutions with influence. The International Monetary Fund (IMF), for example, has recommended that countries increase the scope of private sector supply in health care within the framework of loan conditions, often to reduce the public debt. Equally representative of this trend, the Agenda for Change in development cooperation in the European Union encourages greater involvement of the private sector. This document indicates that “The EU should develop new ways of engaging with the private sector, notably with a view to leveraging private sector activity and resources for delivering public goods”, including health care.

These trends constitute a barrier to universal access to quality health care as seen by the detailed examples in the rest of this report. The report’s different chapters address the impact of commercialisation on availability, accessibility, acceptability and the quality of several fundamental elements of health systems: the provision of services, access to medicines and technology, human resources and financing. Finally the main challenges are covered in the conclusion and are accompanied by some policy recommendations.
Philanthropic foundations devote some 7 to 10 billion dollars to development aid each year\(^2\): significant sums when compared to the public aid spending of States. Belgium, for example, spent 1,844,388,000 euros on public development aid in 2014\(^3\). Philanthropic foundations, however, are not content with being donors, they are using their financial capacity increasingly to exert influence on the global development agenda, especially in the domain of health, and without any democratic controls. Several voices are calling for greater transparency regarding those who hold positions on the boards of these foundations, in order to be able to identify any potential conflicts of interest more readily.

Set up in 2000, the Bill and Melinda Gates Foundation is the most active in the field of health. Just as the Rockefeller Foundation did back in the 1930s, it places a strong emphasis on biomedical solutions. Furthermore, whilst the Gates Foundation supports all players in health, from scientists to international organisations, the majority of its contributions go to public-private partnerships (PPP).

According to a study by Eurodad\(^4\), the sums invested globally in PPPs in developing countries have been multiplied by six from 2004 to 2012, going from 22.7 to 134.2 billion dollars. With regard to the 80 to 85% share of public financing in these investments, this increase seems less determined by States’ lack of funds than it does by companies seeking profitable investments. On the one hand these types of investments are complex, difficult to control and often come at a risk for public institutions. On the other hand, they rarely serve the best interests of those who are poorest.

The initiative Health in Africa (HIA) is one such PPP in which the Gates Foundation has invested alongside the governments of France, Japan and the Netherlands. Launched in 2008 by the International Finance Corporation (IFC), the private sector arm of the World Bank, this initiative aims to encourage African governments to harvest the private sector’s potential in the domain of health care\(^5\). In a study evaluating the initiative\(^6\), Oxfam demonstrates that it is very unlikely that it is able to offer better access to health care to poorer populations. The information publicly available shows that the investments made mainly concern urban hospitals which are costly and towards the upper end of the range, which offer tertiary (specialised) care to the richest citizens in African states and to expatriates.

Hence, global governance in health is also becoming increasingly privatised, via philanthropic foundations and the multiplication of PPPs, which raises many questions in terms of transparency of decision-making, development relevance of decisions and approved projects and democratic control.

**BACKGROUND INFORMATION**

**TOWARDS THE PRIVATISATION OF GLOBAL GOVERNANCE IN HEALTH**
CASE

COMMERCIALISATION OF HEALTH CARE IN PERU

In this case, we will examine the availability, accessibility, acceptability and quality (AAAQ) of health care in Peru and briefly outline the influence of the commercial private sector on the care provided.

1. ACCESSIBILITY:
ACCESS TO HEALTH CARE

ECONOMIC ACCESSIBILITY (AFFORDABILITY)

26 million Peruvians (out of a population of 31 million) are currently affiliated to health insurance schemes in the public sector. The 2009 law on universal health insurance prioritises as many Peruvians as possible signing up to insurance plans. Whilst more and more people are insured on paper, real access to the necessary health care is not yet guaranteed and is certainly not equal.

The law classifies Peruvian citizens into 4 categories.
1. 1 million Peruvians are affiliates of private insurance companies which spend 650 euros per patient per year.
2. 10 million Peruvians are affiliated to the health insurance fund EsSalud, the fund into which employers and workers with formal employment pay contributions so as to benefit from full health care coverage. EsSalud spends 200 euros per year per patient.
3. 16 million Peruvians are affiliates of SIS, the health insurance fund that does not offer full health care coverage but several “basic plans” for poor and vulnerable groups, according to different sub-categories. SIS only spends 90 euros per patient per year.
4. 4 million Peruvians are not insured at all and have to pay all costs out of their own pockets. This category includes several groups: people with handicaps, older citizens, indigenous people and other marginalised groups of society.

Despite the growing number of people with insurance, there is a major economic obstacle standing in the way of real access to health care. In reality, affiliates of EsSalud and SIS only have access to public facilities. Because these are often insufficient, they still have to rely on private sector facilities and have to pay these costs themselves. These ‘out of pocket payments’ represent an average of 200 euros a year and up to 2.2% of the gross domestic product, whereas the public authorities only allocate 2.1% of GDP to health and the contributions made by employers and employees to EsSalud amount to 1.7% of GDP.

PHYSICAL ACCESSIBILITY

Access to health care for the population in rural areas remains very limited due to the lack of roads and means of transport in areas that are remote and difficult to access along the Andes and the Amazon forest. This is a problem that affects approximately 25% of the population.

Over 80% of specialist doctors work in only 3 regions out of 25 (Lima, Arequipa and La Libertad). In all other regions, patients barely have any access to specialists. Ultimately the private sector sees no financial interest in remediating the shortage of services in rural areas: they are difficult to access and profits are (almost) non-existent.
2. AVAILABILITY: 
AVAILABILITY OF HEALTH CARE

The number of public health establishments in Peru is not enough to take care of the real health emergencies. According to the estimates, the public health system would need at least 24,000 additional hospital beds, which would come at a cost of some 15 billion euros. Here we are not taking into account the costs linked to improving the equipment of primary health care centres, despite the drastic needs in this area. The numbers of medical staff in Peru correspond to just over half of that prescribed by the World Health Organisation (WHO), which is 23 doctors and nurses per 10,000 inhabitants.

In the private sector we are witnessing the uncontrolled and chaotic proliferation of all types of lucrative practices, both as far as service provision and insurance are concerned. The Ministry for Health is no longer in control of the sector and is no longer in a position to determine the range of services the sector provides nor how it is financed.

Furthermore, the public health care system itself is feeding into the emerging commercialisation of the sector. The two public bodies EsSalud and SIS are not complementary in terms of insufficient supply, which would nonetheless be a welcome development, especially for emergencies. EsSalud and SIS work with the private sector, essentially in two ways: through uncontrolled purchasing of services in the private sector and through public-private partnerships (PPP).

SIS devotes approximately 3% of its annual budget to purchasing services from private clinics and other market players. This may apply to hospitalisation, treatments, diagnosis, rental of medical materials or the buying of medicines which are not available to public health centres. EsSalud devotes 20% of its annual budget to private providers. Three-quarters of this is allocated to the purchasing of services and a quarter to paying for two hospitals that are managed by Spanish private enterprises as part of a PPP scheme.

3. ACCEPTABILITY: 
ACCEPTABILITY OF HEALTH CARE

In Peru health care is delivered according to a strictly biomedical approach in which the doctor does not take the time to consider the patient’s living situation or any mental health problems. On the contrary, in the doctor’s eyes, the patient is a physical machine that needs to be prescribed treatment (costly) or medicines without explaining exactly what the nature of the problem is.

The system in which public and private services are competing appears to promote practices that run counter to ethics. Many doctors in the public sector attract patients to their private practice with the promise of faster and better quality health care. Those who are insured in the public sector are very often left waiting for their care in vain as their doctor is busy at his/her private practice.

The private sector derives a large share of its high profits by attracting patients through (almost) free consultations. The aim of these consultations is to inject fear into patients and talk them into undergoing examinations, following treatment or taking medicines that serve no purpose. This is how patients often end up paying considerable sums of money out of their own pockets, which are generally not covered by their insurance.

The unnecessary caesareans practised in the private sector are a clear-cut and widely studied example. This procedure is performed in 80% of deliveries (an alarming percentage) and even 95%34 in some private clinics. For a caesarean, the doctor is able to charge a higher fee than for a natural birth. Furthermore, caesareans can be planned and generally do not take up nearly as much time. This unethical practice is plainly an attack on the health and the purse strings of countless women. Unfortunately, SIS and EsSalud also publish caesarean figures that are far too high (25% and 45% respectively). Doctors are spending less time on the delivery itself and more on expectant patients or at their private practices. In an overburdened system, time is money.
4. QUALITY: QUALITY OF HEALTH CARE

All of the problems and failures mentioned leave very little doubt about the fact that the quality of the public health system is inadequate and under pressure due to the shortage of public funds and competition from the private sector. The system has no effective procedure in place for dealing with patients’ problems or complaints, nor is there any protection against blatant errors or medical negligence.

In the private sector, there is a major discrepancy in terms of quality and satisfaction between, on the one hand, a few major insurance companies and clinics and, on the other hand, numerous cheaper centres, which are extremely precarious and lacking in basic equipment and the hygiene measures needed to take care of patients. Therefore we often hear about these in the media, following operations or treatments which have ended badly. This is possible since there are absolutely no (quality) controls in the private sector.
3. HOSPITALS FOR SALE: NOT THE BEST ANSWER TO FAILING HEALTH SERVICE PROVISION

3.1. PUBLIC AND PRIVATE, WHAT’S IN A NAME?

Who is best placed to deliver quality health care services if we want to achieve accessible, good quality health care for all? Public or private providers?

There is no easy answer to this question, firstly because defining what is private and what is public is complex. Private providers are heterogeneous, consisting of formal for-profit entities such as independent hospitals, individual care workers working on a self-employed basis, informal entities that may include unlicensed providers, and not-for-profit providers, such as community and social enterprises, non-governmental organisations, civil society etc. In many countries, individual health workers, like doctors, are often self-employed, but hospitals and health centres are mostly (or all) in the hands of the government or run by social, not for profit, organisations. Elsewhere, health services are provided by a mix of for profit and not for profit enterprises and institution, subsidised by the government or otherwise.

So, we can’t make a simple distinction between public and private, but we can say that there are some clear structural reasons why for-profit health care and competition do not promote efficiency or quality, and impede universal and equitable access to health care. There are specific cases to illustrate this further, elsewhere in this report.

3.2. DIFFERENT GOALS

There are substantial differences to be made between public or not for profit providers on the one hand and commercial service providers on the other. While the commercial sector’s primary goal is to maximise profits, public health services aim to cater for the population’s basic needs. Public health services are not in a good position to compete, because (in principle) they have to provide services also to the people that have the highest needs and the least purchasing power, e.g. the poor, the disabled, the elderly, the unemployed, migrants; in short, people that have a harder time in society.

There are significant marginal costs involved in delivery of care to the most in accessible or the most disadvantaged sections of the population. Health services for those with pre-existing chronic conditions are often relatively more expensive, as is the treatment of rare diseases. Not-for-profit systems based on solidarity and with sufficient financial means can absorb these marginal costs and spread them across an entire population. For-profit systems would typically attempt to exclude those who have special needs or are otherwise disadvantaged.

Public health services are therefore generally not profitable. Commercial services on the other hand focus on the people that can afford them; what you pay is what you get. The defining characteristic of a company is that it should make profits for its shareholders, whose goal is to see their investments grow. They are profitable, but they do not provide universal access to quality health care. To make services profitable, commercialised institutions usually charge high user fees. These result in catastrophic health expenditure. Or
they only accept patients with sufficient medical insurance to cover the fees. In both cases, this reduces the access to health care and thus form a major financial barrier in access to health care.

In a mixed system with public and private health care providers, there are potentially serious implications for equity in health care access. We see how current public-private partnerships leave the public sector with diminished revenues and the responsibility to care for the poorest. In short: the weakened public sector bears the risks while the private sector gets the profit. This is shown in the case of Lesotho (p. 19).

By consequence, the biggest risk of commercialisation of health services consists of the creation of a two-tier system with mainly private, highly technological and specialised care, with qualified health workers, for the affluent few and basic, under-funded, public health services for the poor. Because of this, the poor in rural and urban areas would have less access to quality health services. A two-tier health system raises serious concerns of equity and social justice in health care access. On top of that, the health system, being an important social determinant of health equity, can increase or reduce inequities in health outcomes.

3.3. IMPACTS OF HEALTH SECTOR COMMERCIALISATION ON QUALITY, EFFICIENCY AND AVAILABILITY

1. QUALITY

It is often stated that commercial health care providers would be in a position to offer better quality. However, if “quality care” is understood as “offering the best treatment according to the diagnosis, based on evidence and international treatment guidelines”, then this is not necessarily the case.

For example, in Peru and Chile higher rates of potentially unnecessary procedures, particularly caesarean sections, were reported in private-for-profit settings after privatisation of obstetric services. This is disturbing since caesareans should only be performed upon medical advice because they entail more health risks for the mother. In other cases competition harms collaboration between different providers, often an important ingredient of good quality care, especially in relation to referrals between different kinds of specialists or between different levels of the health care system.

2. EFFICIENCY

Outsourcing health services to the private-for-profit sector does not always seem to increase efficiency either. We understand “efficiency” as “producing the best possible results with the available budget”. The necessity of prevention clashes with the commercial logic that has to sell to survive. Who doesn’t get sick, doesn’t need treatment, doesn’t bring in money. Outsourcing healthcare to the commercial sector in China (still remembered for its former “barefoot doctors”) has led to a decline of less profitable preventative health care; immunisation coverage dropped by half in the following five years. The need to make profits also pushes for-profit providers to apply expensive, complex and often unnecessary treatments, as shown in the case of Peru. It also leads to a biomedical bias,
The non-commercial sector is highly developed in our country compared to other countries such as France. Other countries are seeing a distinct shift towards profit-making private players. In Germany, for example, in 2013, 59 hospitals changed their status from charitable to profit-making! Multinationals in health are also springing up in Eastern Europe.

Although hospitals, both public and private, have been substantially financed through public means (over 90%), the trend seems to be towards reducing the State’s commitments. Economic profitability then enters the hospital via the independent administrators on management committees who view the hospital as a business with financial ratios that have to be respected. This tilts the process in favour of profitable services, or preferred sub-contracting35, in an attempt to maintain the balance. One other way of increasing the financial returns is to attract a wealthy clientele from abroad. The not-for-profit association Healthcare Belgium36, founded in 2007, is a grouping of Belgian hospitals and several private companies specialising in medical technology. Its main ambition is to showcase the value of Belgian health care abroad. Agreements have been signed with certain countries in the Gulf region, Kazakhstan, Azerbaijan and more recently Russia.

Another example of twin-speed medicine: shortening waiting times by offering consultations in a private practice for a surcharge. In outpatient care, there is also an increase in the number of private doctors in certain specialist fields. In 2013, this was the case for 68% of dermatologists, 59% of plastic surgeons, 56% of ophthalmologists and et 51% of gynaecologists and obstetricians.

The danger of privatisation is more on the outpatient side than in the hospital sector as, on the one hand, fee supplements in hospitals have been managed since January 2013, at any rate for shared wards and rooms with two beds. This has generated major tensions with doctors but is a significant victory for access to care. On the other hand, optional hospitalisation insurance policies (which over 60% of Belgians subscribe to) mainly cover hospital costs37.

One problem remains nevertheless, that of the dramatic fluctuations between hospitals in single-room supplements (from 100% of the Inami rate to 300-400%) and the lack of transparency in these rates. This creates competition between hospitals to attract doctors and fee uncertainty for patients.
Commercialised health care systems also have higher transaction costs, required to manage or regulate the market, while public systems are more efficient because they ensure economies of scale in the purchasing, supply and distribution of drugs and equipment. They are also best placed to avoid wasteful capital investment, duplication of equipment and services, and an emphasis on frills that are endemic to hospitals in a competitive market environment.

3. AVAILABILITY

A lack of public infrastructure in rural areas is a barrier to geographical availability. With increasing pressure for commercialisation of health services, it is important to note that the private sector invests mostly in specialised secondary and tertiary hospitals in cities. Rural areas and preventive primary health care are being overlooked by the for-profit sector.

In addition, outsourcing of health care provision to commercial investors is detrimental to the public sector by diverting away scarce resources. One example is how the presence of the private for-profit sector in a country or medical tourism industries in neighbouring countries are enticing health workers away from the public sector by offering higher salaries, for which the Philippines case (p. 20) is exemplary.

3.4. HEALTH IS A CHOICE

Public systems perform a broad range of public health tasks that are not directly linked to providing care. It can be argued that an array of private providers could offer these services if robust regulatory mechanisms imposed conditions that mandated private providers to do so. In practice, however, public goods such as mass coverage, public awareness, community outreach and emergency services are more effectively provided through public programs rather than the sum of regulated private programmes.

To guarantee social protection, health systems should promote equity, accessibility, quality and efficiency. People’s wellbeing should always be prioritised. Economic development should be no more than a tool to help achieve human development. Because of the risks for equity in access to quality health care, we oppose the commercialisation of health care services. Moreover, it is in sharp contrast with the vision of Primary Health Care envisaged in the Alma-Ata declaration of 1978, which calls for the building of health systems that would provide comprehensive care, would be integrated, organised to promote equity and driven by community needs.

Health systems that rely mainly on public provisioning and financing of health care perform better in terms of equitable access. A single public system also seems to perform better in terms of efficiency, while more privatised systems are more fragmented and incur more transaction costs.

Governments need to refrain from committing health services to commercialisation. Additionally, because of the market failures in health care and the proven impact on access to health care, there should be a carve-out for the health system in trade and investment agreements, enabling the state to safeguard health care access.
CASE

PUBLIC-PRIVATE PARTNERSHIPS IN LESOTHO: A DANGEROUS DIVERSION

In a joint 2014 study with the Consumer Protection Association, Oxfam provided an update on the dangers associated with public-private partnerships (PPP) in health by analysing the case of a hospital being built in Lesotho. This case in particular illustrates the fact that PPPs often engage public funds in costly and financially-risky projects which do not benefit the people most in need and do not support the objective of universal and equitable health coverage.

LESOTHO

Lesotho is a very poor country which sees half of its population living beneath the poverty threshold and ¾ of the population living in rural areas where very often health care does not exist due to investment shortages and where the poverty rate is 50% higher than in urban areas. Lesotho has the third highest HIV prevalence rate in the world.

A NEW HOSPITAL

The World Bank’s investment arm, the International Finance Corporation (IFC), advised the Lesotho Government on negotiations of a PPP signed in 2009 in order to replace the old hospital with the Queen Mamohato Memorial Hospital which opened its doors in 2011 and has 425 beds.

The IFC considers the first PPP of its kind in a low income country as a model to be replicated across the whole continent.

THE CONSEQUENCES

The promise of greater effectiveness at the same cost, however, was not kept and the project is rapidly turning into a nightmare. The private (for profit) Consortium Tsepong Ltd won an 18-year tender for the construction and operation of the new hospital: the consortium supplies the clinical services and employs the staff for the State and enjoys a 25% return on investment. At the end of the contract, the hospital becomes the government’s property. This PPP is turning out to be economically disastrous for the State of Lesotho. The running costs and loans are costing the State 67 million dollars per year or 51% of the country’s health budget, i.e. it is three times more expensive than the old hospital. According to economic forecasts, it will cost 7.6 times that of the old hospital by 2026. Given the PPP’s exploding costs, the Lesotho Government has proposed an increase in the health budget by making cuts to the budgets for agriculture and education.

There is also widespread disappointment on the medical performance front. The new hospital has managed to cut the maternal mortality rate in the capital by 10%, but rural areas are being overlooked and infant and maternal mortality rates are rising: four times more pregnant women are dying than the national average. This PPP is a dangerous diversion of public funds, already in short supply, which were previously going towards providing primary health care services in rural areas.

The IFC has a heavy responsibility to bear in this fiasco as the advice it has provided to the State has neither been judicious nor effective: the costs of the PPP increased whilst the contract was being negotiated which worked in the favour of the private partners.
CASE

THE PRIVATISATION OF HEALTH IN THE PHILIPPINES

Today, 8 people out of 10 in the Philippines report never having had a medical check-up or physical examination in their life. 28% of all Filipino women do not enjoy skilled birth attendance. Health care utilisation rates in the Philippines show worse access to health than the regional average. The primary reason is a lack of financial means for the majority of the population. Free health services are very limited and the poorest cannot afford medicines or treatment. Due to poverty, 6 out of 10 people die without ever having seen a doctor.

PUBLIC-PRIVATE PARTNERSHIPS’ PROMISES

With the ‘Philippine Development Plan’ (2011-2016), the government of President Aquino embarked upon two major strategies to supposedly rescue the ailing health system. The first is the expansion of the National Health Insurance Programme Philhealth. The second consists of further corporatisation and public-private partnerships in the health sector. This is not new, but an intensification of policies since the 1990s.

The strategy behind the policy advances a smaller government role and privatisation of health services with hospital corporatisation, medical tourism and opening up for local and foreign corporations in health service provision. By outsourcing public hospitals to the commercial sector, the goal is to reduce government spending, while improving public health outcomes. The Aquino government claims that these public-private partnerships (PPP) are the only alternative to meet health needs. A choice heralded by the European Union: the latest Philippine-EU Strategy Paper (2007-2013) stated that “further privatisation is critical and urgent”, and supported the market-friendly health reform by a €33 million contribution.

UNAFFORDABLE HEALTH SERVICES

Together with increasing privatisation, the government gradually reduced its allocation to health services. When the plan was implemented, the budget for the health sector went down from 1.57% to 1.31% of GDP. Consequently, there have been budget cuts for maintenance and other operating expenses of public hospitals and a zero budget for capital outlay for hospitals targeted for corporatisation and public-private partnerships. Forced to survive on a limited budget and to demonstrate its financial viability to potential private investors, these hospitals, in the meantime, progressively increased their service fees.

The cost of care has risen exorbitantly due to commercialisation. According to the Philippine Department of Health 60% of the country’s hospitals are privately owned, while the WHO estimates that only 30% of the population can afford health services from the private sector. Local think-tank IBON reports that the total cost for transport and treatment at a private facility is sometimes five times the cost of transport and treatment at a public facility.

HIGH OUT-OF-POCKET PAYMENTS

Coverage of health services in the Philippines is much lower among people living in poverty or who did not benefit from having an education. The poorest two-thirds of the population use public facilities, especially Rural Health Units and village health centres. In com-
Social Protection Campaign

comparison, only one-tenth of the richest quintile use these facilities, favouring private hospitals and clinics. However, the availability of public health services remains very poor in the Philippines, with large urban-rural disparities. Moreover, public facilities are mostly crowded, lack equipment, are inaccessible in distance, and lack health personnel and medicine.

The average costs of hospital admission are equivalent to 167.5% of the monthly salary of a minimum wage earner. Philhealth covers only a limited service package. In 2013 out-of-pocket expenditures in the Philippines accounted for 57% of total health expenditure. In 2010, this was 53%.

According to IBON, PhilHealth will not prevent costs of medical services from rising once a public hospital is privatised. If health care prices increase, PhilHealth coverage contributions will also grow: “For as long as the health care provision remains neglected, the expanded coverage of PhilHealth is useless. Social health insurance must be based on a strong health infrastructure and service delivery.” The main reason is that the outsourcing of health care to commercial investors comes at the expense of the public sector. It is diverting resources away from the public sector, for example, by enticing health workers away from the public sector by offering better working conditions and higher salaries.

SUCCESSFUL CAMPAIGNS: CIVIL SOCIETY WINS FIGHT AGAINST PUBLIC-PRIVATE PARTNERSHIP APPROACH

How the PPP-policy often prioritises profit above equal access to services is shown in the case of the Philippine Orthopaedic Hospital. This was the first hospital to be corporatised following the plan. Under the winning bid, the hospital is allowed to reduce beds allocated for indigent patients from current 562 to 70 to prioritise paying patients. Employees also face the possibility of losing their jobs due to retrenchment.

In October 2014, the civil society campaign successfully managed to have a court ruling a Temporary Restraining Order for the privatisation of the Philippine Orthopaedic Centre, on the basis of provisions in the constitution of the Philippines on the right to health. Combined with greater awareness among the health sector and general public, this resulted in a victory. In November 2015, Megawide, the company that was contracted to run the new hospital, terminated the agreement. The Alliance of Health Workers (AHW) reacts: “For four years, an arduous and comprehensive campaign was launched that involved many actions. This victory is the fruit of these struggles. But our people’s right to health is still continually in peril because of policies that commodify health.”

CONCLUSION

The Philippine public-private partnership approach does not resolve the problem of financial barriers to health care access for the majority of people. On the contrary, it results in higher user fees and higher costs. The case of the National Health Insurance Programme, PhilHealth, shows that a highly subsidised social health insurance alone cannot achieve universal access to health services if other health system aspects undermine health outcomes.

According to local organisations – IBON, Gabriela, Council for Health and Development and The Alliance of Health Workers (AHW) – providing health services to the people, especially the poor and vulnerable is one of the fundamental functions of government. This function should not be subject to the profit motive and other influences.
Access to medicines and medical technology is one of the essential elements in determining access to and quality of health care. Over two billion people do not have regular access to essential medicines, with the price of medicines constituting a major hurdle for low and medium income countries. These countries have an even greater need for affordable medicines as they are faced with a dual “health burden”: treating infectious diseases such as HIV/AIDS, hepatitis C or malaria, combined with the scourge of non-communicable diseases such as cancer or diabetes. According to the World Health Organisation (WHO), 80% of deaths linked to these diseases occur in low and medium income countries.

Access to medicines at an affordable price is a key factor in addressing these challenges in developing countries, where a large part of the spending on health is allocated to pharmaceutical products. Furthermore, sick people often have to pay for medicines out of their own pockets as there is no public health system like there is in Belgium, through which medicines are paid for or reimbursed by health insurance with a State contribution.

This means that pharmaceutical companies have a heavy responsibility when setting the prices of their products. Recent years have seen prices steadily rising for new medicines coming onto the market such as cancer-fighting drugs, for example, where prices can sometimes reach the astronomical sums of over 100,000 euros per treatment. Rules on commerce and free trade agreements (FTAs) have a direct impact on the prices of medicines as we will go on to see, and can lead to the economic and financial interests of pharmaceutical giants taking precedence, at the expense of the right to health care.

4. COMMERCIALISATION OF MEDICINES AND INTELLECTUAL PROPERTY RIGHTS

4.1. THE ROLE OF GENERIC MEDICINES

One of the key factors in bringing down the price of medicines is competition between producers and the bringing to market of generic versions of brand-name drugs. Since 1995, the TRIPS agreement (Trade Related Intellectual Property Rights) has governed intellectual property rules at World Trade Organisation (WTO) level. It also provides a patent offering a 20-year monopoly for new medicines. The excessive protection of intellectual property rights is acting as a barrier to competition and research and development (R&D) by state laboratories which limits the access to medicines and the development of a local pharmaceutical industry.

In order to protect health from the wrongdoings from excessively strict intellectual property rules, the TRIPS agreement provides some areas of flexibility, notably a derogation so that the least developed countries do not have to implement provisions on pharmaceutical patents before 2033.

The fight for access to generic medicines in South Africa at the end of the ‘90s marked a turning point in the awareness of the potential risks posed by intellectual property on health and this was depicted on the big screen in the documentary ‘Fire in the Blood’. This legal battle saw patients suffering from HIV/AIDS and health activists going head to head with a coalition of 39 pharmaceutical giants. They were appealing against the decision of South Africa’s government to import Indian generic medicines to treat the 4.7 million South African citizens suffering from HIV/AIDS, under the pretext that it was an infringement of the TRIPS agreements. This episode, which shed light on the supremacy of profits over patient health, shocked the world and led to the WTO producing the...
Doha Declaration on the TRIPS agreement and public health63. It stated that public health had to prevail over intellectual property rules in their interpretation and their implementation and reaffirmed the areas of flexibility provided for by the TRIPS agreement.

India, once nicknamed the “pharmacy of the developing world” played and continues to play a crucial role in falling medicine prices in the developing world. The country has opted for a balanced intellectual property system which protects public health and only grants patents where there is genuine innovation. This allowed India’s generic pharmaceutical industry to supply 20% of generic medicines in the world and 80% of all medicines used to treat HIV/AIDS. The price of first generation antiretrovirals went from 10,000 dollars per patient per year to 100 dollars thanks to competition from India64 and allowed over 5 million patients to benefit from this treatment.

This vision of intellectual property, however, is not the object of consensus and particularly irritates the pharmaceutical companies, as seen by the legal saga between the pharmaceutical company Novartis and the Indian State. On 1 April 2013, India’s supreme court definitively rejected the patent application submitted by the company concerning its cancer treatment Glivec, making the generic version available which was fifteen times less expensive than the original. This decision also confirmed that Indian intellectual property rules complied with the TRIPS agreements, which had been repeatedly called into question by Novartis since 2006. This historic victory confirms that only the truly innovative medicines with therapeutic added value are protected by patents and puts public health before commercial interests.

This episode shows that low and medium income countries that put public health first in their interpretation and implementation of intellectual property have some major legal or political hurdles to face. Thailand, for example, was called to order in 2007 by the European Commissioner for Trade Peter Mandelson after having used the points of flexibility in TRIPS to circumvent a patent process for reasons of public health65. The country still appears alongside India on the American “watch list” which lists the countries the USA considers to be lagging behind in terms of intellectual property66.

4.2. WHEN EUROPEAN TRADE POLICY IS SERIOUSLY DAMAGING TO HEALTH

Within the WTO, the advanced liberalisation of international trade is being met with increasing levels of resistance from developing countries and is seeing multilateralism waning. For over a decade, the United States has been opting to enter into bilateral trade negotiations with several countries or regions of the world. The European Union (EU) has also started to get several free trade agreements (FTAs) underway in particular with India, Thailand, Canada and the United States and with one signed with Vietnam in December 2015.

For the EU, the TRIPS agreement does not go far enough with regard to the protection of intellectual property, which is considered a tool that promotes the R&D of pharmaceutical companies and fosters economic growth and job creation. This is why FTA negotiations with partner countries or regions systematically contain a chapter aimed at reinforcing the protection of intellectual property abroad. Behind the States’ positions, it is mainly the positions of the pharmaceutical industry that are to be found driving them. As part of the Transatlantic Trade and Investment Partnership (TTIP), a document drafted by the American pharmaceutical industry revealed its desire to increase protection for intellectual property and harmonise patentability standards based on the American model, making it easier to obtain patents68.

These rules which reinforce monopolies and limit competition are nicknamed “TRIPS-plus” as they go beyond what is stated in the TRIPS agreements and may take the form of69:
• **An extension in the patent’s protection period** beyond the 20 years stated in the TRIPS agreement;

• **Data exclusivity (5 to 10 years according to the treaties)** which prevents a producer of generic medicines, for a certain number of years, from referring to the results of clinical trials which served to justify the bringing to market of the original product, even if there is no patent or if it has expired; this measure de facto obliges a generics company to produce testing data if it wishes to place a medicine on the market and therefore to conduct new studies. The consequence is the de facto extension of the monopoly, thus restricting the access to medicines;

• **Sanction measures for failing to respect intellectual property rights**; the European Commission (EC) is even contemplating excluding from EU-funded programmes any countries which repeatedly infringe intellectual property rights;

• **Customs measures** such as seizures of medicines on European borders whenever customs agents consider an intellectual property right has been infringed; 19 shipments of generic medicines from Brazil and India heading towards developing countries were unjustly seized between 2008 and 2009, as they were mistaken for counterfeits.

The pharmaceutical industry would also like the right to review decisions made by governments regarding the setting and reimbursement of medicine prices, which risks reducing the leeway that States have for controlling spending on medicines.

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### 4.3. INVESTOR – STATE DISPUTE SETTLEMENT

The mechanisms aiming to protect investor rights are also highly controversial and have some bearing on how medicines are marketed. Since the Lisbon Treaty, the European Commission systematically states in FTAs that it negotiates a settlement mechanism for investor-State disputes. This allows companies which believe that their profits and rights as investors have suffered by a measure, law or other provision laid down by a State to seek legal redress for the damages they have incurred via an arbitration system which is often opaque and subject to conflicts of interest.

Public health measures risk being called into question via this system. The decisions taken by the governments of Australia and Uruguay to introduce new regulations on cigarette packets in order to tackle tobacco addiction were challenged by the tobacco giant Philip Morris using such mechanisms inserted into bilateral investment treaties. In turn, the American pharmaceutical company Eli Lilly questioned Canada’s decision to invalidate the patents of two of its medicines due to a lack of real innovation via the settlement mechanism incorporated into the North American Free Trade Agreement (NAFTA). The multinational is demanding 500 million Canadian dollars from the State of Canada in damages and interest.

Inserting this type of mechanism confers disproportionate power to companies and risks acting as a deterrent to making decisions that could possibly be called into question by companies, such as using the points of flexibility in TRIPS to circumvent a patent for public health reasons. Even if a State emerges as the victor, its public finances will have taken a hit. The Organisation for Economic Cooperation and Development (OECD) has calculated that legal costs and arbitration cost an average of 8 million dollars and in some cases can rise as high as 30 million dollars.
COST OF REINFORCING IPRS

Several studies have quantified the costs of reinforcing intellectual property. Between now and 2030, prolonging the duration of patents could increase Colombia’s spending on medicines by almost 280 million dollars; data exclusivity rules could trigger an increase of over 340 million dollars. Data exclusivity in the FTA between the United States and Jordan that was signed in 2001 delayed the bringing to market of generic medicines for 79% of the medicines analysed and increased the prices of medicines by approximately 20%. The availability of generics would have allowed Jordan to save between 6.3 and 22 million dollars between 2002 and 2006 in spending on medicines. Thailand also risks having to pay for TRIPS-plus measures: a study estimated that data exclusivity and extending the duration of patents could increase the price of medicines by 32% between now and 2027.

4.4. BELGIUM: PHARMACEUTICAL PARADISE AND ONE OF THE LARGEST CONSUMERS OF MEDICINES

Belgium is not spared from the problem of spiralling medicine costs either and has every interest in ensuring that trade policy and policies on medicines do not make a bad situation even worse. Pharmaceutical spending is indeed very high in our country; it represents 16% of total spending on health, or almost 6 billion euros. Medicines also represent the lion’s share of the costs paid by patients. In 2012, spending on pharmaceuticals in Belgium amounted to 550 euros per inhabitant. From this annual bill, patients paid 218 euros (40%) out of their own pockets for medicines not eligible for reimbursement and user fees. The remaining amount, i.e. 332 euros, was reimbursed by obligatory health insurance. This level of expenditure per capita places Belgium among the leaders of the pack in terms of medicine consumption. By way of comparison, in the Netherlands, for the same period the total expenditure was 401 euros per inhabitant and patients only paid 85 euros (21%) out of their own pockets.

Over the last twenty years (1990-2010), pharmaceutical spending has increased by an average of 6.8% per year. This increase has been higher than that of the total health spending which saw an annual increase of 6% over the same period. So as to retain control over these spending increases, the public authorities have had a series of measures in place since 2001 aimed at promoting the provision of less expensive medicines (reference reimbursement system, prescriptions in INN (International Nonproprietary Name) in other words the non-commercial denomination of the pharmacologically active substance defined by the WHO), introduction of a quota for less expensive prescription medicines, generic substitution).

Following the introduction of these measures, it was expected that there would be a decrease in the spending on medicines. The government wanted to use these savings to finance new (often costly) medicines with a high added therapeutic value. During the same period, however, the opposite happened and there was a net increase of 4% in spending on reimbursed medicines. This can be partially explained by the introduction in the reimbursement system of new very costly specialities but in particular by the dramatic growth levels (+20% between 2008 and 2012) of the volumes consumed. Even if this increase in volume partially corresponds to better treatment for patients, concrete measures must be taken to control the volume of prescribed medicines, notably by analysing the behaviour of providers’ prescription habits and making them more aware of their responsibilities. Efforts must also be made to educate patients about more “appropriate” consumption of medicines, by following the example of the campaign launched for more suitable use of antibiotics.
When setting the price of a medicine, a pharmaceutical firm has to send to the Federal Public Service Economy a minimum price setting request for its medicine once the authorisation for placing it on the market has come through. At the same time, it may enquire with Inami, the National Institute for Sickness and Invalidity Insurance, about the possibility of the medicine being eligible for reimbursement. The final price is made by ministerial decision, following an opinion issued by the Commission for Reimbursement of Medicines (CRM) which acts as an advisory body to the Minister of Social Affairs concerning the reimbursement of pharmaceutical specialities. Theoretically, the elements that are relevant in this process are as follows: instructions for the medicine, balance between effectiveness and risks, the number of patients who will derive the greatest benefit depending on the cost, comparison with other existing medicines where applicable, etc. In practice, these bodies often follow the prices suggested by the companies.

The example of Sovaldi (S-sofosbuvir), an effective treatment against hepatitis C from the company Gilead, is particularly telling. Its production costs amount to approximately 100 euros for 3 months of treatment but its retail price puts the cost of these 3 months of treatment at 50,000 euros! An indecent price especially considering that Gilead has not developed the medicine itself nor carried out the necessary studies. It simply bought the property which means ultimately the retail cost is completely disproportionate with its research and development costs.

4.5. CONCLUSION

The range of problems surrounding access to medicines highlights the constant tug-of-war between people’s right to health and the interests of pharmaceutical enterprises. State intervention is therefore important on several levels so as to regulate the activity of these enterprises and keep the prices of essential medicines on a level that the population can afford.

In virtue of the principle of Policy Coherence for Development (Article 208 of the Lisbon Treaty), the EU Member States must avoid European trade policies hindering access to medicines whether in Europe or elsewhere in the world. The WTO’s TRIPS agreement recognises a patent for 20 years but allows certain areas of flexibility in order to put public health interests first. The EU and its Member States must support the States such as India which use these areas of flexibility. The EU must rule out of its trade agreements any “TRIPS plus” measures and the ISDS mechanisms which restrict States’ room for political manoeuvring in the area of health. With these aims in mind, the EU must ensure transparency and limit the intervention of pharmaceutical lobbyists in its trade policies.

Furthermore, the EU must commit to supporting generic competition to allow broad access to medicines in countries with low and medium incomes. To that end, it must involve itself in the technology transfer to the least developed countries to allow for the local production of medicines.

At European level, the Member States must regulate and manage the activities of pharmaceutical companies especially by putting in place a clear and sufficiently restrictive definition of therapeutic innovation giving access to a patent. It would also be interesting to promote a new ‘business model’ which would avoid a purely profit-driven approach to the final price-setting of a medicine by taking into account the real costs of research and development.
Furthermore, the EU and its Member States must support new models of innovation that are needs-based by ensuring that the innovation and biomedical knowledge derived either wholly or in part from publicly-funded health R&D lead to medical products and medicines that are appropriate, affordable and accessible.

Finally, Belgium must cease to be a pharmaceutical paradise and make available to patients medicines that are effective and safe at an acceptable cost. To that end, the prices of medicines must be decided upon in a more transparent way. Prescriptions could be made out systematically using the international non-proprietary name (INN) used by all doctors. Lastly, activities could be put in place to change the (bad) habits in terms of medicine consumption.
5. HEALTH WORKFORCE AND THE RIGHT TO HEALTH

5.1. HUMAN RESOURCES FOR HEALTH POLICY TRENDS

In its analysis of the global health workforce published in 2004, the Joint Learning Initiative on Human Resources for Health and Development (JLI) called for the mobilisation and strengthening of human resources for health (HRH) as a key strategy in combating the health crises in the world’s poorest countries and to build sustainable health systems everywhere. The JLI report marked the beginning of a brief spell when the health workforce crisis enjoyed considerable attention. The World Health Report 2006: Working together for health, and the first Global Forum on Human Resources for Health in 2008 were milestones in this development. In 2006, the World Health Report also led to the launch of a ‘decade of action’ and the creation of the Global Health Workforce Alliance (GHWA). Since then, the GHWA has tried to address the HRH governance challenges, albeit with mixed results. A major reason for this is that governments have not made, or were not in the position to make, considerable additional investments in the health workforce. There were some notable exceptions, including in some Low and Middle-Income Countries (LMICs), but in general the outcomes have been below expectations. Both within domestic and international health financing, recurrent expenditure (salaries and education) for health workers has lagged behind other health investments.

In 2010, the World Health Assembly unanimously adopted the (non-binding) WHO Global Code of Practice on the International Recruitment of Health Personnel. The WHO has recommended that the code be incorporated into national policies and laws so that it can become legally binding. However, some States have suggested that a more formal system for monitoring and implementing the code is necessary for it to become a meaningful response to global HRH recruitment. The adoption of the code, unfortunately, marked the end of a few ‘good years for HRH’ in global health policy. The health workforce crisis should be looked at in a systematic way instead of placing it in its own thematic ‘silo’.

This year WHO has developed a draft global strategy on human resources for health: Workforce 2030. The final version will be endorsed at the 69th World Health Assembly in May 2016. Workforce 2030 provides a new health workforce agenda, but will it be a progressive one?

5.2. BIG CHALLENGES

The Right to Health (RtH), as clarified in the general comment 14 on the International Covenant on Economic, Social and Cultural Rights, refers only partially to the health workforce. In contrast to universal financial affordability of health services, social health protection and universal accessibility to essential medicines this principle is not applied to the health workforce. It might partially explain why a rights-based approach to health workforce development has been so difficult in recent decades. It has actually been a major bottleneck, and relatively neglected, in advancing universal health care.
5.3. STRUCTURAL ADJUSTMENT AND FISCAL SPACE

During these decades there has been a strong push for macro-economic stability and growth in LMICs, by means of deregulation and privatisation of the economy. Conditions by the World Bank and the International Monetary Fund (IMF) on investment loans and crisis funding, forced countries to open up their economies to foreign investments, as well as reducing public spending (austerity) and imposing a strict ceiling on wage bills for public sector employees, such as health workers.

The fiscal realities that frame available public financing for health systems and health workforce salaries are shaped by such issues as untaxed wealth, capital flight, wealth inequalities, etc. This fiscal crisis (including former ‘ceilings’ on expenditure of the health workforce public wage bill, imposed by the IMF in a number of African countries until 2007) has contributed to external migration which, in turn, has brought about significant savings in training costs to importing countries.

For instance, in nine African source countries, the estimated government-subsidised cost of a doctor’s education ranged from 21,000 dollars in Uganda to 58,700 dollars in South Africa. The overall estimated loss of returns from investment for all doctors currently working in the destination countries was 2.17 billion dollars, ranging from 2.16 million dollars for Malawi to 1.41 billion dollars for South Africa. The benefit to destination countries of recruiting trained doctors was largest for the United Kingdom (2.7 billion dollars) and the United States (846 million dollars).

In 2007 the IMF itself concluded that wage bill ceilings had been overused in its poverty reduction programmes. During the period 2003-2005, 17 countries in Africa faced wage bill ceilings. All of these countries, including Malawi, Mozambique and Zambia, were and are facing serious health workforce shortages, worsened by the HIV/AIDS crises and health demands.

Its public governments could not employ new health staff during that period because of the ceilings (although the IMF argues that exceptions could have been possible for the health sector). Instead global health partnerships such as the The Global Fund to Fight AIDS, Tuberculosis and Malaria and the U.S. President's Emergency Plan for AIDS Relief initiative provided funds for NGOs and Faith Based Organisations to provide health services in parallel to the public system, which employed the health workers on private and, too often, short-term contracts.

5.4. THE EUROPEAN HEALTH WORKFORCE

In Europe at present we see that these policies are not limited to LMICs, but that the European Central Bank (ECB), EU and IMF (known as the “Troika”) have forced countries like Greece, Portugal, Ireland and Spain to reduce their public spending considerably. What impact has this had on the health workforce?

In Greece, the austerity plan approved by the Troika led to a reduction of 150,000 jobs in the public sector workforce between 2011 and 2015. The Troika demanded that public spending on health should not exceed 6% of Gross Domestic Product, which led to a 25% decrease in medical doctors employed by the central social security fund, as well as a 25% reduction in physicians’ wages. There has been a sharp increase in the people who required care but were not able to receive it. In Catalonia, there have been reports of health care services closing and cuts made to the numbers of hospital beds and working hours because of austerity. In Portugal public sector employees’ incomes were cut in 2011 and 2012. The expectation is that in Europe, with its free internal labour market, these wage imbalances might lead to an internal European brain drain.
5.5. WHO’S GLOBAL CODE OF PRACTICE: FATALLY DEFICIENT

At the 2013 World Health Assembly, when a report was given on the code’s implementation for the first time, a WHO assistant director general admitted that progress was ‘painfully slow’\(^3\). While the fact that progress in implementation has been slow is a matter of concern, it is important to underline that the code is also fatally deficient in one very important aspect. The code provides guidance on ethical recruitment, the rights of health workers and strengthening of health systems. But one obvious element is missing: that of financial compensation\(^4\). When the code was drafted in 2010 the language was watered down to make it acceptable to all WHO member states (including the powerful countries of the North which gain from health worker migration). As a consequence, the mention of compensation to source countries for the costs incurred in training migrant health workers was removed. It is time to re-politicise the discussion and much stronger instruments need to be developed to address the investment that countries have lost through external migration.

The absence of health workers in Sierra Leone and Liberia due to international migration was one of the key factors undermining an effective response by the health authorities to the Ebola epidemic. However, African countries have not been able to use the code as a negotiating tool in health diplomacy to pursue their own policy interests as Northern countries seem to prefer using development aid to address health worker issues rather than bilateral agreements. There is a perception that these African interests are not taken seriously by the global health community, including most of the ‘donor’ countries in the North. Indeed, promises and pledges on funding for health systems strengthening have not been met over the last years\(^5\).

The feasibility of compensation, e.g., by repatriating taxes paid by ‘imported’ health workers to their countries of origin, should be explored and raised again. Such measures need to be complemented by strategies that can make available significantly enhanced resources to fund health services in LMICs. A policy proposal has been made to set up a Global Health Resource Fund. This would basically use a dynamic fee structure that would obligle high income countries and private sector actors engaged in the recruitment of health workers in resource-poor countries to contribute with funds earmarked for health systems strengthening and employment in the public sector. This fund would build upon the existing efforts of a health systems funding platform by the WHO, World Bank, the Global Fund and the GAVI alliance\(^6\). This proposal fits in well with current suggestions for an international health systems fund\(^7\) and the resolution from the WHO’s Executive Board Special Session on Ebola in January 2015 that called for ‘the establishment of a more extensive global, public health reserve workforce’\(^8\).

BACKGROUND INFORMATION

EUROPEAN MOBILITY IN THE PROVISION OF HOME CARE

In the Netherlands, Wemos observed that hiring cheap personnel from other European countries or even from other continents is becoming an attractive option, both for home care provided via municipalities and for private (24-hour) home-based care. Different civil society organisations and trade unions are seeking collaboration between recruitment agencies, Dutch inspectorates, the Ministry of Health, the Ministry of Social Affairs and Employment and municipalities, in order to ensure fair recruitment and rights for international health workers.

5.6. WHO IS A HEALTH WORKER?

We now turn to a blind spot regarding the health workforce crisis. The World Health Report 2006 accepts that data available on health worker numbers are generally limited to people engaged in paid activities. It further classifies two types of health workers: ‘health service providers’ and ‘health management and support workers’. Thus, only medical doctors, nurses and midwives are counted as professional service providers. When the WHO talks about shortage of health workers, it is mainly talking about these professional categories.

Community health workers (CHWs) are, in many countries, a crucial element of a people-centred health system, but are not generally counted as part of the health workforce. Despite local successes, uptake by governments to have CHWs integrated in sustainable national programmes with proper remuneration and education has remained limited. Proposed solutions such as the recent ‘One million community health workers’ campaign need to be carefully assessed.

This initiative proposes the deployment of health workers equipped with high-tech point-of-care diagnostic tools, communicating with national supervisors via broadband access and smartphones, providing standardised care based on consistent supplies of life-saving medicines and easy-to-follow treatment protocols, and trained in short-term intensive courses.

The obvious questions are:

- How will this be financed? And what are the plans for a sustainable integration of these CHWs in national health systems? How will exploitation of this ‘cheap’ workforce be prevented?
- What will the scope of work of these CHWs be? How will they be linked with the communities they are intended to serve?
- How will such CHWs function optimally without substantial strengthening of national health systems?
5.7. THE HEALTH WORKFORCE IN THE SUSTAINABLE DEVELOPMENT ERA

The new Sustainable Development Goals (SDGs) include as target 3c: ‘Substantially increase health financing ... of the health workforce in developing countries ...’. Workforce 2030 uses a new benchmark indicator, what is known as the SDG composite method. It estimates that 4.45 health workers per 1000 inhabitants are needed to reach the SDG health targets by 2030. This amounts to a total global deficit of 17.6 million health workers in 2030 relative to current supply, with a projected deficit of 13.6 million health workers in LMICs alone. The gaps are most prominent in rural areas. While currently about half of the world’s population is living in rural areas, only 23% of the global health workforce is employed in rural areas. According to estimates, health sector employment in rural areas is currently short of 7.1 out of a total of the current 10.3 million missing workers.

BACKGROUND INFORMATION

NATIONAL POLICY SPACE FOR WORKFORCE DEVELOPMENT: THE THAI AND ETHIOPIAN EXAMPLES

Thailand has four decades of experience with strategies for solving the inequitable distribution of human resources for health (HRH) between urban and rural areas. There are four key components in these strategies: (1) Development of rural health infrastructure. (2) Educational strategies including rural recruitment, training and hometown placement. (3) Professional-replacement strategies such as training in basic medical care capacities for rural health personnel. (4) Financial strategies such as a compulsory public service, incentives for working in rural services, payback for tuition fees by rural public work, reform of the health care financing system to Universal Coverage Health Scheme.

Since 2003 the government of Ethiopia has been deploying specially trained new cadres of community-based health workers named health extension workers (HEWs). This initiative has been called the health extension programme and is also known as the ‘HRH flooding strategy’. HEWs have contributed substantially to the improvement in women’s utilisation of family planning, antenatal care and HIV testing. HEWs may be less competent in assisting births. The Ethiopian Government is developing strategies to support the efforts of HEWs in identifying mothers at risk, preparedness for birth and improving their referral to health centres where midwives are present and there are better facilities.


Workforce 2030 is a strong building block for integrating health workforce development in broader health and socioeconomic development. ‘Workforce 2030 makes the case that investment in the workforce offers a triple return; social- and economic benefits, improved health outcomes and robust front-line defence for global health security’ (par. 9).

However, the strategy relies on the assumption of (strong) economic growth in LMICs to finance workforce deficits. The global additional wage bill needed to scale up the workforce in LMICs is considerable. A major question is: who is going to finance it? Will domestic revenue suffice or will this be a shared responsibility, with also an international financial framework?

Workforce 2030 argues for public sector intervention to ‘recast insufficient provision of health workers and their inequitable deployment’ and public HRH investments should be supported by ‘appropriate macro-economic policies’ while ensuring ‘adequate fiscal space’ (par. 38). The next paragraph mentions ‘expected growth in health labour markets ... as a way to create qualified jobs’ (par. 39).

The crux is that the prevailing, resilient macro-economic model (the ‘Washington consensus’) has led to fiscal contraction, austerity measures across the globe, privatisation of services, liberalisation of trade and capital, deregulation of labour markets etc.

It is a fallacy and a myth to believe that such a monetarist economic model and the “labour market” in itself will overcome the workforce deficits, and improve health outcomes. Privatisation of education and health services will indeed create highly skilled, professional, medical jobs, but these will be only accessible for those who can afford them (e.g. via health insurance schemes). Health equity will be at risk in this approach, because it will stimulate the further (global) mobility of the skilled medical workforce while limited public funding and philanthropy will need to cover other public health functions as well as the deployment of lesser skilled Community Health Workers (CHWs) to impoverished neighbourhoods and rural areas. CHWs are essential for integrated, people-centred health services but the scenario above leads to parallel systems; access to a skilled medical professional for those who can afford it, poor services for the ones that rely on minimum health coverage.

5.8. WAY FORWARD

The good thing is that there are alternative pathways if we dare to imagine and attempt them. A key advice for Workforce 2030 and the actors working on it would be to move away from focusing on the instrumentalist, utilitarian role of the health workforce in economic growth and labour markets, and rather emphasise the intrinsic value of a competent workforce in improving health outcomes and reducing health inequalities. Inspiration can be sought from those that already aim to transform economic performance and policies, and consider them as a means towards social and health outcomes, rather than the goal. In this scenario, Health Workforce 2030 would not merely be a technical programme or lead to yet another global health initiative. It could become part of a wider social and political project of which the time has come. Then, Health Workforce 2030 could help to transform the current global health paradigm.

While the expansion of medical school places in public sector institutions has stagnated in most African countries (with some exceptions such as Ethiopia) there has been a rapid growth of private medical schools in the past decade. The Sub-Saharan Medical School Study in 2009 found 168 medical schools of which thirty-three had been created in the previous decade. At that time approximately 26 per cent of medical schools in sub-Saharan Africa were private schools. The first private schools opened in the 1990s and their number keeps increasing, but reports suggest that several of them are of dubious quality. Further privatisation of medical education needs to be analysed as to assess the pathways and impact on health equity.
The governance of health worker migration has become more complex over the years, as it is now at the nexus of wider global policy initiatives and debates. The ‘migration of health professionals is at the junction of the right to mobility, right to health and the right to decent work. It is about finding an acceptable compromise between the rights and obligations of migrant workers, employers and governments based on sound research findings.\textsuperscript{109}

One should explore broader public policy coordination affecting health workforce migration. This would include amongst others making the policy consistent with the ILO’s Multilateral Framework on Labour Migration. It is also necessary to make health worker migration an issue within the post-2015 development agenda, and in the debate on the role of global trade agreements in the quest for development. Global and regional trade agreements are likely to increase (temporary) labour migration.\textsuperscript{110}

**CASE**

**FREE MARKET FOR HEALTH INSURANCE IN THE NETHERLANDS**

The 2008 economic crisis changed the European social security system’s solidarity-based approach. In an attempt to restore order to the budget, the EU put in place a strategy to liberalise and privatise public services. By allowing the market to manage the health care system, the aim of the political decision-makers was to make the provision of services more efficient and reduce the costs, both for the public authorities and patients.

This strategy has been in place in the Netherlands for ten years and the results are plain for all to see: in spite of good intentions, health care access has deteriorated dramatically.

In 2006, the public fund for health insurance was replaced by a competitive system for private health insurers. The market mechanisms between health insurers and care providers were supposed to ensure that doctors and establishments operated on lower costs, whereas the market mechanisms between patients and health insurers were intended to stoke up competition between the latter. A number of rules were put in place to protect access to care. The law provided a basic formula as well as an obligation to accept which prevents older people and those suffering from illnesses from being excluded. A health care allocation was provided for social correction purposes. This is a flat-rate sum that is calculated on the basis of a certain threshold of resources and which aims to pay part of the insurance premiums charged by private insurers.
AS PREMIUMS RISE, ACCESS TO CARE GOES DOWN

In the case of many treatments, the personal contribution in the form of a monthly premium went up, and a mandatory excess was introduced in 2009. The risk lies in the part of care that has to be paid by the patient. During the first year the amount was 155 euros which then rose to 375 euros in 2015, representing an increase of 142% in six years.

Those defending the reform stress that waiting lists are shorter. This may nevertheless be explained by the fact that more inhabitants of the Netherlands are delaying their care due to these high costs. Between 2010 and 2013, the percentage of Dutch people cancelling a visit to the doctor for cost reasons rose from 2 to 12%. The increase in patients cancelling medical examinations or recommended treatments is of a similar magnitude (rising from 3% to 16%). According to a survey conducted by the Landelijke Huisartsen Vereniging (national association of general practitioners), 94% of GPs stated that patients sometimes chose not to follow their advice because of the cost, 70% saw this occurring on a daily or weekly basis. A large proportion of physiotherapy, dental treatments, several types of psychological care and the reimbursement of certain medicines that can sometimes be costly were also removed from the mandatory basic formula and will no longer be reimbursed. Since 2012, the allowance ceiling for health care has been declining and hundreds of thousands of Dutch people are losing their subsidies each year despite a rise in poverty.

LESS WASTAGE?

Does commercialisation inevitably lead to less wastage? Since 2011, the total costs have indeed increased by less than they were doing before. The average between 2000 and 2013 was 5.5%, whereas the increase in 2011, 2012 and 2013 was limited respectively to 2.5; 4.3 and 2%. According to those defending the reform, commercialisation is largely responsible for this phenomenon. This is why the prices of different certificates have decreased. But decreased costs do not necessarily mean greater efficiency. Partially there are fewer unnecessary tests but essential treatment is also being postponed as patients are having to pay more out of their own pockets. According to the Zorgbalans 2014 (regular update on the state of health care in the Netherlands produced by the Dutch National Institute for Public Health and the Environment), this decrease can mainly be explained by the economic recession and the ensuing budgetary restrictions, as well as erosion of the basic formula.

In the Netherlands, it seems that private health insurers are increasingly influencing how health care is carried out and deciding on the care that such a hospital or such a doctor provides. General practitioners fear that their professional autonomy is under threat. Health insurers are increasingly deciding what medicines a patient should take or which specialist he or she should see.

Commercialisation was intended to bring about a reduction in costs and yet premiums have skyrocketed in 10 years. They have gone from an average of 1,080 euros in 2006 to 1,260 euros in 2014. The question is: where does this money go and is it really spent on health care? Each year, health insurers spend some 500 million euros on advertising. Annual profits amount to over a billion euros. In total, health insurers have a reserve of 9.3 billion euros.

An appeal was made for a new form of basic public insurance. In March 2015, a group of general practitioners published a manifesto which, in the space of a few weeks, collected the signatures of approximately two-thirds of doctors actively practising in the Netherlands.
6. PRIVATISATION OF FINANCING IN HEALTH

6.1. 30 YEARS OF PRIVATISATION OF FINANCING IN HEALTH

One of the reforms that has had the greatest impact on health systems in developing countries (DCs) in recent decades is the introduction of directly paid user fees in public health services. Direct payments are the expenses paid directly by the patient, i.e. the expenses that the user of the service has to pay to access care at the point of service, without any formal way of staggering the payment or possibility for a posteriori reimbursement. This makes it a type of private financing which the patient has to take out individually. The higher this payment is as a proportion of the cost of care, the less the cost of health care can be shared and the greater the financial risk is for patients.

Certainly, this type of payment has always existed but until the beginning of the 1990s its share in the overall financing of health care systems remained marginal in DCs. Only the private profit-making sector (still in its infancy at the time and exclusively urban) and the network of faith-based providers (in very limited numbers) charged patients for the costs. What really began to change as of the end of the 1980s, as affirmed by Gilson in 1997, was the role that this type of private financing played in the overall structure of health system financing in DCs and especially in the financing of public health services which had remained, until then, officially free of charge for users.

When hit with an unprecedented debt crisis, the vast majority of DC governments were forced to introduce economic reforms mainly consisting of liberalising their internal market, limiting public expenditure and developing a fiscal policy to boost economic growth. It was at this time that the WB entered discussions for the first time on how health systems were organised in DCs, notably by publishing in 1987 a report on health financing. An agenda of reforms was put forward so as to allow States to implement the austerity policies their creditors were demanding. The main proposal was the following: compensate for the drop in public financing in the health sector by making the patient pay at the point of service, i.e. the introduction of user fees. The theory of change developed by the authors’ report is clear: asking creditworthy users to pay for health care that was previously free in public services ought to allow the necessary resources to be generated to compensate for the drop in public financing, reduce the abusive use stemming from the fact that care was free and channel more effectively the State-allocated resources towards native populations, improving the performance and equity of public financing in the process. These in any case were the promises of success if the reform agenda were put in place.

The political decision-makers of the time quickly realised that they could no longer use public financing for the provision of free health care. An alternative way of financing the health sector had to be found. For most countries involved, there was no possible alternative: the reform agenda proposed by the Bank was therefore applied in the vast majority of DCs. Thereafter, the World Bank went on to publish two other reports in the 1990s to push through this reform agenda whilst becoming a key player in the domain of health.
6.2. INCREASINGLY HARSH CRITICISM

Voices very quickly spoke out to criticise the introduction of user fees. In 2000, Margareth Whitehead described this component of the World Bank’s strategy as a type of “privatisation of the financing of public services” which, in her view, has two dramatic consequences:

1. It creates an incentive for developing the private sector especially through the dual activities of public health personnel who, in the vast majority of cases, opened private consultation practices, without being subject to any state controls, in order to tap into, at least in part, the financial windfall of direct payments.

2. Then, such a mode of payment creates a poverty trap, called the Medical Poverty Trap which has the knock-on effect of increasing untreated morbidity, reduced access to health care particularly for those most in need, long term impoverishment for those who find it difficult to pay for their care, and increased use of medicines, bought on a burgeoning market of small private pharmacies or on market stalls.

Nevertheless, at the dawn of the new millennium, direct payment by the user was still impervious. There then followed a decade which is (progressively) building a corpus of knowledge demonstrating the negative effects that this privatisation of finances had on health. Proof that was summarised by Robert Yates, a senior expert in health economics, in 2009 in the Lancet using the following words: “A detailed analysis of the research shows that user fees have failed to deliver on all the success criteria outlined in the 1987 agenda for reform report.”

In 2014, the WB’s experts accepted this damning conclusion, like the vast majority of health stakeholders worldwide. Recognition of this failure reached its peak on 3 April 2014 when the executive director of the World Bank, Jim Yong Kim, told the newspaper The Guardian: “There’s now just overwhelming evidence that those user fees actually worsened health outcomes. There’s no question about it. So did the bank get it wrong before? Yeah. I think the bank was ideological.”

6.3. CATASTROPHIC HEALTH EXPENDITURE AND PERSONAL CONTRIBUTIONS

During the 2000s, the World Health Organisation (WHO) introduced a standard on the basis of different analyses carried out on routine data collected from different Member States. From a relative share of 15% of the total financing for health, direct payments are becoming problematic. Above this threshold, the risk of having to face “catastrophic health expenditure”, i.e. a household having to spend a too large share of its means on health becomes much bigger.

When people have to pay costs or user fees for health care, the amount can be so high in comparison to...
their income that it triggers a “financial catastrophe” for the individual or household. The WHO suggests that health care expenditure is considered catastrophic whenever it is higher or equal to 40% of the non-subsistence income of a household, in other words, the income available once the basic needs have been covered. Outgoings this high can imply that the persons will be reducing their access to essential goods such as food and clothing, or that they are incapable of paying for their child’s education. Each year, approximately 44 million households, i.e. over 150 million people in the world have to deal with catastrophic expenditure and approximately 25 million homes or over 100 million individuals find themselves in a situation of poverty on account of having to pay for these services. Furthermore, the impact of these direct payments by the service user extends beyond the catastrophic expenses alone. Several people may decide not to call upon these services, simply because they cannot allow themselves either the direct costs such as consultations, medicines and laboratory tests, or the indirect costs such as transport and special foods. Poor households are likely to sink ever deeper into poverty due to the damaging effects the illness has on their incomes and general well-being. One of political decision-makers’ concerns must be to protect the population against a financial catastrophe and against impoverishment caused by turning to health care services.

6.4. DIRECT PAYMENTS BY THE PATIENT ARE IMPERVIOUS

The avalanche of proof, combined with this WHO recommendation, shows that there is clearly a strong argument for reducing the share of direct private payments when it comes to financing health care. What is it in reality?

A detailed analysis of developments in the share of direct payments is needed to understand how direct payments have evolved during the last 15 years.

The graph above represents health financing structures in each WHO region in 2000 and in 2013, by separating out public financing and private financing, with the latter being subdivided into direct payment by the patient (“out the pocket” or OOP) and other types of private financing. As far as OOP financing is concerned, three aspects are highlighted.

Firstly, despite the huge body of evidence surrounding the negative effects of direct payments, this mode of financing remains very important in health financing terms and even constitutes the majority of funding in some parts of the world. The patient remains responsible for the financing of his/her health care at levels well beyond WHO recommendations. In certain regions (South-East Asia, the Eastern Mediterranean region or even Africa) the share of OOP fluctuates by between a third and over half of the total financing for the health sector.

Then, even if there is a general trend towards reducing the share of OOP, this decrease is relatively small in amplitude. And in places where OOP is falling significantly, such as South-East Asia, patients still have to pay half of the cost of care directly from their own resources.

Lastly, few countries are applying the WHO’s standard of 15%. Only the countries of Europe and America have relatively low levels of financing. Nevertheless, in both situations, we must be cautious not to congratulate ourselves too soon. In Europe, the share of financing generated by direct payments rose steadily.
and consistently between 2000 and 2013. Slowly but surely, Europe is going against the grain of international recommendations on direct payments. A number of countries, some much more quickly than others due to the effects of austerity policies, are in the process of unravelling their solidarity-based health financing systems and, in the process, are increasing the financial pressure on the patient. In America, States undeniably have had greater involvement since the 2000s, especially in Latin America. Countries such as Brazil and even Mexico have put extensive social policies in place with the objective of reducing the financial risk the patient has to take on, especially for the people most in need. The introduction of these new social policies has been accompanied by an increase in public health expenditure of 4.9% to 6.7% of the GDP. Paradoxically, however, private spending increased too, from 6.1% to 6.9% of the GDP. The increase in public spending allowed OOP levels to remain at a level equivalent to that of 2000, but the increase in the power of private insurance firms, which accounted for 4.8% of the GDP in 2013, remains somewhat of a concern. Even if they allow better protection for beneficiaries, these firms exclude large swathes of the population and therefore do not guarantee any real reduction in financial risk for a population.

Analysing the same indicator, this time grouping together countries by income level, brings to light some other interesting trends. Once more, the downward trend is confirmed but in smaller proportions than the discourse on direct payments was suggesting.

This new categorisation also allows us to demonstrate three clearly different situations:

- Firstly, OOPs are clearly a blight on low and medium income countries. In both of these country categories, the proportion of OOPs increased significantly during the last decade, despite international aid for health which has increased during the last 15 years, boosted in particular by the Millennium Development Goals (MDGs).

- For the upper medium income countries, the proportion of OOPs is declining. It seems that when a country reaches this level of income, it triggers a political process that results in greater public investment in health, especially through expanding social protection in health to benefit parts of the population who were not previously protected, such as workers in the informal sector. Brazil, Mexico but also Thailand and even China are examples of countries that have experienced this process. We must, however, be careful not to get carried away, nothing is a given: there are some countries in this category that have not witnessed such transformations.

- Lastly, for high income countries, there has been a significant increase, not only in the share of health in the GDP but also the part financed directly by the patient.

As far as DCs are concerned, one fact is undeniable: the changes to financing structures in health are extremely slow, despite the general discourse condemning direct payments. This shows just how difficult it is to get out of a process that was set in motion 30 years ago. There is a real dependence on decisions that were made in the 1980s, and direct payments therefore continue to have dramatic consequences for families across the globe.
6.5. WHAT ARE THE CONSEQUENCES OF THIS PRIVATISATION OF HEALTH FINANCING IN DCS?

There are a great many consequences of maintaining direct payments as the principal method of funding in a number of DCs. The financial barrier can be added to other barriers in accessing health care with three major consequences at the level of individuals:

1. Firstly, it has been the cause of a growing number of people refusing health care; it is estimated that today almost a billion people refuse health care each year for financial reasons, primarily in DCs.
2. Then, this privatisation of funding forces catastrophic expenditure upon over 150 million households each year and over 100 million of them are living in DCs.
3. Finally, it is estimated that there are almost 100 million households which, if they had had an alternative for financing their health care, would not have fallen below the poverty threshold. In other terms, direct payments for health care is plunging almost 100 million households into poverty each year.

In DCs, households have progressively developed strategies for dealing with these direct payments. When the money is not directly available, households sell off their productive assets such as their land or even tools, the pre-selling of their harvest or the fruits of their labour at rock bottom prices, borrowing from family and friends where possible or turning to private loan companies who loan money to them under scandalous conditions, sometimes with interest rates reaching up to 100% of the amount borrowed ...

These are all adaptation strategies which in the medium term represent a risk for the overall well-being and economic stability of the household.

The consequences have been particularly dramatic for households in vulnerable situations, especially economically. In other words, what Margareth Whitehead called the health poverty trap befalls a large number of households every year, mainly poor ones.

PRIVATE FINANCING IN BELGIUM

With its 22% private financing for health, Belgium is above the EU15 average (20.6%). The share of private financing has remained stable over the last ten years and this comes in spite of total expenditure having grown during the same period.

On the other hand, some types of essential care such as dental care, glasses, hearing aids, certain medicines or even psychotherapy still have a low level of reimbursement. Furthermore, at the service provider level, the introduction of surcharges is leading to two-speed medicine: some specialists no longer agree to provide care at the subsidised rate, they are only accessible upon payment of a surcharge. From one category of care to another, the respective share covered by social insurance and the proportion paid by patients varies dramatically.

Until now, the health sector in Belgium has been spared the effects of commercialisation. Over 78% of health care is financed collectively. But the real challenges lie ahead of us. Whilst the needs continue to rise (ageing of the population, increase in chronic illnesses, etc.), public resources are heading in the opposite direction (savings in public expenditure, institutional reform). A notable development is that of private insurers, mainly for hospital and dental care. Under-financing in certain sectors is encouraging the development of market practices or public-private co-funding. This is particularly visible in the sector of residential care homes which are clearly targeted by private operators.

The low levels of growth in health expenditure that have been authorised up until 2019 risk increasing the pressure on the health care budget until it runs into difficulties, thus creating an incentive for further privatisation of health care provision.
6.6. MOVING AWAY FROM OUT-OF-POCKET?

The discourse would have it that there is a real willingness to leave the era of direct payments in a number of DCs. This growing awareness is being translated into action, be it public or private, focusing mainly on certain vulnerable groups.

Several instruments for health financing have been put to the test: full or partial exemption from direct payments in the public sector for certain services and/or certain categories of patients, subsidised health insurance contributions, the introduction of equity funds to guarantee access to health services for the poorest groups in society, distribution of “maternity vouchers” that allow pregnant women to have access to maternity care at a heavily subsidised cost, national strategies to put in place community health mutual funds which make it easier for communities to deal collectively with health risks, contracting of service providers (contracting in/out) with access to health services as an evaluation criterion, etc. There is a lengthy list of financing mechanisms that have been tested and many are still in the scaling up phase.

It is difficult to draw any valid cross-cutting conclusions for all of these initiatives. Nevertheless, a detailed analysis of the results of these financing mechanisms shows that the results are falling short of expectations, especially in terms of equity. The majority of these initiatives are encountering not only the pre-existing problems in health systems that they do not seem able to curb, but also the surrounding unequal social structures which often do not allow them to reach the most vulnerable in society. Moreover, it is not rare to see the resources set aside for these socially-minded policies being taken up by non-target groups, often to the detriment of particularly vulnerable groups such as women or illiterate persons. The upshot is a low level of acceptance of these targeted strategies by the majority of the population.

6.7. CONCLUSIONS

Today, as the proof gradually mounts, all signs seem to indicate that these new initiatives in the field of health financing will not be enough to mitigate in any significant way the consequences of the health finance privatisation process launched 30 years ago, especially for the most vulnerable in society. Even if they allow resources to be freed up for this objective, they will not be enough to set in motion the transformational dynamics that would allow us to move towards a more equitable health care system.

However, incorporating the Universal Health Coverage (UHC) objective into the new Sustainable Development Goals (SDG’s), set by the United Nations for 2030, opens up a new window of opportunity for more equitable health systems. In terms of funding, experts agree on the two major lessons learned in recent years if a country wishes to progress rapidly towards the UHC objective.

Mobilising additional public resources seems to be the fastest route to achieving universal coverage, especially if these public resources are used as a lever to facilitate access to care for the most vulnerable people. But this is not enough: there must also be strong commitments made on all sides, especially from civil society, to guarantee that any additional funding that is made available is collected and distributed in a manner that is consistently fair: an essential requisite to bring about the desired changes. Equity can only be at the base of the social contract if it brings together different players who all share the same ambition. In countries with rapidly growing social inequalities, having equity guarantors as a central principle of the health system is essential.

It is clear that the challenge of overhauling health systems is far from having been overcome but it is a worthy pursuit because it is this struggle which could significantly reverse the process of health financing privatisation taking place in the majority of DCs, with
the first victims being the most vulnerable groups of society. It also involves the fight against the privatisation process that affects other parts of the health system, in particular the provision of services which almost automatically leads to high inflation of health care costs and tends to cause a bias on the curative care side, in other words health systems that are too medicalised. Over time, this privatisation of the supply of care risks limiting or even annihilating the expected effects of any freeing up of additional public resources in the health sector.

**BACKGROUND INFORMATION**

**HEALTH MUTUALS: AGENTS OF SOCIAL CHANGE**

Over the last decade, several experiments concerning the setting up of health mutuals have been conducted in DCs. Laying the foundations for mutual insurance systems to cover the risk of illness, mutual funds represent a positive step in the progressive introduction of universal health coverage in these countries and there are several reasons for this.

– They make it possible to reach and organise those working in the informal economy and rural areas;
– They serve to raise awareness and assist the emancipation of individuals and communities as well as the organisation of civil society. They allow populations to become responsible for their own health;
– At local level, the interaction between health mutuals and health care providers represents an opportunity to reach a more consensus-based definition of what quality care means;
– They act as a counterweight and have a control function in the governance of health systems and can represent service users’ interests in the definition, implementation and subsequent monitoring of health policies. They ensure that policies remain in touch with the reality on the ground and that they respond to patients’ needs. Their participation in social dialogue also allows them to manage the cost of health care and medicines.

– They also gauge stability and trust levels in a compulsory health insurance system, which can sometimes prove useful in the face of instability or use of this type of instrument for political purposes.
– Through the various roles they take on, mutual funds are progressively learning to master health risk management.

That being said, the mutual projects developed through cooperation have a number of challenges to face. The experiences undertaken have shown that in isolation these health mutuals do not have the capacity to offer their members sufficient protection. Because of financial limitations, they often have to limit the financial coverage they offer to patients according to their ability to pay contributions. Furthermore, not being in a position to make the contributions compulsory, they find it difficult to enrol a large proportion of the population who do not have the culture of foresight and who face the impossible choice of health versus other priorities for survival, often choosing not to become members, not by choice but because they simply do not have the financial means to make contributions. Finally, technically, there is a desperate lack of support to make the progress required in expanding universal coverage (awareness raising, designing...
insurance products, risk management, contracting of service providers).

As a well-known example of social movement, the mutual movement could make a significant contribution through its actions towards good governance in the health system. The ability to represent the interests of all health service users (and not only its members) is a crucial issue.

Furthermore, due to the expertise they have developed in health risk management over the past decade, mutus could also position themselves as the community link to the State and play a decisive role in managing different social protection policies in health at local level.

At Belgian level, major efforts have been made to respond to these challenges, especially by setting up a platform of mutual stakeholders, Masmut. Those backing the Masmut platform consider the commodification and commercialisation of health care a permanent threat to the population’s health. They advocate integrating health care mutuals into universal coverage as a social and solidarity-based mechanism for improving health and access to better quality health care.
CASE

THAILAND’S UNIVERSAL COVERAGE SCHEME

A good practice for health financing under threat?

Thailand achieved universal health coverage in 2002. This meant that all Thais were covered by health insurance guaranteeing them access to a comprehensive package of health services, with a focus on primary health care. The most significant factor contributing to this success was the introduction of the Universal Coverage Scheme (UCS).

One year after its launch (in 2001), the UCS covered 47 million people: 75% of the total population. This included 18 million people who were previously uninsured. The other 25% are government employees, retirees and dependants and private sector employees. Those groups of the population remained under two other schemes of medical insurance.

Besides this very rapid implementation, it is remarkable that the UCS was introduced shortly after the Asian financial crisis. The GDP per capita had fallen back from 2,700 dollars in 1997 to 1,900 dollars in 2002. The introduction also happened against the advice of external experts and financial institutions, who believed the scheme was not financially viable.

IMPRESSIVE RESULTS

The results of the Universal Coverage Scheme are impressive. There is a very low level of unmet need for health services and the number of non-poor households falling below the national poverty line because paying for health services or medicines decreased from 2.71% in 2000 to 0.49% in 2009. Infant mortality fell from 15 per 1000 live births in 2000 to 11 in 2010. The under 5 years old mortality rate fell from 18 to 13 over the same period and the maternal mortality ratio went from 66 to 48 per 100,000 live births. The tuberculosis detection rate improved from 40 per cent to 70 per cent.

There has been a significant increase in government health spending and a strong decline in out-of-pocket expenditure. The government of Thailand explicitly prioritises the UCS budget. Nevertheless total government expenditure for health remained around 4% of GDP. Together with the increased proportion of funding from direct taxes, this eliminated the rich-poor gap in out-of-pocket expenditure. The UCS also increased equity in public subsidies and overall health expenditure was very progressive (pro poor).

CHALLENGES AHEAD

But some important challenges remain. Even though the Thai Government has prioritised the necessary budget for the UCS so far, maintaining this in the future will be a challenge. Funding of hospitals and medical staff has been substantially reduced in recent years.

There is a continuing commercialisation process in the provision of health services, which leads to more expensive coverage, because of the curative bias of commercial health providers.

Finally, harmonisation between the country’s three different health insurance schemes remains a challenge, because there are inequalities between the health packages covered.
Through the various components of our health care systems, we have observed the way in which the profit-making interests of private stakeholders are jeopardising people’s right to health in terms of availability, accessibility, acceptability and quality (AAAQ) of health systems.

AVAILABILITY

The primary interest of any commercial enterprise is to make profits. It has no obligation to provide services or treatment for all. This profit-making logic damages the availability of care for the non-cost-effective parts of the population (e.g. a rural area with low population density) or the non solvent. This observation applies both to companies offering health services and pharmaceutical companies. Developing a medicine for a non solvent group of the population is not economically worthwhile for a pharmaceutical company, unless they receive a specific stream of financing or guaranteed income from the State specifically for that purpose. The lack of public means available for health care or research into new treatments increases the dependency on private commercial enterprises.

The structural adjustment programmes imposed by the international financial institutions on developing countries in the ‘80s and ‘90s and today on the countries in the South of Europe have come at the cost of both public health services but also the training and availability of human resources in health. In developing countries, trained health care staff are often drawn towards the salaries and prospects on offer in the private sector or abroad.

ACCESSIBILITY

The austerity programmes imposed by the IFIs are also putting at risk the financial and physical accessibility of care. To compensate for the reduction in public health spending, direct payments made by the user (OOP - Out of Pocket) have increased, causing more and more delays in treatment and catastrophic health expenditure. Private insurance companies can cover the risks but prove to be too expensive for the most vulnerable in society. Furthermore they have a tendency to exclude patients with pre-existing medical conditions. Solidarity-based financing systems such as health insurance funded by the State and/or mutual funds are one solution but need to be on the one hand guided and supported by the State to ensure they are truly universal and, on the other hand, mirrored by high quality public services so that they do not exist merely to reimburse increasingly expensive private health care, jeopardising financial sustainability in the process.

PPPs and other models aimed at attracting enterprises’ capital in the health sector are causing a diversion of the funds needed to put in place basic health services, without any guarantee that the services on offer in these institutions are affordable for the poorest people. The commercialisation of services, recruitment and training of healthcare staff and financing is leading to a dual health care system in which only the well-off have access to quality health care leaving poorer people with the under-financed public care that is poorly equipped and of low quality. The commercialisation of health care is leaving people in rural or remote areas without any health services close to them.

The EU’s trade policy is equally detrimental to access to health care and medicines. The EU systematically tries to introduce “TRIPS plus” measures in its
bilateral trade agreements. This reinforces intellectual property rights (IPRs) which leads to an extension of patents and delayed access to generic medicines for people in developing countries. Furthermore, the investment protection mechanisms contained in these agreements grant investors the right to lodge complaints against public health policies.

**ACCEPTABILITY**

The lack of regulation for private service providers often leads to abusive prescription practices, resulting in unnecessary treatment and medicines and therefore higher out of pocket (OOP) costs for the user and health insurance (public or solidarity-based). The price of commercial health care is often higher due to the marketing and advertising costs needed to keep up with the competition. Via their lobbying work and investment protection mechanisms, pharmaceutical companies often aim to break apart the regulations on advertising of medicines.

**QUALITY**

Budgetary austerity policies, trade policy and the ageing of the population are causing the trend towards privatisation of financing and creating two-speed medicine: fast, high quality treatment provided by qualified staff for those who can afford it; lower quality public care with longer waiting times for those less well-off. Furthermore, the lack of government control on pharmaceutical companies allows them to apply for patents and ask high prices, even for medicines which do not bring about any real therapeutic innovation.
8. RECOMMENDATIONS

Health cannot be left in the hands of commercial health companies. They do indeed pursue profitable activities first and foremost and do not, as States do, have an obligation to ensure a population’s right to health. In view of this observation, the involvement of States and relevant and representative civil society organisations is necessary in order to guarantee universal health coverage and therefore the availability, accessibility, acceptability and quality of health care and medicines.

TO THAT END, STATES MUST:

1. GUARANTEE SUFFICIENT PUBLIC FINANCING FOR HEALTH:
   - Guarantee a sufficient supply of high quality public health services, distributed equitably across the country;
   - Guarantee sufficient financing for medical and pharmaceutical research to avoid innovation depending solely on commercial players;
   - Guarantee sufficient training and recruitment of health care personnel by public services;
   - Do not exceed 15% of direct payments by users (OOP - Out of Pocket Payments) taking account of the total cost of the care provided so that the most expensive treatments remain accessible to all;
   - Exclude public-private financing models which serve the interests of private investors with the risk weighing upon public investors;
   - Preserve adequate financial leeway to ensure Universal Health Coverage (UHC).

2. REGULATE PRIVATE COMMERCIAL HEALTH OPERATORS:
   - Prohibit the discriminatory practices of private insurance companies;
   - Limit the prices of medicines and private health services that are reimbursed by public health insurance systems;
   - Apply minimum quality standards for health services;
   - Control prescriptions for medicines and treatments so they can be limited to what is truly necessary;
– Regulate advertising for medicines or treatments;
– Guarantee transparency and limit the lobbying activities of pharmaceutical and health care companies.

3. ENSURE TRADE POLICIES REMAIN CONSISTENT WITH THE RIGHT TO HEALTH:
– Exclude health services and solidarity-based health insurers from sectors liberalised by bilateral trade agreements;
– Rule out “TRIPS plus” measures from future trade agreements;
– Rule out investment protection mechanisms which will restrict States’ abilities to legislate on health;
– Conduct ex ante impact assessments to ascertain the possible implications on the population’s health.

4. INCLUDE CIVIL SOCIETY STAKEHOLDERS WHEN DETERMINING, IMPLEMENTING AND MONITORING HEALTH POLICIES:
– Include civil society stakeholders, health mutual funds and other health stakeholders when defining, implementing and monitoring universal health insurance programmes;
– Guarantee that civil society stakeholders are involved in designing health policies;
– Consult civil society organisations and involved stakeholders when setting the prices of medicines.

5. REINFORCE HEALTH SYSTEMS IN DEVELOPING COUNTRIES VIA INTERNATIONAL SOLIDARITY:
– Support instruments for financing health, based on solidarity, in DCs such as health mutuals or health insurance systems;
– Support research into unprofitable illnesses that affect DCs;
– Support the training of health care personnel by financing educational programmes or grants for foreign students;
– Apply the WHO Code of Practice on the International Recruitment of Health Personnel and defend financial compensation for health care personnel’s countries of origin when they are low or medium income countries.
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<th>Endnotes</th>
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<td>3</td>
<td>Respect: Do nothing that may violate the right to health. Protect: Make sure that third parties (non-governmental actors) do not violate the right to health (e.g. by imposing rules on non-governmental actors). Promote: Take positive steps to realize the right to health (e.g. by approving suitable legislation, or policy or budgetary measures). More information: <a href="http://www.who.int/mediacentre/factsheets/fs323/en/">http://www.who.int/mediacentre/factsheets/fs323/en/</a></td>
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<td>15</td>
<td>Global Health Watch 4, p. 79</td>
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<td>16</td>
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<td>18</td>
<td>Holmes D., Margaret Chan: committed to universal health coverage, The Lancet 2012; 380: 879</td>
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<td>21</td>
<td>UN General Assembly, Resolution adopted by the General Assembly on 27 July 2012, 66/228, The Future We Want</td>
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<td>Global Health Watch 4, p. 77-82</td>
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<td>25</td>
<td>Global Health Watch 4, p. 80</td>
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<td>28</td>
<td>The WHO Health Systems Framework uses 6 fundamental components or ‘building blocks’ to describe health systems: (i) leadership/governance, (ii) health care financing, (iii) health workforce, (iv) medical products/technologies, (v) information and research, (vi) service delivery - <a href="http://www.wpro.who.int/health_services/health_systems_framework/en/">http://www.wpro.who.int/health_services/health_systems_framework/en/</a></td>
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34 The WHO considers the ideal rate to be between 10-15%. WHO, WHO Statement on Caesarean Section Rates WHO/RHR/15.02, April 2015.

35 While initially this trend occurred only in catering or laundry services, it has now expanded to medical technical services such as radiology or laboratory investigations.

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62 This was visualised in the documentary Fire in the Blood, http://fireintheblood.com
Australia was able to prove that Philip Morris had invested in the
Commons Network, HAI et al., ibid.


The TRIPS Agreement only protects information that was not made public to prevent unfair commercial usage. It does not attribute exclusive rights nor periods of monopolistic sales possibilities.


You can find the composition of the CRM on http://www.inami.fgov.be/nl/riziv/organen/Paginas/commissie-tegemoetkoming-geneesmiddelen.aspx#.VuvV8-LhCM8

They were used as a starting point:

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123 The health mutuals’ and the Inami websites offer calculation modules to find out which reimbursement you will receive. Inami also provides access to the NomenSoft database. If you enter the codes of medical aid received, which you find on the certificate handed over to you, this database will provide you the following information: the description of the medical aid received, the fee and the reimbursement you are entitled to.
124 Persons who are entitled to enhanced intervention and the maximum invoice system.
126 Xu K., Evans D., Carrin G. et al., Designing health financing systems to reduce catastrophic health expenditure, Bull World Health Organ 85:8, 2005
129 The EU-15 are the countries which were members of the EU between 1995 and 2004. They have a higher economic development level than the new Central-European member countries, which are economically disadvantaged compared to them.
SOCIAL PROTECTION FOR EVERYONE