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A parallel approach to analysis of costs/benefits and efficiency changes resulting from privatisation of health services

by

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DRAFT REPORT

A parallel approach to analysis of costs/benefits and efficiency changes resulting from privatisation of health services

1 Introduction

Privatisation of health services takes many forms. It is an implicit element of health sector reform, which is underpinned by fiscal reform. New systems of fiscal control, new ways of allocating resources in line with overall government goals and pressure to improve the use of resources are three dimensions of fiscal reform that have implications for the health sector (Schick, 1998). Allocation of resources in line with government goals has meant that the interests of the finance and treasury ministries are dominant. This may affect the health sector directly because the goals of the finance ministry will often not be those of the health ministry (Verheul and Rowson, 2001). It also leads to a greater emphasis on performance management (Kaul, 1997). Outputs and outcomes are not always easy to define in the health sector and can lead to a distortion of healthcare delivery e.g. increases in "throughput", which focus on the numbers of patients treated rather than the quality of care.

New systems of fiscal control are often accompanied by the introduction of market mechanisms, which affect the health sector in several ways: business principles and practices are introduced to healthcare institutions, often as part of wider organizational restructuring. This process is known as corporatization and is taking place in both developing and developed countries (Polidano,1999). It is almost always accompanied by the introduction of the purchaser-provider split within a national healthcare system to create an internal market. The outsourcing and contracting out of services, for example, catering, cleaning, facilities management, hospital management and clinical services is part of an overall process of privatisation. Drug manufacturing and drug distribution may also be privatised. Together these processes constitute a process of marketisation.

Public Services International commissioned this study of '*A parallel approach to analysis of costs/benefits and efficiency changes resulting from privatisation of health services*' in December 2010 as a way of drawing together evidence of the impact of health care privatisation on service users and health workers. Although informed by studies in water and municipal services (Bel et al, 2010) which have not found evidence of lower cost with private production, designing a study for the health care sector is more complicated because of some of the difficulties in measuring the costs and benefits of health services as well as the efficiency and effectiveness of health service delivery. Outputs and outcomes are not always easy to define in the health sector and can lead to a distortion of healthcare delivery, for example, increases in "throughput", which focus on the numbers of patients treated rather than the quality of care. The delivery of health care depends on the intervention being given to a patient but also the quality of care received by the patient. Health care delivery is a labour intensive activity whose quality is strongly influenced by the condition of the workforce and their relationships with service users. Overall health care budgets need to analysed in relation to the quantity and quality of care delivered as well as the proportion spent on administration and management.

Some initial search findings were presented to the Public Services International Health Services Taskforce (HSTF) on 14 February 2011 (Appendix 1). The discussions that followed the presentation highlighted a number of issues that PSI affiliates felt should be explored further in the research. These issues were:

- Debt is being used across the world to justify privatisation.
- Marketization, competition and privatization are all linked even though privatisation does not take place immediately.
- Older care services, laundry, pharmacy, cleaning are all being privatised.
- User charges are being introduced in US, Ireland and developing countries.

- Pressure for privatization of social insurance is starting.
- General confusion about the boundaries between the public and private sectors
- Once access to public services is restricted, then private insurance will be promoted to cover costs of co-payments.

There was a consensus that any evidence to show how marketisation introduces processes into public health systems, which eventually lead to privatisation, would be important for campaigning. A second topic that emerged from discussions was the extent of privatisation of care services for older people, which is more extensive in many countries than health care privatisation. Age care (services for older people) is a service which has experienced extensive privatisation in almost all regions of the world. With increasing demographic pressure the demand for age care is growing. The processes which have led to privatisation and the results of privatisation for both service users and workers can be used as an example of the impact of privatisation on access and quality of services as well as quality of working conditions.

The processes that result in health care privatisation covers what can be seen as a continuum of commercialisation. These start from the introduction of internal markets to public health systems, corporatisation of public hospitals, contracting out of services, public–private partnerships and ultimately the privatisation of health care services. These terms have been included in the search terms, so that the literature reviewed would cover many of these stages which influence/ presents how the private sector enters the public health care sector.

Initial use of the terms privatisation of health services generated a number of studies but the use of the term health sector reform generated a much wider range of studies which reflected the nature of the changes taking place in health systems. It is through these studies that privatisation can be explored more fully. It is not always the immediate presence of the private sector that leads to fundamental changes in health systems but rather the introduction of market mechanisms to public health systems, often described as marketisation.

Table 1: Search terms and databases

Criteria	Swets wise	Sci Verse	Wiley	Informa World	Medline	JAMA	Sage
National health expenditure							
Privatis(z)ation health insurance							
Efficiency / effectiveness health care							
Health interventions & choice of care							
Quality of life							
Workers insecurities							
Commodification of health							
Health outcomes							
Privatis(z)ation							
Health sector reform							
Marketis(z)ation health care							
Corporatis(z)ation hospitals							

Contracting out of health services							
Public-private partnerships							
Commercialis(z)ation of health care							

These searches generated a wide range of references which were then grouped according to the main themes identified in the initial proposal.

- Overall national health expenditure
- Privatisation of health insurance schemes
- Efficiency and health care facilities
- Changing access to health services
- Changing patterns of health interventions and choice of care
- Measuring overall patient mortality, morbidity and quality of life
- Changing workers securities, working conditions and health care
- Commodification of health care tasks and impact on health care
- Changes in health outcomes

Terminology

Several authors have tried to explain the changes that take place in health systems as either different ways of classifying privatisation or different categories of marketisation (Leys, 2004; Whitfield, 2006,). These are strongly influenced by the national health care systems that shape the impact of marketisation. The stages of privatisation take several years or even decades to evolve. It is important to identify the stages of marketisation that often precede full privatisation. The use of terms that 'soften' the impact of changes to existing government systems can be seen in words such "diverse providers", "mixed providers", "co-payments", "partnerships". These terms do not mention privatisation but describe new relationships which underpin privatisation. In the table below, a typology of privatisation and marketisation is set out.

Table 2: Typology of privatisation and marketisation for the health sector

Process	Examples
Marketisation and privatisation of global public goods	• Public health • Deregulation of protection of natural resources
Marketisation and privatisation of assets and services	• Commissioning of public services from private & voluntary sector – diverse or mixed providers • Marketisation and expansion of private services • Private financing of infrastructure and services with public-private partnerships/ private finance initiative • Choice and personalisation of services • Deregulation/ liberalisation and reregulation • Commercialisation of public services • Sale of assets to private sector • Sale and lease back of government buildings • Increased household responsibility for payments and care – informal payments, user fees
Privatisation of governance and democracy	• Contract governance • Corporatisation of quasi-public bodies, e.g. hospitals • Private companies established within public services

	• Privatisation of public interest information and resulting reduction of transparency and disclosure
Privatisation of public domain	• Public service values replaced by market ideology and commercial values • Privatisation of public intellectual capital

Source: Adapted from Whitfield, 2006

Another way of examining privatisation is to map out a taxonomy of privatisation, which aims to place the different arrangements for commissioning and provision of services in a public- private framework. The table

Table 3: Public-private taxonomy for health care

Public		Private	
State	Public but not state	Not for profit	For profit
Ministry of Health	Regional & local government	Community based Religious Charitable NGOs	Small businesses, e.g. Primary care physicians
National Boards	Public corporations		Large corporations

Source: Saltman, 2003

This taxonomy shows some of the different categories of public and private arrangements for health care provision. These will not necessarily apply to all countries but will be shaped by the existing arrangements for health care provision. For example, some countries have an existing charitable/ non-governmental organisation health care sector.

Health reforms/ privatisation by country and service

An initial search for articles on privatisation by region, shows that there are a range of studies that examine the impact of privatisation on health care delivery. In terms of the volume of studies, there are many more detailed studies of health care services in specific countries in Europe, Asia and Latin America, than in specific African countries. The majority of the studies identified so far, examine specific countries, for example, Malaysia, India, Indonesia and China or countries in Central and Eastern Europe. There are also a series of multi-country comparisons, most often covering countries of Central and Eastern Europe. A series of country studies may form the basis of a meta-synthesis.

Privatisation of specific services

There are a growing number of studies of specific services and their experience of privatisation, rather than a more general analysis of privatisation of health services. Given that the nature of the health care privatisation process has often been one of step by step privatisation of specific services, the growth of research into specific services, such as pathology and reproductive health services, is helpful.

Institutional changes

One of the issues that almost all studies seem to struggle with, in a methodological sense, is how to asses the impact of institutional changes on service delivery. There are several reasons for difficulties in assessing institutional change. In many countries, the time scale involved is relatively short. For example, in countries of Central and Eastern Europe, the change from the pre-1989 socialist system to a free market system has taken place over a maximum of twenty years.

Secondly, not all public health systems are exactly the same and many have been influenced strongly by their national historical traditions as well the Welfare state model adopted by a country. Some European

countries have had some form of private sector involvement in the public sector for several decades. In other countries, private sector involvement is new. Similarly, the health care systems of Latin America have a different structure and history to health care systems in Africa or Asia. The United States has a history that is also different, but is becoming of greater interest as the level of marketisation in many national health care systems increases.

A smaller group of studies are attempting to explore what happens when public and private health care sectors work together more closely, forming a 'hybrid health space', which is no longer a public health sector. A meta-synthesis of studies of health sector reforms will be used to show how this '*hybrid health space*' is emerging by region.

Finance related issues

One of the issues emerging in the studies of finance-related issues is the timescale that is being examined. Studies take different time periods. Assuming that the implementation of most privatisation policies started in the 1980s, at the earliest, no study will have a time scale of longer than 30 years. Many studies are looking at initial changes in the 1990s, with some taking a longer period which includes the period after 2000. Some of the studies are showing that there are different phases of privatisation and reform and that in some cases the aims of privatisation have not been fulfilled. One of the first phases of decentralisation is often a reform in the way that funding is provided by central government to local and municipal authorities.

Health outcomes

Studies on overall national health expenditure and health outcomes are most likely to have been commissioned by regional and international agencies, such as the European Union, OECD, the World Bank or the World Health Organization. Comparability of studies depends on how figures for national health expenditure are collected and establishing common elements of national health expenditure. One key issue is the extent of spending on management and administration costs and what proportion of expenditure is spent directly on health care. The World Health Organization in the 2000 World Health Report attempted to link health outcomes with organisational issues, which generated extensive debate about whether the methodology was valid.

The issue of how to assess organisational changes becomes even more problematic when examining changes in health outcomes and trying to establish a link with health care expenditure. Institutional reforms often address several aspects of organisational change. Attributing changes in health outcomes to a specific institutional change is difficult.

Changing access to health services

The main indicators of changing access to health services are taken as the introduction of informal payments to staff or user fees for specific treatments. These are often regionally defined. In Central and Eastern Europe informal payments to staff have been subject to a range of research studies. In Africa, the introduction of user fees, following structural adjustment policies in the 1980s and 1990s, has been the subject of many national studies. There is a growing body of research on informal payments and user fees, which will be considered as the basis of further analysis.

Changing patterns of health interventions and choice of care

There are a number of studies which examine how different types of interventions, such as end-stage renal disease, are accessed in different types of health care system, comparing predominantly public provision with private provision. Some of the results showed different levels of access to home based care as compared to hospital based care. Studies of the use of caesarean sections during childbirth have shown to influenced by patterns of public and private provision.

Competition, hospital efficiency and privatisation

An Australian review of literature on privatisation and corporatisation (Centre for Clinical Governance Research in Health, 2007) in the period 1980-2007 found that the assumption that privatisation of health services will ensure private sector efficiency is questioned on many levels. Privatisation can lead to poorer quality services, loss of nursing jobs in the public sector, reduced access to services for poorer patients, weaker trust relationships between doctors and patients.

A review (Rosenau & Linder, 2003) that looked at 20 years of research comparing for-profit and non-profit health providers, in the United States, showed that overall non-profit hospitals show better results on cost than for profit providers and so argues that the America policy of increasing for-profit providers is misguided. This study only looks at non profits and for profits, not at public hospitals but it findings are useful.

A review of several studies that examine the impact of competition on the efficiency of hospitals in different countries show varied results, which can be influenced by the institutional settings (public, private and non-profit). Studies that look at the impact of ownership on efficiency in the health care sector, rather than the impact of competition on efficiency in the public and private sectors, show a slightly more consistent set of results, in that public hospitals are more likely to be efficient, although this too depends on how efficiency is measured.

Studies of European countries show varying results but two studies of German hospitals both show that efficiency varies with types of ownership and that public hospitals are more efficient than private or nonprofits. Several studies have looked at the impact of competition through the internal market in UK and found that competition has had a limited impact on efficiency, even though the studies were undertaken in the early years of the internal market. One or two more recent studies are starting to show slightly different results, but are still only the subject on one or two interventions, which is not a complete health care system.

Changing workers securities

Studies looking at different aspects of workers securities are sometimes single country studies or groups of similar countries or health care systems. This research examines the changing nature of health care work and the impact on training and professionalisation. Health care labour research is gradually building up a body of research but it is frequently nationally framed. Trade union research is most likely to adopt a multi-country approach, although there are country studies commissioned by national trade unions.

Recognition of role of state

Studies of decentralisation and health care reforms in countries of Central and Eastern Europe, are beginning to conclude that a central state has a role to play in policy formulation/ implementation and regulation. A number of studies are beginning to highlight the problems of a lack of regulation in a marketised system and question the assumptions which informed the introduction of health care reforms. Introducing competitive structures when there are a limited number of providers may result in a monopoly situation which does not bring benefits for service users. A lack of expertise to in commissioning and contracting has affected the quality of decisions made by the public sector in relation to the private sector. The influence of the private sector on the health care policy process is only recently becoming a topic for research.

Reduced access to health/ participation in decisions

Studies of Central and Eastern Europe, which have examined how health sector reforms have impacted on health systems, frequently point out the lack of public participation in the decisions about changing funding systems and the problems that this has caused. This is in addition to the introduction of indirect payments which affect the access to health care of the poorest groups

Commentary on types of research

The nature of academic research is that although research methodologies may be made explicit, this does not mean that academic studies are free from value bias. The dominance of a neoliberal model can be identified in many health sector reform studies. Sources of funding can influence research studies, in terms of the topics researched and the methodologies used.

The concepts of efficiency, effectiveness and equity have been used in the context of health sector reforms as a way of justifying changes in health care systems. Several of these concepts have been drawn from research into private sector manufacturing or service industries. The use of the model of SERVQUAL is often used in many studies of hospital and health care efficiency, which is a model developed for services providers in the private sector. It measures customer satisfaction through five dimensions:

1. Tangibles - physical facilities, equipment, staff appearance, etc.
2. Reliability - ability to perform service dependably and accurately
3. Responsiveness - willingness to help and respond to customer need
4. Assurance - ability of staff to inspire confidence and trust
5. Empathy - the extent to which caring individualised service is given

(Source: Buttle, 1996)
It is subject to several critiques in relation to its use in the private sector. One of the main criticisms is that SERVQUAL measures customer satisfaction by a comparison of the expectations and perceptions of customers. The emphasis is on perception rather than actual experience, so is more of a measurement of attitude rather satisfaction with service (Buttle, 2004). The essence of good quality health care is not fully captured by these measures because the long term effectiveness of treatment and care, as measured through health outcomes.

Although there is a large number of research articles published on issues such as health sector reform, a review of the research methodologies used show a mix of historical analysis, policy analysis and stakeholder analysis techniques are drawn on. A broader observation about many research studies into health sector reform is that because many of the studies are about policy implementation, the research that they are based on can range from a systematic study of key informants at different levels, gathered through interviews and document analysis, to a narrative account of reforms, gathered through a series of secondary sources.

2 Methodology

As many studies of the effects of privatisation of health services are qualitative, it is important to find a methodology which can deal with these studies at a meta-level. Meta- synthesis is a "*systematic approach used for the collection and analysis of qualitiative methods to synthesise these findings*" (Lindhal, et al, 2010: 455). This is a method which is appropriate for combining, comparing and contrasting qualitative studies. McCormick et al (2003) found that the use of meta- synthesis in the field of health care research led to a greater understanding of socio-political processes that influence health care. This is significant for an analysis of studies of health care privatisation.

<u>Screening</u>
Once a range of studies had been identified for each framework element, the studies were clustered on the basis of a series of common denominators:

- Nature of process / issues, for example, decentralisation, informal payments, labour
- Study type – quantitative or qualitative;
- Country (low and high income), region or service;

These clusters of studies were then assessed in terms of the problems in synthesizing the existing findings due to:

- Differences in theoretical/ analytical approaches;

- Forms of measurement;
- Reporting quality of studies.

This process of screening led to some clustering of studies, which were subject to a form of meta-analysis or meta-synthesis, depending on whether they used quantitative or qualitative research techniques.

Post-screening stages - meta-synthesis

The approach to meta-synthesis has been informed by the use of two methods: Systematic Descriptive Maps and Narrative Empirical Synthesis, which have enabled the research from a range of qualitative studies to be reviewed and prepared for further synthesis. These methods are explained below.

Systematic descriptive maps draw together qualitative studies by providing a description of research in a specific topic area. It provides a way of interpreting the results of the synthesis including identifying the need for further research (Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI-Centre), 2011). This approach has been used to develop two reviews of informal payments and reforms in Central and Eastern Europe

Narrative Empirical Synthesis brings together the results of empirical research that are in a narrative form to form a structured narrative or series of summary tables. Results from a range of different types of empirical research can be synthesised in this way, including experimental evaluative research and survey research (Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI-Centre), 2011). This approach has been used to develop meta-synthesis reviews of decentralisation and labour.

The results of the grouping of studies show the following topics emerged:

- Decentralisation;
- Indirect payments;
- Central and Eastern Europe;
- Labour;
- Effectiveness of public and private health care sectors.
- Case studies:
    - Social care – privatisation of a public service
    - South Africa
    - Brazil
    - Malaysia

A review of each topic is now presented.

3 Decentralisation

Although local decision-making shaped the development of municipal and local government in many countries, decentralisation policies have been a dominant form of public sector reform or New Public Management. International agencies have played an important role in promoting decentralisation reforms. Decentralisation has been an essential part of many health sector reform programmes and one of the conditionalities associated with World Bank and International Monetary Fund (IMF) loans. Health care financial reforms play an additional role in shaping the impact of decentralisation. In Latin America and Africa, health care decentralisation characterised health sector reforms in the 1990s. In China, a wider process of administrative decentralisation introduced in 1978, has impacted on the health care system. Decentralisation has also be adopted by high income countries, such as Finland and Denmark, introduced changes that moved decision making to municipal level, which have affected the planning and delivery of health care services.

There are many factors that influence the process of health care decentralisation. The reality of implementing decentralisation has often been more complex that expected because of a lack of capacity at local level (Litvak et al, 1998). In many countries it has played a key role in an overall process of marketisation and privatisation. Rondinelli (1983), in an often quoted article, published when working at the World Bank, defines decentralisation as involving four stages:

1. Deconcentration – transfer of responsibility to a lower administrative level;
2. Delegation - transfer of responsibility to a lower organisational level;
3. Devolution – transfer of authority to lower political level;
4. Privatisation – transfer of control from public to private sector.

In this model, the term decentralisation covers several administrative scenarios and eventually leads to privatisation. The multi-faceted nature of decentralisation has made it difficult to evaluate its impact. The rationale for health care decentralisation covers a wide range of factors, such as improvements in technical efficiency, resource allocation, innovation, equity, quality of services, accountability as well as empowering local governments (Saltman et al, 2007: 18).

Approaches to research

Decentralisation has been introduced in many regions with different administrative systems, for example, Africa, Latin America, Central/East Europe, China. Research, often undertaken since 1990, in Africa, Latin America and Europe, has approached health care decentralisation by examining the implementation process and identifying the problems that have emerged as a result. Case studies, which examine a region or sub-region, are one of the most frequently used approaches. Many of the studies use a policy analysis framework. Key informant interviews and focus groups explore the views of officials at central and local government levels as well health care practitioners and managers, with little input from users. Some studies focus specifically on the effect of decentralisation on health workers.

Decentralisation studies reviewed

Study and country	Data collection
Maluka SO, Hurtig AK, Sebastián MS, Shayo E, Byskov J, Kamuzora P. (2010) Decentralization and health care prioritization process in Tanzania: from national International Journal of Health Planning & Management 2010 Jul 5. [Epub ahead of print]	A case study of Mbarali district in Tanzania uses a policy analysis approach analyses the implementation of decentralized health care priority setting. The case study is informed by a review of documents, key informant interviews, focus group discussion, and notes from non-participant observation.
Wyss K, Lorenz N. (2000) Decentralization and central and regional coordination of health services: the case of Switzerland International Journal of Health Planning & Management 15(2): 103–114.	Case study of decentralisation and central coordination of health services in Switzerland.
Lloyd-Sherlock P. (2005) Health sector reform in Argentina: a cautionary tale. Social Science and Medicine 60 (8), 1893–1903.	Case study of health sector reform in Argentina.
Hakkinen U. (2005) The impact of changes in Finland's health care system Health Economics 14: S101–S118	Case study of decentralisation of health financing.
Jeppsson A. 2001. Financial priorities under decentralization in Uganda. Health Policy & Planning 16: 187–192.	Interviews were held with government officials, focus groups with officials and politicians in Uganda. The fiscal choice model was used to analyse choices made at local government level about own resources as well as central government transfers.
Sakyi E. K. (2008) Implementing decentralised management in Ghana The experience of the Sekyere West District health administration Leadership in Health Services 21(4): 307-319	A qualitative exploratory case study approach was used to examine the barriers to the implementation of management decentralisation of health services and programmes at district level in Ghana, Sekyere West district.
Saide MAO, Stewart DE. (2001) Decentralization and human resource management in the health sector: a case study (1996–1998) from Nampula province, Mozambique. International Journal of Health Planning & Management 16: 155–168	Case study informed by interviews with provincial managers in Mozambique. A literature review informed the design of semi-structured interviews.
Wilton P. & Smith R.D. (1998) Primary care reform: a three country comparison of budget holding Health Policy 44(2): 149-166	Analysis of three country GP budget holding
Mayhew S. M. (2003) The Impact of Decentralisation on Sexual and Reproductive Health Services in Ghana Reproductive Health Matters 11(21): 74-87	A multiple-level qualitative case study undertaken in Ghana between 1996–98 with follow-up visits made in 1999 and 2002. The research involved a variety of methods, including policy analysis, document analysis, key informant and semi-structured interviews with policymakers, donors, managers, service providers and service users.
Saltman R.B. Bankauskaite V. Vrangbaek K. (2007) Decentralisation in health care	A series of papers exploring decentralisation in health care in Europe

WHO/ Open University Press	

Research question

- How has decentralisation affected the marketisation of health care?

Emerging themes

The review of national case studies show that, even after taking national differences into consideration, there are a series of processes associated with decentralisation, which are part of marketisation. These are:

a) Central funding reductions;
b) Self-management of hospitals;
c) Changes in position of health workers;
d) Trends towards re-centralisation.

a) Reductions in central government funding

Changes in health care funding arrangements are often an integral part of a decentralisation policy and influence how it is implemented. Traditionally, in centralised systems, funding for hospitals comes from national or central government. The extent to which central funding is transferred or taken away from hospitals and local health services has an impact on the quality of services and on ways in which these services are managed. There are several scenarios which are drawn from specific national experiences.

In Uganda, the effect of financial decentralisation led to increased tension between local authorities which were allowed to allocate resources according to their own priorities, which were initially assumed to fit into national priorities. The actual results showed that local authorities did not prioritise primary health care as much as the national government expected (Jeppsson, 2002). It also showed that local authority views of health care were often negative, seeing healthcare as labour intensive and expensive. The lack of recognition of overall national goals by local decision-makers has implications for overall healthcare inequalities in the country.

In Georgia, after the introduction of health care decentralisation, hospitals were only reimbursed on a fee per case basis for approved items of the basic benefit package. For services not on the basic benefit package, providers were allowed to charge fees and were also allowed to keep money from fees (Atun, 2007). If central funding is removed, hospitals have to find a way of replacing the funding. The assumption is that either local authorities take responsibility by raising revenue through local taxes, or hospitals will be expected to generate income from the sale of services. Hospitals then generate income through the imposition of co-payments or user fees on service users.

In Argentina, the policy of health care decentralisation created self-managed hospitals, designed to be part of hospital networks, which linked public and private providers in a system of universal coverage (Lloyd-Sherlock, 2005). These measures were aimed at reducing provincial government influence over the health system, although there were varying degrees of implementation, with provincial governments retaining some control. Health insurers were to pay hospitals for the treatment received by patients but at the same time the system of health insurance was being reformed and opened to competition, with an expansion of private health insurance companies. This had a negative impact on hospital incomes at a time when hospitals were becoming self-managing and supposedly asserting themselves against provincial authorities.

It is not just the removal of central funding that can affect health services but the form in which central government funding is given to local health services. In Finland, a central government grant, which previously covered all specific costs of health services, was replaced in 1993 by a block grant which was supposed to cover the cost of local health services (Hakkinen, 2005). In the previous system, subsidies were related to real costs but in the new system, municipalities were given lump sums, which were not

allocated to specific services (non ring-fenced) and were calculated prospectively using a specific need-based capitation formula. The aim was to reduce government control and increase local influence over the provision of services. Municipal authorities expanded their purchaser/ commissioner role as purchaser of services and reduced their provider responsibilities. They could purchase from public, private and not-for-profit providers and were allowed to contract out existing public services. As a result of the changes in the way that central funding was allocated, the revenue from central government declined and municipal authorities had to increase municipal taxes for health care. This was accompanied by an increase in user charges for municipal health services. Households contributed an increased percentage of health care financing (Hakkinen, 2005; Koivusalo et al 2007).

Another form of financial decentralisation is GP fundholding, where GP or primary care doctors are responsible for the budget to commission and purchase health care services for a specific group of patients (Wilton & Smith, 1998). Schemes have been implemented in several countries. The importance of looking at the experience of the GP fundholding model is that it can be seen as part of a process that leads to 'managed care', as practiced in the United States, which depends on systems of limiting 'managing' health care according to funding available. A locally based GP fundholding arrangement is a useful basis for setting up managed care.

In a review of the UK, New Zealand and United States (US), Wilton & Smith (1998) found that there were some significant differences between these three countries but some similarities.
There were differences between the three countries in terms of size of budget and the size of population that GP fundholders were responsible for. In the US, Health Maintenance Organisations (HMOs) are a form of GP fundholding but the GP is a gatekeeper to health care and is strongly motivated to keep expenditure within certain limits. The HMO takes the financial risk for provision of services and integrates health insurance with the provision of medical services. Payment is made on a capitation basis, rather than fee for service. In 1998, HMOs had larger budgets and were responsible for larger numbers of people than either the UK or New Zealand. Although the US showed some cost containment benefits, there were additional administrative and operational costs involved in the process of fundholding.

There were differences between the three countries in terms of what budgets were spent on and whether payments were made on a capitation basis or fee for service. In New Zealand, GP fundholders had set up independent practice associations (IPAs) and other umbrella organisations which acted as budget holders rather than individual practices holding a budget. Membership of the IPAs was not restricted to GPs, with specialists, midwives and other health professionals involved, making a broader based decisionmaking process. In the case of the UK, GP fundholding was restricted to specific GP practices and was not opened up to other stakeholders in the health care system.

New systems of health care financing or changes in the system of allocating central government funds can lead to a process of marketisation because of a reduction in resources. Smaller budgets force hospitals and local authorities to find alternative sources of funding. User fees and increased levels of local taxation are two options. Health care services may be contracted out as a way of reducing expenditure. The introduction of contracting out and user fees are considered solutions to shortages in funding because they are expected to lead to improved efficiency and better use of resources. There has been no consideration of what a successful market arrangement is based on or the type ofrent-seeking behaviour which will be adopted by hospitals and private practitioners in the health care system.

b) Self-managing hospitals
Reforms of health care funding may be accompanied by legislative changes that convert public sector hospitals into self-managing entities. These have different names in national health systems, for example state social enterprises, foundation trusts, self-managed hospitals. Frequently these new organisations have a legal status, ownership of assets and autonomy. Although established by legislation, the hospitals may take time to be formally established and fully operational.

The case of China will be used to show how a policy of decentralisation led to changes in local hospital management and privatisation. China introduced decentralisation in 1978 and in almost thirty years of implementation shows how the process of privatisation resulted from the consequences of decentralisation. The following case study shows how the health care system has been affected.

The introduction of decentralisation in China (Yanzhong, 2004) has had an impact on the resource base available for health care institutions. Provinces and localities are no longer given central government funding. Central government now only funds national hospitals, research institutions and medical schools, which it controls directly. In 1989, hospitals, at local level, had to become self-sufficient because central government funding was stopped. Local authorities were supposed to provide funding through local taxation. Tang & Bloom (2000) found, in a case study of a province that devolved finance and management of basic health services, that resources were not effectively mobilised. This affected the way in which hospitals operated (Blumenthal Hsiao 2005).

Hospitals had to sell services in order to generate income. Each department had to work towards targets and doctors were paid a basic salary and a bonus if targets were achieved. This was not formal government policy but the practice was ignored by central government, an example of how policies can evolve through neglect rather than through a set of positive decisions. Strict price regulation of many health services continued but prices for drugs, new tests, and technology were uncontrolled (Blumenthal Hsiao, 2005). As doctors were under pressure to generate income, there has been an expansion in high technology expensive treatments and pharmaceuticals. Although not technically legal, some hospitals have leased or contracted units to external interests (Tam, 2010). This, accompanied by the wider changes taking place in health care, can be described as a form of privatisation (Blumenthal Hsiao, 2005).

The impact of hospitals becoming income generating has restricted access to health care to higher income groups. The combination of making local authorities responsible for funding and the introduction of user fees, has led to increased health inequalities at local and regional level. Agricultural cooperatives have been privatised which destroyed the cooperative medical system and reduced resources available for health care. Hospitals facilities have been reduced and are of poorer quality. The reduction in local government spending has been matched by increased household spending on health care.

These extensive changes took place before local authorities started to sell hospitals in 2000. More hospitals were sold by the poorer local authorities because the sale of hospitals reduced their financial responsibilities. By 2010, only a minority of hospitals have been privatised but the majority of state owned hospitals operate as corporate entities, almost as for-profit hospitals (Tam 2010). There is a lack of regulatory institutions to control the expansion of corporate state hospitals. Tang & Bloom (2000) found no increase in resources from local government and that effectiveness, efficiency and equity were not addressed.

The move from extensive state provision of health care to a more limited set of services, with increased out of pocket payments, has eventually led to central government starting to take action. With only 28% of the population covered by health insurance, the government has introduced mandatory insurance and a new rural cooperative medical scheme in 2002, which is funded by household contributions and central/ local government subsidies. However, attempts to de-privatise the health care system have been hampered by a lack of resources. Making changes to a more commercialised system of health care is difficult because government support to hospitals is still limited (Tam 2010).

There is a growing body of evidence to show that self management of hospitals inevitably lead to the introduction of user charges. The case of China shows how privatisation can result from decentralisation even if there is no coherent policy of privatisation promoted by the government. It also shows how difficult

it is to change a commercialised system back to a more collective system because of a lack of government resources.

c) Changes in the position of health care workers

Health care decentralisation has a profound effect on health care workers. Decentralisation is influenced by public sector reforms, which aim to change working practices, recruitment, retention and pay. The local determination of pay is one of the most controversial aspects of health care decentralisation, which is linked directly to the self-management of hospitals. In some countries, national governments have retained control of health workers but in other countries, responsibility for recruitment and employment was moved to local level. As health care is a labour intensive activity, control over health workers shapes how the reforms develop. In Argentina, national government retained control over staffing because it was a source of patronage (Lloyd-Sherlock, 2005). In Georgia, health care workers were taken off the payroll when hospitals became self-managing. In Uganda, local authorities became responsible for some groups of health care workers (Jeppsson,2001).

Although the research into the effects of decentralisation on health workers has been mainly focused on the impact on human resource management, several studies have attempted to assess how decentralisation affects the professionalisation of workers. Kyaddondo & Whyte (2003) in Uganda found that health workers, at local level, were on several different pay rolls, which were the responsibility of either central government, local/ district authorities or health facilities. This led to staff being on different pay, terms and conditions. Staff at health facilities, who were paid from user fees, often experienced fluctuations in pay, determined by the monthly income from user fees. Workers reported low pay, late payment of wages and in some cases non-payment. After decentralisation health workers were unclear about who to complain about non-payment of wages. They had lost central government allowances that were no longer paid by local authorities. This led to a reduced income. New districts were often unable to fund training, which affected the ability of health workers to improve their professional position and career.

In decentralised systems in Africa, management arrangements became more complex because members of health unit management committees were supposed to manage the work of health facilities and health workers but health workers felt that they were not qualified to do this. They felt that their own status in the community was reduced. The closer arrangements with community leaders could also draw health workers into local political issues which many felt could affect their careers (Kyaddondo & Whyte, 2003). Many responded by becoming involved in private clinics or drug shops to increase their income, which contributed to the process of privatisation.

Decentralisation can also affect the ability of regions to recruit health care staff. Mayhew (2003) in a study of reproductive health service in Ghana, found that the poorest regions had the least resources available to attract staff. They were unable to increase salaries so could only offer housing. Workers in poorest districts want to move on for career reasons and to improve working conditions, leading to a high rate of turnover.

In Mozambique, health care decentralization was introduced in 1987, as part of a structural adjustment policy (SAP). Human resource functions were decentralised to the principal governor, who could delegate responsibilities to provincial directors. Although it was widely recognised that high quality primary health care needed skilled and experienced health workers, many problems emerged in the management of health workers and distribution of health workers, caused by a lack of attention to human resource issues. This was due to a lack of human resource and financial management capacity at local level. Inter-governmental and inter-agency coordination developed slowly. Community participation was weakened because of lack of health workers (Saide & Stewart, 2001).

Even in countries, with highly developed human resource management systems, health care decentralisation has led to problems for health workers. In Finland, since decentralisation, there has been an increase in doctors and nurses but a decrease in less well qualified health workers in specialised services. Dissatisfaction with working conditions and salaries of municipal health workers has led to shortages of staff (Hakkinen, 2005).

Several studies show that health care decentralisation has affected the respect, value and integrity of health workers. Inadequate management systems can lead to a lack of respect for health workers. Reductions in salaries, not only reduce the status but also the integrity of workers because they have to find alternative sources of income. This might be through a second job in the private sector or by introducing informal payments for health care. This is part of a process of individualisation which replaces a 'public sector ethos' with an individual form of motivation, putting private interests before public goals. **(See section on informal payments)**

d) Role of central state and increased health inequalities

A relatively early study of evidence from decentralisation reforms showed that equity across regions is often reduced after the introduction of decentralisation (Klugman, 1994). There is now a growing body of experience from European countries, that show that the long term effects of health care decentralisation, whilst being positive in terms of responsiveness to local needs can also lead to increasing health inequalities. Switzerland has had a longstanding decentralised health care system at canton level with a limited federal health care policy. Wyss and Lorenz,(2000) found that the system has led to an unequal distribution of resources. Any attempts at national investment in resources have limited scope with the existing federal system. Finland, which introduced health care decentralisation in 1994, has also found that safeguards are needed for disadvantaged groups particularly people with mental health issues. A balance between different levels of care and different forms financing needs to be ensured (Koivusalo et al, 2007).

During almost two decades, the experience of many countries in Central and Eastern Europe has shown that there is a need for central government to play a role in regulation and standard setting. National legislation and policies are needed to direct reform. It is not enough to allow decentralisation without central government overview. National systems of regulation and standardised processes of reimbursement are needed if there are to be accessible minimum standards of health care across a country, especially within a market context. Market arrangements may operate in different ways within local circumstances.

Key points

- Reforms to health care financing often lead to reduced funding for health care at local level
- Reductions in funding lead to adoption of user fees and informal payments
- Self management of hospitals introduces income generation through user fees and co-payments
- The status and integrity of health workers are affected by decentralisation
- Recent experiences in many countries are showing the need for a process of re-centralisation to ensure health equity

4 Informal payments, user fees and co-payments

Informal payments, user fees or co-payments for health care are part of a process of privatisation because individuals have to pay directly for health care rather than accessing public health care, free at the point of access. Payment for health care may be part of a government health care policy but it may be adopted informally by individual health care facilities or health workers. It has an impact on the relationship between patient and health care worker because it introduces a commercialised element to the relationship.

There are a range of terms, informal payments, user fees or co-payments, which cover different arrangements, which may vary from country to country. Several types of payments will be discussed in this section. In a review of research on informal payments for care in countries of transition economies, informal payments were defined as "cost contributions, including supplies and salaries, misuse of market position and payments for additional services" (Ensor, 2004). Informal payments are payments which have to be made by the service user in order to receive treatment or, in some cases, are made at the end of a successful treatment.

User fees or co-payments are often official fees that have to be paid at some point of the treatment process. They may cover the cost of medicines or the reason for payment may be less specific. Decisions are made about user fees at national or local level and this often determined what the income from user fees is used for. It is the use of the income of informal payments or user fees that has some influence on patients' attitudes to making the payments. For payments that are paid directly to a health worker and obviously is of benefit only to that health worker, payment is made because there is no other option. For fees that are used for the health care facility, the service user may be more sympathetic. SOURCE

The significance of informal payments/user fees is how they affect access to services. They can also be a symptom of corruption in a health care system. Corruption is defined as the "*use of public office for private gains*" (Ensor & Duran-Moreno, 2002). A better understanding of user fees and informal payments provides an insight into one form of corruption that characterises the health care sector, which has followed a form of privatisation, in some countries. They have emerged as a result of health care reforms in former socialist countries, where health workers have low wages, paid irregularly.

There are several types of user fees. Under-the-counter payments are made individually by the patient to a health worker/ profession for a service. User fees are usually made to the health facility for a drugs, materials, food and nursing services. These contribute to a patient receiving a better treatment. In practice under-the-counter payments and user fees are difficult to identify as two separate processes. Some health workers and doctors distinguish between payments before treatment and gifts for treatment received. If a patient is having a series of treatments then this separation can become unclear.

Research

Several studies have used qualitative research methods to explore how both health workers and patients respond to informal payments and how it influences access to health care.
The growth of informal payments in countries of Central and Eastern Europe, have often started by exploring the historical basis to informal payments. This historical approach helps to place informal payments in an economic, cultural and social context. This is also a significant factor in understanding attitudes to informal payments and user fees in Africa.

Table: Informal payments, user fees and co-payments studies

Study and country	Data collection

Balabanova D. Mc Kee M. (2002) Understanding informal payments for health care: the example of Bulgaria 2002 Health Policy 62: 243–273	Data were derived from a national representative survey of 1547 individuals complemented by in-depth interviews and focus groups with over 100 respondents, conducted in Bulgaria in 1997..
Belli P. Gotsadze G. Shahriari H. (2004) Out-of-pocket and informal payments in health sector: evidence from Georgia Health Policy 70: 109–123	In-depth interviews and focus group discussions with users as well as providers.
Liaropoulos L. Siskou O. Kaitelidou D. Theodorou M. Katostaras T. (2008) Informal payments in public hospitals in Greece Health Policy 87: 72–81	randomized countrywide sample of 1616 households, amounting to 4738 individuals. The survey methodology was telephone interviews with a questionnaire supported by the software of Computer Assisted Telephone Interviewing
Falkingham J. (2004) Poverty, out-of-pocket payments and access to health care: evidence fromTajikistan Social Science & Medicine 58 247–258	Use of the Tajikistan Livings Standard Survey to investigate the level and distribution of out-of-pocket payments for health care in Tajikistan and to examine the extent to which such payments act as barriers to health-care access.
Thompson R. & Witter S. (2000) Informal payments in transitional economies: implications for health sector reform International Journal of Health Planning & Management 15: 169-187	Draws on evidence from recent published studies and key informant interviews, examines the factors that influence informal payment systems in state health facilities in the Former Soviet Union and Central and Eastern Europe
Mæstad O. Mwisongo A. (2011) Informal payments and the quality of health care: Mechanisms revealed by Tanzanian health workers Health Policy 99: 107–115	Study informed by data drawn from eight focus groups with 58 health workers representing different cadres and levels of care in one rural and one urban district in Tanzania.
Owuso F. (2005) Livelihood strategies and performance of Ghana's health & education sectors Public Administration & Development 25: 157-174	Data for the study are drawn from fieldwork conducted between 1995 and 1996 in Wenchi and Techiman in the Brong Ahafo Region of Ghana and supplemented with information from the 1991–1992 Ghana Living Standards Survey (GLSS). Interviews also were conducted with officials at the Ministries of Health and Education at the national and district levels. In addition, heads of selected public and private organisations, current and retired employees and service users in Wenchi and Techiman were interviewed using structured questionnaires and focus-group discussions.

Research questions

- How do user fees/ co-payments/ informal payments influence the process of privatisation?
- What impact do user fees/ co-payments/ informal payments have on corruption?

Themes emerging

The review of a series of studies which have interviewed both health workers and service users about the impact of fees and informal payments show that there are several reforms that create an environment where payments for health care are introduced. These are discussed in three sections:

- Events leading to informal payments and user fees
- Perceptions of informal payments and user fees
- Health worker perspectives.

a) Events leading to informal payments and user fees

User fees or informal payments may follow the legal introduction of fees or they may result from the low pay of health care workers. In Central and Eastern Europe, there has been an increase in the use of informal payments and co-payments for health care since the introduction of health sector reforms after 1990. Several factors influence the introduction of informal payments and user fees. Reduction of funding for government health care may result in health workers being paid erratically. The introduction of legislation that makes it legal for health care practitioners to operate as private practitioners and charge fees introduces the concept of fees into the health care system.

In Georgia, the right to free health care was abolished in 1995. Public health insurance was limited to services included in a basic benefit package. It became legal for practitioners to charge fees. What had been a centrally planned system was converted into an internal market. The State Medical Insurance Company, Municipal Health Funds and the Public Health Department (PHD) became purchasers and commissioners of health care services. Hospitals became independent organisations which were reimbursed on a fee per case basis for approved items of the basic benefit package. Health staff were removed from the payroll. For services not included in the basic benefit package, providers were allowed to charge fees and were also allowed to keep money from fees (Belli et al, 2004) In Georgia, fees had existed before 1989 but became more significant after 1990 as incomes fell for the majority of the population, both health workers and patients.

In Tajikistan, reduced health expenditure has resulted in increased household expenditure on health care through under-the-counter payments and informal payments. There is a cultural tradition of giving gifts after treatment but this is changing because of the need to pay more fees for treatment because of declining government health budgets. Although health care is technically still free, some health care organisations are now allowed to charge fees. Hospitals are also allowed to charge fees for an approved list of services, as defined by the Ministry of Health (Falkingham, 2004).

As well as official charges, there is a growing use of informal payments. Health workers are one of the lowest paid groups in Tajikistan and charge informal payments to increase income. Salaries in the public sector, as well as being low, are often paid late and in arrears. It is difficult to distinguish informal, formal and payments for drugs. Lower income groups report lower levels of health problems and lower rates of health service use. When they do need care, cost of care can be a barrier to access. For hospital care, the families of patients are often taking on the responsibilities of bathing, feeding and even injections and giving drugs (Falkingham, 2004).

User fees in Africa were introduced as a result of structural adjustment policies in the 1980s. The research over several decades shows that user fees affected access to services as well as the attitude of service users to public health care services in general (Palmer, et al, 2004). As with informal payments in former socialist countries, user fees were a mix of official policy and a result of low pay for health workers. Historically, public health services had been free in many countries but mission hospitals often charged a small fee. This was often accepted because mission hospitals were considered to provide better quality services.

b) Perceptions

In Greece, a national health system was set up in 1983 to increase access but funding is partly through national taxation, social insurance and private payments. Private insurance cover is low. Out of pocket payments form 41% of health expenditure. 36% of users of hospitals had paid at least one informal payment. Of these respondents, 19% considered informal payments as extra fees and 17% reported informal payments as a voluntary "*tip or gratuity*" (Liaropoulos et al (2008). Few doctors refused the payments and few patients refused to pay. Many informal payments were due to access problems with admission times being restricted or having to negotiate access through a hospital administrator. Educational or income levels were not related to use of informal payments so poor patients are also expected to pay. Patients were found to be more likely to pay for surgery than non-surgical interventions.

Informal payments also influence the type of care that people are able to access. There is a high rate of caesarean sections in Greek hospitals with 60% of women having them in both public and private hospitals but Roma women and immigrant women have much lower rates (5% and 7%), which constitute 60% of caesarean sections in public hospitals (Liaropoulos, 2008). Whether fees are felt to be voluntary or compulsory determined to extent to which users were put off using health services as a result of having to pay fees. Compulsory fees are more likely to make patients consider whether they could afford health care. Informal payments are related to an inadequate public system rather than cultural reasons.

In Bulgaria, user fees, although illegal before 1989, were allowed for low paid medical workers. Since 1989, the use of informal payments had become more widespread.
There was also some impression that the money needed for payments was scarcer than before 1989. People's incomes had been reduced so that making a gift was more difficult. Cash payments were considered to have greater influence then in-kind payments (flowers, chocolates, coffee) (Daskalova et al, 2005). The government has an ambiguous approach to users fees and informal payments. There was some partial recognition with Decree for the Conditions and Procedure for Payment for Health Care of Patient's Choice in December 1997, which outlined which services were eligible for a fee. Since 1989, informal fees and payments have increased (Babanova & McKee, 2002).

Georgia, about 70-80% of health expenditure is generated through formal and informal user fees. Fees are paid for services which are part of the basic benefits package (BPP) and which are not part of this package. Health workers also ask for fees explicitly. Sometime fees may be negotiated at a rate below the official price and so patient will benefit for direct payment. This will mean the money does not go to the government (Belli et al, 2004). This is an example of where official policy on fees can contribute to the health worker working for their own individual interest In Georgia, there is a tradition of giving a gift as a form of gratitude for successful treatment.

In decentralised systems, the guidelines for user fees may be unclear although there is an expectation that institutions are income generating. Governments may overlook that practice (Thompson & Witter, 2000). Patients are often unaware of whether they are paying informal payments or formal fees. Thompson & Witter (2000) identify several factors that influence informal payments: traditions of giving gifts for health care; poor formal salaries of health workers; availability of supplies and quality of services. If there is a successful private sector, the incidence of informal payments may be limited but if there is no formal private sector, informal may expand. In this sense, the use of informal payments by health workers is an example of privatisation but can be described as an informal sector.

Respondents, in Bulgaria, reported that they were more likely to pay in gift or in kind rather than cash. They were more likely to make informal payments in surgery and obstetrics in hospitals in urban areas. Doctors or surgeons were most likely to benefit from informal payments. Cash payments and gifts are presented at different stages in treatment. In Bulgaria, higher income patients were more likely to make informal payments (Daskalova et al, 2005).

In Poland, by 1999, there was no effective choice of insurer so regional funds had a monopoly. The reimbursement system was on a capitation basis so that there was an incentive for doctors to limit patients. Patients could either wait for treatment for pay a fee to have private health care. At least a third of patients paying for services were technically covered by insurance (Filinson et al,2003).

c) Health workers perspective

In many countries, experiencing health sector reforms, salaries of health workers have fallen and are often paid infrequently. In extreme cases, health workers have been taken off the central government payroll and have to generate salaries themselves. Lack of salaries or low salaries force health workers to ask for informal payments in order to live. This was felt to alter the relationship between doctor and patient.

Some people felt that user fees were part of a longer tradition. Health workers had different attitudes to user fees. Some felt they were unethical but others were more accepting of the practice. A third group felt that presents or gifts were acceptable as long as they were voluntary (Daskalova et al, 2005) .

In Tanzania, health workers receive payments in different contexts. These may affect the relationship between health workers and patient and the delivery of patient care. In 1993, user fees were introduced in public health care facilities for a wide range of services. Fees are used to reduce waiting time, as charges for previously ‘free’ services, when there are shortages of drugs, for a private pharmacy in a hospital, and as gifts for successful treatment (Mæstad & Mwisongo, 2011).

A recent survey in Tanzania found that it is difficult assess how much health workers are paid from informal payments as it varies from place to place. However, the survey found that there was a relationship between informal payments and quality of services. If informal payments are linked to a higher quality of service and to corruption, then health workers who do not ask for informal payments, may reduce their quality of service. In this context, corruption may contribute to better quality of services in some cases (Mæstad & Mwisongo, 2011). In whatever scenario, informal payments upset relationships between service users and health workers. They also impact on relationships between health workers.

Informal payments have also been researched as a way of understanding the livelihood strategies used by public sector workers. In Ghana, workers have been involved in livelihood strategies after the value of wages dropped in the 1970s. In 1985, the Hospital Fees Regulation required the Ministry of Health to generate at least 15% of total recurrent expenditure. This was an initial attempt by the government to reform the health sector (Waddington and Enyimayew, 1990). The opportunities for health workers to increase their income came as a result of recruitment freezes, which enabled them to work overtime and/or convert their annual leave time into money. In 1994, overtime payments to heath sector employees amounted to 10% of the total expenditure. In addition, some health sector employees collected unauthorized fees, whilst others demanded bribes and ‘tips’ before a service was provided. The percentage of people who sought public health care between 1992 and 1998 decreased by 12.8%, most rapidly among the poor. There was a high level of patient dissatisfaction with the service received (Owusu, 2005).

In many African countries, which introduced user fees in the 1980s, governments have started to deliver free health care, often as a way of achieving the Millennium Development Goals. A recent review of literature on the abolition of user fees shows that the elimination of user fees has to be implemented carefully if it is to increase access to services (Riddle & Morestin, 2011). This is another indication that once user charges are introduced, this can change the balance of relationships within health care services. When free access to services is reintroduced, careful implementation is key to success. There has to be a political will, coordination between government departments, adequate human resources to deal with increased demand for services, and incentives to increase the support of health workers (Riddle & Morestin, 2011).

Conclusions

How do user fees/ co-payments/ informal payments influence process of privatisation?
What impact do user fees/ informal payments have on service delivery?

Informal payments and user fees are a characteristic of countries in Central and Eastern Europe, and countries of the former Soviet Union as well as many African countries. Significant stages in the process of introducing informal payments is the legalisation of fee charging by practitioners, which may be part of an opening out of the health care system to competition. When health workers are no longer directly paid but placed in a position where their salary is dependent on fees collected, charging informal fees will be part of a survival strategy.

Although the cultural context may vary, with some countries having a tradition of giving gifts to doctors after successful treatment, this is being superseded by a complex system of informal payments (under-the-counter) and user fees. Inadequate funding of the health care system is one main reason for the expansion of informal payments. However, the low pay and low morale of health workers is another contributory factor. This has an influence on the relationship between service user and health worker. The ability of a service user to access health care is often dependent on making a payment to a health worker. This can erode the sense of trust between service user and health worker. Informal payments can be seen as a form of corruption, where the health worker is making a decision for their own individual benefit that is not necessarily for the benefit of the service user. Informal payments are taking a growing percentage of household expenditure which is resulting in low income households making decisions not to access health care.

Key points

- A sequence of events introduces opportunities for informal payments – legal introduction of co-payments, income generation targets for health care facilities, reduction of government expenditure on health care, low salaries for health workers
- Informal payments influence whether low income service users can access health care services
- Informal payments/ user fees results in increases in the proportion of household expenditure spent on health care and decreases in publicly funded health care
- Informal payments undermine the independence of the public health care sector and makes it subject to individual gain and corruption
- Attempts to eliminate user fees or informal payments need political will, new incentives for health workers and interagency support

5 Central and Eastern Europe health sector reforms

The experience of countries in Central and Eastern Europe and the former Soviet Union provide a series of case studies, which show how health care systems have moved from a state-run health care system to a market orientated system in just over 20 years. This experience is significant in that it provides an illustration of how the processes of marketisation and privatisation can gradually change a publicly funded system, free at the point of access. This review will seek to show whether there are identifiable stages in this process of marketisation that lead from changes in financing and administration.

Central and Eastern European countries and former Soviet Union health sector reforms

Studies	Methodology and analytical approach
Datzova B.V. (2006) The difficult transition to national health insurance in Bulgaria Journal of International Development 18: 425–434	Case study drawing on secondary sources and published surveys of service users
Daskalova N. Tomev L. Ivanova V. Nikolova A. Naydenova Z. Trakieva D. (2005) Health care reforms and privatization – social and economic consequences case of Bulgaria Sofia: Institute for social and trade union research	Analysis of health reforms to outline the labour and social consequences for the health workers and patients of the on-going reforms through use of : focus groups with key players in government and health care system; questionnaire survey of patients and practitioners; analysis of published statistical information; review of health care legislation
Oswald S. Economic Transition in the Czech Republic : Attempts to Privatize the Health System Administration & Society 32(3): 227-254	Case study of Czech Republic and agency theory as theoretical framework
Bonilla-Chacin M.E. & Murrugarra E. with Temourov M. (2005) Health Care during Transition and Health Systems Reform: Evidence from the Poorest CIS Countries Administration & Society 39(4): 381-408	A comparative synthesis of existing knowledge, developed largely through World Bank sector reviews, expenditure reviews and poverty assessments, the WHO Health for All database (HFADB), 2 the UNICEF Trans MONEE database 3 and other country studies.
Nemec J. & Kolisnichenko N. (2006) Market-based health care reforms in Central and Eastern Europe: lessons after ten years of change International Review of Administrative Sciences 72(1):11–26	Draws from series of country studies. Case studies of Armenia, the Czech Republic, Russia and Ukraine, which are drawn from a larger group of eight much longer and highly detailed case studies that also included Albania, Bulgaria, Georgia and Slovakia. Each case study carried out by a country-based scholar or team.
Filinson R. Chmielewski P. Niklas D. (2003) Back to the future: Polish health care reform Communist and Post-Communist Studies 36 (2003) 385–403	A study of Polish reforms informed by interviews with key informants and surveys completed by administrators of the newly developed insurance funds and by health care workers.
Lawson C. & Nemec J. (2003) The Political Economy of Slovak and Czech Health Policy: 1989–2000 International Political Science Review 24 (2): 219–	Analysis of key players and policy relationship with health outcomes in a comparative study of two countries.

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Nemec J. & Lawson C. (2005) Health Policy in Slovakia and the Outcomes of Health Care Reforms: 1989-2003 Journal of Comparative Policy Analysis: Research and Practice 7(1): 49-71	Analysis of key policy players and assessment of outcomes of health care reform in Slovakia, through health status, quality of services delivered, access to services and financial performance .
Albrehta T. Klazingab N. (2009) Privatisation of health care in Slovenia in the period 1992–2008 Health Policy 90: 262–269	Descriptive analyses of legal and policy documents mapping the situation in Slovenia against an internationally established taxonomy and typology of privatisation.

Research into health sector reform in this region has used several research methodologies but the majority of studies are case studies. Some focus on one country, with others using a multi-country approach. Research to identify the impact of reforms on services users and health workers draw on survey methods but these are limited by available resources. Several studies use a policy analysis approach, with interviews with key informants.

Research questions

- What are the key stages in the transformation of a state-run health care system to a market orientated system?
- *How is access to health care affected by this transformation?*
- *How are health workers affected by this transformation*?

Emerging themes

Until 1989, health care was free at the point of use, the state invested in training of doctors but there was under-funding of hospitals and equipment (Oswald, 2000).
Countries in Central and Eastern European countries introduced health sector
reforms after 1989 that aimed to improve access, provide choice, increased efficiency, and competition in health care (Albrecht, Klazinga, 2009). Privatisation was not articulated as a specific goal. This was in contrast to other sectors where privatisation of public enterprises was actively promoted. However, the changes that have taken place in this region can be viewed as a transition from state-run provision of health care to a marketised system.

A review of national and multi-country studies shows that several stages characterise the change towards a market orientated health system:

- Health financing reforms;
- Legislating for private practice;
- Reforms in management of hospitals;
- Payment of fees for health care and corruption;

a) Health care financing

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

However, there is also documented experience that the success of a social insurance scheme is dependent on effective methods to collect contributions, an example of how implementation issues affect policy outcomes. Several countries, have found that collection methods were inadequate to secure regular incomes from insurance funds. In Bulgaria, the 1998 National Health Insurance Act, (and 28 regional health funds) introduced compulsory membership, which aimed to introduce risk pooling and medical care purchasing for the whole population. However, the National Health Insurance Fund (NHIF) has not become fully operational because of delays in the collection of contributions and widespread poverty. Out-of-pocket payments also contributed to the failure of the NHIF to achieve risk pooling because people were unable to afford both contributions and out of pocket payments (Datzova 2006; Daskalova et al, 2005).

Russia has also experienced problems with collection of contributions which has weakened the health care system. In 1991, the law on compulsory health insurance (CHI) was passed, which set up regional insurance funds. There have been problems with the collection of contributions because enterprises and regional administrations did not always make contributions. Health administrators were unwilling to make contributions for the non-economically active population (Bonilla-Chacin et al, 2005).

In the Czech Republic, a new compulsory health insurance system was set up in 1992, with a 13.5% tax on wages (Oswald, 2000). Employers were to pay contributions of two-thirds and employees were to pay a third of the contributions. The General Health Care Insurance Office (GHIO) replaced the national health care system. In 1993, legislation was passed that introduced competitive health insurers. The Sectional Progressive Corporate and Other Health Insurance Act gave a legal framework for competitors, such as employer-backed insurance companies, to enter the health insurance market. Some sectors set up their own insurance companies. The GHIO now has 75% of the health insurance market. The health care system is a 'fee for service' system, which is reimbursed by a third party (health insurance company). The government approves the services and treatments that can be reimbursed so still retains some control over the system.

In Slovakia, new legislation that regulated health insurance and set up 13 health insurance companies was introduced in 1994 (Nemec & Lawson, 2005). As with the Czech Republic, the government sets the level of insurance payments in relation to wages and reimbursement rates for health providers. Armenia set up a new finance system, called the State Health Agency, which operates as a third party payer. It distributes the state allocations to health care facilities and takes full responsibility for the management of state financial resources (Nemec & Kolisnichenko, 2006)

b) Legislating for private practice

There are several legislative changes, which enable a state health care system to become a marketised system. These involve creating a group of health care practitioners who are legally allowed to practice independently of the state sector and charge fees. Within two or three years many new governments in Central and Eastern Europe introduced legislation that made it legal for health professionals to work as private practitioners. Although this did not immediately lead to an expanding private health care sector, the legislation can now be viewed as a significant step in the process of creating health care markets, where practitioners were in competition and service users started to pay for health care.

Reforms of heath care financing and changes in hospital management and funding have also contributed to this process. Several groups of stakeholders have played an important role in supporting these changes. Although these processes are present in all countries, there are examples of where fundamental changes have been challenged and/ or reversed (Oswald, 2000). The strength of a continued goal of a universal health care system should not be underestimated.

Health professionals need to be able to practice legally as independent or private practitioners. For example, in Bulgaria, in 1991, amendments were passed to the People's Health Act (first published in National Assembly of the Republic of Bulgaria Gazette, 1973) which gave rights to all practitioners and

dentists to have private practices. In 1997, it became legal for doctors to charge co-payments for health care (Datsova, 2006). Private providers of outpatient care were allowed to compete against state providers in 2000. Although primary care is now commercialised but the majority of primary care doctors are dependent on the NHIF for contracts in Bulgaria.

In Slovenia, in 1992, health professionals were given the legal right to practice as private practitioners. A system of regulation was put in place, which required private practitioners to apply for recognition as a private provider, involving checking of qualifications and premises (Albrecht, Klazinga, 2009). Co-payments and voluntary health insurance schemes were introduced as the same time, creating a structure for a privatised system. Private providers require service users to pay for health care either directly through co-payments or through voluntary health insurance schemes.

c) Hospital management

The management of hospitals and other health facilities have been subject to reforms, most often delegating responsibility from central to local government level, as part of a decentralisation process. The extent to which hospitals have been privatised varies from country to country.

There has been limited hospital privatisation in Bulgaria but in 1992, the Health Establishments Act led to a transfer of control of hospitals/ health care facilities from central government to local authority ownership. The national state still has ownership of half the capital and municipal authorities own the other half, under the control of the municipal council. The change of ownership and change in legal status gave them opportunities to make profits. In 2002, the privatisation of hospitals was postponed through the 'Privatization and Post privatization control Act' but in 2002 the National Health Insurance Fund (NHIF) started to contract with private hospitals
(Daskalova et al, 2005; Datzova, 2006).

In the Czech Republic, some hospitals were privatised and have an influence over health policy. Local authorities took over some hospitals and local physicians took over equipment, often using government loans to buy equipment, an example of government subsidised privatisation. Community health centres were sold to non-profit, religious or private owners (Oswald, 2000). By contrast, there has been a slower process of privatisation of hospitals in Slovakia. In 2002, the management of hospitals was decentralized, and some hospitals were given self-governing status. By 2003 most of them had been transferred to regional self-governments, or converted into non-profit bodies (Nemec & Lawson, 2005). The remaining state hospitals have set up their own lobbying group.

In Armenia, hospital management was reform initially by the 1991 Law on State Non-Commercial Organizations, which required health care facilities to be reconstituted as state non-commercial organizations. In 1997, as part of the decentralization of the health care system, all health care facilities were reconstituted as non-commercial state joint stock companies following the 1996 Law on Joint Stock Companies (Nemec and Kolisnichenko, 2006).

Changes in the status and management of public hospitals have led to the introduction of some form of marketisation. The levels of competition vary from country to country. This had been taking place at a time when the role of central and municipal government has been changing from a provider to purchaser and commissioner of services. The influence of public and private hospitals as separate interest groups varies from country to country.

d) Payment of fees for health care

Almost every country in the region shows an increase in the percentage of household income being spent on health care after 1989. In Bulgaria, from a position of 100% state funding in 1989, over 98% of health spending is now from out of pocket spending (Datsova, 2006), when defined as fees for public sector

services or fees for access to private providers and medicines. Income has become a major determinant of access to health care.

Some governments have attempted to secure basic health care coverage for the poorest groups. This can be done through the creation of a basic set of health care benefits. In 1996, Armenia introduced a Basic Benefits Package (BBP) as part of a health care reform programme (Nemec & Kolisnichenko, 2006). Another option is for government to pay the social insurance contributions for low income groups. This has proved difficult for several countries as administrations have resisted making the contributions because it contributes to an increase in state spending. In Poland, the failure of a privatisation programme was because government was expected to pay premiums for pensioners and unemployed people (Filinson et al, 2003).

Social insurance schemes are based on an employment model, with contributions made by employees and employers. Unemployed people may be covered by a more basic benefit scheme or will be excluded from health care unless they make direct payments themselves (Datzova, 2006).

Responses to reforms

One of the characteristics of the political process that accompanied the introduction of health reforms in countries of central and Eastern Europe was that the participation of the public was limited. The key actors were doctors, hospitals, pharmaceutical companies, and insurance companies. Patients and local population were the least important group and had the most limited influence (Daskalova et al, 2005; Lawson & Nemec, 2003; Nemec & Lawson, 2005). In Poland, there was patient hostility to insurance funds coupled with a lack of information and some misinformation that led to failure of a reform, which would have introduced universal access to health care (Filinson, 2003). The lack of public participation in reforms should be understood in the context of countries where there is no tradition of civil society organisations or non-governmental organisations.

In several countries, doctors were initially supporters of reforms as well as pharmaceutical companies and insurance companies. The alliance of these three groups has been active in many countries. The role of hospitals as an interest varies according to the level of privatisation of the hospital sector. In Slovakia, state hospitals have formed an interest group. In Czech Republic, private hospitals influence health policy.

Corruption

The incidence of corruption, defined as “the use of public office for private gain” is perceived to have increased since the reforms, although it also existed before 1989. In Bulgaria, both patients and health workers felt that “there is corruption in healthcare and it is even higher after the start of the reforms” (Dalkalova et al, 2005). There are several points in the process of health care delivery that provide opportunities for bribes. The use of informal payments is one of the most common forms but the factors that lead to informal payments are not the same in every country. Low or irregular pay of health workers is one trigger. Inability of patients to access a social insurance system can lead to them making informal payments to access healthcare. In some countries, the existence of a private sector can lead to less pressure for health workers to ask for informal payments because the private sector provides an alternative source of health care, which can be paid for directly or through private health insurance. This is more accessible for high income groups. Low income groups are particularly vulnerable to informal payments because they are unable to afford either social insurance or private health insurance.

There are several stages that have characterised the transformation of a state-run health care system to a market orientated system. The introduction of a new social insurance system for health financing is significant change. Legislative changes that allow health care practitioner to practice as private practitioners as well as charge fees is one of the most significant changes. The management arrangements of hospitals also change, sometimes become self-managing, but always becoming more commercialised.

The introduction of user fees or informal payments is another fundamental change, which affects access to health care by disadvantaged groups.

Key stages

- Changes in insurance for health financing
- Legislation to allow health care practitioners to operate as private practitioners and charge fees
- Decentralisation and self- management of hospitals
- User fees or informal payments
- Access to health services reduced
- Corruption at different levels

6 Labour

Health care is a labour-intensive activity and a highly motivated, well trained, well-paid labour force is an essential part in the delivery of high quality health care. Although it is has a central role to play, it has often been seen as a problem that has to be addressed by public sector reforms. A paper prepared for the OECD (2002) pointed out that:

> *"There is a danger that the constitutional, legal, cultural and leadership factors, which together create what is important and distinctive about public services, are not reflected on, or are dismissed as the bureaucratic problem which must be 'reformed' "* (Matheson, 2002).

Marketisation and privatisation have directly affected health workers, by increasing workloads, changing terms and conditions, and making health workers work towards targets and other aspects of a managerial agenda. This has resulted in changes in the relationship with patients. This section will examine a series of studies that have looked at how the health care workforce in different parts of the world has been affected by the processes of marketisation and commercialisation.

Approaches to research

A series of studies provides some indication of the extensive changes that health workers have experienced and how it has affected their socio-economic security (Healy and Humphries, 1998; Brito el al, 2001; CUPE, 2001; Stepantchikova et al, 2001; Lehmann and Saunders, 2003; Afford, 2003). This research was often commissioned or undertaken by trade unions and other groups committed to workers' rights. More recently, a growing body of research has looked at the impact of public-private partnerships on pay and working conditions, as well as trying to capture how the public sector 'ethos' is changing. This is based on the experience of the UK and provides some useful evidence of how the position of workers is affected by this type of private sector involvement. Research studies of other countries, with varying degrees of private involvement in public health care, show how workers experience increased marketisation and private sector involvement.

Study and country	**Data collection**
Afford C.W. (2003) Corrosive Reform: Failing health reforms in Eastern Europe ILI Socio-Economic Security Programme ILI/ PSI	This study drew from three surveys into health workers' insecurity in Central and Eastern Europe. The first drew from data provided by 15 PSI affiliates who completed a Basic Security Survey for 1990-1999. The second examined four countries, Czech Republic, Lithuania, Romania, and Ukraine, to assess how restructuring was affecting the working lives of health workers through the use of interviews and surveys of management, government representatives, union officials and worker representatives. The third survey looked at evidence of how the socio-economic situation in Russia was affecting health workers, through document analysis and interviews with health workers and their representatives.
Owuso F. (2005) Livelihood strategies and performance of Ghana's health & education sectors Public Administration & Development 25: 157-174	Data for the study was drawn from fieldwork conducted between 1995 and 1996 in Wenchi and Techiman in the Brong Ahafo Region of Ghana and supplemented with information from the 1991–1992 Ghana Living Standards Survey (GLSS). Interviews also were conducted with officials at the Ministries of Health and Education at the national and district levels. In addition, heads of selected public and private organisations, current and retired employees and service users in Wenchi and

	Techiman were interviewed using structured questionnaires and focus-group discussions.
Bhat R. and Maheshwari S.K. (2005) Human Resource Issues : Implications for Health Sector reforms Journal of Health Management 7(1):1-39	A mix of qualitative and quantitative methodologies were used to study the commitment of district level health officials in a newly created state (Chhattisgarh) in India. The exploratory study was conducted through focused group discussions with six district health officials and four officers in the state directorate. Individual interviews with four doctors at a community health centre and focus group discussions informed the development of a questionnaire, to assess relevant issues at management training programmes at the Indian Institute of Management. This was circulated to three groups attending the programmes, which consisted of 75 district and state health officials. 70 responded to the questionnaire.
Zullo R. & Ness I. (2009) Privatization and the Working Conditions of Health Care Support International Journal of Public Administration, 32: 152–165, 2009	This study used an assisted survey approach, to compare health care service employees' perceptions of work between public and privatized health care settings in the US. Two were public (one state and one county), two were public but contracted with private firms for specific services, and two were formerly public that converted to private control. The sample size target was 300.
Engstrom A.K. & Axelsson R. (2010) The double spiral of change—experiences of privatization in a Swedish hospital International Journal of Health Planning & Management 25: 156–168	In-depth interviews have been performed with physicians, paramedics, secretaries, nurses, assistant nurses and local managers, in all 14 respondents, after a private entrepreneur had taken over the management of a hospital. The interviews were tape-recorded and have been analysed and interpreted following a grounded theory approach
Hebson G. Grimshaw D. & Marchington M. (2003) Public Private Partnerships and the Changing Public Sector Ethos Work, Employment and Society 17(3): 481–501	Two detailed case studies of Public-private partnerships, called the Private Finance Initiative in the UK, consisting of one study in the health sector and one in the housing sector.
Grimshaw D. Rubery J. & Marchington M. (2010) Managing people across hospital networks in the UK: multiple employers and the shaping of HRM Human Resource Management Journal 20(4) : 407–423	Two qualitative case studies of 'best practice' in long-term collaborative working. two case studies: a public–public network in health and social care (HSC), and a public–private partnership to manage and deliver ancillary services in a large acute hospital. Empirical observation was conducted at different levels within the inter-organisational partnerships and interviews with individuals employed by different partner organisation were conducted with managers, non-managerial staff and 2 trade union representative as well as analysis of documentary evidence of HR policies. A total of 26 interviews were conducted across the two cases.
Bach S. & Givan R. K. (2010) Regulating employment conditions in a hospital network: the case of the Private Finance Initiative Human Resource Management Journal 20(4): 424-439	A five-year case study of the workforce consequences of Private Finance Initiative (PFI), which formed part of a wider study that examined trade union responses to new public management reforms. The research was based on 33 semi-structured interviews with key actors. At the national level, informants were drawn from national trade unions and the Trade Union Congress (TUC), employer organisations and investors in PFI

	consortia. Each interview lasted between 30 and 90 minutes and was recorded and fully transcribed. A document analysis complemented the interview findings.

Research question

- What is the impact of marketisation and privatisation on the pay, working conditions and identity of health workers?

Emerging themes

- Pay and working conditions
- Dealing with loss of income
- Attitudes to work and public sector ethos

Pay and working conditions

Afford (2003) provides one of the most detailed accounts of how health workers have been affected by health sector reforms in countries of Central and Eastern Europe. Looking at all aspects of workers' security, the study shows that low pay and unpaid overtime were characteristic of almost all countries. Low pay was the result of falling wages, which were often paid late. There was a loss of actual benefits, for example redundancy pay or pensions. Although workers technically still were eligible for sick pay and holiday pay, many were afraid of losing their jobs so were unwilling to take time off.

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

Decentralisation led to local authorities being responsible for health worker employment contracts but they often did not have the expertise and resources, making workers more vulnerable. Some groups of health care professionals had moved into the private sector and this has affected the security of nursing and support staff in each private practice.

There are a range of other studies, often in one country, which contribute to a body of knowledge about how health workers are experiencing changes in the public health care sector in relation to their pay and conditions. One of the most striking similarities in many regions, is that the levels of pay and benefits for health workers are often deteriorating as a result of marketisation and privatisation.

Zullo & Ness (2009) explored the different perceptions of rewards between health ancillary workers in the public and private sectors in the United States. They found that health ancillary workers felt that rewards were lower in the private sector as well as the quality of supervision being lower in private companies. There was also a decrease in opportunities for learning new skills and promotion. Privatisation resulted in employees losing rights to negotiate pay and benefits. This fitted into the belief that the aim of contracting was to reduce costs, which in labour intensive activities, has to involve reducing pay and terms and conditions.

Similar finding were reported by Hebson et al (2003) in a study of two Private Finance Initiatives (PSI) initiatives in the United Kingdom (UK), one of which was a new hospital initiative. They found that for non-managerial workers, terms and conditions had often worsened. Although the UK has a Transfer of Undertakings (Protection of Employment) (TUPE) Regulations, which is supposed to provide some protection for workers who are transferred to a private sector company, that company may introduce a reorganisation for technical, business or organisational reasons or workers may be transferred to another company taking on a public sector contract (Page, 2004).

Another study shows a more nuanced view of how employment conditions have changed in a PFI hospital (Bach & Givan 2010), which reflects some more recent UK governmental strategies. In 2005, the unions, employers and Department of Health in the UK came to an agreement that private contractors in NHS hospitals would give pay and terms and conditions which were 'no less favourable' (Bach & Givan, 2010:427). The costs of this initiative would be split between the NHS and private contractors. This has been seen as a way of reassuring staff when transferring to the private sector. It is also a form of government re-regulation, considered necessary to continue the public private partnership agenda.

In this case the commitment of managers of NHS Trust and private contractor increased the scope for re-regulation. Effective workplace trade union organisation enabled national agreements to be implemented at local level. Union density is not as high in many PFI initiatives, so this option is not always available. This study concludes that PPPs or this form of marketisation does not necessarily lead to the retreat of the state. In the short term, re-regulation may be necessary to resolve issues between the workforce and the private company. However, there are limits to the extent to which the private sector can be 'guided' by the public sector. In the UK, pensions were a contentious issue that were not resolved through re-regulation. Since Bach and Givan (2010) published this article, there has been a change of government which is abandoning many aspects of re-regulation. Public sector pensions are now subject to attack by government, so addressing concerns of the private sector about pension contributions.

Dealing with loss of income

Health workers affected by falling wages and late or non-payment wages have to adopt strategies to deal with loss of income. Migrating to another country to find a better paid job is one solution which has been reflected in high rates of health care worker migration from countries with limited health care resources to countries with countries with a demand for health care workers. This has led to a depletion of skilled health care workers in countries that are already experiencing a weakening of health care systems.

Another solution to falling levels of pay, which also affects the quality of health care, is that health workers either find a second job, often in the private sector. Attempting to do two jobs affects the quality of health care delivered. This may be accompanied by a demand from health workers for informal payments from patients (see section on I**nformal Payments**).

Many health workers in African countries have experienced falls in real wages and loss of benefits since the 1970s and their experience is important in understanding how changes in the pay and conditions of health workers affects the quality of health care. Owuso (2003) reported that Ghanaian workers had been involved in strategies to maintain their incomes after the introduction of the 1985 Hospital Fees Regulation, which required the Ministry of Health (MOH) to generate at least 15% of total recurrent expenditure, which was an early attempt to reform the health sector. This was followed by attempts to promote cost-recovery along with the redeployment of staff and reduction of recruitment. The immediate result was that the quality of health care deteriorated. The percentage of people who accessed public health care between 1992 and 1998 decreased by 12.8% and this percentage was higher among very low income groups. There was an increase in the level of patient dissatisfaction with the service received. Some health sector employees collected unauthorized fees, whist others demand bribes and 'tips' before a service is provided. A freeze of jobs in the health sector meant that health care workers had more opportunities to work overtime and/or convert their annual leave time into money. In 1994, overtime payments to health care employees amounted to 10% of the total expenditure. This study shows that when health worker incomes are reduced, health workers have to adopt survival strategies which affect the quality of health care.

Public sector ethos

Motivation of health care workers plays an important role in high quality health care services. A growing number of studies are looking at changes in the attitudes of health workers following the introduction of marketisation and privatisation. Some studies show that these policies sometimes affect relationships between health care workers.

In the UK, a study of health workers operating in a new public-private partnership, a Private Finance Initiative hospital, which aimed to improve services as an alternative to direct contracting out of services to the private sector. The PFI initiative was an NHS Acute Trust, in partnership with a private sector consortium, which subcontracted building construction and facilities management to two separate private sector companies (Grimshaw et al, 2010). Managers from the hospital trust were trying to develop systems to share information between them and the managers of the company responsible for contracting of facilities management services.

Although extensive time and resources were used, there were several factors that undermined the development of shared information. There was a high turnover of managers in the facilities management company which made sharing information difficult. A second problem was the management of NHS staff by the facilities management company, which NHS managers felt was problematic between of the different goals of the private company. Although the private company was felt able to provide access to training facilities, which an NHS hospital might not have access to; there were some more fundamental problems. It was difficult to encourage staff to apply for supervisory posts because it involved changing employer from the NHS to the private company.

National NHS training policies, such as 'Improving Working Lives', were supposed to be implemented across the hospital, including the private facilities management company but these also cut across the company human resource systems. The private company, although agreeing with the NHS on skill standards, did not open access to its commercial awareness training. This shows that bringing an NHS hospital together with a private company presents difficulties because of the different goals of the two organisations. Public and private goals are different and cannot easily be reconciled.

A study of how public-private partnership arrangements have influenced the public sector 'ethos' looked at the changes that have taken place in the different dimensions of public sector 'ethos' in the health and housing sectors. The four dimensions considered were accountability, bureaucratic behaviour, public interest, motivation and loyalty. Hebson et al (2003) found that the contract system of decision making was replacing a more transparent arrangement of accountability and bureaucratic behaviour. Public and private managers were found to have different priorities and the process of monitoring a contract did not lead to high trust relationships. The greater scope for managerial discretion led to a breakdown of trust and public sector managers became more manipulative to secure value for money.

Although working for performance related targets has replaced working for the public interest, there was evidence that principles of working for the public interest and public accountability have not been completely eroded (Hebson et al, 2003: 498). To what extent this will continue, when the overall motivation is presented as meeting performance targets is unclear.

Looking at the attitudes from the perspectives of health workers in a recently privatisated hospital in Sweden, Engstrom & Alexsson (2010) found that trust in their employer was an important part of their working life. Without trust, their working lives would be more difficult. In this study of a recent privatisation, workers did not have confidence in the new owner, which was affected by the recent acquisition of the employer by an international venture capital company. The workers felt that their employer had to show an interest in them. They were worried about the lack of interest that the employer was showing in the increased sickness absence and the loss of doctors in the hospital. This was part of a lack of confidence in organisation and human resource management. The workers wanted to be part of plans for the future of the hospital, hoping the new owner has plans for its expansion, but they had not heard anything. They did not trust the information that management was giving them and did not feel that the new owner was really leading the organisation.

Health workers were also anxious about the need of the owner to generate profit, not knowing how this would affect the running of the hospital. Being part of a privatised hospital was felt to impact on the scope of health workers to be part of the national health system, for example projects and training. The employees had not been fully involved in the decision to take over the hospital. Well-established teams had been broken up before privatisation but some new smaller teams were developing post-privatisation. Respondents also felt that there had been a deterioration in the services:

> "*the takeover had led to a poorer service, such as reduced telephone access, which resulted in frustration among the population. In addition, the cost of a visit could no longer be invoiced and only cash payments were accepted*" (Engstrom & Alexsson, 2010).

However, pride in their work was considered to be related to how the health workers, performed as professionals, rather than being influenced by who owned the hospital, a separation of professional interests from commercial ones. This study shows how attitudes of health workers are quickly influenced by changes in ownership of a hospital.

India has a large public health care sector that is gradually being affected by the promotion of private health care companies and the encouragement of government doctors to pursue private practice. A study of health care workers in a new state of Chandigarh, India, found they were motivated to provide high quality services through their sense of professional responsibility. A continued sense of job security and a seniority-based pay system in government jobs contributed to a cooperative behaviour among the doctors. However, this cooperative behaviour was gradually being undermined by competitive private practices by government doctors, which was linked to enhancement of their professional interests (Bhat and Maheshwari, 2005).

This research also concluded with some insights about the tasks that health professionals were increased expected to provide. They felt that they had to perform three different types of tasks, which required three different types of skills: regulating and monitoring (authority), provision of health care services (influence), and facilitating and coordinating the provision of services (coordination). These three skills sets are an indication of how the nature of being a health worker is changing (Bhat and Maheshwari, 2005).

Key points

- Health workers have experienced deterioration of pay and working conditions
- Reduced pay or erratic payments of salaries results in workers adopting survival strategies which affect quality of health care
- Working with the private sector is difficult due to different goals
- Re-regulation of workers rights often necessary to persuade workers to move from the public to private sector
- Trust and public sector 'ethos' is affected by trying to being public and private interests together

7 Competition, hospital efficiency and privatisation

In current debates about marketisation and privatisation, the introduction of competition and establishing 'diverse providers' are considered to contribute to the efficiency of health services. This section will consider a series of studies that explore the impact of competition on the efficiency of health services and the relationship between ownership and efficiency.

Research questions

- What is the relationship between competition and efficiency in health services?
- What is the relationship between ownership and efficiency in health services?

Approaches to research

The terms efficiency and effectiveness, both widely used as goals of health sector reform, are difficult to define and measure. Hussey et al (2009) in a systematic review of health care efficiency measures found that there had been few evaluations of the reliability and validity of widely used efficiency measures. A further finding was that quality of care was rarely considered by the 265 different measures of efficiency. It is this lack of consensus about how to measure quality of care that questions the many ways of measuring efficiency.

Hussey et al developed a typology of efficiency measures from the review. This consists of three levels:

- Perspective: Who is evaluating the efficiency of which intervention/ service and what is the objective of the evaluation?
- Outputs: What type of product is being evaluated, e.g. health services or outcomes?
- Inputs: What inputs are used to produce the output? For example, nursing hours, bed days, quantities of drugs, which can be defined as physical inputs and financial inputs (Hussey et al, 2009: 787).

One of the issues arising is whether outputs are comparable, especially in relation to quality. There may be differences within a service or in a group of services. There may be differences between patients. The review also found that most of the studies of efficiency of health care were focused on hospital care. Incorporating measures for quality in efficiency measures is a relatively undeveloped process and it is this lack of quality measures that undermine the validity of current effectiveness measures.

Measurement of efficiency

There are several tools used to measure health care efficiency. Three of the most commonly used are outlined below.

Data Envelopment Analysis/ Stochastic Frontier Analysis

Two benchmarking techniques, Data Envelopment Analysis (DEA) and Stochastic Frontier Analysis, are both forms of 'frontier analysis'. Developed for use in industrial settings, these two techniques measure the inputs and outputs of a process in order to identify the most efficiency combinations of inputs and outputs. Both techniques require a definition of the relationship between inputs and outputs. This is more difficult to define in the context of the health care sector because the factors that influence the efficient delivery of health care may not be just the more obvious factors, such as hours of nursing care or amount of drugs (Hussey et al , 2009: 793)

Malmquist Productivity Index

The Malmquist Productivity Index has been used to measure health care efficiency. This measure has also been developed in a business/ industrial context and then applied to the health care setting.

Herfindahl Hirschman Index
The Herfindahl Hirschman Index (HHI), which measures market share of companies is a measure of firm ownership used in economic studies. It has been applied to hospital ownership and other aspects of hospital activities. The Herfindahl Hirschman Index is drawn up by calculating the sum of the squared market share for all companies/ hospitals/entities. The index ranges from 0 to 10,000 with lower scores indicating a more competitive market (US Dept. of Justice, 2011).

The first two measures originate from industrial organisational studies, which have been designed to measure the efficiency of industrial organisations in terms of inputs and outputs. This immediately raises the question of the appropriateness of using measures designed for an industrial production process but now applied to the delivery of health care. The lack of a quality dimension in many efficiency studies illustrates this problem. Hollingsworth et al (1999), in a review of measuring health care through DEA and the Malmquist Productivity Index, recommended caution in interpreting results. The inability to measure real outputs of health care, for example, change in health status, undermines their validity. Both techniques work better with a simpler manufacturing activity rather then a multi-dimensional process such as health care.

1. Competition and efficiency

Research studies and methodologies

Study	Methodology
Propper C. & Soderlund N. (1998) Competition in the NHS Internal market: an overview of its effects on hospitals prices and costs Health Economics 7:187-197	Pricing
Propper C. Burgess S. Gossage D. (2003) Competition and Quality: Evidence from the NHS Internal market 1991-99 CMPO Working Paper Series No 03/077	Pricing Quality indicator - death rates from acute myocardial infarction as an indicator of quality
Gaynor M. Moreno-Serra R. and Propper C. (2010/11) Death by Market Power Reform, Competition and Patient Outcomes in the National Health Service Working Paper No. 10/242 Centre for Market and Public Organisation	*Herfindahl Hirschman Index(HHI)* Patient flows to a hospital were chosen as an indicator of market share. It was assumed that the greater the number of patients attending the hospital, the higher the degree of market concentration (fewer competitors) and so the lower rate of competition
Ferrari A. (2006) The internal market and hospital efficiency: a stochastic distance function approach Applied Economics 38: 2121-2139	Stochastic frontier analysis used five inputs: total capital charges; medical staff FTE; nursing staff FTE; other staff FTE and; total number of beds. Output was defined as total number of cases treated.
Cooper Z. Gibbons S. Jones S. & McGuire A. (2010) Does hospital competition improve efficiency? An analysis of the recent market-based reforms for the English NHS Centre for Economic Performance Discussion Paper No 988 June 2010 LSE/ESRC	Difference in difference estimator. Length of Stay (LOS) was broken down into two key components: the time from a patient's admission until their surgery (pre-surgery LOS) and the time from their surgery until their discharge (post-surgery LOS).
Chen C-C. Cheng S-H. (2010) Hospitals competition and patient-perceived quality of	HHI – assessed through the number of discharges divided by the total market area

care: evidence from a single payer system in Taiwan Health Economics 98 65-73	discharges Quality indicators - interpersonal skills and clinical competency
Chua C. L. Palangkaraya A. & Yong J. (2011) Hospital competition, technical efficiency The Economic Record 1-17	HHI – assessed by using patient locational information for the main Diagnostic Related Groups and the significance of the local area in supplying patients to a hospital.

NHS internal market

The introduction of an internal market to the NHS in the UK has been the subject of several studies that attempt to assess whether competition has had an impact on efficiency. The results appear to be mixed. Studies which examine data at the beginning of the internal market, between 1991-1999, show that competition has had a limited impact on efficiency. A couple of more recent studies show that the internal market has led to increased efficiency. These studies will be discussed below, with some of their limitations highlighted.

Farrari (2006) studied the changes in technical efficiency of a panel of 52 acute Scottish hospitals, from 1991/92 to 1996/9, which included both trusts (hospitals given ownership of assets, part of a process of corporatisation of public hospitals) and the more traditional general hospitals. The Stochastic Frontier analysis used five inputs: total capital charges; medical staff FTE; nursing staff FTE; other staff FTE and; total number of beds. Output was defined as total number of cases treated.
The changes in the two time periods showed that over time the opportunity cost of treating a patient has increased. More patients were being treated as day cases than as in-patients. The results showed that hospitals changed both the services that they provided as well as the way in which they provided services. The trend was towards the faster treatment of patients on a day basis. However, there was no significant improvement in technical efficiency shown over time or between trusts and non-trusts. This study was undertaken during the early period of the internal market.

A series of studies by Propper and Soderlund (1998), Propper, Burgess and Gossage, (2003) and Gaynor, Moreno-Serra and Propper (2010/1) show that, as the internal market has evolved, the results of competition appear to have changed, although different methodologies were used. These studies are informed by the economic theory that increased competition will lead to decreases in prices and costs of production. Two of these studies used changes in prices as a basis for measuring competition but a third study used the Herfindahl-Hirschman Index (HHI) to measure competition.

Propper and Soderlund (1998) examined competition in the internal market as measured by changes in price and the costs of producing the services. They reviewed a number of studies that examined prices in the internal market and found that NHS pricing rules have been relatively ineffective in the way that providers set prices for extra curricula referrals (ECRs)(extra referrals) and GP fundholding (where GPs held their own budget for contracting health care for their patients). Price variation was mainly determined by cost variations. There was relatively little evidence of competition on prices but there was some indication that it did have some effect on prices for low cost procedures. Many hospitals had actually decreased costs during this period but this might be because at the beginning of the internal market, hospitals started with higher average costs. The period being studied was relatively short, 1992/3 and 1993/4 and only two years after the creation of the internal market.

Propper, Burgess and Gossage (2003) explore the impact of competition in the NHS internal market in the period 1991-1999. This was a period which encompassed two changes in policy emphasis: an initial focus on competition and the new internal market was compared to a second period when the emphasis on price competition was reduced. The study also acknowledges that competition between hospitals in England is difficult to measure because the spatial distribution of hospitals was strongly informed by the historical

development of hospitals. This means that in some areas there are several hospitals and so increased competition, whereas in other areas, there are limited hospitals and so no effective competition.

The study chose death rates from acute myocardial infarction as an indicator of quality. Hospitals in areas where there was a higher level of competition because there were more hospitals, showed higher death rates than in areas with more limited competition. They estimated that although the whole sector experienced reduced death rates, these were probably due to technological innovation.

In a third and more recent study, Gaynor, Moreno-Serra & Propper (2010/1) analysed the impact of the new pricing system, 'Payment by Results', which was introduced in 2006 by comparing data from 2003/4 to 2007/8. 'Payment by Results' was a fixed price prospective reimbursement system. Private providers were introduced into the NHS, through a series of contracts that gave very favourable terms to private companies (Player & Leys, 2008). A third change was that patients were given the opportunity to choose which hospital to go for in-patient care.

Gaynor et al used the Herfindahl-Hirschman Index (HHI) to calculate the degree of competition by measuring the patient flows to a hospital as an indicator of market share. It was assumed that the greater the number of patients attending the hospital, the higher the degree of market concentration (fewer competitors) and so the lower rate of competition. The study found that concentration has a statistically significant positive effect on mortality, so that higher market concentration (a larger HHI) led to lower quality. A 10% increase in the HHI led to an increase of 2.91% in the acute myocardial infarction (AMI) death rate. A 10% fall in the HHI was associated with a fall in the 30 day death rate following AMI admissions, by 2.91%. Reductions in market concentration were found to result in a reduced length of stay. There were no increases in operating costs or expenditure per admission so that markets that became less concentrated did not appear to increase costs. The study concluded that the 2006 reforms in pricing led to improved health outcomes as measured by reductions in mortality and shorter length of stay in hospital, resulting in either no increased expenditure or in some cases reduced expenditure.

This third study of the NHS internal market examines a different time period to the earlier studies. It uses a different methodology, in that it calculated a HHI for hospital rather than using changes in pricing. The assumptions that patient flows to a hospital can be considered as an indicator of competitiveness can be questioned because traditionally competitiveness concentrations are measured by share of sales, which are different to health care interventions. The study explores a new phase in the development of pricing mechanisms in the internal market.

Studies that look at a specific intervention in a specific region/ state/ province need to be interpreted with care. Another study, Cooper et al (2010) looked at the effect of competition on efficiency after 2006 in England after the introduction of 'Payment by Results' (mentioned above). Efficiency was measured using hospitals' average length of stay (LOS) for patients undergoing elective hip replacement. LOS was broken down into two key components: the time from a patient's admission until their surgery (pre-surgery LOS) and the time from their surgery until their discharge (post-surgery LOS). Data from the period 2002 to 2008 was analysed, so covering the period before the introduction of 'Payment by Results'. The study found that hospitals cut down on the pre-surgery LOS but not on post –surgery LOS, which led to reduced length of stay. This was interpreted as being more efficient. The study concludes that the measures to stimulate competition after 2006 (payment by results, private sector competition and patient choice) resulted in improvements in hospital efficiency.

Interestingly, it sees a market with fixed prices *"led to marked improvements in hospital efficiency*". The emphasis on fixed prices is important and seems to be argue against the earlier findings of the studies led by Propper et al. The study is of one single intervention (hip replacements) and uses length of stay as its indicator of efficiency. Using the results of a single intervention to generalise about competition in the NHS is not a basis for drawing conclusions. Also, the impact of increased competition from the private

sector is not technically accurate as the independent treatment centres were given highly favourable conditions for entering the NHS market (Leys & Player, 2008).

These studies on the impact of the internal market on competition in the NHS illustrate how the stage in the development of the internal market can influence results as much as the different ways in which competition and efficiency are measured. The introduction of internal markets to public sector health care systems is a relatively new process and is shaped by public policy as much as more conventional market mechanisms, such as price. The studies also illustrate some of the hazards of trying to calculate the degree of competition in a changing system. In addition, measurements of competition in terms of patient flows, is not necessarily a realistic measure of commercial competition.

Taiwan

Two studies of the health care system in Taiwan also show some of the difficulties in measuring competition in a health care system which is still introducing competition. Chen et al, (2010) used patient satisfaction as an indicator of quality of care. Interpersonal skills and clinical competency were used as two quality indicators. In a study of Taiwan, where there is a single payer system, these two indicators were found to be positively associated with higher levels of competition. This study measured competition using the HH Index. This was assessed through the number of discharges per hospital divided by the total market area discharges. This is an unusual study in that it uses patient views as quality measures rather then more conventional inputs and outputs associated with DEA and SFA. However, measuring competition as number of discharges is also an artificial form of competition.

Chu, Chian and Chang (2010) examined 102 teaching hospitals in Taiwan during the period 1996-2001, by using results from an annual hospital survey. This period was soon after the introduction of competition in Taiwan. New systems of payment were introduced which included fee for services, case payment, global budget and fee for capital. These were gradually introduced between 1995 and 2002. Patients can choose any hospital and co-payments are similar for hospitals of the same accredited level (Chu et al, 2010). The study examines the differences between competition in 1996 and 2001.

The measure of competition to inform the HHI was calculated using patient locational information for the main Diagnostic Related Groups and the significance of the local area in supplying patient to a hospital. The majority of the hospitals are private or community teaching hospitals.

The study found that increased competition did not have an impact on hospital efficiency in delivering inpatient services. Higher regional income was associated with low efficiency. High hospital accreditation status was associated with high efficiency and hospital accreditation upgrades were associated with efficiency.

The study suggested that the reasons for the lack a relationship between market competition and efficiency could be explained because hospitals may compete on quality rather than efficiency. The study also found that hospitals in high competition areas invested more resources but these did not necessarily lead to greater effectiveness. The study concluded that more studies were needed to understand how competition affects quality and effectiveness.

As internal markets in health care are still evolving, it is difficult to design studies that can take this evolution into consideration. The attempts to estimate competition shows that this can be done in many ways. The Herfindahl Hirschman Index(HHI) was designed to measure industrial competition and it is questionable whether hospital competition and industrial competition are similar.

2. Ownership and efficiency

Research studies and methodologies

Study	Methodology
Herr A. (2008) Cost and technical efficiency of German Hospitals: does ownership matter? Health Economics 17: 1057–1071 (2008)	Stochastic Frontier Analysis – hospital ranking based on estimated efficiency score
Tiemann C. & Schreyogg J. (2009) Effects of Ownership on Hospital Efficiency in Germany BuR - Business Research Official Open Access Journal of VHB Verband der Hochschullehrer für Betriebswirtschaft e.V. 2 (2)) :115-145	Data Envelopment Analysis DEA
Barbetta G P. Turati G. Zag A.M. (2001) On the impact of ownership structure and hospitals efficiency in Italy Available from University of Oviedo http://www.unioviedo.es/7ewepa/pdf/barbetta.PDF	Data Envelopment Analysis DEA
Dalmau-Matarrodona E. & Puigunoy J. (1998) Market Structure and Hospital Efficiency: Evaluating Potential Effects of Deregulation in a National Health Service Review of Industrial Organization 13**:** 447–466.	Herfindahl-Hirschman Index HHI – defined through patient flows
Lian Chan C. Palangkaraya A. & Young J. (2011) Hospital Competition, Technical Efficiency and Quality The Economic Record 2011	Herfindahl-Hirschman Index HHI

Studies of ownership and efficiency in European countries show varying results. Two studies of German hospitals show that efficiency varies with types of ownership and that public hospitals are more efficient than private or nonprofits. Details of these studies and several other relevant studies are set out below.

Herr (2008) showed that hospital efficiency does vary with ownership, patient structure, and other external factors. The study looked at data for 2001 to 2003. It calculated hospital costs, subtracting research and out patient care from total costs. Inputs included number of beds, doctors, nurses and other staff. The study found that private and non-profit hospitals are on average less cost efficient and less technically efficient than publicly owned hospitals. The hospital rankings based on estimated efficiency scores turn out to be negatively correlated with average length of stay, which is highest in private hospitals.

Another study of ownership and efficiency in Germany by Tiemann & Schreyogg (2009), which examined public, private for-profit, and private non-profit hospitals in Germany between 2002 and 2006. It found that public hospitals operate at a significantly higher level of efficiency than other types of hospitals. For-profit hospitals were associated with lower efficiency but the authors hypothesize that for-profit hospitals may have found other ways to maximise profits, through maximising revenues. Private for-profit providers are more efficient among the very large hospitals with more than 1,000 beds.

A study of Italian hospitals (Barbetta et al, 2001) looked at the technical efficiency of Italian hospitals (non-profits and public hospitals) for the period 1995 to 1998. The findings suggested that publicly owned hospital are more efficient than not for profit hospitals when the number of discharged patients is

considered as an output. However, different results were obtained when using different techniques, for examples when discharged patients were defined as outputs. Non-profit organizations appear more efficient when considering the length of stay.

Dalmau-Matarrodona & Puigunoy (1998) in a study in Spain which examined the effect of market structure on hospital technical efficiency as a measure of performance controlled by ownership and regulation. Results showed that the number of competitors in the market contributed positively to technical efficiency and there is some evidence that the differences in efficiency scores are attributed to environmental factors such as ownership, market structure and regulation effects. This survey was conducted at an early stage in the development of the Spanish internal health care market.

A study of hospitals in Victoria, Australia looked at links between competition and technical efficiency of public hospitals in Australia. It used the Herfindahl- Hirschman Index (HHI) to measure competition and calculated this by estimating the market for each DRG by using patient locational information defined at the statistical local area and by measuring the significance of the SLA in providing patient for the hospital. This methodology is a similar attempt to construct markets by looking at patient flows.

The study showed that there was a positive relationship between market concentration and efficiency but the study also found that efficiency was reduced with a larger number of competing hospitals. The authors suggest that the reason for this variation was that larger numbers of competing hospitals leads not just to competition for patients but also for doctors, which can causes problems in providing care. This is an important study in that it shows the dangers of competition not just from a perspective of reducing costs but also the effect of competition on the labour market for health care workers.

A review of several studies that examine the impact of competition on the efficiency of hospitals in different countries show varied results, which can be influenced by the institutional settings (public, private and non-profit). Studies that look at the impact of ownership on efficiency in the health care sector, rather than the impact of competition on efficiency in the public and private sectors, show a slightly more consistent set of results, in that public hospitals are more likely to be efficient, although this too depends on how efficiency is measured.

Key points

- The use of techniques designed to measure effectiveness in industrial production are not necessarily appropriate for health care
- The evolution of internal market reforms make comparison of competition studies difficult
- The lack of quality measures of health care undermine existing studies of health care efficiency

8 SOCIAL CARE – A CASE STUDY IN PRIVATISATION OF A PUBLIC SERVICE

Social care is a set of activities that covers non-medical care, which may be delivered at home, in a residential setting or at a community day centre. It may be delivered by paid and unpaid carers. Social care provides essential care for older people, which enables them to live independent lives. Social care is often used as an administrative term, which covers both home and institutional care. The tasks cover physical care but also include '*enabling*' older people to be independent and as active as possible. The delivery of care involves some form of relationship with the older person (Moss, 2004: 6). As a result, a care worker plays a number of roles, which draw from a wide range of skills, as friend, mentor; adviser and service provider (Hansen & Jensen, 2004). These are all complex and demanding roles which are not widely valued by many societies and demand a level of '*emotional*' labour. They are most often performed by women. Social care services are labour intensive and the quality of social care depends on the quality of labour, in terms of pay and conditions and training. Rubery et al (2011) concluding a study of social care in England found that good quality care and good quality jobs are complementary and depend on good relationships between users and care workers.

Process of privatisation

From the 1980s, public sector reforms were introduced to municipal services in many European countries, which led to social care services being subject to an internal market. Many local authorities became purchasers or commissioners of care and gradually gave up their provider roles. Care services were contracted to either profit or non-profit providers. The underlying assumption was that the introduction of competition would lead to a reduction in costs. Delivering care through a quasi-market arrangement introduced cost-efficiencies, managerialism and accountability, which led to a commodification of care services. This process translated care activities into timed and costed tasks, which care workers had to deliver as quickly as possible. As care services are labour intensive services, any reduction in costs has to be a reduction in labour costs. Countries in the Nordic region and the UK/ Ireland illustrate what happens to the delivery of a public service (social care) through an internal market.

In Sweden, full responsibility for long term nursing care was transferred from the county councils to municipalities in 1992. These reforms, known as the ADEL reforms, have led in a similar way to an expansion of private sector provision with the contracting out of long-term care facilities, home-care services, meal and transport services. The total number of nursing home beds has declined since 1992. In 1992, there were about 32,000 beds but following the ADEL reform these beds were transferred to the social care sector and the municipalities with some transfer of beds from the public sector to the private and non-profit sectors (Trydefard, Thorslund, 2001).

The ADEL reform altered the way in which care for older people was funded and impacted on the delivery of social care. It moved the responsibility for funding to municipalities and increased the workload in both institutional and home based care services. This has been accompanied by the closure of local county council hospitals with geriatric beds, although municipalities were unable to expand care for older people. Services are now targeted to those with higher dependency needs (Glenngard et al, 2005). In 1997 the Swedish Parliament decided to give priority to people with greatest demands among those with high degrees of dependency. This left people with lower degrees of dependency having to either pay for extra support or depend on family and friends. There is a shortage of skilled personnel in the primary care sector. At a municipal level, there has been an increase in private provided care for older people.

Many for-profit providers now dominate the market for social care. In the UK, there has been a similar dramatic change in the last two decades from a system where the majority of social care services were delivered by local authorities to a privatised system, where for-profit providers dominate provision.

Canada has been through a similar experience of moving residential care from public or not-for-profit provision to for-profit provision. The United States has a longer term experience of privatised social care.

Research into social care privatisation focuses on several themes

A growing body of research has been commissioned by public agencies, trade unions, and charitable foundations that explores the delivery of social care in relation to public, private and not-for-profit providers of services. Most research has looked at the delivery of care in residential and long term care homes, rather than home care, which is more difficult to assess. It has also been conducted mainly in American care homes, where the existence of a large private sector is well established. Evidence has been gathered on three relationships that help to explain the impact of private ownership on the quality of care. They are:

a) Staffing levels and quality of care;
b) Ownership & health outcomes;
c) Quality working conditions.

Research questions

- What is the relationship between staffing levels and quality of care?
- What is the relationship between private provision, staffing levels and working conditions?

a) Staffing levels and quality of care

In 2001, The United States Congress commissioned the Center for Medicaid and Medicare Services (CMS) to examine relationships between staffing levels, health and safety and health outcomes. The CMS study found that there was a relationship between staffing ratios and the quality of nursing home care. The study identified different staffing thresholds according to type of nurse and whether the nursing home was long or short stay. This was significant because it measured labour inputs, health outcomes and profit status and worked out the number of hours nursing care that was required each day. This was used to set minimum standards of staffing for homes receiving Medicare funding. This study (2001) found that a minimum staffing level of 4.1 worked hours per resident day was required to avoid jeopardizing the health and safety of long term care residents. The 4.1 hours per resident per day included 2.4 to 3.1 nursing assistant hours and 0.95 to 1.55 licensed nurse (Registered Nurse and Licenced Practical Nurse) hours, each with different health outcome improvements. (CMS, 2001). This is one of the largest systematic studies that has looked at levels of staffing and quality of care.

Spilsbury et al (2011) examined the evidence-base that looked at the relationship between the level of staffing and the quality of care received by nursing home residents. The review found that levels of staffing were measured in terms of total staffing, as well as staffing of the different types of nurses, related to level of qualifications and the amount and types of training received. There were no standard quality indicators for care found in the studies reviewed but the most often used indicators were more specific health indicators which included pressure ulcers/ sores, physical restraints, functional status, mortality, hospitalisation, nutritional status.

Total nurse staffing was found to be more likely to influence better outcomes but different nurse groups also have an influence on health outcomes. This review concludes that the existing evidence base is diverse showing a wide range of findings and because of different methods used to assess quality. The evidence showed that the total numbers of nurses, registered nurses and nurse assistant staff have a positive influence on care but licensed practical nurses had a weaker influence on quality of care. However, the research studies did not explain the nature of the relationship between different types of nurses, levels of training and quality indicators. The studies looked at the US experience and so the results cannot necessarily be applied to other countries.

This review also found that the levels of staffing had an impact on levels of quality but there has to be a threshold of staffing before any increases in quality appear. There is also a relationship between

improvements in quality and an increase in resources. There is an upper level of resources after which improvements become smaller (Spilsbury et al, 2011).

Other studies have explored not just the levels of staffing but other aspects of staffing provision. Castle & Engberg (2007) examined how levels of staffing, turnover, worker stability and agency staff affected the quality of care in nursing homes. The research attempted to explore how different mixes of nurses affected the quality of care. It is one of only a few studies to look at several aspects of the workforce, rather than a single element. They found that high use of agency staff and low stability of workers are associated with lower quality. These factors may be as significant as staffing levels. Castle and Engborg (2007) suggest that rather than just setting minimum staffing levels, policy makers should consider that turnover, use of agency staff and stability of staff has an influence on quality of care. These may be more difficult to regulate but use of agency staff may be used to maintain minimum staffing levels. Agency staff may also cost more in the short term but they are not provided with training and other benefits, which will affect their long term quality.

One of the limitations of the studies reviewed was that quality of care was limited to clinical outcomes rather than focusing on quality of life or specific social care indicators. For example, quality of care is not defined in terms of how older people are supported in daily living in a respectful and empowering way. Wild et al (2010) found that there is limited research that examines the 'voice' of residents and quality of life indicators.

There are also limitations in the way in which staffing levels are measured because they are assessed using data provided for a statutory reporting rather than actual numbers in residential homes, which may provide a different picture. Another issue in assessing levels of staffing is that there is no breakdown of time spent on different types of caring activities, for example, direct caring or supervision. In addition, levels of staffing needs to be broken down into the component parts of types of staff and use of agency staff, all of which will influence the nature of the relationship between care workers and older people.

b) Ownership and health outcomes

One of the largest studies to examine the relationship between quality of care and for-profit and not –for-profit nursing homes, where a nursing home was defined as a home where most of the residents require daily nursing care (Comondore et al, 2009). Of 82 studies that were reviewed, 40 studies showed statistically significant relationships between lower quality of care in for-profit homes as compared to not-for- profit homes. Three studies showed positive relationships between for-profit homes and high quality of care. The remaining studies had less consistent findings. Both for–profit and not-for-profit homes are paid fixed rates by the US government for residents, so both are faced with providing services at fixed rates. For-profit homes have the additional payments to shareholders, taxes, and high salaries and bonuses to senior executives, which makes them work to minimise the expenditures of running homes. This may lead to reduced levels of staffing.

Hillmer et al (2005) also looked at the relationship between ownership and for-profits and quality of care in 38 studies. Using eight quality indicators to measure quality of care, which included mortality, infections, pressure ulcers, hospitalizations, functional abilities, incontinence, dehydration, accidents, weight change, the review found that higher quality of care was found in not-for-profit homes. Not-for-profit homes were associated with higher staff skill mix and lower turnover of nursing aides as compared to for-profit homes.

Amirkhanyan (2008) examined the impact of privatisation of public nursing homes in the US, which looked at the changes from public to profit or not-for-profit. It examined data from OSCAR, the national database maintain by the Center for Medicaid and Medicare Services (CMS) which is part of the quality assessment process for Medicaid/Medicare certified health care providers. This study found that there was an increase in the number of violations of quality of life indicators when homes changed their status from 'county-

owned (public) to for-profit'. Lower quality was also found in the for-profit group of homes. Not-for-profit homes did not show a decline in quality of care provided after transfer from public ownership.

Castle and Engberg (2007) also found that for-profit homes and high numbers of beds were associated with low quality of care. They also found in an earlier study (2005) found that higher levels of competition were associated with lower levels of quality.

Comondore et al. (2009) in the study of quality of care and for-profit homes did not explore differences between different types of for-profit, for example, chains versus non-chain and small business versus investor owned. These differences need to be explored because in many countries, the for-profit sector is often fragmented, with large companies and small sized businesses co-existing. Amirkhanyan (2008), in a study of homes transferred from public to profit/ not for profit, found that small for-profit homes had higher quality outcomes than larger for-profit homes. A recent study in the UK, found that single homes have significantly better training outcomes than national or local chains of residential homes. This study also found that medium and large size homes had poorer recruitment and retention outcomes and higher perceived levels of staff absenteeism and staff turnover (Rubery et al, 2011).

Although several studies show that there is a relationship between ownership and quality, they do not explain the nature of this relationship. It may be related to cost structures and the need for for-profit homes to generate profits but it may also be influenced by the type of residents. Some studies have found that residents had higher rates of mortality, infections and dehydration when they had not had family visitors in the previous month (Chou, 2002). Not-for-profit homes may be more effective in creating a positive atmosphere which supported a sense of well-being.

There is a consistent finding that staffing levels and quality of care are linked. For-profit homes are more likely to reduce staffing levels as a way of reducing costs and overall expenditure. For-profits often charge residents for additional services whereas not-for-profit homes include these services in an overall package of care (CUPE, 2009).

Much research has looked at the US experience and there are debates about how much this experience can be generalised to a European situation. The implications of how types of ownership influence care outcomes are useful to highlight overall trends in many European countries.

c) Quality of working conditions

The studies discussed in the previous section show how health outcomes in care homes are strongly influenced by levels of staffing as well as the use of agency staff, staff turnover and other aspects of staffing. This section will look at recent research that had looked at how the care workforce is influenced by changes in the way in which social care is delivered.

A study of Nordic care workers (Kroger et al, 2009) found that although all care workers saw "*their work as meaningful and significant*" they also "*experienced it as physically and mentally wearing*". The "*threat of violence is very high among care workers in all four countries but it is highest in Finland*". Physical and mental strain of care workers contributed to the intention of workers to leave care work (Kroger et al, 2009). Overall, workers felt that to improve the quality of care services, more staff were needed, more time was needed to give older people better care and a balance of both residential and home care services were needed.

In a further study of the Nordic region (Kroger, 2011), examined the effect of market based practices on the level of work satisfaction for care workers. This was a large study that looked at the similarities and differences between four countries – Sweden, Finland, Denmark and Norway. All four countries have introduced market arrangements into care services during the last two decades, to varying degrees. Competition has been considered to be a way of ensuring cost effectiveness.

The survey found the structure of the workforce was slightly different in the four countries. The majority of care workers are women aged over 40 but Sweden has the largest proportion of men and migrant workers working in care. Finland has care workers with the longest professional training and working in residential settings. Finland and Sweden has a higher proportion of not-for profit and for-profit employers, with Finland having the higher proportion of for-profit providers. Over 60% of respondents were affected by quality control systems, separation of needs assessments and presence of for-profit providers. The results showed that levels of work satisfaction were highest for care workers employed in either not-for-profit or public providers. Work satisfaction was positively associated with quality control, user choice and local for-profit providers but it was adversely affected by the separation of needs assessment from provision, suggesting that the commissioning process can affect levels of work satisfaction.

In the UK, the role of home care workers, or 'personal assistants' has moved from "*being a low level, domestic function such as cleaning, cooking and shopping, towards a more personal and caring role that often intensive and was previously done by district nurses*". In the private sector, the pay and working conditions are poor. This is described as "a *24/7 work pattern with no additional unsocial hours payments. Zero hours contracts are common. Workers are sometimes told that, where there is no work available, they must either go to other places, have the time deducted or taken as time they owe the employer*" (UNISON, 2010).

CUPE (2009) highlighted the relationship between understaffing and poor working conditions and abuse and neglect of older people in care homes as well as physical and psychological violence against staff. Research has found that levels of violence experienced by care workers in Canada were higher than those experienced by care workers in the Nordic countries (CUPE, 2009).

A study (Wild et al, 2010) funded by the Joseph Rowntree Foundation in the UK has looked at the nature of the care workforce and the effectiveness of training in improving quality of care. The study recognised that improving quality of care for care home residents depends on the capacity of care staff to support and work with health professionals in caring for older people because the care needs of many older people become more complex with age. This shows that with demographic changes, the demand for caring change and care workers will require training to be able to work with health and other professionals to deliver appropriate care.

One of the effects of training of care staff was to improve confidence and professionalism of staff as well as strengthening relationships between community nurses and GPs. The research recognises that it is still unclear what level of nursing care is needed. However, better skilled care staff will be able to support older people to live independently for longer. The report recognises that if staff are to be trained, there will have to be extra resources available for this. It suggests that more income for care homes will have to be generated to pay for staff training which will increase the costs of care. This is an important issue in a privatised service.

Privatisation of social care in the UK as an example of market failure

In the UK, the NHS and Community Care Act (1990) promoted subcontracting from local authorities to private providers by separating local authority purchasing and provider functions. Initially, this led to an expansion of the private social care residential sector and a transfer of provision from local authorities to private residential homes. Between 1997 and 2002, the percentage of beds in local authority staffed homes fell from 24% to 14%. The overall number of people in either local authority, private or non-profit staffed residential or nursing care home rose from 236,335 in 1997 to 259,490 in 2002. By 2009, about 4% of older people lived in care or residential homes. About two thirds were funded by local authorities and a third were privately funded (Comas-Herrera et al, 2010). In the last five years there has been a move towards personalisation of budgets where the individual is given cash to purchase their own services

Private providers of care services often started as small businesses in the early 1990s, which could respond to user needs, but have been taken over by larger companies, which results in management being further away from the services being delivered. Large, private sector care providers are often publicly limited companies that have to work to generate annual dividends for shareholders. In recent years, private equity investors have bought social care companies, as part of long term investments. This has made the companies subject to the investment strategies of private equity funds, which are focused on a high rate of return for the investor rather than the needs of users.

By 2010, residential care provision for older people was dominated by four companies, which are also involved in provision of mental health services and services for people with learning disabilities. The public sector is the main purchaser of services. Except for one non-profit company, these large providers of residential care all adopted a business model which was based on the 'sale and leaseback' of residential properties. This involved using cheap credit to purchase residential homes, selling them and then leasing them back for use. This was considered a flexible solution to the problem of property ownership, if the market for residential homes started to contract. The success of this model was based on access to cheap credit and a growing demand for residential care.

The financial crisis of 2008 started to undermine this business model. Credit became more expensive and more difficult to access. By 2010, with cuts in local authority budgets, the demand for places in residential care homes was decreasing. Local authorities were also trying to reduce the price of residential care. This can be described as a market contraction. Care companies had to renegotiate their access to credit and the rents paid for the leased back care homes. By 2011, one major private provider declared itself bankrupt after failing to negotiate reduction in rent payments. Other providers have to renegotiate debt arrangements in 2012.

This experience shows how vulnerable social care services are when provision is dominated by the private sector. The aim of the private sector is to maximise profits. For private equity investors, their aim is to maximise their investment. The combination of these goals results in companies taking financial risks which do not consider the needs of people using their care services. The TUC Commission on Vulnerable Employment (2008) found that care services, which had been privatised over the previous decade, showed how the terms and conditions of workers had deteriorated (TUC Commission on Vulnerable Employment, 2008).

Decisions about residential homes are made far away from the communities in which they are based. With the failure of at least one company, the local authorities that have commissioned services from this company are ultimately responsible for finding alternative care services. This is the result of a failure of the privatisation of social care services. Direct local authority provision of residential care services is very limited and so local authorities will be unable to provide their own services. They will continue to be dependent on the private sector.

Conclusion

The privatisation of care services has affected both the quality of care and the quality of working conditions. Research shows that there is a relationship between staffing levels and other factors related to workers employment, such as retention and use of agency staff, and the quality of care received by older people. The experience of the US with a large private care sector, provides evidence that for-profit ownership has an effect on quality of care provided.

Private sector investments and the use of unstable business models illustrates the problems of privatisation of older people's care services and facilities. There is a growing trend for a wider range of arrangements, for example, assisted living, supportive housing, retirement residences, that cover both living and caring arrangements for older people. They are all subject to high levels of private sector investment and because they are not specifically care homes are not subject to care home regulations. The care that is provided is

not as regulated as care or residential homes. The potential impact of these different forms of privatisation of care and housing for older people can be seen in the case of the UK, where the pursuit of a business models based on risky property investments, funded through debt, has resulted in the closure of the largest social care company.

Key points

- There is a relationship between levels of staffing and quality of care
- Other aspects of staffing, for example, use of agency staff, staff turnover, also affect quality of care
- US research shows that quality of care delivered in many for-profit homes is lower than in not-for profit homes
- More research is needed on impact of different sizes of homes and types of for-profit companies on quality of care
- Quality of life indicators are needed to assess how care is delivered as well as health outcomes
- Work satisfaction affected by separation of commissioning of services from provision
- UK experience shows failure of privatisation as example of market failure

9 South Africa: Health case study – Sandra van Niekerk

South Africa is a country of huge inequalities, vast poverty and high unemployment. These factors have a profound impact on the state of health of the majority of the citizens of the country. The living conditions that the majority of people find themselves in, and its implications for their health is exacerbated by the unequal and inadequate health system that bedevils the country. The health system is inequitable with regard to the health service that are delivered, resources that are available, and the quality of the services (Engelbrecht & Crisp, 2010: 196). While the proportion of the GDP spent on health is relatively high – 8.3%, which is higher than in any other African country - most of this spending is concentrated in the private health system (Engelbrecht & Crisp, 2010: 196), with public health making up 4.2% of the GDP. This 4.2% covers 84% of the population, while the 4.1% spent in the private sector only covers 16.2% of the population (DOH, 2001). Thus a skewed perception of the state of health care in South Africa is given if only GDP figures are taken into account.

The ANC government in 1994 inherited a fragmented health system. There was a public health sector financed from the national fiscus, and largely accessed by the black majority; as well as a private health sector which serviced the white minority, funded through medical aid schemes. The health system prioritised the hospital sector, which received over 80% of resources, while the primary health sector was underdeveloped. And there were 14 health departments – one for each of four different race groups, as well as one for each of the ten bantustans[1]. It was a system that sharply favoured urban over rural areas – with the private health care sector, as well as the public academic/tertiary hospitals, well developed in the main urban areas, while the rural areas lacked both infrastructure and medical staff. Even greater inequities crept into the system in the late 1980s when the rules of cross-subsidisation for medical aids was lifted, meaning medical aids could favour healthier and younger members; and the number of private hospitals increased substantially because the approval process for these hospitals was deregulated. This resulted in an 87% increase in private hospital beds between 1988 and 1993 (Schneider, Barron, Fonn, 2007: 292).

> "The new government inherited a reasonably well-resourced health system, able to offer quality services to segments of the population. However, it was also deeply inequitable, disorganised and inefficient, with powerful private sector interests and limited institutional intelligence in the form of knowledge and information to plan restructuring." (Schneider, Barron, Fonn, 2007: 292)

The new government had to try and overcome this legacy, and in the process of restructuring and integrating the 14 different health structures into one, take into account equity and social justice considerations.

In addition the new government had to deal with the rapidly increasing rate of HIV/AIDS, as well as other major diseases such as tuberculosis; and it had to incorporate into the health system new policies put in place such as the right to the termination of pregnancy, and free medical care for children under six and pregnant women (Schneider, Barron, Fonn, 2007: 292).

HIV/AIDS has had a profound impact on the health system and the health of the nation in general. It has meant that South African has become 1 of only 12 countries in the world where maternal mortality and mortality for children under five has increased since 1990 (Schneider, Barron, Fonn, 2007: 292). Currently, there are 69 deaths per 100 000 live births for children under five (Coovadia, Jewkes, Barron, Sanders & McIntyre, 2009). At the same time the number AIDS related deaths has been steadily increasing – from 3% in 1995 to 46% in 2005 (DBSA, 2008).

[1] Bantustans were established in South Africa as part of the apartheid government's measures to create separate geographical areas, which were supposedly self-governing, for black people in South Africa.

Public sector health in South Africa

In terms of the constitution, health is a concurrent function of the three spheres of government, and responsibility for health care is divided between a national Department of Health, nine provincial health departments, and local government. Generally the health policy introduced by the ANC government post 1994 is progressive, with some key programmes introduced which have done much to address some basic health issues. However, there is a major problem with the implementation of the system as a whole, as well as with adequate funding of the system, with the result that the public health sector is in very poor shape. Post 1994, the ANC government developed an approach to the health care system which strove to unify the public health system, improve delivery, and ensure access to health services of all. Key elements of the new health system included:

- The establishment and prioritisation of the Primary Health Care (PHC) approach;
- The development of a district health system through which PHC would be rolled out;
- A unified national health system incorporating both public and private sectors;
- The reduction of inequities and the expanded access to essential health care (Schneider, Barron, Fonn, 2007: 292).

The biggest reorientation of government policy in the health sector post 1994 was to emphasise the importance of the primary health care system, which consists of clinics, community health centres and district level hospitals. It is largely nurse driven, rather than doctor driven. The district health system was seen as the vehicle for delivering these services. This emphasis on primary health is an important departure from the situation that existed in apartheid South Africa.

There have been a number of successful programmes introduced as part of PHC. The table below sets out some of these programmes:

Examples of programmatic interventions since 1994

Women	Free health-care services for pregnant women
	Choice on termination of pregnancy
	Confidential enquiry into maternal deaths
	Cervical cancer screening programme
	Sexual assault services including post-exposure prophylaxis
Children	Free health care for children < 6 years
	Primary school nutrition programme
	Expanding the immunisation programme and mass campaigns
	Integrated management of childhood illness programme
HIV/AIDS	Public education campaigns
	Condom distribution
	Voluntary counselling and testing
	Treatment and surveillance of sexually transmitted infections
	Community-based care and support programmes
	Prevention of mother-to-child transmission of HIV
	Comprehensive HIV & AIDS Care Management and Treatment Programme (incorporating ARV roll-out)
Tuberculosis	Implementation of the WHO-advocated ‘DOTS’[directly observed therapy, short course] policy
	Improved national surveillance
	Integration of HIV and TB
Tobacco	Legislation/regulations to control tobacco product advertising, promotion and

	sponsorship
	Increasing the price of tobacco products
Malaria control	Regional co-operation as part of the Lubombo Spatial Development Initiative including Mozambique, Swaziland and South Africa, involving household spraying, new arteminsinin-based drug regimens and improved surveillance

Table reproduced from Schneider et al, 2007: 303

Despite these successes, the public health sector faces many serious challenges.

Quadruple burden of disease

At the same time that the new government was looking at health policies designed to overcome the inequitable system of the past, HIV/AIDS and all its attendant illnesses, such as tuberculosis, emerged as a major health issue. Until the advent of HIV/Aids, South Africa had declining fertility and mortality rates, and increasing life expectancy. At this time, South Africa was regarded as having a triple burden of disease. Like other developing countries it had the double burden of disease. On the one hand it had diseases related to poverty, such as infectious and parasitic diseases like tuberculosis, lower respiratory infection, diarroheal disease and septicaemia, as well as malnutrition and perinatal and maternal conditions. On the other hand, it had diseases related to an unhealthy lifestyle (smoking, diet, stress, inadequate exercise) such as cardiovascular and metabolic diseases like strokes, heart disease and diabetes. The third leg of the triple burden of disease was high rates of injury and trauma.

With the advent of HIV/AIDS, and the huge number of people affected by it, HIV/AIDS became the fourth leg of the 'quadruple burden of disease' currently facing South Africa (Bradshaw et al, 2006). It is estimated that 1 in 9 South Africans is HIV positive (DBSA, 2008). The HIV prevalence in the country is 23 times the global average (MOH, 2001). And the number of people with tuberculosis, strongly associated with HIV/AIDS, has increased from 269 per 100 000 population in 1996 to 720 per 100 000 population in 2006. This a trebling of the number of people with TB (DBSA, 2008).

This quadruple burden of disease places enormous stress on an already teetering health system.

Problems relating to staffing

One of the biggest constraints currently facing the public health sector is a lack of trained health personnel, particularly at the primary health care level, and even more particularly in the rural areas. But it is not only at the primary health level that staff shortages exist. As von Holdt and Murphy show, the public hospitals are under enormous pressure caused by staff shortages – both of support staff, as well as, crucially, nursing staff Von Holdt & Murphy, 2007).

With 79% of doctors in private practice, there are too few doctors in the state health system. The same can be said for nurses – there are just too few to deal with the number of patients. Over the last 17 years many nurses have moved out of the public sector into the private sector, where conditions and remuneration are better, or have gone overseas to work. It is estimated that attrition through emigration is about 25% (DOH, 2011: 6). The result has been a drop in the nurse-to-population ratio from 149 public-sector professional nurses to 100 000 population in 1998, to 110 per 100 000 population in 2007 (Coovadia, Jewkes, Barron et al, 2009).. The situation has been exacerbated by the government's decision in the late 1990s to close many of the nursing colleges. Attrition due to HIV/AIDS, which has affected 16% of the nursing profession, has also been a factor (Coovadia, Jewkes, Barron et al, 2009).

In 2005, there was a 27.1% vacancy rate of skilled health personnel (Coovadia, Jewkes, Barron et al, 2009). The DBSA 10 point plan estimates that there is a shortfall between actual employment and the employment necessary if population growth is taken into account of 64 087; and a shortfall of 79 791 if

population growth and the disease burden is taken into account (DBSA, 2008). A challenge facing the government, therefore, is to train sufficient personnel, retain them in the public sector, and relocate them to work in the areas of greatest need – generally the rural areas.
Another challenge relating to health personnel, and particularly nurses, is the pervasive perception of them as "harsh, unsympathetic and as readily breaching patient confidentiality (Schneider, et al, 2007: 299), and their relationship with patients being characterised as one of "rudeness , arbitrary acts of unkindness, physical assault, and neglect" (Coovadia, et al, 2009). This is a perception that has been around since the 1950s. Attempts to understand this phenomenon have located explanations in the apartheid government's socialisation of nurses as a "privileged social elite" (Coovadia, et al, 2009), whose task was not only to care for the sick, but also to perpetuate a hierarchical, authoritarian culture where nurses were subordinate to doctors, but had a great deal of authority over patients. As Schneider, Barron and Fonn (2007) argue "little has changed in the culture of service provision in which the apartheid frameworks of patients as subjects to be disciplined, rather than rights- bearing citizens, still dominate(Schneider, Barron and Fonn (2007:299).

At the same time, one of the reasons for the drain of health personnel from the public sector is the way that they are treated in the health workplace. Remuneration in the public sector is low, conditions are often poor, hours are long, and the morale of staff is low. A 2003 South African Medical Association study found that the way they were treated was the main reason doctors left the public sector (Wolvaardt, et al, 2008:15. Engelbrecht and Crisp identify a number of factors that have contributed to the poor organisational culture of the public health system. These include poor leadership and management in institutions, poor human resource practices, poor communication, stress, and high work burdens (Engelbrecht and Crisp, 2010).

Problems with underperforming institutions

Effective management of health services in the public sector has been an ongoing problem.
Operational management is centralised, which makes it difficult for those on the ground to put in place adequate measures to deal with the situation they face on a day-to-day basis.
The NHI Green Paper has noted that public health institutions have been underperforming because of "poor management, underfunding, and deteriorating infrastructure" (RSA, 2011: 9).

Inequities in health care

As has been previously indicated, there are vast inequities in the health system between the private and the public sector, as well as between rural and urban areas.
Even within the public sector, inequities exist. For instance, the care given in the different provinces is not equitable. This can be seen by the different success rates – while the Western Cape has a success rate of 80% in curing TB, the success rate in KwaZulu Natal is only 40 – 60% (Engelbrecht & Crisp, 2010: 201).

Lack of effective implementation of primary health care

Despite a good primary health care policy, the primary health care system has not been effectively implemented. The establishment of the district health system, as the vehicle for implementing the primary health care system, has been messy and inconclusive – with a great deal of confusion and contestation around whether it should be responsibility of local government or provincial government. For instance, the local government trade unions, the South African Municipal Workers' Union (SAMWU) and the Independent Municipal and Allied Trade Union (IMATU) have opposed the shifting of responsibility for primary health care from local government to provincial government. As Schneider, Barron and Fonn argue, the dispute about where best to locate primary health "has inhibited the establishment of the basic building block of the new health system and, with this, the basis for reorganizing the health sector as a whole" (Schneider, et al, 2007: 296).

There is still a great deal of emphasis on the tertiary level hospitals, which receive 30% of total public health expenditure (Schneider, et al, 2007: 296).

Financing for the public health sector

Prior to 1994 health services for the majority of South Africans were underfunded - particularly in the bantustans. For instance, in 1986/87 health spending per head in the Transvaal was about R 150 and R 200 in the Natal province and Cape province; while in the bantustans it ranged from R 23 in Lebowa to R 91 in Ciskei (Coovadia, et al, 2009).

The macroeconomic policy of GEAR (Growth, Employment and Reconstruction Policy), introduced in 1996, imposed fiscal constraints on the public sector, including the health system. Spending on public health services stagnated for a few years as a result, before starting to rise again after 2001. But, as Schneider, Barron and Fonn argue, even after the government had relaxed, to some extent, the tight fiscal constraints of the late 1990s, fiscal constraint continued to shape health services in the country. Cost-containment was clearly established as the driver of everyday practice in the health system.

> "Staying within budget became and remains the key preoccupation of managers, implicitly relegating equity and other dimensions of institutional change to secondary goals" (Schneider, et al, 2007: 297).

With the increase in health spending over the last few years, there has in fact been a net real growth in public health expenditure since 1994. Health represents 12.1% of the total government expenditure (National Treasury, 2009). However, this expenditure has not kept up with the growth in the population, or with the increased demands made on the health system by HIV/AIDS (Schneider et al, 2007).This is acknowledged in the NHI Green Paper, which states that "the public sector is under-resourced relative to the size of the population that it serves and the burden of disease" (RSA, 2011: 4). The result is that government health care continues to be under-funded. To exacerbate the situation, public health services have been burdened with a number of unfunded mandates over the years, which act as a further drain on health resources. These unfunded mandates result from government structures being given additional health responsibilities, or health programme policies being changed, which requires additional or different services being provided, but the additional financing to do this not being provided. However, the additional inflow of resources into the public health sector, and a focus on improving equity has resulted in the closing of the gap between provinces in the amount of money spent on public sector health services. From a five-fold difference in 1992/93, the situation improved to a two-fold difference in 2005/06 (Coovadia, et al, 2009).

Privatisation of health services

The implementation of privatisation takes many forms – as can be seen in the health sector in South Africa. These forms range from financial measures; to partnerships between the public sector and the private sector; and to NGOs, volunteers and so on filling the gap left when the state does not provide a service. All these forms are evident in the health sector in South Africa.

The apartheid government promoted a policy of privatisation in the health services sector from the 1980s onwards – in line with international trends at that time. The result of this policy was that the number of private beds expanded hugely between 1988 and 1993. At the same time, the number of doctors working in the private sector increased rapidly from 40% at the beginning of the 1980s to 62% at the beginning of the 1990s(Coovadia, et al, 2009). This trend was not reversed with the advent of democracy in 1994, but has rather been consolidated over the last 17 years. For instance, by 2007, 79% of doctors in South Africa were in private practice(Coovadia, et al, 2009). The table below reflects the distribution of health care professionals between the public and private sector in 2004. While the data is old, the pattern it reveals is still relevant and reflective of the reality today.

	Total	Public sector no. (%)	Private sector no. (%)
General Practitioners	19 729	5 398 (27.4%)	14 331 (72.6%)
Specialists	7 826	1 938 (24.8%)	5 888 (75.2%)
Dentists	4 269	316 (7.4%)	3 953 (92.6%)
Pharmacists	4 410	1 047 (23.7%)	3 363 (76.3%)
Psychologists	3 808	222 (5.8%)	3 586 (94.2%)

Source: Wolvaardt, G; van Niftrik, Beira, B et al (2008) pg. 231

With the private health sector absorbing a great deal of the health resources (such as the large numbers of doctors and nurses), the ability of the public health system to respond to the health needs of the country is severely restricted (Chopra et al, 2009). With the expansion of private hospitals in the late 1980s/early 1990s, which happened at the same time as budgetary constraints were being imposed in the public sector, there was a concomitant decline in the conditions at public hospitals.

There has been an increasing number of people who are accessing health services, particularly health services related to HIV/AIDS and related illnesses such as tuberculosis, through the private sector, because the public sector is simply unable to meet the demand. Some of these health services are provided on a not-for-profit basis, either through non-governmental organisations (NGOs), community based organisations (CBOs) or faith based organisations (FBOs), who are funded by donors; or through employee assistance programmes. There are a massive number of NGOs, CBOs and FBOs working in South Africa, although the exact number can't be established because there is no requirement for such organisations to register with the Department of Welfare (Wolvaardt, et al, 2008: 225).

One example of donor money being provided to private sector organisations is that of the United States President's Emergency Program for AIDS Relief (PEPFAR). PEPFAR has provided grants worth $856.8 million for AIDS prevention and treatment work in South Africa. It makes this money available to private sector organisations, many of whom provide support to provincial government initiatives through public-private partnerships. The money is spent on programmes such as supporting individuals on antiretroviral (ARV) treatment; caring for and supporting HIV positive people; caring for and supporting vulnerable children and orphans affected by HIV/AIDS; testing people for HIV; running awareness and education (Wolvaardt, et al, 2008: 224).

There is also a large body of community carers, who either act as volunteers, or receive some kind of remuneration, that has emerged as part of response to HIV/AIDS – they act as counsellors, treatment supporters, home-based carers, and support group facilitators. Their work is largely co-ordinated and funded by NGOs, and there is little standardisation of what they do, how they do it, whether they get paid, and how much they get paid. In 2004 the government established the National Community Health Worker Policy Framework to regulate training and remuneration of these workers (Schneider et al, 2007: 304). They are paid a stipend by provinces who channel the funding through various NGOs.

Partly the inflow of donor money and the establishment of employee assistance programmes in the workplace can be understood in the context of the Mbeki government's failure to deal adequately with the HIV/AIDS crisis. It is only in the last three years, since Dr Motsoaledi became the Health Minister, that a more coherent government response to the crisis has been developed. The HIV & AIDS and STI National Strategic Plan for South Africa, 2007 – 2011, sets out such a response, and was developed through cooperation between the government and civil society in the health sector.

The private sector, both the for-profit and not-for-profit components, are involved in a whole range of activities that form part of primary health care. These include:

- the promotion of a healthy lifestyle and other health issues;
- ensuring adequate food supplies, nutrition, adequate water and sanitation;
- family planning, maternal and child care;
- immunisation;
- prevention and control of locally endemic disease;
- appropriate treatment of common diseases;
- promotion of mental, emotional and spiritual health;
- the provision of essential drugs ((Wolvaardt, et al, 2008: 225).

A health road-map, commissioned by the ANC Health and Education Committee of the National Executive Council, and co-ordinated by the Development Bank of South Africa (DBSA) came up with a 10-point plan to guide health policy and, specifically, to identify “opportunities for coordinated public and private health sector efforts towards improved access to affordable, quality healthcare in South Africa.” In other words, bringing in the private sector to assist with all the problems and obstacles bedevilling the health system was an explicit thrust of the 10-point plan. The plan calls for the private sector to take up the slack in the health system – and increase its “catchment population” which is currently at 7.5million. This would then create “fiscal space” of roughly R 12 billion for the public sector. In other words, it would save the public sector R 12 billion if more people, either through medical aids, or out of their own pockets, paid for private health care.

One of the “10 points” called for additional capacity and expertise to be brought in “to strengthen a result-based health system, particularly at the district level (including revised legislation to recruit foreign skills, partnerships with private and public sector, deployment and training for district health management teams, etc.)” (DBSA, 2008). Other roles that the 10-point plan envisages for the private sector include training of new health personnel, particularly nurses; and the rehabilitation of public hospitals.
In 1999, the National Department of Health established a PPP Task Team, which has overseen the introduction of a number of PPPs in the health sector. For example, the BioVac Institute is a public-private partnership between the National Department of Health and the BioVac Consortium. The National Department of Health has a 40% shareholding in the BioVac Institute. BioVac is the only human vaccine producing facility in the country. When the PPP was established, the National Department of Health transferred the staff assets of the State Vaccine Institute to BioVac (Wolvaardt, et al, 2008: 232).
Public-Private Partnerships have also been established in hospitals. Until recently, they were mainly focused on the management of hospitals, but recently have included infrastructure rehabilitation and upgrades. The government’s intention is to enter into partnerships, for up to 20 years, to maintain equipment and facilities, as well as partnerships to provide clinical services.[2]

The main private sector company partnering with government is Life Esidimeni, which is part of the Life Healthcare group. Currently Life Esidimeni runs 12 hospitals jointly with the national or provincial Departments of Health and Social Services. These include a TB hospital and two district hospitals. Other PPPs include a hospital care contract between a company called the Clinix Hospital Group and the Gauteng Province; and two PPPs run with Netcare (Wolvaardt et al, 2008). Netcare is positioning itself to take on more PPPs by offering to partner with government in the implementation of the National Health Insurance (NHI), which the government is in the process of developing (see conclusion)[3].

In terms of PPPs for infrastructure upgrading and rehabilitation, the government has targeted 5 hospitals for upgrading, and 1 newly built hospital. The upgrading of these hospitals and building of a new one form

[2] South Africa; Public-Private Partnerships Offer New Hope for Ailing Health Sector Africa News, March 23, 2010 Tuesday, 929 words, Business Day (Johannesburg)
[3] “Netcare offers its expertise to help implement NHI by 2012” Business Report 17 February 2011

part of the envisaged role out of the NHI (RSA, 2011:49). The aim is for construction work on these projects to begin by 2012. The targeted hospitals are the Chris Hani Baragwanath Hospital in Soweto, the George Mkhari Academic Hospital in Pretoria, the King Edward Hospital in Kwa-Zulu Natal, the Nelson Mandela Academic hospital in the Eastern Cape and a new hospital, the Limpopo Academic hospital, which will be built in Polokwane (National Treasury, 2009). According to Tumisang Moleke, Acting Head of the National Treasury PPP Unit "this is the first time such a suite of services is being proposed for public hospital PPPs: design construction, facilities management and operations management as required. Transaction advisors will be investigating clinical and medical technology issues. We will consider all options: design and construction as usual, but also hard and soft facilities management, medical equipment supply and IT management and systems."

Another form of PPP that occurs in the health sector is that of co-location PPPs. With co-location PPPs the private sector and the public sector exist side-by-side, delivering a similar service without competing. For instance, in some public hospitals around the country, where the public sector is not making use of all the beds available, a section of the hospital is given over to the private sector to run at a profit. They pay over some revenue to the public sector – supposedly representing a "win-win" situation for both the public and private sectors. A number of these co-location PPPs exist. For example:

- Pelonomi and Universitas Hospital in Bloemfontein
- Kouga Partnership Hospital which consists of Humansdorp District Hospital and Isivivana Private Hospital. This partnership involved the refurbishment of Humansdorp Hospital and the construction of the Isivivana Private Hospital. The PPP is with Life Healthcare, and has a concession period of 20 years.

Not surprisingly, the trade unions are opposed to public-private partnerships, believing that the government should rather focus on building capacity in the public sector. According to Sydney Kgara, head of policy at the National Health, Education and Allied Workers Union "Partnerships lead to outsourcing, and when that happens there is a deterioration of conditions of service. People are often re-employed with fewer benefits, and we are concerned about people being retrenched."[4]

Private sector health system

The private sector health system consists of both not-for-profit, as well as for-profit sectors. The not-for-profit component is largely provided by NGOs and employee assistance programmes. For-profit private health care is largely funded through medical aids. Post 1994, the government has attempted to tighten regulations in the medical aid sector again, after the loosening of controls seen in the 1980s. This was largely done through the establishment of a stronger Council for Medical Schemes, which regulated private sector financing. Cross-subsidisation was re-established so that medical aids could no longer discriminate against the old and sick and medical aid became more accessible; and a system of prescribed minimum benefits (PMB) was introduced. In terms of this system, medical aid schemes are required to cover 270 specific diagnosis and treatment interventions, as well as 25 common chronic diseases. Despite the attempts to tighten up the medical aid terrain, the costs in this sector are still very high, and it services an increasingly smaller portion of the population.

Those who have access to private health care, have access to much better resourced health care than is available in the public sector. While less than 15% of the population are members of private medical schemes, these schemes are responsible for 46% of health care expenditure. On the other hand, 64%of the population are dependent on the public health system. 21% of the population uses a combination of private and public health care- private care, which they pay for privately for primary health care, and the public sector for hospital care (Coovadia, et al, 2009). In fact, the number of people accessing private health care, without being members of medical aid schemes has been increasing since 1994 (Wolvaardt et

[4] South Africa; Public-Private Partnerships Offer New Hope for Ailing Health Sector Africa News, March 23, 2010 Tuesday, 929 words, Business Day (Johannesburg)

al, 2008:224). Whereas about R 9500 is spent per person per year for those with private medical aid, about R 1 300 is spent per person per year in the public sector (Coovadia, et al, 2009). This illustrates very graphically the extent of the inequalities in health care in South Africa.

The private hospital sector is dominated by three large companies - Life Healthcare, Netcare and Medi-Clnic, which together command 75% of the market[5]. Life Healthcare listed on the Johannesburg Stock Exchange last year. The International Finance Corporation (IFC) was one of the big investors involved. The IFC is part of the World Bank Group. It has a 5% equity stake in Life Healthcare, and has also jointly financed a subsidiary company of Life Healthcare to take forward its plans for international expansion[6]. According to the IFC, one of its strategic priorities is to support health providers working across countries and regions "to reach lower-income groups"[7].

Conclusion

Despite increases in health expenditure over the last 17 years, and the introduction of sound, progressive health policy, South Africa continues to be dogged by a public health system that is simply not meeting the health needs of the vast majority of South Africans. Partly the weakness of the health system can be traced back to the attempts by the government to extend more equitable health services to all, at a time when HIV/AIDS was becoming a major issue, causing large numbers of people to enter the increasingly strained health system. But the weaknesses can also be attributed to the neo-liberal approach to health care adopted by the government, an approach consistent with the macro-economic policy (GEAR) that the government introduced in 1996.

As Schneider, Barron & Fonn argue:

> "With hindsight, it is clear that the context of health sector reform post-1994 has been an unfavourable one on several fronts. Apart from the constraints imposed by an overwhelming HIV/AIDS epidemic and an emerging human resource crisis, transformation began in the midst of international health systems thinking that was neo-liberal and technocratic in orientation, emphasising, for example, new public management techniques, health-care packages targeting the poor (rather than redistribution), and outsourcing (rather than strengthening) of public sector functions" (Schneider et al, 2007: 305).

Government acknowledges the failure to transform the health sector since 1994, noting that instead of a reformed system, what has been entrenched is a "two-tiered health system, public and private, based on socioeconomic status", which "continues to perpetuate inequalities" (RSA, 2011: 5).

In an attempt to overcome the problems of the bedevilling the public health system, ensure access of all to affordable, quality health services, and increase equity in the health sector by removing the two tier health system, the government is planning to introduce a National Health Insurance (NHI). The NHI Green Paper, released on 5 August 2011, begins to set out the details of what this new system will look like.

The NHI is intended to bring about improvements in the health care provided by the public sector, through its emphasis on primary health care, and the strengthening of the three pillars of primary health care delivery – at district level, ward level and school level. Primary health care will be supplemented by a network of hospitals at different levels ranging from district level through to specialised hospitals. It is envisaged that the full implementation of the NHI will take 14 years.

Despite recognizing, in line with the 200 World Health Report of the World Health Organisation (WHO), that "uncontrolled commercialism" "undermines principles of health as a public good" (RSA, 2011: 9); and despite the envisaged strengthening of the public sector, the Green Paper does provide for the private

[5] HEALTH. Bring us your sick Financial Mail (South Africa), March 23, 2007, ECONOMY, BUSINESS & FINANCE; Pg. 42, 940 words, Shoks Mzolo

[6] IFC and South Africa's Life Healthcare to Expand Health Coverage in Emerging Markets African Press Organization, June 10, 2010 Thursday 7:05 PM EST, 469 words

[7] IFC and South Africa's Life Healthcare to Expand Health Coverage in Emerging Markets African Press Organization, June 10, 2010 Thursday 7:05 PM EST, 469 words

sector to play a key role in the new system. Under the NHI healthcare will be provided through accredited and contracted public **and** private providers (RSA, 2011: 19). There will also continue to be private sector involvement through mechanisms such as PPPs to upgrade, as well as build new hospitals. The plans to refurbish five hospitals around the country and build a completely new hospital, the Limpopo Academic Hospital in Polokwane forms part of the implementation plans of the NHI.
In part, the role of the private sector in the NHI is an acknowledgement of an existing situation, with the private sector already playing a large role in the South African health system. This role has increased rather than decreased since 1994, not only because the private health sector itself has grown (with increasing numbers of medical personnel in the private sector, increased numbers of private hospitals, and the consolidation of the medical aid schemes into fewer, larger schemes), but also because of the privatisation of different aspects of health care. This has included:

- public-private partnerships (PPPs) for, among other things, the refurbishment of hospitals;
- co-location PPPs, where the public and private sectors occupy the same hospital, or adjacent hospitals;
- the provision of health services that the government is not providing, by the private sector (either for-profit or not-for-profit). This is particularly the case in the area of HIV/Aids treatment.

The thinking of the NHI seems to be that the best way of drawing on the capacity and resources of the private sector, while at the same time curtailing the rampant profit-making in this sector, is to pool resources and set up a single-payer system through the NHI Fund. The National Health Insurance Fund, to be set up at an arm's length from the Department of Health, as a separate entity, wholly owned by the government, will have the role of pooling funds and buying in health services for the whole population from both contracted private, as well as contracted public health care providers. Payment for these services will be made by the NHI Fund on the basis of a risk-adjusted capitation system which is meant to both avoid the dangers of over-servicing, which results from a fee-for-services based approach, as well as be a way of containing costs. These public health care providers will include the Department of Health itself, through its national, provincial and district level structures and facilities.

The role of the private sector in the public health system is justified on the basis that government has many competing demands on it, it is unlikely to get more resources and therefore it needs to adopt a number of different strategies, among them collaboration with the private sector (DOH, 2011: 5).
Already the major private hospital groups are positioning themselves to enter into PPPs with the government, or to strengthen their existing presence in the PPP field. Life Healthcare already has entered into a number of PPPs with the government; and in its 2010 annual report, Netcare indicated that "we are ready and willing to share our knowledge and partner with government to leverage health-care spend effectively and so broaden avenues of access."[8]

The Congress of South African Trade Unions (COSATU), the largest trade union federation in the country, in responding to the Green Paper has welcomed the introduction of the NHI, but at the same time, has noted its concern about the envisaged role for the private sector. One of its concerns relates to the ongoing role for medical aids that the Green Paper sets out. When the idea of the NHI was first mooted in 2007, the private medical aid schemes were among the most vociferous critics. There is now concern among organisations like COSATU and other progressive analysists , that the Green Paper is pandering too much to the fears and concerns of the private sector, and has made too many concessions to private sector interests. For example, the Green Paper raises the possibility that instead of a single-payer system, there could be a multi-payer system. This means that instead of the NHI Fund being the only body that can pay health care providers for services provided (single-payer system), medical aids under a multi-payer system could also pay providers and be re-imbursed by the NHI Fund. This will mean that the economic clout of the medical aid schemes will continue under the new system.

[8] Business Report (17/2/2011) "Netcare offers its expertise to help implement NHI by 2012"

COSATU has also noted its concern that private sector healthcare providers will be able to choose whether to contract with the state or not."[9]. The private sector health sector is firmly entrenched in South Africa, and it remains to be seen whether the NHI can both improve the public health services sufficiently, and bring the private health sector in line. In giving such a large role in the NHI to the private sector, there is the danger that the plans for the NHI might ultimately undermine what the NHI is planning to achieve – that of an equitable and universal health system.

[9] Cosatu (11 August 2011) "NHI Green paper welcomed" http://www.cosatu.org.za/docs/pr/2011/pr0811b.htmlm

10 A Profile of the Public and Private Health Sectors in Brazil – Rita Fernandes & Jane Lethbridge

This case study presents a profile of the increasing role of the private sector in the delivery of health services in Brazil, through the development of health care markets. It starts with a demographic and health profile of Brazil and an account of the role of the health sector in the economy.

Brazil – demographic and health profile
Brazil is divided into 26 Federal States, 1 Federal District and 5.565 municipalities.

Brazil has a population of 190,732,694 inhabitants. The age structure of the population is changing with a decline in the percentage of children under 5 (11.3 to 8.9%) and an increase in men (6.8% to 8.3%) and women (7.8% - 10.0%) aged 60 and above in the period 1991 to 2005(WHO, 2007). Life expectancy is 70 years for men and 77 years for women (2005).
Gross national income per capita is $10,160. 5.7% of the population are classified as living in extreme poverty, with 13.5 in rural areas and 4.2% in urban areas. The rate of un-employment was 9.3% in 2005 (WHO, 2007).

The leading causes of death are cerebrovascular diseases (10.1%), ischemic-cardiac diseases (9.7%), homicides (5.4%), diabetes (4.4%), chronic respiratory diseases (4.3%), influenza and pneumonia (4.2%), road accidents (3.9%), heart failure (3.6%), perinatal problems (3.5%) and hypertensive diseases (3.4%) (WHO, 2007). Infant mortality fell from 33.7/1000 in 1996 to 22.6/1000 in 2004 (WHO, 2007).

Unified Health System (SUS)
The National Health Policy is based on the Brazilian Federal Constitution of 1988, which sets out the principles and directives for the delivery of health care in the country, through the Unified Health System (SUS). Under the Constitution, the activities of the federal government are to be based on four year plans approved by the National Congress.

The implementation process of the SUS aims to improve health in the whole country, with an emphasis on a reduction in child mortality. The National Health Plan prioritizes measures to ensure access to activities and services to improve care, and to consolidate the decentralization of SUS management.

The current legal provisions which have governed the organization arrangements of the Brazilian Health System, established in 1996 aim to shift responsibility of SUS administration to municipal governments. Technical and financial cooperation remain the responsibility of the Federal government and federal states.

Healthcare in Brazil is provided by both private and public institutions. The Brazilian Ministry of Health and its National Agencies are responsible for national health policies. The Federal Government is responsible for Primary Health Care but health institutions are administered by each Federal States of Brazil.

The SUS provides health services to 75% of the population. 25% of the population receive services through the Supplementary System, where people also have the right to access services provided by the SUS.

In Brazil, 7.9% of GDP is spent on health care, with 48.1% financed by the public sector and 51.9% financed by the private sector. This percentages financed by the public sector has decreased since 1981. In 2005, a third of private sector expenditure is from companies providing health services or insurance for employees. Two thirds of private sector expenditure is self-financed by individuals and families (WHO, 2007). Out of pocket spending increased from 9% in 1981 to 19% in 2009. Although the out of pocket expenditure as a percentage of total household expenditure is similar for lowest income groups (5.83%) and high income groups (8.31%), the low income groups buy medicines and the high income groups buy private health plans and insurance (Paim et al, 2011)

In terms of health care activities/ services, public health care represents approximately 34.21% of GDP in this sector, while private sector services represents 65.79% of GDP, with 60.79% of GDP in the for profit sector. The private sector consists of companies that are engaged in the following activities:

Other Activities Related to Health Care (21.05%)
Manufacture of Pharmaceutical Products (13.36%)
Trade in Pharmaceuticals (12.28%) and
Hospital Care Activities (8.77%)

The majority are for-profit companies.

Financing of health services

Health services are financed through general taxes, taxes for specific social programmes, employer health care spending and out-of pocket spending. Tax collection from federal taxes for the health sector rose from R$ 7.6 billion (Reais) in 2003 to R$ 17.4 billion in 2009, showing an increase in resources for the sector (Secretariat of Federal Revenue of Brazil). However, the transfer of Federal Government funds to the state and municipal levels for the health sector is only financed by tax revenues and no other sources of revenue, for example specific social programme funding. Funding for the SUS has not been enough to guarantee adequate resources for the public system. Even when a social programme was set up for the health sector, funding is often diverted. In 1997 a new social programme, 'The Provision Contribution on Financial Transactions', was designed for extra health funding. By 2006, 40% of the funding raised through this scheme was used for paying interest and public debts (Paim et al, 2011).

Trade in health services and products

An indication of the commercialisation of health services and related products can be seen in the increase in the number of number of wholesale and retail establishments selling pharmaceutical, medical, orthopaedic, dental and veterinary products between 1996 and 2005. The total number of establishments increased from 60,626 to 87,222. The number of retail establishments increased from 56,172 to 78,356 (Brazilian Institute of Geography and Statistics (IBGE), Department of Research, Coordination of Services and Trade – Annual Trade Survey 1996 – 2005). Brazil imports more health related good than it exports. Imports are predominantly pharmaceuticals, medical and dental equipment and medical instruments.

Between 2000 and 2005, imports of goods and health services accounted on average for 4.2% of total imports of the whole country. While the export sector fluctuated less than the import sector, it was only responsible for 0.6% of exports of the whole country. However, its rate of increase between 2002 and 2005, was faster than for the health import sector (IBGE).

Health services

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

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

The private sector has traditionally been protected by the government, which has encouraged the privatisation of medical practices (Paim et al, 2011).

Currently there are 212.468 Health Services registered in the Brazilian Ministry of Health. Of these, 151.763 are private and 60.705 are public. Public Health Services are delivered at municipal level (58.055), state (2.401) and federal (249). There are 6,742 hospitals in Brazil (Brazil Ministry of Health). Of this total, 70% are private hospitals. Public hospitals are divided by level of government as follows: 21% Municipal hospitals, 8% State hospitals and just 1% Federal hospitals. These hospitals provide 498,562 beds, with 362,368 belonging to SUS and 136.194 are non-SUS (Brazil Ministry of Health). In contrast, the number of private health care facilities is twice that of public health care facilities. Between 1999 and 2005, the number of healthcare facilities - public and private - increased from 56,133 in 1999 to 77,004 in 2005.

There have also been changes in the public-private provision of in-patient health facilities.
58.6% of health facilities were owned by the SUS public sector and 41.4% were in the private sector. A small percentage of the private sector beds are contracted by SUS. An 8.3% reduction in the total number for inpatient health facilities between 1999 and 2005 can be attributed to a decrease in the number of in-patient health facilities run by the private sector and in the private beds that are accredited to SUS. At the same time, there was an increase of 4.1% in the number of inpatient beds in public facilities. Some of these changes can be explained by the trend towards moving from in-patient care to out-patient care. Out-patient care is cheaper to provide.

In-patient health facilities by sector,1999-2005

YEAR	TOTAL	Public Sector	Private Sector of SUS	Private Sector non-SUS	Total Private Sector
1999	484,945	143,074	284,493	57,378	341,871
2002	471,171	146,319	269,028	55,824	324,852
2005	443,210	148,966	241,578	52,666	294,244

Source: Brazilian Institute of Geography and Statistics (IBGE), Department of Population and Social Indicators Research 1999-2005 Medical-Healthcare Professionals

Clinical Specialties offered at Health Facilities (2005)

Specialty	Public health service	Private health services of SUS	Private health services non-SUS
Family Doctors Care	20 240	70	11
Cardiology	2 065	1 048	2 374
General Surgery	4 404	2 283	1 592
Medical Clinic	11 550	2 818	3 890
Dermatology	964	333	1 624
Emergency	2 654	2 212	1 136
Endocrinology	418	187	854
Gastroenterology	546	521	1 289
Gynaecology	10 100	2 613	3 880

Haematology	160	105	151
Obstetrics	6 928	2 278	1 961
Dentistry	19 006	557	3 810
Paediatrics	10 268	2 547	3 180

Brazilian Institute of Geography and Statistics (IBGE), Department of Population and Social Indicators Research 2005 Medical-Healthcare Professionals

Although the private sector has a larger number of clinical facilities then the public sector, there are some significant differences between public and private sector provision of certain specialties. Almost all family doctor care is provided by the public sector. For medical clinics and dentistry, there is a more significant private sector provision. In some specialties, for example, dermatology, endocrinology, gastro-enterology, the private provision is greater than the public provision. This shows that certain specialities are more attractive to the private sector, usually because they can be arranged as a series of tests and interventions, which can be separately costed. Family doctor care is a much wider specialty which covers a range of conditions and is not easy to separate into different costed elements.

Private health plans

In 2008, 26% of the Brazilian population had private health insurance. Civil servants have their own health insurance (Paim et al,2011). Although private health insurance plans have been in existence in Brazil for almost 40 years, it was only in 1998 that there was any attempt to regulate them. Law No. 9.656 of June 03, 1998 established standards for companies in this sector. In 2000, the National Agency for Supplementary Health (ANS) was created by the Brazilian Ministry Of Health, which aimed to regulate the private health insurance and the private health care sector.

From 2000 to 2005, the number of people holding private health insurance plans grew by 11%, to 34 million policy holders. There are regional differences in private health care plan coverage. In the State of São Paulo, located in the Southwest Region of Brazil, 35,7% of its population is covered by private health insurance. On the other hand, Roraima state, located in the Northern Region, has a 2.3% coverage, the lowest rate of any Brazilian region. Of the total number of private health insurance holders in Brazil, 42.5% are in the State of São Paulo and 13.4% in the State of Rio de Janeiro, both in the Southwest Region of Brazil.

All private health insurance companies have to work to agreed rules and procedures, which are reviewed regularly. Non-compliance of rules leads to the payment of fines. This form of regulation has contributed to a reduction in the numbers of companies. In 2005, there were 1.260 healthcare insurance operators.

Private health care companies

In 2004, there were 78,000 private health care companies in Brazil. They can be classified as:

- 66.87% Out-patient services run by physicians and dentists
- 17.87% Diagnostic testing and therapy
- 10.21% Hospital care
- 2.77% health insurance
- 1.40% manufacture of instruments
- 0.88% manufacture of medicines

Over 50% of these companies are concentrated in the south-east of Brazil, with Sao Paulo (27.58%), Minas Gerais (13.3%) and Rio de Janeiro (11.12%).

There are currently 1.748 health insurance companies (operating) in Brazil, of which 1,259 cover medical and hospital care services and 489 cover dental services (.National Agency for Supplementary Health (ANS). The majority (61%) of health insurance companies operate in the South East region, the region with highest incomes. Only 3% of companies operate in the North region, which is the poorest region.

Of the 1017 companies, 8.2% provide plans and insurance to 80.3% of people with health insurance. Demand is influenced by income and occupation. Some people with private health plans also use the SUS system, receiving vaccines, high cost services and procedures such as renal dialysis and transplants. In this sense, the public SUS sector is subsidising the private health insurance sector (Paim et al, 2011).

Labour

The health care sector is highly labour intensive, especially for in-patient care. This section shows the expansion of jobs that has taken place in the health care sector in the period 2003 - 2008. The total number of jobs increased from 900,000 in 2003 to 1.18 million in 2008, with approximately 45% in the private sector. The majority of health care workers work in the hospital sector and this has remained unchanged during this period. The majority of health care workers are located in the three south eastern states, with the highest incomes. This expansion of health workers has been enabled by the expansion of private sector higher education which has expanded the places available to train health professionals (Paim et al, 2011).

Number of workers by sector/ services in 2003 and 2008

Sector/ service	Number of health workers 2003	% of total health workers	Number of health workers 2008	% of total health workers
Hospital care	614,528	67.55	800,762	61.74%
Out-patient clinics – medical and dental	99,306	10.92	182,806	14.10
Diagnostic testing and therapy	82,235	9.04	121,630	9.38
Health insurance companies Manufacturing of instruments/ materials medical and dental use	15,053	4.69	71,165	5.49
Manufacture of medicine	55,892	1.65	73,665	5.68
Total	909.675		1,296,922	

The geographical distribution of health workers

State	% (2003)	%(2008)
Sao Paulo	34.79	35.86
Rio de Janeiro	11.17	11.15
Minas Gerais	11.32	11.01
Rio Grande do Sul	8.58	7.91
Parana	5.44	5.74
Bahia	4.67	4.37

The majority of health workers are located in the three south east states, where there is also the greatest concentration of private health care services. A smaller percentage of health workers are located in the poorer regions, for example Bahia and Parana. The geographical distribution has not changed significantly in the period 2003-2008.

Conclusion

Brazil has a national health policy, which is part of the 1988 Constitution. The federal government has overall responsibility for national health policy although implementation is the responsibility of municipal governments. The public provision of health care services, through the SUS, does not meet the needs of

the whole population. There is growing evidence that the private sector is playing an increasing role in the provision of health care, especially in different clinical specialties. There has been an increase in out-of-pocket spending for all income groups. Private sector provision, whether as health services or health insurance, is concentrated in the south-east of the country, which is the most economically prosperous.

11 State involvement in private health care in Malaysia – Jane Lethbridge

This case study will examine how the private health care sector in Malaysia has developed over the past thirty years. It will outline the demographic and health profile of Malaysia before discussing changes in the public and private health care systems. The impact of the change on public sector health workers will be discussed as well as reactions by civil society organisations.

Demographic and health profile
Malaysia has a population of 28.3 million. With 31.8% of the population aged below 15 years, it has a relatively large young population. 63.6% of the population are aged 15-64 years. 4.6% of the population is 65 years or older. Life expectancy has increased over the last 50 years and is now 71 years for men and 76 years for women. Per capita income is 6,725$, with only 6% of the population living in poverty (WHO, 2009).

The five leading diseases in Malaysia are ischaemic heart disease followed by mental illness, cerebro-vascular disease/stroke, road traffic injuries and cancers, suggesting that the country is moving towards a predominantly high rate of non-communicable diseases. Although there has been an improvement in the rate of maternal mortality, this increase has slowed recently. There has been a gradual improvement in the infant mortality rate from 13.1 per 1000 live births in 1990 to 6.4 in 2008 (WHO, 2009). Malaysia spends 4.8% of its Gross Domestic product on health, which includes public and private expenditure. 44.8% of total health expenditure is provided by the public sector and this has remained unchanged over the last 5 years (World Bank, 2009). Since 2004, private health expenditure has been greater than public health expenditure (MOH, 2009)

Malaysia public health care system
Public sector health care services are subsidised and provided free at the point of access or at low cost. The public health care sector consists of 122 hospitals, which are general hospitals, district hospitals or specialist medical institutions. Polyclinics and rural clinics also provide health care.

The state played a key role in the financing of health care until the 1980s. GPs provide primary health care in urban centres and small towns. Rural health centres and district hospitals provided care for rural population (Leng & Barraclough, 2007). The first private hospital was set up in 1973. Private hospitals began to expand from the 1980s, due to a fall in the quality of government health care services and the rising demands of a growing middle class (Leng & Barraclough, 2007).

In parallel to the expansion of the private sector, the corporatisation of public hospitals is a major change that has affected the way in which the public health care sector operates. Public hospitals are expected to operate in the same way as private companies, working towards targets and income generation. The results of interviews with trade unionists in 2003, set out later in this case study, show how corporatisation affects the control that health workers have over their work.

Health care is funded through a) tax revenue collected by the government, b) by fee for service, and c) by employer-financed health benefit schemes (Rasiah et al, 2009). Public sector health care is funded through taxation, from the federal government (Rasiah et al, 2009).

Privatisation
The introduction of a national privatisation policy in 1983 was accompanied by 'Malaysia Incorporated' and the development of Malaysia as a corporate entity. The state facilitated economic growth but the private

sector was the main driver for growth. Only in the 1990s did the privatisation policy start to impact on the health care sector, with the privatisation of the government medical stores (drug manufacturing, procurement and distribution centre) (Leng & Barraclough, 2007:20).

Privatisation of public health care services was a contentious issue but the establishment of private hospitals was less so. A gradual growth of private hospitals took place from the 1980s. There was no positive government policy towards either stimulating the private provision or in limiting and controlling it. No regulatory structures were set up to oversee the private sector. Only by 1998, was regulatory legislation introduced and new legislation passed in 2006. Tax incentives were made available for the private health care sector, e.g. industrial building allowance for hospitals buildings, exemption from service tax for expenses on medical advice and use of medical equipment and tax deduction for expenses for pre-employment training (Peng & Barraclough, 2007: 21). This shows how the private health sector has benefitted from government subsidies, even though there has not been a specific government policy for developing the private health care sector.

The concept of the public and private sectors 'sharing provision' was introduced by the government, with the private sector providing services for those who could afford to pay. Tax concessions for medical expenses were made available for individuals, children and grandparents, which effectively covered whole families. This led to a government announcement in the 1996-2000 Seventh Malaysia Plan that everyone would be expected to pay for health care included those using public services (WHO, 2009).

Since the 1980s, and the expansion of private hospitals, there has been an increase in out of pocket spending on health care to 40%, which is 70% of private health expenditure (MOH, 2009). Employers have also started to make a significant contribution to health care costs. There is personal tax relief on health insurance. A medical savings scheme, the Employees Provident Funds (1994) can now be drawn on for a risk-related medical insurance scheme offered by Life Insurers Association of Malaysia, a private company (Rasiah et al, 2009).

Privatisation of hospital support services

The government has been involved in the privatisation of four health care services. These include pharmaceutical services, hospital support services, monitoring & consultancy services and monitoring and supervision of foreign workers health certification (Nambiar, 2009:29). The supply of pharmaceutical services was contracted to Pharmaniaga Logistics, a private company, for a 15 year period. There is no specific regulatory authority but the National Pharmaceutical Bureau, the Ministry of Health and the Price Committee are joint regulators. Hospitals support services were contracted out to Pantai Medivest and Faber Mediserve for 15 years, although these companies did not have any background in providing support services. The regulatory arrangements were only put in place a year after privatisation. The two companies were given effective control of specific regions of the country so that they created an effective regional monopoly (Nambiar, 2009).

Private hospitals

The number of private hospitals has increased from 10 in 1980 to 128 in 2003. This is reflected in an increase in the share of hospitals beds provided by the private sector, which has risen from 5.8 - 28.4%. This expansion has been facilitated by an increase in national income. However, 78% of the population is still dependent on the public hospital sector and 18% on private hospitals. 54% of the population use private clinics and 39 % use public facilities. Half of the private hospitals have under 50 beds or fewer. There are 13 large private hospitals with four not-for-profit. Two of the not-for-profit hospitals have origins in Chinese community and two have religious origins (Chee & Barraclough, 2007).

Many of the private hospitals were originally set up by doctors but have been sold to for-profit companies. For example, the Penang Medical Centre was set up by doctors but was then sold to the Gleneagles group, now owned by Parkway Holdings, based in Singapore. Private hospitals were also set up by property

groups as part of the construction of a neighbourhood/ township. For example, Subang Jaya Medical Centre is owned by Sime Darby, the company which built Subang Jaya. As a company, it was originally involved in plantations and now has a wide range of investments (Chee & Barraclough, 2007).

The expansion of the private healthcare sector should also be considered in the context of the *Bumiputeral Malays*, the creation of public enterprises set up to accumulate capital. The state is also investing in health care. One of the largest investors is a state corporation, Kumpulan Perubaten (Johor) KPJ Health care, owned by the Johor State Economic Development Corporation. It owns 13 private hospitals in Malaysia. Other state governments have become involved in private health care. The privatisation of public enterprises has also contributed private capital to Bumiputera (Rasiah et al, 2009). State investment in the private health care sector has led to increased links between the private and public sectors as seen through attendance by politicians, government officials and the private health care sector at conferences and other social gatherings (Rasiah et al, 2009)..

Hospital ownership is beginning to be globalised, with multinational companies operating private hospitals. This is bringing international capital into the private Malaysian market. Malaysian capital is also starting to invest internationally. Khazanah Nasional Holdings have invested in Apollo hospitals in India and Parkway Holdings in Singapore (Chee & Barracligh, 2007).

A further factor that is stimulating the growth of private hospitals is medical tourism. Supported by the Malaysian government policy to increase revenue from tourism, the Asian financial crisis in 1997 pushed companies to develop expansion strategies to attract international patients. The Ministry of Health is facilitating the marketing and regulating advertising and fees of 34 private hospitals (Chee & Barraclough, 2007). The Ministry of International Trade and Industry also contributes. Tax incentives are given to private hospitals involved in medical tourism (Chee & Barraclough, 2007).

The Malaysian state has strong links to the private health care sector. The Ministry of Health is responsible for population health (government health services) as well as for private hospital and medical tourism developments. This dual role, played by the Ministry of Health, has led to a movement of health personnel from the public to the private health care sector. Doctors are now required to work a set number of hours for the public health care sector, a policy introduced as a way of addressing the shortage of health workers in the public sector. With weak regulation, private hospitals can locate where they choose, most often in affluent urban areas. In addition, a process of privatisation has taken place where private companies provide services in government hospitals.

Out-of-pocket health payments are used to pay for private health care and government health care is still funded by taxation. However, the increase in out-of pocket payments is part of the refocusing of government policy on health care financing. Some draft health policy goals for 2020 were identified as: population health; national capacity building for health: and national capacity building towards competitiveness in the health market (WHO, 2009). This shows how establishing a market in the health care sector is a major government goal over the next decade. The 9th Malaysian Plan, 2006-2010, reflected a goal of developing a 'national health care financing mechanism'. The government argues that the demand for health care and the changing disease profile (more non-communicable diseases) is resulting in higher health care costs (WHO, 2009). These will have to be paid for so that health care is 'accessible, affordable and relevant' to those who need it. This does not necessarily mean increasing the level of taxation but moving towards a social insurance system.

Equity of health care and access to services;

Health has been an important public service provided by the government since Independence. Since 1996, government health expenditure has increased but is has not necessarily led to improvements in health care coverage for the population because some of the increase is due to the increased expenditure on contracting out of hospital support services (Wee and Jomo, 2007). More health care facilities are located

in the urban areas, where the population with the highest incomes live. Private doctors tend to locate in urban areas.

The three largest and poorest provinces have the lowest percentage of population living within 5 kilometres of a health facility. There are longer waiting times in poorer provinces because of fewer doctors. Distance and poor facilities can be a barrier for poorer people accessing health care (Wee & Jomo, 2007).

Lower income groups are more likely to use government health services than higher income groups and the gap between these two groups has widened in the last two decades. The higher income groups tend to use government facilities for in-patient care rather than out-patient care. The growth in private health care services since the 1980s has benefitted the higher income groups because they are able to pay. However, access by low income groups to government services is threatened because of the migration of government health workers to the private sector and the introduction of user fees for government health care, introduced by the government (Wee & Jome, 2007)

Labour

Health care workers have been affected by the corporatisation of the public health care sector and by the expansion of the private sector. Public sector health workers have moved to the private sector within Malaysia and have also migrated to Europe to find better paid work. A study of trade union responses to corporatisation of public sector teaching hospital is used to inform an account of how labour has been affected by the changed relationship between public and private sectors (Foon Fang & Lethbridge,2004).

Corporatisation of a public sector hospital involves the adoption of private sector organisational approach, with the introduction of business plans, target setting and close the decentralisation of cost centres. This leads to changes in attitude of staff, with a greater focus on money. With an increased focus on costs, staff are often laid off and the workload for remaining staff increases. This puts pressure on individual workers. New salary schemes are introduced and there is an increase in workers on temporary or time limited contracts, resulting in a loss of job security. Working practices often change after the contracting out of services. Health and safety is no longer a priority and training in protection and prevention is reduced.

The creation of a private patient's unit drew existing staff away from public sector work. Existing staff had to cover for a health worker in the private patient's unit. Sometimes staff worked long hours on both public and private wards, which affected the quality of their work. Private practice raised difficult questions for trade unions because they wanted to ensure their members had access to opportunities to increase their income. However, some specialties were more successful at attracting private patients, which led to some health workers to get special allowances. Other health workers and ancillary workers who were not directly involved in high income generation, did not benefit and so had lower pay. Introduction of competition within the public sector affects the equity and equality of health workers.

Promotion prospects expanded in the last five years. Many new units have been opened which need experienced and qualified staff, which means more senior grades are created. However the Malayan Nurses Union has found that promotion prospects are still the same because of the vacancies. Due to the large number of nurses at lower levels, the opportunities for promotion are limited. A nurse often waits 10-15 years for a level of promotion.

Problems are often solved by contracting out services rather than working together to solve a problem. When a union brought up issues concerning disposal of waste, including clinical and chemical waste, the reaction of the hospital was to privatise the service, rather than working to find a solution. This resulted in a company being contracted to dispose of the waste but "*clinical waste is now charged according to weight and is a more expensive service*".

The Malayan Nurses Union felt that opportunities for training have increased but because of the shortage of staff, it is difficult to release staff to go for training and only one at a time. Anyone over 45 is not considered for long term (6-12 months) courses. For those who want to study further, they have to go on unpaid leave as they can't apply for scholarships
The Malaysian government passed Convention 98 so that ministries and government departments do not qualify for collective bargaining rights. There is also no mechanism for resolving disputes in the government sector. There has been an increase in the number of people joining a trade union. The private hospitals can form unions for one hospital but are not allowed to form a national union of private hospitals.

Workers have been directly affected by processes of corporatisation and privatisation. Increased work loads and reduced job security are two of the most frequent experiences. Reductions in resources going to the public sector have resulted in a movement of health workers to the private sector or to jobs outside Malaysia. This is affected the quality of public health care services.

Challenges to the process of privatisation

There have been some attempts by civil society organisations to challenge the process of privatisation. In 1998, the Malaysia Citizen's Health Initiative (CHI), was launched, which described itself as an "informal grouping of organizations and individuals seeking to promote greater community involvement in healthcare reforms, and more generally in matters of health policy". As an alliance of trade unions and civil society groups, it won a campaign to stop the privatisation of public sector hospitals in Malaysia in May 1999 (Lethbridge, 2004).

In 2004, another coalition to fight for public health care was set up. The Coalition Against Health Care Privatization (CAHCP) was formed from a coalition of 81 NGOs, trade unions and political parties, many of which had also endorsed the Citizens' Health Manifesto a few years earlier (Chee & Barraclough, 2007a). This new coalition was formed because, although the government has agreed abandon corporatization of the public health care system, there were other changes introduced that were contributing to undermining public health care. Private practice was allowed in public hospitals. More outsourcing was introduced. A proposed compulsory insurance scheme would have allowed entitlements in private hospitals. CAHCP has been campaigning to change the overall health care policy and to safeguard public health care through lobbying and mobilisation (Chee & Barraclough, 2007a). Both CHI and CAHCP tried to influence the health policy discourse and move it away from privatisation to a more welfare based model based on universal access. Health has been an issue that has brought together different ethnic and cultural groups.

Conclusion

This study of changes in health care in Malaysia shows how the process of health care privatisation can evolve without a specific government strategy. A level of dissatisfaction with government services can lead to the growth of private health care services. Both state agencies and private companies have contributed to the growth of private health care.

State investment agencies have invested in private health care as part of national economic development strategies. Private companies have diversified from plantation, construction or other activities into health care. The Ministry of Health now has two conflicting roles: a responsibility for the public health care sector and a supporter of private health care. The formation of an alliance of politicians, private investors and the private health care providers is shaping a wider agenda about how health care is financed. Although civil society organisations have challenged privatisation, there is no sign that the policy has been defeated.

12 Conclusion

The conclusions of this review to develop '*A parallel approach to analysis of costs/benefits and efficiency changes resulting from privatisation of health services*' in order to identify the evidence of the impact of health care marketisation and privatisation on services users and health workers will be discussed in the following sections:

- Processes of marketisation and privatisation;
- Impact on health workers;
- Impact on service delivery and services users;
- Implications for the future;
- Types of research.

Processes of marketisation and privatisation

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

One of the most significant changes is the introduction of decentralisation policies which transfer responsibility for management and funding from national/ central government to local level, whether local government or hospital and institutional levels. Decentralisation is presented as benefiting local people because it gives greater control over decision making. When it is linked to reduced resource allocation from government with no balancing powers of local taxation, the result is often a reduction in resources, leading to cuts in services. The impact of decentralisation can be seen throughout the world. Within Europe, there are different gradations of decentralisation policies. In some countries of Central and Eastern Europe, decentralisation was a radical policy which resulted in large cuts in budgets. In Western Europe, a more gradual transfer of power to local authorities has occurred with reductions from central government funding.

Impact on service delivery and services users

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

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

Impact on health workers

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

Implications for the future

The impact of marketisation and privatisation are being felt in many countries. Gradually the structures of public health care are being eroded or dismantled. The growth of out-of-pocket care is placing a greater burden on many service users and governments are beginning to use this to question the financing of public health care. As increased taxation is not considered an option to pay for increased cost of health care, new health insurance is being presented as an option for the future.

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

Public and private sectors operate in different ways with different priorities. This has implications for the 'public sector ethos' underpinning public services. The evidence of long term care homes show that private sector owners have an obligation to their shareholders, which affects their costs and the quality of care they provide. The privatisation of social care can be seen as an indicator of what the privatisation of health care will bring. Apart from reductions in the quality of care, it also brings a loss of local control over public services which should be responding to local needs.

Decentralisation also has an impact on equity across a country. Leaving decision making to local groups can result in greater variations in the types of services and service quality across a country. In the long term this will result in greater health inequalities. Unless central government has powers to introduce minimum standards of services, it will be difficult for any government to address health inequities.

Type of research

Health care marketisation and privatisation, introduced under the guise of health sector reform, have been the subject of research by academics, government agencies and civil society organisations. Academic and government research have greater resources and the links between universities and government are increasingly intertwined. This influences the types of research that have been commissioned to look at the impact of health sector reform.

The rhetoric of health sector reform promoted the need for effectiveness, efficiency and equity but implementation and the resulting research has focused on effectiveness and efficiency. Research into health care efficiency has used methodologies and instruments that were created for measuring industrial efficiency, developed for the private sector. Health care is not an industrial production process. It is dependent on the quality of care as much as the specific health care intervention. There is a surprising lack of quality measures of health and social care. Studies that have looked at the effectiveness of care in long term care homes consider health outcomes but not quality of life. There is a similar absence of systematic research that looks at quality of health care. Future research needs to address ways of measuring in

quantitative and qualitative ways, what is quality health and social care. In assessing quality health and social care, it is important to recognise that not everything can be quantified.

Jane Lethbridge
12 September 2011

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Ministério da Saúde – Portal da Saúde
Site: www.saude.gov.br
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Site: www.ibpt.com.br – Estudos Tributários
Ministério do Desenvolvimento, Indústria e Comércio Exterior
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