Universal access to health care

Third World Health Aid
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Municipal Services Project
www.municipalservicesproject.org/Exploring alternatives to privatization
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1. **Introduction**

There are large disparities in health between developing and rich countries. Low and middle-income countries bear 90% of the global burden of disease, but account for only 12% of global spending on health. In other words, the most vulnerable people with the greatest health needs have poor access to health care. In fact, 1.3 billion people on the planet have no affordable and effective access to health care.

In this module, we focus on the role of the health system in reducing this health gap. We start by defining the main components of a health system and how they interact in improving health outcomes. We then open the discussion by unpacking today’s dominant global health agenda, universal health coverage, and how its prescriptions for health financing obscures essential aspects of healthcare provision and give undue influence to private actors followed by a situation of the current debate in history. Finally, case studies from developing countries examine whether health reforms have led to better health equity in a sustainable, accountable and efficient manner.

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2. Conceptual Framework

2.1. The role of the health system in improving health outcomes

The importance of non-health factors as major predictors of health has long been recognized.² The WHO Commission on Social Determinants of Health concluded its 2008 Report stating that “social injustice is killing people on a grand scale and poses a greater threat to public health than a lack of doctors, medicines or health services” (World Health Organisation 2008). If the health system is not the only responsible for health, then what is its place in the complex web of interrelated factors that influence health? Above all, what is the strength and the responsibility of the health system in addressing the multiple forces that impact upon health?

It is important to recognize that health care alone cannot be responsible for better population health.³ Indeed, there are many interrelated factors that influence health, including socioeconomic development, education, housing, gender and risk behaviors among others. They are termed ‘the social determinants of health’ (Dahlgren & Whitehead, 1991). Health care is one of those factors and can therefore only be part of the solution. However, the health system has an important role to fulfil, because of its ability to increase or reduce health inequities⁴ and to have upwards influence on the broader socioeconomic and political context. Being such an important determinant of health, we focus in this paper on the role of the health system in improving health outcomes.

² Balabanova, D., McKee, M. & Mills, A., 2011, ‘Good health at low cost 25 years on’, The London School of Hygiene and Tropical Medicine, London
³ Population health is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group (Kindig & Stoddart 2003)
2.2. What is a health system?

We use the WHO’s widely used conceptual framework (2000)\(^5\) to understand health systems.

![Health System Diagram]


This model clearly demonstrates the core functions and goals of a health system, but it also emphasises how they interplay. In a nutshell, a health system needs to be governed effectively (stewardship), be adequately funded in relation to needs, and generate resources in a timely manner (infrastructure, health workers, knowledge, etc.) to be able to deliver services. The system should be responsive to people’s expectations and should also provide some level of financial protection to prevent catastrophic expenditure. The end goal is to improve health outcomes. The model offers analytical simplicity and is consistent with the ‘systems thinking’ model\(^6\) that follows, using the ‘health system building blocks’ but placing people at the centre. Individuals, civil society organisations, health workers, managers and policy-makers become the actors driving the system. This contrasts with an approach that sees people merely as beneficiaries and passive participants. The argument is that people are key to explaining how the system works and develops over time.

![Health System Building Blocks Diagram]


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2.3. Health as a human right

The Constitution of the WHO declares health as a fundamental human right. This implies that states have the responsibility to protect, promote and fulfill the right to health, which includes universal access to health care, as further recognized in:

- The **Universal Declaration of Human Rights** (1948), which laid the foundations for the right to the highest attainable standard of health.
- The ‘Health for All’ agenda set by the **Alma-Ata Declaration** in 1978.
- The **International Covenant on Economic, Social and Cultural Rights** (1966) and the **General Comment 14** of the ICESCR (2000) requires that health facilities and services be available, accessible and culturally acceptable for all.
- The **Ottawa Charter for Health Promotion** (1986).

At the centre of the right to health is a well functioning health system, which is available, accessible, acceptable to all without discrimination and of good quality (O’Donnell, 2007):

<table>
<thead>
<tr>
<th>Availability</th>
<th>A sufficient quantity of functioning public health and health care facilities, goods and services, as well as programmes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordability</td>
<td>Financial accessibility</td>
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<td>Acceptability</td>
<td>Culturally appropriate, gender sensitive, respect of medical ethics</td>
</tr>
<tr>
<td>Quality</td>
<td>Health facilities, goods and services must be scientifically and medically appropriate and of good quality.</td>
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</table>

Yet, the right to health extends further than the health care system. It includes a wide range of factors that can help us lead a healthy life and improve the way health is promoted. The Committee on Economic, Social and Cultural Rights refers to these as underlying determinants of health (CESCR 2000). They include:
- Safe drinking water and adequate sanitation
- Safe food
- Adequate nutrition and housing
- Healthy working and environmental conditions
- Health-related education and information, including sexual and reproductive health information
- Gender equality.

The term ‘underlying determinants’ in human rights, is similar to what is referred to as the social determinants of health (WHO 2008b).

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the right to health

UNDERLYING DETERMINANTS

- water
- sanitation
- food
- nutrition
- housing
- healthy occupational & environmental conditions
- education
- information
- etc...

HEALTH CARE

AAAQ

availability accessibility acceptability quality

(CESCR 2000; WHO 2008b) (redrawn by Fennabee)
3. **TRENDS AND HISTORY IN GLOBAL HEALTH POLICIES**

3.1. The current mantra

3.1.1. Universal Health Coverage vs Universal Health Care

Today, Universal Health Coverage (UHC) is often put forward as a solution to strengthen health systems in developing countries. UHC is defined by the World Health Organization (2010) as “ensuring that all people obtain the health services they need without suffering financial hardship when paying for them”. According to the WHO, Universal Health Coverage as a concept is “firmly based on its Constitution of 1946, declaring health a fundamental human right”.

The 2010 World Health Report, *Health systems financing: the path to universal health coverage*, illustrated the concept with the ‘UHC cube’ (see figure), in which there would be a progressive expansion of the package of services covered for the entire population as pooled funds increase to finance health care.

This model is gaining in popularity. Since 2010 more than 80 countries have asked WHO for technical assistance in moving toward this goal. The emerging economies of Brazil, Russia, India, China and South Africa - the BRICS, representing almost half of the world’s population - are all taking steps toward UHC. In 2012, the UN General Assembly passed a landmark resolution, calling on member States to adopt UHC policies and, more recently,
the International Labour Organisation (ILO) also jumped on the bandwagon. Both the World Bank and the WHO have proposed UHC as one of the key components of the Sustainable Development Goals to be finalized in September 2015.

Although many powerful global health actors are now advocating for UHC, including the World Bank and WHO, private players such as the Gates and the Rockefeller Foundations and influential academic outlets such as The Lancet, the concept is sometimes interpreted in different ways. Does UHC mean universal health insurance coverage? Or does UHC mean providing quality healthcare for all? What role should the state play? Must one rely on the private sector?

The concept is not entirely new and, from its early days, the emphasis was put on ‘sustainable financing’. One of the first mentions of UHC was at the 58th World Health Assembly in 2005, where a resolution urged member states to “ensure that health-financing systems include a method for prepayment of financial contributions for health care, with a view to sharing risk among the population and avoiding catastrophic health care expenditure and impoverishment of individuals as a result of seeking care.” This recommendation was based on some experiments in the late 1990s and early 2000s with such universal insurance schemes, especially in Latin American countries. Today, the policy prescription that has come to dominate the UHC agenda is the implementation of insurance schemes covering a limited package of health services.

While there is much debate about health financing arrangements to achieve universal access to health services, other key health system aspects such as health service provision have largely been off the radar. Mainstream research on UHC focuses on health financing by the State but generally limits its role to that of ‘purchaser’ of health services, pushing aside its previously key provider role. Paradoxically, the WHO recognizes that UHC requires a strong, efficient, well-run health system; access to essential medicines and technologies and a sufficient capacity of well-trained and motivated health workers. Vivian Lin, health systems director at the WHO regional office for the Western Pacific reported in The Lancet that “financial risk protection alone is not enough, and that without the availability of quality health care, UHC is meaningless” (2014b).

3.1.2. Privatization of health care

At the same time, civil society organisations have warned that the UHC prescription has come to be dominated by the use of insurance schemes that weakens public health systems, by leaving the door open for the privatization of healthcare delivery. Exemplary of this trend is the European Union Development Cooperation’s Agenda For Change (2011) pushing for more involvement of the private sector. It states that “the European Union should only invest in infrastructure when the private sector is not able to do so on a commercial basis”. The European Commission wants to create a favourable business environment in developing
countries and catalyse private investments. The document states that “the EU should develop new ways of engaging with the private sector, notably with a view to leveraging private sector activity and resources for delivering public goods”, including health care. In a press release (2014), European Commissioner of Development Cooperation Andris Piebalgs confirmed that the Commission aims to foster partnerships with private companies in order to “provide basic services, such as energy, water, health care and education”.

3.1.3. Trade and health

According to the European Commission, privatization and trade liberalization go hand in hand. The Agenda For Change states: “better and more targeted Aid for Trade and trade facilitation must accompany these [privatization] efforts”. Governments promote trade and investment as a means to economic growth and seek reductions in non-tariff barriers including on essential services such as health or education. This shows the complete disregard for the role of the regulation of commercial health sector providers to protect the public interest.

Under the World Trade Organization

Multilateral, regional and bilateral free trade agreements affect health services directly, through trade in health services, and indirectly, through liberalization in support sectors and an impact on people’s daily living conditions and the environment. The World Trade Organization (WTO) provides a multilateral framework for trade liberalization with binding agreements for member states. The General Agreement on Trade in Services (GATS) under the WTO outlines the pathways through which trade affects health services, namely via medical tourism, E-health, health worker migration and foreign direct investment on health infrastructure for example. The biggest risk of trade in health services consists in the creation of a two-tiered system with mainly private, highly technological and specialized care for the affluent few and basic, under resourced, public health services for the poor, as well as the exacerbation of an international brain drain through health worker migration and internal brain drain from public to private services. Because of this, the poor in rural and urban areas would have deteriorating access to quality health services. Present day examples of this have been outlined in the case-studies.

The new regime

Because of increasing resistance from developing countries within the WTO, economically powerful nations such as the USA and the European Union are now placing more emphasis on bilateral and regional trade and investment agreements, circumventing the WTO to advance the trade agenda. The ‘new generation’ trade and investment agreements -among which the Trade in Services Agreement (TISA) and the Transatlantic Trade and Investment Partnership (TTIP) and the Trans-Pacific Partnership (TPP)- currently being negotiated, seek to liberalize service sectors with increasing commercialisation in health care as a consequence, by following the same logic as (but going beyond) the GATS requirements.

Public policy space in danger

Liberalization in the service sector effectively undermines governments’ public policy space. Decisions taken by current governments will be captured in a binding agreement, with an effective dispute settlement mechanism. If, as argued in this module, after having liberalized

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29 Smith RD, Chanda R, Tangcharoensathien V. Trade in health-related services. The Lancet. 2009;373 (9663): 593-601
EFFECTS OF HEALTH CARE LIBERALIZATION

WTO

General Agreement on Trade in Services

Foreign direct investment
Health worker migration
Health tourism

TWO TIERED HEALTH CARE SYSTEM

PRIVATE
Highly specialized

RICH

POOR

Health care

Trade in Service Agreements
Transatlantic Trade and Investment Partnership
Trans Pacific Partnership

Binding Agreements

PUBLIC POLICY SPACE IN DANGER
and commercialized the health sector it seems that it would be better to keep or return health care in public hands to have universal access, then it would be very difficult, if not impossible to reverse negative consequences of previous commitments. Therefore it is important to thoroughly assess potential impacts on health and access to health care before committing services to trade liberalization under binding agreements.

3.2. A little history

The role assigned to the state is an important aspect of the discussion on health systems. There has been a polarized debate on this topic throughout the 20th Century and before. Some consider health as an individual responsibility and health care as a marketable commodity. Others consider access to health services as a human right that should not depend on individual wealth or socio-economic status. These diverging ethical visions at the foundation of health systems have evolved based on the specific histories of particular countries or regions. Generally, the debate has been concentrated around the relative merits of Western health system models, with the United States’ self-help system at one end of the spectrum and universal European models based on social solidarity on the other. Throughout the post-colonial period, debates on the best model have influenced the development of health systems in low-and middle income countries (LMICs).

30 While trying to project the future trajectory of UHC in LMIC’s it is important to learn from historical experiences for two reasons. First, because models of UHC being promoted in LMICs today are justified on the basis of evidence from models in developed countries, yet they are blind to the fact that these are imperfect ones born out of a long history of social struggle and compromise in capitalist states. Second, many of these systems are now under strain and face the prospect of reforms, which are largely designed to open up opportunities for the private sector as is happening in the global South.

In international forums, health strategies have also been divided between so-called ‘horizontal’ versus ‘vertical’ approaches. This discussion is clearly interwoven with the debate on the role of the state in health care, be it explicit or not. Prior to the 1960s the international health community focused their interventions in developing countries on ‘vertical programmes’ focusing on disease-specific actions, such as malaria eradication. After the 1960s it became clear that disease-specific interventions could only work if they relied upon broader basic health service provision. Already in 1966, Halfdan Mahler (subsequently General Director of the World Health Organisation), stated that “all communicable disease campaigns have overwhelmingly demonstrated that only through falling back on strong basic health services in developing countries is it possible to achieve a consolidation of these campaigns”. 32 Within the leading global health institution of the United Nations, the WHO, there was growing awareness that population health would not improve significantly through parallel, independent programmes.

This realization culminated in the 1978 Alma-Ata Declaration ‘Health for All by the year 2000’, promoting integrated health systems based on comprehensive primary health care,

constructed with the participation of communities and intersectoral collaboration to address the social determinants of health (e.g. nutrition, access to water, housing, education, etc). However, this idea was quickly tagged as ‘unrealistic’, ‘costly’ and was replaced by ‘selective primary health care’, with a focus on ‘cost-efficiency’ and the promotion of specific interventions mainly for children and women. In the early 1980s the WHO entered a financial crisis as high-income country members decided to freeze their regular contributions. The WHO’s budget then became more dependent on earmarked funding from private donors, creating a pendulum swing back to a focus on disease-specific and vertical interventions.

Meanwhile, the leading global financial institutions (World Bank and International Monetary Fund) were implementing their infamous Structural Adjustment Programme throughout the 1980s, which later proved to be “a cure worse than the disease,” undermining public services and privatizing health systems in developing countries.

Towards the end of the 1980s, the World Bank started to engage more and more in market-oriented, “cost-effective” health reforms, as clearly spelled out with the publication of the 1993 World Development Report “Investing in health”. Health system reform efforts in LMICs during that period led to massive cuts in public healthcare expenditure, and by the turn of the millennium most health systems in developing countries were crumbling, with poor infrastructure, failing morale among health workers and a rise in catastrophic health care expenditure by households, with a large proportion of out-of-pocket payments.

In the 2000s, there was a renewed effort to define health systems as an integrated set of interrelated functions (World Health Report 2000 and 2007) and an increasing interest in health system strengthening. However, the return to ‘horizontal’ approaches has not necessarily implied that the state should retake a leading role in providing health care. Rather, the widely held view has been that “the state need not provide services directly, but should play an enabling role”. Some have deemed it necessary to “expose public services to market pressures, without necessarily privatizing them”, by corporatizing health care through so-called Public-Private Partnerships. You will find examples of this approach in the case studies.

During the same period, the growing popularity for public-private partnerships for health to pursue disease-specific goals was reflected on a global scale, such as the creation of the GAVI Alliance in 2000 and the Global Fund for Aids, TB and Malaria in 2002. This partnership approach marked a shift from an international health agenda set mainly by public governmental actors within multilateral institutions, to an increased private sector participation in global health governance. An approach that is still obvious today, in national, regional and global development policies.

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4. Case studies

The cases seek to illustrate how the international theoretical discourse on state involvement in the health system affects health care access and population health in developing countries. We therefore give ‘field’ examples from different regions where there have been health interventions with a focus on increasing universal access to health care.

4.1. Criteria for health system performance

The case studies examine whether these interventions succeeded in making quality health care accessible to all in an equitable and efficient manner. Many cases will illustrate tensions emerging from the implementation of the dominant UHC approach in countries of the South, highlighting the need to promote public financing as much as public provision to achieve equitable health outcomes, as opposed to the current focus on private sector solutions.

Equity in access

Implies that health care services are universally accessible to everyone. ‘Access to health services’, as an obligation under ‘the right to health’, is defined as “the timely use of services according to need” (Peters et al, 2008) and has 4 dimensions:

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(O’Donnell, 2007)

Efficiency

In economics, ‘efficiency’ is defined as a resource allocation that results in maximized net benefits from the use of the resource. In practical applications, the notion refers to “cost-benefit” analyses that attempt to determine the net balance between positive and negative effects of any economic act, event, or institution.

Accountability

The accountability of the government, civil servants and politicians to the public or the responsibility to protect the public interest.

Sustainability

Sustainable development is development that meets the needs of the present without compromising the ability of future generations to meet their own needs.
4.2. Case studies

4.2.1. Philippines: Universal Health Care through Public-Private Partnerships?

**Health outcomes**
The Philippines is a lower middle income country with a total population of about 100 million people spread over 7107 islands. Life expectancy at birth is 69 years, which is lower than the regional average. The under five mortality rate with 30 deaths/1000 live births is higher than the regional average. Worryingly, maternal mortality has actually increased from 110 (in 1990) to 120 maternal deaths per 100,000 live births in 2013 (ibid).

**Lack of access to health services**
Filipinos suffer from dismal access to health services. Today, 8 people out of 10 in the country report never having had a medical check-up or physical examination in their life. This glaring lack of access to health services is also illustrated by the fact that 28% of all Filipino women do not enjoy skilled birth attendance. Health care utilization rates in the Philippines show worse access to health than the regional average.

The primary reason for the low coverage is a lack of financial means. Free health services are very limited and the poorest cannot afford medicines and treatment. This is not a surprise given that average costs of hospital admission are equivalent to 167.5% of the monthly salary of a minimum wage earner. Due to poverty, 6 out of 10 people die without ever having seen a doctor.

There are large disparities in access to health services between different socio-economic groups in society. Coverage of health services in the Philippines is much lower among people living in poverty or with no access to education. The poorest two-thirds of the population use public facilities, especially Rural Health Units and village (barangay) health centers; in comparison only 10.6% of the richest quintile use these facilities, favouring private hospitals and clinics. However, the availability of public health services remains very poor in the Philippines, with large urban-rural disparities. In the Philippines there is only 1 hospital bed available per 1000 people, compared with Europe where there are 63 hospital beds per 1000 people. There are only 1 doctor, 3 nurses and 7 midwives available per 100,000 people, while the WHO recommends 228 health workers per 100,000 population.

**Health policy in the Philippines**
President Benigno S. Aquino III is implementing the country’s Philippine Development Plan (2011-2016). Within this framework, his government embarked upon two major strategies to

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36 WHO Philippines country health profile, 2015
40 WHO Philippines Country health profile 2014
supposedly rescue the ailing health system:

1. Expansion of the National Health Insurance Program called Philhealth
2. Corporatization and public-private partnerships in the health sector

Aquino’s Health Agenda claims to bring “equity and access to critical health services to poor Filipinos”. It is a continuation and intensification of previous policies: the ‘Health Sector Reform Agenda’ (Estrada) and ‘Fourmula One for Health’ (Arroyo). The 3 policies advance a smaller government role and privatization of health services with hospital corporatization, medical tourism and opening up for local and foreign corporations in health service provision.

Philhealth social insurance

The National Health Insurance Act of 2013 mandates the state to provide comprehensive health care services to all Filipinos through a socialized health insurance program. The National Health Insurance Program was established in 1994. The Philippine Health Insurance Corporation (Philhealth) is a government-owned and controlled entity. The 1995 law expanding coverage of the National Health Insurance promises that “No one shall be denied access to basic health care services.” In the 2013 budget, the government allocated P12.6 billion ($289 million) for PhilHealth. This is in line with the 2011-2016 Philippine Development Plan and Universal Health Care target to enroll the five million poorest families by the year 2015.

During his State of the Nation Address in 2012, Aquino trumpeted his administration’s accomplishment on Universal Health Care for All under Philhealth. The Aquino administration boasted that there was an increase in the number of Philhealth beneficiaries, and that “nowadays, the poorest among our countrymen can simply walk inside any government hospital, show their Philhealth card, and receive the treatment they need free of charge.” However, PhilHealth as a social health insurance has many limitations and restrictions.

Limited coverage

Despite high contributions for social insurance, access to health services and products is not enough and health care protection does not happen where it is needed most. More than 15 years after implementation the official population coverage is limited to 81%. On top of that, this claim of coverage is based on people with limited benefits. Dependent family members of Philhealth covered individuals are only entitled to coverage up to 45 days of hospital admission per year and this is shared among all dependents. In 2013, 6 out of 10 people covered by the scheme were dependents. This situation can exacerbate existing social exclusion and inequities, because the family might give preference to one dependent over another. In 2013, 6 out of 10 people covered were dependents.

There is economic inequity in coverage. Only 19.6% of the lowest income quintile and only 28.6% of the second quintile have adhered to Philhealth; others have no insurance at all. In contrast, 57% of the richest income quintile are enrolled in PhilHealth.

High out-of-pocket payments

In addition, Philhealth covers a defined and limited service package; whatever needs to be paid for besides the covered costs, are out-of-pocket expenditures for medicines and medical treatment. User fees for health care persist, even if Philhealth is considered a mature social health insurance. In 2011 out-of-pocket expenditures in the Philippines accounted for 52.7% of total household health expenditures, over the WHO threshold for catastrophic expenditure leading to impoverishment.
Of all claims in 2012, Philhealth provided support for only 53%, while 47% of health care costs were paid out-of-pocket. Even the poor who claimed benefits only received a support value of 55%. In a nationwide survey by IBON, 8 out of 10 respondents said they used personal money for health spending while 4 out of 10 claimed they borrowed from family or friends. As much as 40% of Filipino households reported experiencing health shocks in the past three years and the majority were not able to cope with it.

**Public-Private Partnerships’ unkept promises**

**Corporate health policies**

The Aquino government claims that public-private partnerships (PPPs) are the only alternative to meet health needs in the archipelago country. By outsourcing public hospitals to the commercial sector, the goal is to reduce government spending, while improving public health outcomes. Health Secretary Enrique Ona said that all 72 public hospitals in the Philippines would be eligible for corporatization.

This choice is cheered upon by the European Union. An example is its € 33-million financial support for the market-friendly health reform in the Philippines. The latest Philippines-EU Strategy Paper (2007-2013) stated that “further privatisation is critical and urgent” (p.18). The Philippine Orthopedic Hospital (POC) is the first hospital to be corporatized as part of President Benigno Aquino III’s PPP drive, through a P5.6 billion ($135 million) rehabilitation grant from the National Economic and Development Authority. The POC will be privatized under a build, operate, transfer (BOT) scheme. The winning bidder will operate it for 25 years with the option to renegotiate for another contract. So far, there are nine corporations that have expressed their interest in bidding for the project, among them national private companies and transnational ones such as Siemens, General Electric and Philips Electronics. The contract was to be awarded in June 2015 and construction to start and be completed in 2016.

According to the PPP Projects website, the “Modernization of POC” project consists in the construction of a 700-bed “super-speciality tertiary orthopedic hospital” and will be called the Center for Bone and Joint Diseases, Trauma and Rehabilitation Medicine. This center will be integrated with other government-owned and controlled hospitals, such as the Philippine Heart Center, Lung Center of the Philippines, National Kidney and Transplant Institute, and Philippine Children’s Medical Center in Quezon City. The integration will become the Philippine Center for Specialized Care, a part of the medical tourism industry that is being developed by the government.

**Unaffordable health services**

According to the Philippine Department of Health, there are 1,796 hospitals in the country, of which 60% are privately owned. The WHO estimates that only 30% of the population can afford health services from the private sector. The Philippine public-private partnership approach does not resolve the problem of financial barriers to healthcare access for the majority of people. On the contrary, it results in higher user fees.

Together with increasing privatization of public health services, the government gradually reduces its allocation to health services. The budget for the health sector is now only 1.89% of Gross Domestic Product (GDP).

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41 WHO Philippines equity profile, 2008
42 WHO Health system financing country profile, Philippines 2012
There have been budget cuts for maintenance and other operating expenses of public hospitals and a zero budget for capital outlay for hospitals targeted for corporatization and public-private partnerships, such as the Philippine Orthopedic Center (POC) and the Research Institute for Tropical Medicine (RITM). Hospitals are then forced to become self-sufficient by charging user fees and imposing higher rates. Forced to survive with the limited budget and to demonstrate its financial viability to potential private investors, the Philippine Orthopedic Center and the Research Institute for Tropical Medicine have, in the meantime, progressively increased their service fees.

According to local think-tank IBON Foundation, PhilHealth will not prevent costs of medical services from rising once a public hospital is privatized. If health care prices increase, PhilHealth coverage contributions will also grow: “For as long as the health care provision remains neglected, the expanded coverage of PhilHealth is useless. Social health insurance must be based on a strong health infrastructure and service delivery”. The PhilHealth card is not accepted in most private hospitals and is also of little help in poorly provisioned public hospitals, where the covered services are simply unavailable. In remote PhilHealth-accredited health facilities where there is a lack of medicines and health professionals, the insurance is “an ineffective and frustrating proposition,” says the Network Opposed to Privatization, a Philippine network of health workers, patients, health professionals and health advocates.

**Health workers**

The Philippines has among the highest densities of health workers; next to Japan and South Korea in the pharmaceutical industry, next to Cuba and Japan for dentists and next to Cuba and the US for nurses and midwives. The number of medical graduates has increased more than twofold from 60,655 in 2004-05 to 128,381 in 2008-09. Nursing is the program with the highest number of graduates, accounting for 76% in 2011-12, followed by midwifery with 5.3% of the total number of graduates. However, even with such a high health worker density, ironically in the public health sector health workers are sorely lacking.

First of all, the outsourcing of health care to commercial investors goes at the expense of the public sector; it is diverting resources away from the public sector. The private-for-profit sector entices health workers away from the public sector by offering better working conditions and higher salaries. The Philippines also train health workers en masse for export. Indeed, export of health workers is promoted as a strategy to gain foreign exchange. Among the health workers that went abroad, the profession with the highest number was the nursing profession. So there is a net surplus of health workers, but through this “brain drain” the poor in urban and rural areas are left behind with a shortage of doctors and nurses. ⁴³

**Conclusion**

- The poor track record on access to health care in the Philippines is exacerbated by corporatization policies in the health sector.
- Although the policies officially aim to achieve universal health care, in reality they further decrease the availability and affordability of health care for all.
- A highly subsidized social health insurance alone cannot achieve universal access to health services as long as other health system aspects, such as financially unaffordable health services and insufficient availability of health workers, simultaneously undermine health outcomes.

⁴³ WHO country health profile Philippines 2014
4.2. 2. The ambiguity of public and private: Malaysia’s corporatized health system

Since decolonization in the 1950s, Malaysian citizens have become accustomed to a *de facto* entitlement to publicly provided and highly subsidized health care. The country’s primary health care system is one of the most accessible in the world, reportedly second after Cuba.

To address geographical barriers to access, the Health Ministry’s Rural Health Service began in 1953 and expanded rapidly to provide extensive primary care coverage. As of 1993, 93 per cent of the population of Peninsular Malaysia lived within five kilometers of a permanent primary care facility.

Malaysia was notable in achieving much of Alma Ata’s Primary Health Care goals via an institutionalized formal health care delivery system with minimal resort to health auxiliaries and community health workers, as generally envisaged for resource-constrained settings. In addition to vaccination, pre-and post-natal care, maternal and child health programs, primary medical care with referral backup, health education and promotion, and vector control of communicable diseases, the Rural Health Service also addressed social and environmental determinants of health such as potable water supply, sanitary latrines, environmental hygiene, village midwifery practices, and nutrition.

**Exodus of public health workers**

Remarkably, this was achieved with public sector health expenditures that seldom exceeded 2.5 per cent of the gross domestic product (GDP). These modest expenditures, however, also impose limits on the level, timeliness and (perceived) quality of care that can be delivered, and furthermore translates into lower salaries for healthcare professionals than in the private sector. This situation sustains a continuing exodus of experienced staff from the public sector (one third of specialists currently practise in the private sector, attending to a quarter of total hospital beds).

Meanwhile, the unrelenting promotion of medical tourism adds to the lure of private practice, which increasingly services a clientele that is regional in scope (Chan 2010). Many health professionals decide to emigrate too.

By 2008, government health facilities accounted for 74 per cent of hospital admissions and only 38 per cent of outpatient visits (Ministry of Health 2010a). Privatization was gaining ground thanks to complex health sector reforms.

**Corporatizing public health care**

In 1999, the Malaysian government announced plans to corporatize its hospitals and other healthcare facilities, in part to try and stem the outflow of health professionals, and in part due to this growing trend elsewhere in the world. The corporatized institutions would continue to be publicly owned but vested with more operational and financial autonomy outside the purview of civil service rules.

This was intended to allow for more flexibility in salary scales, patient fees, procurements, and timely response to shifts in market demand and client preferences. Coming in the wake of the outsourcing of hospital support services and pharmaceutical supplies, however, it aggravated public anxieties about a future privatization of clinical and hospital services. This
quickly became a contentious issue in the run up to general elections in November of that year, and the blueprint was quietly shelved.

Eight years passed before the issue re-emerged on a pilot scale in the form of opportunities for limited private practice in government hospitals. Effective August 1, 2007, Putrajaya Hospital and Selayang Hospital, two of the newer public hospitals with advanced treatment facilities, began to offer to “full-paying patients” preferential access to consultation and treatment by specialists of their choice, in an ‘executive’ or ‘first-class’ facility - to be charged accordingly.

The state as entrepreneur
In recent years, Malaysian government agencies have acquired controlling stakes in major for-profit healthcare enterprises. The Johor state government, for instance, controls a large diversified healthcare conglomerate which includes the largest chain of private hospitals in the country. Its diversified portfolio of services includes hospital management, training for nurses and allied health professionals, laboratory and pathology services, central procurement and retailing of pharmaceutical products, healthcare informatics, and laundry and sterilization services.

Meanwhile, the Malaysian federal government’s sovereign wealth fund (Khazanah) controls the second largest listed private healthcare provider in the world. Government-linked companies now account for more than 40 per cent of ‘private’ hospital beds in Malaysia.

Domestically, these developments mean that the Malaysian government, in concert with government-linked companies at both federal and state levels, effectively own or operate three parallel systems of healthcare providers in Malaysia:

1. the regular Health Ministry facilities;
2. corporatized hospitals (National Heart Institute and the university teaching hospitals of Universiti Malaya, Universiti Kebangsaan Malaysia and Universiti Sains Malaysia);
3. commercial hospital chains that account for more than 40 per cent of private hospital beds.

How are conflicts of interests playing out, as the state juggles its multiple roles as funder and provider of public sector health care, as regulator of the healthcare system, and as prime investor in the for-profit health services industry?

Targeting policies
Policies of targeting (as opposed to universalism) are an illustration of the public/private tension in the Malaysian healthcare system (Chan 2006). With the devolution of social services to private enterprise, entrepreneurs in search of investment prospects are primarily interested in the “market-capable” segments of society.

As government-linked entities built up their stakes in the commercial healthcare sector in Malaysia, a succession of health ministers have argued that Malaysians who could afford it should avail themselves of private healthcare services (suitably encouraged thus with income tax rebates). This would allow the government to target its limited healthcare resources on the ‘really deserving poorer citizens’.
This intuitively appealing logic ignores the consequential poaching of staff from the public sector, which exacerbates the already burdensome workload of its remaining staff, thus feeding into a vicious downward spiral. Identifying and tracking the “targeted eligibles” (means testing, etc.) would furthermore entail administrative and transactional costs that are unnecessary with a policy of universal entitlements. Most importantly, a policy of selective targeting would detach a politically vocal, well-connected and influential middle class from any remaining interest in public sector health care, hastening the arrival of a rump, underfunded, decrepit public sector for the marginalized poorer classes.

Indeed, government expenditures on health care, amounting to 2.3 per cent of GDP in 2011 are far from extravagant. Whether this is tantamount to an implicit policy of benign neglect of the public sector - to encourage a migration of the “market-capable” to the private sector - is debatable. While health expenditures in the private sector have increased more than four-fold between 1997 and 2009 (Ministry of Health 2011), there has been a parallel increase in government health expenditures so that the private sector share has remained steady at about 45 per cent of total health expenditures.

<table>
<thead>
<tr>
<th>Year</th>
<th>Public</th>
<th>%</th>
<th>Private</th>
<th>%</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>1997</td>
<td>4,540</td>
<td>56.4</td>
<td>3,504</td>
<td>43.6</td>
<td>8,044</td>
</tr>
<tr>
<td>1998</td>
<td>4,879</td>
<td>55.8</td>
<td>3,873</td>
<td>44.2</td>
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<tr>
<td>1999</td>
<td>5,424</td>
<td>55.9</td>
<td>4,288</td>
<td>44.1</td>
<td>9,712</td>
</tr>
<tr>
<td>2000</td>
<td>6,479</td>
<td>55.7</td>
<td>5,156</td>
<td>44.3</td>
<td>11,635</td>
</tr>
<tr>
<td>2001</td>
<td>7,669</td>
<td>58.2</td>
<td>5,513</td>
<td>41.8</td>
<td>13,182</td>
</tr>
<tr>
<td>2002</td>
<td>8,310</td>
<td>60.0</td>
<td>6,278</td>
<td>40.0</td>
<td>14,588</td>
</tr>
<tr>
<td>2003</td>
<td>10,856</td>
<td>59.0</td>
<td>7,543</td>
<td>41.0</td>
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</tr>
<tr>
<td>2004</td>
<td>11,092</td>
<td>55.7</td>
<td>8,820</td>
<td>44.3</td>
<td>19,912</td>
</tr>
<tr>
<td>2005</td>
<td>10,227</td>
<td>50.08</td>
<td>9,904</td>
<td>49.2</td>
<td>20,131</td>
</tr>
<tr>
<td>2006</td>
<td>13,216</td>
<td>54.6</td>
<td>11,012</td>
<td>45.4</td>
<td>24,228</td>
</tr>
<tr>
<td>2007</td>
<td>14,098</td>
<td>53.4</td>
<td>12,291</td>
<td>46.6</td>
<td>26,389</td>
</tr>
<tr>
<td>2008</td>
<td>16,524</td>
<td>54.0</td>
<td>14,077</td>
<td>46.0</td>
<td>30,601</td>
</tr>
<tr>
<td>2009</td>
<td>18,401</td>
<td>54.6</td>
<td>15,291</td>
<td>45.4</td>
<td>33,692</td>
</tr>
</tbody>
</table>

Source: Putrajaya: PEMANDU, Prime Minister’s Dept (2009)

In any case, an alternative scenario that would rely on more progressive taxation regimes to improve universal access to quality care on the basis of need, which dispenses with much of the administrative and transactional costs of managing a proposed national health insurance scheme, is notably absent from the options under consideration.

Today, the issue regulatory conflicts of interest remains unaddressed. There is little evidence that the state is exercising its ownership prerogatives in commercial healthcare enterprises to pursue a balance of social versus pecuniary objectives (e.g. through cross-subsidies or a price-restraining role) beyond cosmetic corporate social responsibility initiatives.

The conclusion that emerges from this investigation is that public ownership (or control) of commercial healthcare enterprises in Malaysia may not work in favour of the equitable provision of health care on the basis of need.
4.2.3. Sri Lanka’s success story

Within the South Asian region, Sri Lanka stands out as a positive example of a public health system. There are several historical reasons for this outcome. The development path followed by Sri Lanka has been described as ‘support-led security’, in which public provision and funding of health and other social services has promoted social progress. Even before independence in 1948 there was a rapid expansion of public investment in education and health facilities in the 1930s and 1940s. Free education was introduced in 1947 and free health care, in 1953. Along with strong support for publicly funded social services, the commitment to social justice, with particular emphasis on addressing the needs of the worst-off, was a key feature of state policy for a long time.

Key health indicators

Despite having low income levels and only gradual economic growth, as well as relatively low levels of spending on health (with public healthcare expenditure equivalent to 2% of GDP), Sri Lanka has achieved remarkably good health status and a high literacy rate. Life expectancy is over 75 years old and skilled attendance at birth is as high as 96%. These achievements are testimony to the effectiveness of sustained public spending on social services and the consistent commitment to equity and social justice, which is also borne out by the relatively equitable distribution of income (with a Gini index of only 33) (McIntyre Di, 2006).

Rural access

The public health system in Sri Lanka has been particularly effective at bridging the rural-urban inequalities in access. It is now constituted by a large network of medical institutions and is divided in 258 Health Unit areas with populations ranging from 40,000 to 60,000 each (Rannan-Eliya and Sikurajapathy 2008). The Health Unit area is a clearly defined region congruent with the administrative divisions of the country. Health Units are managed by Medical Officers and are supported by a team of public health personnel comprising one or two Public Health Nursing Sisters, four to six Public Health Inspectors, one or two Supervising Public Health Midwives and 20-25 Public Health Midwives. Each Health Unit area is subdivided into Public Health Midwife areas, which constitute the smallest working unit in the public system. Each Public Health Midwife has a well-defined area consisting of a population ranging from 2,000 to 4,000 people (Perera 2007).

A creeping private sector

Today, 95% of in-patient care is still provided by the public sector, but those who can afford to can choose to use private sector services. The private health sector only began to develop in earnest during the 1960s. It focuses particularly on ambulatory care in the form of general practitioners (now 50% of services). Although there are some full-time private general practitioners, most private provision takes the form of dual practice by doctors who are employed in the public health sector and have a limited private practice outside of official working hours (Rannan-Eliya and Sikurajapathy 2008).

But Sri Lanka’s system faces the threat of reforms that seek to align it with the neoliberal ethos of commercialization, despite a historically large consensus across the political spectrum on public investment in social infrastructure. In recent years, private expenditure has expanded faster than public expenditure; the entry of corporate private hospitals (often imported from India) is particularly worrying. Popular opposition has been fierce, however, and reforms have not proceeded at the pace projected by the neoliberal lobby.
4.2.4. Thailand: High coverage, low public expenditure

Health reforms in Thailand have drawn global attention for their rapid gains in achieving universal coverage. In 2002 Thailand’s National Health Insurance Bill was enacted, creating the Universal Health Care Coverage scheme, primarily funded by the government based on a per capita calculation, and administered by the National Health Security Office. The focus has been on providing primary healthcare services to Thais who were left out of the healthcare system prior to 2002. Within just over a decade, coverage has increased dramatically and is now nearly universal.

Initial investment in public health infrastructure

However, there is another part of the story. The Thai reform of 2002 was preceded by the “Decade of Health Centre Development Policy (1986-1996)” that worked to establish primary health centres in rural areas. Public investment in health also increased quite dramatically towards the end of this period and the government’s share of total health expenditure increased from 47% in 1995 to 55% in 1998 (Ramesh et al 2013, 8). Consequently, before the turn of the millennium there were few geographical barriers to healthcare access in the country. Thanks to massive infrastructure creation, 78% of hospital beds were in the public sector by 1999 - a trend that has remained fairly constant with 77% of hospital beds continuing to be in the public sector in 2012.

Limiting private health

The Thai reforms, thus, leveraged upon a newly built public health infrastructure. Under the UHC reforms, both public and private facilities can be providers of health services. However, in practice, private participation is low because it was made mandatory for private providers offering tertiary care to also provide primary level care. Further, while formally allowing private sector participation, the reforms delayed private sector entry pending the implementation of regulatory mechanisms.

Private practice by public sector doctors, though allowed, was minimized by providing hefty incentives to those who worked solely in the public sector. Among policy instruments to promote equitable service delivery, there is a mandatory three years of rural service for doctors and nurses.

Neoliberal trends: decreasing expenditure

However, these genuine attempts to provide access to healthcare services are taking shape in an overall neoliberal climate in Thailand, threatening to undermine their viability in the long term. Public financing (67% of which was consumed by public services in 2012) remains fairly low: health expenditure has increased from 1.7% of GDP in 2001 to 2.7% in 2008, but this remains lower than the global average for LMICs.

Health worker shortages

In terms of human resource development low expenditures have worsened the shortage of health workers in many public facilities: there are just three physicians for every 10,000 patients, compared to 9.4 in Malaysia, 11.5 in the Philippines, 12.2 in Vietnam and 18.3 in Singapore; and barely 1.5 nurses for every 1,000 people, compared to 2.3 in Malaysia and 5.9 in Singapore. This is a consequence of tough work conditions, poor job security and low pay. Better wages in private hospitals (strengthened by a burgeoning medical tourism market) draws nurses away from the public sector, as does the lucrative market in nearby Singapore.
4.2.5. India: Public financing for whom?

**Health financing**
In the past six years there has been an impressive roll out of government-funded insurance schemes in India that are meant to improve the country’s public health system. In theory, treatment covered under these schemes can be provided by any accredited facility. But in practice the majority of providers are found in the largely unregulated private sector which already accounts for 80% of outpatient and 60% of in-patient care according to the National Sample Survey Organisation (NSSO), making India one of the most privatized systems in the world and one with an infamous track record of expensive private health services and unethical practices.

As a result, health insurance schemes mostly channel public monies for private profit. For example: from 2007 to 2013 the state of Andhra Pradesh allocated a total Rs.47.23 billion to facilities accredited under the Arogyasri scheme, of which Rs.36.52 billion went to private facilities.

**Limited coverage**
What the majority of Indians lack is comprehensive primary care, but current health insurance “packages” only insure beneficiaries for ailments that require hospitalization. They cover a very small portion of the burden of disease, excluding out-patient treatments for tuberculosis, diabetes, hypertension, heart conditions, and cancer among others. Evidence from the first such scheme in India – Arogyasri – suggests that it consumed 25% of the state’s health budget but addressed only 2% of the burden of disease.

**Limited availability and quality of health services**
This situation ends up distorting the very structure of the health system by starving primary care facilities to the benefit of more profitable secondary and tertiary care. In 2009-2010, direct national government expenditure on tertiary care was slightly over 20% of total health expenditure, but if one adds spending on the insurance schemes the total would be closer to 37%. In Andhra Pradesh, following the implementation of Arogyasri, the proportion of funds allocated for primary care fell by 14%.

Current public health services are marked by poor access, low quality and limited choice. Besides rampant corruption, poor management results in mismatches between demand and supply of services: facilities aren’t distributed optimally; equipment and funds fall short of requirements and don’t flow efficiently. Labour shortages can be partly explained by disinvestment in medical education and flawed deployment mechanisms. Although programs such as the National Rural Mission have made some inroads to improve services, much remains to be done. The problem is largely one of unresponsiveness to citizens coupled with unreliable technical estimates of costs and disease burden, leading to ill-informed prioritization.

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45 www.epw.in/special-articles/healthcare-models-era-medical-neo-liberalism.html
46 planningcommission.nic.in/reports/sereport/ser/ser_heat1305.pdf
47 www.downtoearth.org.in/print/39099
48 www.mohfw.nic.in/NRHM.htm
4.2.6. Brazil: Comprehensive primary care, private hospital care

Brazil went against the neoliberal trend in vogue in the rest of Latin America by creating the tax-funded Sistema Único de Salud (SUS, the Unified Health System) in 1986. The country’s 1988 constitution also proclaimed the government’s duty to provide free health care for all, despite strong opposition from a powerful and mobilized private health sector. This progressive stance was the culmination of decades of mobilization in favour of better health care that was part of the struggle to restore democracy in Brazil.

The creation of the SUS resulted in the roll out of an impressive primary care scheme, which now covers almost the entire country. But paradoxically, when in June 2013 millions came out to demonstrate on the streets of several Brazilian towns, one of the key concerns expressed was the lack of access to health care.

Costly private secondary and tertiary care
The problem is that while most primary health care is provided by a vast network of public providers and facilities, the state contracts out most of secondary and tertiary care services to the private sector. High-volume primary care clinics and emergency units remain largely public, whereas hospitals, outpatient clinics and other profitable services such as diagnostic and therapeutic services are in private hands.

This places several kinds of strains on the system. The private sector continues to ratchet up the cost of care it provides, and with health expenditure standing at 9% of GDP, Brazil now has one the most expensive health systems in the world. No less than 57% of public funding goes to private care (one of the highest in the Latin American region in terms of percentage of total health expenditure, even higher than in the United States). Such dominance of the private sector introduces inequity in access and is further reinforced by the fact that most Brazilians who can afford it (including an influential and growing middle class) purchase private insurance to ‘top-up’ services that they can access through the public system.

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4.2.7. Chile and Costa Rica: Different Paths to Universal Health

A comparative study of health outcomes in Chile, where private and public insurance companies and providers co-exist in the healthcare sector as part of a national policy, and in Costa Rica, where the public sector is dominant, convincingly debunks the myth that the private sector is inherently more efficient than the public sector and should therefore participate in health services.

**Access to health services**

In terms of access to basic services, both Costa Rica and Chile have made major advances. Today, they have the lowest infant mortality and highest life expectancy in the Latin American region. However, availability of basic services is not the same as having access to comprehensive care to resolve most health problems, which may explain why, over the last decade, people in Costa Rica have consistently perceived their access to health services to be better than people in Chile have (66.4% vs 35.0%). This difference has been maintained even after 2005 when Chile sought to remedy the situation by imposing more stringent regulation of insurance companies (Plan AUGE).

**Financial protection**

With respect to financial protection, although the lack of access to health services for economic reasons has been reduced substantially in Chile since 2005 (from 11.7% to 4.2% in 2011), the figure remains much lower in Costa Rica (0.8%). And in comparison with Costa Rica, out-of-pocket expenditure by families and the proportion of households facing catastrophic health expenditure are all substantially higher in Chile. This situation is produced in part by the fact that Chileans pay for services or products that are not covered by their insurance (e.g. drugs or consultations).

**Health system efficiency and affordability**

The relative efficiency and affordability of the Costa Rican health system is all the more impressive given the fact that total per capita health expenditure is lower than in Chile (US $811 vs US $947). The higher cost of the Chilean health system can be attributed in part to the inefficiency of the private sector in that country, where the use of unjustified medical procedures is more frequent and administrative costs are higher.

**Insurance drives costs up**

Health insurance schemes are often promoted on the assumption that competition among different providers should produce higher levels of service quality at lower costs active purchasing and management competition arguments [World Bank 1993]). To the contrary, the Chilean health system is an example of how segmentation produced by the coexistence of private and public insurances is detrimental to efficiency; collusion among private providers and oligopolies are realities that are ignored in these arguments.

This comparative study demonstrates widespread and consistent financial and health outcome advantages of a strong, single public system rather than a fragmented public-private, insurance-driven model. Insurance schemes are neither the only, nor the best policy option.

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50 www.who.int/whr/2010/en/
51 www.dcp2.org/file/627
4.2.8. Cuba: Universal Health Coverage through Free Primary Health Care

**Health situation**

Cuba’s achievements in the area of public health are impressive. The Caribbean island-nation of 11.27 million people is classified as an upper middle-income country. Life expectancy is 78 years, just below the US average even though it is eight times more affluent. Even more telling, the infant mortality rate in Cuba is lower than in the US (4.7 vs 5.8/1,000 live births).

**Access to health care**

After 50 years of offering universal health care services, experts agree that most Cubans have access to quality health care. There is a much higher health worker density than the Latin America and Caribbean regional average and utilization rates of health services are also higher in Cuba. This demonstrates high health system efficiency given that the country’s total health expenditure per capita is also much lower than the regional average. 41

These results are directly related to the political choices Cuba is making, placing the population’s well being at the centre. Progress in health indicators came with the economic and social change in Cuban society after the 1959 revolution. An improvement in general living conditions and a number of important social achievements (a private home per family, guaranteed income, improved education, etc.) have been fundamental to the population’s better health. Campaigns were launched to eradicate illiteracy and an adult education program encouraged people to at least obtain a high school degree. Special attention was also given to women’s rights. Since 1991, every woman has the option to stay at home up to six months after giving birth, while keeping 60% of her salary. A land reform was carried out. Arts, sports and science were promoted and special attention was given to women’s rights and prosperity. People’s organizations (neighborhood committees, women’s organizations, trade unions, youth organizations, etc) played an important part in these change processes.

The right to free quality health care for all was written into the Cuban Constitution. This priority has survived despite all the problems the country has had to face. Straight after the 1959 revolution, the US imposed the first economic embargo measures. The beginning of the 1990s saw the implosion of the Soviet bloc, which had maintained privileged trade relations with Cuba up to then. The country sank into economic crisis, but the Cuban government kept health care as a priority. During these crisis years, the budget for public health was 10% of the national budget. In the same period, other Latin American countries saw drastic reforms and health care privatizations as encouraged by the IMF and the World Bank.

**Comprehensive primary health care**

The Cuban Ministry of Public Health sets up the global health strategy in coordination with provincial and local health councils. After the 1959 revolution, private clinics and the pharmaceutical industry were nationalized and integrated into one single system, managed by the Ministry of Public Health. The country was divided into health zones, each with its own polyclinic. Health care was decentralized to the community level.

The system shows excellent transfer procedures for patients and communication between health workers at different levels of the healthcare system are efficient. General practitioners have access to all their patients’ medical information, allowing them to adapt care to their patients’ needs. Doctors have a central role in the system, are very close to their patients and know their social situation. This allows for large scale prevention.
José Luis Fabio, representative of the Pan-American Health Organization (PAHO) in Havana, reported in *The Lancet* (25 January 2014) that focus on basic health care was essential to achieving good health outcomes. Also, **health care is free for all.** All medical examinations and operations are carried out free of charge, and Cubans pay a symbolic price for their medication at the doctor’s.

**Human resources:**
While many developing countries face a “health worker crisis”, with serious shortages of health workers severely limiting their health systems’ development, the Cuban doctor-patient ratio is at 6.7 doctors per 1,000 inhabitants, far above the WHO minimum set at 2.28 doctors, midwives, and nurses. Cuba emphasizes the importance of education for health workers. Even in times of economic crisis, the medical education’s quality has been improved and the number of medical facilities increased. Medical training for international students is available at the Latin American Medical School in Havana. Cuba also engages in international medical support through the “Integrated Health Program” and showed an example to the world with the impressive response to the West-African Ebola epidemic with massive deployment of human resources.\(^5\)

**Medicines and technology**
Scientific research and production in function of needs for medicine and their rational usage are key factors of the Cuban pharmaceutical policy. Every newly developed and tested product is immediately made available free of charge to the Cuban population. The current Cuban biotechnological industry, the ‘Western Havana Scientific Pole’, includes various institutes with a total of 12,000 staff, of which 7,000 are scientists and engineers. They provide the Cuban health system with 12 regular vaccines, over 40 drugs for common conditions (including recombinant interferon and erythropoietin) and diagnostic tests for screening on 30 diseases. Recent challenges have been non-communicable diseases. Cuba’s pharmaceutical industry has been working on technology for a number of years to counter this situation. Cuba’s example shows the potential of adjusting innovative pharmaceutical production to the population’s needs, at low cost. Cuba produces around 90% of its basic medication. Dr José Luis Fernández Yero, director of the Immunoassay Center in Havana, says sustainable health is primarily built on prevention and health promotion, rather than on the latest technologies advertised by market-driven transnational manufacturers. According to Dr Yero, technology is useful only when available to the people needing it. “The adequate technology,” he says, “contains a higher degree of fairness than cost efficiency”. He adds that policy-makers should meet the population’s right to health with the available means as well as they possibly can.

**Conclusion**
Boasting excellent achievements in the field of health, Cuba demonstrates universal health care is achievable. Putting the population’s well being first and creating general living conditions favourable to health are the basic requirements. In Cuba, public spending on healthcare has always remained a priority even in times of crisis. Health care is still entirely public and free, with a sustained focus on preventive medicine, giving the majority of the population access to quality health care.

However, Cuba is still struggling with **structural issues.** Since April 1960 the US have been imposing ever stricter sanctions on Cuba. Despite the weakening international support for this embargo, the US were until recently maintaining these sanctions. Over the years,

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they had a significant impact on health care. For instance, Cuba only has limited access to specialized medical equipment (kidney dialysis units for example) and the country also misses out on important sources of income as it is not allowed to sell its pharmaceuticals on the North American market. The US embargo also limits the import possibilities of technology, materials and active ingredients needed for medication production.

After the recent exchange of prisoners between the US and Cuba, diplomatic relations may change significantly. According to Gail Reed, founding director of Medical Education Cooperation with Cuba (MEDICC), both the US and Cuba could benefit enormously in terms of health by the lifting of the embargo. It is in this evolving context that the Cuban authorities tried to develop new sources of funding for the health system. This resulted for example in the creation in 2011 of the “Empresa Comercializadora de Servicios Medicos Cubanos” (Company for Cuban medical services commercialization), which ensures the commercialization by the state of some high quality and competitively priced health services for strangers. Although the initiative was set up by the state and aims to improve the health system and preserve its accessibility for Cuban people, current experiments should be closely monitored as different forms of commercialization and trade in services, such as medical tourism, risk to have a negative impact on access to health care.
5. Successful Campaigns

5.1. Philippines: civil society opposes the Public-Private Partnership approach

According to local organizations (IBON, Gabriela, Council for Health and Development (CHD) and Advocates for Community Health) the current privatization policies of the Philippine government do not provide an answer to the enormous health needs. Despite the name of the “Universal Health Care” program that claims to “bring equity and access to critical health services to poor Filipinos”, commercialization of health services will do exactly the opposite and leave the poor behind. Civil society organizations in the Philippines insist that providing health services to the people, especially the poor and vulnerable is one of the fundamental functions of government. This function should not be subject to the profit motive and other influences but should remain a core public function. They insist that health services for Filipinos should be free. People should not be paying for health services because it is an obligation of the government to provide accessible and affordable health services. Instead of spending public money on health insurance, the government should provide government hospitals with budgets for capital outlay, maintenance and expand on key demands.

IBON, Gabriela, Advocates for Community Health and CHD are active members of the Network Opposed to Privatization of Health, a platform composed of groups and organizations of hospital workers, community health workers, students, professionals and individuals belonging to the health sector and from other sectors who oppose the policy of privatization. Together with other progressive health groups: Alliance of Health Workers and the Health Alliance for Democracy, the network leads the forces opposed to privatization of health in nationally coordinated mass campaigns and mobilizations. The Alliance of Health Workers (AHW) recalls: “it is the government, and not the private sector, that has the primordial constitutional mandate to deliver health services, to move toward social justice and equity. Our health system should be managed as a social service, and not as a business that focuses on the extraction of profit”, says a trade union representative of the AHW.

Because it is the first hospital to be corporatized, the campaign is focused on stopping the privatization of the Philippine Orthopedic Center (POC). Following actions have been undertaken:

- A mass walkout of health workers of the POC has been organized simultaneously with actions in three other government hospitals.
- Alternative media have been used to report on the campaign against the privatization of the POC.
- Education forums are organized in hospitals, health sciences schools and communities.
- Dialogue with the Secretary of the Department of Health regarding the POC privatization.
- There have been protest actions at the Department of Health against the privatization with mass distribution of leaflets and reading materials.
- A petition has been organized to demand a prohibition of the privatization or a Temporary Restraining Order for the privatization of the POC.

In October 2014, the civil society campaign successfully managed to have a court ruling issue a Temporary Restraining Order for the privatization of the POC, on the basis of provisions in the constitution of the Philippines on the right to health, such as state responsibility.
in protecting and promoting the right to health and the adoption of an integrated and comprehensive approach to health development and access to essential goods, health and other social services, with priority for the needs of the under-privileged, sick, elderly, disabled, women, and children. Next to that, the campaign enabled to sensitize the health sector and the general public about the negative effects of privatization of public hospitals on universal access to health care.

Within the Philippine government, Health Secretary Enrique Ona is under fierce opposition to the privatization plan of 72 government hospitals, with Abakada party representative Jonathan de la Cruz filing a resolution asking Enrique Ona to attend the house inquiry. He said: “We have been giving the Department of Health huge amounts of money to improve the delivery of medical assistance through government hospitals and now Enrique Ona is coming out with statements on privatization, I don’t think that is a responsible way of handling the budget his department receives.” Also representatives from ‘Gabriela’ denounced the privatization plans, affirming that “it would make medical help more inaccessible to the majority of people” and filed a resolution compelling the Departments of Health, Finance, Budget and Management and the National Economic Development Authority to disclose the blueprint of the modernization plan for public hospitals.

5.2. Communities demanding accountability in Maharashtra, India

Community-based monitoring and planning (CBMP) of health services in Maharashtra state, India represents an innovative participatory approach to improving accountability and healthcare delivery.

This concrete mechanism was first developed on the basis of broad-based mobilization for health rights by Jan Swasthya Abhiyan (JSA), the India chapter of the People’s Health Movement. JSA was initiated at the turn of the millennium as a nationwide coalition of health groups and social organizations committed to achieving the goal of “Health for All”. In 2003-2004, JSA launched a “Right to Health Care” campaign that culminated with a series of regional public hearings on health rights where selected cases of denial of health care were presented to officials from the National Human Rights Commission (NHRC). These hearings mobilized public opinion for improvement of public health services and were followed by a national public hearing, when the NHRC came up with a National Action Plan for the realization of the right to health care.

Influenced by such developments and following a change in national government after the 2004 general elections, the NRHM was launched in 2005 to provide accessible, affordable, equitable and quality health services to the poorest households in the rural areas of the country. As part of the NRHM framework, community-based monitoring and planning was put in place to ensure regular feedback and accountability in the process of strengthening health services. Nine states of the country, including Maharashtra, were selected to implement CBMP on a pilot basis between 2007 and 2009. In subsequent years CBMP processes have continued to expand in Maharashtra, covering 860 villages in 13 districts at present.

CBMP in Maharashtra is organized at multiple levels, from village to state. Health officials, elected local Panchayat representatives, civil society organizations and active community members form multi-stakeholder monitoring and planning committees at each level. The
One of the core strategies of CBMP is the *Jan sunwai* or public hearing, which is attended by large numbers of community members and diverse stakeholders. In these hearings, people are invited to report their experiences of health services in the presence of health officials and panelists from various fields. Since 2008, as part of CBMP, over 450 public hearings have been organized in Maharashtra.

Community-based planning has been developed to complement monitoring activities, focusing on widening participation in the planning process of local health facilities, based on the use of flexible public funds. Major successes and challenges of CBMP have been identified through two recent external evaluations. Data on accessibility and quality of services generated through successive rounds of community-based monitoring demonstrates substantial improvements in services being delivered at village as well as primary health centre levels. Some examples are major improvements in immunization and antenatal care at village level, availability of ambulance services and medical officers staying of on the premises of Primary Health Centres.

More broadly, CBMP has contributed to deepening democracy by:

- Creating forums for direct democracy
- Expanding representative democracy and ensuring participation of community-based actors in local health planning
- Promoting external accountability processes, which have triggered internal accountability mechanisms

Despite positive impacts, there are several challenges in the implementation of CBMP, including the need to address systemic and structural issues, the importance of greater political commitment, and the need to make CBMP a core element of public health policy. Notwithstanding the approach carries the potential to reconfigure power relationships and to strengthen public systems for genuine change over the longer term.

**5.3. Ghana’s NHIS: What success story?**

Ghana launched the National Health Insurance Scheme (NHIS) in 2003. It materialized the 2000 electoral promise of the New Patriot Party, whose manifesto had proposed the abolition of user fees. This outcome was the crowning achievement of decades of citizen mobilization against what was popularly known as the “Cash and Carry” system.

In theory, a NHIS pools risks of ill health and facilitates cross-subsidization among large populations, drawing on epidemiological and actuarial trends. While usually they are partly supported by government budgetary subsidies, the mandatory contributions from members and employers are the main source of funding. However in the example of the Ghana NHIS, only 5% of income drew from direct subscription from registered members.
This is why, in practice, critics argue that it is misleading to think of Ghana’s NHIS as a “health insurance” because it is tax-funded at roughly 70%, while only 24% come from social security contributions from formal sector workers and 5% from mutual health insurance schemes. The remaining 1% accrues from donations and returns on investments. As such, it would be more akin to a national health care system.

Within two years, the scheme was said to cover one third of the population, and roughly two-thirds by 2009. The policy was held up as a success story by international agencies such as the World Bank and World Health Organization.

However, a broad-based coalition came together in 2009 to denounce the inefficiency of the system and documented gross inequalities existing in the scheme. Through the Essential Services Platform hosted by ISODEC, a ‘universal access to healthcare campaign’ was launched using various advocacy tools, such as research, roundtable meetings with sector policy makers, alliance with international health movements as well as local and international media to denounce the largely anti-poor outcomes of the NHIS.

That year a new president was elected with a promise to make it a truly universal system by extending access to all and downsizing the health insurance bureaucracy. When this promise went unfulfilled, civil society organizations active in the campaign published a report that revealed that enrolment could be as low as 18% due to unaffordable annual premium payments and other barriers to access (even though all citizens pay for the scheme through VAT taxes). While acknowledging some advances such as the comprehensiveness of the services package offered and improvements on access and quality, they denounced low national health expenditure levels, stark social inequality (64% of richest registered while only 29% for poorest stratum), high out-of-pocket payments for those falling outside of the scheme, misappropriation of public funds, shortage of human resources, and skyrocketing costs for medicines, among others.

The paper received mixed reactions locally and internationally because it contradicted the careful portrayal of the Ghana NHIS case as a successful model by the World Bank and the Government of Ghana. The foremost critique of the report was the National Health Insurance Authority who felt embarrassed by the report’s evaluation of enrolment at 18% as opposed to their own figure of about 68%. Their strategy then was to deflate the report by attacking its credibility; the criticism focused on the methodology used to reach this lower figure and on the motivations of the international partners of the campaign who were accused of a neo-colonial agenda. Despite the attempts to shoot down the report the shocking statistical reality of the discriminatory nature of the NHIS succeeded in inviting curious minds, both nationally and internationally to find out what the actual situation was. In 2012 the National Health Insurance Authority had to revise their coverage figure to about 32% in their annual report.

The campaign in Ghana is currently demanding the scrapping of annual subscriptions to enroll in the scheme (the premium ranges from $2.25 and $15 while minimum wage is roughly $1.87 per day), which prevents mostly the poor from access even if a small sum. The campaign is also developing and sharing alternative policy and administrative practices that will enable cost savings to extend access.
6. Offering an Alternative

6.1. Universal Health Care through public action

Why are governments moving away from a universal health system model in which a single public entity provides and funds all medical and preventive services to citizens? What evidence is there to support a policy shift toward increased private sector participation in health? In fact, much evidence is pointing in the opposite direction. The case studies show that public health systems with a focus on providing preventive medicine through free health care at the point of delivery generally outperform more commercialized health systems in terms of equity in access and efficiency.

Health is a choice

The best performing countries in terms of health outcomes have a few things in common. First of all, universal access to quality health care is a political choice. Countries that prioritize people’s well-being and choose to invest in making healthcare accessible to all achieve better health outcomes. Even countries with low expenditure on health have been able to build strong health systems, which shows that it is also a feasible choice.

Public control

There are structural reasons why commercialized health care and competition do not promote efficiency and quality. In a mixed system with public and private healthcare providers, there are potentially serious implications for equity in health care access. Public services are not in a good position to compete, because the state generally remains responsible for patients with the highest needs and the lowest purchasing power. Commercial services on the other hand focus on the people who can afford to pay; as such, alone they could not provide universal access to quality health care. Instead, current PPP arrangements leave the public sector with diminished revenues and the responsibility to care for the poorest. Health systems that rely mainly on public provisioning and financing of health care perform better in terms of equitable access. A single public system also seems to perform better in terms of efficiency, while more privatized systems are more fragmented and incur more transaction costs. For example, the comparison of the Chilean and Costa Rican health systems shows that the Chilean market where private and public insurances coexist is detrimental to efficiency. The dominant public health sector in Costa Rica shows better access to health services, while spending less for health than Chile. The Cuban example underlines that good health outcomes are possible to achieve through a single public health system and a focus on comprehensive primary health care.

Free health care

User fees result in catastrophic health expenditures and reduce access to health care and thus form a major financial barrier in access to health care. Therefore UHC seeks to “ensure access to the needed health services for all without suffering financial hardship”. However, with a focus on health financing arrangements alone this goal cannot be reached. The narrowly defined scope of Universal Health Coverage, where the issues of financing and management are divorced from health care provision and where the delivery of services becomes less a responsibility of the government but more a pluralistic mix that includes the private sector and civil society, can result in diminished access to health care. It misses the point that a health system is not a mere aggregate of dispersed facilities and service providers, but an integrated network of facilities and services that are appropriately situated at primary,
secondary and tertiary levels and is in sharp contrast with the vision of Primary Health Care envisaged in the Alma-Ata declaration of 1978, which called for the building of health systems that would provide comprehensive care, would be integrated, organized to promote equity, and driven by community needs. Indeed, in order to achieve Universal Health Coverage, the WHO recognizes that developing the health system in all its aspects is crucial; there is a need for a strong, efficient, well-run health system with free health care at the point of delivery, access to essential medicines and technologies and sufficient capacity of well-trained and motivated health workers. The Brazilian, Sri Lankan and Cuban examples show that free universal health care is possible, and leads to good health outcomes.

**Geographical availability of health infrastructure and health workers**

A lack of public infrastructure in rural areas is a barrier in geographical availability. With increasing pressure for commercialisation of health services, it is important to note that the private sector invests mostly in specialized secondary and tertiary hospitals in cities. Rural areas and preventive primary health care are being overlooked by the for-profit sector. Some countries have therefore increased the availability of health services by investing in public health infrastructure (Thailand, Sri Lanka).

In addition, outsourcing of health care provision to commercial investors is detrimental to the public sector by diverting away scarce resources. One example is how the presence of the private for-profit sector in a country or medical tourism industries in neighbouring countries are enticing health workers away from the public sector by offering higher salaries, as with the Philippines and Malaysia cases. This so-called internal and international “brain drain” can undermine the rural availability of health care among other negative impacts. Also the deliberate promotion of export of health workers as a strategy to gain foreign exchange, for example in the Philippines, is depriving the local population of access to essential health services by creating a shortage of health workers in the public sector and in rural areas. In comparison, countries that offer hefty incentives to retain health workers in the public sector or in rural areas have successfully promoted equitable service delivery.

### 6.2. No trade in health services

Because of the risks for equity in access to quality health care and the obligation to respect, fulfill and protect the ‘right to health and health care’ for all people equally, governments need to be careful in committing service sectors to trade liberalization. Even more so because trade agreements are binding and it becomes therefore difficult if not impossible to reverse any negative consequences at a later stage. Therefore, it is of utmost importance to respect the precautionary principle, meaning that no binding agreements could be signed before evidence exists that population health and health care access would effectively be protected. Health and social impact assessments should be carried out and respected. Additionally, because of the market failures in health care and the proven impact on access to health care, there should be a carve-out for the health system in trade and investment agreements, enabling the state to safeguard health care access.
7. **Conclusion**

7.1. **Universal health care through public action**

The narrowly defined scope of Universal Health Coverage, where the issues of financing and management are divorced from health care provision and where the delivery of services becomes a mix of public and private providers, can result in diminished access to health care. First of all, it ignores that a health system is not a mere aggregate of dispersed facilities and service providers, but an integrated network of facilities and services that are appropriately situated at primary, secondary and tertiary levels. **Public health systems that provide comprehensive health care, free at the point of delivery,** with a **focus on prevention** and **are driven by community needs** generally outperform more commercialized health systems in terms of equity in access and efficiency.

7.2. **No trade in health services**

Health should be the priority of every policy. Because of the risks for equity in access to quality health care and the obligation to respect, fulfill and protect the ‘right to health and health care’ for all people equally, governments need to be careful in committing service sectors to trade liberalization. Even more so because trade agreements are binding and it becomes therefore difficult if not impossible to reverse any negative consequences in a later stadium. Therefore, it is of utmost importance to respect the **precautionary principle,** meaning that no binding agreements should be signed before evidence exists that population health and health care access would effectively be protected. **Health and social impact assessments** should be carried out and respected. Additionally, there should be a complete **carve-out of the health system** in trade and investment agreements, enabling the state to safeguard health care access.
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Abstract

Global commitments by governments to respect, protect and fulfil the ‘right to health’ should give rise to policies that truly promote universal access to health care and population health in an efficient, equitable, sustainable and accountable manner. Instead, as a response to financial and geographical barriers health care access, many developing countries are implementing Universal Health Coverage, understood as a financing arrangement ensuring people can access the health services they need without incurring a financial risk. Underlying this approach are global health policies that tend to promote increased commercial sector involvement in health and liberalization of service sectors, which are undermining equity in health care access. In this context, a focus on health financing arrangements alone will be insufficient to achieve universal health care.

We analyze a broad range of case studies that demonstrate how a strong commitment to building public health systems yields better and more sustainable results in terms of access, quality, affordability, acceptability and equity. Citizen-led campaigns around the world are building up to reverse the increasing commercialisation in health systems and to promote public health systems that are integrated, provide comprehensive care, promote equity and are driven by community needs.