Journal of International Development
J. Int. Dev. **18**, 387–391 (2006)
Published online in Wiley InterScience (www.interscience.wiley.com). DOI: 10.1002/jid.1289

POLICY ARENA

COMMERCIALISATION, INEQUALITY AND TRANSITION IN HEALTH CARE: THE POLICY CHALLENGES IN DEVELOPING AND TRANSITIONAL COUNTRIES

MAUREEN MACKINTOSH[1]*,† and SERGEY KOVALEV[2]‡
[1]*Faculty of Social Sciences, The Open University, Walton Hall, Milton Keynes, UK*
[2]*Institute of Economics and Industrial Engineering, Novosibirsk, Russia*

Effective health systems can be both developmental and socially integrative: they generate well being, help people to continue working, redistribute resources towards the poor and needy, and are a force for social inclusion and democratic accountability. These developmental roles for health systems are increasingly recognised in international policy debate, including research for the UN Millennium Project (Freedman *et al.*, 2005), the UNRISD Social Policy in a Development Context research programme (www.unrisd.org), and in the World Health Organization's welcome reversion to a more inclusive vision of health policy emphasising integrated health systems and primary care (WHO, 2003). Less addressed to date are the policy challenges to such a vision posed by the last 30 years of economic and policy pressure for health care commercialisation, pressures that have instigated a transition in the direction of market-led health care across many developing and transitional economies (Mackintosh and Koivusalo, 2005).

This Policy Arena explores the inter-linkage between health care commercialisation and social and economic inequality, in the context of broader processes of economic liberalisation, and discusses the implied policy challenges. It brings together perspectives of 'transitional' countries' researchers with developing country experiences and analysis. 'Transition' is a widely used metaphor in both economics and health systems research. In

*Correspondence to: M. Mackintosh, Faculty of Social Sciences, The Open University, Walton Hall, Milton Keynes MK7 6AA, UK. E-mail: m.m.mackintosh@open.ac.uk
†Professor of Economics.
‡Research Fellow.

Contract/grant sponsors: Réseau International Universitaire de Genève (RUIG); United Nationas Research Institute for Social Development (UNRISD)

the 'transitional economies' literature, it means in general terms a shift to a market-led economy. In the economic development literature, widespread processes of economic liberalisation in developing countries are less often characterised as 'transition' though they pose some comparable challenges. In the health systems literature 'transition' carries rather loose meanings of structural change and—like the concept of 'health sector reform'—of commercialisation.[1]

In transitional economies, the path of health sector transition is typically contested; in other developing countries the extent to which health services should share in broader market liberalisation is similarly at issue. Policies and regulatory practices/absences that open the health sector to commercialisation—thus treating health care as a commodity like any other—conflict in ways analysed here with other policies for national health insurance, cross-subsidy and partial health care decommodification that aim to use health policy as a vehicle for inclusion and reducing inequality.

The papers in this Policy Arena draw on conceptual and empirical research in South Africa, Bulgaria, Russia and some low-income countries, to analyse the nature of health system commercialisation, its impact on inequality and policy challenges. By 'commercialisation' of health care we mean:

- provision of health care through market relationships to those able to pay;
- investment in and production of those services for the purpose of cash income or profit;
- health care finance derived from individual payment or private insurance.

The papers chart different paths of health care commercialisation, reflecting the different starting points. In transitional countries such as Russia and Bulgaria, as in transitional developing countries in Asia, different forms of spontaneous and official commercialisation of previously state-run systems interact to reshape health care systems in poorly researched ways, and social insurance mechanisms are struggling against market pressures (Blam and Kovalev, Datzova, this issue; Tu *et al.*, 2003). In South Africa, where under apartheid the commercial health system served the dominant White minority, policy makers are faced with the challenge of a still profoundly polarised system, segmented between commercial and public sectors (McIntyre *et al*., this issue). And in low income developing countries including much of the rest of Sub-Saharan Africa, where previous restrictions on commercial clinical practice were removed in the 1980s and 1990s, user fee systems and liberalisation in health care have embedded largely unregulated commercialisation within health systems whose poor quality and inaccessibility to many of the poor pose huge policy challenges (Mackintosh, this issue).

Health care commercialisation is associated, in unequal contexts, with a 'double whammy': not only do the poor get less care, they often pay more for it relative to their income, and high unforeseen payments can lead to long term impoverishment. The papers presented here establish how particular paths of health care commercialisation can be both regressive and divisive, reinforcing and reshaping social segmentation. They use analysis of primary household survey data, and results of other surveys, where available. The research reported here identifies patterns of active conflict between the principled commitment of many governments to the creation of health systems that promote more equitable access to health care, and the disequalising implications of health care

[1]See for example the WHO European Observatory on Health Systems and Policies series on 'Transition in Health Systems' across Europe www.euro.who.int/observatory accessed 20.10.05.

commercialisation that government policies either permit or promote. The South African researchers track aspects of deepening inequality in health care in a country that is one of the most unequal in the world. Evidence from surveys in low-income countries identifies negative correlations between the indictors of commercialisation of health systems and levels of health care access on average and by the poor. In Russia and Bulgaria, health care commercialisation is shown to be exacerbating inequality and to be undermining policies for universal social health insurance and equity of access. In the three middle income countries examined (Russia, South Africa and Bulgaria), health care is thus failing to play its potential socially redistributive or socially integrating role, a conclusion replicated in many low income countries undergoing less heralded transitions to liberalised economies.

Yet despite its developmental importance, policy *towards* commercialisation in health care is still scarcely debated in international policy fora, discussion being typically limited to specific topics such as the desirability of user fees in government and a rather general commitment to better regulation. Development policy, and policy in transition economies, has much to gain from a systematic reopening of an old policy debate about the limits of commercialisation of health care, or to put it another way, the proper limits of 'transition' in health care. The central policy proposition supported by these papers is that it is inappropriate in developing and transitional countries to treat health care simply as one among a number of service sectors in transition to commercialisation. On the contrary, commercialisation of health care needs to be actively managed and partially blocked in the interests of broader social and economic integration.

The reasons why health care cannot be regarded simply as one 'sector' among many to be liberalised and commercialised include the high value put on health care (its price-inelasticity), which implies in turn that fee-based systems exacerbate existing income inequality as well as inequalities in health outcomes. Second, highly segmented health care systems are typically socially divisive and often strongly resented (just as, conversely, 'universalist' systems have been widely used by governments for nation-building and social integration). Third, in the face of commercialisation, national health insurance systems are observed to struggle to establish financial stability and legitimacy. Firms and individuals lack incentives to comply, and commercial providers prefer the immediate benefits of private payment and insurance. Fourth, health care markets display perverse economic logic, creating incentive structures for cost escalation, market segmentation, inefficient and ineffective treatment and exclusion. It is widely observed, for example, that transition economies have expensive hospital-focused systems that tend to resist reform. This is not just political inertia: commercial incentive structures lead in the same direction, creating systems that are expensive and difficult to universalise.

A corollary of these arguments is that health care commercialisation has to be managed actively: it cannot be left to develop by default through a lack of policy focus, understanding or political will. Simply acknowledging the special social and economic role of health care will not prevent its spontaneous commercialisation, nor the associated perverse effects. In transitional countries, the shift from an administrative command economy to a market economy required a fundamental change to the social contract. The Soviet era, for example, saw a continuing attempt to reduce the importance of purchased social services by providing them as part of the social wage: in health care, free basic services enhanced the security even of the poorest people's lives. Substantial inequalities, urban/rural and politically structured, remained as they do in all systems. However, under the Soviet regime the discrepancy between words and deeds was particularly pronounced, the egalitarian slogans of the socialist system's official ideology declaring equal

entitlement to free provision that were never attained. This contributed to the process of social disintegration and eventual national collapse.

The study of Russia presented here demonstrates the dangers of carrying such a gap between words and deeds into the transitional era. As the planned economy of the Soviet Union collapsed, it was quite clear that during transition the social contract needed to change fundamentally. The challenge to the new government was to develop new institutions and policies that would support efficient functioning of the public health system in the environment of an emerging market economy. Regrettably the challenge was not met: the government chose to continue the Soviet practice of vague and mendacious declarations, leaving the door wide open for spontaneous commercialisation of the health sector. Today, a new attempt of rebuilding public health care on the egalitarian principles by a government rich on oil exports faces the need to weed out deep-rooted mechanisms and institutions of commercial provision that have ugly consequences.

Russia is not alone in this conflict between 'equity talk' in health and the experienced effects of commercialised systems—and the resultant disillusion and cynicism. We hope that this Policy Arena will stimulate more research aiming to understand the different dynamics of health care commercialisation in different contexts, and to design policies to manage, shape and constrain it in the interests of the broader society and economy. The papers here from middle-income countries identify as core policy objectives establishing income-related cross-subsidy within the health sector and effective government support for integrated national health financing systems. The evidence provided here also implies, however, that trying to build up an integrated and equitable health system through a national funding mechanism alone—leaving the rest of the health system to commercialise at will—is likely to run aground on conflicts between competing incentive structures.

Rather, the evidence suggests the importance for developing and transitional economies of identifying the scope and purpose of essential non-market health care provision as well as finance, and to develop policies that use non-commercial health provision as leverage to help to impose effective market constraint on the commercial providers and funders. All successful inclusive health care systems have strong non-market elements of both provision and finance, and in a transitional and developing country contexts these need to be consciously (re)constructed as part of an active policy for containing and shaping commercialisation of health care. Otherwise, the health care system will operate as a conflictual and socially divisive force, instead of the developmental, socially inclusive role it can potentially play.

ACKNOWLEDGEMENTS

This Policy Arena reports results from an international research collaboration based at UNRISD, Geneva and the *Institut des Etudes de Développement* (IUED), University of Geneva: the RUIG/UNRISD project on *Globalisation, Inequality and Health Care*, part of the RUIG/ IUED project on *The Social Challenge of Development*; funding is gratefully acknowledged from the *Réseau Universitaire International de Genève* (Geneva International Academic Network) (RUIG/GIAN)) and UNRISD. For more details: www.unrisd.org and www.DSD-RUIG.org. For comments on this Introduction we thank Deniz Kandiyoti and an anonymous referee. The views expressed here are the sole responsibility of the authors.

REFERENCES

Freedman LP, Waldman R, de Pinho H, Wirth ME, Mushtaque A, Chowdury R, Rosenfield A. 2005. *Who's got the power? transforming health systems for women and children*. Task Force on Child Health and Maternal Health, UN Millennium Project and Earthscan: London.

Mackintosh M, Koivusalo M (eds). 2005. *Commercialization of Health Care: Global and Local Dynamics and Policy Responses*. Palgrave: Basingstoke.

Tu NTH, Huong NTL, Diep NB. 2003. Globalisation and its effects on health care and occupational health in Vietnam. www.unrisd.org and www.DSD-RUIG.org

World Health Organization (WHO). 2003. *World Health Report 2003*. WHO: Geneva.

