

FORCES  
AND REACTIONS  
IN HEALTHCARE  
A REPORT ON  
WORLDWIDE TRENDS

2003.1



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# FORCES AND REACTIONS IN HEALTHCARE

## A Report On Worldwide Trends

for the PSI Health Services Taskforce by Jane Lethbridge (j.lethbridge@gre.ac.uk )

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Most of PSIRU's research is published on its website, www.psiru.org . It is centred around the maintenance of an extensive database of information on the economic, political, financial, social and technical experience with privatisation and restructuring of public services worldwide, and the multinational companies involved in these processes. This core database is financed by Public Services International (PSI - www.world-psi.org), the worldwide confederation of public service trade unions.

## INTRODUCTION

This report was commissioned from PSIRU by the PSI Healthcare task force.

The aim is to provide an overview of key global healthcare trends and some of the responses to these changes. Sources used include recent research on aspects of healthcare delivery, international agency strategies and reports, results of the PSIRU questionnaire survey on privatisation of health services and recent PSIRU work on healthcare companies.

### Aim

To present a world wide view of trends within the global healthcare industry and trade union responses

### Objectives

- To identify overall trends in public healthcare services including privatisation and corporatisation of healthcare
- To highlight regional developments
- To identify key players in global healthcare
- To present key companies and major activities
- To outline good practice in union action
- To outline factors influencing trade union campaigns against privatisation

There are 5 sections:

1. Trends
2. Regional developments
3. Global players and financing
4. Companies
5. Campaigning and trade union action

## 1. TRENDS

Within the context of continuing challenges to public services, commitment to a public funded healthcare system remains remarkably strong in many countries. However, there are changes taking place in the relationship between the public and private healthcare sectors that may lead to the weakening of the power of the public sector to influence the direction and delivery of public healthcare services in future.

There are growing debates about the costs of healthcare and the need to make the existing systems more efficient and effective, drawing on the private sector or using the private sector as a source of capital for modernising the health sector. The debates about the costs of healthcare are fuelled by the impact that a growing ageing population in North America, Western Europe, Latin America and Asia may have on future healthcare demand.

### 1.1 PUBLIC-PRIVATE PARTNERSHIPS

- a. The private sector is being drawn into operating within the public health sector through a series of mechanisms. One of the most influential, in terms of redefining public and private sector relationships, are public-private partnerships (PPPs). This covers a wide range of possible relationships, from contracting the private sector to supply goods (e.g. drugs) or services (e.g. cleaning), through to arrangements where a private company may manage a public hospital (e.g. St. Goran's Hospital, Stockholm) or finance a new hospital in return for a long-term concession to provide services (e.g. hospitals built through the Private Finance Initiative (PFI) in the UK). Although usually developed at national, regional or local levels, they also exist at an international level.
- b. The rationale for involving the private sector is that it has skills and resources that will benefit public sector services. A UK Government publication outlines the potential of the private sector through the following skills:
  - Commercial incentives – leading to increased efficiency
  - Focus on customer requirements
  - New and innovative approaches
  - Business and management expertise<sup>1</sup>
- c. The health sector in many countries has introduced public-private partnerships. Private Finance Initiatives (PFI) are most commonly found in the UK. The aim is for the private sector to provide capital to build a new hospital. Several private sector companies, usually operating as consortia build and own a hospital, which is then leased to the NHS for 20 years or longer. The NHS pays for the building's capital and running costs out of its incoming revenue (mainly public funds). Effectively the public sector is subsidising the private sector.<sup>2</sup>
- d. PFI is a form of public-private partnership where a government contracts to purchase services on a long-term basis in order to use private sector management skills "incentivised by having private finance at risk". This may include concessions on franchises where the private sector partner takes on responsibility for providing a public service, including maintaining, enhancing or constructing infrastructure.<sup>3</sup> Canada is beginning to introduce both public-private partnerships (PPPs) and the Private Finance Initiatives (PFIs).
- e. The Global Forum for Health Research is an example of a public – private partnership at international level. It was set up in 1999 to draw attention to the 10/90 gap where only 10% of the research funding worldwide is spent on research on problems affecting 90% of the world's population. The Global Forum for Health Research draws together WHO, World Bank, private foundations, the pharmaceutical industry, NGOs and other stakeholders.<sup>4</sup> There are criticisms of the transparency and accountability of the funds made available for research.<sup>5 6</sup>
- f. WHO has also developed a number of partnerships with the private sector – pharmaceutical companies – to provide drugs for tropical diseases. There has been criticism of the effect that WHO partnerships with the private sector have had on the campaigns and advice that WHO provides.<sup>7 8</sup> WHO's policy is that it supports public/private partnerships in that "such partnerships should be mutually beneficial and must always benefit health"<sup>9</sup> (WHO, 1998). Although some partnerships have led to people having access to treatments that previously were unavailable, the longer-term effects of pharmaceutical companies working in partnership with a public health international agency may compromise the independence of the public health advice it provides.
- g. The more general significance of international public-private partnerships is the process of formalising links and partnerships between organisations and private sector. These links already exist but may become institutionalised thus influencing future policies. These alliances can also influence the type of advice and aid that international agencies give to national governments. The benefits of private sector intervention in the public sector have been promoted for the past 20 years. If internation-

agencies are deeply involved in alliances with the private sector, their capacity to offer independent advice as to the value of private sector involvement will be weakened and in many cases already has been.

- h. There are three major problems that can arise with public-private partnerships and private finance initiatives.
1. The quality of the services delivered
  2. Pay, terms and conditions for workers
  3. Length of payback terms for the public sector, which may result in long-term indebtedness of public sector. It also neutralises any “incentive” for the private sector to be efficient.

There is increasing evidence that the four assets/reasons given for involving the private sector in the delivery of public services are not necessarily true. Commercial incentives have not led to increased efficiency in many cases.

Customer requirements are not always met by the private sector. Business and management expertise from the private sector does not always lead to improved systems, e.g. failure of performance management.

## 1.2 CONTRACTING OUT OF SERVICES - FROM ANCILLARY TO CLINICAL SERVICES

The contracting out of services has been taking place in many health sectors for over 10 years. The contracting out of ancillary services began in the late 1980s in the UK and North America. This process has continued in many countries, with large multinational companies e.g. ISS, Sodexo, selling increasingly complex packages of services, known as facilities management services to different sectors, including the health sector. There is a trend towards greater consolidation of companies.

In the UK, companies already providing ancillary/facilities management, e.g. ISS, have become frequently involved in consortia (partnering with finance companies and construction companies) to bid for Private Finance Initiatives to build new hospitals, because PFI requires that the finance for building a hospital should be linked to a long-term service contract of some kind.

Apart from the contracting out of ancillary services, the contracting out of clinical services is being considered in the UK. The pressure of more people waiting longer for healthcare treatment has led to “waiting lists” becoming an increasingly sensitive political issue in Europe. Recent decisions by the European Court of Justice to

support the right of patients to seek treatment in other European countries other than their home country is putting additional pressure on governments to delivery services more quickly.<sup>10</sup>

One of the short term solutions suggested has been the contracting out of clinical services to the private sector, often based in other European countries. New companies have been set up to deliver teams of specialists to deal with routine waiting lists.<sup>11</sup> Staff will be mobile and able to move to hospitals that need fast delivery of surgery. In addition, there are plans for longer term contracting out of clinical units to private companies.<sup>12</sup>

The recent decision by the UK government to increase funding to the NHS is significant in that it represents a five-year commitment to a publicly funded health service.<sup>13 14</sup> However, some of this money will be used to buy services, e.g. clinical services from the private sector.

## 1.3 DEVELOPMENT OF DIAGNOSTIC SERVICES

The development of diagnostic services, e.g. magnetic resonance imaging (MRI), CT scans and other high technology equipment, to diagnose non-communicable diseases is becoming more widespread. This type of equipment requires large capital investment and highly trained staff to operate it. In many health systems, private companies are already providing the equipment and services. Loans from multilateral organisations are often given for the purchase and establishment of this infrastructure.<sup>15</sup>

In Thailand, there was an expansion of equipment for magnetic resource imaging (MRIs) in both public and private hospitals in the 1990s.<sup>16</sup> This can have implications for the allocation of resources to primary and secondary care/prevention/promotion, with primary care often given limited resources. The majority of poor people need access to accessible, comprehensive primary healthcare. Allocation of resources to high technology services will make fewer resources available for basic healthcare.<sup>17</sup>

## 1.4 CORPORATISATION OF HEALTHCARE INSTITUTIONS

One of the aims of health sector reform was to introduce more efficient ways of operating and managing health services. This was generally interpreted as introducing commercial business practices to healthcare institutions. Part of this process often involved changing the manage-

ment and financial structures of healthcare institutions, creating separate “companies”. The development of healthcare institutions within the public sector that operate under business principles has been called “corporatisation”. When introduced over a decade ago, the process was considered a first step towards moving towards the privatisation of healthcare services. It was assumed that once an institution operated like a business, it could be taken over by the private sector. In New Zealand, Crown Health Enterprises—a form of “corporatised” healthcare institutions, are required to return 10% on investments to the government.

A major issue that this process highlights is the use of public sector resources to develop organisation that may eventually move to the private sector. The development of new business practices; new systems of governance and training for staff are funded by the public sector. This subsidy of new public/private sector companies by the public sector is found in many countries. In India it has led to the expansion of urban secondary care hospitals at the expense of rural, primary healthcare facilities.<sup>18</sup> In India, state governments have restructured hospitals with World Bank loans. Equipment and pharmaceutical companies have developed partnerships with specialist hospitals. The private sector has grown unevenly in India. Part of the private sector is made up of individual private practitioners. There has also been an expansion of hospitals and nursing homes, so expanding the number of private sector beds, but the size of many of these establishments is relatively small. The rise of corporate hospitals often partnered by Indian doctors and non-Indian doctors are based in urban areas. The Apollo hospital group was the first of these hospitals.<sup>19</sup>

However, institutions that have been changed in this way do not always move into the private sector. There are some examples of where corporatisation has led to public health hospitals operating successfully as competing agencies with private health companies, e.g. Singapore. Parkway Healthcare has found that the corporatised public health sector has often an unexpectedly competitive edge, with government hospitals having newer facilities, cheaper rates and also car parks.<sup>20</sup> Singapore is a much smaller country than India, where the process of corporatisation has led to an expansion of several component parts of the private sector including private practitioners, small hospitals and nursing homes and larger corporate hospitals. In the UK, the setting up of hospital trusts in 1991 has not yet led to hospitals moving into the private sector.

A new concept, which may be considered a variant of corporatisation is being introduced in the UK and Chile. “Foundation” hospitals have been suggested as a way of enabling healthcare institutions to operate more independently. In the UK they are being described as “public interest institutions”.<sup>21</sup> They will be able to raise their own capital up to a certain limit, set up subsidiaries and set their own pay levels. There are still unanswered questions about the liability of the public sector if a “foundation” hospital went bankrupt.<sup>22</sup> This issue has not been resolved although the UK Department of Health has now issued detailed guidance for setting up “foundation trusts” which will cover hospitals and other healthcare institutions. The new foundation trusts will be “supported” during their setting up period by the Department of Health in practical and financial terms.<sup>23</sup>

In Chile the proposed healthcare reform published in June 2002, also describes the setting up of a similar type of hospital. The rationale, again, is that hospitals will be given more freedom to operate as effectively as possible.<sup>24</sup>

### 1.5 CHANGING ROLE OF GOVERNMENT IN HEALTHCARE PROVISION

Contracting systems and public-private partnerships in the public health system are part of wider changes in the role of government in the healthcare system. These changes are part of a policy of reforming the public sector which is known as the “new public management”. This is an approach which has included: introducing market mechanisms to the public sector, setting performance targets for agencies and public sector workers, focusing on consumers/ customers and improved quality of services, and introducing private sector management techniques.<sup>25</sup> Moving from being a provider of health services, the public/ government sector has often relinquished direct control over providing healthcare services and taken on a coordinating and in some cases regulatory role. This is sometimes described as moving from a “provider” to an “enabler” role. This process varies from country to country and has been encouraged directly by many health sector reform programmes.

The combination over the last 20 years of underfunding in the public healthcare sector and the changing role of the government has led to changes in people’s perception of the public sector and the private sector. Recent research in Africa has started to explore how people view different providers of healthcare, finding

that perceptions about effectiveness may vary according to type of illness or conditions.<sup>26</sup>

The introduction of user fees for government healthcare services has also meant that government services are often no longer free. The public sector, as a result of years of underfunding, now has staff shortages, is overcrowded, has long waiting times, and has inadequate supplies of drugs. This can lead to both patients and staff moving to the private sector. When private providers are also local and have fees that are no greater than the public sector, people begin to choose the private sector care. This change in attitude also needs to be considered in relation to the role of media in creating an image of a public sector in crisis.

In terms of the future of public services, it is important to consider what type of policies would help to strengthen the role of the government in the healthcare sector. Tendler (1997) is one of very few academics who have examined the role of workers in improving services. She promotes a view of public sector reform that does not involve reducing the size of the public sector but builds on existing strengths, particularly its workforce.<sup>27</sup>

## 1.6 TRADE POLICIES

In the last few years, two major World Trade Organisation agreements have been recognised as a major threat to the future of public health services: The General Agreement on Trade in Services (GATS) and Trade related Intellectual Property Rights (TRIPS). Signed by the members of the WTO, the treaties bind countries to all treaties and the provisions within the treaties.

The General Agreement on Trade in Services (GATS) threatens the existence of public health services in both developing and developed countries by pressuring countries to open up their service sectors to international trade.<sup>28</sup> This will affect the universal rights to services that people experience in relation to public services, including health. The use of commercial and business practices in the health sector make it vulnerable to being considered a business activity and so liable to the same requirements to open its services to competition.

A recent ruling by the Appeals Tribunal of the Competition Commission in the UK (August 2002) where the Commission backed a private company, BetterCare a residential and nursing company in Northern Ireland, in its claim that the local health trust had an unfair monopoly over the care of the elderly, is a significant move

towards opening up public services to competition.<sup>29</sup> If a UK ruling, under its domestic legislation (1998 Competition Act), has decided that commissioning by public bodies is, in some cases, a commercial undertaking then this will weaken any opt out clause made by the UK government under the GATS. This will result in public services being opened to competition with international companies. 18 countries have liberalised their insurance services, which are expected to use this as a way into healthcare systems. GATS will also impact on the international migration of health workers, which is discussed in the next section.

The Trade Related Intellectual Property Rights (TRIPS) seeks to control intellectual property rights through global patent rules. This will make governments grant minimum 20-year patents to pharmaceutical companies, thus stopping the production of cheaper, generic drugs, and leaving pharmaceutical companies free from competition. For developing countries, this will affect their ability to buy and sell generic drugs.<sup>30</sup>

The Declaration on TRIPS and Public Health agreed at the WTO meeting in Doha in November 2001 represented an important development in asserting the needs of public health over intellectual property rights in the short term. If governments integrate the Declaration into national legislation, it will give them the right to authorise “the use of the patent without the consent of the patent holder (compulsory licensing) and determine the ground upon which such licences are granted. These may include public-health objectives”.<sup>31</sup> Current some developing countries import generic drugs from countries, e.g. India, that have not yet complied with the TRIPS Declaration.

There are still major problems to be overcome. Industrialised countries are supposed to be finding a more permanent solution to the problems of TRIPS and public health by the end of 2002. There are signs that their commitment to doing this is limited. By 2005, according to the original TRIPS Agreement, all developing countries will have to adhere to the TRIPS Agreement and so will not be able to export generic drugs. This would affect countries, e.g. Brazil, that challenged TRIPS recently in order provide a supply of cheap drugs for treating AIDS. Longer term, the Agreement will affect not just the export of generic drugs but also their production because the processes for compulsory licensing will be legally complex and many developing countries will be unable to afford the legal expertise needed.<sup>32</sup>

### 1.7 INTERNATIONAL MIGRATION OF HEALTH WORKERS

Healthcare is highly labour intensive. In many countries there is an imbalance in the supply and demand for health workers. Attempts to develop human resource planning by setting training quotas and systems of regulation have not always been successful. Currently, there are shortages of nurses, doctors and professionals allied to medicine in many developed countries. This has led to specific recruitment drives by health ministries of developed countries in several developing countries. The migration of international health workers can lead to a loss of health workers in developing countries, which takes resources away from already fragile health systems. Although pay levels are higher in developed countries, health workers can be subject to exploitation by recruitment agencies, nursing homes and other work settings.

One of the major issues facing health workers is that while accepting that international migration will continue, how can the process be regulated so that health workers are not exploited and that countries with already weak health systems are able to recruit and retain skilled health workers. This situation is affected by the economic situation of many countries as well as the changing dynamics of the healthcare sector. It has also been affected by health sector reform, which has not always put in place human resource policies to support, develop and retain health workers. Poor salaries and conditions of work as well as attractive private sector opportunities are the main reasons why health workers leave the public sector. There is also an international shortage of nurses caused by a decline in the number of people entering the nursing profession regionally and internationally as well as an unwillingness of unemployed nurses to enter the public sector.

Recent action by the South African health workers union NEHAWU has led to the development of draft 'policy guidelines on 'Recruitment of skilled health workers from South Africa'<sup>33</sup> which aims to:

- regulate recruitment of health workers from South Africa by other countries
- protect South African public health workers from possible international exploitation
- retain public health workers and maintain their numbers at a level that ensures efficient public service healthcare delivery
- provide for criteria to determine a levy to sustain acceptable levels of skilled health workers in the public service.

Trade unions have an important role to play in these policy developments.

There are other initiatives which are attempting to both protect health workers who choose to migrate and to stop developed countries creaming off skilled health workers from developing countries.<sup>34</sup> Governments will also need to develop policies to improve salaries, working conditions, working practices, training and retention, and finding solutions which are appropriate to different circumstances and levels of resources.

### 1.8 FROM HEALTHCARE REFORM TO SECTOR-WIDE APPROACHES

International development policies influence the nature and type of programmes delivered in the health sector. The development of health sector reform since the 1980s has been accompanied by decentralisation and privatisation. Health sector reform is now considered to have moved from a "supply led phase" to a more "demand led phase". The supply side period deals with improving health sector management systems, public sector reform, cost-effectiveness of interventions, cost containment and financial reform, decentralisation, and working with the private sector. The "demand" driven period has a slightly different "softer" approach, which tries to develop new partnerships with key stakeholders, address user/community needs and the health/poverty agenda (Standing, 2000).<sup>35</sup>

Two recent policies promoted by bi-lateral and multilateral funders that are beginning to be influential in the health sector are sector wide approaches and output based aid.

The development of sector wide approaches to plan and coordinate health services and development aid has been important in the past 5 years. The "defining characteristics of a Sector Wide Approach (SWAP) are that all significant donors for a sector support a single sector policy and expenditure programme, under government leadership, adopting common approaches across the sector and progressing towards relying on Government procedures to disburse and account for all funds" (ODI, 2001)<sup>36</sup>

Sector Wide Approaches (SWAPs) were originally designed to improve the coordination of aid/development projects, prevent duplication and enable the national government to have some influence over the development of the health sector. This approach has raised some questions about the capacity of governments to play an effective coordinating role and how

equal the partnerships between donors and recipient country actually are. Another result of a sector wide approach is that vertical programmes tend to be discouraged which can result in a loss of interventions.<sup>37</sup>

There is also an emphasis, through the coordination process, on viewing public, private and non-governmental health providers as part of the country's healthcare resources. Although important for avoiding duplication of projects, this may lead to a dilution of the importance of the public sector as a provider of healthcare.

Output-based aid (OBA) refers to the focus on agreed outputs that private sector providers negotiate with the government or public sector. Often used in relation to infrastructure projects, the responsibility for delivery is with the private sector provider. The World Bank Private Sector Development (PSD) strategy argues that this arrangement provides "competitive disciplines that ensure that the profit margins would be bid down to normal levels and that the subsidy would eventually be reflected in lower prices to customers or lower cost to taxpayers." In reality these can be seen to be a form of concession arrangements.<sup>38</sup>

The World Bank Private Sector Development (PSD) strategy acknowledges difficulties in establishing appropriate incentives and monitoring arrangements for output-based aid.<sup>39</sup> However, if the income stream from these projects is secured in order to minimise risk for the investor, the supposed advantage of OBA is an illusion. The investor has no particular advantage to deliver the output more efficiently and effectively, because the income is the result of negotiations, not of market forces.<sup>40</sup> Several donors are currently promoting the policy of output-based aid.

## 2. REGIONAL DEVELOPMENTS

### 2.1 AFRICA REGIONAL DEVELOPMENTS

African countries face large demands on already overstretched healthcare services. HIV/AIDS, TB, and malaria are major sources of mortality and morbidity which affect the demand for health services, the capacity of health facilities to deliver care and the size of the health sector labour force available.<sup>41</sup> In South Africa, there is an increase in non-communicable diseases. There have

been several factors that have influenced both access to health care services and their delivery. Some of these factors illustrate the impact of donor policies on developing countries.

#### 2.1.1 User fees

User fees were introduced for healthcare by many African countries in the 1980s as part of the Structural Adjustment Programmes. In the 1990s, spending on health services often continued to fall. There has been 15 years experience of user fees in many countries. There are often many types of fees, ranging from fees for: drugs; other charges for treatment; fees set by individual health facilities; and unauthorised fees set by providers.<sup>42</sup> One of the results of having a range of fees is that it is difficult for patients to assess costs before their treatment. Hospitals and primary healthcare centres often compete for patients. There is no clear information about fee rates; any exemptions are often poorly publicised and many poor people are unaware of their eligibility to free treatment. This has led to fewer poor people using healthcare services.<sup>43</sup>

In cases where fee income has been used specifically to either improve the quality of the service or to buy drugs, people are found to be more willing to pay fees. If there is no visible impact of the fees on services, people are more reluctant to pay. This is reflected in Zambia, where people felt user fees has been forced on them even after an apparent consultation process. Some people felt that they would be willing to pay if they felt they got value for money, e.g. mission hospitals and traditional healers. As government services had always been free, there was a reluctance to pay and there was a lack of confidence about the quality of the services.<sup>44</sup>

The assumption that people would be willing to pay for health services because they already paid for traditional healers has informed the policies of the World Bank and many other multilateral donors. However there was little understanding of how people use traditional healers and medical services. Hausmann Muella, (2000) found that in southeast Tanzania, people's willingness to pay was based on their perception of treatment success. They often had a clear understanding of what traditional healers were good at – often treating more chronic or mental disorders. Health services were considered better for illnesses such as malaria, schistosomiasis, and diarrhoeal diseases. People were also influenced by the flexibility of the payments system. Family members could often pay in kind over time or traditional healers.

Health services often demanded money before treatment and wanted payment in cash.<sup>45</sup>

Bloom and Nuwagaba (1999) examined the effect of user charges for health services in four poor communities in Uganda. They found that women felt the effect of user fees most acutely. User fees have to be paid in cash, so men in the household who had cash available from crop sales, became the main decision-makers in relation to healthcare. Women were expected to care for the sick, which also meant that they had less time available to earn income.

Bloom and Nuwagaba also found that the nature of using public health facilities changed with the introduction of fees. Many patients, rather than seeing a nurse, saw an “assistant” with unknown qualifications or abilities who then prescribed drugs that were only available from private sector providers (Bloom and Nuwagaba; 1999:33). This is an illustration of how the experience of using public sector facilities is changing people’s view of public and also private healthcare provision. In Togo, these types of changes have led to a trade union initiative to create an organisation to provide care for trade union members and the population of the surrounding population.

In Cameroon, the government is no longer a major provider of public healthcare services. There has been a decrease in health workers’ salaries and many health workers have moved to the private sector. There are long waiting times to use the public healthcare services. Equipment is often obsolete. Patients have to pay at public healthcare facilities and these fees are often higher than at private sector facilities where patients will be treated immediately. The private sector can often provide drugs which are unavailable in the public sector. Trade unions are campaigning for the government to include a budget for healthcare.<sup>46</sup>

In Ghana, the hospital referrals system was corporatised in 1999. This has led to a decline in the quality of services and the number of professionals. Hospital support services have been contracted out. The government continues to run primary care, psychiatric and laboratory services. Plans to set up local health management committees have been postponed for the past 5 years.<sup>47</sup>

### 2.1.2 Insurance

There has been limited development of formal health insurance schemes in many African countries. In Kenya, the health sector reform programmes have tried to

expand the role of the private sector in healthcare delivery and generate more resources. Extra resources were generated through user fees and insurance. The extra income was used for primary and preventive services as well as improvements in the quality of care. The International Finance Corporation has only one healthcare insurance investment, which was to strengthen a managed care company in Kenya.<sup>48</sup>

The majority of the labour force works in the informal or small-scale agriculture with low and infrequent incomes. This sector of the population also needs access to healthcare. Attempts to set up small-scale credit or health insurance schemes have been made by individual hospitals e.g. Nsambya Hospital, Uganda.<sup>49</sup> Cooperatives have been set up in Tanzania, e.g. UMASIDA. Flexible, low cost insurance schemes provide a way of enabling people on low and erratic incomes to have some way of paying for health care. Many of these schemes are at the early stages of development.<sup>50</sup>

### 2.1.3 Privatisation/private sector

The involvement of healthcare multinational companies in the health sector is limited in many countries in Africa, with South Africa having the most activities and opportunities. The South African government is currently promoting healthcare privatisation. The arguments are that the public sector is unable to manage existing public health facilities. However, the private sector often lacks in transparency and accountability.

The case of Afrox/Ahealth, a healthcare company set up by British Oxygen Company (BOC), illustrates the scope for private healthcare expansion in South Africa. Active in private healthcare, occupational health and nursing/care of older people, this company is expanding through acquisition of clinics, nursing homes and hospitals (For more details see Section 4).

One example of how multinational healthcare companies are beginning to find market opportunities in Africa can be seen in the case of World Diagnostics, providing diagnostic tests and laboratory testing. It is a relatively young US company (less than 5 years old) that is expanding rapidly. At the moment it is providing services in South Africa and Egypt but it is negotiating with several other countries to provide testing equipment for sexually transmitted infections and other diagnostic tests. It is aiming to work primarily with distributors and the private sector but in some cases with governments.<sup>51</sup>

Loans from the International Finance Corporation have been used to support individual doctors in Africa operating as small businesses. Often the doctors have practiced out of Africa e.g. United States for several years. Loans are used together with their own capital to set up a private practice with medical facilities. In other cases, doctors with existing private practices are using loans to develop small private clinics and hospitals.<sup>52 53</sup>

In areas of conflict where government services have broken down, non-governmental organisations have started to provide health services.<sup>54 55</sup> In many cases this is an extension of their aid role but the process of managing comprehensive health services may place pressure on existing levels of management skills and systems of governance. It raises questions about the future of health services within these regions when the conflict has ended. Unless there are clear plans for handover and training, non-governmental services may remain the major providers of services.

The case of Tunisia illustrates the slow rate of privatisation in the healthcare sector. Hospitals are still in the public sector but patients pay more to access services. There have been attempts to export health services. Public and private healthcare services have been put on the same basis and the patient is free to choose a provider from either sector. The patient often chooses the private sector provider. Two projects, the export of health services and the development of health finances, have been proposed by the government but are strongly opposed by trade unions because they would change the nature of healthcare provision.<sup>56</sup>

## 2.2 REGIONAL DEVELOPMENTS – ASIA

Many Asian countries are middle-income countries and are experiencing increases in non-communicable diseases although not necessarily rapid reductions in infectious diseases. Cancers and heart disease require increasingly high technology equipment for diagnosis and treatment.

There are some changes taking place in many Asian societies that suggest that the attitude towards using self-medication and paying for both public and private healthcare is changing. This is often reflected in an increase in disposable income used for purchasing healthcare treatment. In Thailand, a survey in 1996 found that the proportion of household income that had previously been used for self-medication was now being spent on paying for both public and private healthcare treatment.<sup>57</sup> The change was most marked in Bangkok, and so can be seen as an urban trend.

National governments have also been reviewing healthcare policies, partly as a result of healthcare reform programmes and increased healthcare expenditure. The economic crisis of 1997 brought an increased awareness that some of the trends moving towards greater involvement of the private sector had limitations in times of economic crisis. However, increasing demand for healthcare services with pressure on government resources, is leading to continued strategies to involve the private sector in healthcare. In Thailand in 2002, the national government, after introducing a health insurance scheme to cover 60% of the population, has also invited key private health insurance companies active in Thailand to participate in the government scheme.<sup>58</sup>

The Thai government is also trying to encourage patients from abroad to have treatment in Thai hospitals. Some aspects of nurse training are being changed so that foreign patients can be treated appropriately. This may limit the access of Thai patients to health services in the long term because nurses and doctors will be attracted to working in cities rather than rural areas.

In Malaysia, the national government privatised support services in 1996. Cleansing services, linen and laundry, clinical waste management, biomedical engineering maintenance and facilities engineering maintenance were contracted out. These constituted 14% of the Health Ministry budget. Contracts were given to three local consortia – Faber Medi-Serve Sdn Bhd, Radicare Sdn Bhd and Tongkah Medivest Sdn Bhd in joint ventures with their foreign partners, in an exercise with little transparency, accountability or competitive tendering. In 2001, the Ministry of health announced the setting up of a National Health Financing Authority. Meanwhile private for profit insurance companies and managed care schemes exist to complement the government scheme. The private insurance companies are largely local companies with foreign companies unwilling to move into the market yet, although the Prudential plc bought into the market during the Asian crisis of 1997 (C. Chee Khoo, 2001).<sup>59</sup>

In the Philippines, healthcare is not seen as a government priority. Public services are not free and users have to pay for care. There is a general level of awareness by patients of their rights and the need for quality healthcare services. There is malpractice legislation going through Parliament at the moment. Some work is being done on the development of regulatory practices. However, the existence of regulation does not encourage public-private partnerships.<sup>60</sup>

In Indonesia the private sector has grown rapidly in the period 1988-1997 from 287 to 491 hospitals, which is 45% of the total hospitals. This expansion can be traced to the deregulation of the hospital sector in 1988, which enabled investors to open for-profit hospitals. In 1994, foreign interests were allowed to open hospitals although they were restricted to hospitals with more than 100 beds and cannot employ foreign doctors. The IMF, during the financial crisis of 1997-8 was pressing the government to remove these barriers. In 2003, as part of the Asean Free Trade Agreement (AFTA), the medical sector will be liberalised. This will allow foreign investors to invest in hospitals, clinics, and laboratories and to employ foreign doctors.<sup>61 62</sup>

In Japan, over 80% of medical care is private. Government services have traditionally focused on rural areas where private investment is less. However public hospitals are larger in urban areas and so account for 46% of hospital beds.

There is excess capacity of hospital beds in a third of all health regions. The ownership of private beds is either by sole owner or medical corporations, which are for-profit corporations set up with shareholder capital that do not pay dividends to shareholders. However, shareholders can demand the return of their capital at any time. Medical corporations are subject to regulations under the Medical Service Act. Most hospitals are well equipped with high technology equipment.<sup>63</sup> There have been recent plans to privatise public sector hospitals but only a few public hospitals are actually being privatised. Hospital assets will be sold under a private finance initiative to corporations and limited companies.<sup>64</sup>

All the population is covered by health insurance although it is a fragmented system. Different insurers cover different segments of the population. This system is being reformed which will lead to increases in the individual contributions. The government has attempted to reduce the excess bed capacity. There have also been public health policies introduced to improve the health of the population.<sup>65</sup>

There has been an increase in the number of medical negligence cases. Although there is no obligation to report medical accidents, some cases are reported and get some media attention. In the private sector, victims of medical accidents receive payments in order to limit publicity. There has been increasing concern in recent years about the lack of quality assurance mechanisms in medical care and the lack of patients' rights to see their own records. The morality of the medical system is seen

as inadequate and trade unions are attempting to challenge this by campaigning for quality medical care and more staff.<sup>66</sup>

### 2.2.1 Multinational healthcare companies

There has not been a widespread move of US healthcare companies into Asian markets. Although health insurance companies such as CIGNA are present in Asia, there are often contradictory processes of expansion and contraction taking place within short periods of time. Some insurance markets, e.g. India, have not proved as profitable as expected.<sup>67</sup> US healthcare companies providing direct hospital management have not expanded into Asia.

Other US companies involved in pharmaceuticals, medical equipment, medical devices, telemedicine and e-health are targeting what is considered to be a growing market for medical products in Asia. The US Trade Development Agency, as part of its remit to promote private sector participation in middle income and developing countries, also provides trade promotion assistance to high technology healthcare companies to establish links in Asia.<sup>68</sup>

The use of telemedicine has started to expand in Asia. A recent project in Malaysia between the Ministry of Health and Worldcare has established arrangements for providing treatment advice through video links. This is a way of providing advice and expertise to health centres that are unable to afford specialist staff. Worldcare is a company in partnership with four large US non-profit hospitals.<sup>69</sup>

### 2.2.2 Asia healthcare companies

Several Asian healthcare companies are expanding through hospital ownership and management into several countries not just in Asia. They are developing a strong position as healthcare providers in Asia. **Parkway Group Healthcare** (Singapore) owns hospitals in India, Indonesia, Malaysia and Singapore but sold its UK hospital in July 2001.<sup>70</sup> **Apollo Hospital Group** (India) is involved in the management of hospitals in Oman, Nepal, Saudi Arabia, Ghana, Bangladesh.<sup>71</sup> **Asia Renal Care Ltd.**, (Hong Kong) which provides renal dialysis in 5 Asian countries, has a technical partner, the US company Satellite, has several private equity investors from outside Asia but is Asian owned.<sup>72</sup> **BUPA** (UK based) has recently acquired **Vista Healthcare Pte. Asia Ltd** (Singapore), which it originally set up as a partner.<sup>73</sup>

During the past five years, the International Finance Corporation (IFC) has invested in high technology and hospital healthcare projects in partnership with local companies, and some large locally based conglomerates.<sup>74</sup>

## 2.3 REGIONAL DEVELOPMENTS – LATIN AMERICA

Health sector reform was introduced to many Latin America countries in the 1990s. This was made up of financial and management reforms with attempts to strengthen the private healthcare sector. The introduction of decentralisation and privatisation are on-going processes that have been supported by multilateral and bilateral donors. Chile and Brazil are used as two case studies to illustrate some of the reforms still taking place.

### 2.3.1 Health insurance

US insurance companies have seen the Latin American market as a potential growth market although often in partnership with local insurance companies. ING has consolidated its purchase of Aetna International in Latin America by either consolidating ING branches with Aetna International or leaving Aetna as an established business. As in Asia, the expansion of health insurance has not been an even process. Some multinational companies have withdrawn from national markets.

In Brazil, about 26% of the population is covered by private health insurance (Almeida et al, 2001).<sup>75</sup> The private sector consists of private health companies, private hospitals, health insurance companies, and private clinics. The role of the private sector has grown under the Unified Health System law (1989). This has been caused by a) the decline in public services and b) the provision of public subsidies for people taking out private healthcare plans by making insurance premiums tax deductible (Lobato, 1998).<sup>76</sup> Private health insurance has been introduced as an alternative to the public health system. Supplementary insurance to complement the public health system, has not been introduced.<sup>77</sup>

In Chile, a system of private health insurance (ISAPREs) was introduced in the 1980s, which enabled people to choose whether to contribute 7% of their income to a government system or a private health insurance institute. ISAPREs are private health insurers, which finance medical benefits and subsidies for occupational disability, under individual or group plans. Of 29 ISAPRES, 11 are only open to workers from a specific company or group of companies. 18 are open to anyone.

They cover 28% of the population. They provide services using their own facilities and outside facilities. Their main sources of funding are compulsory health premiums (7%) plus additional payments to cover the cost of the plan and other co-payments associated with the plan.<sup>78</sup>

In Chile, 61 % of the population is covered by public insurance (FONASA) and 28% by ISAPREs. The setting up of the ISAPREs and the payment by 28% of the population into private health insurance funds has taken resources away from the public sector. “The introduction of the ISAPREs led to a diversion of increasing portions of the mandatory payroll contribution away from the public health system”.<sup>79</sup> Currently, 70% of ISAPRE consumers are under 40 and 2% over 65 years. The demand for public healthcare services is expected to increase as the population ages.

A new health reform law (June 2002) is proposing to establish minimum standards of care for 56 illnesses. Both public and private health sector will be required to provide these levels of care. If the public health system is unable to do this, then it may purchase services from the private sector. However it will only have 10% of its funds available for this. In addition another controversial proposal is that both private insurers and the public health system must pay maternity costs for their patients. 0.5% of the 7% that all employees have to pay to either a private or public health plan will go to a Solidarity Fund. Maternity costs will be paid for from this Solidarity Fund. This is expected to impact on middle class Chileans. Currently the government pays for maternity benefits which are paid in relation to the woman’s salary.<sup>80</sup>

### 2.3.2 Corporatisation/privatisation

In Brazil, by the 1990s, the healthcare system consisted of the public contracting subsystem and a private/voluntary contracting subsystem (Lobato, 1998: Almeida, 2001).<sup>81</sup> <sup>82</sup> Public sector inpatient care is mainly provided by contracted private services (70-80%). University hospitals are mainly public and provide half of public hospital care. Public institutions provide 75% of SUS (the Brazilian Unified Health System) outpatient care. Total national health expenditure is estimated at \$US 250 per capita. Payments are based on fee for service (Lobato, 1998; 31).<sup>83</sup>

Payments are restricted to a maximum of 8 admissions per 100 people per year in order to limit expenditure. Fees for procedures and hospital admissions are paid centrally. Fees are too low to cover actual costs and so

result in lack of maintenance and investment. Some 75% of the population is covered by the public sector services.

In 2002, public hospitals are beginning to be converted from social institutions to companies operating for-profit. There is increased contracting between hospital and primary care services which often results in a reduction of services. There have been widespread cuts in both primary care and hospital services. Due to (national) budget cuts, there has been some reduction in the supply of services. Taxes and other contributions have been cut resulting in worse care for the population.<sup>84</sup>

Current privatisation of health services in Brazil can be characterised as taking three forms:

- support services delivered through a private sector procurer
- public services under private management, mainly hospitals
- some hospital beds and highly complex services offered to those with private insurance (and paid by the insurer).

Some general hospitals have been privatised under private management as well as establishing private beds within public hospitals. However primary and psychiatric care remain government services.<sup>85</sup>

Laboratory services and pharmacies have been privatised with contracts lasting several years. Many medical, nursing, obstetric and paramedical services have been contracted out to either cooperatives or non-governmental organisations. Contracts are for 1 – 10 years. Support services have also been contracted out after public tenders, also for 1-10 years. Some public hospitals have been converted into companies. National and local companies as well as private-public mixed companies have become providers of services. In addition, church and other non-governmental organisations provide services.<sup>86</sup>

Although there have been some improvements in availability and access to services, there have been increased costs for the health services, and the quality of services is considered to have become worse. There have not been any increased payments made by the public.

In terms of impact of privatisation on pay and working conditions, many of the contracts have resulted in fewer permanent contracts with more use of short term or temporary contracts. There has been an increase in the use of agency and self-employed staff. This has caused a worsening of trade union rights and organisation.

Health workers still receive the same pensions and housing benefits but healthcare, training, promotion opportunities, and travel benefits have all decreased. There has also been a decrease in the number of jobs, job security, pay, hours worked, training and safety, experienced by both men and women.<sup>87</sup>

In Chile, during the 1980s, public health services were decentralised into 27 health services (now 29) and many functions were delegated to hospital level. In 1994, primary healthcare services were transferred to municipal control.

A new healthcare reform was announced in May/June 2002. One of the reasons given for this new reform is that the privatisation process has stalled and needed reactivating. Some of the pressures on the system included:

- Increasing demand for family health services via the Family Health Plan
- A conflict between per capita funding provided by central government and increasing demand for services by individuals
- Inability of municipal providers to deliver these services because of lack of funding and lack of financial control at municipal level
- Skimming of the risk pool by ISAPREs with the majority of members aged 25-40 and only 2% over 65.<sup>88 89</sup>

A draft Rights to Health law was published in June 2001 and sets out the health rights that people can expect from health service providers. People will also have an obligation to contribute to the care of their own health, that of their family and the community. The Health Reform will consolidate the protection of people's rights to health and healthcare and clarify their obligations.<sup>90</sup>

The health reform law published in June 2002 sets out these health rights and obligations within a changed health service. One of the aims of the new law is to address some of the fears of those using private healthcare that they will not be covered for a serious illness or when they becomes older (60+). By establishing a series of rights to health, the new system may ensure that both private and public authorities provide access to agreed standards of care. As mentioned in an earlier sector (Trends) the concept of "foundation hospitals" is also being introduced in the 2002 health reform law.

The new Chilean health reform plan was published in June 2002. Known as the AUGE plan (System of universal access with explicit guarantees) it states that the state has a responsibility to guide and develop both the public and private health system and to respond to the

needs and expectations of the population. The plan outlines changes in the management of health services. A new system of regional health authorities accompanied by increased decentralisation and the introduction of self-managing hospitals (Foundation hospitals) is proposed. The health reform is an attempt to bring the private health insurers into line with the public sector, whilst at the same time giving public sector hospitals the opportunity to operate as independent financial units.<sup>91</sup>

The aim of the new system is to separate the financing of health services from the provision of care. Resources will be allocated on the basis of numbers of patients receiving care. This may have implications for patients requiring expensive care. Hospitals will also be restricted in the debts that they are allowed to carry forward. Health unions have criticised this limit.<sup>92</sup>

Treatment for 56 agreed illnesses would be guaranteed from both the National Health Fund and the private health insurers (ISAPREs). A Solidarity Fund will be set up where the government will pay the costs of those that lack resources to contribute to a health fund.

The maternity subsidy that the government has previously paid to the private health insurers (ISAPREs) has been abolished. This resulted in one ISAPRE closing its plans to women aged 18–45. The implications of this are that women may not be eligible for private healthcare.

The major concern for health trade unions is the change in systems of pay for non-medical professionals who will have a system based on hours of work and an additional benefit, which will replace overtime pay. Following the threat of strikes, the government has offered some changes in hours worked, a salary readjustment, incentives for early retirement and increases based on merit.<sup>93</sup> The responses to the new health reform have only just begun. In October 2002 there was a further strike by hospital workers to protest against the proposals.<sup>94</sup>

### 2.3.3 Key issues

Key issues emerging in both Brazil and Chile are: a) the changing role of health insurance; b) the corporatisation of public sector hospitals

In Brazil, the move towards increased private health insurance is increasing. In Chile, the situation is different in that a more widespread private health insurance system was set up almost 15 years ago but now shows signs of being unable to deliver. The new reform is an attempt to regulate both private and public sectors so that patients can expect certain standards of care. The case

of Chile is important to consider because it appears to be a failure of a private health insurance system. The uneven expansion of global health insurance companies also suggests that private health insurance has high risks for companies.

In Brazil the corporatisation of public hospitals has begun as well as the contracting out of a wide range of services to providers outside the public sector. However, cooperatives and non-governmental organisations are the new providers, which is an interesting development. Some of the non-governmental organisations are religious foundations providing healthcare.

In Chile, the move towards corporatisation is going to be given new impetus. In neither country are global multinational companies moving directly into the health sector. It is perhaps significant that in Latin America, the International Finance Corporation has invested in four main areas in the health sector: e-health – using the internet to link health insurers, healthcare providers and patients for payment and information; high technology hospital investment; diagnostic services; and new financial infrastructure (holding companies) to support new health investors. As in Asia, the healthcare companies have only identified products and services that require investment and high technology equipment as growth areas.

The position of the Chilean public health sector illustrates many of the changes in attitude that are taking place towards national healthcare systems. The Chilean system was set up in 1951 and for many decades was effective. In the 1980s, it was one of the first health sector reform programmes to introduce a significant private sector presence into the healthcare system. As a result of systematic underfunding over the last 20 years, the conditions of public sector health facilities have deteriorated. People now view the use of the private health sector as being part of being “successful and well off”. The public healthcare system is for the poor. The democratic government has not yet made it clear whether it supports an active role for the government in healthcare. Many of the recent reforms appear to provide opportunities for the private sector.<sup>95</sup>

## 2.4 REGIONAL DEVELOPMENTS – NORTH AMERICA

In the US and Canada, the impact of a larger, older population and the rise in non-communicable diseases, with associated chronic conditions, is shaping health policies. It is important to question the assumption that

older age equals ill health. Wider public health programmes could lead to lower rates of chronic ill health and a healthier older population.

The pressure to make changes in health/healthcare policies can be seen most clearly in Canada. Canada has a publicly funded and publicly administered system delivered through a mix of public, not for profit and for profit providers. The Canada Health Act in 1984 consolidated the working of the health system. It covers hospital and physician services, including laboratory tests. It provides universal and comprehensive coverage.<sup>96</sup> Physicians are paid on a fee-for-service basis and funding to hospitals is provided on a block funding basis. Services are billed directly to the government by the physician or paid for by the hospital if delivered in that setting. Depending on the province some other services are also covered through government spending e.g., in-home care. Patients are never billed so there is no need to “reimburse” the patient.

In the last few years there have been changes in health insurance coverage. Private insurance as an alternative to public health schemes is expanding. As the Canadian system reimburses healthcare costs to the individual, recently some services have been “de-listed” and so not eligible for reimbursement by the government. Private insurers have often picked up coverage for these services. Alternatively some services have been privatised and then not covered by the government system.<sup>97</sup>

There have been tax cuts leading to cuts in public healthcare services and longer waiting lists. This has resulted in fewer services, a less efficient system, higher “out of pocket” expenses and more caring work at home for women particularly.<sup>98</sup>

Public private partnerships are being promoted actively in the health sector by some provincial governments. There are currently four proposals for PPP hospitals with several others anticipated in the near future. There are several PPPs in the long term care sector. Unions and health coalitions are actively campaigning against PPPs, private clinics and contracting out of health services. The campaigns are largely public campaigns although CUPE has also been commissioning legal opinions to assess the possibilities of legal challenges to both PPP hospitals and for-profit diagnostic clinics. There have been some successes. A proposal for a PPP hospital in Prince Edward Island was stopped as a result of public pressure. A private laboratory contract was halted in Saskatchewan and brought back into the public sector at considerable savings.<sup>99</sup>

There are several major multinational corporations involved in privatization attempts in Canada. The following are all bidding on PPP hospitals. ABN AMRO Bank – Netherlands, Brookfield Lepage Johnson Controls, Borealis Infrastructure Management, Carillion Canada, Oxford Properties, Aecon, SNC – Lavallin, Sodexo. Other major corporations involved in privatization and contracting out are: MDS (labs), Dynacare (labs), Extendicare (long term care), CPL – REIT (long term care), InterHealth Canada (hospitals – primarily off-shore).<sup>100</sup>

Public sector pension plans are being used to finance PPPs across the public sector. One of Canada’s largest pension plans – the Ontario Municipal Employees’ Retirement System (OMERS) has formed a subsidiary company (Borealis Infrastructure Management Inc.) which is a major player in a consortium (The Healthcare Infrastructure Company) that is bidding on two PPP hospitals. This shows the pensions of public sector workers (really deferred wages) are being used to privatize jobs.<sup>101</sup>

Long term care facilities have mixed ownership. Ownership falls into three categories: 1) publicly owned with services that are publicly delivered; 2) owned by not-for-profit agencies; and 3) owned by for-profit corporations. The market is roughly split 50/50 between for-profit and not-for-profit/government. There is increasing pressure in several provinces to increase the for-profit facilities.<sup>102</sup>

Private for-profit diagnostic clinics (particularly MRI and CT-scan clinics) are opening and thriving in several provinces. There is increasing pressure by the private sector to expand the numbers of for-profit clinics, ostensibly to “take the pressure off the public system.” The private clinics are attempting to offer services directly to patients who would pay out-of-pocket for scans rather than wait for scans in the public system. The consequence of this is that those who can afford to pay are able to “jump the queue” for services in the public system creating a two-tier system.<sup>103</sup>

There has been open tendering for some service contracts, especially homecare. Midwifery and some ambulance services have been privatised. There has been widespread privatisation of support services, supplies and building maintenance services.<sup>104</sup> Radiotherapy services, MRIs and some routine surgery, e.g. cataract surgery, have been privatised although operating within public hospitals. The costs private diagnos-

tic and laboratory tests have increased. Fewer drugs are covered by the government system.<sup>105</sup>

Pharmaceutical companies have adopted “aggressive advertising and marketing campaigns”. Doctors are often directly lobbied by drug companies, which raise ethical issues about treatments. The manufacture of drugs has been privatised and there have been restrictions on the manufacture and distribution of generic drugs. Brand name drugs have been given a 20-year patent protection that has led to an increase in costs. Once a patent runs out, pharmaceutical companies file an injunction and delay the introduction of generic drugs for 4-5 years. Increased drug costs have led to higher premiums for employers and employees. The employer’s share of the costs has been passed on to the employee in terms of lower wages.<sup>106</sup>

Privatised services have led to more casualisation of labour, use of agency staff and fewer permanent contracts. Pay and conditions and other aspects of employment have worsened but there have been both gains and losses in terms of trade union rights. Costs of services have increased and the quality of services has decreased.<sup>107</sup>

There has been one example of a reversal of privatisation. Ambulance services in Ottawa were returned to public ownership due partly to public pressure and because “no private company submitted a proposal with evidence that they could deliver the service more efficiently and for less money”.<sup>108</sup>

In Quebec, the arrangements of public and private services are different. The majority of the home care services are publicly run. Reception centres for older people are mainly publicly run. Private centres provide care for people who only need up to 2.5 hours a day and who are not covered by public services. Home care services are increasingly provided by community groups, subcontracted partly by government and also directly by clients.<sup>109</sup>

In Quebec all obstetric services are public. Ambulance services are run by the private sector but under the governance of the public sector. These services are entirely provided by the government. Clients pay costs of transport but this represents only a small part of the costs of operation. Neither radiotherapy nor MRI services are privatised, although these services are also available in the private sector where waiting times are shorter. Diagnostic and laboratory tests are still available free in the public sector.<sup>110</sup>

In British Columbia the provincial government passed Bill 29, legislation which opens collective agreements, rolls back negotiated wage increases, and strips workers of job security rights. The legislation permits whole scale privatisation of ancillary services-housekeeping, dietary, laundry and administration services.

In November 2002, the Romanow Commission reported and recommended that:

- federal funding should increase to 25% of the total cost of Medicare,
- the Canada Health Act should be expanded to cover home care and diagnostic services,
- a new drug formulary and national drug agency be established,
- new mechanisms should be set up to ensure access to healthcare for all citizen and governments to be accountable for healthcare under the Canada Health Act.

However, although the Romanow Commission recommended an expansion of funding for Medicare, it did recommend the privatisation of cleaning, laundry, food preparation and maintenance services because it feels that it is easier to assess the quality of work of these services. Its recommendations on extending the Canada Health Act to cover home care actually only covers palliative care, mental health and post-acute care. It did not recommend coverage for home care services such as “support services” which are essential for older people or people with disabilities to live independently.<sup>111</sup>

In the United States, the impact of privatisation of health services has been felt for much longer. Health services are delivered by the private or non-profit sector and financing is through private insurance. Workplace insurance is in decline with a move towards medical savings accounts. There are now 42 million people without health insurance.

The quality of services has continued to decline and there has been an increase in infection rates and drug resistant bacteria. This is partly due to a lack of health workers. This has led to the growth in use of agency staff, especially nurses. There is a shortage of nurses with nurses being imported from all over the world. Companies providing staff have been floated on the stock exchange. Nurses also feel that working as supply nurses gives them more control over their working lives. However, it has led to less unionisation. Nurse salaries have increased due to their overall shortage of nurses although staff-patient ratios are often low with forced overtime.

Trade unions have tried to negotiate where there are contracts and are currently working on legislation to cover all hospitals.<sup>112</sup>

Recent changes illustrate some of the potential problems that privatised systems face, specifically the dependence of private healthcare companies on government reimbursement schemes. Recent changes to eligibility for Medicare and Medicaid (Balanced Budget Act) have had a major impact on healthcare companies leading to a decline in revenue. It also exposed some of the practices that the companies had established to claim Medicare and Medicaid costs. This had led to several companies filing for bankruptcy. Many of these companies had to sell their international operations. Bankers, involved in refinancing plans, now manage several healthcare companies. Trade unions have had to negotiate wage agreements with the new owners who appear to be more interested in maintaining basic labour standards than the previous owners.<sup>113</sup>

Non-profit hospitals provide a large part of hospital care in the United States. Although technically required to put any profits back into the hospitals, many non-profit directors are generously paid. Many non-profit hospital companies, including religious foundations, are poor employers.<sup>114</sup>

Home care is a growing industry that at the moment is characterised by local and sometimes regional companies in both Canada and the United States. Consolidation of ownership has not yet started.<sup>115</sup>

With a growing older population, more people will be eligible for Medicare (government funded healthcare for people over 65). There are predictions that when the majority of the population are covered by Medicare, this may lead to a public health system being set up.<sup>116</sup>

## 2.5 REGIONAL DEVELOPMENTS - WESTERN EUROPE

All European countries are facing problems with their existing healthcare systems. Expensive high technology treatments, higher public expectations of care and a larger proportion of the population living longer are some of the factors causing existing healthcare systems to feel strained. Vigorous preventive health measures, e.g. tobacco control, physical activity and better nutrition that address health issues for the whole population throughout life would ensure that people lived longer, healthier lives. Old age per se is not linked to increased health costs, but it is diseases and disabilities, often associated with old age, that are costly.

One change over the past decade is the increase in supplementary health insurance. This is used to “top up” care from the public health system. Both mutual and private insurers provide supplementary insurance. The growth of this type of insurance is an indication that people do not feel that they can rely on the public health system to delivery when required, especially for operations.

Growing waiting lists has become an urgent political issue that many governments feel they have to address, e.g. UK, Finland, Norway. In both the UK and Finland, attempts have been made to reduce waiting lists by providing extra resources. Private surgical teams are being set up to provide surgical capacity, with German and Swiss companies offering services.<sup>117</sup>

Although several healthcare systems have experienced some form of healthcare reform in the last decade with the introduction of purchaser/provider arrangements, the public sector has remained the major source of funding for healthcare. The system of fee for services or funding by per capita population has some influence over the total healthcare budget. Fees for services have generally been found to be more expensive although users often feel that the system is accessible and meets their needs.<sup>118</sup> In some countries, e.g. Finland, there are debates about whether vouchers may be a way of funding and providing care for older people. People could purchase services from either public or private companies.<sup>119</sup>

The UK has a contradictory policy towards the public health sector. The UK government has recently announced significant increases of funding by central government to the National Health Service, which is leading to increases in recruitment and education of health workers. However, at the same time, public-private partnerships are being promoted. There is growing evidence that the Private Finance Initiative (PFI) schemes do not represent best value because of high start up costs and high interest rates. Hospitals built through PFI often have a reduced number of beds because of expensive design problems.<sup>120</sup>

Although the contribution of the private sector as providers of healthcare varies from country to country, there has not been a significant move towards privatising the whole healthcare system. The most significant move has been the contracting out of medical and nursing services to the private sector. This is providing opportunities for international private healthcare companies to deliver services within existing public health institutions, for instance BUPA in the UK, Capió in

Nordic countries and UK. This appears one of the most significant changes in recent years.

## 2.6 REGIONAL DEVELOPMENTS – EASTERN / CENTRAL EUROPE

Since 1989, healthcare systems in Eastern and Central Europe have undergone extensive changes, with programmes of health sector reform being introduced with changes in funding and management arrangements. This has led to worsening conditions for health workers and patients in many countries.<sup>121</sup>

### 2.6.1 Health insurance

One of the issues that has emerged in the last decade, are the relative merits of health insurance funds, set up by governments but managed as an agency separate from the government or, health services funded directly from taxation. In several countries, there are arguments that a separate health insurance fund where both employers and employees make contributions, not managed directly by the Ministry of Health, is a more effective way of securing funds for modernising a healthcare system. However some countries have found that with the introduction of a separate health insurance fund, the amount given by the government to the health sector has dropped.

There have been attempts to introduce private health insurance. One of the International Finance Corporation investments that started in Poland was a health insurance company, Medicovert, with integrated occupational health services.<sup>122</sup> In Lithuania, a private health insurance scheme has been introduced as additional to the public health system but there is no alternative private health insurance.<sup>123</sup> In Czech Republic, the situation is similar. Supplementary insurance that pays for additional services in hospital care has been introduced.<sup>124</sup>

Patient charges have been introduced gradually, often for an improved hospital room, TV or telephone. There have also been small payments charged for some services and for drugs.<sup>125</sup> The payments to cover these may be covered by supplementary insurance but may also be covered by informal payments made to the hospital staff.

A recent World Bank report (2002) presents informal payments as a hindrance to health sector reform. Payments made to health workers are considered to draw resources away from the healthcare system because they are given to individuals rather than

institutions and operate as a private unregulated system. The practice is illegal. Poor people are often put off using healthcare facilities.<sup>126</sup> This report shows that the World Bank is becoming aware that informal payments do not contribute to improving healthcare. However there does not seem to be an awareness of why informal payments are demanded or what measures could help to improve working conditions within healthcare systems that would cut the demand for informal payments.

In countries where some form of health insurance has been introduced, there are also separate schemes that operate for poor and uninsured people, including children, people with disabilities and older people. In Lithuania in the period 1998-2001, the amount allocated by the government to each citizen covered by a scheme covering these groups fell from 242 lit per person in 1998 to 183 lit per person. During the same period there were also cuts in hospital services although not primary care.<sup>127</sup>

### 2.6.2 Privatisation

Privatisation has proceeded unevenly and often slowly. Changes in legislation were necessary in many countries even to allow doctors to practice in the private sector.

Hospitals have had new management arrangements introduced, which have made them into separate agencies. In the Czech Republic, several hospitals were privatised in 1993. This has affected the level of salaries of staff, which are 20% lower in the private hospitals than in the state sector. Although clinical services have not been privatised in the Czech Republic, services that operate independently outside a hospital, e.g. dialysis, laboratories and spas, have been privatised.<sup>128</sup>

Some ancillary services have also been contracted out although some contracts have been cancelled. For example, in the Czech Republic catering was contracted out to Sodexo but was later returned to the public sector owing to costs.<sup>129</sup> Although cleaning of common parts of a hospital are contracted out, the cleaning of more specialised wards has remained in the public sector.

Several countries have introduced a system of contracting between different parts of the healthcare systems, e.g. primary care and hospitals. In the Czech Republic, the community or municipality now manages some hospitals.<sup>130</sup>

In countries where separate health insurance funds have been set up, the government often organises tenders for contracts between public health insurance companies and healthcare providers. This process is often characterised by low transparency, corruption and too many providers. There has been some open tendering for healthcare equipment in Lithuania.<sup>131</sup>

In the Czech Republic, there has been an increase in the number of casual and self-employed workers in the health sector, affecting both men and women but especially women. Many self-employed are involved in the trading of pharmaceuticals and medical equipment. Although trade union rights remain the same, it is more difficult to put them into practice. Trade union organisation has become worse since privatisation. Training and further education has improved in larger hospitals but become worse in smaller hospitals. Pensions and housing benefits remain the same but healthcare and travel benefits have worsened. "Promotion opportunities remain equally bad after privatisation. Before one had to be a member of the Communist Party, now it depends and is even more unpredictable".<sup>132</sup>

In Bulgaria, the privatisation of secondary care will be voted on in Parliament in November 2002. Teaching hospitals have been exempted from privatisation. The under-funding of the public health system has led to longer waiting times. This has led people to use the small private health sector.<sup>133</sup>

Privatisation had had an impact on other aspects of employment. Health and safety and pay are now the two main concerns of trade unions. Job security has decreased in parts of the healthcare sector that are insufficiently funded. Grading of posts has worsened because there are no objective criteria for evaluation.<sup>134</sup>

### 2.6.3 Multinational companies

Although multinational companies such as Rentokil-Initial and ISS have contracts in some countries, e.g. Czech Republic and Poland, there is no extensive multi-national presence in the healthcare sector especially in relation to direct provision of healthcare. There have been examples of contracts being cancelled.

However the development of diagnostic and laboratory testing with high technology equipment is beginning to provide more opportunities for private sector companies. Capio, a Swedish company, took over the

management of a laboratory of a public hospital in Warsaw in 2001 and views Central and Eastern Europe as a potential market.<sup>135</sup> Swedish companies have played a role in setting up and financing new healthcare developments.

The Multi-lateral Investment Guarantee Agency (MIGA) has made one investment in Bosnia, a guarantee loan, for a dialysis centre in partnership with International Dialysis Centers BV, a Dutch company. An IFC investment in Euromedic supports this trend in developing diagnostic centres with high technology equipment to diagnose and treat non-communicable diseases, e.g. renal care, in Hungary, Poland and Bosnia.<sup>136 137</sup>

### 2.6.4 Drugs and prescribing

In the Czech Republic, there has been a liberalisation of prescribing. The costs for drugs form 30% of health insurance. There has also been a liberalisation of import restrictions. Foreign drugs undergo only a basic registration process. The price of one drug from every key group is fully paid by the health insurance scheme and these prices are further regulated. However, the prices of drugs not covered by the health insurance schemes have been liberalised. Production and distribution of drugs and pharmacies have also been liberalised. In the Czech Republic, there have been disputes over the TRIPS Agreement. There are only a limited number of generic producers of drugs and this is expected to lead to increased drug costs.<sup>138</sup>

There has been some liberalisation of prescribing in Lithuania, with privatisation of state pharmaceutical manufacturing. As yet no restrictions have been placed on generic drugs. However there have been some disputes about the legality of generic drugs. This has led to increased drug costs, which has put pressure on the state budget for drugs. This has led to financial pressures elsewhere in the healthcare system. Hospitals have remained in debt and some nurses and doctors have not been paid.<sup>139</sup>

The decline in the % of GDP has been the main factor in influencing government decisions towards healthcare restructuring and privatisation. In Lithuania it has fallen from 4.83% in 1998 to 4.3% in 2001. The reasons presented included: problems with healthcare finance; healthcare delivery problems; public health dissatisfaction with the healthcare systems; national economic policies, as well as policies on labour and trade unions. National companies, but not multinational companies, were involved in lobbying for changes.<sup>140</sup>

## 3. GLOBAL PLAYERS

### 3.1 GLOBAL HEALTHCARE INDUSTRY

As some of the regional profiles will have indicated, the influence and growth of multinational healthcare companies is uneven. There are four main types of activity:

- Health insurance
- Health services/healthcare
- Laboratory and diagnostic services
- Support services/facilities management

There is some diversity of ownership, with several European companies playing a strong role. Although there are still a few US companies active in global healthcare services, they are a minority and do not appear to be expanding. More expansion is taking place in laboratory and diagnostic services, with both US and European companies active. Companies that have been involved in support services/facilities management, often in several sectors, are refining their services into more integrated packages of management and support services. More specific profiles of multi-national healthcare companies follow in Section 4.

An account of the links between venture capital, private equity investors and multinational healthcare companies in developing countries and countries in transition can be found in the PSIRU Paper on Private Health Investment – March 2002.

### 3.2 INTERNATIONAL FINANCIAL INSTITUTIONS – IMF/WB /IFC /MIGA

The influence of the International Financial Institutions on health and healthcare is extensive. There are two main types of policy influence in the health sector.

1. Policies relating to structural adjustment, economic growth, debt, trade, public sector reform, private sector development that influence the public sector and labour rights
2. Policies that are specifically targeted at influencing parts of the healthcare sector, e.g private sector investment, health sector reform programmes that influence accessibility to healthcare and the types of healthcare available.

These policies have led to the weakening of health services, labour rights and the public sector more widely.

Two policies which are currently being promoted which will also affect health and healthcare systems are the World Bank Private Sector Development (PSD) Strategy and Poverty Reduction Strategy

Programmes (PRSPs). The Private Sector Development Strategy is discussed at length in two PSIRU papers.<sup>141</sup>

Poverty Reduction Strategy Programmes (PRSPs) are being developed by individual countries as a condition for debt relief and any further loans from the World Bank. PRSPs are managed by the World Bank. A report by the Overseas Development Institute saw the development of PRSPs as providing some hope for changes in policies. PRSPs are usually the responsibility of the finance ministry, traditionally the most powerful government department. This is considered a way of making the wider government more aware of the need to address poverty. However there have been some difficulties encountered in the development of these plans. “Systems to collect data to monitor poverty reduction are crude, government policies fragmented and public servants demoralised”.<sup>142</sup> Civil society has not been involved in the negotiations as much as expected. There are also no signs that the World Bank has started make links between the impact of its economic policies and PRSPs.

There are some signs that policies to promote privatisation, user fees, and decentralisation are being reconsidered within the World Bank, although not necessarily discarded. At a recent meeting at the World Bank, concerns about some of the failures of privatisation were expressed.<sup>143</sup>

In 1998, a paper on “Rethinking Decentralisation in Developing Countries”, written as part of an internal review process at the World Bank, indicated that there had been an underestimation of the capacity of institutions operating at local level in developing countries. This had affected the results of decentralisation strategies.<sup>144</sup>

A recent internal healthcare strategy from the International Finance Corporation admits that introducing private health insurance to systems where there is universal coverage has not been very successful. “Health reforms to promote the role of the private sector financing in countries with universal risk pooling (through national health insurance schemes) have had mixed outcomes, at best”.<sup>145 146</sup>

It is important to monitor the existence of uncertainty in these institutions because they have such a strong influence on health policies. The continuing documentation of the policy failures of the International Financial Institutions are also important to publicise and use for lobbying.

The PSIRU paper, Private Finance Investment (March 2002), covers the impact of IFC and MIGA on the development of healthcare. A Policy Briefing by Jane Lethbridge on the International Finance Corporation Healthcare strategy will appear in issue 2. of Global Social Policy

### 3.3 WORLD HEALTH ORGANIZATION WHO

Although the World Health Organisation (WHO) is the major international public health agency, its influence on health and healthcare has been less significant than that of the World Bank for the past 20 years. As essentially an advisory agency with no significant funds to fund large scale programmes, the organisation is limited in its impact.

Five years ago, Dr Gro Harlem Brundtland was appointed Secretary-General and there were high expectations that WHO could regain some of its credibility. After taking up post, Brundtland made a series of senior appointments that showed that the influence of the Harvard School of Public Health would be significant. Academics in this School had been attempting to predict the future burden of disease in the next 20-30 years, the health transition model and the concept of Disability Adjusted Life Years (DALYs). This illustrates the influence of academic institutions on international organisations and their policies.

WHO's attempts to build relationships with civil society organisations during the past 5 years have been uneven. Its attempts to build partnerships with the private sector have been criticised by many health practitioners (see Trends section – public-private partnerships). However, there have been some campaigns such as the Global Alliances on Vaccine Initiative (GAVI), Roll Back Malaria, Tobacco Free Initiative which have raised WHO's profile. It is also developing a programme on human resources in health, which is looking at international health worker migration.

Perhaps one of the most significant recent developments was the setting up of a Commission on Macroeconomics and Health to examine the evidence linking economic growth and health. Chaired by Professor Jeffrey Sachs, Harvard Department of International Development, the Commission produced a series of reports in December 2001.<sup>147</sup> Although much criticised because of a strong economic focus on the evidence reviewed, the Commission may still be a significant step in strengthening the policy debates about how health and economic development are mutually dependent.

### 3.4 BI-LATERAL AGENCIES

Health sector development in developing countries is strongly influenced by the policies of bi-lateral and multi-lateral agencies. Donor contributions to public health expenditure are relatively high, for example 53% Tanzania, 58% Uganda, 79% Mozambique (Foster et al, 2000). The major bi-lateral donors are the Department of International Development (UK), and the International Development Assistance agencies of Denmark, Sweden, Finland and Canada. Changes in domestic governments can lead to changes in international development policies. Denmark is currently reviewing what used to be an extensive programme.

Currently, poverty elimination policies dominate the approach of bi-lateral donors. The focus on poverty elimination has resulted in rethinking approaches to health sector development. There is a greater emphasis on how to target poor people and increase their access to services. However, structural adjustment programmes that have promoted user fees have often led to poor people using government health services less. There are still some contradictions between the policies of international financial institutions and bi-lateral donors.

The emphasis on poverty elimination has also influenced health reform programmes, moving from financial and public sector reform to the development of partnerships and the involvement of users and the community. It is also trying to address poverty and health within a reform process.

### 3.5 INTERNATIONAL NON-GOVERNMENTAL ORGANISATIONS (NGOS)

International non-governmental organisations are increasingly playing three major roles as providers of health services, donors and advocates in international health. Many international NGOs have evolved from working on disaster and relief programmes or child sponsorship schemes to promoting and funding wider development policies. Major international donors include Save the Children, Oxfam, CARE, Tear Fund, Plan International, International Relief Committee (IRC) and Medicins Sans Frontiers (MSF).

Some international NGOs are playing a significant role in running health services in regions of conflict. International NGOs often recruit local staff to deliver services. For example, CARE, in East Timor, recruits workers to work on a daily basis without any union rights or job security. How these services will be handed over in

future will be an important feature of their success. It is unclear what that approach they take towards trade unions.

NGOs have expanded their role as advocates. Campaigns have covered debt reduction, child labour, terms of trade, GATS and TRIPS. The position of international NGOs, mainly based in developed countries, in relation to issues such as debt reduction and child labour, is often complex. There are some criticisms of NGOs based in developed countries, because of their lack of a base of support in their own countries. The alliance that some NGOs developed with the World Bank in order to lobby for debt reduction and poverty reduction strategy programmes (PRSPs), has been criticised by developing countries because too much control was given to the World Bank in managing the PRSPs.<sup>148</sup>

NGOs are beginning to identify trade unions as potential partners or members of broader alliances. In campaigns against privatisation, the interests of trade unions and NGOs have often brought together the users of services with public sector workers.

## 4. MULTINATIONAL COMPANIES INVOLVED IN THE HEALTH SECTOR

The companies covered in the following section provide:

- Insurance – ING/Aetna, Cigna
- Healthcare services – Afrox, Capio, Générale de Santé, HCA, Parkway Holdings, United Health
- Diagnostic and laboratory services – Quest Diagnostics, Unilabs, Euromedic
- Support/facilities management services – Compass, ISS, Rentokil-Initial, Sodexo
- Vertically integrated services – Adeslas, BUPA, Medcover, Fresenius

### 4.1 INSURANCE

#### 4.1.1 ING/Aetna

Aetna International, a US insurance company with an international division, was taken over by ING, a global provider of financial services in 2000. ING deals with banking, insurance and asset management in 65 countries worldwide. ING provides life insurance and pension products as well as insurance for health, accident

and disability in several of its core markets in Europe, Asia and the Americas.

Aetna Financial and International services are being integrated into ING Europe, ING Americas, and ING Asia/Pacific. ING Europe is seen as ING's most important region. It is active in the Netherlands, Belgium, Luxembourg, Germany, France, Switzerland, UK, Italy, Spain and Greece and the Czech Republic, Poland, and Hungary.

With a strong base in the Netherlands and Belgium, ING Europe plans to expand further. It sees European social security systems as weak due to increased costs and an ageing population, which will provide new opportunities for insurance providers (ING Annual Report, 2001).<sup>149</sup>

#### 4.1.2 Cigna

CIGNA International is part of CIGNA Corporation and offers life, health and employee benefits.

The healthcare insurance products cover government-approved medical benefits and offer an alternative or supplement to governmental programmes. Healthcare includes life and medical insurance products that are provided through group benefit programmes as well as medical insurance products marketed directly to individuals, including managed care. Supplementary insurance products cover accidental death, medical, hospitalisation and income protection. Health products are distributed through independent brokers and agents as well as CIGNA corporation outlets.<sup>150</sup>

CIGNA's annual financial report (SEC, 2001) said, "CIGNA intends to pursue international growth through acquisitions, joint ventures and other investments".

### 4.2 HEALTHCARE SERVICES

#### 4.2.1 Afrox

Afrox Healthcare Limited is southern Africa's leading provider of private healthcare. The company is listed as AHealth in the healthcare sector on the Johannesburg Stock Exchange. It was formed in 1999 when the healthcare interests of African Oxygen Limited (Afrox) was merged and reverse listed into President Medical Investments Limited (PresMed). Afrox, one of South Africa's top 100 companies, is the majority shareholder. Afrox Healthcare competes in both the managed care and fee for service markets, offering some 7 300 private beds to patients in South Africa, Botswana and Zimbabwe.

Afrox operates and has interests in 73 acute care hospitals and some surgical centres with over 7000 hospital beds. It also manages 24 Lifecare hospitals with over 10,000 beds on behalf of African Oxygen Ltd which is 50% of the long term chronic care market. There has been a general expansion of facilities, e.g. ER24 emergency response and medical care services network which is now the most comprehensive emergency trauma network in South Africa. Aprox Occupational healthcare has expanded its patient base from 8,500 to 100,000. It has also acquired Lifehealth, a specialist in long term care for the chronically ill, frail and elderly patients and has 24 hospitals with 10,000 beds

Projects underway include a second hospital in Botswana, the doubling in size of Suikerbosrand Clinic in Heidelberg, a neurological unit at Wilgeheuwel, the expansion of the Bedford Gardens Hospital and the rollout of rehabilitation units into key geographic areas.

The group's healthcare services operations were strengthened by Direct Medicines' acquisition of Home Medication Services (HMS), a chronic medication management company with annual sales of R150 million. In addition, the primary and occupational healthcare company, Aprox, won several major contracts, including one to provide healthcare services to 3 000 inmates at the new Grootvlei maximum security prison which will be opened next year.<sup>151</sup> (Source Aprox.com/healthcare website)

#### 4.2.2 Capiro

Another example of Swedish financial investment in healthcare is Capiro, floated as an independent company on the Swedish stock exchange in late 2000. Previously called Bure healthcare, it was owned by financial investment group Bure.

Capiro AB's principal activity is the provision of healthcare services in Scandinavia and other European countries.

The Company operates through the following divisions:

- Healthcare services: hospitals, outpatient healthcare and psychiatry;
- Diagnostic services: provision of laboratory and radiology services;
- Elderly care services: care services for the elderly.

These are three significant areas in healthcare where private sector/multinational providers are expanding.

Healthcare accounted for 73% of 2000 sales; diagnostic services, 19% and elderly care services, 8%. Capiro Diagnostics is the leading radiology operator in the Nordic countries.

Capiro is currently operating in Sweden, Norway, Denmark, the UK, Switzerland and Poland with an annual turnover of more than SEK 3,300 million. With the acquisition of the Community Hospitals Group in the UK (now Capiro UK division), Capiro's operations outside Sweden now generate more sales than operations within Sweden (Capiro, Annual Report, 2001). Capiro is also becoming a leader in the fields of laboratory medicine and ophthalmic care.

Customers are county councils, municipalities and businesses, as well as public and private insurance companies that buy healthcare services. Capiro's hospitals and other care units in Sweden are under contract to public authorities. Healthcare is provided on equal terms, with the same patient fees and priority rules as within public healthcare.

Annually, Capiro carries out 2 million physician consultations, 8 million laboratory analyses and 500,000 X-rays.

The Capiro Group comprises some 150 operating units with 10,000 employees, of which 2,000 are physicians.

Capiro sees the public/private healthcare relationship as a significant factor in the future growth of the private healthcare sector. It has identified a growing role for the private sector in delivering services to the public health sector in Nordic countries and the UK. Capiro is aware of some national differences, e.g. between UK and Germany, in the different role of the private healthcare sector and is ready to take up opportunities as they arise (Capiro Annual Report, 2001).<sup>152</sup>

Capiro's recent acquisitions include: radiotherapy units in Norway and Finland, older people's homes/facilities/care in Sweden and the UK Community Hospitals Group.

#### 4.2.3 Générale de santé

Set up in 1987, Générale de Santé is a leading French healthcare company that runs hospitals and clinics in France, Italy, Portugal and Canada. It was floated on the French stock exchange in June 2001. The company has 15,000 workers and over 3,800 independent private doctors. It owns a total of 168 clinics: 149 clinics are in France providing 17,269 hospital beds. It has 10% of the French private healthcare market.<sup>153</sup>

In 2001, there was a shortage of nurses in France. Générale de Santé had to increase wages and increase recruitment and training programmes. As a result, there has been a reduction in the shortage of nurses. In April 2002, it only had a 5% nursing shortage. It feels that the salary increases put it in a competitive position in relation to both the private and public health sectors in France.<sup>154</sup> It has also developed several partnerships arrangements with public hospitals in France.

Although Générale de Santé owns three clinics/hospitals in Italy and operates an obstetric hospital and manages a hospital in Fonseca, it has recently sold 19 clinics in Italy and Portugal.<sup>155</sup>

In Canada, operating as Générale des Services Santé, it runs six clinics, 10 long stay homes, and home care and hospital hotel services. Through its Canadian subsidiary, it has invested in healthcare in Venezuela and Chile.

Générale de Santé recently acquired 9 new clinics in France in 2001. In April 2002, it sold the buildings of the Jean-Mermoz private hospital in Lyon, which are currently under construction, to Mutavie, a subsidiary of the French insurance company Macif. "The sale of the buildings and grounds reflects Générale de Santé's strategy of focusing financial resources on the core healthcare business, enabling the Group to have funds to finance its planned growth by acquisition".<sup>156</sup>

#### 4.2.4 HCA

In 2001, HCA owned and operated 184 hospitals (172 general, acute care, 6 psychiatric hospitals and 6 hospitals included in joint ventures) and 79 freestanding surgery centres. These were located in 24 states of the US, England (6 hospitals) and Switzerland (2 hospitals).

In July 1997 Federal investigation into business practices and the company made changes to executive management and plan to restructure to make a more focused company. Since 1997 it has reduced the numbers of hospitals by 42% (144) and the number of surgical centres by 48% (71). It sold most of its home health operations and non-core assets. It also spun off LifePoint Hospital and Triad Hospital to create 2 public traded companies, which operate 57 hospitals. In December 2000 HCA completed the sale of 116 medical office building to MedCap Properties.

In May 2000 Columbia/HCA changed its name to HCA – The Healthcare Company and in 2001 it changed to HCA Inc.

HCA continues to be the subject of government investigations and litigation in relation to business practices – in relation to Medicare and Medicaid. In December 2000 HCA entered into a Corporate Integrity Agreement with OTG – structured to assure the federal government of compliance with Medicare. In March 2002 it came to an agreement with the Center for Medicare and Medicaid Services subject to agreement with Department of Justice. HCA is still subject to litigation taken out by patients and shareholders.<sup>157</sup>

#### 4.2.5 Parkway Holdings

Parkway Holdings Limited owns and operates private hospitals, and provides healthcare services. It incorporates the Gleneagles chain of hospitals. It also owns and manages medical clinics and radiology clinics; deals in medical supplies, equipment and healthcare products; practice dental surgeons and operates dental clinics; provides clinical research centres; provides comprehensive diagnostic laboratory services; and investment holding and trading. Parkway Holdings Ltd operates hospitals in Singapore, Malaysia, Indonesia, Sri Lanka, India and, until August 2001, in the UK.

The Group's healthcare business is owned and managed by the wholly owned subsidiary Parkway Group Healthcare Pte Ltd. The Group's healthcare network includes Shenton Medical Group, one of Singapore's biggest general practices; Sesdaq-listed Medi-Rad Associates Ltd, a leading radiology service company in the region; and Sesdaq-listed Parkway Laboratory Services Ltd, a major provider of laboratory services regionally. These last two subsidiaries were being privatised April 2002 – two years after acquisition.

The Group also provides contract research services through subsidiary Gleneagles Clinical Research Centre Pte Ltd, which serves the research needs of physicians, multinational pharmaceutical companies, contract research firms and biotechnology companies in Asia.

Parkway Holdings Limited has made acquisitions during each of the three previous years. The company acquired 70% of Pulau Pinang Clinic Sdn Bhd in 2000. This followed acquisition of the remaining interest in Westfront Pte Ltd. and Shenton Family Medical Clinics Pte Ltd. in 1999. It purchased Cavendish Clinic Ltd. in 1998. In 2002 it is trying to expand its GP networks.<sup>158</sup>

In August 2001, The Heart Hospital, London was sold by Parkway Holdings to the Department of Health for £29m (£27.5m assets and £2m receivables). The hospital had been making losses of between £10-20

million per year and Parkway Holdings (65% stock owner) took all the losses. In March 2001, Parkway Holdings had been in negotiations to sell equipment and to sub-lease certain assets (including land) of the Heart Hospital to HCA. In May 2001, the Office of Fair Trading (OFT) (UK) was asked to review the deal. Commercial rivals of HCA felt that if the deal went through, HCA would dominate the London private hospital bed market. In July 2001, the Office of Fair Trading ruled that the HCA-Parkways Holdings deal would have to be referred to the Competition Commission. The sale of the hospital to the Department of Health/University College Hospital was announced on 8 August 2001.<sup>159</sup>

Although a member of the Apollo Group (India) has been a member of the Parkway Board since 2000, the expected link up/partnership has not happened. Government hospitals are proving to be challenging competitors in Singapore.

#### 4.2.6 UnitedHealth

UnitedHealth Group Incorporated provides healthcare coverage and related services to healthcare purchasers and providers throughout the United States. The Company also provides specialty managed care products and services to employers, employee groups, insurers, health maintenance organization operators and other healthcare providers.

Set up in 1974, Charter Med Incorporated was founded by a group of physicians and other healthcare professionals. In 1977 United HealthCare Corporation was created and acquired Charter Med Incorporated. In 1998, United HealthCare Corporation became known as UnitedHealth Group. UnitedHealth restructured in 1998 after its plan to buy rival Humana Inc. collapsed. It set up five business divisions: UnitedHealthcare, Ovations, Uniprise, Specialized Care Services and Ingenix. The company in 1999 became the first health maintenance organization to stop requiring patients to get medical care authorised before seeing a doctor, gaining it some advantage in the HMO market. UnitedHealth has recently focused on self-funded customers at big employers and mid-sized firms.

The Company operates :

1. UnitedHealthcare—providing healthcare services and coordinating network-based health and well-being services on behalf of local employers. This includes UnitedHealthcare International, a division of UnitedHealth Group. UnitedHealthcare Inter-

national has created health plan administration companies around the world to manage local healthcare services. It also provides access to international insurers and funds for travellers and visitors to the U.S., temporary residents, and those visiting the U.S. for medical treatment.

2. Ovations—provides health and well being needs of people over 50
3. Uniprise meets the needs of employees and families at more than one-fourth of the Fortune 500 companies.
4. Specialised Care Services include several businesses covering substance abuse, health information, transplant care, dental care, optical services, and insurance.
5. Ingenix - Integrated Pharmaceutical Services provides the pharmaceutical and biotech industries with global drug development and marketing services

Unitedhealth Group also has a venture capital division, United Health Capital that invests in early-stage health services and technology companies.<sup>160</sup>

### 4.3 DIAGNOSTIC AND LABORATORY SERVICES

#### 4.3.1 Quest Diagnostics

Quest Diagnostics is a laboratory testing business that provides diagnostic tests to patients, doctors and healthcare institutions through a network of laboratories. Quest provides routine tests – blood cholesterol, pap smears, HIV tests, pregnancy, alcohol and other substance-abuse tests. It also provides esoteric tests, which cover less frequent tests for endocrinology, genetics, immunology, microbiology, and oncology. Quest Diagnostics manufactures diagnostic test kits for esoteric testing. The company also runs two clinical trials testing centres in the US and the UK as well working in partnership with two centres in Australia and South Africa.

Quest owns one of the largest privately owned clinical laboratories in the UK, which was developed in partnership with an NHS trust/hospital. In Mexico, Quest owns three laboratories and provides testing services throughout Mexico. There is also a centre in Brazil and Quest is aiming to set up additional laboratory services in Brazil. Quest also provides esoteric testing services to the Nichols Institute, involved in clinical trials, which operate worldwide.<sup>161</sup>

Quest Diagnostics employed 29,000 people in 2001, the majority in the United States.

Quest took over SmithKline Beecham Clinical Laboratories, the laboratory business of SmithKline Beecham in 2000. In the past year it has acquired American Medical Laboratories, and Unilabs (California). It has also recently established an alliance with Roche Diagnostics to develop gene-based medical testing (Quest Diagnostics SEC, 2001). Within the UK, Quest was involved in negotiations for a cross district laboratory centre in Manchester, in 2001 which, although unsuccessful, was indicative of interest in the new laboratory structures in the NHS (Health Service Journal, 22 March 2001).<sup>162</sup>

These recent acquisitions and alliances show the shared interests between the laboratory divisions of pharmaceutical companies and diagnostic testing businesses. The growing demand for esoteric tests, including gene testing, provides opportunities for expansion. These are expensive tests to provide requiring high technology equipment and staff.

#### 4.3.2 Unilabs

Unilabs SA is a specialist provider of clinical laboratory tests prescribed by physicians, public or private hospitals and other clinical testing laboratories, based in Switzerland and operating in France, Spain, Italy, Russia,

Since 2000, Unilabs has acquired several laboratories in France and Spain. In France, it has acquired several regional laboratory-testing companies. In Spain, its laboratories have exclusive contracts with leading Spanish health funds to provide specialised laboratory tests to a large Madrid teaching hospital, the Fundacion Jimenez Diaz. Unilabs recently set up a partnership with the Fundacion Jimenez Diaz. It has also signed contracts for medical analysis services with two Spanish hospital groups, one in Madrid (Hospital Oftalmologico Internacional) and the other in the south of the country (Jerez Andalucia).<sup>163</sup>

#### 4.3.3 Euromedic

Euromedic Diagnostics BV and International Dialysis Centre BV are both 100% owned Dutch subsidiaries of Euromedic International NV, a holding company of the group (www.euromedic-group.com).<sup>164</sup> Euromedic operates diagnostic imaging centres in Hungary and Poland and haemodialysis centres in Poland and Bosnia. In Hungary, it has 7 private diagnostic imaging centres seeing 20,000 patients per month. 100-150 staff, mainly

doctors, are employed in Hungary. In Poland, Euromedic has 3 diagnostic imaging centres and 3 haemodialysis centre seeing 2,500 patients per month. In Bosnia, it has one haemodialysis centre which sees 230 patients per month (www.ifc.org).<sup>165</sup>

Euromedic has also received a \$13 million loan from the International Finance Corporation to fund a \$33 million expansion programme in Central and Eastern Europe. Other shareholders include GE Equity – the private equity arm of GE Capital - Dresdner Kleinwort Benson private equity fund, Global Environment Fund, RPM Partners, a Dutch private investment company and private investors led by Euromedic's management. One of the non-executive Directors of Euromedic (Janusz Heath) is the head of Central and Eastern European Private Equity Dresdner Kleinwert Benson.<sup>166</sup>

### 4.4 SUPPORT / FACILITIES MANAGEMENT

#### 4.4.1 Compass

Compass Group is the world's second-largest food service company (behind Sodexo Alliance), with operations in more than 70 countries. It provides contract catering and concession services at airports, hospitals, rest areas, and schools. Compass also operates some 5,000 restaurants such as Upper Crust and Ritazza, and franchises a number of Burger King and TGI Friday outlets. The company also provides corporate food services for clients like France Telecom, Ford, and IBM.

In 2000 Compass merged with UK hospitality giant Granada Group. But the new Granada Compass decided to demerge in 2001, making Compass Group public again. Compass then sold the leftover Le Méridien hotel chain to Japanese investment firm Nomura International.

In April 2001 Compass acquired Morrison Management Specialist Inc – second largest US healthcare food services company. In August 2001, Compass acquired Crothall Services Group, which provides housekeeping, portering, and laundry services in the healthcare sector, in the USA. Both these acquisitions strengthen the position of Compass in the healthcare market.<sup>167</sup>

#### 4.4.2 ISS

International Service Systems ISS is a Danish company providing facilities services including cleaning, catering, and services for hospitals and older people's care homes. It works in a range of sectors and operates through the following divisions:

- Cleaning and maintenance - office cleaning for private and public sectors
- Services for the health sector - targeted at hospitals and other institutions within the health sector
- Services for the food industry
- Services for airports

Other business areas include: Canteen/catering services; energy/industrial high tech services; property services; care services; and after-damage service.

International Service Systems ISS A/S currently has 259,739 employees worldwide (ISS Annual report, 2001).<sup>168</sup>

Facility services represent 87% of sales in 2000/1. Hospital services contribute 14% of sales. Over 80% of hospital sales take place in Europe. ISS hospital services are distributed within Europe as follow: Germany 30%, UK 29%, Netherlands 6%, Central Europe 5%, Denmark 5%, Switzerland 5%, France 4%, Sweden 4%, Belgium 3%, others 9%. (% of ISS hospital services business).

**Create 2005** is a new 5 year vision launched in November 2000. It develops service concepts from multi-services to facility services which is leading to integrated facility services. Separate business areas are being managed across country borders. The development of the facilities services package is most developed in the UK. Specialisation of cleaning concepts is most developed in Germany.<sup>169</sup> ISS has also lost several contracts with the public sector in Denmark due to poor standards of delivery.<sup>170</sup>

ISS has made a large number of acquisitions in the last few years. In the health sector, it has acquired a number of older people's facilities and medical facilities but in some cases it has also divested itself of recent acquisitions in the healthcare sector. The CarePartner division, which delivers medical facilities and older people's care in Denmark, Sweden, Norway and Finland (ISS Annual report, 2001), is being reviewed in 2002 which suggests that ISS's overall role in healthcare provision is still unclear.

#### 4.4.3 Sodexho

Sodexho is a French company which, like ISS, delivers services – cleaning, catering - to a range of sectors including the healthcare sector. It provides a range of services (often described as multi-service) to hospitals and to older people's care homes. These services may include catering, cleaning, housekeeping, building maintenance and management of paramedical

staff. Services delivered within the healthcare sector provide 18% of revenue (Sodexho Annual Report, 2001).

Sodexho has a total of 313,469 employees worldwide with 45% of employees in Europe.

In Europe, Sodexho has contracts with the healthcare sector in Belgium, Finland, France, Germany, Hungary, Italy, Luxembourg, Netherlands, Spain, Sweden, and the UK. It also has contracts with older people's care providers in Austria, Belgium, Finland, France, Germany, Italy, Luxembourg, Netherlands, Spain, Sweden, and UK (Sodexho Annual Report, 2001).<sup>171</sup>

Sodexho sees opportunities in global multi-site, multi-service contracts. It is developing partnerships with public and private sector organisations in order to deliver services. In the health sector in the UK, Sodexho has been involved in several Private Finance Initiatives involving hospital building and management. It has recently been criticised strongly for poor standards of cleanliness at Glasgow Royal Infirmary.<sup>172</sup>

#### 4.4.4 Rentokil-Initial

Rentokil Initial is a global business company in the support services sector.

Working in over 40 countries, Rentokil-Initial provides services in hygiene, personnel, pest control, property, security, and transport. Rentokil is the brand for the company's industrial cleaning, landscaping, pest control, and property care services. The Initial name is used with its catering, electronic surveillance, medical staffing and hospital cleaning services, as well as resort management, and textile services.<sup>173</sup>

The business is structured into two services areas: Focus and Bundling.

Focus deals with Hygiene, Security, Pest Control, Tropical Plants, Conferencing and Parcels delivery. Bundling is the Facilities Management activity, offering multi-service packages to large companies.

Rentokil-Initial works in over 40 countries in Europe, North America, Asia-Pacific and Africa.

#### 4.5 VERTICALLY INTEGRATED SERVICES

This section features three companies that are considered integrated by operating both health insurance and healthcare delivery services: Adeslas, BUPA and Medico. A fourth company, Fresenius, delivers integrated kidney care. It produces equipment and fluids for kidney dialysis and run clinics for dialysis patients, using its own products.

#### 4.5.1 Adeslas

Adeslas is a Spanish healthcare company operating both extensive health insurance and healthcare services. It specialised in the production, management and distribution of health insurance policies. It has about 1.5 million members with 25% of the Spanish health insurance market. It directly manages 11 clinics and hospitals with over 1000 beds.<sup>174</sup> Adeslas took over the management of Ribera Public Hospital in Valencia in 1998. This was an initial attempt by the regional government to privatise public hospitals. There have been reductions in staff and in the quality of service since Adeslas started to manage the hospital.<sup>175</sup>

Aguas de Barcelona, the water and waste management company own Adeslas.

In 2000, operating as a Spanish holding company BBV Adeslas Salud, Adeslas has in partnership with Spanish holding company BBVA Banco Frances bought two clinics, Santa Isabel and Azterrica and set up a new healthcare service, Euromedica with more than 800 employees. The two clinics will be refurbished for 22 million dollars. Euromedica was the result of a merger of three medical centres in Buenos Aires – OMAJA, Clinics Santa Isabel and Bazterrica. Adeslas already owns clinics in Argentina.<sup>176</sup>

#### 4.5.2 BUPA

BUPA (British United Provident Association Ltd) is an international health and care specialist. Established in the United Kingdom in 1947, it provides worldwide health insurance and care services to nearly four million people and 40,000 companies, with members in over 180 countries around the world. It has offices in Ireland, Hong Kong, Saudi Arabia, Spain, Thailand, Singapore, Malaysia, and Australia. BUPA is a provident association with no shareholders. Any profits are reinvested back into the company.

In Hong Kong, BUPA Hong Kong has provided a range of health insurance schemes since 1976, providing insurance for over 145,000 people and over 1,500 companies. BUPA Middle East, established in 1997, is a joint venture partnership between BUPA International and the Nazer Group, a leading Saudi Arabian company with interests in the healthcare, computing, retail and electromechanical engineering fields. BUPA Middle East has established its network of over 190 hospitals and clinics with direct billing arrangements, to help give members maximum flexibility and coverage in all areas of the country. In Spain, BUPA owns the Spanish

healthcare organisation Sanitas. In Thailand, Blue Cross joined with BUPA in 1996 to form BUPA Blue Cross, the largest health insurer in Thailand. In 2001, BUPA recently completed a deal to buy primary healthcare businesses in Australia, Malaysia, Hong Kong and Singapore.<sup>177</sup>

BUPA is the leading UK private healthcare insurer with a growing interest in hospitals, nursing and retirement homes, and children's day care facilities. With an estimated 40% of the private health insurance market in the UK, the company covers nearly 4 million people in the UK. In the UK it also has nearly 40 hospitals, more than 30 health screening centres, and some 230 retirement and care homes. It also entered the childcare market with Children@work, providing day care services to employers and nanny placement services to individuals.

In December 2001, the UK Department of Health announced that NHS would be using a BUPA hospital solely for NHS surgical patients. Under the arrangement, an NHS Trust at Redhill in Surrey is to use Bupa's neighbouring Redwood Hospital as a fast-track surgery centre for NHS patients. The deal was announced in December - the first time the private sector will have run and managed a unit entirely for NHS patients using a mix of NHS and BUPA staff. By April 2002, no price or contract had been agreed.<sup>178</sup>

#### 4.5.3 Medicover

Oresa Ventures, a Swedish venture capital company, established Medicover in 1995. The company offers both medical insurance and a healthcare delivery system, to its clients. Medicover employs most of its physicians directly and provides healthcare through its own facilities. In 2001, it has 66,000 pre-paid members in Poland, 7,000 in Romania, 1,700 in Hungary and 300 in Estonia. It provides health insurance for corporations and individuals, healthcare services through 20 Health Centres staffed by its own doctors and nurses and on-site workplace facilities for large employers.

Although originally a project supported by venture capital company Oresa Ventures, Medicover has become so successful that Oresa Ventures ceased to invest in new initiatives. ORESA Ventures' other holdings are being divested. As a result of the new focus, ORESA Ventures' name changed to Medicover and it become an operating healthcare company ([www.oresaventures.com](http://www.oresaventures.com)).<sup>179</sup> It has received a loan of \$7 million from the International Finance Corporation (out of a budget of \$22million).<sup>180</sup>

#### 4.5.4 Fresenius

Fresenius is an integrated kidney care company. It provides kidney dialysis equipment, products and services through four divisions: Fresenius Medical Care, Fresenius Kabi, Fresenius ProServe, and Fresenius HemoCare.

- **Fresenius Medical Care:** – products and services for individuals with chronic kidney failure, with some 1,300 dialysis clinics worldwide
- **Fresenius Kabi:** - a provider of products for nutrition and infusion therapy and outpatient medical care
- **Fresenius ProServe:** - management services such as project development, consulting, and staff training to hospitals and other health facilities
- **Fresenius HemoCare:** focuses on blood treatment and infusion technology

Fresenius AG has operations in Asia, Europe, Latin America, and North America. North America and Europe are the main focus of sales with 57% and 32% respectively. South America and Asia-Pacific account for 5% and 6% of sales.

The company employed 49,974 staff in 2000 with 52% of the labour force in North America and 35% in Europe. 4,000 employees joined Fresenius in 2000 as the result of acquisitions. Fresenius Medicare (clinics) employs 71% of the labour force and has a 74% share of sales (Fresenius, Annual Report, 2001).<sup>181</sup>

Renal care is a growing area of healthcare and part of a very competitive market worldwide. There is growing evidence that companies, which manufacture drugs and/or equipment for the treatment of kidney diseases are also involved in the provision of healthcare. Multinational companies involved in renal care have combined operations that include:

- healthcare – clinics for treating kidney disease
- renal products – products used during dialysis treatment
- blood compound technologies and blood bank technology –

This is an example of vertical integration of activities in the healthcare sector.

Merrill Lynch Global Fundamental Equity Research Department published a profile of the dialysis industry in September 2001 arguing that the production of dialysis products was no longer driving the industry because there is limited product growth possible as synthetic dialyses have become standard equipment.<sup>182</sup> As a result, major companies will become service providers,

for instance, running dialysis clinics, but may expand into other aspects of healthcare provision. Fresenius has already started to offer treatment for other aspects of patients' care. This will have implications for existing healthcare companies.

## 5. CAMPAIGNING AND TRADE UNION ACTION

### 5.1 TRADE UNION ACTION AGAINST PRIVATISATION OF HEALTH SERVICES

Some of the results of the PSI survey 'Privatisation of health services' show how trade unions have been approaching campaigns against privatisation.

#### 5.1.1 Actions taken to influence the decision-making processes

Brazilian health trade unions have used several types of actions including conferences and the development of proposals for improving the quality of public health services. They have demonstrated in public places against privatisations and supported health sector units already on strike. Wider strikes of health workers have also taken place. They also joined with wider anti-privatisation campaigns. Health unions were only able to use the press and media in a limited way and did not leaflet the public.

In Canada, a wide range of actions, have been taken by trade unions to influence the decision-making processes. This included:

- Conferences to gather support
- Drawing up alternative strategies and solutions
- Leafleting the public
- Using press and media
- Demonstrations and strike action
- Joining wider campaigns against privatisation and campaigns against a specific company
- Election time campaigning

The Canadian government set up a Commission into the Future of Healthcare, which has been examining different aspects of healthcare, e.g. financing. Trade union action has focused on each of the studies undertaken by the Commission.

CUPE is currently involved in a major healthcare campaign with many other unions and health coalition partners. The campaign includes training for CUPE members at the local level to carry the anti-privatization

message to the community and to local and provincial elected politicians.

In February 2003 CUPE will host a healthcare workers meeting for its membership. This meeting will be held in conjunction with a conference on healthcare sponsored by the Council of Canadians (a progressive lobby group) and a "People's Summit" on healthcare sponsored by the Canadian Labour Congress. The Canadian Health Coalition and other provincial and local coalitions will also take part. Following these three days of meetings the delegates will conduct a systematic lobby of Members of Parliament on the importance of a publicly funded and publicly delivered healthcare system. The campaign is designed to pressure the federal government to introduce and implement progressive legislation in the wake of the final report from the Romanow Royal Commission.

In the Czech Republic, health trade unions used petitions, expert communications, press conferences, demonstrations, and strike action. They joined wider campaigns against privatisation and campaigns against a specific company.

In France, health trade unions have used conferences and the development of alternative strategies and solutions to raise awareness of the issues. In addition, they produced leaflets for a wider public and used the press and media. They also organised demonstrations and strikes. Health trade unions have not joined in wider campaigns against privatisation, nor campaigns against specific companies. They did not participate in the wider election campaign on privatisation issues.

In Lithuania, health trade unions have also used conferences, public leafleting and the press and media to raise awareness of the issues. They have developed alternative strategies and solutions. However, health unions did not join wider campaigns against privatisation or against specific companies, nor were they part of wider election campaigns.

### 5.1.2 Alliances

In Brazil, alliances were developed with a wide range of groups – doctors, nurses, patients' groups – especially patients with chronic diseases, NGOs, religious groups, political parties and individual politicians. Although some doctors were included in this wide alliance, other doctors work for cooperatives that are part of the privatisation process and so have different interests.

Canadian health trade unions have developed alliances with nurses, patients' groups, consumer groups, NGOs, religious groups, individual politicians. The one group that they did not include in an alliance were doctors. As in Brazil, doctors may benefit from the privatisation of health services.

Czech health trade unions were unable to develop alliances with any key groups because there was widespread support for privatisation in the country and among other health groups.

In France, the health trade unions joined with doctors, patients' groups and individual politicians in their actions as well as working with other union organisations.

In Lithuania, alliances were made by health worker trade unions with a wider range of other groups in the health sector – doctors, nurses – including groups of health service managers. This was the only case where health services managers were mentioned as playing a campaigning role against privatisation.

### 5.1.3 Results of actions

In Brazil, there has been some success in either changing decisions or slowing down the process of decision making. They have not successfully gained protection for health workers in the privatisation process.

In Canada, there have been some successes in the campaigns against PPPs, private clinics and contracting out of health services. A proposal for a PPP hospital in Prince Edward Island was stopped as a result of public pressure. A private laboratory contract was halted in Saskatchewan and brought back into the public sector at considerable savings.<sup>183</sup>

In Canada the results of the government commission (Romanov) looking into the future of healthcare were delivered in November 2002. This did recommend increased funding from the federal government for Medicare and rejected a second tier of private, for-profit direct healthcare services which can be seen as some success for trade union campaigning. However it did not reject the privatisation of ancillary services.<sup>184</sup>

In the Czech Republic, there have been some successes. The privatisation of some hospitals was cancelled. In other cases where privatisation is continuing, there will be a transfer of employee rights onto the new owners of the units that are going to be privatised, thus providing more protection for health workers.

In France, health trade unions have had some success in either changing or slowing down decisions about

privatisation and in gaining some protection of workers' rights.

In Lithuania, the campaigns have resulted in the delaying of decisions.

#### 5.1.4 Conclusion

The use of conferences and the development of alternative strategies and solutions are used widely. Similarly demonstrations and strike action were used by all the countries mentioned above. Involvement of individual politicians was also an important part of all campaigns, even if there was no involvement in wider election campaigns.

The involvement of the public through leafleting and the press and media varies from country to country. Similarly, involvement with wider campaigns against privatisation or against specific companies varied.

The development of alliances is influenced by the strength of groups in the health sector and in civil society. The involvement of doctors is probably the most difficult because doctors often see their own interests promoted through privatisation of health services.

Trade union action resulted in delaying the decision making process in all cases. In several countries it has led to changing a decision and in others to providing protection for the rights of health workers during privatisation.

## 5.2 SOCIAL DIALOGUE – EXAMPLES OF GOOD PRACTICE

As examples of trade union action in a wider context, four examples of social dialogue in the health sector follow below. These were developed for the Background Report for the ILO Joint Meeting on Social Dialogue in the Health Services to be held in October 2002.

- Brazil – the role of an institutional participative structures
- Canada – the union role within equal opportunities and changing employment practices
- Chile – consultation for new health sector reform
- UK – ‘partnership at work’ at hospital level

### 5.2.1 BRAZIL – the role of institutional participative structures

Municipal Health Councils in Brazil are made up of three groups: health workers, service users and government/health service managers. The aim of the health councils is to monitor and promote the health

of the population and to develop strategies and implementation plans for achieving health improvements. Each municipal health council has the responsibility to oversee the running of the local health service (Unified Health System). The health councils are also responsible for monitoring worker-management relations, addressing complaints from service users and organising health promotion and protection programmes.<sup>185 186</sup>

The National Council for Health has provided support for health councils at state and municipal level. Municipal health councils have also found that in neighbourhoods with a history of campaigning and community involvement, councils have been better prepared for fulfilling their roles.

Members of municipal health councils have different views about their roles. Some felt they had to expose the condition of the health services and to identify those responsible. Others felt that their responsibility was to convey the concerns of the local population about health and health services to the municipal health council and to communicate the views of the council back to local people. Others felt that their main purpose was to improve health services.<sup>187</sup>

The experience of the past decade is that some council have been successful in terms of influencing health policy and overseeing the delivery of health services. In some states and municipalities, however, there are still problems with regard to the capacity of council members to work with other agencies and stakeholders as well as splits between members.

Over 3,000 municipal health councils have been set up during the 1990s. A National Health Council review in 2001 concluded that by 2000 there were “new actors” in the health system who had developed a strategic view and awareness of their power within the decentralized health system.<sup>188</sup> The potential of these new actors to influence and change health policy has only just begun to develop.

Municipal health councils have been established for less than a decade. They provide a useful example of how health workers within an institutional structure can have some influence on the overseeing of health policy and the running of services. The process has not been easy. There are still training needs and other unresolved issues but municipal health councils may provide a model for other health systems that are attempting to increase the involvement of both users and health workers in their structures.

### 5.2.2 CANADA – union role within equal opportunities and changing employment practices

A Partnership Agreement signed on 15 November 2000 between the Saskatchewan Association of Health Organizations (SAHO), the Canadian Union of Public Employees (CUPE) Healthcare Council and the Saskatchewan Department of Intergovernmental and Aboriginal Affairs (IAA) is another example of social dialogue. The aim of the partnership agreement is to increase Aboriginal employment in the healthcare sector in Saskatchewan province, Canada.

After a process of consultation with trade unions, employers, training institutions and the Aboriginal community, led by the Saskatchewan Association of Health Organisation (SAHO), CUPE became increasingly interested in signing its own partnership agreement with SAHO and IAA as a result of the discussions with these partners. The three parties prepared a draft agreement, which they submitted to a number of CUPE members in the province and to employers to review and discuss the document.<sup>189</sup>

Under the agreement, CUPE, SAHO and IAA agree in principle to work together to identify possible solutions with regard to the following issues:

- collective agreement initiatives;
- development of an Aboriginal/health sector communications strategy;
- career planning;
- training needs strategy with appropriate institutions; and
- cooperation with health sector employers to adopt a strategy to recruit, hire, train and retain Aboriginal workers.

Since the signing of the agreement, a tripartite partnership steering committee made up of representatives from CUPE, SAHO, IAA and additional trade unions has been set up to develop a framework for inclusion of the “representative workforce” in the next round of negotiations. This was taken into the negotiations for the next collective agreement, which was ratified in October 2001. Other trade unions have included similar language in their collective agreements.

Extensive training and educational activities have been set up by CUPE and SAHO for the workforce and employers. SAHO is developing on-line training for new employees in the health sector (both Aboriginal and non-Aboriginal).

This is an example of a trade union becoming involved in an equal opportunities employment initiative as a result of consultation processes that drew local stakeholders together to discuss human resource development. It has led to partnership working between unions and health service employers setting up training and education programmes.

### 5.2.3 CHILE – consultation for new health sector reform

A health sector reform programme was implemented in Chile in the 1980s but left the health system facing several problems, including a growing demand for services, lack of services because of inadequate funding and private health insurers taking the healthiest sectors of society into their schemes.

In 2000, the Government initiated a process of social dialogue with trade unions, health service users, health professionals, private sector groups and non-governmental groups. This continued until November 2001, when it broke down amid accusations that there was not enough discussion of fundamental problems and that the elections were politicising the issues.

In June 2002, a draft health law was published by the government, which proposed a set of minimum standards of care for users of both the public and private healthcare systems.<sup>190</sup> It also seeks to change the way in which some groups of health workers are paid and rewarded. Many groups within the health sector have criticisms of the proposals and the process of dialogue continues.

This example shows that the process of consultation for a new health reform may show that different interest groups do share a common set of values, e.g. health rights. However, a lack of openness by the government reflected in an erratic process of consultation may undermine these shared values. The preparation of possible future health strategies by the health trade unions enabled them to play an active role in the process.

### 5.2.4 UNITED KINGDOM – Partnership at work at hospital level

Another example of social dialogue is the Developing Partnership at Work initiative at Wolverhampton Healthcare NHS Trust, a community and mental health organization in the West Midlands region of the United Kingdom.

In 1995, when the Wolverhampton Healthcare NHS Trust was established, several of the services that it delivered were of poor quality and did not meet the needs

of the patients/users. The new chief executive felt that the internal culture of the Trust would have to change from a system divided into “two worlds”, in which managers took the decisions while staff delivered the services, to a more integrated way of working with greater staff involvement in decision-making. Staff involvement was also considered important because of the need to recruit and retain high-quality staff, reduce absenteeism and improve the organization’s ability to cope with change.

From a series of ad hoc initiatives that involved staff in parts of the decision-making process, the approach became more strategic, with management and trade unions working together. In 2000, in partnership with UNISON, the Trust was awarded a DTI Partnership Fund grant for a project to develop training for managers, union representatives and employees in partnership skills, including effective communication and joint problem solving. The approval of DTI funding for a project gave support to the development and dissemination of a model of partnership and staff involvement in the NHS.<sup>191</sup>

The success of the initiative is that managers now take more account of patients and the reality of patient care, and service providers have a better understanding of the external environment within which the Trust operates and why some choices have to be made. Staff turnover is now at its lowest.

There are, however, some reservations about the initiative. The Chief Executive of the Trust feels that there is still a long way to go before employee involvement in decision-making can be considered the “norm”. UNISON’s view of the Partnership at Work initiative is that it has been useful in relation to training, health and safety and involving staff in decision-making but it has been less successful in pay negotiations.<sup>192</sup>

### 5.3 EPSU – raising awareness for a European health/healthcare policy

The European Federation of Public Service Trade Unions (EPSU) has initiated a process to explore how European health and healthcare policy might be addressed within a new European Union Treaty. This should be seen as a trans-European response to challenges to national health systems by European Union liberalisation policies.

A conference held in December 2001, hosted by the Belgium Presidency, entitled **European Integration and National Healthcare Systems: A challenge for**

**Social Policy** resulted in a series of research papers that examined the impact of the internal market of the European Union on national healthcare systems. The papers brought together a range of material that helped to document the impact on the movement of labour, pharmaceutical and medical devices, health systems, health insurance and consumer rights. Although the concept of subsidiarity is important for the control that national governments have over their health systems, the results of the Ghent conference showed that the internal market has begun to impact on many aspects of healthcare systems indirectly.

EPSU felt that the indirect impact of the internal market on national health systems was an important issue that needed further exploration and needed to be discussed by its own Health and Social Services Standing Committee. EPSU commissioned research to bring together the findings of the Ghent conference for presentation and discussion at the Health and Social Services Committee held in March 2002. The paper presented led to a lively debate. It was clear that many of the issues were new to the members and that they felt that more discussion was needed.

The next stage in the process was a joint seminar organised by EPSU and the European Trade Union Confederation. It was well attended by union representatives from both EPSU and ETUC. A range of speakers dealt with different aspects of healthcare in European healthcare systems and how the internal market of the European Union was influencing them. One of the main aims of this meeting was to discuss and agree a resolution on the need for a European health and healthcare policy. A draft resolution presenting the problems and arguments for future health policy development was discussed widely in the joint EPSU/ETUC meeting.

The draft resolution is now being discussed by the respective Boards of EPSU and ETUC and should be agreed by autumn 2002. This will mark the first stage of the process. A strategy setting out how to lobby and develop alliances will follow.

The key points that this stage of the process highlights are:

- The use of research to support and strengthen understanding of the problem
- The importance of a partnership with a similar level trade union organisation to provide mutual support and opportunity for discussion
- Awareness that this is only a small step in raising awareness of a process that is difficult to document and where there is no clear solution.

## 5.4 LESSONS LEARNED

### 5.4.1 5.Key factors that have influenced trade union campaigning against privatisation include:

- Positive and negatives attitudes towards the public health sector by the population
- Whether privatisation is seen as a positive or negative solution by a large proportion of the population and the stakeholders influencing these views
- The strength and broad based support of civil society organisations
- Roles that doctors and nurses organisations play and their relationships with other health worker unions
- Other wider campaigns and issues actively promoted in the country, e.g. wider trade union and civil society campaigns
- Political connections of trade unions, including health sector trade unions

### 5.4.2 Successful social dialogue is influenced by:

- Provision of support for trade unions to take part in the social dialogue process
- Recognition of the different roles of the social partners in the process
- Recognition that trust between partners takes time to develop
- Clarity about consultation processes and the expected outcomes will influence the commitment of social partners
- Influence of national initiatives to support local social dialogue

### 5.4.3 More general learning

- Role of information and research in supporting campaigns
- Value of preparing future scenarios and strategies
- Development of alliances and partnerships important to strengthen actions

## 6. CONCLUSION

### 6.1 GLOBAL TRENDS

- Contracting out of clinical, diagnostic and support services
- Private sector expansion and investment in high technology equipment and treatment
- Relatively small presence of US multinational healthcare companies providing hospital beds
- Uneven development of private health insurance by national and multinational companies
- Slow progress towards privatisation but global trade policies may speed the process up
- Continued role of international financial institutions in promoting the private healthcare sector

### 6.2 TRADE UNION RESPONSES

- Use of wide range of approaches to influence decisions
- Value of developing alternative health strategies
- Importance of monitoring public attitudes to public services and then seeking to influence them
- Strength gained from wide alliances of health workers and other groups but not always doctors
- Collaboration with wider privatisation campaigns when they exist
- Value of working with individual politicians
- Possible to slow decision making processes down and in some cases change them

### 6.3 WHAT REQUIRES MONITORING?

- Results of the corporatisation of hospitals on health workers and services
- Contracting out of clinical services
- Impact of public private partnerships
- Expansion of companies especially Europe and Asia
- Examples of privatised services returned to public ownership

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When you have finished reading this publication, could you please answer the following questions and send the reply back to PSI. It does not matter whether we know who you are (although you can tell us that); the more important thing is that you help us to improve future publications for other public sector workers and their trade unions.

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## **PSI's aims however remain much the same:**

- To promote co-operation amongst the affiliated organisations with the objective of coordinating their activities directed at establishing social justice, and to promote reciprocal assistance in the pursuit of their aims and objectives.
- To represent and defend the interests of employees in the public service before international authorities.
- To ensure the right of those employed in the public service to form and join professional or trade union organisations for the defence of their rights and interests.
- To uphold the right of organisations representing public employees to participate in the determination of conditions of employment by means of free negotiations.
- To campaign for the implementation of ILO Conventions, Recommendations and Resolutions which have a bearing on the well-being of public employees.

## **HOW DOES PSI WORK?**

The highest authority is the Congress, which is composed of delegates from PSI's affiliated organisations and meets every five years. Between Congresses, PSI is governed by an Executive Board elected from PSI's 25 geographical constituencies. Congress also elects a President - who presides over Executive Board meetings - and a General Secretary - who is responsible for the management of PSI's day to day business.

Regional structures have been created to ensure that

the special needs and problems of particular areas are properly dealt with. Within each Congress period, a special Conference is held in each of PSI's four regions - Africa and Arab countries, Asia and the Pacific, Europe and the Interamericas - in which all affiliated organisations from the region are entitled to take part.

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In carrying out the fundamental aims of the organisation, PSI organises an extensive programme of education and training for public service trade unionists at all levels. The objective is to help public service unions all over the world to develop into effective, independent organisations, so as to enable their members to play a full role in decisions that affect their work and life.

In addition to education, PSI engages itself in disseminating information on public service and trade union issues and organises a large number of meetings on vocational and technical subjects, including health and social services, workers in public administration, privatisation, trade union rights, globalisation, pensions, public utilities, multinational corporations, international financial and trading institutions, etc. Particular attention is given to women and young people in the public service.

Despite all the efforts of the free trade union movement over many years, there are still many countries where basic trade union rights and freedoms are not allowed or are being abused. PSI is consistently campaigning for the respect of human dignity, and the right to belong to a trade union.



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PSI welcomes any feedback on these papers and would be very grateful for any documents which readers care to send to PSI in the event that any revision of the material is undertaken.

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