‘**Public vs Private: Developing Accessible Health Systems**’
Just Change, Issue 14, p.7, online [now a dead link] at:
http://www.globalfocus.org.nz/infoservices/justchange/documents/JC%2014_web.pdf
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There are two types of health systems in the world, public and privatised, though in practice virtually all national systems are some form of hybrid. Nevertheless, these two opposing models drive much of the dynamics of health systems.

The best health outcomes (i.e. low preventible disease and low critical mortality rates) come from those countries which have (i) publicly funded and well coordinated systems (ii) universal free access to health services (iii) large numbers of trained health professionals (iv) effective health promotion programs and (v) high general levels of education. These factors are more important than total money spent on health.

Amongst the wealthy countries, virtually all of western Europe has guaranteed universal and free access to health services; the United States does not. The US has a semi-privatised system where private health insurance is required to access health services. Yet almost 20% of the US population does not have such insurance and so can usually only access free medical care at a hospital emergency ward. A wealthy private health industry sits at the centre of the US system, driving costs up. The US spends 13.9% of its total GDP on health, yet has worse health outcomes (e.g. in infant and maternal mortality) than virtually every country in Western Europe, where the biggest spender is Germany, at 10.7% of GDP.

Nevertheless, the US semi-privatised model has been promoted in OECD aid programs, on the basis that ‘public-private partnerships’ and ‘resource pooling’ will add to the overall effort. A W.H.O. panel chaired by Jeffrey Sachs also called for a multibillion dollar injection of funds into developing countries’ health systems. It is a central element of such ‘big money’ notions that private capital will be a central driver of health improvement.

Yet effective developing country health systems are mostly undermined by privatisation and private insurance schemes. The Mexican health system, like the US system, shows us some of these problems. This system combines tripartite social security insurance bodies (with contributions from employees, employers and government), a public system and a large private sector. It has substantial resources and expertise but is fragmented, with highly unequal access to services. All formally employed Mexican workers must belong to a social security/health institution. The IMSS (Instituto Mexicano de Seguro Social) is the biggest of these, with about 40% of the population, including workers’ families. However around 40% of Mexicans have no formal employment and therefore no health cover. In Chiapas state more than 80% of the population has no health insurance.

Each Mexican insurance institution has its own funding arrangements, facilities, doctors, nurses and auxiliary personnel. They could be separate empires, except that the federal government has begun to play a coordination and funding role, in response to the poor levels of insurance cover. The private sector is far more expensive, with around half the country's expenditure and much higher doctor's wages. Yet while it

consumes half the system's resources, it provides only 30% of the systems beds and 32% of the consultations, focussing mainly on curative medicine. The public health system has to carry most of the preventive programs.

By way of contrast, just across the Caribbean is socialist Cuba, with an almost completely public health system, and the best health outcomes in Latin America. With a much lower per capita spending on health than Mexico, Cuba has half Mexico's tuberculosis infection rate, half the rate of underweight children, one third the HIV infection rate and less than one third the infant mortality rate (UNDP 2007). Many of the elements of the Cuban model are similar to the good European public systems, but Cuba has done it with far less resources, demonstrating that good health need not be a luxury. Cuba has consistently prioritised health as a right and has committed to training large numbers of health professionals.

This small country has also developed the largest doctor training program in the world, offering free scholarships to thousands of students from over 60 countries. Cuba does this with a belief that there is a shortage of health professionals in the world, a shortage made worse in developing countries by the 'brain drain' of doctors migrating (and being encouraged to migrate) to wealthier countries.

In summary, processes of privatisation have a series of debilitating effects on the health systems of developing countries. Resources are wasted and unequal access to services is entrenched. The coordination of health systems, along with health promotion and prevention, is undermined. Training of doctors and other health professionals is restricted to a small elite. More money, under privatisation, delivers less. The solution must be a restoration of ethics in public health, affirming basic services as a right and not a traded commodity. Good health is not beyond the means of developing countries.

Further information:

Tim Anderson (2007) 'Health, income and public institutions: explaining Cuba and Costa Rica', *New School Economic Review*, Volume 2(1), 2007, 22-37, online at: http://www.newschooljournal.com/files/22-37%20NSER2-1%20Anderson.pdf

Tim Anderson (2006) 'Policy Coherence and Conflict of Interest: the OECD guidelines on health and poverty', *Critical Public Health*, Vol 16 No 3, September, pp.245-257

Tim Anderson (2006) 'The structuring of health systems and the control of infectious disease: looking at Mexico and Cuba', *Pan American Journal of Public Health*, Vol 19(6), June 2006, pp.423-431, online at: http://journal.paho.org/index.php?a_ID=524