GATS and access to public health care

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Public service reform agenda

Goal:

Trade liberalisation → prosperity → social welfare

How to get there?
Public Service Reform Agenda

Two Models:

Market provision, trickle down, targeting
Minimal state interference, individual rights, private property, residual welfare, targeting, trickle down

versus

Redistribution, universal public services. Extend the role of the state in risk pooling and social solidarity, restrict the role of markets, universal welfare and equity
Current debate

i  Health care financing
   growing consensus that government be “payer” but ‘steer’ not ‘row’

ii  Health care delivery and organisation
   “agnostic” – pro-market plus regulation
Argument

“doesn’t matter who provides care so long as government is payer”

question:

can equity, access, and universality be preserved?
Goals

Principles:
- funding and financing – public versus private
- service delivery and organisation – public versus private
What are the *goals* of a good health service?

i  universal coverage – whole population

ii  comprehensive – ‘cradle to grave’

   prevention – treatment

iii  equity – equal access for equal need

iv  free at point of delivery – barriers – user charges
Principles

Redistribution

Risk pooling: cost of care spread across society

Risk sharing
Redistribution and funding of health care

1. Income tax (Beveridge system)
2. Social insurance (employer, employee contributions) (Bismarkian system)
3. Local taxation –
4. Private insurance
5. Consumption or goods taxes
6. Charges
### Income tax payable: by annual income, 2001–02 United Kingdom

From Office for National Statistics. *Disadvantaged households. Results from the 2000 General Household Survey Supplement A.*

London: ONS 2002. Table 4

<table>
<thead>
<tr>
<th>Income Range (£)</th>
<th>No of taxpayers (millions)</th>
<th>Total tax payable (£m)</th>
<th>Average rate of tax payable (percentages)</th>
<th>Average amount of tax payable (£)</th>
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<td><strong>All incomes</strong></td>
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<td><strong>101,700</strong></td>
<td><strong>17</strong></td>
<td><strong>3,590</strong></td>
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Indirect taxes as a percentage of disposable income: by income grouping of household 2000/01. United Kingdom
Out–of–pocket health spending and income

Older Americans’ family out–of–pocket health costs, on average, are projected to consume 21% of their family income in 1994, up from 15% in 1987.

While, on average, family out–of–pocket costs for the elderly grew by 85% between 1987 and 1994, elderly family income grew by on 28% over the same period.

Older Americans’ spending for family out–of–pocket costs represents a percentage of family income that is almost three times greater than that of younger Americans. For those under 65, family health care costs consume 8% of family income in 1994.
The equity test

Charges are inequitable in two important respects. First, new charges increase the proportion of funding from the unhealthy, old and poor compared with the healthy, young and wealthy. In particular, high charges risk worsening access to healthcare by the poor. As the World Health Organisation report – which assessed the United Kingdom as having one of the fairest systems in the world for funding healthcare – concludes: ‘Fairness of financial risk protection requires the highest possible degrees of separation between contributions and utilisation’.

The NHS Plan, p37
Public funds for healthcare will be devoted solely to NHS patients

The NHS is funded out of public expenditure, primarily by taxation. This is a fair and efficient means for raising funds for healthcare services. Individuals will remain free to spend their own money as they see fit, but public funds will be devoted solely to NHS patients, and not be used to subsidise individuals’ privately funded healthcare.

The NHS Plan, 2000 p5
How redistribution is designed into delivery system

Risk sharing and pooling to prevent fragmentation, duplication, cost sharing, deprivation, inefficiency
Building blocks of universal services

Needs–based resource allocation to planning bodies
service planning
needs–based funding to services
integration
cross–subsidisation
local accountability
strong democratic control
data for monitoring equity
Building blocks of market
Mechanisms to segment risk pools

i  select population: members, enrollees

ii select treatments and patients: price and competition

iii limit risks: reimbursement DRGs, capitate providers, eligibility criteria, core benefits, top-up fees, co-insurance, user charges (copayments), time-limit care
Risk pool is fragmented by:

i excluding groups of people

ii excluding services

iii timelimiting or restricting eligibility

iv externalising / contracting out care
<table>
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<th>Methods of funding</th>
<th>Universalism Risk pooling and social solidarity</th>
<th>‘New’ Universalism ‘Targeting’ Market mechanisms</th>
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<td>Risk pooling - geographic allocations on basis of population needs</td>
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<td>- Block budgets, salaries, state ownership</td>
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<td>Service provision</td>
<td>Planning authorities</td>
<td>Individual</td>
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<td>- 1º, 2º, 3º levels of service within a geographic population</td>
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<td>- Capitation payments based on risk</td>
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<td>Organisation</td>
<td>- Not-for-profit</td>
<td>Service unbundling</td>
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<td>Accountability</td>
<td>National and local electorate, users, staff</td>
<td>- Pricing and competition</td>
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<td>Shareholders, boards</td>
<td>- DRG</td>
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US Healthcare insurance system. Devolving Risk model

- Medicaid
- Medicare
- employers
- individuals
- self-employed

- indemnity insurers
- 700 networks HMOs / IPAs
- insurance intermediaries (eg, 1,200 PPOs)

- physicians
- providers
- physicians
- providers
- physicians
- providers
NHS equity mechanisms depend on risk pooling being built into system

i  progressivity of funding – central taxation

ii  resource allocation to population and services adjusted on basis of need

iii  service integration and planning for need – block budgets, public partnership, salaried
Funding flows and planning: NHS pre 1991

1. Secretary of State
2. Department of Health
3. 14 regions
4. 160 district health authorities
5. Hospitals and community service
6. GPs
7. RAWP
8. Geographic needs-based formula
9. Salaried staff
10. Block budgets
11. Capitation and fee for service
12. Itemised service
13. National ownership and control
Accountability: NHS pre 1991

- Secretary of State
  - 14 regional boards (planning for 1–5m)
  - 160 DHAs (planning for 150–250,000)
  - Service providers

Community Health Councils - watchdogs

Right of appeal on all health decisions
Moving from geographic area-based planning

Internal market (mixed)

Market providers (FHTs) and regulators
Mechanisms used to implement pro–market reforms

UK NHS

uncouple resource allocation from service planning bodies
service ‘unbundling’: contracts, DRGs
fragmentation and disintegration
competition and privatisation– scarcity and duplication
undo national and local accountability mechanisms
abandon data to monitor equity
| Methods of funding | Universalism  
Risk pooling and social solidarity |
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<td>Providers/ Companies</td>
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Funding flows and planning: NHS pre 1991

Secretary of State

Department of Health

14 regions

160 district health authorities

hospitals and community service

GPs

block budgets

capitation and fee for service itemised service

salaried staff

geographic needs-based formula

RAWP

national ownership and control
The structure of the Modern NHS in England, October 2003

Organisations with strategic roles

- Secretary of State for Health
- Modernisation Board
- Department of Health
- 19 Special Health Authorities
- 28 Strategic Health Authorities
- Joint Ventures with Independent Sector

Commissioners of care

- 302 Primary care trusts
- 8 Social care trusts
- Children’s trusts
- Joint Ventures with Independent Sector

Providers of care

- NHS Direct
- Primary Care Walk-in Centres
- GPs, Dentists, Opticians, Pharmacists
- Independent Sector: Hospitals and DTCs
- Diagnostic and Treatment Centres (DTCs)
- Joint Ventures with Independent Sector
- NHS Trusts
- Foundation Trusts

Statutory accountability
Contractual arrangements

Independent Regulator
US Healthcare insurance system. Devolving Risk model

- Medicaid
- Medicare
- employers
- individuals
- self-employed

- indemnity insurers
- 700 networks HMOs / IPAs
- insurance intermediaries (eg, 1,200 PPOs)

- physicians
- providers
- physicians
- providers
- physicians
- providers
REFORMING THE

NHS NHS NHS NHS

NHS NHS NHS NHS

NHS NHS NHS NHS

LIST ISH T SHIT
How market-oriented health system reforms may trigger commercial rules

1. Public services and GATS. Scope of treaty has to be clarified, eg, article 16 could apply if there is not a clear exemption.
2. Regional economic agreements eg ECJ already moving the dividing line between social and economic policy, eg, BetterCare judgement. Introduction of competition may trigger GATS rules even where services have not been submitted.
3. WTO courts ultimately decide what constitutes trade discrimination and hence have supragovernmental authority.
4. Legal doubt about what happens when services are liberalised even when previously excluded from GATS, eg, NHS hospital services which are now provided both competitively and through private finance.
5. GATS necessity test could give WTO courts more power by imposing international standards.
Conclusion

- states are adopting pro-market health care reforms, thereby setting a new normative standard for delivery and organisation
- no evidence that pro-market reforms uphold universality, equity, social solidarity
- the introduction of market mechanisms and agents in public service delivery may trigger commercial rules undermining national autonomy
- the WTO disputes settlement mechanism which interprets trade law and policies makes it possible to extend trade in public services beyond that intended by national trade negotiators
The proposed structure of the Modern NHS in England, October 2003

- Secretary of State for Health
- Modernisation Board
- Department of Health
- Diagnostic and Treatment Centres (DTCs)
- Independent Sector: Hospitals and DTCs
- Independent Sector: Walk-in Centres
- GPs, Dentists, Opticians, Pharmacists
- 28 Strategic Health Authorities
  - Foundation Trusts: Primary care trusts, Social care trusts, Children’s trusts
  - Joint Ventures with Independent Sector
- 19 Special Health Authorities
- 28 Strategic Health Authorities
  - Joint Ventures with Independent Sector
- NHS Direct
- Foundation Hospital Trusts (FHTs)
- 19 Special Health Authorities
  - Joint Ventures with Independent Sector

Organisations with strategic roles

Commissioners of care

Providers of care

Statutory accountability
Contractual arrangement

Commissioners of care

Providers of care
“It shall be the duty of the Minister of Health to promote the establishment in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis, and treatment of illness”

NHS Act 1946