Health policy

How the World Trade Organisation is shaping domestic policies in health care

David Price, Allyson M Pollock, Jean Shaoul

High up on the agenda of the World Trade Organisation (WTO) is the privatisation of education, health, welfare, social housing and transport. The WTO's aim is to extend the free market in the provision of traditional public services. Governments in Europe and the US link the expansion of trade in public services to economic success, and with the backing of powerful medico-pharmaceutical, insurance, and service corporations, the race is on to capture the share of gross domestic product that governments currently spend on public services. They will open domestic European services and domestic markets to global competition by government procurement agreements, dispute-settlement procedures, and the investment rules of global financial institutions. The UK has already set up the necessary mechanisms: the introduction of private-sector accounting rules to public services; the funding of public-sector investment via private-public partnerships or the private finance initiative; and the change to capitation funding streams, which allows the substitution of private for public funds and services. We explain the implications of these changes for European public-health-care systems and the threat they pose to universal coverage, solidarity through risk-pooling, equity, comprehensive care, and democratic accountability.

On Nov 29, 1999, trade ministers from 134 member states will meet in Seattle, USA, for the latest round of talks at the World Trade Organisation (WTO), an international body founded in 1995 to expand free trade and the free market. The meeting will trigger the arrival of more than 1100 public-interest groups from 87 countries who intend to put forward "the real critique" of the WTO.[1] Seattle will be the setting for an unprecedented worldwide campaign in which consumer groups, trade unions, environmentalists, and public-health activists will highlight the global economic implications of the WTO trade talks, not the least of which is the dismantling of European socialised welfare provision with its publicly stated goals of universality and solidarity.

Many governments are deregulating and privatising public-service funding and delivery (www.imf.org/external/pubs/ft/fandd/1999/03/thobani.htm, available November, 1999). The transformation is being engineered through policy initiatives such as New Public Management, contracting out of services, compulsory competitive tendering (best value), and public infrastructure privatisation through public-private partnerships known variously as the private finance initiative (PFI), build-own transfer (BOT), or build, own, operate, and transfer (BOOT). These policies are generally presented as technical and, therefore, neutral adjustments. There has been little public debate about the way in which the privatisation of public services at national level is linked to the global trade-expansion policies of international institutions, such as the WTO, the International Monetary Fund, and the World Bank. There is even less understanding of the huge implications of these policies for European traditions of democracy and community risk-sharing.

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Health Policy and Health Services Research Unit, University College London, London, UK (D Price BSc)**; Social Welfare Research Unit, University of Northumbria, Newcastle upon Tyne** (D Price)**; Health Policy and Health Services Research Unit, University College London, London WC1H 9EZ** (Prof A M Pollock FFPHM)**; and School of Accounting and Finance, University of Manchester, Manchester** (J Shaoul PhD)

Correspondence to: Prof Allyson M Pollock (e-mail: allyson.pollock@ucl.ac.ukBackground)

WTO's expansion of the free market into public-sector service provision

The Geneva-based WTO was established during the Uruguayan round of the General Agreement on Trade and Tariffs. Its aim is economic growth and stability based on free markets and minimum governmental interference. Although the WTO's membership includes 134 nation states (at February 1999), the transnational corporations that sit on all the important advisory committees decide detailed policy and set the agenda. WTO trade agreements have been described as a bill of rights for corporate business.[2,3]

The WTO talks in Seattle will focus on revision of the General Agreement on Trade in Services (GATS), a system of international law intended to expand private-enterprise involvement in the increasingly important service sector. According to the WTO, 160 service sectors are covered by GATS, including telecoms, transport, distribution, postal, insurance, environment, tourism, entertainment, and leisure services. What few people realise is that health care, social services, education, housing, and other services run by government agencies are also included (www.wto.org/wto/services/services.htm, available November, 1999).[4]

The WTO's focus on the service industry reflects the sector's growing commercial importance. As profitability in manufacturing has declined because of international competition, US and European corporations have turned to services as an alternative source of profit. According to the European Commission "The service sector accounts for two thirds of the [European] Union's economy and jobs, almost a quarter of the EU's total exports and a half of all foreign investment flowing from the Union to other parts of the world".[5] In the USA, more than a third of economic growth over the past 5 years has been because of service exports.[6] The World Bank has calculated that in less-developed countries alone, infrastructure development involving some private backing rose from US$15·6 billion

in 1990 to $120·0 billion in 1997. Around 15% was direct foreign investment in public schemes.[7] Governments in Europe and the US link the expansion of trade in public services to economic success, and, with the backing of powerful coalitions of transnational and multinational corporations, the race is on to capture the share of gross domestic product governments currently spend on public services. The European Community has set up the European Services Network of multinational industry representatives, led by Andrew Buxton, chairman of Barclays plc, to "advise European union negotiators on the key barriers and countries on which they should focus . . . " (www.gats-info.eu.int/, available November, 1999).

In the USA, the Coalition of Service Industries is calling for a majority foreign ownership to be allowed for all health facilities. "We believe we can make much progress in the negotiations to allow the opportunity for US businesses to expand into foreign health care markets . . . Historically, health care services in many foreign countries have largely been the responsibility of the public sector. This public ownership of health care has made it difficult for US private-sector health care providers to market in foreign countries . . ." (www.uscsi.org; available November, 1999).

The US trade delegation goes even further. "The United States is of the view that commercial opportunities exist along the entire spectrum of health and social care facilities, including hospitals, outpatient facilities, clinics, nursing homes, assisted living arrangements, and services provided in the home."[8]

Waiting in the wings of the WTO talks are the US multinationals, including the pharmaceutical industry, long-term-care sector, and the health-maintenance organisations. Known in the mid-1990s as "the darlings of Wall Street," the multibillion dollar business of health-maintenance organisations depends heavily on a mixture of public funding, private health insurance, and user charges.[8] Much of its impressive profitability was brought about by the acquisition of non-profit hospitals in the USA.[9]

However, by 1997, the stock-market boom in health-maintenance organisations had ended,[10] and earnings by these businesses of $700 million in 1996 turned into $768 million losses by 1998.[8] Profits fell because of market saturation, government and employer strategies to contain health-care costs, and high-profile scandals. To restore profitability, the industry has begun to lower benefits, increase premiums, and withdraw from selected markets. It has also tried to capture new markets abroad by acquiring publicly run facilities. The industry has received influential backing for its foreign-acquisitions policy from the US government, the World Bank, and multilateral financial institutions such as the Inter-American Development Bank. These bodies have supported "managed care initiatives that convert public health care institutions and social insurance funds to private management, private ownership, or both."[11]

Health-maintenance organisations target the public funding behind foreign health-care systems. Multibillion-dollar social-security or tax pools are effectively privatised when public health care is redirected through private-sector organisations.

Intention to open public services to international global markets through GATS

Expansion of the private services sector depends on the opening of markets in the traditional areas of public provision. The WTO and the World Bank have carefully created policies to ensure that such changes take place. But the WTO has found progress slow in health care.[12] When GATS was introduced in 1995, only 27% of WTO members agreed to open hospital services to foreign suppliers.[12] According to the WTO secretariat, some governments have resisted making the hospital sector commercial because they think of hospitals as part of their country's "national heritage".[12] Consequently, 5 years into GATS, the public-service basis of many health-care systems has not been accessible to transnational corporations.

GATS permits member countries to force the removal of barriers to foreign participation in the service industries of other member countries. The WTO now has three main objectives: to extend coverage of GATS, to toughen procedures for dispute settlements so that member states can more easily be brought into line, and to change government procurement rules to create market access.

Extension of GATS—Articles 1.3, 13, and 19

The previous round of WTO ministerial talks (the Uruguayan round) allowed governments to protect health and social services from GATS treatment by defining them as government services. According to GATS Article 1.3, a government service is one "which is supplied neither on a commercial basis, nor in competition with one or more service suppliers". Article 19 of GATS is, however, intended to end this protection. "Members shall enter into successive rounds of negotiations . . . with a view to achieving a progressively higher level of liberalisation."

The WTO secretariat has argued that for services to be classified under Article 1.3 they should be provided free. Many governments initially protected health services from GATS treatment by defining them in this way. But the WTO has highlighted the inconsistencies in this approach.[12] "The hospital sector in many counties . . . is made up of government-owned and privately-owned entities which both operate on a commercial basis, charging the patient or his insurance for the treatment provided. Supplementary subsidies may be granted for social, regional, and similar policy purposes. It seems unrealistic in such cases to argue for continued application of Article I:3, and/or maintain that no competitive relationship exists between the two groups of suppliers of services." In addition, Article 13 of GATS calls for the end of subsidies that distort trade and requires members to negotiate procedures to combat them.

Therefore, according to the WTO, wherever there is a mixture of public and private funding, such as user charge or private insurance, or there are subsidies for non-public infrastructure, such as public-private partnerships or competitive contracting for services, the service sector should be open to foreign corporations. Health-care systems across Europe are vulnerable on all these counts.

Dispute settlement

The WTO uses dispute settlement to implement market access. These procedures enable states to force changes in the domestic laws of other states and to impose retaliatory trade sanctions in areas unconnected with the disputed practice. Current proposals will enable transnational corporations to take legal action against governments that frustrate their foreign-investment aspirations. Dispute settlement is an important means of US influence and a vital weapon in its trade expansion. According to Ambassador Charlene Barshefsky, leader of the US trade delegation and chairperson of the Seattle round, "the

United States has demonstrated a record as the most aggressive user of the WTO dispute resolution process".[6]

Dispute settlement is a form of attack on government powers. The procedures promote the least trade-restrictive regulation, which is voluntary rather than compulsory, involves consumer information rather than prohibition, and puts individual before public responsibility. The US trade delegation has announced that it will be supporting the introduction of regulation in the service sector that "promotes rather than restrains competition".[6]

Creation of market access: government procurement rules

The WTO proposes to use a reformed government procurement agreement as the primary mechanism for opening public services to the private sector. Government procurement rules supply the legal and regulatory framework within which public bodies contract for goods, services, and investment funds. This procedure opens up domestic services and markets to international competition. The influential Euopean Union reform proposals focus on "[unlocking] new potential markets" by extension of private firms' involvement with public services and by creation of contracting rules to ensure "acceptable returns for investors".[13]

Use of government-procurement-agreement reforms to shape health-care policy in the UK

The World Bank has famously described public services as a barrier to the abolition of world poverty.[14] It maintains that "if market monopolies in public services cannot be avoided then regulated private ownership is preferable to public ownership".[11] The WTO sees one of its roles as coordinating the international transfer of such policies. It asks "How can WTO Members ensure that ongoing reforms in national health systems are mutually supportive and, whenever relevant, market-based?"[12]

The UK provides a fascinating insight into the assimilation of the WTO agenda into domestic policy. The UK was one of the first states among more-developed countries to take up two key recommendations of global financial institutions: the introduction to the public sector of commercial accounting and appraisal of commercial investment. Procurement reforms are being used to breach socialised provision to enable private firms to exploit the public-funding base of traditional public services.

Changes to resource allocation

Money now follows the individual to the point of service. In 1991, the National Health Service internal market replaced resource allocation based on area needs with capitation funding. Payments per person are generally seen simply as a cost-containment strategy because they provide organisations with an incentive to withhold care (necesary and unnecessary). However, per-person payments, which are fixed sums of money that lend themselves to copayments and consumer purchases in the private sector, also facilitate the substitution of private funding for public funding (through private insurance and user charges) and private services for public services. Capitation models are promoted by the World Bank (www.worldbank.org/nor/class/module1/sec7i.hbm 7i).

In the UK, the devolution of capitation payments to family-physician fundholders has enabled the substitution of private health insurance and user charges for some publicly funded care (eg, pharmaceuticals, elective surgery) as well as the diversion of public funds into the private sector (eg, elective surgery, private outpatient clinics, podiatry, physiotherapy, and capital infrastructure).[15,16] The introduction of primary-care groups and primary-care trusts in April, 1999, will accelerate this process.[17,18] Primary-care groups will have an incentive to expand private health insurance and user charges or copayments when their National Health Service per-person budgets are capped, and they will have more freedom to use the private sector.

A copayment template is about to be tried in the UK by the department of employment and education. Next year the department will give a UK£10 000 "individual learning account" to school-leavers to pay for education after age 18 years, as well as training costs in the public or the private sector.[19] Public funds will be triggered by private contributions.

Service delivery changes in creation of corporations

In the UK, National Health Service entities have been re-established on private-sector lines, or corporatised, by the imposition of commercial accounting practices.[20] For example, the sole statutory duties of National Health Service provider trusts (hospital and community services) are financial and not health-care duties; National Health Service bodies must break even after having made a profit for their owners (the government) equivalent to a 6% return on capital. The same will apply to primary-care trusts, which will also be made to behave commercially as if they have shareholders. This resource accounting, which is shortly to be introduced throughout all UK public services, makes public and private sectors seem interchangeable. Resource accounting is a prerequisite for public-private partnerships.

Public-private partnerships

The UK government is outsourcing labour-intensive services and capital-intensive infrastructure projects through public-private partnerships (or private finance initiative in the National Health Service). These changes give the private sector access to public funds, but are presented as offering the public sector access to private funds. The privatisation of public funds has been achieved by almost eliminating new public funding for capital projects such as hospital refurbishment;[21] through the introduction of direct government subsidies to the private sector;[22] and through creation of revenue that can be diverted to the private sector as rental income.[22]

These policies are occurring to a greater or lesser degree in all UK public services and are being widely copied in other more-developed countries.

Implications for health and health care

These structural changes in the financing and delivery of health-care conflict with the principles of universal coverage and shared risk that tax-funded or social-insurance-funded systems generally uphold. The changes provide insurers and providers with the means and making maximum profit the incentive to engineer favourable risk pools. Experience in the USA and more recently in Latin America is that the viability of public and voluntary hospitals and health services is threatened when they have to compete with commercial providers for per-person public funds, private insurance, and copayments.

Typically, the public sector has been left to bear the risk for more vulnerable populations but with diminished risk pools (or pooled funding) to finance care.[11]

Competition for per-person funds among autonomous providers leads to competition for patients. Evidence from the UK shows that such competition has destabilised the provision of care and diverted planning and service priorities away from the needs of their local populations. For example, private-finance-initiative business cases show that hospitals are currently being planned according to trusts' financial needs and not local clinical need: access to the acute sector is controlled by financial imperatives.[23]

Democracy versus consumerism

In the UK, the substitution of market mechanisms and competitition has fractured the traditional mechanisms for local accountability. National Health Service providers are governed by trust boards, with no democratic or legal mechanisms to ensure that they uphold the interests of the local communities from which they draw patients.[24,25] Increasingly, the goals of universality and equity are being replaced by consumer sovereignty. This effect is reflected in the growing governmental emphasis on league tables, performance measures, and quality frameworks, rather than on substantive health-care rights, such as to a universal, comprehensive health-care service.

The cumulative effect of these market-based reforms in the UK[21–23,26] and the US[8,9,27–30] is a decrease in the supply of publicly funded services. An early example of this was the long-term-care sectors. Later, despite government recognition of major shortages in the labour force and physical capacity, the introduction of the private finance initiative to the acute hospital sector in the National Health Service has resulted in a reduction of 30% in capacity at the hospitals concerned and of 20% in clinical budgets and workforce.

Inequalities in health

Income and health inequalities continue to widen in the UK.[31] The restrictions on national sovereignty imposed by the WTO through GATS will make it increasingly difficult to reverse these trends. As the UK trade minister, Richard Caborn, goes to Seattle, the UK Government has yet to adopt the first recommendation of its own Independent Inquiry into Inequalities in Health that "all policies likely to have a direct or indirect effect on health should be evaluated in terms of their impact on health inequalities … and formulated . . . to reduce such inequalities".[31] Resource accounting, private finance initiatives, outsourcing, capitation, and corporatisation continue to be imposed under the modernisation programme of the "third way", but the government has yet to sponsor a thorough assessment of their impact on health inequalities.

Conclusion

The WTO is stage-managing a new privatisation bonanza at Seattle. Multinational and transnational corporations, including the pharmaceutical, insurance, and service sectors, are lining up to capture the chunks of gross domestic product that governments currently spend on public services such as education and health. The long tradition of European welfare states based on solidarity through community risk-pooling and publicly accountable services is being dismantled. The US and European Union governments are aggressively backing this project in the interests of their business corporations. But the assault on our hospitals and schools and public-service infrastructure depends ultimately on a promise from one government to another to expand private markets. Such promises can be kept only if domestic opposition to privatisation is held in check. We need to constantly reassert the principles and values on which European health-care systems are based and resist the WTO agenda.

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