

# The Impact of Reliance on Private Sector Health Services on the Right to Health

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## Abstract

A human rights approach is predicated on the responsibility of states to design health systems and implement health policies that are consistent with human rights requirements. However, in the contemporary health landscape, health services are increasingly delivered through private health sector institutions, and governments often lack direct control over some or many components of the health system. Private provision of health services does not change the role of the state as the ultimate guarantor of the realization of health rights obligations, but it makes implementing its responsibilities more difficult. This article explores the extent and ways in which privatization of health services potentially is and is not compatible with human rights commitments. Additionally, the article identifies factors and policies that can mitigate or exacerbate the impact of private health services on the realization of the right to health.

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## Introduction

A human rights approach assumes that states are responsible for shaping and implementing the delivery of health services to assure consistency with human rights requirements. However, in the contemporary health landscape, health services are increasingly delivered through private health sector institutions, and governments lack direct control over some or many components of the health system. As the World Health Organization (WHO) observes, “Private provision is a substantial and growing sector that is capturing an increasing share of the health market across the world.”<sup>1</sup> Today, private health institutions and providers play a major role in both developed and developing countries. Even the National Health Service in the United Kingdom, long an icon of state-funded universal health care, is currently undergoing major structural changes, opening services up to competition with the private sector, ostensibly to improve efficiency.<sup>2</sup> Private provision of health services does not change the role of the state as the ultimate guarantor of the realization of health rights obligations, but it makes implementing its responsibilities more difficult. Fragmentation of the health system complicates oversight and the promotion of a rights-based approach to health. Segmentation of the health system, with a poorly functioning public sector catering primarily to the poor and better quality private health institutions catering to the more affluent, tends to undermine support for investing in improvements in institutions for the public provision and financing of health care and likely erodes commitment to the right to health as well. Additionally, the goals and priorities of private health care institutions tend to differ, often significantly, from the values and norms in the human rights paradigm. Working effectively with and through private-sector providers also requires management skills and complex health information systems that many governments, particularly those in poor and middle-income countries, often lack.<sup>3</sup>

To date, the issues that private-sector health

provision raises for the right to health have received little systematic attention from those working on health and human rights issues. As will be discussed in a later section of this article, international human rights law does not specify how health care services should be delivered or paid for as long as the health care provision is consistent with human rights obligations. Although some UN human rights treaty body committees have acknowledged that reliance on private health care may be problematic, they have generally not been inclined to offer guidance at the level of depth and complexity it requires. The few human rights specialists who have addressed the subject have differed in their views.<sup>4</sup>

This article uses a human rights lens through which to evaluate private-sector health services provision and the privatization of health care. It explores the extent and ways in which privatization of health services potentially is and is not compatible with human rights commitments. It also considers other ways that an expanding or dominant role for the private health sector can complicate efforts to promote and protect the right to health. Additionally, the paper identifies factors and policies that can mitigate or exacerbate the impact of private health provision on the realization of the right to health.

## Private health sector provision

Private-sector health delivery covers many different realities. It includes both for-profit commercial companies and not-for-profit actors and institutions. It incorporates faith-based and other nongovernment non-profit organizations, as well as individual health care entrepreneurs and private for-profit firms and corporations.<sup>5</sup> It may also entail private sources of financing, such as shifting from public funding of health to private health insurance. In some countries with well-developed public health systems, private health provision plays a relatively minor and supplementary role, but in some others

there are extensive networks of private providers for ambulatory, hospital, and in-patient care. In developed countries, private provision usually entails care by well-trained medical professionals in settings with sophisticated equipment.<sup>6</sup> In contrast, in many poor countries the private sector is diverse and fragmented. In these countries, the private health sector is likely to be dominated by informal for-profit and small-scale providers, most of whom who are unlicensed, unregulated, uninspected, and frequently untrained in modern medical practice.<sup>7</sup> In low-income countries in Asia and sub-Saharan Africa, small-scale private provision dominates outpatient care, while public provision tends to be the rule in hospital in-patient services. Individual entrepreneurship is also prevalent in middle income countries, but large private firms, including multinational corporations, are capturing a growing share of the market, particularly the high-income segment, and increasingly competing for contracts with public and social security systems.<sup>8</sup>

### Factors encouraging the privatization of health services

The first and most significant factor encouraging the privatization of health services is the advent of neoliberal ideas as applied to health care sector policy.<sup>9</sup> Neoliberalism, sometimes referred to as market fundamentalism, describes a set of policies that favors a reduction of the role of the state in the provision of social services, a decrease in state budgets, tight limits on public health care expenditures, deregulation of markets facilitating the entry of corporate health business to operate more freely, the imposition of user fees even in the poorest countries, and the transfer of social services formerly provided by the state, including health care, to the private sector.<sup>10</sup> Neoliberal policies have translated into progressive abolition of rights related to health as well as to other social services.<sup>11</sup>

Proponents of neoliberal policies anticipated that these policies would increase productivity and efficiency and introduce greater choice while improving the quality of health care. This argument, borrowed from the economics literature, wrongly

juxtaposes efficiency and equity in health systems.<sup>12</sup> Moreover, it is not supported by empirical literature. A systematic study of peer-reviewed literature on the health sector in middle-income and poor countries does not support claims that the private sector has been more efficient, accountable, or medically effective than the public sector.<sup>13</sup>

If the role of neoliberal policies in the US and some European health care policymaking has reflected the pull of neoliberal ideas, the encouragement or scaling up of private sector provision in many poor and middle-income countries has resulted from the push of neoliberal market solutions by the World Bank, the United States Agency for International Development (USAID), and the Gates Foundation.<sup>14</sup> As the World Bank became more involved in health financing in the 1980s, it made health sector restructuring and the adoption of neoliberal policies a condition of refinancing existing loans and extending new loans.<sup>15</sup> Private sector proponents argued that the failures of the public health sector called for a greater role for private health providers and insurers in poor and low-income countries.<sup>16</sup> However, critics of the admittedly poorly functioning public health sector in many of these countries often have failed to acknowledge the impact of World Bank and International Monetary Fund-mandated austerity and funding limits imposed on publicly provided social services, which have been major factors undermining the viability of public health institutions.

In many countries, privatization has been a default option given the deterioration and—in some cases—the near collapse of public sector health facilities. Neoliberal policies have had a major, and often very deleterious, impact on the health systems of countries in the Global South. As a result of neoliberal health reforms, the government share of health expenditures, which was frequently already quite low, fell precipitously; health workers were laid off; the rural-urban divide increased; regional disparities in access to health care widened; and public health systems in many countries further deteriorated.<sup>17</sup> In the case of India, for example, the reliance on private health care, even by the poor,

results primarily from the fact that after many years of very low public expenditure on health, the country's public health facilities are very limited, of poor quality, and often poorly run.<sup>18</sup>

Budgetary strain has been another important factor pushing privatization forward. Public health systems in Europe and elsewhere are increasingly coming under economic pressure because of the rising costs of health care due to a variety of factors, including the high cost of new drugs and technologies; the aging of the population, with older persons requiring more and often more expensive health care; and rising expectations about the use and quality of health care services. According to Hans Maarse, the search for public-sector health care cost controls encourages privatization through cost sharing and outsourcing. While cost shifting from public to private spending usually does not lower total health care spending, it does reduce pressures on government budgets.<sup>19</sup>

To deal with economic constraints, made worse by the recent global economic recession, several European countries have made major structural changes in the health sector to reduce public responsibility for health service funding and/or delivery. For example, in 2006, the Netherlands transferred its sickness fund system to a regulated market structure, with most individuals responsible for a substantially larger segment of the cost of the insurance.<sup>20</sup> Since 2007, about 50% of all primary care services in Sweden have been shifted to private providers.<sup>21</sup>

The situation in poor and middle-income countries tends to be the converse of wealthier countries' efforts to offload services to the private sector so as to reduce governmental expenditures. Private-sector provision of comprehensive health services to poor people is generally not profitable, and therefore requires significant public subsidies to make investment attractive to the private sector. Recognizing this need, the International Finance Corporation, a subsidiary of the World Bank, advocates that both governments and donors earmark a higher proportion of public money and aid to fund private sector health entities. This then reduces the financial resources available for

the public sector.<sup>22</sup> In some countries—Brazil, for example—the expansion of the private subsector has been subsidized by the state at the expense of investments in public-sector health institutions. This policy has compromised the ability of the underfunded public subsector to improve the quality of and access to care.<sup>23</sup>

Consumer preference may also encourage privatization. Consumers may prefer private facilities because they believe they will gain access to better quality of care or escape from long waiting lists and other unappealing patient conditions.<sup>24</sup> In some developing countries, private-sector providers are more geographically accessible and have a greater availability of staff and drugs.<sup>25</sup> Growing affluence tends to increase the demand for private health care services outside the public sector along with the ability to pay for them. The downside of affluent people opting out of the public health system is that it risks the loss of political and economic support for public provision and investment in good quality health services for the poor.

### Private health sector provision and international human rights law

In principle, international human rights law is agnostic as to how health care services should be delivered or paid for, as long as the health care provision is consistent with human rights obligations. General Comment No. 3 of the UN Committee on Economic, Cultural and Social Rights (CESCR), adopted in 1990, states that the Committee is neutral on the type of economic systems required for the fulfillment of human rights obligations enumerated in the International Covenant on Economic, Social and Cultural Rights (ICESCR):

The Committee notes that the undertaking “to take steps...by all appropriate means...” neither requires nor precludes any particular form of government or economic system...., provided only that it is democratic and that all human rights are thereby respected. Thus in terms of political and economic systems the Covenant is neutral and its principles cannot accurately be

described as being predicated exclusively upon the need for, or the desirability of a socialist or capitalist system, or a mixed, centrally planned, or *laissez-faire* economy...<sup>26</sup>

The CESCR's General Comment No. 14 on the right to health, adopted 10 years later, reiterates:

The most appropriate feasible measures to implement the right to health will vary from one State to another. Every State has a margin of discretion in assessing which measures are most suitable to meet its specific circumstances. The Covenant, however, clearly imposes a duty on each State to take whatever steps are necessary to ensure that everyone has access to health facilities, goods and services so that they can enjoy, as soon as possible, the highest attainable standard of physical and mental health.<sup>27</sup>

The General Comment directs that, whether privately or publicly provided, health care services must be affordable to all, including socially disadvantaged and poorer households.<sup>28</sup> It further stipulates that state parties should take appropriate steps to ensure that members of the private business sector are aware of and consider the importance of the right to health in pursuing their activities.<sup>29</sup> The General Comment specifically states that the obligation to protect requires that the privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability, and quality of health facilities,<sup>30</sup> but it does not provide direction on how to make this assessment.

The General Recommendation on Health from the Committee on the Elimination of Discrimination Against Women (CEDAW) specifies that "States parties cannot absolve themselves of responsibility in these areas [women's ill-health] by delegating or transferring these powers to private sector agencies."<sup>31</sup> In 2011, CEDAW issued a decision in a landmark case on maternal mortality, *Alyne da Silva Pimentel v. Brazil*, based on this standard. The case dealt with a woman who died from pregnancy-related causes due to inadequate care in a private health care facility. As a matter

of international human rights law, the Committee found Brazil directly responsible for the failure to monitor private institutions when medical services were outsourced to such institutions.<sup>32</sup> The decision underscored that state parties are obligated to ensure that private health care facilities comply with national and international reproductive health care standards.<sup>33</sup> The significance of the decision will depend in part on what kinds of measures Brazil takes to implement the ruling and whether other countries follow this precedent.

Of the UN human rights treaty monitoring bodies, the Committee on the Rights of the Child (CRC) has given the most attention to issues relating to private provision of health care. In 2002, the CRC devoted a day of general discussion to the theme of "The Private Sector as Service Provider and its Role in Implementing Child Rights." Paul Hunt, who was to become the first Special Rapporteur on the right to the highest attainable standard of physical and mental health, represented the CESCR. His statement reiterated the position that international human rights law was neutral with regard to the privatization of service provision, provided it observed all human rights. He did add that the adoption of any national policy, including privatization, should be preceded by an independent, objective, and publicly available assessment of the impact, especially on the right to health of the poor.<sup>34</sup> According to Hunt, private-sector delivery should involve explicit respect for national and international human rights law at all stages, including policy formulation, monitoring, and accountability arrangements.<sup>35</sup> Hunt did not, however, identify the specifics of the criteria to apply.

In its general comment on children's right to health, the CRC reiterates the principle of state responsibility regardless of whether it delegates the provision of services to non-state actors.<sup>36</sup> The CRC also calls on all non-state actors engaged in health promotion and services, especially those in the private sector, to act in compliance with provisions of the Convention on the Rights of the Child.<sup>37</sup> In 2013, the CRC also adopted a second general comment on the impact of the business sector on children's rights

that acknowledges that there is no international legally binding instrument on the business sector's responsibilities vis-à-vis human rights. Nevertheless, it maintains that businesses must meet responsibilities regarding children's rights, and reminds states of their obligation to ensure they do so.<sup>38</sup>

Not many human rights practitioners or theorists have addressed the issues that private provision of health services present, and of those that have, there is a difference in views as to whether the realization of the right to health is in conflict with privatization of health services. While some analysts are aware of the issues that private provision presents, particularly those who are critics of neoliberalism, M. Gregg Bloche contends that privatization in itself is no more or less likely to fail in fulfilling human rights obligations than is public financing and provision of health services.<sup>39</sup> His position is that both private and public systems can be designed to respect, protect, and fulfill human rights, and both are equally susceptible to not doing so. He claims that private provision of medical care has little effect in practice on legal accountability for violations of international human rights law.<sup>40</sup> Bloche acknowledges that privatization is risky in societies where social cohesion is low, where there is disregard for the rule of law, and a general state failure—the situation besetting many poor countries affected by World Bank conditionality requiring privatization of health services—but he counters that in such states it is equally unlikely that public actors will fulfill their human rights responsibilities.<sup>41</sup>

Brigid Toebes takes another approach. Aware of the potential hazards of privatization for the realization of the right to health, she proposes conducting a human rights impact analysis to assess the consistency of specific privatization proposals and laws with the requirements of the right to health. Toebes examined privatization of health insurance in the Netherlands using the criteria outlined in General Comment 14: availability, accessibility, acceptability, and quality (AAAQ).<sup>42</sup> The aim of her analysis was to determine the kinds of checks and balances government must create when they privatize health systems in order to ensure

compliance with the international human rights obligation for the right to health.<sup>43</sup> However, the privatization of health insurance in the Netherlands was too recent for her to have the data to assess its impact. Also, while the AAAQ criteria provide a starting point, the Committee has not sufficiently developed how they should be translated into a human rights assessment or monitoring program.

### Impact of privatization of health services on the right to health

Privatized health care affects both the expression of the values on which effective realization of health rights depend and the institutional capacity of the government to implement a right to health approach in the ways that follow.

#### *Solidarity*

Support for a human rights approach to health may depend on, or at least be strengthened by, a strong sense of societal solidarity or social citizenship. Solidarity is both a moral concept and a public value. The notion of solidarity is associated with mutual respect, support for the weak and needy, shared responsibility, and commitment to the common good. Solidarity supports the principle that all members of society, including and particularly those in need, have access to health care, regardless of their ability to pay. "Solidarity is not a woolly notion about the common good. It has a specific meaning that a health care system is organized and managed on the basis of universal access, without risk selection, based on income related premiums and with no significant differences in the benefit package."<sup>44</sup> According to a study of the role of solidarity as it shapes attitudes toward health care in Europe, the basic understanding in many European countries is that everyone will make a fair financial contribution to a collectively organized insurance system that guarantees equal access to health and social care for all members of society.<sup>45</sup> In some countries, solidarity underpins a commitment to a uniform standard of health care for all members of the society, regardless of their economic status. A few countries, Canada and Israel for example, have laws limiting the

development of supplementary health insurance policies for the benefits covered by the basic health package to avoid the development of a dual system of unequal benefits.<sup>46</sup>

There is concern in some countries with a heritage of social solidarity that the sense of solidarity across income groups will be weakened by modernization, economic constraints, and privatization of social services. Some analysts anticipate these developments will encourage the emergence of two-tier systems of health care with fuller coverage and benefits for those who can afford to pay extra for them.<sup>47</sup> Such segmentation may also decrease support for and willingness to fund the public health system—which is possibly an intentional outcome of neoliberal ideology.

Assuming that the implementation of the right to health and other economic and social rights require some commitment to social solidarity, if only through an implicit social contract, an important question is how privatization and commercialization will impact countries that do not have the benefit of Europe's historical traditions of social solidarity. Many low- and middle-income countries can be considered fragile societies with deep ethnic, language, economic, and sometimes racial divisions. Will privatization and commercialization of key social services retard the development of political trust and social solidarity? Conversely, can a strong policy commitment to universal health care with some form of financial cross-subsidization promote the emergence of a sense of social solidarity based on an implicit social contract among the members of the country and between them and the government? There is a need for further and continuing research on these issues.

#### *Obligation to protect*

Privatization expands the human rights obligation of the state to protect its inhabitants from infringements of human rights by private health providers. To do so, it requires the state to assume different and more complex roles than the government's previous functions. A UN Department of Economic and Social Affairs paper on "Privatisation of Public Sector Activities" describes the role of government in the

context of privatization as shifting from producing and delivering services to enabling and regulating them. The paper points out that these roles require different skills:

Governments need to be able to analyse market conditions, set policy frameworks, draw up, negotiate and enforce contracts, regulate monopolies; coordinate, finance and support producers; enable community self-provision; and provide consumers with information on their options and remedies.<sup>748</sup>

But just as governments are privatizing more health care services and thereby requiring a greater vigilance over the private sector, the neoliberal policies promoting privatization are also advocating cutting back on the size and capacity of the public sector, making it more difficult to do so. The smaller, weaker, and less resourced governments fashioned by neoliberal policies are less able to implement their human rights obligations to protect their members from abuses by third party institutions and actors or to effectively regulate private sector health institutions.

#### *Accountability*

Accountability is also more difficult to achieve in a mixed health system. Human rights law imposes duties on states, not on private actors. In theory, the government is responsible for assuring that the private sector operates in a manner consistent with human rights principles, but in reality, it is often difficult for the government to do so. In many cases, the private health sector consists of a very large number of actors and institutions. Unless there is a rigorous registration or licensure system and an effective health information system, which rarely exists in middle- and low-income countries, governments may not even have an accurate sense of the number and location of the private sector health institutions; what kinds of health services are being provided by specific actors; and the quality of these services, let alone who they are serving and how much they are charging. Accountability also requires having an effective regulatory system and

both the ability and willingness to impose penalties on private institutions that violate human rights norms, all of which are rarely present in less-developed countries.

Citizens also encounter problems holding their governments or private health institutions accountable for the provision of health care entitlements in a privatized health system. Unlike providers, consumers of health care are not organized into pressure groups, and individual healthcare consumers therefore lack effective bargaining power within the health system.<sup>49</sup> Often there are no mechanisms for redress. Even where individuals have been able to use the legal system to attempt to claim their health rights, as for example in the Colombian privately managed system, there are long delays which result in suffering and medical complications affecting their health status.<sup>50</sup>

#### *Access and equity*

According to Anand Grover, the current Special Rapporteur on the right to health, “the global trend toward privatization in health systems poses significant risks to the equitable availability and accessibility of health facilities, good and services, especially for the poor and other vulnerable or marginalized groups.”<sup>51</sup> With the exception of a small number of not-for-profits, the private sector typically consists predominantly of for-profit entities which invest in healthcare to make money and not to provide affordable health care services. Rising costs in market-based health care systems reflect inbuilt incentives to pursue the most profitable treatments and their higher administrative costs. The small number of private sector programs that improve access for marginalized communities in most cases are developed and operated by philanthropic organizations or not-for-profits.<sup>52</sup>

Research in a wide range of countries indicates that privatization increases costs and thereby decreases access to health services. Studies of the impact of neoliberal reforms in Colombia document that public health programs have deteriorated while privatization has increased health expenditures and failed to improve efficiency and equity. The increase in public expense has predominantly benefited the

wealthy while the poor continue to have difficulties in accessing services because of high co-payments.<sup>53</sup> A study of privatization in 15 sub-Saharan countries in Africa, for example, showed that two in 10 persons used private providers, another three in 10 utilized public facilities, but five in 10 were priced out of access to health care.<sup>54</sup> Only 3% of the poorest fifth of the population were able to afford a private doctor when ill.<sup>55</sup>

In addition, private health services usually require out-of-pocket payment at the point of service. USAID has expressed concern that in Africa and Asia out-of-pocket payments for private health services account for 50% to 80% of total health spending leading to system inefficiencies, inequitable access, and catastrophic costs for individuals and families.<sup>56</sup>

#### Factors affecting the impact of private sector provision

Research suggests that the impact of private sector provision on the right to health depends on a number of factors. The following section highlights some of these.

#### *Strength of the commitment to protecting health access and the right to health*

The extent of the continuing commitment of a state to its human rights obligations is a significant factor. The expectations and demands of its citizens that universal access to health services and other human rights guarantees continue to be a universal right regardless of the chosen method of delivery is another prerequisite. A related feature is whether the health system continues to be treated as a core social institution existing for the benefit of society, or whether health services are conceptualized as a commodity.

One disturbing trend is the number of countries moving away from a commitment to the right to health or at least significantly qualifying it. For example, research on Canada—a single-payer health system with a historical commitment to universal coverage, if not to a right to health—shows that health care is increasingly portrayed as a consumer



commodity and a business that can be a source of profit.<sup>57</sup> Critics of these trends claim that the entitlements once designed to enable all social classes to participate fully in social life are being displaced by a notion of market citizenship, the self-reliant and self-interested seller and buyer of classical liberalism.<sup>58</sup>

*Type of health system into which privatization is introduced*

As Jean Drèze and Amartya Sen point out in their recently published book on India, it has quite different implications to introduce private health services in a health system with the solid foundations of universal health coverage provided by the state, as compared with relying on private health care where the state provides very little in terms of health facilities. In the former case, such as in Kerala, private health care for the newly rich can provide additional options without harming the public health system. In the latter case, such as in the northern Indian states, poor people are reliant on poor quality and often expensive private care because of the low allocation of funds to and the resulting inadequacies of public health care.<sup>59</sup>

*Degree of privatization*

Another factor is the type or degree of privatization. A health system in which privatization is used selectively and strategically to accomplish specific objectives is very different from one in which privatization occurs in a wholesale and indiscriminate manner. A comparison of the selective use in many European countries with the wholesale embrace of private health provision in the US provides a telling example. However, some European countries, such as Britain, Sweden, Germany, and Switzerland, seem to be sliding into a greater role for private sector health provision, particularly at the tertiary care level.

A growing body of international research affirms the importance of providing publicly financed health care to achieve universal and equitable health care. An Oxfam study references data from 44 middle- and low-income countries documenting an inverse correlation between the level of private-

sector participation in primary health care and access to treatment.<sup>60</sup> Public-sector financing and delivery also plays an important role in achieving universality of health coverage. No low- or middle-income country in Asia has achieved universal or near-universal access to health care without relying solely or predominantly on tax-funded public delivery.<sup>61</sup> The 2008 report of the WHO Commission on the Social Determinants of Health comes to similar conclusions about the importance of the public sector for attaining universal health care.<sup>62</sup>

*Capacity and willingness to regulate the private sector*

The capacity and willingness of the state to regulate the private sector and try to ensure its adherence to human rights principles constitutes a critical factor. Most high-income countries have an extensive and effective regulatory system built up over decades that regulates prices, quality, levels of service, and citizens' entitlements.<sup>63</sup> If the government is committed to doing so, these capacities can be brought to bear to require that the private sector operates in a manner consistent with human rights norms.

The limited institutional capacity of many low- and middle-income countries constrains constructive engagement with and regulation of private-sector health providers. In part, this reflects the trend towards understaffing and underfunding of regulatory institutions, often a consequence of past disinvestment in health.<sup>64</sup> Regulations are often inappropriate or outdated and enforcement is weak.<sup>65</sup> Thus the states where public provision of health care has failed to provide the minimum standards of decent universal and affordable health care are those least able to oversee that the private sector does so.

*Cost of private health services*

General Comment 14 requires that health care be affordable and articulates a stringent standard of what affordability entails. According to General Comment 14,

[P]ayment for health-care services, as well as services related to the underlying determinants of health has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.<sup>66</sup>

How health care services are financed constitutes a major determinant of access and equity. Financial arrangements determine which people can afford to use private health services when they need them and the financial burdens ill health imposes on individuals and families. Given pressures for cost recovery, public facilities often entail some form of user fees. In Asian countries, for example, it is common for public facilities to charge users for medicines prescribed.<sup>67</sup> Private-sector health institutions, particularly those that are for-profit, usually impose much higher charges than public-sector institutions.<sup>68</sup> Moreover, in poor countries, private health care institutions—especially those at the primary care level—usually require direct payments at the point of service to underwrite the full costs. This is the least equitable approach to financing. It prevents millions from accessing services and results in financial hardships, even impoverishment, for many millions more. The incidence of financial catastrophe associated with direct payments for health services, calculated as the proportion of people who spend more than 40% of their incomes on health care, can be high. Research suggests that households with a member who has a disability, those with children, and those with elderly members are particularly vulnerable to catastrophic health expenditures.<sup>69</sup>

There are a variety of ways that high-income countries committed to universal health coverage reduce reliance on direct payments for private health services: through underwriting the basic cost of medically necessary physician and hospital services, including those secured through the private sector through general tax revenue (Canada, Denmark, England, Italy, New Zealand, Norway); through

social insurance financed by employer-employee payroll taxes and in some cases central taxes (France, Germany); through a regulated private insurance market with subsidies for insurance for the poor and others, like those with disabilities, unemployed, and the elderly, along with government compensation to underwriters based upon a risk-adjustment formula (Netherlands, Switzerland).<sup>70</sup> However, it should be noted that these schemes do not necessarily protect individuals from paying high costs. Cost sharing is rising in many countries to alleviate financial deficits, and there is evidence to suggest that higher co-payments have created barriers to access in some developed countries, for example, Israel.<sup>71</sup>

Unfortunately, most poor countries neither have the resources nor in some cases, the inclination, to regulate private sector payments for medical services or the resources to underwrite or subsidize them. Direct payment at the point of delivery is the default form of financing.

WHO attributes the reliance on direct payment to governments being unwilling to spend more on health or believing they do not have the capacity to expand prepayment and pooling systems. It also observes that many countries impose some form of direct payment to curb the use of health services as a form of cost-containment—at the expense of deterring access to many of those who need it most.<sup>72</sup>

## Concluding reflections

Mixed health systems with health care provision and financing divided into public and private sectors pose significant issues for the realization of a human rights approach. It is therefore important that health and human rights advocates recognize the issues raised and be a consistent voice in the deliberations about the future of health systems.

However, there is little in international human rights law, key human rights interpretative documents, or human rights research which addresses the challenges of mixed or predominantly private health systems in any depth. Simply reiterating that states remain responsible for ensuring that private providers act in accordance

with human rights norms is only a beginning. There is a need to offer specifics as to how this might be accomplished.

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