

# GATS and access to public health care

Professor Allyson Pollock  
Director, Public Health Policy Unit  
University College London

# 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:

public funding and financing –  
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

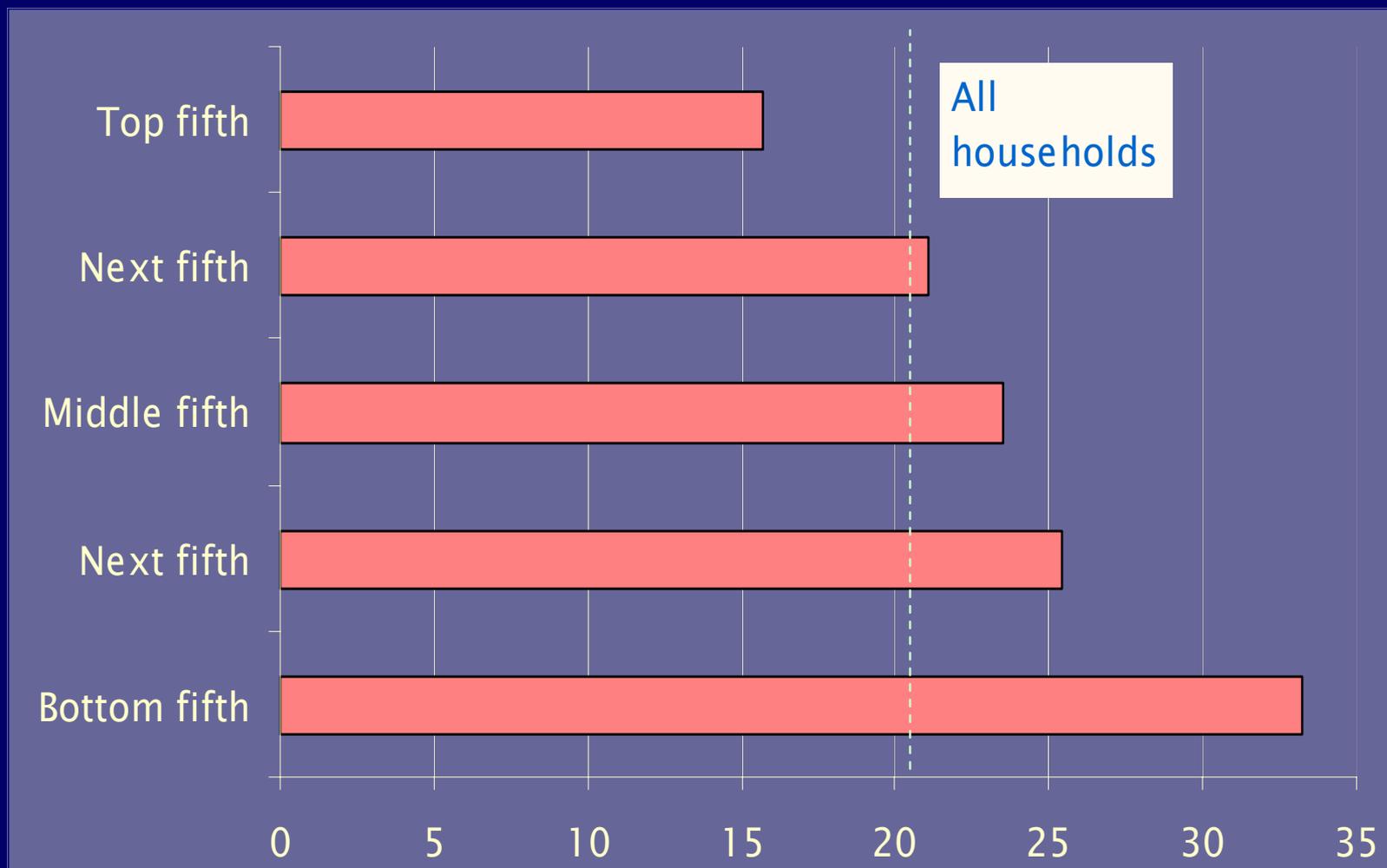
- 1 Income tax (Beveridge system)
- 2 Social insurance (employer, employee contributions) (Bismarkian system)
- 3 Local taxation –
- 4 Private insurance
- 5 Consumption or goods taxes
- 6 Charges

## 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

	No of taxpayers (millions)	Total tax payable (£m)	Average rate of tax payable (percentages)	Average amount of tax payable (£)
£4,535–£4,999	0.5	10	0	20
£5,000–£7,499	3.3	500	3	170
£7,500–£9,999	3.3	2,000	6	550
£10,000–£14,999	6.2	8,500	10	1,260
£15,000–£19,999	4.6	11,000	13	2,270
£20,000–£29,999	5.4	20,700	15	3,690
£30,000–£49,999	3.0	20,800	18	6,810
£50,000–£99,999	1.0	16,700	26	17,400
£100,000 and over	0.3	21,400	34	71,500
<b>All incomes</b>	<b>27.6</b>	<b>101,700</b>	<b>17</b>	<b>3,590</b>

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

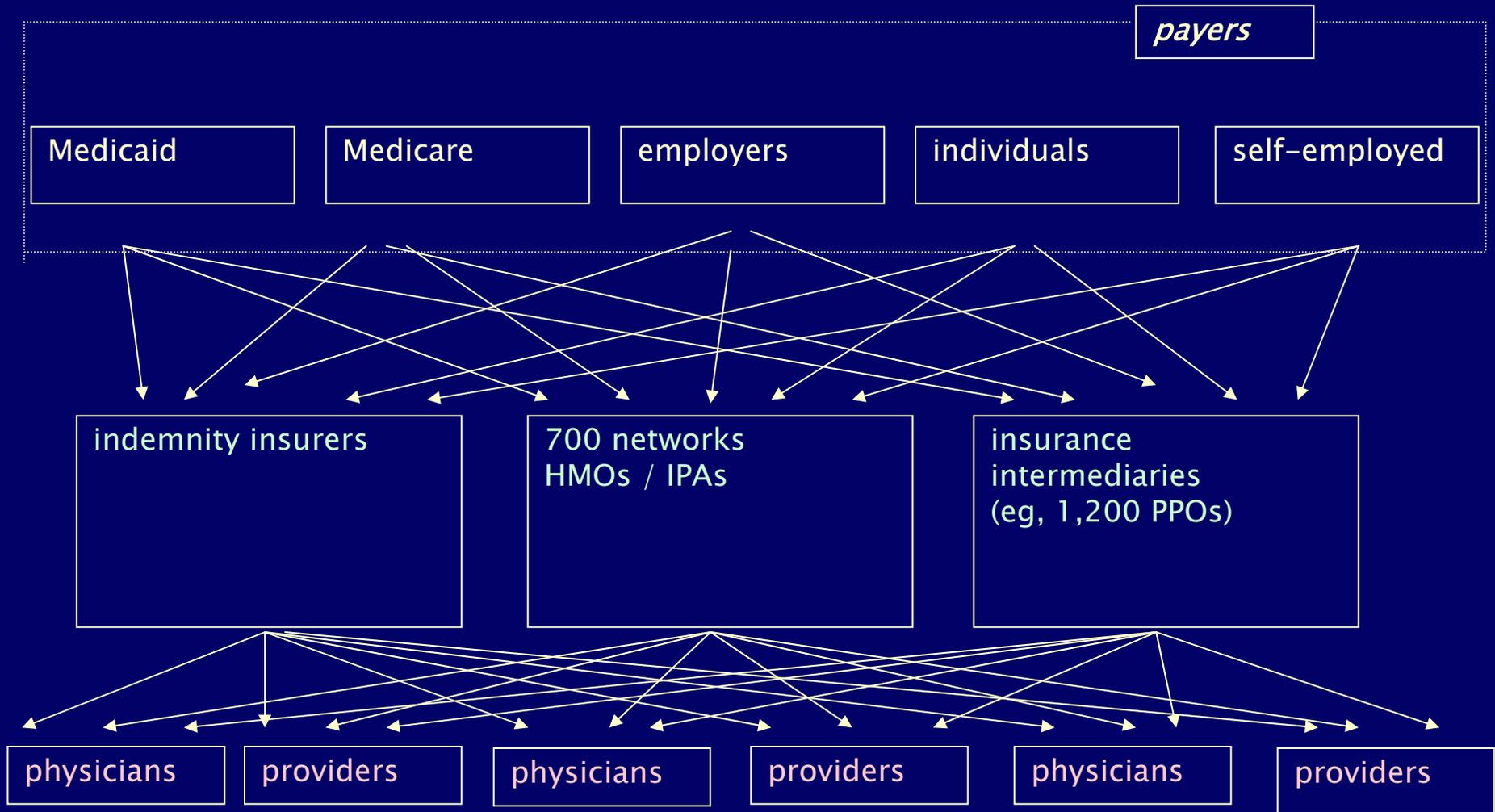
- i select population: members, enrollees
- ii select treatments and patients: price and competition
- iii limit risks: reimbursement DRGs, capitate providers, eligibility criteria, core benefits, top-up fees, co-insurance, user charges (copayments), time-limit care

# Risk pool is fragmented by:

- i excluding groups of people
- ii excluding services
- iii timelimiting or restricting eligibility
- iv externalising / contracting out care

	<b>Universalism Risk pooling and social solidarity</b>	<b>'New' Universalism 'Targeting' Market mechanisms</b>
<b>Methods of funding</b>	Progressive taxation <ul style="list-style-type: none"> <li>- Social insurance</li> <li>- Central taxation</li> </ul>	Regressive taxation <ul style="list-style-type: none"> <li>- Private insurance</li> <li>- local taxation</li> <li>- Charges</li> </ul>
<b>Resource allocation</b>	Risk pooling - geographic allocations on basis of population needs	Individual <ul style="list-style-type: none"> <li>- Capitation payments based on risk</li> </ul>
<b>Service provision</b>	Cross subsidisation of services <ul style="list-style-type: none"> <li>- Block budgets, salaries, state ownership</li> </ul>	Service unbundling <ul style="list-style-type: none"> <li>- Pricing and competition</li> <li>- DRG</li> </ul>
<b>Organisation</b>	Planning authorities <ul style="list-style-type: none"> <li>- 1<sup>o</sup>, 2<sup>o</sup>, 3<sup>o</sup> levels of service within a geographic population</li> <li>- Not- for- profit</li> </ul>	Providers/ Companies <ul style="list-style-type: none"> <li>- enrollees/ members</li> <li>- combine insurance + provider</li> </ul>
<b>Accountability</b>	National and local electorate, users, staff	Shareholders, boards

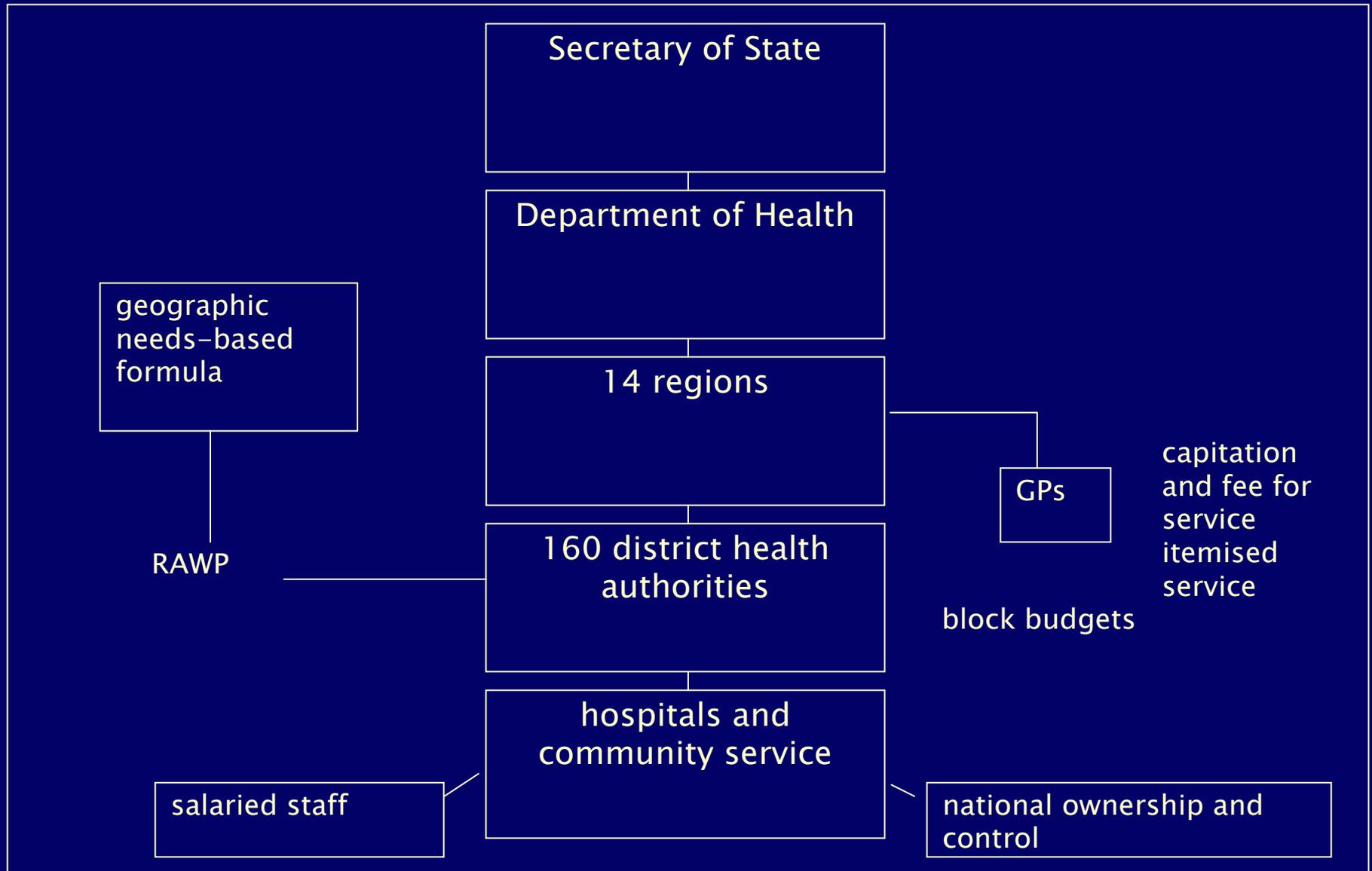
# US Healthcare insurance system. Devolving Risk model



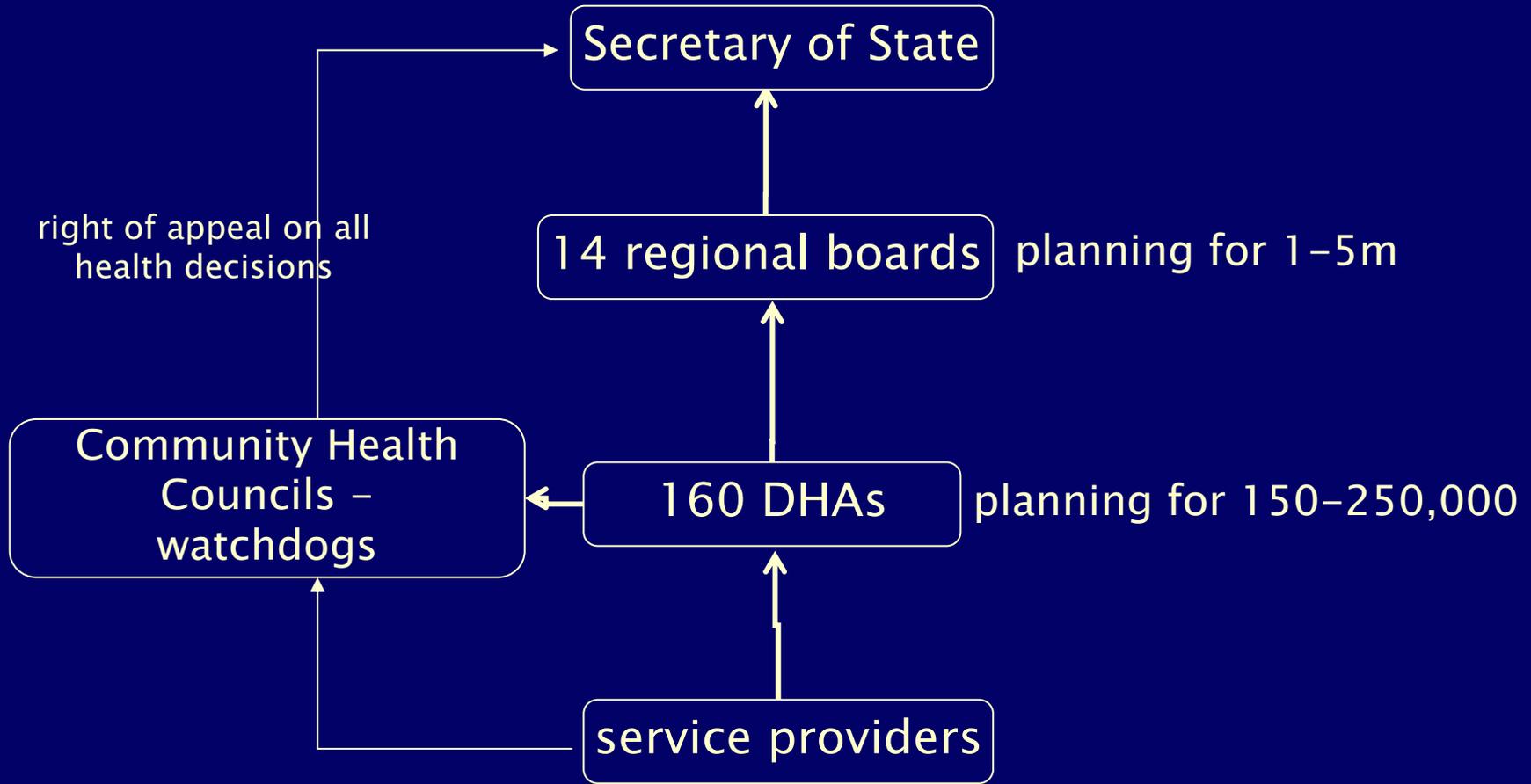
NHS equity mechanisms depend on risk pooling being built into system

- 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 pre1991



# Accountability: NHS pre 1991



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

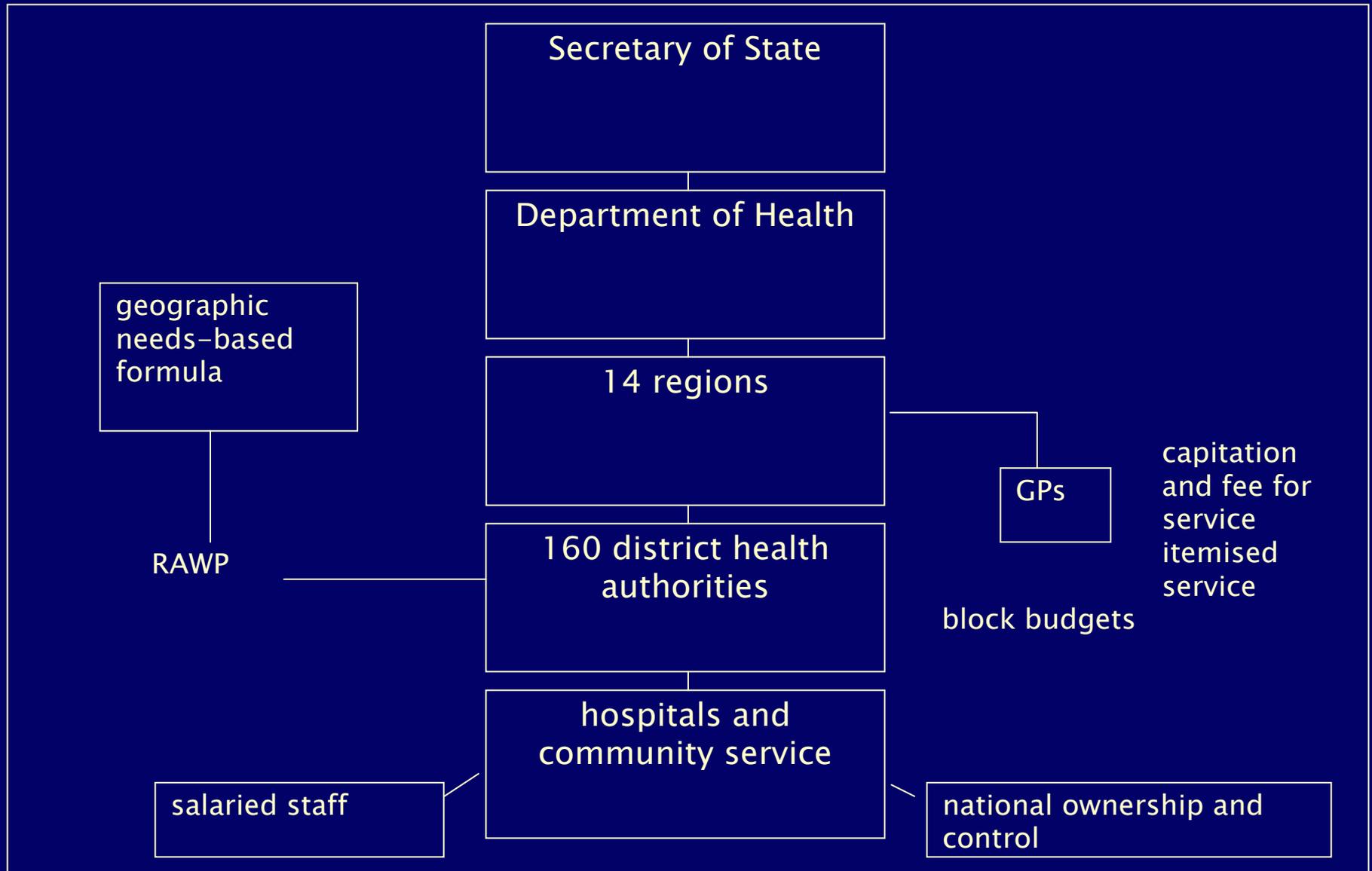
competition and privatisation– scarcity and duplication

undo national and local accountability mechanisms

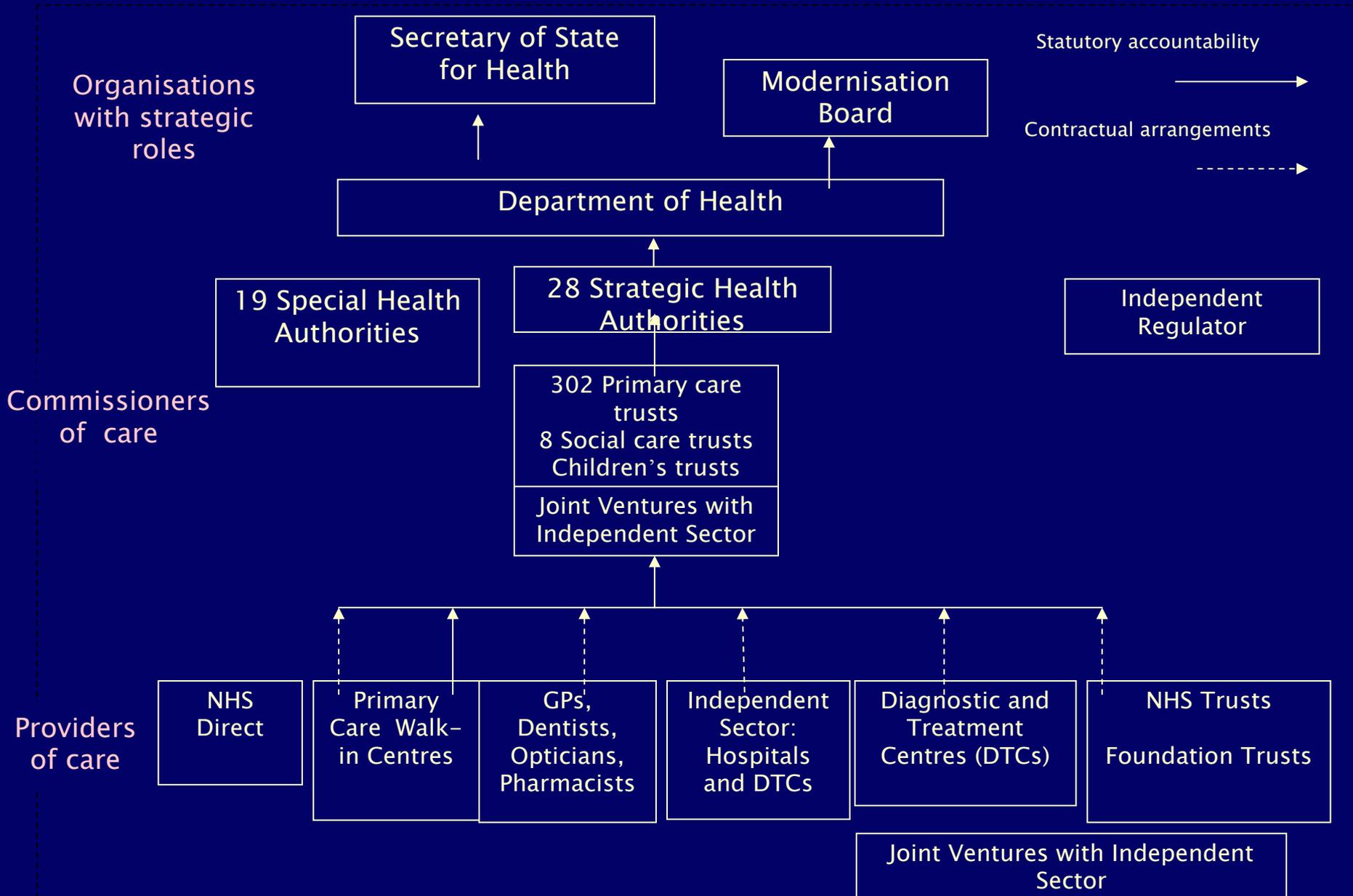
abandon data to monitor equity

	<b>Universalism Risk pooling and social solidarity</b>	<b>'New' Universalism 'Targeting' Market mechanisms</b>
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<b>Resource allocation</b>	<p>Risk pooling - geographic allocations on basis of population needs</p>	<p>Individual</p> <ul style="list-style-type: none"> <li>- Capitation payments based on risk and not need</li> </ul>
<b>Service provision</b>	<p>Cross subsidisation of services</p> <ul style="list-style-type: none"> <li>- Block budgets, salaries, state ownership, low transaction costs, salaried service</li> </ul>	<p>Service unbundling</p> <ul style="list-style-type: none"> <li>- Pricing and competition, transaction costs, DRGs individual risk</li> </ul>
<b>Organisation</b>	<p>Planning authorities</p> <ul style="list-style-type: none"> <li>- 1<sup>o</sup>, 2<sup>o</sup>, 3<sup>o</sup> levels of service for defined geographic populations</li> <li>- Not- for- profit</li> </ul>	<p>Providers/ Companies</p> <ul style="list-style-type: none"> <li>- enrollees/ members</li> <li>- combine insurance + provider</li> </ul>
<b>Accountability</b>	<p>National and local electorate, users, staff. national universal data</p>	<p>Shareholders, boards, no common national data sets</p>

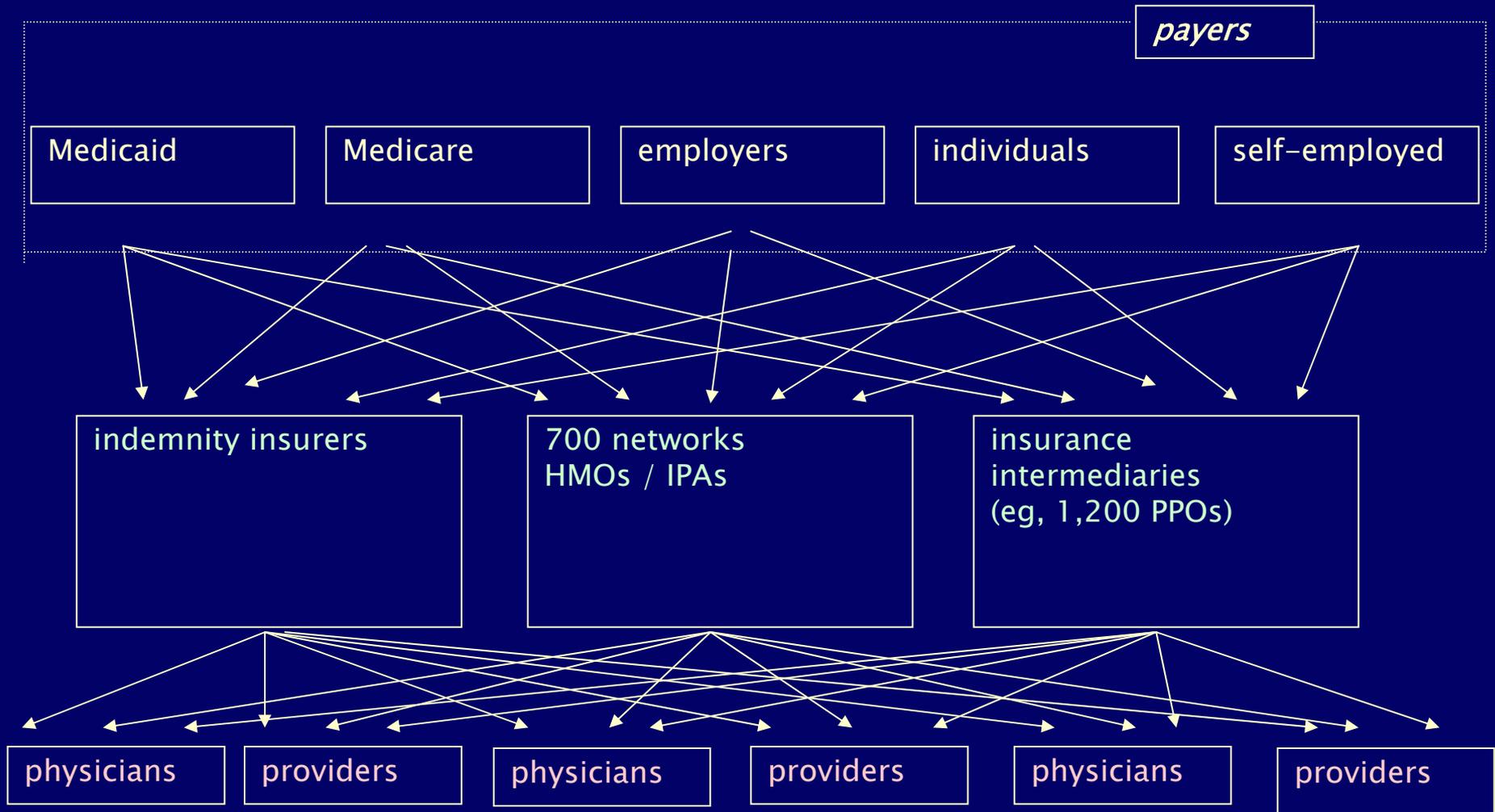
# Funding flows and planning:NHS pre1991



# The structure of the Modern NHS in England, October 2003



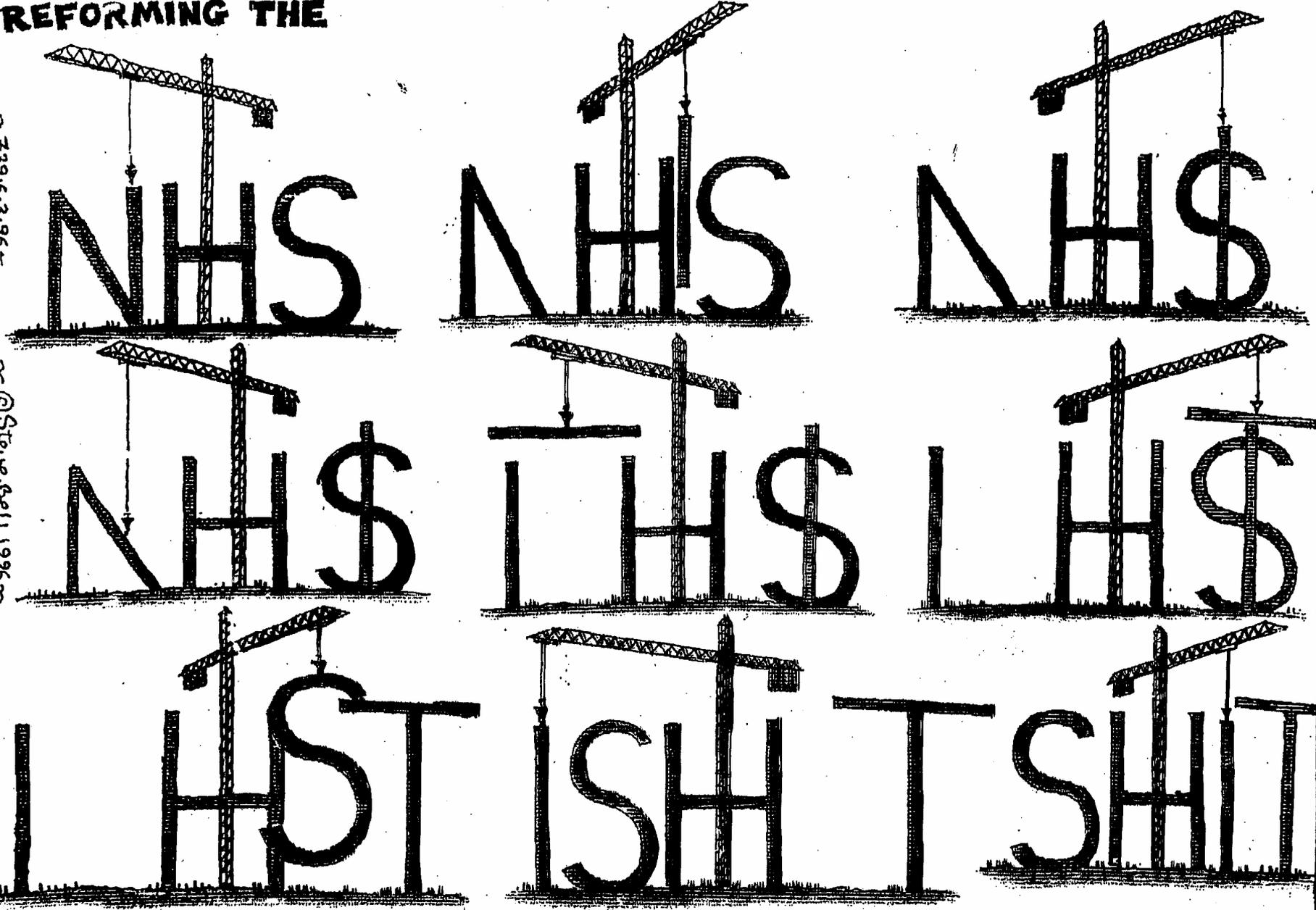
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~ © Steve Selu 1996 ~



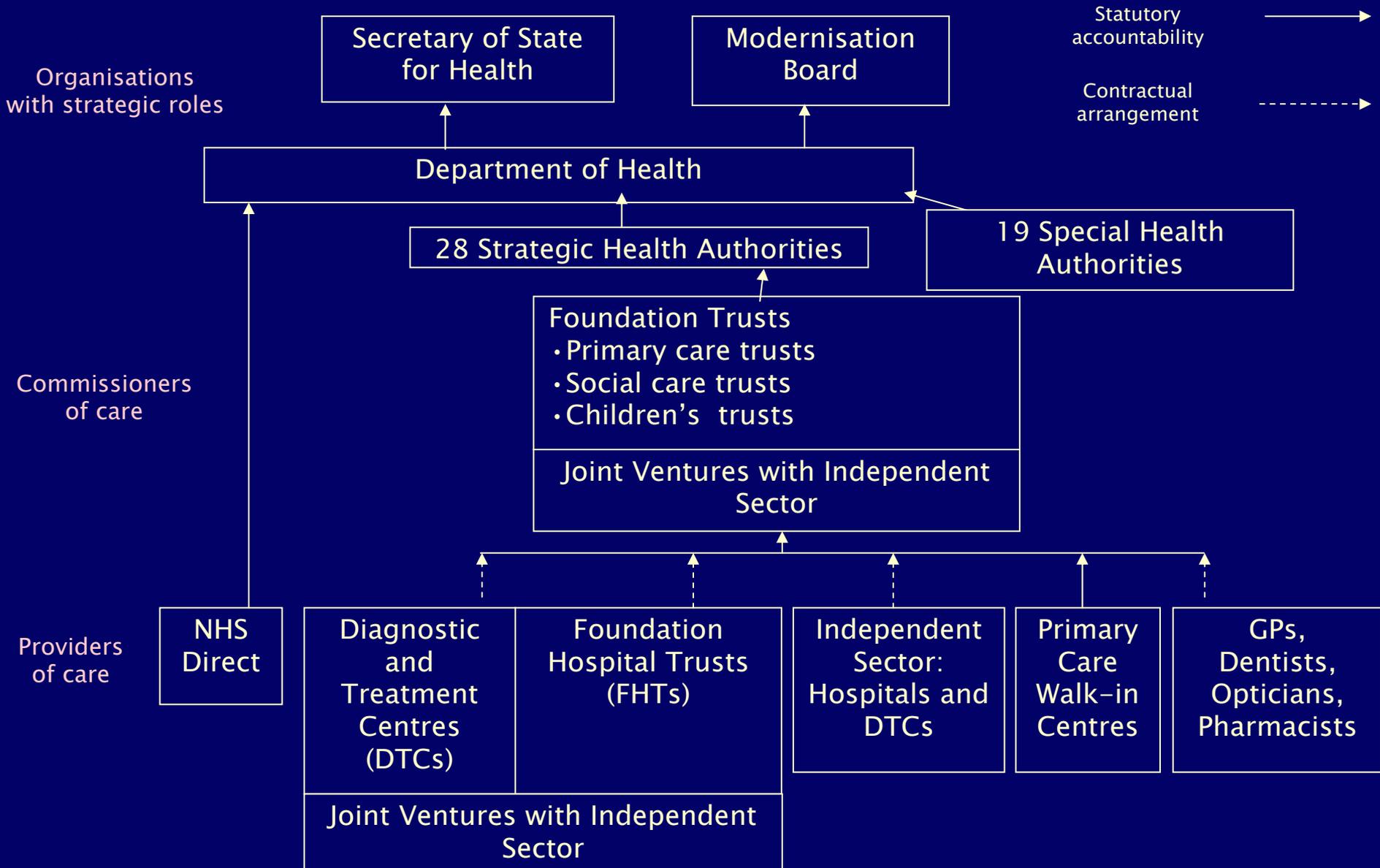
# How market-oriented health system reforms may trigger commercial rules

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 promarket 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



“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