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ESSENTIALS The argument commonly made by politicians in richer countries is that a universal health system is unaffordable because of the enor- mous gains in life expectancy leading to an ageing population, and that market-driven competition and choice is preferred because it in- creases efficiency. There is no evidence to support these claims, and evidence to the contrary on both counts. The ageing of the popula- tion contributes little to the overall growth in expenditure, which is largely attributable to increasing marketization of health systems and costs of medicines and technologies. Since 1948, the United Kingdom has had a universal integrated public health system free at the point of delivery and funded through central taxation. The UK NHS became the model for many countries’ health systems across the world, as having the lowest cost, most effi- cient and fairest system, and guaranteeing healthcare to all its citizens without fear of charges or denial of care. In 2012, after two decades of market incrementalism, the universal public model was abolished in England (although Scotland and Wales still retain it) in favour of a model which increasingly resembles the nonuniversal market form of the United States where risk selection and denial of care prevails. The United States is one of the richest countries in the world and has the most expensive healthcare, but in spite of that it denies more than one in five of its population access to healthcare. Overtreatment and denial of care, catastrophic costs, and spiralling health expend- iture, go hand in hand in the United States. Those countries that have adopted the US model of mixed funding and private provision have more marketization, the greatest inequalities in access, lack of coverage, and highest out-of-pocket payments because market models operate on the basis of risk selection and risk avoidance. We conclude that the decision to have a universal public healthcare system is political. Many countries have decided that universal healthcare is the hallmark of a civilized society and that it is both necessary and affordable for governments to legislate for its citizens to that end. The question of how much any country should spend is inextricably linked to the chosen model of funding and provision, the degree of marketization, and

how much risk selec- tion and denial of care a government is prepared to tolerate in its health system. Introduction Among many high-income countries, healthcare spending has been in relative decline since 2007, when the latest economic recession began. According to the Organisation for Economic Cooperation and Development (OECD), a grouping of the richest countries in the world,1 a third of developed world governments reported a 'real term cut in overall health spending in 2013'. In Italy, Portugal, and Greece real reductions have been taking place for several years. At the same time, checks on future spending levels are being discussed throughout the European Union. A common claim is that advanced economies can no longer afford universal health systems, that is, sys- tems which guarantee a right of access to healthcare for everyone in need of it. What should higher income countries spend? The relative decline in health spending has been accompanied by a growing tendency to treat this question as a technical and non- political issue. According to the International Monetary Fund (IMF), reform is needed because public health spending is 'an im- portant macro-fiscal issue': 'Public spending on health care has been a key driver of aggregate increases in public spending over the past 40 years. [. . .] [S]pending is projected to continue rising as a share of gross domestic product (GDP) unless reforms are undertaken to help break these trends'. Both the European Commission (EC) and the IMF have advised or forced some of the countries worst af- fected by the recession and the aftershock of the banking crisis in 2007–2008 to cut health spending, and Greece to abandon universal healthcare, in return for financial assistance. Throughout the developed world this technical rationale for what has become known as 'austerity' is bolstered by the hypothesis that rich countries are victims of their own success in improving the life expectancy of their citizens. A longer-lived population will 2.15 How much should rich countries' governments spend on healthcare? Allyson M. Pollock and David Price 1 The OECD consists of the following high-income countries: Australia, Austria, Belgium, Canada, Chile, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Japan, Luxembourg, Netherlands, New Zealand, Norway, Poland, Portugal, Republic of Korea, Slovakia, Slovenia, Spain, Sweden, Switzerland, United Kingdom of Great Britain and Northern Ireland, United States of America.

 contain a higher proportion of elderly people than a shorter-lived one and this, it is argued, has created public budgetary pressures that threaten economic well-being. The proffered solution to an 'ageing society' is to cap or reduce public health budgets so that they take up a declining (or no greater than at present) share of national wealth. However, decisions about future levels of spending on healthcare are fundamentally political, or normative, just as are decisions on public expenditure on defence or international development. Today, most governments of the wealthiest countries spend between 7 and 10% of their national wealth on healthcare: the United States is an out- lier at almost 18% (Fig. 2.15.1), and judging how much they should spend in the future is now a pressing political question. To address it we examine, first, the political basis of austerity policy. Secondly, since all normative claims have testable elements or can be reframed so that they are testable, we examine the concepts and empirical evidence that can be used in debates about future levels of spending. To simplify mat- ters we look at the role of politics and austerity through four research lenses, namely, public health, law, finance, and economics and trade. The role of politics and austerity in determining healthcare expenditure Austerity policy is based on claims that are no less political than those that inform alternative spending policies. This is because the econometric models that underpin the policy of reducing public expenditure and public services involve implicit and con- testable value judgements about the benefits of free markets and of a diminishing role for government or relatively low public ex-

penditure. Standard economic theory, according to Paul Krugman, prescribes increased public spending during a recession in order to stimulate demand, even at the expense of growing public deficits (in which governments spend more than they collect). However, the dominant international political policy position known as the ‘Washington consensus’ has been to support the adoption of pri- vate markets with relatively low government involvement in place of tax funded public services. Following the banking crisis in 2008, many governments pursued the policy of reducing health expenditure. Those European Union (EU) countries worst affected by austerity—Italy, Greece, Spain, Portugal, and Ireland—all experienced severe reductions in total and public and private per capita spending on healthcare. The EC and the IMF have required some countries to reduce healthcare spending substantially in exchange for financial assistance. Since 2008, the UK government has opted for substantial cuts in public ex- penditure, provoking criticism from some leading economists that this was less conventional economics than ideological commitment to the private sector and markets. Since 2000, alternative hypotheses about economic develop- ment have been used to generate testable questions about or rebut Health expenditure 2014 for selected OECD countries plus Argentina, Brazil, Costa Rica, Cuba, Dominican Republic, Peru and Venezuela Total health expenditure as a percentage of gross domestic product (public and private) by country 18.0 16.0 14.0 12.0 10.0 8.0 6.0 4.0 2.0 0.0 USA Sweden Switzerland France Germany Austria Cuba New Zealand Netherlands Denmark Belgium Canada Japan Norway Finland Portugal Australia Costa Rica Italy United Kingdom Spain Brazil Greece Chile South Korea Peru Venezuela Argentina Dominican Rep Private Public Fig. 2.15.1 Health expenditure for OECD countries plus some Latin American countries. Data from World Health Organization Global Health Expenditure Database.

2.15 How much should rich countries’ governments spend on healthcare? 163 claims that public spending on healthcare is an economic burden that impairs future rates of economic development. There is now a large body of research that shows that growing inequalities in in- come and health status themselves create economic burdens that retard growth, and that investing in healthcare can stimulate the economy. Several studies have examined the costs of high levels of inequality for developed economies. Wilkinson and Pickett’s The Spirit Level (2009) and Thomas Piketty’s Capital in the Twenty-first Century (2014) challenge the hypothesis that health spending is an eco- nomic burden. Adding weight to the analysis is the World Health Organization’s (WHO) Macroeconomics and Health Commission final report (2003) and the EU’s Investing in Health (2013), the au- thors of which argued that investing in health is a desirable eco- nomic goal because it ‘contributes to the Europe 2020 objective of smart, sustainable and inclusive growth’. Contrary to the IMF, the EU maintains that health spending is now ‘recognised as growth- friendly expenditure’. In a further sign of a changing policy arena, the United Nations Conference on Trade and Development suggested in 2014 that a more flexible approach was needed to public spending and govern- ment institutions than allowed under the Washington consensus (UNCTAD, 2014). A second argument for the political basis of austerity policy arises from findings that economic forecasts have proved to be badly wrong. In April 2014, IMF research staff published an acknowledge- ment that their econometric models had proved to be wide of the mark after it was found that those countries that had implemented the deepest public spending cuts subsequently experienced the lowest levels of economic growth. Thirdly, while the ageing society hypothesis has taken on a mythical status among politicians, it has been rebutted in a series of studies around the world. Ageing, it turns out, is too gradual to explain anything more than quite marginal changes in total health spending. This is because most people’s healthcare costs are incurred in the last six months of life at whatever

age they die. Additionally, there is a body of research which shows that not only do older people contribute more financially and in kind than they take out of the system, but they are living longer and healthier and productive lives (the compression of morbidity). In any event, the ageing hypothesis lacks plausibility when used to suggest that a finite population has infinite healthcare needs. In the United Kingdom, for example, older people have accounted for a relatively small proportion of the increase in spending on healthcare, and while overall spending on health services between 1965 and 1999 grew by 3.8% a year in real terms, demographic change (ageing) accounted for a real increase of just 0.5% a year in sharp contrast to the cost of pharmaceuticals and technology, which rise well above inflation. Background—trends in health spending in richer and some middle-income countries (OECD area plus some Latin American countries) Fig. 2.15.1 and Table 2.15.1 show total spending on healthcare as a proportion of GDP for 2013/2014. Poor-quality data on private spending It is important to note that the quality of data on private spending in both rich and poor countries is limited by the fact that they are based on household surveys, are not comprehensive, and often lack comparability. Moreover, most data reflect spending by or on those who use services, not those who are excluded, and data on the poor and workers in informal economies might not be collected. The re- liability of data about unmet need and inequality remains a critical issue in all countries. Allowing for these limitations, the spending data show: 1. That there are political differences among all countries in the total health expenditure as a proportion of GDP, and in the rela- tive spending on public and private healthcare. The United States is an outlier among all countries, with the highest public and private expenditure. 2. That national (non-insurance-based) health systems (United Kingdom, Norway, Denmark, Italy, New Zealand, Sweden) have Table 2.15.1 Health expenditure 2014 for selected OECD countries plus Argentina, Brazil, Costa Rica, Cuba, Dominican Republic, Peru, and Venezuela as a percentage of gross domestic product Country Public Private Total United States 8.3 8.9 17.1 Sweden 10.0 1.9 11.9 Switzerland 7.7 4.0 11.7 France 9.0 2.5 11.5 Germany 8.7 2.6 11.3 Austria 8.7 2.5 11.2 Cuba 10.6 0.5 11.1 New Zealand 9.1 1.9 11.0 Netherlands 9.5 1.4 10.9 Denmark 9.2 1.6 10.8 Belgium 8.2 2.3 10.6 Canada 7.4 3.0 10.4 Japan 8.6 1.7 10.2 Norway 8.3 1.4 9.7 Finland 7.3 2.4 9.7 Portugal 6.2 3.3 9.5 Australia 6.3 3.1 9.4 Costa Rica 6.8 2.5 9.3 Italy 7.0 2.3 9.2 United Kingdom 7.6 1.5 9.1 Spain 6.4 2.6 9.0 Brazil 3.8 4.5 8.3 Greece 5.0 3.1 8.1 Chile 3.9 3.9 7.8 South Korea 4.0 3.4 7.4 Peru 3.3 2.2 5.5 Venezuela 1.5 3.7 5.3 Argentina 2.7 2.1 4.8 Dominican Rep 2.9 1.4 4.4

 similar levels of total spending to insurance-based countries, but relatively higher levels of public spending, expressed as a propor- tion of GDP, while private spending on health is relatively low in these countries. 3. Countries with high levels of private spending may have mul- tiple public and private insurance systems. 4. Latin American countries also show major differences in public and private expenditure which are related to the design of their health systems. For example, Costa Rica and Cuba both have high levels of public expenditure and universal tax-funded public health systems, whereas Brazil, the Dominican Republic, and Chile have mixed funding and private insurance systems which are not universal. Spending levels The perspective of public health Public health sciences seek to understand, among other things, the best ways in which to maximize population health status and meet public health needs through fairness of funding and services. Within the international public health community, universal access to healthcare has been adopted as the preferred goal of rational health systems for the last 45 years (World Health Organization, 1978). This is the case because it is now accepted that although healthcare is only one of several factors contributing to population health, uni- versal access to it makes a measurably greater contribution than more limited access. In 2015, the two

major international health agencies, the WHO and the World Bank Group, jointly announced that universal healthcare ‘is a critical component of the new Sustainable Development Goals (SDGs)’, which have replaced the Millennium Development Goals as the standard against which to measure policy progress in popula- tion health. Included among SDGs is a target to ‘Achieve [. . .] access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all’ (World Health Organization and World Bank, 2015). The agencies declare: ‘Supporting the right to health and ending extreme poverty can both be pursued through universal health coverage.’ Goals such as the SDGs therefore provide a framework based on public health science for normative debate about health spending. From them it follows that governments committed to the public health goal of maximizing population health status should spend sufficient to ensure universal access to healthcare. The perspective of laws and conventions National laws, constitutions, and international conventions on human rights provide a second framework for debate. Legal analysis can be used to determine to what extent domestic laws may influ- ence governments’ healthcare budgets. In most developed coun- tries, governments are required by primary legislation to fund public healthcare of some description, and within reason to vote through sufficient money to discharge that duty. For example, the parliamen- tary act of 1946 which brought in the NHS throughout the United Kingdom, committed the UK government to funding and providing key listed services for everyone throughout the United Kingdom, a duty that was abolished by the Health and Social Care Act 2012. Similar laws can be found in other countries with universal sys- tems. The Danish Health Act (amended June 2010) requires the gov- ernment to meet, among other things, ‘the need for [. . .] free and equal access to health care’. The objective of Sweden’s health act (the Health and Medical Services Act 1982:763) is ‘care on equal terms for the entire population’. Italy’s national health service law requires that health benefits must be guaranteed to all citizens. The EU, which shares with member states responsibility for healthcare, has adopted ‘principles of equality of access and solidarity in funding ar- rangements, whether that is primarily through taxation or through regulated social insurance’. These principles are applied through the European Court of Justice, the judgements of which are superior to national courts. National laws can be amended and revoked, however, and simply describing them may provide insufficient guidance about duties. Spain abolished its national health service by royal decree in 2010. England’s NHS legislation was changed in 2012 so as to absolve the government of the day from the duty to meet specific service re- quirements for everyone throughout England. Legal analysis was crucial to show the scale and nature of the proposed changes and the ways in which the government can now reduce public expend- iture and withdraw entitlements to healthcare and restrict access to public services without fear of legal challenge. However, the implications of the repeal are still not widely appreciated, and for political reasons the government claims still to be committed to universality. Apart from duties and responsibilities set out in national legis- lation, high-income countries are also subject to provisions of international conventions on human rights to which they are signa- tories. These, though not always enforceable in domestic courts, are relevant to normative debate. Among the most important human rights instruments are the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination Against Women, and the Covenant on Economic, Social, and Cultural Rights. All, according to the WHO, provide ‘a legal and nor- mative framework for the respect, protection and fulfilment of the right to health and other related rights of women, children and ado- lescents’. It is generally accepted that the instruments place national governments under a duty (although not necessarily enforceable) to ‘ensure that health facilities, goods, and services are of good quality, are available in sufficient quantity, and are physically accessible and affordable on the basis of

non-discrimination’. These various laws and conventions constitute a range of legal or quasi-legal provisions that can guide decisions about future spending. The perspective of financing Financial analysis derives from both public health and legal ana- lyses, for if there is an obligation to fund universal healthcare, how should money be raised and distributed so that the duty can be discharged most successfully and at least cost? In general, this question bears on the extent to which there is equity in resource distribution across society, and particularly on the role of publicly financed health spending in redistributing resources from the rich to the poor and from the well to the sick. It resolves itself into three testable questions. The first is the extent to which low incomes are barriers to access, that is, the extent to which patients are required to pay at the point of use (so-called out-of-pocket payments or user

 charges) for the services that they need instead of paying in advance through taxes or insurance. The second is the extent to which ad- vanced payments (instead of user charges) are equitably calibrated and collected, either through insurance premiums or taxes (i.e. are they in line with earnings or income?). The third question concerns the extent to which healthcare funds are allocated according to healthcare needs. Solutions to the first two questions depend largely on the way in which governments raise money to pay for healthcare, that is, on which type of financing maximizes universality. Evidence shows that universality is more likely to be achieved when out-of-pocket payments are minimized, and personal incomes cease to be a bar- rier to access. In many countries, user charges, or private spending, entail catastrophic costs for the household and the individual be- cause of the way they redirect resources from other necessities of life and basic household expenses (absorbing more than 20% of mean household income). In the United Kingdom, most people who re- quire medicines are exempt prescription charges, while in Scotland and Wales prescription charges have been abolished. However, in most countries the cost of medicines is borne by individuals. This is often very expensive for the patient and household expenditure. For example, in poorer countries a single course of medicines for common conditions such as malaria or diabetes may cost several days’ wages. Medical costs including medicine costs are a common cause of personal bankruptcy in all countries, and in the United States they account for three-fifths of all bankruptcies. Since poverty and income inequality are the main causes of ill health it would be paradoxical to raise health funds by means that deepened or failed to address either. Hence, if money is raised in advance rather than at point of use, it needs to be raised by methods that impinge the least (or at least proportionately) on the incomes of the poor. The most equitable funding mechanism is progressive direct tax. The main alternatives, social or private insurance, both involve user charges, sometimes substantial, at point of use and have more limited capacity to address inequality by spreading costs across the whole of the population (a practice known as ‘risk pooling’). In a public healthcare system, the optimal form of financing is progres- sive taxation with a maximum separation between the user and the caregiver to reduce any conflicts of interest. How should money be distributed around the system? Selection versus inclusion Raising money equitably is only half the battle; resources must be al- located according to need if universality is to be achieved. Clearly, if healthcare money is not allocated according to need, or is siphoned off for non-healthcare purposes, healthcare budgets are likely to be underestimated for some parts of the population and overestimated for others. Whether markets or market-like bodies are capable of needs- based allocation is a testable question. One key measure concerns the extent to which the institutions within a health system that are responsible for securing healthcare and the institutions that provide it are inclusive, that is, are

responsible for everyone in a geographical area and are not able to exclude more expensive population groups such as older people and the chronically sick. Were selection of this type to occur the universal goal would be more expensive to achieve or might not be achieved at all. Systems based on private insurance or privately run provision are inherently selective. In these systems corporations manage their financial risks by excluding high cost pa- tients or by limiting the range and nature of services available. Risk selection and out-of-pocket costs: Integrated universal systems and market models Universal public systems must be designed so that they cannot ex- clude patients and citizens from care and are built on redistribution and solidarity and universal risk pooling. In contrast, commercial health insurers and providers select risks (cherry picking). They seek to exclude unprofitable patients such as the chronically ill and elderly, either directly by refusing coverage, or indirectly by char- ging very high premiums, often restrict coverage for pre-existing medical conditions, and frequently leave patients with unaffordable out-of-pocket costs. These insurance practices explain why, in the United States, mainly unprofitable patients' groups are covered by public programmes namely—the poor by Medicaid and the elders by Medicare. Solidarity mechanisms which are integral to the design of public integrated systems cannot operate in commercial health insurance or among private providers because their objective is profitability and solidarity among the wealthy. Private insurers and private pro- viders tailor coverage to purchasing power, not to need, often leaving patients with the most expensive conditions uncovered. Premiums generally rise with age, and high copayments often restrict the use of medical services. Bureaucratic administrative procedures are neces- sary to select out patient who require high-cost care and those who are at high risk. This can lead to patient and system delays. These problems have been observed not only in the United States, but also in middle-income countries that have adopted market-oriented health policies. A second key measure of the wisdom of utilizing market bodies in the pursuit of a population's health provision is the extent to which commercial pressures to consume more may inflate total (public plus private) healthcare costs so that more is spent than required from a public health perspective. This brings us to economic analysis. The perspective of economics and trade All governments want their nation's economies to grow faster, and health spending is often conceived as a factor in economic growth. But both increases and reductions in spending can be supported by different economic analyses. In 2014, for example, a measurable drop of 1.2% in the United States' economic growth forecasts was at- tributed to steps taken by the Obama government to increase access to healthcare and reduce costs and waste, reductions that were hotly contested by the healthcare industry. Similarly, attempts by the UK government in 1957 to control pharmaceutical profits were successfully opposed by the com- panies affected. The industry body, the Association of the British Pharmaceutical Industry, argued—and the government ultimately accepted—that generous profits from proprietary medicines sold to the NHS subsidized standard drugs, funded export marketing, and supported research and development. That principle survived until 2008. Health spending can thus be conceived, economically, as a bene- ficial component of growth or as aid to industry. Alternatively, as we show earlier, under the austerity project it can be seen as an eco- nomic burden, at least so far as public spending is concerned, but as we show next, public and private spending are linked.

 The cost of markets Economists frequently consider the determinants of spending levels in the form of the structural arrangements that lie behind prices and how some structures lead to higher prices than others. The evidence shows that publicly run systems based on geographic areas of administration are cheaper to run. By contrast, markets are

relatively expensive. For example, before market elements were introduced, the United Kingdom's NHS had administration costs of around 6% of total expenditure. These costs now exceed 15% of total expenditure, while in the United States, since 1974 one of the most heavily marketized health systems in the developed world, they exceed 30%. Critiques of the role that markets play in inflating costs have been a staple of American economists for some years. In 2012 the USA's Institute of Medicine published a report in which it reproduced find- ings showing that in the United States, wasted expenditure (approxi- mately $765 billion) made up a large part its uniquely high level of spending on healthcare: 'a substantial proportion of health care expenditures is wasted, leading to little improvement in health or in the quality of care. [Table 2.15.2] contains estimates of excess costs in six domains: unnecessary services, services inefficiently delivered, prices that are too high, excess admin- istrative costs, missed prevention opportunities, and medical fraud.' (Institute of Medicine, 2012) From a public health perspective these excess costs are inefficient, for not only do they represent a huge loss of productive health cap- acity, but to the extent that the wastage is publicly funded they also waste scarce tax resources. In the United States, high levels of pri- vate spending on healthcare have generated public spending levels broadly comparable to those of European countries with universal health systems. However, the United States does not achieve uni- versality, or anything like it, because much of the public spending is devoted to the sort of market-driven costs and wastage listed in Table 2.15.2 and because commercial considerations dominate in resource allocation. The United States has the most expensive system in the world, with around 60 million people uninsured and almost 120 million people underinsured at any one time. Overtreatment and overdiagnosis go hand in hand with the denial of care. Catastrophic health expend- iture due to out-of-pocket health charges is very high. Case study of cost of markets: Medicines One of the biggest drivers of catastrophic costs and healthcare costs in most countries is pharmaceuticals. On average 25% of a country's total health expenditure is spent on medicines, with a wide range from 7.7% to 67.6%, but the source of spending varies enormously. In many low-income countries medicines can absorb as much as 50% of the public healthcare budget annually, compared with 12% in the UK NHS. However, most expenditure on medicines is due to out-of-pocket costs and charges, with pharmaceutical costs ac- counting for 64% of all out-of-pocket payments on healthcare in some countries. Since 1995, the private share of total pharmaceutical expenditure has increased across the world. According to the WHO, across all income groups, private spending by households in 2000 was the principal source of pharmaceutical expenditure, at 57.8% in high in- come, 70.9% in middle-income, and 71.6% in low-income countries. Most of the money that the pharmaceutical industry makes is not spent on producing medicines. It is estimated that 60% of all pharma- ceutical revenues are diverted from healthcare to profits, administra- tion, and marketing costs. According to one analysis of the Forbes 500 drug companies in 2003, of all revenues, 30.8% was spent on marketing and administration, 17% on profits and 14% on research and development (R&D). In the United Kingdom, the Association of the British Pharmaceutical Industry estimated that R&D was 33% of sales compared with 3.7% in the manufacturing industry, and com- pany profits as a percentage of sales ranged from 20 to 43% in 2014. Economists will argue that 'waste' such as the diversion of funds to market bureaucracy, including marketing and billing and invoicing, is nevertheless beneficial in a broader sense because, being eco- nomic activity, it contributes to employment and economic growth. Table 2.15.2 Estimated sources of excess costs in healthcare in the United States, 2009 Category Sources Estimate of excess costs Unnecessary services • Overuse—beyond evidence-established levels • Discretionary use beyond benchmarks • Unnecessary choice of higher-cost services $210 billion Inefficiently delivered services • Mistakes—errors, preventable complications

• Care fragmentation • Unnecessary use of higher-cost providers • Operational inefficiencies at care delivery sites $130 billion Excess administrative costs • Insurance paperwork costs beyond benchmarks • Insurers' administrative inefficiencies • Inefficiencies due to care documentation requirements $190 billion Prices that are too high • Service prices beyond competitive benchmarks • Produce prices beyond competitive benchmarks $105 billion Missed prevention opportunities • Primary prevention • Secondary prevention • Tertiary prevention $55 billion Fraud • All sources—payers, clinicians, patients $75 billion Adapted from Institute of Medicine (2010). The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary. Washington, DC: The National Academies Press.

2.15 How much should rich countries' governments spend on healthcare? 167 The cost of free trade agreements Free trade is another economic perspective which has a bearing on spending. Economists frequently point to the importance of international trade for economic growth, and to the role of healthcare, health insurance, and related goods, principally pharmaceuticals, in generating export-led growth. However, the promotion of free trade (the international equivalent of free mar- kets) can have major implications for spending levels when it is associated with extending healthcare markets and diluting gov- ernment controls. For example, free trade treaties can prevent governments applying price controls, the logical approach to containing inflationary pres- sures on public healthcare budgets. Today, more rigorous pharma- ceutical price controls continue to be opposed by the industry and are under assault by governments of pharmaceutical producing countries through trade treaty negotiations, such as those involving the Trans-Pacific Partnership (TPP) and the Transatlantic Trade and Investment Partnership (TTIP). Both these draft treaties could outlaw or restrict the use of pharmaceutical price controls in cen- trally administered health systems. Such measures threaten the use of global budgets where governments set annual limits to health spending. Rates of expenditure growth are lowest in countries that cap health budgets under central oversight rules, such as England, Italy, Japan, and Sweden, and do not allow the market, consumer de- mand, and provider price-setting to determine global expenditure, such as in the United States. The TPP and TTIP are only the most recent of a series of trade treaties with implications for health spending. In the 1990s, a World Trade Organization (WTO) treaty known as the General Agreement on Tariffs and Trade was exploited by the US insur- ance industry and the US government as a means of opening up new markets for the then struggling, multibillion-dollar busi- ness of health-maintenance organizations. Profits had fallen after 1997 because of market saturation, government, and employer strategies to contain healthcare costs and high-profile scandals. To restore profitability, the industry sought to capture new mar- kets abroad by acquiring publicly run facilities, converting public funds into profits, and repatriating the profits to the United States. In this, it received influential backing for its foreign acquisitions policy in Latin America from the US government, the World Bank, and multilateral financial institutions such as the Inter-American Development Bank. The universal health systems of Europe are the latest target of healthcare corporations with international trade strategies. As can be seen, the aforementioned analyses lead to contradictory findings for health spending using a market model. The branch of economics that deals with supply and demand, microeconomics, is not relevant to our question if universal healthcare is adopted as a goal. This is because microeconomics is built on a principle of effi- ciency in which maximizing individual utility—not access—is the desideratum, and in which healthcare is defined as a private com- modity not an essential public service. The United States offers prac- tical lessons into the effects of the market model which relies on commercial insurers and providers. The inhumanity of that system is a warning to other rich nations and yet it is rapidly becoming the alternative model to the integrated public health system that the United Kingdom

once had. Conclusion We conclude that the decision to have a universal public healthcare system is political. There is strong evidence that universal healthcare is sustainable. In contrast, the United States shows that the more marketized and privatized the systems, the higher the costs, the waste, and the greater the risks of being denied care. The question of how much any country should spend is inextricably linked to the chosen model of funding and provision, the degree of marketiza- tion, and how much risk selection and denial of care a government is prepared to tolerate in its health system. FURTHER READING Anderson GF, et al. (2003). It's the prices, stupid: why the United States is so different from other countries. Health Affairs, 22(3), 89–105. Cameron A, et al. (2011). The World Medicines Situation 2011— Medicines Prices, Availability and Affordability. World Health Organization, Geneva. http://www.who.int/medicines/areas/policy/ world_medicines_situation/WMS_ch6_wPricing_v6.pdf Clements B, Coady D, Gupta S (eds) (2012). The economics of public health care reform in advanced and emerging economies. International Monetary Fund, Washington DC. Institute of Medicine (2012). Best care at lower cost: the path to continu- ously learning health care in America. The National Academies Press, Washington DC. Krugman P (2012). End this depression now. Norton, New York. Marmot M (2016). The health gap: the challenge of an unequal world. Bloomsbury, London. Mossialos EP, Govin BR, Hervey TK (2010). Health systems govern- ance in Europe: the role of EU law and policy. In: Mossialos Elias P, Govin BR, Hervey TK (eds), Health systems governance in Europe, pp. 1–83. Cambridge University Press, Cambridge. Piketty T (2014). Capital in the twenty-first century. Harvard University Press, Harvard. Pollock A (2005). NHS plc: the privatisation of our health care. Verso, London. Price, D, Pollock AM, Shaoul J (1999). How the World Trade Organisation is shaping domestic policies in health care. Lancet, 354(9193), 1889–92. Rosenbaum SJ (2009). Insurance discrimination on the basis of health status: an overview of discrimination practices, federal law, and fed- eral reform options. J Law Med Ethics, 37(2), 101–20. Starfield B (2008). The future of primary care: refocusing the system. N Engl J Med, 359 (20), 2087–91. UNCTAD (2014). Trade and development report. United Nations, New York. Webster C (1988). The health services since the war. Vol 1: Problems of health care: the National Health Service before 1957. HMSO, London. Wilkinson R, Pickett K (2010). The spirit level: why more equal societies almost always do better. Penguin, Harmondsworth. World Health Organization (1978). Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978.
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