GLOBALISATION AND COMMERCIALISATION OF HEALTHCARE SERVICES

With Particular Reference to the United States and the United Kingdom

by

Michael Drymoussis

This thesis is re-submitted in fulfilment of the requirements for the degree of Master of Philosophy, in the School of Law, Politics and Sociology at the University of Sussex, Falmer, Brighton.

April 2014

Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

_____

Dedication

Dedicated to Lily Sykes (1919-2007), loving grandmother and source of undying positive thinking in the gloomiest of times. It is people like herself, who experienced the world before an NHS, who have seen the great difference good public health services can make to people's lives from cradle to grave.

May she rest in peace.

UNIVERSITY OF SUSSEX

Michael Drymoussis

Master of Philosopy, in the School of Law, Politics and Sociology

GLOBALISATION AND COMMERCIALISATION OF HEALTHCARE SERVICES

With Reference to the United States and United Kingdom

SUMMARY

The thesis seeks to interrogate historically the relationship between multinational healthcare service companies and states in the pursuit of market-oriented reforms for healthcare. It constitutes a critical reading of the idea of globalisation as a concept with substantive explanatory value to analyse the causal role of multinational service firms in a commercial transformation in national healthcare service sectors. It analyses the development and expansion of commercial (for-profit) healthcare service provision and financing in the healthcare systems of OECD countries. The hospital and health insurance sectors in the US and UK are analysed as case studies towards developing this critical reading from a more specific national setting.

The thesis contributes to developing a framework for analysing the emergence of an international market for trade in healthcare services, which is a recently emerging area of research in the social sciences. As such, it uses an interdisciplinary approach, utilising insights from health policy and international political economy. The research entails a longitudinal study of secondary and primary sources of qualitative data broadly covering the period 1975-2005. I have also made extensive use of quantitative data to illustrate key economic trends that are relevant to the changes in the particular healthcare services sectors analysed.

The research finds a substantive shift in the mixed economy of healthcare in which commercial healthcare service provision and financing are increasing. However, while the internationalisation of healthcare service firms is a key element in helping to drive some of this change, the changes are ultimately highly dependent on state-level decision making and regulation. In this context, the thesis argues that globalisation presents an inadequate and potentially misleading conceptual framework for analysing these changes without a historical grounding in the particular developments of national and international markets for healthcare services.

Acknowledgements

To acknowledge all the people to whom thanks is due would be a formidable task. While it is impossible to thank individually all those who made this study possible, I would at least mention the following, since their cooperation and help was vital.

First and foremost, I wish to thank my supervisor, Professor John Abraham, for his unflagging support and unending patience throughout the course of this work, especially during the hard times, and for his criticism, knowledge and perceptiveness in keeping me on the right track.

While Professor Kees Van der Pijl was the first to inspire my interest in critical understanding of the international political economy, thus sowing the seeds for my current work, John MacLean, co-supervisor during my first year of the PhD, gave important early inspiration and help.

I owe a debt of gratitude to the Economic and Social Research Council for their economic support. For providing me with the environment and support for my work I warmly thank the administrative and academic staff in the School of Law, Politics and Sociology, formerly under the School of Social Sciences and Cultural Studies, and particularly the Department of Sociology and Department of International Relations at the University of Sussex.

For access to the data necessary to my study, I am most grateful to the Public Services International Research Unit; the library search facility at Sussex University Library; the British Library of Development Studies; the Library of the London School of Hygiene and Tropical Medicine; the British Library Humanities Reading Room and the Business and Intellectual Property Reading Room; and the kind help of the staff of the King's Fund Library. A great debt goes to many academics whose collective body of work has allowed mine to be realised and have set the standard for me to strive for in this and future work. In addition, thanks must go to friends and DPhil colleagues, past and current, whose impact on the thesis has been felt one way or another.

A special tribute is paid to my family, especially to my parents, Diane and Ioannis Drymoussis and my sister Zoe for their never-ending encouragement and constant belief in me as well as

their financial, emotional and logistical support, without which, I could not have completed this study.

A special mention goes to my dear colleague and adoptive brother, Dr. Bhabani Nayak, who has been not only a great source of emotional support but provided me with important intellectual inspiration, and to my dear girlfriend, Sabine Schild, to whom I am indebted for her understanding and great emotional support during the final period of my thesis write-up. Their support and advice, throughout the last months of the PhD has helped keep me away from the dark side.

For any errors or inadequacies that may remain in this work, the responsibility is entirely my own.

January 2010

Acronyms

ABHI	Association of British Healthcare Industries
AHA	American Hospital Association
AHCA	Agency for Health Care Administration
AMI	American Medical International, Inc.
BMA	British Medical Association
BUPA	British United Provident Association
CiGNA	Formed from insurance firms CG (Connecticut General Life Insurance Company) INA (Insurance Company of North America)
CMH	Commission on Macroeconomics and Health
CMS	Centres for Medicare and Medicaid Services (US: 2001- current)
DH	Department of Health (UK: 1988-current)
DHHS	Department of Health and Human Services (US government)
DHSS	Department of Health and Social Services (UK: 1968-1988)
DRG	Diagnosis-Related Group
DTC	Diagnosis and Treatment Centre
EEA	European Economic Area
EU	European Union
EurCom	European Commission
FDI	Foreign Direct Investment
FFS	Fee-For-Service
FT	Foundation Trust (UK: 2003-current)
FTAA	Free Trade Area of the Americas
G500	Fortune Global 500
GATS	General Agreement on Trade in Services
GDP	Gross Domestic Product
GHG	General Health Group
GRE	Guardian Royal Exchange
HCA	Hospital Corporation of America
HCFA	Health Care Financing Administration (US: 1977-2001)
HMO	Health Maintenance Organization (US)
ICT	Information and Communications Technologies
IHA	Independent Healthcare Association
IHC	'independent hospital and clinical provider' (UK) (term)
IMF	International Monetary Fund
IPA	Independent Practice Association
IPE	International Political Economy
IPT	Insurance Premium Tax (UK)
IR	International Relations
ISTC	Independent Sector Treatment Centre
LIFT	Local Investment Finance Trust
LSHTM	London School of Hygiene and Tropical Medicine
MCO	Managed Care Organization
MNC	Multinational Corporation
MTA	Regional and International Multilateral Trade Agreement

NEH	National Expenditure on Health
NHS	National Health Service (UK)
NME	National Medical Enterprises
OECD	Organisation for Economic Cooperation and Development
OHE	Office of Health Economics
OLI	'location and internalisation advantages' (term)
OOP	Out of the pocket
PCG	Primary Care Group (UK)
PCT	Primary Care Trust (UK: 2002-current)
PFI	Private Finance initiative
PHI	Private Health Insurance
PMI	British private medical insurance
PPO	Preferred provider organizations
PPP	'Public-Private Partnership' (term)
PPP	Private Patients Plan (company)
PPS	Prospective Payer System
PSIRU	Public Services International Research Unit
PSP	Point of service plan
SEA	European Medicines Evaluation Agency
SHA	Strategic Health Authority (UK)
SME	Small and Medium Enterprises
TEH	Total Expenditure on Health
UK	United Kingdom
UN	United Nations
UNISON	Public Services Union (UK)
US / USA	United States of America
VA	Veterans Administration
WDR	World Development Reports
WHO	World Health Organization
WHR	World Health Report
WPA	Western Provident Association (UK company)
WSF	'Welfare State Formation' (term)
WTO	World Trade Organization
WWII	World War II

Table of Contents

List of tables

List of Figures

Chapter 1: Introduction

By the late 1990s healthcare systems in the Organisation of Economic Cooperation and Development (OECD) member countries had already been undergoing several years of incremental restructuring in which 'the market' had become a much more ubiquitous feature in the organisation and delivery of healthcare services.[1] In the first decade of the 21st century this appears to be a firmly entrenched aspect in public policy for healthcare; as governments in most OECD countries, with state-based as much as with market-based healthcare systems, have continued to explore ways in which market-oriented institutional structures can be employed to address some of the core challenges in the financing and provision of healthcare (Cutler, 2002; Docteur & Oxley, 2001).[2] This trend has seen an array of reform measures across the OECD member states including, most commonly, increases in the share of costs for healthcare assumed by households and individuals, the introduction of competitive relations between health service providers and health financing institutions (whether insurers or other funding bodies), and the privatisation of various segments of national healthcare service capacity.

The onset of the market form in healthcare systems has marked a profound disjuncture from the post-war period of incremental 'de-commodification' in social welfare provisions, such as healthcare, which has been a common trend amongst most developed countries in this period. Over the past three decades the emergence of market-oriented healthcare policy has also been accompanied by a steady proliferation of for-profit organizations involved in the provision and financing of healthcare services. An important aspect of this trend has been the penetration of such

---

[1] At this stage I would like to distinguish between my use of the term 'market' when referring to the organisational changes I am examining (i.e. 'market-style' or 'market-oriented' public policies) which are aimed at fundamentally changing medical or administrative practices or the framework in which provider-patient relations are carried out for instance, and the 'market' to refer to a particular segment or sector in healthcare (i.e. 'the health insurance market') as an analytically discrete area in which organisations examined share a common product. In the former case it is a reference to the use of a competitive model for the organisation of healthcare services which may operate within either a designated public sector context as much as in a private 'non-profit' or private 'for-profit' context. In the latter case I do not assume either a 'competitive' or 'non-competitive' framework since, given the multitude of public and private sector provision and financing that is intrinsic to all healthcare systems this may generically be referred to as a market.

[2] In this thesis I am using the OECD as a proxy for a group of countries with a broadly similar economic status, that is developed countries, and to distinguish my broader comparative statements from developing countries. While this study takes account of an extended time period including the post-WWII era but with greater focus on the last quarter of the 20th century, I acknowledge that the member states comprising the OECD have changed over time, with newer members added over the past few decades. As such I do not assume this to be a diachronically static category for describing developed countries.

for-profit firms into markets in other national locations, and this is a feature which seems to have intensified since the mid-1990s (Hall, 2001).

Moreover, since this period, such cross-border market penetration appears to be a key feature often encouraged within the fold of the public policy agendas for market-oriented healthcare reform in a number of countries (Mackintosh & Koivusalo *eds*, 2005). This can be seen as much within the national public policy sphere as within the international policy domain, propagated and perpetuated via international organisations including the World Bank and IMF, whereby the adoption of market-oriented reforms to public sector welfare institutions and the proliferation of private sector involvement in these is highly valorised and promoted (Koivusalo, 2001; Lister, 2005). The activities of multilateral institutions such as the WTO's General Agreement on Trade in Services (GATS) and the European Unions's (EU) Directive for the liberalisation of its internal market only serve to enhance the pressure on national healthcare systems to become absorbed into an international commercial agenda for healthcare (Pollock & Price, 2000; Rowland *et al*, 2004). The intensification of the internationalisation trend that I am talking about, against the background of the commercialisation of healthcare services constitutes the central component of the research agenda underlying my thesis.

Throughout the 1990s and into the 2000s a dominant analytical framework for explaining the relationship between internationalising commercial agents and national structural changes has been that of 'globalisation'. It has become a ubiquitous conceptual tool to refer to the multiplicity of structural changes and the causal relationships between them that I have been describing (Lee, Fustukian, & Buse, 2002; Lee, K. *ed*, 2003; Mackintosh & Koivusalo *eds*, 2005). Its explanatory value is implicit within the fact that it offers a means of describing new levels of complexity in social relations over the past few decades. Typically this rests on the understanding that there is an intensification of links between institutions and agents across national territorial spaces that were unprecedented prior to a specific chronological period, usually taken to be around the 1990s. It brings supposed order to this increasingly complex level of interaction, which is bringing different national locations into a common framework of change. In this reading, the expansion of commercial enterprises is essentially part of a natural convergence of different national healthcare systems towards a more highly market-oriented structure.

What I am arguing, however, in this thesis is that 'globalisation' offers an inadequate conceptual framework to explain the emergence of an international healthcare services market. It does not provide a basis to explain the commercial transformation of healthcare services against the

background of market-oriented reforms that have become a widespread trend across the OECD member states. Instead, I argue that the commercialisation of healthcare services and the causal role of internationalising companies in this scenario is something that needs to be interrogated from within the specific national context where healthcare service firms are based. This requires an understanding of the historical context in which commercialisation has developed in different national locations.

In my research I have sought to interrogate historically the interplay between multinational healthcare companies and states in the pursuit of market-oriented reforms for healthcare. On one level my thesis is a critical reading of the idea of globalisation as a concept with substantive explanatory value to analyse the causal role of multinational service firms in a commercial transformation in national healthcare service sectors. This forms the crux of my discussion, in Chapter 2, of several different strands of literature aiming towards a synthesis approach of understanding the changes qualitative changes that form the basis of my research agenda.

On another level, my thesis is a historical analysis of the development and expansion of commercial (for-profit) healthcare service provision and financing in the healthcare systems of 'developed' countries. By historical, I mean tracking the evolution over and extended time period of the emergence of market-oriented healthcare reforms in a comparative context across several different national locations. The purpose of this is to establish the degree to which there is an actual convergence towards a specific market-oriented framework that creates the space for commercial transformation of healthcare services which I do in Chapter 3, through an exploration of trends in the OECD group of countries leading towards market oriented healthcare reforms. This exercise provides both a useful insight into the broader trend of market-oriented healthcare reforms, but also helps to situate my research of specific national cases of the US and UK hospital and health insurance sectors which I develop in the 5th and 6th chapters respectively.

A key component of the 'globalisation' thesis is to do with the intensification of international linkages between different national territorial locations and the emergence of new cross-national structures. The emergence of an international healthcare market thus requires an assessment of the degree to which the expansion of commercial organisations has become a substantively new development. As such, I have sought to develop a framework for empirical research into the scale of internationalisation, which is necessary prior to extrapolating a general 'global' trend about these substantive changes in healthcare services. Mapping the scale and scope of internationalisation of the world's largest companies within key segments of the international healthcare services market

in Chapter 4, I have sought to contribute to field of research a framework for generating a fuller picture of what is actually internationalising about healthcare service corporations.

In the next section I briefly elaborate on the context of my research and develop the core research questions driving this thesis. Next I briefly discuss my methodology and some key limitations of my research, and I conclude this introductory chapter with an outline of the chapters in the thesis.

1.1. The research agenda: market-oriented healthcare reform and the development of an international healthcare services market

1.1.1. Historical context

The post-war involvement of governments in healthcare has arguably been the most important driving force in creating the vast and complex institutional landscape that characterises contemporary healthcare systems, combining a massive and complex network of medical service providers, financing organisations, convalescent and rehabilitative care services, mental health, public health systems, medical technologies manufacturers and suppliers, and numerous related non-health-specific industries that count on the healthcare sector as a major source of business and revenue. For several decades after the Second World War (WWII), most OECD countries made reforms by moving towards universalising access to healthcare through the expansion of public sector financing and, in many cases, of public sector provision with a view to limiting or eliminating financial barriers for access to healthcare for households. The chief logic of these efforts were focused on 'de-commodifying' healthcare as a sphere of social relations (Esping-Andersen, 1990; Roemer, 1976). While this development had been quite uneven across the OECD membership - in terms of the *timing* of universalisation,[3] the *extent* to which public sector intervention had been instituted,[4] and in the *form* of state intervention [5] - this formative period has seen healthcare systems become increasingly a major component of national economic production.[6]

[3] While a large number of OECD countries introduced universalisation of coverage in the first couple of decades after WWII, many did not introduce legislation to this end until the 1970s and 1980s.
[4] Many countries retained extensive private sector provision albeit regulated by public agencies, though in most cases public sector spending accounts for the largest portion of overall healthcare spending.

In a dominant interpretation, the massive expansion of healthcare systems and the scale of resources they absorbed by the 1970s have posed a significant challenge to the fiscal sustainability of the public contribution to healthcare (Cutler, 2002). This challenge is understood by many as following from *endogenous* limits reached by post-war healthcare systems in developed countries, including the pressures generated by ageing demographics, the increasing costs associated with adoption of new medical technologies, and an epidemiological shift from acute conditions and infectious disease to chronic conditions and non-communicable disease (Wilkinson, 1996; Blank & Burau, 2004). In addition, the growing expectations of patients and citizens of what healthcare systems can and should provide are often cited as an important political factor for reforming healthcare systems to become more responsive to patient needs and wants. The endogenous challenge has been accompanied by an *exogenous* challenge widely associated with changing conditions in the international political economy. With the world oil shocks in the early-1970s, most countries faced a protracted period of uncertainty with rising inflation and economic stagnation, a situation which prompted most governments in developed countries to seek ways to control public expenditure in general (Schieber & Poullier, 1990; Armstrong, Glynn & Harrison, 1991). In the face of a growing *fiscal crisis*, the Keynesian policy approach which had largely sustained the post-WWII growth in public spending in developed economies was rapidly losing favour and most OECD countries entered a period from the late 1970s marked by attempts to contain public spending in general and associated with the ascent of a neoliberal ideological framework for economic and social policy from the 1980s (Altenstetter & Haywood, 1991; Harvey, 2005).

In the early 21st century the fiscal challenge remains a central issue of healthcare policy: how to pay for healthcare without undermining the equity, quality and efficiency goals of healthcare policy (Cutler, 2002). The past two to three decades have seen a number of policy responses which have sought one way or another to balance this particular 'trade-off'. However, not all of these have been based on economic solutions even while many of these policies have been instituted accompanied by justifications of cost-containment, improvement of efficiency and responsiveness of providers to patient needs (and wants), and an increase in the value for the money spent on

---

[5] There are a lot of features in common between healthcare systems, but the way in which financing and provision have been organised do vary considerably between countries largely due to the historical-political development of healthcare systems (key distinctions for instance being between 'Bismark', 'Beveridge', 'Hybrid' or 'Semashko' models: cf. Lister, 2005, p. 127).

[6] To illustrate this point, total expenditure on healthcare has risen from less than 3% of GDP in most developed countries in the earlier part of the 20th century to around 8%-9% in most Western European countries and a staggering 15%-16% in the US in the early 21st century (OECD, 2006b).

healthcare. Changes in medical practices, administrative arrangements, and a greater emphasis on primary care and public health (if only rhetorically) have been important in shifting the discourse on healthcare in the past twenty years. But the fundamental distributional problem that underlies this 'trade-off' has meant that the economic aspect in healthcare reform has continued to be central to policy analysis and debate (Mossialos & Dixon, 2002). In a bid to address the fiscal problem of healthcare most governments of OECD countries sought increasingly to regulate and contain spending growth during the 1980s through a wide spectrum of policies including rationalisation of hospital capacity and various macroeconomic controls. The attention that such control measures brought on the inefficiencies inherent in healthcare services was, however, accompanied by the realisation that cost-controls in themselves potentially threaten the other variables in the trade-off (i.e. equity and quality).

Throughout the 1990s and into the 21st century, market-oriented solutions became increasingly popular. Many governments of OECD countries relied on such solutions as a means of containing the continuing growth on healthcare spending, whilst enabling greater responsiveness to patient demand but also increasing the efficiency of providers in the use of their resources and raising productivity (Cutler, 2002). Whether focused on containing costs or on fundamentally changing the institutional structure of healthcare services, such market-oriented reforms have impacted upon the dynamic of the *mixed economy of healthcare* which, although variably manifested and implemented between countries, marks a common transition towards a more commercial context for healthcare services provision and financing across OECD countries.

However, the research undertaken for this thesis has indicated that the commercialisation process is not only uneven between countries but also within each country, and the same can be said for the internationalisation of commercial healthcare services. While there is much recognition that this is a significantly developing trend it remains under-researched, while a lack of clarity about the extent to which these developments are progressing persists both within academia and in public policy.

The international agenda for the liberalisation of services raises several important questions about the commercialisation trend. For cross-border trade in healthcare services to be gauged, it is important to have an understanding of the extent to which commercial enterprises have expanded internationally. I explore this in Chapter 4 and examine the different modes of internationalisation of healthcare services, keeping in mind the scope for their commercial development. However, prior to the analysis of internationalisation, it is important to understand the development of

commercialisation in a national setting and I have started my empirical investigation with an international assessment of commercialisation across the OECD countries which I do in Chapter 3. Within this context the key research questions for my thesis are summarised in the rest of this section.

1.1.2. The commercialisation of healthcare services

Of the two main components of my thesis, the issue of commercialisation in healthcare is the most extensively documented and analysed in existing literature. However this is still largely confined to national-level (as opposed to international comparative) and sector-level studies. Market-oriented reforms do not necessarily spell a 'for-profit' orientation of healthcare services even though the expansion of commercial enterprise in healthcare services is still a notable trend that has been pinpointed in various national-based studies. My first aim has therefore been to determine to what extent commercialisation has been a substantive trend so far on an international scale and to explore the conditions that have generated a commercial transformation of healthcare services. In the third chapter of this thesis I approach these issues with an overview of market-oriented reforms that set the basis for the commercialisation of services.

Commercialisation of healthcare services, where it has taken place, has mostly been a national and fairly localised phenomenon: commercial healthcare providers have typically expanded their market share within national boundaries and more usually in urban metropolitan areas where for-profit healthcare is more viable. However, though cross-border commercial expansion has developed less than at national level expansion, since the early to mid-1990s, it has become a more notable feature of the healthcare services market. Moreover, while international market penetration by commercial providers is overshadowed in scale by national-level developments there is already evidence showing the capacity of such cross-border commercial penetration to have a transformative effect on national healthcare service markets.

In the context of the current international agenda for the liberalisation of trade in services and the erosion of the public sector status of healthcare financing and provision, there is the growing possibility of an intensifying commercial transformation of healthcare services facilitated by public policies. An international overview, however, is still limited to looking for commonalities and differences. Having analysed the extent of the commercialisation trend there are still questions about the mechanisms of commercialisation, tentatively identified in the international overview.

Equally important is to investigate how and to what extent commercialisation has impacted on the different segments of the healthcare services sector particularly those segments that have experienced substantive changes in the post-WWII period following increased governmental intervention. It is also important to understand the way in which they have been transforming in the more recent period of market-oriented healthcare policy. With my historical analysis of the US and UK cases, I demonstrate that commercialisation has no evident outcome. That is to say it has historically been a negotiated development dependent as much on the agency of provider and financing organisations as on the role of state policy making. Because of the historical context of commercialisation trend for healthcare services, and in view of a more recently emerging international agenda for the liberalisation for trade in services, an association between *globalisation* and *commercialisation* is often made both in academia and in public policy to explain these changes. This is why an overarching concern of my thesis is with the extent to which the notion of 'globalisation' provides an adequate conceptual basis for understanding this 'commercialisation' trend and the degree to which it is being precipitated by the internationalisation of healthcare service firms.

1.1.3. Internationalisation and a global transformation of healthcare services

The key focus in examining the internationalisation of healthcare services is the extent of the international market penetration by commercial firms. There is considerable variation in the degree of overseas market penetration across different segments of the international healthcare market. The more traditional supply chain (i.e. pharmacy wholesale) and retail firms have displayed considerably greater levels of market penetration than more narrowly defined medical service suppliers. Hospital firms, even where they have established major leading commercial conglomerates in their home market, have had a variable experience in penetrating and remaining in overseas markets. It is therefore crucial to explore what role international forces play in driving these developments.

As demonstrated in Chapter 4 it seems that internationalisation is quite uneven and moreover healthcare remains somewhat insulated. A crucial implication of the overseas market penetration of commercial healthcare corporations is to raise questions about the capacity of national healthcare systems to remain insulated from the exigencies of 'globalisation' which has been a dominant conceptual vehicle for explaining structural changes such as I am describing within national political economies for at least the past two decades (Mishra, 1999; Scholte, 2000; Gilpin, 2001). This in turn raises questions about the potential for the development of an international market in

healthcare services dominated by multinationals as has been the case in several other economic sectors historically; a hallmark of what is generally understood as 'globalisation' (Lee *et al*, 2002; Mackintosh & Koivusalo *eds*, 2005).

1.2. Methodology and limitations

I developed the research for my thesis through use of an interdisciplinary approach since the questions I address in the analysis of internationalisation and commercialisation of healthcare have, in my view, seen relatively little cross-over across the different social science disciplines I have drawn on for my investigation. I have found invaluable and insightful analysis in economics literature, business and management literature, sociology, International Political Economy (IPE), and in policy analysis. While I address this thesis largely towards health policy studies, which is itself a rather interdisciplinary field of inquiry, I draw significant insights from the socio-historical methods of critical IPE and the analytical milieu of business studies.[7]

The research itself entails a longitudinal study of qualitative data of both secondary and primary sources broadly covering the period 1975-2005. I have also made extensive use of quantitative data to illustrate key economic trends that are relevant to the changes in the particular healthcare services sectors analysed. The year 1975 marks a period just prior to the ascent of the Thatcher-led Conservative government and the sea-change in British politics and welfare state which ensued, leading to an embryonic expansion of private for-profit healthcare services in the UK following the entry of foreign-owned healthcare service firms in UK's private healthcare market. The year 2005 marks the end of the second term of the New Labour government which was responsible for generating a strategy of incorporating private providers into the UK National Health Service (NHS). I do not strictly limit myself throughout to this period, since reference to pre-1975 developments is necessary to elaborate some of my arguments based on historical analysis.

[7] Critical IPE encompasess a wide set of approaches, from Marxism through Critical Realism, Institutionalism and Post-structuralist (i.e. Foucauldian) methods of analysis. The reason I make this distinction of 'critical' IPE is a reference to a common strand of thought amongst critical scholars of IPE which is to reject a neat distinction between the political and economic spheres as has been the dominant mode of interpretation in economics and in international political economy since the emergence of the Chicago School (a key analysis of this issue can be found in Wood, 1981). The chief approach I identify with is that of marxist political economy, though at the same time I choose not to force this point since although I derive considerable guidance from marxist method of analysis and conception of political economy I would hesitate to claim that my thesis is strictly speaking marxist.

Moreover, my focus on the US also takes note of key developments in the 1960s that have had direct impact on the commercial transformation of healthcare services in that country and indirectly internationally with the cross-border market penetration of US healthcare corporations. Also, with regard to my chapters on the internationalisation of healthcare services (Chapter 4), and my chapter on the UK (Chapter 6), some data extends to 2007 to incorporate important developments that have emerged during the course of my research and which have enabled me to put in further perspective the issues I engage with in my thesis.

1.2.1. Data collection

Research for this thesis has relied on a variety of sources, most of which were collected using the library search facility at Sussex University Library, British Library of Development Studies, the Library of the London School of Hygiene and Tropical Medicine (LSTHM), the British Library and the King's Fund library.

A great deal of the research has relied on peer reviewed academic journals published mainly between 1975 and 2007, although I have included material where relevant from earlier years towards developing a longer term historical view. Initially I made key word searches through the WorldCat academic search engine and, at later stages once these became available through the Sussex University Library of more specialised search engines of Medline and PubMed. While these search tools have proved invaluable, I have supplemented it through *Google Search* tools (Scholar, News, and Book) employing a variety of search terms. This has also proved an invaluable means of identifying and employing data sources and new research in the subject area that could not be ascertained via the more traditional library searches and compilation of sources from other readings. Often enough this brought me back to the Medline and PubMed search tools.

Qualitative data has been collected from a variety of sources that are publicly available including: *national governmental sources* such as the UK Department of Health (DH), National Health Service (NHS) organisations (mainly for England, but for other UK countries where relevant), and Parliamentary papers and debates. I have also made use of *International governmental organisation* policy documents, reports, working papers and press releases such as the World Bank' annual World Development Reports (WDR); various OECD publications; the European Union online resource *EUropa.eu*; the World Health Organisation's (WHO) World Health Report (WHR) and Commission on Macroeconomics and Health (CMH) publications, and documents relating to the World Trade Organisation's (WTO) GATS. Qualitative data has also been

drawn from *private sector data sources* such as Laing and Buisson's annual *Healthcare Market Review* (1999 - 2008). The Public Services International Research Unit (PSIRU) database (available online on request) was also used initially to map key multinational companies involved in the healthcare services sector. While this resource has been used to supplement the data collected by myself, its variable content and quality means that it has remained a secondary source of data.

A further key source of qualitative data has included *private organisation press releases and newsletter publications* such as business press releases and healthcare service newsletters and updates, which have been useful to gauge the positions of private for-profit firms and business associations in the international healthcare services market. Furthermore, political party policy statements and manifestos have supplemented government documents in assessing changes in political discourse. Reports, papers and research from *think tanks, epistemic communities, lobby groups and advocacy associations* have also been drawn on to varying degrees for ascertaining information about healthcare sector reform, but also for identifying key debates in the commercialising healthcare reform agenda. Finally, *general and business media reports*: from the British and US press have been used extensively to cross reference historical contextualisation and supplementary information about political change and news in the healthcare services market. These sources were a first port of call in the initial phases of the research in order to familiarise myself with the current state of the healthcare sector in the UK. At a later stage in the research, press reports became more a means to maintain continuity with current changes in the health sector.

Quantitative data has been drawn from a mix of public and private sources. It is notable that such data with regard to the private sector has been considerably variable making for quite a frustrating search for data.[8] A key source of international comparative data has been the *OECD Health Data* sourcebook.[9] This has been supplemented by the World Bank's *World Development Report* and the WHO's *World Health Report* to a lesser degree, but useful for gauging cross country and national data for health expenditure and welfare expenditure. Important national data sources have included the UK's Office of Health Economics (OHE) *Compendium of Health Statistics* (various years), and the Centres for Medicaid and Medicare (CMS) database of national health

[8] Data for public sector spending and overall expenditure is available from these sources, otherwise data for private healthcare sector is virtually non existent, except for data for consumption. It is also revealing to see that most national data is very patchy until the late 1970s and early 1980s. The most comprehensive datasets start from 1990s.

[9] Initially this was through print copy and later through the CD-Rom version once this became available during the course of my research.

expenditure available for download on their respective website. It is notable that UK long time-series data have been more accessible through private publications including the aforementioned OHE *Compendium*, and also the previously mentioned Laing and Buisson's *Healthcare Market Review*. In addition, Fortune Magazine's *Global 500* list of top international companies (by revenue), was used for the chapter analysing the growth of an international market in health services (Chapter 4). This was used to build a database of key companies involved in the healthcare services sector, with quantitative data drawn from the same company publications used for qualitative data collection. The aforementioned PSIRU database was also used partially to supplement some of this quantitative data I collected myself for my research of multinational companies.

Data collection on private sector is quite limited, and where it does exist, it is most frequently commercial in confidence. Little empirical research has been conducted on private sector healthcare services provision; what data does exist is largely in private sector databases, for which the monetary cost of access has been too high to justify use in this current research project.[10] Furthermore, the data is not widely available - even in most libraries. However, some of these sources are available for consultation on location in the British Library and London's King's Fund Library. These are composite data sources, compiling data from a variety of other official and publicly inaccessible sources and some data from their own research presented in a single resource. I have used what limited data I could acquire from publicly accessible resources.

1.2.2. Limitations of the study

While I have devoted much effort to be thorough in my research and coherent in my articulation of my analysis, I acknowledge that there are inevitable limitations to what is possible in a single study. Given the interdisciplinary nature of the thesis, I have covered a great deal of literature from different fields of social scientific research. Although this has enriched considerably my analysis, it has also meant that I have had to be fairly brief in my engagement with different debates within the various academic fields of inquiry. Whilst the eclectic approach to the secondary literature is intended to draw on the strengths of each method of analysis, I am aware of causes for critique in each of the bodies of literature that I have not been able to fully develop.

---

[10] See also an article by Radical Statistics Group (2000) and also report by Association of British Health Industries (2002) which discuss the limitations of empirical data. The former on the accessibility to private research data, the latter for the limited amount of empirical data available even to private enterprises.

A key limitation I acknowledge is in the use of raw data. Whilst early in the study I considered employing survey and interview techniques as one of a number of sources of data for eventual triangulation of data sources, the longitudinal changes that I have analysed and the type of questions of interest to the study have meant that interviews would have had limited usefulness. Interviews may be useful in a smaller, more focused study. This has not meant a complete absence of personal input from policy actors. Moreover my analysis of the US case has meant relatively constrained access to data from US sources. Access to databases of US industry representative associations or of market analysis compendia such as the UK's Laing and Buisson sources have proved even more costly to access, partly due to distance. As such, I have endeavoured where possible to piece together publicly available primary data and data supplied in various secondary sources regarding US healthcare corporations.

A further important point for which I must insert a caveat is that international and country-level studies carry with them the danger of over-extending the conclusions drawn to the entire national constituencies analysed. Just as the UK is composed of four different countries, each with particular variations in the way in which they manage the NHS and its relation to the private sector, this also applies to the US which is a federation of 50 states each with different degrees of commercialisation of healthcare services. Due to space restrictions and an interest to capture general international trends, the sub-national level of analysis is something that regrettably suffers absence in this thesis.

Finally, due to language restrictions, I have chosen to focus exclusively on English language literature which has also been a key reason for my choice to focus on the British and American cases. On the other hand, my focus on these countries is not entirely based on language restrictions. My justification for studying these two countries lies in the historical relationship between their healthcare sectors, which in one sense are both outliers vis-à-vis the healthcare systems in the rest of the world; one is dominated by market structure, whilst the other is paid for through general taxation and the public sector.

1.3. An overview of the chapters

The structure of the present thesis is organised as follows:

In Chapter 2, I provide a framework for the analysis of the thesis and dealing with the treatment of key ideas about accounting for substantive change over time in national healthcare systems and how this links to changes in healthcare services markets. I did not initially set out to develop a synthesis approach, which can be seen in the overview of three strands of literature n this chapter centred around health policy studies, International Relations/International Political Economy and International Business Studies. While this began as a simple literature review, I eventually developed it as a survey of these key literature strands because this allows for a more extensive and systematic discussion of how the different key concepts regarding healthcare reform, commercialisation and internationalisation of healthcare services markets complement each other.

In Chapter 3, the state of the international healthcare services market is analysed and key areas are identified where internationalisation of for-profit healthcare providers has taken place. The objective of this chapter grew out of a need to gain a comparative overview of the advancement of market-oriented healthcare reforms across different national locations in order to be able to situate the subsequent US and UK national case studies within a broader set of trends.

In a similar way to Chapter 3, Chapter 4 developed out of a need to gain a general overview of what the international healthcare services market looks like within the broader international economy. Data collection in this respect proved much more difficult than initially anticipated, and out of this frustration, my research utilising Fortune Magazine's annual ranking of Global 500 companies provided an alternative route to gaining perspective on this. Though it has its limitations as a data source - something I discuss at greater length in the chapter itself – it has been a useful means to establish systematically how internationalisation is quite uneven across different segments of the health services market.

The national case studies in the following two chapters bring into perspective the role of internationalising commercial organisations within the context of changes in specific national locations. An initial desire to gain a broad overview of commercialisation in each of these markets led me to focus on the hospital and health insurance sectors, because I found these to be well documented in initial stages of my research and found intriguing the linkages between these two market segments in their parallel evolution as 'producer' and 'financer' institutions respectively.

Chapter 5 looks at changes in the US healthcare sector by focusing on commercial transformation in the US healthcare services market and the implications for the international market in healthcare services. My selection of the US as a core case study has rested on its status as one of the most highly market-oriented healthcare systems in the world. An extensive literature base

on the US on account of it having undergone the earliest commercial transformation compared to other countries means on the one hand there is a wealth of secondary literature, which is reflected in the overwhelming amount of literature in academic searches for commercialisation relates to this country. An account of specific companies and how has been harder to piece together from diffuse sources of market analysis and references to these within the academic literature.

In Chapter 6, I take a substantive look at the evolution of the private sector in the UK, considering how this has developed in relation to public health policy. Similar to the US, my choice of the UK as a case study rested on it being one of the earliest countries to develop an extensive public healthcare system. As such, the UK provides an insightful test case for the onset of privatisation and how this is impacted upon by penetration by foreign-owned companies.

In the concluding chapter (7), I reflect on my analysis of the commercialisation and internationalisation in the healthcare services sector with reference to the specific national cases analysed.

Chapter 2: Internationalisation, commercialisation and the 'new' mixed economy of healthcare

In this chapter I develop more explicitly my analytical framework in relation to the questions opened in the introductory chapter. I engage more directly with various key debates and analyses in the literature that I have researched to illuminate the issues relating the internationalisation and commercialisation of healthcare services within the context of market-oriented reforms. As I have suggested in the introductory chapter, my research indicates a limited amount of output directly on this subject. While over the past three decades much research was carried out on the direct impact of national-level market-oriented reforms on healthcare services, primarily in the health policy field, comparatively little engagement seems to have been made with the interplay between internationalisation of healthcare services firms and the commercialisation of healthcare services in specific national locations. Moreover, in fields of inquiry where considerable amount of research has been dedicated to understanding globalization and the internationalisation of business - such as International Relations, IPE and International Business Studies - nearly no engagement with the healthcare services sector has been undertaken.

As such, my objective in this chapter is to set out how the following issues have been engaged with so far in these academic research fields. The overarching issue I have been looking to engage with has been how 'globalization' is understood to impact upon healthcare systems particularly within the context of the reform of social welfare provisions in a market-oriented direction. Furthermore, I have explored how commercialisation in healthcare is conceptualised and explained across the various strands of literature. Within the context of these two issues, I focus attention on the emergence of a 'new' mixed economy of healthcare, which has entailed not just the privatization of public healthcare services but new forms of incorporation of private sector provision and financing into governmental agendas for the delivery of healthcare services. Moreover, I seek to set the grounds for the ensuing empirical chapters in which I develop my questioning of whether globalization puts a different perspective on commercialisation.

In the first section I review policy analysis literature, considering the place of policy analysis in this study.

The second section discusses more theoretical and historical contextual factors drawing largely from IPE literature. Here I devote attention to welfare state restructuring, the reconstitution of healthcare services from de-commodified to commodified, and the international dimension for healthcare services. In the third section I discuss the analysis of the healthcare market in order to map the international healthcare services market and to provide a framework for analysing the internationalisation strategies of firms. Here I draw more from international business and management literature. I conclude the chapter with a summary of main arguments to guide the rest of the thesis.

2.1. The Policy Process and Healthcare Reform

The issue of healthcare sector reform is not a new one. Since late 19th century and early 20th century turning points in the history of state intervention in the financing and/or provision of healthcare, we can see a regular re-negotiation of the framework in which healthcare is conceived and acted upon. The emergence of a market-oriented healthcare reform agenda and the related commercialisation of healthcare services is something that seems to have been intensifying in recent years, but nonetheless is something that is frequently identified with a historical juncture since the 1970s. The great majority of health policy analysis researching current developments seems however to dehistoricise the development of commercialisation over time, with a considerable emphasis on the analysis of policy content. In this first section of the chapter I essentially make my case, through a review of key literature as to why historical method is an essential component to understanding long-term changes, whilst considering the limitations of a focus on policy content.

2.1.1. Beyond content: analysing health policy change

Walt and Gilson make a valid critique of the study of health policy and the implications for the conceptualisation and implementation of reform, when they draw our attention to the fact that:

> '[…] much health policy wrongly focuses attention on the *content* of reform, and neglects the *actors* involved in policy reform (at the international, national and subnational levels), the *processes* contingent on developing and implementing change and the *context* within which policy is developed' (authors italics: Walt & Gilson, 1994, p.354).

This blinkered focus on policy content, consequently 'diverts attention from understanding the processes which explain why desired policy outcomes fail to emerge' (p.354). Their urgent call for 'new paradigms of thinking…to be applied to the health sector, to understand the factors influencing the effectiveness of policy change' (p.354), represents a broader discontent with understanding the complexity of factors in policy change in healthcare and other areas of public policy. This has only recently begun to be addressed by various authors (e.g. Salter, 1998; Lee & Goodman, 2001; Langley, Denis & Lamothe, 2003; Lister, 2005). Though none of these authors have necessarily developed an entirely 'new paradigm', a broader perspective in analysis has been developing. A key contribution has been made primarily by political scientists whose awareness of structural factors and how these shape health policy, and public policy more generally, helps to illuminate the politics of welfare reform in contemporary 'developed' states as well as highlighting cross-national commonalities in healthcare reform agendas. Though not all are as concerned with the implications of research practices and the direct links to policy influence, it signals an opening of the health policy research agenda in academia for analysis beyond content.

This broader perspective has not yet reached far outside academic circles; major institutional actors with a significant influence in policy making at both international and national levels continue to lack sufficient reflection on the contextual and process aspects in the practice of learning from past policy. An example is the USA where, for decades, little appears to have been learned from past mistakes in national (federal) healthcare reform, whilst at the same time there is impetus to export these same mistakes (Walker, 1999; Krugman, 2007), as policy makers in other countries look for quick-fix solutions to the inadequacies of their own healthcare systems. At the same time, there is little evidence of substantial transformation in the premises of policy advice stemming from influential organisations such as the World Bank (IBRD, 1993), which has had considerable impact on the form of development programmes for the 'South', successfully overturning the dominant paradigm for economic development towards the neoliberal model of economic liberalisation and public sector privatisation (Cammack, 2002 & 2004).

An important point about Walt and Gilson's intervention is that their commentary is focused on the paucity of policy analysis and policy transfer for health reform in relation to developing countries. They cite important historical reasons for this paucity, noting the impact of international donor agencies and international governmental organisations policy prescriptions on national public policy changes and failure to restructure developing countries according to flawed criteria for development. They note how 'economic adjustment programmes affected the health sector through

cuts in budgets, promotion of the private sector, and the introduction of user charges for health services', but 'the tendency of those advocating policy reforms was to perceive them as technical', so that 'international experts negotiated reform programmes with national policy-makers' (Walt & Gilson, 1994, p.355).

This latter point has been no less relevant to developed countries where, in spite of deeply entrenched public systems of welfare that have not been so easily displaced as in many developing countries in the past few decades.[11] Overall, there has been greater investment in strengthening 'evidence-based' policy making and evaluation research (Langley, Denis & Lamothe, 2003, p.196) - in official state-sponsored research institutions, such as NICE in the UK, as well as in academic research agendas - at the expense of understanding processes.[12] The focus is primarily on quantitative data collection and analysis intended to lead to evaluation and adjustment of what are effectively rendered technical decisions (Walt & Gilson, 1994, p. 355). Again, this is not for a lack of research on policy process, context or actors. But insofar as this research is employed for policy making itself, there are significant gaps. At one level this may be attributed to a 'cultural gap' between policy-makers and academic policy research (Caplan, 1979). It can also be attributed to the difficulties of the immediate applicability of contextual and process research into policy-formulation as policy is also often inherently tied to short-term political agendas, for as Reich (1994) argues, 'policy reform is a profoundly political process, affecting the origins, formulation and implementation of policy' (cited in Walt & Gilson, 1994, p. 354).

Some of the reasons are clearly world historical. An ideological shift from '*consensus'* to *conflict* has had an important impact on the trajectory of healthcare reform policies, not only in their content but also in the way in which the normative basis for healthcare provision outcomes *should* be achieved (Walt & Gilson, 1994, pp.355-257). In the immediate post-WWII period, the construction of contemporary healthcare systems in western 'developed' economies was part of a broader set of economic changes and a 'consensus' politics which prioritised the development of

---

[11] For this we can cite the importance of popular and political resistance to privatisation and market-oriented restructuring of welfare systems; although, as I also argue, this resistance has been met by other approaches to introducing market structures. Whilst the technical dimension to policy change discourse is still present in 'developed' countries a key basis for overcoming resistance has been to focus on consumer choice as a criterion for public service 'improvement' (Henderson & Petersen, 2002).

[12] A key reason for this lies in the paucity of empirical evidence for the purposes of quantitative evaluation of healthcare systems. Indeed, most data on healthcare systems only began to become available from the late-1960s and mid-1970s, and even then there is only very patchy longitudinal data to draw on. The logic of organisations such as the National Institute of Health and Clinical Excellence (NICE) is specifically to counter this lack of data.

publicly owned industry and public welfare services; with a dominant role of the state in regulating markets even where these were not owned by the state. In developing countries, during the 1950s and 1960s, 'state directed development was justified through economic analysis that identified market mechanisms as being inadequate in developing countries legitimizing governments' role in intervening to correct market imperfections through public sector investment' (Chowdhury & Kirkpatrick, 1994, p.1; cited in Walt & Gilson, p.355). Similarly, in Western European economies the dominance of the Keynesian model of macro-economic planning and the objectives of full-employment in public policy thinking, helped to perpetuate for some time a broad 'consensus' on the notion of the failure of the market to adequately meet social and economic objectives (Gough, 1979; Offe, 1984; O'Connor, 2000). A prime example of this has been 'Butskelite' paradigm of a mixed economy in Britain from the 1950s - a political-ideological climate in which the recently founded NHS and public education programmes flourished - until the ascent of the New Right in the UK under Thatcher in 1979 (Ranade & Haywood, 1991, p.93; Singleton, 1995, p.22; Kerr, 1999).[13]

The mixed economy thus became a mainstay of post-WWII economic growth as well as the de-commodifying role of the welfare state (Holden, 2003b). In the UK, the nationalisation of industries extended in many respects to areas such as healthcare, whilst in Germany and France a corporatist model for universalising healthcare access was pursued via state regulated social insurance systems linked to employment rather than taxation-derived funding (Freeman, 2000). Private sector medical and health care thus developed in quite different ways within a group of countries all of which, to one extent or another, emphasised nationalised industry and public welfare. By contrast, in the US, the institution of Medicaid and Medicare had the adverse result of contributing to the commercial development of healthcare (Himmelstein & Woolhandler, 1990; Relman, 1997). But although the mixed economy model was rendered unproblematic in the context of the post-WWII decades of economic recovery and growth, governments began to subvert the existing political-ideological 'consensus' in the early 1980s and by the 1990s began looking to the private for-profit sector for solutions to the problems of healthcare systems.

---

[13] We should note, however, that this conception of a political-ideological 'consensus' in defining public policy in 1950s and 60s western Europe has also come under criticism and revision (Kerr, 1999), particularly in terms of the perceived continuities and discontinuities before and after 1979 in British politics (Marsh et al, 1999).

The approach to health policy proposed by Walt and Gilson is effectively a method of examining structure and agency in policy formulation and implementation. Underlying this point is that the structure-agency is a problem that social scientists cannot escape (Giddens, 1984), and also constitutes one of the most contested features of social scientific inquiry (Weik, 2006). By arguing for analysis beyond policy content, their model 'offers a much broader framework for thinking about health policy' wherein policy is not simply about prescription or description, and nor is it developed in a social vacuum, but is 'the outcome of complex social, political and economic interactions' (Walt & Gilson, 1994, p. 359). Thus, whilst *content* is about the policy output, and *context* constitutes the broader structural framework or conditions within which *actors* (individuals, collectives, or networks) must operate, then *process* refers to the means by which the agenda is constructed and determines the output and ultimately the outcomes.

2.1.2. Policy analysis: an overview

Policy analysis has no singular origin but draws on concepts from a number of disciplines ranging from economics, political science, sociology, public administration, and history, emerging in the late 1960s in the United States. With such a heterogeneity of different theories and definitions (Heclo, 1972) it is worthwhile setting apart how I intend to use policy analysis from the historical development of the technique as a method of social scientific investigation.

Understanding process

Where *process* is the focus in policy analysis, policy-makers tend to be viewed as rational and acting within a well-defined framework of choices between policy alternatives towards the procurement of 'complex yet compatible goals' (Walt & Gilson, 1994, p. 358). Conducting policy analysis in this view has a primarily instrumental objective comprising, in Dror's definition, a set of 'approaches, methods, methodologies and techniques for improving discrete policy decisions' (1993, p.4: cited in Walt & Gilson, 1994, p.). Thus, the rational choice foundation is a strong epistemological feature in the analytic techniques of many key proponents of policy analysis.[14] The task is one of providing policy-makers and/or other relevant actors with choices between alternatives towards meeting their goals, built on analysis and evaluation of public policy options.

[14] This is particularly the case in US traditions of policy analysis literature where rational choice, pluralist and functionalist schools of thought have been most prevalent.

As such, we see a tendency to break down the policy process into stages of activity that can be analysed each in their own right and which collectively are taken to constitute *process*. For example, Laswell's (1956) conceptualization of the main stages of policy process consist of (i) *agenda-setting*, (ii) *decision-making*, (iii) *adoption*, and (iv) *evaluation* (Sabatier, 1999; Buse, Mays and Walt, 2005). Concerned with improving the process of policy making itself, Lindblom (1959) proposes analysis of what happens in organizations and how particular decisions lead to particular outcomes. In contrast to Laswell, he asserts that the 'stages' are not necessarily followed in sequence, nor are they all necessarily visited upon. Rather, policy actors essentially '*muddle through*' most of the time in an incremental process of policy construction.

Agenda formation

Agenda-setting constitutes a crucial stage at which actors can influence policy outcomes. The prevailing socio-political situation can either lead to issues reaching the policy agenda just as the policy process mechanisms can dictate which issues are excluded (Sabatier, 1999; Sutton, 1999). Following Kingdon's (1995) *multiple streams* model, for an issue to get on the governmental agenda,[15] three streams must converge to create a 'window of opportunity': (i) how it is perceived and defined by policy actors and how it is brought to light (*the problem*); (ii) how relevant and plausible the proposed solutions are to the policymakers and stakeholders alike (*its solutions*); and how it fits into the current state of affairs and how influential the interest groups and coalitions are/can be in ensuring its dominance (*the political situation*). If appropriately adhered to these 'windows' of opportunity ensure that issues receive a policy response (Kingdon, 1995; Zahariadis, 1998), which also requires the right *actor* or as Kingdon calls it a 'policy entrepreneur' (1991; 1995), competing with others for the attention of decision-makers. The ideal policy entrepreneur is the capable advocate who can foresee the solution and the required political climate in which to present his issue whilst simultaneously balancing an intricate web of *policy networks*.

The importance of different actors throughout the different stages of the policy making cycle is thus a key point for analysis (Sabatier, 1999; Grindle & Thomas, 1991; Lindblom, 1979; Stone, 1999). However, the way in which actors attempt to influence the policy agenda depends largely on the premises of policy analysis - i.e. whether it focuses on policy as conditioned by norms and

[15] There is also an important distinction between the 'governmental' and the 'decision' agenda (Kingdon, 1995, p.4). The *agenda* itself defined as 'the list of subjects or problems to which governmental officials, and people outside of government closely associated with those officials, are paying some serious attention at any given time' (p.3).

values, ideas and interests or institutions – something reflected in a variety of authors discussing policy networks (Reimers and McGinn, 1997). Due to the nature of the policy system consisting of conflict and bargaining, coalition formation amongst groups to advance certain interests and protect others is an integral part of the process (Grindle and Thomas, 1991). Actors can be divided into different groups for analysis: issue networks (Heclo, 1978; Berry, 1989), epistemic communities (Haas, 1992); policy communities (Stone, 1999), and advocacy coalitions (Sabatier & Jenkins-Smith, 1993).[16]

Lindblom acknowledges and is interested in a process of bargaining taken as inherent between different *interest groups* in the process of policymaking.[17] This is particularly useful approach when considering the array of actors involved in the policy process, locating their relative interests, and identifying how they relate to each other. For our research, private for-profit firms are a key 'interest group' in the healthcare reform agenda. However, as I discuss later in this chapter, for-profit firms – variably referred to as 'business' or 'capital' - by no means constitute a uniform group, whether taken within the healthcare sector or more generally as business actors seeking market share and profit-maximisation. Moreover, it is not only within the business sphere that we find advocates of market-oriented welfare reform. Rather this reflects a wider ideological and contextual environment in which a broader array of actors (with no obvious or direct stake in market share), seek to influence governmental agenda formation. Thus, in these different coalitions of agency, actors are responsible for placing themselves in a position of power and subsequently competing to maintain it through use of external actors (the foremost example of the media) and contextual opportunities, and they do this by framing of certain issues, thereby either expanding or curtailing policy debates.

Leichter (1979) categorises the systemic contextual factors as *situational* – idiosyncratic 'focusing events' that are either one-off occurrences or lengthy diffused issues; *structural* – the moderately unchanging elements including economic typology, demographics, political structure, etc; *cultural* – the cultural make-up of society and the extent of its influence and diffusion; and *international or exogenous* – the influence of international organisations or movements and level of inter-dependence between states (Leichter, 1979; Buse, Mays and Walt, 2005, p11). The

---

[16] This is simplified in Walt & Gilson (1994) by dividing *actors* into *individuals*, *organisations* and *groups*.
[17] Lindblom's analysis is often described as having a pluralist outlook, given his emphasis on various actors within the policy field, and their interests ultimately (in a democracy; as defined by Lindblom/Dahl) will make their way through to the agenda of policy making and implementation.

implication is that each factor holds a different balance of the political, economic and social triptych at national and international levels and can interchangeably be used to frame a discourse on particular issue, whether this is on a political party electoral campaign (Lakoff, 2005), development policy (Apthorpe & Gasper, 1996), or the impact of globalisation on national decision-making (Hay, 2001; Watson & Hay, 2003).[18]

Regardless of how analysts view power, the literature discussed above highlights a power driven inter-dependence between all aspects of the policy making system that combine, implicitly or explicitly, to enable or suppress specific agendas within policy-making. To quote Lindblom (1979), 'fragmentation of policy making and consequent political interaction among many participants are not only methods for curbing power but are methods, in many circumstances, of raising the level of information and rationality brought to bear on decisions' (p.524). However, as Lukes (1974) argues, power is a multi-dimensional concept that cannot be understood as a purely behavioural relation, but one in which ideological context has an important role in the exertion of power in distorting agents' perceptions of their real interests and in the contestation over framing agendas (Couzens Hoy, 1986, pp.125-126). But an over-emphasis on structural limits to agency can also be damaging to an understanding of the role of agents. Thus, it is necessary to be cautious of both a pluralist approach, which looks only at interest group activity and policy-making, as well as any approach which considers power solely in terms of ideological or structural control. An understanding of the broader contextual basis for policy decision making at the state level must also be sought outside of the policy process.

Continuity, Discontinuity or Path Dependency

Though we may understand the policy process within a national political context, policy analysis does not in itself explain the reasons for a particular policy direction being chosen. In rejecting the pluralist and functionalist models, I am acknowledging that the choices available to policy makers are not necessarily *a priori* choices, nor is a particular direction for policy inevitable. For instance, when in 1988 Margaret Thatcher announced on a BBC broadcast of the *Panorama*

[18] Although policy analysis will be more effective with a consideration of process, actors and context, it does not mean that content need be ignored or undermined. Indeed, much can be gained from the techniques of discourse analysis (Hay, 1998). However, whilst I incorporate observations of discourse from other authors, this is not the primary mode of analysis in this thesis. Rather it is used at times to illuminate the thinking of various actors, and the way official statements by policy actors demonstrate how they frame the agenda conceptually.

programme that there would be a "fundamental review of the NHS", the particular direction announced was anticipated by neither party insiders, nor opposition party actors, nor indeed most actors outside of the party political system (Leys, 2001). Overall, this announcement did not mark a fundamental disjuncture from Thatcherite economic doctrine for restructuring the national economy and for welfare services reform. However, it still constitutes a significant turning point for the then government's policy on the NHS. At least from the late 1970s but especially under New Labour, healthcare reform policy has in many ways appeared disjointed and incoherent, with many short term goals being set at the expense successful long-term reform. Echoed over a decade later, was the announcement of the 2000 *NHS Plan* (Secretary of State for Health, 2000) in which New Labour laid out its programme for fundamental reform of the NHS. Again, this appeared to deviate from earlier electoral promises implying a retreat from market solutions (Greener, 2004; Jenkins, 2005).

This scenario has prompted some to question the substantive nature of reform - and thereby change - for the NHS, echoing questions regarding the broader public policy agenda for public sector reform (Hay, 1999; LeGrand & Vizard, 1998). If there is no fundamental discontinuity, then is there essentially a path dependency underlying the policy agenda for healthcare reform? This question becomes more pertinent when we consider diachronic continuities. For instance, whilst the NHS has undergone a variety of transformations to its administrative structure since its foundation, the foundational premises of its operation have remained largely unaltered. Indeed, access remains in most areas essentially free at the point of use and continues to be regulated by indirect rationing mechanisms of queuing (waiting lists), whilst the co-existence of private and public sector delivery (and provision) of services has remained essentially unchallenged throughout its existence.[19] Still, this does not detract from the fact that the policies since the 1980s in the UK which can be

[19] This has not precluded actual challenges in Parliament, such as when Labour Secretary of State for Social Services Barbara Castle headed a challenge to the public private mix in calling for the banning of pay-beds in NHS hospitals in the late 1970s. The irony of the outcome was that this challenge was undermined by her own party colleagues and the then prime minister (Harold Wilson) in coalition with Conservative counterparts. Moreover, when Thatcher as prime minister sought to reverse any possibility of banning pay-beds with the intent of safeguarding the mixed-economy in healthcare and indirectly encouraging private sector healthcare alternatives, the consequence was to stunt the domestic private sector healthcare services market (Griffith, Illife & Rayner, 1987).

understood to favour and encourage market structures - whether in 'quasi' form or in 'genuine' competitive market by opening up to for-profit competitors for service contracts – do reflect a fundamental shift in the way in which government of public sector provision is undertaken.

I would argue that one should not assume that specific discontinuities in certain areas amount to substantive change. For instance, whilst the internal market outlined in the *Working For Patients* Bill (1989) was touted as a great innovation for addressing the fundamental problems of the NHS, empirical research indicates that the market structures proposed were not substantially implemented, so that the essential relationships that were to be changed remained barely altered (West, 1998). Related here, is the question of the level at which change takes place. Indeed, reform at micro-level, such as quality standards in clinical surgery practices, may be relatively straightforward to enforce, whilst more macro-level cultural-organisational changes which affect multiple tiers of medical or health practice are much harder to implement.

2.2. International Political Economy and Healthcare Reform

A limitation in utilizing policy analytic techniques is its confinement to actor relationships and the process of policy making, so that contextual factors remain under-emphasised or even absent from the analytical framework. Contextual factors tend to be taken as given aspects within which effectively timeless categories of actors or actor groups must negotiate their way through the policy process. Here a political economy approach is particularly useful for developing an explanatory framework for the historical and social context within which processes related to formulation and implementation of welfare state restructuring take place. The prioritisation of the 'international' in International Political Economy [20] is no mere extension of the 'national' to another level. It is an interdisciplinary field containing various approaches concerned with international trade and finance, as well as state policies and how these affect the former. More mainstream works since the 1970s focused on the relationship between state and market in international regimes (Keohane, 1984; Krasner, 1976, 1994). However a more critical strand of research has developed since the mid-1980s from the work of Susan Strange (1994, 1998) and Robert W. Cox (1983, 1987) taking a broader view of the relationship between state and market.

[20] Similarly we could talk of an extension of the 'global' in Global Political Economy (Palan, 2000; Gilpin, 2001).

With regard to the application of political economy in healthcare, some of the most explicit examples of political economy approach have been from Marxian authors (Doyal & Pennel, 1994; Navarro, 1976, 1978; McKinley ed., 1984). There are also examples where the more 'classical' rationalist economic methodology is employed to analyse the policy challenges in healthcare financing and provision (Keynes, Coleman & Dimsdale, 1988). Overall we find that the political economy approach is characterised by a multitude of authors - derived from areas as diverse as epidemiology, political science, sociology, history, health planning and medicine - highlighting once again, the inter-disciplinary nature of this approach (Baer, 1982). Moreover, whilst the political economy of health is a subject that has been 'dropped and rediscovered several times since the mid-19th century',[21] a revival of the approach in the late 1970s and early 1980s,

> 'struck a responsive chord among certain medical social scientists was related to a growing dissatisfaction with functionalism and the failure of many studies to place an analysis of health problems and the organization of medical care in a larger societal context' (ibid, p. 2).

The currency of such an approach is in a concern with 'the impact that the capitalist mode of production has on the production, distribution, and consumption of health services and how these processes reflect the class relations of the larger societies within which medical institutions are embedded' (Baer, 1982, p.2). Moreover, the intimate link between the economic and political spheres means than they cannot be disentangled from each other without, at least, losing a sense of the bigger picture and, crucially, gravely misidentifying the context within which policy is made (Wood, 1981, 2002). In this sense, the 'international' or 'global' is already imbued within the Marxian political economy approach.

Despite these interventions by a number of authors employing the political economy approach, there continues to be a substantive gap in the literature investigating the link between changes in the welfare state, changes in healthcare systems, and the internationalisation of welfare and healthcare service provision (Moran, 2000, p. 136). What follows in this section of the chapter involves as much an unpicking of the relationship between international and national levels of analysis as it does between the healthcare, the state and capitalism.

---

[21] A reference to the work of Friedrich Engels in his *The Condition of the Working Class in England in 1844*, (Baer, 1982, p.2)

2.2.1. Welfare State Restructuring

One thing that is striking is the resilience of institutions such as the NHS in a political and ideological environment that seems otherwise quite hostile (or at least intolerant) of social provision. It is clear from historical analysis that the NHS was substantively not the socialist ideal presented in political rhetoric (Doyal, 1994; Fielding et al, 1995; Porter, 1999), nor is it the socialist nightmare presented by its detractors. Yet, the social contract that brought it into being in the context of post-WWII West European welfare states remains an essential part of ongoing political landscape. But whilst the strength of popular support for public social provision in most countries makes wholesale *dismantling* the welfare state highly unlikely, at the same time, it is this very social contract which has been under increasing pressure for revision in the past thirty years (Cox, R.H., 1998) so that *restructuring* and *modernisation* have become the predominant language for change in 'mature' welfare states (Pierson, P. 1996, 1998).

Retreat of the state from social provision

One of the key points of debate during the 1990s was over whether and how the state was retreating from social provision. In this view 'social policy is subordinated to the needs of labour flexibility and/or the constraints of international competition' (Loader & Burrows, 1994, p. 2), so that effectively there was a shift from 'welfare state' to 'workfare state' or 'competition state' (Jessop, 1994; Cerny, 1997; Mishra, 1999). Even prior to the ascent of 'globalisation' as a dominant explanatory variable, the subject of welfare state restructuring had occupied numerous pages and research agendas; though the 'globalisation' era (at least intellectually) has done nothing but accentuate a sense that (radical) transformation has been taking place (Strange, 1998; Shaw, 1997). Critical analysis of these decades illustrates that far from retreat, states have often increased their financial input into welfare and public services (Pierson, P. 1998; Navarro, Schmitt & Astudillo, 2004). Moreover, public support for the retention of social provision is still high, in spite of serious concerns and misgivings with the actual state of public welfare services (Donelan et al, 1999; Koivusalo, 2003, p. 98). This creates a puzzle regarding what is really changing.

The political discourse of the New Right latched on to the problem of constantly growing expenditure on public services, and argued for its curtailment by a number of strategies, including privatisation, and marketisation of public services, arguing that the absence of competitive drive in public sector only leads to inefficient use of resources, spiralling costs, and services that are unresponsive to the needs and wants of their users as consumers (Altenstetter & Heywood eds,

1991). Thus, whilst there has been an increase in social spending, the form in which social provision takes place has been changing. Certain areas have been privatized whilst those which remain in the public sphere have been subject to a much more monitored and market-oriented thinking. Yet, in the long-run there have been mixed results following the application of such measures generating the desired outcomes across countries with widely differing models for healthcare (Cabiades & Guillen, 2001; Andersen, Smedby & Vagero, 2001; Lieverdink, 2001; Light, 2001; Fougere, 2001).

By the 1980s almost all OECD healthcare systems [22] could be said to have achieved some semblance of universal coverage for basic healthcare services, to which the principle of *equity* in access to care constitutes the core normative foundation (Cutler, D. 2002). Yet by this time it also became apparent that universalisation of coverage could not be implemented without ultimately presenting challenges regarding rising expenditure on healthcare and the efficiency of resource allocation, as few constraints on medical care demand or supply were in conflict with rising demands for healthcare services.

> 'Countries were willing to accept spending *above* efficient levels to meet distributional goals. But spending was also *growing* more rapidly than countries could easily afford. While tax revenues were increasing at the rate of payroll or consumption growth, roughly the rate of GDP growth, medical-care spending was increasing twice as rapidly. In the average OECD country, medical care rose from 3.8 percent of GDP in 1960 to 7.2 percent in 1980.' (Cutler, D. 2002, p. 887)

The rising costs confronted by governments in OECD countries, particularly, are chiefly associated with the adoption of new medical technologies. A significant portion of national expenditure on healthcare has been absorbed by pharmaceutical products (both prescription and over-the-counter), and the use of high-tech innovations in the clinical setting account for the greater part of this technological cost rise (Moran, 1999). Though the costs of medical and support workforce, as well as of the expansion of clinical facilities have also been important, the technological aspect overshadows their impact.

Another challenge is associated with the growing expectations of patients in terms of having access to services and making use of healthcare resources. The impact of changing demographics is

[22] The US is a notable outlier here with around 40% of its population remaining uninsured for healthcare.

further seen as a challenge to the fiscal sustainability of healthcare systems as ageing populations put pressure on the fiscal pool of resources. This fate is shared by all funding systems one way or another, whether compulsory social security (France, Belgium, Japan, or Germany), taxation based funding (UK's NHS), single-payer (USA Medicare and Medicaid), or private insurance (USA, and many other countries where public and private funding co-exist) (Donaldson et al, 2005, pp. 55-72; Poullier et al, 2002; Abel-Smith & Mossialos, 1994).

Economists tend to express these pressures in terms of a cost, efficiency and equity mismatch (Cutler, D. 2002; LeGrand, 1990). But while policy makers and health administrators seek to control costs, this will not necessarily correspond with the attainment of productive efficiency. The objective of population equity in access and quality of treatment cannot be easily reconciled with the organisational objectives of cost control and productive efficiency. But there is also, in essence, a tension between the technical objectives of policy analysis and organisational management, and the normative values for social provision and citizenship. One author, commenting on the politics of Community care policy reform in early 1990s Britain, has expressed this in terms of a political-ideological mismatch between the principles of the welfare state and the resources available (Salter, 1994). Importantly, these are not autonomous developments but intimately bound up with the development of welfare states as a de-commodifying intervention by capitalist states as well as the broader political, economic and social changes surrounding healthcare systems.

Thus, debates surrounding the reform of healthcare have become focused on the issues of *financing / taxation*, *regulation*, and *provision*, and it is these three dimensions which frame the basis for transformation of welfare states (LeGrand, Propper & Robinson, 1992). Nonetheless, these dimensions tend to obscure the fundamental absence of substantive debate over the normative basis for legislative or constitutional clarification on what the state is due to its citizens. For Salter (1994):

> 'The restricted agenda on the appropriate relationship between social rights and state responsibilities has left policy makers and their legions of advisers unable to analyse, understand or answer the problems inherent in the apparently inexorable and uncontrollable expansion of the welfare state' (p.120).

We can see that this tension is derived from the fundamental contradictions of the welfare state itself as a *de-commodifying* mediatory agent. In a bid to see through substantive restructuring of

social provision, reforming states have also experimented with the reformulation of this decommodifying role.

De-commodification / Re-commodification: back to the market

De-commodification as a concept goes back to Polanyi (1957) who, building on an existing body of political economy literature and somewhat critical of the marginalist tradition, noted how capitalism treats labour as a commodity produced for exchange.[23] For Polanyi, the commodification of labour is an unstable 'fiction' that in turn requires non-commodified support systems to preserve and enhance the capitalist system whenever labour is forced to exit the labour 'market' (Polanyi, 1957; Offe, 1984; Holden 2003b, pp. 303). The concept has been extended and brought to greater popularity since the 1990s by Esping-Andersen, who understands de-commodification as 'when a service is rendered as a matter of right, and when a person can maintain a livelihood without reliance on the market' (1990, pp. 21-22). It is a view entrenched in T.H. Marshall's conception of social rights and citizenship in modern capitalist states, wherein social rights given the same status as property rights 'will entail a decommodification of the status of individuals *vis-à-vis* the market' (Marshall, 1950). Others have extended the concept in terms of *empowerment* expressed through citizenship *against* the forces of the market, whereby decommodified social policies afford greater autonomy and choice to citizens in their lives; choices over marriage, having children, seeking higher education, and to engage in political activity which in principle are unconstrained by market relations (Messner & Rosenfeld, 1997, p. 1394, cited in Holden (2003b), p. 304).

De-commodification entails an active intervention from the state to create 'non-market' spheres. This can be seen in employment policies that assist in times of unemployment and finding new jobs, in the compulsory social insurance payments, in the provision of free school education, or the direct state financing of healthcare. Public services came to be associated with de-commodification, particularly in the development of post-WWII welfare state institutions. The Keynesian policies of full-employment and state intervention in the economy, which dominated the post-war era until the 1980s, derived much of their logic from the recognition of the fact that

---

[23] Marx's conceptualisation of commodification has been hugely influential: 'The *transformation of labour* (as living, purposive activity) into *capital* is, *in itself,* the result of the exchange between capital and labour, in so far as it gives the capitalist the title of ownership to the product of labour (and command over the same). […]Labour itself is *productive only* if absorbed into capital, where capital forms the basis of production, and where the capitalist is therefore in command of production. The productivity of labour becomes the productive force of capital just as the general exchange value of commodities fixes itself in money.' (author's italics: Marx, 1973, p. 308)

markets are not self-regulating mechanisms. In economic terminology the basis for de-commodification is expressed in terms of the problem of 'market failure'; that is the inadequacy of market-organised services to meet collective needs and the inherent (Pareto) inefficiency of the market in providing social goods due to a tendency towards concentration (monopoly or oligopoly) and informational asymmetries between producer (physician, hospital providers, or health insurance firms) and consumer (Wonderling, Gruen & Black, 2005, pp.138-145; LeGrand, 1990).

Nonetheless, de-commodification is only ever partial because it continues to remain within the system of capitalist accumulation and is thereby defined by it: it is neither a return to the 'pre-commodified' state of affairs nor a full retreat from the commodified relationship. Rather, it is a constant mediation by the state of the contradictory relations between capital and labour. Consequently the state resorts to a strategy of, what Offe (1984) calls, *administrative re-commodification* under which legal and economic subjects can function as commodities. It is a three pronged strategy including the saleability of labour, the saleability of capital, and ultimately the exposure of certain sectors previously insulated to market processes.

Thus from the 1980s, market practices have been infused into social policies and public services, whilst the private sector has on the one hand been brought into more direct competition with public sector, and on the other the boundaries between public and private have continued to be smudged in certain areas. For Leys (2001) this transformation is a threat to non-market spheres of life, requiring active policies of commodification of something that previously was not, by the following means: (i) a reconstitution of goods and services as tradeable (we can note the ascent of health economics as a policy framework and the triumph of the technical agenda), (ii) people are induced to want to buy them (through the privatisation, quasi-markets, and the consumerisation of public service usage), (iii) a change in workforce ethic (labour flexibilization and New Managerialism), and (iv) ultimately where the risk is underwritten by state (examples such as the Private Finance Initiative where the state effectively has been expected to underwrite what otherwise were privately financed construction projects).

What we are witnessing then is not a complete reversal of the de-commodifying role of welfare state practices, but a partial re-commodification. Indeed, as I have suggested, policies which focus on competitiveness - presented within a modernisation discourse - to meet the challenges of increased international integration tend to see welfare services being reconfigured in order to serve effectively the needs of the market. Thus, New Labour for example has not attempted to reverse

social rights in any simple way but rather has sought to redefine them by arguing that they must be attached to obligations or 'responsibilities' in its *workfare* programme (Holden, 2003b, p.310).[24]

Welfare state and the internationalisation of public services providers

Under partial re-commodification welfare restructuring and public service modernisation agendas possess an essentially experimental character as programmes for welfare reform. It is in this framework of trying to introduce competition in public healthcare systems that the presence of international for-profit firms has primarily been fostered. But the form of internationalisation also has a very specific character in each country since, as has already been emphasised, healthcare reform is also bound up with the historical specificities of national healthcare systems.

The UK private sector market in healthcare remains small in relation to the public NHS system, despite deliberate public policies to expand the private sector role since the 1980s. Moves under the Thatcher governments to restructure the power relations within the public healthcare system, alongside broader policies of privatisation of post-WWII nationalized industries and utilities, marked the first wave of de-regulation and liberalization of the healthcare sector in the UK (Rayner, 1986;). However, this only extended to certain areas of the healthcare services and, moreover, did not comprise a unified and coherent privatization programme for healthcare services as was the case in other economic spheres and in much of the social services sector. By the 1990s, the emphasis was less on privatization and more on introducing market forms to the public sector, with PFI projects for the construction of new facilities, business oriented accounting and managerial practices extended from reforms that were instituted in the 1980s, and the infamous quasi-market relationships within the organisational structure of the NHS.

Western European social-democratic countries also experienced market-oriented reforms in the 1980s and 1990s. However, the extent and form of market-oriented changes were fairly different in that the structure of these healthcare systems was more corporatist than the centralised tax-based system of the UK. Private provision was already the modus operandi of healthcare services in Germany[25] and the Netherlands for example. But heavy state regulation maintained limits on the business orientation in healthcare, whilst compulsory employment-related insurance schemes cover

---

[24] A strategy in which the provision of state income has become a means of commodifying rather than decommodifying labour, by seeking to eliminate surplus labour power via active engagement in job-seeking or (re-) training.

[25] Inevitably after unification the former German Democratic Republic's healthcare system became restructured according to the new unified Federal Republic of Germany.

the bulk of the costs of care. This has not prevented, however, the growth of domestic private sectors - whether in co-existence with the public sector or outside it – and also the expansion of activities for a small number of such firms into foreign markets (Roemer, 1987; Hall, 2001).

As Holden argues '…the nature of the welfare state, in both home and host countries, plays a pivotal role in determining firms' internationalisation strategies in the social care sector', since due to the extensive role of states in welfare provision '…states are likely to have the greatest impact on the strategic decisions of welfare-related firms…' (2003a, p. 292). Noting LeGrand et al's (1992) observations regarding three possible forms of state intervention to secure social welfare - *direct provision*, *taxes and subsidies*, and *regulation* - Holden proceeds to relocate the focus from the analytical restrictions of 'regime-based' conceptualisations of the welfare state such as Esping-Andersen's to a more flexible notion of 'Welfare State Formation' (WSF) (Holden, 2003a, p. 292). This view allows for greater consideration for change in the political and economic dimensions of social policy, particularly when we wish to account for the relationship between social policy and private sector organisations. Moreover, it provides a firmer basis for analysing the relations in view of internationalising strategies of care sector firms, which are not directly comparable to other (i.e. manufacturing) sectors where internationalisation has received greater attention academically, but also where the patterns and objectives may be quite different. He goes on to argue that '*…it is the particular mix of direct state provision, taxes and subsidies, and regulation in the welfare state formation that provides the opportunities for, or barriers to, the international expansion of private providers of health services*' (my italics: Holden, 2003a, p.288).

The key is not the existing WSF but *change* in the WSF, the opportunities this opens up for private providers and its influence on the internationalizing strategies of such firms. For where in the UK, 'the publicly funded NHS is expanding the scope of private provision through a substantial increase in taxation and subsidy' (ibid, p.293), historically the state has not supported domestic care firms, so that the entrance of foreign owned organisations into the market have posed a considerable competitive pressure in key areas of the private care market. By contrast, 'countries like the USA which have long tradition of private insurance are likely to have markets dominated by domestically based private providers, rather than by foreign-owned firms' (ibid, p.293). Moreover, US firms abroad 'will have a competitive advantage on the world market due to accumulated experience' (ibid, p.293). The WSF concept is also valuable for comparative assessments in that it is this combination of factors that firms will regard in developing strategies for entering foreign markets.

2.2.2. The State, 'Globalization' and Policy Change

As transformations in the role of the state vis-à-vis social provision have been taking place, the explanatory importance of 'globalisation' has increased with a search for causal factors for these transformations. It has also been the subject of considerable debate over its actual explanatory value; a debate that has taken place predominantly in IR and IPE have addressed the theorisation of international integration/globalization, particularly given its domination of conceptual space throughout the 1990s, whereby the two main approaches were in contestation. For many scholars, 'globalisation' has been understood as the intensification of temporal and spatial integration of international political, economic, social, cultural and informational relations and processes (Dicken, 1998; Scholte, 2000). This view suggests a self-effacing tendency in the state, and the possibility of its ultimate demise or at least decline as a significant socio-political institution or actor (Levitt, 1983; Ohmae, 1990, 1995). A contesting and sceptical view has been that 'globalisation' entails little more than 'internationalisation' by another name, whereby states continued to remain the predominant actors in the international system, but also that the resilience of national sovereignty countered the assertions of 'globalists' (Hirst & Thompson, 1999; Strange, 1998; Weiss, 1997).

Its meaning has often been adapted to the intellectual agenda of each author, and despite each 'discipline' claiming some unique take on the questions that arise with regard to 'globalisation', little deep engagement has taken place within the field of healthcare policy. Where authors do speak of globalisation there has remained an implicit and at times explicit acceptance of the 'globalist' thesis. Even so, as the debate has matured in more recent years, there has been re-engagement with its meaning in framing political discourse and action and constraining national decision making (Hay, 2001; Greener, 2004a), and the beginnings of a research agenda to take stock of what concrete impact it has on people's lives and the social determinants of health (Hong, 2000; Lee *ed*, 2003; Navarro, Schmitt & Astudillo, 2005; Labonte & Schrecker, 2007a,b,c).

At least the common denominator amongst all analysis utilizing the concept (globalisation) is that it constitutes an agar-like medium with which the interpretation of complex social and institutional change can be *a priori* reduced conceptually to a singular point of reference for the empirical examination of the subject of analytical focus. Thus it can just as powerfully be employed to talk about a number of subjects as Walt (2000) has systematically pinpointed, ranging from: (i) *economic transformation*: i.e. financial volatility, marginalisation, labour insecurity; (ii) *new trade regimes*: 'winners and losers'; (iii) the *growing poverty gap*: i.e. rising health inequalities; (iv) *electronic (technological) revolution*: the 'knows' and 'not-knows'; (v) *new forms of governance*:

such as the proliferation of non-state actors. Yet, in its contested and at times fluid nature as a medium of interpretation, little clarity over the impact of 'globalisation' can be derived from simply attaching it as a concept to the analytical objectives of understanding more specific changes in, for instance, the policy making process and policy change. Yet, in the plurality of different contexts to which 'globalization' may refer, it also looses considerable explanatory power with regard to a specific set of changes such as healthcare reform. The dangers of appropriating this terminology for too many different contexts is discussed briefly next.

Policy change and 'globalisation'/ 'internationalisation'

Moran and Wood (1996) discuss how internationalisation in healthcare remains more *potential* than *actual*. One point on which they stumble, however, is in the premise of 'internationalisation' being synonymous with 'globalisation' (p.128). My point is not to assume globalisation as internationalisation 'writ large' (Mishra, 1999), since this negates the point of employing globalisation as a concept of 'higher' or different explanatory value than the former (MacLean, 2000; Weiss, 1997). Rather it is to argue that the significance of 'globalisation' pertains more to a potent discursive framework than to its actual explanatory capacity as a concept.[26]

Moran and Wood nonetheless have examined the potential for evaluating empirically the actuality of globalisation as a structural phenomenon. Their working definition, therefore, does not deviate from a mainstream conception:

> 'internationalization is a process through *which the authority and autonomy of the nation state is challenged or supplanted by structures, processes or policy developments which cut across national boundaries*.' (my italicisation: Moran & Wood, 1996, p.125)

The problem with 'globalisation', as critics have noted, is that whilst it is portrayed as a universalising concept it falls well short of adequately capturing the continued variations in national and local experiences. Healthcare continues even now to be one area where the state remains central to its funding and provision (ibid, p.126), and healthcare systems remain highly distinctive in their national institutional structures (Poullier, 1989, p.6).

---

[26] There is an element here of what we mentioned regarding ideology; though 'globalisation' or even 'globalism' cannot be considered an ideology but the product of an ideological framework.

The logic in talking of 'internationalisation' therefore, as opposed to 'globalisation', is in remaining conscious of the uneven development of the different processes that comprise it both within and between different national locations. Thus,

> 'internationalization cannot be conceived as a single wave washing over national health care systems. It is perfectly possible that there is occurring, for example, internationalization in the markets for health care products, and in the regulation of those markets, without any corresponding internationalization at any significant level in the markets for the labour of health care professionals.' (Moran & Wood, 1996, p.127)

After all, many of the processes described are not particularly *new*. Migration of labour has a much longer historical trajectory than the past couple of decades in view of market-oriented reforms. The cross-national exchange of medical knowledge and information also has a prior history. International trade in healthcare goods has been taking place long before 'Big Pharma' became nearly synonymous with the 'global pharmaceutical industry' (Braithwaite & Drahos, 2000). An international sensibility about the cross-border spread of disease, and the need for cross-border co-ordination to tackle such issues has preceded the era of 'globalisation' historically (Fidler, 2002). For an assessment of substantive change in healthcare, therefore, Moran and Wood propose four distinct ways in which it might take place (Moran & Wood, 1996, pp.126-7) and which can be employed as indicators of change: (i) the *structure of policy making*; (ii) changes in the *implementation or application* of health policy; (iii) internationalisation of *product markets in health*; and (iv) a '*contextual'* or, as Lee et al (2002) describe it, a 'cognitive' dimension.

Several authors have made an important contribution to studying globalisation and healthcare (Lee, Fustukian & Buse, 2002; Lee, 2003; Lee, 2004), drawing on the work of sociologists, political scientists and particularly scholars of International Relations, who dominate the theorisation of the international and globalisation. However, Lee's appropriation of the dichotomous model of analysis of 'temporal' and 'territorial' dimensions, in emphasising the change in scale and pace of the 'flow of goods, capital and people across political and economic boundaries' (Daulaire, 1999, p.22, cited in Walt, 2000, p.1) tends to reproduce the weakness of conceptualising 'globalization' present in earlier scholarship. This is not to reject such findings, but to acknowledge a deep contradiction in an approach which remains essentially descriptive whilst claiming to offer explanatory value (Rosenberg, 2007). The chief proponents of Globalization Theory (including Giddens, 1999; Held et al, 1998, 1999; Scholte, 1999) rather than being critical at a deep level of neoliberal

hegemony/globalisation or capitalist social relations, as they purport to be, actually contribute to reproducing the dominant discourse of globalization and 'individual liberty' which is the basis of neoliberal *ideology*.[27] As such globalization will continue to be current as long as it is perceived as a satisfactory descriptive concept (for this is its chief attribute) and it is a complex of socially located processes and is also derived from social relations (Joseph, 2006).

The implications are not just on a theoretical level, but resound in the conceptualisation of policy, as globalisation is rendered unproblematic conceptually itself. This has consequences in the framing policy making and inevitably in its implementation. On one level it provides policy makers in health care (and in other areas of public policy) with a means of legitimizing particular choices (Moran & Wood, p.140; Watson & Hay, 2003). From this viewpoint, the restructuring and modernisation agendas I have been referring to are legitimized in a way that evacuates removes agency from policy makers (Watson, 1999; Hay, 2001; Watson & Hay, 2003; Farnsworth, 2004). It renders them at the mercy of external forces that cannot be controlled by national decision-makers. On another level, however, there are concrete processes taking place which, as I have discussed earlier, are changing the character of healthcare systems.

How national is healthcare reform?

If the framework for healthcare policy-making is influenced by the processes of internationalisation then what changes are taking place? And how can we measure and evaluate the change? A starting point may be the creation of contemporary healthcare systems. The post-WWII healthcare systems of OECD countries are now considerably different to the 'cottage-industries' that characterised medical practice and the small-scale and employment-related insurance systems which developed until the mid-20th century. It is clear that state intervention (whether local or national/federal) has been a key part of their development, particularly in terms of the dimensions of regulation, taxation/public expenditure, and direct provision of services and/or infrastructure development, and must be seen in terms of a complex historical process of social and economic transformation.

---

[27] One further key critique related to this is that in seeking to theorise *modernity*, *globalization theory* has in effect 'latched itself on' to prior weak and shallow explanatory frameworks of 'post-fordism', 'post-industrialism', 'post-modernity', etc. without successfully either theorising the totality of change and its social basis, or providing an emancipatory politics vis-à-vis neoliberalism.

The ‘nationalisation’ of hospitals and medical practice in the UK with the foundation of the NHS, may mark the first instance of the institution of ‘universal’ access to healthcare services under a single unitary framework. However, the terms of universalisation were also limited by essential compromises within the system, which permitted private practice parallel to public service, as well as a small contingent of private organisations to continue to exist outside the overarching NHS structure (Rayner, 1986). This situation was not replicated in the rest of Western Europe, which by the 1950s was also firmly within the sphere of US dominance via Marshall Aid for post-war economic reconstruction (Armstrong, Glynn & Harrison, 1991; Van Der Pijl, 1984). The systems which developed were based on prior corporatist structures of health and medical insurance, which although eventually were legislated to become ‘universal’, were built on considerably different premises of financing and infrastructure development to the UK. Here I re-emphasise the national variation in healthcare systems and the problem this poses for comparative assessments of internationalising change.

Localised differences also remain, not only between sovereign territories but within them. In federal government systems, for example, the federal structure may act as a unifying legislative force, but also states or municipalities will differ in their legislation (this is most apparent in the US) (Blackman, 1995). Even in countries without federal structure, there is evidence of geographical inequalities in the kind of healthcare services available, the metropolitan centres often being host to some of the most highly regarded institutions which have greater resources at their disposal (Mohan, 1995). On the other hand in the same national geographical constituency, we may find that facilities are again unequally distributed between more affluent sectors and those that are more deprived (Hart, 1971; Wilkinson, 1996). In the UK we find further differences in view of the state structure variance between the different countries that make up the United Kingdom. Existing differences between Northern Ireland, Wales, Scotland and England have become even more significant because of the devolutionary politics in the last decade (Woods, 2004).[28]

Some focus has also been made on the impact of Regional and International Multilateral Trade Agreements (MTAs) and Treaties. The European Union (EU) is the most significant in the European region due to the degree of political as well as economic integration that it represents and

[28] This point is more significant given the rejection by Scottish and Welsh Assemblies to not pursue the integration and closer cooperation between NHS and private for-profit sector.

fosters. Nonetheless, its direct influence on healthcare systems is still fairly limited. However, it does have impact in some key areas: the free movement of professionals between member states (Single European Act, 1986); the regulation of pharmaceutical products (European Medicines Evaluation Agency, following the SEA); public health and health protection, including consumer rights (Treaty of the EU, 1992; Treaty of Amsterdam, 1997, Article 152); and labour relations (Working Time Directive, 1993) (Lethbridge, 2002; Laing & Buisson, 2003). But whilst healthcare issues cut across most all areas and institutions of the EU (including the European Parliament and various directives), its reiteration of the subsidiarity principle especially in relation to health care in the *Maastricht Treaty* (1992), has meant that little coordination takes place at the EU level. But this still does not preclude that it is a vital point for interest groups (such as corporate advocacy groups) to seek application of influence.

There have been concerns, however, over the implications of its in-built liberalisation agenda for services sector (European Commission, 2004; Rowland, Price & Pollock, 2004). Elsewhere, Multilateral Trade Agreements of the WTO and FTAA negotiations are also causing a stir over what influence they may have in liberalising national healthcare services markets by forcing states to accept international competition and capital investment in private sector health. Though in the case of the WTO's General Agreement on Trade In Services (WTO 1994),[29] is a process that remains far from completion and implementation – and moreover there has been considerable resistance to the inclusion of healthcare services within its remit – the potential impact it poses for the opening of domestic healthcare services markets is still symbolic of a broader drive for healthcare commercialisation (Price, Pollock & Shaoul, 1999). The bilateral and multilateral negotiations FTAA has been more successful in developing trade avenues for US firms to Latin American countries; although again, there is no explicit provision for healthcare services. Rather it is an indirect pressure in terms of gaining overall trade concessions between US and other countries. The point about regional Trade Agreements is that they potentially treat healthcare services as any other service sector. In doing so, they contribute to an economic reductionism in the treatment of healthcare, reneglecting the social role of such services.

However, it is crucial to understand that such '*trade-creep*' (Koivusalo, 2001) - ways in which trade policies influence, intentionally or unintentionally, various non-trade policy issues,

[29] According to the GATS: "A service supplied in the exercise of governmental authority means any service which is supplied neither on a commercial basis, nor in competition with one or more service suppliers."

taking place through legal, legal-administrative or non-legal routes - depends a great deal on the way in which social provision is organised and legally/normatively supported in any participating state. Moreover, as Braithwaite and Drahos (2000) have demonstrated extensively, Trade Agreements are but one forum where business actors pursue a liberalisation agenda via state representatives and advocacy groups.

2.3. International Healthcare Services Market and Healthcare Reform

If internationalisation of trade is an emergent issue for most countries, the capacity of the key actors in international trade need to be understood. Business, as has become increasingly evident since the early 1980s, exerts both *structural* power and *agency* in a variety of ways which have an impact on social policy formation and by extension social provision (Farnsworth, 2004; Marsh & Locksley, 1983). Hence it is important to examine in what ways government policies relate to business preferences and what kind of preferences these are. If one is to analyze the commercialisation of healthcare services, one must be clear about who has an interest in such an outcome. Farnsworth (2004) emphasises the need to bring the role of business and business influence into the analysis of social policy formation and, further, to overcome taken-for-granted assumptions about the role and interests of business in shaping social policy. In view of the 'pro-business' stance of governments and the increasing involvement of business in issues of social policy and welfare state services provision, there arises the question of whether there is a business agenda for healthcare. A 'business agenda for healthcare' does not simply refer to the way in which the interests of 'business' or 'capital' are developed in healthcare sector, but also the business oriented framework within which social policy - in this case healthcare policy - is developed and implemented.

2.3.1. Analysing business interests in social policy

Pluralist analyses (Dahl, 1971; Lindblom, 1977; Lindblom & Woodhouse, 1993) tend to view 'business' as an interest group amongst a broad set of groups contending for influence, rather than assigning it special privilege. Moreover, the majority of studies in the heyday of policy and interest group analysis tended to focus on industrial or manufacturing industry power. No less important is the point that, in Anglo-Saxon at least, academic research we find a higher proportion of works concentrated in US policy making and business-state or business-social policy nexus. The application of US studies to European cases inevitably requires a cautionary approach, although this

is not to say that there has been a complete dearth of European or UK analyses, just that due to the US origins of policy analysis it has inevitably also shaped the research agenda in countries outside.

Out of the US dominated pluralist tradition in studying the structure of power in capitalist democracies also grew elite theory, business actors have been shown to have particular purchase on government policy-making due to their social and economic power. Some authors have attempted to combine Marxist methodology and elite theory to demonstrate the deep links between the state and capitalist ruling class (Mills, 1956; Miliband, 1969). This reflects not only a concern with the nature of the contemporary capitalist state but also with unpicking the ideological content of business-government relationships. However, 'business' and 'capital' have often been used interchangeably in political science and social policy literature, particularly given the Marxist preference for 'capital'. Yet, as one commentator suggests, with the concept of capital we are not only interested in the study of interest group activity,

> 'but also with the capacity of capital as a whole, and of its various sectors or fractions, to constrain the autonomy of Government, and with the question of how far the ideological framework within which decision makers' work serves capital's interests' (Editorial, 1983, p.2).

Thus, as Farnsworth (2004) reminds us, it is no monolithic category but constitutes a variety of different positions and interests, and which are neither necessarily coherent nor in agreement. Upon deeper analysis, it becomes apparent that there are a great number of different and sometimes competing interests involved, as *capital* is much more fragmented than purely structuralist analysis may suggest, but also 'capital' and 'business' – though often taken as synonymous – do not express the same thing. While 'business' is a privileged interest, its power and influence vary over time and between policy areas (Hacker & Pierson, 2002; Vogel, 1989); its dominance is neither constant nor unassailable.

In this analysis, capital and business are understood as having a special privilege, but I wish to distinguish 'business' from 'capital' in emphasising the agency aspect of the analysis in reference to corporate and private for-profit enterprises involved in the social policy domain rather than capital and it's more totalising connotations. I treat 'business' primarily as signifying 'private for-profit firms' and secondarily as the business associations and lobbying networks that organized to advance their specific and collective agendas. A key distinction is to be made between *industrial* and *financial* business (Sargent, 1983; Marsh, 1983b; Farnsworth, 2004), particularly in view of the

rise of financial capital above industrial manufacturing as a key site of influence on government decision-making and economic policy, and the displacement of traditional manufacturing industries with services as a major source of economic activity and growth since the 1980s (Gray, 1990; Castells, 2000).[30] This point reflects the treatment of the healthcare sector in international business literature and an emphasis on the effects of increased integration of the international economy on the strategies of national governments and particularly of firms (Porter, 1986; Dunning, 1997). As firms (particularly in manufacturing industries) have altered their market strategies - i.e. *just-in-time* and *lean production* methods, flexible wage-labour contracts, outsourcing of production, or relocating production to countries with cheaper labour and minimal labour protection legislation - so too states have had to change their policy approach to enticing FDI and supporting economic growth (Amin & Palan, 2001). This is a key justification for the increasing opening of welfare services to private markets (Pfaler *et a*l), and an indication for some analysts of the post-Fordist turn in the international economy. If healthcare gets any attention, it is most often subordinated by default to this conception of the international service economy; acknowledging simultaneously the high value-adding activities of pharmaceuticals and medical technologies producers within the manufacturing sector. With regard to the medical component of healthcare services it is after all a high skill, knowledge-driven industry.

With the sensitisation of researchers to the importance of globalization - whether an actual set of substantive changes or in the cognitive dimension - there is also a sense of the way it has changed the power dynamic between business and nation states. As I have been suggesting, IPE literature, noting the claims of international business and management has also contributed to a re-conceptualisation. Stopford and Strange's (1991) model of agenda formation is particularly influential (El Kahal, 1994, pp.78-9; Brown, 1999; Lawton et al, 2000). They posit firm-firm, state-firm and state-state interrelationships as defining a new 'triangular diplomacy' of a more integrated and competitive world economy, in which firms and states are in bargaining positions for defining the terms of investment and governance authority. More classical Marxist theorists have developed further the class analytic methods, discussing a Transnational Capitalist Class (Sklair, 2001; Van Der Pijl, 1998; Robinson & Harris, 2000), combining a broad group (even itself containing multiple and variable interests) of managers, owners and corporate heads which transcend national territories. This is effectively a trans-nationalisation of elite theory, though taking a much more

[30] Indeed, the current list of Fortune 500 companies shows more service companies and fewer manufacturers than in previous decades (Fortune 500)

nuanced approach to the relationship between state and business actors than previous elite theory, and being explicitly Marxist (or Gramscian) in content.[31] This is further framed by the rise of financial capital and offshore financial centres, as capital becomes more remote from the controls of the state whilst at the same time the state becomes a chief arbiter of capital's liberalisation (Cerny, 1996; Palan, 1998a,b). Furthermore this constitutes the predominant realisation of anything that may be called 'globalisation' (Boyer, 2000, p.274; Blecker, 2005).

Some social policy authors have begun to research the interest of business actors in the value of social provision to business needs or agendas (Hacker & Pierson, 2002; Farnsworth, 2004, 2006c). For Martin, 'business managers' strategies for economic competition have shaped their reception to public policies that simultaneously enhance workers' skills and add to the costs of labor'; so that it is important to see the difference 'between a business community accommodating growth in government services and one resisting expansion of the public sphere' (Martin, 2003, p.1). This analysis also rebalances, somewhat, the focus on 'business' as employers onto the other key variable, that of labour (Marsh, 1983). The West European corporatist structure of labour relations and the US structure vary considerably, so that post-Fordism also is not expressed quite in the same way in different national locations (Palan, 2006). Yet, this still leaves the importance of examining actual firm strategies, how these are shaped by business preferences and state policies, but also how they shape state policies.

2.3.2. Strategies of Firms

Firms exert both structural power and agency. Structural power takes place in a number of ways (Farnsworth, 2004, pp.13-16) including, first and foremost, the ability of business actors to make free investment decisions within the capitalist market system. This 'institutionalised right of capital withdrawal' (Hirshman, 1970) derives from the fact that both government and labour are dependent on the collective investments of business, so that 'the pursuit of personal or 'national' interest must take account of the impact that such pursuits have on future investment decisions' (Farnsworth, 2004, p. 13). Thus, governments are acutely conscious of the importance of (i) maintaining a pro-business investment environment - one which does not overburden with administrative costs, provides favourable tax regime, and an attractive labour market - (Pfaller & Gough, 1991, p.34-6), and (ii) co-opting labour into business-oriented educational requirements

[31] See Cox, R.W. (1983) or Gill, S. (1993) for the Gramscian turn in International Relations and International Political Economy Research.

(Bottery, 2001; Stedward, 2003; Finn, 2001; Bedgood, 1999). Second, as Offe and Ronge (1982) argue, the state is structurally dependent on the capitalist sector for its revenue, so that fundamentally governments in capitalist states are averse to undermining capital accumulation. Thus the state has an 'institutional self-interest', which is 'conditioned by the fact that the state is denied the power to control the flow of those resources which are indispensable for the use of state power' (Offe & Ronge, 1982, p.145). Third, the power capital exerts with regard to labour given the relative dependence of labour for its livelihood on private firms. Though it is not exclusive, especially given the size of the public sector as an employer in most countries, the asymmetrical power over labour is secured by the continuation of profitability and accumulation as coterminous with ultimate interests of labour to remain in employment. Finally, ideological control is a corollary of the first three dimensions of its structural power, wherein the hegemonic power to legitimise business as national interests, means that business may be normalised as being central to most social and economic activities. This may be just as powerful in spite of resistance or challenge from organised labour, which ultimately is bargaining with business for a better deal for labour (Gill, 1995).

Firms also actively exert agency power, of which the following are most prevalent. Direct involvement in government machine is one of the older methods of influence. A useful paradigm to describe this is the notion of the 'revolving door' between government and business whereby civil servant and government official may work on boards of directorship in private for-profit firms, just as businessmen or managers of private firms may be brought into government positions either as active political agents or in an advisory capacity. A further, though less direct, example is that of *party political donations* and the development of partisan relations which has long been recognised as a method of business actors for influencing government (Lindblom, 1977; Podhorzer, 1995; Polsky, 2005). A further means of influence is via informational strategies which include the following: (i) lobbying - this includes hiring firms or individuals that specialise in lobbying government actors, or the direct approach of government officials by representatives of peak business associations; (ii) press releases; and (iii) think tanks – this is done either through sponsorship of research institutes or participation by business actors in the organisations themselves, which in turn have an impact on the framing of policy. A further way for business to exert agency is in *participation in social commitments* (a corollary of which is the doctrine of 'corporate social responsibility'); this is not just about the provision of social goods or services under contract with government. This has in more recent years been framed by notions of 'corporate social responsibility'.

Yet, identifying the structural power and agency of business still leaves questions about what determines firms' preferences in choosing particular strategies for influencing public policy, and in forming particular decisions about what fits with their corporate strategy overall. Martin (2003) finds that, first, 'the further an issue is from the company's core profit-making activity, the greater the degrees of freedom in the construction of the firm's interests', which suggests that 'in areas such as social policy firms have even greater range of possible preference positions' (ibid, pp.24-25). Thus, for example, while a firm in the consumer electronics sector may have an acute interest in changing environmental regulations and how these affect their costs of production and profit returns, the same company may have little direct interest in questions of healthcare reform. Second, 'processes of employer engagement with the political sphere seem to vary across regions', so that national specificities in firm coalition and association as well as relations to government vary between national (and even more localised) settings (ibid, p.25). This is an issue that has as much to do with the historical location of firms within the welfare state social contract between state and citizenry, and firm with state. Thus, the corporate association culture can be seen to differ between corporatist regimes that dominate in Germany, US liberal politics, and UK liberalism (Alcock & Craig, 2000; Palan, 2006). Third, as public policy is not the primary activity which firms are engaged in, 'business managers tend to be *reactive*, following the lead of others in deciding to get involved with policy issues' (my italics:, Martin, 2003, p.26). This does not mean that business actors wait around until a policy proposition is made, but pro-active engagement in social policy is unlikely unless it is to attain goals which pertain to firm profitability.

2.3.3. A Business Agenda for Healthcare Reform

There is an interesting variance in the debates which dominate the political agenda in different countries regarding healthcare reform; after all it is in reform agendas that we are able to see the objectives for change by various actors. In the US we can see contesting groups of firms in terms of their position vis-à-vis healthcare reform: employers not associated with healthcare but which do provide health insurance in their employment package have an interest in reducing the costs of care, whilst many insurance firms and HMOs have an interest in subverting any substantive change from the current arrangements for healthcare financing. In the UK, where healthcare has been predominantly funded by general taxation and insurance firms have a relatively weak stake in the sector, we find the greatest amount of pressure coming from domestic firms that had previously had virtual monopoly market share within the domestic private sector as their position is being threatened by international competition from new foreign entrants.

As far as liberalisation of services is concerned, there is little indication of business advocacy specifically for liberalisation of healthcare services markets from the level of multilateral trade agreements and international governance institutions. *It is important to note that this is something that remains considerably under-researched*. However, with the negotiations over the GATS, there was no comparable coalition of business actors pushing for healthcare liberalisation as had been the case with the TRIPS agreement. For TRIPS a coalition of services firms, under PhRMA, was set up to gain amongst other things, a shifting of the site of international regulatory authority from the WIPO to the WTO which was seen as a more favourable forum to pursue more stringent IP regulations that would favour their existing market position (Purdue, 1995; Braithwaite and Drahos, 2000). Moreover, despite the advocacy by the European Services Forum for service liberalisation in the EU, there has been considerable resistance to EU intervening directly in member state healthcare services markets. However, no matter what the current status of international trade regimes in so far as these may affect the healthcare services sector, there is still a need to understand the causes for firm entry into foreign markets and consequent internationalisation of their business strategy.

2.3.4. Blurring the boundaries: The mixed economy of healthcare provision

Key works on the subject cite the lack of empirical data, and at the very least imply the paucity of research on the linkages between healthcare reform and commercialisation. A number of works have focused on the public-private mix in health, though containing widely differing approaches to the subject. Maynard's edited volume, *The Public-Private Mix for Health* (1982; 2005),[32] gives a general overview of the variation of the public-private mix across a set of similar healthcare systems of the OECD. It highlights the significance of that mix for conceptualising and making healthcare policy, as well as the importance of generating more substantial body of empirically led research in the area. Keen, Light and Mays' report on the *Public-Private Relations in Healthcare* (2001) consists of one of the most comprehensive overviews recently published focusing on the UK healthcare sector. Despite the brevity with which it covers each area of healthcare provision, the report provides a much more practical basis for empirical investigation, as well as an overview of theoretical frameworks which assist in conceptualising the public-private mix.

---

[32] First published in 1982 and recently revised and substantially rewritten in 2005, it contains a cross-country perspective despite its rather flawed comparative analytical credentials as each chapter focuses on different aspects making sound comparative impracticable (McLachlan & Maynard (eds), 1982; Maynard (ed), 2005).

The diversity of relationships and practices that cut across public and private boundaries highlights the difficulty of assessing the structure of healthcare systems in terms of a neat distinction between public and private spheres (Salter, 1995; Ham, 1996; Keen & Mays, 1998). Indeed, there is often a blurring of boundaries between the public and private sectors. This has been an endemic factor in the UK's political economy of healthcare, effectively written into the foundation of the NHS (Salter, 1995 & 1998). This includes medical consultant's part-time employment between NHS and private sector, pay-beds in NHS hospitals, and GPs legal status as private entrepreneurs. Other aspects developed since the early 1980s include the outsourcing of ancillary services. Since the 1990s, the most visible examples of the blurring process have included the expansion of 'contracting out' of ancillary cleaning and catering services; the Private Finance Initiative (PFI) and more recently the Local Investment Finance Trusts (LIFT) for the building of hospitals and primary care facilities respectively; the commissioning of an ongoing institution-wide IT project; and since 2002 the commissioning of independent sector treatment centres (ISTCs) by the NHS to provide specialised services such as cataracts operations and hip-replacements (Unison, 2005).

Nonetheless, outside cross-national comparative research, analysis of the internationalisation processes in contemporary healthcare systems is an important omission in these publications. A small number of authors covering the expansion of private healthcare in the UK (Griffith, Illife & Rayner, 1987; Higgins, 1988) have made invaluable contributions to a historical overview of the impact of US domestic policy in the corporate exportation of healthcare services firms into the UK. These works draw upon, and echo already growing literature from the USA, that is illuminating on, but also critical of, the corporate transformation of American medicine and healthcare. This literature goes as far back as 1971 (Ehrenreich & Ehrenreich), and has since expanded throughout the 1980s and 1990s into the current post-Clinton reform era (Relman, 1980 & 1997; Salmon, 1984 & 1995; Himmelstein & Woolhandler, 1990; Navarro, 1995; Geyman, 2004). Whilst, these are generally limited by the absence of theorisation in their analyses, they do provide a basis for examining some of the changes that have taken place since the mid-1980s. We can also see the difference between the state of the private sector and its relationship to the public from the late 1960s when the private sector in the UK still remained fairly marginal and distinctly an appendage

of the NHS compromise (Mencher, 1967),[33] and later in the 1990s by which time the importance of private sector growth had already demonstrated a policy challenge for the public system (Salter, 1995).

Despite scant research on the topic since that time, various critiques have contributed to empirical research on issues ranging from PFI schemes in primary and secondary care (Gaffney & Pollock, 1999; Goddard, Pollock & Player, 2001) in the UK, and the importation of ideas behind the managed care from the US (Churchill, 1999) in the UK (Robinson & Steiner, 1998) and in other countries (i.e. Germany: Altenstetter, 2002). However, their specialised focus means that an examination of the international dimension of the healthcare services market is still fairly limited and, furthermore, it is most often assumed that there is a *natural* business agenda for the privatisation and commercialisation of healthcare. Whilst it does follow that firms are by definition profit-seeking organisations whose first priority is attaining and maintaining profitability, not all firms operating abroad have made huge profits and some have even had to concede to failure and withdrawal from a new market.

2.3.5. Internationalisation of Firms and Healthcare Services

Most literature on internationalisation and foreign market entry strategies focuses on manufacturing which follows from their significance in terms of the historical development of international trade and of national economies, and most firms are manufacturing based (Arvidsson, 1997, p.71). Much of the research has also tended to be on multinational companies (MNCs), which by definition are firms with an international strategic outlook, though some work has been done on small and medium enterprises (SMEs) in more recent years, which reflects more appropriately the scale of healthcare service firms. The predominant methods for internationalisation usually identified include: export, licensing, subcontracting and franchising, joint ventures, mergers and acquisitions, and direct investment (Buckley & Casson, 2000; El Kahal, 1994).[34] Dunning's (1988)

---

[33] The compromise entailed the retention of private practice alongside public service provision. Whilst the UK government sought to 'nationalise', or essentially 'municipalise', the majority of hospitals and bring medical practitioners into public wage scheme, in a concession to practitioners GPs remained legally as private entrepreneurs whilst hospital consultants and medics also retained certain rights to practice part time in the private sector, whilst fulfilling public service duties in the NHS (Webster, 1998) [more in Chapter 4].

[34] In the 1960s export and FDI were the predominant methods that were concerning researchers, form the 1970s the internalisation strategies of licensing, franchising and subcontracting gained more attention, whilst the resurgence of mergers and acquisitions as a strategy in the 1980s was followed by a further turn to FDI in the 1990s, particularly with regard to 'transitional' or 'emerging' economies of Central and Eastern Europe and Southern and East Asia (Buckley & Casson, 2000, pp. 61-62).

'eclectic' theory of international production[35] places emphasis on ownership, location and internalisation advantages (OLI) as the foundation for most business internationalisation considerations. As we have suggested already, research specifically on services firm internationalisation has overwhelmingly focused on ICT, telecommunications, and financial services industries. Services firms cannot make the same kind of production efficiency savings as manufacturing firms in internationalising production. Some of the key considerations that emerge from the literature have to do with the prior existence of corporate networks in the target market, which includes early starters as well as firms operating in markets outside of the key market studied (in this case healthcare) but are still potential customers of the key market studied (Arvidsson, 1997, p. 80).

Despite growing research on services, however, this still leaves a considerable gap in the literature specifically examining the internationalisation of firms operating in the healthcare services sector of either category (i) or (ii) as identified in section 5.3 above. This is in part due to the relative novelty of discussing international trade in healthcare services (Chanda, 1998; Drache & Sullivan, 1999, p.1). However, some authors have identified at least some strategies, whereby hospital firms, having entered foreign markets by an initial purchase of an existing private clinic or hospital, following an initial phase of market evaluation and entry have expanded rapidly through aggressive acquisitions of small (often single-unit) independent not-for-profit or for-profit providers (Mohan, 1991; Holden, 2002b). Holden (ibid, 2002b), drawing on management literature, discusses the '*market seeking*' behaviour of healthcare firms in expanding their activities outside the home market. This analysis reflects findings in the ancillary services (Mohan, 1991), in private hospital (Mohan, 1991; Keen, Light & Mays, 2001) and in long-term care industries (Holden 2002b; Lethbridge 2005). It is a way of describing a strategy by which companies spend time at first scouting out potential new markets with initially a small presence of a single unit, followed by an (often aggressive) acquisitions strategy - as well as new buildings in the case of hospitals and long term care providers - once the market is understood and opportunities for expansion are secured due to government policy environment and/or regulatory conditions.

From early on, US firms were reaching limits to domestic markets because of federal regulation, and sought to expand into markets abroad. One of the ironies is that they found

[35] It is eclectic because it recognises the need to look beyond FDI theory for a framework of understanding the rationale and considerations behind internationalisation strategies (Dunning, 1988, p.1).

opportunities in the UK healthcare sector, where the virtual monopoly of the healthcare services sector was held by the state. This has partly been explained by reference to the favourable political climate of the early 1980s in which the Conservative government was seeking strategies for restructuring the economy and the monopoly power of the medical profession. The converse holds for the US domestic market, which is dominated by domestic firms, expanding their activities between US states.

2.4. Concluding Remarks

In this chapter I have sought to develop a synthesis approach towards a critical reading of 'globalization' as an explanatory concept to understand the commercialisation of healthcare services. My review of largely secondary academic literature indicates the following key points. Health policy analysis as a field of inquiry is considerably limited so far in having developed an understanding of the impact of globalization on healthcare services. While a large number of publications have been made over the past decade in this area from a health policy perspective, a key issue that is considerably under-researched is the interplay between internationalising commercial healthcare firms and the changing structure of national healthcare service sectors.

To develop a framework for analysing this particular issue historically, I have sought recourse in a reading of authors employing a critical political economy approach, which itself demonstrates a strong historical perspective of analysis. However, despite important interventions by a number of authors employing the political economy approach, there continues to be a substantive gap in the literature investigating the link between changes in the welfare state, changes in healthcare systems, and the internationalisation of welfare and healthcare services (Moran, 2000, p. 136). Moreover, while business studies research is relatively more developed in the analysis of business strategy (i.e. for internationalisation), there is still considerable lack of engagement with firms in the healthcare service sector, while the relationship between firms and welfare state reform is generally rather limited to its impact on businesses themselves in terms of the development of opportunities or barriers to commercial activity.

Meanwhile a number of substantive points can be made from the literature reviewed in considering the internationalisation and commercialisation of healthcare services which offers some guidance to developing the empirical section of the thesis. It is indicated that both internationalisation and commercialisation appear to have largely stemmed from state policies and practices. Moreover, the penetration of foreign-owned firms into the national healthcare economy

has had a significant impact on re-shaping the dynamic within the private sector (both for-profit and voluntary) as well as public healthcare service structures. Furthermore, the processes of internationalisation and commercialisation in healthcare services appear to be highly contingent on each other.

The findings of this chapter raise a further set of questions that I focus on in the following two chapters. First, what kind of reforms have been implemented which may appreciably give space for the commercialisation of healthcare services? Second, to what extent have healthcare service firms actually internationalised? In the ensuing chapters I develop an overview of state policies in OECD countries, followed by an investigation of the extent to which healthcare services have been internationalising. In turn, I re-visit the long-term emergence of the commercialisation trend and its relation to the internationalisation of healthcare service firms through a substantive examination of these developments in the US and the UK.

Chapter 3: Dynamic of the healthcare services market in OECD countries: the US and UK in international perspective

In this chapter I analyse national-level conditions for the emergence of an international healthcare services market. As suggested in the preceding two chapters, in the context of a market-oriented turn in public policy for healthcare over the past few decades, the emergence since the 1990s of an international agenda for liberalization of trade in services has brought into sharp relief the possibility for healthcare services to become absorbed into such an agenda for market liberalization. Nonetheless, many changes in the dynamic of the mixed economy of healthcare services have so far taken place without the direct compulsion of international trade liberalization regimes. Given that healthcare services are historically embedded in territorial national-level policy decision-making settings and local-level (sub-national) delivery structures, this raises a question about the degree to which healthcare systems have been moving towards a situation that may be conducive to competition in an international market for healthcare services.

A key problem for cross-country analysis, however, is that healthcare systems are historically embedded in the social, economic and political specificities of their respective national settings (Porter, 1999; Blank & Burau, 2004). Nonetheless, while both the UK and US are quite unique in a number of respects compared with other 'state-based' and 'market-based' healthcare systems respectively, locating them in terms of more general trends in the OECD countries is helpful to laying the ground for assessing the (potential) emergence of an international healthcare services market. As such, for my analysis in this chapter I take a broad international comparative approach to highlight key trends of market-oriented healthcare services reform across the OECD countries.

What I am looking for is the extent to which public policy in 'developed' countries has been following a similar path towards market-oriented restructuring of healthcare services with attendant consequences for the dynamics of the mixed economy of healthcare. This in turn should reveal pointers towards key mechanisms for commercialisation in the healthcare services sectors of 'developed' countries. Furthermore, the analysis in this chapter may help to illuminate, to some degree, a more general overarching theme of the thesis regarding the relationship between globalization and commercialisation of healthcare services by considering the extent to which a convergence has been taking place in terms of market-oriented reform across the OECD countries.

The chapter begins with a general overview of the shift in the dynamic in the healthcare services market across OECD countries in the years, pinpointing the emergence of a commercial form of healthcare service provision and financing in the post-WWII era. The following section (3.2) consists of a more in depth overview of market-oriented reforms across OECD countries, while the final section (3.3) reflects on the degree to which space for the private sector and particularly commercial provision and health insurance has been opened up over the past few decades.

3.1. Healthcare reform and the dynamic healthcare services market in OECD countries

The shift in the public-private healthcare mix has varied considerably between OECD countries depending on the prior scale of public sector contribution, and the particular structure of the public-private mix to begin with. The most important tendency, evident to some degree in all OECD countries during the 1990s, has been the pursuit of a more 'pro-competitive' market-oriented structure of healthcare services, in which providers have been encouraged to act in a more competitive way for healthcare service consumers and in more public-integrated systems for public organizations to compete with private sector service financing and provision. The greater space opened up for the private sector has, in some countries, also opened up opportunities for commercial ('for-profit') health insurance and provision, though this tendency is still comparatively limited.

3.1.1. Long-term changes in the 'mixed economy' of healthcare

The expansion of public sector involvement in healthcare services in the post-WWII years largely sought to limit the financial barriers for access to healthcare (Roemer, 1976; Cutler, 2002). The political commitment of governments in a post-war world to improvement of health status

through social provisions was a major aspect of this.[36] On a pragmatic level, the inadequacies of private markets and voluntary insurance for large sections of the population provided a strong stimulus in the early post-war period in gaining equitable access to healthcare for universalisation of coverage through public programmes in many developed countries, including New Zealand, the UK, Sweden, and the Netherlands. Some countries however, moved to universalise coverage comparatively late, in periods when post-war economic recovery was no longer a driving force (i.e. Canada, Japan, and Italy in the 1970s). Still other countries, such as Greece, Australia and South Korea, expanded coverage to a universal or near-universal level through public programmes or compulsory social or private insurance as late as the 1980s.[37] Some of the former Soviet-bloc countries that had developed state-based healthcare during the post-war period, began to reform towards a social insurance system in the 1990s following the collapse of the Soviet Union, though still retained universal coverage (i.e. Hungary and Poland) (Table 3.1).

In a number of OECD countries, provision of healthcare services was also brought under direct public ownership and/or control; though mainly limited to hospitals, with primary care practitioners often brought into a public contract system. Most of these followed the UK's model of nationalisation of hospitals and the creation of a National Health Service (NHS) regulated by government or public agencies and paid for through a system of public taxation and, to varying degrees, combined with compulsory social health insurance administered through public or quasi-public agencies (i.e. Sweden, Norway, Italy, Spain, Denmark, Portugal and Greece) (Freeman, 2000; Mossialos *et al*, 2002). However, in many cases, ownership of healthcare service providers remained split between the public and private sector, the latter usually dominating market share by

---

[36] Although post-WWII social programmes were strongly linked to the process of post-war economic recovery, the plans to expand social protection had, in many cases, preceded the experience of the Second World War. For instance, New Zealand had legislated for universal healthcare coverage in 1938, even if its National Health Service programme was only implemented in the 1950s. The UK had also been developing plans for an NHS since the early 1940s, before to the full impact of WWII was felt by British society. Meanwhile, not all countries that developed highly solidaristic public healthcare systems experienced the same kind of consequences to their economy or to their society as a consequence of the Second World War. Nonetheless, within the context of post-war Keynesian economic thinking that had begun to pervade much of the developed world, the notion of public financing and provision of services was much more ideologically supported.

[37] In some cases universal coverage followed only after the dissolution of dictatorships, and the ascent of socialist or social-democratic governments such as in Spain, Portugal and Greece. In others, 'universalisation' in the 1980s was more about completion of programmes already offering fairly extensive coverage. Besides these historical differences in timing of universalisation, the kind of financing systems put in place have varied between countries, a great number of which, in Europe, established 'Beveridge-type' systems in which public taxation constitutes the primary source of financing, while a smaller number established 'Bismark-type' systems based around social health insurance.

number of hospitals, beds and in terms of the proportion of medical practitioners working in the private sector (i.e. Germany, France, Netherlands, Mexico, Turkey, South Korea and Japan). In the US a *residual* public hospital sector is limited to hospitals for army veterans and small number of municipal hospitals left over from before the Second World War (Patel & Rushefsky, 2006); although acute bed numbers in legally defined 'for-profit' hospitals still only amounted to around 11% of total US acute bed capacity in 1995, the rest being split between non-profit (65%) and public institutions (24%) (Cutler, 2000, p.1).

In most cases - including those systems where the private sector became *residual* after the 1940s (most notably the UK and the Scandinavian countries) - the current private healthcare sector has been rooted in non-profit charity and mutual organisations, largely for historical reasons, preceding public ownership where this became instituted (Griffith *et al*, 1987; Starr, 1982; Porter, 1999). However the distinction between non-profit and for-profit healthcare has also been important insofar as for-profit private healthcare services are still widely regarded as antithetical to equitable objectives of medical practice, while 'non-profit' status is also typically distinguished from the profit-motive in healthcare.[38]

In practice, the non-profit status of healthcare services varies considerably between countries, and this depends a great deal on the position of these services within the overall mixed economy of care. The *mutual* health insurance companies in France or Germany which make up the bulk of their health financing source (mandatory social health insurance) are non-profit private entities (Freeman, 2000). But their 'public mission' is much clearer than, for instance, the UK's non-profit BUPA (the major market leader in the UK private health insurance market since the 1950s) which occupies a voluntary complementary market space as a form of financing to that of the dominant public NHS. While both these 'non-profit' types rely on profit margins from subscriptions which essentially are re-invested in their organisations rather than paying share-holders (as is the case for 'for-profit' insurers), the nature of their market is quite different, as is their competitive position within that

[38] This is important when we consider that the private sector is a major source of healthcare provision in the world, including OECD and developing countries (Uplekar, 2000).

market.[39] Incidentally, both France and Germany have voluntary private health insurers in addition to their social insurance providers, occupying a similar complementary and supplementary market space to that of British private medical insurance (PMI).

The 'market failure' inherent in healthcare financing and delivery - particularly when it comes to costly acute and long-term care - means few are able to afford the high cost of technology-intensive treatment and long-term cost-burden of chronic conditions without severe economic consequences for households (Arrow, 1963). This is one reason that led to restrictions being imposed in a number of OECD countries on the expansion of the private sector, and particularly of for-profit healthcare organizations in some OECD countries. Such measures have included banning private doctors working in the public sector or using public sector facilities (Lister, 2005). By contrast, doctors contracted to the public sector are typically allowed to operate in the private sector simultaneously (mainly hospital-based consultants), and in some cases have been encouraged to expand their private practice as in the UK in 1979 after the repeal of the NHS pay-beds ban that had been instituted in 1976 (Griffith *et al*, 1987). In this case, private beds in NHS hospitals (where consultants could treat private patients) were part of the historic compromise between the government and medical professionals which led to the establishment of the British NHS in 1948. Interestingly, the retention of NHS pay-beds had been an important feature that slowed the growth of the non-NHS private sector in the late-1980s (Laing, 1992) despite a significant boom in private health insurance subscriptions between 1979 and 1981 (Rayner, 1987; Laurance, 1983).

Even in the US, which stands out for having developed one of the largest for-profit healthcare services sectors, the distinction between 'non-profit' and 'for-profit' healthcare has been very important in the development of health policy and in healthcare worker perception of the nature of these organisations. For instance, the medical profession was for a long time highly (and successfully) resistant to the development of for-profit healthcare provision from the 1920s regarding the making of profit ('commercialism') from medical services rendered as antithetical to the ethics of medical practice (Starr, 1982). Interestingly, the establishment of federal programmes

---

[39] Many of the social health insurance providers in France and Germany have faced severe debts for many years, with this being a key area targeted for healthcare reform in these countries. By contrast, the voluntary market in which BUPA operates, while having a much smaller risk pool, is more intimately aligned to an equally small number of private hospitals. Although private health insurers in the UK have also faced periods of low profitability - as an outcome of reduced subscription rates in the late 1980s and mid-1990s - they have not faced the kind of 'debt spending' (debt resultant from spending at higher rates than rates of income) of mandatory private health insurance in other countries.

for healthcare financing (Medicare and Medicaid) acted unintentionally to provide an important impetus to the growth of 'for-profit' healthcare services by generating a significant source of income for newly emergent commercial providers and health insurers. Moreover, federal policies for controlling the growing cost of these programmes in subsequent years - the 1973 *Health Maintenance Organization* (HMO) *Act* and the Medicare *Prospective Payment System* - created greater openings for commercial hospital providers and insurers as the federal government openly pursued a more market-oriented ('pro-competitive') approach to organizing the healthcare system (Marmor, 1998).

On the other hand, despite a high level of dissatisfaction reported with the US healthcare system in consumer surveys (Donelan *et al*, 1999) it is not clear whether consumers are so much concerned about the for-profit versus non-profit nature of providers than whether or not they have access to needed health services and the health insurance coverage to pay for these. For instance, with the majority of Americans who *are* covered for their health costs by some form of health insurance plan, consumer choice over which provider to use is typically circumscribed by managed care organizations (MCOs) which have come to dominate the market for health insurance (Robinson, 1999). Indeed, for most American healthcare consumers, the biggest challenge comes from high levels of cost-sharing (at least for those who have access to health insurance), while a substantial portion of the population remains without health insurance due to its high economic cost and the absence of a mandatory universal contribution system (DeNavas-Walt *et al*, 2007).

Nevertheless even those systems most extensively financed by the government did not exclude private sector financing and provision altogether. Rather, the nationalisation of medical facilities and public financing largely displaced the private sector, still characterised as a "cottage industry" until the 1960s at the earliest. In the last couple of decades however, the dominance of the public sector role in healthcare financing has been changing in most OECD countries, as has the limitation over the private sector role in provision. Indeed, in many countries the private sector has itself changed substantively since the post-war decades of public sector expansion. In some countries it can justifiably be described as "big business", particularly the US, where private for-profit healthcare providers entered the market at a rapid rate establishing a strong presence by the 1980s (Gray, 1986; Starr, 1982). In Germany, for-profit providers also made substantial market gains during the 1990s being one of the few OECD countries still experiencing over-capacity in the

hospital sector following a broader trend of hospital rationalization in most OECD countries during the 1980s (Busse & Riesberg, 2000 & 2004).[40]

3.2. Rising expenditure and the fiscal problem

Structural transformation of the mixed economy of healthcare has stemmed foremost from efforts to scale back the public sector role in healthcare in face of the growing cost of healthcare expenditure. In all OECD countries total healthcare expenditure increased substantially (on average) from 3.8% of the GDP in 1960, to 7% in 1980, and 9.1% in 2004, with the US displaying a respectively sharp increase from 8.8% in 1980, to 15.3% in 2004 (Figure 3.1 & Table 3.2). Moreover, the public share of financing came to compose a major part of healthcare expenditure and, with a few exceptions, it has come to account for at least two thirds of total expenditure on healthcare in the late 1990s and early 2000s (Table 3.3).

In 1960, the OECD average for the public share of total healthcare expenditure stood at 61.4%, rising considerably to 73.3% by 1970. This high level has remained fairly constant in subsequent years and in 2004 the bulk of spending on healthcare in most OECD countries continued to come from public sources, with just under 73% of health spending on average (Table 3.3). Even in those countries with a historically smaller portion of public coverage (i.e. US, Mexico and Turkey), it is still a significant amount from a single source in per-capita terms. In the case of the US, despite public coverage being below 50% of TEH, compared to over 85% in the UK, current per capita public spending on healthcare has actually been of a comparable level to countries of similar levels of economic development, such as Sweden or Switzerland in 1990, and even exceeding the UK's per capita public spending on healthcare since the 1980s (Tables 3.3 & 3.4).[41]

By the late 1970s however, healthcare spending had been already growing at a rate that began to put into question the sustainability of public expenditure. Notably the period 1965-1970 saw the highest rates of growth for health expenditure in the post-war period in almost all OECD countries (Table 3.5). With the world oil shocks in the mid-1970s, most countries faced a protracted period of

---

[40] Nonetheless, where healthcare services have become big business, in most countries this still needs to be put into the context of the healthcare sector. These are large firms often dominating local or regional markets and in a few cases national markets, but few if any can be compared directly with the national and international scale and scope of the major pharmaceutical giants or most other major corporate sectors.

[41] In spite of this comparable share of per capita spending from public sources, these resources are much less evenly distributed than in other countries since they are limited to specific population groups. Moreover, per capita spending in itself is a dubious indicator insofar as it cannot account for inequalities within national populations, assuming by definition equal spending levels per head of population.

inflation and economic stagnation, a situation which prompted governments to seek ways to control public expenditure in general (Schieber & Poullier, 1990). In the face of a growing 'fiscal crisis', public policies prioritising government expenditure on public services and public works that had predominated in the post-war years were losing favour along with the administrative planning approach to public policy characteristic of the Keynesian 'consensus' that pervaded most developed countries in the post-war decades. The healthcare sector has been no exception to this changing political context, and the ascent of several neoliberal oriented governments in the 1980s only further cemented the retreat from an interventionist state as they clamoured to cut back public spending as a whole (Altenstetter & Haywood, 1991).

Though health spending rates were a key target area in healthcare reforms during the 1980s and 1990s across the OECD countries, increased spending in itself has not been the biggest problem. Rather, the realisation that marginal increases in spending did not translate into substantive marginal gains in health status helped to feed scepticism about the value extracted from this growing level of investment (Light, 1993; Docteur & Oxley, 2003). Emergent critiques of medicine and its therapeutic achievements since the 1960s helped to anchor the broader concern with fiscal sustainability of public funding in observable population health outcomes (Porter, 1999). Reduced mortality rates in developed countries were shown to have been an outcome more of public health measures and initiatives outside of medical intervention and generally improving standards of living (i.e. sanitation, education, or housing). For Wilkinson (1996) it is essentially 'the nature of social and economic life rather than medical services which determines the health of populations' while 'the role of medicine is to pick up the pieces' (p.67). Medical scientific advances had still been important in reducing communicable disease and reducing early life-stage mortality, while conditions of affluence and greater life expectancy (non-communicable and chronic diseases) were taking over as the main burden on health (Wilkinson, 1996, pp.29-49).

3.2.1. Cost-control and macroeconomic reforms

The growing demand for healthcare, stimulated by the publicly subsidised expansion of medical services and the generous coverage afforded through public systems of financing, seemed to be predicated on an unprecedented expansion of medical-technological intervention that could neither be repressed (Starr, 1982; Klein, 2001), such being the value of scientific progress, nor fully

afforded without a more concerted cost-benefit decision-making taking place.[42] An introductory comment in a 1990 joint OECD-Health Care Financing Administration (HCFA) publication highlights this thinking:

> 'Despite slightly slower growth in health care outlays in more recent years relative to that experienced in the 1960s and 1970s, concern persists among [OECD] Member countries because of continuing economic constraints coupled with competing pressures in the use of resources' (OECD, 1990, p.5).

By the late-1980s the protracted period of post-war expansion of public sector involvement in healthcare seemed to be coming to an end as many OECD governments sought ways to control the rate of expenditure growth, becoming a driving factor in health policy discussions in industrialised countries over the past three decades (Abel-Smith, 1992; Mossialos *et al*, 2002). Initial efforts focused more on macroeconomic restrictions to contain healthcare spending which have included budgetary spending caps, wage and price controls, resource allocation mechanisms, as well as measures to increase the cost of care to individuals through co-payments or cost-sharing policies (Abel-Smith, 1992, Docteur & Oxley, 2003; Mossialos & Dixon, 2002; Blank & Burau, 2004) as presented for selected countries in (Table 3.6).

For much of the late 1970s through to the late 1980s the hospital sector was the key sector targeted with such macroeconomic reforms, as in most OECD countries it peaked in the 1970s and 1980s as the largest spending category. By 1985, hospital spending ranged between 33.8% of TEH in South Korea and 49.2% in Denmark, as compared with 23.9% and 15.2% in the same countries for 'ambulatory' care services such as primary care (Table 3.7).[43]

---

[42] Certainly from the perspective of welfare economics which has been a key intellectual influence on healthcare policy since the 1970s: 'a cost cannot be held too high or too low in relation either to itself or to costs elsewhere. This is true at a microeconomic level. For instance, the capital and recurrent costs of a new imaging procedure in diagnosis or treatment are worth incurring only if the expected benefit is deemed high enough. […] It is also true at the macroeconomic level: The overall expenditure (public and private) on health care is worthwhile only for what it enables the system to accomplish, bearing in mind that benefits at the margin from extra health spending have as their real costs the non-health benefits that could have been had, but were not, because less is being spent on other sources of human welfare. (These are opportunity costs)' (Culyer, 1990, p. 29).

[43] NB: These figures are effectively cumulative categories that for hospital care include general, specialist, local and psychiatric hospital services, while 'ambulatory care' includes figures for primary care, dental and some aspects of opthalmic services in the OECD composite data (2006b). National statistical classifications may differ while also the practice of physicians and medical specialists differs between countries in terms of access to secondary specialist treatment, whereby such access is limited in some countries by a GP 'gatekeeper' system. The figures are still indicative of the share of hospital expenditure within total healthcare expenditure.

With cost-containment measures increasingly targeted at the hospital sector in several OECD countries, a drop in the share of spending going to hospital inpatient care between the early 1980s and late 1990s is clearly visible. For example, cumulative figures for 'hospital services' show how spending in this area peaked at 51.6% of TEH in 1980 in Australia, dropping significantly to 42.8% in 1995 and 37% of TEH in 2000; though there has been a slight resurgence in this share in more recent years. Similarly in the US it peaked in the early 1980s (43.9% in 1980) dropping to between 28% and 29% in the late-1990s and early 2000s, though in some cases undersupply in the 1980s has led to an increase in this share in the 1990s (as in Portugal: from 28.7% in 1980 to 33.9% in 1995) in a period characterised by greater investment in the hospital sector (Table 3.8).

The urgency of targeting the hospital sector has been no less important in terms of the scale of *public* sector spending for which this has been a major spending category. While international data for public expenditure on hospitals is rather sparse prior to the 2000s (Table 3.9), public spending on inpatient care as a proportion of total public spending on health provides a crude indicator for cost burden of hospital-based services for the public sector historically. It clearly exceeded 50% of total public expenditure on health for most countries between 1960 and 1995. Following cost-control measures targeted at the hospital sector, there is a perceptible decline in the proportion of public spending on this sector through the last third of the 20th century, especially for inpatient services, with few exceptions (Switzerland and Austria) increasing the share of total public contribution to inpatient care (Table 3.10). The hospital sector has been a key target area for cost-control in the US for which public coverage of in-patient care has not exceeded 27% of the population even in the early 2000s when the public sector programmes have been expanded to include greater numbers of the population (Table 3.11) (Docteur & Oxley, 2003).

Reductions in hospital spending were partly being achieved at this time by limiting capital investment in hospitals: in the US, the federal *Hill-Burton* grant programme for hospital construction and renovation begun in 1946 was halted by 1975 (Patel & Rushefsky, 2006), while in the UK, public capital investment for hospitals was not instituted until the 1960s with the 1962 *Hospital Plan* - a level of public spending not seen again until the late 1990s under the *Private Finance Initiative* (PFI) programme (Mohan, 2002a).[44] A key strategy for limiting hospital

[44] Though the Private Finance Initiative (PFI) construction programme was, in principle, developed to attract private sector investment in hospital construction, in practice, the cost to public expenditure on hospital construction and refurbishment has been much higher than planned in view of the failure of many of the projects to stay within budget (Pollock, Price & Player, 2005).

spending, however, was manifest in a trend of hospital rationalisation during the 1980s in many OECD countries, with government mandated hospital closures and bed-number reduction in the UK (Mohan, 2002a), and a more costly operating environment in the US (after the introduction of the Medicare Prospective Payment System) pushing many hospital operators to reduce bed numbers whilst also witnessing a period of market concentration through mergers (Patel & Rushefsky, 2006). This is reflected in a notable drop in the number of inpatient beds in the US from around 7 beds per thousand heads of population in 1975 to just over 4 in 1995 and 3.3 in 2004. Only more recent data for this measure are available for the UK which shows a drop from just under 5 beds per thousand heads of population in 1995 to just over 4 in 2004 (Table 3.12).

Wage controls have been prevalent in public-integrated systems especially in hospital and ambulatory sectors which compose the main areas of provision under public control and/or ownership. Although wages have been re-negotiated regularly in healthcare systems since their creation (for instance, the UK's NHS undertook wage re-negotiations for nurses, consultants and GPs even prior to 1980s), this became a key instrument of NHS cost control in the 1980s (Webster, 1998b). In Denmark, Ireland and the UK, hospital salaried personnel have been subject to pay cuts or wage freezes, while in Finland, Sweden, and Spain, such wage controls have also extended to ambulatory sectors (primary care and dentistry) (Freeman, 2000; Docteur & Oxley, 2003). Moreover, where specific aspects of public service provision have been outsourced, such as ancillary services, this has effectively amounted to an indirect restructuring of the remuneration for formerly public sector employees as they shifted from public sector salaries to private sector contract labour.[45] Particularly in public-integrated systems, wage controls have been part of broader public sector pay controls implemented since the 1980s (Altenstetter & Haywood, 1991).

Price controls have been used relatively early on, particularly as governments in public-integrated systems can set prices administratively or, more generally, have oversight on prices agreed between healthcare purchasers and providers (Docteur & Oxley, 2003, p.25). Such controls have been employed in all sub-sectors of healthcare provision. Some set fees for healthcare services directly after negotiations with health-care providers broke down (including Australia, Belgium, France, Japan, Luxembourg and Canada). In Japan, price fixing by the government has been an important policy instrument for primary and secondary care. In other countries, after fixing budget

[45] Notably in the UK in the 1980s under the Compulsory Competitive Tendering process for Local Authorities which were also responsible for many aspects of healthcare service provision.

ceilings, prices have been automatically adjusted as a function of the volume of care, such as in Germany (ambulatory care), Austria (hospital care), Hungary (outpatient care) and in Belgium. Price schedules have also been used in some cases to reduce marginal return to doctors for additional supply of services beyond defined ceilings (Canada (Quebec), Hungary, Germany), indicating a combination of price and volume controls to reduce overall expenditure (Docteur & Oxley, 2003, p.25; Freeman, 2000, p.54).

Budgetary caps have been another widespread strategy for cost control. While earlier 'cash limits' tended to be directed at the hospital sector, they have been often complemented by global and supplementary spending caps on ambulatory care and pharmaceuticals. Global budgets have reflected the difficulty in controlling overall spending by focusing on only one care component (Docteur & Oxley, 2003, p.27). These were most popular in the UK (as early as 1976) and Denmark (in the 1980s), while this approach was built into more recently formed National Health Service systems such as Portugal (1980s) or Italy (1970s). For systems such as these, organized along 'Beveridgian' lines, whereby annual budgets have been covered directly by public financing, global budgets were a simple means of cost-containment. In insurance based systems like Germany, France and the US, the implementation of such spending limits focused on the problem of reimbursement by insurers, in view of the 'moral hazard' produced by indemnity insurance. Budget caps have also been introduced within broader reform packages. For instance, in 1977, West Germany introduced its *Health Insurance Cost Containment Act* which limited the level of contributions to sickness funds to the level of salaries and sought to prevent any spending growth in real terms by intending to limit the scale of charges imposed by health care providers (Busse & Riesberg, 2000).[46] In the US, substantive spending controls were introduced in 1982 with the *Medicare Prospective Payment System*, which transformed the prior re-imbursement structure of Medicare without substantive limits to one based on specific Diagnostic Related Groups (DRGs), a model that has since been emulated in part by other countries (Patel & Rushefsky, 2006).

3.2.2. Microeconomic incentives for cost control: user fees and cost-sharing

In systems where coverage was free at the point of access for scheduled goods and services, the introduction of user fees has marked a more noticeable transition towards partial re-

[46] The latter did not get fully implemented until 1992 after reunification with East Germany.

commodification by requiring patients to assume a greater portion of health expenses than after the introduction of universal coverage (Table 3.13).

Although in a more immediate sense this is effectively a method for externalising costs to a third-party payer for reimbursement (health insurance) or resource allocation (governments), earlier 'cost-sharing' schemes were introduced with the idea of increasing the personal responsibility and cost-consciousness of patients. Many cost-sharing initiatives still being implemented have a similar primary objective, though since the late-1990s cost-sharing has been more explicitly tied to efficiency objectives of healthcare reform. Nonetheless, as with the other macroeconomic strategies mentioned, the implementation of cost-sharing policies has varied between countries in the timing of their adoption and in the scope of implementation. For instance, the UK government started to introduce patient contributions for spectacles and prescription drugs as early as the 1950s (Griffith *et al*, 1987). These contributions gradually increased over the next few decades, although caps on the level of cost-sharing were also implemented with a flat rate for prescription drugs. While this is only part of the full cost, its regressive nature tends to discriminate against poorer households so that measures have tended to be introduced to offset this negative impact on lower income groups – at least in more socialised systems such as Sweden, France and the UK (Docteur & Oxley, 2003, p.29).

Meanwhile from the early 1990s the withdrawal of public coverage for dental and ophthalmic services has meant that a larger proportion of the costs of these services are effectively left for patients to cover, which has been one of the key areas taken up in private health insurance (PHI) schemes in the UK during the 1990s (Keen, Light & Mays, 2001; Foubister *et al*, 2006). Cost sharing for prescription pharmaceuticals has been the biggest category where cost-sharing has been implemented, partly explained in the economic literature as being due to the higher degree of elasticity of demand for pharmaceuticals (and generally consumables) than for services (OECD 1990). Crucially, pharmaceuticals have been a major area of spending for the public sector in most countries - a significant area of total spending on health itself for most OECD countries - especially those with high levels of public coverage for healthcare overall. For instance, between 1970 and 1980 public expenditure on pharmaceuticals and other non-durable medical goods was at around 67% of total expenditure on pharmaceuticals in the UK, and above 70% in Sweden and Germany (Table 3.14). In the US, by contrast, private out-of-pocket payments and private health insurance have been a more significant source of coverage for pharmaceutical consumption; though interestingly, public coverage of drugs spending in the US rose significantly from 8.7% in 1980, to

over 19% after the year 2000 (Table 3.14). The latter development is in part related to extension of the Medicare programme in the late 1990s and early 2000s specifically for coverage of pharmaceutical costs (Patel & Rushefsky, 2006).

Cost-sharing in itself has not necessarily been a recent innovation linked to market-oriented healthcare reforms. In a number of countries user fees or co-payments for prescription healthcare goods were already in place at the point of introduction of universal coverage, highlighting that universal coverage has not necessarily gone hand-in-hand with comprehensive coverage. Moreover, co-payments as a means of influencing consumer behaviour have historically been more associated with systems reliant on health insurance as the main mode of financing. For instance, co-payments such as those introduced in the 1970s in the US were an effort to introduce demand-side incentives for cost control in relation to the fee-for-service reimbursement by private health insurance firms.

Cost-sharing, is thus chiefly manifest in terms of 'deductibles' in health insurance schemes introduced in the 1970s with the passing of the *HMO Act* and expanded during the 1980s and 1990s as HMOs became more widespread.[47] A 'deductible' refers to coverage that begins only after a contractually set ceiling has been passed in the cost of drugs or the use of healthcare services for the subscriber of health insurance (Enthoven, 1993; Hoffman, 2006). On the other hand, a significant portion of out-of-pocket payments in the US is due to lack of insurance coverage (over 15% uninsured by 2005; cf. DeNavas-Walt *et al*, 2007). This highlights how the nationally specific context of cost-sharing is important to bear in mind, since it has not been employed in the same way in every country or to the same degree. This can have considerably different outcomes between national context regarding access to treatment and the net cost-burden and related de-commodification of healthcare when located in the overall financing structure.

Cost-sharing has to some extent contributed to the growth of private healthcare spending,[48] and a relative rise in out-of-pocket (OOP) payments both as a component of private spending and in terms of overall expenditure (Table 3.15 & 3.16).

---

[47] The expansion of managed care organisations (the predominant form being HMOs or health maintenance organizations) in the US during the 1990s led many traditional indemnity insurance firms to also adopt cost-sharing through deductibles in a market that was becoming increasingly difficult to compete in.

[48] Besides direct patient expenditure, two forms of private funding have had historical significance: charity donation and health insurance. Spontaneous charity donation is a significant source of funding mostly in niche areas (usually channelled through issue-specific NGOs) or in institution-specific money raising campaigns. But this has been dwarfed by health insurance since the inter-war decades.

The impact of cost-sharing is not fully evident in OOP payments data, particularly as some of the cost is redirected to private health insurance in countries where public coverage is strong, or has been off-set in some cases by establishing ceilings for certain population groups (OECD, 2004a). While cost-sharing measures have to some degree reduced the public share of total healthcare spending, the impact of co-payments on reducing overall household demand and consumption of care seems on balance to be fairly limited (Docteur & Oxley, 2003, p.29). Though intended to reduce "unnecessary" consultations and/or treatment, because it is extremely difficult to predict "necessary" and "unnecessary" intervention, crucial early diagnosis can be suppressed as an outcome of attendant disincentives to use healthcare services, so that treatment may be more costly when addressed at a later date while problems may arise from patients not taking drugs when they need them (Docteur & Oxley, 2003). This in turn raises important questions about the impact of cost-sharing on more vulnerable population groups - especially the poor, chronically sick and elderly - who consume the bulk of health-care services. A number of countries have responded to this problem by placing ceilings on annual spending on healthcare by individuals and households (i.e. Sweden), and allowing complementary insurance to cover the cost-sharing burden (i.e. France) (OECD, 2004a). Net budget savings, however, may be reduced where multiple exemptions and ceilings of this sort are implemented due to the administrative costs incurred as a result.

3.3. Restructuring and market incentives for providers and third party payers

Cost-containment became a central feature of healthcare reform during the 1980s and, in terms of the balance sheet, has in some cases been successful in temporarily stemming annual cost growth rates. However, such policies frequently created problems with access to care (i.e. exacerbating access inequalities), increasing waiting times, reductions in quality and in some cases, amounted to constrictions on investment in the healthcare infrastructure at the cost of longer-term service performance (Docteur & Oxley, 2003). While the overall healthcare spending growth rate slowed down by the late-1980s for most countries, it continued to increase in most cases at a higher rate than economic growth (Culyer, 1990, pp.30-33). By the 1990s, attention in most health ministries had shifted from mere cost-control to 'performance' improvements, provider efficiency being the centre of focus. Cost-containment became more explicitly tied to efficiency goals in many

OECD countries (Docteur & Oxley, 2003).[49] The most significant development internationally during the 1990s, in terms of developing competition in healthcare services, was the widespread use of micro-economic incentive mechanisms at the level of providers and third-party payers (as purchasing agents), and a shift towards greater autonomy for providers, markedly in systems characterised by public ownership.

The idea of a market-competitive system in healthcare stems largely from the US, where the principles of 'managed competition' were first developed in the 1970s to create HMOs (or 'managed care organizations', MCOs) a form of health insurance organization to bargain with providers for lower prices (Enthoven, 1993). Though encouraged with federal legislation in 1973 (with the HMO Act) to become the mainstay of health insurance to compete with the established fee-for-service retrospective reimbursement of the predominant indemnity insurers, MCOs did not attract significant demand until the 1990s (Robinson, 1999). By the end of the 1990s, MCOs had overtaken indemnity insurers as the predominant form of health insurance provision. While contributing to the reduction in overall hospital expenditure in the 1990s, their dominance has not ensured the kind of price competition anticipated by their proponents, and the cost-inflationary tendency within US healthcare continues to be a core issue for US public policy on healthcare (Robinson, 1999).

Managed competition was crudely replicated in a different context in a number of European countries, most notably the UK (Light, 2001a), where the Conservative government introduced a purchaser-provider split in the public NHS (implemented in 1991 after passing the Community Care Act) to induce greater efficiency from providers, while also making health authorities as quasi-autonomous entities to manage annually limited budgets.[50] Though the purchaser-provider split was repealed in 1998 following the election of New Labour a year prior, the notion of micro-economic incentives for providers to contain costs and increase efficiency has remained a central feature of the NHS with the greater autonomy given to regional NHS Trusts as purchasing agents to set annual budgets for hospitals and to penalise them when they over-spend, while Primary Care Trusts (PCTs) do the same for GPs (Lister, 2005). The most significant innovation for providers under New Labour in this respect was the greater autonomy given to a number of hospitals (made Foundation

[49] Indeed, one outcome of this has been a marked emphasis on the need for greater amounts of data and collection of empirical indicators to monitor evidence-based outcomes (Nunes, 2003; Timmermans & Kolker, 2004).

[50] The form of budgetary caps was changed from global to 'capitated' budgets, whereby patient number throughput was made a chief measure of budgetary allocation for health authorities.

Trusts since 2002) approximating a non-profit *mutual* organizational structure and allowing hospital management greater decision-making power and responsibility over raising capital though still with strong limitations on revenue that can be acquired through non-NHS (i.e. private sector and international) patients (Lister, 2005; Talbot-Smith & Pollock, 2005).

A purchaser-provider split was also introduced in Sweden in the late 1980s so that a decade later three quarters of county councils had established separate purchasing bodies to manage county budgets for hospital and primary care. While market structures have become more pervasive in Swedish public healthcare, the private sector is relatively limited with only a few private hospitals and few PHI carriers (based on voluntary supplementary coverage). In 2002, legislation to allow state insurance funds (a prospective payment system which for the public sector is combined with tax based contributions) to pay part of the cost for private hospitalization costs has since been reversed, in an attempt to limit the extension of privatization of the public sector (Glenngard et al, 2005). Meanwhile in 2001, legislation was passed to prevent privatization of public hospitals, as had occurred in a few cases in the late-1990s, bought by the largest private provider in Sweden (Capio) while in 2004, legislation has prevented simultaneous treatment of public and private patients by private hospitals (Lister, 2005, pp.161-2). New Zealand also implemented legislation for a purchaser-provider split in 1993 and in the process also introduced greater autonomy for hospital authorities as newly Crown Health Enterprises. In the process the conservative National Party in power at the time sought to stimulate greater competition between public and private providers and encourage private health insurance; though it should be mentioned that the purchaser-provider split was repealed in 1999 after a new government replaced it with more cooperative, if still quite decentralized structure, bringing more control over budgets back to the Ministry of Health (Lister, 2005, p.247).

In some countries a purchaser-provider split characterised the *de facto* relationship between insurers and providers from inception of the healthcare system, notably in those countries where mandatory social insurance has been the predominant form of financing and providers are mostly in the private sector. In Germany, France and the Netherlands the most significant changes involved the increase of user fees and diversification of the financing base. The Netherlands had already one of the most mixed systems of health financing, with a substantial contribution from out-of-pocket spending (co-payments accounted for 8% of funding in 1998). More important is the large private health sector which benefits from statutory mandatory subscription between 30 regional sickness funds and 50 private insurance plans which pay for healthcare services on a fee-for-service basis

(Schippers, 2002). However, while there is a fairly large selection of PHI firms, the functional division between PHI and sickness funds means there is not much direct competition between these different forms of health insurance as it operates currently. Rather than a purchaser-provider split, the Netherlands sought to introduce managed competition for insurance in 1987 (with the 'Dekker' reforms) into an otherwise highly regulated hybrid system, seeking to break the cost-inflationary effects of the private sector (Van de Ven & Schut, 2000).

Already containing a purchaser-provider split, the French healthcare system lacks adequate price competition as the private sector has become entrenched in a system of insurance reimbursement that allows high charging level but also minimizes market competition. Imai, Jacobzone and Lenain argue that 'the financial distortions in the system have resulted in a segmentation of supply by type of care but without any price competition' (2000, p.24). Indeed, as Lister (2005) notes,

> 'the private sector may appear to charge a lower rate than the public sector for some hospital care, but its selective provision and its incentive to drive up demand for care means that it can still exert a constant upward pressure both on prices and on costs, intensifying competition for scarce qualified staff'. (p.176)

Consequently, private practice has been an important factor in the rising expenditure, and this extends beyond hospitals, as two-thirds of French doctors are in private practice and paid on a fee-for-service basis (Durand-Zaleski et al, 1997, p.944), a scenario that to some extent is quite similar in Germany.

Having essentially worked on the basis of a purchaser-provider split since its inception the German system of social health insurance, does not seem to benefit greatly from competition-induced cost-control and efficiency since both providers and insurance carriers maintain a strong position within the healthcare economy. Part of this stems from the freedom for patients to choose healthcare providers directly. In the absence of a 'gatekeeper' system of referral, there remain incentives from providers to increase fees (Busse & Riesberg, 2000). Moreover, insurance is not limited to the sickness funds. Private health insurance has become a more prominent feature of the German health economy. With over 14 million subscribers in the early 2000s, 52 PHI carriers compose one of the largest voluntary health insurance markets in Europe (Busse, *et al*, 2002, p.48).[51] The combination of a weak primary care system, strong hospital providers and health

[51] These PHI carriers are organised in the Association of Private Health Insurance Companies.

insurance has meant the purchaser-provider split has fallen short of the substantial cost savings through competitive incentives. Instead a fragmented network of powerful interests between providers, insurers and health product companies has repeatedly created a major barrier to government attempts to break the cost-inflationary effects of the German health economy (Busse & Riesberg, 2000, p.16).

3.4. Market-oriented reform: a climate for a commercialising healthcare services mix

Having taken this broad comparative look at market-oriented reform across the OECD countries, it is useful to reflect briefly on what these trends mean for the changing dynamic of the healthcare services market internationally. The hospital and health insurance sectors are still the key segments of interest, although it is important to stress that structural change in other market segments can impact upon the former two as well.

Convergence

As can be seen in the overview so far, there is wide variation in the experience of market-oriented healthcare reform in OECD countries. Spending limits through wage, price or budget controls have, in most cases, grown out of incremental changes over extended periods of time and within different components of broader reform programmes for public sector restructuring. In some cases they have been explicitly introduced as part of specific healthcare reform programmes. For instance, as efficiency became more explicitly a focus of healthcare sector reforms, spending controls and remuneration negotiations increasingly have been tied to output-based indicators, such as patient throughput targets, and 'value-for money' definitions, something that has seen a major trend in the UK (Lister, 2005).[52]

Changing mixed economy of care

Although I have noted a few cases in which wage, price, and budget controls have impacted on the public-private mix, it is more accurate to say that these policy areas provide a contextual

[52] However, these definitions themselves are only more recently testable insofar as evaluation relies on extensive data for which collection has only more recently been implemented in most countries. Questions have also been raised in many cases regarding the use of targets to achieve efficiency goals and that these goals may be undermined by providers finding alternative ways of classifying work performed in order to circumvent spending caps for specific categories for instance.

background within broader reform programmes, than having an immediate impact on the public-private mix. For instance wage controls may act as a stimulus for healthcare workers to leave the public sector, seeking employment in the private sector or in other countries (Docteur & Oxley, 2003), while outsourcing can function as an indirect method of wage control for the public sector. Budgetary caps and price controls may also be a stimulus to divest certain activities from public sector provision, although this can take place in more indirect ways. For instance the closure of small community hospitals and concentration of beds in larger regional or general hospitals in order to reduce budgetary outlays has had the indirect outcome of privatising provision by leaving gaps in the market for private sector providers (Lister, 2005). However, budgetary constraints in the case of hospitals have tended to work in tandem, rather than singly, with policies to rationalise overall hospital capacity, being an outcome of local authority or sickness fund budgetary constraints on providers.

While the marketisation of healthcare provision has been an important trend it still has a somewhat experimental character. Though a purchaser-provider split has been essentially present in a number of OECD countries since inception (US, France, Germany, the Netherlands), attempts to introduce such a structure into the healthcare system in the UK, Sweden, and New Zealand for instance have had mixed outcomes, with the latter two turning away from more overt 'pro-competitive' approaches in the early 2000s. In the UK, by contrast, the overt purchaser-provider split has been reversed within the NHS, though elements of a competitive structure have been retained, particularly as in the early 2000s the New Labour government sought to open up greater space for private providers to offer elective surgery on NHS contracts.

Related to marketisation, the privatisation of consumption has been a key trend during the 1990s. A rise in out-of-pocket payments has stemmed from a trend to increase the level of the cost-burden on households through cost-sharing for private health insurance and through reduction of coverage by public financing and social health insurance. In some cases, efforts to increase the role of private health insurance in the healthcare mix has been a key element of the privatisation of consumption, most notably in the Netherlands and in New Zealand, though while in the former case PHI has been balanced with social health insurance for defined population groups, in the latter case low demand for PHI has meant a reversal of this policy approach and return to greater public sector coverage (Lister, 2005).

In the US, PHI has been the *de facto* form of coverage for most of the population insured for healthcare costs, and while the federal government introduced public reimbursement for defined

population groups in the mid-1960s, it has since pursued a greater role for private health insurance to top-up public financing (Medicare-Plus) for those who can afford it (Patel & Rushefsky, 2006). The expansion of PHI in the UK has been more tentative, though in the 1990s and early 2000s it is also linked to the increase in the share of costs for services with reduced public coverage for dental care and ophthalmic services that have been largely divested from public coverage.

Private sector expansion and commercialisation

The expansion of the private sector is thus in many cases predicated to a large extent on the space either left unoccupied by the public sector or where the private sector is already a firmly established part of the healthcare mix. The most obvious case is the US where private provision is for the most part the *de facto* form of healthcare service provision and financing. Space opened up following attempts to create a more competitive healthcare system with a greater selection of health insurance schemes and/or withdrawal from the provision of hospital and ambulatory services (particularly dental care, ophthalmic services, but also to some extent of primary care) has been the most important tendency during the 1990s. This has been most evident in systems where public financing and provision were made key components of the healthcare mix in the post-war decades. Moreover, in most countries the private sector remains dominated by 'non-profit' organizations, so that in only a few countries have for-profit healthcare providers made much headway in the past two decades (most notably the US). In a number of countries, for-profit and investor-owned providers are banned or face limitations to operate in markets served by the public sector.

The growth of private sector provision and financing has been a key tendency between 1990s and the early 2000s, but it is still a tentative trend that does not have an inevitable outcome. It is difficult to imagine a complete reversal from the incremental privatisation that has been taking place, particularly as governments are still keen to diversify the choice available to patients and the limits of public financing and provision in meeting changing demand patterns. However, as the private sector is subject to the trappings of market failure, due to its cost-inflationary tendency as a result of high administrative costs associated with it and the difficulty of ensuring equitable access to healthcare, OECD countries that still have a strong public sector presence are more cautiously creating space for private sector expansion.

3.5. Concluding Remarks

In this chapter, I have made a broad overview of market oriented healthcare reforms with a mind to establishing the degree to which this is a substantive trend across developed countries, for

which I have used health economic data from OECD countries. While there is a definite shift towards market-oriented restructuring in healthcare systems ranging from the more socialised and 'state-based' systems such as the UK and Nordic countries, to the more 'pro-competitive' market-based systems of the US and South Korea, as well as systems with more mixed state and private sector structures of provision and financing, the notion of convergence towards a similar type of structure is rather tenuous to extrapolate from the data I have shown. Nonetheless, there is a noticeably common move towards increasing the personal burden of cost for healthcare services, a key indicator of *commodification* in the sense of requiring patients to contribute a greater percentage of direct out-of-pocket costs to care: from covering pharmaceutical costs, to the costs of primary care, dental and ophthalmic services ('ambulatory care' in the cumulative OECD data category), and even the cost of hospitalisation to some degree.

My research here, however, has not been dedicated sufficiently to this question to make a strong empirical statement on the substantive degree of commodification. Considering that some countries have also included certain measures to off-set increases in personal outlays for healthcare for lower-income groups this indicates at most a partial re-commodification, though it is not in itself indicative of commercialisation *qua* expansion of 'for-profit' service provision and financing. Even so, there are some clear indications of the space being opened up for the private sector, whether non-profit or for-profit, which in a 'pro-competitive' climate in public policy could well create greater niches for the commercial ('for-profit') sector. One particular area of potential growth of the commercial sector seems to be in PHI where coverage withdrawal could open up space more easily for the private sector than in the relatively harder to penetrate and more highly regulated hospital sector.

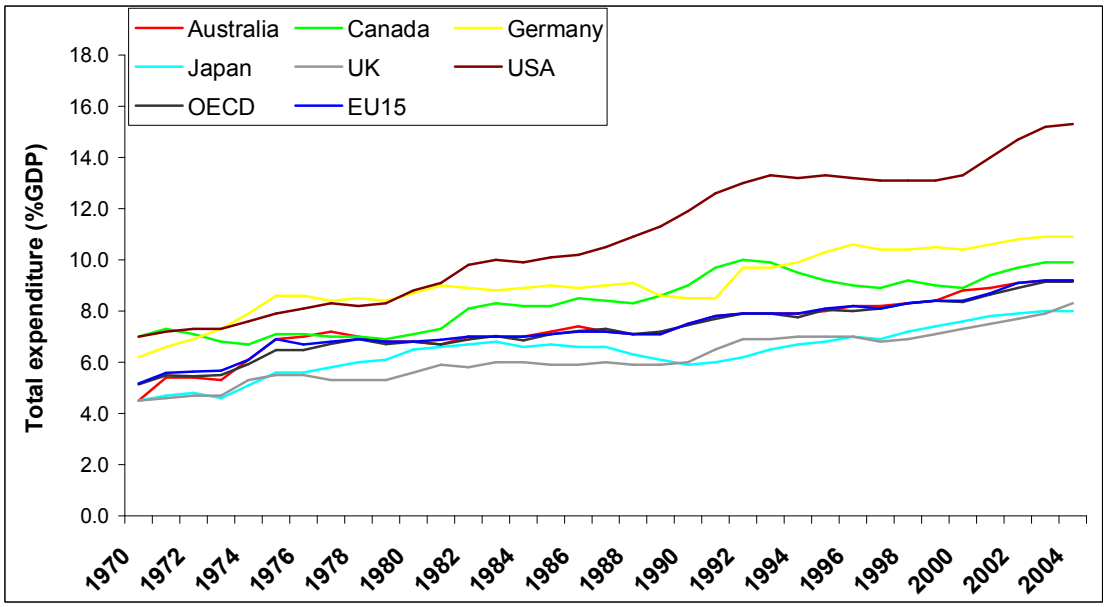
While globalization may not quite be extrapolated from the picture painted in this chapter in terms of a convergence towards a bottom line for healthcare provision and financing, the increased space gradually being created for private healthcare services could well provide a basis for the development of an international healthcare services market. The form of such a market remains to be examined, which I do in the following chapter. Meanwhile, with regard to identifying mechanisms for commercialisation, the current overview has not shown very much in detail. One thing that does seem clear is the importance of looking at the nationally specific context for commercialisation. This is a reason for my examination in greater depth of the development of commercialisation in the hospital and health insurance sectors in subsequent chapters 5 and 6 looking at the US and UK respectively.

Table 3.1: Historical trajectory of universalisation of healthcare financing in selected OECD countries

1938	New Zealand*	Establishment of universal coverage
1948	UK	NHS implemented instituting majority tax-based financing for universal comprehensive coverage
1950s	Mexico*	Foundation of social security system
1961	Japan*	All local governments implement National Health Insurance (mandated in 1958)
1965	USA	Medicare and Medicaid passed providing universal coverage for over 65s and delimited coverage for disabled and medically indigent (later added specific diagnostic groups)
1971	Canada	Last Province enacts Medicare (established in 1966)
1970s	Portugal	Nationalisation of hospitals, and clinics (1974-1977) and formation of NHS
1975	Hungary*	National Health Service established
1978	France	Universal coverage achieved (National insurance fund for salaried workers: agricultural and self-employed covered by other funds in 1967)
1978	Italy	National health service created
1981	Germany	90% coverage achieved (remains the same level today)
1983	Greece	National Health System established
1984	Australia*	Universal tax-funded health insurance established
1986	Spain	NHS created
1989	South Korea*	(social insurance system established 1977)

Notes: **(*)** Countries admitted to the OECD after its founding in 1961: Japan (1964), Finland (1969), Australia (1971), New Zealand (1973), Mexico (1994), Czech Republic (1995), S Korea, Hungary, and Poland (1996), and Slovakia (2000). *Sources*: Cutler (2002), p.884; Lister (2005)

Figure 3.1: Total expenditure on health as percentage of GDP: selected countries (OECD), OECD mean and EU 15 mean, 1970-2004



Source: OECD (2006b)

Table 3.2: Total expenditure on health as percentage of GDP in selected OECD countries (i): selected years 1960-2004

	1960	1965	1970	1975	1980	1985	1990	1995	2000	2004
Australia	4.0	4.2	4.5	6.9	6.8	7.2	7.5	8.0	8.8	9.2
Austria	4.3	4.6	5.2	7.0	7.5	6.5	7.0	9.7	9.4	9.6
Belgium	-	-	3.9	5.6	6.3	7.0	7.2	8.2	8.6	10.1
Canada	5.4	5.9	7.0	7.1	7.1	8.2	9.0	9.2	8.9	9.9
Denmark			7.9	8.7	8.9	8.5	8.3	8.1	8.3	8.9
Finland	3.8	4.8	5.6	6.2	6.3	7.1	7.8	7.4	6.7	7.5
France	3.8	4.7	5.3	6.4	7.0	7.9	8.4	9.4	9.2	10.5
Germany	-	-	6.2	8.6	8.7	9.0	8.5	10.3	10.4	10.9
Greece	-	-	6.1		6.6	7.4	7.4	9.6	9.9	10.0
Iceland	3.0	3.5	4.7	5.7	6.2	7.2	7.9	8.4	9.2	10.2
Ireland	3.7	4.0	5.1	7.3	8.3	7.5	6.1	6.7	6.3	7.1
Italy	-	-	-	-	-	-	7.7	7.1	7.9	8.4
Japan	3.0	4.4	4.5	5.6	6.5	6.7	5.9	6.8	7.6	8.0
Luxembourg	-	-	3.1	4.3	5.2	5.2	5.4	5.6	5.8	8.0
Netherlands	-	-	-	6.9	7.2	7.1	7.7	8.1	7.9	9.2
New Zealand	-	-	5.1	6.5	5.9	5.1	6.9	7.2	7.7	8.4
Norway	2.9	3.4	4.4	5.9	7.0	6.6	7.7	7.9	8.5	9.2
Portugal	-	-	2.6	5.4	5.6	6.0	6.2	8.2	9.4	10.0
Spain	1.5	2.5	3.5	4.6	5.3	5.4	6.5	7.4	7.2	8.1
Sweden	-	-	6.8	7.6	9.0	8.6	8.3	8.1	8.4	9.1
Switzerland	4.9	4.6	5.5	7.0	7.4	7.8	8.3	9.7	10.4	11.6
United Kingdom	3.9	4.1	4.5	5.5	5.6	5.9	6.0	7.0	7.3	8.3
United States	5.1	5.6	7.0	7.9	8.8	10.1	11.9	13.3	13.3	15.3
EU 15 (mean)	3.8	4.1	5.2	6.4	7.0	7.1	7.3	8.1	8.2	8.9
OECD (mean) (ii)	3.8	4.4	5.2	6.6	7.0	7.1	7.4	8.1	8.3	9.1

Notes: (i) Countries not shown have sparse data in OECD database and/or joined OECD after 1990; (ii) In order to reduce statistical error, the mean values are presented for the OECD member states included here (at time of year shown); (-) No data available (in OECD database)

Source: OECD (2006b)

Table 3.3: Public health expenditure as proportion of total expenditure on health: selected OECD countries (i), selected years (1960-2004)

	1960	1970	1980	1990	2000	2004
Australia	50.4	57.2	63.0	67.1	68.9	67.5
Austria	69.4	63.0	68.8	73.5	69.9	70.7
Belgium	-	-	-	-	75.8	71.1
Canada	42.6	69.9	75.6	74.5	70.3	69.8
Czech Republic	-	96.6	96.8	97.4	90.5	89.2
Denmark	-	83.7	87.8	82.7	82.4	-
Finland	54.1	73.8	79.0	80.9	75.1	76.6
France	62.4	75.5	80.1	76.6	75.8	78.4
Germany	-	72.8	78.7	76.2	78.6	78.2
Greece	-	42.6	55.6	53.7	52.6	52.8
Hungary	-	-	-	89.1	70.7	72.5
Iceland	66.7	66.2	88.2	86.6	82.6	83.4
Ireland	76.0	81.7	81.6	71.9	73.3	79.5
Italy	-	-	-	79.1	73.5	76.4
Japan	60.4	69.8	71.3	77.6	81.3	81.5
Korea	-	-	-	38.5	46.2	51.4
Luxembourg	-	88.9	92.8	93.1	89.3	90.4
Mexico	-	-	-	40.4	46.6	46.4
Netherlands	-	-	69.4	67.1	63.1	62.3
New Zealand	-	80.3	88.0	82.4	78.0	77.4
Norway	77.8	91.6	85.1	82.8	82.5	83.5
Poland	-	-	-	91.7	70.0	68.6
Portugal	-	59.0	64.3	65.5	72.5	71.9
Slovak Republic	-	-	-	-	89.4	88.3
Spain	58.7	65.4	79.9	78.7	71.6	70.9
Sweden	-	86.0	92.5	89.9	84.9	84.9
Switzerland	-	-	-	52.4	55.6	58.4
Turkey	-	-	29.4	61.0	62.9	72.1
United Kingdom	85.2	87.0	89.4	83.6	80.9	85.5
United States	23.4	36.5	41.3	39.7	44.0	44.7
Mean (ii)	61.4	73.3	79.5	77.1	73.4	72.5

Notes: (i) Countries not shown have sparse data in OECD database and/or joined OECD after 1990. (ii) In order to reduce statistical error, the mean values are presented for the OECD member states included here (at time of year shown); (-) No data available (in OECD database)

Source: OECD (2006b)

Table 3.4: Public expenditure on health, per capita (US$ mil purchasing power parity) in selected OECD countries: selected years (1960-2004)

	1960	1970	1980	1985	1990	1995	2000	2004
Australia	48	107	435	717	876	1161	1652	1940
Austria	53	121	530	702	976	1544	1863	2207
Belgium	-	-	-	-	-	1434	1726	2165
Canada	53	209	592	955	1295	1466	1760	2210
Czech Republic	-	-	-	-	547	820	887	1214
Denmark	-	321	814	1072	1259	1522	1962	-
Finland	34	141	467	759	1148	1080	1289	1712
France	44	155	558	855	1174	1548	1858	2475
Germany	-	196	756	1070	1325	1829	2098	2350
Greece	-	68	270	-	453	651	849	1141
Hungary	-	-	-	-	530	576	606	959
Iceland	38	108	620	964	1380	1556	2166	2777
Ireland	32	96	423	501	571	870	1326	2063
Italy	-	-	-	-	1097	1103	1499	1828
Japan	18	104	414	614	866	1279	1599	1832
Korea	-	-	-	69	139	191	359	591
Luxembourg	-	145	594	822	1427	1879	2663	4603
Mexico	-	-	-	-	124	164	235	307
Netherlands	-	-	524	698	962	1294	1424	1894
New Zealand	-	169	446	559	820	962	1252	1611
Norway	38	129	566	815	1153	1594	2541	3311
Poland	-	-	-	-	275	308	413	552
Portugal	-	30	188	230	441	686	1178	1304
Slovak Republic	-	-	-	-	-	-	532	687
Spain	9	62	290	403	687	861	1088	1484
Sweden	-	268	874	1147	1428	1503	1928	2399
Switzerland	-	-	-	741	1063	1383	1768	2382
Turkey	-	-	22	37	103	132	284	418
United Kingdom	72	142	429	608	825	1161	1502	2176
United States	34	128	443	707	1093	1664	2017	2727

Notes: (i) Countries not shown have sparse data in OECD database and/or joined OECD after 1990; (-) No data available (in OECD database)

Sources: OECD (2006b)

Table 3.5: Total expenditure on health growth rate ($US mil. at purchasing power parity): selected OECD countries, 1960-2005 (5 year intervals)

	1960-1965	1965-1970	1970-1975	1975-1980	1980-1985	1985-1990	1990-1995	1995-2000	2000-2004
Australia	0.38	0.31	0.64	0.36	0.36	0.29	0.29	0.32	0.20
Austria	0.30	0.46	0.56	0.44	0.17	0.32	0.43	0.17	0.15
Belgium	-	1.00	0.58	0.46	0.34	0.29	0.28	0.21	0.26
Canada	0.36	0.45	0.43	0.42	0.41	0.32	0.20	0.22	0.24
Czech Republic	-	-	-	-	-	1.00	0.38	0.07	0.28
Denmark	-	1.00	0.34	0.39	0.26	0.18	0.19	0.24	0.18
Finland	0.43	0.45	0.48	0.40	0.40	0.33	0.03	0.18	0.24
France	0.44	0.45	0.49	0.45	0.38	0.31	0.26	0.19	0.24
Germany	-	1.00	0.54	0.41	0.30	0.23	0.41	0.15	0.12
Greece	-	1.00	-	1.00	-	1.00	0.36	0.25	0.26
Hungary	-	-	-	-	-	1.00	0.13	0.19	0.35
Iceland	0.44	0.45	0.57	0.53	0.40	0.34	0.18	0.33	0.24
Ireland	0.31	0.49	0.61	0.50	0.25	0.16	0.36	0.36	0.35
Italy	-	-	-	-	-	1.00	0.10	0.25	0.15
Japan	0.61	0.54	0.53	0.51	0.35	0.24	0.29	0.23	0.13
Korea	-	-	-	-	1.00	0.49	0.36	0.33	0.34
Luxembourg	-	1.00	0.55	0.48	0.31	0.43	0.30	0.36	0.43
Mexico	-	-	-	-	-	1.00	0.30	0.29	0.28
Netherlands	-	-	1.00	0.41	0.25	0.33	0.24	0.22	0.27
New Zealand	-	1.00	0.54	0.19	0.24	0.37	0.27	0.26	0.27
Norway	0.39	0.47	0.57	0.53	0.31	0.33	0.28	0.40	0.24
Poland	-	-	-	-	-	1.00	0.30	0.28	0.27
Portugal		1.00	0.71	0.47	0.32	0.37	0.38	0.35	0.13
Slovakia	-	-	-	-	-	-	-	1.00	0.23
Spain	0.64	0.58	0.57	0.44	0.29	0.44	0.28	0.23	0.32
Sweden		1.00	0.42	0.45	0.26	0.22	0.11	0.24	0.21
Switzerland	0.24	0.46	0.46	0.39	0.32	0.30	0.25	0.21	0.24
Turkey	-	-	1.00	0.43	0.09	0.61	0.18	0.62	0.27
UK	0.26	0.34	0.46	0.38	0.33	0.29	0.30	0.27	0.28
USA	0.34	0.44	0.44	0.47	0.42	0.38	0.30	0.25	0.28

Notes: (*) Countries not shown have sparse data in OECD database and/or joined OECD after 1990. (**) In order to reduce statistical error, the mean values are presented for the OECD member states included here (at time of year shown).

Source: OECD (2006b)

Table 3.6: Macroeconomic cost control measures for healthcare in selected OECD countries

	Hospitals	**Physicians**	**Prescription Drugs**
Canada	- Global budgets established with universal coverage; tightened in 1970s; - Certificate of Need required for expansion	1984: Physicians must accept government payment as payment in full.	-
France	1984-85: Global budgets introduced for public hospitals; 1993: Global budgets introduced for private hospitals	1979: Fee schedules tightened.	1994: National target: for pharmaceutical expenditures
Germany	1977: Health Insurance Cost Containment Act 1984-86: Global budgets introduced for hospitals	1977: Expenditure cap on ambulatory care / Global budgets for physician associations; 1993: Prescription drug budgets for physicians.	1982: Out-of-pocket payments for drugs increased. 1989: Reference pricing system.
Italy	1990s: Move from per diem to DRG, payment	-	-
Japan	Early 1980s: Tighter fee schedules; 1985-87: Hospital beds and expansion capped.	Early 1980s: Tighter fee schedules.	-
UK	Global budgets established with NHS.	Salaries established with NHS.	-
US	1983: Prospective payment for hospital admissions	1992: Fee schedule for physicians.	-

Sources: Cutler (2002); Docteur & Oxley (2003); Lister (2005)

Table 3.7: Healthcare expenditure by type of provider (i) (%TEH): Selected OECD countries (ii), 1985, 1995 & 2000

	Hospi-tals	Nursing homes & resid'l care	Ambula-tory (iii)	Medical goods (iv)	Public health orgs	Admini stration	Other ind's (v)	Total (vi)
1985								
Australia	40.2	8.4	29.7	10.1	0.8	3.1	-	92.3
Canada	41.2	10.4	27.3	10.0	4.5	1.3	0.5	95.2
Denmark	49.2	25.1	15.2	8.9	-	0.5	-	98.9
France	48.7	0.7	24.3	18.9	2.8	1.5	0.8	97.7
S. Korea	33.8	-	23.9	25.1	2.6	9.8	2.4	97.6
UK	-	-	-	-	-	-	-	-
USA	36.6	7.5	30.3	10.8	2.7	6.1	0.7	94.7
1995								
Australia	35.7	7.1	32.8	13.9	1.6	3.2	-	94.3
Canada	34.8	9.8	29.0	14.6	5.3	2.2	0.4	96.1
Denmark	47.8	20.6	17.6	11.7	-	0.9	-	98.6
France	44.5	1.2	25.1	21.2	2.4	1.7	1.3	97.4
Germany	31.4	7.1	26.7	19.6	1.8	5.5	4.1	96.2
Japan	49.8	1.2	28.7	9.1	3.0	2.0	-	93.8
S. Korea	31.5	-	33.1	19.9	-	5.6	3.0	93.1
Switzerland	32.6	15.8	30.8	9.4	2.8	5.3	-	96.7
UK	-	-	15.3*	17.3*	1.6	2.1	3.2	39.5
USA	34.9	7.6	34.9	10.4	3.2	5.8	0.6	97.4
2000								
Australia	33.8	6.4	32.0	17.3	0.3	4.3	-	94.1
Canada	30.7	9.6	27.3	18.5	5.1	3.6	0.3	95.1
Denmark	47.6	21.7	16.6	11.3	-	0.9	-	98.1
France	41.6	1.4	24.9	24.1	2.5	1.9	1.2	97.6
Germany	30.2	7.9	27.1	20.5	1.8	5.8	3.8	97.1
Japan	48.7	2.8	27.9	11.8	3.0	2.2	-	96.4
S. Korea	32.2	0.3**	36.8	17.1	1.1	4.9	2.5	94.9
Luxembourg	32.3	17.6	26.7	13.3	-	6.0	0.3	96.2
Netherlands	35.2	10.4	23.2	16.5	1.5	4.6	3.6	95.0
Norway	35.9	16.3	23.9	13.7	1.5	-	1.7	93.0
Portugal	36.3	1.7	30.7	24.1	-	1.4	1.4	95.6
Switzerland	32.4	17.0	30.8	9.5	2.6	5.1	-	97.4
UK ***	56.4	2.7	15.3	17.3	0.3	2.1	3.2	97.3
USA	32.2	7.4	34.7	13.2	3.3	6.3	0.6	97.7
Mean (vii)	37.0	8.2	26.4	19.5	2.2	3.6	1.6	98.5

Notes: (i) The categories for provider types vary between countries, particularly between hospital and long term care which often share similar characteristics. Therefore figures show must be taken as more or less indicative rather than absolute; (ii) Countries have been selected based on availability of data; (iii) 'Ambulatory' includes physician services, dental services and other primary care, (iv) 'Medical goods'(v) 'Other Industries' includes secondary providers of services in the healthcare sector, (vi) 'Total' indicates sum of categories shown (because of inconsistencies between categories the total does not sum up to 100%); (vii) Mean shown only for 2000 due to greater sample of countries; (-) No data available (in OECD database); (*) 1998 figures; (**) 2003 figures; (***) 1999 figures. *Sources*: OECD (2006b)

Table 3.8: Total expenditure on inpatient care as proportion of total expenditure on health: OECD countries, selected years 1960-2004

	1960	1965	1970	1975	1980	1985	1990	1995	2000	2004
Australia	43.0	43.5	44.1	47.9	51.6	48.6	46.3	42.8	37.0	-
Austria	-	-	-	-	-	-	-	41.3	39.3	41.7
Belgium	-	-	25.7	29.3	33.1	34.0	32.8	34.4	-	-
Canada	43.7	49.1	52.6	54.4	53.8	51.6	49.1	44.6	30.5	28.9
Czech Republic	-	-	-	-	-	-	-	29.0	33.6	-
Denmark	-	-	-	-	61.6	60.4	55.3	55.0	53.2	30.1
Finland	39.9	44.4	46.4	44.4	46.3	46	44.7	42.0	38.2	34.8
France	38.4	40.0	40.2	44.5	49.4	47.6	44.3	43.2	39.9	33.8
Germany	-	-	30.8	33.6	33.2	34.1	34.7	36.1	35.8	34.7
Greece	-	-	-	-	-	-	-	-	-	-
Hungary	-	-	-	-	-	-	65.2	54.8	29.3	-
Iceland	37.0	37.8	50.9	48.4	59.1	56.5	53.8	53.3	53.5	54.8
Ireland	-	-	-	-	58.8	-	-	-	-	-
Italy	-	-	-	-	-	-	42.4	44.5	41.2	42.4
Japan	34.1	28.0	26.4	30.3	30.9	32.8	33.0	36.8	38.4	39.1
Korea	-	-	-	-	-	25.0	28.1	22.0	23.8	23.0
Luxembourg	-	-	-	27.6	31.3	27.4	26.4	31.3	36.0	33.1
Mexico	-	-	-	-	-	-	-	-	37.3	33.9
Netherlands	-	-	-	52.8	54.6	54.1	49.2	49.1	36.5	-
New Zealand	-	-	-	-	72.2	76.2	60.4	-	-	-
Norway	38.1	37.1	68.2	69.8	63.9	64.8	61.7	-	42.8	40.9
Poland	-	-	-	-	-	-	-	-	-	28.1
Portugal	-	-	-	-	28.7	26.4	32.3	33.9	-	-
Slovak Republic	-	-	-	-	-	-	-	-	26.4	30.4
Spain	-	-	-	34.4	54.1	55.7	44.1	31.0	28.2	25.9
Sweden	-	-	-	-	-	-	-	53.4	50.9	31.3
Switzerland	35.7	40.5	44.4	47.5	47.5	46.7	47.9	47.9	46.8	47.6
Turkey	-	-	-	-	-	-	33.4	28.7	19.9	-
United Kingdom	-	-	-	-	-	-	-	-	-	-
United States	34.6	34.9	40.2	42.4	43.9	40.0	35.6	31.8	28.4	26.8

Notes: (i) Countries not shown have sparse data in OECD database and/or joined OECD after 1990. (-) No data available (in OECD database)

Source: OECD (2006b)

Table 3.9: Public expenditure on hospital services (%TEH): selected OECD countries, selected years (1960-2003)

	1960	1965	1970	1975	1980	1985	1990	1995	2000	2003
Australia	29.6	27.6	28.3	33.8	34.7	32.8	28.9	26.2	26.9	27.6
Canada	27.5	38.3	42.6	42.5	38.9	37.4	35.8	31.6	28.0	27.0
Czech Republic	-	-	-	-	-	-	-	-	-	41.2
Denmark	-	-	51.7	52.8	50.1	47.3	45.7	46.6	45.9	46.2
France	29.3	34.0	36.0	40.9	46.5	43.7	41.6	40.9	38.1	35.2
Germany	-	-	-	-	-	-	-	28.2	26.9	25.8
Hungary	-	-	-	-	-	-	-	-	31.5	31.2
Ireland	-	-	-	-	-	-	-	-	45.8	40.3
Japan	-	-	-	-	-	-	-	44.5	42.9	42.0
Korea	-	-	-	-	-	11.4	14.8	15.6	18.6	17.8
Luxembourg	-	-	-	-	-	-	-	-	30.9	30.0
Mexico	-	-	-	-	-	-	-	-	25.4	27.0
Netherlands	-	-	-	-	-	-	-	-	27.1	25.9
Norway	-	-	-	-	-	-	-	-	34.5	34.5
Poland	-	-	-	-	-	-	-	-	-	26.8
Portugal	-	-	-	-	-	-	-	-	35.2	32.8
Slovakia	-	-	-	-	-	-	-	-	25.5	30.4
Spain	-	-	-	-	-	-	-	-	36.5	35.2
Switzerland	-	-	-	-	-	-	-	21.9	22.7	25.2
Turkey	-	-	-	-	-	-	-	-	32.0	35.3
UK (*)	-	-	-	58.7	56.5	52.8	47.9	45.6	41.7	39.2
USA	14.6	12.8	21.1	22.5	22.0	21.1	19.2	21.0	18.4	17.9

Notes: (i) Countries not shown have sparse data in OECD database and/or joined OECD after 1990; (*) Figures were not available in OECD data but calculated from Office of Health Economics (2007) pp 71, 133; (-) No data available (in OECD database)

Sources: OECD (2006b); Office of Health Economics (2007)

Table 3.10: Public spending on inpatient care as percentage of total public spending on healthcare: OECD countries, 1960-2003

	1960	1965	1970	1975	1980	1985	1990	1995	2000	2003
Australia	63.5	59.4	56.1	52.3	63.4	55.5	52.5	47.5	39.0	40.7
Austria	-	-	-	-	-	-	-	44.5	45.2	47.6
Belgium	-	-	-	-	-	-	-	29.1	33.7	-
Canada	70.3	79.5	67.9	64.3	62.3	59.7	57.4	53.9	37.4	35.5
Czech Republic	-	-	-	-	-	-	-	31.9	37.1	38.5
Denmark	-	-	-	-	67.1	66.8	66.0	63.1	60.6	58.0
Finland	56.1	58.3	55.8	52.6	53.9	53.2	51.4	50.6	46.7	44.4
France	46.3	47.0	46.8	51.3	56.8	54.7	53.3	52.4	48.6	41.0
Germany	-	-	33.7	35.8	36.1	37.6	39.1	38.5	38.1	36.9
Greece	-	-	-	-	-	-	-	-	-	-
Hungary	-	-	-	-	-	-	-	32.8	36.7	36.7
Iceland	55.6	60.0	76.9	55.5	67.0	64.9	62.1	63.5	64.8	66.7
Ireland	-	-	-	67.2	59.8	77.9	80.1	80.4	71.0	-
Italy	-	-	-	-	-	-	51.6	57.9	53.0	52.6
Japan		38.0	31.0	38.1	40.6	43.1	39.4	40.1	42.4	42.6
Korea	-	-	-			26.0	33.8	36.8	33.0	29.3
Luxembourg	-	-	-	27.0	27.6	29.0	26.9	32.9	37.9	34.0
Mexico	-	-	-						54.5	48.0
Netherlands	-	-	-	64.4	64.4	63.1	56.9	56.4	46.8	47.4
New Zealand	-	-	69.3	75.5	77.9	83.2	69.6	-	-	-
Norway	48.9	45.9	74.4	72.6	75.0	75.6	74.5	-	47.8	45.9
Poland	-	-	-	-	-	-	46.0	46.2	41.1	40.9
Portugal	-	-	46.6	42.0	41.7	41.8	45.0	50.2	-	-
Slovak Republic	-	-	-	-	-	-	-	-	29.5	34.4
Spain	42.8	33.6	28.4	39.6	54.9	55.9	54.2	37.9	34.2	32.0
Sweden	-	-	69.5	72.0	74.0	59.1	55.5	60.9	59.4	36.6
Switzerland	-	-	-	-	-	-	-	49.4	48.4	50.1
Turkey	-	-	-	-	40.0	20.5	28.2	-	26.9	-
UK	52.1	51.1	56.3	58.1	41.9	37.2	34.9	34.8	-	-
USA	59.0	56.9	58.9	57.2	57.1	53.9	46.8	41.8	36.9	35.1

Notes: (i) Countries not shown have sparse data in OECD database and/or joined OECD after 1990.
(-) No data available (in OECD database)

Sources: OECD (2006b)

Table 3.11: Public coverage of population against costs of in-patient care: OECD, selected years 1960-2004 (% of population covered)

	1960	1965	1970	1975	1980	1985	1990	1995	2000	2004
Australia	77.0	84.0	89.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Austria	78.0	92.0	91.0	96.0	99.0	99.0	99.0	99.0	99.0	98.0
Belgium	58.0	86.0	99.0	99.0	99.0	98.0	98.0	99.0	99.0	99.0
Canada	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Czech Republic	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Denmark	95.0	95.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Finland	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
France	76.0	-	95.6	97.3	99.1	99.2	99.4	99.4	99.9	99.9
Germany	85.2	87.0	89.2	92.1	92.3	91.2	88.8	91.4	90.7	89.8
Greece	30.0	40.0	91.0	98.0	98.0	100.0	100.0	100.0	100.0	100.0
Hungary	-	-	-	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Iceland	90.0	90.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Ireland	85.0	85.0	85.0	85.0	100.0	100.0	100.0	100.0	100.0	100.0
Italy	87.0	91.0	93.0	100.0	100.0	100.0	100.0	100.0	-	-
Japan	99.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Korea	-	-	-	-	29.8	52.1	100.0	100.0	100.0	100.0
Luxembourg	90.0	-	99.6	99.8	99.8	-	-	98.6	98.2	99.7
Mexico	-	-	-	-	-	-	-	-	-	-
Netherlands	72.6	71.9	69.1	69.2	68.8	76.6	72.9	74.1	72.3	69.8
New Zealand	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Norway	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Poland	-	-	-	-	-	-	-	-	-	-
Portugal	18.0	32.0	52.0	90.0	100.0	100.0	100.0	100.0	100.0	100.0
Slovakia	-	-	-	-	-	-	-	19.2	19.7	19.0
Spain	50.0	55.0	61.0	81.0	84.0	-	98.1	98.6	98.9	98.9
Sweden	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Switzerland	74.0	82.	89.0	94.0	96.5	98.0	99.5	99.5	100.0	100.0
Turkey			26.9	33.6	38.4	42.1	55.1	65.0	-	67.2
UK	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
USA	-	-	-	-	-	-	24.5	26.4	24.7	26.6

Notes: (-) No data available (in OECD database)

Sources: OECD (2006b)

Table 3.12: Inpatient beds per 1000 head of population in selected OECD countries (including acute and long-term care beds): selected years 1960-2004

	1960	1965	1970	1975	1980	1985	1990	1995	2000	2004
Australia	9.7	9.1	8.2	7.9	7.8	6.2	5.4	4.6	4.0	3.8
Austria	-	-	-	-	-	10.9	10.1	9.3	8.6	7.7
Belgium	-	-	-	-	-	-	8.1	7.3	7.1	6.8
Canada	-	-	-	6.9	6.8	6.8	6.0	5.0	3.8	3.4
Czech Republic	-	-	-	-	-	-	-	-	8.8	8.7
Denmark	-	-	-	8.5	8.1	7.0	5.6	4.9	4.3	4.0
France	-	-	-	10.6	11.1	10.5	9.7	8.9	8.1	7.5
Germany	-	-	-	-	-	-	10.1	9.7	9.1	8.6
Greece	5.8	5.9	6.2	6.5	6.2	5.5	-	4.9	4.7	-
Hungary	-	-	-	-	-	-	-	8.8	8.1	7.8
Ireland	-	-	-	-	9.1	8.2	6.1	5.2	4.7	4.2
Italy	9.1	9.8	10.8	10.7	9.7	8.3	7.2	6.3	4.7	4.2
Japan	-	-	-	-	-	-	-	15.4	14.7	14.2
Korea	-	-	-	-	-	-	3.1	4.4	6.1	7.3
Luxembourg	-	-	-	-	-	12.5	11.7	10.7	6.9	6.7
Mexico	-	-	-	-	-	-	1.6	2.0	1.9	1.9
Netherlands	-	-	-	-	-	-	5.9	5.3	5.2	4.8
Norway	-	-	-	-	-	5.9	4.6	4.0	3.8	3.7
Portugal	-	-	-	-	-	4.0	4.1	4.0	3.8	3.7
Slovak Republic	-	-	-	-	-	-	-	8.3	7.8	7.2
Spain	-	-	-	-	5.4	4.9	4.6	4.3	3.7	3.4
Switzerland	8.2	8.0	7.1	7.1	7.2	6.8	6.5	5.5	4.1	3.8
Turkey	1.7	1.8	2.0	2.0	2.2	2.1	2.4	2.5	2.6	2.6
United Kingdom	-	-	-	-	-	-	-	4.8	4.3	4.1
United States	9.2	8.8	7.9	6.8	6.0	5.5	4.9	4.1	3.5	3.3

Notes: (i) Countries not shown have sparse data in OECD database and/or joined OECD after 1990.
(-) No data available (in OECD database)

Source: OECD (2006b)

Table 3.13: Microeconomic measures, (market) incentives in selected OECD countries

	Legislation / Reforms
Canada	1991: Federal Payments to provinces cut 1991: Tighter supply-side limits by provinces (closing & merging of hospitals)
France	1996: proposal for Global Budget
Germany	1989 Health Reform Act 1993: Healthcare Structure Reform Act
Italy	1992: Reform to create regional enterprises
Japan	1997: Reform to increase coinsurance substantially
Sweden	1989: Purchaser-provider split introduced
UK	1990: Community Care Act introducing 'internal market' (purchaser-provider split & GP 'fundholders') 1998: Internal market repealed; Primary Health Groups introduced to replace GP fundholders 2000: NHS Modernisation Act
US	1973: HMO Act 1997: Balanced Budget Act

Sources: Cutler (2002); Docteur & Oxley (2003) ; Lister (2005)

Table 3.14: Public expenditure on pharmaceuticals* and other non-durable medical goods (% total expenditure on pharmaceuticals): OECD countries in selected years 1960-2004

	1960	1965	1970	1975	1980	1985	1990	1995	2000	2004
Australia	36.4	41.5	44.9	56.1	43.7	46.5	44.8	54.0	54.0	-
Austria	-	-	-	-	-	-	-	58.3	68.5	70.7
Belgium	-	-	58.5	56.5	57.3	51.0	46.8	43.0	-	77.4
Canada	0.7	1.0	2.1	14.7	24.7	29.4	32.9	33.3	35.4	37.8
Czech Republic	-	-	-	-	-	-	89.0	83.8	76.0	-
Denmark	-	-	-	-	49.9	45.5	34.2	48.6	48.7	55.9
Finland	-	22.2	33.7	46.5	46.7	44.5	47.4	45.3	50.2	56.0
France	53.8	63.3	67.3	66.4	66.5	67.1	61.9	61.4	65.1	70.6
Germany	-	-	63.4	73.0	73.7	71.9	73.1	71.7	72.5	74.8
Greece	-	-	60.0	-	60.0	-	56.7	70.9	70.5	77.9
Hungary	-	-	-	-	-	-	79.3	66.7	61.2	-
Iceland	-	35.7	43.2	49.5	51.1	61.9	82.4	78.2	60.8	59.2
Ireland	-	-	50.0	42.9	52.7	60.7	65.0	77.3	80.1	88.7
Italy	-	-	-	-	-	-	62.8	38.3	44.4	51.2
Japan	-	-	-	-	-	60.6	61.1	68.3	66.0	68.7
Korea	-	-	-	-	-	11.8	13.3	16.2	33.0	48.0
Luxembourg	-	-	83.5	85.3	86.4	86.0	84.6	81.7	81.6	83.7
Mexico	-	-	-	-	-	-	-	-	0.3	11.6
Netherlands	-	-	-	64.4	66.7	63.3	66.6	88.8	58.3	-
New Zealand	-	-	77.0	77.7	81.1	80.4	74.6	70.1	-	-
Norway	-	21.9	35.8	50.8	42.1	43.2	78.5		58.1	60.2
Poland	-	-	-	-	-	-	-	-	-	36.5
Portugal	-	-	68.7	-	68.6	64.7	62.3	63.3	56.2	57.6
Slovakia	-	-	-	-	-	-	-	-	82.6	82.7
Spain	-	-	-	-	64.0	62.5	71.7	71.1	73.5	72.3
Sweden	-	-	62.9	67.1	71.8	70.1	71.7	73.4	70.0	70.0
Switzerland	-	-	-	-	-	-	-	53.3	60.8	67.2
Turkey	-	-	-	-	100.0	90.0	88.4	88.0	62.6	-
UK	-	66.7	59.4	66.9	67.6	64.1	66.6	63.5	-	-
USA	1.7	2.4	5.6	8.1	8.7	9.3	12.5	16.4	19.2	24.4

Notes: (*) Includes prescription and OTC drugs; (-) No data available (in OECD database).

Sources: OECD (2006b)

Table 3.15: Out-of-pocket expenditure on health as percentage of total private expenditure on health (OECD countries): selected years 1980-2004

	1980	1985	1990	1995	2000	2004
Australia	43.4	50.0	50.5	49.6	65.2	-
Austria	-	-	-	49.7	55.3	50.1
Belgium	-	-	-	-	-	83.5
Canada	-	-	56.7	55.4	53.5	49.4
Czech Republic	-	-	100.0	100.0	100.0	95.5
Denmark	93.1	94.6	92.6	93.3	91.0	-
Finland	87.7	85.8	81.4	83.9	82.0	80.9
France	64.0	66.9	48.7	45.5	43.4	34.9
Germany	48.5	49.6	46.8	51.2	49.6	47.9
Greece	-	-	-	-	94.7	95.7
Hungary	-	-	100.0	100.0	89.8	88.0
Iceland	-	100.0	100.0	100.0	100.0	100.0
Ireland	-	59.5	58.7	54.7	50.5	65.9
Italy	-	68.2	73.8	87.9	86.2	83.0
Japan	-	-	-	90.2	90.1	93.4
Korea	-	88.0	91.7	84.4	80.1	76.0
Luxembourg	100.0	85.5	79.5	81.9	65.2	69.9
Mexico	-	-	97.9	97.0	95.3	94.4
Netherlands	-	-	-	-	24.3	20.8
NZ	86.8	82.8	82.2	70.7	69.9	76.1
Norway	-	-	84.6	96.5	95.5	95.2
Poland	-	-	100.0	100.0	100.0	89.5
Portugal	-	-	-	-	80.8	76.8
Slovakia	-	-	-	-	100.0	100.0
Spain	-	-	83.2	84.6	83.1	81.0
Sweden	-	-	-	-	-	-
Switzerland	-	75.7	74.9	71.4	74.1	76.8
Turkey	-	-	-	100.0	74.6	69.1
UK	80.8	-	64.5	67.6	-	-
USA	41.0	37.6	32.9	27.4	26.5	23.8

Sources: OECD (2006b)

Table 3.16: Health expenditure by source of funding in selected OECD countries: 1980, 1990 and 2000

	1980					1990					2000				
	Govt	SHI	PHI	OOP	Other	Govt	SHI	PHI	OOP	Other	Govt	SHI	PHI	OOP	Other
Australia	63.0	0.0	15.7	16.1	5.3	67.1	0.0	11.4	16.6	4.9	68.9	0.0	6.8	20.3	4.0
Austria	-	-	7.6	-	-	-	-	9.0	-	-	20.2	49.6	8.7	16.7	4.8
Belgium	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Canada	74.5	1.0	-	-	-	73.5	1.1	8.1	14.4	2.9	68.9	1.4	11.5	15.9	2.3
Czech Rep.	-	-	-	-	-	96.7	-	-	2.6	-	10.4	80.1	-	9.5	-
Denmark	87.8	0.0	0.8	11.4	-	82.7	0.0	1.3	16.0	-	82.4	0.0	1.6	16.0	-
Finland	66.6	12.5	1.4	18.4	1.2	70.3	10.6	2.1	15.5	1.4	59.7	15.4	2.6	20.4	1.9
France	4.3	75.8	5.7	12.8	1.5	2.3	74.3	11.0	11.4	1.0	2.6	73.3	12.6	10.5	1.0
Germany	11.7	67.0	5.9	10.3	5.1	10.8	65.4	7.2	11.1	5.4	10.0	68.6	8.3	10.6	2.5
Greece	-	-	-	-	-	-	-	-	-	-	27.7	27.7	2.5	44.9	-
Hungary	-	-	-	-	-	16.1	73.0	-	10.9	-	11.4	59.3	0.2	26.3	2.8
Iceland	31.8	-	-	-	-	52.8	33.8	0.0	13.4	-	58.5	24.1	0.0	17.4	-
Ireland	-	-	-	-	-	71.1	0.8	9.1	16.5	2.5	72.4	0.9	7.6	13.5	5.6
Italy	-	-	-	-	-	78.8	0.3	0.6	15.4	4.9	73.4	0.1	0.9	22.8	2.8
Japan	-	-	-	-	-	-	-	-	-	-	15.5	65.7	0.3	16.9	1.5
Korea	-	-	-	-	-	10.3	28.3	0.8	56.4	4.3	9.5	36.6	4.1	43.1	6.6
Luxembourg	-	-	-	7.2	-	20.9	-	-	5.5	-	15.6	73.8	1.1	7.0	2.6
Mexico	-	-	-	-	-	7.7	32.8	1.2	58.3	-	15.1	31.5	2.5	50.9	-
Netherlands	5.4	64.0	-	-	-	4.7	62.4	-	-	-	3.9	59.2	15.9	9.0	7.1
N. Zealand	88.0	0.0	1.1	10.4	0.4	82.4	0.0	2.8	14.5	0.3	78.0	0.0	6.3	15.4	0.4
Norway	85.1	-	-	-	-	83.4	-	-	14.6	-	68.4	14.1	-	16.7	0.8
Poland	-	-	-	-	-	91.7	-	-	8.3	-	12.2	57.9	-	30.0	-
Portugal	-	-	0.1	-	-	-	-	0.8	-	-	71.6	0.9	3.1	22.2	2.2
Spain	-	-	3.2	-	-	55.7	21.8	3.7	18.7	0.9	64.8	6.9	3.9	23.6	0.9
Sweden	92.5	0.0	-	-	-	89.9	0.0	-	-	-	84.9	0.0	-	-	-
Switzerland	20.0	-	-	-	1.0	19.1	33.3	11.0	35.7	1.0	15.2	40.4	10.5	32.9	1.0
Turkey	-	-	-	-	-	-	-	0.1	-	-	28.0	34.9	4.4	27.6	8.4
UK	89.0	0.0	1.3	8.6	-	83.6	0.0	3.3	10.6	1.8	80.9	0.0	-	-	-
USA	27.9	13.4	28.3	24.1	6.3	25.0	14.7	34.0	19.8	6.4	29.2	14.8	35.1	14.9	6.0

Notes: 'Govt' relates to governmental sources of financing based on taxation; 'SHI' is for Social Health Insurance; PHI is for Private Health or Medical Insurance; 'OOP' is for Out-of-Pocket Payments. *Source*: OECD (2006b)

Chapter 4: Rise of an International Healthcare Services Market

The trend of commercialisation within the context of market-oriented reforms for healthcare services, indicated in the preceding chapter, suggests that the ground is increasingly fertile for an expanding international market in healthcare services across the OECD member states. Some policies have evidently been more receptive than others to privatizing consumption and the provision of healthcare services. Yet there is significant evidence of a shift in the dynamic of the mixed economy of care across countries whether moving towards 'state-based' or 'market-based' healthcare systems.

This shift can be seen as healthcare services becoming increasingly commodified and the private for-profit sector is, in many cases, an increasingly expanding component of the public-private mix for healthcare as states seek to strengthen competition in service delivery and/or financing within their healthcare systems. Even if public and private sector providers or financing institutions are not required to compete directly, the for-profit private sector has tended to capitalise the most on the 'pro-competitive' turn in healthcare policy.

Against the background of a broader international agenda for the liberalization of services markets, the space gradually being opened for private operators as a result of public policy raises an important question about the extent to which internationalisation of cross-border trade in healthcare services has actually been developing. While arguably the vast majority of healthcare service firms do not operate internationally,[53] most segments of the sector are populated by at least a handful of providers that have established market presence overseas in at least one and often more countries. As shown in subsequent chapters, the strategies for expansion of market share of several for-profit healthcare service companies over the years has involved the development of overseas portfolios alongside their core domestic business.

This chapter explores this theme of long-term changes in internationalisation of healthcare sector companies. The key question it raises is whether, and how, we can gauge a significant expansion of private healthcare service companies in their global reach through investments and

[53] Here I wish to distinguish between participation in a global economic system which virtually no institution is completely isolated from – such as the impact of transnational circulation of capital, international supply-chains, or the effects of information and communication technologies – and presence in overseas markets through joint ventures, acquisition of competitors, or establishment of new facilities.

business operations overseas. Moreover, what does this reveal about the commercialisation trend that has been developing over the past few decades?

As such, in this chapter I have focused on developing a framework for analysis of the internationalisation of healthcare service companies. To do this I have looked for quantitative and qualitative data that would help to formulate a picture of the scale and scope of internationalisation. While data scarcity has not allowed me to locate an overarching international dataset providing an overview of international trade in healthcare services, the tentative results of my research of rather fragmented sources are still indicative of an intensification of international trade in healthcare services.

As a starting point I have used *Fortune Magazine's* Global 500 (G500) annual ranking of the largest companies in the world in terms of revenues (Fortune, 1995 & 2005).[54] I have used the listing for two separate years in 1995 and 2005 as a means of gauging the extent to which the number of large companies involved in the healthcare sector has changed over time. Having selected companies that are involved in the healthcare sector, I have utilised available data from company annual reports, websites and any supplementary market research data in order to map the ways in which such companies have developed international market share through overseas investments, joint ventures and acquisitions strategies. The picture generated from this data allows us to reflect more clearly on patterns in an emerging international healthcare services market.

In the first section of the chapter I briefly situate cross-border trade in healthcare services within the broader trend of international trade in services and discuss some key issues and limitations in the analysis of international trade data regarding healthcare services. In the following section, I focus on a breakdown of the healthcare sector companies listed in the G500 in the two years mentioned, looking for key patterns and trends in the development of their overseas portfolios. I conclude the chapter with a reflection on the key findings.

---

[54] Until 1989 *Fortune* listed only non-US *industrial* corporations under the title 'International 500', while the 'Fortune 500' contained and still contains exclusively US corporations. US companies were added to the 'International' list to compile a global list of top *industrial* corporations as ranked by sales in 1990. Since 1995 the list has taken its current form to include top financial corporations and service providers by revenue.

4.1. A global market? Measuring the intensification of international trade in healthcare services

While a quantitative assessment of the internationalisation of trade in services is rather limited on its own, in terms of understanding the deep linkages between national markets, it is still an important precursor to being able to gain a sense of what is being analysed when we discuss the international healthcare services market and qualitative changes within it. However, in my research it has become clear that data that may be utilized to gain a holistic and fully accurate picture of international trade in healthcare services - whether relating to public or private sector organizations – and typically are rather fragmented, partial and usually only cover very recent time periods. Therefore, analysis of long-term historical trends is rather difficult to carry out.

International trade in services has been a steadily growing sector of the world economy over the past three decades and a great body of export data has grown around this field. Though relatively small compared to manufactured goods, the share of total world annual 'exports' in services grew from 15.8% of combined goods and services exports in 1980 to around 19% in the early 2000s (WTO, 2006). How much of this growth in services as an 'export' product is accounted for by the healthcare sector, however, is currently hard to determine despite the healthcare sector having indeed become an increasingly significant component of national economic output (measured in terms of GDP) in most OECD countries.

4.1.1. Methodology and issues with data collection

In spite of fairly good international comparative healthcare expenditure data supplied by the OECD, there is little indication from composite international datasets – such as the *UN National Accounts* and *UN Service Trade* databases (UN, 2008a&b), or the *OECD Industry Structural Analysis* (STAN) database (OECD, 2008) - of precisely the scale of international *trade* in healthcare services that has been taking place over the past few decades. Instead, most international data available on exports is composed of aggregate cross-sector figures so that data specifically on healthcare services is usually buried within these. Moreover, the *OECD Health* database (OECD 2008b), while containing export data for the pharmaceutical sector, itself derived from the OECD STAN, contains no such data for healthcare services.

Thus, faced with the lack of an existing systematic data source for the international healthcare service market, using the G500 listing offers a rather imperfect but nonetheless insightful way to track the changing number of healthcare companies that are amongst the worlds largest in terms of

revenues. Initial inspiration for using the G500 listing rests on J.W. Salmon's study of the corporate transformation of healthcare in the US, in which he derives a US-focused listing of 'major investor-owned' US healthcare corporations from the US-focused *Business Week* magazine (Salmon, 1995, p23). Salmon's use of this business listing serves mainly to demonstrate the scale that US healthcare corporations had reached at that time within the US economy overall, supporting his arguments about the need to assess changing ownership patterns of these companies, the growing corporatisation of the US healthcare sector and the implication of these rapid changes for US healthcare policy; issues already tentatively raised by Relman (1980) and Star (1982). While Salmon (1995) provides an insightful historical analysis in his paper, his use of this dataset does not go beyond simply listing the companies along with revenue figures and key areas of business.

Meanwhile, Holden's study of the internationalisation of corporate healthcare tentatively showcases the potential for the G500 listing as a means to gain an overview of the international healthcare market (Holden, 2005a). It offers a starting point for identifying criteria on which to measure the degree to which the world's largest healthcare corporations have internationalised their operations, how many of them are internationalised and, like Salmon's study, intimates a basis for discussing related changes in the structure of the international healthcare market. The insight of this approach, however, is limited by the presentation of data from only one year of the G500. Moreover, the data presented are almost entirely based on crude quantitative indicators of the degree of internationalisation ('sales abroad', 'staff numbers overseas' and 'number of countries with operations') for the year 2002.

While such indicators offer some empirical measurement of internationalisation they also obscure the more specific dynamic of each market segment as well as the companies analysed. This is a feature that is present, although only superficially developed by Hall (2001) in an earlier exploratory listing of internationalised healthcare corporations within a broader analysis of several dimensions of the *Globalization, Privatisation and Healthcare,* which seeks to identify the complex of international agents involved in the furthering of commercial interests in healthcare globally, including international institutions with an impact on national health policy (World Bank, WTO, and IMF) and healthcare MNCs. In this case the data on companies is derived from the *Public Services International Research Unit* (PSIRU) database which, although containing an extensive number of entries for healthcare and healthcare-related companies, is somewhat limited by the fact that entries in this database seem to be on the basis of links to trade union activity as opposed to the goal of listing companies based on degree of internationalisation.

Despite the limitations I have noted in these studies, I have sought to build on these for analysing the scale and scope of internationalisation of healthcare companies. Building on Holden's approach, I have grouped different firms operating in the healthcare services sector by broad categories relating to market segments of the healthcare sector in which these companies operate. This includes: (i) private health and medical insurers, (ii) secondary providers of services to the healthcare sector, (iii) direct providers of healthcare services, and (iv) producers of medical / healthcare products. While I include pharmaceutical companies in the overall summary of healthcare companies from the G500, I have chosen to exclude them from further analysis in the chapter due to their status as manufacturing companies as opposed to service providers.

Besides using Holden's broad categories, my analysis takes a step further by examining more closely the degree of internationalisation of different sectors based on the development of firms in the various market segments, and including factors such as sub-sectors and additional dimensions of market penetration overseas where this has proven relevant. Part of this has been to select two years by means of which it is possible to see changes over an extended time period. The extended tables that follow in each sub-section (Tables 4-5-4.7) show greater detail for individual companies organized around the market categories mentioned.

4.2. Examining the global reach of the Global 500 companies in the healthcare sector

The company data used, shows that the number of G500 companies operating in the healthcare sector increased more than 60% between 1995 (48) and 2005 (77), both as main area of business and as a subsidiary business.

In the health sector overall the largest number of firms is concentrated in the production of medical and medical-related goods: 60.4% of the total health sector firms listed in 1995 and 42.8% in 2005. Of these around two thirds were pharmaceutical firms with the rest focused on manufacture of medical equipment and IT (Table 4.2)

If we exclude producers of medical and healthcare technologies from the list, there were more than twice the number in 2005 (44) than a decade previously (19) (Tables 4.2). The extended

table 4.4 shows greater detail for individual producers of medical and health goods organised around key areas of business.

4.2.1. Private Health and Medical Insurance

Looking at the different market segments in the G500, by far the largest category for healthcare services firms has been in the provision of health/medical insurance: over 29.2% in 1995 and 27.3% 2005 (Table 4.2). Of these, the majority are major diversified financial services conglomerates for which insurance in general, and health/medical insurance specifically, is a subsidiary area of business (Table 4.4, 4.5). Five of the 23 companies in the G500 - *CIGNA*, *Humana*, *Wellpoint*, *Aetna*, and *United Health Group*, all of which are US-based corporations - count healthcare as a core part of their business activity. In either case, health insurance has tended to be an outgrowth of life insurance activities, though in the case of specialist health insurance providers these are all firms that have engaged in the provision of health insurance and managed care services for much longer than many of the diversified insurance firms and in some cases are exclusively focused on the healthcare sector (Table 4.4, 4.5).

One thing in common is that, prior to moving into international ventures, all of the health insurance providers in the G500 developed substantial market share in their home markets. The key difference, however, is that many of the diversified financial services firms have come to the healthcare sector through expansion from banking and general insurance, after acquisitions of smaller competitors in previous years. A case in point is *Allianz*, which developed its health insurance portfolio initially in Germany,[55] where it is now the third largest private health insurance provider (Allianz, 2006), and then in Western Europe, through acquisitions of smaller life/health insurance firms in the region.[56] During the 1990s, *Allianz* stepped up its international expansion with acquisition of US life insurance firms, as well as in the Asian region (particularly South Korea) so that it now has commercial presence providing life and health insurance products in 30 countries across Europe, North and South America and South East Asia. *Allianz's* non-German ventures amounted to nearly 68.2% of life/health premiums earned in 2005 (Allianz, 2006, p.58). Similarly,

---

[55] *Allianz* was a German-based firm, amassing market share mainly in Germany and Western Europe, until 2006, when it legally converted to a European company (Societas Europaea). In a juridical sense this could be regarded as one of the more internationalised ownership structures for large multinationals.

[56] Italy, France, Switzerland and Spain, *Allianz's* biggest markets outside of Germany, accounted for roughly 33% of premium earnings in 2005; this is my own estimation based on Annual Report data (Allianz, 2006, p.58).

the Dutch-based *ING Group* developed from a primarily banking and asset management market to insurance markets in which it came to dominate in the Netherlands (also becoming prominent in Europe by the end of the 1990s), with the union of two major Dutch banking conglomerates in 1990.[57] From its initial acquisition of a US life/health insurance provider (*Life of Georgia*) prior to formation of *ING Group*,[58] it has since diversified its activities in health insurance in Europe, North America and Asia, notably with the acquisition of *Aetna International* from *Aetna Inc.* in 2000 (Aetna, 2000).

Meanwhile *Cigna*, *Humana*, and *Aetna* all came to health insurance in the US from the life insurance market finding opportunities in commercial provision of health insurance in the post-WWII period and exploring the managed care market since the 1970s. They since became amongst the top five managed care providers in the US, and all have explored to some degree the exportation of the managed care concept overseas - particularly in South America - with the formation of a Latin American equity fund (*Latin Health Fund*) in which they have all been partners since the early 1990s (Lethbridge, 2002). Nonetheless, not all the G500 firms have sought overseas expansion, while some that had delved in international market expansion during the 1980s and 1990s have also withdrawn, or significantly reduced, their international ventures in order to concentrate on their home market.

A case in point is *Wellpoint* which has no international interests currently, being a for-profit spin-off and 'independent lisencee' of the *Blue Cross Blue Shield Association* (BCBSA); itself a federation of 39 independent, largely non-profit health insurance companies with market presence in all 50 US states but also two further independent licencees in South America (Blue Cross Blue Shield Association, 2006).[59] The remaining four health insurance/managed care firms also display varying degrees of international market penetration. Besides participation in the *Latin Health Fund*, *Humana's* first major international foray began in 2004 with the setting up of a European venture in London offering 'independent' commissioning services to the UK's NHS (Humana, 2006) while *Aetna Inc*. divested a minor portion of its *Aetna International* subsidiary to a Mexican insurance

---

[57] *ING* was formed in 1990 with the merger of two major Dutch banking companies, *Nationale-Nederlanden* and *NMB Postbank Groep* (ING Group, 2005).

[58] *Nationale-Nederlanden* had minor presence in the Dutch insurance sector prior to the merger, but made its first major entrance into the international insurance market with the acquisition in 1979 of the US insurer *Life of Georgia* and in turn, gave ING Group significant market presence in Asia, maintained even after the eventual sale of *Life of Georgia* in 2004 (ING Group, 2005).

[59] Taking the entire Blue Cross Blue Shield companies including non-profit and for-profit (including Wellpoint), it is estimated to account for 44% of national US health insurance market (Robinson, 2004b).

firm and the majority to ING Group in 2000 allegedly in order to concentrate on the domestic US market (Aetna, 2000).

Three main strands of business characterise the health insurance firms that have developed international market presence. One key strand has been the provision of (supplementary) private health insurance for expatriates and their dependants in the multinational corporate sector. In many cases this has been an outgrowth of the national corporate markets in which these companies had gained considerable market share to begin with (i.e. Robinson, 2004b; Foubister *et al,* 2006). The expatriate corporate market continues to comprise a significant part of the international private health/medical insurance operations of the major insurance conglomerates, and in some cases has resulted in spin-off companies dedicated to this sector. For example, *Aetna International* and *UnitedHealth International* (of *UnitedHealth Group*) both were formed in the early- to mid-1990s specifically to develop this market segment, and while the former was sold off in 2000, Aetna still retains a foothold in this market through a re-formulated programme for expatriates (*Aetna Global Benefits*) set up in 2004. Nearly all the major diversified financial services firms that offer health insurance products engage in the corporate market to some degree where group employer subscriptions constitute the bulk of revenue from premiums. A further aspect to this strand is that it also provides a basis for supporting 'medical tourism', a market which has been explored increasingly over the past decade by health insurers seeking to offer reduced cost treatment for prospective patients.

The second, related, strand of international business is focused on providing insurance products to corporate group clients and individuals through firms they have acquired in other countries or through joint ventures with overseas insurers. It is related to the first strand in view of the facility that commercial presence gives to serving the corporate sector in different national locations. However, the nature of the private health/medical coverage depends on the specific market characteristics of the countries where they operate (Mossialos *et al* 2002, OECD, 2004b). Indeed, the bulk of these ventures tend to be voluntary supplementary and/or complementary private health/medical insurance packages. They cover primarily hospitalisation and pharmaceutical costs, where the greatest opportunities have been to expand market share in view of a general drift in many countries towards expanding voluntary private health insurance as part of the healthcare financing mix (OECD, 2004b).

In a third strand of business, the major insurance firms are important, not just because of their presence in the health insurance market, but also as re-insurers for secondary providers offering

health/medical insurance products, including some retail chains or other health insurance providers. Indeed, French-based insurance conglomerate *AXA*, which has a major stake in the European insurance sector, is a key re-insurer in the UK private medical insurance market (Foubister *et al*, 2006), particularly since its acquisition of *Guardian Royal Exchange* - which itself had acquired *PPP*, the second largest private medical insurance (PMI) provider in the UK, a year previously - in 1999. In the UK *AXA/PPP* underwrites several health insurance packages offered by UK providers, including some of the country's main supermarket retailers that have sought to offer insurance through their retail branches, and several smaller health/life insurance firms.

4.2.2. Secondary Supply of Services to the Healthcare services sector

The biggest shift in the G500 between 1995 and 2005 has been for secondary suppliers of services to the healthcare sector (from one in 1995 to thirteen in 2005), which includes a quite diverse set of business activities ranging from catering, to medical equipment supply services, Health IT infrastructure developers, and one management consultant firm (Table 4.6). Some of these firms operate in quite a large number of countries compared to direct service providers or even core health/medical insurance providers. Even so, with the exception of the medical goods distributors, the healthcare sector tends to constitute only a small portion of their overall business activity.

For instance *Compass Group*, a UK based food services and support firm established a presence in up to 90 countries through around 20 different brands and subsidiaries, accounting for 67% of its total sales, though after 2003 it also sold several core assets in the catering sector, reducing its overall operations to 55 countries over the next three years. While only 13% of its annual turnover came from serving the healthcare sector in 2005 (Compass, 2005), the group established significant market presence contracting in healthcare food services and facilities management in North America and Western Europe (mainly the UK), since its acquisition of three key subsidiaries in 2001. This includes the US-based *Morrison* which supplies services to the North American hospital and senior living sector, including some 475 clients in the US and 11 hospitals in Canada (King, 2001)[60]; the UK-based *Medirest* whose supply of 'hotel services' to the hospital sector includes contracts with 130 UK NHS and private hospitals (in addition to contracts in North America, Europe and Australia through one of its own subsidiaries) (Compass UK, 2006); and

[60] In 2001 Morrison ranked as the third largest provider in the US healthcare food service sector just behind Sodexho (King, 2001).

Crothall Services Group which provides janitorial and facilities management services primarily in the US market (Compass Group, 2006). A similar trend of diversification within catering and support services is visible in the French-based *Sodexho*, which has an extensive portfolio of contracts in North America (43% of its total revenues in 2005) and the European region (46% of revenues in 2005), while 17.6% of its total revenues are derived from serving the healthcare sector, with a further 5.9% serving the seniors convalescent market (Sodexho, 2005).

The supply and distribution of pharmaceutical, medical and surgical products is also a sector where there is a notable trend of internationalisation through acquisition. For instance the US-based *Cardinal Health* has operations in 20 countries with around 10% of its revenue generated abroad through a number of subsidiaries and brand medical products distributors (Cardinal Health, 2005). Most of its non-US business is concentrated on the marketing and distribution of medical equipment and products through two key medical technology brands ('Alaris' and 'Pyxis') with its most important commercial presence in Western Europe, followed by Australia, New Zealand, South Africa, and Taiwan.

Another pharmacy supply/wholesale and retail firm *Alliance Unichem*, demonstrates a similar pattern of organic growth and mega-merger as this company came together in 1997 combining what was already a major UK pharmacy distributor/wholesaler with retail interests (*UniChem Plc*) with another major cross-European pharmacy retailer/distributor (*Alliance Sante AM*).[61] Between them, the originating firms had established commercial presence in pharmacy wholesale and retail through acquisition and joint venture in the UK and Ireland, Italy, France, Germany, the Netherlands, Switzerland, and Spain. After 1997, *Alliance Unichem* strengthened its position in these existing markets, also entering the pharmacy wholesale markets in Portugal, and Egypt (Alliance Boots, 2006). In 2006 *Alliance Unichem* was acquired by *Boots Group*, creating the UK's largest pharmacy retailer (17% market share) and one of the largest distributors/wholesalers of medical and pharmaceutical products (*Alliance Boots Ltd*). Outside of the European market where *Alliance Boots* has significant commercial presence through ownership,[62] the 2006 merger also created a company with a market presence through joint venture in Thailand as well as several Middle

[61] Alliance Sante had been formed in 1991 through the merger of *Alleanza Alute Italia* and two French firms *ERPI* and *IFP* (Alliance Boots, 2006).

[62] In 2007, 97% of Alliance Boots pharmaceutical wholesale revenues are derived in Western Europe (nearly two thirds of which is in France and UK and Spain combined), while 10% of pharmacy retail revenues (including health and beauty products) were derived from outside the UK (Alliance Boots 2008, p.35).

Eastern Countries, and brand presence and franchises in the US, bringing its total market scope of direct ownership, associated trading and franchises to 20 countries (Alliance Boots, 2008).

4.2.3. Direct supply of healthcare services

By contrast with insurance and secondary services, direct suppliers of healthcare services (i.e. hospitals, pharmacy firms, and nursing homes) have not increased so dramatically in number amongst the G500 (Tables 4.2 & 4.7. Nonetheless, underlying this modest increase are still some rather interesting developments particularly with regard to the pharmacy sector, which has seen a rapid and continuing growth, concentration and market consolidation of large, in some cases diversified, national and international retail conglomerates. Several of the firms involved in wholesale and distribution are also present in pharmacy retail giving firms that have diversified in both these areas of the pharmacy sector added capacity to expand nationally and/or internationally. Having said this, the trend of concentration and international expansion is still quite uneven, with mainly a handful of firms (including those in the G500) actually achieving rapid and diversified growth through national and/or international acquisition. While historically rapid national growth through acquisition is also a trend identifiable with the hospital sector, international expansion by the same means has been more uneven than compared with the retail sector.

Pharmacy retail and wholesale

Three key trends are notable in the period between 1995 and 2005, which underlie the increasing number of horizontally and vertically integrated companies involved in the pharmacy sector. First, market consolidation through acquisition and merger has been an important trend in both pharmacy wholesale/supply and retail. The *Alliance Unichem* merger in 1997 consisted of one of the most important such unions in the European market at the time. Since this company's acquisition by *Boots Group*, its expansionary strategy nationally (UK) and internationally has been all the more significant for a company that continually seeks to grow its wholesale and related distribution activities 'organically and through acquisitions, including investments in associates and joint ventures', particularly 'in new geographical markets which are typically large, fast growing and where we see the potential for market consolidation'; in reference to Russia and China, its two most recent locations of commercial presence (Alliance Boots 2008, p.3). *Alliance Unichem*, was already established as a cross-European pharmacy wholesale and retail firm, and since 2006 *Alliance Boots* operates pharmacies in nine countries, including the UK where the majority of its revenues are derived in this segment. As a counterpart to this 'mega-merger' trend in the US, *CVS*

demonstrated spectacular growth through acquisition between the late-1980s and late-1990s, placing it in the position of being the largest pharmacy retail chain in the country by the end of 2005. Unlike its UK counterpart, however, *CVS* is not engaged in overseas ventures, focusing instead on national market consolidation in pharmacy retail and establishing market presence across 34 states at the end of 2005 (Jack, 2006). Moreover, few US-based G500 pharmacy retail chains have actually established international commercial presence.

A second key trend emerging primarily in the national setting but which has secondary implications for internationally established firms is that pharmacy retail has also increasingly been engaged in by retailers whose primary business is outside the pharmacy sector. For example, the major supermarket chains in the UK (including *Tesco*, *Sainsbury's*, *ASDA* and *Morrisons*) now have in-store pharmacy dispensaries in a significant number of their major stores around the UK. *ASDA* for instance has a rapidly expanding presence in the UK pharmacy sector with pharmacy units in 30% of its stores in 2004 and a 100% annual growth rate in a number of in-store pharmacies in the early 2000s (Burgess & Rigby 2004; Schmidt & Ploch 2004). Similarly, the US market has seen several national retailers providing pharmacy services in-store (i.e. *Publix* and *Albertsons*).

Despite such bold entries by general retailers into the pharmacy sector, internationalisation is still rather uneven in this sector, given that few of the UK or US supermarket retail chains mentioned have developed international portfolios. One key exception has been *Wal-Mart* which by late 2005 has come to operate in 15 countries through its various subsidiary retailers and joint ventures, accounting for around 20% of its total revenues. *Wal-Mart's* acquisition of the UK's *ASDA* in 1999 also put the latter in the position of being one of the strongest retail chains in the country, also seeing rapid expansion of its pharmacy segment since the early 2000s. On the other hand, *Tesco*, already an internationalising retail chain (primarily in the European region) since the early 1990s,[63] has entered into pharmacy retail only in the UK, which accounts for 79% of its total sales revenues in 2005. Despite only offering a pharmacy service in the UK, it had nonetheless established in-store pharmacies in around a third of its UK stores by the mid-2000s.

A third key trend has been the diversification of both general and pharmacy-specific retailers into non-core clinical and para-clinical services, such as the optician and dental service sectors. Several large pharmacy retail conglomerates diversified rapidly into such sectors between the mid-1990s and 2000s (*CVS, Rite Aid, Walgreen*) primarily through acquisitions. Prior to its acquisition

[63] Tesco established commercial presence in 13 different countries by 2005 (Tesco, 2005).

of *Alliance UniChem, Boots the Chemist* already made forays into the supply of spectacles and basic opthalmic services. More recently it acquired a company offering optical laser surgery, whilst also entering the dental services market to compete in a more liberalized UK market after both these sectors began to see a scaling back of public (NHS) coverage during the 1990s. Its venture into the delivery of non-core clinical services, however, is still rather limited in scale with no international spread as yet.

Hospital services

Though the hospital sector seems rather weakly represented in the G500 listing, there have been a couple of companies entering this league in the years between 1995 and 2005 (Table 4.6). Based on my broader research into this sector I should note that this obscures a larger group of hospital service providers that have engaged in overseas ventures which do not have sufficient revenue levels to be entered in the international listing.[64] This point reflects perhaps more strongly than analysis of the other market segments so far, that the G500 listing presents limitations for extrapolating the degree to which a particular market segment has become internationalised. Nonetheless, some key points can still be made based on those entries included that resonate more broadly with the international commercial hospital services sector.

First, as with most other market segments analysed so far, it is notable that international expansion has followed from domestic market dominance for most hospital firms engaged in overseas ventures. A prime example is the largest of the international hospital service providers represented in the G500 in 2005, namely *Hospital Corporation of America* (HCA). In its home market (the US) HCA gradually established itself since its foundation in the 1960s as one of the largest hospital chains across both for-profit and non-profit categories, eventually operating 165 hospitals across 20 states by 2005 (HCA, 2005). In the same year, HCA operated in three countries outside the US, with six units in the UK and two in Switzerland, employing around 2% of its total staff abroad. Similarly, the US for-profit hospital chain, *Tenet* was formed in 1996 as a result of the

[64] Several European companies have engaged in overseas ventures during the 1990s, including the Swedish Capio and the German Fresenius (Hall, 2001). Moreover, the East Asian market has seen some companies engaged in overseas ventures with hospital firms making acquisitions of hospitals and nursing home facilities mainly within the region (Hall, 2003). Also, the UK's BUPA began investing in a few overseas hospital ventures during the 1990s, while from the mid-2000s the Australian Ramsay Healthcare and the South African Netcare have also demonstrated aspirations for entry into the international hospital market with key acquisitions in the UK since 2006 marking important steps for these companies' expansionary strategies (Laing & Buisson, 2008).

merger between two of the top five for-profit hospital chains competing with HCA since the 1960s: *National Medical Enterprises* (NME) and *American Medical Holdings Inc* (AMI). Prior to this merger, these two companies had projects in 10 countries between them.[65] Though NME and AMI's international commercial presence appears greater than HCA's, the bulk of these projects consisted of consulting contracts for the construction of private hospitals in most of the countries. Even so, a notable overseas venture involved *AMI's* acquisition of London's *Harley St. Clinic* as early as the 1960s making it the first major hospital corporation to undertake international expansion. Overseas expansion for *HCA*, *NME* and *AMI*, was mainly built up during the 1970s and 1980s only after having developed a strong market base in their domestic market (Berliner & Regan, 1987).

By contrast to these US corporations, the presence of *Samsung* (South Korea) in the G500 listing represents a rather unique case of a large diversified trading company that has entered the healthcare services sector as a direct provider. As an MNC, around 18% of *Samsung's* gross revenues are derived from overseas markets dealing in products ranging from electronic devices, to shipbuilding and engineering, with operations in over 80 countries (Samsung, 2006a). As a healthcare service provider, *Samsung* owns and operates a handful of hospitals exclusively in South Korea. The parent company's strong position in the high-tech electronic devices market has been a key factor behind its emphasis of cutting-edge high-tech medical services provided in its hospitals (Samsung, 2006b). *Samsung* shows no indication of being interested in international expansion in the hospital sector. However, while its presence in the hospital services market is an exception in terms of organizational structure to the other examples presented so far, it does reflect the diversified business portfolios of many parent companies involved in the healthcare services sector.

A second point is that the few companies that have engaged in international ventures reflect the difficulties of establishing and developing an international portfolio in this sector. While *HCA* and *Tenet* (at least the international activities of its predecessors) engaged in several overseas ventures between the 1960s and early 1990s, by the late 1990s both these companies had started to reduce their international commercial presence. The first of the two to divest overseas ventures was *Tenet* which sold its international portfolio in late 1990s to concentrate on the domestic US market, particularly at a time that it was facing adversity in its home market. Interestingly, some of *Tenet's* overseas market share was absorbed by *HCA* which at the time was still expanding its market share

[65] These included contracts in Saudi Arabia, Greece, Canada, the UK, Spain, Singapore, Australia, and Malaysia.

domestically. (However, even HCA also sold part of its international portfolio during the 1990s, notably in the UK, as the company faced financial trouble in its domestic market.[66] More recently, during the mid-2000s, reports indicate that *HCA* pulled out of the Swiss market selling its units to local private hospital firms in face of declining revenues in that market.

To some degree, the difficulties faced by private hospital corporations in developing and retaining overseas ventures can in part be explained by the fact that this is a typically highly regulated sector. However, regulatory barriers to entry are not single-handedly causal to market entrance and subsequent expansion of market share. Indeed, the highly regulated hospital sector in the UK, where public sector dominance of hospital services initially left limited space for the private hospital sector, also proved a propitious market to enter at a time when the private sector competition was rather weak in the 1960s and 1970s. The subsequent entrance of a government sympathetic to the private sector in 1979 was also to some degree a boon for overseas market entrants in the UK (Higgins, 1988). By contrast, entry into markets with an already strong private sector presence seems to present a greater barrier to foreign-owned market entrants. Non-regulatory structural constraints (such as demand) can have an impact on the opportunities to expand in overseas markets for all companies, though in a market segment such as hospitals with high fixed costs this can be an important deterrent from international expansion of their business.

Besides regulatory and demand-based factors, a third point is the role of investment the expansion of commercial hospital enterprises. This has been of key importance in the development of the US for-profit hospital sector since its inception in the 1960s and has become increasingly so in subsequent decades (Reinhardt, 1989; Cutler & Horwitz, 2000; Robinson, 2002a). For the most part, it has been investment partnerships in their domestic market that have assisted international expansion. However, an important development can be noted in more recent years, with the acquisition of HCA in 2006 by investment firm *Kohlberg Kravis Roberts & Co.*, in partnership with *Bain Capital* (equity) *Meryll Lynch* (investors) in 2006 (Bank Loan Report, 2007). In the process, HCA became a privately owned corporation, after having been a publicly listed company in the US for over 30 years. The significance of this particular investment decision for the hospital sector, as well as for the healthcare services sector, is hard to tell at this point in time. However, the

[66] Following a 'mega-merger' with Columbia in 1996, the recently formed Columbia/HCA became the subject of a federal healthcare fraud investigation. Managing this high-profile negative exposure and a change in corporate direction were key reasons for HCS scaling back its international and US operations (Galewitz, 2000).

acquisition of *Alliance Boots* by the same investor group in the following year presents an important development in the healthcare services market, with a major international capital investment that could well set a precedent for future multinational investment decisions.

4.3. The commercial basis of internationalisation

While data offering an insight into the scale and scope of internationalisation of healthcare services is rather limited, the analysis of available data is revealing about the degree to which internationalisation has been a substantive trend - at least since the mid-1990s. At the broadest level, my findings show that internationalisation of healthcare services is growing but continues to be a rather limited development. This reflects somewhat Moran and Wood's (1996) findings over a decade earlier when comparing globalization in the healthcare sector to other spheres of economic activity. Nevertheless, I have found that internationalisation is highly variable in the extent to which it has developed between and within different market segments, as well as between different national locations. In this last section of the chapter, I briefly reflect on some key points emerging from the analysis so far about the extent of internationalisation in healthcare services and about the commercial basis for the internationalisation of healthcare.

4.3.1. The scale and scope of internationalisation of healthcare services

Internationalisation has not been an altogether new phenomenon in several of the dimensions of service supply analysed in this chapter.

While overseas market penetration by commercial healthcare service providers and insurers is not especially novel, it is nonetheless a trend that has seen some intensification in the past couple of decades. A key observation is that there seems to be a regional dynamic in internationalisation as companies seek expansion through acquisition, or establish themselves in markets where other major national and multinational corporations from outside the healthcare sector provide a key customer base for their private healthcare services. For example, many of the US firms have established their most important overseas markets in North and South America, while Western Europe is a second major sphere of commercial presence for US firms. Likewise, most of the European firms have made substantial acquisitions within the European Economic Area (EEA), with the North American market being a close second in some cases. In any case strong links between North America and Western Europe are notable as, for example, where US insurance firms have made acquisitions in Europe, much as European firms have made entries into the US market.

Cross-border commercial links are by no means isolated to Western Europe and North America. Indeed, an important trend in the past couple of decades has been the establishment of commercial presence by US and European firms in developing countries. Several US HMOs have established a market presence in South America which has been a steadily growing market for commercial hospital and health insurance ventures, especially over the past decade. For instance, the *Latin America Fund*, mentioned above, was set up specifically to develop ties with this region (Waitzkin & Iriart, 2001; Iriart *et al*, 2001; Iriart, 2005). Developing countries, however, are not singly host to North-South flows of market penetration. Indeed, there are notable regional relations that have developed in the past couple of decades. South East Asia, and Latin America have seen especially entrance from regional players. India, Nepal, Sri Lanka, Thailand have seen entrance from Singapore for instance, while Chile and Argentina have seen entrants from Mexico. Also a handful of Asian companies have also penetrated Northern markets with acquisitions of European and US healthcare service firms. The most significant perhaps in recent years has been the acquisition of both *HCA* and *Alliance-Boots* by the same Hong Kong-based investment firm.

Meanwhile, there is considerable variation in the capacity for firms to internationalise between market segments. For instance, the more traditional supply chain (i.e. pharmacy wholesale) and retail firms (whether mainly pharmacy suppliers or larger diversified retail firms) have displayed considerably greater levels of market penetration than specifically medical service suppliers. Hospital firms, even where they have established major leading commercial conglomerates in their home market, have had a variable experience in penetrating and staying in overseas markets. With the exception of the US, such hospital conglomerates are limited in number in most countries.

This point partly reflects the inevitable bias towards large national and international conglomerates in using the G500 listing as a method of mapping international commercial presence in the healthcare services sector. An extensive geographic market such as that of the US means that national market share is large enough to account for sufficient revenues to be listed for a number of hospital corporations that is not reflected in the 'global' market share of many other companies with an even larger number of overseas ventures. Thus, firms that are engaged in overseas ventures do not feature in the G500 list even while being significant market leaders within their national markets (i.e. *Tenet* hospitals) as well as, in some cases, being engaged in several overseas ventures. Examples include several US hospital chains and managed care firms that actually feature amongst

the Fortune 500 top US firms (by revenues), while several European hospital providers can also be included amongst the more internationalised firms.

4.3.2. Internationalisation and the expansion of commercial healthcare services

So far, except for a few hints, this chapter has uncovered little overtly, on the way in which internationalisation of healthcare services contribute toward changing the structure of national healthcare service markets. For instance, where healthcare systems have developed niche markets for overseas patients, this may be seen as an important source of economic growth, and has been particularly important for those developing countries that have been able to capitalise on lower cost-margins arising from exchange rate differences between higher-income and lower income countries in such a market. However, this also may come at a cost of supplying sufficient access to services for domestic populations, which is symptomatic both of national healthcare planning in cases where they are employed by public providers but, as is apparent from the examples I have given here, it also contributes to some extent to the expansion of private sector market share since private providers are often major employers of overseas staff. Though it would be rather tenuous to cite this as a causal factor in the commercialisation of domestic healthcare service providers, there are indications that commercial hospital providers rely considerably on overseas staff, which can be a useful factor in keeping down labour costs, to the extent that many of these are frequently junior doctors or recently qualified nurses.

The cross-border establishment of commercial presence, on the other hand, suggests a much more significant impact on national markets. Although a focus on the G500 listing means there is an inevitable bias towards analysis of larger corporations, many of which are multinationals, it is still indicative of some important trends with regard to the potential for internationalising commercial corporations to impact on overseas national markets. Indeed, considering several large multinational conglomerates amongst both health insurance suppliers and hospital providers, they have been important in changing the structure of their domestic markets as companies through expansion of market share prior significant internationalisation. In the former case the trend has been for absorption into ever larger diversified insurance and financial product companies, allowing parent companies to spread risk more easily across their different fields of business, but also demonstrating a tendency to focus on the most profitable areas of health insurance such as the ‘corporate market’ supplying corporate professionals in other multinationals or large national corporations.

For the most part, their entrance into the health insurance market can be seen as an addendum to their main portfolio of business, having either acquired smaller providers of diverse insurance products over the years, or entered in to the health insurance market as a strategy of penetrating new and upcoming opportunities in what looks likely to become a much more liberal market for healthcare service products in many developed and developing countries. Particularly in the latter case, where East Asian markets are frequently cited as being promising new markets for entrance due to the opening up of formerly rather protectionist economies with highly restrictive regulations for foreign direct investment. For instance the Chinese market, particularly after joining the WTO, has been increasingly open to new entrants, which have regularly entered joint ventures with domestic insurance providers since the middle of this decade. Those that 'traditionally' have engaged primarily or exclusively, in health or medical insurance have also internationalised by seeking opportunities in countries with more liberalised market conditions, which is exemplified by a number of US managed care organizations (MCOs) entering several Latin American countries. Broader economic liberalization and privatization policies in these countries, leading to the dismantlement or undermining of domestic social insurance and tax financing systems, have facilitated the growth of private health insurance which has been a key target market for the US MCOs.

As such, the analysis so far points to the importance of the national context for creating the conditions for internationalisation of trade in healthcare services. The regulatory environment in different national locations can be as important as the specificities of the national market structure in determining the opportunities arising for the development of commercial (for-profit) provision and financing of healthcare services. This point is developed in greater depth in the following two chapters with historical analysis of the US and UK healthcare service sectors.

4.4. Concluding Remarks

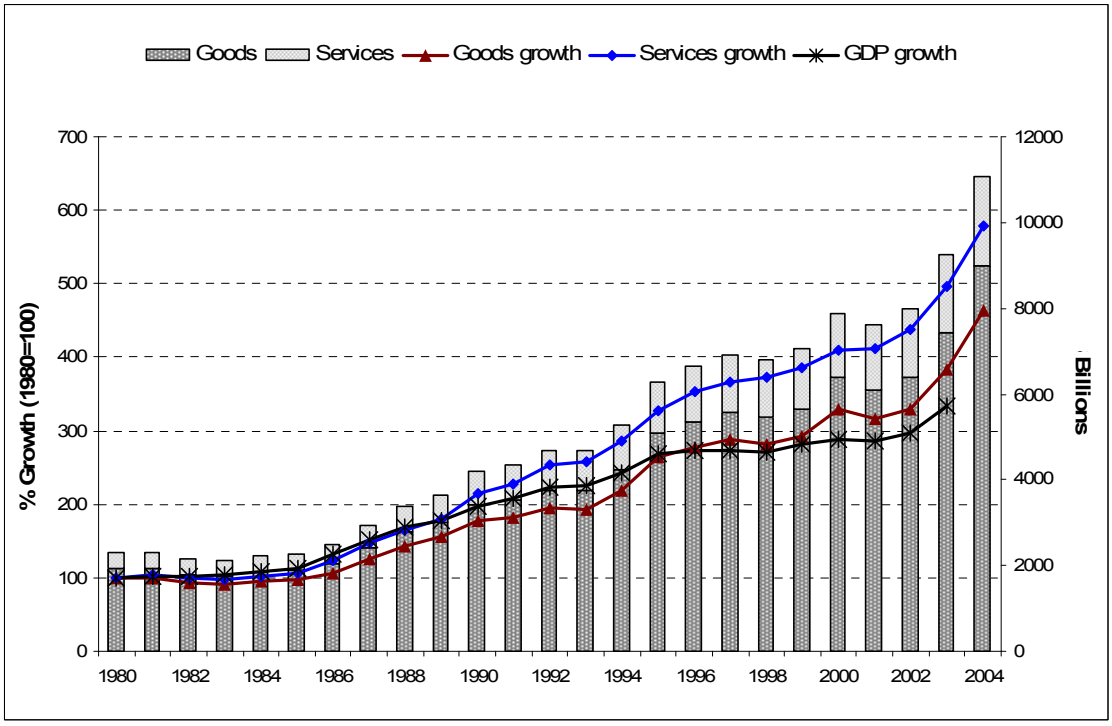
This chapter has focused on developing a framework for analysing trends in the emergence of an international healthcare services market. Researching companies listed in the *Fortune*

Magazine's Global 500 (G500) indicates the degree to which the healthcare sector is not only an area of growing national expenditure (as percentage of GDP) but also one that is increasingly host to major nationally established as well as multinational corporations (MNCs).

The tentative results of my research based on limited data and rather fragmented sources are still indicative of an intensification of international trade in healthcare services. The primary finding is that the international healthcare services market demonstrates a highly uneven degree of internationalisation between individual firms and market segments. A second key finding is that internationalisation is, to a considerable extent, dependent on the facility for commercial opportunities to develop, which in turn is rather dependent on the specificities of the national market structure and regulatory context. The analysis so far indicates an intensification of international commercial exchanges in the healthcare services sector.

To appreciate what this might mean in terms of the changing market structure in the national context, the next step for the thesis is to examine the way in which commercial transformation has been developing within specific national locations. As such, in the following two chapters I explore in particular, cases of the US and UK, the national context for the development of an international market in healthcare services.

Figure 4.1: World Exports in Goods and Services ($USD), annual: 1980-2004



Source: World Trade Organisation (2006)

Table 4.1: World Exports in Goods and Services ($USD), selected years: 1980-2004

	Goods		Services		Total
	$ bill	%	$ bill	%	$ bill
1980	1,934	84.2	363	15.8	2,297
1985	1,877	83.1	382	16.9	2,259
1990	3,433	81.5	780	18.5	4,213
1995	5,105	81.1	1,189	18.9	6,294
2000	6,374	81.1	1,485	18.9	7,859
2004	8,974	81.0	2,100	19.0	11,074

Source: World Trade Organisation (2006)

Table 4.2: Healthcare Sector Firms listed in the Fortune Global 500 (summarised by type of business): 1995 and 2005

	1995				2005			
Type of Firm	**Core**	**Subs**	**Total by area of activity**	**Total as % of health sector**	**Core**	**Subs**	**Total by area of activity**	**Total as % of health sector**
(a) Providers of services to the end consumer	**1**	**3**	**4**	**8.3**	**5**	**5**	**10**	**13.0**
•Hospital providers	1	0	1		2	1	3	
• Pharmacy	0	2	2		3	4	7	
• Assisted living	0	1	1		0	0	0	
(b) Producers of goods	**9**	**20**	**29**	**60.4**	**13**	**20**	**33**	**42.9**
• Pharmaceutical products (Prescription & OTC)	9	6	15		13	5	18	
•Health IT systems	0	6	6		0	2	2	
• Medical electronic equipment (imaging & other)	0	8	8		0	10	10	
• Medical products	0	0	0		0	3	3	
(c) Suppliers of services to state providers or private providers	**0**	**1**	**1**	**2.1**	**6**	**7**	**13**	**16.9**
• Distributors/ Wholesalers of pharma or medical supply	0	0	0		6	0	6	
• Health IT	0	0	0		0	3	3	
• Catering (hospitals/ nursing homes)	0	1	1		0	3	3	
• Cleaning (clinical premises)	0	0	0		0	0	0	
• Health Consulting	0	0	0		0	1	1	
(d) Private health/ medical insurance	**2**	**12**	**14**	**29.2**	**6**	**15**	**21**	**27.3**
Health Services Total (a, c & d)	**3**	**16**	**19**	**39.6**	**17**	**27**	**44**	**57.1**
Health Total	**12**	**36**	**48**	**100.0**	**30**	**47**	**77**	**100.0**

Sources: Fortune (1995 & 2005); Company documents and websites

Table 4.3: Producers of medical and health goods listed in Fortune's G500, 1995 & 2005

Company	Home Country	G500 Rank	Areas of Business		Total Revenues ($mill)
			Core	Subsidiary	
Pfizer	USA	75	Pharmaceuticals	Animal Health	$52,921
Johnson & Johnson	USA	88	Pharmaceuticals	Surgical Instruments	$47,348
GlaxoSmithKline	UK	122	Pharmaceuticals	-	$37,304
Bayer	DE	124	Pharmaceuticals	Diagnostic Equipment	-
Novartis	CH	186	Pharmaceuticals	-	$28,247
Roche Group	CH	209	Pharmaceuticals	Diagnostics	$25,166
Merck & Co. Inc.	USA	239	Pharmaceuticals	-	$22,939
Bristol-Myers-Squibb	USA	258	Pharmaceuticals	-	$21,886
Astrazeneca	UK	267	Pharmaceuticals	Medical Devices	$21,426
Abbott Laboratories	USA	285	Pharmaceuticals	Medical Equipment	$20,473
Sanofi-Aventis	FR	321	Pharmaceuticals	Vaccines	$18,710
Wyeth	USA	346	Pharmaceuticals	-	$17,358
Eli Lilly	USA	445	Pharmaceuticals	-	$13,858
Procter & Gamble	USA	77	Household Products	Pharmaceuticals	$51,407
Nestle	CH	43	Food	Pharmaceuticals	$69,826
Tyco	USA	103	Electrical Products	Medical Products	$41,042
3M	USA	295	Diversified	Medical Products	$20,011
Kimberly-Clarke	USA	394	Personal Paper Products	Medical Products	$15,401
Mitsubishi Chemical	JAP	288	Chemicals	Pharmaceuticals	$20,372
Loreal	FR	336	Cosmetics	Pharmaceuticals	$18,077
Akzo Nobel	NL	380	Chemicals	Pharmaceuticals	$15,781

Sources: Fortune (2005)

Table 4.4: Healthcare Sector Firms in the Fortune Global G500 summarising the number of overseas ventures and areas of business in 2005

Company	Home Country	No. Overseas Ventures[1]	Areas of Business		Total Revenues ($mill)
			Core	Subsidiary	
Health insurance providers					
CIGNA	USA	27	Health Insurance/ Managed Care	Life, accident & disability insurance	$18,176
Humana	USA	At least 6	Health Insurance/ Managed Care	Equity Investment & health system management services	$14,418
Wellpoint	USA	0	Health Insurance/ Managed Care	Pharmacy Benefit Management	$20,815
Aetna	USA	9	Health Insurance/ Managed Care	Life insurance/ Pensions	$19,904
UnitedHealth Group	USA	At least 40	Health Insurance/ Managed Care	Health Information Services/ Health IT	$37,218
Aegon	NL	13	General Insurance	Pensions, Asset management, Life& accident, Health insurance	$35,463
Assicurazioni Generali	IT	64	General Insurance	Accident & Health insurance/ managed care	$83,268
Allianz Group	DE	70	Property/Casualty & Life Insurance	Asset Management Banking; Health insurance (subset of Life insurance)	$118,937
AXA	FR	90	Property & Life Insurance	Pensions & retirement products; Asset Management; Health Insurance	$121,606
Legal & General	UK	3	General Insurance; Life & Pensions	Health insurance (subset of Life & Pensions)	$21,770
Massachusetts Mutual Life Insurance Company	USA	6	General Insurance; Life Insurance	Health & Accident Insurance; Long Term Care Insurance; Pension products; Asset Management	$23,159

Table 4.4: (continued)

Company	Home Country	No. Overseas Ventures[1]	Areas of Business		Total Revenues ($mill)
			Core	Subsidiary	
Health insurance providers (cont.)					
Fortis	BENELUX	10	Banking; General Insurance	Accident & Health insurance	$75,518
MetLife	USA	16	General Insurance; Life; Retail banking; Liability	Accident & Health; Dental insurance/; Long-Term Care; Reinsurance	$39,535
Munich Re Group	DE	43	Reinsurance; Primary Insurance	Asset Management; Health Insurance; Managed care	$60,706
NorthWestern Mutual	USA	-	Life Insurance	Long Term Care insurance; Asset Management; Investment Services; Employee Benefits	$17,806
New York Life Insurance	USA	9	Life Insurance & Annuity; Investment Management	Health insurance / managed care products	$27,176
State Farm Insurance	USA	-	General & Life Insurance; Investment; Banking	Health & Disability insurance/ Managed care; Long Term Care insurance; Business insurance	$58,819
ING Group	NL	50	Banking; Life and general insurance; Asset Management	Health Insurance; Pensions; Reinsurance; Real estate; Employee Benefits	$105,886
Sumimoto Life Insurance	JAP	3	General & Life Insurance	Health insurance; real estate	$31,000
American International Group (AIG)	USA	50	Financial services; General Insurance	Corporate sector Health Insurance	$97,987
AFLAC	USA	1	Supplemental Health & Life Insurance	Supplemental Accident & Illness insurance	$13,281

Table 4.4: (continued)

Company	Home Country	No. Overseas Ventures[1]	Areas of Business		Total Revenues ($mill)
			Core	Subsidiary	
Providers of secondary services to the healthcare sector					
Compass Group	UK	90	Contract catering for various types of business; Restaurants	Hospital Catering; Vending; Cleaning and other janitorial services under various subsidiaries	$21,104
Sodexho Alliance	FR	80	Catering	Hospital & nursing home catering	$14,854
Sysco	USA	1	Catering	Hospital & nursing home catering	$29,335
Amerisource Bergen	USA	2	Pharmaceuticals Distribution	Med Supplies Distribution; Pharmaceuticals Packaging	$53,179
Cardinal Health	USA	6	Pharmaceuticals Distribution	Medical & Pharma Equipment/Technologies Provision; Clinical Improvement Services	$65,131
Alliance Unichem	UK	15	Wholesale Pharmacy and Distribution	Retail Pharmacy; Marketing of beauty products	$16,305
Franz Haniel (Group)	DE	15	Pharmaceuticals Distribution/ Wholesale	Retail Pharmacy; Property restoration; Steel recycling; Textile services; Mail order; Building materials	$30,245
McKesson	USA	9	Pharmaceuticals Distribution/ Wholesale & Supply	Medical-Surgical Equipment Supply & Logistics; Health IT	$80,515
Computer Sciences Corporation	USA	29	IT Services (Outsourcing & Systems Development)	Health IT; Consulting	$15,849

Table 4.4: (continued)

Company	Home Country	No. Overseas Ventures	Areas of Business		Total Revenues ($mill)
			Core	Subsidiary	
Providers of secondary services to the healthcare sector (cont.)					
Electronic Data Systems	USA	48	IT Services (Outsourcing & Systems Development)	Health IT	$21,033
Accenture	USA	75	Management Consulting	Health Consulting	$13,674
Mediceo Holdings	JAP	0	Wholesale pharmaceutical & medical products	-	$15,500
Direct providers of healthcare services					
Hospital Corporation of America (HCA)	USA	2	Hospitals	-	$23,502
Tenet Healthcare	USA	0	Hospitals	-	$12,496
Samsung Group	S.Korea	World-wide	Electronics Manufacture and Trading	Hospitals, Medical school & Life Sciences research; Life Insurance; Financial Services; ICT & Networks; Heavy Industries; Engineering & Construction; Chemicals	$13,919
CVS	USA	0	Pharmacies	-	$30,919
Rite Aid	USA	0	Pharmacies	-	$16,816
Walgreen	USA	0	Pharmacies	General Merchandise	$37,508
Albertsons	USA	0	Supermarkets	Pharmacy	$40,052
Publix	USA	0	Supermarkets	Pharmacy	$18,686
Tesco Plc	UK	13	Supermarkets	Pharmacy; health insurance	$62,458
Wal-Mart Stores	USA	14	Supermarkets	Pharmacy; Optician and clinical services	$287,989

[1] Includes different types of subsidiary business, whether wholly owned by G500 company listed, part owned through joint venture, or where G500 company has direct equity stake.
Sources: Fortune (2005)

Table 4.5: Health Insurance Providers listed in Fortune's G500 annual ranking, 2005 [1]

COMPANY {Home Country; G500 Rank; Revenues ($mil)}	**AREAS OF BUSINESS** Core & Subsidiary	**INTERNATIONAL HEALTHCARE MARKET**
CIGNA {USA; #333; $18,176}	**Core**: Health insurance/ Managed care **Subs**: Life, accident & disability insurance	• **USA**: market presence in 50 states (72.5% Medical & other Health Insurance; 16.5% Life, Accident & Disability Insurance) • ***CIGNA International***: 9% of total *CIGNA* revenues from premiums and fees derived from international business; **Commercial presence** in 27 countries: Europe, North America, Asia Pacific (South Korea the largest market in its international segment); Expatriates covered in 200 countries • **International revenues** (including expatriates) by segment: 46% Health Insurance; 54% Life, Accident & Health
Humana {USA; #474; $14,418}	**Core**: Health insurance/ Managed care **Subs**: Equity investment & health system management services	• **USA**: market presence in 35 states offering diverse health and medical insurance products. • ***Latin Healthcare Fund*** (LHF) [*2*]: Private equity-investment fund that is part of *Humana's* venture capital arm *Humana Ventures* (though this, *Humana* is a strategic partner with several other health insurance and equity investment firms); **LHF key investments**: - *International Hospital Corporation SA* (based in Mexico)[*3*]: *CIMA* hospitals in Mexico (four) & Costa Rica (one); *VITA* hospitals in Brazil (five); Hospitals facilitate overseas patients through *Medical Value Travel* primarily aimed at US market. - 7.7% stake since 1999 in *Farmacias Ahumada SA*: Chile based retail pharmacy chain with units in Chile (250); Peru (130); Mexico (529) (figures end 2005). - *Delboni Auriemo Medicina Diagnostica Ltda (Delboni)*[*3*]: Clinical laboratory and diagnostic imaging (Brazil) in which *LHF* acquired 100% stake in one of its 20 clinics (*Bio-Ciencia Lavoisier Analisis Clinicas*) • ***Humana Europe*** (established 2006 in England): supplying 'commissioning services' to NHS; contracts with several PCTs (100% owned by Humana Inc.)
Wellpoint {USA; #280; $20,815}	**Core**: Health insurance/ Managed care **Subs**: Pharmacy benefit Management	• **USA**: Market presence in 14 states after merger with *Anthem Inc* in 2004 (up from 10 states by 1996) - *Wellpoint* is a for-profit 'independent lisencee' of *Blue Cross Blue Shield Association* (established in 1986 as managed care wing of *Blue Cross of California*) which has presence in 50 states • **No international interests currently** {BCBSA has two independent licencees in South America}

Table 4.5: ***continued***

COMPANY {Home Country; G500 Rank; Revenues ($mil)}	**AREAS OF BUSINESS** Core & Subsidiary	**INTERNATIONAL HEALTHCARE MARKET**
Aetna {USA; #298; $19,904}	**Core**: Health Insurance; Managed care **Subs**: Life insurance; Pensions	• **USA**: Market presence in 50 states, serving government and commercial markets: 90% of total revenues from Health insurance products; 0.8% Life and Accident (Group) insurance; 0.2% from Large case pensions • **International acquisitions & joint ventures** since 1960s primarily in Life insurance sector: Canada; Australia; Chile; England; Spain; Hong Kong; Taiwan; Indonesia; South Korea. • ***Aetna International*** (former subsidiary managing all international business): sold to *ING Group* in 2000 as part of corporate restructuring to focus company on US market for health insurance and group benefits. • ***Aetna Global Benefits***: Expatriate insurance coverage for multinational corporate sector; *Aetna*'s remaining international segment (offices in US, Europe, Asia and Middle East)
UnitedHealth Group {USA; #123; $37,218}	**Core**: Health insurance/ Managed care **Subs**: Health information Services; Health IT	• **USA**: market presence in 50 states through several subsidiaries offering diverse set of health and medical insurance products, health management services and pharmacy benefit management services. {*Note*: Has become largest and most vertically integrated health insurance and related products firms in US since becoming UHG in 2000 and restructuring its business} • **Commercial presence**: (key overseas market links: China, India, Philippines, and Portugal) - Health insurance through acquisitions, joint ventures and partnerships: North America, Asia, Latin America & Europe. - Health IT & info management: Subsidiary *Ingenix* in 40 countries; key overseas UK & Australia. - *Latin Healthcare Fund* (LHF) [2]: Strategic Partner (Cf. section for *Humana* above) - ***UnitedHealth International***: Expatriate corporate sector, facilitating medical tourism to US and from US to other countries.
Aegon {NL; #136; $35,463}	**Core**: General Insurance **Subs**: Pensions, Asset Management, Life & accident, Health insurance	• **Netherlands** (2005) : geographically 34% of total revenues; 1% of Accident & Health revenues • Overall **commercial presence** through: Acquisitions in North America, Spain, UK, Hungary, Slovakia, Czech Republic, Poland and Romania; Partnerships, joint ventures & greenfield ventures in: India, Japan, China, France, and Taiwan. {Key overseas markets 2005: North America 54% & UK 0.05% of total revenues} • **Accident & health coverage** (subsidiary business of life insurance segment): markets in North America (primarily US), NL & Asia - 17.5% of total overseas (non-NL) revenues; 14.3% of total net income (NL & overseas)

Table 4.5: ***continued***

COMPANY {Home Country; G500 Rank; Revenues ($mil)}	**AREAS OF BUSINESS** Core & Subsidiary	**INTERNATIONAL HEALTHCARE MARKET**
Assicurazioni Generali {IT; #24; $83,268}	**Core**: General Insurance **Subs**: Accident & Health insurance/ managed care	• **Italy**: 33.8% of total gross direct premiums; No health insurance products • **Commercial presence** in 64 countries: *{figures shown in % of total gross direct premiums}* - Key markets: Germany (25%), France (25%), Austria (2%), Spain (2%), Switzerland (2%) - Presence in Western and Eastern Europe, North America, Asia, Central & South America, Africa. • **Health segment**: 0.07% of total gross direct premiums; - Of health segment: West & East Europe (94.7%); Germany (62.9%); France (24%); Austria (6%); Rest of Europe (1%); Rest of World (5%)
Allianz Group {DE; #14; $118,937}	**Core**: Property/Casualty & Life Insurance **Subs**: Asset Management Banking; Health insurance (subset of Life insurance)	• **Germany**: 32% of Total consolidated revenues; 31.7% of Life/Health segment (of which health accounts for 24.8%); Health insurance 0.06% of Total statutory premiums. • **Commercial presence** (70 countries overall): West and East Europe, North and South America and South East Asia • **Life & Health segment** (30 countries): *{figures in % of total statutory premiums for this segment}* - Segment accounted for 47.7% of Total revenues; Of this, 68.2% of statutory premiums from outside Germany; Key overseas markets: Italy (19.3%); France (10.9%); Switzerland (0.2%); Spain (0.01%) {**Note**: *Allianz Group* became a European Company (*Societas Europea*) in 2006, following acquisitions of *Riunione Adriatica di Sicurtà S.p.A.*; while German business remains under *Allianz*.}
AXA {FR;#13; $121,606}	**Core**: Property & Life Insurance **Subs**: Pensions & retirement products; Asset Management; Health Insurance	• **Commercial presence** through acquisition in 20 countries offering diverse insurance and other financial products (products available in total of 90 countries) across North America, Europe, Asia-Pacific, Middle East; Africa. 78% of employees outside France - Key markets: (% Gross revenues): US (30.9%), France (29.3%); Japan (10.5%); UK (5%); DE (8%); Belgium (6%) • **Health segment**: 0.05% of total revenues (10% of Life & Savings segment, which is 63% of total) - Key markets (Health as % of Total gross premiums written for Life & Savings segment): FR (9%: Life & Health); Japan (2.3%: Health); DE (2%: Health) {**Note**: Acquired UK's *Guardian Royal Exchange* in 1999 which in 1998 had acquired *PPP* (UK's 2nd largest private medical insurance provider)}

Table 4.5: ***continued***

COMPANY {Home Country; G500 Rank; Revenues ($mil)}	**AREAS OF BUSINESS** Core & Subsidiary	**INTERNATIONAL HEALTHCARE MARKET**
Legal & General {USA; #261; $21,770}	**Core**: General Insurance; Life & Pensions **Subs**: Health insurance (subset of Life & Pensions)	• **UK** is primary market accounting for around 90% of total business • **International Commercial Presence**: through acquisitions only in three other countries for Life & Pensions: US (1980s) under *Banner Life* & *William Penn* brands (1% of total revenues); NL (1980s) under L&G Netherlands (1.1%); France (1930s) under L&G France (1.2%) • **Health Segment**: "Healthcare contracts are primarily private medical insurance, which compensate customers for the costs of eligible medical consultations, diagnostic tests, inpatient day care and outpatient". Health products only in UK market {**Note**: Health products ended Feb 2007; Sold to *AXA PPP*}
Massachusetts Mutual Life Insurance Company {USA; #236; $23,159}	**Core**: General Insurance; Life Insurance **Subs**: Health & Accident Insurance; Long Term Care Insurance; Pension products; Asset Management	• **USA**: Key market; Health segment focused mainly on Long Term Care coverage (aimed at managing Medicare & Medicaid funds of enrolees) • **Commercial Presence**: (6 countries) → *Mass Mutual International Inc*. (international division): Through subsidiaries & partnerships offers life, health and accident insurance, annuity, pension products, and asset management products and services; Regional headquarters in Hong Kong & Macau (since 2000); Taiwan (since 2001); Japan (2nd largest market after US); Luxembourg, also covering other EU (mainly asset management, since 1988); Chile, including general, life, & health insurance, & Asset management (minority stake since 1995).
Fortis {BENELUX; #30; $75,518}	**Core**: Banking; General Insurance **Subs**: Accident & Health insurance	• **Benelux**: 87.2% of Total Revenues (All segments); Insurance in NL and Belgium sold through dedicated Insurance subsidiaries for those countries. • **Commercial Presence** (Insurance) in 10 countries: Luxembourg, France and UK via *Fortis Insurance International* and its subsidiaries. Insurance activities performed in Portugal, Spain, China, Malaysia and Thailand in cooperation with local partners. • **Accident & Health Insurance**: 1.4% of Total revenues; 9.7% of total insurance segment (gross); 30.5% of non-life insurance segment (net). - Key markets (% of net premiums earned): NL (64.6%); Belgium (24.5%); Other countries (10.4%) {**Note**: Sale of US private health insurance firms in 2000 & further sale of US insurance in 2003 meant a drop in US Accident & Health as % of revenues (from 26.3% in 2004 to 4.3% in 2005)}

Table 4.5: ***continued***

COMPANY {Home Country; G500 Rank; Revenues ($mil)}	**AREAS OF BUSINESS** Core & Subsidiary	**INTERNATIONAL HEALTHCARE MARKET**
MetLife {USA; #108; $39,535}	**Core**: General Insurance; Life; Retail banking; Liability **Subs**: Accident & Health; Dental insurance/; Long-Term Care; Reinsurance	• **USA**: 91.9% of total revenue; Health segment focused on individual and group Long Term Care insurance in 50 states, and Dental (managed care) plans for employers in three states. • **Commercial Presence**: in 16 countries accounting for 8.1% of total revenues in Latin America (5); Asia-Pacific (7); Europe (3) • **Health/Medical Segment** (private health medical insurance): Chile, Mexico, Australia, China, Hong Kong, South Korea, Taiwan.
Munich Re Group {DE; #55; $60,706}	**Core**: Reinsurance; Primary Insurance **Subs**: Asset Management; Health Insurance; Managed care	• **Germany**: 45.5% of total consolidated revenues; health: 10.2% of total consolidated revenues • International commercial presence: total 43 countries - Reinsurance (31); Primary Insurance (24) • **Health Segment**: • **Europe**: *DKV* (Life & Health) - "Europe's largest private health insurer"; health segment accounts for 12.8% of total gross premiums written by Munich Re Group of which 80% in Germany. - Part of *ERGO Insurance Group* formed after *DKV* merger with *DAS* in 1997/98 (*Munich Re* has 94.7% stake in *ERGO*); Presence seven European countries for Health through subsidiaries (acquisitions & joint ventures) Germany, Spain, Italy, Luxembourg, Belgium, Norway, Sweden - Spanish subsidiary *DKV Seguros* set up hospital in partnership with *Marina Salud* • **Rest of World**: *Cairnstone Inc*, *Sterling Life Insurance Co.*, & *Munich Re America HealthCare* (USA); *PICC Health* (China; partnership); *Apollo DKV* (India); *DKV South Korea*; *DAMAN National Health Insurance* (UAE; majority share); *DKV UK* (2006) • Expatriate health insurance (in-patient & other medical) aimed at multinational group/corporate sector under *DKV* {**Note**: Since early 2009, *Munich Re* reorganized its international health segment under *Munich Health* subsidiary to focus and develop presence in the healthcare sector}
NorthWestern Mutual {USA; #342; $17,806}	**Core**: Life Insurance **Subs**: Long Term Care insurance; Asset Management; Investment Services; Employee Benefits	• **USA**: Majority of business (presence in 50 states); 10% of US direct life insurance market • **Health Segment** (USA only): Group and individual Long Term Care insurance (*Northwestern Long Term Care Insurance Co.*); products offered in 50 states

Table 4.5: ***continued***

COMPANY {Home Country; G500 Rank; Revenues ($mil)}	**AREAS OF BUSINESS** Core & Subsidiary	**INTERNATIONAL HEALTHCARE MARKET**
New York Life Insurance {USA; #193; $27,176}	**Core**: Life Insurance & Annuity; Investment Management **Subs**: Health insurance / managed care products	• **USA**: Majority of business (presence in 50 states); Health segment US only (offered in all US) • **International Commercial Presence**: 9 countries through joint ventures, partnerships, acquisitions and new ventures providing mainly life insurance products: Argentina, China, Hong Kong, India, Mexico, Philippines, S Korea, Taiwan, Thailand. • **Health Segment**: Primarily Long Term Care coverage (special segment for supplementary products to Medicare); Health coverage under Group insurance (corporate sector employers) partnerships with *Humana, CIGNA, Assurant Health, First National, and Benefit Mall*; Individual policies through partnerships with *Assurant Health*, *Humana* & *UnitedHealth*
State Farm Insurance {USA; #62; $58,819}	**Core**: General & Life Insurance; Investment; Banking **Subs**: Health & Disability insurance/ Managed care; Long Term Care insurance; Business insurance	• **USA**: Majority of business (presence in 50 states); No international interests as far as visible • **Health Segment** (*US only*): Long Term Care: offered in all 50 states (underwritten by *SFI*) - Health: (Offered in most US states) Individual medical insurance products in partnership with *Assurant Health*; Prescription drugs coverage (Medicare Part D) in partnership with *Humana Insurance*; Supplemental Hospital Indemnity. **NB**: External companies underwrite and offer products through *State Farm* as broker
Sumimoto Life Insurance {JAP; #158; $31,000}	**Core**: General & Life Insurance **Subs**: Health insurance; real estate;	• **International Commercial Presence:** - USA: *NY Sumimoto Life* (2001), *Sumitomo Life Realty (N.Y.)* (real estate; since 1982), Inc., & *Sumitomo Life Insurance Agency America, Inc.* (employee welfare/benefits products; since 1986) - China: partnership with *PICC Holdings* forming *PICC Life Insurance Co.* (since 2005) - UK: London representative office as node for European business (since 2001) • **Health Segment**: SLI Agency America offers corporate health insurance, & dental insurance to corporate group clients (US only; presence in four states)
American International Group (AIG) {USA; #19; $97,987}	**Core**: Financial services; General Insurance **Subs**: Corporate sector Health Insurance	• **USA**: Main market (presence in all 50 states) • **International Commercial Presence**: 16.7% of insurance segment revenues from international business; Life and general insurance products through various subsidiaries and joint ventures in 50 countries in Latin America, Europe & Asia-Pacific; • **Health Segment:** Group life/health segment is 15.8% of domestic life insurance and retirement segment; Personal accident & health is 21.7% of overseas life insurance and retirement segment

Table 4.5: *continued*

COMPANY {Home Country; G500 Rank; Revenues ($mil)}	**AREAS OF BUSINESS** Core & Subsidiary	**INTERNATIONAL HEALTHCARE MARKET**
ING Group {NL; #17; $105,886}	**Core**: Banking; Life and general insurance; Asset Management **Subs**: Health Insurance; Pensions; Reinsurance; Real estate; Employee Benefits	• **NL**: 66% of premium income from Insurance segment & 55% of Banking business • **International Commercial Presence:** 50 countries across different business segments *Insurance*: Europe (23% of premium revenues), Americas (50%; of which 80% USA), Asia-Pacific (27%; of which 52% Japan); *Banking*: Europe (85% of loans and advances to customers), North America (9%), Latin America, Asia & Australia (6%) • **Health Segment:** - Accounted for 2.5% of total insurance revenues (premiums written) and 17.4% of non-life segment in 2005; Down from 2.9% of total premiums written and 22.3% of non-life segment in 2001 - By 2005 health products consisted of mostly accident and critical illness coverage aimed primarily at corporate group sector as a subset of employee benefits; Products offered mainly in US, but also in Europe and Asia-Pacific. - Acquisitions in US, Latin America and Asia Pacific have included health insurance business elements. However, after acquisition of *Aetna Financial Services* and *Aetna International* in 2000, ING has been slowly divesting aspects of health business (i.e. HMOs and other direct health insurance) from its portfolio to concentrate on Life Insurance and other Financial services. Example: Sale of *Orange HealthCare* (HMO in Philippines) to PhilamCare (*UnitedHealth/ Philippine American Life* joint venture) in 2002; Sale of *Aetna ING Life Indonesia* to *Manulife Indonesia* in 2003; Sale of Mexican health component in 2008 to *AXA*, along with other aspects of non-life business under subsidiary *Seguros ING SA*
AFLAC {USA; #465; $13,281}	**Core**: Supplemental Health & Life Insurance **Subs**: Supplemental Accident & Illness insurance	• Key business offering Life and health/medical coverage to individual and (mainly) group employer customers - USA: products sold through several other national and regional carriers - Japan: Products marketed through 13 other Japanese health insurance firms and *AXA Japan* • **Health segment**: - Accounts for 83.4% of total consolidated revenues from supplemental health insurance business; - In US also offers hospitalization, long term care, dental, & lump sum critical illness products.

Table 4.5: ***continued***

Notes:
Nearly all percentage figures shown are my own calculations based on company annual reports and other reported data where available.
[1] All information gathered for this table was as close as possible in accuracy to year 2005, though some account of previous years in made, whilst some relevant information for subsequent years in included in notes for each row where deemed useful by author.
[2] Information on *Latin Healthcare Fund* from Lethbridge (2002c, pp.9-11) website has been offline for some time.
[3] Unclear what stake G500 company has in this venture.

Sources: Columns 1&2: Fortune (2005); Columns 2&3: Company Annual Reports & Websites; Lethbridge (2002c)

Table 4.6: Providers of Secondary Services to the Healthcare Sector in Fortune's G500, 2005

COMPANY {Home Country; G500 Rank; Revenues ($mil)}	**AREAS OF BUSINESS** Core & Subsidiary	**INTERNATIONAL HEALTHCARE MARKET**
Compass Group {UK; #272; $21,104}	**Core**: Contract catering for various types of business; Restaurants **Subs**: Hospital Catering; Vending; Cleaning and other janitorial services under various subsidiaries	• **Commercial Presence** (90 countries): Geographic share of revenues: US 32.3%; UK 23%; Europe (incl. France 4%, Germany 4%) 32%; Japan 4%; Rest of World 9%. • **Health Sector**: Subsidiaries serving healthcare sector all acquired in 2001 (13% of revenues): - **USA**: *Crothall Services Group*: Primarily catering, but also cleaning and janitorial services, facilities management and clinical equipment maintenance for hospitals (services mainly US market, but also presence in Canada); *Morrison*: mainly catering for hospitals sector and senior living (US only) - **UK:** *Medirest*: Catering and some facilities management ("hotel services"): UK private & public hospitals (incl. 130 NHS Trusts) and senior living centres; also some sites in Europe and Australia
Sodexho Alliance {FR; #443; $14,854}	**Core**: Catering **Subs**: Hospital & nursing home catering	• **Commercial Presence:** Geographic share of revenues: Europe 46% (UK & Ireland 11%); North America 43%; Latin America 4%; Africa, Asia & Pacific 7% (80 countries total) • **Health Sector**: - Hospitals: 18% of revenues (France, Italy, UK, US) - Seniors (Nursing homes and home care): 6% of revenues (US, Canada, 10 EU, Australia, Chile)
Sysco {USA; #171; $29,335}	**Core**: Catering **Subs**: Hospital and nursing home catering	• **Commercial Presence**: USA (92% of sales revenues) and Canada (8% of sales revenues) - All business primarily through two key subsidiaries (*Broadline* & *SYGMA*) • **Health Sector:** Hospitals & Nursing homes 10% of sales revenues
Amerisource Bergen {USA; #74; $53,179}	**Core**: Pharma's Distribution **Subs**: Med Supplies Distribution; Pharma's Packaging	• **Commercial Presence**: through acquisitions and subsidiaries - **USA**: 20% of US pharmaceutical distribution/supply market; - **Canada** (distribution centres) - **UK** (*Brecon Pharmaceuticals*: drugs packaging production)
Cardinal Health {USA; #48; $65,131}	**Core**: Pharmaceuticals Distribution **Subs**: Medical & Pharma Equipment/Technologies Provision; Clinical Improvement Services	• **USA**: Presence in 50 states; **Key business segments**: Pharmaceuticals Distribution & Provision: 81.1%; Medical Products, Pharmaceutical & Clinical Technologies, and Services relating to each of these: 18.9%; **Commercial Presence**: Overseas accounts for 10% of revenues of overall business • **Key international business:** - Subsidiaries: *Medicine Shoppe International* (acquired 1995). Retail pharmacy arm, present in 6 countries outside USA (Canada, China, Japan, Indonesia, India, & Taiwan) - Brands: *Alaris*, and *Pyxis* marketed in 20 countries between them through local offices

Table 4.6: *continued*

COMPANY {Home Country; G500 Rank; Revenues ($mil)}	**AREAS OF BUSINESS** Core & Subsidiary	**INTERNATIONAL HEALTHCARE MARKET**
Alliance Unichem {UK; #369; $16,305}	**Core**: Wholesale Pharmacy and Distribution **Subs**: Retail Pharmacy; Marketing of beauty products	• Formed after merger between *UniChem Plc* (UK) and *Alliance Santè SA* (Italy/France) in 1997, making 3rd largest pharmacy wholesale/retail in Europe (1998-2005) • **Commercial Presence**: (10 countries) - Acquisitions & new ventures: UK, Spain (*Grupo Safa & Farmacen*); Norway (*Holtung & Alliance Apoteke*), Netherlands (*Interpharm & De Vier Vijzels*), Italy (*Alliance Farmacie*), Germany (*ANZAG*), Portugal (*Alliance UniChem Farmacêutica S.A*); Czech Rep. (*Plus S.r.o. & Pragopharm S.r.o*), N. Ireland (*Bairds Chemists*) - Partnerships: Switzerland (*Galencia AG*: wholesale), Turkey (*Hedef*: retail) through which also indirect stake in Egyptian wholesale pharmacy chain (*UCP*). {**Note**: Acquired by UK retail pharmacy giant *Boots Group* in 2006 forming *Alliance Boots*. 2007-2008 Annual Report for *Alliance Boots* indicates presence in 20 countries • Wholesale & Distribution: 15 countries, 62.4% of total revenues (of which UK 89.8%) • Retail (health & beauty): 7 countries; 44.7% of revenues (of which FR 41.1%; UK 21.8%) - In USA only marketing of products through franchises}
Franz Haniel (Group) {DE; #164; $30,245}	**Core**: Pharmaceuticals Distribution/Wholesale **Subs**: Retail Pharmacy; Property restoration; Steel recycling; Textile services; Mail order; Building materials	• **Commercial Presence**: Through 6 subsidiaries in diverse business segments - Revenues: Germany (21%); Rest of Europe (73%); US (4.6%); Rest of World (1.4%) • **Health Segment**: - ***Celesio AG*** (Wholesale & Retail pharmacy): 79.1% of total sales revenues of *Franz Haniel Group* - Presence in 15 European countries through local acquisitions & subsidiaries: *Wholesale* (13 countries); Retail (7); Logistics (8) - Segments (revenues): *Wholesale*: 82.4%; *Retail*: 14.1%; *Pharmacy Logistics*: 0.6% • Key Markets (revenues by segment): - *Wholesale*: FR 42.1%, DE 21.4%, UK 18.8%, Other 17.7% - *Retail*: UK 68.6%, NOR 11.2%, IT 1.5%; Other 11.9%
McKesson {USA; #26; $80,515}	**Core**: Pharmaceuticals Distribution/Wholesale & Supply Subs: Medical-Surgical Equipment Supply & Logistics; Health IT	• **Segments** (revenues): Pharma's Distribution (95%); Medical-Surgical (4%); Health IT (1%) - Since 2000 operates wholly in healthcare sector (previously had holdings in other industries) • **International Commercial Presence**: "Largest pharmaceuticals distributor in North America" • Pharma's Distro: USA (93.2% of revenues in this segment) - presence in all 50 States; Canada (6.8% of revenues); Mexico (49% interest in *Nadro, S.A. de C.V.* pharma's distributor since 1993) • Medical-Surgical: USA & Canada • Health IT ('Provider Solutions'): Supply management software & services through subsidiaries & partnerships in Canada, UK, Ireland, France, Netherlands, Australia, New Zealand & Puerto Rico

Table 4.6: ***continued***

COMPANY {Home Country; G500 Rank; Revenues ($mil)}	**AREAS OF BUSINESS** Core & Subsidiary	**INTERNATIONAL HEALTHCARE MARKET**
Computer Sciences Corporation {USA; #378; $15,849}	**Core**: IT Services (Outsourcing & Systems Development) **Subs**: Health IT; Consulting	• **USA**: 60.2% of total consolidated revenues of which: Commercial (44.7%); Dept. of Defense (34.1%); Civil Agencies & Other US Federal Govt (21.1%) • **International Commercial Presence**: Presence in 29 countries: Europe (17), Asia (9), Canada, Australia & South Africa / Including outsourcing contracts, in a total of 88 countries in 2005 - Share of total consolidated revenues: Europe (30.4%); Other International (1.3%) • **Health Segment**: Sectors: Life Sciences, Direct Providers, Managed Care/Health Insurance, Government; Unclear what proportion of revenues or what countries, changes depending on short and long-term contracts. Reports of several contracts with government health services in North America and Europe including contracts with US Dept of Health and Human Resources, and 2002 contract with UK's Dept of Health to develop online information website and patient forum.
Electronic Data Systems {USA; #274; $21,033}	**Core**: IT Services (Outsourcing & Systems Development) **Subs**: Health IT	• **International Commercial Presence**: 48 countries; Commercial and Government contracts Revenues share: Americas 54.8% (USA, Canada & Latin America); Europe, Mid East & Africa 36.5%; Asia-Pacific 1.5% • **Health Sector**: (Key businesses) USA: Has been managing Medicare claims since 1966 contracts with *Blue Cross Blue Shield* which has been the main administrator of Medicare & Medicaid claim process; Also formed *National Heritage Insurance Company* (NHIC) subsidiary in 1977 to concentrate its state healthcare business, and now "handles 35% of all Medicare and Medicaid claims". Consequently is still the largest supplier of computer services to the U.S. health insurance industry. UK: contract with *BUPA* (1984)
Accenture {USA; #455; $13,674}	**Core**: Management Consulting **Subs**: Health Consulting	• **International Commercial Presence**: Presence in 45 countries & services provision to clients m more than 75 countries. By Revenues: Americas 43%; Europe, Mid East & Africa 50%; Asia-Pacific 7% • **Health Sector**: Unclear what scale of presence in health sector; Clients include Life Sciences companies, Health Insurance providers, and Government clients: organizational restructuring, eHealth system development (i.e. patient records), and other systems design projects; - Major contracts have included US hospitals; Italian, Australian and UK government healthcare agencies (incl. NHS contract); Pharmaceutical companies.
Mediceo Holdings {JAP; #390; $15,500}	**Core**: Wholesale pharmaceutical & medical products	• **International Commercial Presence**: No international interests; All its business is in Japan {**Note**: *Mediceo Holdings Co. Ltd* was formed in 2004 after spinning off its substantial portfolio of subsidiaries and becoming an operating holding company}

Sources: Columns 1&2:Fortune (2005); Columns 2&3: Company Annual Reports & Websites

Table 4.7: Direct providers of healthcare services in Fortune's G500, 1995 & 2005

COMPANY {Home Country; G500 Rank; Revenues ($mil)}	AREAS OF BUSINESS Core & Subsidiary	INTERNATIONAL HEALTHCARE MARKET
2005		
Hospital Corporation of America (HCA) {USA; #228; $23,502}	**Core**: Hospitals	• **USA**: 173 hospitals and clinics across 20 states (largest private for-profit hospital chain in US) • **International Commercial Presence**: - Six hospitals in UK; Two hospitals in Switzerland; 2% of staff abroad {**Notes**: HCA sold its two Swiss hospitals in 2007 due to declining profits; HCA acquired by *Kohlberg Kravis Roberts & Co.* and partnership with *Bain Capital* (equity) *Meryll Lynch* (investors) in 2006, same equity fund which in 2007 acquired *Alliance Boots*}
Tenet Healthcare {USA; #495; $12,496}	**Core**: Hospitals	• **USA**: 82 general and specialist hospitals and medical facilities across 13 states (second largest private for-profit hospital chain in US) • **International Commercial Presence**: None. US operations only {**Notes**: Most of *Tenet*'s international portfolio had been developed prior to 1996 when *Tenet* was formed after merger of *National Medical Enterprises* (NME) and *American Medical Holdings Inc* (AMI). Between then these companies had projects in 10 countries including Saudi Arabia, Greece, Canada, the UK, Spain, Singapore, Australia, and Malaysia. Much of this entailed consulting contracts for the construction of hospitals, though some involved acquisition (i.e. London Harley St. Clinic acquired by *AMI* in 1960s). Tenet sold its international portfolio in late 1990s - some of which was absorbed by HCA - to concentrate on domestic market}
Samsung Group {S. Korea; #442; $13,919}	**Core**: Electronics Manufacture and Trading **Subs**: Hospitals, Medical school & Life Sciences research; Life Insurance; Financial Services; ICT & Networks; Heavy Industries; Engineering & Construction; Chemicals	• One of the World's largest electronics companies (*Samsung Electronics* division spun off from Samsung Group in early 2000s); intensification of international acquisitions for Group since 1990s • **Commercial Presence** (through variety of subsidiaries): N. America, Latin America, Europe, SE Asia, China, Africa, Pacific. • **Health Segment:** All based in S. Korea. *Samsung Medical Centre* (subsidiary) consists of three private Hospitals including Seoul Samsung Hospital (teaching hospital which serves *Sungkyunkwan University School of Medicine*) and one Life Sciences research centre. Seoul Hospital also provides International Health Services aimed at overseas patients (mainly Asia & Middle East markets) offering in-patient and out-patient services.
CVS {USA; #161; $30,919}	**Core**: Pharmacies	• **Commercial Presence**: USA only: 34 states (end 2005); Amongst top three US pharmacy retailers {Note: 44 states after equal merger with *Caremark Rx* (forming *CVS Caremark*) in 2007}
Rite Aid {USA; #351; $16,816}	**Core**: Pharmacies	• **Commercial Presence**: USA only: 31 states - Amongst the top three US pharmacy retailers

Table 4.7: ***continued***

COMPANY {Home Country; G500 Rank; Revenues ($mil)}	**AREAS OF BUSINESS** Core & Subsidiary	**INTERNATIONAL HEALTHCARE MARKET**
2005		
Walgreen {USA; #119; $37,508}	**Core**: Pharmacies **Subs**: General Merchandise	• **Commercial Presence**: USA only: 49 states (and Puerto Rico); - Amongst the top three US pharmacy retailers
Albertsons {USA; #105; $40,052}	**Core**: Supermarkets **Subs**: Pharmacy	• **Commercial Presence**: USA only: 15 states • **Health Segment**: *Osco Drug* & *Sav-On Drugs* subsidiaries with standalone stores and supplying ins-store pharmacy services in Albertsons stores. {**Note**: *Albertsons* was split in 2006 in acquisitions so that pharmacy services were largely absorbed by *CVS* (see above) which acquired freestanding *Osco* & *Sav-On* stores (702), *Supervalu Group* (grocery retail & distribution) acquired 906 (including *Albertsons'* in-store units), and *Cerberus Capital Management* (private equity) acquired 655 stores with in-store pharmacy services}
Publix {USA; #322; $18,686}	**Core**: Supermarkets **Subs**: Pharmacy	• Commercial Presence: USA only: stores, distribution centres & manufacturing facilities in 5 states (15th largest retailer in US end 2006; main concentration in Florida) • **Health Segment**: 700 in-store pharmacies in 5 states (approx. two thirds of total Publix stores)
Tesco Plc {UK; #54; $62,458}	**Core**: Supermarkets **Subs**: Pharmacy; health insurance	• **International Commercial Presence**: 13 countries including acquisitions and joint ventures; Sales revenues: UK (79.6%), Rest of Europe (11.7%), SE Asia (8.6%); UK supermarket sector: 31% of market share • **Health Segment**: In-store pharmacies (in 7% of total stores); Health Insurance (private supplemental medical insurance provided by *AXA PPP*)
Wal-Mart Stores {USA; #1; $287,989}	**Core**: Supermarkets **Subs**: Pharmacy; Optician and clinical services	• **USA**: Largest Retailer in US & largest company in the US by revenues (based on US presence) • **Commercial Presence**: Subsidiaries in 14 countries accounting for 19.7% of total annual revenues Including: UK's *ASDA* (acquired 1999) 17% of market share in UK supermarkets/ 40% of WalMart's international division sales. • **Health Segment:** In-store pharmacies in many of its chains in US and overseas, targeting low-cost generic OTC and prescription pharmaceuticals market; In US (Walmart Store) has also begun to offer optician services and in-store walk-in medical clinics (partnerships with local clinicians and hospitals) in several stores since 2005 (unclear how many). {**Notes**: Walmart Vision Centres in nearly 3000 locations in 47 US states (2008)}

Table 4.7: *continued*

COMPANY {Home Country; G500 Rank; Revenues ($mil)}	**AREAS OF BUSINESS** Core & Subsidiary	**INTERNATIONAL HEALTHCARE MARKET**
1995		
Columbia/HCA Healthcare {USA; #335; $11,132}	**Core**: Hospitals	• **Commercial Presence**: - USA: 190 hospitals in 26 states (after 1994 merger) - International: London (6 hospitals) & Switzerland (2 hospitals) {**Notes**: Formed after merger between *Columbia Hospital Corporation* and *HCA* in 1993-94 in a bid to expand to national level provision. *Columbia* had acquired *Galen Healthcare* (formerly the hospital segment of *Humana*) earlier in 1993 which included international hospitals}
Marriot International {USA; #466; $8,415}	**Core**: Hotels **Subs**: Assisted living	• International portfolio of hotels and related lodging facilities (direct ownership and franchises) • **Commercial Presence**: 67 countries (majority focus in US) • **Health Segment**: One assisted living home in US
Publix {USA; #443; $8,742}	**Core**: Supermarkets **Subs**: Pharmacies	• **Commercial Presence**: US only (3 states by 1995) • **Health Segment**: 1/3 of stores had in-store pharmacies
Winn-Dixie Stores {USA; #339; $11,082}	**Core**: Supermarkets **Subs**: Pharmacies	• **Commercial Presence**: US (14 states) & Bahama Islands • **Health Segment**: {**Note**: *Winn-Dixie* filed for bankruptcy in 2005 having hit financial trouble by 2003, shrinking markedly in size and as a consequence was not present in the G500 rankings thereafter. Still remains standalone company}

Sources: Columns 1&2:Fortune (2005); Columns 2&3: Company Annual Reports & Websites

Chapter 5: Between Market, State and (Global) Market: Commercial Transformation of the US Healthcare Services

The key focus of this chapter is to examine the emergence of a commercial (for-profit) healthcare services market in the US and the qualitative implications of this transition for the structure of the US healthcare system and its particular mixed economy of healthcare. I focus primarily on the hospital sector and its interaction with the changing structure of health insurance marked by the emergence of large healthcare service conglomerates and amongst these at least a handful of major multinationals. While the US in many ways is an outlier compared to most other OECD countries, examining these changes in the US provides insight in terms of the more general trend internationally regarding the commercialisation of healthcare services, as well as offering and offers an important reference point for analysing commercialisation in other countries.

Indeed, the US healthcare system was the earliest to experience a structural shift in its healthcare services from a sector characterized by private non-profit organizations to one in which several large multi-institutional for-profit organizations have come to dominate market share during the last quarter of the 20th century. By the end of the 1990s a considerable number of both for-profit and non-profit entities across a range of healthcare services were absorbed into 'investor-owned' commercial conglomerates, with concentration of ownership in a relatively small number of these. While at the beginning of the 21st century the corporate commercial expansion is an almost taken-for-granted feature of the US healthcare system, it is nonetheless a development that is intimately connected to changes in public policy that saw a shift from an *accommodatory* (Starr, 1992) to a *pro-competitive* (Marmor, 1998) framework of engagement with the private healthcare services sector. Despite little indications from my research that international expansion of a handful of these commercial actors was an intentional outcome of public policy, the impact of the 'pro-competitive' turn has been a significant contingent factor in the internationalisation strategies of a number of the healthcare service corporations.

In the first section of the chapter I briefly situate the context out of which a for-profit healthcare market structure arose during the 1960s and 1970s, noting the important role played by (Federal) public policy in this process. The next section (5.2) tracks the emergence of commercial

conglomerates in the hospital sector, while in section 5.3 I look at developments in the health insurance sector. The chapter then makes a brief analysis of the relationship between these two sectors and developments in public policy (section 5.4), followed by a brief analysis of the international expansion of US hospital and insurance firms in section 5.5.

5.1. From cottage industry to corporate growth industry: The changing mixed economy of healthcare in the US

Although the US stands out, in relation to most other OECD countries, for the degree to which healthcare has remained outside of direct public regulation and administration, this has meant neither a complete absence of government role, nor a purely profit-driven system of healthcare historically. Examining some features of the earlier structure of healthcare services is necessary to contrast with the changes that have taken place in the last quarter of the 20th century, which are the most relevant to this thesis.

5.1.1. The non-profit roots of the US healthcare services sector

The extremely limited presence of the federal government in both healthcare financing and provision from the inter-war years through to the post-WWII decades,[67] set it apart from most other advanced capitalist countries of the era that had already begun to develop sizeable public insurance schemes for healthcare.[68] Instead, fraternal and benevolent societies largely filled the gap in collective health financing, while religious-based and other non-denominational philanthropic charities provided most of the hospital services, and a substantial number of physician-owned proprietary hospitals were also in operation, making up around half of the total hospital stock until the early 1930s (Stevens, 1999, pp.30-39, Steinwald & Neuhauser, 1970).[69] Physicians were almost

[67] No cabinet-level department existed for healthcare until 1953 when, under President Eisenhower, the US Department of Healthcare, Education and Welfare was legislated in Congress.
[68] At the state level, sparse initiatives had developed to give means-tested assistance to the poor and a small number of public hospitals were developed in some municipalities, while after 1930 US war veterans, through the Veterans Administration, received some degree of support and access to a small number of public hospitals of variable quality (Starr, 1982, 154-162).
[69] Most of these were affiliated to specific labour unions or others that were locally based working men's clubs linked to manufacturing, heavy industry, extractive industries, and railways, while a small number of service sectors such as banking and public sector employment groups were also host to health sickness funds (Dobbin, 1992).

exclusively individual private practitioners offering their services on a fee-for-service (FFS) basis through solo primary care practices, hospitals and/or clinics, or hired by large companies (particularly in labour-intensive sectors) to provide basic in-house medical services to their workers (Starr, 1982, pp.200-215).[70] From the mid-1930s, however, what could arguably be referred to as a "cottage industry" (Himmelstein & Woolhandler, 1984, pp.15-20), composed of diffuse localised networks of physician-led clinical services and voluntarist health insurance schemes, began to shift towards a hospital-centred medical sector in which employer-based health insurance was the defining feature of collective financing of healthcare.

Amid a number of different and independently emerging organizational innovations in the 1920s and 1930s, the (non-profit) *Blue Cross* health plan (founded in 1929 by hospitals in Texas), was welcomed by employers and grew over the next few decades to become one of the biggest health insurance groups across the US, but also essentially defined the model for all subsequent employee health plans (Starr, 1982, pp.331-4).[71] Excluded from the Social Security infrastructure that was set up in the mid-1930s under the New Deal, health insurance became crystallized as a fringe benefit. A series of war-time federal wage and price controls (and in the absence of comparable controls on fringe benefits) indirectly and unintentionally encouraged health insurance to become a core aspect of US corporate wage-bargaining between organized labour and especially large employers from the 1940s (Dobbin, 1992; Quadagno, 2004b).[72] This had not been single-handedly the work of *Blue Cross*, but its success paved the way for a number of other non-profit organisations also entering similar relationships with healthcare providers. Furthermore, many

---

[70] Fee-for-service involves the unbundled billing of individual services. Particularly in the hospital setting, where a number of medical practitioners of different specialisms may offer services to patients, the bill involves the separate invoicing of services to the payer.

[71] By the late-1930s a number of innovatory changes had taken place in healthcare delivery as a variety of autonomous initiatives experimented with more rationalised medical service provision - such as the division of labour between clinicians, and laboratory and diagnostic work - and greater integration between service delivery and financing. Particularly the advent of *multispecialty group practices* (such as the Mayo clinic) and *medical cooperatives* in the 1920s, and *pre-paid* hospitalization schemes and group practice in the 1930s (such as the Ross-Loos clinic, the Kaiser group, Blue Cross, Blue Shield, and Group Health Association) were beginning to challenge the existing social organization of medicine (Starr, 1982, pp.290-310).

[72] The most notable of these federal interventions included the 1942 National Labor Wage Board (NLWB) which instituted a national wage freeze and the Revenue Act of the same year (Dobbin, 1992, pp. 1436-8).

commercial (for-profit) insurance companies entered the health insurance business during the 1930s to take advantage of the growing demand for health insurance.[73]

5.1.2. The post-New Deal era

After 1945, the first major federal capital investment programme for hospitals, together with financial support for medical training and biomedical research increased dramatically in the ensuing three decades and created the impetus for massive expansion in the supply of healthcare services and medical products (Stevens 1999; Starr, 1982). Where *Blue Cross* had previously covered much of the cost of capital investment in hospitals, the 1946 National Hospital Survey and Construction Act (or 'Hill-Burton' Act after its chief sponsors in Congress) effectively took over this function for the majority of the nation's community hospitals until 1974.[74] The Hill-Burton programme allocated over $4.6 billion in grants and $1.5 billion in loans that led to the construction of, or equipment for, roughly 6,800 healthcare facilities in more than 4,000 communities, contributing to 30% of the annual cost of construction (Mantone, 2005, p.6-7).[75] By 1968 it had helped to finance 9,200 new medical facilities (including hospitals and other clinical service providers), with a total of 416,000 new beds. When expenditures ended under the act by 1975, the federal government had assisted in financing almost one-third of all hospital projects in the nation, contributing about 10% of the annual costs of all hospital construction (Starr, 1982, p.285).

Notably this financial contribution to the development of the hospital system was focused predominantly on public and secondarily on non-profit community hospitals, but excluded

---

[73] The commercial insurers set limits on benefits, often custom-tailored to the desires of each employer, and competed largely for the younger cohorts offering lower premium prices to groups that were effectively understood to require less usage of healthcare services. This was an important distinction early on between non-profit and for-profit health insurance, which although on the one hand related to distinct markets, also threatened considerably the risk pool constructed by non-profit health insurers which made their business viable.

[74] The Hill-Burton Act (42 U.S.C. §§291-291ol) expired in 1966, and was followed by the Comprehensive Health Planning and Public Health Services Amendments of 1966 (42 U.S.C. §§243, 245a, 246), which expired in 1974. This was then expanded in 1974 under the National Health Planning and Resources Development Act (42 U.S.C. §§300k-l-300k-3) and repealed by Public Law (No. 99-660 §701(a), 100 Stat. 3799) in 1986 under the Reagan administration (cf. Paschall, 2007, note 1, p.475).

[75] The popular 'Hill-Burton' title for this Act of Congress is derived from its two chief advocates, Senators Lister Hill of Alabama and Harold H. Burton of Ohio, Hill being the main driving force behind it. Their original proposal languished in the Senate Education and Labor Committee until November 1945 when the then President, Harry S. Truman, announced a comprehensive and prepaid medical insurance program for all Americans that would be tied to the Social Security program of the pre-WWII New Deal. (Perlstadt, 1995).

proprietary (for-profit) facilities.[76] Over its life span, the vast majority of this funding went into private non-profit hospitals and, as such, helped to prop up a large number of hospitals that were economically unviable due either to their dilapidated condition and/or lack of resources to offer sufficient array of services. Recipient organizations were consequently protected to a certain degree from the direct pressures that market competition had wrought over the past three decades (Himmelstein & Woolhandler, 1984, p.18; Stevens 1999).[77]

The federal government also put money into expanding the number of medical personnel and actively promoted the training of physicians after 1945. Between 1950 and 1970 the medical workforce increased from 1.2 million to 3.9 million, while medical research grants (largely distributed through the National Institute of Health) rose from $180,000 in 1945 to $4 million two years later, $46.3 million in 1950 and $400 million in 1960 (Starr, 1982, p.335-347). Medical schools expanded rapidly between the 1940s and 1970s as the infusion of large amounts of public money generated new opportunities for developing specialist research and training and also for the employment of larger faculties. The average income of medical schools tripled from $500,000 to $1.5 million a year during the 1940s, and by 1958-59 the average school's income was up to $3.7 million and ten years later to $15 million (Starr, 1982, p.352).

Meanwhile, a small though growing number of federal state-based assistance programmes began to provide some coverage for those groups that were effectively disenfranchised from employer-based health insurance. Much of this relied on the New Deal era provisions for social assistance and security,[78] but also appeared in numerous abortive attempts to insert some provisions for national health insurance either as separate bills of Congress, or attached to other programmes for health care including both The Hill-Burton hospital investment programme and its short-lived

---

[76] Despite insistence by its Congressional sponsors that it should be directed towards those institutions that were most in need of capital investment in relatively deprived parts of the country (Stevens, 1999, p.217).

[77] While the 'market' did not rely on profit margins or investor accountability at this time (at least to the extent that it does currently), competitive survival did rely to a considerable extent on links to health insurance providers and their ability to provide the necessary cash for capital investment.

[78] Particularly, what was to be Medicaid, drew on a number of programmes of categorical cash assistance, including old-age assistance, aid for the blind, aid to families with dependent children and, added in 1950, aid to the permanently and totally disabled. Medicaid's federal matching funds provided a key impetus for expanding these general assistance programmes as most states or local government units would benefit a great deal from the extra funds (Stevens & Stevens, 2007, p.118).

predecessor the National Hospital Bill (1942) (Perlstadt, 1995, pp.82-83).[79] However, it was the introduction of the public Medicare and Medicaid programmes as amendments to the 1935 Social Security Act in 1965 which did the most to increase the scale of public financing for healthcare services. From 24.7% in 1960, the public share of total expenditure on healthcare had quickly grown to 37.5% by 1970 increasing further in recent years to 45.4% by 2005 (Table 5.1 & Figure 5.1. By far the greatest share of public spending was soon directed at Medicare (which is exclusively federal) and Medicaid (split between federal and state administration and sourcing of funds), as their combined outlay grew from 22.6% of total public expenditure in 1966 to 46.1% in 1970, expanding further to 72.6% by 2005 (Table5.2 & Figure 5.2. An important feature was that these programmes were administered by and closely modelled after *Blue Cross*, and included unlimited payments to hospitals for capital expenditures (Himmelstein & Woolhandler, 1984 p.17). As such, the newly established public financing programmes were set up in a way that would further reinforce the private sector structure of US healthcare, but also preserve employer-based financing as the keystone of its financing structure.

Like the Hill-Burton Act the 1965 public programmes played an important public subsidy role for the private healthcare sector; particularly Medicare, given its primary focus on hospitals. Lacking adequate regulation of this public expenditure, the greatly increased public funding that these programmes delivered became a key source of capital accumulation for an array of industries related to healthcare, constituting a major impetus for expansion of the healthcare services sector as an industry (Relman, 1980; Starr, 1982; Stevens, 1999). Financed on a 'cost-plus' basis, the emerging healthcare industries were reminiscent of the sprawling "military-industrial complex" which had been growing on the basis of a vast public subsidy system particularly since the Second World War (Perelman, 1993, pp.93-108). Indeed, certain critics of the corporate transformation of healthcare at the time describe what was emerging in healthcare as, a "medical-industrial complex" (Ehenreich & Ehenreich, 1971; Salmon, 1975), for which the hospital sector, though still largely non-profit, became an ideal conduit for the generation of substantial surplus extraction by

[79] Under President Roosevelt, an attempt had been made to attach national health insurance to the investment in hospitals and other clinical facilities. Resistance from both the medical profession and what, by this time, was the dominant employer-based health insurance industry saw that the National Hospital Bill did not survive the Congressional stage. A similar pattern developed leading up to the Hill-Burton Act, but this time an early example of incrementalist politics undertaken by the sponsors of the Bill, which ultimately climbed down from a request for national health insurance to seek merely that recipient organisations should allocate a certain amount of hospitalisation to those unable to pay (Perlstadt, 1995).

increasingly bigger and more powerful for-profit healthcare firms (Himmelstein & Woolhandler, 1984, p.18).

This early manifestation of for-profit business in healthcare was chiefly composed of medical goods manufacturers and suppliers - particularly pharmaceutical firms and medical equipment producers - making the most of the expanded healthcare service infrastructure and growing public financing for scientific research. But a new dimension of the "medical-industrial complex" was emergent between the late 1960s and 1970s - the full scale and implications of which were only realised from the 1980s and intensified during the 1990s - involving the market expansion of peripheral supply firms[80] and of financial intermediaries[81] (Salmon, 1975, pp.610-1). A further aspect of the "new medical-industrial complex" (Relman, 1980) involved the rapid growth of corporate organisational forms in healthcare services and the concentration of many for-profit and non-profit hospitals and health insurance organizations into large conglomerates, but also the eventual diversification of many of these large multi-institutional groups into several spheres of healthcare provision, ranging from hospital management services, to nursing homes and long-term care facilities, the supply of medical equipment and later, even the provision of some health insurance tied to specific hospital groups.

Meanwhile, by the 1990s, the 'revolution' in health insurance, which ensued when Health Maintenance Organizations (HMOs) began to expand as a competing institutional form to the still predominant indemnity insurers, further deepened this corporate transformation that was taking place. The transformation taking place in the hospital and health insurance sectors, however, was not only one of corporatization through the concentration into larger conglomerates. It was also driven to a considerable degree by a new commercial form of organization where investment capital, acquired through independent financers or through public listing to bankroll these emergent corporation's strategic growth, were becoming a commonplace feature in the post-1970s US healthcare services market.

---

[80] This included construction firms, pharmaceuticals supply, hospital equipment and supplies, information systems and communications.

[81] Particularly *Blue Cross* and *Blue Shield*, as well as the commercial insurance firms, whether those focused on health insurance or offering health insurance as part of a broader insurance market.

5.2. Commercial transformation in the hospital sector

The first major change came shortly after the introduction of the Medicare and Medicaid programmes, as the proprietary (for-profit) hospitals began to rapidly consolidate from a large number of small independent physician-owned entities into a relatively small number of large hospital chains (Steinwald & Neuhauser, 1970; Bays, 1983b). The chain concept was by no means new,[82] but the key difference was how this transformed the nature of the for-profit hospital in its management and source of funds. Excluded from the tax-exemptions that were enjoyed by the non-profit sector, corporate concentration was in many respects a business strategy to make the most of newly available public spending through Medicare/Medicaid. But also excluded from access to Hill-Burton funds it was, furthermore, a strategy for attracting capital investment funding from investor groups.

The *Hospital Corporation of America* (HCA) is the archetypal example of this first wave of hospital mergers. Established in the mid-1960s in Nashville Tennessee as a 50-bed acute care facility, its founders sought to create a chain of hospitals in a similar vein to the Holiday Inn hotel chain, buying supplies in bulk and raising money from Wall Street investors as a national corporation (Geyman, 2004, p.23). The 1965 public funding programmes proved ideal for such a new venture, particularly as their payment criteria did not bar proprietary hospitals from access to this source of funding. HCA expanded considerably over the next few years buying out small proprietary hospitals, and rapidly becoming the market leader for several years operating 50 hospitals by 1973 and 376 by 1983 (Lutz & Gee, 1998).[83]

Another hospital chain firm, *National Medical Enterprises* (NME) also developed a large network of hospitals. Incorporated in 1968, NME acquired its first hospitals in California in 1969 (four general and three convalescent facilities) and offered public stock. Cost management and physician input techniques became part of NME's trademark features as it concentrated on building services around community hospitals over the next few years. Having already developed diversified aspects of the business,[84] during the early 1970s, it focused on growth mainly through the building

---

[82] Catholic hospitals and other non-profit and VA hospitals were also frequently organised as chains (Steinwald & Neuhauser, 1970, p.832).
[83] It should be noted that while these figures include the full number of hospitals that HCA operated, it only owned half of these, while managing the rest.
[84] This included hospital equipment and supplies, a hospital-consulting firm, and even a construction company that specialized in building hospitals (Eamer, 1989).

of new facilities and through some purchases of existing hospitals, soon expanding outside of its California base to surrounding states (Eamer, 1989). A first wave of concentration thus revolved largely around acquisition of individual hospitals and the construction of new facilities, amounting to what was for the most part a geographically proximate corporate expansion and rationalisation. Nonetheless, these emergent healthcare corporations began to show aspirations for establishing market presence beyond their headquartered regions, and national market presence became an important objective for several for-profit hospital corporations.

5.2.1. Expansion and market concentration in the 1980s

On the whole, the majority of chain proprietary hospitals in this first wave of concentration posed relatively little anti-competitive threat to the bulk of non-profit hospitals, having only one unit in most cases in each market where they were present (Reardon & Reardon, 1995; Dranove, 2000, p.116). The non-profit hospital sector had gained much market strength since the interwar years, particularly with the success of indemnity insurers like Blue Cross, but also with tax exemptions encouraging the expansion of non-profit hospitals. The generous public capital investment from Hill-Burton after 1945 and the inclusion of capital costs in Medicare were especially important factors that helped to place non-profit hospitals in the lead for most of the post-WWII decades. By the mid-1980s, however, few could mistake the fact that corporate hospital chains were fundamentally changing the structure of the market and that proprietary hospitals could no longer be regarded as mere transitional entities with only secondary position vis-à-vis non-profit hospitals (Reardon & Reardon, 1995; Stevens, 1999).[85] The 1980s saw the concentration trend develop further, as some of the largest chain groups had grown considerably in scale and market share throughout the 1970s. By 1987, *HCA* had become the largest for-profit hospital chain in the US, owning almost 200 acute-care facilities across 28 states and a further 45 facilities in eight other countries (Geyman, 2004, p.23); while *NME* had become the fourth largest investor-owned hospital chain in the US, with the majority of its revenues coming from acute-care hospitals (Eamer, 1989).

[85] This earlier 'transitional' nature of proprietary hospitals is attested by the massive reduction of what were basically small physician-owned facilities that were originally set up to fill the gap, largely in areas that were underserved or where hospitals were absent. By the 1930s, with the growth of non-profit institutions, many of these actually sought conversion to non-profit status, largely due to the economic advantages offered by tax-exemptions for charities, but also in view of the deep antipathy for 'for-profit' medicine held by the majority of the medical profession, and informally sanctioned through the medical associations.

But the 1980s also saw a substantial reduction in the scale of the hospital sector overall. While the hospital sector was (and still is) by far the largest sector of the health care industry (fig 5.3), and although the growth rate in hospital expenditures increased rapidly in the 1980s (Stevens, 1999), the total number of community hospitals in the US declined from 5,830 in 1980, to 5,194 in 1995, and 4.915 in 2000 (Table 5.3).[86] This trend is also reflected in the decline in number of community hospital beds and beds per 1,000 of population, going down to 988,287 hospital beds in 1980, and continuing declining so that by 1995 there were only 871,976 reduced further to 823,560 hospitals beds by 2000 (a total decrease of 17%), which corresponds to only 2.9 hospital beds per 1000 people in 2005, down from 4.3 beds in 1980 (Table 5.4). The contraction of the hospital sector had a great deal to do with the massive growth in costs which brought pressure to control them involving a strategy to reduce hospital length of stay, leaving many facilities with unused bed capacity. In these changing market conditions, between the late 1970s and late-1980s, hospital chains sought to diversify their activities outside of the acute and community hospital sector. *NME's* hospital management expertise was already being hired out from the late-1970s to non-*NME* owned hospitals both within the US and in some facilities outside the US (Eamer, 1989).[87] It also began to shift focus from acute-care hospitals to nursing homes, acquiring the rival *National Health Enterprises* (NHE) in 1982. This move brought an additional 66 long-term care facilities into *NME's* ownership and made it the second largest nursing home owner in the early 1980s. Furthermore, it focused on developing its products-and-services segment, including health-care equipment rental for home use and visiting-nurses agencies until Medicare and Medicaid restrictions from the mid-1980s made the latter less lucrative.

Another example is *American Medical International* (AMI), which had emerged from its early days as the first investor-owned healthcare service firm in 1960, and had already been diversifying since the late 1960s. In the early 1980s especially, *AMI* set about rapid growth by acquisition of small hospitals across the country (and internationally) spending $750 million

---

[86]) (American Hospital Association, 2002).
[87] Particularly in Saudi Arabia, helping to develop Saudi hospitals during the 1970s.

between 1980 and 1983 to expand, modernize and diversify its operations.[88] But this strategy proved unsustainable as occupancy rates in *AMI's* hospitals dropped almost 50% by 1986, and in the face of profit losses and potential takeover bids, the company proceeded to divest a significant amount of its hospital stock after 1987, eventually merging with *IMA Holdings Corporation* in 1989 to form *American Medical Holdings*, as the new company continued to divest a number of companies, including many of its international acquisitions.

The non-profit sector was no less affected by declining hospital business. Mergers between non-profit hospitals, as well as between for-profit and non-profit hospitals, were a key development of the 1980s in addition to developments exclusively within the for-profit field (Stevens, 1999). While policy makers began to relax the antitrust specifications that had previously been a barrier to major concentration trend, many of the mergers that came in this period involved the acquisition of more profitable entities by larger firms (Dor & Friedman, 1994). This was despite the claim by many hospital providers that acquisitions and mergers were simply a strategy for survival in a declining hospital sector. That is not to underplay the significance of the decline, since many hospitals began to face the challenge of the cost-control agenda that was emerging at this time in Federal public policy for the health sector (Marmor, 1998). This was particularly so after the introduction of Medicare Prospective Payer System (PPS) in 1982, when reimbursement according to Diagnosis-Related Groups (DRGs) for Medicare patients and the growth in managed care began to undercut the economies of cost-plus billing that had been a key pillar of hospital profitability (Kuttner, 1996a, p.363). The changing regulatory and market situation became a stimulus for a second wave of corporate transformation as concentration accelerated along with the massive growth in scale of large for-profit chains, their increase in market power and new strategies employed to retain and/or increase profitability.

The most (in)famous example was the merger of *HCA* and *Columbia*, by which the merged company came to own and control over half the entire for-profit hospital stock in the country (Kuttner, 1996a). *Columbia* was one of the main hospital market giants to emerge in the late-1980s. Formed in 1987, *Columbia Healthcare Corporation* began with the acquisition of two hospitals in

---

[88] AMI's origins are in an independent medical reference laboratory (Medlabs) that contracted with Los Angeles-area hospitals. After buying a failing hospital in 1960 it went public, changing its name to American Laboratories and engaged in a number of acquisitions over the next few years. Renamed American Medical Enterprises in 1965 after it began to diversify into pharmacies, medical supplies, and further acquisitions of hospitals, of which a notable case is its acquisition of London's Harley Street Clinic in 1969 (Griffith, Illife & Rayner, 1987).

Texas, and soon formed a partnership with a group of physician investors (*El Paso Healthcare System, Ltd*. (EPHS)). This marked the beginning of a series of acquisitions of medical/surgical centres and hospitals in a rapid consolidation of the Texas market over the next three years and establishing a full-service network, while creating limited partnerships with physician investors. By 1993, *Columbia* had broadened its scope to 19 other states with the acquisition of *Galen Health Care* (formerly under the *Humana* hospital management group), quadrupling its total number of hospitals, and increasing its revenues to over $5 billion (Lutz & Gee, 1998).

Meanwhile *HCA* had gone through a period of divestment of much of its hospital stock during the mid-1980s following the decline in bed occupancy and increased pressures placed on its profitability by state and federal cost-control regulations. Another key example was the controversy that followed from *NME's* overcharging, fraudulent and illegal billing practices, particularly in its psychiatric units.[89] The negative publicity that followed led *NME* to divest most of its psychiatric stock (selling 71 of its 81 psychiatric units) partly to offset the cost of court settlements and re-brand itself as *Tenet*.

5.2.2. Structural change in the 1990s

Concentration into systems increased considerably in the 1990s as the share of patient care in hospital systems vis-à-vis independent hospitals rose from 39% to 57% between 1991 and 1999 (Andrews, 2005). In this period, hospital concentration developed as much among non-profits, as amongst proprietary hospitals, as competition increased considerably not only between for-profit institutions but also between for-profits and non-profits. Indeed, as community hospital numbers were in decline, a number of hospitals were being absorbed into multi-institutional systems. Where 1,579 hospitals nationally could be found in such systems in 1985, by 1999 the number of hospitals absorbed into larger groups had grown by just over a third to 2,238 (Table 5.3; see above). A crucial impetus for the competitive environment was an announcement in 1993 by the Federal Trade Commission and Department of Justice issuing guidelines that effectively encouraged hospital mergers and acquisitions with the view that they were not necessarily anti-competitive (Andrews, 2005).

---

[89] Specifically, NME was fined $379 million 1994 on criminal charges by the Justice Department and the Department of Health and Human Services (after a court case brought in 1991, which started a chain of 130 suits against NME over the next three years) that its psychiatric hospitals had paid for referrals and kept patients incarcerated until their insurance ran out (Myerson, 1994; Kuttner, 1996a, p. 363).

While not completely removing the anti-trust edifice upon which government regulation of the healthcare sector had been built (Havighurst, 2001), it did relax it considerably based upon the premise that, as with the first wave of hospital consolidations, most hospital chains did not pose a substantial anti-competitive threat in local markets. Nonetheless, the evidence of actors such as *Columbia/HCA* and *NME (Tenet)* serve as examples that competitive (or anti-competitive) behaviour frequently took place in a way other than simply local market penetration. While cases such as these represent the pinnacle of corporate for-profit ownership and its consequences for market structure, the great bulk of healthcare groups are much smaller in terms of their portfolio and impact on national and local market share. Antitrust cases have been brought against several other hospital groups over the years. Yet, this also highlights the geographic dispersion of the healthcare market across the 50 US states and their respective legislative procedures where antitrust regulations are actually enforced.

By the late-1990s a third period in structural transformation of the hospital sector had been taking place, which involved the more open targeting of non-profit hospitals and by the early 2000s a trend of for-profit conversion of non-profit hospitals seeking means to survive in a competitive market.[90] At this point, the investor role continued to be an important source of finance as non-profit hospital providers sought to bolster their waning fortunes in times of increased purchaser activism in the face of rising costs of insurance subscriptions (Robinson, 2000 & 2002a). The major hospital systems that had consolidated over the previous three decades continued with renewed acquisitions, although at this stage the hospital sector has already declined considerably in face of a shift towards home care and primary care that has resulted from longer-term market changes and public policies. Nonetheless, by 2000 80% of hospitals were part of multi-hospital systems (Bodenheimer & Grumbach, 2005, p. 171).

5.3. Health Insurance and the rise of Managed Care

The changes described regarding the hospitals sector cannot be abstracted from important developments in the health insurance market - still the primary source of funding for hospitals after the introduction of Medicare and Medicaid - where a profound shift took place after the 1970s.

---

[90] A somewhat eerie echo of the developments in the hospital sector in the early 20th century but in reverse, although this may be to oversimplify the most recent trend

Indemnity insurers had been criticised heavily for reimbursing hospital fees without adequate control over expenditure (Patel & Rushefsky, 2006). This was beginning to be an issue as much for employers experiencing increasing subscription premiums as for the public sector programmes which were spending rapidly increasing amounts after 1965 to pay for hospital reimbursement. In 1973 the Health Maintenance Organization Act (HMO Act) was passed, encouraging the conversion of health insurance plans to HMOs or the setting up of new ones in order to stimulate competition in the insurance sector. The HMO Act was part of a number of 'pro-competitive' policy strategies being introduced from the 1970s by the Federal government to induce cost control in healthcare provision (Marmor, 1998).

For most of the 1970s, HMOs did not in fact grow as rapidly as expected with poor rates of enrolment and take-up by employers (Enthoven, 1993). On the other hand this was a formative period for what would become a dominant organizational form for managing and organizing healthcare services consumption two decades later. By the early-1990s the HMO 'revolution' became much more visible particularly as the 1980s were a decade of both high healthcare prices and changes in public policy that sought much more stringent controls on costs. From analysis of the managed care market in the early 2000s significant growth in numbers of HMOs and also in the numbers of people enrolled under such schemes were reported between the mid-1980s and mid-1990s. Where in 1984 there were only 337 HMOs with 17 million enrolees by 1988, there were 31 million members enrolled in 643 HMOs and by 1996 there were more than 50 million managed care enrolees (Estes, 2001). To give a better picture of the scale of the pervasiveness of managed care, nearly 75% of U.S. workers with health insurance received that coverage through an HMO, a PPO, or a point of service plan (PSP) by this time (ibid).

Interestingly, the 1973 HMO Act actually stipulated that HMOs would be non-profit institutions. Though there may have been a premonition of the consequences for moral hazard in having for-profit institutions to control costs, the simple fact was that the majority of insurance firms with the possibility of becoming HMOs were non-profit institutions in the early 1970s. However, by the late-1980s, the health insurance sector had taken a definitive swing towards an increase in for-profit institutions gaining significant market share. For-profit conversion increased considerably during the 1990s. For-profit institutions, which already owned 35-40% of health care services and facilities in 1990 continued to expand over the next decade so that nine out of the ten

largest HMOs were for-profit institutions by the mid-1990s (Relman, 1992[91] cited in Bodenheimer & Grumbach, 2005, p.172; Zelman, 1996).The consolidation of most of the larger insurers, more aggressive selective contracting, and an increased rate of conversion to for-profit status, so that 'by the mid-1990s, there were more for-profit HMOs than not-for-profits' and after a period of intense competition, mergers and consolidation a relatively small number of large and mostly non-profit HMOs covered over 80 million people (Geyman, 2004, pp. 38-39). Most notable was the consolidation activity amongst health maintenance organizations (HMOs), as larger ones bought out numerous smaller competitors and/or merged with other large conglomerates. By the late-1990s six HMOs controlled around 40% of the market (Bodenheimer & Grumbach, 2005, p. 171), amongst which were some of the largest companies in the country by revenues and, as indicated in the last chapter, a number of the largest 500 companies in the world by revenues: *Aetna, Cigna, United HealthCare, Foundation Health Systems, Pacificare, and Wellpoint Health Networks.*

5.4. The commercial transformation of American healthcare

While the 1965 Medicare and Medicaid programmes were an important turning point in expanding the role of government in healthcare financing, the transformation of the US healthcare services sector has been a process that has developed through a series of often contradictory public policies that have sought, in various ways and to various degrees, to address the tensions that emerged after 1965 in the financing and delivery of healthcare. As public financing mushroomed dramatically after 1965, with the share of public spending on health historically remaining at less than 46% of total expenditure on health (Table 5.1), one of the biggest issues has been the ever growing total expenditure on healthcare, which had already reached 7.2% of GDP in 1970 (up from 5.2% in 1960), and has grown incredibly to 12.3% in 1990 and already in excess of 15% since 2002 (Figure 5.4). The public share of this rising expenditure was the biggest cause for concern, particularly as the post-WWII era of economic growth and prosperity that had been an essential element in the expansion of both public financing and of private employer-based health insurance.

Direct financing has also been supplemented through tax exemptions for health insurance and non-profit hospitals, contributing about $25 billion more in 1982 (Himmelstein & Woolhandler, 1984, p.18), while tax exemptions for health insurance in 1995 reached $45 billion (Howard, 1997, p.28). These figures are not easy to pin down in the same way that for instance public expenditures

[91] Relman, A.S. (1992), *The choices for healthcare reform*, Pennsylvania Blue Shield Institute.

are recorded, however they reveal a significant aspect of the overall public contribution to healthcare that is not typically accounted for in either national healthcare expenditure accounts, and for this reason nor do they feature in international comparative assessments of the US public outlay for healthcare. Howard points out the relevance of tax exemptions as 'the exclusion of employer's contributions for health insurance premiums from corporate income taxation is a huge subsidy', which together with the tax expenditure for employer pensions constitute the largest single components of the '*hidden welfare state*' (Howard, 1997, pp. 28-29).[92]

The key to this point is that for-profit hospitals were excluded from access to the same kind of public sources of finance. While tax subsidies have benefited non-profit private hospitals, particularly in the post-WWII years, for-profit hospitals were obliged to look elsewhere for covering capital costs. While in receipt of Federal payments channelled through MCOs and other insurers, capital costs were to a large extent derived from private investors and shareholders for those for-profit hospitals that were publicly listed. As indicated in the earlier examples of hospital providers, investment capital helped support the expansion of several of the larger for-profit groups. Adding to this situation, the elimination of indirect subsidies and tax exemptions in the late 1970s and early 1980s, compounded by reductions in both Medicare and Medicaid payments as part of a more general Federal cost-containment strategy brought many non-profit hospitals into a position of reduced revenue flows. Several of these hospitals were pushed towards for-profit conversion and in many cases absorption into larger for-profit groups (Himmelstein & Woolhandler 1984, p.20).

Compounding this situation, the promotion of DRG-based payment would mean that hospitals could no longer benefit from 'cost-plus' financing, with a fixed lump sum determined by the patient's diagnosis instead, so that for the first time, hospitals would profit by providing fewer services to each patient. (Himmelstein & Woolhandler, 1984). Even so, the for-profit conversion of hospitals has actually been somewhat limited compared, for instance, to the insurance sector. Throughout the early to mid-1990s, over 100 non-profit hospitals were taken over by for-profit chains, of which Columbia/HCA for instance, itself the product of an earlier merger of two major HMOs, was particularly effective at buying out its small competitors (Bodenheimer & Grumbach, 2006, p.172). Non-profit status has continued to remain strong in the private hospital sector, mainly

[92] Tax exemptions for both insurance and pensions enable employers to write off the costs of providing benefits to workers as a business expense.

due to intense community resistance to for-profit conversion. As such, there is in fact a pattern of hostile competition between non-profit and for-profit hospitals which is often overlooked in publications that focus solely on the for-profit conversion aspect (Wells, 2000, p. 643). Even so, the process of for-profit conversion is not an inevitable situation, particularly as non-profit hospitals may opt for retaining their ties with their local communities where key stakeholders in their organizational structure may place these interests above acquisition of investment capital (Cutler & Horwitz, 2000).

One key trend is that the payers (insurers) are the ones that are increasingly holding economic power in the financing-provision nexus. By controlling a key source of income for hospitals, large MCOs with extensive market share such as *Aetna*, *Humana*, and *Cigna* are able to set the terms on pricing. This scenario points to a double-sided relationship in the concentration process witnessed amongst both hospitals and health insurance firms. The emergence of preferred provider networks during the 1990s as a mechanism for MCOs to be selective over health service providers offering services at lower cost has been a major factor in shaping the dynamic of the US private healthcare service market. With the concentration of payers (each in their respective geographic market niches) and their power to determine the terms of payment, particularly smaller hospitals (in terms of bed numbers) have also been pushed to rationalise their activity (i.e. reductions in bed numbers and buildings) and in some cases to merge with larger multi-institutional hospital systems (Robinson, 1999; Cutler *ed*, 2000). Thus integration may be a strategy in many cases for survival in a market with high uncertainties stemming from reduced public cash flows relating to changing regulatory conditions (i.e. changes in Medicare and Medicaid conditions for payment), as much as a product of commercial expansionism in the search of increasing profit margins.

5.5. Internationalisation of commercial healthcare services

Several of the larger hospital groups demonstrated international expansionary strategies over the years, although as shown in Chapter 4 some of these did not gain long-term success in overseas ventures. For several hospital firms, international expansion started with a handful of contracts in Middle Eastern countries to develop healthcare provision serving US military bases located in these countries during the early-1970s. This initial penetration soon expanded into contracts to build and manage facilities with the host states since these countries had little experience with modern hospitals and medical care services (Berliner & Regan, 1987). Many of these contracts were made available to American for-profit hospital companies, though as these countries began to develop their own capacity of (often US-trained) managers and develop their own building industries, these

contracts began to dry up. Lack of funds in the post-oil crisis era and political instability in the region at the time also led to contract terminations, though as Berliner and Regan have noted, 'the experience that the companies acquired in building and managing hospitals in the Middle Eastern countries was certainly a positive incentive to expand such operations' (1987, p.1281).

Entry into several European countries followed as next steps in a search for overseas opportunities, with US hospital chains able to establish a distinct niche within the European market largely focused on high-tech services and high amenity hospitals, particularly in countries which presented limited or weak domestic competition. A particular example for this was the UK, where several US for-profit chains established their market presence since *AMI's* acquisition of London's Harley St. Clinic, and the subsequent penetration by *HCA* and *Humana* with a small but steadily growing portion of the UK market throughout the 1980s (Mohan, 1991).

It is interesting to compare the incentives for internationalisation at this time compared with the incentives in later decades, particularly the 1990s when the big 'boom' in overseas markets began to take place amongst HMOs. By the 1990s, several of the internationalising hospital chains had begun to withdraw from their overseas ventures. Instead some HMOs began to invest more actively in overseas markets, particularly in several Latin American countries where MCOs *Humana* and *United Health,* for instance, have established strategic partnerships with private investment consortia. The fate of HMOs overseas however has been variable also, despite a greater capacity for insurance firms to find markets in covering overseas patients and corporate clients consisting of US multinational employers in different national locations (Wells, 2000).

5.6. Concluding Remarks

In this chapter I have been examining historical trends in the emergence of commercial healthcare services in the US. In doing so, I have been looking at the nationally specific conditions for the emergence of commercial (for-profit) forms of healthcare provision in the US as a point of reflection vis-à-vis other OECD countries and particularly the UK case, which I analyse in the following chapter. Indeed, a key general observation from this chapter is that although the US diverged considerably from many other OECD countries - particularly those of Western Europe - in developing a more socialized healthcare system, the commercial transformation in private healthcare services was, to a large extent, an indirect outcome of Federal public policy for healthcare reform.

Having gained momentum by the late 1970s, the commercial transformation rapidly came to define and shape the structure of the US healthcare system, becoming an embedded feature of the political economy of healthcare policy over the coming decades. Attempts by the Federal government over the past three decades to contain growing costs of healthcare - in part associated with this corporate for-profit growth pattern, by introducing mechanisms for controlling growing hospital costs through market-based principles, without addressing the fundamental imbalances in the system, particularly the ever growing problems of un-insurance and under-insurance – have, in a number of ways, been instrumental in maintaining the corporate for-profit element in the hospital and health insurance sectors.

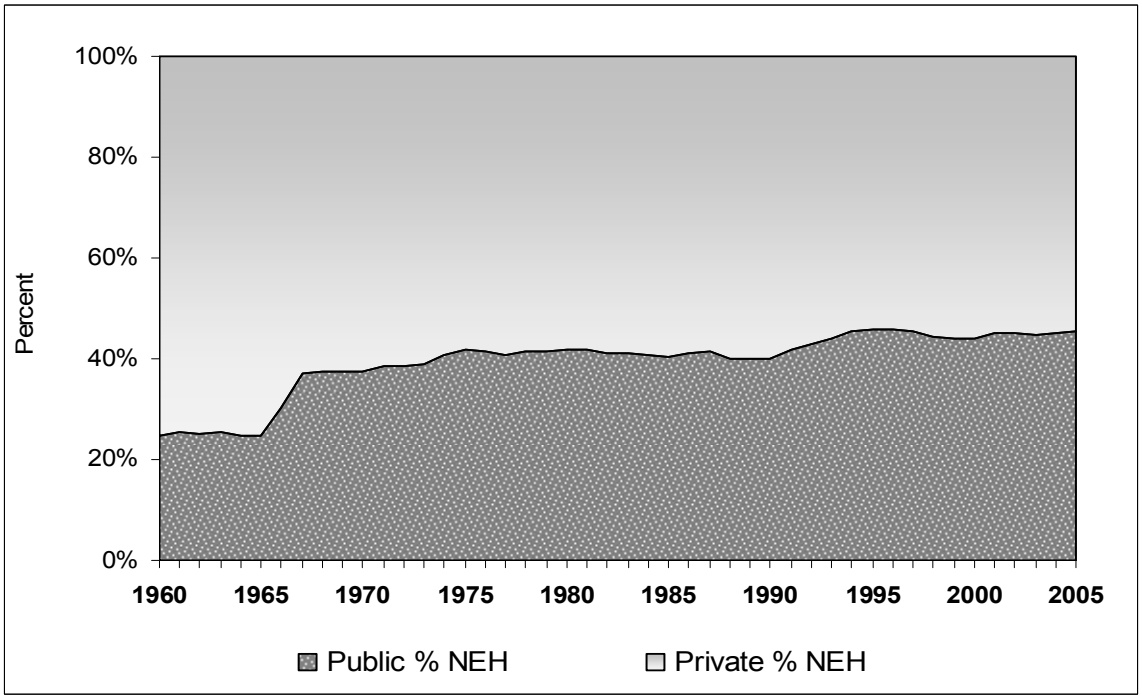
Compared to most other OECD countries the US can be seen as a 'net-exporter' of healthcare services as several large corporations have, over the years, sought to enter overseas markets. The latter trend can be explained in terms of the market conditions within the US but also in terms of the capacity of large commercial entities already used to acquiring capital finance for the development of market share in their domestic market. How such international market expansion is articulated in the overseas markets is reflected on through examination of commercial transformation in the UK's private hospital and insurance sectors in the following chapter.

Table 5.1: National Expenditure on Health (NEH) by source of funds in $USD (bill) and as percent of NEH by source of funding: (selected calendar years) 1960-2005

NEH	1960	1965	1970	1975	1980	1985	1990	1995	2000	2005
$bill										
Total	27.5	42.2	74.9	133.1	253.4	439.3	714.0	1,016.5	1,353.6	1,973.3
Private	20.7	31.7	46.8	77.2	147.0	261.9	427.3	551.7	757.0	1,076.6
Public	6.8	10.5	28.1	55.9	106.3	177.4	286.7	464.8	596.6	896.8
%										
Private	75.3	75.1	62.5	58.0	58.0	59.6	59.8	54.3	55.9	54.6
Public	24.7	24.9	37.5	42.0	41.9	40.4	40.2	45.7	44.1	45.4

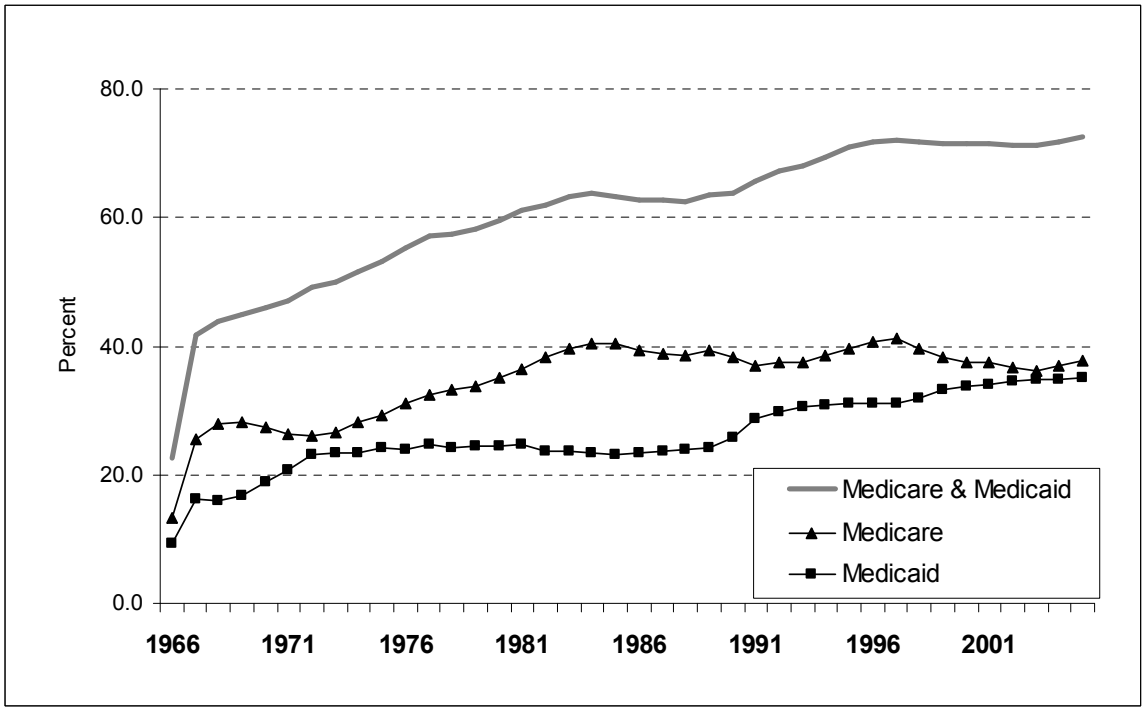
Source: Centres for Medicare & Medicaid (2006)

Figure 5.1: Public and Private Share of Spending on Healthcare in the USA: 1960-2005



Source: Centres for Medicare and Medicaid (2006)

Figure 5.2: Medicare and Medicaid expenditure as a percentage of public expenditure: 1966-2005



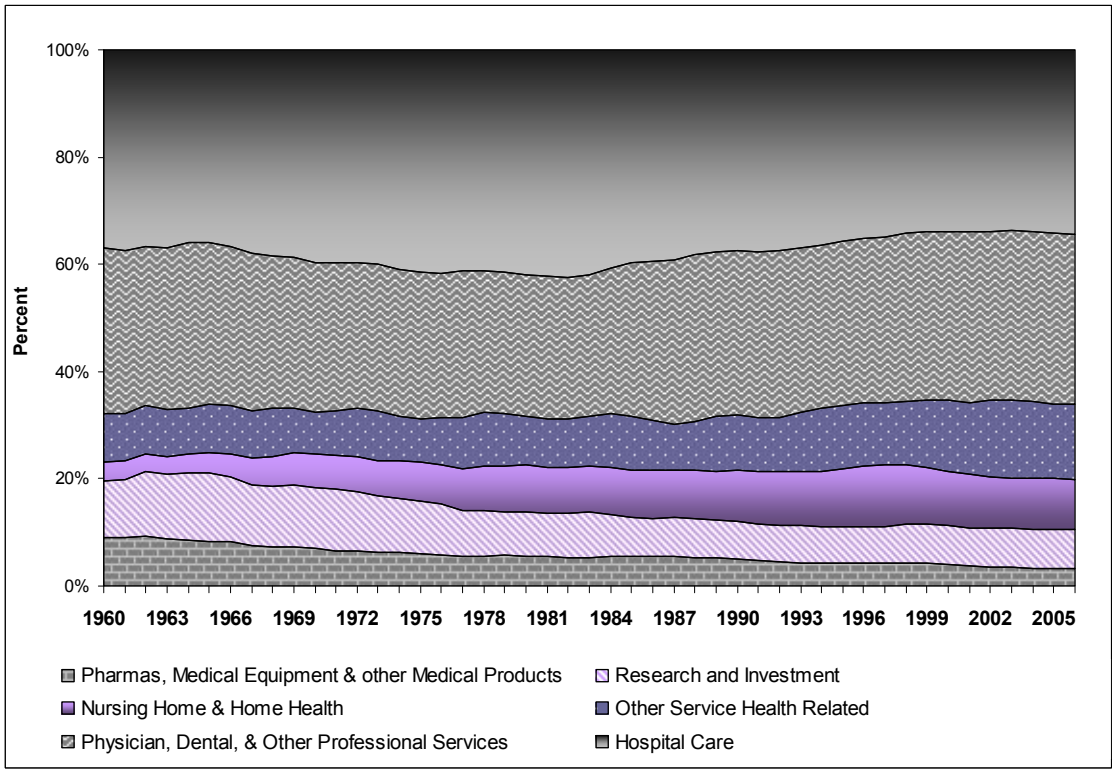
Source: CMS (2006)

Table 5.2: Medicare and Medicaid expenditure ($mill and percentages of National, Public, Federal and State/Local expenditure) over 5 year intervals: 1966-2005

	1966	1970	1975	1980	1985	1990	1995	2000	2005
NEH									
Total ($mill)	**46,430**	**74,894**	**133,126**	**253,365**	**439,275**	**714,011**	**1,016,497**	**1,353,593**	**1,973,340**
Public	13,939	28,132	55,901	106,344	177,353	286,696	464,819	596,577	896,789
Federal	7,588	17,740	36,352	71,555	123,048	193,852	327,284	417,552	639,099
State & Local	6,351	10,391	19,549	34,789	54,306	92,844	137,535	179,026	257,691
MEDICARE									
Total ($mill)	**1,842**	**7,672**	**16,336**	**37,180**	**71,444**	**109,504**	**184,393**	**224,360**	**338,020**
% NEH	4.0	10.2	12.3	14.7	16.3	15.3	18.1	16.6	17.1
% Public	13.2	27.3	29.2	35.0	40.3	38.2	39.7	37.6	37.7
% Federal	24.3	43.2	44.9	52.0	58.1	56.5	56.3	53.7	52.9
MEDICAID (*)									
Total ($mill)	**1,304**	**5,289**	**13,446**	**26,032**	**40,937**	**73,661**	**144,862**	**201,595**	**313,489**
% NEH	2.8	7.1	10.1	10.3	9.3	10.3	14.3	14.9	15.9
% Public	9.4	18.8	24.1	24.5	23.1	25.7	31.2	33.8	35.0
% Federal & State/ Local	18.9	39.6	51.3	53.4	52.1	55.5	69.0	74.9	80.2
MEDICARE & MEDICAID									
TOTAL ($mill)	**3,146**	**12,961**	**29,782**	**63,212**	**112,381**	**183,165**	**329,255**	**425,955**	**651,509**
% NEH	6.8	17.3	22.4	24.9	25.6	25.7	32.4	31.5	33.0
% Public	22.6	46.1	53.3	59.4	63.4	63.9	70.8	71.4	72.6

Notes: (*) Includes Federal and State/Local expenditure; Also Medicaid (Title XIX) figures include SCHIP (title XIX) expansion after 1998
Source: CMS (2006)

Figure 5.3: Share of national expenditure on health by category: 1960-2005



Source: CMS (2006)

Table 5.3: Number of community hospitals (i): 1980-2000

Year	All Hospitals	In Health System (ii)
1980	5,830	-
1981	5,813	-
1982	5,801	-
1983	5,783	-
1984	5,759	-
1985	5,732	1,579
1986	5,678	1,735
1987	5,611	1,781
1988	5,533	1,857
1989	5,455	1,835
1990	5,384	1,822
1991	5,342	1,827
1992	5,292	1,814
1993	5,261	1,829
1994	5,229	1,956
1995	5,194	1,990
1996	5,134	2,058
1997	5,057	2,222
1998	5,015	2,176
1999	4,956	2,238
2000	4,915	2,217

Notes: (i) All non federal, short-term general, and special hospitals whose facilities and services are available to the public; (ii) Hospitals that are part of a corporate body that may own and/or manage health provider facilities or health-related subsidiaries as well as non-health-related facilities including freestanding and/or subsidiary corporations; (-) Data not available.

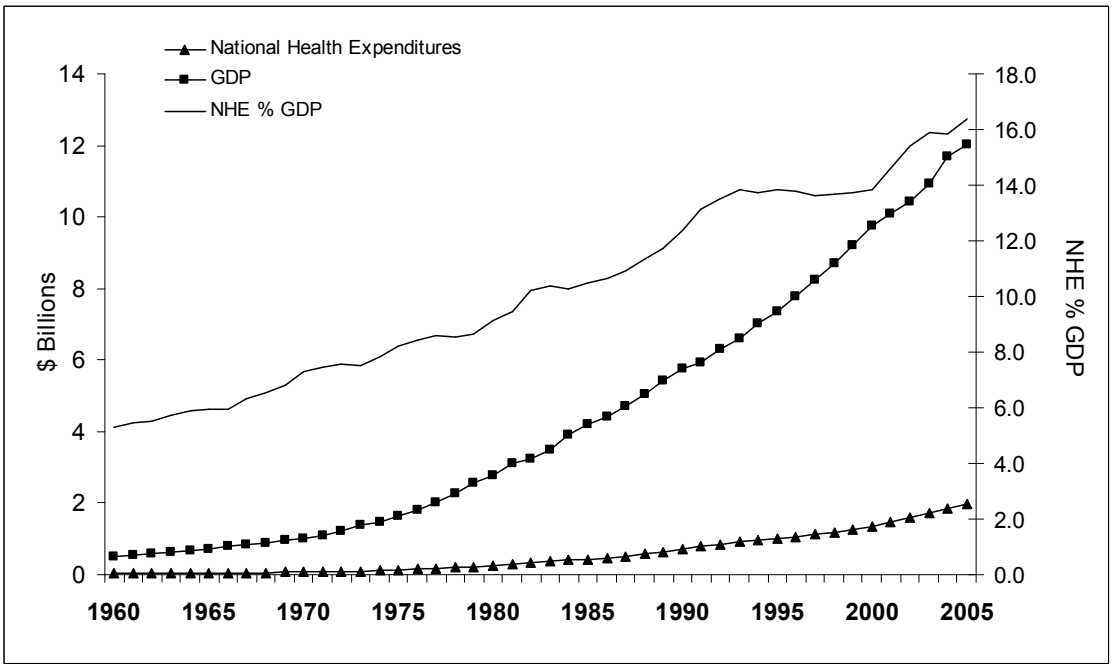
Source: American Hospital Association (2002)

Table 5.4: Number of beds and number of beds per 1000 people: 1980-2000

Year	Number of Beds	Beds per 1,000
1980	988,287	4.36
1981	1,001,801	4.37
1982	1,011,989	4.37
1983	1,018,452	4.36
1984	1,016,987	4.31
1985	1,000,598	4.21
1986	978,283	4.07
1987	956,529	3.95
1988	944,276	3.86
1989	932,185	3.78
1990	926,436	3.72
1991	922,822	3.66
1992	919,505	3.61
1993	917,847	3.56
1994	901,056	3.46
1995	871,976	3.32
1996	862,352	3.25
1997	853,287	3.19
1998	839,988	3.11
1999	829,575	3.04
2000	823,560	2.93

Source: American Hospital Association (2002)

Figure 5.4: National Expenditure on Health trends ($USD bill and as percentage of GDP), selected years: 1960-2005



Source: Centres for Medicare and Medicaid (2006)

Chapter 6: Towards the Global Market: Transformation of the UK's Private Healthcare Services Sector

At first glance, the UK's private healthcare services sector seems rather diminutive compared to the extensive network of commercial providers and insurers in the United States. The differences are not just apparent in terms of scale, but also in terms of the degree to which commercial (for-profit) healthcare is embedded in the political economic structure of the two countries' healthcare systems. While commercial healthcare services in the US have grown out of a system heavily oriented towards a market-based mode of organization, even as increasing Federal and State intervention contributed to a growing public sector role in the US healthcare system, the dominance of the public sector NHS in the UK's healthcare service landscape - coupled with the preponderance of a public and largely tax-based system to finance it - has tended to overshadow the role played by the private sector in the post-WWII era. Yet, over time, the UK's private sector has grown considerably in size and in recent years has begun to absorb a growing share of the UK's healthcare services market. This has been the case particularly as public policy has begun to overtly pursue a role for the private sector in the country's healthcare mix.

In this chapter I focus on the development of the UK's private acute hospital and insurance sectors to gain a picture of the changing market structure since they began to break with their post-war residual market position in the late-1970s. The significance of this juncture is that it is closely linked to the entrance of the first foreign-owned healthcare service firms in the UK market. The chapter looks at the reconstitution of the private sector following this juncture, while focusing in greater detail on its development during the 1990s and into the mid-2000s. In doing so, I seek to understand the relationship between public policy for healthcare services and changes in the private healthcare services market structure in the UK as a contrasting case study to my analysis in the previous chapter of this relationship in the US. As such, I analyse key mechanisms that have been important in the commercial transformation of the private sector during this time. What emerges from this analysis is the importance of public policy in laying the ground for expansion of the private sector, whereby an initially *accommodatory* and later more overtly *pro-competitive* policy

context have been the backdrop against which intra-private sector competition has gradually resulted in a more commercial and, moreover, more internationalised market structure.

The first section of the chapter briefly situates the emergence of a commercial private healthcare services sector within the context of the UK's post-WWII mixed economy of healthcare. In this section I also elaborate on the key juncture of the late 1970s for the ensuing commercial transformation of the sector. In the following section (6.2) I look more closely at developments in the 1990s, pinpointing key mechanisms in the changing structure of the private market. This is followed (section 6.3) with an analysis of more recent developments between the late 1990s and mid-2000s, noting the transformation not only in the structure of the private sector, but also in its relationship to public policy for healthcare services. Section 6.4 looks more closely at the 'new' mixed economy of care in which private provision has become an increasingly important component of total healthcare service production, with considerable assistance from a change in the public sector contracting regime. I conclude the chapter with a brief reflection (section 6.5) on the significance of the developments analysed in the chapter in terms of the relationship between internationalising healthcare services and the commercial transformation witnessed in the UK's private hospital and medical insurance sectors.

6.1. The private sector in an era of accommodation

After 1948 the private provision of healthcare services assumed a complementary position in relation to the newly established public NHS. As a result of absorption of the majority of the country's hospitals into the public sector, the NHS established a near monopoly of healthcare provision. It substituted what had previously been a rather fragmented system of charities and voluntary hospitals, private medical clubs, occupational medical services and works clubs, fee-for-service insurance, friendly societies, as well as subscription-funded public medical services, and *ad hoc* medical fee payment (Doyle & Bull, 2000; Rivett, 1998). The 1946 NHS Act brought the bulk of the country's hospital stock (including acute, mental and elderly care facilities) into public ownership. In addition, the 1946 Act brought the vast majority of general practitioners into a public service contract, ensured the coverage of most dental, opthalmological services and medical prescriptions through public taxation, combined with national insurance contributions (a form of hypothecated taxation). Thus, a healthcare system was created that would be free at the point of use and guaranteeing, as much as possible, universal and equitable coverage, even while substantial elements of the system remained outside state ownership (Mencher, 1967; Rivett, 1998).

The result of the establishment of the NHS was a healthcare system in which the state would be responsible for the vast majority of overall health expenditure, a trend that has persisted into the 21st century (as shown in Table 6.1). But though the NHS still accounts for the bulk of the country's total expenditure on healthcare there has been a slight decline over the years in the public share of this expenditure, marking to some degree a growth in private consumption of healthcare services and products. Indeed, from a mere 2.4% of total health expenditure accounted for by private health and medical insurance products in 1975, by the early 2000s this source of funding has come to account for over 7% of total health expenditure. Coupled with personal expenditure on medical products, total private spending (including PMI and OOP payments) has almost doubled over the same period from 7.4% in 1975 to 14.3% in 2004 (Table 6.1).

Nonetheless, in the immediate post-war years the private healthcare services sector was very much in a marginalised position. It consisted primarily of the private acute hospitals that were not nationalized with a closely linked private medical insurance sector. Out of over 2000 hospitals across the UK in 1948 about 300, mainly small religious charity-based units, remained outside the national scheme. This residual number of private hospitals consisted of mainly small-scale units - of less than 50 beds and often no more than 20 beds each - mostly based in the mental health sector and elective surgery (Mohan, 1970, pp.3-4). Meanwhile nearly half of private acute provision was actually retained within the NHS structure as NHS 'pay-beds'. This had been part of a key political compromise between the then Labour government and the medical profession (through its various representative bodies) to retain the possibility of private practice, which enabled the NHS Act to come into legislation (Navarro, 1978).

6.1.1. Emergent post-WWII private sector

While the creation of the NHS essentially marginalised the private acute sector - at least for the coming three decades - the latter had already begun to reorganize as a complementary niche sector catering to wealthier members of the population. Such people were willing and able to pay for more rapid access to treatment (and thereby avoid NHS waiting lists), were able to choose the timing of elective surgery, and experienced the greater sense of comfort offered to paying patients with more individualised space (i.e. single-bed wards) with more attentive service, whether perceived or real (Laing, 1992; Calnan, Cant & Gabe, 1993).

In the face of competition from the NHS, both as universal provider and having cornered a substantial portion of the private acute market share, some private hospital providers also began a process of concentration (Higgins 1988); notably the creation of the *Nuffield* network of hospitals which, in the long run, established itself as an undisputed market leader in private acute care.[93] However, private hospital services were only made affordable to most users through the development of private medical insurance, and by the late 1950s, a structured health insurance sector was already taking shape to substitute what had otherwise remained a highly fragmented and often quite unreliable private financing structure (Higgins, 1988).[94] The instigation of the London based *Hospital Services Plan* (later becoming *PPP Healthcare*) and the amalgamation of 89 small scale regional health insurance providers came to form the *British United Provident Association* (BUPA), which formed the financial backbone of private healthcare for the next few decades and eventually, along with *Western Provident Association* (WPA), became the largest private medical insurance (PMI) providers in the UK in subsequent years. Indeed, PMI saw 'a strong underlying increase in the volume of demand (subscriber numbers)' through modest though constant levels of

[93] In the immediate post-WWII years, *Nuffield* had been primarily focused on elderly and disabled long term care (as the *Nuffield Nursing Homes Trust*). But as many other small operators of care homes and acute hospital facilities were finding it hard to continue operating in such an intense climate of competition from the NHS, *Nuffield's* move to concentrate and re-position itself as a key player in the private acute market, initially absorbing smaller providers and, by the upturn in the private hospital market of the late 1970s and early 1980s, to build new facilities (Higgins, 1988). Since that time, despite various reconfigurations in the private acute market, *Nuffield* has retained a leading position amongst the three top private hospital providers in the UK with over 50 hospital and clinical facilities (Laing & Buisson, 2005) (as shown in Table 6.4 later in the chapter).

[94] Until the creation of NHS, many hospitals (including the most prestigious London based clinics) relied heavily on charitable donations, as wealthy patients were could not provide a sufficient source of income to sustain annual costs. Patients without the financial means often had to rely on the altruism of doctors (Higgins, 1988; Rivett, 1998).

growth between the 1950s and early 1970s (Laing & Buisson, 2002, p.169), as depicted in Figure 6.1 below.

While the universal coverage provided through the 1946 NHS Act would now deliver a basis for access to healthcare to a substantial portion of the population (both working class and middle class) that previously could not support or struggled with the financial burden of seeking basic and acute medical services, 'nationalization' itself was not sufficient to eliminate demand for private healthcare. As many hospital consultants retained the right to practice privately, this was matched by a continued demand - at least by those who could and would pay for private consultation and treatment – thereby keeping alive a two-tier system in some areas of healthcare, even while the private aspect of the healthcare mix equation was now considerably diminished (Mencher, 1967). Moreover, though founded as a comprehensive service, the NHS maintained gaps of coverage in certain areas of care. Most notable were long-term care for the elderly and disabled and, to some degree, for mental health services (Rivett, 1998). Primarily the provision of pregnancy termination services - and later fertilization treatment once more commonly available - were areas that notably continued to be offered to a large extent outside of NHS provision (Laing, 1991). Furthermore, disengagement of the need to pay for treatment from access to services could not be maintained comprehensively in the long run in all areas. Soon enough, limited prescription costs began to be levied, including on spectacles, certain dental treatments and on medicines.

Crucially, the lack of an extensive capital investment programme (at least until the 1960s with the *Hospital Plan*) to help fill the geographical and infrastructural gaps of a network of hospitals that was essentially a holdover from the pre-WWII period (Mohan, 1970 & 2002b), meant that supply of clinical services in all specialties was insufficient in the long run. At the same time, increasing utilisation by patients previously effectively disenfranchised from regular access to healthcare services meant that growing demand was soon pushing supply of resources - both infrastructural and financial - to the point where, lengthy waiting lists were an increasingly common feature by the late 1970s. In the event, an ambitious programme for construction of new public hospitals and refurbishment and expansion of existing facilities in 1962, neither succeeded in creating the necessary geographic redistribution of resources to meet all access inequalities, nor arrived in time to stem the expansion of an embryonic post-WWII private hospital sector (Mohan, 2002).

6.1.2. The private sector as a substantive component of the healthcare mix

Private hospital provision experienced an unprecedented (and yet to be superseded) spectacular period of growth between the late 1970s and mid-1980s. It was based around a combination of mutually impacting - though not necessarily causally related - developments. A rapidly growing overseas patient market, based initially on an influx of Arab patients as a result of new oil wealth at the time, was accompanied by a massive, though short-lived, increase in private medical services targeted at overseas patients. This spike in demand was centred on London-based private hospitals such as the Harley Street clinic specialising in cardiac surgery (Rayner, 1984; Laing, 1992, p.13).[95] The NHS-based private sector also benefited considerably from this boom in overseas patients. However, concerned about the implications of a public institution (the NHS) being complicit in two-tier healthcare provision, but more importantly, with the problem of hospital consultants (even if a minority) exploiting NHS resources to support their part-time private practice (within or without the NHS), the 1974-79 Labour government sought to abolish this intra-NHS private provision (Rivett, 1998).

While never fully implemented and eventually reversed under the Conservative government almost immediately after election in 1979,[96] the ban created an environment in which the non-NHS ('independent')[97] private sector anticipated opportunities to develop its market share in the absence of its main private sector rival, NHS pay-beds, which still accounted for over 40% of private acute market share by income until the late 1970s (Table 6.2). The pay-bed abolition policy inadvertently created the stimulus for subsequent expansion of private acute medical services; though some analysts impute a broader stimulus to demand for private sector healthcare relating to already increasing NHS waiting lists (Laing, 1992 & 2002). Between 1979 and 1981, in a period of decreasing public confidence in the NHS and with the newly elected Conservative government in

---

[95] By 1983 the sudden increase in overseas patients from the Middle East had already dissipated, dropping to a mere 398 from 1,699 three years previously (Rayner, 1984).

[96] Only around a quarter of NHS pay beds had been phased out by this time (Laing; 1992; Mohan, 1986)

[97] 'Independent' as a descriptor of the private healthcare sector can be used only rather circumspectly, considering the degree to which: *first*, the majority of surgical staff are employed by both public and private sector providers (even after liberalisation of working time regulations in 1981, allowing for a greater number of hours worked in the private sector); *second,* the focus of the majority of private acute providers on elective surgery procedures that the private sector has historically relied on as an 'alleviation' of the public sector case load; *third*, and related to the second point, the continued reliance of private providers on outsourcing of the NHS case load to the private sector; *fourth*, private medical staff receive the majority of their training in the public sector institutions, thereby limiting if not eliminating a substantial overhead cost.

power, which signalled a more pro-private-sector stance from public policy, private medical insurance saw a massive growth in subscription rates (Laurance, 1983; Rayner, 1986).

Much of the growth in demand stemmed from employer group subscriptions offered as fringe-benefits, which accounted for the largest growth area in private medical insurance during the 1980s. However, this was not immediately a sign of weakening of the NHS in favour of the private sector. Indeed, the initial boom quickly gave way to a drop in subscription rates both in their rate of growth and in real terms: many policies were not renewed and corporate subscribers became gradually more wary of spending on such fringe benefits for their employees as long as the public sector remained a universally accessible service. Nonetheless, by 1985 already 8.9% of the population was covered by PMI compared with 4.1% in 1975 (Laing & Buisson, 2008, p.166) (Table 6.3),[98] making it the largest percentage growth in total PMI coverage for the UK since the mid-1950s when the UK PMI market was first attempting to transform itself as a substantive element in the mixed economy of UK healthcare.

Even though the 1979-1981 PMI 'boom' was short-lived (see Fig 6.1 above), it still signalled the growing mainstream significance of the private sector in healthcare for, belying the temporary spike in PMI subscriptions was a substantial expansion in private sector acute capacity. Indeed, possibly the most important consequence of the governmental pay-beds policy had been a rapid expansion in private hospital construction, with nearly half the new buildings centred in the London region. By the early 1990s there were nearly double the number of private hospitals and bed numbers in the London area compared with the late 1970s and early 1980s. Laing (1992) quotes 25 private hospitals comprising a total of 1,605 beds between them in the London region in 1977, growing to 42 hospitals and 3,054 beds in 1991, with 154 hospitals (7,035 beds) in 1980 compared with 216 hospitals (10,911) for the UK as a whole (Laing, 1992, p.13).

By the time the Thatcher government sought to reinstate NHS pay beds and reduce restrictions on consultant's private practice with a new contract in 1979 (Griffith et al, 1987), the expansion of the non-NHS private sector was already well under way. In 1979 a *Royal Commission*

[98] But even then as is also the case currently, consumption of private sector healthcare was not to the exclusion of consumption of NHS services, these being free to all and, moreover, covering the bulk of acute and primary care services *not* available in the private sector.

on the National Health Service had determined the private sector contribution to acute care as not more than marginal nationally.[99] The authors stated that although

> '[i]nformation to enable us to reach precise conclusions about the relationship between the NHS and private practice was lacking, […] it was clear to us that the private sector was too small to make a significant impact on the NHS, except locally and temporarily' (Parliament, 1979, § 22.64).

Acknowledging 'that the private sector probably responded much more directly to patients' demands for services than the NHS, and provided a useful pointer to areas where the NHS was defective' (ibid) the crucial point was the gaps in service provision offered by the NHS:

> 'One such was clearly the provision of abortion services: half the abortions performed on residents of the UK were undertaken privately. Another was the provision of nursing homes for the elderly; and patients waiting for cold surgery in the NHS might opt to pay rather than suffer discomfort and inconvenience for months or even years. Other important reasons for choosing the private sector were the convenience of being able to time your entry into hospital to suit yourself, being assured of reasonable privacy and choosing your own doctor'. (ibid)

Rather than concluding with a justification for expanding the private sector, this was taken as a pointer to the more pressing need for the NHS to 'make more effort to meet reasonable requirements of this kind' (ibid).

Even so, studies conducted during the 1980s and early 1990s, showed how private provision was growing in more than just the areas that had structurally been neglected with the creation of the NHS. Sure enough, the largest segment of post-1948 private sector provision lay in long-term care. Besides this, however, private clinics in England and Wales were responsible for 22.4% of pregnancy terminations in 1981, far exceeding private sector case load in any other category. The next largest share was located in orthopaedic services (5.8%) and various skin and subcutaneous related treatments (5.4%) (Williams *et al*, 1984, p.447). Other specialties demonstrated a considerably lower share of non-NHS treatment of less than 4% of cases. Nonetheless, non-NHS private sector acute case load was already estimated at around 7-8% of overall acute care services for England and Wales (Williams *et al*, 1984, p.448), while total privately funded admissions (including NHS pay beds and non-NHS facilities) amounted to 13% of total elective operations and procedures (excluding abortions) in 1981 (Laing & Buisson, 2005, p.135).

---

[99] Though private healthcare was not the main focus of the Royal Commission's report, it did offer an assessment of its likely impact on the NHS, still a contentious issue at a time when the 1979 Conservative government was intent on reversing the abolition of private practice within the NHS.

It is hard to tell precisely the scale of increase in non-NHS private acute case load compared with the pre-1974 period due to lack of available reliable data. However, it is clear that the NHS privately financed share of elective surgery had been substantially supplanted by the non-NHS private sector, declining further to 12.3% of market share by 1986 (having decreased from 25.3% in 1981) (Table 6.2). The substantive growth in the private sector provision, as well as the notable shift towards the non-NHS private sector demonstrated at least that while still marginal in terms of overall service provision, the private sector could no longer simply be an easily neglected component in an assessment of the UK's healthcare service capacity (Williams *et al*, 1984; Rayner, 1987; Laing, 1992).

6.2. Structural change in the private hospital and health insurance markets in the 1990s

Though underlying demand for private healthcare did not fundamentally decline during the 1990s, the decade proved to be one of substantive change in both the structure of the private market and furthermore, in the way the sector related to the public sector as both competitor and collaborator. In a number of respects this was a period of intense competition, with changes driven largely by cost pressures that had a mutual impact between hospital providers and PMI carriers. This situation stemmed in part from changes in developments in the healthcare market overall with overcapacity of bed numbers, following prior expansion, leading to some contraction in the scale of private bed capacity, but also a small reduction in numbers of hospitals.

6.2.1. Key developments in the 1990s

Overcapacity was a long standing problem for the private acute sector. Having expanded rapidly in the early 1980s, occupancy rates increased but, with a shift towards day surgery, bed capacity was already being used differently to what it was before. While total private acute care activity continued to increase until the late 1990s, the number of beds registered with the Department of Health in hospitals and clinics was falling. Average bed occupancy decreased somewhat from 54% in 1990 to around 50% in 1997 (Department of Health, 1998). Some changes in the pattern of supply were also evident, which have contributed in the long-term strategic focus of much of the private acute sector towards elective surgery and ultimately, set the basis for the later attention given to contracting with the public sector in the 2000s. One of the most important outcomes was that the independent acute hospital sector underwent a further period of consolidation

as large hospital groups expanded their portfolio of hospitals and market share, primarily through acquisition in the late 1990s.

Changing patterns of supply

Possibly the most important trend in terms of the type of work that private sector providers undertake is found in a concerted shift towards day surgery. Research during the 1990s demonstrated a clear decline in numbers of inpatients compared with a rise in numbers of patients treated with minimally invasive procedures. Between 1992 and 1998 there was a substantive increase in day case surgical patient numbers, estimated at around 68% upwards change, compared with a 5.2% decline in inpatient numbers (Laing & Buisson, 2005). Parallel to the shift towards day surgery has been an increasing specialization based around high-technology. Procedures, including more complex neurosurgery, health surgery and other highly invasive procedures requiring use of intensive care beds became a key part of niche market building.

One analysis reported that in the early 2000s, a relatively small number of private hospitals have intensive care beds, estimating fewer than 100 beds across the UK at the time (Keen, Light and Mays, 2001, p.44). Despite the provision of such high tech and invasive procedures, limited resources were available for recovery in the case of post-operative complications, being staffed and equipped only for immediate recovery from surgery. Their explanation for this has been that costs reasons fundamentally underlay the lack of provision of long-term post-operative care, given the relatively high costs of long-term intensive care. NHS intensive care units were at times passed on cases where post-operative complications arose.

Vertical Integration

Vertical integration has not been commonly practiced by PMI and Hospital providers. A key exception has been *BUPA* which, having begun as a federation of various small private health/medical insurers, entered the hospital market through acquisitions in the late 1960s. At the time, the private acute market was so small that this type of vertical integration was more an outcome of the private sector trying to maintain its space in an otherwise adverse market environment where the NHS clearly dominated acute and most other medical services. With such a

strong position in the private acute and PMI market, *BUPA* maintained this combined structure for most of the succeeding years.[100]

As *BUPA* developed its hospital division in the 1980s, in the relatively buoyant private market of the decade, vertical integration seemed to be a more important strategy for securing market share. However, *BUPA* also maintained that its provider and insurance branches of business were not integrated operationally. Meanwhile a brief flirtation with vertical integration in the PMI-Hospital market came with a joint venture in 1997 between the US-based *HCA Columbia* (having recently been created out of a joint venture in the US) and the UK's *PPP Healthcare*. By 2000 *PPP* sold its four London hospitals to *HCA*, following acquisition by the French multinational insurer *AXA*.

Hospital–Insurer Relations: Networks

Consolidation was facilitated through the development of hospital networks by the two major PMI carriers, which in turn threatened the stability of demand in hospitals excluded from the networks. The mid- to late-1990s led to some key innovations in the relations between PMI and private acute providers, to some extent based on techniques borrowed from the US market, as the development of network products by the major insurers marked a new approach to cost containment which led to a degree of restructuring of private health in the UK. Underlying this approach had been the realisation that low utilisation of hospital capacity rendered hospital provision unnecessarily expensive. If patient referrals can be channelled to the most efficient, high quality hospitals then their high fixed costs are spread over larger volumes of activity and resulting unit cost savings can be shared between the hospital and insurer (Laing & Buisson, 2005). By directing their subscribers to a limited network of preferred providers (efficient/high quality), insurers can close the circle linking efficiency to demand, which the previous market structure failed to do.

Thus insurers moved towards selecting hospitals to give preferred provider status to those hospitals they judged as having best quality-price trade-off (high quality service at competitive prices). Preferred provider status was also accompanied by a move towards prospective payment for services, whereby insurers would agree fixed prices for procedures with hospitals in the network.

---

[100] In the late 1990s and mid-2000s BUPA, interestingly, began to divest itself of its hospital stock in order to focus more on its PMI business. By mid-2007 it had entirely exited the hospital market, though the following year re-entered with the acquisition of a single London-based hospital unit (the Cromwell Hospital), and more recent reports show that it has continued with acquisition of a further few hospital units.

Key to this was the utilization of pricing mechanisms based on diagnostic related groups (DRG) and other group based payments according to a schedule agreed by the PMI carrier.

Monopolistic tendencies at the end of the 1990s

Consequent to this move towards preferred provider networks, the larger hospital groups, with greater resources and capacity to monitor the quality of consultants work, tended to benefit primarily from this development. This also had a detrimental effect on smaller hospitals, including commercial but especially charitable hospitals, whether free-standing or of a small number of units. The rise in preferred provider trend was also met with alternatives by different providers, seeking simultaneously to capture a growing self-pay market and to counter-act the growing influence of PMI companies. In some cases hospitals developed their own services based on guaranteed fixed prices for selected procedures, some of which they offered directly to patients rather than insurers. This particular strategy also saw a slight rise in self-paying patients. Nuffield Hospitals, for example, started to offer low interest and interest-free loans to patients, enabling private users to pay for hospital care by instalments rather than having to rely on PMI.

For the largest insurers, in particular *BUPA* and *AXA PPP*, a network strategy gave them the opportunity of demanding larger discounts from their participating hospitals, keeping premium rates more competitive and offering added value to their customers in the form of enhanced quality assurance. *BUPA's* first national network product, 'Health Fund', was launched in May 1996 involving the first case in the UK of a 'directional' PMI product whereby individual subscribers were offered the option of receiving discounts (or additional benefits) in return for agreeing to use a restricted 'network' of 150 hospitals. The insurer's approach to selecting network partners was to include in its list all the hospitals belonging to the major independent chains *en bloc*, and to fill in with others according to local requirements. Though it initially excluded NHS PPUs, *BUPA* soon moved to set up routine referral routes for tertiary treatment in private patient facilities in NHS centres of excellence. In 2004, 'industry sources indicated that around 54% of *BUPA's* company and individual subscribers had opted for network products, with the proportion on the rise as a higher proportion of subscribers are choosing network products' (Laing & Buisson, 2005, p.72).

In February 1997, *PPP Healthcare* (acquired by *AXA* in 1999) launched its own preferred provider network scheme, encouraging customers to opt into the network by offering a cash discount claimed to equate to a 15% cut on comparable premiums outside the network. Whereas *BUPA* included major chains en bloc, *PPP* opted to select hospitals locally, by locality, following a

tendering and quality assessment process. Moreover, NHS PPU's were able to bid to be PPP network hospitals (Laing & Buisson, 2005, p.72), neutering somewhat *BUPA's* prior attempt to exclude NHS PPU's, being its closest competitor for market share (29% of subscriber income, to *BUPA's* 37% in 1997; See Table 6.4).

The danger with the preferred provider networks, noticeable increasingly since the early 2000s, has been the tendency towards generating monopolies. The larger insurers recognised - and intended - that it would lead to closure of some hospitals (with smaller non-affiliated hospitals being the most vulnerable) and the emergence of more local monopoly situations by certain providers. Once local competitors have been eliminated, the bargaining power of network hospitals is increased. In such a situation, market analysts have suggested that 'the continued existence of large numbers of relatively small scale NHS pay bed units, and now possibly Independent Sector Treatment Centres (ISTCs), can be essential to maintain a healthy degree of competition' (Laing & Buisson, 2008, p.71)

Relations with workforce

Keen, Light and Mays (2001) reported an important trend in the 1990s of private hospitals focusing attention on quality assurance. The trend could be interpreted as an important measure to garner prospective and existing customer assurance in the face of several media-reported cases of adverse outcomes from private treatment, such as a case of the heart surgeons based in a Bristol unit of BUPA Hospitals found guilty of professional misconduct by the General Medical Council in 1998. Indeed, the problem of quality was a concern of a Health Committee of the House of Commons examining a wide range of evidence given on bad experiences of using private hospitals (ibid, p.46)

> 'For aspects of services delivered by their employees, particularly nurses and their general management, they had implemented a number of processes, including the Health Quality Service's organisational audit, and processes based on ISO 9002, an international set of quality standards'. (ibid, p.45)

However, it was a key point that quality measures such as these were primarily focused on general organisational processes, rather than directly on clinical quality assurance.

Safety and quality assurance had several applications and implications. One has been to gain greater control over the work of health professionals, including consultants and nursing staff. As consultants are not employed directly by hospital providers, but rather as independent contractors,

there is reason to find ways to extend control over the activities of private practitioners. For example

> 'BUPA, had been implementing rules that would ensure surgeons had to undertake reasonable numbers of a particular operation before they could operate in its hospitals' (ibid, p.45).

> 'On the other hand, given the status of private practitioners, it has also been rather difficult for hospital firms to successfully implement clinical quality measures given that they negotiate with consultants on a range of issues including clinical quality, and pricing' (ibid, p.46).

Nevertheless, to date there has been no clear move to offer prospective patients information over practitioner outcomes, and there is no more transparency of this sort than in the public sector.

6.3. Pro-competitive public policy for healthcare under New Labour and further structural change in the private sector

While a component of the healthcare mix was firmly established by the late 1990s, the turn to the 21st century has seen further structural change for the private healthcare sector, whereby the state has provided a stimulus for renewed competitive re-organisation in the sector. By 2003, the large independent hospital groups began to restructure their business 'in response to perceived competitive challenges' (Laing & Buisson, 2008, p.78) arising from a struggle to acquire a part of the market share emerging from public sector contracts for the delivery of a variety of diagnostic and elective surgical services. The competitive struggle for new market share from public sector procurement was precipitated by a radical shift in New Labour's policy position on healthcare: one that would come to embrace provider diversification, grafted uneasily onto (greater) competitive stimuli within the public NHS as part of a major programme for its 'modernization'.

The expansion of private sector procurement that has ensued is clearly visible in the growth of independent hospital and clinical (IHC) revenues, based on estimates summarised by Laing & Buisson between 1992 and 2007. NHS purchase of acute care services from the private sector as a whole has risen markedly in the past two decades, going from under an estimated 4.9% (£53 mil.) in 1992 to 14.4% (£615 mil.) in 2007 of total IHC revenues (Table 6.5). Growth has been particularly notable after the commencement of a more concerted procurement programme by the NHS, growing by 3% annually between 2004 (7.7% of total IHC revenues) and 2005 (10.8% of IHC revenues), compared with nearer 1% annually (and more frequently nearer 0.5% annually) in previous years since the early 1990s (Table 6.5). The considerably expanded market in public sector

procurement thus appears potentially lucrative for IHC providers if it continues to expand, though arguably, even if it remains relatively stable.

After giving some background on the development of New Labour's 'pro-competitive' policy position for healthcare services, I focus on two aspects of the new regime for a mixed economy of care which have had a variable impact on private sector strategy for gaining and maintaining market share. The first is a shift towards contracting directly with IHC providers to supplement NHS hospital capacity, while the second is the development of the ISTC programme which has seen units specifically catered to NHS procurement set up or occupied by IHC providers. Data in both cases is rather limited, and hard to come by due to commercial confidentiality clauses and bureaucratic obfuscation (House of Commons Health Committee, 2006; Player & Leys, 2008), but what figures can be given, I have drawn from data collected by healthcare market analysts Laing & Buisson (2008) in a more recent edition of their *Healthcare Market Review*.

6.3.1. Competition as a mechanism for healthcare service reform

The pro-competitive stance for direct healthcare service provision of the New Labour government was not immediately apparent upon election in 1997, and indeed it took until the second half of its first term in government to even begin to develop this position more thoroughly.[101] Upon election in 1997, the New Labour government was relatively cautious in its approach to the private sector, having been elected on a mandate, amongst other things, to abolish the predecessor government's internal market policies (Department of Health, 1997). Under Secretary of State for Health, Frank Dobson, the Department of Health issued planning guidance that clinical purchase of services from the non-NHS private sector should only be undertaken as a last resort measure, subject to approval by the NHS Executive (Department of Health / NHS Executive, 1997).[102] Furthermore, its abolition of *GP fundholding* from 1999 eliminated 'a small but significant source of private hospital revenue' derived from the NHS (Laing & Buisson, 2005).

---

[101] I distinguish the procurement of direct service provision from the tendering process for hospital construction under the Private Finance Initiative (PFI) which began already with the first contract in 1999. This had been one of the first elements of commercial 'inclusiveness' in healthcare policy under New Labour, although as this related initially to construction (and later of facilities management) contracts this is a rather different area of pro-competitive policy from that which I discuss in this chapter.

[102] The NHS Executive guidance (EL(97)39) stated that 'Health Authorities, GPs and NHS trusts should explore the scope to make maximum cost-effective use of local NHS capacity *before contemplating recourse to private sector hospital provision*' (my italics; Department of Health / NHS Executive, 1997, §17).

Even PMI was subject to a cooler reception, with a repeal of tax relief to company benefits (including PMI subscription) for the over 60s and the closure of an Insurance Premium Tax loophole in the 1997 budget (HM Treasury, 1997),[103] followed by the extension of employer's national insurance contributions as part of a bundle of wider welfare reform measures in the 1999 budget (Laing & Buisson, 2005).

Modernization: structural change in the public healthcare system

The government's rapprochement with the IHC sector had its roots in 2000, when it announced an unprecedented level of expenditure on the NHS. The investment would be released over a four year period from 2000 until 2004, raising government spending by over 6% each year in real terms; to increase total healthcare spending to 7.6% of GDP by the end of this period (HM Treasury, 2000). The commitment to increase funds for the NHS was extended in 2002, after the Chancellor Gordon Brown announced the increase to last until 2007/08 amounting to an average annual real growth of 7.4% (HM Treasury, 2002). A crisis of rapidly expanding waiting lists primarily for elective surgery by the winter of 1999/2000, but also a sense of frustrated public opinion on the state of the NHS conveyed through the government's focus groups and the media, had given a strong political impetus to make a substantive intervention in the public sector's capacity to deliver services more effectively and efficiently (NHS Executive, 2000, pp.134-6).

Though policy documents and political and press release statements of the government continued to re-affirm their commitment to a public NHS that would be comprehensive, universal and free at the point of use, acknowledgement of a place for utilizing private sector capacity was increasingly becoming a fixture of the new agenda for healthcare. The government continued to underscore its commitment to maintaining a tax-based system of financing, rejecting any move towards a social insurance system or even one in which private insurance would become a stronger component (NHS Executive, 2000, pp.34-39):

> '[…] the way that the NHS is financed continues to make sense. It meets the tests of efficiency and equity. The principles on which the NHS was constructed in 1948 remain fundamentally sound'. (NHS Executive, 2000, p.40)

---

[103] The removal of PMI tax relief (an indirect subsidy) was made on the basis that it did not significantly improve PMI uptake and would save money for the Treasury, while the IPT loophole enabled insurers to avoid payment of this tax at the rate of 4% by writing PMI in a long term fund (Laing & Buisson, 2005).

This position was also reinforced by a key report on the long-term financial viability of the healthcare system headed by Derek Wanless (2002) for the Treasury, in which he emphasised that a public tax-based system continued to be the most efficient mode of financing healthcare for the UK:

> 'The UK system of financing appears to be relatively efficient and equitable. It delivers strong cost control and prioritisation and minimises economic distortions and disincentives. A further key advantage of the UK's funding system is its fairness, providing maximum separation between an individual's financial contributions and their use of health care.' (Wanless, 2002, p.141)[104]

Whilst rejecting both social insurance and a private insurance model for the UK, the Report acknowledged that 'the main weakness of public financing of health care (whether through general taxation or social insurance) is that it provides limited scope for expression of individual preferences and choice' (Wanless, 2002, p.142). Moreover, in its concluding recommendations, the Wanless Report managed to reinforce the notion that scope for greater future cooperation between the NHS and the private sector should be explored in the delivery of services, stating (once again in reticet language) that: 'This should be seen as just one of the many ways in which the health service – like any organisation – is constantly examining new ways of working to deliver its objectives more effectively' (Wanless, 2002, p.105).[105]

That notion of greater public-private cooperation, was already something that had been laid out in the government's keystone document for healthcare reform, the *NHS Plan* (NHS Executive, 2000), in which it had outlined its strategy for modernisation and re-structuring for the NHS to accompany the new spending programme. By no means a central component of the reform strategy, it nonetheless allowed for a greater, if still somewhat restricted space, for the private sector within its overarching strategy. Limited to the delivery of services on contract to the NHS, it stated that new planning guidance would be formally defined by a national framework for partnership between the private sector and the NHS (NHS Executive, 2000, pp.97-8). This came in October 2000 with the publication of a '*Concordat'* between the private sector - represented by the Independent Healthcare Association (IHA) at the time - and the NHS, setting out the details for putting NHS

---

[104] This observation was derived from the Interim Report by Wanless, published in 2001, and republished under the 2002 report under Annex C (Wanless, 2002, pp.137-163).

[105] Though crucially, the Report made clear that this method of delivery should 'not be confused with the method of financing' (Wanless, 2002, p.105).

commissioning of elective, critical and intermediate care in the independent sector into practice (Department of Health & Independent Hospital Association, 2000, §2.6-§2.12).[106]

The new structure of inclusiveness would function on much wider-reaching reform to the structure of the NHS, and this was much more central to the reform agenda insofar as it has focused on provider diversification. While the 'internal market' of the 1990s was formally abolished, a 'purchaser-provider' split was nonetheless ultimately retained as a central feature of the (post-*NHS Plan*) 'New NHS' in the first decade of the 2000s. Though there is a whole gamut of purchasing and provider organisations within the current NHS structure (Talbot-Smith et al, 2006), two of these have been central to the expansion of IHC market share. Primary Care Trusts (PCTs) were established in 2002 to replace Primary Care Groups (PCGs) and would function as local commissioning bodies - 'active purchasers of care for their geographical populations' - and by 2004, PCTs were in control of some 75% of the total NHS budget for primary, community and hospital services (Stevens, 2004, p.41).[107] One of their key roles has been to commission secondary care services from NHS Trusts, which encompass a wide array of providers including acute hospitals, specialist trusts (i.e. orthopaedic or learning disability services), mental health trusts and ambulance trusts. The bulk of services commissioned are with these various NHS Trusts. However, since the mid-2000s, PCTs have also begun to commission services from NHS Foundation Trusts (FTs), a new quasi-public form of Trust, as well as from IHC providers (both commercial and non-profit). While in the former case commissioning is through non-legally binding contracts ('service level agreements') overseen by the Department of Health, in the latter case contracts are legally binding. (Talbot-Smith *et al*, 2006)

Essentially providers in the new 'quasi-market' equation, FTs (established in 2003) have become another key component of the new, *pro-competitive,* NHS. These are non-profit public

---

[106] With regard to elective care, this could involve NHS Trusts renting clinical facilities or accommodation but with services delivered by NHS staff from the IHC providers, or NHS Trusts and Primary Care Groups or Trusts subcontracting directly (purchasing) services from IHC providers. For critical care, the Concordat, encouraged the NHS and IHC providers to be able to support each other (i.e. transfer patients between them) whenever clinically appropriate, though with cost arrangements needing to be agreed between collaborating parties. Intermediate care arrangements would be aimed at reducing NHS hospital occupancy by diverting preventive and rehabilitative services to the private and voluntary sector.

[107] PCTs were first introduced in 1997 in the *New NHS* White Paper (DoH, 1997). Their role is 'to improve the health of the community, to secure high quality primary, secondary and community care services, and to integrate local health and social care services'. As such, they are the principle commissioning bodies within the NHS, overseeing commissioning undertaken by GP practices of all healthcare and community services for their local populations (Talbot-Smith et al, 2005, p.37).

companies ('public benefit corporations'), controlled by local boards and accountable to a new independent regulator (Monitor) rather than the Department of Health. They are also free of the 'performance management' that other NHS Trusts are subject to from local Strategic Health Authorities (SHAs), whilst also being free to borrow from the private sector for the purposes of supplementing capital investment from SHAs. This bounded independence has been in aid of promoting a more business-like functioning of Foundation Trusts compared with other NHS Trusts, including responsibility to manage their own budgetary requirements but also to face higher levels of business risk. For example: 'an FT's ability to service debt determines its ability to achieve a credit rating, the possession of which enables it to borrow on commercial terms' (Talbot-Smith et al, 2005, p.65). For the long-term, the significance of FTs is the aspiration of the government to convert all NHS Trusts to FTs.

Patient 'Choice' as the driver of provider diversification

Though the NHS Plan/Concordat era made the initial steps towards including the private sector in planning for healthcare provision, a more substantive shift has taken place more recently which marks a potentially more profound basis for developing public-private partnerships in direct healthcare service provision. A central feature of Labour's NHS strategy, following its second electoral victory in 2002, was to focus on cutting waiting lists and to create choice for patients in location and timing of treatment, leaning more towards the choice available for many years in the private sector. Since the early-2000s, as waiting lists began to reduce, the principal focus has increasingly been placed on the development of choice as a feature of using the NHS. Though certain pilot projects had been taking place since 2001, the current agenda for choice has been implemented since 2006, when NHS patients were given the right to choose from at least four hospitals selected by PCTs and would have to include an IHC provider in the list (Talbot Smith *et al*, 2006, p.40).

By May 2006, the choice included any ISTC or Foundation Trust alongside NHS hospitals. GPs still act as gatekeepers to the choice process and, within the framework of PCTs, in principle, are expected to give patients full information about provider choice. By August 2006, after a small selection of IHC providers had already been added to the NHS patient choice list under local deals with PCTs, a formal contract arrangement known as the Extended Choice Network (ECN) was implemented which sought to formalise and extend the agenda for including 'independent' providers. With the implementation of the ECN, fourteen independent providers were added to the patient choice list (Laing & Buisson, 2007).

6.3.2. A new role for private sector providers

Though the Concordat made a clear statement about the government's wish to make use of private sector capacity, and while it signified a concerted break from its prior stance in the first couple of years after election,[108] neither the NHS Plan nor the Concordat offered a strong commitment to private providers in the long-term. Rather, the NHS Plan/Concordat period, insofar as public policy statements revealed, still retained a sense of 'partnership' as being a quick fix to an otherwise short-term public sector problem, rather than actualising a blueprint for a more integrated mixed economy of healthcare. Moreover, as long waiting lists began to reduce, the apparent need for extra capacity from IHC providers seemed to diminish, and left open the question of whether this would be a sustainable relationship between the NHS and the private sector (at least with regard to elective care).

The *NHS Plan* had proposed the opening of eight Diagnostic and Treatment Centres (DTCs) by 2005 which would kick-start the new 'partnership' programme. These were aimed more at routine diagnostic and surgery procedures to day-case and short-stay patients, already the mainstay of the private acute sector. The centres would divert patients away from NHS hospitals allowing them to concentrate on emergency and more complex elective cases, through free-standing units (organizationally and, in cases, physically) though still located within NHS hospital premises ('co-located').

Contracts with Independent Hospitals (G -Supp Etc)

Initially parallel and separate to the DTC programme, was a system for providing NHS elective care by outsourcing to private sector providers, called General Supplementary Contracts ('G-Supp'). Although it proved rather limited in scale compared to the extent of procurement that followed under the ISTC programme, several of the top UK independent private hospital providers benefited from these contracts. Initially these were contracts to provide supplementary ear, nose and throat (ENT), general surgery, and urology - areas that were experiencing long waiting times - while orthopaedic procedures were also added to the programme later.

---

[108] In 1997, under-Secretary of State for Health, Frank Dobson, the Department of Health issued planning guidance (EL(97)39) that clinical purchase of services from the non-NHS private sector should only be undertaken as a last resort measure, subject to approval by the NHS Executive: 'Health Authorities, GPs and NHS trusts should explore the scope to make maximum cost-effective use of local NHS capacity *before contemplating recourse to private sector hospital provision*' (my italics; Department of Health / NHS Executive, 1997).

Nuffield and *Capio* were amongst the chief beneficiaries of this programme, with *Nuffield* delivering the majority of its NHS contract work under the G-Supp programme between 2004 and 2005. In May 2004, it secured a £40 million G-supp contract to deliver 17,000 procedures worth around £15-20 million. *BUPA Hospitals* secured several NHS contracts including a G-supp in 2005 worth around £15 million, while *General Health Group* secured a major G-Supp general surgery contract carrying out 5000 procedures for the NHS in around half of its subsidiary's (*BMI*) hospitals for total revenues of £22 million, along with a number of other smaller NHS contracts (Laing & Buisson, 2007, pp. 79-82).

The G-Supp procurement period was quite fortuitous for IHC providers as, for example, *Nuffield's* NHS patient volumes increased dramatically from around 7% in 2004, to 20% in 2005 (around 32,000 procedures). By 2006, however, revenues from G-Supp for IHC providers fell back as both Nuffield's and *BUPA's* G-supp contracts were discontinued (Laing & Buisson, 2008). Local NHS commissioning began to be held back by fiscal tightening and this had a direct impact on the future development of G-Supp contracts.

Independent Sector Diagnostic and Treatment Centres

Perhaps due to its relative novelty as a service provision strategy in the NHS, the most visible outcome in terms of NHS procurement of 'independent' sector acute services following the 2001 *Concordat* has been the contracting of a variety of diagnostic and common elective surgery procedures to private sector providers in so-called DTCs and ISTCs. The first wave of Diagnostic and Treatment Centres (DTCs), later re-named as Independent Sector Treatment Centres (ISTCs), were announced in 2003, while a second wave was soon scheduled to begin in 2005/2006. The awarding of contracts has developed incrementally over time so that the independent diagnostic and treatment centres that, as a generic and cumulative category are currently operational, have grown out of an assortment of different contracting phases and provide different types of healthcare services between them. I discuss them here as a group because I want to focus on a particular aspect that has been important for the private sector which has stemmed from the procurement process.[109]

A common feature of procurement of ISTC services is that they work on pre-arranged bulk contracts. These contracts are nominally set at or below the same national tariff on which NHS

[109] Though this is an ongoing process and new contracts have continued to be awarded and set in motion, the data I present ends at the end of 2007 for the sake of a cut-off point for my research.

hospitals charge commissioning PCTs. A key feature of the contracting is that treatments are paid for in advance, regardless of the rate of actual bed occupancy and throughput of patients, or of the success rate in treatment outcomes. This is something that has attracted criticism for being wasteful of public resources but which private suppliers have defended on the basis that with unpredictable annual case loads, this would otherwise be a risky venture (Laing & Buisson, 2008).

The main type of procedures offered by such centres include: general surgery (34% of procedures contracted for in *Wave 1*); orthopaedic and spinal surgery consisting largely of artificial hip joint replacement (33% of *Wave 1* contracted procedures); and ophthalmology treatments such as cataracts operations (14% of *Wave 1* contracted procedures).[110] Other key services covered include urology, ENT, gynaecology and cardiothoracic procedures. The majority of both *Wave 1* and *Wave 2* contracts have been with PCTs in South Eastern parts of England (nearly 39% of all operational contracts),[111] although a handful of contracts have also been made in Northern metropolitan centres, the North West, East Midlands, South West, as well as one in Scotland (Laing & Buisson, 2008).

The cumulative value of ISTC contracts operational between 2003 and the end of 2007 ranges from an estimated £1,873 million to £1,923 million and is likely to account increasingly for the value of NHS procurement from IHC providers.[112] I should make clear that these are only reported estimates of contract values and not a confirmation of actual transactions. However, it still presents the possibility that total value across IHC provision to the NHS is increasingly accounted for by ISTC contracts, given that total estimated value of NHS procurement from IHC providers between 2003 and 2007 amounts to around £1.9 billion.

While continually emphasising that this was not going to be a marketisation of the NHS, public policy on the NHS has clearly retained a strong undercurrent of the competitive 'tensions' expected of market structures (Stevens, 2004). The post-NHS Plan structure of the NHS has still ultimately remained a 'quasi market' in nature even if not in name (King's Fund, 2005, p.11). But

---

[110] Figures calculated based on data from a Freedom of Information Request made to the Department of Health by Stuart Player and Colin Leys, and reproduced in Player & Leys (2008, p.9)

[111] South Eastern operational contracts have amounted to 12 in number by the end of 2007 (including the BUPA Redhill DTC contract which ended in 2007). Percentage is my own calculation based on data showing operational ISTCs in Laing & Buisson (2008).

[112] Reporting on individual cumulative values per IHC provider is not possible, since provider ownership structures have changed during the time frame reported, while some of the values reported extend beyond the end of 2007, so that it may portray an inaccurate picture per company. However, individual contract values have ranged from as low as £5 million to as high as £140-145 million (Laing & Buisson, 2008).

differentiating it from the Conservative *laissez faire* era towards the private sector, New Labour's programme for provider diversification under a regime of NHS commissioning has been assisted by a number of regulatory levers.

6.4. The 'new' mixed economy of care

The new mixed-economy of care that has been steadily engineered through incremental steps of public policy, has provided a critical impetus for changes in the structure of the private IHC sector. On the one hand, it has created a stimulus for further intense intra-private sector competition, with larger players ultimately being the main beneficiaries of the new public sector commissioning regime, though with some newer market entrants managing to retain an important stake in the market so far. On the other hand, this competition has also created greater space for overseas market entrants to gain an even greater foothold in the UK market. Finally, the potential for destabilizing of the NHS as a consequence of government mandated competition between public and private sector providers sits uneasily on the boundaries of a controlled experiment with market-based instruments for health services reform and divesting an increasingly larger component of public service provision to private multinational commercial operators.

The key outcome of the development of the NHS procurement programme for elective hospital care services has been for IHC providers to restructure their business towards meeting NHS commissioning requirements. This has not been a linear or straightforward process, but one that has seen several stages of change as the procurement process developed through G-Supp, to the currently predominant ISTC/DTC model of NHS procurement of private sector elective care services.

Market share amongst the main private hospital providers has seen some important changes during the 2000s. Significant concentration in the IHC sector has occurred as key players have consolidated market share through acquisitions and mergers of smaller providers, while by the end of 2007, a number of larger providers had been acquired by recent overseas market entrants. One indicator of this changing market profile has been the shift in ownership of bed capacity, as between 2000 and 2008 the top ten IHC providers (including hospitals with overnight beds, units with day surgery only, and ISTCs) increased their cumulative market share from 79.5% to 85.9% of private overnight bed capacity. Some of this has been accounted for by consolidation towards the top three providers as in 2000, the top three providers (*GHG*, *Bupa Hospitals*, and *Nuffield Hospitals*), held 56.2% of total IHC market share by bed numbers, while by mid-2008, the top three providers

(*Netcare*, *Nuffield Health*, and *Spire Healthcare*) held 60.8% of total IHC overnight bed capacity between them (Table 6.6).

This concentration of market share in bed numbers has been accompanied by net-reductions in IHC provider bed numbers, a trend that followed through from the mid- to late-1990s as a consequence of changing market conditions during this period (discussed in section 5 of the chapter). The largest decline was registered in 1999-2000 with total IHC bed numbers declining from 10,565 to 9,980 (a decline of 585 beds in total) between these years, and accompanied several hospital closures between 1995/1996 through to 2002/2003. Indeed, while units with overnight beds appear to have continued to decline somewhat in number, a distinct growth in day surgery-based facilities is a trend that would be consistent with the ISTC/DTC roster of services.[113] As such, the net-decline in bed numbers and IHC facilities, seen periodically since the early 1990s, was halted temporarily following the start of the NHS provider diversification programme and commissioning of *Wave 2* ISTCs, as the year 2004/2005 saw a net increase of 321 beds (from 9,256 in 2004 to 9,578 in 2005), contrasting with the previous year's (2004) net decline in the IHC bed numbers by 216 beds (down from 9,473 in 2003) (See Table 6.6).

In contrast to bed numbers, the top ten providers (including hospitals with overnight beds, units with day surgery only, and ISTCs) held 86.3% of total IHC market share by revenues in 2000, falling slightly to 82% of total IHC provider revenues by mid-2007. Of these, the top three in 2000 (*GHG*, *Bupa Hospitals*, and *Nuffield Hospitals*) shared 59.1% of the market by revenues, while by 2007, the top three held 50.8% of market share by revenues between them (See Table 6.7). Several new IHC companies entered the UK market in the early to mid-2000s in response to signs of a growing NHS commissioning market. Overseas entrants included the US consortium *Nations Healthcare*, US group *New Park Presbytarian Healthcare System*, Canadian *InterHealth Canada*, and South African groups, *Netcare* and *Life Healthcare*. If we consider that *Bupa Hospitals* (though UK-owned and legally a not-for-profit company) has international interests, if it is included amongst the internationalised providers group, its revenue share of the IHC market would raise the total market share (by revenues) of multinationals to 60.3% in 2007 (Table 6.7).

---

[113] Although a shift towards day surgery was already evident during the 1990s, data differentiating overnight stay facilities and day surgery has only been available since 2004 – as reported in Laing & Buisson (2006-2008) - making direct comparison over the long term rather limited, with the exception of a small number of studies conducted during the 1980s and 1990s on private acute sector case mix (Williams & Nicholl, 1994).

Meanwhile, of the 33 DTC and ISTC contracts operational by late 2007, more than half (52.4%) have been taken by foreign-owned companies (Table 6.8). This includes certain units that were originally held by UK-based firms but subsequently acquired by foreign-owned firms. While this is the most recent market structure, it does not accurately reflect the change over the previous five years when ISTC units were first begun, since there have also been acquisitions of formerly foreign-owned units by UK-based firms. Even so, a significant proportion of foreign-owned companies were successful in gaining contracts in the first phase of the contracting process.

The largest groups initially adopted different strategies to compete for NHS business, but the common ground was that lower costs could only be achieved by maximizing throughput per operating session and reducing consultant's costs (Laing & Buisson 2008, p.78). The restructuring delivered some results for those groups with a stronger position in the market. The NHS as a commissioner, applies pressure on providers to achieve value for money and high quality standards (Laing & Buisson, 2008, p.79). In terms of an overall impact on the private non-NHS sector the development of NHS commissioning has been important in several ways. Of these, one of the most important has been that demand for additional capacity has significantly expanded the non-NHS medical/surgical market, an expansion that has almost exclusively come from new entrants to the market since the early 2000s. Though these have been both UK-based and foreign-owned companies, the majority have been commercial firms. Their entrance into this market segment has changed the structure of non-NHS private provision by creating competition over market share in NHS procurement. In turn seeking such contracts has meant a shift towards lower cost models of healthcare delivery as determined by NHS procurement requirements.

A key point is that despite the rapid expansion in the market for private acute care services resulting from NHS commissioning, at least in the view expressed by market analysts and companies themselves, this remains a market with some significant uncertainty. Both the scale of future growth and the nature of future contracts are relatively unpredictable in view of the slow progression of the capacity to implement patient choice through the NHS (Laing & Buisson, 2008, p.79). Even so, the contracting that has developed over the past few years between NHS and 'independent' sector providers has, in the analysis of Laing and Buisson, 'formed foundation stones for future contracting in many areas should the appetite exist' (Laing & Buisson, 2008, p.109). In their critical study of ISTCs, Player and Leys conclude that exactly such an appetite exists, stating that '…the next phase will be much more diverse. The 'reconfiguration' of secondary care […] will see much greater variety in purchasing from private providers, private provision being locally

procured but under central direction…' (Player & Leys, 2008, p.111). Indeed, upon a thoroughly researched investigation of the ISTC programme, they stipulate how this has been a 'crucial first step in a fairly well thought-out plan to create a private provider industry in the UK to compete with the NHS using NHS funds, and eventually to subject all health care to market principles' (p.65)

6.5. From accommodation to a new 'pro-competitive' mixed economy of healthcare

Between the late 1970s and the mid- to late-2000s there has been a considerable shift in the position of the private healthcare services sector in the UK. While the private sector still occupies a relatively marginal position in the country's overall healthcare spending levels, the balance has demonstrably shifted towards a growing market share for the private sector, as indicated by the consumption patterns for PMI and the now growing market in public sector procurement of private services. While from the stand point of public policy this growth has not been an *a priori* objective in terms of healthcare services reform - at least until more recent years - the state has also been complicit to some degree in a process of commercialisation that has, for the majority of the period from the late 1970s to the mid-2000s, predominantly impacted on the private sector.

6.5.1. Public policy shift

In the late 1970s, the post-war mixed economy of healthcare saw a rather dramatic change in the scale of private sector healthcare services, particularly in the acute care sector and the closely linked PMI market. There was a period of rapid growth, instigated in part, by a combination of weaknesses in the public sector and an unintended development of public policy in the then Labour government's attempt to disengage private practice from the NHS. While this may be regarded in a sense, as a policy failure for those public policy actors (under Barbara Castle) seeking to address what they saw as a fundamental contradiction in an otherwise socialistic project that was the NHS, in the long-term this juncture did not break massively with what would best be described as an *accommodatory* position towards the private sector. Even on the eve of the sea-change in UK politics that saw the rise of a neoliberal regime under the Thatcherite Conservative governments of the next decade, the House of Commons did not perceive much of a challenge from the private sector. The foundational compromise underlying the creation of the NHS required a continued position for the private sector.

With the entrance of the Conservative party to government in the 1990s, the NHS came under concerted pressure, even if taken in gradual steps, to develop a much more market-like structure. Yet, the momentum gained by the Conservative governments during their nearly two decades in power for market-oriented reform of the public sector, did not translate into a concerted and overt 'pro-competitive' plan for the private sector. Rather, this was more *laissez faire* in nature, after part-dismantling and part-reconfiguring the public sector. This was essentially a continuation of the *accommodatory* compromise that maintained a mixed economy of care, but with a desire to see the public sector NHS emulate private sector practices and restructure as a market-based system of healthcare.

The current regime is at a completely different place from the 1970s-1980s juncture, and equally different from the 1990s period of 'laissez-faireism'. Under New Labour, there has been for the first time, a more *integrative* approach in its pro-competitive policy for healthcare reform so that, despite political controversy and under an often obfuscating public policy arena, IHC providers have been given a 'leg up', so to speak, in a way that has been historically unprecedented. While the future development of public policy towards the private sector is hard to predict, given the uncertainties of contracting in a system (the NHS) that still in principle is focused on addressing population needs rather than individual consumer wants (as is the case for the private sector), it is difficult to envision a return to the more passive approach of earlier years. What has been common across all three junctures in public policy is, however, that the interaction between the public sector and the private sector with regard to the terms of service provision has been an important driving factor in shaping the changing dynamic of commercial expansion in the private sector over the past three decades.

6.5.2. The dynamics of commercial transformation

Commercial expansion has been one of the primary characteristics of the private sector market, particularly as overseas market-entrants increasingly sought a major stake in the UK's complementary IHC market. Anticipation of liberalization of the public sector from the late-1970s and into the 1980s made the UK a key target market for US corporations. Already they have a decade or more of experience in gaining market share through aggressive acquisition and market positioning, backed by a home-market capital investment infrastructure that would put them in a strong position to compete with the UK's domestic private sector, until then used to a rather limited non-existent field of competition.

Yet, despite some degree of liberalization by partial withdrawal of public sector coverage for certain aspects of public sector provision, and a concerted drive by public policy makers to inject competitive structure into the NHS, the private IHC and PMI sectors did not benefit as markedly as anticipated by both proponents and detractors, from a *marketizing* public sector (after the Community Care Act 1990) during the 1990s. Instead, intra-private sector competition for the remaining, though still relatively slowly growing complementary market, had been the defining feature of the 1990s for the private sector. What resulted was an even more commercialised and internationalised structure, as key providers fought over market share, while key PMI carriers were able to utilize their oligopolistic position in the complementary market to push market forces in their favour. The competition expressed through cost/price-based pressures and a focus on quality and standards of practice have been important levers in filtering out smaller and weaker competitors for the bigger players. Such state regulatory-based factors have been a recurrent determinant of the incremental commercialisation of the private sector, while international entrants have been able to establish a key position in the private acute hospital services market over the years. As can be seen in Table 6.9, the non-UK for-profit groups, both European and American, increased their share of beds from 17.8% in 1991 to 48.2% in 2008.

The most significant changes for the private sector in the 2000s have been a return to pro-competitive health policy, but this time with a clearer agenda for integration of the private sector in the programme of reform. Private sector providers were now expected to become *fully integrated* components of the mixed economy of care, not simply a *mutually coexisting* (even if 'parasitic' from the side of private acute provision) economy of healthcare that had characterised the UK healthcare economy since the post-war years. The intra-private sector competition for market share in public sector procurement has been a key driver for renewed structural change, as new market entrants have been given contracts in this emerging market.

Already by the end of 2007 there has been a notable consolidation after further mergers and acquisitions have begun to filter out the smaller and weaker players in the UK IHC sector. While some of the companies with leading market share across the IHC sector are new, they have built on top of market share developed by prior overseas commercial market entrants. The current market structure has decidedly shifted towards commercial (for-profit) multinationals, even while some market leaders retain *de jure* non-profit status. Thus the latest market scenario has tended to favour larger players which, despite newcomers to the private sector scene taking advantage of the new

market in public sector procurement, has already resulted in some of the top players in the UK acute care market consolidating across both the IHC and public sector procurement sectors (i.e. ISTCs).

6.6. Concluding Remarks

In this chapter I have been looking at the transformation of the UK's private acute hospital sector and the PMI market in order to situate this structural shift within the context of market-oriented changes in the national context of public policy for healthcare services and the emergence of an international healthcare service market. My analysis indicates several key developments since the contingent relationship between market penetration by foreign-owned firms and commercial transformation of these sectors began to take place in the late 1970s (Mohan, 1991; Rayner, 1986). One is the recurrently shifting dynamic in the relationship between the UK's IHC and PMI sectors as the two sectors have developed to some extent in relation to changing priorities of public policy. As public policy has increasingly sought rapprochement between the NHS and private sector provision of healthcare services, the impact of public sector requirements of the private sector on the dynamic of the private sector market has been significant in influencing the competitive reconfigurations of market share within the private sector.

Meanwhile, penetration of the UK's private sector markets for acute hospital services and for PMI continues to demonstrate a contingent impact on the national private market structure, as overseas market entrants have all been commercial entities seeking to develop a stake in markets such as that of the UK where openings are emerging for such companies. As such, the importance of public policy remains high in shaping the terrain for both commercialisation and internationalisation, whether this has been a result of unintended outcomes of public policy such as in the late-1970s, or part of a more overt strategy for reforming the public healthcare system, as has been the case since the early 2000s.

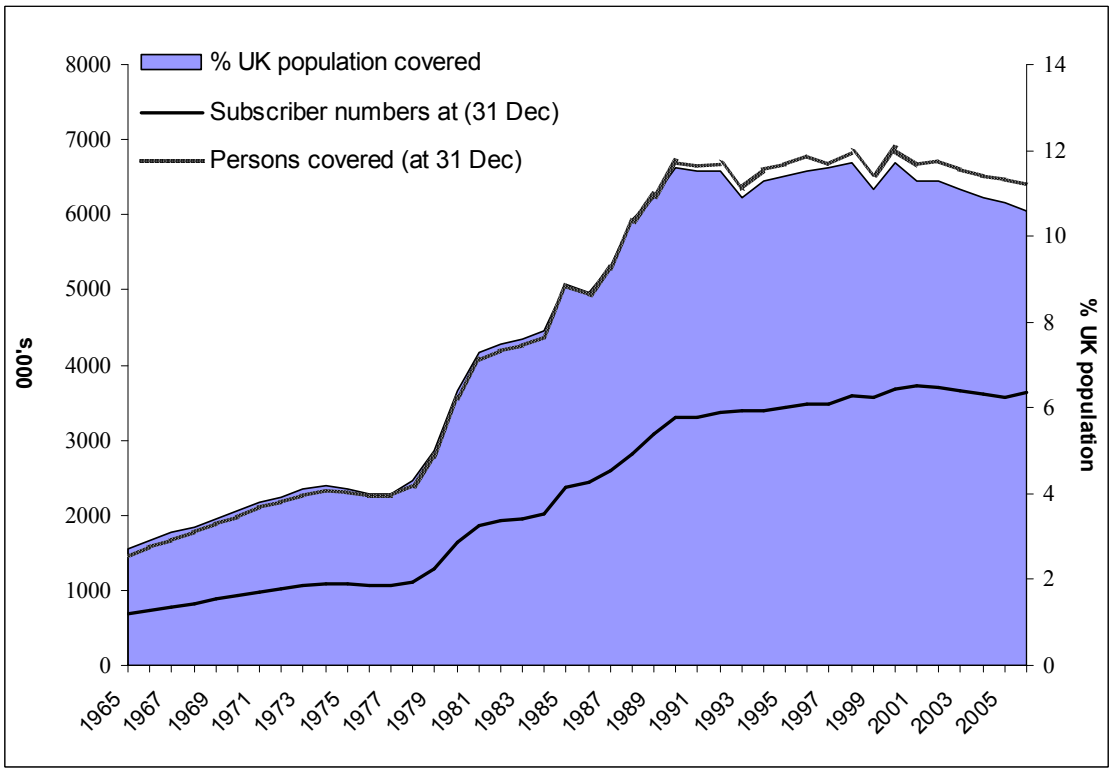
Table 6.1: Total health care expenditure in the UK: NHS and private spending for selected years 1975 - 2006

	UK health expenditure								UK health care sector as % of GDP [4]		
Calendar year	A. NHS [1]		B. Private health care [2]		C. Other medical Products [3]		D. Total Private consump-tion (B + C)	Total (A + B + C)	NHS	Private & Other	Total
	£m	%	£m	%	£m	%	%	£m	%	%	%
1975	5,126	92.6	134	2.4	276	5.0	7.4	5,536	4.8	0.4	5.2
1980	11,257	92.1	355	2.9	615	5.0	7.9	12,227	4.9	0.4	5.3
1985	17,154	89.9	738	3.9	1,190	6.2	10.1	19,082	4.8	0.5	5.4
1990	28,426	88.9	1,623	5.1	1,919	6.0	11.1	31,968	5.1	0.6	5.7
1995	41,853	86.2	2,808	5.8	3,919	8.1	13.8	48,580	5.8	0.9	6.8
2000	57,067	84.8	4,927	7.3	5,294	7.9	15.2	67,288	6.0	1.1	7.1
2004	86,324	85.7	7,690	7.6	6,750	6.7	14.3	100,764	7.3	1.2	8.6
2005e	95,951	86.8	8,118	7.3	6,434	5.8	13.2	110,503	7.8	1.2	9
2006e	104,101	86.8	8,676	7.2	7,199	6.0	13.2	119,976	8.2	1.2	9.4

Notes: e = OHE estimates; [1] Including charges paid by patients; [2] Consumer expenditure on private medical insurance (PMI) and private medical treatment; [3] Figures relate to consumer expenditure on medical goods including medicines not purchased on NHS prescription, and expenditure on therapeutic equipment such as spectacles, contact lenses and hearing aids; [4] GDP at market prices.

Sources: Office of Health Economics (2003 & 2007): using data from Office of National Statistics ('Consumer Trends'; 'Annual Abstract of Statistics'; 'Economic Trends'); Department of Health ('The Government's Expenditure Plans'); Laing's Healthcare Market Review (Laing and Buisson)

Figure 6.1: PMI subscriptions UK (numbers subscribed and % of population covered), 1965-2006



Source: Laing & Buisson (1999 & 2008)

Table 6.2: NHS income from private treatment & share of private acute healthcare market, UK 1972-2006

Year Beginning 1 April	NHS private patient income £million	Market Share [1] %
1972	14	48.3
1973	13	39.4
1974	17	41.5
1975	22	42.3
1976	27	44.3
1977	30	40.5
1978	32	41.0
1979	37	38.9
1980	48	33.1
1981	56	25.3
1982	54	19.5
1983	60	18.2
1984	61	15.8
1985	67	14.3
1986	65	12.3
1987	73	11.7
1988	83	11.2
1989	99	11.5
1990	113	11.1
1991	147	12.9
1992	164	13.3
1993	185	13.8
1994	209	14.3
1995	229	14.6
1996	249	14.7
1997	288	15.7
1998	309	15.2
1999	321	14.6
2000	334	14.0
2001	359	13.4
2002	388	12.9
2003	389	12.1
2004	401	11.0
2005	417	10.1
2006	429	9.7

Notes: [1] NHS private patient income as % of (NHS private patient income + Total Independent Hospital Revenue)
Source: 1972/1973 to 1993/94 NHS summarised accounts; 1994/5 onwards Laing & Buisson's NHS Trusts & Primary Care Trusts Financial Database 2003 & 2008: 1972-2000 in Laing & Buisson (2002), 2001-2006 in Laing & Buisson (2008)

Table 6.3: Private medical insurance coverage in the UK: 1955-2005 (5 year intervals)

	Subscriber numbers at 31 Dec	Percent Growth on previous year shown	Persons covered 31 Dec	Percent growth on previous year shown	Persons covered	Percent Growth on previous year shown
	000's	%	000's	%	% UK pop.	%
1955	274	-	585	-	1.2	-
1960	467	+70.4	995	+70.1	1.9	+58.3
1965	680	+45.6	1445	+45.2	2.7	+42.1
1970	930	+36.8	1982	+37.2	3.6	+33.3
1975	1087	+16.9	2315	+16.8	4.1	+13.9
1980	1647	+51.5	3577	+54.5	6.4	+56.1
1985	2380	+44.5	5057	+41.4	8.9	+39.1
1990	3300	+38.7	6692	+32.3	11.6	+30.3
1995	3430	+3.9	6673	-0.3	11.4	-1.7
2000	3677	+7.2	6867	+2.9	11.7	+2.6
2005	3574	-2.8	6474	-5.7	10.8	-7.7

Sources: Laing & Buisson (1999, 2005 & 2008)

Table 6.4: PMI provider market share by subscription income, UK 1992-2006*

	1992	1997	2001	2002	2003	2004	2005	2006
					£ millions			
BUPA	-	-	994	1,113	1,193	1,263	1,335	1,381
AXA PPP healthcare	-	-	673	675	675	685	724	775
Norwich Union	-	-	227	255	270 [1]	280 [1]	281	309
Standard Life H/care	-	-	167 [1]	173 [1]	194 [1]	207 [2]	200 [1]	244 [1]
CIGNA	-	-	90	96	94	86	na	106
WPA	-	-	113 [1]	109 [1]	102 [1]	101 [1]	100 [1]	101 [1]
Simplyhealth Group [3]	-	-	21	na	na	na	80	84
Pru Health	-	-	na	na	-	-	9 [1]	36
Exeter Friendly	-	-	22	25	30	34	35	36
CS Healthcare	-	-	15	na	na	18	19	19 [1]
Clinicare [4]	-	-	na	na	30	31	36 [1]	-
FirstAssist (R&SA) [5]	-	-	na	na	121	105	na	na
BCWA [3]	-	-	58	62	65	63 [1]	-	-
AIG Europe	-	-	na	na	13	na	na	na
Other insurers [6]	-	-	156	235	193	181	326	173
ALL PMI CARRIERS [7]	**-**	**-**	**2,657**	**2,879**	**2,980**	**3,053**	**3,145**	**3,263**

Table 6.4: *continued*

	1992	1997	2001	2002	2003	2004	2005	2006
	% of total PMI subscription income							
BUPA	44.0	37.0	37.0	38.5	40.0	41.5	42.5	42.5
AXA PPP healthcare	28.0	29.0	25.0	23.5	22.5	22.5	23.0	24.0
Norwich Union	3.5	7.0	9.0	9.0	9.0	9.0	9.0	9.5
Standard Life H/care	3.0	5.5	6.0	6.0	6.5	7.0	6.5	7.5
CIGNA	3.0	2.5	3.0	3.0	3.0	3.0	na	3.0
WPA	5.0	5.0	4.0	4.0	3.5	3.5	3.0	3.0
Simplyhealth Group [3]	<1.0	<1.0	<1.0	na	na	na	2.5	2.5
Pru Health	-	-	-	-	-	-	< 0.5	1.0
Exeter Friendly	<1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
CS Healthcare	<1.0	<1.0	<1.0	na	na	0.5	0.5	0.5
Clinicare [4]	-	-	-	-	1.0	1.0	1.0	-
FirstAssist (R&SA) [5]	2.5	2.0	5.0	5.0	4.0	3.5	na	na
BCWA [3]	2.0	2.0	2.0	2.0	2.0	2.0	-	-
AIG Europe	-	-	-	-	0.5	na	na	na
Other insurers [6]	-	-	-	-	6.5	6.0	10.5	5.5
ALL PMI CARRIERS [7]	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Notes: [*] Ranking at 2006 figures; [1] Taken from annual report & accounts; [2] Estimated from 13.5 month period reported in annual report and accounts; [3] Simplyhealth Group includes BCWA (acquired 2002) and HAS Personal Medical Plans; [4] Clinicare acquired by Groupama Insurances Group in October 2005. Groupama's subscription income and market share for 2006 included in 'Other Insurers'; [5] First Assist's PMI business acquired by Standard Life Healthcare in September 2005. Royal & Sun Alliance prior to 2003; [6] 'Other private medical insurers' includes providers with market shares in excess of 1% which do not wish their premium income figures to be published separately and no other income figure is publicly available in their accounts (or their accounts are not yet available). Also includes insurers with market shares below 1%; [7] Sum of market share may not be equal to 100 due to rounding.

Source: 1991-2002 from Laing & Buisson (2002); 2003-2006 from Laing & Buisson (2008)

Table 6.5: NHS procurement from independent hospitals and clinics (IHC), UK: By revenues, 1992-2007

Year	Total IHC Revenue [a] (£ millions)	NHS purchase of independent acute medical/surgical services [b]		
		£ millions	% of Total IHC revenue [c]	% change on prev. year [c]
1992	1073	53	*4.9*	-
1993	1154	63	*5.5*	*0.5*
1994	1249	75	*6.0*	*0.5*
1995	1350	83	*6.1*	*0.1*
1996	1445	88	*6.1*	*-0.1*
1997	1541	96	*6.2*	*0.1*
1998	1720	108	*6.3*	*0.0*
1999	1884	149	*7.9*	*1.6*
2000	2059	136	*6.6*	*-1.3*
2001	2318	170	*7.3*	*0.7*
2002	2611	190	*7.3*	*-0.1*
2003	2927	205	*7.0*	*-0.3*
2004	3291	255	*7.7*	*0.7*
2005	3753	405	*10.8*	*3.0*
2006	3972	470	*11.8*	*1.0*
2007	4274	615	*14.4*	*2.6*

Notes: [a] Figures for 'Total IHC Revenue' are derived from value estimates of the non-NHS private hospital and clinical sector (£millions) quoted in Laing & Buisson (see Sources). These figures are strictly estimates for 'independent' hospitals and clinics, and do not include revenues from NHS PPUs (including PPUs managed by private hospital and clinical providers). Estimates are based on revenues reported in the *Fitzhugh Directory of Independent Healthcare* (period 1992-1999), and reports from audited accounts of hospital operators reported in Laing & Buisson's *Healthcare Market Review* (period 2000-2007);
[b] NHS purchase of acute medical/surgical treatment and mental health services from independent hospitals are estimated from Department of Health 'Reference Costs 2003/04: Non NHS Providers Schedule' & 'Reference Costs 2006/07: Non NHS Providers Schedule' in England, published expenditure totals on centrally procured elective and diagnostic services, and published accounts of ISTC operators;
[c] Percentage figures are my own calculations based on data presented in Laing & Buisson's *Healthcare Market Review* (see Sources)

Sources: Laing & Buisson (2003, 2004 & 2008)

Table 6.6: Independent Hospital and Clinical (Acute Care) Providers: Market Share by Units, UK (2000-2008)

	2000				2004				2008			
	Operator	**Hospitals**	**Beds**	**Share of Beds (%)**	**Operator**	**Hospitals**	**Beds**	**Share of Beds (%)**	**Operator**	**Hospitals**	**Beds**	**Share of Beds (%)**
1	GHG (BMI)	43	2180	21.8	GHG (BMI)	45	2267	24.7	Netcare	56	2660	28.0
2	BUPA Hospitals Ltd.	36	1810	18.1	Nuffield hospitals	43	1689	18.4	Spire Healthcare	36	1787	18.8
3	Nuffield Hospitals	41	1618	16.2	BUPA Hospitals Ltd	35	1590	17.3	Nuffield Health	30	1318	13.9
	Top 3 Providers	**120**	**5608**	**56.2**	**Top 3 Providers**	**123**	**5546**	**60.4**	**Top 3 Providers**	**122**	**5765**	**60.8**
4	Community Hospitals Group plc	22	826	8.3	Capio Healthcare Ltd	23	868	9.5	Ramsay Health Care	33	939	9.9
5	HCA International Ltd	7	755	7.6	HCA International Ltd	6	730	8.0	HCA	6	749	7.9
6	British Pregnancy Advisory Service	9	211	2.1	Medical Services International	1	150	1.6	St. John & Elizabeth	1	155	1.6
7	Abbey Hospitals Ltd/	7	146	1.5	United Surgical Partners (Aspen)	3	149	1.6	Aspen HC	3	147	1.5
8	King Edward VII hospital Group	2	131	1.3	Benenden Hospital Trust	1	145	1.6	The London Clinic	1	144	1.5
9	United Surgical Partners (Aspen Healthcare)	2	127	1.3	The London Clinic	1	144	1.6	Covenent HC	8	133	1.4
10	Hospital Management Trust	3	112	1.1	Covenant Healthcare Ltd.	9	143	1.6	BUPA	1	128	1.3
	Top 10 Providers	**172**	**7916**	**79.4**	**Top 10 Providers**	**167**	**7875**	**85.9**	**Top 10 Providers**	**175**	**8160**	**85.9**
	All Other	49	1962	20.6	All Other	78	1301	14.1	All Other	160	1329	14.1
	TOTAL	**225**	**9980**	**100.0**	**TOTAL**	**249**	**9176**	**100.0**	**TOTAL**	**335**	**9489**	**100.0**

Sources: Laing & Buisson (2000-2008)

Table 6.7: Independent Hospital and Clinical (Acute Care) Providers: Market Share by Revenues, UK (2000-2007)

	2000			2003			2007		
	Operator	**Revenues** (£ millions)	**Share of Total IHC revenues** (%)	**Operator**	**Revenues** (£ millions)	**Share of Total IHC revenues** (%)	**Operator**	**Revenues** (£ millions)	**Share of Total IHC revenues** (%)
1	GHG plc[1]	392.8	24.0	GHG	324.2	23.4	GHG plc*	665.1	20.5
							Netcare Healthcare UK*	23.8	0.7
2	BUPA Hospitals	328.1	20.1	BUPA Hospitals	441.2	20.0	BUPA Hospitals	505.9	15.6
3	Nuffield Nursing Homes Trust Ltd	243.9	14.9	Nuffield Hospitals	409.4	18.6	Nuffield Nursing Homes Trust Ltd	449.3	13.9
	Top 3 Providers	**964.8**	**59.1**		**1365.1**	**62.0**		**1644.1**	**50.8**
4	HCA International Ltd	170.0	10.4	HCA International	226.0	10.3	HCA	368.7	11.4
5	Community Hospitals Group plc [2]	123.9	7.6	Capio healthcare	169.1	7.7	Ramsay Health Care UK	236.2	7.3
6	Trustees of the London Clinic Ltd	44.6	2.7	Trustees of the London Clinic	60.0	2.7	Classic Hospitals	94.4	2.9
7	Medical Services International Ltd	45.7	2.6	Medical Services International	55.3	2.5	Partnerhsip Health Group UK**	54.4	1.7
							Care UK**	40.0	1.2
8	Aspen Healthcare Ltd	24.0	1.5	Covenant Healthcare	36.9	1.7	Trustees of London Clinic	84.7	2.6
9	King Edward VII Hospital Group	21.0	1.3	Aspen Healthcare	32.6	1.5	Covenant Healthcare	71.2	2.2
10	Healthcare Scotland [3]	14.9	1.1	Hospital of St john & Elizabeth	23.7	1.1	Bupa's Cromwell hospital	61.3	1.9
	Top 10 Providers	**1408.8**	**86.3**	**Top 10 Providers**	**1968.7**	**89.4**	**Top 10 Providers**	**2655.1**	**82.0**
	TOTAL	**1632**	**100.0**	**TOTAL**	**2201.7**	**100.0**	**TOTAL**	**3239.2**	**100.0**

Notes: (*) GHG plc and Netcare Healthcare UK merged at the end of 2007; (**) Partnership Health Group UK and Care UK merged at the end of 2007

Sources: Laing & Buisson (2000-2008)

Table 6.8: Market Share of Operational [1] ISTC and Diagnostic Contracts with NHS: by number of contracts and number of procedures contracted for (2003-2007) [2]

Parent companies [3]	Country of origin	Number of procedures contracted for	Market share by number of procedures contracted for	Cumulative contract value by parent firm (£mil) [7]	Market share by cumulative contract value (%)	Total contracts with NHS
Netcare SA [4]	South Africa	1,497,600	41.5	280	14.9	4
InHealth Group [4]	UK	1,400,000	38.8	140	7.5	1
Ramsay Healthcare	Australia	229,600	6.4	350	18.7	10
Dubai International Capital	UAE	130,000	3.6	75	4.0	1
Care UK	UK	106,100	2.9	495	26.4	8
Circle Health	UK	93,300	2.6	112	6.0	2
BUPA [5]	UK	60,000	1.7	55	2.9	1
Independent Physician Groups	UK	56,250	1.6	110	5.9	1
Inter Health Canada	Canada	33,800	0.9	136	7.3	2
Birkdale	UK	5,150	0.1	5	0.3	1
Cinven	Europe	na	na	115	6.1	2
TOTAL [6]		**3,611,800**	**100.0**	**1873**	**100.0**	**33**
Non-UK total		**1,891,000**	**52.4**	**956**	**51.0**	**19**

Notes: [1] Includes some units that have been approved but not yet started; [2] NB: Figures should be read with caution as they relate to an estimated measure for all figures based on cumulative sums from 2003 to end-2007; [3] Parent companies as at end of 2007 (some of the contracts operate as different subsidiaries under the same parent company); [4] Joint venture between Netcare and *InHealth*; [5] BUPA's sole contract ended at the end of 2007; [6] Birkdale contract terminated Feb 2006; [7] Minimum stated contract value selected for these calculations.

Source: Laing & Buisson (2008)

Table 6.9: Acute hospital percentage share of bed numbers by ownership type, 1991-2008[1]

Ownership Type [2]:	1991	2000	2004	2008
British For-Profit Groups	32.7	50.4	44.6	24.3
European For-Profit Groups	(15.4)	na	na	na
American / Other For-Profit Groups [3]	(2.4)	(9.7)	na	na
Non-UK For-Profit Groups [4]	17.8 [5]	9.7 [5]	20.7	48.2
Not-For-Profit Groups [6]	25.3	21.1	21.1	16.6
Not-For-Profit Non-Affiliated [6]	14.5	12.3	10.6	7.1
Non-Affiliated For-Profit	9.7	6.6	3.1	3.7
Total	100.0	100.0	100.0	100.0
Summaries [6]:				
For-Profit	60.2	66.6	68.3	76.2
Not For Profit [4]	39.8	33.4	31.7	23.8
Groups	75.9	81.2	86.4	89.1
Non-affiliated	24.1	18.8	13.6	10.9
UK	82.2	90.3	79.3	51.8
Non-UK	17.8	9.7	20.7	48.2

Notes: [1] Figures for years shown are for mid-year; [2] Figures relate to acute medical/surgical beds in hospitals with one or more operating theatres, registered to take in-patients, including establishments specialising in termination of pregnancy; [3] Classed as 'American (joint-venture) for profit Groups; [4] For years 2004-2008 the distinction between 'European' and 'US/Other' For-Profit Groups is not made in the Laing & Buisson data but presented in aggregated for as 'Non-UK For-Profit Groups'; [5] Shows sum of above two categories in brackets; [6] 'Not-For-Profit' is variably classed as 'Charitable' and 'Charitable/ Religious', or just 'Not-For-Profit' in Laing (1991) and different editions of Laing & Buisson data; [6] My own calculations based on above data.

Sources: Laing (1992, p.15); Laing & Buisson (annual editions 1999 through 2008)

Chapter 7: Conclusion

This thesis has made a contribution towards analysing the relationship between globalisation and the commercialisation in the healthcare services sector and - the way in which these changes are articulated in the healthcare systems of OECD countries; a group of countries that in principle share a broadly similar socio-economic status as 'developed' countries. In this thesis I set out to examine the actual substance of globalisation as an explanatory concept with regard to particular areas within the healthcare service sector which have been experiencing a substantive trend of commercialisation over the past few decades. The empirical focus of the study has given weight to examining the public policy context for commercialisation of healthcare services in OECD countries. Furthermore, I have examined a number of key dimensions of the internationalisation of commercial relations regarding the healthcare services sector, in this case focusing more on particular segments of the healthcare service market.

A more focused historical investigation of key segments in the US and UK private healthcare services sector has provided a more concrete analytical basis to ascertain how the relationship between globalisation and commercialisation is articulated in a national context. Although not set out explicitly as a comparative study, a historical examination of the experience of these countries with a commercial transformation in their respective healthcare sectors brings to the fore issues that resonate with the OECD countries more broadly. The substantially different context in which commercialisation of healthcare services has taken place in each of them also provides a more diverse viewpoint from which to interrogate the relationship between globalisation and commercialisation as developments that have become increasingly important dimensions facing public policy over the past three decades.

7.1. Key findings of the thesis

While an increasing amount of literature has engaged with the challenge of globalisation in relation to health and the healthcare sector since the late 1990s, my view is that little of this has explicitly considered the substance of globalisation as an explanatory factor with regard to qualitative changes experienced in the healthcare sector. Ultimately, my argument is that globalisation offers an inadequate conceptual framework to explain the emergence of an international healthcare services market and the commercial transformation of healthcare services against the background of market-oriented reforms that have become a widespread trend across the OECD member states.

While the varying degrees of adoption of market-oriented healthcare reforms have been important in opening up space to the private sector in many OECD countries, the bottom line is that the specific national regulatory environment, together with public policy priorities for healthcare reforms, are key defining factors in driving particular patterns of commercialisation in individual countries. As such, an understanding of the internationalisation of trade in healthcare services requires vigorous analysis of these mechanisms driving commercialisation in the specific national context.

This, however, does not preclude the importance of internationalisation of healthcare service firms and its impact on national market structures. As shown by the analysis of private healthcare services in the UK, market penetration from foreign-owned firms has been an important factor in changing the structure of the private sector healthcare market. However, this development could not have taken place without either particular regimes of *accommodation* and later of *pro-competitive* public policy in either the US and the UK. While one might extrapolate international diffusion of ideas between countries about healthcare reform, the specific dynamic that the regulatory structures implemented in each country has generated in their respective private healthcare service sectors is very much related to the particular public policy objectives of each of these countries and the political economy structure of their respective healthcare systems. In the rest of this section, I briefly reflect on the key findings of the thesis.

Shifting in the public-private mix

I have shown that there is wide variation in the experience of market-oriented healthcare reform in the OECD countries. For instance, spending limits through wage, price or budget controls have, in most cases, been both a product of incremental changes over extended periods of time and

changing public policy priorities within broader reform programmes. As such, wage, price, and budget controls provide a contextual background within broader reforms rather than having an immediate impact on the public-private mix. Budgetary caps and price controls may also be a stimulus to divest certain activities from public sector provision. However, budgetary constraints in the case of hospitals have also tended to work in tandem with policies to rationalise overall hospital capacity.

While the marketisation of healthcare provision has been an important trend over the past three decades, the expansion of increasingly largeer commercial healthcare corporations is mainly predicated on the space either left unoccupied by the public sector or where the private sector is already firmly established. The most obvious case is the US, where private provision makes up the bulk of healthcare service provision and financing. In the UK, the space opened for the private hospital sector, while initially based on residual gaps in NHS provision and the foundational compromise with medical professionals, has in most recent years been a product of government priorities for restructuring the NHS in a 'pro-competitive' form. Overall, between the 1990s and the early 2000s, the growth of private healthcare sector provision and financing has been a key development in several OECD countries, but it is still a tentative trend. It appears rather unlikely that a complete reversal from incremental privatisation will take place, particularly since governments are still keen to diversify the choice available to patients, taking into account both the limits of public financing and the need to meet changing demand patterns.

International comparison of commercialisation trends

The trends of privatisation and commercialisation in contemporary OECD healthcare systems, as discussed in chapter 3, provide clear indications for an expanding international market in healthcare services. Changing structural economic conditions that have been accompanied by a shift in public policy favoured a more 'market-oriented' approach to the financing and delivery of healthcare services. The evidence supports that the private sector is increasingly expanding its share in the public-private mix in most OECD healthcare systems. Moreover, it is the commercial private sector which has tended to capitalise the most on the 'pro-competitive' turn in healthcare policy. As such, it is not only the public sector *per se* that is being affected, but also the private non-profit sector which has been losing ground to commercial modes of financing and provision.

This trend has mostly been a national and rather localised phenomenon: that is, commercial healthcare providers have expanded their market share within national boundaries, while cross-

border commercial expansion has become a more notable feature of the healthcare services market since the early 1990s. Moreover, while international market penetration by commercial providers is overshadowed in scale by national-level developments, there is already evidence showing the capacity of such cross-border commercial penetration to have a transformative effect on national healthcare service markets.

In the context of the current international agenda for liberalisation of trade in services, the possibility of an intensifying commercial transformation of healthcare services, facilitated by public policies for liberalisation and for privatisation of healthcare financing and provision, the international expansionary activities of commercial providers merit further examination. Due attention should also be paid, to developments of international trade in healthcare services. Following the four *modes of supply,* comprising the basis for the WTO's General Agreement on Trade in Services, there are indications of a significant growth in international exchanges in healthcare services.

Internationalisation of healthcare service providers

The internationalisation of healthcare services is highly variable with regard to the development of its different dimensions, being highly uneven between firms and sectors, and largely dependent on the facility for commercial opportunities to develop. I have noted considerable variation in the degree of overseas market penetration across different segments of the international healthcare services market. Nonetheless, there are a number of cases of large multinational conglomerates amongst both health insurance suppliers and hospital providers.

In the former case, the trend has been for absorption into ever larger diversified insurance and financial product companies. This allows parent companies to spread risk more easily across their different fields of business. It also demonstrates a tendency to focus on the most profitable areas of health insurance such as the 'corporate market' supplying professionals in other multinationals or large national corporations.

The US experience

The US system is closer to being a market-oriented healthcare economy, whereas the UK is closer to a state-funded healthcare provider. Nevertheless, both systems are composed of extensive regulatory structures, with quality of care problems being prevalent in both countries. Private healthcare service provision has been a ubiquitous feature of US healthcare from its early days.

However, historical analysis indicates that the commercial dimension of healthcare has been a much more recent development in the US and has been contingent on a combination of the particular political-institutional structure of the federation and the recurrent political compromises, illustrated by historic efforts to reform healthcare service provision and financing.

The continuous accommodation of particularly strong capitalist interests in US public policy has been a key factor in enabling the rapid corporatisation and commercialisation of US healthcare service provision and financing, to the extent that this has become a deeply entrenched feature of the US healthcare economy. A relatively small number of healthcare service firms have in turn become even stronger through increasing market share. The US case provides a basis for examining the process of commercial transformation in a location where such a process had been historically unprecedented in other countries. It also provides an impetus to understanding the causes for the internationalisation of commercial healthcare service operators, given the relatively large number of US firms seeking to expand their activities into overseas markets.

The UK experience

Since the establishment of the NHS in 1948, changes in the UK's public-private mix healthcare services by the clear dominance of the public sector as the primary payer of healthcare services since that time, retaining its position at above 80% of national health expenditure. Indeed, the transformation of the UK's private acute sector and its strong relationship to the PMI market is indicative of the private sector market for healthcare as it is, on the other hand, of its changing relationship with the public sector over the past three decades.

In the first case, commercial expansion has been one of the primary characteristics of the private sector, as overseas market-entrants increasingly sought a major stake in the UK's complementary IHC market. Anticipation of liberalisation of the public sector from the late-1970s to the 1980s made the UK a key target market for US firms through aggressive acquisition and market positioning, backed by a home-market investment infrastructure of market entrants.

Yet, despite some degree of liberalisation and a concerted drive by public policy makers to inject competitive structure into the NHS, the private IHC and PMI sectors did not benefit as much as anticipated from a *marketising* public sector during the 1990s. Instead, intra-private sector competition for the remaining complementary market intensified, thus driving it towards a more commercialised and internationalised structure. Price competition and a focus on quality have been important levers for the bigger players in filtering out smaller competitors.

The most significant changes for the private sector in the 2000s have been a return to pro-competitive health policy but with greater interventionism. Private sector providers are now expected to become *fully integrated* in the mixed economy of care. The intra-private sector competition for market share in public sector procurement has been a key driver for structural change in both the private acute sector and the PMI market. By the end of 2007, there has been a notable consolidation after further mergers and acquisitions have begun to filter out the smaller players in the UK IHC sector with the current market structure decidedly shifted towards commercial multinationals.

In the second case, there has clearly been a sea-change in the way the private sector has been given greater space by public policy. Yet, the current regime is at a completely different place from the 1970s-1980s juncture where *accommodation* of the private sector would best characterise the approach of public policy to IHC providers and PMI. The momentum gained by the consecutive Conservative governments for market-oriented reforms during their term in office, did not translate into a concerted pro-competitive plan for the private sector. Only under New Labour has there been an *integrated* approach in its pro-competitive policy for reform so that IHC providers have been given a 'leg up', in a way that has been historically unprecedented.

7.2. Key Reflections on commercialisation and internationalisation of healthcare services

Commercialisation of healthcare services encompasses a broad set of changes that are articulated to varying degrees in different national contexts. In the most specific sense, services that are *commercialised* are those rendered for a fee, which is clearly aimed at the generation of profit margins for the benefit of private owners, as opposed to being reinvested in the organisation for the benefit of its users as is typically the case for non-profit or public institutions.

While the boundaries of ownership are relatively clear from a legal perspective, from an operational system perspective, the boundaries can be more fudged and have become increasingly ambiguous over the past few decades. Public sector funding may cover private sector provision, as is the case in the German social health insurance system, the UK's ISTC programme, or the US Medicaid and Medicare programmes. Private sector provision may be undertaken by 'non-profit' and 'for-profit' owned organisations under the same organisational umbrella, as is the case with the Blue Cross Blue Shield network in the US or the BUPA network's hospital portfolio.

Moreover, the commercial nature of healthcare services contains a further layer of meaning in this context. Where public participation is scaled back, minimal or absent, the space left is *de facto* ceded to private sources of financing. With the majority of costs of care being out of reach for most individuals and households, this means an expanded role for private health/ medical insurance. This is the case for acute hospital-based services, for long-term care for chronic conditions and the elderly, mental health, dental and ophthalmic services, but also for many prescription pharmaceuticals. In the absence of, or with scaling back of public investment in the provision of healthcare services, private sector provision is likely to fill the remaining gaps, as is the case for long-term care, mental health facilities or dental and ophthalmic services.

Key mechanisms encouraging or facilitating commercialisation may include: active public policy measures as a means to promote deregulation, which would allow greater scope for expanded market share of commercial operators at both national and international levels. In addition, putting forward pro-competitive policy measures as a means of generating anticipated efficiency gains and cost reduction focusing on actions such as marketisation policies (UK) specified for different segments and Managed Care initiatives (US), or encouraging the expansion of private operators through: competitive contracting (UK) or competitive relations within the managed care fold (US). However, some public policy action facilitating commercialisation has been decidedly passive, such as the accommodatory stance and laissez-faire periods of UK policy towards the growth of the private sector, so that intra-market structural changes have been un-anticipated outcomes of regulations for the public sector, whilst applied unevenly to the private sector (i.e. the establishment of preferred provider networks in the UK).

The growing international market presence of large corporate healthcare service firms has brought an additional dimension into the picture. Even so, the global reach of such firms is quite uneven, with substantial variation in the degree of market penetration across different segments of the international healthcare market. For instance, hospital service providers have generally been limited to relatively small numbers of overseas operations. By contrast, the health insurance sector demonstrates a bifurcation between larger multi-product insurance firms and specialised health and medical care insurers.

In both provision and financing, the larger players have been at a distinct advantage in establishing overseas ventures, being also commercial firms with significant stakes in their domestic markets. Although early stages of overseas market penetration had preceded the degree to

which market-oriented healthcare reforms have become commonplace since the 1990s, this enabled commercial firms to expand further at international level.

7.3. Policy recommendations

Although I have not set out to make policy recommendations in writing this thesis, a few points arising from my research I feel ought to be laid out briefly which I think are important for public policy. Whether the advance of commercialisation continues to develop more intensively in the coming years or whether such a development is curtailed, as national governments find alternative methods of addressing the challenges to healthcare service financing and provision, my points rest on both long-standing issues regarding commercial healthcare services and the implications of continuing or future commercialisation of healthcare services.

On an instrumental level, and with direct implications for both public policy formation and academic research, is the issue of collection of quantitative data. Data regarding the private sector in healthcare services is considerably limited, particularly in the UK. In an era of 'evidence-based policy', if the use of market-oriented healthcare reforms is to have an impact other than ceding responsibility and control to private sector organisations for the delivery and financing of healthcare services, this is a crucial issue for governing and regulatory agencies to pay attention to. It is especially important for national governmental agencies, tasked with monitoring provision, financing or regulation of healthcare services, to compile reliable and more systematic, high-quality data - not only for expenditures but providing a wider coverage for the activities and performance of private sector providers and insurers - and to ensure that this is transparent and accessible to all.

The regulation of healthcare services in all countries tends to be a fragmented patchwork of self-regulatory institutional arrangements, semi-formal state regulation, and full-on state regulation, with intersections between private self-regulation and public/state regulation varying between market segments and aspects of healthcare service provision and financing. Commercialisation, in a strict sense, implies a shift from state control and regulation to greater private sector control and self-regulating practices. However, in practice this shift is not definitive, especially considering the multiplicity of institutional forms that prevail in both highly market-oriented healthcare systems (US) and more public-oriented systems (UK). Moreover, historical analysis of the evolution of these systems indicates that regulation becomes an increasingly important factor as market-based structures become more pervasive. As such, regulatory competence needs to be improved including

through increasing quality of regulation, and enhancing the existing structures of monitoring and public accountability of both regulators and the regulated.

If commercialisation continues to be pursued in public policy it should be done extremely cautiously. Although market-oriented reforms have helped to highlight certain deficiencies of public owned and controlled healthcare, extant examples of market-based healthcare financing and provision put into question the validity of commercialising healthcare. It is likely to create greater inequalities, reduce transparency and accountability with choice being limited, by necessity, to the packages that serve the interests of commercial providers rather than the immediate or long-term needs of patients.

7.4. Developing the research agenda

The research and analysis undertaken for this thesis points to a number of issues that require further research and can be considered as part of a future research agenda developing out of this thesis. A growing body of research can already be seen exploring how market-oriented reforms have been and are transforming healthcare systems and specific sub-sectors within these. However, I think that there is still a lot to be done to analyse how market-oriented reforms and international commercial regulatory frameworks are transforming domestic/national private sectors, and also how these have been changing over extended time-frames. In the first instance there is a need to devote more research to such issues as the motivations and strategies of private sector healthcare providers (whether hospitals, long-term care providers, primary care providers or public health organisations) and financing organisations (i.e. insurers). Studies exploring how their market position, the structure of their respective markets, and the interactions between these market segments are being changed by public policy and also how they are impacted on by other economic and political factors are still very much in the minority. In the second instance, I am arguing for more extensive historical research on the transformation of private healthcare services, whether non-profit or for-profit. As several authors have pointed out, history has a habit of repeating itself, especially as ideas about how to think about certain problems go through fashions (Light, 2007; Hunter, 2008), while many of the problems at the root of social, economic and political relations continue to be present (Stevens, 2006; Marmor, 2000)

Related to these points, key questions that should be part of ongoing research need to focus on such issues as the constraints and opportunities for commercial providers generated by international trade agreements and to what extent commercial healthcare services are engaged in

driving international liberalisation. This has been the case in other areas of international trade liberalisation, but there is currently little or no research on the role of healthcare services firms in this context. A further issue that requires analysis is the role of investment capital in the development of commercial healthcare services. So far, from my limited research on this question with regard to the hospital and insurance sectors, it appears that investment capital tends to follow from opportunities arising out of national deregulation. However, with a few cases shown of major investment capital groups buying out some of the top players in these sectors (even if for short term), this is a tendency to observe in future.

7.5. Final concluding note

International economic changes highlight what are already grave pressures on healthcare systems, they do not in themselves generate these pressures. Yet, the role of states remains central to the commercial orientation of healthcare services and will continue to do so in the near future. Decisions about the allocation of public resources remain central even in historically more market-oriented systems (US) and this is unlikely to be avoided even as the commercial provision and financing of healthcare are encouraged. While I believe that commercialisation in healthcare services is a trend that should be regarded cautiously by public policy makers and citizens alike, it is difficult to envisage the current trend for commercialisation being reversed, since it is hard to dislodge these relationships once they are in place. Indeed this is a key reason for resisting the commercialisation route in the first place, since the solid gains made in the post-WWII era for healthcare which are already being eroded by the market-oriented turn.

Bibliography

Abel-Smith, B. & Mossialos, E. (1994) *Cost Containment and Health Care Reform: A Study of the European Union*, Occasional Paper in Health Policy No. 2, London: London School of Economics & Political Science.

Abel-Smith, B. (1992) *Cost Containment and New Priorities in Health Care: A study of the European Community*, Aldershot: Avebury Publishing Ltd.

Aetna (2000) 'Aetna Completes Sale of Financial Services and International Businesses to ING and Spinoff of Health Business to its Shareholders', Aetna Inc., <http://www.aetna.com/news/2000/pr_20001213b.htm> [Pub: December 2000; Acc: July 2004].

Aiken, L.H., Buchan, J., Sochalski, J., Nichols, B. & Powell, M. (2004) 'Trends In International Nurse Migration', *Health Affairs*, 23(3), pp.69-77.

Alcock, P. & Craig, G. (eds) (2001) *International Social Policy: Welfare Regimes in the Developed World*, Basingstoke & New York: Palgrave.

Alliance Boots (2006) 'About Us: Our History', Alliance Boots, <http://www.allianceboots.com/About_Us/Our_history.aspx> [Acc: June 2006].

_____(2008) *Alliance Boots Annual Review, 2007/08*, Zurich: Alliance Boots.

Allianz (2006) *Annual Report, Allianz Group 2005*, Munich: Allianz AG

Altenstetter, C. & Haywood, S.C. (eds) (1991) *Comparative Health Policy and the New Right: From Rhetoric to Reality*, Houndmills & London: MacMillan Academic and Professional Ltd.

Altenstetter, C. (2002) 'Health Care in Germany', *Occasional Paper Series No. 49, European Union Studies Center*, <http://www.ciaonet.org/wps/alc02/alc02.html> [Acc: October 2006].

American Hospital Association (2002) *Trend watch chart book 2002, trands affecting hospitals and health systems*, Washington, D.D.: American Hospital Association, Lewing Group, Inc.

Amin, A. & Palan, R., (2001) 'Towards a non-rationalist international political economy', *Review of International Political Economy*, 8(4), pp. 559-577

Andersen, R., Smedby, B. & Vagero, D. (2001) 'Cost containment, solidarity and cautious experimentation: Swedish dilemmas', *Social Science & Medicine*, 52(8), pp.1195-1204.

Andrews, C. (2005) 'Concentration of U.S. Hospitals, 1991–1999, and its Implications for a National Health Program', *International Journal of Health Services*, 35(1), pp.39-61.

Apthorpe, R. & Gasper, D. (eds) (1996) Arguing *Development Policy: Frames and Discourses Introduction: Discourse Analysis and Policy Discourse*, London: Frank Cass.

Armstrong, P., Glynn, A. & Harrison, J. (1991) *Capitalism Since World War II: the making and breakup of the great boom*, Oxford: Basil Blackwell.

Arrow, KJ. (1963) 'Uncertainty and the Welfare Economics of Medical Care', *The American Economic Review*, 53(5), pp.941-973.

Arvidsson, N. (1997) 'Internationalisation of Services Firms: Strategic Considerations', in Chryssochoidis, G., Millar, C. & Clegg, J. (eds) *Internationalisation Strategies*, Houndmills: MacMillan Press Ltd., pp.71-89.

Bach, S. (2006) 'International Mobility of Health Professionals, Brain Drain or Brain Exchange?', Research Paper No. 2006/82, United Nations University/ World Institute for Development Economics.

Bank Loan Report, (2007), 'Healthcare is healthy, but risky', *Bank loan report,* 22(11), pp. 7-8

Bays, C. (1983b) 'Patterns of Hospital Growth: The Case of Profit Hospitals', *Medical Care*, 21(9), pp.850-857.

Beddgood, D. (1999) 'Beyond Dependency or Beyond Capitalism? A Critique of New Zealand's Drive towards Workfare', *Policy Studies*, 20 (2), 133-141.

Berliner, H.S., & Regan, C. (1987) 'Multinational Operations of US For-Profit Hospital Chains: Trends and Implications', *American Journal of Public Health*, 77:10, pp.1280-4.

Berry, J.M. (1989) *Interest Group Society*, London: Harper Collins Publishers.

Blackman, T. (1995) 'Recent Developments in British National Health Policy: An Emerging Role For Local Government?', *Policy And Politics*, 23(1), pp.31-48.

Blank, R.H. & Burau, V. (2004) *Comparative Health Policy*, Basingstoke & New York: Palgrave MacMillan.

Blecker, R.A. (2005) 'Financial Globalisation, Exchange Rates and International Trade', in Epstein, G.A. (ed) *Financialisation and the World Economy*, Cheltenham & Northampton, MA: Edward Elgar, pp.183-209.

Blue Cross Blue Shield Association (2006) 'History of Blue Cross Blue Shield', <http://www.bcbs.com/about/history/2000s.html>, [Pub: August 2006; Acc: November 2006].

Bodenheimer, T.S. & Grumbach, K. (2005) *Understanding Health Policy: A clinical approach*, 4th ed, London: Lange Medical books / McGraw-Hill.

Bottery, M. (2001) 'Globalisation and the UK Competition State: no room for transformational leadership in education?', *School Leadership & Management*, 21(2), pp.199–218.

Boyer, R. (2000) 'The Political in the Era of Globalisation and Finance: Focus on Some *Regulation* School Research', *International Journal of Urban & Regional Research*, 24 (2), pp.274-322.

Braithwaite, J. & Drahos, P. (2000) *Global Business Regulation*, Cambridge: Cambridge University Press.

Brown, C. (1999) 'Susan Strange - a critical appreciation', *Review of International Studies*, 25, pp.531-535.

Buchan, J. & Dovlo, D. (2004) 'International Recruitment of Health Workers to the UK: A Report of DFID', *Health Policy & Development*, 2(3), pp.271-280.

Buckley, PJ. & Casson, M.J. (2000) 'Analyzing Foreign Market Entry Strategies: Extending the Internalisation Approach', in Buckley, P.J. (ed) *Multinational Firms, Cooperation and Competition in the World Economy*, Houndmills & London: MacMillan Press Ltd., pp.61-93.

Burgess, K. & Rigby, E. (2004) 'Prescription for a changing industry', *Financial Times*, Aug 19th.

Buse, K., Mays, N. & Walt, G. (2005) *Making health policy. Understanding public health*, Berkshire: Open University Press.

Busse, R. & Riesberg, A. (2000) *Health in Transition: Germany*, Copenhagen: WHO / European Observatory on Health and Policies.

_____ (2004) *Health in Transition: Germany*, Copenhagen: WHO / European Observatory on Health and Policies.

Cabiades, L. & Guillen, A. (2001) 'Adopting and adapting managed competition: health care reform in Southern Europe', *Social Science & Medicine*, 52(8), pp.1205-1217.

Calnan, M., Cant, S. & Gabe, J. (1993) *Going Private: Why People Pay for their Health Care*, Buckingham: Open University Press.

Cardinal Health (2005) *Cardinal Health Annual Report 2005*, Dublin, OH: Cardinal Health.

Castells, M. (2000) The *Rise of the Network Society, The Information Age: Economy, Society and Culture,* Vol. I., 2nd Edition, Cambridge, MA & Oxford, UK: Blackwell.

Centers for Medicare & Medicaid Services (2006) *The National Health Expenditure Accounts*, U.S. Department of Health & Human Services, <http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp> [Pub: July 2007; Latest version Acc: June 2008].

Cerny, P. (1996) 'International Finance and the Erosion of State Policy Capacity', in Gummett, P. (ed) *Globalisation and Public Policy*, Cheltenham, UK & Brookfield, US: Edward Elgar, pp.83-104.

_____ (1997) 'Paradoxes of the competition state: the dynamics of political globalisation', *Government and Opposition*, 32(2), pp.251–274.

Chanda, R. (2001) *Trade in Health Services*, Working Paper, N. WG4:5, Commission on Macroeconomics and Health, Geneva: World Health Organizaiton.

_____ (2002) 'Trade in Health Services', *Bulletin of the World Health Organization*, 80(2), pp.158-163.

Chowdhury, A. & Kirkpatrick, C. (1994) *Development Policy and Planning*, London & New York: Routledge.

Churchill, L.R. (1999) 'The United States Health Care System under Managed Care', *Health Care Analysis*, 7(4), pp.393-411.

Commission of the European Communities (2000) *Communication from the Commission to the Council, The European Parliament, The Economic And Social Committee and The Committee Of The Regions: On the Health Strategy of the European Community*, COM(2000) 285 final, 2000/0119 (COD), Brussels: European Commission.

Compass Group (2005) *Compass Group PLC, Annual Report 2005*, Chertsey: Compass Group PLC.

_____ (2006) 'Markets', *Compass Group,* <http://www.compass-group.com/aboutus/markets.htm> [Pub: 2006; Acc: 2006].

_____ (2006) 'Providing hotel services to the public and private healthcare markets', Compass UK, <http://www.compass-group.co.uk/OurBusiness/SpecialistMarkets/healthcare.htm> [Pub: 2006; Acc: 2006].

Couzens Hoy, D. (1986) 'Power, Repression, Progress: Foucault, Lukes, and the Frankfurt School', in Couzens Hoy, D. (ed) *Foucault: A Critical Reader*, Oxford: Basil Blackwell Ltd, pp.123-147.

Cox, R.H. (1998) 'The Consequences of Welfare Reform: How Conceptions of Social Rights are Changing', *Journal of Social Policy*, 27(1), pp.1-16.

Culyer, A.J. (1990) 'Cost Containment in Europe', *Healthcare Systems in Transition: The Search for Efficiency*, Paris: Organisation for Economic Co-operation and Development, pp.29-40.

Cutler, D.M. & Horwitz, J.R. (2000) 'Converting hospitals from not-for-profit to for-profit status, Why and what effects?' *In The Changing Hospital Industry: Comparing not-for-profit and for-profit institutions.* A National Bureau of Economic Research Conference Report, Chicago and London: The University of Chicago Press, pp. 45-89

Cutler, D.M. (2002) 'Equality, Efficiency and Market Fundamentals: The Dynamics of International Healthcare Reform', *Journal of Economic Literature*, Vol. XL, pp.881-906.

Dahl, R.A. (1971) *Polyarchy: Participation and Opposition*, Yale University Press.

Daulaire, N. (1999) 'Globalisation and health', *Development*, 42(4), pp.22-24.

DeNavas-Walt, C., Proctor, B.D. & Smith, J., U.S. Census Bureau (2007) *Income, Poverty, and Health Insurance Coverage in the United States: 2006*, Washington, D.C.: U.S. Government Printing Office.

Department of Health & Independent Healthcare Association (2000) *For the Benefit of Patients: A Concordat with the Private and Voluntary Health Care Provider Sector*, London: Department of Health/Independent Healthcare Association.

Department of Health (1997) *The New NHS: Modern, Dependable*, Cm 3807, London: The Stationery Office.

_____ (1998) *Private Hospitals, Homes and Clinics*. Statistical Bulletin, 1998/14, London: HMSO.

Department of Health / NHS Executive (1997) *NHS Priorities and Planning Guidance: 1998-99*, Leeds: Department of Health, Executive Letter: EL(97)39.

Dicken, P. (1998) *Global Shift: Transforming the World Economy*, 3rd edition, London: Paul Chapman.

Dobbin, F. (1992) 'The Origins of Private Social Insurance: Public Policy and Fringe Benefits in America, 1920-1950', *The American Journal of Sociology*, 97 (5), pp.1416-1450.

Docteur, E. & Oxley, H. (2003) 'Health-Care Systems: Lessons from the Reform Experience', *OECD Health Working Papers 9*, OECD, DELSA/ELSA/WD/HEA(2003)9.

Donaldson, C., Gerard, K., Jan, S., Mitton, C. & Wiseman, V. (2005) *Economics of Health Care Financing: The Visible Hand*, 2nd edition, Houndmills & New York: MacMillan Press Ltd.

Donelan, K., Blendon, R.J., Schoen, C., David, K. & Binns, K. (1999) 'The Cost of Health System Change: Public Discontent in Five Nations', *Health Affairs*, 18(3), pp.206-216.

Dor, A. & Friedman, B. (1994) 'Mergers of Not-for-profit Hospitals in the 1980s: Who Were the Most Likely Targets?', *Review of Industrial Organisation*, 9, pp.393-407.

Doyal, L., & Pennel, I. (1994[1979]) *The Political Economy of Health*, Pluto Press: London.

Doyle, Y. & Bull, A. (2000) 'Role of private sector in United Kingdom healthcare system', *British Medical Journal,* 321, pp.563-565.

Drache, D. & Sullivan, T. (eds) (1999) *Market Limits in Health Reform: Public Success, Private Failure,* Routledge: London & New York

Dunning, J.H. (1988) 'The Eclectic Paradigm of International Production: a Restatement and Some Possible Extensions', *Journal of International Business Studies*, 19 (1), pp.1-31.

_____ (ed) (1997) *Governments, Globalisation, and International Business*, Oxford: Oxford University Press.

Durand-Zaleski, I., Colin, C. & Blum-Boisgard, C. (1997) 'An attempt to save money by using mandatory practice guidelines in France', *British Medical Journal*, 315, pp.943-946.

Eamer, R.K. (1989) *The History of National Medical Enterprises, Inc. and the Investor-Owned Hospital Industry*, New York: The Newcomen Society in North America.

Editorial (1983) 'Introduction', *Western European Politics*, 6(4), pp.1-2.

Ehrenreich, B. & Ehrenreich, J. (1971) *The American Health Empire: Power, Profits and Politics*, Vintage: New York.

El Kahal, S. (1994) *Introduction to International Business*, Maidenhead, UK: McGraw-Hill Publishing.

Enthoven, A.C. (1993) 'The History and Principles of Managed Competition', *Health Affairs*, Supplement, pp.24-48.

Esping-Andersen, G. (1990) *The Three Worlds of Welfare Capitalism*, Cambridge: Polity Press.

Estes, C.L., Harrington, C. & Pellow, D.N. (2001), 'Medical Industrial Complex*' In* Harrington, C. and C. L. Estes (Eds.) *Health Policy*, Boston: Jones & Bartlett Publishers, pp.136-148 (Reprint).

European Commission (2003-2006/7) *The European e-Business Report 2002/2003 to 2006/2007, A portrait of e-business in 15 sectors of the EU economy*, 1st- 5th Synthesis Report of the e-Business W@tch, Brussels: Enterprise Directorate General, European Commission.

_____ (2004) *Proposal for a Directive of the European Parliament and of the Council: On Services In The Internal Market*, COM (2004) 2 Final/3, 2004/0001 (COD).

_____ (2007a) 'Consultation on eHealth Lead Market Initiative', European Commission, <http://ec.europa.eu/information_society/activities/health/docs/policy/ehealth-lmi-question-20070330.pdf> [Acc: January 2008].

Farnsworth, K. (2004) *Corporate Power, Social Policy in a Global Economy, British welfare under the influence,* Bristol: The Policy Press.

_____ (2006) 'The Business-Social Policy Nexus: Corporate Power and Corporate Inputs into Social Policy', *Journal of Social Policy*, 35(3), pp.473–494.

Feldstein, P.J. (1986) 'The emergence of market competition in the US health care system. Its causes, likely structure and implications'. *Health Policy*, 6, pp 1-20.

Fidler, D. (2002) 'Global Health Governance: Overview of the Role of International Law in Protecting and Promoting Global Public Health', *Discussion Paper N.3*, London: Centre on Global Change & Health, LSHTM / WHO.

Fielding, S., Thompson, P. & Tiratsoo, N. (1995) 'New Labour and 1945?', *History Today*, 45(7), pp.11-14.

Finn, (2001) 'Modernisation or Workfare? New Labour's Work-Based Welfare State', *Competition & Change*, 5, pp.355-374.

Fortune (1995) 'Fortune Global 500: 1995', *Fortune Magazine*, July.

Fortune (2005) 'Fortune Global 500: 2005', *Fortune Magazine*, July

Foubister, J., Thompson, S., Mossialos, E. & Macquire, A. (2006) *Private Medical Insurance in the United Kingdom*, Copenhagen: World Health Organization / European Observatory on Health Systems and Policies, <http://www.euro.who.int/InformationSources/Publications/Catalogue/20060602_1> [Acc: 2007].

Fougere, G. (2001) 'Transforming health sectors: new logics of organising in the New Zealand health system', *Social Science & Medicine*, 52(8), pp.1233-1242.

Fredriksen, S. (2003) 'Instrumental colonisation in modern medicine', *Medicine, Healthcare & Philosophy*, 6, pp.287-296.

Freeman, R. (2000) *The Politics of Health in Europe*, European Policy Research Unit, Manchester: Manchester University Press.

Gaffney, D. and Pollock, A.M., (1999), 'Pump-priming the PFI: Why are privately financed hospital schemes being subsidised?', *Public Money & Management,* January – March, pp. 55-62

Galewitz, B. (2001) *in* Carey, K. & Dor, A. (2004) 'Trends in contract management: the hidden evolution of hospital organisation', *Health Affairs,* 23(6), pp.192-199

Geyman, J.P. (2004) *The Corporate Transformation of Health Care: Can the Public Interest be Served?*, New York: Springer Publishing Company Inc.

Giddens, A. (1984) *The Constitution of Society: Outline of the Theory of Structuration*, Cambridge: Polity.

_____ (1999) *Runaway World: How Globalisation is Reshaping Our Lives*, London: Profile.

Gill, S. (1995) 'Globalisation, Market Civilisation and Disciplinary Neoliberalism', *Millennium: Journal of International Studies*, 24(3), pp.399-423.

Gilpin, R. (2001) *Global Political Economy: Understanding The International Economic Order*, Princeton & Oxford: Princeton University Press.

Glenngård, A.H., Hjalte, F., Svensson, M., Anell, A. & Bankauskaite, V. (2005) *Health Systems in Transition: Sweden*, Copenhagen: EOHSP/WHO.

Godden, S., Pollock, A.M. & Player, S. (2001) 'Capital Invenstment in Primary Care – The Funding and Ownership of Primary Care Premises', *Public Money & Management*, 21(4), pp.43-50.

Gough, I. (1979) *The Political Economy of the Welfare State*, MacMillan Press Ltd: London.

Gray, B. (ed) (1986) *For-Profit Enterprise in Health Care*, Committee on Implications of For-Profit Enterprise in Health Care, Institute of Medicine, Washington, D.C.: National Academy Press.

Gray, P. (1990) 'The role of services in global structural change', in Webster, A. & Dunning, J.H. (eds) *Structural change in the world economy*, London & New York: Routledge, pp.67-90.

Greener, I. (2004a) 'The three moments of New Labour's health policy discourse', *Policy & Politics*, 32 (3), pp.303–316

_____ (2004b) 'The new political economy of the UK NHS', *Critical Public Health,* 14 (3), pp.239–250.

Griffith, B., Illife, S. & Rayner, G. (1987) *Banking on Sickness: Commercial Medicine in Britain and the USA*, London: Lawrence & Wishart.

Grindle, M. & Thomas, J. (1991) *Public Choices and Policy Change: The Political Economy of Reform in Developing Countries*, Baltimore: John Hopkins University Press.

Haas, P.M. (1992) 'Introduction: Epistemic Communities and International Policy Co-ordination', *International Organisation*, 46(1), pp.1-36.

Hacker, J.S. & Pierson, P. (2002) 'Business Power and Social Policy: Employers and the formation of the American Welfare State', *Politics & Society*, 30(2), pp.277-325.

Hall, D. (2001) *Globalisation, privatisation and healthcare: a preliminary report*, Public Services International Research Unit (PSIRU), London: University of Greenwich, <http://www.psiru.org/publicationsindex.asp> [Acc: December 2003].

Ham, C. (1996) *Public, Private or Community, What Next for the NHS?*, London: Demos.

Harrington, C. & Pollock, A.M. (1998), 'Decentralisation and privatisation of long-term care in UK and USA', *The Lancet,* 351, pp. 1805-1808

Harrison, M.I. (2004) *Implementing Change in Health Systems: Market Reforms in the United Kingdom, Sweden, and the Netherlands*, London: Sage Publications

Hart, J.T. (1971) 'The inverse care law', *The Lancet*, 1 (7696), pp.405-12.

Harvey, D. (2005) *A Brief History of Neoliberalism*, New York: Oxford University Press.

Havighurst, C.C. (2001) 'Health Care as a (Big) Business: The Antitrust Response', *Journal of Health Politics, Policy and Law*, 26(5), pp. 939-955.

____(2004) 'Starr on the Corporatisation and Commodification of Health Care: The Sequel', *Journal of Health Politics, Policy and Law*, 29(4-5), pp. 947-967.

Hawes, C. & Phillips, C.D. (1986) 'The Changing Structure of the Nursing Home Industry and the Impact of Ownership on Quality, Cost and Access', in *For-Profit Enterprise in Health Care*, Washington, D.C.: Institute of Medicine/National Academy Press, pp.492-541.

Hay, C. (1998) 'The Tangled Webs we Weave: The Discourse, Strategy and Practice of Networking', in Marsh, D. (ed) *Comparing Policy Networks*, Buckingham & Philadelphia: Open University Press, pp.33-51.

____ (1999) 'Continuity and Discontinuity in British Political Development', in Marsh, D. *et al*, *Postwar British Politics in Perspective*, Cambridge: Polity Press / Oxford: Blackwell Publishers Ltd., pp.23-42.

_____ (2001) 'Negotiating International Constraints: The Antinomies of Credibility and Competitiveness in the Political Economy of New Labour', *Competition & Change*, 5, pp.269-289.

HCA (2005) '2005 Annual Report', HCA Inc, Nashville, TN:

Heclo, H. (1972) 'Review Article: Policy Analysis', *British Journal of Political Science*, 2(1), pp.83-108.

_____ (1978) 'Issue Networks and the Executive Establishment', in King, A. (ed) *The New American Political System*, Washington, D.C.: American Enterprise Institute for Public Policy Research.

Held, D. & McGrew, A. (1998) 'The End of the Old Order? Globalisation and the Prospects for World Order', *Review of International Studies*, 24, pp.219-243.

Held, D., McGrew, A., Goldblatt, D. and Perraton, J. (1999) *Global Transformations: Politics, Economics, Culture*, Cambridge: Polity Press.

Higgins, J. (1988) *The Business of Medicine: Private Healthcare in Britain*, Basingstoke: MacMillan Education Ltd.

Himmelstein, D.U., & Woolhandler, S. (1984) 'Medicine as Industry: The Health-care Sector in the United States', *Monthly Review*, April, pp.13-25.

_____ (1990) 'The Corporate Compromise: A Marxist View of Health Policy', *Monthly Review* (May), pp.14-29.

Hirschman, A.O. (1970) *Exit, Voice and Loyalty: Responses to decline in firms, organisations and states,* Cambridge, MA: Harvard University Press.

Hirst, P. & Thompson, G. (1999) *Globalisation in Question: The international economy and the possibilities of governance*, 2nd edition, Oxford: Polity.

HM Treasury (1997) *The Chancellor's 1997 Budget Speech*, London: HMSO, <http://archive.treasury.gov.uk/pub/html/budget_ftp.html> [Acc: March 2004]

_____ (2000) *Chancellor of the Exchequer's Budget Statement*, 21 March 2000, London: TSO, <www.hm-treasury.gov.uk> [Acc: March 2004].

_____ (2002) *Chancellor of the Exchequer's Budget Statement*, 17 April 2002, <www.hm-treasury.gov.uk> [Acc: March 2004].

Hoffman, B. (2006) 'Restraining the Health Care Consumer: The History of Deductibles and Co-payments in U.S. Health Insurance', *Social Science History*, 30(4), pp.501-528.

Holden, C. (2002) 'The Internationalisation of Long Term Care Provision', *Global Social Policy,* 2(1), pp.47-67.

_____ (2003a) 'Actors and Motives in the Internationalisation of Health Businesses', *Business & Politics*, 5(3), pp.287-302.

_____ (2003b) 'Decommodification and the Workfare State', *Political Studies Review*, 1, pp.303-316.

_____ (2005) 'Investigating International Health Markets: Methodological Problems and Challenges', *Social Policy & Society*, 4(4), pp.427-437.

Hong, E. (2000) *Globalisation and the Impact on Health, A Third World View*, Issue Paper Prepared for The People's Health Assembly, People's Health Movement, <http://www.phmovement.org/pubs/issuepapers/hong24.html> [Acc: December 2002].

House of Commons Health Committee (2006) *Independent sector treatment centres: 4th report of session 2005-06,* Vol 1, HC934-I, London: The Stationary Office Ltd.

Howard, C. (1997), *The hidden welfare state: Tax expenditures and social policy in the United States,* Princeton, New Jersey: Princeton University Press.

Humana (2006) *Latin American Ventures*, <http://www.humanaventures.com/port.html> [Acc: 2006].

Hunter, D.J. (2008) *The Health Debate* Great Britain: Policy Press

Iglehart, J.K. (1989) 'American Business looks abroad', *Health Affairs*, Winter, pp 165-172

Imai, Y., Jacobzone, S. & Lenain, P. (2000) 'The changing health system in France', *Economics Department Working Papers*, 269, Nov 2000, Paris: Organisation for Economic Co-operation and Development.

ING Group (2005) *ING Group Annual Report, 2005: Executing Our Strategy for Profitable Growth*, Amsterdam: ING Groep N.V.

Iriart, C. (2005) 'The Transnationalisation of the Health Care Systems in Argentina', in Mackintosh, M. & Koivusalo, M. (eds) *Commercialisation of Health Care, Global and Local Dynamics and Policy Responses*, London: Palgrave / MacMillan.

Iriart, C., Merhy, E. & Waitzkin, H. (2001) 'Managed care in Latin America: the new common sense in health policy reform', *Social Science & Medicine*, 52, pp.1243-1253.

Jack, A., 'A prescription for global expansion', *Financial Times,* London (UK): Nov 2 2006, p. 26

Jenkins, S. (2005) 'The NHS needs localisation, not regulated privatisation', *The Guardian*, December 14th 2005, <http://www.guardian.co.uk/Columnists/Column/0,,1666717,00.html> [Acc: December 2005].

Jessop, B. (1994) 'The Transition to post-Fordism and the Schumpeterian workfare state', in Burrows, R. & Loader, B. (1992) *Post-Fordist Welfare State*, London & New York: Routledge, pp.13-37.

Johnson, O. (2002) 'Bogota launches health tourism project', *British Medical Journal*, 325, p.10.

Joseph, J. (2006) 'Globalisation and Governmentality', *International Politics*, 43, pp.402-418.

Kassirer, J.P. (1996) 'Mergers and acquisitions: Who benefits? Who loses?', *New England Journal of Medicine,* 334(11), pp.722-723

Keen, J. & Mays, N. (1998) 'The NHS is not an island: Public-private relations in UK health care', in Appleby, J. & Harrisson, A. (eds) *Health Care UK, 1999/2000*, London: King's Fund, pp.210-219.

Keen, J., Light, D. & Mays, N. (2001) *Public-Private Relations in Healthcare*, London: King's Fund.

Kerr, P. (1999) 'The Postwar Consesus: A Woozle That Wasn't', in Marsh, D. *et al, Postwar British Politics in Perspective*, Cambridge: Polity Press & Oxford: Blackwell Publishers Ltd.

King, P. (2001) 'Compass to spend $1.1B for Morrison, Selecta', *Nation's Restaurant News*, February 19th.

King's Fund (2005) *An Independent Audit of the NHS Under Labour (1997-2005)*, London: King's Fund.

Kingdon, J.W. (1991) *Government and Politics in Britain: An Introduction*, Cambridge: Polity.

_____ (1995) *Agendas, Alternatives and Public Policies*, New York: Harper Collins College Publishers.

Klein, R. (2001) *The New Politics of the National Health Service*, Harlow: Pearson Education Ltd.

_____ (2001) *The New Politics of the National Health Service*, Harlow: Pearson Education Ltd.

Koivusalo M.http://www.ingentaconnect.com/content/rsm/jhsrp/2001/00000006/00000002/art00001/references;jsessionid=ar493492am5oo.alice - aff_1 (2001) 'World Trade Organization and trade-creep in health services', *Journal of Health Services Research and Policy*, 6(2), pp.65-67.

_____ (2003) 'Health Systems Solidarity and European Community Policies', in Sen, K. (ed) *Restructuring Health Services*, London: Zed Books Ltd, pp.93-114.

Kuttner, R. (1996a), 'Columbia/Hca And The Resurgence Of The For-Profit Hospital Business', Part 1, *New England Journal of Medicine*, 335(5), pp.362-367.

Kyprianou, M. (2005) 'The new European Healthcare Agenda', Transcript of speech delivered by EU Commissioner for Health at *The European Voice conference "Healthcare: Is Europe getting better?"*, Brussels, 20 January 2005, Brussels: European Commission Press Room, <http://europa.eu/rapid/pressReleasesAction.do?reference=SPEECH/05/24&format=HTML&aged=0&language=EN&guiLanguage=en> [Acc: February 2005].

Labonte, R. & Schecker, T. (2007a) 'Globalisation and social determinants of health: Introduction and methodological background (part 1 of 3)', *Globalisation and Health*, 3(5), <http://www.globalisationandhealth.com/content/3/1/5>, [Acc: August 2007].

_____ (2007b) 'Globalisation and social determinants of health: The role of the global marketplace (part 2 of 3)', *Globalisation and Health*, 3(6), <http://www.globalisationandhealth.com/content/3/1/6>, [Acc: August 2007].

_____ (2007c) 'Globalisation and social determinants of health: Promoting health equity in global governance (part 3 of 3)', *Globalisation and Health*, 3(7), <http://www.globalisationandhealth.com/content/3/1/7>, [Acc: August 2007].

Laing & Buisson (2002) *Laing's Healthcare Market Review 2000-2001*, 18th edition, London: Laing & Buisson

_____ (2003) *Laing's Healthcare Market Review 2003-2004*, 16th edition, London: Laing & Buisson.

_____ (2005) *Laing's Healthcare Market Review 2005-2006,* 18th edition, London: Laing & Buisson

_____ (2007) *Laing's Healthcare Market Review 2007-2008*, 18th edition, London: Laing & Buisson

_____ (2008) *Laing's Healthcare Market Review 2008-2009*, 21st edition, London: Laing & Buisson.

Laing, W. (1992) *Going Private: Independent health care in London*, London: King's Fund London Initiative.

Lakoff, G. (2004) *Don't Think of an Elephant!*, Vermont: Chelsea Green Publishing.

Laswell, H.D. (1956) *The Decision Process: Seven categories of functional analysis*, College Park, Maryland: University of Maryland.

Laurance, J. (1983) 'The collapse of the BUPA boom', *New Society*, 24 Feb 1983, pp.295-296.

Lawton, T.C., Rosenau, J.N. & Verdun, A.C. (eds) (2000) *Strange Power: Shaping the parameters of international relations and international political economy*, Aldershot: Ashgate.

Lee, K.(ed) (2003) *Health Impacts of Globalisation: Towards Global Governance*, London & New York: Palgrave / MacMillan.

_____ (2004) *Globalisation and Health: An Introduction*, London & New York: Palgrave / MacMillan.

Lee, K., Fustukian, S. & Buse, K. (2002) 'An introduction to global health policy', in Lee, K. *et al* (eds) *Health Policy in a Globalising World*, Cambridge: Cambridge University Press, pp.3-17.

Lee, T.H. (1999), 'What constitutes a useful economic study? The health systems perspective', *American Heart Journal,*137: S67-S70

LeGrand, J. & Vizard, P. (1998) 'The National Health Service: Crisis, Change or Continuity?, in Glennerster, H. & Hills J. (eds) *The State of Welfare : The Economics of Social Spending*, 2nd edition, Oxford: Oxford University Press.

LeGrand, J. (1990) 'Equity Versus Efficiency: The Elusive Trade-Off', Ethics, 100(3), pp.554-568.

LeGrand, J., Propper, C. & Robinson, R. (1992) *The Economics of Social Problems*, Basingstoke: MacMillan.

Leichter, H.M. (1979) *A Comparative Approach to Policy Analysis*, Cambridge: Cambridge Univerity Press.

Lethbridge, J. (2002) *Are Health Systems National?*, Public Services International Research Unit (PSIRU), London: University of Greenwich, <http://www.psiru.org/publicationsindex.asp> [Acc: December 2003].

_____ (2005) *Care Services in Europe*, PSIRU, London: University of Greenwich.

Levitt, T. (1983) 'The Globalisation of Markets', *Harvard Business Review*, May-June, pp.92-102.Lieverdink, H. (2001) 'The marginal success of regulated competition policy in the Netherlands', *Social Science & Medicine*, 52(8), pp.1183-1194.

Leys, C. (2001) *Market-driven Politics: Neoliberal Democracy and the Public Interest*, London: Verso.

Light, D. (1993) 'Escaping the traps of postwar Western medicine, How to maximize health and minimize expenses', *European Journal Of Public Health*, 3(4), pp.281-289.

_____ (2001a) 'Cost Containment And The Backdraft Of Competition Policies', *International Journal of Health Services*, 31(4), pp.681–708,

_____ (2001b) 'Managed competition, governmentality and institutional response in the United Kingdom', *Social Science & Medicine*, 52(8), pp.1167-1181.

_____ (2007) 'Globalising restricted and segmented markets: Challenges to theory and values in economic sociology', *The ANNALS of the American Academy of Political and Social Science*, 610, pp 232-245

Lindblom, C.E. (1959) 'The Science of "Muddling Through"', *Public Administration Review*, 19(2), pp.79-88.

_____(1977) *Politics and Markets*, New York: Basic Books.

_____(1979) 'Still Muddling, Not Yet Through', *Public Administration Review*, 39(6), pp.517-526.

Lindblom, C.E. & Woodhouse, E.J. (1993) *The Policy Making Process*, 3rd edition, Englewood Cliffs, NJ: Prentice Hall

Lister, J. (2005) *Health Policy Reform – Driving the wrong way? A critical guide to the global 'health reform' industry*, London: Middlesex University Press.

Loader, B. & Burrows, R. (1994) 'Towards a post-Fordist welfare state? The restructuring of Britain, social policy and the future of welfare', in Burrows, R. & Loader, B. (eds) (1994) *Post-Fordist Welfare State,* London & New York: Routledge, pp.1-10.

Lukes, S. (1974) *Power: A Radical View*, Houndmills & London: MacMillan Education Ltd.

Lutz, S. & Gee, P. (1998) *Columbia/HCA: Healthcare on Overdrive,* New York: McGraw-Hill.

Mackintosh, J. & Koivusalo, M. (eds) (2005) *Commercialisation of Health Care, Global and Local Dynamics and Policy Responses*, London: Palgrave / MacMillan.

MacLean, J. (2000) 'Philosophical Roots of Globalisation and Philosophical Routes to Globalisation', in Germain, R.D. (ed) *Globalisation and its Critics*, MacMillan & Political Economy Research Centre: University of Sheffield, pp.3-66.

Majeed, F.A., Cook, D.G., Poloniecki, J. & Martin, D. (1995) 'Using data from the 1991 census', *British Medical Journal*, 310, pp.1511-1514 (10 June), <http://www.bmj.com/cgi/content/full/310/6993/1511?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=international+migration&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT> [Acc: October 2007].

Mantone, J. (2005) 'The Big Bang', *Modern Healthcare*, 35(33), pp.6-8.

Marmor, T. (1998), 'The procompetitive movement in American medical politics', in Ranade, W. (ed.), *Markets and Healthcare: A Comparative Analysis*, London & New York: Addison Wesley Longman Ltd.

Marmor, T.R. (2000) *The politics of Medicare,* Wright, J.D. (ed), New York: Aldine de Gruyter.

Marsh, D. & Locksley, G. (1983) 'Capital in Britain: Its Structural Power and Influence over Policy', *Western European Politics*, 6 (2), pp.36-60.

Marsh, D. (1983) 'Interest Group Activity & Structural Power: Lindblom's Politics and Markets', *Western European Politics*, 6(2), pp.3-13.

Marsh, D., Buller, J., Hay, C., Johnston, J., Kerr, P., McAnulla, S. & Watson, M. (1999) *Postwar British Politics in Perspective*, Cambridge: Polity Press, & Oxford: Blackwell Publishers Ltd.

Marshall, T. H. (1950) 'Citizenship and Social Class', in T. H. Marshall (ed) *Citizenship and Social Class and Other Essays*, Cambridge: Cambridge University Press.

Martin, C.J. (2003) 'Consider the Source! Determinants of Corporate Preferences for Public Policy', *Working Paper 1*, Presented At The International Political Science Association Business-Government Roundtable School Of Public Policy, 24-25 May 2002, London: University College London.

Marx, K. (1973) *Grundrisse*, Nicholaus, M. (trans) London: Penguin.

Maynard, A. (ed) (2005) *The Public–Private Mix for Health*, Oxford: The Nuffield Trust / Radcliffe Publishing.

McLachlan, G. & Maynard, M. (eds) (1982) *The Public/PrivateMix for Health: The Relevance and Effects of Change,* London: The Nuffield Provincial Hospitals Trust.

Mencher, S. (1967) *Private Practice in Britain: The Relationship of Private Medical Care to the National Health Service*, Occasional Papers on Social Administration N.24, London: G. Bell & Sons.

Messner, S. F. & Rosenfield, R. (1997) 'Political Restraint of the Market and Levels of Criminal Homicide: a Cross-National Application of Institutional-Anomie Theory', *Social Forces*, 75(4), pp.1393–1416.

Miliband, R. (1973 [1969]) *The State in Capitalist Society*, London: Quartet Books Ltd.

Mills, C.W. (1956) *The Power Elite*, New York: Oxford University Press.

Mishra, R. (1999) *Globalisation and the Welfare State*, London & New York: Routledge.

Modern Healthcare (1990), 'Hillhaven to Become Independent Jan. 31', *Modern Healthcare,* January 8, 1990, p.10.

Mohan, J. (1970) *Building for health,* Office of Health Economics, England: Hindson Reid Jordison

_____ (1991) 'The internationalisation and commercialisation of healthcare in Britain', *Environment and Planning A*, 23, pp.853-867.

_____ (1995) *A National Health Service?*, London: MacMillan Press Ltd..

_____ (2002a) *Planning, Markets and Hospitals*, London: Routledge.

_____ (2002b) 'The past and future of the NHS: New Labour and foundation hospitals*',* *History & Policy*, <http://www.historyandpolicy.org/archive/policy-paper-14.html>, [Acc: December 2005]

_____ (1986) 'Private medical care and the British Conservative government: What price independence?', *Journal of Social Policy,* 15(3), pp. 337-360.

Moran, M. (1999) *Governing the Healthcare State: A Comparative Study of the United Kingdom, The United States and Germany*, Manchester: Manchester University Press.

_____ (2000) 'Understanding the welfare state: the case of healthcare', *British Journal of Politics and International Relations*, 2(2) pp.135-160.

Moran, M. & Wood, B. (1996) 'The Globalisation of Health Care Policy?', in Gummett, P. (ed) *Globalisation and Public Policy*, Cheltenham, UK & Brookfield, US: Edward Elgar, pp.125-141.

Mossialos, E. & Dixon, A. (2002) 'Funding Healthcare: an introduction', in Mossialos, E., Dixon, A., Figueras, J., & Kutzin, J. (eds) *Funding Health Care: Options for Europe*, Buckingham & Philadelphia: Open University Press.

Mossialos, E., Dixon, A., Figueras, J., & Kutzin, J. (eds) (2002) *Funding Health Care: Options for Europe*, Buckingham & Philadelphia: Open University Press.

Myerson, A. (1994), 'Hospital Chain Sets Guilty Plea', *The New York Times*, June 29, 1994, p.D1.

Navarro, V. (1978) *Class Struggle, The State and Medicine*, London: Martin Robertson & Co Ltd.

Navarro, V., Schmitt, J. & Astudillo, J, (2004) 'Is globalisation undermining the welfare state?', *Cambridge Journal of Economics*, 28, pp.133-152.

_____ (1995) 'The Politics of Healthcare Reform in the United States, 1992-1994: A Historical Review', *International Journal of Health Services*, 25(2), pp.185-201.

NHS Executive (2000) *The NHS Plan: A Plan for Investment, A Plan for Reform*, Cm 4818-1, London: The Stationery Office.

Nunes, R. (2003) 'Evidence-Based Medicine: A new tool for resource allocation?', *Medicine, Health Care and Philosophy*, 6, pp.297–301.

O'Connor, J. (2000) 'Introduction to the 2001 edition to the Fiscal Crisis of the State', *Capitalism Nature Socialism*, 12(1), pp.99-114.

OECD (1990) *Healthcare Systems in Transition: The Search For Efficiency*, Paris: Paris: Organisation for Economic Co-operation and Development.

_____ (2004a) *Towards High-Performing Health Systems*, Paris: Organisation for Economic Co-operation and Development, SG/HEALTH/MIN

_____ (2004b) *Private Health Insurance in OECD Countries*, Paris: Organisation for Economic Co-operation and Development.

_____ (2006a) *Health Policy in Mexico*, Policy Note, September 2006, Mexico: Directorate for Employment, Labour & Social Affairs.

_____ (2006b) *OECD Health Data 2006*, Paris: Organisation for Economic Co-operation and Development.

_____ (2007a) *OECD Factbook 2007: Economic, Environmental and Social Statistics*, Paris: Organisation for Economic Co-operation and Development.

_____ (2007b) *International Migration Outlook, Sopemi 2007*, Paris: Organisation for Economic Co-operation and Development.

_____ (2008) *OECD Structural Analysis Statistics*, Organisation for Economic Co-operation and Development, <http://puck.sourceoecd.org> [Acc: June 2008].

Offe, C. & Ronge, V. (1982) 'Theses on the theory of the state', in Giddens, A. & Held, D. (eds) *Classes, Power and Conflict: Classical and Contemporary Debates*, Basingstoke: MacMillan, pp249-56.

Offe, C. (1984) *Contradictions of the welfare state,* London: Hutchinson.

Office of Health Economics (2007) *Compendium of Health Statistics,* 18th edition, London: Office of Health Economics

Ohmae, K. (1990) *The Borderless World: Power and Strategy in the Global Marketplace*, London: Collins.

_____ (1995) *The End of the Nation State: The rise of regional economies*, New York, Free Press.

Palan, R. (1998a) 'Luring Buffaloes and the Game of Industrial Subsidies: A Critique of National Competitive Policies in the Era of the Competition State', *Global Society*, 12(3), pp.323-341.

Palan, R. (2006) 'Is the Competition State the New, Post-Fordist, Mode of Regulation? Regulation Theory from an International Political Economic Perspective', *Competition & Change*, 10(2), pp.246-262.

_____ (1998b) 'Trying to Have Your Cake and Eating It: How and Why the State System Has Created Offshore', *International Studies Quarterly*, 42, pp.625-644.

Palmer, J. (2007) 'The boom in health tourism: a lasting trend?', *Private Hospital Healthcare Europe*, London: Campden Media, pp.6-8.

Parliament (Chairman: Sir Alec Merrison) (1979) *Royal Commission on the National Health Service,* Cmnd 7615, London: HMSO

Paschall, S.P. (2007) 'The transition from planning to markets in National Health Policy for acute care hospitals: the Pittsburgh experience', *Journal of Economic Issues,* XLI(2), pp 469-476

Patel, K. & Rushefsky, M. (2006) *Health Care Politics and Policy in America*, 3rd edition, London: M.E. Sharpe Inc.

Perelman, M. (1993) *The Pathology of the U.S. Economy: The Costs of a Low-Wage System*, Basingstoke: MacMillan.

Perlstadt, H. (1995) 'The Development of the Hill-Burton Legislation: Interests, Issues and Compromises', *Journal of Health & Social Policy*, 6(3), pp.77-96.

Pfaler, A., Gough, I. & Therborn, G. (1991) *Can the Welfare State Compete? A Comparative Study of Five Advanced Capitalist Countries*, Basingstoke: MacMillan Press Ltd.

Pfaller, A. & Gough, I. (1991) 'The Competitiveness of Industrialised Welfare States: A Cross-country Survey', in Pfaler, A., Gough, I. & Therborn, G., *Can the Welfare State Compete? A Comparative Study of Five Advanced Capitalist Countries*, Basingstoke: MacMillan Press Ltd., pp.15-43.

Pierson, P. (1996) 'The New Politics of the Welfare State', *World Politics*, 48 (January), pp.143–79.

_____ (1998) 'Irresistible Forces, Immovable Objects: Post-Industrial Welfare States Confront Permanent Austerity', *Journal of European Public Policy*, 5(4), pp.539–60.

Player, S. & Leys, C. (2008) *Confuse & Conceal: The NHS and Independent Sector Treatment Centres*, Monmouth: Merlin Press.

Plock, E.D. (1998) 'Telemedicine is emerging as a cost-effective healthcare alternative', *Business America*, 119(1), p.42.

Podhorzer, M. (1995) 'Unhealthy Money: Health Reform and the 1994 Elections', *International Journal of Health Services,* 25(3), pp.393-401.

Polanyi, K. (1957 [1944]) *The Great Transformation: The Political and Economic Origins of Our Time,* Beacon Hill, Boston: Beacon Press.

Pollock, A.M. & Price, D. (2000) 'Rewriting the regulations: How the World Trade Organization could accelerate privatisation in health-care systems', *The Lancet*, 356, pp.1995-2000.

Polsky, A. (2005) 'When Business Speaks: Political Entrepreneurship, Discourse and Mobilisation in American Partisan Regimes', *Journal of Theoretical Politics*, 12(4), pp.455-476.

Porter, D. (1999) *Health, Civilisation and the State: a history of public health from ancient to modern times*, London & New York: Routledge.

Porter, M. E. (ed) (1986) *Competition in Global Industries,* Boston: Harvard Business School Press.

Poullier, J.P. (1989) 'Managing health in the 1990s: a European overview', *Health Services Journal,* 27 April

Poullier, J.P., Hernandez, P., Kawabata, K., & Savedoff, W.D. (2002) *Patterns of Global Health Expenditures: 191 Countries*, EIP/HFS/FAR, Discussion Paper No. 51, World Health Organization, November 2002.

Price, D., Pollock, A.M., & Shaoul, J. (1999) 'How the World Trade Organization is shaping domestic policies in health care', *The Lancet*, 354, pp.1889-1891.

Quadagno, J. (2004b) 'Why the United States Has No National Health Insurance: Stakeholder Mobilisation Against the Welfare State, 1945-1996', *Journal of Health and Social Behavior*, 45(Extra Issue) pp.25-44.

Ranade, W. & Haywood, S.C. (1991) 'Privatising from within: The National Health Service under Thatcher', in Altenstetter, C. & Haywood, S.C., *Comparative Health Policy and the New Right: From Rhetoric to Reality*, Houndmills & London: MacMillan, pp.91-110.

Rayner, G. (1984) 'NHS Pay Beds', *Public Money*, December, pp.8-9.

_____ (1986) 'Health Care as a Business?: The emergence of a commercial hospital sector in Britain', *Policy and Politics*, 14(4), pp.439-459.

_____ (1987) 'Lessons from America? Commercialisation and growth of private medicine in Britain', *International Journal of Health Services*, 17(2), pp.197-216.

Reardon, J. & Reardon, L. (1995) 'The Restructuring of the Hospital Services Industry', *Journal of Economic Issues*, 29(4), pp.1063-1081.

Reimers, F. & McGinn, N. (1997) *Informed Dialogue: Using Research to Shape Education Policy Around the World,* Westport: Praeger.

Reinhardt, U. (1989) 'Health Care Spending and American Competitiveness', *Health Affairs*, Winter, pp.5-21.

Relman, A.S. (1980) 'The New Medical-Industrial Complex', *New England Journal of Medicine*, 303(17), pp.963–970.

_____ (1997) 'The market for health care: where is the patient?', *Clinical Chemistry* 43:12, pp.2225–2229.

Richards, T. (2001) 'Health issues rise up the EU agenda', *British Medical Journal***,** 323, pp.772.

Rivett, G. (1998) *From Cradle to Grave: 50 Years of the NHS*, London: King's Fund.

Robinson, J.C. (1999) *The Corporate Practice of Medicine: Competition and innovation in healthcare*, London: University of California Press Ltd.

_____ (2002) 'Bond-Market Skepticism and Stock Market Exuberance in the Hospital industry', *Health Affairs*, 21(1), pp.104-117.

_____ (2004) 'Consolidation and the Transformation of Competition in Health Insurance', *Health Affairs*, 23(6), pp.11-24.

_____ (2006) 'The Commercial Health Insurance Industry In An Era Of Eroding Employer Coverage', *Health Affairs*, 25(6), pp.1475-1486.

Robinson, R. & Steiner, A. (1998) *Managed Health Care: US Evidence and Lessons for the National Health Service*, Buckingham & Philadelphia: Open University Press.

Robinson, W. & Harris, (2000) 'Towards a Global Ruling Class? Globalisation and the Transnational, Capitalist Class, *Science & Society*, 64(1), pp.11–54

Roemer, M.I. (1976) *Healthcare Systems in World Perspective*, New York: Health Administration Press.

_____ (1987) 'Foreign Privatisation of National Health Systems', *American Journal of Public Health*, 77 (10), pp.1271-2.

Rosenberg, J. (2007) 'International Relations – "The Higher Bullshit": A Reply to the Globalisation Theory Debate', *International Politics*, 44, pp.450-482.

Rowland, D., Price, D., Pollock, A.M, (2004) 'Implications of the draft European Union services directive for health care', *The Lancet*, 364, pp.1200-1202.

Sabatier, P.A. & Jenkins-Smith, H. (1993) *Policy Change and Learning: An Advocacy Coalition Framework*, Boulder: Westview Press.

Sabatier, P.A. (ed) (1999) *Theories of Policy Process*, Oxford: Westview Press.

Salmon, J.W. (1984) 'Organising medical care for profit', in McKinley, *Issues in the Political Economy of Healthcare*, New York & London: Tavistock Publications, pp.143-186.

_____ (1995), 'A perspective on the corporate transformation of health care', *International Journal of Health Services*, 25(1), pp. 11-42.

Salter, B. (1994) 'The politics of community care: social rights and welfare limits', *Policy and Politics*, 22(2), pp.119-131.

_____ (1995) 'The Private Sector and the NHS: Redefining the Welfare State', *Policy and Politics,* 23(1), pp.17-30.

_____ (1998) *The Politics of Change in the Health Service*, Basingstoke: MacMillan Press Ltd.

Samsung, (2006a) Samsung website and 'Corporate profile', <(http://www.samsung.com>, [Acc: July 2006].

Samsung, (2006b) 'Samsung medical centre' <http://samsunghospital.com>, [Acc: July 2006].

Sargent, J.A. (1983) 'British Finance and Industrial Capital and the European Communities', *Western European Politics*, 6(2), pp.14-35.

Schieber, G.J. & Poullier, J. (1990) 'Overview of international comparisons of healthcare services', *Healthcare Systems in Transition: The Search for Efficiency*, Paris: Organisation for Economic Co-operation and Development, pp.9-15.

Schippers, E. (2002) 'Towards a sound system of medical insurance? Consumer driven healthcare reform in the Netherlands: The relaxation of supply side restrictions and greater role of market forces', <www.civitas.org.uk/pdf/dutch.pdf> [Acc: September 2006].

Schmidt, R.A. & Ploch, E.A. (2004) 'Community pharmacies under pressure: issues of deregulation and competition', *International Journal of Retail & Distribution Management*, 32(6/7), pp.354-357.

Scholte, J.A. (1999) 'Globalisation: Prospects for a Paradigm Shift', in Shaw, M. (ed) *Politics and Globalisation*, London: Routledge.

_____ (2000) *Globalisation: a critical introduction*, Basingstoke: Macmillan Press Ltd.

Secretary of State for Health (2000) *The NHS plan: A plan for investment, a plan for reform*, London: HMSO.

Shaw, M. (1997) 'The state of globalisation: towards a theory of state transformation', *Review of International Political Economy*, 4(3), pp.497–513.

Singleton, J. (1995) 'Labour, the Conservatives and nationalisation', in Millward, R. & Singleton, J. (eds) *The Political Economy of Nationalisation in Britain*, Cambridge & New York: Cambridge University Press., pp.13-36.

Sklair, L. (2001) *The Transnational Capitalist Class*, Oxford: Blackwell.

Sodexho (2005) *Sodexho Alliance Annual Report 2004-2005*, Montigny-le-Bretonneux: Sodexho Alliance.

Starr, P. (1982) *The Social Transformation of American Medicine*, New York: Basic Books.

Stedward, G. (2003) 'Education as industrial policy: New Labour's marriage of the social and the economic', *Policy & Politics*, 31(2), pp.139–52

Steinwald, B. & Neuhauser, D. (1970) 'The Role of the Proprietary Hospital', *Law and Contemporary Problems*, 35(4), Health Care: Part 2, pp.817-838.

Stevens, R. & Stevens, R. (2007) 'Anatomy of a Dilemma: Creating & Implementing Medicaid, 1965-1970', in Stevens, R., *The Public-Private Health Care State: Essays in the history of American health care policy*, London: Transaction Publishers, pp. 117-156.

Stevens, R. (1999) *In Sickness and in Health: American Hospitals in the Twentieth Century*, Baltimore, MD: The Johns Hopkins University Press.

Stevens, R.A., Rosenberg, C.E. & Burns, L.R. (eds) (2006) *History and Health Policy in the United States: Putting the Past Back in.* New Brunswick, New Jersey and London: Rutgers University Press.

Stevens, S. (2004) 'Reform strategies for the English NHS', *Health Affairs,* 23(3), pp.37-44.

Stone, D. (2000) 'Learning Lessons, Policy Transfer and the International Diffusion of Policy Ideas', Centre for the Study of Globalisation and Regionalisation, <http://poli.haifa.ac.il/~levi/res/stone-2000.pdf> [Acc: August 2007].

Stopford, J. & Strange, S. (1991) *Rival States Rival Firms*, Cambridge: Cambridge University Press.

Strange, S. (1996) *Retreat of the State: the diffusion of power in the world economy,* Cambridge University Press: Cambridge.

Sutton, R. (1999) 'The Policy Process: An Overview', Overseas Development Institute, <http://www.odi.org.uk/publications/wp118.pdf > [Acc: August 2006].

Talbot-Smith, A., & Pollock, A.M. with Leys, C. & McNally, N. (2006) *The New NHS: A Guide*, London: Routledge.

Tesco (2005) *Annual report and financial statements*: Tesco PLC, <http://www.tescoplc.com/plc/ir/ar/archive/ar2005/> [Acc: July 2006].

Timmermans, S. & Kolker, E.S. (2004) 'Evidence-Based Medicine and the Reconfiguration of Medical Knowledge', *Journal of Health and Social Behavior*, 45 (Extra Issue), pp.177-193.

Unison (2005) 'Private Sector in NHS Healthcare', *Factsheet*, Unison, <http://www.unison.org.uk/acrobat/B1992.pdf> [Acc: September 2005].

United Nations (2008a) *UN Service Trade*, United Nations, <http://unstats.un.org/unsd/ServiceTrade> [Acc: June 2008].

_____ (2008b) *National Accounts Main Aggregates Database*, United Nations, <http://unstats.un.org/unsd/snaama> [Last Acc: June 2008].

Uplekar, M.W. (2000) 'Private Health Care', *Social Science & Medicine*, 51, pp.897-904.

Van de Ven, W. & Schut, F.T. (2000) *The first decade of market oriented health care reforms in the Netherlands,* Institute of Health Care Policy and Management, Rotterdam: Erasmus University Rotterdam.

Van der Pijl, K. (1984) *The Making of an Atlantic Ruling Class*, London: Verso.

_____ (1998) *Transnational classes and international relations*, London: Routledge

Van Doosselaere, C., Herveg, J., Silber, D. & Wilson, P. (2008) *Legally eHealth - Putting eHealth in its European Legal Context*, Brussels: European Communities.

Vogel, D. (1989) *Fluctuating fortunes: The political power of business in America*, New York: Basic Books.

Waitzkin, H. & Iriart, C. (2001) 'How the United States Exports Managed Care to Developing Countries', *International Journal of Health Services*, 31(3), pp.495-505.

Walt, G. & Gilson, L. (1994) 'Reforming the health sector in developing countries: the central role of policy analysis', *Health Policy and Planning*, 9(4), pp.353-370.

Walt, G. (2000) 'Globalisation and Health', Issue Paper, Presented at Medact Meeting, 13th May 2000, People's Health Assembly, <http://phmovement.org/pubs/issuepapers/walt.html> [Acc: December 2002].

Wanless, D. (2002) *Securing our Future Health: Taking a Long-Term View*, Final Report, London: HM Treasury.

Watson, M. & Hay, C. (2003) 'The discourse of globalisation and the politics of no alternative: rendering the contingent necessary in the political economy of New Labour', *Policy & Politics*, 31:3, pp.289-305.

Watson, M. (1999) 'Globalisation and the Development of the British Political Economy', in Marsh *et al, Postwar British Politics in* Perspective, Cambridge: Polity Press, & Oxford: Blackwell Publishers Ltd., pp.125-143.

Webster, C. (1998a) 'The BMA and the NHS', *BMJ*, 317, pp.45-47.

_____ (1998b) *The National Health Service: A Political History*, Oxford: Oxford University Press.

_____ (2003) *The National Health Service: a political history,* New York: Oxford Press.

Weik, E. (2006) 'Working Relationships: A Meta-view on Structure and Agency', *Theory & Science,* 7(1), <http://theoryandscience.icaap.org/content/vol7.1/weik.html> [Acc: October 2006].

Weiss, L. (1997) 'Globalisation and the Myth of the Powerless State', *New Left Review*, 225, pp.3-27.West, P.A. (1998) 'Market - what market? A review of Health Authority purchasing in the NHS internal market', *Health Policy*, 44, pp.167-183.

Wells, R. & Banaszak-Holb, J. (2000) A critical review of recent US market level health care strategy literature, *Social Science and Medicine*, 51, pp.639-656.

West, P.A. (1998) 'Market - what market? A review of Health Authority purchasing in the NHS internal market', *Health Policy*, 44, pp.167-183.

WHO (2006) *World Health Report 2006: Working Together for Health*, Geneva: World Health Organization.

Wilkinson, R.G. (1996) *Unhealthy societies: the afflictions of inequality*, Routledge: London.

Williams, B.T. & Nicholl, J.P. (1994) 'Patient characteristics and clinical caseload of short stay independent hospitals in England and Wales, 1992-3', *British Medical Journal*, 308, pp.1699-1701.

Williams, B.T., Nicholl, J.P., Thomas, K.J. & Knowelden, J., (1984) 'Analysis of the work of independent acute hospitals in England and Wales, 1981', *British Medical Journal (Clin Res Ed)*, 289, pp.446-448

Williamson, H. (2005) 'Medical tourism keeps hospital budgets healthy', *Financial Times*, March 1.

Wonderling, D., Gruen, R. & Black, N. (2005) *Introduction to Health Economics*, Berkshire: Open University Press / McGraw-Hill.

Wood, E.M. (1981) 'The Separation of the "Economic" and the "Political" in Capitalism', *New Left Review*, 127, May-June, pp.66-95.

Woods, K.J. (2004) 'Political Devolution and the Health Services in Great Britain', *International Journal of Health Services*, 34(2), pp.323-339.

World Trade Organization (2006) *Measuring Trade in Services*, A training module produced by WTO / OMC in collaboration with the Inter-agency Task Force on Statistics of International Trade in Services, Economic Research and Statistics Division, World Trade Organization.

Zahariadis, N. (1998) 'Comparing Three Lenses of Policy Choice', *Policy Studies Journal*, 26(3), pp.434-448.

Zelman, W.A. (1996), *The Changing Healthcare Marketplace*, San Fransisco: Jossey-Bass.