

The Future of Health: Person Centred Care in Policy and Practice

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1 Introduction

The January OECD policy forum will address the future of healthcare with a focus on person-centred care (PCC) which is to be the “new normal” of tomorrow’s health systems. In addition, the Forum will consider ways in which healthcare spending can be improved by increasing efficiency and reducing waste. According to the OECD: “In a world of increasing complexity as well as opportunity, our healthcare systems simply must organize around the needs of the service user. A people-centred approach promises to raise quality, reduce waste and - most importantly - improve our health and well-being”.¹

PCC is a theme which has been taken up by numerous international agencies including the World Health Organisation (WHO).² Underlying this shift to PCC is a change in focus from supply side of health systems to a greater emphasis on patient outcomes. In addition, patients themselves are required to “become better partners in ensuring they get the care they need” (OECD 2016a).

While such a move to greater coordination of health services and improved patient outcomes is highly desirable, this shift in health systems rhetoric needs to be set in the context of recent policy in practice. This Briefing Paper shows that, while there is considerable diversity across health systems, some common themes are emerging. In the past decade, public health systems across the world are facing extensive funding cuts. As part of current austerity programmes, health workers are under increasing pressure, with many enduring falling real wages as well as an increasing workload. Many countries have seen an increase in out-of-pocket payments for healthcare, and

¹ <https://www.oecd.org/health/ministerial/policy-forum/>.

² <http://www.who.int/servicedeliverysafety/areas/people-centred-care/en/>

health sectors have been subject to extensive restructuring with a view to increasing market-like structures. Much of the restructuring has been to pave the way for increasing privatisation. In this wider context, the person-centred approach is at best largely peripheral to the major challenges facing intensely pressurised health systems and at worst, will shift greater responsibility on to individuals and households as well as private and voluntary health providers while public services are placed under greater strain.

2 Health services under austerity

Public health spending is coming under increasing scrutiny across the world, particularly since the 2008 financial crisis. In some countries, large-scale cuts in public spending as well as public sector reforms were imposed as a pre-condition by the troika (IMF, European Commission and European Central Bank) for financial rescue packages (for example in Greece, Ireland and Portugal). However, austerity measures are not limited to Europe. Research into national IMF programmes by Ortiz et al (2016) shows that many adjustment measures are observed in developing countries. Ruckert and Labonte (2012) conclude that the IMF-driven effort to restore balanced budgets through fiscal austerity arguably represents an immediate threat to global health. Cuts to sector funding often penalise health workers and lead to reduced services at a time when demand is increasing, as the recession impacts on the wider economy.

Austerity policies are linked to declines in health services. The European Centre for Disease Control has warned that serious health hazards are emerging because of the fiscal consolidation measures introduced since 2008 (cited in Ortiz et al 2016). In Greece, Portugal and Spain, citizens' access to public health services has been constrained to the extent that there are reported increases in mortality and morbidity. The experience of Greece has been particularly harsh in this regard. Spending on healthcare fell by 25% between 2009 and 2012 after the country's bailout package capped spending. With health insurance linked to employment, huge increases in unemployment have left many without access to healthcare.³ (For more details on the austerity driven public health crisis in Greece, see Kentikelenis et al., 2014).

The impact of public spending cuts reaches beyond direct health expenditure. Cuts to development assistance also present health related dangers to populations in developing countries. In SSA for example, half of public health budgets depend on foreign aid (Ortiz et al 2016, p.41).

2.1 Austerity and health workers

The provision of health services is labour intensive. Employment in health and social care represents a large and growing share of the labour force. Across OECD countries, employment in health and social work has grown on average by 48% since 2000 (James 2016). Scheil-Adlung (2016) finds that currently health employment in 185 countries amounts to jobs for 234 million workers, although many countries have major shortages in health staffing. In England, staff costs are the biggest area of spending for National Health Service (NHS) providers, accounting for almost two thirds of

³ <https://www.theguardian.com/world/2015/jul/09/greek-debt-crisis-damage-healthcare-hospital-austerity>

expenditure (Buchan et al 2016). In contrast with other services, health outcomes rely crucially on the interaction between the service provider and service user.

Fiscal discipline imposed under austerity policies have put a strain on health workers. A desk study of 187 IMF country reports found that wage bill cuts/caps including the salaries of education, health and other public sector workers were evident in 130 countries (Ortiz et al 2016). Containing the wage bill is the second most common austerity measure in sub-Saharan Africa (SSA) adopted in 27 countries, limiting the ability of some of the poorest countries to deliver public services including health and education. This is not universal and a very limited number of low income countries are expanding the number of health and education workers.⁴ However in most countries reviewed in their study, policy discussions focused on “necessary” adjustments to the wage bill to achieve cost savings. In England, much of the national efficiency saving targeted in the NHS Five Year Forward View is to be achieved via the government’s 1% cap on public sector pay (Buchan et al 2016).

This means, then, that the response to the financial crisis has been to cut the real wages of public sector staff, including in the health sector. In England, the Office of Budget Responsibility (OBR) predicts that whole economy average earnings will rise by around 2% a year in real terms so the pay freeze will mean that health care workers’ pay will fall relative to other occupations (Buchan et al 2016). The 1% cap on pay increases since 2010 has meant a 14% fall in nursing pay in real terms.⁵

Falling wages is taking its toll on the health workforce. Low pay is a key factor behind absenteeism, informal fees and brain drain (Ortiz et al 2016). In England, the pay freeze has damaged the morale and finances of NHS staff. Around 20% of nurses and health care assistants are reported to have taken another job to make ends meet.⁶ In addition there are high levels of reported stress.⁷ In a study of more than 23,000 nurses across ten countries, the UK recorded the highest level of “burnout” which is associated with intention to leave the nursing profession (Heinen et al 2013).⁸

Cuts in real wages and increasing stress are having an impact on staffing levels. A survey of NHS employers in late 2015 found that 93% of NHS trusts in England reported a shortage of registered nurses. Spending on higher cost agency staff has increased by 27% in 2014/15 rising to £3.4bn from £2.7bn in 2013/14 and £3.7bn at the end of 2015/16. This high spend on agency staff indicates difficulties in retaining and recruiting permanent staff (Buchan et al 2016) and is a major drain on public funds. Thus, short term attempts to cut expenditure by freezing wages results in higher long term costs and a weakened workforce with greater reliance on temporary staff.

⁴ Central African Republic, Gambia, Lao PDR, Mozambique and Niger.

⁵ <https://www.theguardian.com/healthcare-network/2015/jun/12/nhs-staff-most-stressed-public-sector-workers-survey-finds>

⁶ <https://www.rcn.org.uk/employment-and-pay>

⁷ <https://www.theguardian.com/healthcare-network/2015/jun/12/nhs-staff-most-stressed-public-sector-workers-survey-finds>

⁸ Burnout is caused by too many job demands, too few job resources and too little recovery resulting in chronic exhaustion and low morale and leading to absenteeism.

Putting such pressures on health workers has been proven to have a negative effect on patient welfare. There is a considerable body of evidence to indicate that the patient experience and health outcomes are affected by the working conditions of medical staff. For example, in a study of more than 60,000 nurses and 131,000 patients across 12 European countries and the USA, researchers found that nurse staffing and the quality of the hospital work environment were significantly associated with patient satisfaction and the quality and safety of care outcomes (Aiken et al 2012). Research from the USA finds that better work environments and lower patient-to-nurse ratios are associated with increased survival from in-hospital cardiac arrest patients (McHugh et al 2016). The findings from these (and other) studies suggest that staffing ratios and working conditions are key to improving patient outcomes. The relationship between staff and patients is at the centre of health care services and “person centred care” needs to include health workers as well as those that they provide services to. Austerity measures which are placing extreme pressure on healthcare staff are working against the interests of patients and may prove counterproductive in the long run.

2.2 Social impacts

Austerity is exacerbating inequalities in health. It is long established that poor people have worse health outcomes, with increased deprivation and reduced access. Unemployed people in Great Britain are almost twice as likely to have a long-standing illness or disability (ONS 2012 cited in James 2016, and see references cited in Alderwick et al 2015 p.7). Although the results are mixed, weakened mental health, increased substance abuse and higher suicide rates have all been linked with fiscal consolidation measures (Ortiz et al 2016 p.33 citing WHO 2011 and Stucker and Basu 2011). A comprehensive literature review of the consequences of the financial crisis both for health and for health behaviour found a worsening of mental health indicators and an increase in suicides reversing a long standing downward trend in EU member states after 2007 (Karanikolos et al 2016).

A number of countries⁹ have reduced the extent of coverage by instituting or increasing user charges for some health services in response to the financial crisis. While the impact of this is not yet known, Karanikolos et al (2013) draw on wider literature to suggest that rises in user charges will increase the financial burden on households and probably reduce the use of services especially by people with low incomes and high users of health care, even if user charges are low. They suggest that the introduction of or increases in user charges for primary or secondary specialist care may worsen outcomes and lead to increased use of free but resource-intensive services such as emergency care. Thus, such a move has an adverse impact on both cost savings and efficiency. Greece has experienced many adverse health outcomes following austerity including a 19% increase in the number of low-birthweight babies between 2008 and 2010 and a 21% rise in stillbirths between 2008 and 2011 which is attributed to reduced access to prenatal services for pregnant women. The country’s long term fall in infant mortality has reversed (Kentikelenis et al 2014).

⁹ Czech Republic, Denmark, Estonia, Finland, France, Greece, Ireland, Italy, Latvia, the Netherlands, Portugal, Romania and Slovenia.

Maintenance of spending in other sectors is as important as safeguarding health budgets. Karanikolos et al (2013, p.1326) cite a historical study of selected OECD countries that showed that each US\$100 increase per person per year in social welfare spending was associated with a 1.19% decrease in all-cause mortality. Spending on social welfare has a significant benefit for health outcomes. Ortiz et al (2016) document the widespread cuts in social protection planned as part of austerity packages. In England, and elsewhere, cuts in spending on social care have put a significant pressure on hospital services.¹⁰

Funding gaps for health put a strain on households. In Africa, despite commitments to the Millennium Development Goals, many countries have seen an increase in out-of-pocket payments (OOP) for health. Patients in low and lower-middle income countries are the least protected against high OOP, and payments for health have increased in nearly all countries in the African region and the regional average has increased from US\$15 per capita in 1995 to US\$38 in 2014. The share of households with catastrophic health payments has increased from 1.2% to 5% over the last 25 years with an increasing proportion of the population pushed into poverty as a result (WHO 2016).¹¹

While the financial crisis is widely associated with fiscal austerity, Iceland stands out for rejecting an IMF rescue package. The country suffered a major economic shock after 2008 that led to a collapse in the value of the currency, a major increase in the price of imports and substantial reduction in income for many Icelanders faced substantial reductions in income. Yet, in contrast to the austerity programmes adopted in much of Europe, Iceland's response to the financial crisis, was to invest in social protection. As a result, and unlike many other countries, the financial crisis seems to have had few or no discernible effects on health (Karanikolos et al 2013).

3 Health sector reforms

Health services have been dominated by a process of increasing marketization under neoliberal reforms since the 1980s. The separation of the role of purchaser and provider of health care has been at the core of reforms across countries and this allows the introduction of "market" structures and the commodification of health with a price put on services. With such a structure, services can be provided by the state or private or not-for-profit sectors. The need for public health services is removed and the private sector may be favoured in the name of efficiency and competition (Sengupta 2015).

In their study of IMF country reports, Ortiz et al (2016) found that healthcare system reforms were being considered by 56 governments in 22 developing and 34 high income countries. They say (p.34): "Typical health adjustment measures include increased user fees or charges for health services, reductions in medical personnel, discontinuation of allowances and increased copayments for pharmaceuticals."

¹⁰ <https://www.theguardian.com/society/2017/jan/06/three-deaths-worcestershire-royal-hospital-nhs-winter-crisis>

¹¹ In constant US\$,

3.1 Commercialisation and marketization

Many countries have seen a general shift towards more market-like structures in health services, for example, with a shift from block contracts to the separation of providers and commissioners of care and more recently “pay for performance” (P4P). In England, the publicly owned, funded and managed NHS was established in 1948 but a series of reforms have brought about increasing commercialization and marketization. A shift to internal markets in the early 1990s has been followed by incremental measures to increase the role of commercial incentives.

Such a policy is based on the premise that health providers – even in the public sector - will be motivated by financial incentives so that greater effort will be made to improve care quality if this is financially rewarded. However, there is little evidence of the effectiveness of such an approach. A study by Milstein and Schreyoegg (2016) of 34 P4P programmes found that outcomes were not much researched and what evaluations there were, found mixed, modest and short lived improvements. Causalities were unclear and raised the possibility of adverse impacts for example with adverse selection where the hospitals that are penalized tend to be those dealing with the most disadvantaged patient groups.

Health systems are seen in terms of a market, and so even public providers face financial sanctions, with for example, these being applied to local authorities in the case of delays in discharging patients from hospital (in Norway, Denmark and England) (OECD 2016b). Imposing financial penalties on cash-strapped state providers treats public providers as if they were private. Yet many are facing major financial deficits and so reducing their finances further is unlikely to lead to performance improvements.

In the UK, the separation of responsibilities between providers and commissioners of care makes the system more complex and fragmented and this is accentuated when organisations are under pressure to improve performance. Ham and Alderwick (2016) describe a “fortress mentality” among healthcare providers which they see as “a logical response in the existing NHS environment where provider autonomy, competition and regulation figure prominently.” They add (p.6):

Faced with persistent demands from regulators to improve performance, the leaders of provider organisations in particular are under pressure to focus on the services for which they are responsible rather than working with other providers and commissioners for the greater good of the population they serve ... Success for one organization almost invariably accentuates the challenges facing others ... Organisations commissioning and providing care with a common pool of limited resources find themselves in a zero-sum game in which winners co-exist with losers in a set of relationships that are often fragile.

The context of fiscal austerity combined with multiple providers in a fragmented system works against the interests of PCC. Klein and Maybin (2012) analyse the rationing responses of health providers in the context of tighter financing. Particularly significant to PCC is what they term “rationing by deflection” where patients are pushed from one health provider to another, as organisations are under pressure to contain spending. An example is provided in England where 81% of local authorities have cut adult social

care funding in the past five years which has led to an increase in the pressure on hospital accident and emergency departments with more emergency admissions of elderly and delayed discharge from hospital.

3.2 Efficiency

According to the OECD, health spending is often wasted (and even harms patients) and countries could potentially spend significantly less on health care with no impact on health system performance or on health outcomes (OECD 2016a). The OECD (2016b) identifies three categories of waste: Wasteful clinical care, operational waste and governance-related waste and proposes four categories of policy levers to address the “waste agenda”-

- Economic and financial incentives – which seek to influence the behaviour of patients, clinicians or managers
- Behaviour change – training
- Organisational changes eg reducing the number of providers
- Regulation which mandates changes in behaviour, organisation, information

While wasteful spending has clearly deleterious effects, these are often difficult to pin down and harder still to rectify. Policy measures (such as pay freezes) are often blunt instruments.

Research in Greece, where spending cuts have been imposed across all aspects of provider, suggests that this is not the result of a targeted strategy to increase efficiency so much as a quick response to urgent pressure for rapid and complex changes. Economou et al (2014) point out that these reforms are focused on operational financial and managerial dimensions which have more or less ignored the patient side of the equation (p.34): “The formulation of a patient centred health system seems to be out of the scope of the current reform package ... up to now the content and the process of change have been reduced to a strictly technocratic / managerial exercise without adequate consideration of the real health needs of the population”.

One method proposed to reduce cost relates to changing the skill mix, with care provided by a less qualified practitioner (for example OECD 2016a). However, such measures need to be undertaken with care. In England, this is to be achieved with the introduction in England of the nursing associate role.¹² However, reducing the skill mix of patient care is associated with poorer health outcomes. A detailed study across 243 acute care hospitals in Belgium, England, Finland, Ireland, Spain and Switzerland found that a richer nurse skill mix was associated with lower mortality. Each 10 percentage point reduction in the proportion of professional nurses was associated with an 11% increase in the odds of death. Substituting one nurse assistant for a professional nurse for every 25 patients was found to be associated with a 21% increase in the odds of dying (Aiken et al 2016).

In England, pressures to induce efficiency savings in practice are creating service cuts and the boundary between the two is blurred. Efficiency savings are supposed to mean that the same service is provided at lower cost but in practice, while quality has been

¹² <https://www.hee.nhs.uk/our-work/developing-our-workforce/nursing/nursing-associate-new-support-role-nursing>

maintained, the impact is often felt in longer waiting times (an implicit form of rationing) and cuts in staff wages. This often places a considerable burden on unpaid care. The costs of supposed efficiency gains are felt by households.

Discussions on efficiency often come down to cutting costs in the short term but this can be at the expense of long term strategic investment, and policies risk being counter-productive. Measures which are intended to lower costs may have the opposite effect over time. For example, cuts in real wages for health staff contribute to absenteeism and staffing shortages which lead to increased reliance on temporary, high-cost agency staff. Financial incentives aimed at increasing efficiency, similarly may lead to lack of integration in health services with patients pushed on to other service providers as health operators strive to meet targets.

In addition, efficiency narratives tend to be selective with some significant costs omitted from the analysis. For example, OECD does not refer to the costs associated with restructuring and reorganisation. In England, in December 2016 it was reported that a merger between two hospital trusts - a deal which eventually failed to be achieved - cost £10m. The NHS spent £6.6m in “professional adviser” fees alone.¹³ The private provision of health services is associated with high transaction costs. Sengupta (2013) cites a study of the US that found that around 31% of healthcare expenditures represented administrative costs. In contrast a study of transaction costs in the UK’s national health service in the 1970s before the introduction of internal markets let alone privatisation estimated these to be between 5 and 6% of total expenditure (Leys 2009 cited in Sengupta 2013 p.11). Public-private partnerships (PPPs) are the most expensive way to finance health infrastructure (see below), and these high fixed finance costs are potentially a significant source of inefficiency in health systems.

4 Privatisation and the private sector

The private sector has long been involved in health services. More recently policies promoted by governments and international agencies have sought to increase the role of private investors. While this aims to increase efficiency and raise investment, such measures are typically associated with higher long term costs and reduced accountability.

4.1 Public private partnerships for health infrastructure

There has been an increase in the role of the private sector in health provision through long-term lease contracts for the construction and management of health facilities through public private partnerships (PPPs). This was pioneered with the Private Finance Initiative (PFI) in the UK and has since been adopted worldwide with strong support in Canada and Australia. Donors such as EBRD and the World Bank Group’s International Finance Corporation (IFC) are supporting PPPs in health in developing regions.¹⁴

¹³ <https://www.bma.org.uk/news/2016/december/collapsed-hospital-merger-costs-eye-watering-10>

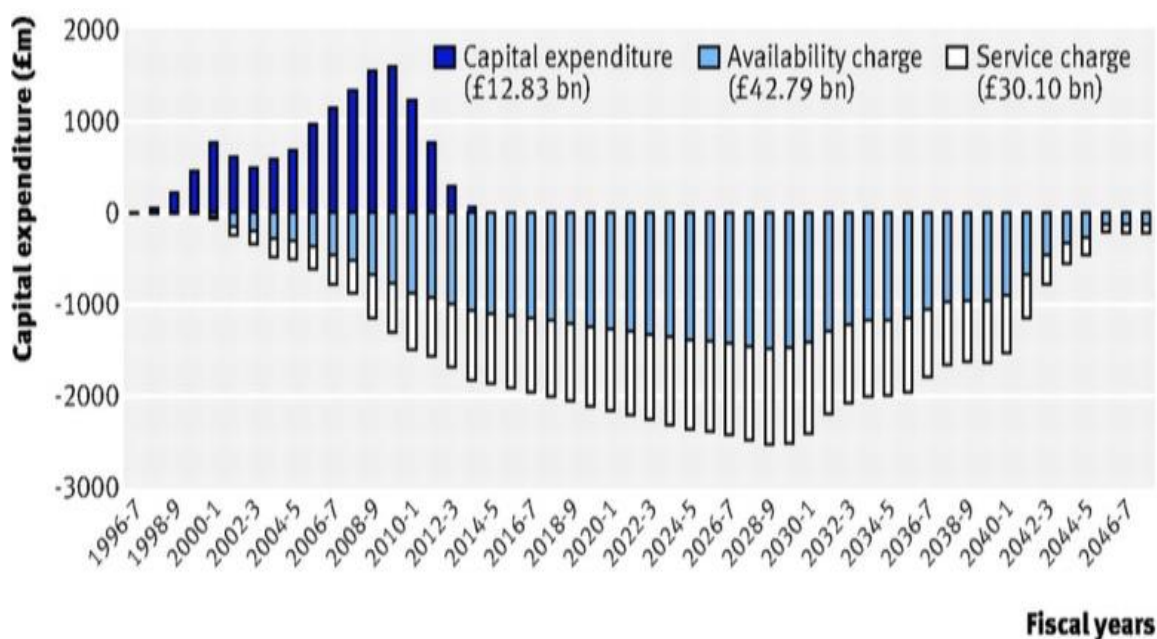
¹⁴

http://www.ifc.org/wps/wcm/connect/industry_ext_content/ifc_external_corporate_site/pp/priorities/health

PPPs are politically attractive because the private sector provides infrastructure finance up front. However, the state is committed to high lease payments for decades into the future. PPPs have been likened to buying a hospital with a credit card in terms of the “buy now, pay later” approach to finance. They are the most expensive way to finance infrastructure. Private finance comes at considerably higher cost than government borrowing and it is not just the high cost but the rigidity of fixed payments that creates challenges for health financing.

In England, PFI contracts were introduced in the late 1990s for the construction of health facilities and now while the NHS is under increasing financial strain, hospitals are tied into decades-long contracts for construction and facility management which greatly outweigh the initial costs as Figure 1 below shows.

Figure 1: Capital expenditure and unitary payments for 150 UK PFI hospital projects signed by December 2009



Source: Pollock, Price and Liebe 2013

Payments for PFI contracts constitutes a significant element of expenditure for some NHS hospitals and yet discussions on efficiency and cost reduction seldom refer to this example of extreme inefficiency. South London Healthcare NHS Trust went into administration in 2012. At the time the Trust was spending 16% of its income on six PFI contracts. These contracts cost the Trust substantially more per year than if they had been financed through traditional public financing arrangements (NHS 2013).

Investors in PFI contracts have made considerable profits from selling (“flipping”) their stakes at the same time that hospitals are having to cut staff (Whitfield 2012). This “secondary market” in stakes in PFI contracts has led to a concentration of ownership in offshore private infrastructure funds which pay little tax and offer little transparency (Whitfield 2016).

Outside the UK there are other examples of extensive challenges emerging from using the private sector to finance infrastructure. Examples of this include the Lesotho Queen Elizabeth II hospital. This is heralded as a success by the World Bank.¹⁵ But a Report from Oxfam shows that this PPP is taking up more than half the country's public health budget, providing high returns to the private investor while diverting funds from primary and secondary healthcare in rural areas.¹⁶ Focusing on aligning incentives to attract private investment can divert scarce state resources and skills away from the matter of directly providing health care.

In her book on PPPs in the Canadian health sector, Heather Whiteside (2015) finds a number of adverse impacts from using PPPs to develop public infrastructure: "higher long-run costs, disintegrated internal hospital management, a loss of democratic control, creates a more market-oriented public sector and generates precarious conditions for labour, among other concerns."

PPPs are expensive not just in the costs of service provision but also in the tendering processes as well as in regulating the contracts. One of the biggest UK NHS contracts for patient services in the Cambridgeshire and Peterborough Trust area collapsed after only eight months because it proved financially unsustainable.¹⁷ According to a review by the Public Accounts Committee, the termination led to unfunded costs totaling at least £16m. The contract failure worsened the finances of an already struggling local health economy and reduced the money available to provide patient services in the area (HoC 2016). Where contracts collapse, the state retains responsibility which can lead to a chaotic ad hoc service, as happened with some of the contracts in the UK.¹⁸

Despite extensive evidence of the high costs and rigid contracts associated with health PPPs, they continue to feature in policy. Turkey, for example, is pursuing a large PPP programme in health covering up to 60 facilities across the country worth 12 billion euro with financial support from the EBRD.¹⁹ However greater attention is needed to the potentially crippling long-term costs for the state.

4.2 Private insurance

The pooling of risk and of financing for health costs is cheaper than out-of-pocket (OOP) payments for healthcare. However, private health insurance raises a further set of issues. Insurance premiums are beyond the scope of many of the poorest households and insurance firms avoid insuring the most in need and avoid paying out where

¹⁵ <http://www.worldbank.org/en/country/lesotho/brief/lesotho-health-network-ppp>.

¹⁶ <https://www.oxfam.org/sites/www.oxfam.org/files/bn-dangerous-diversion-lesotho-health-ppp-070414-en.pdf>.

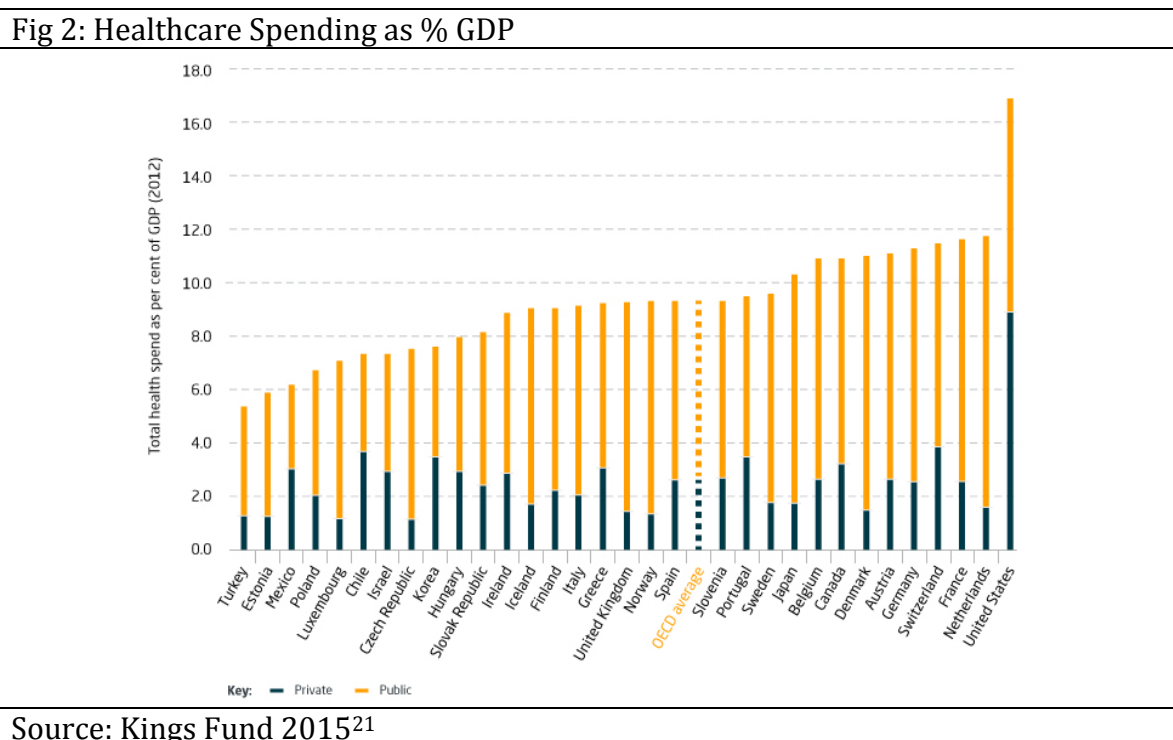
¹⁷ <https://www.ft.com/content/4c008640-9a70-11e5-987b-d6cdef1b205c>

¹⁸ <http://www.telegraph.co.uk/news/health/news/10209863/NHS-111-helpline-is-on-brink-of-collapse-after-contracts-abandoned.html>

¹⁹ <http://www.ebrd.com/work-with-us/projects/psd/extension-of-hospital-ppp-framework-in-turkey.html>

possible, pushing even the insured to OOPs. In the USA many with health insurance still have to pay high amounts in OOP.²⁰

Financial extraction by private insurance companies and health providers creates an additional cost to such systems. The financial sector is undeveloped in locations where health needs are greatest and even if there is capacity for insurance provision there are limitations on regulation of insurance providers. The regulation of the financial sector is extremely challenging as the 2008 financial crisis demonstrated. Figure 2 shows financing costs as a percentage of GDP. The USA spends a much higher proportion on health than other OECD countries.



4.3 Other privatisations in health

Aside from infrastructure PPPs and private insurance, the private sector is making increasing inroads in various ways. In England, 2012 legislation calls for greater scope of private contracting across clinical services. The private sector has been involved in community and mental health and social care for some years in the UK with financial investors often taking ownership stakes in health and social care providers. Aside from the challenges of implementing and regulating contracts with private providers, these investors are focused on revenue maximisation, with financial investors adopting increasingly predatory activities. Examples include the purchase of a UK chain of care homes by private equity investor, Blackstone, which, via a complex ‘sale and leaseback’

²⁰ <https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lchs-dig-deep-hidden-costs-112414.pdf>

²¹ <https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/health-care-spending-compared>

scheme of the company's properties led to bankruptcy of the care provider and eviction of elderly residents, despite a substantial profit on the property sale (Bayliss 2015). Private health companies often are structured so that tax liabilities are minimised, for example with large loans from group companies that create high, tax deductible interest payments so that taxable profit is eroded.

Public health providers also treat private patients. In England, under 2012 legislation, the cap of the proportion of income that public hospitals can raise from treating private patients was increased from 2% to 49% (see Bayliss 2015). In Greece, under new reforms, private doctors are allowed to work in public hospitals. According to Economou et al (2014, p. 36), "as a revenue raising measure 500 public hospital beds will be set aside for priority use by private insurance companies for their clients" (p.20).

Supporters claim that income from private patients subsidises public systems but more research is needed to determine the flow of resources in practice, particularly when the wider systemic aspects of provision are taken into account. Private practitioners in these cases are typically using public trained staff, in publicly funded facilities with public sector emergency back up facilities (Bayliss 2015), and a two-tier system is likely to emerge.

5 Conclusion

The shift to patient centred care, as advocated by OECD and other institutions, is notable for its failure to address the fundamental issues that give rise to the deficiencies of health provision. Many countries face major challenges with tightening health and social care budgets, inadequate staffing levels and declining staff morale. Empowering individuals and communities to take part in health care decisions under PCC reforms will have limited impact where the ability to access medical treatment and health services is under threat.

The main policy tools in the orthodox approach to health sector financing risk being counter-productive. Efforts to reduce costs by increasing competition have created fragmented structures that work against the integration and coordination of healthcare. Bringing in the private sector is likely to accentuate this silo mentality in provision, in the name of commercial confidentiality and profit maximisation. Cutting spending on wages has often led to low morale, absenteeism and shortages of nursing staff. In England, this has led to increasing staff costs with much greater use of agency staff. While in the short run spending may fall, in the longer term these measures will work against the provision of an effective, integrated health system.

Cuts in health spending have had devastating outcomes in some cases. The Ebola outbreak has directed attention to the failings of the development model and led to calls for greater coordinated public financed health systems (for example, O'Hare 2015) such as a dedicated health fund to boost fragile health systems and human resource shortages.²²

²² [http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X\(14\)70369-9.pdf](http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(14)70369-9.pdf)

Some countries, such as Iceland have resisted fiscal adjustment measures and looked for alternatives to austerity, despite their difficult economic position. Research by Ortiz et al (2015) highlights innovative approaches to increase fiscal space for social protection and there are numerous and diverse approaches adopted across countries. These include specific taxes on tourism or mineral extraction or financial transactions; tackling illicit financial flows and reallocating military expenditure. More research is needed to explore alternative approaches.

While the principle of person-centred care is welcomed, much of the policy in practice currently works against the interests of both patients and health workers. The efficiency discourse needs to be broadened to look beyond short term spending cuts to long term investment. Reorienting health systems away from the supply side to focus patient outcomes still requires a strong health service capacity. An adequately resourced, integrated, publicly funded and provided health system would seem to offer the most efficient means by which patients' needs can be met.

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