

Commodification in the reforms of the German, French and British health systems

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Abstract *Since the 1980s, European health systems have undergone several reforms, with emphasis on the tendency of their commodification. The objective of this article is to demonstrate how market mechanisms were implemented in the functioning of these systems, German, British and French – from the 1980s. The “mercantile” reforms were justified on the premise that the insertion of market logic could both reduce the need for public spending and increase the efficiency of existing expenditure. The work presents different forms of commodification implemented in the reforms, with the distinction between processes of explicit commodification, in which there is an effective increase in private, and implicit presence, in which there is incorporation of principles from the private sector in the public system, both in financing and in the provision of health services. In addition to detailing the different ways in which this phenomenon is expressed, the article briefly presents the potential negative effects of this process for health systems, especially in terms of access and equity, stating that the initial assumptions surrounding commodification (cost reduction and efficiency improvement) appear to be false.*

Key words *Commodification, Health systems reform, Germany, France, United Kingdom*

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Introduction

One of the main brands of post-war social protection, with emphasis on health systems, was the decommodification of access to goods and social services, that is, access was not dependent on purchasing power and price definition¹. Germany, France and the United Kingdom, as well as several other European countries, structure broad health systems. These three countries have developed distinct health systems, but with some common central characteristics: predominantly public financing (through taxes or social contributions) and broad access, close to universality, even in countries such as Germany and France where the system was intended, and not to every citizen (as in the United Kingdom).

However, in the face of a series of economic crises since the 1970s, the reduction in the pace of economic growth and the rise in the unemployment rate have put pressure on the public budget. Added to the growth of the neoliberal influence, which called for important changes in the action of the State and acquired greater force from the 1980s, the actions of the National States underwent a series of changes, affecting social protection systems.

In this new context, health systems have undergone reforms that have introduced, albeit partially, market mechanisms. The reforms were justified on the premise that the insertion of market logic could both reduce the need for public spending – with the private sector assuming certain functions – such as increasing the efficiency of existing expenditures – by inserting, within a public structure, “market mechanisms”, such as competition, pay by result, etc.^{2,3}.

It is important, however, to highlight that the private sector is not a new agent to the systems. None of the postwar systems of health has ever been – even before the changes adopted since the 1980s – totally public. In turn, the various mechanisms that have been adopted over the last three decades, have represented a quantitative and qualitative alteration of private presence and market logic in public health systems.

The aim of this article is, therefore, to present the main trends in commodification in health systems in Germany, France and the United Kingdom and how they have developed during the reforms implemented in the last decades, besides pointing out some already identifiable consequences and possible risks in the deepening the process. It is important to point out that, although we are referring to the United King-

dom, and all available data cover the territory as a whole, after 1999 the reforms carried out refer only to the English NHS (with Scotland and Wales making different changes to their systems).

Our study is justified by the importance of understanding the dynamics of changes in universal health systems, by expanding existing forms and creating new market mechanisms.

For this, the article is structured in five parts, besides this introduction and the conclusion. The first part presents the analytical referential, presenting the main historical characteristics of the three health systems and the classification of forms of commodification. In the following four parts, each trend is detailed: the explicit commodification of the financing; explicit commodification in the supply of services; the implicit commercialization of financing and the implicit commercialization of health service provision.

Analytical referential

This paper is based on a comparative study on how the introduction of market mechanisms affected three different health systems. Germany, France and the United Kingdom were selected for having similar characteristics that allow comparison (such as the development of their health systems after the Second world war, the effects of the crisis of the 1970s and 1980s and challenges in the context of the European common market), as well as relevant differences that contribute to understand how different institutional designs respond to the introduction of market mechanisms.

In this sense, it is initially for us to present some analytical categories that describe the main characteristics of the systems used as unit of work in this article. These categories are summarized in Chart 1.

In addition to the choice of the countries studied, the authors chose to address a specific aspect of the reforms carried out in the three health systems, namely, the introduction of market mechanisms. In order to carry out this analysis, we have chosen to classify it as a tendency towards “commodification”. In the literature on the subject, we find authors adopting the terms mercantilization, privatization and commercialization²⁻⁸. In this article we have chosen commodification because it is an expression that accommodates a broader process, that is, the increase of private logic within public health systems, by increasing the direct participation of

Chart 1. Main characteristics of the Social Health Systems, Germany, France and the United Kingdom, after 1945 until the 1970s.

	Germany	France	United Kingdom
Modality	Social insurance system	Social insurance system	National system
Access	Workers	Workers	Citizens
Financing	Social contributions	Social contributions	Taxes
Contributions	Defined by each Fund	Variable according to salary (up to a general ceiling)	-----
Accession	Automatic (up to a certain salary range)	Automatic	Automatic
Benefits	Uniform	Uniform	Uniform
Free choice	Yes	Yes	No
Regulation	Funds (regional and by categories)	Funds (national and special categories)	Ministry of Health
Organization	Contractual	Reimbursement	Integrated
Degree of centralization	Decentralized	Centralized	Centralized
General practitioner	Individual private physicians	Individual private physicians	Private physicians in group
Specialist physician	Individual private physicians /hospitals	Individual private physicians s/private clinics/hospitals	Public hospitals
Remuneration physicians	Payment by act (outpatient) / salary (hospital)	Payment by act (outpatient) / salary (hospital)	Payment by capitation (outpatient)/salary (hospital)
Physician "gateway"	No	No	Yes

Source: own elaboration.

the private sector as a provider of services and private resources in the financing, as well as the adoption of private principles of management, remuneration and systems organization.

Based on the observation of commodification, we systematize that this process is concentrated in two spheres: in the financing and in the provision of health services^{2,3}.

Another important feature concerns differentiating commodification in terms of explicit and implicit processes. We understand the explicit process when it involves direct transfer of responsibility from the public to the private sector. In turn, the implicit process is characterized by the increasing adoption of a logic of private performance by the public sector^{2,8}.

From these references, the classification of reforms^{9,10} of the countries studied was developed. The four trends are briefly summarized in terms of characteristics captured in health system reforms, in Chart 2.

Explicit commodification: financing

Private participation in total health spending has increased, in the last decades, in several European countries¹¹. However, it is important to explain that, in percentage terms, the three countries maintained predominantly public health expenditures. As presented in Table 1, between 1975 and 2015, private participation has never reached 25% of total health spending.

Private resources are concentrated in the contracting of private insurances and direct disbursement carried out by households. As shown in Table 2, most private expenditure, in Germany and the United Kingdom, was of direct disbursement: 81% and 73%, respectively. In France, in turn, there is a predominance of private insurance expenditure, which accounted for 67% of the total.

The French case deserves emphasis, due to its particularity. The post-war health system provided for a reimbursement mechanism. That is, the patient pays directly for the consultation or purchase of medications, and is subsequently

Chart 2. Typology of commodification.

Explicit commodification		Implicit commodification	
Financing	Service offer	Financing	Service offer
Direct payment / Co-payment	Outsourcing of auxiliary services	Public-private partnership	New public management
Private Insurance	Assistance of private patients in the public network		Increased competition between service providers (public)
	Incorporation of the private sector in the provision of services		Payment by result - hospitals
	Private management of public institutions		Payment for result - physicians
	Privatization (<i>stricto sensu</i>)		

Source: own elaboration.

Table 1. Private spending on health (in % of total expenditure on health), Germany, France and the United Kingdom, 1975 to 2015.

	1975	1980	1985	1990	1995	2000	2005	2010	2015
Germany	21,9	22,2	23,4	24,6	18,3	20,6	23,7	16,6	15,5
France	22,5	20,4	22,0	24,0	20,9	21,1	21,3	21,6	21,1
United Kingdom	9,1	10,5	13,9	15,7	15,9	20,7	18,7	16,9	20,3

Source: OECD¹².

Table 2. Private health expenditure by financing scheme (in % of the total private expenditure), Germany, France and the United Kingdom, 2015.

	Private Insurer	Direct disbursement (including co-payment)
Germany	19%	81%
France¹	67%	32%
United Kingdom	27%	73%

Source: OECD¹².

¹ French private insurers are, mostly, mutual, worker-run and non-profit institutions. Nevertheless, by the methodology presented in the OECD data, all mutuals are classified together with the private insurers. It should also be pointed out that the participation of profitable private insurers has been increasing, but the mutual ones still predominate in the French system.

reimbursed by Social Security. As Security does not reimburse the entirety of the expenses, a private supplementary insurance system has been developed, with the objective of coping with the co-payments. This system, however, was organized around mutual institutions, managed by employees and non-profit making.

With regard to co-payment mechanisms, these have existed since the creation of the three health systems in the post-war period, with the proposal of co-participation of the user in fi-

nancing¹⁰. However, the values were, generally, very low and a large part of the population (elderly, pregnant women, children, those with chronic diseases) was (and continues to be) exempt. This is the case of the British system, where co-payments are very limited and restricted to dentistry and medicines.

Even so, from the 1980s, its dimension and values have been increasing. Table 3 summarizes the main co-payment mechanisms and their values.

Co-payment is also thought of as an instrument to rationalize the use of the system. An example of this is the differentiation of co-payment in the French system depending on the physician accessed, implemented in 2004. If the patient consulted with his/her referring physician (usually a general practitioner), the co-payment would be 30%, as well as to access other professionals, provided under your referral of the physician. However, if the patient decided to consult with another professional, without prior recommendation, he/she would have to pay a higher co-payment, of 40%. This figure was raised to 50%, in 2007, and to 70%, in 2009^{15,16}.

The systems also have other mechanisms of direct disbursement, as in the case of medicines. In the three countries, by means of cost-effectiveness analyzes, the drugs that are paid by the public system were reduced in the years 2000¹⁷.

Table 3. Co-payment in health systems, Germany, France and the United Kingdom, 2015.

	Germany	France ^I	United Kingdom ^{II}
Consultation	----	30% (€ 6,90)	----
Medication	€ 5-10	€ 0,50	£ 7,20
Dental Care	20% orthodontics	30% (from €5,07 to €83,85)	from £ 16,50 to £ 198
Transportation ambulance	€ 5-10	€ 2	----
Hospital stay	€ 10	€ 18	----

Source: Harker¹³; Busse e Blümel¹⁴; Ameli¹⁵.

^ICo-payment, in France, is a % of the value of the consultation (in 2015, the value of the consultation agreed with the Social Security was €23). If the consultation is with the physician responsible for the patient (*médecin traitant*) or a specialist indicated by the same, the co-payment is 30% (€6.90). If there is no indication of the physician, the co-payment increases to 70% (€16.10).

^{II} The presented co-payment amounts refer only to England, in 2012 values.

The other form of raising private participation in financing is private health insurances. They may have very different roles in each country: substitutes (such as in Germany, where the population with the highest incomes may choose to adopt social or private insurance); complementary (french case, where private insurance finances costs not covered by Social Security, and to a lesser extent in the Germany case) or supplementary (where it covers care not provided by the public sector or in order to access private beds, avoiding queues, as occurs in the United Kingdom).

In France, the increase in co-payment mechanisms has led to the expansion of complementary private insurance. In 1980, 72% of the french population had complementary insurance to cover co-payments; in 1995, the proportion was 85% and, in 2008, 95%¹⁷⁻¹⁹.

In Germany and the United Kingdom, the share of the population with private insurance is much lower than in the case of France, in view of the different objectives of obtaining insurance. In both countries, there was a strong increase in the population with private insurance throughout the 1980s (from 6.5% to around 11%), with relative stability in the 1990s and 2000^{14,20}.

In the british case, as the entire population is automatically covered by the public system, private insurance finances care outside the NHS, in private hospitals, sought by the highest income population, or for procedures not covered by the NHS (such as elective plastic surgery). In addition, private insurance is used to access private beds in public hospitals²¹.

In the german system, private insurance is mainly substitute, in other words, those who opt for private insurance are not tied to social insurance. In 2008, two important changes were implemented in the german system that affected

both social and private insurance: the obligation of membership to some kind of insurance and the determination that those who choose private insurance will not be able to return to the public, after reaching 55 years¹¹.

Thus, the tendency of explicit commodification in financing has a marked feature in the expansion of the participation of private resources, mainly through the increase of co-payments. The greatest risk derived from this trend is to reduce universality of access, by making co-payment a relevant factor.

Until the beginning of the decade of 2010, this danger seemed reasonably controlled: Germany and the United Kingdom had a number of exemptions, which allowed 50% and 80% of the medicines, respectively, to be completely free. Still, it is important to highlight that pernicious effects have been avoided by population pressure, as in the case of an attempt by the german government to insert co-payment for medical consultations¹⁴.

In the french case, the greater diffusion of co-payments led the french government to create, in 2003, a mechanism called universal supplementary health coverage, allowing the low-income population to have access to complementary insurance free of charge and thus not having to pay with no co-payment^{16-18,22}. Thus, the increase from 85% to 95% of the population with private health insurance was derived from this mechanism, meaning a greater guarantee of universality to the low-income population.

Explicit commodification: provision of services

The provision of health services is performed by both public and private service providers (philanthropic or profitable). In the three coun-

tries studied, general practitioners have remained as post-war liberal professionals, while hospital professionals became civil servants. Hospital networks were organized in different ways: while the British system nationalized its network, Germany and France maintained private hospitals as part of the provision of services².

Nevertheless, private participation has grown with the reforms implemented since the 1980s. As early as the beginning of the decade, the outsourcing of auxiliary services became a current practice, initially in the contracting of private services for auxiliary activities, such as laundry, food, cleaning and security^{2,3}.

In Germany and France, the signs of outsourcing are small, even if present. In both cases, private hospitals that provide services to the public network are released to contract these services and public institutions have restrictions, even though the practice occurs in security services, laundry, maintenance of equipment and informatics^{14,23,24}.

In the United Kingdom, outsourcing was much higher. As early as 1983, the Health Department instructed all health authorities to open up to competition in the cleaning, laundry and catering sectors, with authorization, in 1988, so that all non-medical service (from parking to the presence of television in the rooms) could be outsourced. In the 1990s, the process expanded to medical services, with contracting for clinical and laboratory analysis of exams^{3,25,26}.

The United Kingdom has also expanded the care of private patients in the public structure. Since the creation of the NHS, in 1948, this was a controversial point. Although legal, the existence of restrictions meant that between the 1950s and 1970s, only about 1% of the NHS beds were intended for private patients. In the 1980s, the demand for more resources boosted the expansion of this service, increasing to 3% of the beds^{21,26,27}.

As of 2002, with the conversion of hospitals into *foundation trusts* (autonomous public institutions of private law), the pressure for private patient care in the NHS has increased. The biggest change occurred in 2012, with *foundation trusts* hospitals being able to obtain up to 49% of their income from private sources – given the radical nature of the change, its adoption was still under discussion in 2017^{28,29}.

A third trend was the incorporation of the private sector in the provision of health services, mainly in the hospital sector. In the United Kingdom, the hiring of the private sector for service provision in the NHS occurred on an *ad hoc* basis

until the 1990s. This situation underwent a major transformation in the 2000s, with the implementation of an agreement which provided for the possibility of *NHS hospitals trusts* to hire local private providers to perform elective surgeries. In 2003, the establishment of the *Independent Sector Treatment Center* (ISTC) facilitated the hiring of private hospitals to provide services in the NHS. In 2012, the private hospitals participating in the program were compulsorily included among the choices of the patients. Every patient can, from then on, choose from five hospitals for treatment, always including at least one private institution^{29,30}.

In the French case, the great change occurred with the 2004 reform (*loi Mattei*). The reform created the Regional Health Agencies (ARS), which had autonomy to contract services (in order to fulfill health missions) in public, philanthropic or private hospitals. The private sector gained more space in the system, considering the perspective that the contracting of private institutions would allow a greater attendance of health needs^{18,31}.

In Germany, the situation is somewhat different. The state sphere (*Länder*) always had the autonomy to credit, in the provision of health services in the public system, any type of hospital – public, philanthropic or private profit –, passing on resources according to its regional hospital planning. The hiring of large private institutions increased in the 1990s in some *Länder*, for the construction and operationalization of hospitals within the regional planning, with remuneration according to the number of social insurance patients attended^{31,32}.

A fourth phenomenon is the growing hiring of private managers for public institutions. In Germany, in the early 2000s, the legal structure of hospitals was modified, allowing the contracting of private institutions to run public hospitals^{2,33}. In the British case, throughout the 1990s, rather than hiring private managers, hospitals underwent an increasing process of incorporating private business logic – until their transformation into *foundation trusts*, as of 2002. However, once converted into *foundations*, some hospitals opted for privately hired management. In addition, in the outpatient sector, the government allowed, from 2005 on, the private sector to manage health centers, the *NHS Health Centers*, in its various modalities³⁴.

Explicit commodification in service provision is also present in the privatization *stricto sensu*, most recurrent in Germany. In the 1990s,

small public hospitals, especially in the former East Germany, were privatized. Already in the 2000s, the process reached large institutions of the former western part of the country. Between 1992 and 2006, private for-profit German hospitals rose from 15.5% to 27.8% of the total, with private beds offering increasing from 8.9% to 13.6%, in the same period, reaching 15% in 2009^{24,32}. Although they represent a small portion, it is worth mentioning the pace of expansion of private participation.

Implicit commodification: financing

As discussed in the explicit commodification of funding, health systems in Europe have been increasingly engaging the private sector in financing systems in terms of resources that come via direct disbursement (including co-payments) and private insurance. However, private participation in financing is not limited to this.

In the United Kingdom, budget constraints have led the hospital sector to borrow money from the private sector, in order to make investments. This process occurs in four ways: private loans taken directly by hospitals; private loans taken by regional health agencies; formation of public-private partnerships (PPPs), with the private sector being responsible for the design, construction and operation of non-clinical hospital services; and PPPs involving the management of clinical functions by the private sector³⁵.

Direct borrowing from the private sector is possible in France and Germany. In both countries, a five-year public plan foresees the number of hospitals and the expansion needs of the services, conditioned to the regional specificities and may include private hospitals that are part of the provision of public system services^{18,33,35}.

In Germany, in terms of hospital financing, we must first understand that, while the Social Health Insurance Funds are responsible for the financing of current costs and small investments, larger investments, involving the construction and renovation of hospitals, depend on state resources (*Länder*). Hospitals are free to borrow from the private sector, provided there is regional approval^{6,32}.

The implementation of a PPP by a German hospital is an exclusive decision of the owner (municipality or state), allowed to public hospitals under private law (up to 2007, 38% of German public hospitals). Between 2002 and 2012, nine PPPs were constituted in the hospital sector and another twelve projects were under evaluation.

In the French case, although the possibility of borrowing money from the private sector was already present, only from 2003, the hospital sector was included in the institutions that could carry out a PPP. Between 2005 and 2012, 50 contracts of PPPs were approved, with the complete construction of 35 hospitals, totaling €7 billion, equivalent to 15% of total hospital investments in the period²⁴.

In turn, the British case is the most prominent in our analysis – both for its precursor aspect and for the extension of this modality. The partnership was created through the creation of the PFI (*Private Finance Initiative*), in 1997, on the grounds that the Treasury was not able to meet all investment demands in the health sector. The use of private resources would enable the expansion of infrastructure, transferring risks and allowing a reduction in construction costs^{7,24,35}.

The contracts via PFI predicted that private investors would be responsible for the design, operation, financing and construction of the infrastructure. The public authority would later pay a fee of 12% to 20% of the annual income for the consortium involved, in contracts that would last, in principle, 25 years. Between 1997 and 2013, 118 financing projects were signed in this modality, which corresponded to 90% of hospital infrastructure investments in the country, totaling £11.6 billion^{7,24,27}.

The adoption of PPPs in British hospitals, however, faces important questions. The costs would have, instead of reducing, been expanded. This is because the private sector borrows at a higher cost than the public sector; the dividends to be paid by hospitals are high; and new costs arose, usually undersized, from monitoring contracts. As a result, construction costs were higher than expected, increasing the rate of later payment by the public sector and the duration of contracts (which increased from 25 to 30 and up to 40 years). In addition, private investments in hospitals changed management and extended *turn-overs* of employees^{24,27}.

Implicit commodification: offer

The implied commodification in offer is understood as the increasing adoption of market principles in the performance of the public sector, through new management models (*new public management*), with the justification of increasing efficiency and “modernization”.

In European healthcare systems, the new public management emerged in the United Kingdom

in the 1980s, with the replacement, in the top NHS administrative positions and hospitals, of health professionals by private sector executives with business experience. This trend also occurred in France and Germany in the following decade^{27,36}.

In addition, the new management is associated with changes in the organization of health systems. One of the most profound transformations was the idea that it was possible to incorporate the basic premise of a private system: the organization as a market. The pioneer country in this process was the United Kingdom, with a series of changes in the NHS, starting in 1989, to establish an internal market or quasi-market.

The reform proposed the separation of the functions of purchasers and service providers, in the outpatient and hospital systems. The health authorities started to buy the services of the providers, and the hospitals could be constituted as autonomous institutions, the *hospitals trusts*. General practitioners (GPs), in turn, could have their own budget, such as *fundholders*, in order to hire the necessary (not emergency) services for their patients. Although the creation of *fundholders* did not disseminate as the government planned, a “quasi-market” was created, taking into consideration that, although most of the agents involved were from the public sphere, mercantile competition was being promoted²⁵.

The internal market of the NHS was reformed several times in the 1990s and 2000s. In 1997, the Labor government proposed the reconfiguration of the system, with the creation of *Primary Care Groups* (PCGs), which should be an evolution of *fundholders*, extending its sphere of responsibility by allocating resources in the system. However, this institutional design was unsuccessful and, in 2001, the government created the *Primary Care Trusts* (PCTs). The PCTs acted as management structures, integrating, in the same geographic space, the activities of public health, the provision of the services of GPs and hospitals. In 2010, local health authorities and PCTs were abolished, with the contracting of health services transferred to the *Clinical Commissioning Groups* (CCGs)^{26,28,30}.

In the hospital sector, *hospitals trusts* have become, through the years 2000, *foundation trusts*, becoming public institutions of private law. As a result, these hospitals acquired autonomy for borrowing from the private sector, selling goods, setting their own salary scale and contracting services. In terms of resources, hospital financing, previously budgeted, started to be performed through payment by procedure²⁷.

In fact, this form of hospital remuneration was part of a wider process of change, which affected not only the British system. With the premise of reducing costs, governments adopted budget ceilings in hospitals, Germany and France in the 1980s. Subsequently, this logic was supplanted by contracts with productivity clauses, under the American influence of the principles of “medicine based in evidence”, in which the choices of health treatments went through the premise of evaluating the most efficient methods. From the 1990s, this process led to the adoption of the hospital payment based on the *Diagnosis Related Group* (DRG)^{2,18}.

The DRG is based on the definition of national tariffs, with the establishment of a uniform price for the same procedure. The objective is to homogenize the payment and encourage institutions to increase their efficiency, since they only receive the amount defined in the national table and would have to differentiate by the greater efficiency³². Although the rhythms and adoption process were different, in 2010, the mechanism for payment to hospitals via DRG was responsible for 60% of all hospital revenue, in England, and 80% in France and Germany^{11,30}.

In addition to the hospital payment, the remuneration of physicians began to incorporate payment for performance mechanisms. The premise was that, by linking the payment to the performance achieved, there would be a more efficient system. In addition, it would be possible to overcome the “incentive” problems derived from the forms of remuneration present in the health systems until then. Up until the early 2000s, was predominant, for ambulatory physicians, the payment by medical act in Germany and France and by capitation in the United Kingdom³⁷.

England pioneered the association between the remuneration of physicians and the setting of “outcome” parameters to be met, with the establishment, in 2002, of 146 indicators. Each goal fully met (with rates ranging from 50% to 90% of patients) would generate a gain^{37,38}. As of 2010, this mechanism was extended to the national system, called the *Commissioning for Quality and Innovation* (CQUIN).

Both in Germany and France, this type of remuneration began to be adopted in 2009. In the German case, medical remuneration was determined by three factors: number of patients attended, weighted by a morbidity rate; individual services, such as immunization and outpatient surgeries; and emergency care, such as epidemics^{14,37}. In France, the government initially estab-

lished several objectives, centered on two axes: “tracking and chronic diseases” and “optimization of prescriptions”^{18,38}. Although the variable remuneration still corresponds to a small proportion of the german and french physicians (less than 10%), the mechanism already comprises the remuneration of almost all the professionals of the public systems.

In terms of implied commodification in the provision of services, we highlight the risks involved in the adoption of DRG as hospital remuneration. In Europe, research on their impact is still very incipient, given the short period in which the mechanism is in place in the various countries. Still, some concerns can already be pointed out. Early research on the english case indicates an increase in administrative costs associated with implementing the DRG mechanism – around £100.000 per institution³⁰.

Besides the concern with financial impacts, the payment mechanisms by procedure, by homogenizing the payment made to the hospitals, would not be able to apprehend that the same care can be carried out in very different circumstances (the placement of a prosthesis for the first time, in comparison with the substitution of an existing one), as well as not incorporating in the value the previous socioeconomic conditions of the patients, that can affect the amount of days of treatment necessary and possible complications. In this sense, the risk of patient selection would have become more intense^{30,32}.

France is a good example of this concern. Private institutions would have prioritized the care of patients whose care generates larger payments and increased their readmission rate. Public hospitals, on the other hand, were more burdened in the care of patients with multiple health problems^{11,18}.

Conclusion

This article was not intended to deplete the presentation of all the market mechanisms that expanded its presence in these health systems in the last three decades, but, rather, to allow a broad view of the process, explaining that commodification affected all fields of health systems, albeit at distinct intensities, especially when analyzing each of the three countries.

Germany is the country, in comparative terms, in which explicit commodification is higher, especially with regard to the provision of services, since the provision by private insti-

tutions is broader, including the privatization of an important part of the hospital network (although historically it has always been higher). In addition, from the financing point of view, it is the country with the largest private participation in health expenditures, both in terms of GDP, either in *per capita* terms, although it is worth noting that, in 2016, 76% of expenditures remained public.

The United Kingdom, in turn, is the country with the highest degree of implied commodification, mainly in the provision of services. The NHS did not have a structural change in its fiscal financing, nor did the supply of services cease to be carried out, mainly, by a public hospital network. However, the incorporation of precepts of market, mainly based on the competition, modified both the outpatient and hospital systems.

In France the reforms instilled market mechanisms throughout their health system, although, generally, with less intensity than in the german and british cases. The market reforms were proposed under more resistance, which made its implementation more difficult. However, when adopted, in some cases, the changes were more abrupt, as in the case of hospital remuneration for procedures (DRG).

Although this article does not propose to carry out a detailed analysis of the consequences of commodification, it is possible to point out some identifiable consequences from the bibliographic review and the data analysis performed in this work for each of the four trends mentioned.

In terms of the explicit commodification of financing, the continuity of the predominance of public resources and the existence of several exemptions of co-payment has, so far, prevented universality of access from being affected.

As for the implied commodification of financing, it is already clearer possible negative impacts. The british PPPs, precursors of the process, point to the increase of costs in the system, which raises questions about the efficiency of the reform. Although this does not directly affect users, it has increased construction costs, as well as expanding employee turnover, with the potential to affect quality.

In terms of the consequences of implied commodification, the adoption of payment mechanisms by result, especially with regard to hospitals, has generated risks of patient selection, with possible inequality of access. The french hospitals are illustrative of the trend: the private institutions have privileged the care of patients without previous health complications and with diseases whose

remuneration is high. This makes public hospitals more crowded, addressing more complex health problems and yet “accused” of inefficiency.

Finally, with regard to explicit commodification, the incorporation of private institutions in the provision of services must be accompanied

by guarantees that it does not affect access to the system. Another important element is the care of private patients in the public network. The significant increase in the possibility of private patient care in the English NHS scratches isonomy and can reduce the effective universality of access.

Collaborations

MRJ Ferreira and AN Mendes participated equally in all stages of preparation of the article.

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