On June 24, 2000, the WHO released a report that assessed the world’s health-care systems based on an overall index of performance. The report had an immediate and enormous impact and was discussed on the front page of almost every major newspaper in the western world and on the broadcast news. The WHO, the health agency of the United Nations (UN), had assessed health-care systems around the world and everyone wanted to know where his or her country was placed in the health-care system league.

In health-policy circles, the report caused some big surprises. At the top of the WHO’s health-care league were countries such as Spain and Italy, whose health-care systems were rarely considered models of efficiency or effectiveness before. In Spain, for example, release of the WHO report, which ranked the Spanish system as the third best in Europe, after Italy and France, coincided with unprecedented demonstrations against the Spanish health-care authorities. Demonstrators were protesting against the long waiting lists for critical life-and-death interventions (which had been responsible for a large number of deaths) and the short consultation times in primary-care centres (an average of 3 mins per consultation). This state of affairs in the Spanish system had forced prominent professional associations, including the Spanish Association of Primary Care Physicians, to denounce the current situation as “intolerable” (these events were widely reported in the Spanish press in June and July; see, for example, the series “Spanish public services are intolerable” in El País in June 2000). The growing popular protest had put Spain’s Conservative government on the defensive, until the WHO brought out its report listing the Spanish system as the third best in Europe and the seventh best in the world. Spain’s Conservative Minister of Health showed the WHO report to the protesters as proof of the unjustified nature of their complaints and demands.

The protesters, however, were not impressed by the WHO’s ranking of Spain’s health-care system. Something seemed profoundly wrong in the report’s claiming that the performance of the Spanish system was the seventh best in the world. The report’s conclusions certainly did not coincide with the perceptions of most Spanish people. In one of the most rigorous surveys of views of the Spanish population regarding health care, Spaniards expressed more discontent with their system than did the population of any other major country in the European Union, except Italy, whose health care was also listed among the “best” in the WHO report. An impressive 28% of the Spanish population (and an even more impressive 40% of the Italian population) indicated “there was so much wrong with their HCS (health-care system) that they needed to completely rebuild it”, and an additional 49% of the Spanish population (and 46% of the Italian population) stated that “there were some good things in their HCS but fundamental changes were needed to make it better.” There was indeed a disagreement about the definition of performance by the WHO and by the Spanish and Italian populations. Who is right? In order to answer this question, we must first understand that the WHO is not a scientific but rather a political institution whose positions and reports must be assessed both scientifically and politically.

**The objective of the WHO ranking**

Why do we need to rank countries according to the performance of their health services? Presumably, an important objective is to see what we can learn from “the best”, using them as points of reference on the road to better health. A very important element in the WHO ranking, however, is the credibility of the indicators of performance that it uses. It is therefore important to know how the ranking was developed, the assumptions behind the preparation of the indicators used in the ranking, and the consequences for health policy of choosing one indicator versus another.

Let us start with the nature of the indicators. The WHO report develops three types of indicators. The first is related to the effectiveness of the health-care system (mainly medical care plus traditional public-health services) in reducing mortality and morbidity. The second is related to the responsiveness of the system to the user, understanding responsiveness as the ability to protect the user’s dignity; to provide confidentiality and autonomy; to provide care promptly with high-quality amenities; to provide access to social support; and to ensure a choice of provider. And the third type of indicator is related to the fairness of the system, measured by the degree of progressiveness in the funding of health care.

All three types of indicators are weighted and added to create a single indicator, the indicator of performance. It is unclear why the WHO felt the need to come up with one synthetic indicator of performance. There is not, after all, a single UN indicator for ranking countries by economic performance. Rather, the annual UN economic reports use specific indicators to measure different components of economic efficiency such as unemployment, economic growth per capita, rate of productivity growth, and so on. But no single indicator summarises the many dimensions of the equally complex issue of economic performance. So why did the WHO decide to make a single indicator for performance of health-care systems? The WHO report is silent on this point.
Effectiveness of health-care systems
In the WHO’s conceptualisation of medical-care effectiveness, the report uncritically reproduces a major assumption in medical-care cultures that medicine is very effective in reducing mortality and morbidity. I find it astonishing that a prominent public-health agency could state:

“The differing degrees of efficiency with which health systems organize and finance themselves, and react to the needs of their populations explain much of the widening gap in death rates between the rich and poor, in countries and between countries, around the world”.6

No evidence is given for such a statement. Actually, published literature shows that much of the widening gap in mortality rates within and among countries is primarily related to the growing differentials in wealth and income.3

“Health systems have played a part in the dramatic rise in life expectancy that occurred during the XX century”.7

Here again, no scientific data are given to support such a statement. Actually, the evidence shows that the most dramatic declines in mortality and increases in life expectancy occurred during the 20th century before medical care proved effective. Indeed, most dramatic changes in mortality during the century were the result of social and economic interventions.4,5

“...astonishing that a prominent public-health agency could...”8

“...effective in reducing mortality and morbidity...”9

Again, no evidence is given for this statement. All the scientific data show there is no link between the level of expenditures in health-care systems and level of mortality. There is evidence, however, for a link between political interventions, wealth and income distribution, and mortality indicators.3

This enormous faith in the effectiveness of medical care reaches extreme proportions when the WHO report indicates that with “an investment in health care of $12 per person, one third of the disease burden in the world in 1990 would have been averted”.10 Thus, the report gives the impression that the major problems of mortality and morbidity are a consequence of the limited resources of health-care systems. Give more money to a health system and more lives will be saved. The report even quantifies how many lives could be saved per dollar invested. Very neat, but profoundly wrong. Nowhere does the WHO report present any scientific evidence to support these wild assertions. Again, most available data show that other factors are far more important in explaining a country’s level of health and mortality than are its medical services.

Any student of public health knows that medicine is not as effective in reducing mortality and morbidity as the medical establishment believes. Indeed, there is extensive literature on the social, cultural, economic, and political causes of health and disease. That medical care is less effective in reducing mortality than the WHO report assumes does not mean, of course, that medicine is not useful in taking care of patients’ medical conditions and improving their quality of life. But it is wrong to explain a country’s level of mortality by its medical services. Not even public-health interventions (such as immunising against childhood diseases), which have been far more effective in reducing mortality than have medical-care interventions, can be considered the main reasons for the mortality decline in the 20th century. Social, economic, and political interventions are the primary reasons for this decline.

This mistaken assumption—overestimating the effectiveness of medical and health care—explains why some countries, such as the Mediterranean countries, Spain, Italy, Portugal, and Greece, which traditionally have good health indicators with long life expectancies, earn high marks in the WHO’s classification of effectiveness. The report erroneously attributes the low mortality in these countries to the effectiveness of medical care. Actually, these various Mediterranean countries have different types of health services, but all share the characteristic that public expenditures in the health-care system as a percentage of gross national product are among the lowest in the EU. Table 2 (basic indicators for all member states) of the WHO report shows these are among the countries with the lowest probability of dying (per 1000) for children under 5 years and for adults between 15 and 59 years, and with the longest life expectancy in the world. None of them have large health-system expenditures. Their types of funding and organisation are extremely varied—with the common denominator, however, of the populations’ high level of dissatisfaction with their health systems. Actually, the WHO report lists these health systems as among the least responsive (to users) in all European systems. In the ranking for responsiveness, Spain is listed 34th, Greece 36th, Portugal 38th, and Italy 23rd, all of them among the least responsive in the EU. It would seem then, according to the authors of the WHO report, that the effectiveness of health-care systems in reducing mortality outweighs their limited responsiveness. They are thus considered user-unfriendly but very effective nevertheless. It is highly questionable, however, whether the good mortality indicators of these countries are the results of health-care system interventions.

Who defines the indicators of responsiveness?
The second component of performance is related to what the report called “responsiveness” of the health-care system to users. The report includes here two major groups of considerations. The first deals with what the report calls “respect for persons”, which includes the dignity afforded to the patient, the confidentiality of patients’ information, and patients’ autonomy. The second group is referred to as “client-oriented attributes”, such as prompt attention to the patient, the quality of the amenities, access to social support networks, and choice of provider. It would seem that these characteristics should give a fairly good idea of how responsive a health-care system is to its users.

Conceptually, then, indicators of responsiveness seem to be reasonable. The problem arises when we see that the people who defined the values of these indicators and the weights given to each (derived from questionnaires) are what the WHO report calls “key informants”, without specifying who those key informants are. These unknown key informants are most likely experts on health care in the various countries. And the survey of these informants is therefore likely to be a survey of the “conventional wisdom” among experts who define the degree of responsiveness of health-care systems to users. The report does not explain who these key informants are, nor does it explain the criteria for their selection. It is likely, however, that the choice of these informants and experts was highly biased towards what are called health-care-establishment figures. Indeed, the selection of references in the report’s bibliography is quite biased and prejudiced against critical positions, issues, or authors. One can find consistent references to conservative and neoliberal authors (such as Alain Enthoven of Stanford University, USA) and mainstream medical journals, but never does the report...
make reference to critical authors or scientific journals that question established wisdom.

Not surprisingly, therefore, the survey of responsiveness reveals that the countries with more responsive health-care systems are those whose health policies better fit what has become the new conventional wisdom. In this thinking, health-care services that combine public funding with a provision of health-care systems (which has characterised national health services) are out. They are constantly referred to as examples of “heavily handed state intervention . . . the type of intervention discredited everywhere”, “highly impersonal and inhuman (as in the pre-1990 Soviet Union)”, and “monolithic”. The abusive nature of the disqualification of these types of health services is all too clear when the collapse of the Soviet Union is used as an example of the deficiencies of national health services. The fashionable thing now, in current conventional thinking, is an insurance system with a public-private mix that allows for competition between managed care plans, giving patients—referred to as clients—increased choice of providers and permitting more flexibility. The WHO report presents the Thatcher reforms in the British national health service as worth extrapolating to other systems. We should not be surprised that these key informants and experts selected the USA as having the system that is most responsive to users, and Colombia, a Latin American country whose national health service has been replaced by an insurance-based managed care competition model, as having the most responsive system in Latin America.

This profoundly ideological position of the WHO report also comes across in its analysis of what the WHO considers the “failure” of the Alma-Ata approach. The Alma-Ata Declaration was a famous WHO report, written in 1978, which emphasised the importance of primary-care services, combining medical with social interventions at the primary level of care. The new WHO report assumes that implementation of the Alma-Ata report failed because, in designing such primary-care models, too much attention was given to the health needs of the population and not enough to the demand for services; the Alma-Ata report was too oblivious to the importance of the private sector and the market. According to the WHO’s June, 2000, report, countries should give far more importance to reforms that aim at “making money follow the patient, shifting away from simply giving providers budgets, which in turn are often determined by supposed needs”, as many countries are now doing. The report also indicates that there is a link (nowhere documented) between expansion of private delivery of services and responsiveness of the health-care system. This shift from planning according to need toward demand in the market is a radical change in WHO policy, a change I consider antagonistic to the basic principles of public health.

Not surprisingly, besides choosing the USA as the country with the most responsive system, the WHO report considers the greatest challenge facing government-based health systems is to respond to the need for regulating the private sector, a function, say the authors, that most countries are not prepared for. The model they advocate is that put forward by Enthoven (an author cited approvingly in the report), which inspired the Thatcher reforms in the British national health service.

Consequently, given the political and propagandistic character of the report, nowhere do we find quoted, cited, or argued the huge amount of scientific evidence that questions each of the assumptions made in the report and challenges the superiority of insurance-based health-care systems. (There is an extensive literature critical of insurance-based managed care, mostly published in the International Journal of Health Services in the 1990s). To make the USA the top-ranked country in responsiveness to health-care users not only ignores the large body of scientific evidence that shows just how unresponsive the US health service actually is, but also sets aside any observation of the political context of health policy in the USA. The Democratic Party is now trying to identify managed care and managed competition, and their unresponsiveness to users, with the Republican Party as a way of gaining some political advantage in the coming Presidential and Congressional elections, knowing how unpopular managed care and managed competition are with most citizens of the USA.

Unfortunately, however, the WHO is doing what its American branch, the Pan-American Health Organisation (PAHO), has been doing for years—functioning as a transmission belt for Latin America of the conventional wisdom in US financial and political circles. In recent years we have been witnessing how the PAHO and now the WHO, with the assistance of the World Bank and private foundations, are presenting insurance-based managed care as part of the solution to the burgeoning health-care problems in Latin America. The privately managed health-insurance schemes are seen as playing a positive role in complementing and competing with the government health-care systems. In a recent speech to corporate and academic leaders in the USA, the Director General of the PAHO referred to the successful experience of several private health insurance schemes in Latin America, taking Instituciones de Salud Previsional (ISAPRES), the major private insurance scheme in Chile, as an example: “The example of ISAPRES in Chile shows the possible success of the privately managed health and social insurance schemes [in Latin America].”

The question that needs to be asked is, for whom is ISAPRES successful? This private insurance scheme, introduced when the dictatorship of General Pinochet dismantled the Chilean national health service, owes its commercial success to the selection of patients, catering to the upper-income sectors of the population while leaving chronically ill and low-income patients to the public sector, reproducing a well-documented social polarisation in the health sector as characterised by the allocation of resources according to the type of insurance coverage and ability to pay rather than according to need. This is the unavoidable result of having insurance, competition, and private entrepreneurship (key words in the dominant discourse) in the health sector. The extreme expression of this model is the health-care system of the USA, which the WHO report presents as exemplary for its responsiveness to users. The US population, however, does not concur. According to a report on a nationwide poll by the American Hospital Association: “the majority of the people in the US see [in the health services they received] neither a planned system nor a consumer-oriented organization except one devoted to maximizing profits by blocking access, reducing quality, and limiting spending . . . . They blame most of it on the pursuit of profits by health insurance companies . . . . Americans believe that their health insurance companies have too much influence and exert too much control over their care.”

Because of the enormous influence of the US government on many international agencies, we are seeing their promotion of dominant US values and practices, including managed care and managed competition. Here it is important to note something that has escaped the attention of most observers: the WHO’s protective shield against worldwide criticism of its political positions. The
WHO has been surrounded by an aura of humanism and social concern that has protected it from close scrutiny. But, just as the World Trade Organization (WTO), the World Bank, and the International Monetary Fund (IMF) have come under increasing criticism, so too should the WHO. It is a political institution, heavily involved in propaganda in the guise of apolitical neutrality, ignoring the critical voices that denounced its behaviour. Debabar Banerji has recently criticised the damage that some WHO policies are causing in developing countries. We need to be far more critical of the currents in the WHO that are increasingly attuned to the needs of large interest groups, responding to a culture of entrepreneurship, competition, and market values that conflicts with the needs of our populations, as the US experience with its health-care system clearly shows.

How to define progressiveness of funding

Finally, some concerns need to be raised about the third type of indicator used in the WHO Report, related to the degree of “progressiveness” in funding health services. The authors of the report analysed the percentage of household funds spent on health care by several deciles of the population in each country, assuming that the same percentage spent on health care (as percentage of capacity to pay) by different income groups means fair funding arrangements. As the WHO report indicates, “the way that health care is financed is perfectly fair if the ratio of total health contribution to total non-food spending is identical for all households, independently of their income, their health status or their use of the health system.” Fairness is a highly subjective concept. But if by fairness in health-care financing we mean that each person should receive health-care services according to his or her needs while contributing according to his or her ability and command of resources, then a criterion of fairness should be the degree to which the financing of health care is redistributive. According to that criterion, to be authentically progressive, the system of funding should be optimally redistributive—that is, the percentage of household contribution to the funding of health services (as percentage of capacity to pay) should be larger (not the same) as household income increases. But this indicator by itself would also be insufficient to tell us much about fairness or progressivity, since fairness depends on the destiny of the household health spending, a topic untouched in the WHO report. A healthy family may spend much more on health care than a low-income family without having any bearing on progressiveness, if those higher expenses go into higher or more luxurious consumption without having any redistributive effect. In that sense, progressiveness of funding cannot be analysed independently of the channels through which the funding moves. Progressive funding will have a redistributive effect only when the payments are connected to the same system in which funds are transferred from one group to another.

Conclusions

Most experts in health care would agree that the assessment of health-care systems is not an exact science. As in many dimensions of the scientific project, the barrier between science and ideology is not an impermeable one; on the contrary, it is highly porous. The WHO’s June, 2000, report is a good example. The issue under discussion, therefore, is what values sustain the ideology reproduced in the WHO report and whether these values are a help or a hindrance on the road to a healthier world.

The principal values reproduced in the WHO report are those that sustain the dominant conventional wisdom in the foremost medical, financial, and political arenas in the USA and other major more-developed countries, based on two main assumptions. The first is the belief that the most prominent health problems our societies now face can be resolved by technological-scientific medical bullets or interventions, without reference to changes in the social, political, and economic environments in which these problems are produced. The second assumption is that the supposed “failures” of health-care systems are due to an excessive reliance on public interventions without allowing for the development of the (assumed) great potential of the private sectors. Thus, there is a growing call for increased partnership between public and private interests in which the latter are increasingly influential in shaping the nature of public decisions. In the new wisdom, client demand replaces patients’ needs, risk is valued over security, market shares dominate over government planning, and entrepreneurship dominates over public services. This conventional wisdom has become almost a dogma, which, like all dogmas, is based more on faith than on evidence. It is wrong for the WHO report to uncritically reproduce this thinking.

References

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