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Book reviews

KASTURI SEN (Ed.), **Restructuring Health Services: Changing Contexts and Comparative Perspectives**, Zed Books, 2003, 272pp, ISBN 1 84277 288 0(hbk) £45.00, $55.00, ISBN 1 84277 289 9(pbk) £14.95, $22.50.

Main Thesis: Ms Sen and her colleagues argue that systematic seismographic political and economic changes directly led to transformational global reforms in most national health systems. The core of the major reorientation was to accept the neo-conservative operating system from the 1970s and to replace the neo-liberal tenants. This neo-conservative revolution was led by key decision makers in the UK and USA, then adopted in Europe, Latin America, many developing countries, enshrined and legitimized in international institutions of the World Trade Organization (particularly through the General Agreement on Trade and Services), The World Bank, World Health Organization and by the globalization of multinational/transnational corporations. While these 'sea changes' affected key service sectors in health, the conscious economic and finance decisions were to replace first principles of welfare delivered through public subsidy and apparatus with efficiency provided by the private interests predominately focused on their 'bottom line'. This strategy and operations (with Cuba the exception) at national level resulted in significantly greater inequity and not necessarily improvements in health status, and correspondingly increased growth in health/medical care expenditure.

Presentation: The arguments are well presented and, in general, substantiated in three parts: Conceptual and Legislative Framework, The Process of Change, and Case Studies (9) of Restructuring: Comparative Perspectives—though these could have been even more potent were the strident rhetoric less pervasive. Due to the general nature of the restructuring health services do we believe decision makers were consciously selected to 'be on the same page' or did financial constraints dictate the pace? One wonders why major transformations in health policy from North to the South and among European countries apparently were introduced without adequate trials since the resultant dissatisfaction among health/medical professionals, administrators and families are clearly revealed. It is particularly unnerving to read of the complicit nature of politicians and international bureaucrats setting health policies, finance and systems which negatively impact billions of people in the third world who have no voice in their own affairs.

Dynamic Reforms: Can the 'ship be righted', as it were? Clearly health economics, policy and finance are under continual and increasing pressure in all countries, North and South. It would have been useful if Ms Sen and her colleagues had shared their keen insights on sets of real reforms that could lead to improved access and effective health systems. Cost-effectiveness is not incorrect; it may be in the current market oriented health policies and context; but why would we expect Cuban health planners not to embrace 'cost-effectiveness' with the fiscal constraints that they

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face? If disciplined preventive and primary health care yields improved health status why not see what triggers genuinely sustained positive changes in lifelong health behaviour, particularly in the relatively wealthy countries? Demographic trajectories and technological innovations will have very real implications for health economic and finance decisions. Perhaps Ms Sen and her colleagues will follow up this volume with constructive recommendations to continually reform health systems—and these may lead to a further reorientation embracing principles of equity and access with the goal of competing with improved health status among the politicians and the public. Would not that be novel?

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COMMITTEE ON THE CONSEQUENCES OF UNINSURANCE, BOARD ON HEALTH CARE SERVICES, INSTITUTE OF MEDICINE, **Health Insurance is a Family Matter**, The National Academies Press: Washington, DC, 2002, 278pp. ISBN 0-309-08518-7 (pbk) $29.00/$23.20.

Main Foci and Conclusions: This third of six planned reports by the Institute of Medicine (IOM) on the 'Consequences of Uninsurance' in the USA is a well researched and presented set of seven (plus the Executive Summary) chapters backed up by a highly useful background of literature review and data in appendixes. Using numerous current studies and data including those on the publicly financed (Medicaid and State Children's Health Insurance Program) health services, the main conclusions make for stark reading. In quantitative terms: about one in five families (17 million) have one or more members uninsured; the 38 million uninsured people live with about 20 million insured family members; hence, 58 million people may be affected by the consequences of uninsurance; and there are 38 million families with minor children, 20% do not have all their members insured. When at least one parent receives employment-based insurance more than 95% of the time their children are also covered, with their health status being significantly improved. In reality we (and the politicians) have heard these numbers and know that most uninsured parents have the following demographic characteristics in common: lower income, single parenthood, racial and ethnic minority status and immigrant status. The health impacts are presented from numerous studies and follow the predicted pattern—reduced maternal and child health indicators as well as leading to poor health behaviour for later life of the children. One nagging query remains: that numerous publicly funded programmes (with billions of national, state and local dollars) are available (most with gradually reduced bureaucratic barriers) for the uninsured yet these are not being taken advantage of by the targeted uninsured people.

Action Orientation: Since this is not path breaking science we may ask how best to use this and other reports from the IOM's Consequence Uninsurance Series. Is there no system other than US style insurance plans that will provide significantly improved health status for poor mothers and children? What can we learn from the reforms in the British National Health System to provide quality health services to

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USA uninsured individuals'. What will be the cost to enroll the 38 million uninsured in a USA styled insurance or NHS type system? Let's have a quick 'reality check' on US government finances. Given the mounting and projected US and states deficit, high defense budget, entitlements, high voting percent of elderly with a very strongly lobby effort for 'prescription drug benefits' (some estimates are up to $80 billion annually, see the 2003 Medicare Prescription Drug Bill and other modifications to follow), Medicare claims for the 'baby boom' generation—in the vernacular of 'bare knuckle Washington politics': *how are the IOM and other interested advocates going to sell the necessity of adopting solid insurance programs/laws to significantly improve health care outcomes to poor mothers and children*? Further, with the current reluctance for politicians to expand public programs, particularly with low voter impact, the challenge is formidable. The unfortunate reality is that: poor mothers and children do not add many votes in key districts. Take a lesson from agriculture programs where the 'voter calculus' generates massive public expenditure on a sustained basis. As the 2004 Presidential election cycle begins with slow job growth among the poor, up to 12 million illegal immigrants without health insurance, and health care a key policy issue; the IOM and their advocates can martial their arguments and forces. Perhaps they will focus on questions like: *Can the world's only superpower promoting 'family values' be seen to tolerate one in five families with members uninsured and health status indicators for poor mothers' and children nearing the levels in some developing countries?* Some politicians of stature will want these arguments and costs for alternative plans in their 'briefing book'.

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