

Who defines failures of health care privatisation?

by

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There are extensive changes taking place in the public health care sector, globally, which have been described as the commercialisation of public health care. ¹ Originating as part of neo-liberal policies promoted by multi-lateral institutions in both high and low income countries, often as health sector reform, they take a variety of forms. They cover the development of public-private partnerships, private finance initiatives, contracting out of services, including cleaning, catering, facilities management, the establishment of health insurance systems and the corporatisation of public sector institutions. They are characterised as either adopting private sector practices by the public sector or as increasing the involvement of the private sector in public sector services. The role of government in health care provision is changing. Private sector companies are becoming a growing presence in public health care systems.

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This paper refers to the overall process of commercialisation of health care but acknowledges the definition of privatisation as “*the transfer of ownership and government functions from public and private bodies, which may consist of voluntary organization and for profit and not for profit private organizations*”.² The nature of privatisation processes in health care are often different to those of other utilities. Although there are increasing demands for capital investment in high technology equipment, health care remains a labour intensive service and requires constant supplies of labour. This has influenced the private sector involvement in public health care systems, particularly the expansion of multi-national company activities, and has often restricted private sector expansion.

There are several types of private sector involvement in public health care services which can be seen as part of a continuum of privatisation within the public health care sector.

- Private sector contracted to run ancillary services
- Private sector contracted to run clinical services
- Public private partnerships - private sector invests in high technology equipment
- Public private partnerships - private sector builds new hospitals and is contracted to run the hospitals on long-term management contracts
- Private sector purchases hospitals

Company goals to expand into the public sector market are influenced by the relationship that already exists between a company and the public sector. The experience of contracting between companies and the public sector has contributed to the development of these relationships in Europe. The development and evolution of contracting in different countries has been part of the process of introducing market principles to the public healthcare sector.³ In some countries, in the Nordic region, there has been a decade of experience built up between public commissioners and private providers. This has led to companies in this region viewing their relationships with the public sector as mutually dependent.

1. What is failure?

There are national and regional differences in the ways in which the private sector has become part of the public health care sector. The influence of the historical development of public health care systems, as well as existing arrangements, has often determined the relationship with the private sector. This will also have some influence on how failure is defined and by whom. In some countries, private healthcare providers provide for the public sector and are reimbursed directly, for example, France, and so they have a clearly defined role in relation to the public sector. In other countries, where public and private healthcare sectors are more separate, private healthcare providers deliver care to privately insured patients, for example, Germany, although reforms are moving towards direct privatisation of public sector hospitals. In other countries, the private sector is only just beginning to deliver clinical care services to the public sector.

Any discussion of “failure” means starting from the meanings of failure. Failure can be defined as “not succeeding or not being successful or non-performance”⁴. In considering the failures of privatisation, the most important question is who defines the lack of success. It is this question, which will be explored in these two examples of “failures” of privatisation. There are an increasing number of stakeholders involved in processes of commercialisation and ultimately the privatisation of health care. The main stakeholders are governments, at national, regional and local level. The private sector may include local, national and multi-national companies. Health professionals constitute an important group, which are often segmented. Patients and services users should be the focus of all services, but often find it difficult to articulate their interests, at all stages, in health sector reforms. A growing interest group are financial investors who consider that short term investments in health care can provide high yields.

This paper considers that the failure of privatisation can be viewed from three main perspectives:

- Failure from the user view, characterised as restricted access to services and deterioration in the quality of services;
- Failure from the company view, which entails bankruptcy and withdrawal from market;
- Failure from the government view, where private sector providers are not providing value for money or are not effectiveness.

These two case studies will identify and analyse some of the processes that inform decisions about failure and the results of these decisions. They also show that failure in one specific case does not necessarily raise fundamental questions at national policy level, about privatisation overall. This provides insight into the nature of the policy process which is promoting commercialisation and privatisation of public health care.

2. Mechanisms for private sector involvement

The development of contracting by the public sector has led to refinements in methods of pricing health care. There has been a slow process of identifying the total costs of public healthcare treatments. The private sector has been critical of how public healthcare systems are often unaware of their costs, implying that until the public sector is more realistic about its own costing and pricing, the private sector will not be able to compete effectively. This suggests that European private companies feel that they are working towards an "ideal" level of competition with public sector providers.⁵

Diagnostic related groups (DRGs) are a system of categorising patients based on diagnosis, treatment/ procedures, age and length of stay. Categories establish a uniform cost of each category and a maximum price for reimbursement. Medicare, the United States government health insurance programme, originally introduced DRGs in 1983 as a way of trying to control the Medicare budget. The system is now being promoted and refined in many countries and is used in relation to resource allocation and pricing.⁶

Throughout Europe, diagnostic related groups (DRGs) are one of the most important and significant systems of pricing currently being introduced by governments. Several multinational companies view this system as a positive contribution towards facilitating better engagement of the private healthcare sector with the public sector, although with some reservations.⁷ Pricing systems are one form of infrastructure necessary for the development of healthcare markets. They feature strongly in these two case studies.

3. Failure as decided by a private company⁸

Fresenius is a German company, whose main activity is the manufacture of equipment and products for renal care. The company is a key player in the global medical devices industry. It has only recently become involved in delivering general health care services. As the global medical devices industry is highly competitive and the manufacturing of equipment for kidney dialysis has currently little scope for innovation, Fresenius views the delivery of general health care services as an area of potential expansion. Coming from the German healthcare system, the corporate company view sees opportunities in the privatisation of hospitals rather than becoming a provider for the public healthcare system.

In 2001, the Fresenius Chairman, Gerd Krick, pointed out that there was the potential for Fresenius ProServe, the international management division, to expand because "*health systems, not only in Germany but all over the world, are in a state of change which is marked by increasing privatisation of hospitals and the demand for qualified, economically-efficient care of patients*".⁹ Krick predicted that, in Germany, the current 7% of hospitals operated privately

will increase and there will also be an increase in integrated hospital services, where primary and secondary care are brought together.

As part of its expansion into general health care management, Fresenius has acquired several German private health care companies in the last five years. Starting with the acquisition of Wittgensteiner Kliniken Group in 2002, Fresenius also acquired the HELIOS group in 2005, a German private hospital group, which has 55 hospitals and 26,000 employees. The Wittgensteiner Kliniken Group was merged with the Helios Group. Helios now operates as part of the Fresenius ProServe division. In 2006, Fresenius bought the HUMAINE clinic group, with 6 hospitals and 2,900 employees.¹⁰ This shows the pattern of Fresenius expansion into general health services management.

In 2002, Herbolzheim hospital, north of Freiburg, was taken over from the Wittgensteiner Kliniken AG and converted into the town hospital Herbolzheim GmbH.¹¹ The hospital had 135 beds and became part of the Helios Klinik Group, owned by Fresenius.¹² The Herbolzheim Helios-Klinik GmbH was 74% owned by Fresenius but the town council retained 26% ownership. Herbolzheim hospital is an interesting example because it was still part owned by the local town council. This can be seen as a partial form of privatisation, but reflects an increasing trend, whereby private companies are involved in the public health care system but not to the extent of full privatisation.

In October 2006, Fresenius/ Helios announced that it was going to return its 74% share ownership of the Herbolzheim hospital back to the town council because the hospital had become '*uneconomic*'.¹³ The reasons given by the company were that with better medical knowledge, improved treatments and shorter bed occupancy, it was not possible to run the hospital at a profit. This was set in the context of wider changes in the German health care system, which were higher VAT rates, increased energy prices and a small reduction of 0.07% of the health budget.¹⁴

Ver.di, the trade union, presents a different view of the crisis. It considered that the recent announcement of closure of the hospital was a failure of privatisation of the hospital by Helios. Ver.di also mentions the Mayor of the local town council, who was considered to have taken a '*sales adventure*' by pursuing the policy of selling 74% of the hospital ownership to Helios.¹⁵ The management at the hospital was considered '*chaotic*' with managers changing three times in three years. There was no support, for the hospital, from neighbouring Helios hospitals.¹⁶

Although the hospital workers took on longer working hours and gave up their holiday pay, this was not enough to stop the proposed closure of the hospital. There was no employee participation and there was no functioning works committee.¹⁷ Ver.di felt that the Helios Group was not interested in providing health care services to the local population.¹⁸

On 5 December 2006, the town council voted to take the hospital back into 100% local authority ownership.¹⁹ This was seen as the only solution available, unless the hospital was declared insolvent and was closed. The local council wanted to avoid this so that it could continue to provide medical care and to maintain employment.²⁰

Part of the agreement was that the local town council would take on two thirds of the staff of the hospital. 105 of the 160 hospital staff were taken on by a hospital in Emmendingen local authority.²¹ However, the remainder of the staff could not be taken on by the local Emmendingen hospital and so negotiations started between the Herbolzheim hospital management and the works council, about a possible social plan.²²

The final agreement was that Helios would pay €2 million for the costs of redundancy for the hospital workers, who could not be relocated to local hospitals. A further €10 million was paid by Helios to clear any outstanding debts of the hospital, before handing over 100% of the ownership to the town council. What was not resolved was whether the €4 million that had been given to the company over the past 5 years would also be returned to the town council.²³

In the debates and negotiations that took place after the company announced that it would be returning the hospital to local authority ownership, there were some undercurrents of criticism of the local authority. Questions were raised about whether the local council was aware of the financial position of the hospital and about the wisdom of the original decision to sell part of the hospital to a private company.

Although the head of the Hurth District authority said that "*The news has shocked everyone*", he acknowledged the frustration and irritation of the local population.²⁴ The priority was to incorporate the workers and hospital into other local hospitals. The CDP country commissioner, Alfred Haas, said that "*Helios is responsible for the plight*" of the hospital, firmly blaming the company, although the Herbolzheim hospital had not been incorporated into the regional care plan, a year before.²⁵

One of the reasons given, for the crisis at Herbolzheim Klinik, was the introduction, in 2003, of the diagnostic related groups (DRG) pricing system. Under the DRG system, payments are made for a medical condition rather than a set of specific treatments. There is no scope for adjusting prices to the circumstances of the hospital. Smaller hospitals are paid the same price as larger hospitals, which may have better economies of scale. This makes it difficult for smaller hospitals to compete.²⁶

This example of privatisation failure shows that once a company views a hospital as "*uneconomic*", it will act rapidly to get rid of the problem. The company was not concerned about the loss of services to the local population. This illustrates the dangers of involving the private sector in the provision of public services, without any agreements about maintaining public services.

The case of Herbolzheim hospital also shows some of the results of local authorities, and the public sector, taking opportunities to sell assets to the private sector so that the private sector can make investments in new equipment and services. Although, in this case, the local authority was willing to take the hospital back into local authority control, this cannot always be assumed. The responsibility for providing health care services to local people has to be defined in any future contractual arrangements with the private sector. Similarly the impact of new pricing systems needs to be monitored for all hospitals by the government.

4. Failure as decided by government

The second case study examines the cancelled contract for the third 'wave' of Independent Sector Treatment Centres (ISTCs) in the United Kingdom. In 2000, the UK government announced an increase in investment in the NHS, as set out in the NHS Plan.²⁷ In *Delivering the NHS Plan: next steps on investment, next steps on reform*, the Department of Health set out plans for the use of the extra investment.²⁸ This included the creation of a network of Treatment Centres, described as a "*network of fast-track surgery units*", which would reduce waiting lists. Some of the new treatment centres were to be run by the NHS and some by the private sector. £700 million per year was to be invested into these new centres. The aim of a treatment centre was to streamline the process of consultation, diagnostic tests and surgery for common conditions, such as hip replacement and cataract surgery. Some NHS treatment centres had already been developed as a way of improving the coordination of treatment and care.

The significance of the independent treatment centres was that it was the first time that the private sector has been commissioned to provide clinical services for the NHS on such a large scale. Twenty seven centres were planned initially, with 11 new buildings. Local health care commissioners were expected to contract out 15% of clinical services to the private sector.

Private companies were invited to build and run the centres, in some regions. This was one of the biggest opportunities for the private sector to bid for contracts with the NHS. The bidding process, initially, was arranged at national level by the Department of Health. Bids were invited from the private sector, particularly international companies, in December 2002. The first contracts were signed in September 2003. The Department of Health was also keen to give contracts to international private health care companies, rather than UK private sector companies.²⁹

Table 1: International companies awarded first 'wave' of Independent sector treatment centre contracts

Companies
Mercury Health Ltd
Care UK Afrox
Anglo Canadian
Nations Healthcare
Birkdale Clinic
Netcare UK
New York Presbyterian

Source: The Guardian Friday 12 September 2003

All the initial contracts were with international companies, although some were partnered with UK companies. None of the main UK private health care providers were commissioned in this first phase. Two of the companies, Netcare and Afrox, were South African private health care companies. The South African private health care market is saturated and two of the largest companies saw the opportunities in the UK as a strategy for international expansion.

A number of issues have emerged in the implementation of the Independent Sector Treatment Centres (ISTCs). These include questions of value for money, overpayment, prices, contractual arrangements, threats to doctor training, staff, lack of data collection, and changes to NHS referral systems,

Value for money

The contract negotiations were undertaken by the Department of Health on behalf of local commissioning agencies (Primary Care Trusts). Soon, there were several cases of local health commissioners refusing to accept a treatment centre contract. A majority of local NHS chief executives did not think that the new centres were "*value for money*".

Many of the major criticisms have been made in relation to the terms of the contracts awarded to private companies. Many were awarded five year contracts to treat a set number of patients. The terms of the contract allow the private company to be paid even if it does not treat the number of patients stated in the contract. The result of this arrangement is that local NHS health service commissioners have to continue to pay for the contract, even if the number of patients being treated is less than that originally contracted. This is effectively money lost to the NHS.

It is estimated that an Independent Sector Treatment Centre (ISTC) in Greater Manchester, which is run by Netcare, the South African company, lost £2m to the local NHS in its first six months. 14 local health services commissioners paid £1.9m to Netcare for operations that were not carried out because patients opted for traditional NHS care. Consequently the ISTC only performed 4,000 out of 6,000 contracted operations, yet under the contract Netcare was paid for the full amount.³⁰ This also led to local health commissioners paying local doctors a bribe to refer patients to the ISTC. An investigation by Hospital Doctor magazine found GPs in the area were being paid £30 for every patient sent to Greater Manchester ISTC.³¹

In 2006, details emerged of “*residual value*” packages, which are agreed sums to be paid to the private companies for their facilities should their five-year contracts not be renewed. Some companies may be receiving up to £25 million more than the NHS would, for a similar service.³²

In August 2007, the Department of Health announced that the ISTC programme was running 16% under capacity but the remaining £222 million is still being paid because the contracts that were negotiated with the private companies, agreed to pay in full whether or not the NHS sends patients.³³ The NHS, at local level, is still having to pay even though there are no patients.³⁴ PCTs are “locked” into 5 year contracts. There were also problems of local monitoring as responsibility for ISTCs at local level were hard to identify.³⁵

Costs and prices

It has been difficult to obtain information on the prices of operations undertaken by ISTCs. The Department of Health has admitted that the costs are 11.2% higher than NHS equivalent costs, which are higher than the NHS tariff (standard costs).³⁶ This can be illustrated by the example of cataract operations in Portsmouth.

In 2006, every cataract operation at the Mercury Healthcare ISTC at St Mary's Hospital, Portsmouth, cost £5,590 compared to the standard NHS price of £847. The public has so far paid £335,412 for 60 cataract operations at the private-sector centre, since it opened on December 19 2005. The same number would cost £50,820 at an NHS hospital. Mercury Healthcare has an £84m, five-year contract, with local NHS commissioners. The contract states that Mercury should carry out 1,650 cataract operations a year, but the company gets paid whether patients are referred or not. The government also pays out an extra 20% to compensate Mercury for setting up the £10m centre.³⁷

Staff training

By 2005, there was alarm at the scope that the new ISTCs would have for poaching NHS staff. The British Medical Association raised its concerns at the scope for international companies to take on NHS staff.³⁸ Although the first wave of ISTCs were not allowed to poach NHS staff, the second wave were allowed to take NHS staff on secondment.³⁹ International companies have recruited international doctors, who are often untrained in NHS systems and procedures. As a result there have been a growing number of complaints about the quality of care received in the ISTCS.

There was also concern, by doctors, that by sending routine surgery to the new ISTCs, the NHS was in danger of being left with the more complicated surgical cases. This has implications for training of junior doctors who depend on routine surgery for practice. This was also admitted by the Department of Health's Head of access, policy development and capacity, Bob Ricketts. In a statement to the Health Select Committee (2006), he stated that doctors' training is being put at risk by the government's introduction of independent treatment centres”. He felt it was the “*biggest issue*” to do with the ISTC policy. Strategic Health Authorities, in charge of local governance and monitoring, would be expected to monitor training.⁴⁰

In the report to the Select Committee, the Department of Health, stated that in next stage of ISTCs, the centres would be expected to provide training.⁴¹ This is a very significant change in training provision for NHS doctors because it is involving private providers in the mainstream NHS training process.

Lack of data

There is growing evidence that data collected by the ISTCs is often incomparable to NHS data. In addition, secrecy at the Department of Health has made it difficult for Parliamentary Select Committees to review the scheme. The Department of Health refused to publish the methodology that it used to evaluate contract bidders, nor to provide the business cases of the successful bidders.

The issue of lack of data was highlighted in a report from the Healthcare Commission, the government health care regulator. The Healthcare Commission found that it was unable to evaluate the ISTCs because there was a lack of data available to compare them to NHS services. There were fewer patients treated by the ISTCs than had been expected but the centres are still being paid for operations even when not performed. The director of the Healthcare Commission commented that the emphasis on speed for setting up the new centres meant that systems for collecting data had not been set up. The Department of Health had asked companies to collect data, as part of their contract, but this was not data at patient level and so could not be compared to the NHS. The first wave of ISTCs were asked to report “*key performance indicators*” as well as routine NHS statistics. However, much of this routine data has not been collected. The Healthcare Commissions observed that the emergency readmission rates for hip replacements was similar to NHS rates but said “*This is perhaps unexpected, given the mix of patients treated at ISTCs, which excluded those with the most complex needs*”.⁴² This suggests a slightly higher emergency admission rate.

Longer strategic goals

Within eighteen months of the first ISTCs opening, there were examples of underuse by local commissioners. By 2005, the government had to admit that the contracts used for the private sector gave them an unfair advantage over NHS hospitals.⁴³ It emerged that, as part of the invitation for bids for the second wave of ISTCs, “*the primary purpose of the contracts would be to help create a “sustainable” market in the provision of elective care to NHS patients and encourage competition between NHS and private providers.*” Private providers would also be given an opportunity to take over NHS buildings and equipment.⁴⁴

Changes in NHS referral systems

In January 2007, the British Medical Association (BMA) drew attention to proposals designed to cut hospital waiting lists by creating a network of private centres under contract to the government that would assess and test patients before they are allowed to get treatment as hospital outpatients. The private medical chain Netcare will set up 10 centres in the north west of England, where the company expects to be able to deal with 60% of patients without needing to send them for an assessment by an NHS consultant. This means that GPs will lose their right to refer NHS patients to a hospital consultant.⁴⁵

Change of policy

Already by May 2006, not all ISTCs in the second wave were being commissioned by the Department of Health.⁴⁶ This was partly because there were too few bidders, which suggests that the private sector was having concerns about the viability of the centres. Almost a year later, in July 2007, the new Brown government signalled a change in policy towards ISTCs. The new Health Secretary Alan Johnson announced in July 26 2007 that there would not be a third wave of ISTCs. He also sacked a private sector provider, US IT company Atos Health care, for failing to deliver a contract for diagnostic services in two regions in England.⁴⁷

These announcements caused a certain degree of alarm for private health care providers and the private sector more generally, for example the Confederation of British Industry. There were accusations of “*being in retreat*” over Blairite reforms. Johnson made it clear at the Select Committee that if the private / independent sector was inefficient or not offering good value for money or high quality patient care then the contract would be terminated.

Health care analysts for the private sector have predicted a slowing of private sector contracts with the NHS. Perhaps an indication of this was the sale by BUPA, of its acute hospitals, so that it could concentrate on social care and international expansion.⁴⁸ Another dimension of this process is how the private sector has changed during this period.

Netcare, a South African company, expanded from four hospitals in 1996 to a current total of 62 hospitals. Netcare International operates in the UK and the Middle East as a healthcare management company. A significant expansion for Netcare, was its entry into the British

healthcare market in 2002. The company is currently fulfilling a five-year contract to perform 44,500 cataract operations for the NHS via mobile services. The Greater Manchester Surgical Centre (GMSC) is a newly built facility attached to the Trafford General Hospital where specialists from Netcare UK perform elective orthopaedic, ENT and general surgical procedures.⁴⁹

In 2006, Netcare acquired, with funds advised by Apax Partners Worldwide LLP, London and Regional Properties and funds advised by Brockton Capital LLP the General Hospital Group (GHG) in the UK. Netcare will own 50.1% of GHG in return for an investment of approximately £217m, along with the injection of its wholly owned UK subsidiary Netcare Healthcare UK Limited. Netcare cited the limited opportunities for acquisition in South Africa as the reason for the General Health Group purchase.⁵⁰

Netcare, as seen through an account of a Strategy Day in August 2007, thinks that there will be a reduction on of resources for the UK NHS which will lead to rationing and the introduction of user fees. The company sees opportunities for the development of personal medical insurance, following the decrease in resources going into the NHS.⁵¹ This illustrates how private companies, providing healthcare to a publicly funded system, also consider possibilities for an expansion of private healthcare.

This account of Independent Sector Treatment Centres illustrates some of the results of involving private sector providers in the public health care sector, the NHS. One of the biggest problems of the ISTC programme has been the way in which contracts were drawn up. The government wanted to introduce the ISTC programme as quickly as possible. This meant that the whole initiative was driven by national government but local commissioners had to deal with the consequences of unrealistic contracts. There are signs that the Department of Health has recognised some of these problems.

ISTCs have also affected the "*local health economy*" and impacted on NHS providers at local level. There are examples of closures of wards and staff being made redundant as a result of new local ISTCs. The involvement of the private sector in training of doctors introduces a new dimension to medical training. There is also evidence that the process of involving the private sector in clinical service provision has resulted in some significant changes in practice in the NHS, which may compromise the public nature of the service in future.

Meanwhile, a new opportunity for private sector involvement in the NHS is the invitation to a group of international companies to bid for contracts to commission services in the NHS. Whatever the failures of the ISTC initiative, it has not persuaded the Government to abandon the use of the private sector.

5. Conclusion

The failures of Herbolzheim hospital and the third 'wave' of Independent Sector Treatment Centres (ISTCs) show that what follows on from a 'failure' can result in a return of services to the public sector or it can result in an adjustment to the policy, but not necessarily an abandonment of the privatisation process. Fresenius, the owner of Herbolzhiem Hospital, will not necessarily change its policy of buying private hospitals. The local authority may be more circumspect about selling off assets. In the UK, the Department of Health has not abandoned the process of contracting out services to the private sector. It is about to contract out the commissioning of health services at local level, an even more fundamental change than contracting clinical services to the private sector.

The roles of government, at local and national level, are changing. The new public management literature sets out the functions of the enabling state.⁵² However, what is not explored fully, are the stages of change that governments are going through. Governments do not immediately

change from being providers of services to commissioners. Effective commissioning requires skills that many civil servants have not developed. Even more importantly, the influencing processes that the private sector is using to get access to public service contracts, are sophisticated.⁵³ Governments are not always able to counter some of these influences.

In the UK, one of the most significant events in the account of ISTCs is the report published by the Healthcare Commission, the government regulator, which criticised the lack of data available to compare the practice of the ISTCs with the NHS. The failure of government to ensure that rigorous and adequate data is collected shows that it is also failing in its role of regulator.

Health care pricing is central to the commercialisation of health care. The impact of new systems of pricing was influential in both the case of a small district hospital and a national initiative of privatising clinical care. The system of setting prices and the secrecy which surrounds the contracting process are two tools that push forward the process of privatisation. There is a need for greater transparency about the way in which health care is costed and a debate about the appropriateness of converting a health care service into a series of costed activities.

Whatever the success or failure of individual initiatives in the public health care sector, the private sector is establishing a growing presence in the sector. Whether the companies view future profits that result from the contracting process or from a future where health insurance and individual user fees are the norm, the role of government and users as monitors and regulators needs to be strengthened. One of the reasons why the Department of Health in the UK has partly succumbed to pressure to abandon the third wave of ISTCs is because of the publicity that Parliament, the Healthcare Commission and campaigners have generated about the failings of ISTCs.

Health care is a labour intensive activity. How health workers are treated and the role that they play in the process of privatisation will influence the nature of the public health care services in the future. In the short term, failure of privatisation may result in job losses. In the long term, some of the changes that are taking place will also affect the way in which health workers are trained. Many health care multinational companies, including Fresenius and Netcare, have their own training colleges for health workers. This influence has the potential to affect the way in which health care services are delivered, in the future. Maintaining a publicly funded training and education system for health workers is central to the future of public health care services.

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⁸ Thanks to Chris Rock, University of Greenwich, for help with translation of German articles

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