Contents

The Privatisation of Health Care in Europe

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The evolution and role of public health care in Europe

The financing and provision of health care in Europe has always involved a variety of institutions and actors some of whom were public and others were private. The situation is all the more complex as, in several European countries, private health services can either be provided for-profit or not-for-profit. However, what makes health care a traditional public service and what distinguishes (western) Europe from the United States is the compulsory character of the insurance system – either through mandatory contributions paid into social insurance funds as in the Bismarck system or taxes as in the Beveridge system –, the subordinated role of private for-profit insurers and the crucial role of the state in planning and overseeing the system. In the United States, in contrast, almost 15% of the population lack any health insurance and almost 75% of those insured are covered by a voluntary private insurance mostly attached to their workplaces.

Drivers of health care restructuring

Technological and organisational innovations, decentralisation, the need for new skills and qualifications, as well as a growing awareness for patient rights and the extension of the coverage of population, certainly played a role in the restructuring of the health care sector in the past three decades, but the most important driver of change was the objective of cost containment. All European countries experienced difficulties to cover increasing health care costs after the end of the long postwar boom in the 1970s. With the economic recession, the acceleration of health care costs caused by increasingly expensive equipment and medication as well as growing needs of the population, surpassed the growth of GDP with the effect that with the exception of some years in the 1980s when spending actually decreased an ever larger proportion of public budgets had to be spent on health care.

In several countries the slow down of the economic growth from the mid-1970s was followed by changes in government. The neo-conservative parties that came to power at several times promised tax-cuts to their voters. This was part of a new neoliberal agenda which was aiming at a roll back of the state in favour of private initiative and capital. The prime example was Margaret Thatcher in Britain. But more moderate forms of economic austerity were also introduced in other European countries. According to the Stability and Growth Pact economic austerity became in fact one of the major goals of the European Union and especially of the member states that have joined the euro. This Pact limits the yearly budget deficit to a maximum of 3% of GDP. The combination of tax-cuts and of budgetary austerity not surprisingly resulted in a financial crisis of public health care systems.

Apart from the financial crisis, a second major driver of change is due to the growing profits expected from the health sector by the multinational health care companies and pharmaceutical and medical equipment firms, in a context where a huge amount of financial assets are waiting to be invested profitably. Despite the crisis of public budgets and cost-containment efforts, the health care sector is expected to grow in the future.

Table 1: The development of public health care spending

	Public health spending in % of GDP				Public health spending in % of total health spending			
	1980	1990	2000	2005	1980	1990	2000	2005
CC: Belgium			6.6	7.4 e			76	72.3e
Netherlands	5.2	5.4	5		69.4	67.1	63.1	
Germany	6.6	6.3	8.2	8.2	78.8	76.2	79.7	76.9
France	5.6	6.4	7.5	8.9	80.1	76.6	78.3	79.8
Austria	5.1	5.1	7.6	7.7	68.8	73.5	75.9	75.7
NC: Denmark	7.9	6.9	6.8	7.7 e	87.8	82.7	82.4	84.1 e
Sweden	8.3	7.5	7.1	7.7	92.5	89.9	84.9	84.6
Finland	5	6.2	4.9	5.9	79	80.9	75.1	77.8
ASC: Unit.Kingd.	5	5	5.9	7.2 d	89.4	83.6	80.9	87.1 d
Ireland	6.8	4.4 b	4.6	5.8	81.6	71.7b	72.9	78
SC: Italy		6.1	5.8	6.8		79.5	72.5	76.6
Spain	4.2	5.1	5.2	5.9 e	79.9	78.7	71.6	71.4 e
Portugal	3.4	3.8	6.4 b	7.4 e	64.3	65.5	72.5 b	72.7 e
Greece	2.8	3.1	4.1	4.3	55.6	53.7	44.2 b	42.8
CEEC: Hungary			4.9				70.7	
Poland		4.4	3.9	4.3 e		91.7	70	69.3 e
Czech R.		4.6	5.9 b	6.4	96.8	97.4	90.3 b	88.6
Slovak R.			4.9	5.3			89.4	74.4

-Empty box : data not available.
-Abbreviations : CC : Continental countries ; NC : Nordic countries ; ASC ; Anglo-Saxon countries ; SC : Southern countries ; CEEC : Central and Eastern European countries.
-Notes : b : break in series ; e : estimate ; d : differences in methodology.
-Source : OECD Health Data 2007

Forms of privatisation, liberalisation and economisation

In the privatisation literature authors often make a distinction between liberalisation and privatisation. While liberalisation refers to the introduction of competition i.e. the admission of more than one provider for the same service, privatisation involves the transfer of company assets from a public to a private holder. In reality, however, these are only two extremes in a rather complex and fluid process in which the nature of the provision of public services is altered. This is particular evident in those sectors and services that do not function according to normal market principles or where the introduction of markets and the sale to private investors has obvious unwanted effects. In such cases supporters of liberalisation and privatisation often look for alternative methods to achieve similar effects. The health care sector is a classical example for such a strategy. It is true that in some countries and eras competition between different providers has been introduced and public hospitals have been sold to private investors, but so far these activities do not constitute a general trend. Instead what can be observed as common tendency across the different national health sectors in Europe is a tendency for economisation. Another particular feature of the health care sector is the dual character of this transformation including a specific set of changes in the way health care is financed (on a macro- and micro-level) and another set of changes focussing on the provision of health services.

Macro-level changes in the health care financing

The relative decrease of public health care spending went hand in hand with an increasing importance of private health insurance companies and of out-of pocket payments in the financing of health care costs. Today private health insurances are particularly important in the Netherlands where their share in total health financing reached 15.9% in 2000, followed by France (12.5% in 2005) and Germany (9.2%). There are different forms of private insurances. While the diffusion of substitutive and supplementary health insurances is still limited in Europe, complementary insurance schemes play an increasingly important role in a number of EU countries including France, the Netherlands, Belgium and Ireland. The growing importance of complementary health insurance in Europe is largely due to another important trend: the delisting or the lowering of the reimbursement of treatments and medication funded by public health insurance. A classical case in all countries is dental care which is financed to a large extent by complementary private insurances or out-of-pocket payments by patients.

The increase in out-of-pocket payments can be observed in many European health care systems and is in fact more important for the decrease of public spending as proportion of total health care spending than the growth of private insurances. Out-of-pocket payments include direct payments (payments for goods and services that are not covered by insurance), co-payments (insured patients are required to cover parts of the costs for treatment and medication; this is also referred to as user charges) and informal payments for preferential treatment. In Poland, for instance, patients pay ‘tokens of gratitude’ for preferential treatment in public hospitals.

Micro-level changes in the health care financing

Several changes have also been implemented through the development of competition mechanisms within the public health sector and increasing autonomy of public health services (changes of modes of governance, internal markets and outsourcing, decentralisation, legal status of hospitals etc.). A common trend in the Beveridge model of integrated financing

and delivery of health care has been the separation of funding and provision of health care. The objective is on the one hand to improve control over spending and on the other hand to increase the autonomy and the responsibility of the health care provider. On the other hand the separation of funding and provision enable funding organisations to increasingly operate as purchasers of health care services. So funding organisations can increase pressure on health care providers to compete for contracts.

This, at least, was the idea behind the introduction of National Health Service (NHS) Trusts in Britain. NHS trusts are no longer granted a fixed budget. Instead they have to secure their financing by winning contracts from commissioning bodies including District Health Authorities (DHAs) and general practitioners with fundholding status and with a budget to purchase treatment for their patients. The Labour Government even enhanced the autonomy of trusts by giving them the possibility to apply for foundation status. Foundation Trusts enjoy additional freedom to generate income and allocate resources including not only the winning of contracts but also the establishment of commercial arms or the engagement in existing commercial ventures, the sale of land and property, the borrowing of money from private lenders and the transfer of staff to the private sector.

While the establishment of NHS Trusts and Trust Foundations are a special feature of the British health system, the split between purchaser and provider is also characteristic for health care reforms in other tax-based systems. In Sweden, for example, county councils have established separate purchasing organisations in the county or district level in order to fund the local hospitals.
In connection with the separation of funding and provision, the system of funding has also been altered. On the one hand, hospitals have been given global budgets for infrastructure maintenance and investments instead of full-cost coverage, with the effect that management has to set priorities with respect to spending the limited funds. On the other hand, compensation of costs which was based on the number of days a patient stays in a hospital is now more and more replaced by a Diagnosis Related Groups (DRG) system in which treatments are compensated according to flat rates rather than according to the real costs, which many increase due to unforeseen complications. As result of the introduction of DRG systems are decreasing average hospital stays.

A special form financing health care is the British Private Finance Initiative (PFI). PFI not only concerns the financing of a project but includes a variety of services such as the design and construction of hospital buildings, catering, cleaning and security. Once the facility is up and running, the PFI consortium charges the relevant public authority – the NHS Trust or District Health Authority – an annual fee during the 25 to 30 years lifetime of the project. Since 1997 nearly all NHS hospitals have been financed under PFI. However, there are increasing doubts about transfer of risks given the long duration of PFI contracts and growing evidence that the costs are higher than if the same projects would haven been financed by regular public loans. The higher interest rates have an impact on the provision of services as hospitals struggling to pay their annual fees cut services in order to reduce costs.

Changes in the provision of health care

Cost-containment has in a number of countries led to concentration processes and hospital closures. In Belgium the number of hospitals has been reduced by more than 70% since 1981. Yet while the number of hospitals has decreased the number of hospital beds remained relatively stable be-

tween 1990 and 2005. In the UK thousands of hospital beds have been withdrawn from service during the conservative tenure in government. While the following Labour Government announced the reversal of this trend in 2000, OECD data actually shows a reduction of hospital beds between 2000 and 2005. In Austria, 15% of hospitals were closed between 1990 and 2003, accounting for almost 8% of all hospitals beds. In Germany 10% of hospitals were closed between 1991 and 2004, but 20% of hospital beds were withdrawn. This means an elimination of a total of 134,232 beds.

The most radical form of privatisation in health care provision is the sale of public hospitals to private investors. A number of countries experimented with the privatisation of public hospitals including Sweden where, in 1999, the St Görans hospital in Stockholm has been privatised after it had been converted to an independent publicly owned private law company in 1994. In Austria so far two public hospitals have been sold to private investors. One of them has already been re-converted to a public hospital. While a number of countries have experimented with hospital privatisation, Germany stands out as the only country in Europe where the sale of public hospitals was carried out at a large scale and in a systematic way (see Schulten further below). Between 1991 and 2004 the proportion of private hospitals in Germany increased from 14.8 to 25.4%. While in the past private investors have focused on small hospitals, more recently Germany has faced a number of stunning takeovers involving large and prestigious clinics. Apart from the sale of public hospitals to private investors, several countries have also seen an increase in the number of newly built private hospitals. These hospitals often specialise in the treatment of patients with private insurance. This means that their market share is limited. However, there has been a trend to build new hospitals for privately insured or self-paying patients in the new member states in CEE. In Poland, for example, private clinics account for less than five percent of hospital beds but their number has doubled in a few years only and there are plans to build five private hospitals in Warsaw in the next years.

A common reform which has been introduced in the provision of health care across Europe is the development of internal markets or quasi-markets. Again, it was Britain which pioneered the incorporation of markets into health service provision. As mentioned before, the split between purchasers and providers of health care services increased pressure on the NHS trusts to reduce costs in order to win contracts. However, while the reform did not translate into measurable efficiency gains, it nevertheless changed the way health services are provided. Every treatment received a price to be charged from some other part of the NHS while each organisation within the NHS was obliged to operate a balance sheet with revenues and expenses. This not only greatly increased transaction costs but also undermined the possibility to plan and distribute resources according to health needs instead of profitability.

The internal market also opened the way for outsourcing. Initially, outsourcing only concerned secondary services such as cleaning and catering. Then, more and more sophisticated services have been outsourced to the private sector including information technology, accounting and partly even hospital planning. Public medical services, such as laboratory and diagnostic services and even elective surgery, have been increasingly contracted out to the private sector. Outsourcing is expected to concern an even-greater part of service provision in the future. Long-term outsourcing contracts can also constitute what is often described as Private Public Partnerships (PPPs). As outsourcing, PPPs have become increasingly popular in the

organisation of health care provision. PPPs can take different forms such as the financing and lease of hospital buildings and technical equipment, the provision of maintenance services, as well as the private management of public hospitals. In Austria, for example, several public hospitals are now run in cooperation with private hospital companies and a number of new hospitals with private involvement are planned.

The Privatisation of Hospital Care in Germany

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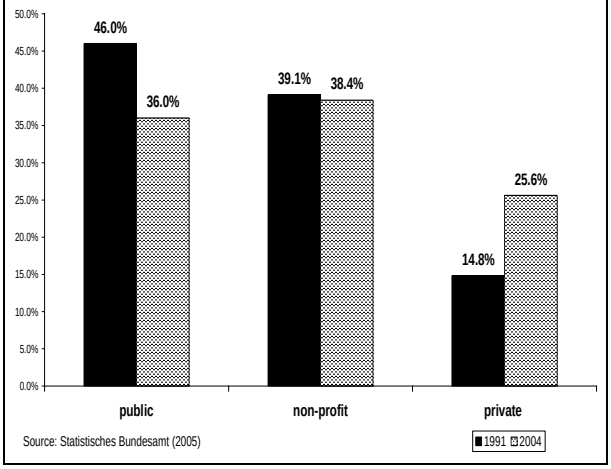
Germany is a particular interesting case as so far it is the only country in Europe where privatisation of public hospitals, i.e. the sale of shares in public hospitals to private investors, took place systematically and at a large scale. Although the first privatisation of a public hospital happened as early as 1984, there was not much change in the composition of hospital ownership which traditionally includes public, private not for profit and private for profit providers, until the early 1990s. After German unification in 1990 a first wave of privatisations of hospitals took place – mainly in eastern Germany – as part of the transformation process from a former state-socialist towards a capitalist market economy. Since the beginning of the new millennium a second wave of hospital privatisations has started which now covers all regions of Germany. Between 1991 and 2004 the proportion of private hospitals increased from 14.8% to 25.6% (*Figure 1*). At the same time the share of public hospitals decreased from 46% to 36% while the proportion of non-profit hospitals remained relatively stable. There are also significant regional differences in the share of private hospitals varying from 45% in Berlin to still 0% in Saarland.

Figure 1: Ownership of German hospitals 1991 and 2004



Although public ownership has lost its majority regarding the total number of hospitals it still has a dominant position when the numbers of hospital beds are considered. In 2004 a majority of 52.8% of all beds were still provided by public hospitals in comparison to only 11.5% provided by private hospitals. The dominant position of public hospitals becomes even more pronounced regarding the number of employees: Nearly 60% of all hospital workers were employed by public hospitals, while private hospitals still had less than 10% of all employees. So far the privatisation of German hospitals has been the domain of smaller clinics. In 2004 more than 82% of all private hospitals had less than 200 beds and more than 63% even provided less than 100 beds. Only about 4% of all private hospitals were larger clinics with more than 500 beds. In contrast to that a majority of 62% of public hospitals were of medium or large size. Nearly one quarter (23%) provided more than 500 beds.

While in the past private hospital investors tended to focus on smaller clinics, more recently Germany has been faced with a

[1] A full report on hospital privatisation in Germany is downloadable from www.pique.at. Reports from Germany and other countries are also published in the journal *Sozialpolitik in Diskussion* downloadable from: http://wien.arbeiterkammer.at/pictures/d60/Sozialpolitik_5.pdf.

number of more spectacular cases where larger hospitals have become privatised:

- In July 2001 the private hospital chain *Helios* bought 51% of the shares of the clinic of the city of Erfurt (*Klinikum Erfurt*), which had around 1,121 beds. In November 2002 it also bought the remaining 49% of the shares, so that *Klinikum Erfurt* is now a 100% owned by *Helios*.
- In January 2003 *Helios* took over 94.9% of the shares of the clinic of the city of Wuppertal (*Klinikum Wuppertal*) which had more than 1,000 beds.
- In 2004 the private hospital company *Asklepios* bought the main hospital group of the federal state of Hamburg (*Landesbetrieb Krankenhäuser*, LBK) which covered seven clinics with 5,688 beds.
- In January 2006 Germany saw the first privatisation of a university hospital when the private hospital corporation *Rhön Klinikum AG* acquired the university clinics of Marburg and Gießen from the federal state of Hesse. Together, the two university clinics provided more than 2,400 beds.

Almost all studies on the German hospital sector estimate that the privatisation process will continue in the future and will also include larger clinics. For example, a study carried out by the economic research department of the Allianz Group predicts that by 2020 the proportion of private hospital will have increased from currently 25% up to 40%. Other studies estimate that the share of private hospitals might even grow to 50%. Regarding university hospitals a study by Dr. Wieselhuber & Partner Consultancy estimates that in 2015 about 23% of all hospital clinics will have been privatised and further 29% will be organised through public-private-partnerships.

The ongoing restructuring of the German hospital sector has led to the emergence of some major private hospitals companies. Among them there is a group of four large corporations including *Asklepios, Rhön-Klinikum, Fresenius* and *Sana Kliniken* which together account for nearly one third of all private hospitals. Since all of these four companies are following a strategy of continuous expansion they are expected to acquire a much larger market share in future. Thereby, the restructuring of the hospital sector does not only include privatisations but also mergers and acquisitions among private hospital companies. The largest takeover of a private hospital so far took place in October 2005, when the medical care company *Fresnius* bought the private hospital chain *Helios Kliniken.* Privatisation coupled with mergers and acquisitions in the private health sector attracted the attention of the Federal Cartel Office. In 2005 it prohibited the takeover of two public hospitals in the district of Rhön-Grabfeld by the private hospital company *Rhön-Klinikum AG* in order to prevent a dominant position of a single hospital provider in a certain regional market. In the same year the competition watchdog also prohibited *Rhön* from acquiring the municipal hospital of the city of Eisenhüttenstadt. However it accepted the takeover of the *LBK Hamburg* by the private hospital company *Asklepios* with the obligation to sell one of the seven hospitals to a competitor.

The Privatisation of Landesbetrieb Krankenhäuser Hamburg

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The privatisation of Landesbetrieb Krankenhäuser Hamburg (LKB), the municpal owned hospitals of the city of Hamburg, was so far the largest hospital privatisation in Europe. Together the seven hospitals operated more than 5,688 hospitals

[2] A longer article in German was published in the journal *Sozialismus 10/2007*. The article is downloadable from www.pique.at

beds. In 2004 the conservative major of the city of Hamburg decided the sell the hospitals to the private health care provider Asklepios although 76.8% of the citizens voted against privatisation in a local ballot pushed for by the proponents of the campaign 'Health is Not a Commodity'. The major promised that privatisation will lead to improvements in the quality of hospital care in Hamburg. According to a patient survey carried out by one of the major social insurance funds the Asklepios-clinics with the exception of the clinic in the district of Altona received the lowest rankings of all hospitals included in the survey. The consumer advice centre of the city of Hamburg has recently informed the management of Asklepios about a dramatic increase in patient complaints. The deterioration of service quality should not come as a surprise given the changes that were introduced by the new owners after privatisation including a substantial reduction of hospital staff. According to a work council representative there are some departments with only one employee (with possibly a temporary contract) available for serving and overseeing the entire department. However, the deterioration of the quality of service provision is not only the result of privatisation. The introduction of Diagnosis-Related-Group-Systems (DRG) has caused management to keep patients as shortly as possible allowing hospitals to reduce the average number of staff per hospital bed. While in public hospitals one employee is 'responsible' for 164 beds, in private hospitals there is one employee per 208 beds. With the introduction of DRG-System, patient satisfaction has not only decreased in private but also in public hospitals. However, in the case of LBK Hamburg reorganisation and increasing work strains haveled to an exodus of hospital staff. Almost 2,000 out of 4,000 eligible employees took the possibility negotiated between the major and the union and have left the hospital within 2 years after privatisation and continue to work for the city of Hamburg thereby creating an enormous financial burden for the municipality. The management of Asklepios declined to join the public service collective agreement (Tarifvertrag Öffentlicher Dienst) and only recently the United Service Worker Union Verdi reached a company agreement.

Is British Health Care Being Privatised?

Grazia Ietto-Gillies (Centre for International Business Studies, London South Bank University)[3]

1. Introduction

The British National Health System (NHS) was established in 1947 and, in theory, it was based on the principles of *comprehensiveness, universality* and *equity.* It was a system free at the point of delivery - that is free for patients as users - and funded by the State through taxation. Alongside it, there was always a small amount of care privately funded directly by the patients or through their insurance companies.

From the 1970s onwards, and particularly throughout the 1980s and 1990s, as the NHS was progressively starved of resources the share of privately-funded care increased, largely through health insurance schemes. The Thatcher and Major Conservative Governments encouraged the involvement of private providers in health care and also the funding through private insurance.

In 1997 the New Labour government brought high expectations for improved services, but no extra resources were allocated to the NHS in the first few years. In 2005 the Chancellor of the Exchequer Gordon Brown announced a package of considerable and sustained expansion in health care expenditure which was re-

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ceived enthusiastically. However, it came with strings attached: the strings of restructuring and 'modernisation'. In most cases the strings meant a greater involvement by the private sector in the provision of health care services. Many in the labour and trade union movements speak of wholesale privatisation of the NHS. The Government denies any such move, plans or intentions and cites as evidence the fact that the service is and will remain free at the point of delivery: the patient does not and will not pay directly or through private insurance because the system is funded via taxation.

In order to try and understand what is going on I shall first present – in section two - a framework for the analysis of different health care regimes. Section three gives a brief summary of developments in British Health Care in the last few decades and interprets them on the basis of the theoretical framework. The last section will draw conclusion for the current changes taking place in the British system.

Funding and provision: two dimensions of health care

There are two main dimensions to the health care business. First, the provision/production dimension which refers to such aspects as: how the services are produced and delivered and how production is organized. Second, the funding dimension which refers to who pays for the services and how, as well as to the funding methods and the processes underpinning them. The payers can be the users of the service (directly or via their private insurance companies) or the State via taxation in which case the citizens pay as taxpayers and not as users of the service. The charities and voluntary sector in general can also be involved in funding and/or providing; however, in practice their role in developed countries is very small.

Table 2 sets up a framework in terms of these two dimensions (funding versus provision/production) in terms of two different regimes: private versus public/social funding regime and private versus public provision regime.

Table 2: The funding and provision of health care: private versus public regimes

Funding regime	**Provision/production regime**	
	Public/Social (C)	*Private (D)*
Public/Social (A)	I	II
Private (B)	III	IV

The *funding regime* tells us whether the care system is funded via taxation (A) or whether the patients pay (B) either directly or through their private insurance. The *provision production regime* tells us whether the producers/providers of care are the state and public institutions (C) or private companies (D). These two sets of regimes generate scope for four different healthcare systems as in Cells I-IV.

Cell I defines a system in which health care is funded via taxation and is provided by public (not-for-profit) institutions. Cell II denotes a system in which the funding is via taxation and the provision is via private health care companies. Cell III relates to a system in which the funding is private – by the individual patient directly or through a private health insurance – but the provision is undertaken by public institutions. Cell IV relates to a system in which to private funding - as in III - corresponds provision by private companies.

These are broad theoretical categories and no country has an actual overall system that perfectly matches any of the four cells.

Moreover, different regimes may apply to different elements of the health and care services: clinical or diagnostic or acute versus Primary Care services. Nonetheless all four situations find correspondence in some aspects of care in a variety of countries and/or periods. I will give here some examples of possible matching between the situations in the four cells and actual system of health care.

The situation in Cell I matches quite well the care in British NHS hospitals since 1947; however, matching British Primary Care (by GPs) since 1947 is more problematic for the following reason. Primary Case was – and still is – publicly funded, through taxation; however, GPs have always been independent contractors though with strings attached, such as restrictions on the sale of the practice. The GPs' services have had many strings removed during the Blair Government: for example they can now sell their practices and sell the related 'goodwill'. Moreover, the Government has recently been encouraging British and foreign – particularly American – Health Care companies to set up Primary Care practices. Therefore this aspect of the British Health Care services increasingly fits well into Cell II.

Cell III might at first appear to present problematic matches. It does, indeed, relate only to a minority of situations; specifically it fits in well with the development of entrepreneurial activities on the part of NHS hospitals. During the Thatcher and Major years the hospitals were encouraged to raise money by opening private wings and thus creating systems in which the provision was public but funding took place via the patient or their insurance companies.

Cell IV is exemplified by very large parts of the USA health care system in which the patients fund their care via private insurance while private health care companies – often linked to the insurance companies – provide the care. It should be noted that other parts of the American system may fit with II or I.

Regarding the British system, the nearest situation we had in cell IV was during the Thatcher-Major years when an American style of health care was promoted and forced on to many middle class people by the deterioration of the NHS. These developments created severe problems. Unlike in the US where this system grew organically, in Britain it was attempted as imposition from above or rather as imposition on a public weary of an NHS which had been starved of resources. Politically, the attempt to implement such a system became a hot potato, something difficult to defend and get away with at the ballot box. Socially, it became a very divisive issue. But most important the system was not economically viable. In a relatively small country like the UK the market for fully privatised funding via private insurance is not large enough to be profitable. Moreover, the glaring failure of the US market system on the funding side may have taught lessons to the next Government.

Developments in British Health Care: an overview

As already mentioned the Thatcher and Major governments encouraged the expansion not only of private funding but also of private provision of core services. New Labour has kept in place many of the changes introduced by the Conservatives. However, there are major developments; some of these relate specifically to health care others are more related to general care; they will both be mentioned here because they interact with each other.

As regards the core, c*linical services* there had always been a certain amount of privately funded and privately provided health care since the establishment of the NHS: ranging from private hospitals and diagnostic centres to the private services of

consultants and General Practioneers (GPs). Moreover, the publicly-funded general practice was organised as public provision up to a point; as already mentioned, the GPs had always been contractors of patients' care to the government. This is still the case though the nature of the contract has been changing. It can, therefore, be claimed that the GPs always provided care on the basis of privately/independently run surgeries though for many years they had restrictions on selling their 'business' to third parties.
The New Labour Government has greatly extended the scope for private sector involvement in most aspects of clinical services. In Primary Care the GPs' practices are increasingly being driven by profits motives: the partners are the owners of the practice and they distribute the surplus after paying the salaries of salaried health workers such as nurses, physiotherapists, administrators and those doctors who are employed on a salary by the partners. Moreover, large foreign Primary Care providers are encouraged to bid for practices. It is not difficult to foresee that, as old doctors partners retire many more practices will be sold to large scale providers; the ownership of the practices will gradually pass on to non-health workers or to people who are not linked to the practice by their professional involvement.

Private provision is being extended to other core services such as: diagnostic; surgical and other acute treatment; use of beds in private hospitals paid by the NHS. Both British and foreign health care companies are encouraged to bid for contracts.

Care and nursing homes. In the 1980s and 1990s the Conservative governments more or less wiped out Council-owned and managed care homes: local *residential and nursing homes* were closed down and patients/disabled/old people assigned to either the responsibility of relatives – the so called 'care in the community' – or forced to rely on the mushrooming private sector care homes. The Council would pay for the care of the poorest needy patients to be delivered by for-profit organizations and/or to a lesser extent by the voluntary sector. The New Labour Government has increased the scope for the involvement by private providers of nursing/care homes through the following. In order to free overstretched bed capacity (and possibly also to generate further areas for profitable investment by the corporate providers of health care) the Department of Health has created an extra category of patients, those in need of 'intermediate care'. They are the elderly people who occupy hospital beds though their acute clinical needs are over – or cannot be met; they still need nursing and care and this is to be provided by private nursing homes at the state's expense. Currently this sector is therefore run largely on a private funding and private provision basis with public funding available for the very poor.

Building infrastructure. The key development here was the Private Finance Initiative (PFI) developed in 1992 by the Major government largely under pressure from an ailing construction industry. The scheme involves the public sector institution entering into a contract with a private sector consortium of construction and facilities management companies as well as banks, for a variety of services ranging from the raising of funds and the construction of buildings to the leasing, maintenance, security and cleaning of the same buildings. The leasing contracts last for an average of 30 years. The public institution pays: interest to the private banks for the funding; rent for the leasing; fees for the various services provided.
Though the scheme was first introduced by Major, it is the Blair government that has developed and implemented it under the new name of Public Private Partnership (PPP). Moreover, since 2001 the involvement of private consortia in the funding

and provision of physical infrastructure has been extended to the Primary Care part of the service. In terms of our two dimensions, this area of activity is publicly funded and privately provided: the private sectors involved range from banks to building contractors to providers of management services.

Ancillary services. The process of contracting out non core services (catering, IT, cleaning and laundering, security) had already started under the Conservative governments. New Labour has continued this practice. The funding is public while the provision is largely private.

Is British Health Care being privatised or not?

The developments discussed in section three clearly illustrate that, under New Labour, British health care is; (a) being funded mainly publicly i.e. by the taxpayer; and (b) that private provision of care and related infrastructure is being introduced very fast and extensively.

The State funding of public services combined with private provision is a general trend in New Labour: indeed, it is argued that this is the defining strategy and characteristic of Third Way politics and economics (http://www.paecon.net/PAEReview/issue39/IettoGillies39.htm)

Given the characteristics in (a) and (b) can we say that the New Labour system of health care is equivalent to privatisation? The answer to this question is most definitely: YES; British health care is in the *process of being privatised* in spite of the fact that its funding remains social. The italics want to stress the dynamics of what is going on; it is a process of slow – though not that slow! – privatization; the legal and institutional frameworks conditions are in place for further and bigger inroads into the privatization process.

In all the regimes highlighted in table 1 *the main/core activity of each system is provision of health care* and therefore it is this activity that should be seen as paramount in analysing the system: funding is not the core activity for the health care sector. Therefore, when Ministers state that the health service is not being privatised because it is free for patients, they are concentrating on the non-core dimension of the service.

Moreover, in any business activity and particularly in services, the production side is the most relevant in terms of processes and their impact on the quality of the product and thus on the consumer/user. However, such activity is exercised for different ultimate aims according to the type of provider: when the provider is a private company – whatever its business, whether production of shoes or buildings or transport or health care - the aim of its activities *is and cannot but be profit*. In the case of a public provider the ultimate aim is the provision of service - in our case health care - per se. The ultimate aim informs strategies, processes and ultimately the structure, quantity and quality of services themselves.

It is therefore the relevance of the production/provision side over the funding side combined with the profit motive that identifies the New Labour system of health care as moving towards a private rather than public regime. Nonetheless, there are differences between a regime in which both sides of the equation (funding *and* provision) are private (as in Cell IV) and one in which provision only is privatised and specifically the following. If both the funding and provision are private one expects the profit motive to affect both sides in terms of costs, strategies and access; the costs are higher because profits to both the insurance and providers companies have to be passed on. Moreover, the fragmentation into several providers may increase costs

via forgone economies of scale; the existence of several operators on the funding and providing side increases transaction costs. All these elements are present in the American Health Care system which is notoriously very costly. It should also be added that private providers tend to neglect the prevention side of care and this increase social costs.

Private funding generates different problems and, in particular, problems of health inequalities with associated social costs. The poorest sections of the community may not be able to afford either direct payments or insurance premiums and this will lead to further increases in health inequalities.

The Emergence of European Health Care Multinationals
Christoph Hermann (FORBA, Vienna)

Privatisation and economisation of health care in Europe has facilitated the emergence of European health care multinationals. Among them is the Swedish health care specialist Capio AB. Capio has subsidiary companies in six more European countries including Spain, France and the UK. The company furthermore operates diagnostic centres and psychiatric hospitals in Denmark, Finland and Norway. In 2006, Capio was bought by the British private equity group Apax and Swedish Nordic Capital. Apax is also one of the partners in the South African Network Healthcare Holdings Consortium (Nedcare). Nedcare in the same year acquired the General Health Care Group, Britain's leading private hospital owner. Following the takeover of Capio the European Commission's competition authority required Apax to sell Capio's UK hospitals and treatment centres. Apax and Nordic Capital also control the French private hospital chain Vedici. Yet Vedici and Capio Santé together still account for significantly less than the leading private health care provider in France, Générale de Santé. So far, Générale de Santé has concentrated its foreign expansion on Italy but it announced plans to expand into the German market. The German market is dominated by Fresenius, the world market leader in dialysis procedures and products. Outside Europe, the company operates more than 2,000 dialysis clinics in North America, Latin America, Asia and Africa. In 2004, Fresenius acquired Helios Kliniken Group. In addition, Fresenius has founded the subsidiary Vamed which has specialised in technical support for hospitals. So far, Helios concentrated its activities on the German market, but it has attempted to expand into neighbouring Austria and the Czech Republic. Medicover from Sweden and Euromedic from the Netherlands are two private health care companies that have specialised on providing services in the new member states in Central and Eastern Europe.

Health Care Privatisation and the Role of the European Union
Christoph Hermann (FORBA, Vienna)

EU member states have repeatedly argued that health care is not an economic activity since the majority of providers do not intend to make a profit. After fierce resistance by a broad coalition of actors and groups health care was excluded from the scope of the Internal Service Market Directive adopted in December 2006. As a result, the Commission circulated a draft for a specific Directive on Safe, High-Quality and Efficient Cross-Border Healthcare in 2007. Apart from facilitating mutual recognition of professional qualification and the cross-border transfer of personal patient data, a major goal of the directive is to regulate cross-border health care provision. This is a reaction to a series of decisions by European Court of Justice (EJC) in which the court has decided in favour of

patients who went for treatment in other Member States and subsequently asked for reimbursement from their national public insurances. While the Commission rightly argues for the need for legal clarity, it at the same time supports the idea that patients can shop around in Europe for the best medical treatment.

Yet what at first sight may seem as a measure that increases patient's choice may in the long term backfire as a considerable threat to the existing health care systems (so far the number of patients that go abroad for treatment is marginal). First, although the directive claims not to interfere with the member states' right to organise their national health care systems, it nevertheless makes planning difficult since the number of patients that is looking for treatment will dependent on the decision of other member states to expand or reduce services. Secondly, patients may be forced to go to other countries for treatment since Member States may no longer feel obliged to provide sufficient capacity in their home countries. Thirdly, patients who are not mobile and do not speak foreign languages are disadvantaged and have to wait at home while others who feel comfortable to be treated in a different language and environment that is mostly the better-off part of the society may go abroad. Fourthly, there is the danger that patients will be send to countries that can provide the same treatments for lower costs – e.g. the New Member States in CEE. The question then is if there will be enough facilities and qualified personnel in these countries to treat the local population in addition to treating patients from abroad paying in much needed euros. Hence the overall result of promoting cross-border health care could easily be growing differences in the accessibility and quality of health care in Europe.

Grazia Ietto-Gillies (Centre for International Business Studies, London South Bank University)[4]

Summary: The Other Invisible Hand. Delivering Public Services through Choice and Competition by Julian Le Grand (Princeton and Oxford: Princeton University Press, 2007, pp.195+xi. No index.)

This book comes at a key point in the life of the British National Health Service (NHS) which is currently celebrating its 60th birthday. It is written by an author who had a role in the strategic directions taken by the UK health care system as "senior policy adviser to the prime minister at 10 Downing Street" (p. 2). The competence of the author in the subject emerges throughout this clearly structured and written book making it a pleasure to read for anybody interested in the fate of the NHS whether the readers are experts or just interested and whether they agree with the approach or are critical as the present commentator.

The theoretical framework

Le Grand begins by telling us that the expression 'public service' may be interpreted to mean: "services for the public"; "services that are of fundamental importance to the public, such as education, health care, social care, housing and transport"; and "…services for which there is some form of state or government intervention, whether in its finance, provision, regulation or all three." (p. 4).

The following attributes are needed to achieve the 'end' of providing 'good' public services: *quality, efficiency, responsiveness/accountability* and *equitability.* None of them are completely straightforward. *Quality* can be seen in relation to: (1) *in-*

[4] This note contains a summary of the book. A full review article is being prepared for the *International Review of Applied Economics.*

puts (such as number and qualifications of health professionals); (2) *processes* (waiting times, courtesy in dealing with patients etc.); (3) *outputs*, (i.e. how many patients have been seen in the year, how many operations performed); and (4) *outcomes* (i.e. the final results in terms of improvement in patients' health or – in the case of education services – increase in levels of literacy and numeracy and other skills).

Efficiency should be seen in terms of the opportunity cost of the expenditure on the service. *Responsiveness* to the needs of users of the service as well as to the "…needs and wants of those who *are* paying for it i.e. the taxpayers; ultimately it is about *accountability* to the taxpayer. *Equity*, '- i.e. social justice and fairness - …is the reason why services such as health care and education are in the public domain" (p. 12-13).

What are the *means* at our disposal to achieve the above *ends*? Le Grand discusses four models based on: (1) *trust*, (2) *command-and-control*; (3) *voice*; and (4) *choice* and *competition.* The *trust* model is the one with most appeal to the professionals being based on the assumption that they know best. "But can providers be trusted to deliver?" asks Le Grand. Only if we assume that their main primary motivation is the "welfare of those they are serving and not…their own material self-interest." (p. 17). In other words the trust model can work if we assume that the professionals involved in the delivery of public services are 'knights' rather than 'knaves'. Even if knightly behaviour is preponderant we are still left with several problems in the *trust* model ranging from: who is interpreting what is 'best' for the users; the fact that agency may lead to paternalism; possible disagreement among professionals on what is best for the users. The final conclusion is that a sole reliance on the *trust* model "is unlikely to achieve our aim of a good service" (p. 22).

The C*ommand-and-Control* model is largely based on the setting of targets. Targets and performance management have been introduced by the New Labour Government in the public services and specifically in education and health care in imitation to the setting of targets in private companies. The model is not without problems which range from: hostility by professionals who dislike the control element within it; conflicts between core service professionals (such as doctors or teachers) and the managers in charge of the service; behaviour adaptation on the part of professionals who start working to achieve targets rather than for the good of the users; possible disagreement between professionals and Government on priorities.

The *voice* model is a form of bottom-up management of the system. It is based on the idea that actual and potential users can and should be encouraged to express their view of the service by direct communication with the professionals, through complaints or via collective democratic processes. The model has several drawbacks ranging from: low incentive to improve efficiency and remedy underperformance to favouring the vocal and articulate middle classes thus exacerbating inequalities of access to quality services.

The C*hoice and Competition* model is the one favoured by Le Grand who sees it as a model in which Adam Smith's invisible hand leads to the achievement of good public services. He devotes the whole of chapter two to it, while the other three models as well as the 'ends' are dealt with in a single chapter.

Choice has an intrinsic value – because users feel empowered – and an instrumental value – because it forces providers to improve. It raises two main issues: who is doing the choosing? The professional, the manager or the user of the service? And what type of choice are we talking about in

relation to public services? There are several types: *where* (which provider and medical facility; *who* (which professional such as consultant or General Practitioner); *what* (i.e. types of medical treatment); *when* (timetable for consultations or treatment); *how* (modality of consultation such as face to face versus phone or Web).

Three common objections to choice are discussed: (1) people do not want choice: they want quality; however, the author argues that people should be asked whether they think that improvements in quality without choice are possible. (2) Choice is a middle class obsession; and (3) Choice has no place in the public sector where professionals are dedicated to the public good. Le Grand argues that the latter point leads to a position in which one believes that professionals behave as 'knights' when working in the public sector but as 'knaves' when working in the private sector. He concludes that this is an implausible situation since we are talking of the same group of professionals say doctors and nurses in the case of the health care service: professionals may or may not display altruistic feelings whether they are employed by the public or private sector.

Competition is defined as "…the presence in the public service of a number of providers…" (p. 41). There is an implication that the competing providers may be non-profit as well as for-profit ones; however, most of the arguments are based on for-profit operators.

Application to health care

The rest of the book is devoted to discussions about how the various theoretical models, and particularly the preferred one of Choice and Competition, can be applied in the case of two specific types of public services: School Education – on which there is, however, only one chapter - and Health Care. I will not consider here the specifics of the chapter on School Education other than to note the following. There is evidence that the setting of targets has led to cream-skimming in which State schools choose the best, usually middle-class, students who are more likely to perform well.

Chapter four deals with specific policy instruments designed to achieve 'good' health care services. First, two experiences are reviewed critically: the current US system and the British health care system under the Conservative Governments of the 1980s-90s. The lessons drawn from these experiences are that: competition must be real; choice must be informed and cream-skimming must be avoided.

These three issues are then addresses in turn. For competition to be real the users must be helped and encouraged to exercise their choice. Two specific remedies are suggested: meeting costs of patients' transports for movements to far away from hospitals and employing Patients Care Advisers to help them with their choices. Moreover, there must be no barriers to market entry and exit. Entry by new providers must be assisted for example "through guaranteeing them a higher price for their services, or by guaranteeing a specific volume of business" (p. 111). In a note Le Grand mentions that both types of assistance to private providers were indeed given on early rounds of market entry by the New Labour Government: the private companies were offered: "a price that was on average 11% higher than the standard NHS price and a guaranteed contract." (p. 111 note 10). To ensure proper working of market forces, exits must be allowed to occur and failing hospitals must be closed without political interference. Here he proposes moving decision power over closures away from politicians and to the independent agency Monitor.

What about risk selection – by the managers of the service - commonly known as

cream-skimming? He concludes that: "Overall, we do not know whether risk selection or cream-skimming will turn out to be a problem associated with extending patient choice" (p. 126). The problems may be exaggerated because: (a) people who decide on queues may not know about the risks that each patient represent; (b) doctors want to cure, they are 'knights' not 'knaves' and so they will admit the seriously ill; and (c) the more seriously ill patients present an intellectual challenge that good doctors may want to face. He accepts that the problem may be a real one and cream-skimming may indeed be intensified by the profit-motive of private providers; however, we are told that this is not a big problem because competition to existing hospitals will be exercised by both for-profit and not-for-profit (i.e. the voluntary sector) providers. In terms of policies to deal with the real problem of cream-skimming he proposes the following: (1) "introduce some kind of stop-loss insurance scheme whereby hospitals faced with a patient whose treatment costs lie well outside the normal range receive extra resources once the cost has passed a certain threshold." (p. 124); (2) take admissions decisions away from hospitals; and (3) introduce deprivation-adjustment in the tariff to correct socio-economic inequities.

Chapter five is about 'New Ideas' regarding policies; the following are particularly interesting. (1) Extending choice from provider to type of treatment; the setting up of patients' budgets may give empowerment in this type of choice; (2) establishing a 'Disadvantage Premium' for both education and health; and (3) setting up Social Care Practices to take care of all needs for children in care.

The last chapter analyses the possible attitude towards the four models presented in chapter two from the perspectives of "two kinds of interest group: ideological and functional. The ideological groups are the social democratic left and the conservative right […]. The functional groups can also be split into two: those who work in the public sector and those who benefit from it, users or potential users." (pp. 156-7).

Privatisation of Public Services and the Impact on Quality, Employment and Productivity (PIQUE):

Parts of the findings presented in this Newsletter are based on research carried out in the PIQUE project. As PRESOM it is a three-year project funded by the European Commission in its 6th Framework Programme. Apart from health care/hospitals the project includes three more sectors (electricity, postal services and local public transport) and covers six countries (Austria, Belgium Germany, Poland, Sweden, UK).

Newsletters, policy papers, research reports and related publications are downloadable from: www.pique.at

Recent documents added include reports on the *Varieties and Variations of Public Service Liberalisation and Privatisation in Europe* and *Liberalisation and Privatisation of Public Services and the Impact on Labour Relations*.

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