Melting public–private boundaries in European health systems

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Renewed debates about the superiority of either predominantly public or predominantly private health services arrangements have tended to be more ideologically charged than conceptually precise. Historically, the public/private split in European systems has often been more sharply defined in principle than in practice. This real-world variation was further complicated during the 1990s by reforms that enabled publicly owned hospitals and health centres to manage their daily operations more independently. Most recently, several new initiatives have established complex cross-boundary arrangements that cannot easily be characterized as either public or private. This article presents a conceptually rigorous four-part classification of past public/private arrangements that can provide a theoretical baseline from which to judge future cross-boundary developments.

Keywords: cross-boundary arrangements, private health care, privatization, public health services

Privatization’ is among the most controversial and value-laden terms in the European health reform lexicography. Proponents harp on it as an all-purpose solution, trumpeting the benefits of entrepreneurialism and innovation. Opponents hurl it as a vile epithet, associated with personal greed announcing the end of social solidarity. The degree to which this emotional battle has continued unabated for 20 years1 suggests the centrality of this issue for a wide variety of health reform strategies. Indeed, one of the most striking aspects of this public–private debate is that it never seems to be finally settled. In various forms (e.g. state vs. market or equity vs. efficiency), and with varying degrees of ideological heat, this debate appears to have become a permanent fixture on the European health policy scene. Despite this continual attention, however, many versions of this long-running saga betray a surprising lack of information as to how key issues of public and private have been handled in the past in European health systems, and how traditional public/private boundaries are beginning to fade away in a number of countries.

This article focuses on the characteristics and implications of this renewed debate about privatization in European health policy. It begins by setting out a precise definition of privatization, using a specific four-point typology that can better facilitate cross-national comparison. The article then reviews a range of long-standing relationships in European health systems in terms of this definition. Having established both the conceptual and organizational context, the paper presents recent evidence from a variety of countries concerning indications of what can be termed the melting of this specific four-part public–private distinction, as national policymakers seek to improve fiscal sustainability and service quality by infusing entrepreneurial innovation into publicly accountable and/or publicly operated hospitals, primary care, and home care sectors. The paper concludes with a brief consideration of potential future concerns as the present process unfolds.

DEFINING PRIVATIZATION

The central notion behind the concept of privatization seems deceptively simple: it is the turning of public assets over to private ownership.2 This may entail the sale of shares on the stock exchange for large companies, direct sale of smaller assets, or it could involve transferring ownership of public assets to a not-for-profit private foundation.3 The central requirement is an explicit shift in ownership of capital. Examples of privatization in the 1990s have typically come from the utility, telecommunication, and transportation sectors of the economy.4 Defining privatization as the transfer of ownership of assets can help clarify the terminological confusion that has suffused several national health policy debates. First, privatization has little if anything to do with the introduction of competitive forces.5 Recent economic history highlights numerous examples of large privately owned corporations that are monopolistic or oligopolistic in nature and do not engage in competitive behaviour (e.g. the pre-1984 American Telephone and Telegraph Company in the United States). Conversely, wholly or majority publicly owned entities can compete fiercely in the open market, e.g. Scandinavian Airline Systems in
the Nordic Region. Further, wholly publicly owned entities often compete amongst themselves in various public sector markets, as for example for hospital contracts in the UK, Sweden, Finland, and parts of several other Western European countries. This disconnect between private ownership and competitive behaviour does not fit the standard assumption in economic theory that it is pursuit of profit by private owners which drives efficient market behaviour, yet it clearly reflects the 'facts on the ground' which have emerged in a number of Western European health sectors during the reforms over the 1990s.

Second, privatization is structurally different from organizational concepts that encourage more independent management of publicly owned providers such as hospitals and primary health centres. Notions of 'autonomization' and the more independent 'corporatization', for example, involve a loosening of the command-and-control approach that has traditionally characterized government management of publicly owned and operated entities. The two concepts represent a further refinement on the notions of 'public firms' or 'self-governing trusts' as developed in the early 1990s to encourage more entrepreneurial behaviour inside publicly owned and operated hospitals. It is important to underscore here that autonomization and corporatization refer only to managerial status. Since there is continued public sector ownership of the institutions involved, without any transfer of assets, there is no privatization.

Third, for very similar reasons, privatization is different from the notion of 'marketization'. Again, marketization – like autonomization and corporatization – refers to the introduction of market-style incentives within what remain publicly owned institutions. Marketization typically has been employed to describe the behaviour and/or consequences of the 'internal' or 'quasi-market' introduced in England and Wales into the NHS hospital sector in the early 1990s. The fact that these self-governing trusts remain publicly owned and operated, and that their Boards of Trustees remain accountable to the NHS Executive, explicitly separates their status from that of privatization.

Stitching the above points together, the traditional notion of a bipolar public/private dichotomy needs to be expanded into a four-point framework if it is to reflect recent reality within the European health sector. Such a framework understands the terms public and private to be a form of intellectual shorthand for what are considerably more complex configurations. As figure 1 suggests, public has both not-for-profit as well as for-profit. Further, there are additional sub-categories within all but the 'state' category. Inside 'public but non-state', one finds regional and local government-run institutions (e.g. autonomous provinces in Spain; Länder in Germany; county councils in Sweden or Denmark; municipal governments in Finland), reflecting the independently elected and often constitutionally defined political status of these lower level governments in many Western European countries. This 'public but non-state' category also includes the rapidly growing number of managerially independent but publicly accountable 'public firms' (hospital trusts in UK; independently managed hospitals in Norway, Sweden, and Spain, as well as primary health centres in Sweden). Within the private not-for-profit category one finds a range of community-based religious and charitable institutions, as well as most non-governmental organizations (NGOs). The central thread that draws the somewhat disparate private not-for-profit group together is that all these institutions are community-based and they are mission (not profit) driven. Lastly, the private for-profit category incorporates two distinct sub-groups – small business (including solo and group physician practices) as well as large shareholder-owned corporations – whose interests are often visibly opposed each to the other.

This four-part framework provides clear and explicit criteria for judging whether a particular institution or service has undergone privatization. First, ownership of its capital and/or assets must be transferred either by sale or donation to a new owner. Second, the old owner must have been within one of the two categories on the public side of figure 1, while the new owner must be within one of the two categories on the private side. Only then can one properly speak of privatization.

### PAST ANOMALIES

A large majority of European health system arrangements both past and present can be readily characterized within the above four-fold definition of public and private. In addition, while distinctions separating public and private were relatively clear in the past, many systems also have had and continue to have cross-boundary financial flows, typically from public funders of various kinds of private providers. In Sweden and Denmark, for example, private not-for-profit nursing homes, owned by religious organizations, receive substantial public funding to care for patients. In the UK, the NHS purchased a considerable volume of elective surgery from private for-profit and not-for-profit hospitals during the 1980s and has announced recently that it will do so again. Similarly, the

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**Figure 1** A public/private taxonomy in the health sector
new Primary Care Trusts in the UK have been authorized
to contract with private as well as public hospital providers.

Intriguingly, however, two long-standing arrangements
within what are typically viewed as model health systems do not readily fit the above framework’s four-part classification scheme. The fact that one set of examples concerns providers while the other set involves insurers, and, further, that the provider anomalies are found in the archetypal tax-funded national health system (the UK) while the insurer anomalies exist in the archetypal social insurance system (Germany) makes these anomalies all the more notable.

In the UK, although general practitioners are entirely in the private sector – technically they would be classified as small businessmen in the for-profit private category – they have received public pensions funded jointly with the state since the earliest days of the National Health Service. In effect, while retaining their status as for-profit businesses, they nonetheless have received public sector pension benefits.

In Germany, the transgressor across these public/private categories has been the statutory sickness funds that provide health insurance to approximately 75% of the population. These funds are technically private not-for-profit in their ownership and management, sponsored variously by private for-profit industry (Betriebskrankenkassen/industry funds), private not-for-profit guilds (Innungskrankenkassen/guild funds), regional Länder government (Allgemeine Ortskrankenkassen/local funds) or the state (seamen’s and farmers funds). These private not-for-profit entities are administered by a board equally composed of employers and employees. However, these private not-for-profit bodies are administered under the aegis not of private law, like the rest of the private sector, but under public law.

Disputes between subscribers and their sickness fund, for example, are resolved by social courts working according to public sector administrative criteria. Further, the responsibilities and behaviour of these private funds is tightly fixed by both national legislation – by law – and by federal regulation – the Social Code Book. In short, while German sickness funds are indeed private in formal ownership status, they are public in their responsibilities and liabilities.

Both these anomalies suggest that, beyond simple public–private contracting, complexly intertwined cross-boundary relationships between public and private entities have played a noticeable role in European health systems for a half-century or more. One can point to additional examples in other countries – for example, the Voluntary Health Insurance Board in Ireland, which is a not-for-profit entity but directly controlled by the Ministry of Health and Children – as further confirmation.

What is intriguing about the current period is the extent to which these complex cross-boundary relationships are no longer isolated anomalies, but rather are increasingly appearing in a number of European health care systems.

Although public–private contracting and – also interesting – shifts in provider status inside the ‘public but not-state’ category (from regional-or-local-government-operated to public firms) have provided the majority of recent health system changes, it is the growing number of complex cross-boundary arrangements that highlight the melting around the edges of clearly defined public/private boundaries in the health sector, and the increasingly anachronistic character of the four-part public–private framework just detailed.

CURRENT ANOMALIES

As national policymakers have sought financial efficiencies and quality improvements from public health-care systems through various types of planned markets, an increasing number of anomalous public/private structures have appeared. Three examples are particularly noteworthy: the role of Bure AB in Sweden (and with it that of St Göran’s Hospital in Stockholm); the role of newly established public firms in the hospital system of Spain; and the role of Primary Care Trusts in the UK. Each will be briefly explored in turn.

Bure AB in Sweden

The story of Bure involves a considerable blurring of the public–private boundaries defined in figure 1. Bure Investment AB was one of several companies established by the Conservative-led national government in the early 1990s, utilizing tax funds collected by the previous Social Democratic-led government under the discontinued Lönstagenfonden (Wage Earner Funds) initiative. These wage earner funds had been originally intended to channel a percentage of corporate profits into collective purchases of private corporate shares on the stock market. Under the Conservatives, a substantial portion of Bure’s own stock (worth 2.2 billion SEK, about $300 million) was sold off to private investors on the Swedish stock exchange, with the state retaining a substantial minority position in Bure (reported at one point in the late 1990s to be 27% of shares). The national government formally divested its last shares of Bure when the (now re-elected) Social Democratic leadership arranged to transfer those shares to a state-administered supplemental pension fund, the 6th AP-fonden. Thus, despite this complicated history, Bure Investment’s largest shareholder still remains an agency of the state.

In 1994, Bure had purchased several health sector businesses from Procordia, another part-state-owned Swedish company, and established its Health and Hospital Care unit. In December 1999, after several failed attempts with non-Swedish owned companies, Stockholm County reached an agreement to ‘sell’ the operations of St Göran’s hospital to Bure for 225 million SEK. However, the physical buildings of the hospital remain owned by a separate public company established by Stockholm County to own and operate all its property, Locum AB. In effect, therefore, Bure Health and Hospital Care purchased only the operations of St Göran’s hospital, not its capital assets.
The implications with regard to melting public/private boundaries in the Stockholm County health system are fascinating. The central actor (Bure) was founded with (state-raised) tax funds, sold most of its shares on the (private for-profit) stock exchange, but still has as its largest stockholder a (state) pension agency. It bought the operations of a (public but non-state) county hospital, but the buildings continue to be owned by a (public but non-state) public firm. Lastly, the sale contract is contingent upon continued (public but non-state) county purchase of services. Referring back to figure 1, three of the four categories continue to be involved, including both on the ‘public’ side. What, exactly, has been ‘privatized’ and, given Bure’s complex characteristics, to what kind of ‘private’ company?

The St Göran’s–Bure story is the most complex of a new ownership pattern that will transform the remaining hospitals in Stockholm County into public firms. The County has announced that, in several stages, its six hospitals will be re-structured into individual public corporations, wholly owned by Stockholm County but each independently managed with its own Board of Trustees.23 Further, in the South District of Stockholm County, all 16 primary health care centres will have their management contracted out to independent operators.24 Some centres are expected to be run by new companies set up by existing staff, others will likely be contracted out to Praktikertjänst A.B., a private company owned solely by the physicians who work for it (when they retire, they are required to sell their shares back to the company, making it a type of physician-owned cooperative).25

Additional hospitals in Sweden are being transformed into public firms in Hälsingborg and elsewhere. Primary health care centres in Dalarna, Jonköping, and Hälsingland counties are now operated by their personnel.26 These transformations reflect, in structural terms, a response to the continued desire of county-level decision-makers to introduce a planned market inside the publicly operated health system, in which publicly owned providers must earn their revenues by attracting patients, contracts, or (typically) both.5,27 While elements of a planned market were introduced in some counties as early as 1988, the current period of reform appears to reflect a more complete adoption of the public market model, now including complex cross-boundary relationships as well as an expanding range of public firms.

Hospitals in Spain
Efforts to restructure hospitals into public firms in Spain have recently become widespread and notably diverse.7 At least five of the autonomous communities (regions) which control their own health care systems have developed innovative models to establish autonomatized or corporatized hospitals. Several, including the Basque Region, have gone further to establish complex cross-boundary relationships that place hospitals in a new legal category in which they are a ‘public entity under private law’.7 In Andalucia, three newly built hospitals have been structured in this fashion.28 Other regions have created various types of intermediate public–private categories, often adopting new terms to describe the hospital’s mixed public–private responsibilities. In all these cases, regional policymakers have sought to sever the hospital’s administrative relationship to traditional public sector bureaucracy by creating entities which, while remaining publicly owned, must obtain their revenues through public contracts, and will have sufficient managerial independence to make improvements in both operating efficiency and quality of care. In most of these instances, ownership remains within the public but non-state category of the public sector, yet the legal structure is typically that of a private not-for-profit foundation. Once again, there is a melting of traditional public–private boundaries into a more flexible cross-boundary configuration. Similar events are beginning to occur in Portugal, and one can expect to see a parallel burst of creative cross-boundary activity in Italy as the Regions gain greater control over provider institutions.29

Primary Care Groups in the UK
The new structure of Primary Care Trusts (PCTs), which came into being in April 2000, reflects the prior pattern of private-for-profit GP fundholders but with a stronger public supervisory input. These new mandatory management arrangements (the prior GP fundholders were voluntary arrangements) require private GPs who contract with the NHS to work in large group practices designed and closely regulated by the state (through the NHS Executive). This creates a curious merger of private-for-profit with state interests. To argue that this new arrangement is either public or private seems almost irrelevant. It is equally difficult to contend that PCTs are a form of ‘privatization’, since GPs in the UK have been for-profit small businessmen throughout the history of the National Health Service. Rather, as in the hospital sector in Sweden and Spain, what appears to be occurring is yet a further blurring of traditional public–private boundaries. The charge of privatization seems particularly strained given that these PCTs represent a new public–private hybrid which is considerably more publicly accountable than the immediate (private for-profit) fund-holding predecessor model. In the UK primary care sector, then, unlike the public-but-non-state configuration of self-governing trusts in the hospital sector, there is a new complex arrangement which does reflect a continued melting of public–private boundaries, but of privately owned medical practices into more publicly accountable hands.

FUTURE PROSPECTS
The above review of the concept of privatization, in conjunction with a consideration of ongoing innovative institutional changes in tax-funded health systems in northern, southern, and also eastern Europe, suggests that the overall profile of what is public and what is private is in the process of a fairly substantial transformation. First, the notion of ‘public’ is becoming more variegated and diffuse, more similar to the notion of ‘private’ in this...
regard. Second, specifically on the provider side of health systems, the clear fixed boundary between public and private – which has driven debate on this topic for two decades – is beginning to melt. New organizational arrangements are emerging that combine public and private in complex, often unique, ways. Pushing well beyond the notion of a ‘public market’ among publicly operated service providers, these new configurations are experiments in forming what are new types of public–private organizational arrangements. The fact that these new entities are neither wholly public nor wholly private confounds efforts to characterize them – either positively or negatively – as simply privatization. These new institutional structures bear carefully watching. They raise a number of important questions about the future direction and character of publicly operated health systems in Europe. Previously established cross-boundary arrangements – what are referred to earlier as past anomalies – served to cement private sector elements such as British GPs and German Sickness Funds into what was a dominant publicly defined framework. By contributing to existing solidarity-oriented policy objectives, these cross-boundary anomalies helped stabilize and strengthen the core publicly operated system. Similarly, in the 1990s, the various new planned market arrangements injected private sector market mechanisms into what remained publicly operated, publicly accountable provider systems. These new competitive structures were intentionally constructed by governments to strengthen and reinforce existing publicly operated providers, and, not unimportantly, core normative values of solidarity and equality.

The central policy question over the next period of years will be whether these new cross-boundary arrangements also serve to improve the ability of European health systems to fulfill core clinical and social objectives, or whether, in practice, these new initiatives undermine these objectives. Emphasis will need to be placed on monitoring the behaviour and outcomes generated by these new structures, and in evaluating their contribution to overall health system development. A premium will inevitably be placed on the stewardship role of the state in steering the future evolution of provider institutions, and in ensuring through regulatory measures that inappropriate arrangements and/or profiteering are not allowed to overwhelm these new structures. Potential future efforts to extend these complex public–private arrangements from service providers to the far riskier area of service funding will demand severe scrutiny and most likely, severe restrictions.

Confidence in the trustworthiness of governments and in the longevity of these new public–private arrangements will not be helped by recent proposals from the Conservative-led Stockholm County Council to sell off all stock in its new hospital ‘public firms’ on the Swedish stock exchange – mooted for 2003. Such a sale of existing ‘public firms’ – while technically that of a ‘public but not state’ rather than a mixed public–private structure – would raise serious concerns as to whether Conservatives are truly interested in the improved financial and service outcomes associated with these new cross-boundary structures, or whether they have simply adopted a new route by which to attain traditional (and often counter-productive) ideological imperatives. It will also be important to restrain tendencies inside the European Union, both in the Commission and in the European Court, to undermine the social good character of the health sector in the name of the Single European Market, and thereby to force complex public–private arrangements among health service providers towards the for-profit private end of the organizational continuum. Potential pressures towards full privatization from international trade agencies such as GATT and WTO will also have to be stoutly resisted.

There will continue to be complaints from traditionalist public health proponents that these structural innovations necessarily damage solidarity, while more hard-line health economists will continue to dismiss these same reforms as necessarily insufficient. Despite such now-standard concerns, it appears likely that the seeds of an important structural transformation have been sown. The challenge to policymakers in both publicly operated and social-health-insurance-based health systems will be to ensure that these new arrangements evolve in socially as well as economically appropriate directions.
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