# Privatisation in Western European health care: a comparative study

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**Summary**

Since the mid 1970's many countries have attempted to develop a strategy for controlling the ratio of growth of public spending. In this strategy privatisation is used as a general instrument for healing public finance. This paper describes the different types of privatisation in health care which are possible. Further we will analyse in a more quantitative way to what extent privatisation is used in 4 European countries. These countries are the Federal Republic of Germany, The Netherlands, both representatives of social security based health care systems, and the United Kingdom and Italy, as representatives of countries with a National Health Service. The development of the public health expenditures as a percentage of total health expenditures is related to the development of the total health expenditures as a proportion of the gross domestic product for each country. It is concluded that privatisation is in general of limited importance in health care. Cost sharing at the demand side and contracting out at the supply side are the most used types of privatisation. We expect that self-governance will increasingly become a public management tool for healing public health care spending.

Key words: Public/private mix, privatisation, cost containment, international comparison.

## 1. Introduction

Since the Second World War and especially during the 1960's, health care expenditures have grown rapidly in nearly all Western industrialised countries[29].

After the world-wide economic crisis in the early 1970's, many efforts were made to roll back public spending, including public health expenditures. Cost containment was the starting-point for many reforms of the insurance and financing systems. In addition, privatisation was also one of the policy instruments used to decrease public expenditures. Because privatisation does not have to imply a real termination of public functions, it was considered as an attractive alternative for putting the public finance on a healthy basis. The use of privatisation resulted in a decrease of the growth of public health care expenditures in almost all countries after the mid 1970's[24], although there are essential differences between the health care systems.

It is common practice to categorise health care systems as one of three basic models: the national health service model, the social insurance model and the private insurance model[20]. Generally speaking, the health care systems of Western Europe can be characterised as either a na-

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tional health service or a social insurance system. Examples of the former are the United Kingdom, Italy and Portugal; examples of the latter are Germany, France and the Netherlands. In fact, none of these models exist in a pure form. Each country uses a specific mix, which is dominated by one of the prototypes. Irrespective of these prototypes voluntary associations perform important tasks in all health care systems. Insomuch as these tasks have a statutory basis and are financed publicly, we will consider the voluntary associations as being a part of the public sector.

Comparative policy studies often emphasise the similarities between the health care systems based on one particular model and underline the differences between contrasting models. It would be interesting to explore the opposites, i.e. the differences between the most similar systems, and the similarities between the most different systems. In other words: is there more intra-system variance than inter-system variance?

This paper has two purposes. In the first place we will describe privatisation policies in Western European countries. Because this subject cannot be dealt with in a single paper, we will confine our discussion to four countries: the former Federal Republic of Germany (FRG), the Netherlands, the United Kingdom, and Italy. The health care systems of the first two countries are dominated by the social insurance model, whereas the health care systems of the last two countries are based on the national health service model. The second purpose of the paper is to analyse whether there is more intra-system variance than inter-system variance as far as privatisation is concerned.

We will address ourselves especially to the experiences since the early eighties.

Section 2 gives an overview of the various concepts of privatisation. A motivation is given for the choice of a particular concept. Section 3 deals with a description of the privatisation policies of the four countries mentioned earlier. Section 4 presents the results of the comparison of the developments in the four countries. Finally we will make some concluding remarks.

## 2. Concepts of privatisation

In countries with many state-owned enterprises such as the UK, France and the FRG, privatisation is often conceived as the selling of assets by the state to private owners. This is, however, a very narrow definition, which is of no use in countries in which the government does not own the health care institutions. Therefore we need a broader definition of privatisation, such as Boorsma's[4]. He describes privatisation as the calling in of private enterprises by the government. The OECD[19] defines privatisation as the adoption of public functions by the private sector, whereas sometimes the responsibility for these functions remains with the public sector. In fact this definition refers to the more specific description of privatisation by White[33]. He distinguishes two types of privatisation: contracting out and load shedding of public tasks. Contracting out of public tasks means that tasks are taken over by the private sector, but responsibility remains with the public sector. In the case of load shedding, the performance of as well as the responsibility for public tasks no longer belong to the public sector.

Blankart[3] refers to some typical arrangements of supply and capital ownership when using privatisation. He points out that on the one hand a service may be provided under public, regulated or private supply, and that on the other hand ownership of capital may be public or private. Combination of both varieties of supply and capital ownership leads to a matrix with six cells. Consequently he makes a distinction between privatisation of supply and privatisation of capital ownership. Den Hoed[16] uses two other criteria i.e. responsibilities and tasks, for his classification of privatisation. He specifies three types of privatisation:

- complete termination of public tasks (termination)
- contracting out of public tasks (contracting out)
- independent performance of public tasks (self-governance)

It is obvious that the first two types correspond with the distinction made by White. The third type, however, is new. In case of self-governance, responsibility and performance remain public, for example, a public department gets its

own budget and greater freedom in the performance of its tasks.

In elaborating his global definition, Boorsma[4] considers the public sector as a production process. The production process consists of planning, financing, production and distribution. The entire production process or single elements of it may be subjected to privatisation. In this way Boorsma constructs a matrix to distinguish different types of privatisation.

In our analysis of privatisation, we will use the above-mentioned distinctions of Den Hoed between termination, contracting-out and self-governing varieties of privatisation. There are two reasons for this choice. First, his distinction is connected with changes in public responsibilities and tasks. Regarding health care this seems more relevant than capital ownership. Second, his distinction of three types of privatisation does greater justice to the gradations of privatisation that can be observed in reality. In addition we will use a second criterion: the different elements of the production process that may be subjected to privatisation. According to Boorsma, these elements are: policies (planning), financing and supply of insurances and health services. If we combine the criteria of Den Hoed's types of changes in public responsibilities with the possible subjects of those public responsibilities according to Boorsma's elements of the production process, we get a matrix with the possible types of privatisation in health care (Table 1). We distinguish four possible combinations of responsibilities and tasks. For example, both responsibility and tasks regarding a specific aspect of health care may be public, or the responsibility is public while the performing of tasks is private, and so on. Every shift to the right may be seen as a kind of privatisation. We differentiate between the combination 'no public responsibility/tasks', and 'private responsibility/tasks', to be able to observe developments in the private sector, which are not the result of government policies.

The following standards will be used to measure the process of privatisation. In the first place, the development of the part of the total expenditures of health care that is financed by public resources is used as a standard for privatisation of financing. Regarding the field of health insurances we will pay attention to coverage, benefits and performance. Further we will use the devel-

Table 1. Possible types of privatisation in health care

| | Changes in public responsibilities and tasks | | | |
|---|---|---|---|---|
| Aspects of health care | public resp.<br>public task | public resp.<br>no public task<br>(contracting-out) | no public resp.<br>no public task<br>(termination) | private resp.<br>private task |
| Financing*: | | | | |
| Insurances:<br>– coverage**<br>– benefits***<br>– performance****<br>(public, associational, private) | | | | |
| Delivery of services:<br>– organisation<br>(public, associational, private) | | | | |
| * Ratio of Public Health Expenditures and Total Health Expenditures<br>** Percentages of population<br>*** Qualitative<br>**** Market share | | | | |

opment of the share of the private profit organisations in the total turnover as a standard for privatisation of the supply of health services.

In the next section we will use the matrix as a framework for the categorisation of the empirically observed types of privatisation in the health care systems of the Federal Republic of Germany (FRG), the Netherlands, the UK, and Italy.

## 3. Privatisation in four Western European countries

### 3.1. Federal Republic of Germany

The former German Empire (GE) can be considered as the mother country of the health care systems based on a social insurance model. Is was the legendary Bismarck who introduced in 1883 a statutory health insurance in the GE. In 1986 there were 1.184 sickness funds covering about 90% of the population[27] of the FRG. All blue-collar workers, white-collar workers below a certain income level, farmers, students, unemployed persons as well as their family dependents fall under compulsory insurance. About 8% of the population is covered by private health insurance schemes, while less than 0.5% has no health insurance at all. The main type of sickness funds are the local funds, the industrial funds and the crafts funds. The local funds comprise 23% of all funds with nearly 47% of those compulsorily insured; the industrial funds, comprising 62% of all funds, cover only about 12% of the same population; finally the crafts funds account for 9% of all funds and cover approximately 7% of those compulsorily insured. All these data refer to 1986 and show a picture of a very decentralised statutory health insurance system.

The administrative autonomy of the sickness funds is limited by the Health Insurance Act (Reichsversicherungsordnung), which is the legal framework for the comprehensive social security system[15]. The benefits of the statutory health insurance include free health care, i.e. free ambulatory care and free (unlimited) hospital care, freedom to choose any general practitioner or specialist registered under the sickness fund, preventive care, all kinds of services related to family planning and medical services in case of rehabilitation. A striking aspect of the Health Insurance Act is that the employed person insured in the statutory health insurance receives, when he is unfit for work, sickness benefits (80% of normal wages/salary) for a period up to 78 weeks (within 3 years). To a certain extent private insurance schemes cover the same benefits as listed.

The provision of health services in the FRG has a predominantly non-public character. Hospitals are private institutions, in general of the type of voluntary associations, which have no profit aims. There is a sharp distinction between ambulatory physician care and hospital care. Office-based physicians (niedergelasse Ärtzte ) do not normally have hospital privileges. Hospital-based physicians work on a salary basis, and their salaries are covered by the per diem rates negotiated between the sickness funds and the hospitals.

For ambulatory care the patients are free to choose among all doctors who are members of the insurancedoctors' association (Kassenärtztliche Vereinigung) which includes about 95% of all office-based physicians.

The office-based physicians play a dominant role in the German health care sector[30]. Every patient who is covered by a statutory sickness fund must first consult a physician in order to receive any type of medical care. Only office-based doctors may provide ambulatory care, prescribe drugs and medical appliances, and decide on hospitalisation.

The financing of hospitals is regulated by federal law, i.e. the Hospital Financing Act (Krankenhausfinanzierungsgesetz) of 1972 and 1985 and the Hospital Care Rating Decree (Bundespflegesatzverordnung) of 1973. The capital expenditures are completely financed by the state, as far as they are included in the Hospital Need Plan (Krankenhausbedarfsplan). The hospital's operating costs are financed by per diem rates. These are fixed at the level which enables the hospital to cover all current costs of management. These rates are uniform for all patients, but differ among hospitals.

The ambulatory physicians are reimbursed on a fee-for-service basis. The level of the remuneration of physician services has been the object of

negotiations between the sickness funds and the association of sickness funds physicians. The latter functions as an agency which receives the fees of the sickness funds and pays the individual physician.

When in the early 1970's the average annual growth rate of health care expenditures increased to about 20%, while economic growth had, on average, fallen to below 3%, attempts were made to contain the "cost explosion" in the health care sector[12]. As a result, regulatory measures taken by the State and the Federal Governments produced the Health Insurance Cost containment Act of 1977 (Krankenversicherungs- kostendämpfungsgesetz), which introduced expenditure limits on ambulatory medical care including dental services as well as on prescribed drugs. These expenditure limits were based on the development of the wage sum. Representatives of the (central and state) governments, the funds and providers, called "Concerted Action", attend two meetings a year at which prospective growth rates (ceilings) are put forward for future development of expenditures in various sectors of service delivery, except hospital services. In addition, various benefits were curtailed by introducing or raising consumer charges, especially in the fields of pharmaceuticals and dental treatment. Referring to the fact that already two years earlier, in 1975 the structural growth of health care expenditures had been broken down, Von der Schulenburg[30] noticed that it is quite possible that the public discussion of the problem and the reorientation of the sickness funds' own concept of what type of service they should provide and for whom, were actually more important than the Cost containment Act in stopping the escalation of medical costs.

In 1981 the Cost Containment Amendment Act (Kostendämpfungs-Ergänzungsgesetz) reduced various benefits such as the hospitalisation period after child birth, and further increased consumer charges in the fields of pharmaceuticals and dentures. In addition competition on the supply side was encouraged by the introduction of maximum rather than fixed prices. At the same time the Hospital Cost Containment Act (Krankenhauskostendämpfungsgesetz) made the hitherto decreed daily rates an object of collective bargaining between hospitals and insurance funds, and extended the responsibilities of the Concerted Action to include the hospital sector.

The Supplementary Budget Act of 1982 focused on the benefit side. A negative list of drugs no longer paid by the insurance scheme was issued, and consumer charges for pharmaceuticals were raised once again. In addition pensioners had to pay an individual sickness insurance contribution, which was to increase from 1% to 5% of their pensions up to 1985. The 1983 Supplementary Budget Act (Haushaltsbegleitgesetz 1983) made hitherto exempted components of earnings liable for sickness insurance contributions, and obliged recipients of sickness insurance cash benefits to pay contributions to the pension and unemployment insurance schemes. The Hospital Reordering Act (Krankenhaus- Neuordnungsgesetz) of 1984 and the Federal Decree on Hospital Rates (Bundespflegesatzverordnung) of 1985 brought a retreat of the federal government from the financing of hospital investments and gave the state governments the sole responsibility for a sufficient supply of stationary care. In addition, hospitals and health insurance funds became entitled to negotiate prospective budgets, serving as a basis for the calculation of daily rates. The change in the reimbursement system resulted in greater cost-awareness of the management, because they became responsible for any losses and for opportunities to realise profits[21].

One of the principal objectives of the Health Insurance Reform (Gesundheitsreformgesetz) of 1988 was to reduce the contribution rates in 1990 to about 12.7% (13.4% in 1989) and then to stabilise them. To achieve this objective and to finance some new benefits, certain existing benefits had to be curtailed or were abolished. Further the reform implies some increase in cost-sharing by consumers of health services and, more important, narrows the coverage of medical expenses to more basic services while improving incentives for preventive care. Finally the distinction between blue-collar and white-collar workers, as regards the possibility to opt for a private insurance scheme when their income exceeded a certain threshold level was abolished[21].

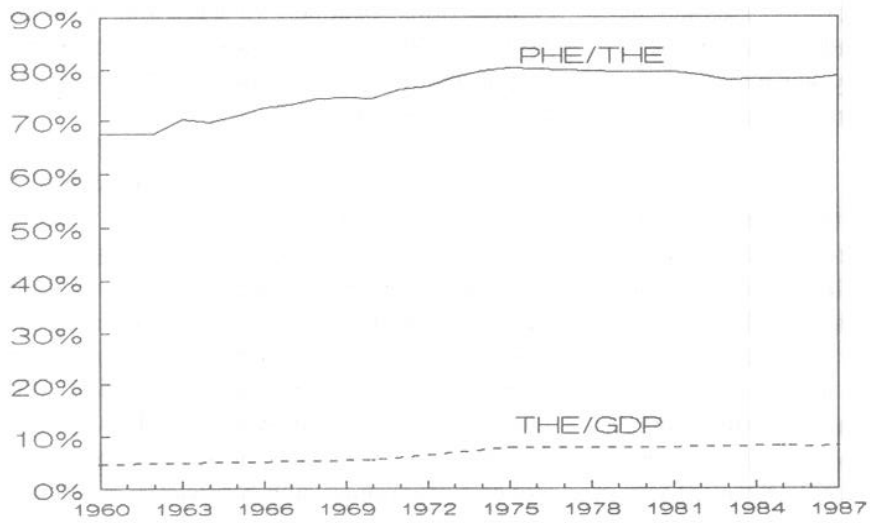



Figure 1.1. Total health expenditures (THE) as a percentage of gross domestic product (GDP) and public health expenditures (PHE) as a percentage of total health expenditures (THE) in the FRG

Source: Schieber and Poullier, 1989

The different reforms in the field of cost containment resulted in changes in the reimbursement system of the providers, the introduction of user charges, a less comprehensive compulsory insurance scheme, and a stabilisation if not a small reduction of the part of the population insured by the statutory health insurance. The last three consequences resulted in a shift from public to private resources. Experts estimate the amount of co-payments as being about 5% of the total health care expenditures of the statutory sickness funds[15]. Figure 1.1. shows that the growth of the public financed part increased from 67.5% in 1960 to 80.2% in 1975. Since that time a reduction of the publicly financed part occurred, leading to 77% in 1987.

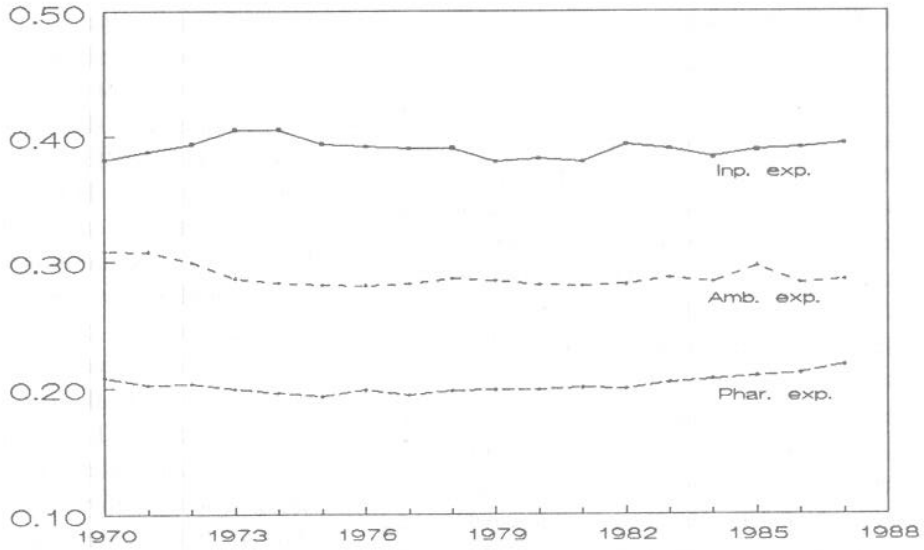
Historically the supply of health insurances is dominated by sickness funds. Until 1976 the part of the population covered by statutory health insurance was growing. Since that time there appears to be a stabilisation at the level of 90% of the population until 1981, when a structural decrease of the part of the population covered by statutory health insurance started[27]. The Health Insurance Reform of 1988, which introduced a threshold level in income for blue-collar workers, may result in a more substantial increase of the market share of private health insurance. There are no current data available on the extent of the shift.

Traditionally the supply of stationary health services is dominated by voluntary associations. By contrast the ambulatory health services are dominated by the so-called office-based physicians. Many of these physicians use very expensive diagnostic equipment and are therefore serious competitors of the hospitals. Even the very expensive MRI is available in some private practices. If we consider all ambulatory services, including dental care and pharmaceuticals as private markets, we may use the development in the distribution of expenditures between the stationary and ambulatory market as an indicator for possible forms of privatisation of the delivery of services. Figure 1.2. shows the development of the inpatient expenditures, ambulatory expenditures and the pharmaceutical expenditures as a percentage of the total health care expenditures. For the period under consideration the figure indicates a very stable distribution of the markets. Therefore we may conclude that privatisation of supply of health services is not significant in the German situation.

As a result of the establishment of prospective budgets, hospital management uses contracting out of non-medical activities to improve efficiency.

The most recent report of the Concerted Action Committee outlines future reforms. It proposes the introduction of a per capita reimbursement of general practitioners with a decreasing remuneration related to the number of patients. It also proposes the establishment of an individual degressive remuneration of the office-based

Figure 1.2. Development of share of inpatient, ambulatory and pharmaceutical expenditures in the total health care expenditures in the FRG




physicians, whereby the capital costs are no longer part of the remuneration. In addition the starting-point of the hospital budgets will be differentiated per diem rates related to diagnosis, whereby the hotel-function is reimbursed separately. None of these proposals will directly lead to privatisation. The considerations of the Concerted Action Committee on future reforms of the social insurance system do not threaten the central position of the sickness funds within the West German health care system either.

Table 2.1. summarises the empirical observations described in this section.

Table 2.1. Privatisation in German health care

| | Changes in public responsibilities and tasks | | | |
|---|---|---|---|---|
| Aspects of health care | public resp.<br>public task | public resp.<br>no public task<br>(contracting-out) | no public resp.<br>no public task<br>(termination) | private resp.<br>private task |
| Financing*: | | Increase of<br>cost-sharing<br>(amount and scope) | | |
| Insurances:<br>– coverage**<br><br><br>– benefits***<br><br>– performance****<br>(public, associational,<br>private) | | | – Reduction of<br>number of persons insured<br>publicly<br>– Limitation of<br>benefits | |
| Delivery of services:<br>– organisation (public,<br>associational, private) | | Contracting-out<br>of non-medical<br>production | | |

* Ratio of Public Health Expenditures and Total Health Expenditures
** Percentages of population
*** Qualitative
**** Market share

### 3.2. The Netherlands

With reference to the above-mentioned historical prototypes of health care systems, the Dutch system can be characterised as a combination of a social insurance and a private insurance model[2]. The insurance system is composed of three elements. Firstly, the Exceptional Medical Expenses Act (AWBZ) provides social insurance for all Dutch citizens. This compulsory insurance covers exceptional medical expenses such as stays in nursing homes or institutions for the handicapped and prolonged stays in hospitals, etc. Secondly, the Sickness Funds Insurance Act (Ziekenfondswet) covers short-term care and is compulsory for wage-earners and social security beneficiaries with an income below a certain level. About 62% of the population is compulsorily insured under the Sickness Funds Insurance Act, which is operated by the sickness funds. The premiums for both statutory medical insurances is proportional to gross income, up to a certain ceiling. The remaining 38% have to buy private insurance with risk-related premiums. They have the choice to opt out for part of their health care and pay deductibles in return for premium reductions.

In the past, the AWBZ was only operated by the sickness funds, but nowadays the private insurers join in the operation of the AWBZ. The sickness funds are organisations of the voluntary associational type.

The provision of health care facilities in the Netherlands, like the provision of health care facilities in the FRG, has a predominantly non-public character. Hospitals and other intramural institutions are voluntary associations. Physicians, hospital-based as well as office-based, and other medical professionals are working as free commercial entrepreneurs. Their turnover accounts for 29% of the total turnover of the health care sector[5]. In addition, some services such as community health services, but sometimes also hospitals are publicly owned (municipality). They account for 3% of the total health care expenditures.

Under the terms of the Hospital Facilities Act (Wet Ziekenhuisvoorzieningen) government plans the capacity and distribution of intramural health care facilities such as hospitals and nursing homes. Before 1982 all intramural facilities were reimbursed by per diem rates. Since that time a prospective budget system has been introduced. The inpatient and outpatient services of specialists are still charged separately on a fee-for-service basis. General practitioners are paid through a capitation system for publicly insured patients and on a fee-for-service basis for privately insured patients[26].

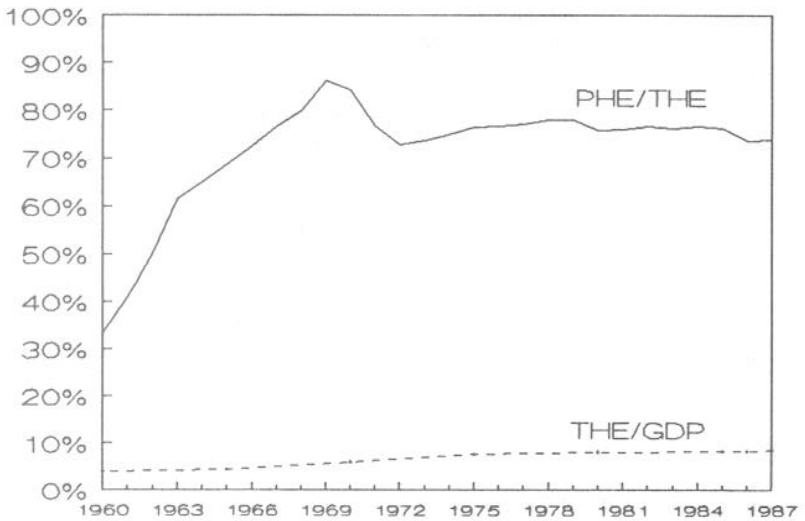



Figure 1.3. Total health care expenditures (THE) as a percentage of GDP and public health expenditures (PHE) as a percentage of total health care expenditures (THE) in the Netherlands

Source: Schieber and Poullier, 1989

Figure 1.3. shows the development of the share of total health care expenditures as a percentage of GDP and the share of public resources in the total costs of health care. This figure clearly indicates that the total health care expenditures grew relatively fast until the mid seventies, and from then on have shown a very modest growth. After a steep growth until 1969, the share of public resources increased again from 70 to 76 per cent in the period 1972-1981. Between 1981 and 1984 it stabilised at the level of 76 per cent. From 1984 on it decreased and in 1988 it reached the level of the years 1975 and 1976.

The shift from public to private resources was brought about by three factors. Firstly, the number of persons inside the social insurance was cut down. Secondly, social insurance became less comprehensive. Finally, cost-sharing was introduced in the social insurance scheme. The reduction of the number of persons insured was brought about using two policy instruments: in the first place by a relative decrease of the income level which is a condition for social insurance, and in addition by the termination of the Fund for Elderly Persons' Insurance and the Voluntary Public Insurance Scheme on April 1, 1986. The termination of these two public insurance schemes resulted in a transfer of 0.75 million insured persons from public to private insurance[5]. With regard to the different types of privatisation we can characterise the first two policies as examples of termination of public responsibility. On the other hand new forms of public regulation were introduced in the private insurance market.

The government keeps its formal responsibility when introducing cost-sharing in social insurance. Haselbekke[14] regards the introduction of the benefit principle as a form of privatisation which equals contracting out.

It will be clear that the forms of privatisation dealt with above influence the supply of insurances. It caused a reduction of the market share of the sickness funds in favour of the private insurers. At this point two remarks are in order. First, the termination of the Fund for Elderly Persons' Insurance and the Voluntary Public Insurance was accompanied by the introduction of new forms of public regulation in the private insurance market. Two new acts have been issued: the Access to Health Insurance Act (Wet Toegang Ziektekostenverzekering, WTZ) and the Co-financing Overrepresentation of the Elderly in Social Insurance Act (Wet Medefinanciering Oververtegenwoordiging Oudere Ziekenfondsverzekerden, MOOZ). The first act mainly concerns an acceptation duty for private insurers to avoid adverse selection. The second act (MOOZ) concerns a smoothening out of the unequal distribution of the higher risks related to elderly insured people between private insurers and sickness funds. Second, the sickness funds are initiating new activities on the private insurance market, causing a shift in market shares. In this way they try to limit their decreasing turnover of social insurance schemes. We may conclude that in the field of supply of insurance schemes the share of social insurance schemes is reduced substantially and therefore the market share of the voluntary associations is reduced too. The latter try to expand their market share of private insurance schemes. At the same time, the government is issuing more rules to which the private insurers have to adhere[17].

Until now the government has not taken initiatives for the privatisation of the supply of health services, nor does it stimulate efforts of commercial organisations to penetrate this market, although current policy is aimed at a more market-like behaviour of the voluntary associations. An important instrument for this purpose has been the introduction of a prospective budgeting system in 1983. The introduction of hospital budgeting included the relaxation of various public regulations of hospital finance. It gives hospital management greater freedom to make their own decisions. Hospitals have become more autonomous. For example organisations are allowed to realise 'profits' in this new financing system. This leads to the situation in which hospital management can benefit if it is able to improve efficiency and reduce costs. The prospective budget system effected a more commercial management of health services organisations. The buying in of non-medical services in stead of in-house provision, provides a clear-cut example of this new management style. Consequently we may speak of a certain kind of 'privatisation' of voluntary associations. In

brief, providers of health care have obtained more room for self-governance, and consequently they behave more and more like profit organisations.

In summary, first the decrease of the share of public resources of total health expenditures led to a decrease of the market share of the sickness funds in the insurance market. Second, the change in the reimbursement of health services led to an increase of autonomy and more market-like behaviour of the voluntary associations as providers of health services. In Table 2.2. we recapitulate the empirical observations describes in this section.

In 1986 the government announced a review of the health care system. The review was carried out by an independent committee, chaired by a former captain of industry, the so-called Dekker-committee. One of the objectives of the committee was to reduce the extent of public financing resources with another 1.2 billion Dutch guilders. The results of the review were published in 1987. One year later the government published a White Paper[6] in which it agreed with the proposals of the committee. The change of the government in 1989 implied only a slight modification of the reform.

The key features of the proposed system focus on the gradual introduction of a compulsory health insurance covering all citizens and including 95 per cent of the current public insurance package. The public insurance scheme will be financed partly (75 per cent) by an income-related premium (e.g. percentage of income) and partly (25 per cent) by a fixed premium. The income-related premium will be collected by the tax authorities and paid to a central fund, from where it will be distributed among the insurers on a specially weighted basis. The insured will pay the fixed premium directly to the insurers.

The amount of the fixed premium will vary with the number of insured persons in a family and with the presence of a deductible. Further, the sickness funds no longer have the privilege of execution of the public insurance programme. So private profit insurers will also be involved in the operation of this programme. In fact, all insurers will be obliged to provide the

Table 2.2. Privatisation in Dutch health care

| | Changes in public responsibilities and tasks | | | |
|---|---|---|---|---|
| Aspects of health care | public resp. public task | public resp. no public task (contracting-out) | no public resp. no public task (termination) | private resp. private task |
| Financing*: | | Introduction of cost-sharing | | |
| Insurances:<br>– coverage**<br>– benefits***<br>– performance**** (public, associational, private) | | | – Reduction of number of persons insured publicly<br>– Limitation of public insurance schemes | |
| Delivery of services:<br>– organisation (public, associational, private) | | Contracting-out of non-medical production | | |

* Ratio of Public Health Expenditures and Total Health Expenditures
** Percentages of population
*** Qualitative
**** Market share

basic package to any applicant. This avoids the problem of some insurers refusing high risks. The insurers are expected to compete on the basis of the fixed part of the premium of the public insurance scheme and of the premiums of the non-public, 'supplementary' insurance schemes. From these changes in the insurance market, an influence can be expected on the relations between insurers and health services organisations. The latter are not any longer protected by regulated prices or contract duty. Therefore it is expected that insurers will have more market power in buying services from the health service providers. Therefore there will be an incentive to provide services in line with demand and to shift resources where required.

In this respect, we expect a change of the market position of the sickness funds in two ways. First, the market structure for public insurance schemes has shown a movement of horizontal concentration[28]. This means that many sickness funds have merged which resulted in a territorial division of the market. Sickness funds often have a monopoly in the local market for public insurance schemes[13]. This situation will be abolished if private insurers also have the ability to sell public insurance schemes. They will then be able by cross-subsidisation to sell insurance schemes below the level of cost prices to penetrate a local market. We expect that there will be more competition on the supply side of the insurance market. A second change in the market position of the sickness funds concerns their role as buyers of health services. As a result of the mentioned market concentration process they may have monopsony power in relation to the health service providers[31]. This position will be put under pressure if private insurers succeed in getting a substantial share of the market for public insurance schemes. At present we can witness two reactions of the sickness funds. Firstly, a new merging process of sickness funds on the national level. Secondly, they start new activities in the insurance branch. The latter is a way of product diversification.

Government policies do not touch upon the position of the voluntary associations in the market for health services. Except individual health workers, no profit organisations will be permitted to operate as a provider of stationary health services. As we already mentioned, uniform price regulation and contract duty will be abolished, aiming at an increase of price competition between providers. Furthermore, the government proposes to incorporate the payments for specialist care into the hospital budget. This may be regarded as a limitation of the commercial possibilities of independent physicians.

In short, the position of the voluntary associations in the role of providers is not really threatened by profit organisations. Price competition will force the hospital management to increase efficiency. This will result in further contracting out of non-medical services to profit organisations. Voluntary associations will show more market-like behaviour. This agrees with Pauly's[23] conclusions that economic incentives are more relevant to economic behaviour than nominal ownership of an organisation.

### 3.3. United Kingdom

The British National Health Service came into operation in 1948. The NHS created a free and universally accessible public health care system, financed by general taxation. Hospitals, previously managed by local government or voluntary boards, became the responsibility of the central government. Take-overs of private hospitals did not occur[22].

In forty years the NHS has witnessed hardly any major reforms. Only in 1951, 1974 and 1982 there have been some changes. Co-payments for drug prescriptions and optical and dental treatment were introduced in 1951. Although the amounts of co-payments increased, the scope did not change. The reorganisations of 1974 and 1982 proposed changes in the administrative structure. In 1974 hospitals, family practitioners and community health services were integrated under regional and area boards. In 1982 the area level was abolished.

In some respects the year 1983 marked a break with tradition. Firstly, decentralisation was replaced by centralisation i.e. the freedom of health authorities was curtailed by central government, in an attempt to control expenditures. Secondly, the government proposed a new man-

agement style for the NHS, taking private, profit management as a model.

During the 1980's the private sector expanded. Between 1979 and 1988 the number of beds in private hospitals increased from 6.600 to 10.370. There are approximately 200 small hospitals, mostly offering acute medical care. The private sector does not provide comprehensive care[25]. Therefore it represents only a tiny part of total hospital care. By contrast, the private sector was in 1987 the largest provider of long-term care for the elderly. There are two types of private hospitals and nursing homes: non-profit charitable hospitals and profit investor-owned hospitals.

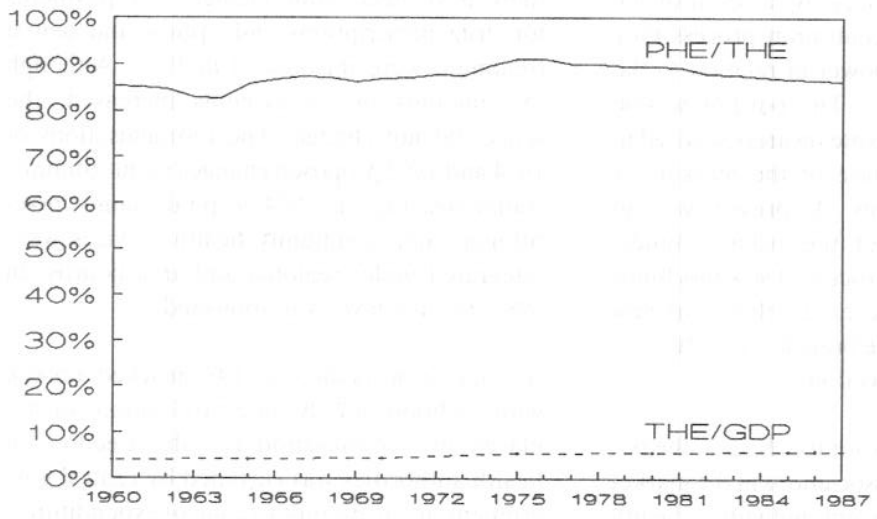
Private hospital treatment does not only occur outside the NHS. The NHS has private beds too, known as pay-beds. Since 1979, the number of pay-beds (3.000 in 1987) has decreased considerably because of the growth of private facilities outside the NHS[25].

During the last decade the proportion of the population covered by private health insurance rose from 5 to 10 per cent[8]. Private health insurance in Britain does not cover all benefits. "It is mainly a way of paying for hospital expenses and surgeon's fees"[25].

The growth of the private sector, which was not as great as expected by private providers in the beginning of the 1980's, was not so much the result of government policies, although some restrictions put on the private sector have been abolished. On the contrary, despite the rhetoric, the government hardly advanced the cause of private medicine. It has not made, for instance, private health insurance premiums tax-deductible for individual subscribers. The growth was more a reflection of changes in the socio-economic environment. People who could afford it more and more opted for either the NHS or private medicine. In addition many companies arranged for group schemes and paid the premiums for their employees[18].

"The introduction of competitive tendering in the NHS in 1983 would, at first sight, seem to provide a more clean-cut example of policy being shaped by the government's new style and ideological stance. In 1983 the DHSS decreed that cleaning, laundry, and catering services should be put to competitive tender; these account for roughly 12 per cent of the NHS's total expenditures"[8]. The effect of the decree was not spectacular. By the end of 1986 only 18 per cent went to private contractors; but it led undoubtedly to more efficiency of some in house services.

Finally the 1980's witnessed governmental concern for the lack of control over general practitioners, who determine to a considerable extent the demand for health care. In subsequent years, the government curbed the autonomy of these small entrepreneurs by limiting the prescription behaviour and strenghtening managerial control.




Source: Schieber and Poullier, 1989

Figure 1.4. Total health care expenditures (THE) as a percentage of GDP and public expenditures (PHE) as a percentage of total health care expenditures (THE) in the UK

In spite of all efforts to control public spending, total health expenditures as a percentage of GDP still rose from 5.8% in 1980 to 6.1% in 1987. This is indeed a lower rate of expansion when compared to the previous decade as shown in Figure 1.4. The small growth was not, however, enough to cover demographic and technological changes and wage increases[25]. The PH/TH rate decreased in the same period from 89.6% to 86.6%, as shown in Figure 1.4.

The comparison of the actual spending levels with the expenditures needed to meet rising demands caused a vivid debate about the underfunding of the NHS. One of the results of the debate seems to be the announcement in 1988 of a review of the NHS. The government's review "Working for Patients" was published in 1989[32].

Most striking is that the funding and administrative structure of the NHS are not to be changed. The review underwrites the existing state of affairs in this respect. "It is, rather, a design for an evolving organisation, intended to change the managerial and professional culture of the NHS"[8]. The review's main objective is to provide patients with better quality of care and greater choice of services. The two most far-reaching proposals for change are the creation of self-governing hospitals and the introduction of GP budgets for larger practices, both aiming at competition between providers. The self-governing status will allow hospitals to determine the pay of their staff and to borrow on the capital market. GP budgets mean that GPs are to be given a fixed budget, out of which they will have to buy services now provided for free by NHS hospitals. Thus hospitals have to compete for business from GPs. GPs will compete for patients because the existing restrictions on patients with regard to changing from one GP to another will be removed. The separation between the purchase of health care and its provision and the flow of resources with patient movements will lead to the creation of an internal market within the NHS[7].

Furthermore "Working for Patients" seeks to

Table 2.3. Privatisation in British health care

| | Changes in public responsibilities and tasks | | | |
|---|---|---|---|---|
| Aspects of health care | public resp.<br>public task | public resp.<br>no public task<br>(contracting-out) | no public resp.<br>no public task<br>(termination) | private resp.<br>private task |
| Financing*: | | Modest increase of cost-sharing (amounts) | | |
| Insurances:<br>– coverage**<br>– benefits***<br>– organisation****<br>(public, associational, private) | | | | Increase number of persons covered by private insurances |
| Delivery of services:<br>– organisation (public, associational, private) | | Contracting-out of non-medical hospital services | | Increase of capacity of private hospitals |

* Ratio of Public Health Expenditures and Total Health Expenditures
** Percentages of population
*** Qualitative
**** Market share

establish a clear chain of command throughout the NHS, separating political from managerial accountability, and offers tax relief on private medical insurance for retired people. The latter is in fact the only use made of private resources in order to relieve the pressure on public spending.

The outcome of the review, by general agreement the most formidable reform in the 40-year history[7] of the NHS is still uncertain. Table 2.3. summarises the main empirical observations described in this section.

### 3.4. Italy

Concerning the period before 1978 the Italian health system can be characterised as a social insurance system. It consisted of several occupational schemes, which in the mid seventies covered approximately 93% of the population. The schemes were administered by more or less independent insurance funds. Although some insurance funds had their own medical centres, basic medical assistance was mostly contracted out through agreements with private doctors, hospitals, and so on. In other words, the provision of health services relied heavily on the private sector. "Hospitals were subject to state control, but with large administrative and financial autonomy. The state itself provided public sanitation through local offices in charge of the maintenance of minimum hygienic standards"[9].

The economic growth of the 1960s gave rise to the wish to balance economic and social developments. As a result various reform plans were drawn up, amongst which health reform occupied an important position. The idea of a health reform had already been voiced by a group of influential bureaucrats and intellectuals in 1959. The reform stressed one thing in particular: the intervention of the state had to be reinforced to provide every citizen with uniform access to health care. However, it took several years before the reform came through.

The institutional change of the Italian health care system started in 1968 with the reform of the administrative and financial regulations for hospitals. It continued in 1974 with a restructuring of the hospital sector, and culminated in 1978 in the establishment of the National Health Service (Servizio Sanitario Nazionale, SSN).

The SSN replaced all occupational schemes and created a single unitary scheme with universal coverage, providing free and equal benefits to every citizen. New regional and local structures for public service provision have been created abolishing all existing regulations. The 1978 reform also aimed at a profound change in the financing of the public health sector. Premiums were to be replaced by general taxes. This change, however, never came through. Earmarked contributions still represent the most important method of financing[10].

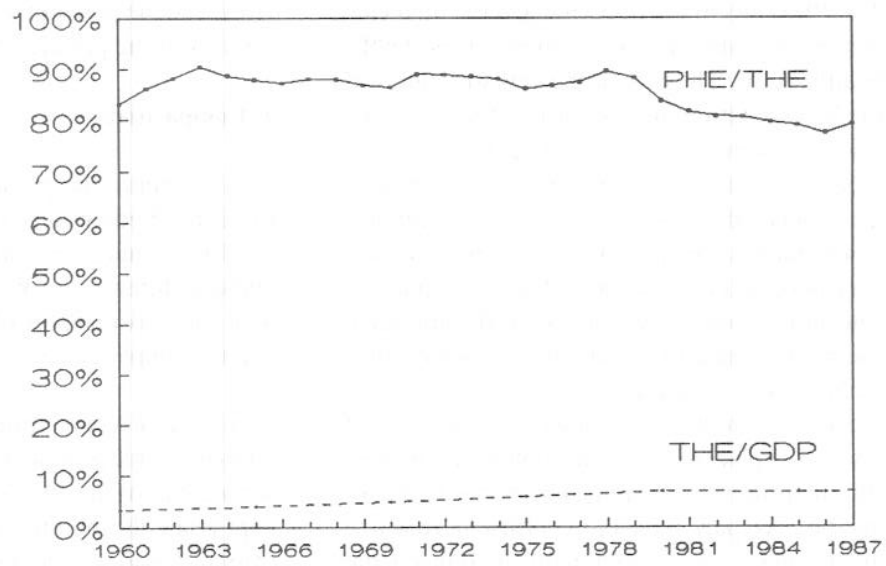
Ferrera[10] argues that a decade after its establishment, the balance sheet of the new Italian health service appears to be highly negative. He lists several shortcomings. In the first place the persistent resorting to private provision of publicly financed services, especially in the area between ambulatory and hospital care. In the second place, the failure to reorient the health system towards community care. Thirdly the political penetration into the management of the services, and finally the lack of financial control. We will pay especially attention to the financial and organisational shortcomings.

The financial deficiencies which were already obvious in the beginning caused the Italian government to revise the SSN, although the sharp increase in health expenditures (from 3.3% in 1960 till 5.8% of GDP in 1975) came to an end shortly before the establishment of the SSN as a result of the new law of 1974 which curbed the enormous growth of hospital costs.

The implementation of the SSN generated a further increase till 6.8% in 1980 due to the growth of pharmaceutical expenditures and expenditures for specialist treatment. Since then health expenditures as a percentage of the gross domestic product fluctuates between 6.6% and 6.9%.

The 1980's have witnessed a gradual introduction of demand regulation by means of cost-sharing. It started in 1978 in a very modest way with a deductible for pharmaceuticals not included in the "therapeutical catalogue". Later

Figuur 1.5. Total health care expenditures (THE) as a percentage of GDP and public expenditures (PHE) as a percentage of total health care expenditures (THE) in Italy




Source: Schieber and Poullier, 1989

cost-sharing was extended to other services, simultaneously raising the amounts. The cost-sharing policy may explain the decrease in public health expenditures as a percentage of total health expenditures. The PH/TH dropped from 82.4% in 1980 till 78.0% in 1987.

According to Ferrera,[11] the cost-sharing policy has profoundly changed the relationship between users and the SSN. The equal and free benefits in the original approach have been replaced by benefits with co-payments, meaning a shift from public to private financial resources of the SSN.

Table 2.4. Privatisation in Italian health care

| | Changes in public responsibilities and tasks | | | |
|---|---|---|---|---|
| Aspects of health care | public resp.<br>public task | public resp.<br>no public task<br>(contracting-out) | no public resp.<br>no public task<br>(termination) | private resp.<br>private task |
| Financing*: | | Increase of<br>cost-sharing<br>(amount and scope) | | |
| Insurances:<br>– coverage**<br><br>– benefits***<br><br>– performance****<br>(public, associational,<br>private) | | | | Increase number<br>of persons covered<br>by private insurances |
| Delivery of services:<br>– organisation (public,<br>associational, private) | | | | |

* Ratio of Public Health Expenditures and Total Health Expenditures
** Percentages of population
*** Qualitative
**** Market share

The 1978 reform not only changed the financing system, but also the organisation of the public health sector. The core of the new structure was the local health unit, responsible for the provision and administration of health services in areas comprising 50.000-200.000 inhabitants, and managed by elected political committees. Consequently management performance was very poor and the standard of service very low. The latter is one of the reasons for the growth of the market share of private insurers which offer additional or even full coverage.

Since the mid 1980's, however, a process of gradual replacement of the politicised leadership by professional management has been going on. As part of a more efficient resource management, the government announced the possibility of disconnecting larger hospitals from the local health units, giving them more autonomy. Even privatisation is not excluded.

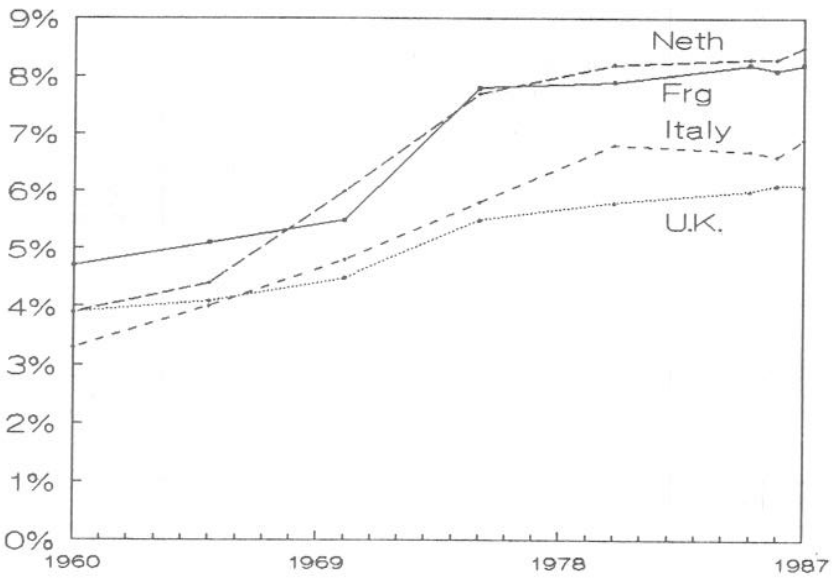
Table 2.4. recapitulates the empirical observations described above. The debate on the future of the SSN still continues. In September 1989 the government presented a draft concerning the reform of the SSN. The government proposes, among other things, the introduction of a regional budget, the transformation of local health units into more or less autonomous public agencies for service provision, the transformation of larger hospitals into self-governing hospitals, contracting out of certain public services, and the possibility for patients to purchase services in the private sector[11].

## 4. Comparisons

If we compare the privatisation policies of the FRG, the Netherlands, the UK and Italy during the 1980's there are common factors, but also marked differences. We will deal successively with the privatisation of financing, insurances and the supply of services.

Total health expenditures as a percentage of gross domestic product rose considerably till the second half of the 1970's in all four countries. It kept rising during the 1980's but to a far lesser extent, due to cost containment policies, as can be seen in Figure 2.1. During the last year of the period under consideration in all countries the total health expenditures tends to increase slightly faster than during the rest of the 1980's.

Figure 2.2. shows that the public health expenditures as a percentage of total health expenditures has been in general reasonably stable for the past 20 years. However, in all countries there has been a small shift from public to private resources since the end of the seventies. In this respect Italy shows a stronger decrease of the PHE/THE ratio than the other countries under consideration.




Source: Schieber and Poullier, 1989

Figure 2.1. Total health expenditures (THE) as a percentage of gross domestic product (GDP)