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THE ROLE OF THE PRIVATE SECTOR AND PRIVATIZATION IN EUROPEAN HEALTH SYSTEMS

Many Member States in the Region are looking at the role of the private sector and privatization in the context of the reform of their health systems. This document explores current developments in this field, addresses two elements central to the debate (definitions of terms and the role of the values and ideology), outlines existing evidence and highlights the importance of government stewardship. Its ultimate purpose is to address how WHO can assist Member States in providing evidence and through direct country support.

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Background

1. Many countries in the WHO European Region are looking at the role of the private sector and privatization in the context of reforms to their health care systems. Technological developments, ageing populations and increasing public expectations all create demand for increased health care expenditure, while the macroeconomic context exerts pressure to reduce public sector deficits. In response, Member States have developed reform strategies which seek to increase the cost-effective allocation of resources and promote efficiency while maintaining solidarity in funding services *(1,2)*. The increasing interest in the role of the private sector must be understood both in this broader reform context and as part of the debate on how to contain costs and increase efficiency without compromising standards in order to achieve a financially sustainable, high quality health care system.

2. Privatization of the financing of health and social care is seen as a means of decreasing public expenditure by shifting costs from the public purse to the individual consumer. Measures such as introducing or increasing private (voluntary) insurance, out-of-pocket payments and cost-sharing, and reducing the package of publicly-provided services are intended to moderate demand and provide resources for health care that governments do not have to raise through taxation or insurance. Privatization of the provision of services is in part linked to a wider belief that public sector bureaucracies are inefficient and unresponsive and their objectives subject to capture by those who work for them. It is expected, therefore, that market mechanisms will promote efficiency and ensure cost-effective, good quality and responsive services.

3. Policy-makers face a series of predicaments when having to decide on the appropriate role of the public and private sectors in health care. There is very real conceptual confusion and a lack of clear definitions about what is meant by “privatization”, “the private sector” or indeed “the public sector”. For instance, privatization is often used when there might more properly be a discussion about entrepreneurial behaviour or the application of market mechanisms in the public sector. Also, the distinction between private-for-profit, private-not-for-profit and self-employment is frequently blurred. A wide range of mechanisms is included under the private sector banner even though they have very different implications.

4. In addition, there is too little evidence about the actual impact of these mechanisms on societal goals. In particular, we know relatively little about how new models of the public and private mix of provision are functioning. Perhaps as a result of this lack of evidence, the debate about the role of the public and private sectors in health care is chiefly held on ideological grounds, so that privatization has become one of the most controversial and value-laden terms in the European health reform lexicon. Proponents, trumpeting the benefits of privatization, put it forward as a “magic pill” that will cure all the “ills” of the health care system. Opponents vilify privatization and associate it with personal greed and the end of social solidarity. The debate is often fierce yet there is surprisingly little clarity and the evidence on the implications of private sector involvement in health is uneven at best. Ironically, while much of the debate about the superiority of predominantly public or predominantly private models is highly charged ideologically, there is little explicit recognition of this or of the values that underpin health services arrangements.

5. The situation is further complicated by the variety of ways in which different countries across the European Region relate to private involvement in health. In western European countries with social health insurance systems, the private sector has traditionally played a central role in the delivery of health services which is largely unquestioned. In northern and southern European countries with national health services, reforms have been spurred by the failures of the command-and-control approach that has traditionally characterized government management of publicly owned and operated entities. Thus, in these countries reforms aim to increase entrepreneurialism within the public sector. They allow for services to be purchased from the private sector with public money and generally confer a more significant role on the private sector (both not-for-profit and for-profit) in service delivery.

6. In the countries of central and eastern Europe (CCEE) and the newly independent states (NIS), the fall of the former communist systems and public disappointment with highly centralized, low quality and unresponsive official bureaucracies, coupled in some instances with difficulties in raising taxes, has led to the initiation of wide-scale privatization programmes throughout their economies. In health care there is a marked trend towards social health insurance systems, with an increased role for private providers especially in pharmaceuticals and primary care. In addition, in some countries there is an implicit privatization of financing due to a lack of public funding and a pronounced reliance on out-of pocket (informal) payments.

7. These conceptual uncertainties, the ideologically highly charged debate, the lack of evidence on impact and substantial regional differences pose a challenge for decision-makers.

8. This document seeks to provide some conceptual precision and marshal the evidence base by exploring briefly current developments in the role of the public and private sectors in European health systems. Its main aim is to identify key issues and ascertain how WHO can assist Member States by providing evidence and through direct country support. The first two sections address two central elements in this debate, the definitions and the role of values. Next, it outlines existing evidence on trends and impact before highlighting the importance of stewardship by governments. Finally, it explores the role of WHO in supporting Member States.

9. The paper draws on existing evidence from the European Observatory on Health Care Systems, including the Health Systems in Transition (HiT) country profiles and relevant Observatory studies in key areas such as funding, purchasing or regulation, as well as on evidence from other WHO programmes, country work and external sources.

What defines “private” and what does not

10. The word “private” as used in the health field is difficult to characterize, and private elements take many and complex forms. Increasingly, new initiatives are establishing complex cross-boundary arrangements that cannot be easily classified as either public or private. There is a need, therefore, for social actors to have a shared understanding of what is meant by the public and private sectors and to set up a definitional framework to serve as a compass through the conceptual jungle of privatization.

11. The central notion behind the concept of a private sector in health care is deceptively simple: it consists of *the private ownership of health care assets*. Privatization, then, is *the transfer of public assets to private ownership*, where assets are the infrastructure of the health care system, its buildings, equipment and the control of its resources and functions. This definition, or rather its simplicity, may help to clarify the terminological confusion that has suffused national health policy debates because it allows policy-makers to separate private ownership from the organizational and management features that are often associated with it but are not inherently a part of it.

12. The focus on ownership allows the role of the private sector and privatization schemes to be distinguished from the broader issues of entrepreneurial behaviour within the health sector. Privatization would clearly be one strategy to encourage “entrepreneurialism” but it should not be confused with it. Entrepreneurialism embraces a wider range of market-inspired efforts to stimulate service innovation and increase quality and efficiency, whether in the public or private health sectors. It includes the introduction of strategies such as performance-related payment systems, internal markets, the corporatization of public providers, provider choice, and the contracting and transfer of services and functions to the private sector *(3)*. Privatization constitutes only one of many approaches to entrepreneurialism.

13. So, if privatization is seen as a strategy to introduce market competition it will not necessarily deliver. Private ownership does not per se involve the existence of competitive forces, and privatization is not therefore an automatic step towards harnessing the benefits of competition. There are numerous examples of large privately-owned corporations that are monopolistic and do not engage in competition.

Conversely, public entities can compete among themselves or in an open market, as they do for hospital contracts in Finland, Sweden and the United Kingdom.

14. Furthermore, private ownership and privatization are structurally distinct from, rather than precursors to, initiatives designed to encourage more independent management of hospitals and primary health centres. Such initiatives revolve around organizational models such as "autonomization" or "corporatization" and involve a switch in the role of government from command-and-control to a steer-and-channel approach. They often take the form of self governing hospital trusts or public firms. It is important to underline that these models refer only to managerial status. The providers concerned continue to be publicly owned and there is no transfer of assets, thus no privatization. This, of course, does not resolve the issues of management, efficiency and responsiveness that need to be addressed.

Values and ideology

15. Much of the tension in the debate about the roles of the public and private sectors is rooted in the political values and ideology of the protagonists. Clarity about terminology and what is or is not private can help policy-makers to focus on the issues. The evidence that is available can illustrate the consequences of a given model. However, there is no single "scientific" and "rational" solution to most policy dilemmas. There is a point when countries will simply choose the approach to privatization that they prefer.

16. It is unavoidable that this choice will be political and that some groups will pursue privatization on solely ideological grounds. However, privatization in the health field should not be an end in itself, but should be discussed as a means to achieve a desired end consistent with the values of each society. This requires that the objectives of each society are determined and the roles of ideology, culture and values are made explicit.

17. Countries have different sets of health objectives and place different priorities on these objectives. They require health system strategies that are tailored to their own cultural and historical contexts and are designed to achieve their specific societal goals. The type and scope of private health care in a country ought therefore to be assessed in terms of that country's objectives and its strategy for the whole health care sector. The appropriateness of the private sector can then be tested against the extent to which it can effectively assist in achieving the agreed objective *(4)*.

18. Inevitably policy-makers will have to engage in a continuous attempt to balance competing demands. They will need to make trade-offs between various societal goals such as free choice of provider or equity of access and cost-containment. This is not a straightforward proposition. We should recognize the difficulties for decision-makers in taking this kind of very explicit choice. Nevertheless, the debate on the role of the private sector and privatization and its balance with the public sector will only move forward when ideologies and values can be oriented towards priorities and the trade-offs between objectives rather than on the instruments to achieve them.

19. A decision-making framework is needed in which the identification of societal objectives is made more explicit at the outset. Only then can an assessment be made of the effectiveness of the private sector and privatization strategies (among other possible options) in achieving these objectives. The assessment must include in its understanding of effectiveness the impact on health gain, equity, cost-containment, technical and allocative efficiency and consumer responsiveness. This framework should help Member States to assess the evidence without precluding the role of ideology and policy judgement and enable them to make decisions that reflect the values of their societies.

20. While policy-makers in Member States will make decisions according to their individual societal values, the values and principles put forward by WHO are clear. WHO advocates a series of core principles including solidarity, health attainment, equity and responsiveness to consumers *(5,6)*.

Experience and evidence

21. It is not possible in a short paper to include a comprehensive review of existing evidence in this field, and indeed the evidence is somewhat patchy. Rather, this section will give an overview of the range of experience in the European Region and single out the main lessons emerging from the evidence on trends in and the impact of the private sector in European health systems. The section follows the widely used distinction between the role of the private sector in funding and in the provision of health services.

Private funding

22. Most health systems in Europe rely on a mix of public and private funding but despite recent increases in the share of private sources, most funding still comes from taxation and social health insurance, except in some NIS. The main sources of private funding are private (or voluntary) health insurance and out-of-pocket payments including direct payments, formal cost-sharing and informal payments. In those NIS where there is a heavy reliance on private funding the shortfall in prepaid sources of revenue is made up from out-of-pocket (predominantly informal) payments. In western Europe, only Greece, Italy, Portugal and Switzerland draw 30% or more of total health expenditure from private sources (mostly out-of-pocket payments). In all European countries apart from France and the Netherlands, out-of-pocket payments form a larger proportion of private health expenditure than private (or voluntary) health insurance *(7)*.

Private health insurance

23. As noted above, private insurance does not play a dominant role as a main source of funding for health care in the European Region. European Member States have traditionally tried to preserve the principle of health care funded by state or social (compulsory) health insurance for every citizen, regardless of ability to pay. Evidence from countries outside the Region such as the United States is unambiguous. When private health insurance is voluntary, without adequate regulation, it will fail to meet societal objectives, not only in terms of values such as equity and access to care but also as regards cost-containment and efficiency. Even with regulation, there is compelling evidence that it is not an efficient or equitable way of funding health care *(8)*.

24. Private health insurance can, however, can play a role in countries such as Switzerland where insurance is compulsory and is provided by public and private insurers. Since 1996, all permanent residents in Switzerland have been legally obliged to purchase health insurance from a limited number of insurers (whether public or private). Insurers must register with the Federal Office for Social Insurance, which monitors their activities and scrutinizes their accounts. Insurance companies are not allowed to make profits from their compulsory insurance activities and contributions are community-rated.

25. Private health insurance may be substitutive, supplementary or complementary. *Substitutive insurance* is an alternative to statutory (or public) insurance and is for sections of the population who are excluded from public cover or who are allowed to opt out of the public system. It has a relatively limited role in Germany and the Netherlands, where individuals with high incomes may purchase substitutive health insurance. As income is related to the risk of ill health, the separation of public and private insurance along income lines will concentrate those with a high risk in the public system. This makes the combination of funding mechanisms regressive.

26. Private health insurance in Europe mostly takes the form of *complementary insurance* and covers services that are excluded (or not fully covered) by the statutory sector, or *supplementary insurance* to ensure faster access and increased consumer choice. While there are important differences across the Region, there is no clear evidence of Member States favouring an expansion of voluntary health insurance. Coverage remains low in many countries, even where people make substantial out-of-pocket payments to health care providers. There are some exceptions, such as France, where supplementary health insurance is supported by the government and coverage is very high. The evidence available in the CCEE and NIS is limited, but the role of voluntary insurance in these countries is even smaller than in

western Europe. On the whole, where the boundaries between public and private health care are not clearly defined, private (complementary or supplementary) health insurance may have a negative impact on the wider health care system. It may be at odds with societal objectives, increasing inequality in terms of access and even undermining efforts to improve efficiency *(9)*.

Out-of-pocket payments

27. Out-of-pocket payments include all costs met by the consumer, including direct payments, formal cost-sharing and informal payments.

28. *Direct payments* are made for services not covered by the public system or to which access is limited. They are usually made in the private sector and are often to dentists, pharmacists (for over-the-counter or de-listed drugs), laboratories or physicians and hospitals for private treatment. Private health expenditure is tax-deductible in some countries of the Region, which provides incentives for individuals to seek private care and in effect delivers quite significant subsidies to the private sector.

29. Proponents of *cost-sharing* or *user charges* claim that charging patients reduces the unnecessary demand for services overall and raises revenue to expand service provision. There are wide variations between countries, but across the Region as a whole formal user charges form a relatively small (but increasing) percentage of overall expenditure. In western Europe, about half the countries use some form of cost-sharing for first contact care, and about half apply cost-sharing to outpatient care. However, charges tend to be nominal and are often accompanied by exemptions for vulnerable populations. Only a few countries rely on cost-sharing as a significant source of health sector revenue, and in most of these (for example France and Slovenia) patients purchase supplementary insurance to defray out-of-pocket spending. The only exception to this general pattern is the widespread use of cost-sharing for pharmaceuticals, although here too vulnerable populations are typically buffered against undue costs. Several CCEE and NIS introduced formal cost-sharing arrangements in the 1990s as part of their new social health insurance systems. As in western Europe, charges are relatively low for ambulatory, specialist and hospital care and there are exemptions for vulnerable groups. User charges are widespread for pharmaceuticals and represent a sizeable proportion of pharmaceutical expenditure.

30. The evidence suggests that cost-sharing is a weak instrument for improving efficiency and for containing health care costs. The providers heavily determine the demand for health services, and service intensity (which is also provider-driven) is a key influence on health care costs. Cost-sharing, which can only reduce consumer-initiated utilization, is not therefore the most effective tool for cost-containment. Without compensatory administrative procedures and exemptions, cost-sharing also has detrimental effects on the equity and financing of health services. In spite of these objections, policy-makers continue to use cost-sharing widely, in large part for political and ideological reasons. Difficulties in increasing and/or collecting tax and social insurance payments have contributed to the appeal of cost-sharing as a means of raising much needed revenue for the health sector. In summary, cost-sharing is likely to be used to generate additional revenue or to discourage utilization at the margins, but is unlikely to become a major policy instrument in its own right *(10,11)*.

31. *Informal payments* take a number of forms and may exist for a number of reasons. These payments or gifts may reflect the national culture, or stem from a lack of finances to pay health care workers or to provide drugs and basic equipment to treat patients, or they may be rooted in the lack of a formal private sector. They may be due to weak governance and at their worst are a form of corruption which undermines official payment systems and reduces access to health services *(12)*. Data on the extent of informal payments in a selection of eastern European countries suggest that they are widespread in both ambulatory and hospital care, and in a small number of NIS they form the largest source of funding. The evidence suggests that formalizing payments and establishing systems of pre-payment (or insurance) is extremely difficult and requires government and technical capacity and the recognition of external constraints *(13)*.

32. On the whole, the evidence shows that when payment for health services is linked to need and service utilization in the form of out-of-pocket payments, it will have negative consequences over health outcomes and equity unless it is accompanied by wide exemption measures for vulnerable populations. The recent *World health report 2000* on health systems performance makes a good case for moving health funding from out-of-pocket payments to forms of pre-payment (based on taxation or insurance) linked to income rather than to health risk *(4)*. Private health insurance will also have a negative impact on access when it forms the main source of coverage in a voluntary health insurance environment. However, when insurance is compulsory and well regulated, it may play a role as a provider of statutory insurance as well as of substitutive, supplementary or complementary insurance.

Private provision

33. Private provision includes a number of notions: the private ownership of facilities in which services are delivered; the private delivery of services; the privatization of employment with job contracts shifting into the private sector; and the contracting out of hotel and other services. Again, many of the concepts are poorly defined and overlap. There is an ideological dimension too in whether or not a self-employed family practitioner working under contract and paid by public funds is seen as a private entity or a public servant. The evidence suggests that these distinctions can cloud but do not obscure the fundamental debates about ownership, privatization as a means to achieve efficiency, and the trade-offs between various societal objectives.

34. In reviewing the role of the private sector in provision we need to distinguish between the private not-for-profit sector that includes nongovernmental organizations as well as community-based, religious and charitable institutions which are mission-driven, and the private for-profit sector, which incorporates small businesses, e.g. pharmacies or dental practices as well as large shareholder-owned corporations.

35. Certainly, the strongest levels of private provision across the Region are in dental care and pharmaceuticals. The advantages of the private over the public sector, particularly in pharmaceuticals, are relatively uncontroversial and are accepted by many Member States. During the 1990s, the private sector also increased its role in the most important and expensive areas of hospitals, primary care and social and home care.

Hospitals

36. In national health service (NHS)-based systems in northern Europe (i.e. the Scandinavian countries and the United Kingdom), hospitals are almost entirely public with less than 10% of private beds. The percentage of private hospital beds is higher in southern European countries with NHS systems, and in Italy, Portugal and Spain the share of private beds is between 20% and 30%, about half of them being private for-profit. In the CCEE and NIS, most hospitals are public and are usually owned by the local government or, less frequently, by the national government.

37. There have been a number of changes in hospital organization that have come as a response to the introduction of a purchaser-provider split *(14)* both in a number of NHS and in those CCEE and NIS that have recently adopted social health insurance models. Most changes have focused on increasing governance and autonomy, and moving from command and control (or budgetary units) to more independent forms of organization. There is a range of models that includes autonomous, corporatized and privatized institutions. The underlying aim of these changes is to provide a context within which these various forms of self-governing hospitals can compete with each other and with the private sector for contracts from purchasers, e.g. insurers or health authorities. It should be noted that it has been less common for these organizational transitions to lead to a change in ownership and privatization.

38. There is some evidence showing that these more independent forms of hospital organization (autonomous or corporatized institutions) are more cost-effective than the traditional command and control forms of organization. There is little evidence, however, about the additional advantages or disadvantages provided by moving towards the private ownership of hospital organizations.

39. Another related form of private sector involvement, which has played a particularly important role in the hospital sector, is the contracting out of support services such as hotel and diagnostic services. In many instances, these have proved to have lower direct costs than when they were publicly provided, although the implications for the health sector workforce should also feature in the equation.

40. In western European countries with social health insurance systems, hospitals are also mainly public, but the share of private beds (mostly not-for-profit) is larger than in countries with NHS systems, amounting to about a third of total bed numbers. This figure gives a broad sense of the share of beds but there are wide variations between countries: in France, for example, the share of private for-profit beds is approximately 20% and takes second place after the number of public beds (65%). Only in the Netherlands are most hospitals legally constituted as private not-for-profit entities. Due to the natural purchaser-provider split in these countries, all public hospitals have a certain degree of managerial independence and take autonomous and often corporatized institutional forms *(15–17)*.

41. The role of the private sector in hospital provision is accepted and is often scarcely distinguishable from the highly decentralized forms of public sector hospitals. There is, however, some debate about whether private-for-profit institutions are more or less cost-effective than not-for-profit ones. Shareholders expect returns on their investment in for-profit institutions and this may offset gains in efficiency. Also, it may exert a negative impact on quality, for instance by forcing hospitals to cut corners on skills.

Primary care

42. Ambulatory/primary care is often multidimensional and delivered by physicians working on their own or in partnership with other physicians and/or other health care professionals in their own premises or from government-owned premises and polyclinics. Thus, in primary care the differentiation between public and private is less clear-cut and we distinguish between public employees, those self-employed under contract to the public sector, and private entrepreneurs operating independently of the public sector.

43. In general, in countries with social insurance systems general practitioners (GPs) are self-employed working under contract and paid by fee-for-service, while in national health care systems they can be either self-employed (United Kingdom) or salaried public employees (Finland and Portugal). The past decade has seen increased entrepreneurialism in public primary care. In many countries GPs have a growing degree of autonomy while remaining within the public system. There have also been a number of innovations in private primary care, which uses increasingly diverse models including individual professionals, partnerships, cooperatives, networks, voluntary organizations, self-help groups and commercial firms. Lumping all of them together under “private” obscures important differences. These different actors pursue different goals and respond to different incentives. Again, the experience on the impact of these models is varied and it is not possible to provide a single diagnosis as to the superiority of one model over another. A re-conceptualization is necessary, replacing the idea of undifferentiated providers with more discriminating categories for further study and evaluation *(18)*.

44. In the CCEE and NIS, GPs used to be public employees but are increasingly becoming self-employed working under contract with the new sickness funds and employing their own practice nurses. The numbers who have actually switched from state employment to independent practice differ widely between countries and only preliminary evidence is available on the impact of these changes. In a number of cases, preliminary analysis has shown improvements in efficiency, quality or responsiveness. The experience does demonstrate nonetheless that privatization has important implications that must be considered *ex ante*. For example, the sudden privatization of primary care can be shown to have introduced competition among general practitioners before professional values had developed to serve as a countervailing power to personal interests *(19)*. Stepwise approaches to transition may therefore be preferable to rapid, wholesale changes.

Social and home care

45. In social and home care there are a number of entrepreneurial experiments that involve the state or the insurer making payments to the individuals, who can then spend the funds on various public or private for-profit or not-for-profit services (Denmark, Germany or the Netherlands). As a result, the role of private sector provision has increased significantly in this sector. Experience to date has shown both positive and negative results and has uncovered considerable implications for the structure and regulation of social services.

Mixed models

46. This preliminary review of private provision shows an increase of what has been characterized as the "melting of public-private boundaries" *(20)* with a series of new schemes that combine public and private elements and where the boundaries between public and private entities are closely intertwined. For instance, a model that has raised some expectations is the franchising of public hospitals to private management. Another example is that of public sector hospitals borrowing funds from the private sector for infrastructure development under the Private Finance Initiative in the United Kingdom.

47. The amount and scope of experimentation with private sector involvement and privatization is considerable, but there is still too little evidence about its impact on health care provision and even less about the implications of these new forms of public-private partnership. Overall, the case for privately-owned providers being more efficient than public sector providers, particularly when there is a level playing field between sectors, has yet to be proved. There are, however, many instances where private ownership has been seen to increase efficiency. There is also evidence of problems that are generated when private providers are poorly regulated.

Exercising government stewardship

48. Policy-makers' responses to the elements of private funding and private provision will be tempered by ideology and values but must also reflect the evidence available. Experiments with private involvement in health are already taking place and WHO must therefore help to equip national governments to respond. The concept of stewardship as defined in *The world health report 2000 (5)* addresses directly the responsibility of Member States for oversight of their health systems. It has three main components: (i) health policy formulation – defining the vision and direction for the health system; (ii) regulation – setting fair rules of the game with a level playing field; and (iii) intelligence – assessing performance and sharing information. Stewardship must also be highly ethical in the values it pursues, and highly efficient in the use of resources.

49. Recent experience with privatization and the evidence examined show clearly that if private sector models are to succeed, there will be a need for a strong regulatory, managerial and information capacity that is not currently available in many Member States. If the stewardship role of the government is weak, and regardless of the merits or otherwise of particular models, privatization will inevitably create severe new problems for a society.

50. Good stewardship requires the construction of a robust regulatory framework. To ensure that both the ethical and the efficiency requirements of stewardship are met, this regulatory framework needs to restrict private market activities when they risk damaging essential health policy objectives *(21)*. So there must be regulation that restricts individual entrepreneurial behaviour in order to facilitate sustainable markets. In Germany, for example, increased competition since 1989 for subscribers by sickness funds has been accompanied by an increasingly strict set of retrospective and collective risk adjustment mechanisms, to ensure that adverse selection does not destabilize the long-term financial stability of funds with higher percentages of elderly, unemployed or chronically ill subscribers *(22)*.

51. Second, there must be regulation that restricts individual entrepreneurial behaviour so as to protect core societal objectives in such areas as public health and safety, access, social cohesion and quality of

care. The wide variety of regulatory mechanisms in Member States that, for instance, require community-based rather than experience-based rating for insurance companies, or that mandate delivery of appropriate services to all patients, or that require accreditation of hospitals and providers, are cases in point.

52. Successfully constructing and implementing this regulatory framework requires that a number of organizational prerequisites be met. These include adequate information about the activities of all health care providers and appropriate monitoring of provider behaviour. Good stewardship requires that privatized as well as public providers be held to the same high performance standards.

The way forward

53. The private sector is acquiring increasing importance in health systems in many Member States and generating powerful policy dilemmas. WHO is well placed to focus the attention of policy-makers on the key elements that require consideration in determining the most appropriate public-private mix of services. Four fundamental points arising from this paper are summarized here.

54. First, decision-makers should not look at the role of the private sector and privatization in isolation but rather at the most appropriate mix of public and private involvement in different sectors of the health system in the context of their impact on societal goals. The issue, therefore, is not only what parts of the health services are best served by privatizing ownership but also in which instances privately-owned services should be moved into public ownership.

55. Second, policy-makers need to have a clear understanding of what is meant by the private sector, i.e. private ownership of health care assets, and appreciate that this does not necessarily involve the presence of competitive and/or entrepreneurial behaviour, nor increases in efficiency.

56. Third, the debate on the role of the private and public sectors can only progress when the (necessary) political deliberations around societal values, ideology and trade-offs are disentangled and a rigorous assessment of the evidence on the actual impact of private sector models on those societal values is undertaken. There is a need for a decision-making framework that allows the evidence to be assessed without precluding the key role of ideology and policy judgement.

57. Fourth, while the results from the review of the evidence are not consistent across all Member States – and while this highlights the importance of differing health system and country contexts – a key point does emerge from the review. The privatization of funding, by introducing private voluntary insurance and/or by increasing out-of-pocket payments, including cost-sharing or under-the-table payments, has a negative impact on solidarity, decreases the access of underprivileged groups to care and worsens health outcomes. On the provider side, while the private sector has traditionally played a significant role in pharmaceuticals and dental care, there has been much innovation. This has been particularly marked in primary care, social and home care, and in the contracting out of hotel and diagnostic services with varying results. There also seems to be a melting of boundaries, with care providers incorporating both public and private characteristics. Overall, however, the evidence about the functioning and impact of these models is scarce. It is clear, though, that privatization can only succeed in meeting societal objectives when the state exercises a strong stewardship role.

58. The WHO secretariat is seeking guidance about how best it can support its Member States in this policy arena. In the light of the above, three areas for possible action are put forward for consideration by the Regional Committee.

- While respecting diverse societal values in Member States, WHO should strongly advocate the goals of solidarity, equity and efficiency in the health system. It should advocate evidence-based decision-making as regards the shifting of services between the public and private spheres, and

assist Member States in ensuring that any changes are supported by appropriate leadership and stewardship.

- WHO should continue to strengthen its capacity to assess health systems in general and the private sector in particular, and continue to disseminate the results in a way that helps policy-making. In this context, and in the light of the scarcity of evidence on private provision models, it is suggested that WHO conduct an in-depth study in this field that draws on the fullest possible evidence and engages actively with public and private provider networks as well as expert and academic analysts to secure that evidence.
- WHO should support Member States in building capacity for effective and vigorous stewardship of the public and private sectors and in pursuing a vision which sees government as above all else protecting the public interest.

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