Health Systems

Privatization – a balancing act

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The author examines the potential advantages and drawbacks of privatization and shows how governments are obliged to continue playing a major part in the health sector so that equity and other social goals are not abandoned.

Privatization is a process in which non-governmental actors become increasingly involved in the financing and/or provision of health care services and in which changes occur in public and private roles and responsibilities. The term is often loosely applied to policies intended to encourage competition or market-like behaviour in the public sector; performance-related payment mechanisms and policies designed to give patients a choice of providers are in this category. However, such policies are not necessarily accompanied by changes in the ultimate responsibility for the financing and provision of services.

The private sector includes not only health workers in private practice but also non-governmental organizations, mission organizations, voluntary associations and other groups. The objectives and incentives of its not-for-profit subsector differ in some respects from those of the for-profit subsector. Indeed, the behaviour of providers in the not-for-profit subsector may have much in common with that of public sector providers. Because the survival of providers in both private subsectors is not guaranteed, however, they are more likely to be concerned with efficiency and resource management than are providers in the public sector.

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Why privatize?

One of the main reasons why countries seek more active involvement of the private sector in health is the perception that it is free from the administrative and political constraints commonly associated with public bureaucracies: privatization is seen as a way to improve resource management and increase the efficiency and effectiveness with which services are delivered. It is also argued that privatization leads increased numbers of people to seek care outside the public sector, thus releasing scarce state resources to provide services for the poor. However, this depends on the extent to which government money is needed to monitor private activity and enforce compliance with official standards.

There has been a widespread move from central decision-making towards an acceptance of market economics, with the result that the presence of government in many sectors has shrunk. The role of government in the health sector is changing markedly in some countries and privatization is rapidly taking shape. It is

commonly assumed that the introduction of competition and incentives is bound to lead to improvements in the quality of service. In the private provision of health services, however, the quality of care is often in delicate balance

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with the objectives of efficiency and resource generation, and it is therefore conceivable that efforts to improve the quality of service could be compromised by considerations of cost containment and/or profitability.

If government actively encourages growth of the private sector the process can be termed active privatization. Passive privatization, on the other hand, does not involve official influence of this kind.

Approaches to active privatization

Policies aimed at increasing the involvement of the private sector in the financing and provision of health care can result in complex relationships between the private and public sectors. Because of the difficulty of assessing the ultimate impact of active privatization on health status, evaluation of the process should focus on its contribution to interim policy objectives such as care of satisfactory quality, equitable access to services, efficient resource use, and the generation of additional resources.

Divestiture of public assets

In the strictest sense, privatization involves public assets being transferred to private owners. The primary objective of such divestiture is to reduce the scale of government commitments.

The Czech Republic is planning to transfer 70% of hospital beds to the private sector by 1996, and is encouraging the development of private health insurance schemes. Although divestiture can be expected to reduce public sector financing there is already evidence that health care costs are increasing rapidly. Moreover, private insurance companies are beginning to compete on the basis of patient selection, and this could diminish equity. In China many village health centres were sold and converted to private clinics during the 1980s. The rural health care system is thought to have deteriorated, and questions have been raised on the extent to which privatization has led to a decline in the health status of poor people in the affected areas. Adverse effects on equity may have resulted from a failure to maintain financial "safety nets". Having recognized this problem, the government of China has in recent years taken steps to improve the health status of the rural poor.

Public contracting for private provision

Perhaps the commonest and most flexible form of active privatization involves shifting partial or complete responsibility for the provision of health care services to the private sector, while the responsibility for financing remains with the public sector, the aim being to improve the productivity of public resources. Arrangements of this kind with for-profit providers have long existed for laundry, catering and other non-clinical services, and contracts with such providers in the fields of preventive and curative health care are becoming more common.

- In Namibia surgical care is sometimes provided in rural areas by teams of private general practitioners working under contract to the Ministry of Health. Although the service has been reasonably successful in containing costs there is

evidence of general practitioners giving better care to their private patients than to those covered by contracts.

- In Zimbabwe, contracts have been drawn up between the Ministry of Health and hospitals in mining areas for the provision of services to eligible populations.
- In the United Kingdom some 30 different clinical services have been contracted to the for-profit subsector.
- Some countries use social security funds to pay providers in the for-profit subsector. In Chile, beneficiaries of the National Health Fund use a wide range of public or private providers and receive a standard government contribution to the cost of care through a system of vouchers. Consumers who are registered with the National Health Service System are entitled to free care in public facilities but may also elect to receive a voucher, obtain care in the private sector, and pay any additional costs themselves.

Contracts with the for-profit subsector potentially increase access to health services for disadvantaged groups in so far as increased availability is encouraged. There is little evidence that improvements in equity have been achieved, but gains in efficiency seem more probable. The potential for cost containment and quality improvement through contracting is maximized where there is competition for contracts. Countries with poorly developed private provider markets are therefore unlikely to realize the full potential of service contracting.

In the not-for-profit subsector there is a long history of providing both curative and preventive services, usually with government support, which may include subsidies in the form of lump sums, the secondment of health personnel, and salary grants. Incentives are often provided as tax concessions on imports of equipment and drugs, rights of purchasing from government stores, and the payment of employees' retirement benefits. There is scope for improving equity through the development of more formal contracts between governments and not-for-profit providers, which are usually nongovernmental organizations. These bodies frequently establish health facilities in areas where these are not provided by the state. In return for some form of government subsidy, disadvantaged groups can be given access to essential services.

Incentives and regulatory stimulation

Another approach to active privatization involves government encouragement of the financing and provision of health services by the private sector. In Mozambique and Tanzania, laws and regulations banning or restricting private practice have been repealed, and an effort is being made to develop incentives for private initiatives supporting the aims of public policy. One form of incentive is to allow private sector activity in public sector facilities. Medical staff in Mozambique are allowed to run private clinics in government facilities outside normal working hours. In Indonesia, Mexico, Tanzania, Zimbabwe and other countries there are private beds in public hospitals. In these ways private funding sources pay for some health services that would otherwise be financed with public money.

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Other incentives include tax breaks, as with the duty-free importation of medical supplies, and bonus payments for doctors working in underserved areas. In Ethiopia, private providers can purchase drugs and some medical supplies from government sources, thus benefiting from the lower prices associated with bulk buying. Indonesia, Nigeria and Zimbabwe offer tax relief to not-for-profit providers, and in Mexico there is tax relief for certain categories of private health expenditure. Such measures not only stimulate the growth of private capacity but also encourage increases in private expenditure on health care.

User charges in the public sector shift some of the responsibility for financing health care to private sources and stimulate the private sector through price competition. The encouragement of private health insurance can also shift financing towards the private sector and may induce people to use private providers. The public sector may continue to provide the bulk of health care services in both of these circumstances.

Incentives may give rise to a range of problems.

- Rapid increases may occur in the numbers of people engaged in private practice, and monitoring is required in order to ensure that acceptable standards are maintained.
- It is necessary to guard against the neglect of public patients where private practice is allowed in public facilities.
- Where tax relief is given for private insurance contributions or private health expenditure, inequity may result if, in effect, subsidies are being given to those most able to pay *(1)*.

These and other potential difficulties mean that policies designed to favour the growth of the private sector should be developed and implemented cautiously. Where privatization is being encouraged, government is likely to become increasingly involved in regulation and monitoring.

Passive privatization

Passive privatization may occur where a tolerant regulatory environment coexists with tight budgetary constraints and/or a falling quality of service in the public sector, in which circumstances skilled personnel may move to the private sector. It can also take place where rapid economic growth causes the demand for health care to outstrip the quantity, and perhaps the quality, of services provided in the public sector.

In major urban areas of China and India there is often a rapid growth in private pharmacies, maternity clinics, specialized clinics and small private hospitals. The quality of care is a major concern, particularly if public monitoring and regulatory capacity do not keep pace with the expansion of the private sector.

Social objectives

The private sector is often skilled in resource mobilization and management, it tends to be comparatively flexible in its operations, and to some extent it can avoid political obstacles that delay innovation *(1)*. This does not imply that government should withdraw from the health sector. Successful management of changes in the roles of the public and private sectors depends on clearly expressed aims for privatization policies and on sensitive and specific regulatory mechanisms.

The production and distribution of goods and services in an uncontrolled private market reflect the distribution of income. If there are no restrictions on the pricing of health services and if competition fails to keep prices

down or quality high, poor and vulnerable populations may be denied affordable and equitable access to care. A government role in health care is therefore needed to ensure the attainment of equity and other social goals.

The development of public policies towards the private sector requires investment in information systems that can generate data on resource flows and performance in both the public and private sectors (2). The organizations charged with managing the health sector should have the capacity – including flexible and responsive structures – to monitor and motivate the private sector so that social goals are achieved. It is also necessary to strengthen management skills, particularly those connected with establishing and supervising contracts.

This brief review shows that while there may be advantages to privatization, there are limits to the scale on which private finance and service provision can grow without conflicting with public objectives of acceptable access to health care through cost-effective services. Each of the forms of privatization described above reflects a different trend, and will necessitate different policy responses. Multilateral and bilateral health development agencies must continue to support governments in performing new roles to ensure equitable access to health care of the best possible quality from the resources available. ■

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References

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