The Privatization of Health Care in Europe: An Eight-Country Analysis

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Abstract This article presents an analysis of recent changes in the public-private mix in health care in eight European countries. The leading question is to what extent a process of privatization in health care can be observed. The framework for the analysis of privatization draws on the idea that there are multiple public/private boundaries in health care. The overall picture that emerges from our analysis is diverse, but there is evidence that health care in Europe has become somewhat more private. The growth of the public fraction in health care spending has come to an end since the 1980s, and in a few countries the private fraction even increased substantially. We also found some evidence for a shift from public to private in health care provision. Furthermore, there are signs of privatization in health care management and operations, as well as investments. Specific attention is spent on the identification of factors that push privatization forward and factors that work as a barrier to privatization.

The history of health care in Europe during the nineteenth and twentieth centuries can be depicted in terms of an ever-extending state involvement (Flora 1986; Rogers Hollingsworth, Hage, and Hanneman 1990; Glaser 1991). Particularly in the twentieth century, everywhere in Europe the state began to assume political responsibility for large parts of health care. The creation of the "health care state" (Moran 1999) was the result of a gradual extension of the scope of state intervention through legislative measures and other state programs concerning a variety of issues, including the legal protection of the medical profession and patients, the quality of health care, access to health care, the payment of medical doctors and other provider agents, the organization of health services delivery, and

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so on. More or less as a universal trend, health care throughout Europe entered into what may be called the *public domain*. A by-product of this development was the rollback of the private sector in health care spending and, in some countries, health care provision.

The "socialization" of health care did not follow an identical pattern in each country. As we will see later in more detail, health care in Europe features remarkable differences in what may be termed the *public-private mix*. For instance, in 2002 the public fraction in health care spending ranged from 85.3 percent in Sweden to 57.9 percent in Switzerland (Organisation of Economic Co-operation and Development [OECD] 2005). Whereas France developed a sizable for-profit hospital sector—in 2000, 20 percent of all beds for medicine, surgery, and obstetrics were in private for-profit hospitals (Bellanger 2004)—such hospitals remained largely absent in most other European countries or were even forbidden in health legislation as was the case in, for instance, the Netherlands.

This article investigates the impact of what may be termed *modern reform programs* on the public-private mix in European health care. All over Europe, governments have started such programs over the last twenty-five years, including the introduction of market elements in health care financing and/or provision, the enhancement of the scope of private practice or for-profit medicine, the closure of public hospitals, the reduction in the list of publicly funded health services, the extension of cost sharing, the introduction of performance-related payment schemes, the reconstruction of the role of state and private agents in health care, and many other programs (Saltman and Figueras 1997; Harrison 2004). The main policy challenge of these programs was to curb the rise of public health care spending while retaining universal access to basic health services and further improving the quality of care. Our leading question is to investigate how modern reform programs have been influencing the public-private mix in European health care and, in particular, to what extent they have been triggering a process of *privatization*, resulting in a health care system with fewer public and more private elements.

Assuming a relationship between privatization and modern health care reform does not imply that reform programs are modeled as the only factor explaining privatization. Any model that conceptualizes privatization as a purely reform-driven activity fails to account for the complexity of privatization. Therefore, we also briefly examine the influence of other factors on privatization.

The study of the public-private mix and privatization in health care is not new. There are several recent studies on this topic. For instance, Øvretveit

(2001) compared the public-private mix in the Northern Countries (Iceland, Norway, Sweden, Denmark, and Finland) and concluded that there are more private elements in these systems than is often assumed. Interestingly, these elements also tend to extend, though not at large scale. Tuohy, Flood, and Stabile (2004) investigated the impact of private financing on publicly funded health care systems in five countries (Australia, Canada, New Zealand, the Netherlands, and the United Kingdom) that exemplify different ways of drawing the public/private boundary. They concluded, among other things, that private parallel systems do not reduce waiting times and waiting lists in public systems and that changes in the level of public spending are not significant either with system satisfaction or with support for increased public expenditure. They also explored the public-private relationship in health care financing over a longer period. Using data over the period 1980–1997, they cautiously claimed some empirical evidence for the hypothesis that increases in private spending on health care are followed by declines in public spending.[1] Other comparative studies were edited recently by Maynard (2005a); Keen, Light, and Mays (2001); and Maarse (2004a). A very critical analysis of what she called the privatization of the National Health Service in the United Kingdom was published by Pollock (2004).

This article adopts a comparative perspective by analyzing changes in the public-private mix in eight European countries. Four of them—Belgium, Germany, the Netherlands, and France—feature a social health insurance scheme in health care financing and a mix of public and private provider agents in health care provision. They belong to the category of the so-called *Bismarck* countries, named after German Chancellor Bismarck, who introduced social health insurance in the late nineteenth century. Three other countries selected—Denmark, Sweden, and the United Kingdom—finance health care mainly by tax resources. Hospital care in these countries is largely in the hands of public provider agents. Ambulatory care is provided by either public or private agents or a combination of both. These countries will be referred to as countries with a *public health service* model (the U.K. model is often referred to as the *Beveridge* model). The eighth country selected is Poland, which developed its own version of the public health service model—the so-called *Semashko* model—after it had become part of the Soviet-dominated part of Europe. Before the fall of the Berlin Wall in 1989, health care in Poland

1. All OECD countries are included in this analysis, with the exception of Luxembourg and Iceland.

was highly centralized and subject to strong political control. Health care facilities were state owned and managed by district and regional authorities. Government taxes were the prime source of financing (Marrée and Groenewegen 1997).

The distinction between the Bismarck model and the public health service model is important for our analysis, because health care financing and provision will be conceptualized as important dimensions of privatization in health care (see the next section). The sample of countries gives us the opportunity to compare the pattern of privatization in countries with a Bismarck model with the pattern in countries with a public health service model.

In summary, the purpose of this article is to present a comparative analysis of health system changes in European health care from a specific theoretical perspective—the perspective of privatization. Our interest is not only to describe these changes, but also to search for explanations. The evaluation of their impact, for instance, on the efficiency and accessibility of health care or its quality, falls largely beyond the scope of our analysis. Our analysis fits in a number of recent comparative studies on health system change (e.g., Freeman [2000], Giaimo [2002], Harrison [2004]) and a recent special issue of the *Journal of Health Politics, Policy and Law* (Oliver and Mossialos [2005]).

The study of privatization in health care requires a conceptual framework to unravel its complexity and multidimensionality. What is privatization? What do the concepts *public* and *private* mean? What is the public-private mix in health care? Which models of privatization exist? How can privatization be distinguished from related concepts such as market competition or decentralization? The following section outlines an analytical framework.

The Concept of Privatization

Whatever definition chosen, the concept of privatization always rests on a notion of public and private. The meaning of both concepts, however, is far from clear. In fact, various intellectual traditions exist in defining public and private. Economists, for instance, tend to equate the public sector with the state[2] and the private sector with the market. A sociological

2. The *state* is conceptualized here as the formal political institution in society in charge of the pursuit of public interests. The *government* is the public agent fulfilling the role of the state in practice.

type of distinction between public and private is to associate private with private life and public with the world outside private life. Whereas private life is characterized by a high degree of closeness as expressed by the concept of privacy, public life features a high degree of openness. Sociologists do not associate public with the state and private with the market. These conceptualizations indicate that a single dividing line between public and private does not exist, but depends on the theoretical perspective taken (Starr 1982; Weintraub and Kumar 1997).

Another problem with the distinction between public and private is that a clear dividing line does not exist, regardless of how the distinction is conceptualized. As we will see later in more detail, the distinction is often ambiguous. For instance, associating the public sector with state agents raises the question of how to deal with agents that formally do not belong to the state hierarchy but in practice operate very close to it. The sickness funds in Belgium and the Netherlands are private not-for-profit agents but, as the implementing agencies of social health insurance legislation, are intimately involved in state activity. For that reason, they are often considered part of the public sector in health care. Two decades ago, Hood (1986) coined the term "hidden public sector" to describe the position of these quasi-public task agencies in the public sector. His concept clearly illustrates the absence of a sharp demarcation line between the public and private sectors.

Note that the boundary lines of private agents are not clear either because of public regulations. France has indeed many for-profit hospitals, but they are subject to extensive government regulation on tariff setting after the introduction of a collective cap in the early 1990s. Thus portraying the for-profit hospitals as a purely private entity the activities of which are only market driven is highly misleading. In fact, one may argue that purely private agents do not exist because they are always embedded in a system of public regulation that determines the scope for private activity (Letza, Smallman, and Sun 2004). Private health insurance presents another area where private agents are often bound to extensive public regulations; for instance, on the benefit catalog (material scope), requirements for contract renewal, portability, and risk rating (Colombo and Tapay 2004).

The boundary lines between public and private are not static either but continuously shifting (Rose 1989). As a result of increasing interaction between public and private agents, they may even largely melt (Saltman 2003). National conventions also influence the meaning of public and private. For instance, in Germany, it is common to reserve the term *private hospital sector* solely for for-profit hospitals. Private not-for-profit

hospitals that were established by religious or other community groups are placed between the public and private sectors. In the Netherlands, the term *private activities* is usually associated with health services that are excluded from public funding. In the United Kingdom, it is common to depict the private sector as the *independent sector* to express its separate position from the National Health Service.

The absence of a clear and commonly accepted demarcation line between public and private has implications for the concept of privatization. If one describes privatization broadly as any shift from public to private or as "the act of reducing the role of the government or increasing the role of the private institutions of society in satisfying people's needs" (Savas 2000), its concrete meaning depends on the conceptualization of public and private. Missing a clear-cut dividing line also proves to be a rich source of confusion and misunderstanding on privatization and its impact on, for instance, efficiency, accessibility, and quality of care.

In this article, we follow a pragmatic approach by investigating privatization from four different perspectives: health care financing, health care provision, health care management and operations and, finally, health care investment. Each section starts with a brief discussion of how the concepts public and private as well as privatization are concretely interpreted. Our approach rests on the idea that there is no single public-private boundary in health care. Instead, there are multiple boundaries leading to different public-private mixes (see also Tuohy, Flood, and Stabile 2004). Looking at privatization in health care from different perspectives yields not only a more complete picture of privatization, but also highlights that the picture of privatization varies with the perspective taken.

To elaborate the concept of privatization a little bit further, it is helpful to introduce a few distinctions. The first distinction is policy-driven privatization and privatization that is driven by other factors than public policy (Starr 1982). Privatization is *policy driven* when it is the result of purposive government action. The government pursues a policy of privatization, for instance, to make health care more efficient and consumer driven or to enhance individual responsibility. Examples of policy-driven privatization are delisting, introducing cost-sharing arrangements, transforming public provider organizations into private organizations, contracting out health care management and operations to the private sector, or giving private investors more room for commercial activity in health care. Policy-driven privatization is based on the claim that private structures perform better than public structures.

Not all privatization is policy driven. It may also be brought about by

spontaneous or unorganized processes in society. For instance, technological innovation may facilitate a change from inpatient to outpatient care, which often creates more opportunity for private practice (*technology-driven* privatization). *Demand-led* privatization may develop as a social response to public failures; for instance, when long waiting times in public hospitals induce a demand for private services. The consumers' belief that the clinical quality of private health services is superior to the quality provided in a public setting may also provoke demand-led privatization. In a similar way, privatization may be the result of the elite's demand for a more or less exclusive (parallel) structure in health care.

A second helpful distinction is that between termination and contracting out (Vickers and Yarrow 1988). *Termination* means that the government reduces the scope of public intervention. Tasks and responsibilities that were formerly defined as a public responsibility are shifted to the private sector. Restricting the material and/or personal scope of public arrangements in health care financing is a good example of privatization by termination. When *contracting out* or *outsourcing*, the government does not reduce the scope of public intervention, but contracts with private agents to accomplish public tasks. In contrast with termination, the government retains its political responsibility. Thus privatization by contracting out is less radical than privatization by termination. The strategy of contracting out was frequently followed in countries with a Bismarck type of health care system: to increase the legitimacy of social health insurance legislation, the government deliberately built upon the preexisting structure of private sickness funds that were charged with the implementation of public health insurance programs. In a similar way, the government outsourced the provision of hospital care to private agents in return for public funding. More recent examples are contracts of public hospitals with private agents for the delivery of laundry, catering, security, and administrative services or contracts of public funding authorities with private provider organizations to shorten waiting periods. Both termination and contracting belong analytically to the category of policy-driven privatization.

A third distinction refers to the locus of decision making. One approach is that the national or federal government takes the lead. Examples of *top-down* privatization are national government decisions to delist health services, extend cost sharing, or enact legislation on privatization. Decisions to privatize can also be taken at a lower administrative level, for instance, when public hospitals contract with private companies to outsource operational activities or when local governments privatize local public hospitals to relieve their budgetary problems. *Bottom-up* privatization may not fit

into a national policy framework for privatization and prompt the national government to take policy measures to revoke or discourage privatization that in its view conflicts with national policy objectives.

It is useful to distinguish privatization analytically from *liberalization* (Starr 1982) or market competition, because there are many examples of privatization without market exposure. In these cases, former public agents continue their activities as a private monopolist. Public regulations, too, may impose severe restrictions on a privatized entity to operate as a market player. However, privatization without market exposure may turn out to be a first but essential step to market competition.

Privatization must also be distinguished analytically from *decentralization*. A transfer of decision rights from the national to the regional or local level or the devolution of decision rights from public to (semi-)independent administrative agents falls beyond the scope of privatization (Starr 1982). Decentralization is, unlike privatization, not a boundary-crossing process but a development inside the public sector. Nevertheless, decentralization or *autonomization* may turn out to be a precursor of privatization. For instance, the transformation of budgetary hospitals into autonomized or even corporatized agents[3] (Preker and Harding 2003) as is presently occurring in many European countries may be regarded as a first step to privatization of hospital care. In a similar way, one may view the introduction of an internal market in countries with a public health service as the starting point of a process of "hidden" privatization.

The latter two points lead to a more general observation. It is too simple to conceptualize privatization as a simple dichotomy between public and private. Such a conceptualization would not only ignore the gray area between public and private but also disregard the evolutionary character of privatization. It is useful to introduce the notion of a continuum ranging from precursors of privatization to moderate forms of privatization to radical forms of privatization. The notion of a continuum concept reminds us that privatization can be shaped differently and that structural changes within the public sector may eventually appear a precursor of privatization at a later point of time.

3. In the terminology of Harding and Preker (2003), budgetary provider organizations have little autonomy, are funded by public budgets, cannot retain a budget surplus (a deficit is covered by the public authority), lack market exposure, and are subject to hierarchical supervision by the public authority. Corporatized provider organizations have considerable autonomy, are funded by performance-related methods, can retain a budget surplus, may be exposed to market competition, and are supervised by the public authorities by means of management contracts. Autonomized organizations have an intermediate position between budgetary and autonomized organizations.

Privatization in Health Care Financing

To what extent can a shift from public to private financing arrangements be observed in the eight countries selected? Privatization in health care financing is an important policy issue because of its potential impact on the accessibility of health care. The primary objective of the extension of the scope of public arrangements in health care financing in the twentieth century was to guarantee access to health care for all citizens. Esping-Andersen (1990) coined the term *decommodification* to describe the stepwise transformation of health care from a market commodity into a nonmarket commodity. The larger the private fraction in spending, the more health care will regain its former character of a market commodity. Precisely for this reason privatization appears a contested policy issue in many countries. Opponents to privatization consider it a step toward less solidarity in health care, whereas advocates of privatization see it as a necessary step to making health care financing sustainable in the future. In their view, solidarity arrangements have gone too far in the past and should be redressed to a more reasonable level. Opponents to privatization also cast serious doubt on its presumed impact on efficiency. They argue that it may have the opposite effect and cause further escalation of health care expenditures.

Privatization in health care financing is measured here in monetary terms as a shift from public to private spending or, more concretely, as a decrease in the public fraction in health care spending (or an increase in the fraction of private spending). This indicator of privatization requires a clarification of the concepts of public and private spending. According to the OECD (2000), *public* spending in health care includes all government expenditures for health care (national, regional, local, etc.) and all expenditures of agencies, whatever their legal status, implementing compulsory health insurance programs. In other words, public spending refers to tax funding and funding by compulsory income-related contributions for health care. Health care expenditures of private health insurers, private enterprises, households, and a few other agents are classified as *private*.[4]

4. The OECD uses a functional approach to define the boundaries of health care (OECD 2000). *Functional* means that activities must pertain to the goals or purposes of health care. The following functions are included: (1) personal health services and goods (curative care, rehabilitative care, long-term nursing care, ancillary services, and medical goods dispensed to outpatients); (2) collective health services (prevention and public health services, and health administration), and (3) health-related functions (capital formation; education and training of health personnel; research and development in health, food, hygiene, and drinking-water control; environmental health; administration and provision of social services in kind to assist

The dividing line between public and private financing is often ambiguous. This is well illustrated by the hybrid concept of private social health insurance, a terminological convention to classify those social programs "where the policyholder is obliged or encouraged by the intervention of a third party but which is—unlike social security funds—not under the direct control of general government" (ibid.: 72). Health insurance schemes set up for government personnel only, as exist, for instance, in the Netherlands, are classified as private social health insurance schemes. The new legislation on complementary health insurance in France (Couverture Médicale Universelle Complémentaire [CMUC]) presents another example of fuzzy public-private boundaries. CMUC blurs the traditional distinction between statutory health insurance (public) and complementary health insurance (private), because it ensures access to complementary health insurance for all citizens, outlaws "cream skimming" by the insurance companies and regulates that the premiums of the very poor must be borne by the rest of the population by means of a compulsory solidarity arrangement (Buechmueller et al. 2004).

Figure 1 presents an overview of the public fraction in health care spending in 2003 in the eight countries selected. The data clearly indicate that health care spending in 2003 was highly redistributive in all countries, but particularly in those countries that use tax funding as their primary instrument for health care financing. Only the Netherlands has a relatively low score. A high public fraction indicates that the rich cofinance for the poor (income solidarity) and the healthy cofinance for the unhealthy (risk solidarity) (Maarse and Paulus 2003). Solidarity can still be regarded as the cornerstone of the "moral infrastructure" (Hinrichs 1995: 670) of health care financing in Europe.

Note that the public (and private) fraction in health care spending varies with the type of health care. For instance, more detailed research (not presented here) indicates a higher fraction in inpatient care than in pharmaceutical care: whereas the public fraction in inpatient care in the eight countries selected averaged 76.1 percent in 2002, it was "only" 55.2 percent in pharmaceutical care. Dental care is another sector in health care where one usually finds a high degree of private spending (e.g., 70 percent in Denmark).

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living with disease and impairment; and administration and provision of health-related cash benefits). See Van Mosseveld (2003) for a critical overview of international comparisons of health care expenditures.

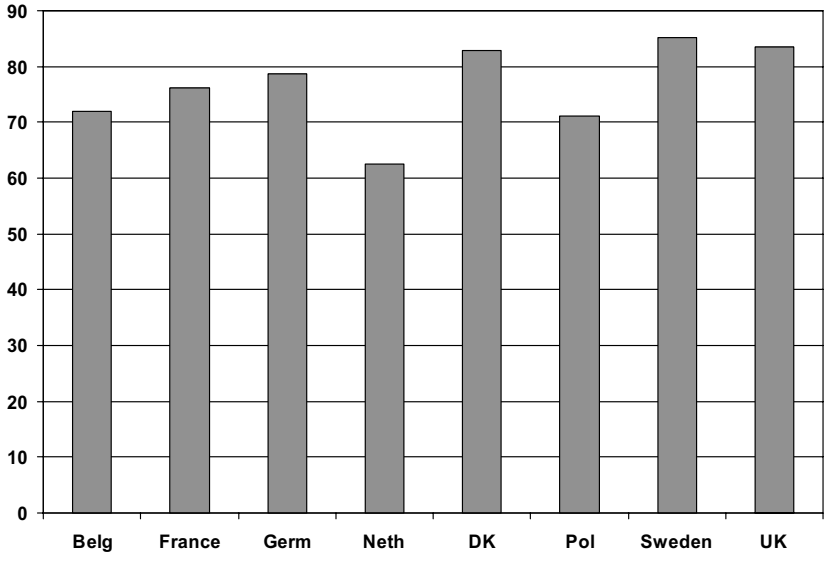

Figure 1 Fraction of Public Health Care Spending (Percentages), 2003. *Source*: OECD 2005; Poullier 2004.

Figure 1 by definition implies a low private fraction in health care spending; that is, the role of private (voluntary) health insurance arrangements and out-of-pocket payments in health care spending is restricted in the eight countries selected. Public financing arrangements cover in most countries the entire population and a wide range of health services. Germany and particularly the Netherlands are the only countries where a substantial part of the population is covered by a substitutive[5] private arrangement (approximately 10 percent in Germany and 33 percent in the Netherlands).[6] The relatively low public fraction of health care spending in the Netherlands is associated with the high percentage of persons with private insurance. Private complementary health insurance arrangements covering the costs of health services that are excluded from public funding or copayments are only relevant in the four *Bismarck countries* (Belgium, France, Germany, and the Netherlands) and to some extent in Denmark,

5. Substitute private health insurance must be distinguished from complementary and supplementary health insurance.

6. The traditional distinction between people with social health insurance and private health insurance will disappear after the new health insurance law comes into effect in 2006.

as well, where they provide extended access to elective health services (Pedersen 2005). Nevertheless, the role of complementary health insurance as a supportive arrangement for public arrangements in health care financing is still limited (Mossialos and Thomson 2004; Colombo and Tapay 2004). In the United Kingdom, just over 11 percent of the population has a private scheme to get access to private (independent) health care facilities (Maynard 2005b). This percentage has remained more or less stable over the period 1990–2002 (Higgins 2004).

Out-of-pocket payments (copayments, self-payment, and so on) also play a restricted role in financing, although there is substantial variation, not only between countries but also between health care sectors. For instance, in 2000, the fraction of private payments varied from 6 percent in the Netherlands (Maarse and Okma 2004) to 19 percent in Belgium (Kesenne, Alosse, and Leonard 2004). Kawiorska (2004) reported that private expenditures accounted for 26.4 percent of health care expenditures in Poland in 1999.[7] Out-of-pocket payments are usually higher in outpatient care than in inpatient care.

How did the public fraction in health care spending change over time and, in particular, to what extent can a trend toward privatization be observed? Table 1 highlights that a substantial fraction of health care spending was already public in 1970. With the exception of the Netherlands, it was more than 70 percent in each country for which data are available. In countries with tax funding, the public fraction even exceeded the 80 percent level.

Furthermore, table 1 shows an increase in the public fraction over the period 1970–1980: the average fraction grew from 77.5 percent in 1970 to 83.0 percent in 1980. We find no significant differences here between countries with tax funding and countries where social health insurance is used as the primary tool for health care financing. The rise of the public fraction was associated with the introduction of new public arrangements in health care financing and further extensions of the material and personal scope of public arrangements already in place.

Finally, table 1 suggests that in six of the eight countries selected, the growth of the public fraction in health care spending has come to an end. With two exceptions (Belgium and Poland), the general pattern is

7. Note that these percentages are not taken from OECD (2005) health data but from country sources. They may differ from the OECD figures because of variations in national accounting procedures for health care spending.

Table 1 Evolution in Health Care Spending, Percentage Points, 1970–2002

Country	Fraction Public Spending, 1970 (%)	Change in % Points 1970–1980	1980–1990	1990–2002
Belgium	NA	NA	NA	–14.3
France	75.5	6.1	–4.4	–0.7
Germany	72.8	8.1	–3.2	3.1
Netherlands	60.2	15.3	–3.3	–6.9
Denmark	83.7	4.9	–5.8	0.2
Poland	NA	NA	NA	–22.4
Sweden	86	7.6	–2.8	–5.3
United Kingdom	87	2.8	–6.5	–0.2

Source: OECD 2005
NA = not available

that of an incremental decline of the public fraction that is interpreted as privatization in health care financing. Government policies that may have effected this type of privatization include, among others, expenditure cuts in public spending, the introduction of cost-sharing arrangements, and the implementation of restrictions in the health services package (*basket*) of public financing arrangements.

A relatively high degree of privatization is observed in Belgium. Though there seems to be some uncertainty about the accuracy on the data for Belgium, this finding is in accordance with the observation of Belgium commentators who have argued in recent studies that health care spending in Belgium features a process of "creeping privatization." For instance, a recent study by the National Association of the Christian Mutualities found that private payments for a hospital stay had increased by 12.8 percent over the period 1998–2000 (from Kesenne, Alosse, and Leonard 2004). Another cause of rising private spending lies in the growing practice of extra billing by physicians.

Poland presents the second notable exception to the general pattern. The reform of the health care system after the fall of the Berlin Wall in 1989 seems to be associated with an increase in out-of-pocket payments for health care. Various Polish studies conclude that the burden of household spending has risen considerably. For instance, the fraction of private spending measured as a percentage of gross domestic product (GDP) had increased from 1.6 percent in 1993 to 1.8 percent in 2000 (Wlodarczyk

2004). Out-of-pocket payments ranged from 1.2 percent in hospital expenditures to 32.7 percent in expenditures for ambulatory care and 59.4 percent in expenditures for medical goods (Kawiorska 2004).

Our observation that privatization in health care spending has been limited in six of the eight countries selected seems to contrast with the experience of many people in these countries that their private expenditures for health care have significantly risen. Absolute private spending for health care indeed increased considerably. However, public expenditures for health care also increased considerably over the same period due to medical inflation and further extensions of the scope of public financing arrangements. Perhaps with the exception of Poland, there is little evidence for a crowding-out effect of an increase in private spending on public spending (Tuohy, Flood, and Stabile 2004). A hypothesis for explaining the "privatization illusion" is that the growth of private spending was concentrated in ambulatory care and was less pronounced in inpatient care (hospital care, long-term care, etc.). Because most people only "consume" ambulatory health services, they tend to believe that health care spending has become more private.

Privatization in Health Care Provision

This section investigates changes in the public-private mix in health care provision. Our focus is on hospital care, some primary care services (family medicine, dental care, and outpatient pharmacy), and residential care for the elderly. The main type of privatization is when the ownership of a provider organization is shifted from a public to a private agent that operates on either a not-for-profit or for-profit (commercial) basis.

Privatization in health care provision often appears to be a contested policy issue in health care policy making in the countries selected. Many politicians reject this type of privatization because of private failures. Privatization implies a growing government dependency on the private sector that undermines its capability to achieve public goals in health care. Private agents will also manage to exploit the public sector by shifting costs to public hospitals and other public providers; for instance, by picking out the most attractive patients (*cherry picking*). Privatization is further expected to have adverse consequences for cost control and the accessibility of health services. Advocates of privatization contend that private provider organizations perform better than public organizations. Their claim of the superiority of private ownership over public ownership is underlined by the

modern public choice and property rights perspectives in neo-institutional economics (Martin and Parker 1997; Villalonga 2000).

An analysis of privatization in health care provision in the four Bismarck countries yields a diverse picture. In the Netherlands, almost all hospital and residential care is provided by private not-for-profit organizations. Many hospitals were once owned by public agents, in particular local governments, but were converted into private entities before 1990. For-profit medicine hardly exists, because social health insurance legislation has always excluded commercial medicine from public funding. The few private clinics could hardly survive economically due to "unfriendly" government regulation. Family medicine, dental care, and pharmacy are provided in private practice. There has been little privatization in the 1990s. A new but still small-scale phenomenon is the advent of a few investor-owned private clinics (e.g., eye clinics) that deliver health services for which patients must pay privately. Not-for-profit provider organizations have also established subsidiaries for private initiatives. A remarkable element of the ongoing market reform is that the traditional ban on commercial hospital and residential care will be lifted.

The public-private mix of health care provision in Belgium differs in several respects from that in the Netherlands. Whereas family medicine, dental care, and pharmacy are organized in private practice, hospital care is provided by a mix of public and private not-for-profit hospitals. In 2000, Belgium had 77 private general hospitals among a total of 122 hospitals, and 22 private specialized hospitals among a total of 35 hospitals (Kesenne, Alosse, and Leonard 2004). The number of public hospitals has declined over the last two decades, mainly as a by-product of mergers between public and private hospitals. An advantage of private hospitals over public hospitals is greater flexibility due to fewer political and bureaucratic constraints. Residential care features a mix of public and private elements. In 2000, 26 percent of all provider organizations were public, 26 percent had an ASBL status[8] (private not-for-profit), and 48 percent operated on a for-profit basis (ibid.). Social health insurance covers only the costs of residential care in for-profit organizations but not the costs of living.

A remarkable feature of the public-private mix in French health care is concerned with the prominent role of for-profit hospital care. In 2000,

8. ASBL means Association Sans But Lucratif (Association without Commercial Purpose).

about 38 percent of the hospitals were for-profit, 32 percent were public, and 30 percent were private not-for-profit. For-profit hospitals outnumber public hospitals, but most of for-profit hospitals have fewer beds (eighty beds on average compared to four hundred beds in public hospitals), which explains why the share of for-profit hospitals in the total bed volume is 20 percent compared to 65 percent for public hospitals and 15 percent for private not-for-profit hospitals. For-profit hospitals represent half of all surgical beds and one-third of all beds for obstetrics. Most of their activity is day care or short-term surgery (Rochaux and Hartmann 2005). For-profit hospitals are run as a business organization and owned either by clinicians or by investor companies. France has a few hospital chains, too. Family medicine, dental care, and pharmacy are traditionally mainly private, but residential care is mainly public. In 2000, the fraction of public provider organizations in residential care amounted to more than 90 percent (Bellanger 2004).

Privatization in health care provision has not been a big issue in French health care policy making in the 1990s and later. The fraction of public, private not-for-profit, and for-profit hospitals in the total number of hospitals, as well as their share of beds, have remained more or less stable for the period 1990–2000.[9] An important policy issue was to create a common level playing field for the public and private sectors. Whereas in 1984–1985 public and most not-for-profit hospitals were imposed a fixed budget, for-profit hospitals continued to be paid per diem rates. The advantageous situation of the for-profit hospitals was altered in the early 1990s by the introduction of a collective cap for the for-profits, with collective sanctions in case of overshooting the cap at the end of the year and tariff increases in case of undershooting (Rochaux and Hartmann 2005).

Contrary to France, the public-private mix in German health care is characterized by a remarkable trend to privatization. After the reunification, there was a massive and unprecedented privatization in primary care in the eastern part of Germany. In only one year, what was primarily a public provider system converted to a mainly private system. There was also a significant growth of for-profit hospital care, largely through takeovers, both in the East and in the West. Whereas the fraction of public hospitals in the total bed capacity declined from 63 percent to 53 percent over the period 1990–2003, for-profit hospitals realized a growth from 4 percent to 10 percent (Deutsche Krankenhaus Gesellschaft). The remain-

9. In 1990, about 40 percent of the hospitals had a for-profit status, 28 percent of the hospitals were public, and 29 percent private not-for-profit.

ing 37 percent of the hospital beds are in not-for-profit hospitals. Germany presently is witnessing a rapid extension of a few hospital chains of which Rhön Klinikum, Sana, and Asklepios are probably the most well known. Primary health services are almost exclusively organized in private practice. Residential care, on the other hand, is dominated by not-for-profit provider organizations. In 2000, they owned 54 percent of all institutions, compared to 36 percent owned by for-profit institutions and the remaining 10 percent by public agents.

Germany uses several models for the privatization of hospital care. Privatization by a shift of ownership is only one model. Another model is that a public hospital is transformed into an organization under private law with all shares retained by a public agent (particularly local government). There is even a third model, which will be discussed in the next section. Interestingly, privatization of hospital care in Germany does not rest on an explicit federal policy to shift ownership from the public sector to the private sector (top-down privatization). Instead, it is largely the result of decision making by mostly local governments (bottom-up privatization). After the lifting of the full cost-coverage principle in hospital financing by the federal government in 1993, many hospitals incurred a deficit. Local governments perceived privatization as an effective tool to avoid massive public spending on health care and hence to relieve the local government's budget (Busse and Wörz 2004; Wendt, Rothnagel, and Helmert 2005).

Our brief overview of the structure of the public-private mix in health care provision in the four Bismarck countries highlights that these countries combine a high level of public financing with a high degree of private provision. Primary care is almost exclusively private in each country. The public-private balance is diverse only in hospital care and residential care for the elderly. Privatization of health care provision has been limited in the Netherlands, Belgium, and France, but considerable in German hospital care.

Which developments took place in the countries with a public health service? In Denmark, only little happened. Whereas hospital and residential care remained in public hands, primary care continued to be private (Pedersen 2005). A few attempts to introduce private elements in the public provision of hospital care largely failed, although there are now a few private clinics for mainly elective health services (Vrangbaek and Christiansen 2005). On several occasions, the national government rectified county councils' decisions to permit hospitals to reserve a number of beds for private patients. The national government argued that private beds in public hospitals contradicted the principle of free hospital care.

Furthermore, it denounced the idea of giving hospitals full autonomy: the county councils had to preserve their general responsibility for hospital care (Krasnik 2004). Public hospital care still has strong support among physicians. Residential care also continues to be provided by mainly public provider organizations that are run by the municipalities. There are a few not-for-profit nursing homes, too.

The expansion of the private sector in Sweden should not be overstated (Pedersen 2005; Saltman and Bergman 2005). Health care provision has largely remained public, although there are presently a few private hospitals, private day-surgery centers, private centers for rehabilitation and renal dialysis, and other specialist centers. Privatization in Sweden has appeared rather ambiguous. In the early 1990s, the Swedish government encouraged the establishment of private practices that could contract with the public authorities for funding, but when the new Social Democratic government took office, this policy was terminated. A similar development occurred in family medicine. Here, too, the policy for more private practice was overturned by the Social Democratic government, although the newly established private practices were permitted to remain. Dental care and pharmacy are largely public. A new development is the introduction of internal markets in Swedish counties, which may be a prelude to a larger private provider sector, because internal market competition may be expected to place public authorities under pressure to confer more decision rights upon public provider agents (Øvretveit 2004).

Developments in the public-private mix in the United Kingdom are diverse (Klein 2005). According to estimates of Laing (2005), the private (independent) sector grew from £1.5 billion in 1990 to £3.9 billion in 2002, of which £388 million was spent on private care in National Health Service (NHS) hospitals and £1 billion on consultants in private practice. The yearly average net growth was calculated at 5–6 percent over the period 1990–2003 (ibid.). On the other hand, the number of acute and surgical beds in the private sector remained more or less stable. What changed, however, was case mix. The private sector managed to extend its range of health services, which presently includes critical care facilities and facilities for complex surgery and aftercare. The number of private units in NHS hospitals only slightly increased. In addition, there was a further privatization of dental care (Higgins 2004).

A dramatic development took place in long-term care with a significant decrease in public provision after the adoption of the 1990 NHS and Community Care Act. The number of NHS beds specifically designated for the elderly decreased by almost 40 percent over the period 1990–2000, the

number of public beds for people with mental illness by 40 percent, and the number of public beds for people with a learning disability by almost 75 percent. There was also a rapid decline in the public provision of domiciliary health services. The private sector rushed in to fill the gap, but this development came to an end after the adoption of the Care Standards Act 2000 and the National Minimum Wage Act of 2001. Presently, the United Kingdom faces great problems because the public sector is unable to fill the gap that was left by private owners who stepped out of what is now an uninteresting market (Higgins 2004).

Another remarkable development was the attempt of the Conservative and Labour governments to involve the private sector in tackling the waiting-list crisis in the NHS. For that purpose, the government signed a concordat with the private sector in 2000 to boost the work of the private sector. It is unclear, however, whether the collaboration between the NHS and the private sector has been successful. There are signs that the concordat did not alter the traditionally cool relationship between the NHS and the private sector fundamentally (Laing 2005). The figures indicate that the private sector has only marginally benefited from public funding. Another notable development is the government's initiative to start a process of corporatization of the NHS hospitals (Higgins 2004). If they perform well, they earn more decision rights. Some observers argue that corporatization will eventually prove to be the first step toward privatization in the NHS (Pollock 2004).

Poland should be considered a special case. The post-Communist revolution in Poland significantly altered the public-private mix in health care provision. The figures indicate a massive privatization in primary care. For instance, the number of private pharmacies grew from 56 (1.6 percent) to 8,449 (93.7 percent), whereas the number of public provider agents fell from 9,912 in 1990 to 3,751 in 2001. In 2001, the number of private physician practices with a contract for public resources amounted to 2,366 and the number of practices without such a contract amounted to approximately 31,000; for dental care, these figures were respectively 6,419 and 9,700. Nowadays, many providers combine a private practice with part-time employment in the public sector. The rise of private practice may be considered a market response to the growing demand for private health services (demand-led privatization). Private practice does not present a new phenomenon in Polish health care. It is more correct to speak of a reconstruction or reinvention of the private sector that already existed in the pre-Communist times but had largely disappeared due to the creation of a Semashko-type of health care system (Wlodarczyk 2004).

Privatization in hospital care has been much less pronounced so far. As in Germany, decision making on privatization largely concentrates at the local level, where the authorities seek to privatize local public health care facilities to relieve budgetary problems. In some cases, privatization tends to follow a haphazard pathway. There are some cases in which it appeared the eventual result of a series of decisions in which none of the agents involved explicitly strove for privatization (ibid.).

Our overview of health care provision in the four countries with a public health service model suggests diversity again. A single public provider model does not exist but neither does a single pattern of privatization. Contrary to Sweden and Poland before reform, Denmark and the United Kingdom combine public funding with a private provision structure in primary care. Privatization was largely absent in Denmark and Sweden but pronounced in the United Kingdom (residential care) and, particularly, Poland (primary care).

A comparison of privatization in the Bismarck countries and the countries with a public health service model does not reveal salient differences, yet one may argue that privatization in health care provision seems less controversial in the Bismarck countries than in the countries with a public health service model. Privatization in the Bismarck countries is more a matter of degree than of principle. These countries feature a long history of coexistent public and private provider agents, and the state's political responsibility for health care never implied a largely public provision system. Commercial hospital care has always been contested in Belgium and the Netherlands, but, remarkably enough, neither in France nor in Germany, where now a significant expansion of the private market can be observed. Privatization of public hospitals in the countries with a public health service model has always met more resistance, as the experiences in Denmark, Sweden, and the United Kingdom demonstrate.

Other Forms of Privatization in Health Care

This section briefly explores two other forms of privatization in health care: privatization in health care management and operations, and privatization in health care investment. Public provider organizations[10] in all countries have been engaged in contracting out a growing part of their nonclinical operational activities to the private sector. Frequently out-

10. Private hospitals may follow a similar strategy. Since it is not a boundary-crossing activity, the strategy falls beyond the scope of privatization.

sourced operational activities are laundry, catering, cleaning, and security, as well as administrative services. Sometimes, hospitals also contract with private organizations for diagnostic testing. Outsourcing operational activities rests on an efficiency and quality argument: hospitals are expected to improve the efficiency and quality of their operations by contracting them out to specialized private agents.

Privatization can also be observed in management. Various public hospitals in Germany have completely contracted out their strategic and operational management to private chains or consultancy firms to improve hospital efficiency. Although no official data are available on this type of privatization, it seems to be an expanding phenomenon. In Sweden, too, the privatization of hospital management has been experimented with, yet the government has legally prevented freestanding companies from buying acute care hospitals to protect the hospital sector against uncontrolled privatization. Poland is another country where one can observe privatization of hospital management on a small scale.

Furthermore, a private businesslike management style is penetrating social health insurance. This trend has been most pronounced in the Netherlands since the early 1990s, when sickness funds lost their regional monopoly status and had to compete with one another. The new legislation on health insurance (2006) also permits for-profit insurance companies to contract for the implementation of the new social health insurance scheme. The introduction of market competition in health insurance has a profound impact on health insurance management. It requires health insurers to transform themselves from bureaucratic task organizations into market-driven entrepreneurial agents that must adopt the management style of private business organizations to survive. The fight for market share makes aggressive marketing and a strong consumer orientation indispensable. Because of this development, health insurers are moving away from the hidden public sector. A somewhat similar development can be observed in Germany after the introduction of regulated market competition in social health insurance in the mid-1990s. However, sickness funds are still required to be not-for-profit.[11]

The penetration of a private businesslike management style into health care—which may be termed *cultural* privatization—is not confined to health insurance, but can be observed in many areas of health care.

11. Interestingly, for-profit insurers are not excluded from the implementation of another social health insurance scheme—the so-called federal nursing care insurance scheme—but they incur no financial risk in carrying out the scheme.

The driving force is modern health care reform. The new trend in many European countries is that provider organizations are no longer funded by fixed budgets, but must sign contracts with health insurers or other funding authorities. The funding of hospital care becomes more performance related. On the demand side, consumers are given greater freedom of choice (in particular in countries with a public health service model). Waiting-time initiatives provide another incentive to improve productivity. These developments are visible in each country and are likely to alter the future of European health care. Pedersen (2005: 174), in his analysis of the alterations in the public-private mix, even argues that cultural privatization has been the most important, in his terms "almost dramatic," change in health care in Norway, Sweden, Finland, and Denmark.

Health care investment presents another area for privatization. Although there is great variety in health care investment models, one may conclude by and large that the bulk of investments in the countries selected are financed from public resources. Investments are either financed by government taxes or financed through a markup on tariffs. Investment decisions on construction, major medical equipment, and other facilities, too, are usually subject to pre-authorization by the government as part of the state planning system. Thus capital investments are heavily state controlled (Thompson and McKee 2004). The role of private investors has always been limited.

Some countries are now witnessing the emergence of private investors in health care. For instance, in the Netherlands, they are supplying, albeit only on a small scale, capital resources for building private clinics or residential services for the elderly. The main market for their investment activity so far consists of health services that are not funded under social health insurance, but their intent is to invest in health services that are not excluded from public funding (note that the latter private investments do not change the public-private mix in health care spending). Private investors are also active in Sweden and Poland. An increasing number of mainly public hospitals in Germany are seeking private capital to realize their investments. In their view, public planning procedures often cause long delays, because most regional governments (*Länder*) struggle with a chronic lack of financial resources. Decision making on hospital investment plans also frequently involves a complex political process. Public hospitals view "going private" as a serious option to get access to capital resources for their investments and to circumvent politics and bureaucracy. However, health legislation does not permit hospitals using private capital resources to include investment costs in the calculation of patient

charges, which implies that these costs must be recovered by higher efficiency (Busse and Wörz 2004).

The Private Finance Initiative (PFI) (1992) in the United Kingdom marks another notable step to privatization in investments. The Conservative government considered the PFI, which was continued by the Labour government, as a promising attempt to open the NHS for private investors and to establish a true public-private partnership in health care. The PFI rested on the belief that the treasury would be unable to meet all demands for public funding of investments. The expenditures deemed necessary simply outstripped the amount of public resources available. Furthermore, it was assumed that the PFI could improve efficiency in the NHS. Part of the deal with private investors was that hospitals would outsource part of the operational activities (catering, security, laundry, and the like) to the private sector. The PFI has always been a controversial innovation in the NHS. Evidence of its impact on the NHS is patchy and unclear because it is too early to make a more definite assessment (Higgins 2004).

Explaining Privatization

The results of our study indicate limited privatization in health care spending in all countries selected with the exception of Belgium and, particularly, Poland. We also found some evidence for a shift from public to private in health care provision, notably in Germany (hospital care), the United Kingdom (long-term care and community care), and Poland (primary care). There are also signs of privatization in health care management and operations, as well as health care investments. How can these results be explained? What factors are pushing privatization forward and what factors are working as a barrier to privatization? We begin with the factors pushing privatization forward.

First, the advent of privatization reflects a change in policy orientation and preferences. *Neoliberal ideas* are gaining political weight in public policy making across Europe, including health care. Drawing upon theoretical insights from the so-called new public management movement, policy makers expect that privatization will increase productivity, social welfare, and the quality of health care. In their view, privatization will also make health care more consumer driven, restore individual responsibility, and enhance consumer choice. Furthermore, they see privatization as an effective tool to scale down state intervention in health care by termination and contracting out.

There are many examples where privatization rested on neoliberal

arguments. For instance, the introduction or extension of cost sharing is expected to improve efficiency and enhance individual responsibility. Restricting the basket of publicly funded health services is not only associated with the need for setting priorities, but also reflects a search for a redefinition of the state's role in health care (privatization by termination). The conversion of public provider organizations into private organizations is expected to boost efficiency. Private organizations exposed to market competition are assumed to be more capable than public organizations to run the system. The penetration of a businesslike (private) management style into health care is linked to the introduction of market competition and performance-related payment schemes for provider organizations. The belief that private organizations perform better than public organizations in nonclinical activity is one of the principal arguments for the introduction of the PFI in the United Kingdom.

Budgetary strain is a second factor pushing privatization forward. Cost control has evolved as a big political issue throughout Europe since the economic crisis in the mid-1970s after the oil crisis (Mossialos and Le Grand 1999). Cost control created a need for rationalizing health care. Privatization through priority setting, cost sharing, and other policy measures, including outsourcing, was regarded as an appropriate policy tool for cost control. Relieving the public budget was also used by local governments as justification for the privatization of local public facilities. In Germany, local governments and public hospitals consider privatization an attractive policy option because state authorities increasingly fail to supply the capital resources needed for the modernization of their facilities. Scarce public resources for capital investments in the NHS were also a main argument of the U.K. government for the introduction of the PFI.

It is important to note that the search for health care cost control in various countries mainly focused on the control of *public* health care expenditures. What happened with private expenditures was considered to be less important or even not important at all. For that reason, it became common practice to accept shifts from public to private spending as an effective tool for cost control, even if they did not lower total health care spending. The Netherlands presents a good example of this approach to cost control (Maarse 2002). A related observation in this respect is that the budgetary rules of the European Monetary Union also call for the control of public health care spending. These rules, which obligate the member states involved to reduce public deficits to a maximum of 3 percent of the GDP, may impact public health care expenditures and, for instance, restrict the

room for including new services in the basket of health services that are publicly funded (with or without a copayment).[12]

Third, privatization may be encouraged by *public failures*. Consumers may prefer health care in a private setting to escape from the public sector, which they associate with low quality, long waiting lists, or other forms of unappealing patient conditions. Medical entrepreneurs use similar arguments to set up private practices. Complaints about health care in a public setting can be heard everywhere, but it is fair to argue that Poland presents the best example of this explanation. The rise—or, better, reconstruction—of a private ambulatory care sector Poland cannot be viewed apart from the poor performance and bad reputation of public provider organizations. Many patients prefer health services in a private setting in order to gain access to better care. The emergence of a private management style in the public sector and the privatization of health care investments can also be associated with public failures.

A fourth factor fostering privatization is *affluence*. Greater affluence boosts the demand for private health care services outside the public sector. There is a link between this development and the greater value placed on health. Affluent people may be expected to pay for exclusivity, privacy, and what they perceive as better quality of care. Greater affluence will also elicit a response from medical entrepreneurs and, hence, encourage private investment in health care.

The impact of the affluence factor is difficult to measure, but the private sector in the United Kingdom can be depicted as evidence for how it works. For many years now, there has been a private parallel sector that is mainly accessible[13] to affluent people who can afford to pay for private services or private health insurance or who have access to private services as a fringe benefit paid by their employer. Furthermore, we refer to a study by Di Matteo (2000), who found some evidence for a link between private payments and affluence in Canadian health care: there is a positive association between affluence and the demand for health services for which patients pay privately.

Fifth, *advancements in medical technology* effecting a shift from high-tech to low-tech care or from high-quality care to low-quality care have been pushing privatization forward. They cause a shift from inpatient to

12. Oliver and Mossialos (2005: 12) have argued that the requirements of the European Monetary Union have restricted public sector spending in Portugal and Greece, "which undermined any movement to extend the coverage of publicly provided health care in those countries."

13. Note that there is some change here: now private providers also contract with the NHS to solve the NHS waiting-list crisis.

day care or outpatient care, which is often organized in a private setting. Cataract surgery is a good example. Whereas it was considered once a high-tech intervention, it is viewed nowadays as a low-tech, routine activity that no longer requires a large medical infrastructure. As a result, medical interventions once exclusively performed in large (public) hospitals can now be displaced to private stand-alone clinics. Financial investments to set up private clinics are also limited.

Sixth, privatization may be linked to *wider political or social developments*. The reunification of western and eastern Germany in 1990, which triggered an unprecedented process of privatization within a very short period, is an excellent example of how wider political developments may influence the public-private mix in health care. Health care reform in Poland after the fall of the Berlin Wall in 1989 is another example of the impact of this factor. Furthermore, privatization should be considered an embedded process that is heavily influenced by wider developments in public policy making, in particular a paradigm shift from state planning to market competition, individual responsibility, consumer choice, and so on.

This brief overview of factors pushing privatization forward demonstrates the complexity of privatization. Privatization is not a single-factor process but rather the outcome of various interdependent factors that cannot be easily disentangled. For instance, the emergence of neoliberal ideas has always been linked to budgetary strain and the need for effective cost control. A clear-cut dividing line between the public-failure factor and the affluence factor does not exist. The overview also indicates that privatization is only partly policy driven. Neoliberal policy ideas on reforming health care and strains in public spending call for policy-driven privatization. Public failure and affluence, however, trigger demand-led privatization, although the government may facilitate it by accompanying policy measures; for instance, by permitting physicians to set up private practice or by accepting the emergence of a private parallel sector.

Our study also suggests barriers to privatization. The first barrier relates to *values*. Access to necessary health services is considered a right of each patient in the eight countries selected. Guaranteeing access to health care is seen as a state responsibility. The value of universal access does not exclude intercountry differences in the interpretation of its meaning or differences in the emphasis placed on it. For instance, there are striking differences in long-term care for the elderly where a north-south differential exists: the fraction of publicly funded services tends to be significantly higher in Scandinavian countries than in southern European countries

(Lunsgaard 2002). In some countries, high out-of-pocket payments must be paid to primary care services such as dental care. Universal access may also prove a myth in practice. Nevertheless, it is fair to say that the value of universal access limits the political and social feasibility of privatization. In this context, it is no surprise to see how controversial political decisions on the publicly funded "health care menu" may be (Coulter and Ham 2000; Jost 2005). Public decisions on delisting (popular targets are pharmaceutical drugs, physiotherapy, dental care, and a few other health services) or restricting the personal scope of public funding arrangements tend to follow an incremental pattern. The same is true for cost sharing. There are clear indications that cost sharing has increased since the 1980s, but as spelled out in the section on privatization in health care financing, its role should not be overstated, more so because of the introduction of social protection mechanisms, including reduced rates or annual caps and exemptions for the poor or people with chronic illness (Thomson, Mossialos, and Jemiai 2003).

Two examples of countries where the value of universal access constrained the room for privatization in health care provision are Denmark and Sweden. The Danish government has been reluctant to allow hospitals to undertake initiatives toward privatization. In the mid-1990s, the newly elected Social Democratic government in Sweden put an end to its predecessor's policy of encouraging private practice. According to Harrison and Calltrop (2000), that policy lacked popular support. Also illustrative is a statement by the socialist candidate for premiership in the 2002 elections: "I don't want to put the nation's health on the stock exchange" (from Saltman and Bergman 2005: 264).

Interestingly, the political resistance to privatization in hospital care seems less pronounced in the countries with a Bismarck type of health care system than in the countries with a public health service model. France has a long tradition in for-profit hospital care and the for-profit market in German hospital care is growing rapidly. Policy makers in these countries see no principal conflict between privatization and universal access on the condition that for-profit provider organizations or physicians with private practice are permitted to contract with sickness funds or public authorities.

Expanding public activity may also prove a barrier to privatization in health care. The impact of increasing private spending on the public-private mix may be neutralized by a concomitant or even faster growth of public health care spending. The vast investments of the Blair administration to strengthen the NHS and reduce waiting times may crowd out pri-

vate spending and have a profound impact on the evolution of the public-private mix.

Privatization may also be slowed or revoked because of *private failures*. Examples of private failures often mentioned as an argument against privatization are the following: impossibility of effective macro cost control, cost shifting to the public sector, cherry picking, growing dependence of the state on self-interested players, restricted access to health care, and less potential for public accountability.

A final barrier to privatization lies in the *institutional structure* of health care. Several studies have shown that health care reform tends to follow an incremental pattern rather than a radical pattern (Harrison 2004). Corporatist governance structures—characterized by intense administrative and political relationships between the government and representative associations of employers, employees, provider agents, and health insurance agents—limit the potential for radical reform. They breed a culture of mutual adjustment by consensus seeking and political compromise. Center-local relationships may further limit the scope for privatization. In Denmark and Sweden, counties have always been relatively independent in making health care policy. A policy of privatization initiated by a right-wing government may be counteracted at the local administrative level because local politicians do not want to lose their grip on health care. Center-local relationships may also work the other way around when local decisions to privatize are overturned by the national government.

Discussion

This article has investigated a few recent changes in the public-private mix in health care in eight European countries. Our intent was to determine to what extent a process of privatization can be observed in health care. We used a broad conceptualization of privatization. The overall picture that emerges from our analysis is diverse, but there is evidence that health care in Europe has become somewhat more private. The growth of the public fraction in health care spending has come to an end since the 1980s and, in a few countries (like Belgium and Poland), the private fraction even increased substantially. We also found some evidence for a shift from public to private in health care provision, notably in Germany (hospital care), the United Kingdom (long-term care and community care), and Poland (ambulatory care). There are also signs of privatization in health care management and operations. Investments are another area for privatization, particularly in Germany and the United Kingdom. From

this brief overview follows the general conclusion that privatization in the eight countries selected should be depicted as a process characterized by a high degree of path dependency (Oliver and Mossialos 2005) rather than by rapid and major changes in the public-private mix. Only Poland can be considered an exception to this general pattern, in particular in health care financing and primary care services. Within the framework of historical institutionalism, its exceptional status may be largely explained by a major event or critical juncture—the fall of the Berlin Wall that set the stage for a process of significant though often chaotic change.

The picture outlined in this article is only global and needs further investigation, for instance, by examining developments in the public/private boundaries in specific areas; for example, acute care, long-term care for the elderly, mental health, or dental care. There are indications that some health services—for instance, dental care, psychotherapy, physiotherapy, and forms of long-term care for the elderly—are more prone to privatization than other sectors. The relationship between public and private agents constitutes another important topic of research. For instance, to what extent can it be classified as either competitive or complementary? How does it develop over time? How do developments in the public sector affect the private sector and vice versa (Tuohy, Flood, and Stabile 2004). Also, more attention should be paid to the impact of the regulatory regimes on the public-private mix.

We can only speculate on the generalizability of our findings to other European countries. A plausible hypothesis might be that many aspects of privatization depicted in this article will also be found in European countries other than the eight countries selected. In this respect, it is interesting to refer to Poullier's (2004) study of privatization in health care financing. He found in all Eastern European countries that joined the European Union in 2004 a significant drop in the public fraction in health care financing over the period 1990–2002 (note that health care reform in these countries only started in the 1990s after the fall of the Berlin Wall in 1989). Thus the Polish experience is not unique at all. Poullier's analysis also indicates that the pattern of incremental privatization in health care financing is characteristic for most western European countries. He also identified a few countries where the public fraction in health care spending increased over the period 1990–2002, notably in Portugal and Switzerland (ibid.).

How may privatization develop on the European continent in the future? This question obviously cannot be answered definitively. A few expectations for the next ten years are possible, though. First, one may expect that

much will depend on wider policy developments in public policy making. Health care does not present an island in public policy making but is embedded in a context of experiences and ideological shifts in general public policy making.

A second expectation is that public arrangements will remain the prime tool for health care financing. Europe has a history of ensuring universal access to basic health services, which makes any private model in which health care will be a market commodity again and public financing arrangements are used only as a safety network unlikely. This does not mean, however, that the private fraction in health care spending will remain at the present level. It is even plausible to assume that it will increase because of new restrictions in the package of publicly funded services and further extension of cost sharing. To some extent, these policy changes reflect a redefinition of the concept of solidarity by placing a stronger emphasis on the notion (value) of individual responsibility. An increase in private spending may also lead to growth of the market for private complementary health insurance arrangements covering the cost of health services not or no longer covered publicly.

A further privatization in health care provision, management, and operations, as well as health care investment, is also likely to be expected. Privatization in these areas may even develop faster than privatization in health care financing, because it is not at odds with the principle of universal access if for-profit provider organizations contract with health insurers or public health authorities. This is precisely what happens in France and Germany, where most for-profit hospitals contract with the sickness funds. For this reason, we expect that privatization in health care provision will prove to be contested less than privatization in health care financing, not only in countries with a Bismarck type of health care system but also in countries with a public health service model. The same is true for health care management and operations, as well as investments.

A following expectation draws upon the previous one. Public-private partnerships featuring intensive forms of collaboration between public and private agents that are based on long-term contracts for the delivery of services, financial and other resources, pooling of risks, and agreements on the distribution of profits made, are also likely to develop further. These partnerships will increase mutual dependencies between public and private agents and cause a (further) melting of preexisting public-private boundaries (Saltman 2003).

Our last comment concerns the impact of privatization on key health system parameters, including costs, sustainability, efficiency, accessibil-

ity, solidarity, quality of care, health status, and freedom of choice. Does a more private system perform better than a more public system? Unfortunately, the impact of privatization on health system parameters (values) has remained so far a largely unexplored area in European health policy research, with the exception of cost sharing, the effects of which have been widely studied (Thomson, Mossialos, and Jemiai 2003). To fill the gap, the impact of privatization on health system parameters in Europe should be identified as a highly relevant research topic, both politically and scientifically. Privatization should not only be conceptualized as a dependent variable in health policy research, as this article has done, but also as an independent variable.

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