

“2nd LSE PhD Symposium on Modern Greece”

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1. Introduction

This paper explores the situation which exists in the private health sector in Greece. The challenge we are facing is the following: Which can be the new role of the Private Health Sector in the Greek National Health System (NHS)?

The question set is going to be dealt with in three steps. First, we examine the Public and the Private health care sectors, second we examine basic aspects, background information, recent reforms of the Greek NHS, as well as the reasons behind the inevitable movement towards collaboration of Public and Private Health sectors. Finally, we examine the respected European experience on Public Private Partnerships (PPPs), since such cooperation between the Public and Private Sector has been developed a long time ago and it is now a tradition of the NHS in many EU countries like the UK.

The analyses can not come to a conclusion due to the fact that the research is still on process. Nevertheless, some key points are provided for consideration at the present stage.

2. Public and Private Health Care Sectors

2.1 Basic characteristics

Most health care systems involve a mixture of public and private provision. In a National Health Service (NHS) though, the role of private health care is quite different than in private (or mixed) health care systems along several dimensions¹.

In particular, within the Public sector, Health care is mainly provided publicly and financed by general taxation rather than private insurance payments. Nevertheless, there exists with the NHS, a private sector alongside the public one in most countries. An important difference, though, is that patients in the public sector receive public health care for free, when others seeking private health care often have to cover the costs of the medical treatment by themselves.

Another interesting feature of NHS systems is that a substantial share of doctors tends to work in both sectors. For example, in the UK most private medical services are provided by physicians whose main

¹ Besley and Gouveia, 1994

commitment is to the NHS. Similar observations can be made in Norway, Sweden, France, etc. In other words, there seem to be close links between the public and the private sector not only on the demand side but also on the supply side². This is the reason that nowadays, the health sector reform plans, in most countries, include developing structural Public-Private Partnerships (PPPs), using the word "Partnership" to refer to the long term, task oriented, and formal relationships.

2.2 The Public Sector

The Public sector refers to national provincial/state and district governments, municipal administrators, local government institutions and all other government and inter-governmental agencies with a mandate of delivering "Public Goods". In particular, in most settings when we use the term "Public Health Service" we understand a service which belongs to the state. It is well known that the Public Health Sector stands on the top of the health care debates for years. Examples of organizations funded and administered by the public sector include national health ministries, national police or military hospitals, provincial or state health departments, district hospitals, and public health centers.

Advantages

- ❖ Universal coverage
- ❖ High quality of scientific and other personnel
- ❖ Great potential Market

Disadvantages

- ❖ Corruption
- ❖ Waiting lists
- ❖ High cost
- ❖ Maladministration (misgovernment)
- ❖ Particularism
- ❖ An excess of beds
- ❖ Financial shortage
- ❖ Low quality of services provided

2.3 The Private Sector

The word Private devotes two sets of structures; the for-profit private encompassing commercial enterprises of any size and the non-profit private referring to Non Governmental Organizations (NGOs),

² Kurt R. Brekke, Lars Sorgard, "Public versus Private Health Care in a National Health Service, 2003

philanthropies, and other non-for-profits. Examples of private sector organizations include community-based organizations, NGOs, private businesses, private voluntary organizations (PVOs), and commercial sector firms. Specifically in the health sector, the term "Private" is used when health care is delivered by individuals and /or institutions not administered by the state³. The private health care sector in Greece covers 50% of the total activity.

Advantages

- ❖ Own funds
- ❖ Modern infrastructure
- ❖ Biomedical Technology
- ❖ Managerial adequacy

Disadvantages

- ❖ High Costs
- ❖ Uncertainty concerning the quality of health services provided
- ❖ Small-scale market
- ❖ Inability to provide specific services

3. Greek Health Care System (ESY)

3.1 Main Features

The development of the health sector is closely related to the social and political evolution of the country. Greece, just like other countries, has adapted its health system based on the geographical and population needs, as well as, on the financial and political situation in order to ensure effectiveness and patient satisfaction. Attempts for the establishment of a universal health care system in Greece began with the founding of the Modern Greek state and took a concrete form with the establishment of a National Health System in 1983. Its aims were to provide universal access to healthcare and, in particular, free, equitable and comprehensive health care coverage to all citizens.

The Greek NHS can be characterized as a "Mixed" system for both funding and delivery, with elements both of the Bismarck model (increased importance of social insurance in funding health care) and the Beveridge model (health care primarily funded by the state budget). The State runs the public hospitals and Provides primary and hospital health care as well as emergency pre-hospital care on a

³ D.Giusti, B Criel and X De Bethune, "Viewpoint: public versus private health care delivery: beyond the slogans, Health Policy and Planning, vol 12, 192-198, 1997

universal basis. On the other hand, the private sector plays a strong role in hospital, diagnostic and out-patient services.

3.2 The Organizational Structure of the Health Care System

The Ministry of Health and Social Solidarity has the responsibility for ensuring the general objectives and fundamental principles of the Greek NHS, such as free and equal access to quality health services for every citizen. For this reason the Ministry decides on the overall health policy issues, planning and implementing the national strategy for health. The Ministry sets priorities at a national level, defines the extent of funding for proposed activities and allocates relevant resources, proposes legislative framework changes and undertakes the implementation of laws, and generally of any change and reformative measures. It is also responsible for health care professionals and coordinates the hiring of new health care personnel, subject to approval by the Ministerial Cabinet.

Until 2001, the Ministry was responsible for the planning and regulation of the NHS at central, regional and local level. With the establishment of the Regional Health and Welfare Authorities, known as (Pe.S.Y.P.), some of those responsibilities have been transferred to these new administrative bodies. Nevertheless, the core function of the Ministry is still the regulation, planning and management of the National Health Service and the regulation and control of the private sector, while social health insurance is under the auspices of the Ministry of Labor and Social Affairs.

Apart from the Ministry of Health and Social Solidarity, a number of other Ministries⁴ have responsibilities, which are linked in one way or another with the public health care system and leads to a lack of coordination, excesses in spending, mismanagement, and the development in recent years of an extensive parallel private health care system. Indeed, the involvement of the private sector in health care delivery is extensive and has been growing rapidly over the last 10 years⁵.

3.3 Health Coverage

Insurance coverage is compulsory for all employed persons and their dependants and is based on occupation. The unemployed continue to be covered where they were before. Furthermore, several people are

⁴ More specifically, the Ministries of: Labor and Social Affairs, National Defense, Education & Religious Affairs, Development, Economics and Public Administration & Decentralization.

⁵ Kontozamanis V, "Greece: Pricing and Reimbursement Policies", 2000

insured with more than one insurance fund.⁶ The three largest funds are IKA (Fund of Social Insurance)⁷, OGA (Organization of Agricultural Insurance) and OAEE (Fund of self-employed). Insurance funds are funded through employer-employee contributions. Thirty-nine Social Health insurance organisations provide coverage to about 95% of the Greek population by contracting with public and private providers.⁸ Approximately 5-8% of the Greek population has private insurance. Payments from private health insurance account for 2.3% and out-of-pocket payments for the remaining 41.4%.

3.4 Health Financing and Expenditure

The Greek NHS is mainly financed from the central government budget (general taxation), from social insurance, as well as from the Private insurance Schemes. In 2000 taxes accounted for 30.4% of total expenditure on health (compared to 33.7% in 1987)⁹. According to the Greek Ministry of Finance, tax revenues are mainly from indirect taxes on goods and services and taxes on income represent a much smaller proportion.

Viewed in aggregate economic terms, Greece, despite having one of the lowest levels of per capita GDP in the European Union (EU), spent 9.6 % of its GDP on health care in 2002, and lies above the mean in a ranking of EU countries. Health expenditure as a proportion of GDP rose steadily from 5.6% in 1970 to its current level. Greece spends more on healthcare than other southern European countries like Italy (8.2 %|), Portugal (7.7%), Spain (7.0%) as well as Austria (8.0%), Finland (6.9%) and Sweden (6.9%).¹⁰

The structure of the Health care delivery and financing system is shown at **figure 1**.

3.5 Health Care Reforms

During the 1980's and 1990's Greece began to face major problems.¹¹ These problems mostly refer to the rising cost of health care and the

⁶ This may happen if an individual has two occupations covered by different funds, or if he is insured directly in one and indirectly (in case of another working member of the family) in another (Kanavos P, "Pharmaceutical pricing and reimbursement in Europe"-Scrip Reports, 1999).

⁷ IKA covers 55% of the population, and is responsible for the funding and provision of primary health services through "policlinics". OGA covers about 23% and takes advantage of the NHS facilities.

⁸ Lycurgos Liaropoulos, "Ethics and the management of health care in Greece.

⁹ In reality the percentage of health expenditure through taxation is much higher since the government subsidises the contributions of civil servants and the deficits of insurance funds.

¹⁰ "Health care developments in Greece: Looking back to see forward?" (Elias Mossialos and Dina Davaki, 2002).

¹¹ 1) Continuous cost raise, 2) Low financing resources, 3) Demand for better health care, 4) Shortages in resources, staff and facilities in the public health sector, 5) Fragmented administrative framework, 6) Low levels of Public expenditure, 7) There is a lack of coordination of purchasing policies and inefficiencies, (such as over- treatment and the depletion of diagnostic and therapeutic treatments and prescriptions), 8) Different access to services and choice of services undermining the equity principle of access to services based on need and not on ability to pay, 9) Lack of credibility, 10) Unethical practices (under-the-table payments to doctors).

low effectiveness of resources. Several attempts to reform the Greek health care system have taken place. Most of them intended to resolve organizational problems, funding issues, and the efficiency and effectiveness of services. Implementation of cost containment measures has been intense but with minimal impact. Policy priorities, lack of continuity in health care, administrative inefficiencies, prevailing perverse financial incentives and vested interests, as well as lack of co-ordination of financial resources, have all been blamed for this.

Two reform attempts are considered as large-scale interventions that changed the structure of the health care sector, despite the fact they were not completed.

Law 1397/1983 establishing the Greek NHS was a landmark in the development of health care, as it was the first time the basic principles of health care organization and policymaking were embodied into a reform. It is characterized as the most significant attempt for a radical reform in the health sector, as it led to the evolution of a complete public health care system. The years that followed the voting of the law were most productive, mainly concerning quantitative growth of the system. Until the beginning of the 1990's, many rural health centers, a certain number of regional and prefectural hospitals were built, equipment was renewed to a large extent, and health system personnel was upgraded. But in the areas of organization, decentralization, administration and effectiveness the results were very poor. The lack of sufficient financing, oppositions and disagreements interrupted and finally stopped the completion of a series of reform attempts in the 1990's (laws 2071/92, 2194/94, 2519/97).

The implementation of the second most significant Law 2889/2001, led to, amongst others, the regional organization of the NHS into 17 Regional Health Authorities (Pe.S.Y.P.), the modification of the terms of employment of NHS doctors and the introduction of professional hospital management. This reform changed basic elements of the structure, management and administration of the system.

Further to NHS decentralization and improving the administration and operational effectiveness of public hospitals, more specific reforms were implemented. The establishment of Health and Welfare Auditors (Law 2920/2001), Hospital Procurements (Law 2955/2001), the Welfare law (3106/2003) and the development of Public Health Services (Law 3172/2003).

The most recent reform of the Greek NHS is the 3329/2005 law, after a major the political change.¹² The new law changed the 17 Pe.S.Y.P.,

¹² The Government now is Nea Dimokratia.

and created 17 Administrations of Health Regions (D.Y.PE.) which hold extensive responsibility for the coordination of regional activities and the effective organization, operation and management of all health and welfare units within their catchment area. Each D.Y.PE. is a public entity, managed by an administrative board and chaired by a Director appointed by the Minister of Health & Social Solidarity, subject to parliamentary approval. All health care units operate as Legal Entities of Public Law and are controlled as well as supervised by the Director of each D.Y.PE. NHS hospitals are managed by a Governing board and by a Hospital Manager.

With Law 3329/2005 the Greek government allows NHS hospitals and other public healthcare units, to sign contracts with private companies for household services like security, catering, cleaning, as well as for the administration of hospital grounds. Other reforms are still underway, primarily for the merging of social insurance funds, the development of Primary Health Care (especially in urban areas, and the introduction of family doctors), and the introduction of Services' Accreditation and Quality Assurance.

Greece today is still undergoing a reform process in the health care sector. Although we examine the Greek NHS, most countries face similar problems. The different approaches taken to dealing with these problems, allow a country to understand and learn by the experience of others, and the various alternative solutions that exist, such as the entrepreneurial approach, more specifically the PPPs, which will be the subject of the remaining part of the paper. Therefore, it is important to investigate first the methods of public/private interaction.

4. Methods of public/private interaction

The purpose of this paper is to investigate the interaction between the public and private health sectors in a National Health Service. It is well known that the public sector holds a dominant role in the development of European societies. Nevertheless, during the last decades, a new role for the private sector emerged in many countries, sometimes as a competitor in the coverage of the population and sometimes as a cooperating agent in dealing with problems.¹³ We consider that there are various methods by which services can be privatized, such as contracts, formal/franchise agreements, vouchers, grants, subsidies, and Public/Private partnerships (PPPs). According to Savas,¹⁴ the selection of a particular model of privatization must consider the unique dynamics of the "control function mix." Ownership,

¹³ Lycurgos Liaropoulos, "Public and Private Health Care Sector in the current welfare state", 2003.

¹⁴ Savas, E.S., *Privatization: The Key to Better Government*, Ghatham, NJ: Chatham House Publishers, Inc., 1987, p. 87.

management and day-to-day operations of any particular sector or segment could be controlled by either the public or private sector. A policy matrix to reflect this complexity has been suggested by Savas in **Exhibit 1**. Our analysis will focus on PPPs, and for this we must first explain what we mean by the term “privatization”.

4.1 Privatization

Privatization refers to the provision of publicly-funded services and activities by non-governmental entities. In particular, we talk about a formal contracting out of services by the government to the private for-profit or non-profit sector. The market competition and the role of public sector vis-à-vis other sectors are the two separate but related dimensions of privatization.

Competition holds the key that will unlock the bureaucratic gridlock that hamstrings so many public agencies. According to Osborne and Gaebler in *Reinventing Government* (1992) quote Gov. Mario Cuomo, who stated (p.30) that “It is not government’s obligation to provide services, but to see that they’re provided”. This would mean ending the tradition that certain public agencies be providers of services. Public agencies would have to compete against each other and against non-profit providers for a particular service market¹⁵.

A second dimension of the privatization concept relates to activities or functions performed by the governmental and non-governmental sectors, regardless of whether funds actually are exchanged and regardless of whether there is a formal contract or agreement.

As Le Grand puts it:¹⁶ *Privatization can take many forms. A simple interpretation, such as the replacement of the state by the market, will not suffice. The kind of state intervention to be replaced must be specified; so too must be the type of non-state institution that will replace it. For this reason, LeGrand concludes that it is not easy to argue about the merits and de-merits of privatization in the abstract; the arguments will vary according to the types of state and private activities involved*¹⁷.

4.2 Public Private Partnerships (PPPs) in Health Care

Public Private Partnerships (PPPs) are forms of cooperation between public authorities and the world of business which aim to ensure that infrastructure projects can be carried out or that services of use to the

¹⁵ Demetra Smith Nightingale, Nancy M. Pindus, “Privatization of Public Social Services”, 1997.

¹⁶ Legrand, Julian, Robinson, Ray, “Privatization and the Welfare state”, London: George Allen & Unwin, 1984, p4.

¹⁷ Ibid.

public can be provided. S. Johnson & D. Collins defined the public-private partnership as “*an inter-sectoral collaboration, either non-contractual or contractual, between two or more organizations*”.

According to Roy Widdus¹⁸, a strict definition of PPPs would probably require a significant degree of joint decision-making. More broadly speaking, a partnership usually involves collaboration between two or more organizations, each having specified rights and responsibilities related to their partnership. Partners tend to pool their resources, technical, organizational, geographic, human or financial. Also, potential partners must consider and discuss a number of things before entering into partnership, including their goal, the type of agreement, the length of time they expect the partnership to last, the resources they can commit to the partnership, and the client population they intend to reach.

These forms of partnership have been developed in several areas of the public sector, such as transport, public health, education, public safety, waste management and water distribution.

PPPs is often confused with privatization or used interchangeably with public sector “decentralization” and/or “liberalization”. Moreover, PPPs initiatives can be fragile and must be carefully planned and implemented to achieve their intended results in the health sector¹⁹. For this reason it needs to be differentiated from privatization, which involves permanent transfer of control through transfer of ownership right or an arrangement in which the public sector shareholder has waived its right to subscribe.

The need for public-private partnerships in the health sector arose against the backdrop of the inadequacies of the public sector to provide public goods, in an efficient and effective manner, because of a lack of resources and management issues. These considerations led to the evolution of a range of interface arrangements that brought together organizations with the mandate to offer public good on one hand, and those that could facilitate this goal through the provision of resources, technical expertise or outreach, on the other.²⁰ There are examples of individual governments forming partnerships with the for-profit private sector and situations when a government partners with a non-profit organization (NGO).²¹ Participation of the private sector into the public sector requires legislative authorization, within the

¹⁸ Roy Widdus, “Private-Public partnerships for health require thoughtful evaluation”, Bulletin of the World Health Organization 2003, 81 (4).

¹⁹ James A. Rice, “Methods of PPP: Global Experiences and insights”.

²⁰ Sania Nishtar, Public-Private ‘Partnerships’ in health- a global call to action, 2004.

²¹ Cross C., “Partnerships between non-governmental development organizations” Annals of Tropical Medicine & Parasitology. 92 Suppl 1: S69-71, 1998.

framework of which, procedural and process-related guidelines need to be developed.

The aim of the Public-Private partnerships is to create district health care systems in which the various independent actors operate as entities towards common goals and the performance of the entire health system is maximized. Public Health consultant's experiences show that to achieve these aims, the partners should be allowed to participate in all aspects of health care development and the collaboration needs to be institutionalized among all partners and at all levels. Important steps that need to be taken are the development of a specific partnership policy, the development of additional capacity and skills of staff within the institutions, representation of the partners in the organizational structures, adoption of the working methods and arrangements, and the development of new tools.

Moreover, the complex nature of healthcare demands an approach that mobilizes expertise, resources and efficiency from both the private and public sectors. Whilst governments play a vital strategic role in healthcare delivery, the private sector can be used in a variety of creative ways to meet investment and operational needs (**exhibit 2**). Many different *models* for public-private partnerships in health are being developed to illustrate solutions in broad areas like *clinical care infrastructure, and financing*.

Indeed, Governments are using a variety of contractual methods to achieve the efficiency gains of using the private sector to provide services. For instance, *clinical services* have been formally contracted to the private sector extensively in Latin America under various forms of contract. The crucial difference between them is the payment mechanism,²² which establishes the private sector incentives and is therefore critical in determining the overall success of the service in promoting equitable and universal healthcare access.

On the other hand, models for injecting private investment to modernize healthcare systems *infrastructure* are well-developed and should be urgently considered by developing country governments. Private sector consortia contract with governments to design, build, finance and operate hospital facilities. The operational element may or may not extend to private sector management of the clinical services.²³ A key advantage of this approach is that the private sector takes the risk of maintaining the property for the life of the contract, usually 25 years, ensuring the quality of the asset in the long term. The Inkosi Albert Luthuli Central Hospital in South Africa follows the UK

²² The population based/ historical payment model or the service-based allocation model.

²³ The next few years will probably see developing countries taking this to the next stage and including clinical care in the package of services passed to the private sector, as has been the case in Australia

model of privately financing hospitals in which support services such as laundry, security and catering are provided by the private sector, with clinical and care services provided by the public sector.

Finally, social insurance has been identified as a potential "middle-way" between financing through private insurance and tax-based systems. Formal insurance markets are lacking in most developing countries, and a response to this has been the creation of 'social health insurance' that finances medical care predominantly through compulsory payments by employer and employee, collected through payroll taxes. This is a growing model in developing countries, with the objective to reduce the financial cost of healthcare provision and shifting the burden of the day-to-day provision of health services from the public to the private sector. This has the added value of transferring much of the operational risk, such as recruitment of medical personnel, to the private sector. Social insurance represents a potentially sustainable means of financing growing healthcare costs while meeting the objective of universal healthcare access.

A general theme in healthcare reform is the formalization of contractual arrangements with the not-for-profit sector, which have traditionally worked on 'understandings' without a contractual obligation to provide services. One of many examples is in Costa Rica, where the Government has contracted with the National Health Foundation to construct and manage the Hospital de la Imaculada Concepcion in Heredia. This is a welcome trend as it enables governments to monitor the quality of service provision under agreed contractual criteria.

5. European and US Experience on PPPs

Many governments have undertaken substantial health system reforms over the past decade. An important one is the introduction of PPPs. Comparisons are essential if one is to achieve an understanding of one's own national health care system. Logically, it is impossible to make a statement about cause, effect or the necessity of a reform (in particular for the PPPs), within a national system without considering the experience in other countries.²⁴ Therefore, a brief presentation of the European experience on PPPs is essential.

Several Western European countries (UK, Sweden, etc.) have recently known heated debates on the issue of privatization (Saltman, 2002c forthcoming). These debates have often shed more political heat than substantive light.

²⁴ Rudolf Klein, *Risks and Benefits of Comparative studies: Notes from another shore*, 1991.

What is intriguing about the current period is the extent to which complex cross-boundary relationships are increasingly appearing in a number of European health care systems. Policymakers are pursuing these in an effort to generate social not private entrepreneurialism.²⁵ Three examples are particularly noteworthy: the role of Bure AB in Sweden (and with it that of St. Goran's Hospital in Stockholm); the role of newly established public firms in the hospital system of Spain; and the role of primary care groups in the United Kingdom.

Sweden:

The Swedish health system is regionally-based, (it is organized on three levels: national, regional and local), publicly financed mainly through county council tax revenues, and publicly provided by hospitals and health centers owned and managed by the public county councils. Sweden's healthcare system is considered to be among the best in the world. The country has a low infant mortality and a high average life expectancy.

It can be described as a system that has been put under economic pressure during the 1990's and has undergone several major structural reforms. The government has launched a programme to tackle long waiting lists, reduce stress on staff, and improve the care of patients by putting more emphasis on cooperation among existing bodies. Changes have been initiated both at national level through legislation, and locally at county council level. The locally initiated reforms are mainly associated with the introduction of new management systems and new organizational structures, such as contracting out to private providers.

Bure's role with regard to melting public/private boundaries in the Stockholm county health system is fascinating. The central actor (Bure) was founded with (state-raised) tax funds; sold most of its shares on the (private for-profit) stock exchange, but still has a (state) pension agency as its largest stockholder (Johansson, 2000). It bought the operations of St Goran's, a (public but non-state) county hospital, but the hospital building continues to be owned by a (public non-state) public firm. The sale contract is contingent upon continued (public non-state) county purchase of services.

The Swedish coalition government recently banned the privatization of hospitals, amid fears that the expansion of private health care could destroy the principle of a fair and free public health service. Health minister Lars Engqvist, said that new legislation would end the practice

²⁵ Busse et al., 2002

of private patients “buying their way past” hospital waiting lists. Provincial authorities, which are responsible in Sweden for the local healthcare system, will not be allowed in the future to hand over the running of a hospital to a profit making company, because medical treatment must be given to every patient according to their need, not their ability to pay. The ban comes after two provincial authorities began to privatize state hospitals that had expanded their private care.²⁶

Under the terms of the new reform, private companies will not be allowed to run hospitals that treat state insured patients as well as private patients. In addition, private companies will not be allowed to buy regional or university hospitals; only foundations and non-profit providers are to be allowed to manage hospitals. Also, provincial authorities will be forbidden from handing over the day to day running of hospitals to profit making companies. Existing private hospitals will be allowed to continue in existence, and private profit making companies will be allowed to start new hospitals, as long as they do not treat state insured patients.

Spain:

The Spanish health care system has been set up as an integrated National Health Service, publicly financed out of general taxation and providing nearly universal health care free of charge at the point of service, delivered through 17 Autonomous Communities. Under the direct authority of the Ministry of Health is the National Institute of Health (INSALUD). While autonomous health services and INSALUD provide health care through their own hospital networks, they also contract out services, where necessary, to private hospitals (profit or non-profit) so that both private and public beds support the delivery of public inpatient care.

Since 1986, the public health sector has undergone considerable development. The 1990 Catalan Health Care Law opened the way for the introduction of new flexible forms of organization and management of health care centers, explicitly including, for the first time, the possibility of contracting out the management of publicly-owned health centers to the private sector or to public providers opting out of the public system.

Efforts in Spain to restructure hospitals into Public firms involve several similar cross-boundary experiences. At least five of the autonomous communities (regions) which control their own health care systems have developed innovative models to establish autonomous or

²⁶ Vienna Jane Burgermeister, “Sweden bans privatization of hospitals”, *British Medical Journal*, 2004.

corporative hospitals. Several, including the Basque Region, have gone further to establish complex cross-boundary relationships that place hospitals in a new legal category in which they are a “public entity under private law” (Busse et al., 2002). In Andalusia, three newly built hospitals have been structured in this fashion.²⁷

Furthermore in Alcorcon a suburb of Madrid, the Fundacion hospital was built in 1997 by INSALUD, but contracted out to private clinical management. It is regarded by Celia Villalobos, health minister in Spain's rightwing People's Party government, as the jewel in her crown.

The Alcorcon hospital's board of ministry and town council representatives contracted a private team to manage the service and the government freed it from many of the rules imposed on Insalud hospitals. The company running the Alcorcon hospital is not allowed to make a profit, but receives a management fee. This arrangement allows the hospital to reach its own wage, productivity and working hours agreements with doctors, nurses and other health workers.

The Alcorcon hospital outperformed centrally controlled hospitals in virtually every category. It boasts shorter waiting times for serious operations. It has also reduced the number of hospital beds taken up by accident and emergency department patients. The management company has invested heavily in computer equipment and software, which, has also helped to reduce the time patients spend in hospital.

Nevertheless, from the Spanish trade unions point of view, the management company cut waiting lists by increasing working hours and sending difficult cases, complicated pregnancies, and the badly injured from traffic accidents, to publicly run hospitals.

Some of the new ideas harboured by health care politicians in Spain are: private sector to build and run some of the diagnosis and treatment centres that are to be set up to provide a fast-track service for common operations such as cataract surgery and hip replacements. They are also interested in an experiment in Bologna, Italy, where patients are given a prescription for an operation and can shop around for the hospital offering the best treatment, and finally, they are looking at New York, where patients can view data on the performance of individual heart surgeons.²⁸

²⁷ De Manuel, 2000.

²⁸ John Carvel and Giles Tremlett, “Milburn seeks hospital role model in Spain”, 2001

United Kingdom:

The United Kingdom has a long history of well-organized and successful health care, although some reforms are now underway. The health care system of the UK known as the National Health Service (NHS) is fully administrated and funded by the state without the contribution of insurance funds. The UK's population has excellent access to health care, with a high percentage of people being covered. The NHS is a model frequently referred due to its low cost, efficiency and effectiveness.

Some of the main elements of the present day organizational structure of the NHS can be traced back to the major changes that were introduced through the NHS Act of 1973. An important development in the history of the NHS occurred in 1979 by the government of Margaret Thatcher and with its commitment to a programme of radical economic and social reform. This government saw public expenditure and state involvement as the source of Britain's economic difficulties and embarked upon a major programme of privatization. Although early policy on privatization in relation to the NHS was restricted to mainly contracting out ancillary services (ie. laundry, catering and cleaning), the government's belief in the superior efficiency of private sector efficiency led to major changes in management arrangements.

Reforms introduced during the period 1989-1999, were part of a wider policy aimed at introducing a greater element of market discipline in the public sector. Following the election of the Labour Government in 1997, a new policy direction was announced. A system based upon competition within the internal market is in the process of being replaced by one based on *partnership and collaboration*. At the present time these policy changes are in the process of being implemented.

Private Finance Initiative (PFI) is one model of Public Private Partnership (PPPs), which have been implemented in the British NHS. PFI is a key policy for improving the quality and cost-effectiveness of public services. It enlists the skills and expertise of the private sector in providing public services and facilities. PFI is about building long term and mutually beneficial partnerships between public and private sector partners. In the health sector, the NHS continues to be responsible for providing high quality clinical care to patients. But, where capital investment is required, there will increasingly be a role for a private sector partner in the provision of facilities. Major PFI schemes are typically to design, build, finance and operate.

Furthermore, over time other forms of PPPs have been developed in the UK. For instance, the new structure of Primary Care Group (now Primary Care Trusts), introduced in April 2000, reflects the prior

pattern of private for-profit GP fund holders but with a stronger public supervisory input. These new mandatory management arrangements (the prior GP fund holders were voluntary arrangements) require private GPs who contract with the NHS to work in large group practices designed and closely regulated by the state (through the NHS Executive). This creates a merger of private for-profit with state interests.

On the hospital side, the UK has also, sought to deal with long waiting lists for elective procedure by collaborating more closely with private sector institutions both in the UK and on the Continent. This is not new – in the mid 1980s, the NHS had contracted out some 50% of certain elective procedures.²⁹ Moreover, a recent tendency on the public-private mix comes from the European Court which gives EU citizens the right to seek care across national boundaries paid for by their national health budgets. In the United Kingdom, this regulation has encouraged the NHS to reduce waiting times through contracts with, among others, British United Provident Association (BUPA) and also several not-for-profit French and Belgian hospitals.

Similar attempts have been made in Britain when government, in order to limit the up-front costs of much-needed new hospitals or to upgrade hospitals, decided to contract with private companies to build them and run non-clinical services for a set period, say 30 years for an annual fee. However, according to the British Health Service Union, the above attempt has been an unmitigated disaster.³⁰

Nowadays, the government has reintroduced the internal market, but on a more ambitious scale than in the 1990s. Labour's boldest step has been to complement the internal market with an external one. It has turned to the private sector, contracting out more and more NHS work to independent firms. This landmark decision has buried the dogma that public financing of health care must mean that it is also publicly provided. Already, by the end of this year, private providers will carry out around 4% of publicly financed elective (non-emergency) treatments and Labour wants this to rise fast, towards 15% of elective work.³¹ Despite its virtues and reform attempts, the system encounters problems, such as long wait lists for outpatient visits, hospital admissions and surgeries.

²⁹ Higgins, 1988.

³⁰ Health service union, "Private Sector versus the public sector", 2003.

³¹ The Economist, "Health in Britain: Getting it right", April 23rd 2005.

Portugal:

The health care system in Portugal has been in a state of continuous change since the political revolution of 1974, which brought about a constitutional commitment to a universal coverage and free access for all citizens. It is financed by taxpayers, centrally directed and highly regulated. Most hospitals and primary care centres are owned by the public sector and the system is complemented by a liberal ambulatory medical system.

The Portuguese reforms are a response to dissatisfaction both of consumers and professionals with the services provided by the government. There is an increasing perception that higher quality services are provided in the private sector, particularly primary care and high technology services. It is also a response to centralised control of the services and to inadequate public funding. A new law passed in 1990 gave support to the development of private services, provided that they were licensed and inspected by the government. It sanctioned user's co-payments and encouraged the development of private services in public hospitals.

Moreover, during the 1993 reform, the Portuguese government allowed full-time salaried doctors to engage in private practice, provided it did not interfere with their duties for the National Health Service. Also, public services could be managed or provided by other organizations (public or private) under contract. In addition, regional health authorities could contract individual private doctors to provide services.³²

The system of healthcare in Portugal currently is characterized by a public-private mix of both the funding and delivery function. Most public hospitals are public sector bodies and managed publicly. However, a pilot scheme has been in operation at one hospital where management has been handed over to a private company. Staff in this hospital is employed under contracts with the private management company and are not employed as civil servants, as are other NHS doctors. Furthermore, non-clinical services, e.g. maintenance, security, catering, laundry and incineration, are generally contracted out to the private sector.³³ Since 2001 there is an attempt to corporatize public hospitals. The government introduced the PPP Hospital program, which developed in two phases.

After the last general election in Portugal, the government's main strategic concept for public hospital management has changed. From a

³² OECD, "The reform of health care systems: A review of seventeen OECD countries", 1994.

³³ Anna Dixon and Elias Mossialos, "Has the Portuguese NHS achieved its objectives of equity and efficiency?", International Social Security Association, 2000.

fully corporatized and “private” management approach maintaining public sector ownership to a semi-corporatization and less “private” approach (EPE Model). The main features of the EPE Model are: Corporate semi-equity and public management in conjunction with limited private management elements (more flexibility in public procurement, staff incentives and staff recruitment).

The new agenda for NHS reform include revision of PPPs legal framework, emergence of a new generation of PPP schemes (smaller scope and duration), enlargement of the role of the newly created health regulatory agency, more competences regarding competition among providers, evaluation of the existing corporate hospitals, and transformation of all administrative public hospitals into public corporations (EPE Model).

United States:

The US health system is unique in its heavy reliance on the private sector for both financing and delivery of health care. The public sector plays a not-insignificant role, providing coverage for the elderly, disabled and poor,³⁴ and spending as much on health as a share of GDP as most OECD countries (14 per cent of GDP as compared with an OECD average of 8 per cent).

Public-private partnership (PPP) models and methodologies in the United States began to emerge in the 1970s. By the early 1980s, privatization of public services began in earnest. By the mid-90s, a number of US public services were privately built, financed, managed, operated, or owned. Today the PPP market in the US covers the whole range from “pure public” to “pure private”, having employed a diverse range of techniques and their hybrids in almost every sector of the economy. In the United States, most of the effort today is aimed at improving the design and implementation of PPP arrangements, strengthening PPP techniques, enhancing legislative support, and increasing the scope of PPP utilization in yet more groundbreaking areas.

Public-private partnerships are becoming more sophisticated, innovative, financially viable, and consumer-oriented, addressing both public and private needs in many ways. Building upon the experience of the last 25 years, the number of PPP transactions has increased dramatically as have the cost savings in most cases. The benchmarks for cost savings to national and local governments from PPP

³⁴ Medicare, a social insurance programme, covers virtually all senior citizens and some of the disabled. Medicaid and the State Children’s Health Insurance Program serve as a social assistance safety net, covering the poorest and those whose medical expenses consume a large portion of their income, along with near-poor children (up to a family income level set by the state).

arrangements are ranging between 20-25%, as opposed to the 10-15% in previous years. Now, new PPP arrangements are designed to feature longer-term contracts, greater levels of service delivery, and the use of new technologies. Contracts are increasingly more sophisticated in allocating the risks between the public and private sectors, and PPP opportunities in general are becoming more financially attractive to government and consumers alike.

Greater opportunities for public-private partnerships in the US are driving the creation of better and more transactions. Across the sectors, the performance targets are met and exceeded in short periods of time, allowing governments to rip full benefits from PPPs. Technically experienced private sector partners are now more capable of offering better services at lower cost. Having tested the PPP success in traditional sectors, governments are realizing the need to further liberalize the regulatory control of public-private partnerships and bring PPPs to less customary sectors of the economy and society, through effective tri-sector partnerships³⁵.

Taken overall from the European and US experience on PPPs, new organizational arrangements on the provider/supply side of European health care system are emerging that combine public and private in complex, sometimes unique, ways. Far from being exercises in privatization, these new configurations are experiments in forming new types of public-private organizational arrangements that promote socially responsible entrepreneurial behavior.³⁶

6. Key Points:

As we already mentioned, the analysis can not end to a conclusion due to the fact that the research is still on process. Nevertheless, some key points are provided for the moment.

First, it is well known how difficult it is to implement actual reform. We should always mobilize the involved agencies, and be aware that reform is an iterative process. Nevertheless, countries that seek methods to improve their NHS (Greece for instance), should never forget that international comparisons provide valuable guidelines. Model use as well as coordination is two necessary factors which can drive health care systems to success. But still, even if Knowledge is our

³⁵ Katia Karpova, "Public-Private Partnerships (PPP) in the United States: A Snapshot of Recent Developments and New Directions".

³⁶ Richard B. Saltman, Ph.D., 2002 "The western European Experience with Health Care Reform", the European Observatory.

advantage, improving output of the Health Care Systems is never a breeze case. Some compromises in the political targets are inevitable.

Privatization is not inherently good or bad. The performance or effectiveness depends on implementation. It is still too soon to know whether the most recent and highly publicized privatization efforts, will be effective or not. And of course, cooperation between the public and private sectors requires an organization, such as the state, to act as coordinator and guarantor of equitable access of care and fair distribution of costs.

However, new approaches must be implemented and public-private partnership innovations in the structure of health systems and infrastructure are developing across the globe. Combining public and private sector strengths is increasingly seen as an important tool in finding solutions to the challenge of universal healthcare provision.

Making public-private partnerships in health care a reality requires political commitment and a clear understanding of how they can be best implemented in a particular country. The first step is for health professionals to establish a dialogue with finance officials and agree on a strategy to engage private sector investment and commitment.

Health policy officials should take advantage of the variety of experience in carrying out PPP health projects by conducting site visits and talking to other officials and private sector providers who have been through the process and are in operation. Expert advice should be sought in order to have the best chance of selecting the right approach and then implementing it effectively through the development of the legal and regulatory framework, institutional arrangements, and the development of success-oriented pilot projects.

The most important lesson learned from countries where this model have been adopted, is that the government in question must have sufficient skills and a capacity to deal effectively with the private sector. Badly structured contracts can result in the opposite effects to those intended. Governments must be equipped with the knowledge to extract maximum benefits from these arrangements, in key areas such as project design, procurement, negotiation and monitoring.

Public-private partnerships should be actively considered by developing the tools to use in meeting the objective of expanding health services and making resources work more effectively. Nevertheless, these partnerships should be regarded as social experiments; they show promise but are not a panacea.³⁷

³⁷ Roy Widdus, "Public-private partnerships for health: their main targets, their diversity, and their future directions", *Bulletin of the World Health Organization* 2001, 79(8).

Different solutions will, of course, be appropriate for different countries, depending on the current infrastructure and health system arrangements. Public-private partnerships offer governments the opportunity to benefit from private sector efficiency and access to investment, whilst retaining an overall strategic responsibility for healthcare systems. In the challenge of improving the health of all people, governments must look to all sectors for assistance and public-private partnerships can offer viable and sustainable solutions.³⁸

³⁸ Emma Thomas, "Public-Private Partnerships in Healthcare".

Exhibits

Exhibit 1: Policy Control Mix Alternatives

Option Ownership	Management	Operation	Policy Description
Public	Public	Public	Typical Public System or State - Owned enterprise
Public	Private	Public	Management Contract
Public	Private	Private	Management & Operations Contract
Public	Public	Private	Operations Contract
Private	Public	Public	Equipment & Facility Leasing
Private	Private	Private	Typical Private System
Private	Public	Private	Government takeover
Private	Private	Public	Government-paid Workers assigned to a private firm

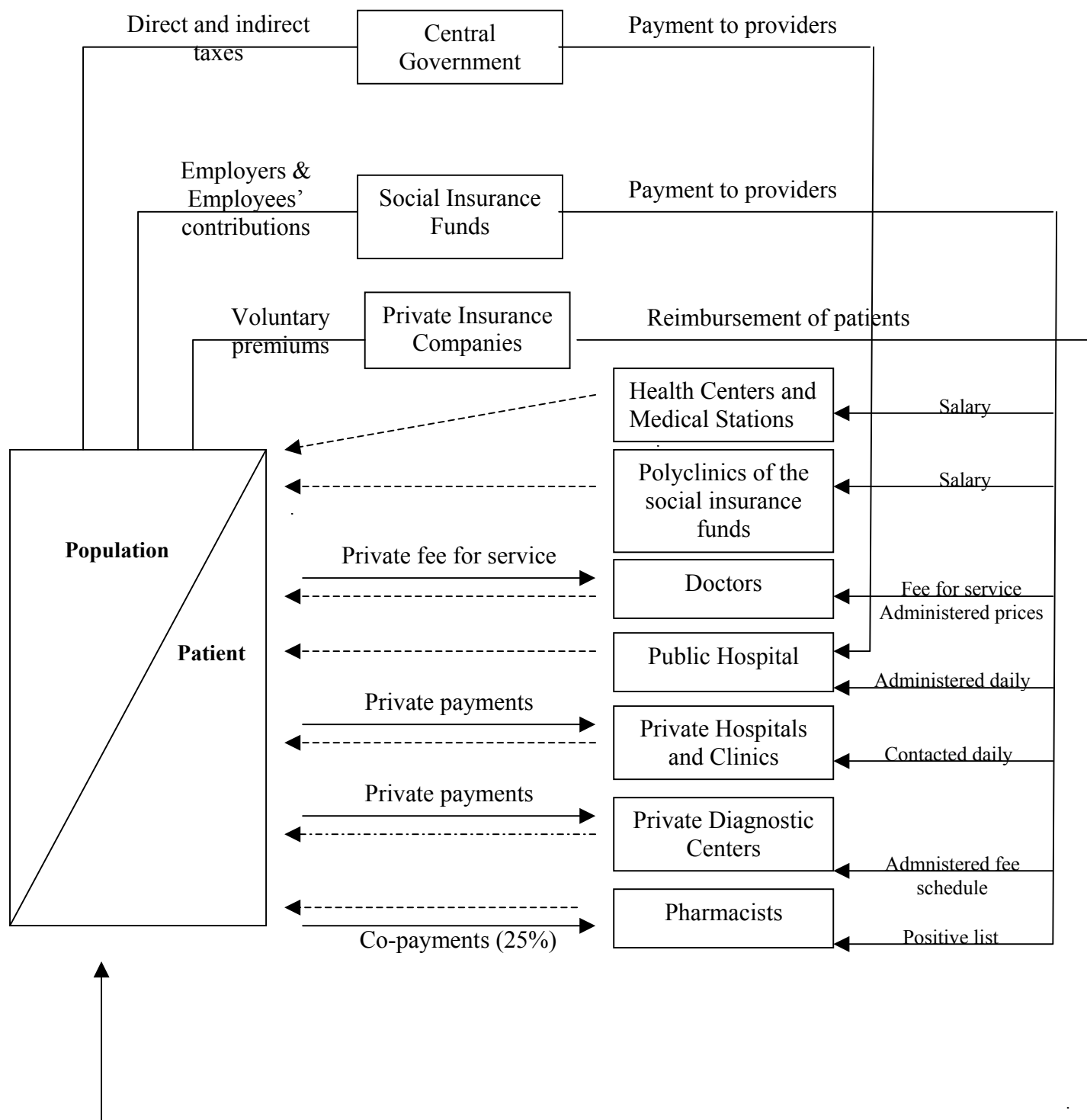
Exhibit 2: Overview of Options for using the private sector in the public health sector³⁹

Option	Private Role	Public Role
Co-location of private wing	Operates wing and may provide accommodation or clinical services Manages public hospital/contract	Manages public hospital/contract
Outsourcing non-clinical support services	Provides nonclinical services and employs staff	Provides all clinical services and hospital management
Outsourcing clinical support services	Provides clinical support services e.g radiology	Manages hospital and clinical services
Outsourcing specialized clinical services	Provides specialized services	Manages hospital and provides most services
Private management of a public hospital	Manages hospital under contract and provides services. May employ all staff and be responsible for capital investment	Contracts with private firm for provision of services, pay for services and monitors compliance
Private financing, construction and leaseback of new hospital	Finances, constructs and owns new hospital and leases it back to government	Manages hospital and makes phased lease payments to private developer
Private financing, construction and operation of new hospital	Finances, constructs and operates new public hospital and provides nonclinical and clinical services	Reimburses operator annually for capital costs and recurrent costs for services provided
Sale of public hospital as going concern	Purchases facility and continues to operate it as public hospital under contract	Pays operator for clinical services and monitors compliance

³⁹ Katia Karpova, "Public-Private Partnerships (PPP) in the United States: A Snapshot of Recent Developments and New Directions".

Figures

Figure 1: The Greek Health Care System



Source: OECD Health Data 1999

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