PRIVATIZATION IN HEALTH CARE: THEORETICAL CONSIDERATIONS AND REAL OUTCOMES

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ABSTRACT

Over the last two decades privatization of health care services has received a great deal of attention in virtually all industrialized nations. Privatization and the free market system have been particularly appealing models for countries that face rapidly escalating health care costs, increasing dissatisfaction with the efficiency and quality of care provided in public health facilities, and, most importantly, shrinking public resources to support provision of health care services. The main purpose of this paper is to systematically examine the role of privatization in the health care field. The paper concludes that privatization of health services has the potential to solve some, but not all, of the problems faced by many countries in their health care systems. A properly designed and managed system of partnership between the public and the private sector, rather than total elimination of the government role in health care is advocated based on the experiences of different countries with privatization of their health care systems.

INTRODUCTION

Over the last two decades privatization of health care services has received a great deal of attention in virtually all industrialized nations. Privatization and the free market system have been particularly appealing models for countries that face rapidly escalating health care costs, increasing dissatisfaction with the efficiency and quality of care provided in public health facilities, and, most importantly, shrinking public resources to support provision of health care services (Manga, 1987; Scarpaci, 1989; Young, 1990; Banoob, 1994; McLaughlin, 1998). Although advocates of privatization believe that the sale or administrative transfer of public goods and services to the private sector will stimulate market competition and improve the efficiency and quality of

service provision, opponents see serious limitations to the role of privatization and free market forces in health care.

The main purpose of this paper is to systematically examine the role of privatization in the health care field. The paper is organized as follows. First, I discuss the role of markets in health care and provide the economic rationale for government intervention in cases where competitive markets tend to fail. The next section explains the meaning of privatization and distinguishes various types of privatization that have been observed in health care. This section is followed by the discussion on potential benefits and problems of privatization. I then present the detailed literature findings, paying particular attention to published reports of actual experiences of industrialized nations including Great Britain, United States, and Canada as well as other eastern and European countries and evaluate the extent to which their efforts have been successful. The last section summarizes the lessons to be learned from the privatization initiatives and discusses important policy and research implications for the future.

The paper concludes that privatization of health services has the potential to solve some, but not all, of the problems faced by many countries in their health care systems. A properly designed and managed system of partnership between the public and the private sector, rather than total elimination of the government role in health care is advocated based on the experiences of different countries with privatization of their health care systems.

THE ROLE OF MARKETS IN HEALTH CARE AND ECONOMIC RATIONALE FOR GOVERNMENT INTERVENTION

Competition versus regulation has been a fundamental health policy choice in many countries for improving both financing and delivery of their health care services. Economics shows that if certain conditions are met, then allowing market competition to operate unencumbered by government interference will result in economically efficient outcomes (Fielding & Rice, 1993). One of the most important aspects of pure competition is the long-run behavior of firms in this market structure. In the lung run, purely competitive firms "operate at the lowest possible cost, charge the lowest price that they can without going out of business, and earn no economic profit " (Welch & Welch, 1992). Competitive markets are likely to produce the optimal rate of output, because individuals benefiting a service pay the full costs of producing that service in such markets.

Resources are also optimally allocated since additional benefits from consuming the last unit are equal the cost of producing that last unit (Feldstein, 1994).

However, there are several conditions that need to be met for such an outcome to occur. First, there must be numerous buyers and sellers in the market, each with no power over price. Second, entry into and exit from the market must be free. Third, the goods and services produced must be homogeneous, and consumers and producers must possess perfect information regarding the price and quality of alternative choices. Finally, the efficiency of competitive markets is derived under conditions where there are no significant externalities, public goods, and monopolies (Folland, Goodman & Stano, 2001).

There is little doubt that some of these conditions are not met in the health care market. The health care markets depart from competition in several important ways. First, there are barriers to entry such as licensure laws and health planning controls on prices and facility construction. Second, products and services produced in the health care market anything but homogeneous, and consumers have limited information. Third, firms have the potential to form monopolies given their small size in certain markets. Finally, externalities are prevalent in health care (Fielding & Rice, 1993; Folland, Goodman & Stano, 2001).

In general, when the prices of all goods and services equal the marginal social benefits and marginal social costs of these items, the market system is said to achieve an efficient outcome (Hyman, 1993). Governments can have a role in improving market efficiency in cases where competitive markets tend to fail. Therefore, government intervention in health care industry is generally justified on the basis of some form of market failure. The most prominent examples of market failure involve monopoly power, externalities, and public goods (Folland, Goodman & Stano, 2001).

A firm exercises monopolistic power when it influences the price of the product it sells by reducing output to a level at which the price it sets exceeds marginal cost of production (Hyman, 1993). Examples of health care markets where firms can exercise monopoly power include hospital services in markets with few providers, pharmaceutical products that are protected by patents, and licensure laws and other forms of regulation that restrict entry into professions like physicians and dentists (Folland, Goodman, & Stano, 2001). Monopoly is inefficient because it produces too small a level of output than a competitive market. Efficiency could be attained by forcing the monopolist to increase his output until prices fell to a level equal to marginal social costs. The appropriate

government remedy to decrease monopoly power include elimination of barriers to entry into a market, preventing price collusion, and improving information among consumers (Feldstein, 1994).

The second situation where the allocation of resources can be improved is when there are externalities in a market. An externality can be defined as "an uncompensated direct effect of the production or consumption of a good on persons other than the producers or consumers" (Folland, Goodman, & Stano, 2001). The effects on others could be positive or negative. Negative externalities are costs to third parties, other than the buyers or the sellers of an item, not reflected in the market price (Hyman, 1993). An example of a negative externality is the damage done by industrial pollution to persons and their property. Positive externalities, on the other hand, represent benefits to third parties, other than buyers or sellers of a good or a service, not reflected in prices. For example, inoculation against a disease results in a positive externality. Those who are vaccinated benefit themselves, of course, but the external benefit of inoculations is the reduction in the probability that those other than persons purchasing vaccinations will contract the disease (Folland, Goodman & Stano, 2001).

When a negative externality exists, too much output will be produced and sold in a competitive market relative to the efficient amount. In this case, the marginal social cost will exceed the marginal benefit. Conversely, positive externalities will lead to underproduction and higher-than-optimum prices, where marginal social benefits exceed the marginal cost. When such external costs and benefits exist, governments should calculate their magnitude, then use subsidies and taxes to achieve the optimum rate of output in the market place (Folland, Goodman & Stano, 2001; Feldstein, 1994).

Market failure also arises because only an inefficiently small quantity of pure public goods will be provided in private markets. A pure public good is "one for which consumption is nonrival (i.e., consumption by one individual does not reduce someone else's consumption) and nonexcludable (i.e., a consumer cannot be excluded from consuming the good either by having to pay or through some other mechanism)" (Folland, Goodman & Stano, 2001). National defense is often given as a prominent example of a pure public good. Even if one refuses to pay the costs of national defense, that person will still be defended. Although it has been argued that health care services represent private goods (Folland, Goodman & Stano, 2001), certain public health services such as, inoculations and environmental protection do share the characteristics of public goods and

governments are expected to be provide these services given their predicted undersupply in private markets (Hyman, 1993).

Finally, efficiency is not the only criterion that is used to evaluate resource allocation in a society. It has been argued that outcomes should also be evaluated in terms of equity, that is, in terms of the perceived fairness of an outcome (Hyman, 1993). Critics of the market system claim that many participants in the system cannot satisfy their most basic needs because low incomes provide them with little capacity to pay for market goods and services. Therefore, they argue, it is necessary that these disadvantaged group of people receive transfers financed by taxes on more fortunate members of society. In the context of health care markets, redistributive government programs (i.e., Medicare and Medicaid in the United States) have the function of lowering the cost of services to a particular group by enabling them to purchase those services at below-market prices (Feldstein, 1994).

To summarize, under certain circumstances competitive markets are shown to fail in providing health care services efficiently. Even if the competitive markets can achieve efficient distribution of health care services, it is possible to find many people in society who are not satisfied with the way these services are being provided in the market place (i.e., equity considerations). Therefore, the market failure to achieve efficient and equitable outcomes is commonly used as a basis for recommending government intervention in health care markets or government provision of services.

CONCEPTS OF PRIVATIZATION

At the most basic level, privatization refers to the transfer of ownership and management of publicly owned assets to the private sector. While in its narrowest sense, privatization has been described as a tool used by public sector agencies to improve efficiency or lower costs, in a much broader sense it is defined as "a philosophy of government that advocates a greater role for private market incentives and the mechanism of competition in achieving public purposes" (Gardner & Scheffler, 1988).

In the context of health care, the term "privatization" is equated with reduced levels of public provision, subsidy, or regulation of either preventive or curative health services (Scarpaci, 1989). The emphasis on provision, subsidy and regulation is particularly important given privatization is mostly associated only with the private provision of public services. However, privatization in

health care often includes a broad range of arrangements (contracting-out, contract management, and load-shedding) rather than sale of public assets to the private sector. Indeed, it has been argued that health care privatization rarely entails the sale of an entire health program to a private fee-for-service provider (Scarpaci, 1989).

While contracting out particular health services with the private sector is said to represent commercialization rather than privatization (Forde & Malley, 1992), this form of privatization has been widely used by many state governments to provide health care services to their Medicaid and Medicare beneficiaries in the United States. Through contracting states have been able to shift some of the financial risk and responsibility to the private sector while maintaining their actual accountability and oversight responsibility (Gardner & Scheffler, 1988).

Another example of privatization in health care is the contract management of public hospitals. With contract management, provision and control of certain components of hospital operation, such as management services, laundry and food services are transferred to the private sector but the responsibility and accountability remains with the public sector.

Load-shedding represents one of the most extreme forms of privatization in health care. In the case of load-shedding, the performance as well as the responsibility of service delivery are transferred to the private sector. This form of privatization often manifests itself when the government totally withdraws itself from the delivery of a service that it no longer considers to be the responsibility of the public sector (Gardner & Scheffler, 1988; Smith & Lipsky, 1992).

POTENTIAL BENEFITS OF PRIVATIZATION

During the past two decades, governments have frequently turned to the private sector to lower costs and increase efficiency because of increased health care costs, decreased government subsidies, and a myriad of constraints on resources. The reliance on privatization as a cure for the health care sector's rapidly increasing costs is mainly due to ingrained beliefs about the nature of publicly-owned entities and their privately-owned counterparts. Many of the arguments in favor of privatization reflect the views of those people who belong to the public-choice school, such as James Buchanan, Anthony Downs, Gordon Tullock, and writers associated with the Institute of Economic Affairs as well as Frederick von Hayek and Milton Friedman of the Department of Economics at the University of Chicago (Scarpaci, 1989). The main argument of this school is that

the invisible hand of the market is more efficient and responsive to consumer needs than the government and the government should play only a minimal role in society.

The proponents of privatization not only believe that the government is inefficient mainly because it can not provide services at a minimal cost, but they also contend that efficiency and innovation in the private sector is frequently hampered by the government interference with private sector activities through regulation (Scarpaci, 1989; Smith & Lipsky, 1992).

Advocates of privatization also claim that privatization introduces savings of community financial resources because the private sector is assumed to manage public assets more efficiently (Forde & Malley, 1992). The role of managers in the private sector is one of the key factors in this regard. Generally speaking, managers in the private sector are said to be more accountable and sensitive to consumer demands since they are often subject to removal by their respective stockholders (Scarpaci, 1989).

In contrast, managers in the public sector are mainly salaried and do not have the same monetary incentives that their private counterparts enjoy. Therefore, they are assumed to be less concerned with the efficiency of their service provisions. However, it is important to note that in health care, not all private firms are for-profit. In economic terms, the most important distinction of the nonprofit firm is the nondistribution constraint which means that no one is allowed to have a legal claim on the nonprofit's residual (revenues over expenses) (Folland, Goodman & Stano, 2001). Indeed, there is evidence to suggest that nonprofit entities and their managers are more likely to emphasize "a mission of community service in addition to the maintenance of financial viability", "provision of charity care", and "commitment to medical education and clinical training programs for physicians and other health care personnel" than their for-profit counterparts (Gardner & Scheffler, 1988).

Another important factor assumed to facilitate higher efficiency and innovation in the private sector is the lack of government bureaucracies that are often thought to hamper innovations. Through privatization, it is possible to free a particular service from government restrictions which allows it to expand according to consumer demands.

One of the key arguments in favor of privatization is that it promotes and maximizes "individual choice". Proposals favoring voucher like systems in health care, which allow individual choice of providers while fostering competition among service providers, have their roots in this individual choice

argument (Smith & Lipsky, 1992). It has also been argued that through increased competition, privatization encourages the public sector to become more cost conscious, and improve overall efficiency of service provision and resource allocation (Forde & Malley, 1992). Finally, the removal of the responsibility of providing health services from the public sector is said to decrease the financial burden of the public sector and release public resources for other alternative programs (Mohan, 1989; Forde & Malley, 1992).

PROBLEMS OF PRIVATIZING HEALTH SERVICES

The underlying assumption of privatization is that through competition in the market place it is possible to maximize consumers' freedom of choice and providers' autonomy which will eventually lead to higher quality and minimum costs. However, there are a few economists, in particular Kenneth Arrow, Robert Evans, and Eli Ginzberg, who are convinced that the paradigm of the competitive market cannot be applied to health care (Ginzberg, 1988).

One of the key assumptions of a competitive market is that consumers have the necessary knowledge and expertise to make a free choice on the services available in the marketplace. This is a particularly problematic assumption in health care because consumers' knowledge of health and medical care is usually inadequate to make informed decisions (Scarpaci, 1989; Banoob, 1994). Another concern about market competition is the potential that some health care providers can form monopolies and keep increasing fees indefinitely unless they are regulated (Forde & Malley, 1992; Banoob, 1994). It has been also argued that private insurance companies can skim the market to minimize their own risks and maximize their profits (Manga, 1987). Finally, under a fee-for-service reimbursement system, providers can initiate unnecessary diagnostic and therapeutic procedures in the absence of an aggressive system of utilization review and quality monitoring (Banoob, 1994).

Because of the several market failures described above and earlier in this paper, the opponents of privatization argue that a dominant role of the public sector in financing and provision of health care is essential to avoid waste and social inequity (Janssen & Van der Made, 1990).

In contrast to public provision of services, free market approaches are also said to fail in promoting altruistic behavior in a society which is essential for the formation of social cohesion (Scarpaci, 1989). In fact, one of the most persuasive rationale for public provision of services is the fact that some individuals in

society feel altruistic concern about the health or level of medical-care consumption of their fellow citizens, especially those with low incomes than themselves (Bovbjerg, Held & Pauly, 1987).

Finally, it has also been noted that public provision of health services through central coordination is more efficient than market-oriented approaches especially in developing countries with less mature-private markets (Scarpaci, 1989).

PRIVATIZATION INITIATIVES OF SELECTED COUNTRIES

Having discussed the pros and cons of privatization in health care, this section will take a closer look at the privatization efforts of different countries within their health care systems to draw some general lessons to be learned from their experiences. I will first provide a rather detailed assessment of the privatization initiatives in Great Britain, United States, and Canada. This will be followed by a brief review of the experiences of other eastern and European countries.

Great Britain

In Great Britain, establishment of a proprivatization policy by the Conservative government in 1979 has been the key factor for the development and implementation of various privatization initiatives. The primary examples of these include the sale of unneeded NHS property to private developers, increasing contracting out of clinical and nonclinical services, and provision of tax-based and other incentives to people for the purchase of private health insurance. With the government's "ideologic commitment to a reduction of the State's role in the economy, together with creating a climate in which the private sector can flourish" (Gardner & Scheffler, 1988) governmental privatization initiatives have been instrumental in stimulating the shift of responsibilities for health care delivery from the public to the private sector in Great Britain.

An excellent analysis of the extent of health care privatization under the Conservative government and its potential effects is provided by Mohan (1989). In his article, the author discusses the arguments for and against privatization in the British context by examining four key aspects of privatization: (a) the private finance and provision of health care; (b) the public finance and private provision of health care; (c) the subcontracting of NHS services to the private sector, and (d)

commercialization of the activities of health authorities. The following details about the privatization initiatives in Great Britain come from Mohan (1989).

Although the National Health System (NHS) model of Great Britain is characterized by national ownership or control of production factors, the Conservative government has encouraged the growth of the private sector on the grounds that it can supplement the state's limited resources to provide the necessary health care services to the public. Therefore, in Great Britain "the private sector is seen by the government as supplementing, not supplanting, the NHS."

Private funding and provision of acute hospital care services represents one of the first privatization initiatives in Great Britain. This particular privatization initiative has initially increased the resources available in the health care market place and facilitated greater individual choice of services in the country. However, increased competition later resulted in excess capacity, leading to the closure of under-capitalized individual hospital units, and serious concerns about the profit motives of the hospital chains which was incompatible with the British tradition of non-profit health care.

The private provision of publicly funded long-term care services for the elderly populations represents another form of privatization in Great Britain. The nursing home industry has enjoyed a rapid expansion in the country after the Conservative government adopted a policy which allowed the cost of accommodating elderly people in private nursing homes to be met by the social security budget where no suitable public-sector accommodation is available.

Again while this form of privatization has increased the supply of nursing beds in communities with a high proportion of retirees, it has been reported that the concentration of nursing homes had varied greatly both geographically (areas with high retirement migration having more nursing homes) and within health authorities. In addition, maintaining a standard level of care provision in nursing homes has proven to be critically important given the empirical evidence of poor care practices in a number of nursing homes. While this has required greater regulation and monitoring of such homes in order to assure compliance, increased regulation by the state is said to have an undesirable effect of compromising the independence of privately run nursing home facilities.

Another striking example of the effect of privatization on health care services in Great Britain involves a government policy of transferring former patients of long-stay psychiatric hospitals out of institutions into the community. While the goals of this policy were "to help patients lead autonomous lives and to

avoid the stigma and institutionalization associated with long-stay hospitals", the lack of resources in the community to provide replacement facilities when long-stay hospitals are closed produced very disturbing outcomes for the patients. Having been discharged into communities that are unable to care for them, many of the patients ended up on the streets, in doss-houses (flop-houses), or in prison. Others, who could afford private-sector accommodations, have become vulnerable to exploitation by landlords.

The other principal form of privatization in Great Britain involves the private provision of ancillary services. After the 1983 election, the government required all health authorities in England to expose their main support services (laundry, cleaning, and catering) to competitive bidding. Although this initiative was mainly aimed at achieving greater efficiency in the NHS, it also served the government's desire to weaken NHS trade unions following their involvement in major NHS industrial disputes. In implementing its policy, the government faced considerable resistance from the work force given the fact that almost two thousand jobs were threatened by this initiative. In addition, many District Health Authorities (DHAs) were unwilling to disrupt their positive relationships with the work forces. Therefore, there was conflict between not only DHAs and the central government, but also trade unions and DHAs. Moreover, the extent of contracting-out of services has been reported to be uneven between the rural and urban areas with private contractors being more successful in rural than urban DHAs.

In Great Britain, both technical and political factors have been the main causes of observed variations in contracting-out initiatives. With regard to the technical factors, the high cost of capital was one of the barriers to entry for laundry and catering industries for many private contractors. In addition, private contractors have had a difficult time in breaking into the market because recent capital investments made a large proportion of laundry and catering plans in NHS hospitals relatively modern and efficient. Therefore, private contractors have been active mostly in tendering for cleaning services where barrier to entry was less of a problem. They have also been able to undercut NHS tenders by cutting down on worker wages. In terms of the role of political factors, it has been reported that some health authorities in Great Britain have been forced to put contracts out to a private contractor, even though the private contract has not always been the economical option.

Overall, while the government has claimed some cash saving as a result of subcontracting the ancillary services, it has been argued that these alleged savings

have not been weighed against a set of unquantified costs. Examples of these costs include unemployment payments to former NHS employees, social security payments to those forced to accept lower wages as well as the costs associated with staff time and efforts of preparing specifications for contract tender documents. In addition, this form of privatization has received serious criticisms from the labor force, which maintained that cost savings have been realized at the expense of the worst-paid section of the NHS labor force- predominantly female part-timers. Given the total gross savings amounted to only less than 0.5 percent of the NHS budget, the success of the government's competitive tendering initiative was very limited in the country.

Finally, a more recent trend in terms of privatization initiatives in Great Britain has been the development of more collaborative types of relationships between the government and the private sector. Some primary examples of such initiatives include the encouragement of charitable fundraising for hospitals, a proposal for joint planning between a DHA and the private sector, and the possibility of commercial involvement in the running of parts of some hospitals in London.

United States

In American health care, production of health care services is largely in the private sector regardless of whether financing is public or private. Most privatization initiatives in the United States represent a number of attempts made by the government to control the rapidly rising cost of health care. The primary examples of privatization in the United States that I would like to discuss briefly include: the use of selective contracting and competitive bidding by states, contract management of public hospitals, and, more recently, the use of case management and managed care approaches in health care delivery.

Selective contracting in health care is defined as "a system by which a payer (either public or private) defines a restricted list of health care providers for its subscribers or recipients" (Gardner & Scheffler, 1988). Under such a system, a process of competitive bidding is generally used to determine the ultimate providers of care with reimbursement arrangements ranging from fixed fee schedules to some sort of capitation payments. According to Christianson (1985), the major assumption underlying the use of competitive bidding and selective contracting is that the process "rewards providers who restrain fee and charge increases or develop cost-effective ways to organize and deliver care, since

these actions could result in lower bids and, consequently, increase the likelihood of winning a contract."

The reality check of this assumption is provided by Gardner & Scheffler (1988) who reviewed the literature on states' experiences with selective contracting and competitive bidding in the United States. The authors' assessment of the state of Arizona's Medicaid program -Arizona Health Care Cost Containment System (AHCCCS)- indicated that while the program had achieved a modest degree of success in caring for the indigent without increasing total public health expenditure in the first year, the state funding for the program increased dramatically between the first and second year as a result of the expansions of benefits. Further, the authors noted many problems with the administration of the AHCCCS such as, failure to pay providers promptly and excessive overhead costs which necessitated the return of the program administration to public control from the private sector. Finally, the competitive bidding process had to be modified in practice because the state had no choice but to give the bidders the opportunity to negotiate or re-bid given that some providers' initial bids exceeded anticipated levels. This, in turn, resulted in inflated bids in the initial round of the bidding process which raised costs to the government in the long term.

The California Medicaid program, Medi-Cal, is another example of selective contracting in the United States. It has been reported that by using competitive bidding and selective contracting, the state saved close to $200 million dollars in the first six months of the program (Iglehart, 1984). In the first full year, actual expenditures for the program were reported to be $165 million below the projected costs with little documented harm to beneficiaries (Johns, Derzon, and Anderson, 1985). According to the most recent evidence, Medicaid selective contracting is said to reduce the rate of inflation in average costs per admission and per patient day during the period of 1982 to 1986 (Gardner & Scheffler, 1988).

Another common form of privatization in the United States is the contract management of public hospitals. Contract management generally involves a formal agreement between a private firm and the board of trustees of a hospital, under which the private sector assumes responsibility for the day-to-day management of the hospital (Alexander & Lewis, 1984; Manga, 1987). However, under contract management, the hospital remains a part of the public sector and the legal responsibility of the managed institution still rests with the board of trustees.

Many of the arguments in favor of private management of the public hospitals are based on the superior performance of the private sector over the public sector. Easy access to increased management expertise, joint purchasing and capital, ability to make decisions quickly, and timely response to consumer demands are some of the examples of the advantages of the private management often cited in the literature (Alexander & Lewis, 1984; Manga, 1987: Gardner & Scheffler, 1988).

In contrast to the theoretical propositions, the available empirical evidence regarding the performance of contract-managed hospitals by the private sector (especially by for-profit firms) indicated that reported profitability increases were most likely to be achieved as a result of higher mark-ups as opposed to the increased productive efficiency, expenses per patient day were higher under contract management, and certain services, such as occupational therapy, psychiatric outpatient, and psychiatric emergency services are likely to be dropped when a public hospital becomes contract managed (Rundell & Lambert, 1984; Kralewski et al., 1984; Gardner & Scheffler, 1988). In addition, it is also argued that private management corporations tend to target hospitals that are experiencing greater than average operating and financial problems and most likely to be small and located in rural areas in the United States (Manga, 1987).

Case management and managed care approaches to patient care have also been viewed as other important manifestations of privatization in the American health care sector given the fact that when the public sector requires either of these approaches for the delivery of care, these services are generally contracted out to private organizations (Gardner & Scheffler, 1988). Gardner and Scheffler argued that although these two terms are conceptually related, they represent different methodological approaches to health care delivery. Therefore, they suggested that "case management" be used to refer to "the coordinated evaluation, selection, and provision of appropriate clinical alternatives at the individual patient level." On the other hand, the term "managed care" is said to imply "a more macro approach, involving the integration, monitoring, and control of the use of health care resources, generally instituted at the organizational level for the purpose of constraining utilization and thereby containing costs" (Gardner & Scheffler, 1988).

In recent years, attention in both the private and public sectors increasingly has turned to managed care as a means for both holding down growing health care costs and increasing access to health services in the United States. Indeed, virtually every state is increasing their reliance on managed care

as a health care delivery model for its Medicaid population. While in 1983, only 3 percent of the Medicaid population (750,000 beneficiaries) were enrolled in managed care, this figure has increased to 11.6 million Medicaid beneficiaries (almost one-third of all beneficiaries) by 1995 (Rowland & Hanson, 1996).

Currently there are three major Medicaid managed care models being used by most states: (a) fee-for-service primary care case management, (b) limited-risk prepaid health plans, and (c) full-risk plans (Health Maintenance Organizations -HMOs or Health Insuring Organizations- HIO. Although the primary care case management model has accounted for much of the growth in managed care enrollment in the early 1990s, the HMO full-risk model is the type of plan now used most often by states in their Medicaid managed care programs (Rowland & Hanson, 1996).

As with other forms of privatization analyzed in this paper, it is necessary to monitor the impact of managed care on access to and quality of care for the Medicaid population as the share of Medicaid beneficiaries in managed care continues to grow. In my view, this is critical given Medicaid managed care programs are being implemented primarily to contain rising costs of the Medicaid program and the Medicaid population is comprised primarily of low-income women and children, disabled persons and the elderly- a population that needs even greater protection against any undesirable effects of market-oriented approaches to health care in this country.

However, most recent evidence regarding the experiences of five states with Medicaid managed care does not seem to present a desirable picture of the states' monitoring ability. Along with many problems with the administration of these programs, Rowland and Hanson (1996) reports that "none of the states had sufficient data to routinely monitor either baseline care patterns and access or the effects of the initiative... Virtually no state had information on care patterns and access to care for the uninsured before they were eligible for the program." Of course, valid assessment of the performance of Medicaid managed care programs is almost impossible without the presence of complete and reliable information.

Canada

Unlike the Great Britain and the United States, there has never been a substantive drive toward privatization in Canada. Available evidence also indicates that presently there is no serious advocacy of privately owned acute care hospitals or a desire to return to a private insurance system for services currently

covered by the Canada Health Act (Manga, 1987). Perhaps more importantly, private insurance is outlawed by most provincial legislations in the country.

In a theoretical paper, Manga (1987) discussed the pros and cons of health care privatization in the context of Canada's current health care system. According to the author, the most common forms of privatization that have been implemented or are under consideration for future implementation in Canada include the following: (a) increased private financing of physician services through extra-billing, (b) increased funding of hospital operating expenses through user fees, (c) increasing funding of hospitals through philanthropy, commercial activities or contracts for purposes of capital replacement or facility or program expansion, (d) the increased use of private for-profit management of hospitals, (e) contracting- out in part or in whole certain activities of hospitals such as laundry, laboratory, and purchasing of supplies) to private for-profit firms, and (f) the administration and management of certain governmental activities such as medical claims processing and maintaining information systems by private firms.

The author's assessment of the privatization initiatives listed above is based on the following three major health policy objectives: economic efficiency, containment of overall or public sector expenditures, and equality of access to health services. Manga argues that any specific privatization initiative should meet these policy objectives in order for it to be considered an acceptable health policy option in Canada. The author's detailed discussions of the individual privatization proposals using the three health policy objectives shape his overall judgment (rejection) of privatization in health care.

In this section I would like to explain the first type of privatization that played a dominant role in the discussions presented by Manga. Underlying the user fees approach, Manga argues, is the assumption that excessive consumer demand is the main driving force for escalating health care costs. Therefore, it has often been argued that it is possible to discourage unnecessary use of health care services by increasing "patient responsibility" for health care costs. In the Canadian context, the notion of increased "patient responsibility" has been translated into patients paying a greater proportion of total health care costs directly through hospital per diems and physician charges through extra-billing. Based on the available evidence from empirical studies on extra-billing, Manga concludes that this form of privatization is not likely to enhance the technical efficiency with which medical services are produced, less likely to reduce total

expenditure on health care services, and most likely to reduce accessibility to care largely among the poor people.

With regards to the technical efficiency objective, Manga points to the evidence that physicians who practice extra-billing themselves believe that their productivity in terms of hours of work and patients seen per day would rise if extra-billing were to be banned. In addition, extra-billing is said to reinforce the fee-for-service method of reimbursing physicians which is less likely to improve technical efficiency by encouraging health manpower substitution in the production of health services, especially in a period of rising supply of physicians.

In terms of the effect of extra-billing on total health care expenditures, Manga argues since the price elasticity of physician services is quite low, the increased price per service more than offsets the reduction in utilization that might occur under extra-billing. Further, he claims, there is no guarantee that the reduction in utilization will produce savings to the health care system as a whole because patients may substitute a more expensive type of hospital services (emergency care) for physician services, they may forego preventive care which latter necessitates more expensive care, and finally physicians themselves may increase their service intensity as a response to a decline in the number of patients. Based on these arguments, Manga concludes that total (public and private) health expenditures are more likely to rise under extra-billing. Finally, the author argues that extra-billing might have serious negative consequences for the equity objective because it reintroduces financial risk to the sick and might deter the use of necessary care, at least among the poor.

As for the other forms of privatization, Manga summarizes his discussion by stating that the empirical findings are "confusing and inconsistent and preclude a definite conclusion as to the wisdom of a general push for privatization". Only contracting out hospital services was favorably judged by the author and it is felt that Canadian hospitals have not used this form of privatization sufficiently to take advantage of lower cost opportunities in the private market. Overall, the author favors even more regulatory government involvement to achieve greater economic efficiency and equity in the health care sector.

Other Eastern and European Countries

In a recent article Banoob (1994) provides some valuable lessons to be learned from the health services privatization initiatives of selected eastern and

European countries. For example, in Russia a new approach to decentralize the health services, based on the health maintenance organization (HMO) model of the United States, is reported to produce some undesirable outcomes as a result of the system's efforts to control costs. Restrictions of referrals from polyclinics to hospitals, refusals of certain diagnostic procedures, and practice of performing outpatient surgical procedures in polyclinics are said to put an increasing number of patients at risk of suffering serious complications given a lack of quality monitoring systems in place.

Another unexpected outcome with the market-oriented approach to health care in Russia relates to the requirement of mandatory health insurance for all citizens of the country. Despite the fact that some large companies did in fact offer health insurance for their employees, many newly formed private insurance companies experienced low revenues given the employers allocate only 3.5% of employees' wage to health care- a figure that poorly compares with corresponding figures of Germany (12.5%) and the United States (10%).

Czech Republic is another country which also began to explore policies of privatization and reducing the role of government in 1990 by setting the basic principles of health care in two stages: "first, to eliminate unnecessary bureaucratic barriers and deformations and release latent resources for health care; second, to reform management and make communities the owners of health institutions." It has been reported that the country has had many implementation problems which required several redesigns in the second stage and delayed the scheduled implementation (Banoob, 1994).

Finally, the case of Hungary provides an excellent example of the extent to which health policies can be formulated to be explicit about the principle of privatization in any health care reform initiative. In 1990, all national and regional authorities in Hungary were abolished and replaced with autonomous health facilities with the implementation of a program called "The National Renewal Programme." Despite this program specifically stating that "putting institutions in private hands, we give impetus to enterprises flexibility in meeting the needs of the population. The restructuring of the service system will be integrated with the diversity of ownership.", similar to the case of Czech Republic, this privatization initiative could not be implemented as scheduled, and modifications have been made to facilitate a slower and practical approach with a more balanced mix of public and private financing.

Based on the experiences of the eastern and central European countries explained above, Banoob (1994) stresses the need for a careful examination of the

other market economy health systems, focusing especially on their mistakes, before rushing into any kind of radical health care reform. He reminds us that in this century, learning by doing in health care is too expensive and risky. Therefore, the author recommends a long-term planning period of at least 7-10 years to effectively build a health care system with a mix of public and private components rather than totally eliminating the existing government-run systems (Banoob, 1994).

Similarly, Young (1990) encourages European countries to develop health policies that favor maintaining an appropriate mix between competition and regulation rather than moving toward a completely unregulated health care system.

CONCLUSIONS AND SUMMARY OF THE LESSONS TO BE LEARNED

At first glance, privatization of health care services seems to be a panacea for the current fiscal crises faced by many countries. However, it is important to assess both short-term and long-term realities to understand the full impact of privatizing any area of service. Privatization can lead to lower costs and some savings in the short-term but it may not match with long-term objectives. Scarpaci (1989) specifically rejects the proposition that health services privatization is merely a response to the fiscal crises of the government or part of a global conspiracy to roll back the welfare state. Instead he argues that "health services privatization depends on the specific nature of conflict among the state, the private sector, health care consumers, and capital." It is also important to note that the results of a particular privatization initiative may be heavily affected by the political, economic, and social situation of the country under consideration.

The review of the literature on the privatization of health care services suggested that the case for and against privatization is not clear. In theory, privatization can lead to higher market competition, higher efficiency and quality of service provision, lower costs, and greater consumer choice. However in practice, it has proven to be very difficult to materialize many of the theoretical promises, if it is not properly designed and implemented.

According to Gardner and Scheffler (1988) there are two factors that can cause difficulties in implementing any privatization initiative: " (a) failure of those who are designing and implementing the process to understand (or trust, or be patient with) the basic "philosophy" of privatization, resulting in improperly structured incentives or other design flaws, and (b) political constraints, which compromise even a well-designed privatization effort."

In the case of the United States, selective contracting through competitive bidding presented a primary example of how implementation difficulties might require even a greater involvement of the government in the bidding process which clearly undermines the real price-cutting impact of the private sector. The experience of Great Britain with contracting-out demonstrated how political constraints could sometimes lead to choices that are not always economical. In addition, both Great Britain's experience with the private provision of nursing home services, and the United States' experience with Medicaid managed care arrangements demonstrate the importance of having appropriate monitoring mechanisms in place to maintain the quality of care provision by the private sector

and protect consumers against any undesirable effects of privatization. Further, the case of Canada highlights the importance of assessing individual privatization proposals against well-specified health policy objectives in any country where privatization of health care services is considered as a viable policy option. Finally, it has also been documented that the need for hasty implementation and unrealistic time frames of privatization initiatives as well as the immaturity of private market systems can lead to several redesigns and compromises in practice based on the experiences of Russia, the Czech Republic and Hungary.

The present review also revealed the need for more empirical studies to document the likely effects of privatization on health care costs, quality, and accessibility. As evidenced from the articles that were reviewed in this paper, most of the analyses of health services privatization tend to be descriptive in nature with extensive theoretical discussions of the merits and weaknesses of privatization.

Another important limitation of the literature on health care privatization relates the indiscriminate use of the term "private sector" by many scholars to represent only for-profit organizations. While there is a general agreement that the term "privatization" refers to the process of transferring certain governmental responsibilities to the private sector, it is important to note that these activities can be assumed by either investor-owned for-profit or not-for-profit private organizations. Since there is considerable evidence to suggest that investor-owned for-profit and not-for-profit firms differ in their approaches to health care delivery (Alexander & Lewis, 1984; Schlesinger, Marmor & Smithey, 1987), it is important to make the distinction between the for-profit and not-for-profit firms in future studies of any types of privatization initiatives.

A common theme has emerged from a number of articles that were reviewed in this paper: It is the public-private partnership, rather than total elimination of the government role that has the greatest potential to address many of the problems that each country faces in its health care system. However, since each country has its unique set of resources to support health services and organization and delivery systems to provide care, it is necessary that each country design and manage its own system of partnership between the public and the private sector.

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