Pragmatism is beginning to trump ideology in Europe's 'public-private' debate over healthcare

blogs.lse.ac.uk/europpblog/2014/10/09/pragmatism-is-beginning-to-trump-ideology-in-europes-public-private-debate-over-healthcare/

09/10/2014

The merits of public vs private healthcare have traditionally formed one of the key ideological divisions between European political parties. **Richard B. Saltman** *writes that while this debate has often been exceptionally heated, over the last few decades a number of European countries have started to take a more pragmatic approach in terms of both the use of private healthcare and the operating philosophy adopted in public hospitals. Although the public-private debate is unlikely to ever disappear entirely, these trends and the pressures of prolonged austerity have steadily reduced its relevance to actual service delivery.*

The debate in Europe between proponents of public vs privately run health care providers is long-running and often acrimonious. While the tenor of discourse has improved somewhat from the first international meeting in Brussels in 1984, which was broken up after 10 minutes by chair-throwing, the topic remains ideologically infused and in some countries like England it is still difficult to discuss calmly.

The dimensions of this debate have however changed quite dramatically since the early 1980s. In a number of tax-funded health systems, for example, the majority of primary care services have been shifted from public clinics to private GPs (most Central European countries, also Norway and Sweden). In home care services, similarly, private for-profit actors have become major players (all four Nordic countries, also Central Europe).

Moreover, the operating character of public hospitals has also changed. In many tax-funded health systems, public hospitals are now managed as semi-autonomous institutions, with their own boards of trustees and non-politically appointed managers. Whether they are called foundation hospitals (England), state enterprises (Norway), limited stock companies (Estonia and Czech Republic), or consortios (Spain), the practical impact is that public institutions are being managed more by clinical and financial results and less by political directive. Taken together, these two major changes suggest a melting of the boundaries that previously separated public and private providers.

One missing element in this diversifying provider picture is the not-for-profit private sector. While for-profit private actors are increasing, and public sector actors are becoming increasingly professional rather than political in their orientation, the traditional voluntary and/or religious not-for-profit sector is hardly growing at all. While some attribute this structural stunting to unstable legal requirements from an over-regulatory state, the result is that the widely diversified not-for-profit sector that existed before the arrival of the state-run welfare state has not regenerated as part of the new diversity in private service providers.

This evolving picture has been further pressured by the onset in 2008 of prolonged austerity in all public sector activities in Europe, including health care. New strategies for how to cope with increasing demand while public funding is fixed or falling in countries like England and Finland suggest that the effects of public sector austerity will lead toward an even more diverse provider mix in the future, with individual patient co-production joining a growing range of different types of private sector organisations as strained public providers struggle with less money and personnel for more patients.

Taken overall, from a policy perspective, the traditional debate about public versus private providers has become less and less relevant to the actual service delivery world. The central issue for national policymakers will likely continue to be not whether tax-funded health systems will continue to diversify, but rather how and how effectively they will do so. The challenge will be to find strategies and mechanisms to intelligently regulate what will be an increasingly diverse provider sector, in order to harness private, individual patient and family providers so that broad

public sector objectives can be achieved.

This will require not only lighter-touch regulation (as political scientists often note, the right to regulate is also the right to destroy) but also novel strategies to encourage investment and structural innovation. Recent experience in the Netherlands with encouraging new for-profit approaches to integrating home care services such as Cordaan and new community-based nursing home strategies like the not-for-profit RvB Saffier De Residentiegroep in Amsterdam suggest that governments can stimulate a wide range of alternatives. How fast and how well this occurs will require even new left-of-centre administrations like that just elected in September in Sweden to set aside electioneering ideology and to govern in a pragmatic and results-oriented fashion.

Ultimately, while the public-private debate in European health care may never disappear, it can be sufficiently housebroken to enable real improvement in health care service delivery to become possible. Certainly the next stages in this ongoing process will remain important for patients and analysts alike.

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