

EXECUTIVE SUMMARY

The public sector is the dominant financier of health care in most OECD countries. But in the last two decades the extent of private finance has increased in most of these countries, and private finance now accounts for around a quarter of all health care finance. On the delivery side, the dominance of the public sector is much less strong and mixed public and private provision is common. Many recent reforms in health care have sought to increase the role for the private sector in health care provision.

Against this backdrop, this paper examines the case for, and the empirical evidence to support, an increase in the role for the private sector in finance and delivery. The paper starts with a brief overview of the current position. It then examines the case and evidence on the finance side, and then the case and evidence on the delivery side. The evidence used is drawn primarily from the experience of OECD countries other than the USA, both because the American experience is better known and because the USA is an outlier in terms of the level of private finance and delivery within this group of countries. Nearly all of the recent reforms, which have sought to increase the role for the private sector, have been in countries where the public sector plays a greater role in both finance and delivery than in the USA.

The conclusions from this review are the following. First, it seems likely that reforms that increase the role for the private sector in financing health care will increase health care expenditure. High shares of private finance in the overall financing of health care are accompanied by higher costs, and systems which have high shares of public finance appear to have been better at cost containment. But lower cost does not necessarily mean better health care. The higher expenditure that accompanies private finance may in part reflect lower access costs and higher quality. Second, systems that rely heavily on private finance for health care tend to be less progressive than those that use public finance. Third, the argument that a marginal increase in private finance will necessarily lead to the evolution of the public sector into a 'poor service for the poor' is not strongly supported by empirical evidence. High levels of private finance do not appear to be associated with later lower growth of public finance. And while those who buy supplementary private finance in systems where individuals have public cover are less supportive of spending on public services, the evolution of their attitudes is not necessarily very different from that of users of the public system. Fourth, recently implemented reforms intended to promote competition on the delivery side in systems which have high level of public sector involvement in the delivery of health care appear to have been

accompanied by increased debate over the appropriate role for the public sector in the finance of health care.

But these conclusions come with a caveat. Whilst there are strongly articulated arguments for and against an increased role for the private sector, the evidence to support many of these arguments is relatively weak. Much of the evidence at system level is from time series data in which there are relatively few independent data points. At the micro level, the residual role for the private sector on the finance side in many countries seems to have meant that the private sector has received little attention. While this may be redressed as a result of recent reforms which have sought to increase the role for the private sector in delivery, many are too recent for clear evidence of their effects to emerge.