Ownership matters: using ownership as a policy tool for reaching health system goals

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The Country Connector on Private Sector in Health (CCPSH) is multi-sectoral platform that is convened by the World Health Organization. The CCPSH strengthens the governance of mixed health systems through aligning efforts and collaborative initiatives between the public and private sectors, under a shared vision as a means for ensuring equity in service use, quality, financial protection and health security.

KEY MESSAGES

1. Ownership within the health sector is an important yet neglected policy tool that governments can use to help reach their health system goals.
2. Market approaches have occurred in a policy vacuum and downplay known downsides to ownership within market models which have not been readily identified, discussed and strategically managed by governments.
3. In the context of the market model and an ownership policy void, ownership arrangements can determine whose interests are prioritised.
4. To retain the upsides and manage the downsides of different ownership forms the first step is to talk about ownership and name it as a policy tool. The second and third steps relate to filling this policy vacuum.
5. The authors suggest that governments assess how each ownership model of service provision can meet population health need by considering ownership types and mix of service providers available, how government resources flow to them, on what terms, with an eye on how services contribute to strategic health goals.

Ownership within the health sector is an important yet neglected policy tool that governments can use to help reach their health system goals (1). Ownership significantly influences structural arrangements and the political economy of the health sector, its culture and health outcomes (2). Ownership interests can drive the behaviour of system actors: healthcare workers, government, business and the community. It affects how health workers balance professional and employment obligations against business and political interests or duties to shareholders. Importantly, ownership affects the standing of the service user (3) (as a citizen, patient, customer or a mixture of these) and how service user needs are factored into models of care. Ownership can influence the impact and amount of public spending for health gain, and how health system activity (both public and private) addresses health system strategic goals and population health improvement.

Despite its importance globally there has been little discussion about ownership since the 1980s, possibly because of the idea that service ownership has been seen as much less important as availability of services and competition in and for the market. New Zealand's experience reflects the global experience: We have 40 years of experience of market-led approaches to aspects of health and social systems which has yielded upsides, including increased speed of service innovation and responsiveness, and the emergence of new providers to meet hitherto unmet need for different population groups. In particular, corporately owned service provision allows advantages of economies of scale, and cross-subsidisation across a business.

However, in our pursuit of market approaches we have downplayed the fact that ownership is far from incidental - the interests of the ultimate owners of services affect health system outcomes. The upshot is that market-led developments have often occurred in a government policy vacuum about ownership. Consequently, known downsides to ownership within market models have not been readily identified, discussed and strategically managed by governments.

Downsides are linked to the fact that health services do not operate in a proper market, they only mimic a market. Within the health market there is information asymmetry between supplier and service user and demand will always outstrip supply (4). In the context of the market model and an ownership policy void, ownership arrangements can determine whose interests are prioritised. Thus, for example, health professionals report difficulty in balancing professional and fiduciary duties in some ownership paradigms, where the ultimate duty to return a profit to shareholders can erode professional satisfaction and professional clinical autonomy (5).

Further, a dominant market-led model leaves high-need populations underserved. High-need populations require services that can be uneconomic in a market paradigm: a mix of population health profile, geographic location and the model of care needed to meet the population's needs are often different from what markets will deliver (6). Bluntly, serving the high-health needs is rarely a good business proposition.

What can we do to retain the upsides and manage the downsides of different ownership forms?

The first step is to talk about ownership and name it as a policy tool. The second and third steps relate to filling this policy vacuum.

Firstly, policy makers should identify service ownership as an important element that affects health system goals. This action is based on the idea that the government of the day has the responsibility, authority and mandate to set the long term direction of the health system and its strategic goals. The state, overseen by government, exists for all citizens, not only shareholders, subscribers or party members, or people in a particular location. It is the trustee/steward of the health system for the benefit of its citizens. The government has a bird's eye view of a country's health and health outcomes. While the government can fund non-government services, it cannot divest itself of the responsibility to make the services work for health gain and health system sustainability.

Secondly, to support using ownership as a policy tool, governments should develop a strategic approach so ownership arrangements serve health system goals. This means understanding what health systems aim to achieve, with explicit government policy about ownership of health services and how ownership affects achieving health system goals.

Thirdly, and linked to the second point, is understanding the mix of service providers in the service landscape and their strengths and weaknesses. We suggest that instead of taking a hands-off approach to provision, governments can assess how each ownership model of service provision can meet population health need. This involves considering the ownership types and mix of service providers available, how government resources flow to them, on what terms and with an eye on how services contribute to strategic health goals. In New Zealand (7) there are four main ownership groupings that we identify:

1. Government owned and provided
2. Private-for-profit provision with government subsidy
3. Private-not-for-profit provision with government subsidy
4. Indigenous ownership models that take into account indigenous sovereignty. In New Zealand this is expressed as Māori ownership models (8). These models are intrinsically linked to fulfilling the government's commitment to meeting its historic Treaty obligations which include self-determination, redressing the negative health impacts of colonisation, and achieving a health system goal of equitable health outcomes for the whole population.

Additionally New Zealand also has a small, yet growing, private-for-profit provision without government involvement except for regulation for quality and safety. In other countries wholly private health systems provide a larger share of health services and would be in the list of ownership groupings above. While theoretically self-contained, activity in the wholly private for-profit sector has documented knock-on cost effects on the public sector, especially as the public sector is the provider of last resort for services initiated in the private sector (9).

In New Zealand the four main ownership groupings are far from being exclusive, and hybrid forms are common in the health system. Each model has its strengths and weaknesses, and each single example of each type of ownership structure should be judged by how it behaves in practice rather than by how it behaves according to theory. Overall, harnessing known strengths and mitigating against known weaknesses will help the system as a whole respond to health need and health improvement with health system goals at the fore.

To this end we recommend that governments treat ownership as a tool to achieve health system goals. Governments can exercise their role as the trustee/steward of the health system by being clear about ownership in planning, funding and accountability mechanisms, and consider the impacts on health provision of different types of providers.

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