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ORIGINAL ARTICLE

Can Questions of the Privatization and Corporatization, and the Autonomy and Accountability of Public Hospitals, Ever be Resolved?

Jeffrey Braithwaite · Joanne F. Travaglia · Angus Corbett

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Abstract Although there is a long-standing international debate concerning the privatization and corporatization of health services, there has been relatively little systematic analysis of the ways these types of reform manifest. We examine the impact of privatization and corporatization on public hospitals, and in particular on hospitals' autonomy and accountability, with two aims: to uncover the key themes in the literature, and to consider implementation issues. The review of 2,319 articles was conducted using content analysis and a discussion of selected key issues. Several major themes appear in the privatization and corporatization literature, including their use as tools in health systems reform, and the role of governments in sponsoring the processes. We show that much of the underlying argument is ideological rather than evidence based. Those who promote versions of privatization or corporatization claim that decreased government involvement in the management of hospitals leads inter alia to benefits such as greater efficiency, better quality services, and increased choice for patients. Those who argue against say that increased privatization leads to deleterious outcomes such as decreased equity, compromised efficiency and poorer quality of care. The evidence is often weak and

J. Braithwaite · J. F. Travaglia (✉) · A. Corbett
Centre for Clinical Governance Research, Australian Institute of Health Innovation, Faculty of Medicine, University of New South Wales, Sydney, NSW, Australia
e-mail: j.travaglia@unsw.edu.au

J. Braithwaite
e-mail: j.braithwaite@unsw.edu.au

A. Corbett
e-mail: Angus.Corbett@uts.edu.au

A. Corbett
Faculty of Medicine, University of New South Wales, Sydney, NSW, Australia

A. Corbett
Faculty of Law, University of Technology, Sydney, NSW, Australia

at times conflicting. Privatization and corporatization are difficult to implement, and at best produce mixed results, and their impact seems to depend more on the motivation of the evaluator than the standard of the results. These debates are of a type that is to a large extent only resolvable ideologically.

Keywords Hospitals · Health systems reform · Privatization · Corporatization · Autonomy · Accountability

Introduction

What mix of public and private care is appropriate and relevant for any given health care system? Deliberations on this issue have been stimulated by factors such as how to pay for health care, governments' perceived responsibilities for its provision, who should own and operate services, and how to induce greater levels of performance. There has been a worldwide dialogue about the appropriate role of governments in the health sector [48, p. 408, 8, 37, 45] and the extent to which the private sector should be involved [29, 46, 49]. At one end of the debate, some commentators say that governments should retain or regain primary responsibility for the health of all citizens, and hence the health system itself, in order to ensure there is equity through public provision [20, 21, 46, 50]. At the other end, the government's main role is seen to be ensuring that the market for health services is working well, and whether provision is by public or private providers, or a combination of both, is irrelevant [28, 35]. In effect, the tectonic plates of publicly and privately funded health and hospital care have been grinding against each other for several decades, as governments determine what public–private proportion is appropriate and the extent to which one is privileged over the other.

Responsibility for the provision of acute hospital care is a particularly apposite case in the broader debate about the public–private mix. Although the specific language of hospital reform differs across countries and health care systems, mainly because of local legal requirements and terminologies, nevertheless there are commonalities in initiatives. The goal for most reformers is to establish frameworks that will allow for markets to coordinate the interactions between stakeholders to produce acceptable outcomes. The literatures on privatization and corporatization reflect distinguishable approaches, ideologies and objectives within this reform framework, and surveying what is happening internationally can prove useful in understanding the major shifts.

The aim of this paper is to discuss, via a comprehensive review of the literature, the arguments for and against privatization and corporatization of publicly funded hospitals in international context. We argue that the process by which policy issues about privatization and corporatization are entangled has made it very difficult to test empirically whether or not any particular implementation of privatization or corporatization has achieved its expected policy outcomes. For this reason it is not our intention to compare the performance of the public and private sectors per se, but rather to explore the rationales which underpin the arguments to move along the continuum from complete public funding and responsibility to private ownership

and control. The literature comparing the performance of both systems is addressed in several other review papers, notably Rosenau and Linder [34] and Eggleston et al. [11].

In our analysis, we pay particular attention to issues of autonomy and accountability. These are matters which are at the heart of the public–private debate. Proponents argue, essentially, that privatization and corporatization lead to several benefits including greater efficiency, better services and more choice [1, 24, 31]. Critics demur, and contend that privatization and corporatization engender mixed outcomes at best, and often induce confusion, poor responses and inequities which, as a result, compromise efficiency and quality of care [46, 50, 51].

We argue that each reform process considering privatization or corporatization as core strategies has to settle on how much autonomy to allow and how much accountability to demand. By autonomy we mean the degree of decision-making which will pass from governments to private hands and by accountability we mean the extent to which care providers accept responsibility for various actions and the requirements whereby they must justify their actions to government agencies, individuals or other actors. Our focus is the types of actions designed to increase autonomy of hospitals, and the relationship between this and accountability, to analyse relevant literature on privatization, corporatization, accountability and autonomy and then identify the arguments within and associations between these key variables. But first, we seek to define our terms.

Privatization and Corporatization

Privatization and Equitization

The European Observatory on Health Systems and Policies [13] defined privatization of healthcare services and hospitals as the transfer of ownership of what was a public body into private hands, that is, into either private for-profit or private non-profit organizations. Most commentators believe that equitization has the same meaning—but it is much less frequently used [4].

In actuality, the differences are minor. They probably reflect views on marketing of the idea rather than concrete differences. We use the term privatization because it is probably better understood by most people and it is certainly much more commonly used in the international literature.

Privatization can be full or partial. Partial privatization usually means that only some of the assets are transferred from government to private ownership. Alternatively, it might mean shared ownership of the hospital, whereby the government retained ownership in part, and the remainder is transferred to private hands.

Corporations and Corporatization

Corporatization may be simply defined as the reorganization of a government or semi-government agency so that it is able to operate in a financially responsible way. This means ensuring that it applies good business practices and that it is

accountable for any financial losses. Harding and Preker [19, p. 15] indicated that the main objective is to cause the agency "… to achieve the efficiency and structure of private organisations, while still ensuring that social objectives are emphasized in healthcare through the continuation of the public ownership of these services".

There are many complexities in practice, including the definition of a corporation. Within the scope of this paper, corporatization means establishing a hospital as an incorporated, separate legal entity that has a set of rights (powers and privileges) and obligations, including financial liabilities. A corporation usually has the right to enter into contracts and to own property, and can in some models issue stocks and bonds.

The rights and obligations of the group of persons working for the hospital (the corporation) are distinct and separate from those of its individual members. They are also different from the rights and obligations of the owners, and therefore it might be that shareholders have no or limited legal liability for the corporation's debts.

Privatization or Corporatization of Government Hospitals

One dominant aim of privatization or corporatization of government organizations such as hospitals is to give hospital managers greater autonomy to operate, and if possible, innovate. Most governments want to retain an element of control, to reduce legal complexities, and engender a process of change that is simple to handle. One recurring issue is the degree of financial freedom. There are limits to the extent that hospitals can be given the right to earn surpluses and to incur financial losses. Most obvious, there are risks associated with allowing a hospital to cease to operate as a consequence of becoming bankrupt.

Method

Against this background, we turn to our study. We comprehensively reviewed the literature to consider the narratives for and against privatization and corporatization, rather than strictly to compare the empirical evidence used to support each case. Only articles and abstracts in English were reviewed, which limits this study. We acknowledge that while the databases searched are the standard in this field, both their limitations and our search terms may have resulted in the exclusion of some relevant references. In order to hold true to our method, however, we present our findings within the parameters outlined below.

Figure 1 provides a schematic diagram of the review process. It shows the search strategies and methods used to conduct and validate the analysis of the literature.

Search Strategies

Search Strategy 1: Search of Databases

The search terms used were 'privatization', 'corporatization', 'hospital privatization' and 'hospital corporatization'. Each term was interrogated for the widest

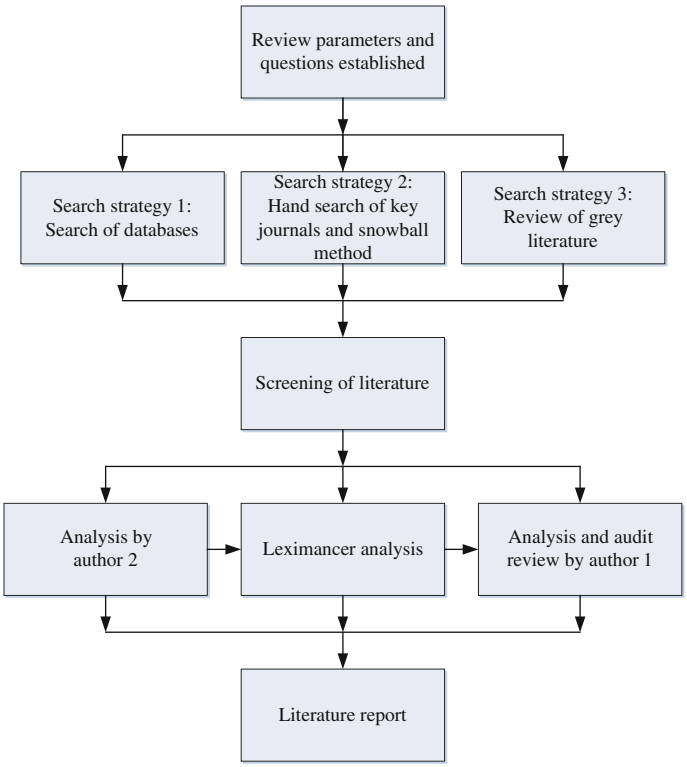

Fig. 1 Literature review process

possible capture ('exploded') including where 's' is used in place of 'z' in the search terms. The databases searched were: Medline (medicine) from 1950; Embase (medicine and health services) from 1988; CINAHL (allied health) from 1982; Biomed Central (medicine) from inception; and Pubmed Central (medicine and health services) from inception. The searches were conducted in May 2007. The references were downloaded to Endnote version X.02, a bibliographic software package, for further analysis.

Search Strategy 2: Hand Search of Journals and Snowball Method

Using the same terms we hand-searched a selection of journals which consistently addressed the issue of the privatization and corporatization of healthcare, including *Health Affairs, Health Policy, Health Policy and Planning, International Journal of Health Planning and Management, Journal of Health Politics, Policy and the Law* and *Social Science & Medicine*. Most of the relevant articles had already been identified although an additional group ($n = 8$) was located via this method. An additional article ($n = 1$) was discovered by using the snowball method. This involved examining the reference lists and bibliographies of documents as they were obtained for relevant, but otherwise unidentified, references.

Search Strategy 3: Review of Grey Literature and Websites

The Google Scholar and Google search engines were employed to identify grey literature, including items such as unpublished reports, policy documents, statements, and strategies and frameworks. Relevant documents were identified ($n = 6$). These contributions often speak to the strength of feeling about this issue, but they are not generally independent studies. Rather they provided insights into the tenor of the debates at a local level.

Analysis

The second author independently reviewed the downloaded abstracts and citations and categorized them using a grounded theory process [5, 15, 16]. The literature was analysed using Leximancer, an automated content analysis package [41]. This data mining software package enables researchers to conduct content analysis of large bodies of data. The software's default is the automatic generation of concepts: that is, no researcher's input is required in the analysis. Leximancer identifies concepts using Baysean logic, with no predetermined thesauri or list of terms applied to the data. The results are presented as a ranked list of concepts (with the highest ranking concept that to which all or most other concepts relate). The program provides a concept map, a relational schema of the concepts found in the literature, their frequency of occurrence and the strength of relationships between them [42, 44, 47]. Researcher bias does not influence the selection of concepts, thereby providing both a method of triangulation and a verification of the results [30]. Once the data are analysed by Leximancer, the researchers are able to interpret the results based on the context and purpose of the data [44].

Results

We identified a large and varied body of literature on the privatization and corporatization of health services. Table 1 presents the numeric results of this search. Some 4,491 references were found, which reduced to 2,319 after duplicates were removed and the additional 15 references were included.

The overall concept map of the literature is presented in Fig. 2. Key concept clusters, or themes, identified through the literature and Leximancer analysis, are highlighted.

Seven major themes run through the literature: the impact of privatization (on hospitals, patients, service quality and cost, and treatments); the role of governments in the process of privatization and the healthcare market; the social and political role of privatization in healthcare reform; the privatization process; the management of national and local resources; privatization and National Health Services (NHSs) in the UK; and studies of privatization.

Table 2 provides a ranked list of the 67 concepts exposed by the content analysis. The impact of privatization at an individual and service level is marked by the concepts: *patients, hospital(s), treatment, community, medical, private, service*

Table 1 Results of databases searches on privatization and corporatization

Search term	Database results: number of articles					
	Medline	Embase	Cinahl	Biomed Central	Pubmed Central	Total
1. Privatization	1,583	324	94	13	12	2,026
2. Privatisation	171	120	140	25	1,814	2,270
3. Corporatization	14	13	4	1	0	32
4. Corporatisation	83	30	18	0	85	216
5. Hospital privatization	3	1	3	9	2	18
6. Hospital privatisation	0	0	0	18	33	51
7. Hospital corporatization	0	0	0	1	0	1
8. Hospital corporatisation	1	0	0	0	1	2
9. Total	1,855	488	259	67	1,947	4,616

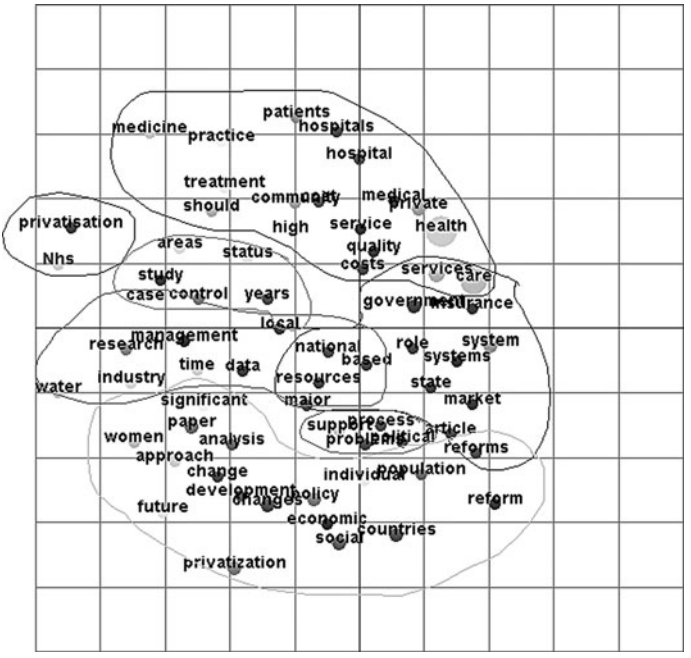

Fig. 2 Map of key concepts relating to privatization and corporatization of hospitals and healthcare

quality, and *cost*. The role of governments is identified in these concepts: *system, systems, insurance, state, market, role, services, care* and *reforms*. The social and political implications of privatization are denoted by these concepts: *reform, population, individual, economic, social countries, policy, change(s), development, future, approach, change, analysis* and *women*. The process of *privatization*, at the centre of the literature, is captured by that term, but also closely associated with the

Table 2 Ranked list of 67 concepts relating to privatization and corporatization of healthcare and hospitals

Concept	Absolute count	Relative count (%)	Concept	Absolute count	Relative count (%)
Health	3,871	100	Costs	224	5.7
Care	3,078	79.5	Political	219	5.6
Services	858	22.1	Change	216	5.5
Private	764	19.7	Based	215	5.5
Privatization	757	19.5	Research	205	5.2
System	658	16.9	Cost	201	5.1
Policy	435	11.2	Control	199	5.1
Paper	410	10.5	Population	197	5
Countries	401	10.3	Patients	197	5
Social	393	10.1	Local	195	5
Market	373	9.6	Data	195	5
Changes	366	9.4	Future	193	4.9
Government	348	8.9	Resources	192	4.9
Management	339	8.7	Should	191	4.9
Economic	322	8.3	Analysis	190	4.9
Systems	320	8.2	Major	190	4.9
Medical	317	8.1	Community	188	4.8
Reform	308	7.9	Practice	186	4.8
Study	292	7.5	NHS	182	4.7
Service	285	7.3	Case	171	4.4
Privatization	280	7.2	Support	167	4.3
Quality	279	7.2	Time	165	4.2
Hospitals	269	6.9	High	157	4
Article	266	6.8	Significant	151	3.9
Insurance	261	6.7	Treatment	142	3.6
State	259	6.6	Medicine	138	3.5
Hospital	256	6.6	Water	137	3.5
Years	249	6.4	Status	135	3.4
Reforms	242	6.2	Individual	134	3.4
Role	242	6.2	Industry	133	3.4
Development	238	6.1	Approach	132	3.4
Process	233	6	Areas	131	3.3
National	224	5.7	Women	109	2.8
Problems	224	5.7			

terms *support, problem* and *political*. The management of privatization, including the issue of the *generation* and or potential loss of *resources* associated with the privatization of public healthcare, is identified by those terms and associated terms; *national, major, based, local* and *industry*. *Water* also appears in this group, both because its privatization has health implications (particularly for developing countries) and because it is often used as a comparative model for the privatization

of hospitals. The privatization of Britain's National Health Services (NHSs) appears as a separate cluster, which is predictable given that 199 articles (of the 2,319) discuss various aspects of privatization in this service. The last grouping of concepts simply relates to the studies of privatization (*study, years, case, control*).

Further content analysis using Leximancer produced the following maps. They show how different issues are brought to the fore when different key terms (privatization, corporatization, autonomy and accountability) are used to interrogate the literature with Leximancer. These maps were produced by analysing the different sub-sets of the literature pertaining to each concept (Fig. 3).

A total of 11 themes was identified in relation to privatization: *privatization, health, policy, market, major, care, paper, water, privatization, service* and *NHS*. This map shows evidence of the links in the arguments made between the social implications of privatization (centred at the top of the map), through the required political and policy changes, to the market and system reforms, to the impact of privatization on the provision and quality of care (Fig. 4).

In relation to the corporatization literature a total of eleven themes were generated. These were: *hospital, health, power, medical, medicine, practice, care, treatment, corporatisation, quality* and *services*. Although less conceptually rich than the concept map of privatization, the corporatization concept map serves to reinforce the centrality of the key concepts of the debate, that is the issue of service quality, and the social and professional implications of changes to the health system (Fig. 5).

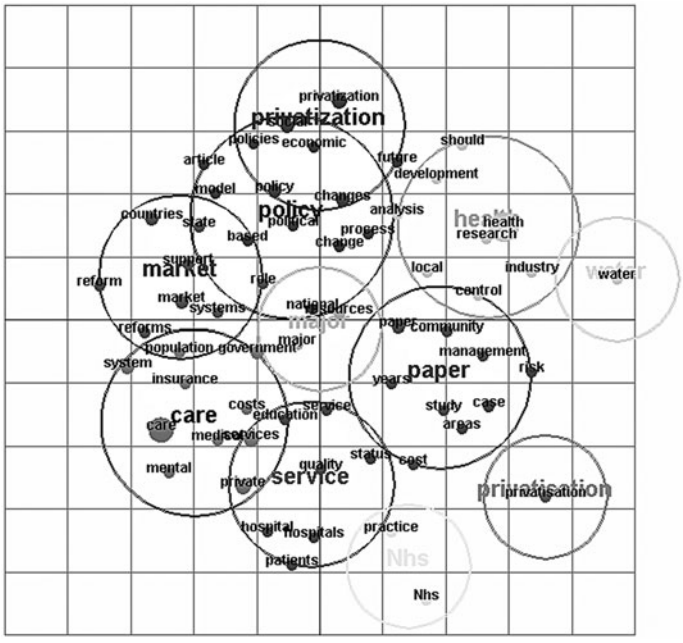

Fig. 3 Map of key concepts relating to privatization of hospitals and healthcare

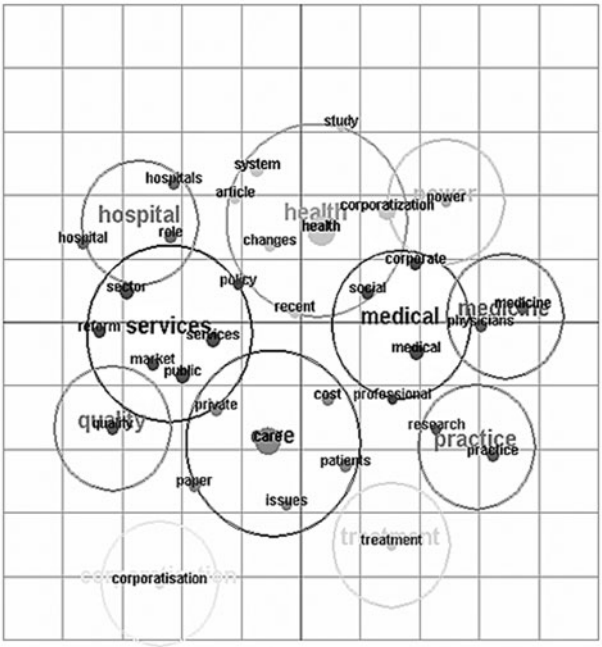

Fig. 4 Map of key concepts relating to corporatization of hospitals and healthcare

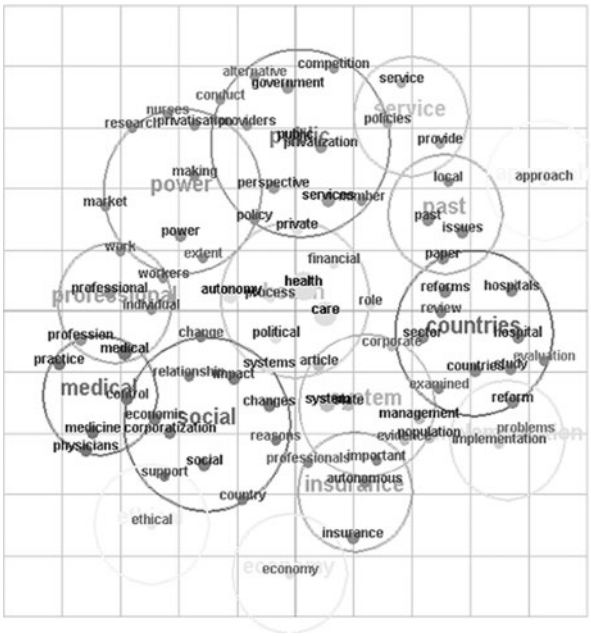

Fig. 5 Map of key concepts relating to autonomy of hospitals and healthcare

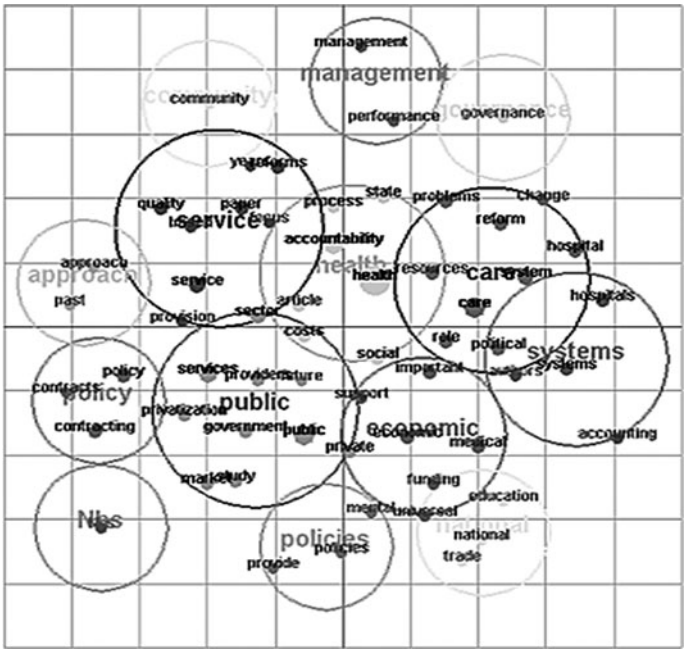

Fig. 6 Map of key concepts relating to accountability of hospitals and healthcare

The autonomy map, the most conceptually rich of the concept maps, shows 15 themes. These include: *power, public, service, past, approach, countries, implementation, insurance, economy, system, health, social, medical* and *professional*. Although many of the same concepts are shared with previous maps, the analysis of autonomy brings to the fore issues of power, professional autonomy, especially in relation to the practice of medicine and issues of economic and political reforms, including to health insurance. The balance between the professions, the pubic (social) and funding reform are clearly visible (Fig. 6).

The final map, that of accountability, has 14 themes. These include: *community, management, governance, care, systems, economic, national, policies, public, NHS, policy, approach, service* and *health*. As with the map for autonomy, the concept *public* is a prominent theme, and as with all the maps we see the conceptual tensions between economic requirements, national interest, systems and healthcare reform, and service provision. Two new themes, *community* and *governance*, linked by the concept of *management*, encapsulate the macro arguments within this literature.

Discussion

The aim here is to provide a narrative representation of the literature uncovered by our review. The concepts identified in the Leximancer analysis are taken up and

discussed in relation to the key themes in the literature. While much of the literature is ideological or assumptive, our operational research principle was to provide, so far as possible, a balanced view.

General Arguments for and Against Privatization and Corporatization

The literature presents five main arguments in favour of changing from a single government-owned and operated hospital sector [9, 10, 17, 22, 27] as follows:

1. more competition between hospitals, which will encourage them to improve their efficiency, quality, or consumer sensitivity
2. increased freedom for hospital managers to innovate
3. enhanced rewards for hospitals that perform well
4. reduction of government bureaucracy
5. greater choice of hospitals, clinicians, and types of services for consumers.

Many commentators in the literature argue that these consequences are important. Others agree that improvements are needed but they can be achieved without abandoning the model of a single government-owned and operated hospital sector.

Some opponents contend that competition can never be perfect in the hospital sector, or it can be destructive. They also doubt that more choice is always good. Providing more choice often increases administrative costs. Health sector resources are scarce: if the more wealthy and powerful choose the best hospitals and doctors, they will not be available for the poor and the powerless citizens.

Moreover, opponents usually argue that any kind of privatization or corporatization will reduce equity for citizens [7]. Even proponents who favour dismantling aspects of an integrated government system recognize there is a risk of reduced equity. However, they tend to argue that equity can be maintained if the government provides special kinds of health insurance and health services for the disadvantaged, a recurring theme in the literature.

Propper et al. [32] assessed the effect of competition induced in Britain's NHS through the internal market reforms of the 1990s. They found that increased competition was associated with increased death rates, and, more generally, that competition equates to reduced quality of care [32].

Øvretveit [29] reviewed the situation in Nordic countries. He concluded there was little evidence of success of privatization and argued that governments should increase their understanding and control of the private sector. They should not simply be leaving "…the developments to be shaped by growing consumer demands or market logic." [29, p. 233]

Advantages and Disadvantages of Privatization

Megginson and Netter [26] examined the economic theory of private ownership. They concluded that the theory favours private ownership if four assumptions are valid: that there are no externalities in production or consumption; the output of

the private agency is not a public good; there is no natural monopoly; and there are low information costs [26]. If these assumptions are unreasonable, there will be what economists label market failure, and the results of privatization will be unsatisfactory. The assumptions are clearly unreasonable for hospital services, and therefore we cannot theoretically expect privatization to result in universal benefits.

Janssen and Van Der Made [23] reviewed privatization plans in Holland. They argued that privatization would be beneficial because it would transfer costs and responsibilities away from government agencies [23]. In a later review of the Danish health care system Janssen [22] found that it was operating in a generally satisfactory way but there would be improvements if government hospitals were privatized. It is not clear why this would be so [22].

Megginson and Netter [26], as well as arguing that assumptions drawn about private ownership do not ultimately hold in the hospital sector, made an important additional point—that, whether or not the conditions are present for successful privatization, even unsuccessful privatization might be better than keeping a government-dominated system that is obviously working ineffectually. They suggested that it is common for government-dominated systems to work badly because politicians or bureaucrats may serve their own interests, rather than the wellbeing of citizens. Shleifer and Vishny [39] argued that government bureaucrats are often not interested in the efficiency of government hospitals because any budget surpluses will flow into the government budget rather than into the bureaucrats' own pockets.

Several authors have pointed out that pressure for privatization is sometimes a direct consequence of a government's attempts to resolve poor performance to the satisfaction of consumers. For example, Tountas et al. [43] noted that recent Greek governments have attempted to reduce private health care provision because of citizen's fears of higher costs and reduced equity. Their actions have succeeded in controlling the growth of private hospitals but ambulatory care from private doctors and private diagnostic centers have significantly increased. The authors concluded this was mainly a consequence of some citizens' dissatisfaction with the quality of government services. It was also a consequence of increased prosperity and the growth of voluntary health insurance [43].

Advantages and Disadvantages of Corporatization

Supporters of corporatization claim similar kinds of advantages as for privatization. For example, Govindaraj [17] argued that corporatization increases technical and allocative efficiency for two main reasons: there are greater personal incentives for managers and employees to make efficient decisions, with increased freedom to make those decisions. Therefore managers are likely to make better choices that lead to "… optimal employment of personnel, improvements in staff performance, increased availability of drugs and services, and improved maintenance of facilities and equipment." [17, p. 9] NHS specialists Ham and Maynard's [18] seminal work pointed out, however, that any degree of corporatization was unlikely to succeed in

the UK unless various criteria are met. The criteria were: openness of information, control of labour and capital markets, regulation of mergers and takeovers, arbitrating in disputes, protection of unprofitable functions such as research and development, overseeing national provision of health services, protection of basic principles of the government health system and handling of closures and redundancy [18].

Schlesinger, Bentkover et al. [36] presented an analysis of the effects of the increased dominance of for-profit providers and large corporations. They concluded that this dominance has been a primary cause of reduced access to health care for the poor and uninsured [36].

Govindaraj [17] also noted some problems with corporatization. He said there are difficulties in applying private sector structures and incentives in government hospitals of developing countries. Often, there are weak decision-making and management capacities, and there may be political constraints to change. Some hospitals may have a monopoly on services in their catchment area, there may be government rules that constrain changes in staffing, and the government might be reluctant to allow a corporatized hospital to become bankrupt and go out of business. Govindaraj [17] concluded there was little reliable evidence of the successes and failures of corporatization. He indicated there are no agreed methods of measurement of performance, and it is difficult to distinguish the effects of corporatization from other factors causing change such as the behaviour of citizens or the method of payment of hospitals by Health Insurance Funds [17].

In contrast, Dirnfeld [9] argued the case for more privatization and corporatization in the context of Canada. He said that the universal government-funded health system created in the 1960s had failed because it "… can no longer meet the expectations of the public or of the health care professions." Several options needed to be considered, and all of them would involve increased non-government participation and more businesslike approached in a competitive environment [9, p. 407]. His preference was for the creation of "… a parallel private system, funded by voluntary insurance" that would "… relieve the overstressed public system without decreasing the quality of care in that system." [9, p. 408]

The Impact of Privatization and Corporatization is Often Lower than Expected and the Evidence is Hard to find

In essence, then, our analysis suggests that the impact of privatization and corporatization on public hospitals is often less than envisaged by proponents at the outset, there is a limited range of well-designed scientific evaluations, much of the work is of a case comparison type [14], evaluation lags implementation often by substantial time periods, and thus views from the literature must be treated cautiously. Claims are often made that privatization and corporatization will lead, a priori, to improvements in efficiency. However, others often predict that there will be losses in terms of equity. In practice, hospital services sometimes change little, and care providers such as doctors and nurses continue to work in much the same way as before. For example, McGuire et al. [2] studied the effects of privatization of

outpatient mental health and substance abuse services in Puerto Rico, finding that privatization had minimal impact on use. Clark et al. [6] reviewed evidence on differences in the performance of care provider agencies that ranged from fully government-owned to fully private, and noted no obvious differences in performance in terms of ownership.

Liu et al. [25] attempted to find evidence of the effects of various forms of privatization and corporatization in China. They found that "… research in this area, however, is almost non-existent at either national or international levels." [25, p. 157] Shiell [38] reviewed new policies in favour of increased competition in the UK's National Health Service after 1989, arguing that very little was known about the effects of competition on health care provision, and the evidence that existed was contradictory.

Reichard [33] analysed nearly 15 years of movement towards the market in Chile. Before 1975, Chile's health care system was one of the most progressive in Latin America, and was one of the first to provide universal access to all citizens. After 1975, market ideology has been dominant and this has resulted in increased costs and reduced equity. The author said that "… other developing nations considering free-market reforms may wish to consider the high costs of the Chilean experiment." [33, p. 98]

Relationships to Autonomy and Accountability

We indicated earlier that whatever the privatization or corporatization mix, or model chosen, governments are obliged to consider the extent of autonomy they are prepared to allow (what we might label *the delegation regime*) and how much accountability to require (we label this *the compliance regime*). Tables 3 and 4, which are drawn from our synthesis and analysis of the literature, illustrate some of the major parameters in these kinds of decisions. Table 3 shows the types of autonomy allowed, which runs along a sliding scale from high levels of delegation, described as complete privatization with minimal public control, middle levels, with differing models, to the lowest levels, which typically include purchaser provider contracts where the assets and management remain in control of the government.

Table 4, the amount of accountability required is an adaptation of Emanuel and Emanuel's work [12]. Each of the seven compliance domains is clearly visible in the content analysis of the literature, and closely linked in the concepts maps, speaking to the persistence of these concerns within the literature.

Based on our review we developed a simplified model, Fig. 7, to summarise these findings and as an outcome of our analysis. The model suggests that regardless of the privatization–corporatization choices made, explicit decisions are needed about autonomy (how much delegation is permitted?) and accountability (how much compliance is demanded?). Stakeholders' discussions about health reform will be incomplete if inadequate attention is paid to these key factors.

Table 3 Types of autonomy allowed—the delegation regime

Model	Meaning
High levels of autonomy	
1 Complete privatization with minimal government control	The hospital's ownership changes from government to a private agency. Staff are private sector employees or contractors. The hospital is free to contract with health insurance funds or with individual citizens. Their fees are determined by negotiation in the marketplace. The government's role is restricted to ensuring the market is working correctly and that methods of care are safe
2 Complete privatization but with strong government control	The hospital's ownership changes from government to a private agency. Staff are private sector employees or contractors. The hospital is free to contract with health insurance funds or with individual citizens. The government's role is restricted to ensuring the market is working correctly and methods of care are safe. However, the government also exercises strong control over hospital fees. It also specifies the kinds of services the hospital will provide
Moderate levels of autonomy	
3 Partial privatization, government staff	Ownership of the hospital's assets (land, buildings, equipment, etc.) changes from government to a private agency. The agency negotiates a contract allowing the government to use the hospital's assets. The hospital is managed by government staff. Staff are employees of the government. The government determines the hospitals' fees. It also specifies the kinds of services the hospital will provide
Public private partnership	A special type of partial privatization. The government and a private agency have a formal agreement to work together. The private agency often provides financing for asset acquisition or upgrading. It might also provide support for operations
4 Partial privatization, private staff	Ownership of the hospital's assets (land, buildings, equipment, etc.) remains in government hands. A private agency negotiates a contract with the government to allow it to use the hospital's assets. The hospital is managed by the private agency. All staff are employees of the agency. The government determines the hospitals' fees. It also specifies the kinds of services the hospital will provide
Outsourcing (contracting out)	The government-owned hospital contracts with a private agency for selected services. They are most often non-clinical services such as cleaning, transport, and building services. They can also include clinical services like pathology, pharmacy, or radiology
5 Equitization of assets	In many contexts, equitization means the same as privatization. However, in some circumstances it only means privatization of assets. We use it to mean privatization of assets
6 Partial equitization of assets	The transfer of some of the ownership of hospital assets from the government to private agencies. For example, the government could retain a 10% share of all assets, or it could retain full ownership of the land but no ownership of the building and equipment

Table 3 continued

Model	Meaning
7 Corporatization	The formation of a legal entity (a corporation) to manage and operate a hospital. The corporation employs all staff and has financial autonomy (responsibility for profits and losses). The assets remain the property of the government
Low levels of autonomy	
8 Individual employment contracts	The assets and management of the hospital remain in government hands. However, staff are private workers: they are employed on short- or medium- term individual contracts under the same conditions as employees of a private sector agency
9 Purchaser-provider contracts	The assets and management of the hospital remain in government hands. However, the hospital has a precise contract that covers all operations (including production volumes, payment rates per unit of volume, and quality. There are financial and other penalties for failure to meet contract requirements

Table 4 Amount of accountability required—the compliance regime

Seven domains of accountability[a]	
Domain	Meaning
1 Professional competence	Accountability for specific content area and managerial responsibilities: for example, risk adjusted mortality or complication rates, hospital mortality rates and malpractice claims, or overall patient satisfaction
2 Legal and ethical conduct	Accountability to: professional associations (through education, licensure and certification); colleagues (professional standards of practice and conduct); organizations (through regulatory regimes based upon inspection, measurement, and rule adherence [3] and individual patients
3 Financial performance	Accountability for price of service, efficiency of provision, assurance that services billed for were received, overall financial performance and economic health of service, including number or referrals and test-ordering patterns
4 Adequacy of access	Accountability for duty of care to the 'poor', amelioration of health inequities
5 Public health promotion	Accountability for preventative health strategies, including pre-emptive approaches to chronic and complex diseases, social determinants of health
6 Community benefit	Local democratic accountability: operating in areas where low contestability, choice and quasi-markets don't produce improvement in services, pressure from local accountability is said to force responsiveness instead [40, p. 319]
7 Quality of care and patient safety	Accountability through organizational accreditation; clinical governance; Smith [40] incident reporting; professional collaborative and communities of practice

[a] Domains adapted from Emanuel and Emanuel [12]

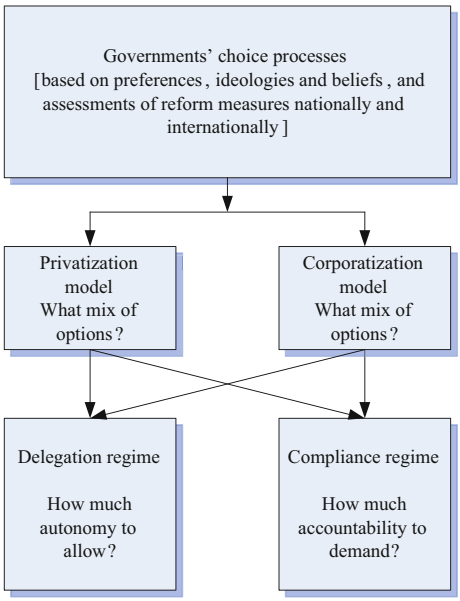

Fig. 7 A simplified model of the relationships between privatization, corporatization, autonomy and accountability

Conclusion

The Evidence is Weak and Often Conflicting

We suggest that no-one knows how to position the public–private tectonic plates in relation to each other for optimal effect because the positioning of these plates engages a series of highly visible and controversial public policy concerns. There are rarely any clear answers to recurring privatization and corporatization questions. The evidence is weak, and mixed. Our review suggests there are many strategies that can lead to the changes attributed to privatization or corporatization, and outcomes are either poorly evaluated or not well empiricised. It also indicates that there is far more argumentation in favour of the merits of privatization and corporatization than scientific evaluation of their benefits. As we suggest, the debates about the merits of privatization and corporatization are often vehicles for engaging in advocacy about a range of public policy issues. For example arguments are sometimes concerned with innovation, sometimes with efficiency and sometimes with the safety and quality of health care services provided. Overwhelmingly, there is a great deal of mobilization of ideology. Where performance has improved after privatization or corporatization, it is possible for those in favour to argue causality, and opponents to say that the improvements would have occurred anyway. Where performance has not improved after privatization or corporatisation, those who wanted it are able to claim that the idea was good but it was not implemented correctly, and those against it can say this outcome was predictable.

It is not Easy to Implement Privatization and Corporatization

It is clear that privatization and corporatization are typically difficult to institute. They are particularly challenging to implement in developing health systems if any of the supporting features (such as a well-trained workforce, good information systems, and a well-informed population) are lacking.

Autonomy and Accountability

Some of the central issues that decisions about privatization and corporatization have to resolve are those concerned with autonomy and accountability. Governments and other decision-makers need a clear understanding of the fiscal goals of privatization and corporatization, but also the politics of and bureaucratic tolerance for autonomy and accountability. Yet in truth, our analysis shows the debates about privatization and corporatization, and with autonomy and accountability, are not resolvable in the absence, to a considerable degree, of an ideological position. In these types of debates, objectivity is a perennial casualty, and bias the norm.

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