The role of private non-profit healthcare organizations in nhs systems: implications for the Portuguese hospital devolution program

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THE ROLE OF PRIVATE NON-PROFIT HEALTHCARE ORGANIZATIONS IN NHS SYSTEMS: IMPLICATIONS FOR THE PORTUGUESE HOSPITAL DEVOLUTION PROGRAM

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ABSTRACT

The national health services (NHS) of England, Portugal, Finland and other single-payer universalist systems financed by general taxation, are based on the theoretical principle of an integrated public sector payer-provider. However, in practice one can find different forms of participation of non-public healthcare providers in those NHS, including private for profit providers, but also third sector non-profit organizations (NPO).

This paper reviews the role of non-public non-profit healthcare organizations in NHS systems. By crossing a literature review on privatization of national health services with a literature review on the comparative performance of non-profit and for-profit healthcare organizations, this paper assesses the impact of contracting private non-profit healthcare organizations on the efficiency, quality and responsiveness of services, in public universal health care systems. The results of the review were then compared to the existing evidence on the Portuguese hospital devolution to NPO program.

The evidence in this paper suggests that NHS health system reforms that transfer some public sector hospitals to NPO should deliver improvements to the health system with minimal downside risks. The very limited existing evidence on the Portuguese hospital devolution program suggests it improved efficiency and access, without sacrificing quality.

Keywords: health systems, non-profit organizations, privatization

JEL Classification: I11, I18
1. INTRODUCTION

Private nonprofit organizations (NPO) have always had a significant role in the provision of healthcare, at least until the 20th century. Today, the role of NPO in healthcare varies significantly across health systems, ranging from a significant presence in some social or voluntary health insurance systems,¹ to the case of National Health Services (NHS) systems, where healthcare NPO are needless (in theory).

In Portugal, before 1974, the majority of hospitals were owned and operated by the local Santa Casa da Misericórdia (Holy House of Mercy - HHM), a specific type of NPO.² After the 1974 revolution, the HHM hospitals were transformed into public sector hospitals, and in 1979 they were integrated in the Portuguese National Health Service. In 2013, the Portuguese government started a program of devolution of hospitals, under which the management of a NHS hospital could be returned to the HHM that owned the hospital, and managed it before 1974. The devolved hospital would be owned and managed by the local HHM, but remained a NHS hospital, with a contract with the regional health authority to provide services to NHS patients. Three hospitals were devolved in 2015, and the agreements to devolve two other hospitals were signed but their execution was suspended by a new government in early 2016. The program received two types of criticism: some criticized the privatization of NHS hospitals, claiming that this would destroy the (public) NHS; others criticized the preference given in the privatization to NPO, instead of opening the process to for-profit companies.

This paper reviews the role of non-public non-profit healthcare organizations in NHS health systems, and analyses the implications of its results for the impact on the Portuguese health system of the hospital devolution program. Section 2 reviews the literature on privatization of national health services. Section 3 reviews the literature on the comparative performance of

¹ According to Sloan (2000), in the United States 60% of hospitals and a third of nursing homes adopted the legal form of NPO; NPO were a significant part of the hospital sector also in the Netherlands (60%), Germany (35%), Switzerland (32%) and France (16%).

² A HHM is a brotherhood of layman inspired by catholic faith, whose objective is to help victims of any form of misery, and whose works include feeding the hungry, curing the sick, and other types of social work. There are almost 400 HHM in Portugal, but only a minority provide healthcare services, including 23 hospitals, 112 nursing homes, and 101 other healthcare activities (UMP, 2015).
non-profit and for-profit healthcare organizations. By crossing these two literature reviews, section 4 assesses the impact of contracting private non-profit healthcare organizations on the efficiency, quality and responsiveness of services, in NHS health systems, and, in particular, the implications for the Portuguese health system of privatizing some NHS hospitals through NPO. Section 5 concludes.

2. PRIVATIZING NHS SYSTEMS

What characterizes a health system as a NHS is a subject of controversy. The landmark OECD (1987) study established a “trichotomous classification of health care systems into national health service, social insurance and private insurance types” (Freeman and Frisina, 2010), where the main classification criterion was the financing model. According to this classification, a NHS system is defined as a single-payer insurance scheme financed through taxation. The limitations of the trichotomous classification have led to a number of proposals for alternative classifications, usually with a larger number of categories. Böhm et al. (2013) condensed the 27 categories defined by Wendt et al. (2009) using the three core dimensions of the healthcare system (regulation, financing, and service provision) into five theoretically plausible system types: National Health Service, National Health Insurance, Social Health Insurance, Etatist Social Health Insurance, and Private Health System. Böhm et al. (2013) define a NHS as “an ideal type where regulation, financing and provision are governed by the state”, and classify the Nordic countries (Denmark, Finland, Iceland, Norway, and Sweden), the UK, Portugal and Spain under this category. More recently, Toth (2016) combined five models of financing (voluntary insurance, social health insurance, residual programs, national health insurance and the universalist system) with the integration or separation of insurers and providers to create a 10-categories health system classification, where NHS systems are defined as an integrated single-payer insurance scheme, covering all residents, financed through taxation.

Even the most restrictive definitions of NHS systems consider the health systems of the UK, Denmark, Finland, Norway, Sweden, Portugal and Spain as a NHS, but none of these systems is exactly the fully integrated single-payer insurance scheme financed through taxation, with only public healthcare providers, of the theoretical classification. The “Scandinavian countries
and the UK have experimented with internal markets” (Wendt, 2014), and both Portugal and Spain have pronounced “private insurance and out-of-pocket spending as well as private provision” (Böhm et al., 2013).

In practice, in NHS systems not all healthcare providers are public sector organizations. One can find different forms of participation of non-public healthcare providers in those NHS health systems. Some form of separation between the single public universal payer and the organizations providing healthcare services is a feature of the existing NHS systems, although there are significant differences between systems, regarding the breadth of the separation and the ownership structure of provider organizations. These may be public sector corporations (GOV), or private for profit providers (PFP), but may also include third sector NPO such as charities, cooperatives or social enterprises.

Although healthcare providers in the theoretical NHS are integrated with the public single-payer, in recent years several experiments of health care provision privatization have moved actual NHS systems away from the theoretical model. Privatization of health care provision may be defined as the transfer of responsibilities to deliver public health goods to private (either for-profit or not-for-profit) organizations that previously were the exclusive responsibility of public entities (Vargas Bustamante and Mendez, 2014). In this sense, one may find examples of privatization in every NHS system.

In England, an internal market was introduced (by a Conservative Government) in the early 1990s in the English NHS, by means of making a split between the state owned purchasers of care (health authorities and general practitioners who held funds to purchase other forms of healthcare) and its (state owned) providers (Allen et al., 2011). Once a separation between the public purchaser and the provider of healthcare is introduced, one might question why the providers must be public sector institutions, or whether the public interest of the payer (which in a NHS must be a public institution that administers the funds collected through taxation) could be served as well (or better) by private sector healthcare providers (Anderson, 2012). The predominant scheme through which private sector companies have been awarded English NHS contracts is the Independent Sector Treatment Centre (ISTC) program, introduced in 2002 (by a Labour Government). By 2011/12, almost 8% of total secondary care budget was spent on care provided by independent sector providers, almost double the proportion in 2006/07 (Arora...
In Sweden, there is freedom of choice of primary care provider for the population and freedom of establishment for providers. Patients can register with any public or private provider accredited by the local county council, although the proportion of private primary care units varies substantially between the county councils. In Stockholm, Halland and Västmanland about half of all units are privately owned, whereas only a few private primary care units exist in other county councils, in the less densely populated middle and northern parts of the country (Anell et al., 2012). Freedom of choice of primary care provider is also a feature of the NHS in Finland. Patients can choose between municipal health centres and private health care providers commissioned by the municipalities, and are allowed to change the unit once a year. Patients are also able to choose the hospital at which they want to be treated (Tynkkynen et al., 2016).

In Denmark, the primary sector consists of private (self-employed) practitioners – that is, GPs, specialists, physiotherapists, dentists, chiropractors and pharmacists – and municipal health services. GPs run private practices, either on their own as solo practitioners (approximately a third of all GPs) or in collaboration with other GPs. They are responsible for the costs of their practice, including buildings (rented or owned) and staff (Olejaz et al., 2012). In Norway, most GPs are self-employed and work under contract with the municipalities. Inpatient specialized care is mainly provided by the hospital trusts owned by the Regional Health Authorities (RHAs), but a few privately owned hospitals provide services under contracts with the RHAs (Ringard et al. 2013), although the number of in-hospital beds in private hospitals as a proportion of the total number of hospital beds is relatively low, as is the number of private contract specialists as a proportion of the total number of medical specialists (Midttun and Hagen, 2006).

Finally, in Spain it is common for the regional governments to contract the provision of very specific diagnostic or surgical services with private providers (often related to the reduction of waiting lists), and the regional governments of Valencia and Madrid have used administrative concessions to private companies for the construction of NHS hospitals (Garcia-Armesto et al., 2010). The same mechanism has also been used in Portugal, where, in 2014, 47% of the NHS

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3 In the UK, NPO represent about 15% of the private hospital market, per revenue (CMA, 2014), and less than 1% of the total secondary care budget (Arora et al., 2013).
current expenditure in ambulatory care, and 10% of the NHS current hospital expenditure was on private providers (Statistics Portugal, 2016).

The introduction of market mechanisms and private provision in NHS systems had three main objectives. First, privatization allowed the budget constrained NHS to increase capacity, in order to clear backlogs and waiting lists, without public investment.

Second, the introduction of freedom of choice for patients associated with “money follows the patient” financing mechanisms should create the incentive for institutions and their professionals to be more responsive to the desires and needs of patients. The stimulus to improve service quality and outcomes that patient choice introduces should not be underestimated (Wells and Moore, 2007).

Third, the introduction of competition between providers is expected to improve efficiency and productivity. In almost all instances of private provision in NHS systems, competition is on the basis of quality, not price, with tariffs set by the public single payer that should reflect average costs (Allen et al., 2011). In this case, all providers have incentives to improve productivity in order to reduce costs: for those providers with higher than average costs initially, improving productivity is a question of survival; for the others, it is a way to increase profits.

It is important to note that privatization increases productivity even if productivity in the private sector is not superior to that in the public sector initially, which may be the case in NHS systems. Since public sector providers are dominant in NHS systems, most private providers in these systems are staffed by public sector-trained consultants and nurses following public sector-inspired procedures. It is the freedom of choice for patients associated with “money follows the patient” financing mechanisms that induces competing providers to increase quality (to attract patients), and to reduce costs (to ensure survival). A competitive marketplace would induce greater productivity in public providers, but also in private providers (Wells and Moore, 2007).

Existing evidence tends to confirm the positive impact of privatization on productivity. Turner et al. (2011) show that ISTCs in England have introduced new models of service delivery for elective care, and that their clinical procedures (especially those related to systematising the care process) have influenced neighbouring public sector hospitals.

However, the increase in efficiency in private providers seems to arise more from cost-cutting and economies of scale, rather than qualitative innovation in care (Krachler and Greer, 2015). Public sector hospitals that combine service delivery, research and teaching represent stronger
learning environments in which medical innovations are more likely to emerge (Turner et al., 2011).

Privatization entails risks, and may have a negative impact on health policy goals if not properly designed. First, competition should not be based on price, and tariffs set by the public single payer must properly reflect clinical complexity, so that the private sector does not have an incentive to cherry-pick straightforward cases while leaving the complex ones to public providers (Klein, 2013). The existence of an independent regulator that monitors and sanctions any such cream-skimming could be an important mechanism to improve the positive impact of privatization. Second, patients must be given the relevant information and helped in making choices, especially the less well off, and that there should be help with transport costs, preferably again targeted at the less well off (Le Grand, 2009). Third, there must be mechanisms for ensuring that the entrance for new providers is easy and that exit can take place, and that the relevant decisions are immune from political interference.

Easy entry mechanisms for private providers are key for the success of privatization reforms. In many of the examples above, the share of private providers is small. Krachler and Greer (2015) tried to identify barriers to profitability of private providers to the English NHS following the 2012 Health and Social Care Act. Barriers to profitability identified by interviewees included the extraction of price concessions through reducing the tariff and through competitive tendering exercises that pit the private sector against low-cost and high-quality public providers, the uncertainty built into the rules of this market, and the high degree of public attention and staff resistance directed at privatisation attempts.

3. NON-PROFIT VS. FOR-PROFIT HEALTHCARE ORGANIZATIONS

Is the ownership of a healthcare provider relevant? Are health systems different if there are more or less healthcare NPO than PFP or GOV? This paper addresses these issues by reviewing the theoretical and empirical evidence on two related questions:

- What is the objective function of NPO, and is it really different from the objective
function of PFP?
- Do NPO behave differently, and do these differences in behavior matter for the efficiency, quality and responsiveness of services?

3.1. Objective function of NPO

The question of differences in the objective functions of NPO and PFP is as old as health economics. Arrow (1963), on his seminal health economics paper, related the very important presence of NPO in the hospital business to asymmetric information and agency. He did not use these exact words, but that was certainly what he meant by “trust and delegation” being one of the special characteristics of the Medical-Care Market. One consequence of such trust relations is that the physician cannot act, or at least appear to act, as if he is maximizing his income at every moment of time. NPO would be preferred by patients because the “very word, ‘profit’, is a signal that denies the trust relations” (Arrow, 1963, p. 965). Hansmann (1980) expanded this idea, theorizing that NPO help to solve the contract failure that arises from the patient’s inability to observe the quality of services provided, since NPO are free of incentives for exploiting their market power and informational advantages.

A few years later, Newhouse (1970) modelled the objective function of hospital NPO with the quantity and the quality of services as arguments. The decision makers in a hospital NPO – that Newhouse (1970) identified as the trustees, the administrator and the medical staff – want to maximize both the quantity and quality of services provided, in order to maximize the hospitals’ social function, to improve their professional and institutional standing, or for other reasons. Maximizing quantity implies (on the assumption of a downward-sloping demand curve) keeping price as low as possible, and possibly involves price discrimination (charity care). Other “altruistic” objective functions proposed included as arguments price and quality (Brekke et al., 2012), reducing unmet needs in the community (Frank and Salkever, 1991) and meeting donor expectations and ideological beliefs (Rose-Ackerman, 1996). The latter two motivations should make NPO have a stronger commitment to place, meaning that they are less likely than PFP to exit the market of their original communities and to expand outside their communities (Needleman, 2001).

The importance of medical staff on decision making led Pauly and Redisch (1973) to develop a model where the hospital NPO objective function is to maximize the net income per member of the physician staff, meaning that hospital NPO are profit-maximizers, albeit with a somewhat
unusual definition of profit. The implication is that NPO and PFP have similar short-run behavior, but in the longer run the model yields different predictions regarding the institution’s response to changes in demand and supply parameters, for NPO and PFP. Another implication is that hospital NPO have a special concern for ‘quality’, because ‘quality’ “is a synonym for application of nonphysician labor and capital in physician-income-enhancing ways, and noncooperative behavior could easily lead to ‘too high’ quality” (Pauly and Redisch, 1973, p. 98).

NPO may be guided by social concerns, but still be profit-motivated. Objective functions that combine profits with some altruistic motive (quantity, quality or price) were proposed by Gaynor and Vogt (2003), Harrison and Lybecker (2005) and Lakdawalla and Philipson (2006). Some NPO may be for-profits in disguise, like for profit companies that assume nonprofit status to exploit the perceived trustworthiness of the nonprofit sector (Hirth, 1999).

The evidence on NPO objective function is not vast, and it is mixed. Needleman (2001), after reviewing 8 studies comparing the ‘trustworthiness’ of NPO and PFP hospitals, claims that the evidence, while not conclusive, provides some support for the concern that PFP tend to engage more in bill increasing activities. More recently, Bayindir (2012) shows that in a sample of US hospitals not-for-profits are in between government and for-profit hospitals in terms of profit seeking behavior when treatment choices of patients are considered, providing support for the theories that associate NPO with higher quality. However, Borzaga and Fazzi (2014) in an analysis of the third sector in the Italian healthcare system, claim that although many of the social cooperatives furnish high-quality services, their concern for the needs of the more disadvantaged social groups is scant, suggesting that there are no significant differences between NPOs and PFPs, which the authors explain with policies which induce the third sector to operate in a competitive public or private healthcare market lead to the selection of organizational models and business strategies little different from those of for-profit firms, even if they are organized in cooperativist form. Drevs et al. (2014) study this issue using the perceptions of patients, from a German sample, and conclude that nonprofit hospitals are perceived as more trustworthy and warm but less competent than for-profit institutions, and that the perceptions of religious nonprofit and other nonprofit hospitals are similar. Malani and

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4 Note that profits (or at least the break-even condition) are always a constraint in NPO decisions, even when profits not enter the objective function.
David (2008) show that nonprofits do not advertise their status, and hence conclude that being a NPO is not a signal of quality. Finally, in a forthcoming paper, Gomes and myself show that Portuguese hospital NPO charge significantly lower prices than equivalent PFP hospitals, which is consistent with the output maximization theory of Newhouse (1970).

3.2. Relative performance of NPOs

From the theoretical models of NPO, one may extract five key predictions regarding the performance of NPO and PFP: (1) quality should be higher in (markets with) NPO; (2) prices should be lower or charity care and other unprofitable services should be expanded; (3) NPO should have a stronger commitment to the communities in which they are established; (4) PFP should be more responsive to patients; and (5) PFP should be more efficient. Empirical studies about the performance of NPO, PFP, and GOV healthcare providers are numerous, and the literature provides several examples of systematic reviews of these studies, and even an overview of systematic reviews (Herrera et al., 2014).

The evidence on the quality of care in NPO is not clear, but tends to favor the idea that NPO provide higher quality. Eggleston et al. (2008) reviewed 31 studies relative to US hospitals and conclude that the relationship between hospital ownership and adverse patient outcomes differ systematically according to a study’s data source, time period examined, and region covered, although studies representative of the US as a whole tend to find lower quality among PFP than NPO. Comondore et al. (2009) review 82 studies about the quality of care in nursing homes and conclude that NPO deliver higher quality care than do PFP, a result that was confirmed more recently by Grabowski et al. (2013). Devereaux et al. (2002) review eight studies comparing hemodialysis patients and conclude that NPO centers are associated with a lower risk of mortality compared with PFP centers.

The differences in efficiency and responsiveness are even less clear. Berendes et al. (2011) review 80 studies of ambulatory health care in low and middle income countries and conclude that the results for responsiveness and effort were similar in NPOs and PFPs. Sibbel and Nagarajah (2012) review 8 international studies but are unable to reach a really convincing answer to the question of whether PFP hospitals are more efficient. Shen et al. (2007) reached similar results on their review of 40 studies about hospital ownership, but conclude that the conventional wisdom that PFP hospitals would operate more efficiently was not consistently supported in their review.
4. IMPLICATIONS FOR THE HOSPITAL DEVOLUTION PROGRAM

The theoretical and empirical evidence reviewed in this paper suggests that privatization in NHS systems will improve efficiency, access and responsiveness to needs of patients throughout the health system, but entails some risks, namely cherry-picking of patients by private providers and other quality and clinical innovation concerns.

The other strand of literature reviewed in this paper, regarding the comparative performance of non-profit and for-profit healthcare organizations, suggests that a significant presence of NPO in healthcare markets tends to increase quality and expand the supply of unprofitable services, without affecting significantly efficiency and responsiveness. This implies that including NPO in NHS privatization processes will generate an increase in efficiency and responsiveness of the health system that is similar to PFP-only processes, with the advantage of increased quality and less cherry-picking of patients.

Thus, the evidence in this paper suggests that NHS health system reforms that transfer some public sector hospitals to NPO should deliver improvements to the health system with minimal downside risks. The Portuguese hospital devolution program should contribute to improve efficiency, access and responsiveness to needs of patients of the health system, without sacrificing quality or the access to care of less profitable patients.

It is still too early to assess whether these positive effects of devolution have materialized, but indications from the first year of activity seem to confirm these expectations. Table 1 provides information on the activity of the three devolved hospitals (Anadia, Fafe and Serpa), before (2014) and after (2015) devolution to the local HHM (which occurred on January 1st, 2015). The interpretation of the data in Table 1 must take into consideration that the Portuguese NHS operates under a gatekeeping system, which implies that access to specialist consultations and

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5 The information in this section was extracted from the 2015 Annual Report of Financial and Economic Execution of the Cooperation Agreement of each devolved hospital, and other documents submitted by UMP - União das Misericórdias Portuguesas (Union of the Portuguese HHM) to the Comissão de Acompanhamento do Processo de Devolução dos Hospitais às Misericórdias (Monitoring Committee of the Hospital Devolution Program), a committee that includes representatives of the national and regional health authorities and of the HHM and UMP. All the documents were provided to the author by UMP.
surgeries requires a NHS physician referral (although no referral is necessary for emergency room visits), and that the referral system from NHS primary care physicians to specialist consultations in the devolved hospitals was not operational on January 1st, 2015: referrals to Anadia started only partially in January and were not fully operational until May, referrals to Fafe started only in March, while there were no referrals to Serpa in 2015 (hence the absence of specialist consultations and of surgeries that would result from those consultations).

Table 1: Activity in the devolved hospitals, before and after devolution

<table>
<thead>
<tr>
<th></th>
<th>ER visits</th>
<th>Specialist consultations</th>
<th>Surgeries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anadia</td>
<td>10 852</td>
<td>22 492</td>
<td>473</td>
</tr>
<tr>
<td>2014</td>
<td>2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fafe</td>
<td>26 979</td>
<td>4 714</td>
<td>1 080</td>
</tr>
<tr>
<td>2014</td>
<td>2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serpa</td>
<td>15 542</td>
<td>7 902</td>
<td>1 551</td>
</tr>
<tr>
<td>2014</td>
<td>2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>42 521</td>
<td>15 566</td>
<td>1 553</td>
</tr>
<tr>
<td>2014</td>
<td>2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% change</td>
<td>3.9%</td>
<td>95.3%</td>
<td>108.8%</td>
</tr>
</tbody>
</table>

In spite of the referral difficulties, programmed activity in Anadia and Fafe approximately doubled from 2014 to 2015, an increase in production that would be valued at 2.3 million euros using 2015 prices (see Table 2). At the same time, the cost for the NHS of the operation of these two hospitals was reduced by 3.1 million euros (36% of 2014 costs). The total efficiency gains (total cost reduction plus production increase) are estimated at 5.4 million euros, which corresponds to 64% of 2014 costs.

The significant efficiency gains do not seem to have affected the quality of services in Anadia and Fafe. Both contracts include targets for quality indicators, and in 2015 none of these targets was missed, suggesting that the quality of services provided was according to NHS standards.

In conclusion, the existing evidence, although early, very tentative, and limited to two devolved hospitals (which implies that any spillover effects are being ignored) is consistent with the theoretical prediction that a hospital privatization program involving NPO will increase in

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6 The cost for the NHS in 2014 corresponds to the estimated operational costs of each hospital under public management. The cost in 2015 corresponds to the net payments of the NHS to each local HHM.
efficiency without affecting quality.

Table 2: Efficiency gains in the devolved hospitals (unit: € 1000)

<table>
<thead>
<tr>
<th></th>
<th>Anadia</th>
<th>Fafe</th>
<th>Anadia + Fafe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost to the NHS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>3 500</td>
<td>4 887</td>
<td>8 387</td>
</tr>
<tr>
<td>2015</td>
<td>2 565</td>
<td>2 772</td>
<td>5 337</td>
</tr>
<tr>
<td>Cost reduction</td>
<td>935</td>
<td>2 115</td>
<td>3 050</td>
</tr>
<tr>
<td>as % of 2014 cost</td>
<td>27%</td>
<td>43%</td>
<td>36%</td>
</tr>
<tr>
<td>Production increase</td>
<td>1 656</td>
<td>679</td>
<td>2 335</td>
</tr>
<tr>
<td>Total efficiency gains</td>
<td>2 591</td>
<td>2 794</td>
<td>5 385</td>
</tr>
<tr>
<td>as % of 2014 cost</td>
<td>74%</td>
<td>57%</td>
<td>64%</td>
</tr>
</tbody>
</table>

5. CONCLUSION

This paper reviewed the role of non-public non-profit healthcare organizations in NHS systems. By crossing a literature review on privatization of national health services with a literature review on the comparative performance of non-profit and for-profit healthcare organizations, this paper assesses the impact of contracting private non-profit healthcare organizations on the efficiency, quality and responsiveness of services, in public universal health care systems. The results of the review were then compared to the existing evidence on the Portuguese hospital devolution to NPO program.

The evidence in this paper suggests that NHS health system reforms that transfer some public sector hospitals to NPO should deliver improvements to the health system with minimal downside risks. The Portuguese hospital devolution program should contribute to improve efficiency, access and responsiveness to needs of patients of the health system, without sacrificing quality or the access to care of less profitable patients. The very limited existing evidence suggests this was the case.
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