

HOSPITALS

in the 27 Member States of the European Union



DEXIA

*F*or the past several years, most European Union Member States have been facing the same issue - the need to provide quality health care, tailored to the needs of the population and accessible to all, while still addressing the increasing health expenditure on restricted public finances which represents some 9% of GDP in the European Union. Meanwhile, public funds, which cover most healthcare expenditure, are strained everywhere. As a result, public authorities in many EU Member States have recently initiated reforms in their respective healthcare systems. The hospital sector plays a crucial and specific role within healthcare systems and is usually the largest element of healthcare spending. It is therefore no surprise that it comes under the microscope during reforms of the health sector.

Across most countries, the healthcare reform aims to rationalise care by using three different strategies: decentralising hospitals competencies, changing the ways of hospitals financing and finally reorganising hospital care. Each country has its own strategy or strategies because of the vast differences in the EU hospital systems. Some kind of pathology-based payment, for example, are increasingly implemented in hospitals. The way in which this payment is made, however, varies widely from country to country. Similarly, the restructuring of hospitals taking place across Europe usually results in fewer beds for short-term stays although the pace at which this reform is being implemented and its scope is different depending on the country.

Increasingly, European hospital systems, which are part of public services for the most part, must usually operate in coordination with a private sector with regards to funding operating expenses but sometimes also in funding capital expenditure or service provider. Some governments have partly encouraged the development of these private initiatives as an alternative solution to public funding.

It may still be too early to speak of a "European health system", but European integration seems to be spurring a certain degree of convergence. This is particularly obvious in some recent Union's entrants, which are going through a genuine "hospital transition". Improved health indicators are accompanied by a streamlining of the healthcare system, in which hospitals are likely to be less dominant.

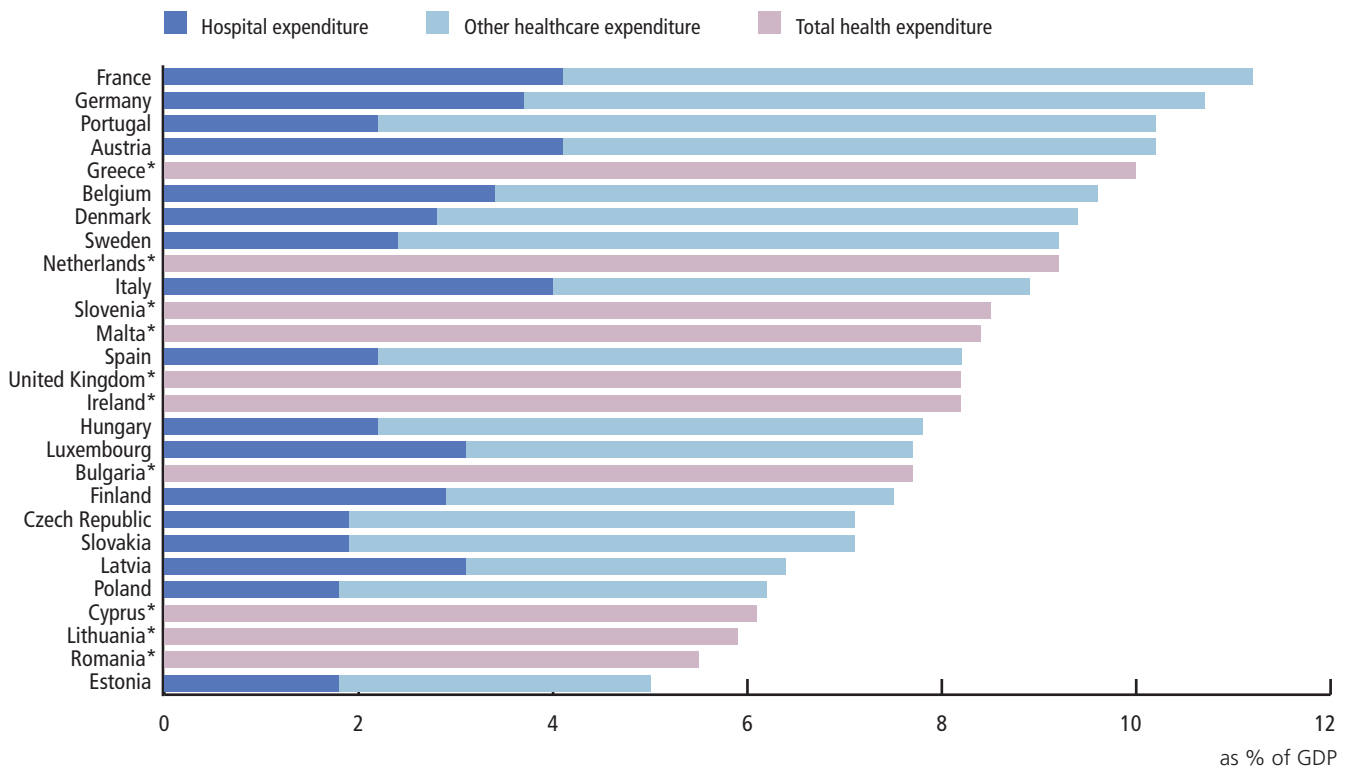


THE WEIGHT OF HOSPITAL EXPENDITURE IN THE ECONOMY

In 2005, the weight of hospital spending as a proportion of Gross Domestic Product (GDP) ranged from a little under 2% in Estonia, Poland, the Czech Republic and Slovakia to just over 4% in Austria, France and Italy. Across the majority of European countries, this weight has changed little since 1998¹. This stability is the result of two opposite factors that,

overall, cancel each other out. The weight of total health spending as a percentage of GDP rose between 1998 and 2005 in the vast majority of European Union Member States while the weight of hospital expenditure as a proportion of total health spending, over the same period, has gone down in most countries.

Health expenditure (hospitals and totals) as % of GDP in 2005



Source : WHO, 2009 - * countries for which hospital expenditure is not available in 2005.

Total health spending on the rise overall

On average, the 27 Member States of the European Union allocated 8.9% of their national wealth to healthcare spending in 2005², compared to 7.9% in 1998. From one country to the next, this percentage more than doubles between 5% of GDP in Estonia to 11.2% in France in 2005.

Between 1998 and 2005, healthcare spending, as a percentage of GDP, rose in 22 of the 27 Member States of the European Union; 4 of these 5 are Central or Eastern European countries³. Estonia is both the European country with the lowest spending for healthcare (5.0%) and the only one recording a drop, between 1998 and 2005 (-0.5 point). Latvia, Lithuania and Poland saw their ratios stabilise at around 6% to 6.5% between 1998 and 2005. In all, the weight of spending as a percentage of GDP in EU countries did not tighten over the period.

Hospital sector/overall healthcare expenditure ratio dropping

In all of the EU countries, the hospital sector is one of the most important items in healthcare expenditure. Yet its ranking varies widely between countries, ranging from slightly over 20% of total health expenditure in Portugal to just under 50% in Latvia in 2005.

Hospital spending as a percentage of overall healthcare spending shrunk in most European countries between 1998 and 2005. This is a result of policies aimed at controlling healthcare expenditure, as well as faster growth in spending for medication owing to medical and technological advances or, sometimes, the liberalisation of the medicines market in Central and Eastern European countries.

Health as a contributing factor in economic growth

Healthcare spending must not be considered as merely an expense but also as a resource. The health sector does indeed contribute to economic growth namely by improving “human capital”. Three factors are generally considered to determine human capital: competencies, experience and knowledge, which together forge the aptitude of an individual to work and thus be productive. As such, human capital is a fundamental component of technical progress, which is one of the essential drivers of economic growth.

Human capital can be acquired through education, maintained and developed through continuing education programmes for example but also by keeping a close watch on the health of the

individual. The role of education in growth has often been highlighted. Countries and regions that spend more on education, and in particular those that do so with better results, are also those that have the highest economic growth.

The role of healthcare in economic growth has not been studied as extensively but research is starting to address the topic⁴. Studies have shown that the initial level and rise in life expectancy has had positive effects on GDP growth per capita. Health investment aims, firstly, to guarantee the availability of productive labour. Future growth can also be fed by healthcare investment today as it offers individuals the ability to plan ahead in life with certainty. This ability is driven by investment in education and by nurturing an attitude that encourages savings.



DECENTRALISING HEALTH COMPETENCIES

Since the 1970s, one of the major thrusts of European healthcare reform has been the territorialisation of healthcare jurisdiction. This can take the form of deconcentration, that is, the transfer of decisions from the central administration to its local or regional counterparts; or, more often, decentralisation, wherein the State transfers jurisdiction to local authorities (local governments). The territorialisation of healthcare jurisdictions, including those related to hospitals, is sometimes considered to be a way of rationalising hospital care and continues to gain followers today. Some European countries have furthered the delegation of competencies amongst local players while others have abandoned the idea. The different organisational methods in Europe that are presented here are estimated to change in the years to come.

Only 7 of the 27 Member States of the European Union still use a centralised healthcare system. This is particularly true of the smallest of European countries which have not felt the need to decentralise healthcare services. The deconcentrated organisation of the healthcare system is only used in 5 countries. In Bulgaria, France, Greece, Portugal and Romania, agencies have been set up by the government to manage healthcare services at a sub-national level. 15 Member States feature a decentralised healthcare system. However, central regulation of this system is deemed necessary.

Countries with a decentralised health system

The Nordic countries (Denmark, Finland and Sweden) have been typically quite decentralised. In **Finland**, hospital care is managed by 20 hospital districts, which are inter-communal structures of varying sizes - the smallest district covers less than 100 000 inhabitants, while the largest covers over a million. Hospital districts own health establishments. However, municipalities provide direct funding for hospitals with which they negotiate the rates of each service and their investment needs.

In the Federal countries (Germany, Austria and Belgium), a significant portion of healthcare - in particular, hospital care - is administered by the federated entities (*Länder*, Communities) which have a great degree of autonomy from the federal government. Hospitals’ operating expenses are essentially financed by health insurance funds.

Spain and Italy have, over the course of the last decade, slowly regionalised their health systems and by extension their hospital sectors. In **Italy**, most hospital services are carried out by the regions. They own public hospitals and finance their operating budgets and investments. Most public hospitals are under an *Azienda sanitaria locale*⁵ (ASL). The ASL is a territorial public establishment, with the status of a legal person, and with autonomy for financial and human resources matters. Other public hospitals have the status of the *Azienda Ospedaliera*⁶ (AO). The AOs are responsible for their budget although placed under the authority of the region, which names their director.

Healthcare systems in Central and Eastern European countries formerly under communist regimes were highly centralised and had abundant supply of hospital services. Starting in the early 1990s, most countries began the decentralisation process. Certain reforms have not been completed while others have clearly advanced, like in the **Czech Republic**. Following a law signed January 1, 2003 reforming territorial administration, the 14 regions became owners of all public hospitals with the exception of university hospitals, which remain property of the State. Regions also received the right to organise the administration of the hospitals they own. Investment is also the responsibility of regions while the State takes on the largest investments. Operating budgets in Czech hospitals are mainly financed by health insurance funds.

Territorial organisation of European healthcare systems in 2009



In the **United Kingdom**, the National Health Service (NHS) was decentralised in 1998 to the four countries: England, Wales, Scotland and Northern Ireland. At local level, its organisation ranges from a high level of deconcentration in England and Wales, to a more limited one in Scotland and Northern Ireland. In 2000, the Head of the Department of Health in the United Kingdom launched a vast reform of the NHS in an effort to further deconcentrate it. The Primary Care Trusts (PCT), which include doctors, nurses, social workers and patients were implemented in 2002 and are responsible for financing and organising healthcare services. They are recipients of 80% of the NHS' budget. The 152 PCTs fall under the governance of the 10 Strategic Health Authorities (SHA), local representatives of the Department of Health on general healthcare policy issues. Hospitals have become more independent. With the 1990 reform, they had become NHS Trusts, public bodies with a corporate statute and considerable autonomy concerning their budgets and the services they perform. They are separate from the local administration in which they were previously integrated. Most of the 245 NHS Trusts were transformed into Foundation Trusts as a result of the 2004 reform, which gave them increased autonomy in matters of investment in particular. Hospitals negotiate service contracts directly with the PCTs .

Countries that have recently revised territorial organisation of their health system

The decentralisation of health competencies is a question that remains important today in numerous European countries. It has taken three different forms including a movement towards decentralisation (e.g. Romania), abandoning decentralisation (e.g. Ireland) or restructuring various levels of competency (e.g. France and Denmark).

In **Romania**, the organisation of the health system is deconcentrated. Local authorities only play a marginal role although they own most health establishment including hospitals. In the works for several years, decentralising central level hospital competencies in favour of local authorities seems

to be on its way. In May 2009, the Romanian government passed a resolution setting decentralisation strategy in the area of healthcare. It outlines the transfer of hospital management to local authorities and the necessary resources starting in 2010. Because health insurance funds are responsible for hospital financing, municipalities will be mostly responsible for investment only.

In **Ireland**, the reform of January 2005 led to the re-centralisation of the healthcare system, with the creation of the Health Service Executive (HSE) to replace the ten existing health boards. The State owns public hospitals and the HSE finances their operating budgets and investments. As such, the HSE centralises management of the country's health system and manages the Ministry of Health's budget on its own.

The organisation of health competencies in **Denmark** was shuffled significantly following reforms of the public sector that took effect in January 1, 2007. The reforms did away with the 13 counties and replaced them with 5 new regions. Counties were responsible for health competencies but have been divided up between municipalities and regions, which picked up hospital competencies without receiving fiscal powers. The State and municipalities finance the budgets of hospitals and other health services. The State covers 80% of the new regions health expenditure through subsidies and grants distributed according to socio-economic and demographic criteria. The municipalities finance the remaining 20% of public spending.

In **France**, 26 *Agences régionales de santé*⁷ (ARS) are to be created in 2010. This new organisation aims to unify, in one agency, health competencies that were already quite deconcentrated but managed by various bodies. The objective of this effort is to improve regional coordination of hospital activities, care provided in cities and services related to social care. It will not, however, change the way in which hospitals are financed, which is provided by health insurance funds.



HOSPITAL FINANCING UNDER REVIEW

Throughout Europe, governments have decided to review the ways in which hospitals are funded in order to better control operating costs. Most European countries have decided, one after another, to use, in part, pathology-based payment while adapting it to their own healthcare structure. The search for budgetary leeway caused by this new payment method has not called into question the launch of hefty investment programmes in several countries across Europe.

Pathology-based payment on the rise

Over the last fifteen years, most European countries have changed the way in which their hospitals are financed by

introducing pathology-based payment. This mechanism is based on the classification of patient stays according to disease groups, defined according to the similar diagnostic and treatment and financial resources needed for their management. Several classifications exist, the best-known of which are the "Diagnosis-Related Groups" (DRGs) from the United States.

Pathology-based payment first appeared in certain counties of Sweden and in Hungary in 1992 and 1993. 20 other Member States of the European Union have since introduced similar measures and 5 other European countries are considering implementing it. In the **Czech Republic** for instance, as has been the case in most Central and European

countries, successive reforms in hospital payment methods have been put in place since the 1990s.

On the European scale, improving cost control, increasing transparency and even reducing waiting lists (e.g., for Sweden) are the main reasons for introduction pathology-based payment in hospitals. The main objectives of this new type of payment seem to be shared across EU Member States. Nevertheless, its implementation visibly varies from one Member State to another.

In most Member States, pathology-based payment only applies to acute care. This may extend to other disciplines, such as psychiatry in Italy or medium-term care in Hungary. In other cases, extension of this payment type is in the works (for example, psychiatry in England).

In addition to a strict activity-based or pathology-based payment scheme, the mechanism for allocating hospital

resources in the vast majority of European countries continues to include an overall budget used mainly to finance general-interest missions (typically medical training and research) that are separate from activities related to hospital stays.

Most Member States offer their hospital sectors a progressive rollout of pathology-based payment reforms, to ensure a smooth transition from previous means of funding.

In many countries, the State is behind the effort to introduce pathology-based payment, which may lead to a form of “centralised” budgetary powers in countries with decentralized health systems (Austria and Italy in particular). However, although central governments generally propel such initiatives, their application may be decentralised at an infra-national level and vary from one local authority to another within the same country, especially in Italy and Sweden.

Implementing the pathology-based payment in Sweden

Sweden is composed of 20 counties and all did not introduced pathology-based payment at the beginning of the 1990s. In the counties which have introduced it, the first studies conducted after this reform showed that it had led to shorter waiting lists but little gains in productivity - the two main goals of the reform in Sweden. Health establishments had, in fact, focused more on maximising their revenues instead of cost control. Consequently, activities grew faster than expected in some counties, and spending grew out of hand. To control health expenditure and encourage greater productivity, some counties modified the modalities of the pricing reform. Rates were computed according to the costs of the top 10% most performing hospitals (instead of the average). The share of financing that was directly linked to activity, initially close to 100%, was reduced at times. Following these adjustments, productivity gains were observed for several years. They appeared to be greater in counties that had chosen pathology-based payment than in those who had not made this pick. Such gains were realised without any measurable reduction in healthcare access or quality. The reduction in the length of stay does not seem to have had an impact on the readmission rate of hospitalised patients or resulted in discrimination against older patients⁸. Productivity gains for health establishments have also been seen in other EU countries using the pathology-orientated payment in the 90s, particularly in Italy, Finland, Austria, and Portugal.

Relaunching hospital investment

The need to modernise hospitals has increased as a result of the rapid spread of innovations in medical techniques. This has notably been the case in countries that for a time neglected their hospitals, which is the case in numerous European countries. In recent years, several of them have deliberately supported the boosting in hospital investment, an area into which the State or local authorities have been eager to inject massive amounts of public funds. As part of these local or national hospital investment recovery plans, several governments including the United Kingdom, France, Spain, Portugal and others have decided to call on the private sector including private-public partnerships (PPP)⁹.

In the **United Kingdom**, the Labour Party committed, in 1997 when it came to power, to reforming the healthcare system including a reform of hospital investment launched in 2000. In England, the government made extensive use of the Private Financing Initiative (PFI). It builds on the experience of implementing a vast programme modernising its hospitals as a third of its hospitals dated from before 1948. The goal of rebuilding 100 hospitals before 2010, one of the programme's

goals, has already been reached. With the reconstruction of the 100th hospital already complete, another 30 are under way. Since 1997, more than €19bn has been invested including 80% as part of PFI. Annual hospital investment reached €7bn in 2008 versus €1.9bn in 1998 (lowest total during the 1990s).

In **France**, the government formed in 2002 decided to increase hospital investment. The goal of the stimulus plan, known as “Hospital 2007”, was to increase hospital investment by €10bn over 5 years by allocating €6bn in government aid. More than 1,000 projects, both public and private, were supported by Hospital 2007 for a total of more than €16bn invested for a period vastly exceeding the initial end of the programme, initially set for 2007. As a result, annual investment in public hospitals more than doubled between 2002 and 2008 jumping from €3bn to €6.8bn. Certain projects carried out under the auspices of the plan were public-private partnerships. Since 2004, 50 projects for a total of €2bn have been carried out. Launched in 2008, the Hospital 2012 plan picks up where Hospital 2007 left off. Indeed, €5bn in public aid should translate into €10bn in additional investment. This plan is, however, more focused on reconfiguring hospitals.

In **Belgium**, the regions, with the financial help of the federal government, are in charge of hospital investment. Each region has launched projects to renovate ageing hospitals in the years to come. More than €3bn is scheduled to be invested with 90% of financing coming from the federal government, for priority projects, versus the more typical contribution of 40%.

In **Spain**, the regional health services of the Autonomous Communities manage hospital investment without interference from the national government. The more “historic” Communities that were first to gain independence, such as Catalonia and Andalusia, have injected massive funding into the renovation of hospitals in the years following the transfer of healthcare

competencies to them. More “recent” Communities such as Madrid and Valence are now modernising their hospitals. These two regions have taken the initiative to commence renovations. Between 2004 and 2005, the Autonomous Community of Madrid began the construction of 7 new hospitals, which are all PPPs. In 2009, it announced that it was building another hospital and 3 others are in the works. The region of Valencia has gone a step further by calling on the private sector to not only build 5 hospitals but to manage them as well.

The hospital sector has often taken a back seat to transport or to a lesser extent, education and the dependency sector when it came to doling out the stimulus plan funds designed to head off the economic and financial crisis in 2008.

Healthcare systems and the stimulus plans that followed the economic crisis

The economic stimulus plans that have been adopted to confront the worldwide economic and financial crisis that started in September 2008 have only on rare occasions included measures for the hospital sector. Stimulating the hospital sector has been outlined in only a few stimulus packages including, notably, in Germany, Luxembourg and in the Netherlands where its importance as part of the overall effort has been marginal. In Germany, for example, less than 1% (€18bn) of funds is expected to be set aside for the hospital sector.

Before these various stimulus plans were rolled out, several European countries had already committed significant funds to either hospital investment (Germany, Belgium, Denmark, France and the United Kingdom, amongst others) or the reorganisation of the industry (Hungary and Estonia, for example). This could help explain why the hospital sector has been largely ignored in the stimulus debate.

Moreover, rather than increasing public spending by bolstering hospital investment, many countries are trying to reduce the impact of health spending on public deficits in the wake of the financial crisis. In a host of countries including many of those in Central and Eastern Europe (Estonia, Hungary, Latvia, Lithuania and Romania, for example) cuts in health spending have been announced. Estonia, Latvia and the Czech Republic are examples of countries in which public medical insurance coverage has been reduced¹⁰.



HOSPITAL REORGANISATION: SHRINKING ACUTE CARE SERVICES

In recent years, the majority of European countries have begun to rationalise their healthcare capacities, which were often deemed to be excessive and poorly spread across the territory and therefore not efficient enough. Rationalisation policies, using planning tools with varying degrees of effectiveness and cohesion depending on the configuration of the hospital system, have all included reducing the density of beds in acute care units. The closing of beds in acute care has had various impacts depending on the country (hospital closings, development of home care, rehabilitation, etc.).

In 2007, the Member States of the European Union had 4.2 acute care beds per 1,000 inhabitants and 2 acute care hospitals for every 100,000 of its inhabitants. These two numbers have dropped considerably since 1990 (app. -30%) and even since 2000 (app. -10%). Despite a marked drop in acute care bed density across Europe there are large discrepancies from one country to the next. It more than tripled; in Finland there were 2.3 beds per 1,000 inhabitants

in 2007 whereas in Austria this number was 6.4. The differences thus remain significant even if the deviation from the average has been shrinking from numbers produced in 1990.

For nearly all Member States of the European Union, acute care beds density has dropped markedly over the course of the past decades. However, changes have not come at the same pace or with the same intensity. They have not come at the same time either. Excluding the countries of Central and Eastern Europe which only experienced slowing acute care bed densities at the beginning of the 1990s, this trend was already taking place, generally speaking, starting in the 1990s in the other Member States. In most countries, this trend continued from 2000 onwards even though it was at a slower pace than over the previous two decades.

Belgium and Greece (3.8 beds) were the only two countries that had similar levels of beds per capita in 1990 and 2007.

Acute care bed and hospital in 2007 versus 1990 levels

	Acute care bed density		Acute care hospital density	
	Level in 2007	Changed since 1990	Level in 2007	Changed since 1990
Austria	6,4	-21%	2,2	-23%
Slovakia	6,0	-19%	2,0	35%
Czech Republic	6,0	-27%	1,9	20%
Germany	5,7	-23%	2,2	-19%
Latvia	5,2	n/a	3,1	n/a
Lithuania	5,1	-47%	2,4	-44%
Luxembourg	5,1	-27%	2,0	-58%
Romania	5,1	-27%	n/a	n/a
Belgium	4,7	-4%	1,4	-54%
Hungary	4,1	-42%	1,1	n/a
Poland	4,1	-35%	n/a	n/a
Greece	3,9	1%	2,4	-29%
Estonia	3,8	-59%	2,7	-60%
Slovenia	3,8	-25%	1,1	n/a
France	3,6	-29%	2,7	-25%
Cyprus	3,5	-22%	12,2	n/a
Netherlands	3,4	-15%	0,6	-34%
Italy	3,4	-44%	1,9	-23%
Denmark	3,1	-25%	n/a	n/a
Portugal	3,0	-17%	1,5	-20%
Sweden	2,8	-32%	n/a	n/a
Ireland	2,7	-14%	1,2	-34%
Spain	2,7	-19%	1,3	-21%
Malta	2,7	n/a	1,5	n/a
Finland	2,3	-46%	n/a	n/a

Source : WHO, 2009 - n/a = not available.

In **Belgium**, acute care bed density increased up until the early 1990s reaching 5.9 beds/1,000 inhabitants in 1985. In 1982, a series of measures lead to the transformation of some acute care beds into nursing home care beds and to the freezing of hospital capacity at 1 July 1982 levels. Financial compensation was awarded for all bed closings. The drop in the number of beds as a result of these measures has been inconclusive. Again, in 1989, legislation capped minimum capacity at 150 beds for acute care hospitals and funded mergers or closings of hospitals that did not respect this standard. This new reform, having encouraged hospital centralisation, was able to halve the number of acute care hospitals to 1.4 hospitals for every 100,000 inhabitants in 2007 versus 2.9 in 1990. To a lesser extent, it also reduced bed density, which in 2007 stood at 4.7 beds/1,000 inhabitants.

This density was weaker in 2007 than in 1990 in 25 other Member States (excluding Belgium and Greece). This drop was particularly strong in certain Eastern and Central European countries. At the start of the 1990s, these countries had a surplus in hospitals inherited from the Soviet era. Hospital reorganisation was launched at the same time as political transitions and at the mercy of political and economic pressure. These changes have been more or less successful depending on the country. 5 of the 8 countries with more than 5 acute care beds per 1,000 inhabitants in 2007 were Central and European countries including Latvia, Lithuania, The Czech Republic, Romania and Slovakia. These countries still have above average densities.

Estonia had 3.8 beds per 1,000 inhabitants in 2007 versus 9.2 in 1990. Reforms in Estonia in the past fifteen years have been radical and have shaken up the hospital industry landscape¹¹. In 1994, a law on the organisation of health services ushered in an accreditation system for acute care providers leading to the closing of numerous small acute care hospitals, which were converted into retirement homes. The "2015 Hospital Plan", started in 2000, has continued to push efforts to reduce acute care hospital capacity while encouraging efficiencies. Through these efforts, Estonia aims to reduce capacity to 2 acute care beds per 1,000 inhabitants and approximately 1.5 acute care hospitals per 100,000 inhabitants in 2015.

In **Hungary**, hospital restructuring began much more recently. In these countries, political opposition to hospital restructuring stood in the way of consequential reductions in the number of acute care beds available. A law was passed in late 2006 aimed at closing 10% of acute care beds and giving more emphasis to long-stay beds. This law included financial incentives for hospitals based on the number of acute care beds they could close or convert to long-stay care beds. These financial incentives created results that surpassed the initial goals. In fact, acute care beds dropped by 25% in 2007 to 4.1 beds/1,000 inhabitants where they had only dropped by slightly over 20% from 1990-2006.

Despite the already low density of acute care beds in the 1980s in **Finland** and in the Nordic countries in general (just under 5% compared with an EU average of 6%), it was halved in the 1990s. Following the economic recession of the early 1990s, the Finnish government proceeded with significant social and health budget cuts, which led to the closure of many acute care beds. Hospital capacity was reduced by 30% between 1990 and 1995. This rapid drop continued at a good pace until the late 1990s. These changes were accompanied by a significant reduction in the average length of stay, as well as new coordination of hospital and community-based care, to the advantage of the latter¹². Nonetheless, problems with the waiting time for access to care appeared during the 1990s, with the creation of waiting lists. They appear to be decreasing since the introduction of the 2004 law on healthcare access and thanks to a marked slowdown in the reduction of acute care beds. In Sweden and Denmark similar changes, although to a lesser extent, took place.

For a majority of European countries, the density of acute care hospitals has experienced a slower drop than that of acute care beds. The Czech Republic and Slovakia are two exceptions because acute care hospital density has risen over the 1990s while bed densities dropped. In the Czech Republic, two explanations have been suggested including the decentralisation process of the healthcare industry, which encouraged local hospital care and the development of the private hospital sector, made possible by the privatisation of public hospitals but also by the creation of new establishments. In the last few years, the number of acute care hospitals has shrunk but remains higher than in the 1990s, unlike the other members of the European Union.



THE GROWTH OF THE PRIVATE SECTOR IN HEALTHCARE

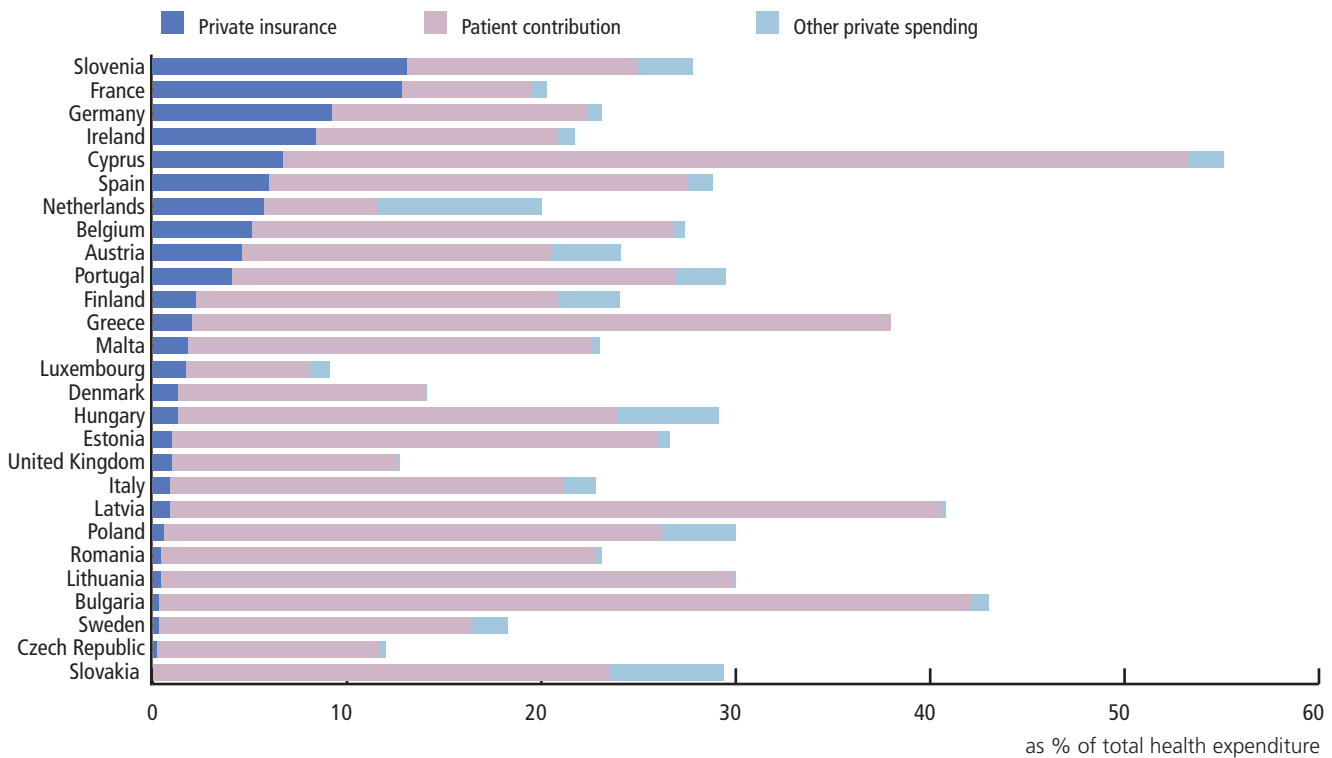
The involvement of public authorities is one of the hallmarks of healthcare systems across Europe. However, in several European countries, the privatisation process is currently underway for financing health expenditure but also in providing health services. Recent private initiatives come most often at the behest of the government as it tries to liberalise the healthcare system in an effort to reduce its weight on public finances and to increase efficiency, to cite just two reasons.

Private sources of financing health expenditure

Financing healthcare systems across most European countries principally relies on the public coffer whether through taxes

and/or social contributions. In 2006, public funds financed over 70% of health expenditure in 23 Member States and only the healthcare system in Cyprus uses, just slightly, more private resources. In Europe, private sources of financing represented on average 23.2% of health expenditure in 2006 dipping slightly from 2000 (24.9%). There are two primary sources of private financing of healthcare expenditure: direct contributions by patients (representing three-quarters of private financing) and private health insurance. Even if private medical insurance aims to reduce direct contributions by patients, at the European level, there is no correlation between the two private sources of health expenditure financing.

Percentage and nature of private financing of health expenditure in 2006



Source : WHO, 2009.

Direct patient contributions have been dropping in the majority of European Union countries in recent years; after reaching an average of 18.4% in 2000 they fell to 17% in 2006. The drop was significant in several Central and Eastern European countries including Hungary, Latvia, Poland and Romania as a result of the complete makeover of health systems that began in the 1990s. This was also the case in the two other new members (Cyprus and Malta) and in countries with a long-standing tradition of public health coverage such as Belgium, Denmark, Italy and the United Kingdom.

Direct patient contributions are much less significant for hospital care than they are for general practitioner visits or pharmaceuticals¹³ in Germany, Belgium, France, the Netherlands, Sweden and Switzerland. It is important to note that access to hospitals is entirely free of charge in nearly half of all European countries.

Throughout Europe, private health insurance systems exist alongside public health coverage in order to reduce direct patient contributions. Private health insurance plays a role at

various levels and for different reasons in each EU country. It is usually used as a complement to public coverage. It also replaces, albeit less often, certain patient categories covered by public insurance as in Germany and Austria. It was also the case in the Netherlands prior to a 2006 reform that significantly changed the role of private health insurance in the healthcare system. Besides the Netherlands, the average

percentage of healthcare expenditure financed by private health insurance grew in Europe between 2000 and 2006 passing from 4.4% to 4.8%¹⁴. This average, low compared to countries beyond Europe's borders such as the United States, masks substantial discrepancies as in 2006 it was zero or close to zero in Lithuania, Czech Republic, Slovakia and Sweden but close to 13% in France and Slovenia.

Health insurance reform in the Netherlands in 2006

In the Netherlands, the risks considered to be the highest have been absorbed, since the passing of specific legislation in 1968, by a universal public coverage called the *Algemene Wet Bijzondere Ziektekosten* or *AWBZ*. Insurance covering other risks underwent a major reform at the beginning of 2006. Prior to 2006, other risks were covered by compulsory and public coverage called *Ziekenfondswet* or *ZFW* for two-thirds of the population who earned less than €33,000 per year in 2005 set by the government and by a private insurance that was optional for all other people. This optional private insurance meant that private health insurance paid for a sizeable proportion, 16%, of healthcare expenditure in the Netherlands in 2006. The 2006 reform introduced two structural changes into the Dutch healthcare system: public funds cover risk (in order to provide universal coverage) but coverage is also provided by private insurance companies so as to introduce market mechanisms into the system¹⁵. Insured patients are free to choose between private insurance companies while a complex risk equalisation system was imposed on insurance companies in order to avoid risk selection. The proportion of health expenditure in the Netherlands paid out by private health insurance plummeted to 5.7% as risk coverage is provided by public funds. This does not mean, however, that the private sector has less influence on the healthcare system in the Netherlands now than it did before the reform as demonstrated by the fact that it is the private companies that cover these risks. The first evaluations of this reform show that it has achieved its goal of universal coverage. However, competition between insurance companies is only in its early stages and seems to be limited to prices and has not yet extended to the range of services provided.

Progress in the private hospital sector

In Europe, the vast majority of hospitals have public status. The private sector, in 2006, represented fewer than 20% of hospital beds but its weight has been growing in the last few years. Its role varies tremendously from one country to the next normally depending on national history and efforts, or a lack thereof, to liberalise healthcare. In 2006, more than 85% of hospital beds had private status in the Netherlands while the private healthcare sector is virtually non-existent in Lithuania, Romania and Slovenia. Its role has grown since the start of the 1990s in 14 European countries and has remained stable in 11 others¹⁶.

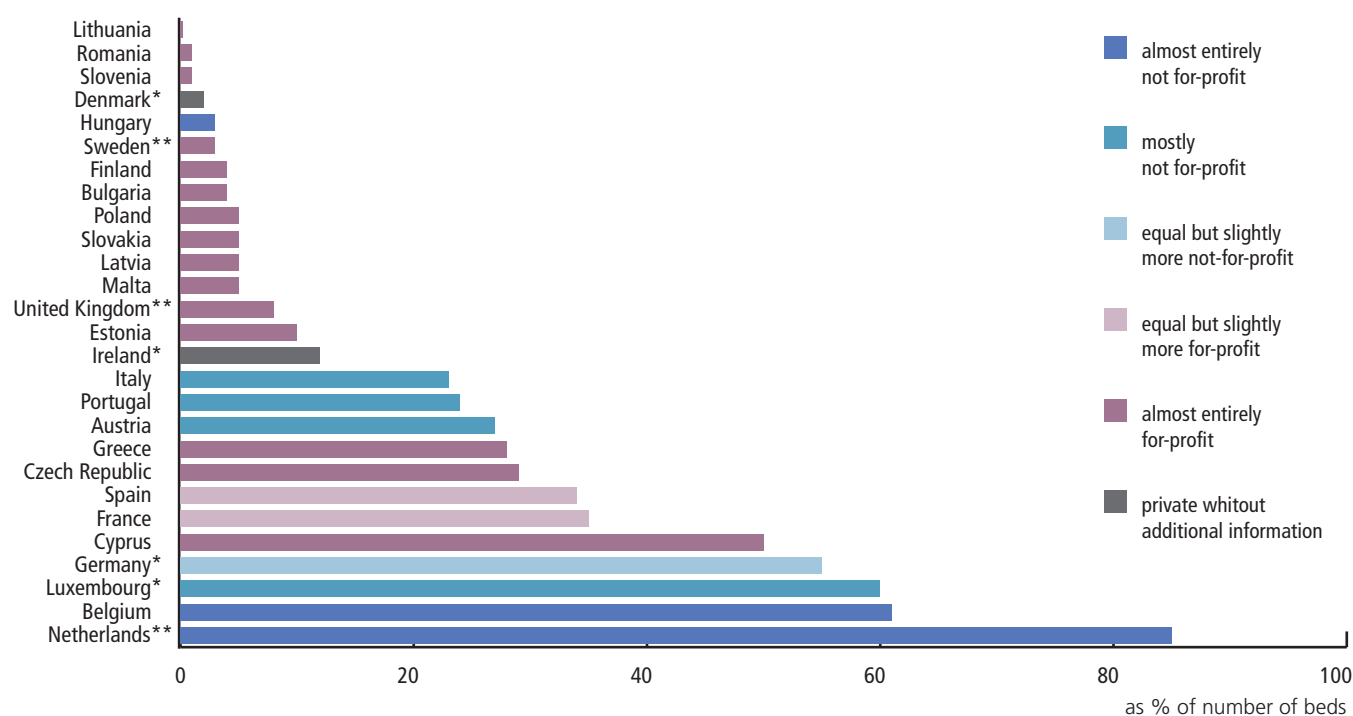
The private hospital sector can include, from one country to another but also within countries themselves, establishments with various statutes and missions. The World Health Organization (WHO) defines private as opposed to public as not belonging to the State, a local authority or a social insurance body. Private establishments can be either not-for-profit or for-profit, which are often designated by the word "clinic". Care provided by private establishments may or may not be proposed by the public health coverage.

Despite their diversity on the European scale, private hospitals have several characteristics in common. Their average size is markedly smaller than the size of public hospitals in most countries such as Spain, Ireland, Poland and Portugal. On account of their smaller size, private health establishments are generally specialised in a specific activity such as surgery in France or rehabilitation centres

in Germany while public hospitals offer a much wider range of care.

Half the countries in which the private hospital sector has played an increasing role since the start of the 1990s are found in countries of Central and Eastern Europe. In these countries, hospitals were the property of the State before the political and economic transition of the 1990s. Decentralisation of healthcare competencies and the privatisation of a part of the healthcare system constituted two major areas of reform. The creation of private establishments was authorised, generally at the beginning of the 1990s, but privatisation affected, first, primary care providers and pharmacies. Nevertheless, private hospital care, as shown in the number of beds available, increased in most countries. It remains marginal, however, compared with public care with the exception of the **Czech Republic**, which is undoubtedly the European country in which the private hospital sector is expanding the fastest. Nearly 30% of beds, in 2006, were private whereas this number was virtually nil prior to 1990. This increase was notably obtained by the voluntary privatisation of state hospital infrastructure, which was authorised by the passing of a law reforming territorial administration on January 1, 2003. In 2008, the Ministry of Health, who owns the university hospitals, considered transforming them into limited companies in order to shore up their financial situation.

Role of private hospital sector by of number of beds in 2006 and breakdown between not-for-profit an for-profit establishments



Source : WHO, 2009 - * country data - ** estimation.

The role played by private hospitals has been on the rise since the 1990s in **Germany**, where it represented 55% of beds in 2006. This expansion is linked to the voluntary withdrawal of the public sector, which no longer has the funds to continue to manage and invest in the ailing balance sheets of the hospital infrastructure. The public sector has been selling them to, notably, the large clinic chains in Germany.

The **Netherlands** and **Belgium** are two European countries in which the private hospital sector plays an important role with 85% and 60% of hospital beds, respectively. These percentages are very close to those recorded in 1990 as the importance of the private hospital sector dates back to medieval times when the religious congregations founded the first hospitals. Private hospitals are therefore nearly exclusively not-for-profit in these countries.

The strong presence of the private, for-profit sector in providing hospital care is different in Spain, France and Greece than in other European countries. This presence has existed throughout the history of these countries and has not increased since the 1990s. **Greece** recorded a drop in private care compared to the 1980s. In the countries, nearly 30% of beds were part of private centres in 2006. This percentage seems to be higher than in the early 1980s because the private sector had more beds than the public sector. In the 1960s and 1970s, companies created private insurance for their employees and signed contracts with healthcare providers, notably those with a private status, which boosted

the private hospital sector. In Greece, a socialist-leaning government swept to power in the early 1980s ushering in a reform of the healthcare system. A national health service was created in 1983 and the public range of hospital care was increased. The creation of new private establishments was forbidden, for instance, and a number of clinics were closed or taken over by public hospitals. As a result, the weight of the private sector, the number of beds, dropped dramatically in less than 5 years from 54% in 1982 to 32% in 1986. This ban was removed in 1992 but private care has remained relatively stable since.



THE INCREASING INFLUENCE OF THE EUROPEAN UNION

The European Union has very limited direct competences in the healthcare field and has only been able to develop a rather constrained public health policy. According to the principle of subsidiarity, the organisation and financing of healthcare remains a Member State's competence. However, the European Union has developed other policies that have been influencing hospital and health services. In addition to these interventions, European integration is taking place by cooperation activities developed within the remit of European programmes as well as outside them.

A European public health policy

European competence in the field of public health really appeared in 1992 with the Maastricht Treaty and was strengthened in 1997 by the Treaty of Amsterdam. To implement this new policy, specific tools were created: public health funds to develop projects and a Directorate General Health and Consumers (DG SANCO). The funds have been revised and improved along the years. The second programme of community action in the field of health is currently running for the period 2008-2013. It has three main objectives: to improve citizens' health security; to promote health, including reducing inequalities; and to generate and disseminate health information and knowledge. However, the financial envelope for these programmes (321.5 million euros for the second programme) limits its ambitions.

To complement the work of DG SANCO, several agencies have been created. The European Centre for Disease Prevention and Control was for example set up in 2005 with the mission to coordinate the laboratories of Member States to improve the EU capacity to cope with communicable disease and bioterrorism. Its purpose is to play a defining role in the prevention of serious health threats such as avian flu and HIV/AIDS, as well as infections associated with healthcare services. Although limited, the legal basis given by the Treaty in the field of public health allowed the adoption of several measures. The first Directive concerned blood products, with the introduction of a quality management system in laboratories, hospitals and other establishments collecting, handing, and processing blood and blood components. It was followed by a directive on human cells and tissues and there is an ongoing discussion on the topic of organ donation and transplantation.

According to the Treaty, all Community actions and activities shall contribute towards a high level of health protection. There is then a need for coordinated actions involving other policy areas. Health issues are obviously linked to other issues, such as the economy and the environment for example. The integration of health concerns in the Lisbon programme, the main EU policy for economic growth and productivity, is one example, as evidenced by the highlighting of the "Healthy Life Years" indicator. Similarly, a strategy called SCALE (Science,

Children, Awareness, Legislation, Evaluated) was adopted in 2003 to reduce the impact of environmental factors on human health, specifically in children, who are most exposed to pollution. Moreover, the introduction of the Open Method of Coordination (OMC) in the field of healthcare is providing Member States with an instrument that should help them come closer to objectives defined at the European level and to exchange good practices.

An influence of the internal market

But the European Union is above all economy-oriented, founded on the principles of the free circulation of goods, services, persons and capital, as well as on the rules of competition. These rules and principles apply one way or another to almost all sectors of activity, including the hospital sector. Although they do not necessarily measure its impact on a daily basis, hospitals thus live in an environment that is governed to a great extent by community legislation. As purchasers of goods and services, hospitals and healthcare services have been affected by the removal of barriers to free movement of all kind of goods and services. Within this framework, a special attention has been directed to pharmaceuticals and medical devices, leading to specific legislation in this field. The European Court of Justice even confirmed that medical care and hospital care were themselves services and as such falling under the scope of the free movement principles. Mobility is also meant for workers as well as for other persons.

For health professionals, European directives have harmonized the minimum conditions of training and provided for mutual recognition of professional qualifications and introduced some specificities for health professions (doctor, nurse, midwife, dentist and pharmacist). More generally other measures have been adopted in the social sphere to avoid social dumping, following in particular the coordination of social protection. All of this had an impact of the hospital and healthcare workforce. At the same time European rules on competition are also growingly interfering with the healthcare sector and as the major part of hospital and health financing are public, various questions of their position regarding the community legislation on state aid are currently raised.

Blossoming cooperation activities

The development of cooperation between healthcare providers of the different EU Member States has also facilitated European integration. This takes the form of cooperation between providers in border regions or further, directly financed by European funds or not. Institutional cooperation, developed in particular by the European Hospital and Healthcare Federation (HOPE) has also boosted exchanges. Hospital and healthcare institutions have developed cooperation activities in border regions. In some

cases, it has also been the starting point of framework agreements between service providers, health funds and national and local authorities, in order to organise healthcare provision on both sides of the border. The EU financed EUREGIO project (Evaluation of Border Regions in the European Union), launched in June 2004 to take an inventory of transborder health co-operation in the European Union, has identified more than 300 collaborations, concerning mainly training projects, equipment pooling, and prevention of health threats. Cooperation activities are not limited to border regions. Through various financial mechanisms, hospital and healthcare providers have successfully worked together. The European programmes have considerably facilitated collaborations. With the support of the European Framework Programme on Research and Technology Development,

research has been widely experimented in various medical subjects, as well as in the organisational ones. *HESCUAEP* ("Health emergency national regional programmes for an improved co-ordination in pre-hospital setting") for example contributed to networking national research programmes in health emergency. *MARQuIS* (Methods of Assessing Response to Quality Improvement Strategies) assessed the value of different existing quality strategies. In the field of continuous training, the *Leonardo da Vinci* programme promoted actions such as *Europhamili*, a three-month transnational professional training programme created in 2002 for healthcare managers. Among many other projects, the Public Health programme financed *Orphanet*, an information portal on rare diseases and orphan drugs, whose purpose is to contribute to improving the diagnosis, management and treatment of rare diseases.

Notes

¹ Data from the World Health Organization (WHO) used in calculating the weight of hospital spending as part of GDP are only available from 1998-2005.

² These averages, as well as all others that follow in this study, are weighted per capita in each country.

³ Austria is the other country.

⁴ See, notably, Adhion P., Howitt P. and Murtin F., *Is health growth-enhancing?*, Mimeo, 2008.

⁵ Local health enterprise.

⁶ Hospital enterprise.

⁷ Regional health agencies.

⁸ Häkansson S., *Productivity changes after introduction of prospective hospital payments in Sweden*, in *Casemix*, vol. 2, n°2, June 2000.

⁹ It is important to note that the use of PPPs has most often been limited to construction, maintenance and the upkeep of hospital buildings. The management of care services has remained the responsibility of public authorities. In Spain, however, several PPPs include providing medical services.

¹⁰ WHO, *Health in times of global economic crisis: implications for the WHO European region*, 2009.

¹¹ WHO, *Health in transition, Estonia*, 2008.

¹² In effect, as bed numbers decrease, there is an increase in the number of community-based physicians.

¹³ Chambaretaud S. and Hartmann L., *Cost sharing, out of pocket payments and exemption mechanisms in Europe*, *Practices and organization of care*, volume 40, n°1, January-March 2009.

¹⁴ This average is calculated among the 26 other Member States of the European Union. When the Netherlands is included in the average, healthcare expenditure financed by private health insurance moves from 4.8% in 2000 to 4.7% in 2006.

¹⁵ Back in 1987, The Dekker-Simons Commission fought for inclusion of market mechanisms in the Dutch health insurance system.

¹⁶ For Ireland and Sweden, statistics are not available on the role of the private hospital sector in the early 1990s.

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