Trends in Hospital Financing in the European Union

This document presents briefly
the Health Systems
of the member states of the European Union
plus Cyprus and Switzerland

It also includes a discussion paper prepared by the
Sub-Committee on Economics and Planning
on Hospital Financing

(HOPE 01.07.1998)

This leaflet has been revised in December 2000: only the statistical data, "Financing" and "Acces and quality assurance" from each country description was updated !!
The general introduction ("Background", "The present situation", "Future Trends" and "Conclusion") has not been updated" !!!
The revised version is only being published on this document

Trends in hospital Financing in the European Union

1. Background

1.1 During the last decade or more those who are responsible for health and hospital services in many member states have started to restructure health care systems and their financing and, at the same time, to reform strict central quantitative planning systems. In some countries part of the reform has been the introduction of some techniques of market or quasi market forces into health care with the intention of limiting the growth, or even reducing the level, of hospital expenditures

1.2 Whatever the basic structure of the system, hospitals will continue to consume the majority of the health care resources in most individual European member states. Consequently, Governments have been examining closely and critically how hospitals should be financed. Simultaneously with their restructured systems they have introduced and retained strict regulation in the form of cash limits, efficiency savings targets and even budget reductions for hospitals.

1.3 At the same time, new medical science and technology have led to significant reductions in lengths of stay in acute care and even in admissions to hospital beds. The result has been pressure to seek opportunities to reduce the number of expensive acute beds in hospitals and to use alternatives in, for example, other residential institutions. Moreover, in response to the changing demography, community and primary care are being developed in most EU countries.

1.4 The remaining hospital beds are therefore being used more intensively, treating ever more, and older, patients with more and more costly facilities, equipment, staff and drugs. Yet there remain pressures to ensure that efficiency and effectiveness produce lower unit costs (costs per case). Consequently, the traditional financing of acute hospitals based on (historically derived) budgets or the number of bed days only is becoming inadequate.

1.5 In short, after thirty years of expansion, hospitals are now generally being squeezed by external and internal pressures to restructure. The fiscal and social insurance systems are also under scrutiny of a kind that, for some, questions the very foundations or ethos of the welfare state and the hospital as an important element of health care provision.

1.6 In this paper, HOPE examines what is happening within hospital financing in member states; how the fiscal, social funding and philosophical issues are being handled; as well as the directions which might be taken in different EU member states in the future.

2. The present position

2.1 Hospital ownership and sources of income

2.1.1 There are two main models of hospital financing in Europe. The first is the (public compulsory) insurance model, and the second is the tax-based one. In both these types, however, can be seen supplementary provisions of different kinds, for example, there may be varying levels of supplementary, voluntary contributions in both systems. Approximately half the member states use the insurance model. This is common in the central part of Europe, while taxation-based systems tend to be found more in the periphery.

An attempt to classify models of health care financing can be found in a publication of the OECD, in which a distinction is made between (a) the voluntary out-of-pocket model, (b) the voluntary reimbursement model, (c) the public reimbursement model, (d) the voluntary contract model, (e) the public contract model, (f) the voluntary integrated model and (g) the public integrated model. The basis for this typology is provided first of all by the type of financing, i.e., (a) voluntary or (b) compulsory insurance. Then it deals with four ways of paying the providers of care: (a) out-of-pocket without insurance, (b) out-of-pocket with reimbursement by way of insurance, (c) indirect payment by the insurers on the basis of contracts, or (d) budgeting and paying salaries in an integrated system. None of the systems in the seven countries which were examined in the study fits precisely into the typology. "The seven countries all have health care systems which are mixtures of several of these seven sub-systems of financing and delivery of health care" (OECD: The Reform of Health Care. A comparative Analysis of seven OECD Countries, pp. 19-29, Paris, 1992).

2.1.2 More than 70 per cent of hospitals in Europe are owned by public authorities whatever the financing model. In general, hospital financing in Europe is based on the solidarity principle, even in countries where private - especially not for profit - hospitals, and insurers are more common, like in Belgium and Germany. This is also the case for the Netherlands. For the Netherlands as well as for Switzerland the term ownership sometimes has a peculiar meaning; for instance, though privately owned, hospitals are almost fully subsidised by the central Government.

2.1.3 In all Nordic countries the Local Government finances hospitals: they pay for hospital services and for that they have the right to levy taxes. In other member states the central government finances hospitals, but the proportion of that varies. The lowest is about 5% in The Netherlands and the largest nearly 100% in the United Kingdom.

2.1.4 While private contributions (direct "out-of-pocket" or co-payments and private health insurance schemes) still account for a relatively small proportion of hospital incomes, this is growing. The highest figure is now found in Finland (8-10% of hospital incomes) when the average is about 3 - 4%. Patient fees do not yet exist in the public hospital sector in the UK, Denmark and Spain.

2.1.5 A common development, as regards the financing of health care is that throughout Europe the consumer, if he becomes ill, can less often fall back on a complete insurance arrangement, particularly since the early 1990's. Personal contributions and excesses are increasing and extended in range, while the benefit package is being thinned out.

2.2 Hospital expenditure

2.2.1 The share of hospital expenditure in total health budgets in Europe varies from 33% to 75%. Nevertheless, the definition, functions and service mix of a hospital and the included cost items are not the same in all member states, which makes it difficult to interpret the meaning of that difference. For

example the hospital budgets in many countries do not always include physicians' salaries. As a further example there appears to be no logic in the reasoning as to why a long-stay patient (e.g. elderly, chronically ill) should be cared for in a hospital or in a 'community' institution. However, in all countries except Germany and Switzerland hospitals consume more than half the expenditure.

2.2.2 Among hospitals general hospitals are the major consumers of hospital funding in every country. In some countries, however, mental care institutions and services consume a greater proportion of hospital resources than in most others, for example in Portugal and in the United Kingdom. This may mean that the orientation between institutional care and outpatient and community psychiatric care is, at present, different in the member states. It is inevitable, however, that community care as an alternative to hospital admission will continue to evolve in both the mental health sector and the general care sector (e.g. care for the elderly, maternity care).

2.3 How the money is allocated and used

2.3.1 As we have said, in most European countries hospitals operate under strict budgetary constraints. Some hospital budgets are still generally historical and resource-based and, therefore, rigid and incremental. Budgets in three countries are constructed on the basis of projected business/financial plans consistent with specific objectives required to implement an agreed strategy, (UK, Belgium, The Netherlands) and therefore hospital incomes there are dependent on activity and tariffs. However, the impression is that the importance of the budget as an economic management instrument is meaningful in most member states, though other instruments are tried out.

2.3.2 In eight member states different service definitions and groups (like Diagnostic Related Groups) are already being used to some extent in determining, financing and describing the services delivered. The variation of definitions is considerable. Variants of DRGs from the USA (HCFA, 3M) are in use in the Nordic countries, Portugal, Spain, Italy and Ireland. Similar systems based on national development work are in use or under development in the United Kingdom (e.g. Health Related Groups), Belgium, Germany and France and soon in the Netherlands. In Belgium and Luxembourg a minimum nursing dataset is used for ward budget allocation

Hospital day case groups and hospital out patient visit groups are also being developed. These service definitions, however, are becoming more important, as different forms of day-hospitalisation increase. Some are still using more traditional billing instruments such as average costs per bed day, day care, and outpatient visit.

2.3.3 Hospitals in the European Union are increasingly contracting with financing bodies, public or private, whether or not their financing system is based fundamentally on taxation or insurance premiums. The purchaser/provider relationship which is evidenced in the "insurance-based" systems is common also in countries where tax financing is the main source of hospital income. However, it is not yet in use in all member states. This split relationship is fully present in eight countries, partially in two and does not exist in four. This policy can be carried out even if the hospitals are owned by the same body (government, local authority) which is resourcing hospital recurrent and investment expenditures. The aim in this case is to use an artificial market situation to improve efficiency.

2.3.4 Large scale investments are strictly regulated by the state or by regional authorities in most countries. Government subsidies may be available in, for example, Belgium, Germany, Luxembourg

and the Netherlands. Investments are generally based on national or regional plans. If the owners are public bodies and, consequently, bigger than single owners, the regulatory power is unquestionable. In all sectors investments must be justified by a business plan and a financial model.

2.3.5 Teaching and research are increasingly considered as a separate human capital investment made by hospitals, especially by teaching hospitals. Therefore, they are also financed separately. The financing body is usually the state or the state jointly with a regional and/or local authority. The allocation for that purpose is sometimes based on indicators describing the teaching and research outcome but mostly it is only an explicit line in the budget or implicitly included in a global budget (viz. input)

2.4 The independence of hospitals

2.4.1 In some countries, for example, Portugal, The Netherlands and Belgium, hospitals can keep all or part of the surplus or profit, if they manage to make it, for future use or for recurrent or investment expenditure. Commonly, profit is divided between the "owners" and the hospital itself. If clinical departments are the actual budget holders, they can keep part of the surplus they make. In Spain and Greece hospitals have to give up all their profit or surplus to the Government.

2.4.2 Both investment and staff development are strongly regulated in most member states (in some cases by statute) by numbers, structures and salary expenditure in budget. This principle applies whatever the form of financing or ownership of hospitals. The motivation for a strong regulation is evidently a will to control overall public spending on health and, in particular hospital services, making hospital financing an instrument of government fiscal policy.

3. Future trends

3.1 General features

3.1.1 After providing information on their present circumstances, respondents to HOPE’s questionnaire have attempted to anticipate the most likely future trends in hospital and health service resourcing.

3.1.2 As far as the insurance-based systems are concerned the replies do not indicate any significant movements towards a tax-based system except in Spain, where the dominance of compulsory (and statutory) public insurance is decreasing and the state taxation element increasing. Otherwise, in countries like Belgium, France, Germany, Switzerland and The Netherlands, the future may hold more of the same with possible adjustments being sought between compulsory public, compulsory private and voluntary private contributions.

3.1.3 In those countries characterised by an essentially tax-based system there might be a general move towards an increasing share of insurance contribution, be this of the compulsory public kind (for example, Greece) or voluntary private (for example Finland, Ireland, Portugal, UK) - except in Spain where the share of compulsory public insurance is decreasing.

3.1.4 Personal, "out of pocket" direct payment contributions for services at the point of consumption exist across Europe and can be expected to continue. They contribute to a wide range of services including, as far as hospitals are concerned, such elements as hotel services, drugs and appliances costs. They are also common outside hospitals for such elements as drugs (again), eye tests, dental treatment and physiotherapists. The risk may be insurable (voluntary) and exemptions may apply, for example, to the elderly, children, chronically ill, pregnant women, and the unemployed and those in receipt of low income support/ social security benefits.

3.2 Hospital ownership and source of income

3.2.1 The trend in ownership of public hospitals, formerly owned by the state or local municipalities, appears to be moving in a lot of countries towards regional or local bodies (like hospital trusts, hospital districts, county councils) reflecting the similar development of incorporation within private hospitals. Except in large urban areas these new hospital consortia are geographical monopolies by their very nature. The single buyer (purchaser) may face the single provider, which may equalise negotiating power in contracting but, at the same time, may aggravate competition between hospitals.

3.2.2 The relative balance between public, non profit and private hospital services is evidently shifting. The evolution of medical and information technologies makes decentralisation possible to an extent that could not be contemplated even a decade ago. Telemedicine is no longer a concept but an operational reality. There is, however, a tension between the capacity to *decentralise* (and, in so doing, improve access to quality health care) and the search for greater cost efficiency which seeks to *centralise* (for example, "centres of excellence" for certain specialties). As far as hospital non-clinical support services are concerned, the trend is increasingly towards outsourcing and networking.

3.3. The availability of finance

3.3.1 Because of competing needs (and sectors) in societies the supply of public finances will be even shorter in the future than it is now. Consequently, private financing initiatives (PFI) within the public sector, stricter control of hospital expenditures and budgetary efficiency will become more prominent.

3.3.2 Special attention should be paid to questions of liquidity. Especially in the insurance based systems the (waiting) time between invoicing and effective reimbursement in a third payer system can be long and cause (unnecessary) interest costs to the system or to the hospital. In Belgium e.g. the unpaid hospital bills amounted at the end of 1996 to BEF 70 billion, which means a half year delay.

3.4 Income and expenditure control

3.4.1 Governments will have difficulties or may even find it impossible to maintain the present level of control of total health care expenditures because of increasing private activity and financing within health services. (they can only of course control the share of public finance). More private finance may, also, undermine the whole idea of solidarity because authorities may reduce part of their commitment causing a vicious circle of successive increases in private, and decreases in public, finance.

3.4.2 Quality control and improvement mechanisms, which have assumed greater prominence in recent years as financial stringencies have increased, can be expected to play a significant, continuing, role in the future.

3.5 Health care and hospital policy

The basic package will be provided for all citizens in Europe with public money but some services now provided within public systems will be provided in private settings. The difficult and never ending task of politicians will be to define what services should be retained in that basic package. As already pointed out, there are many differences, even within the two broad categories of tax-based and insurance-based systems, and it is a matter for individual governments within their own national competencies to seek their own solutions. As far as broader health care policies are concerned, hospitals will have to accept that greater emphasis will be placed on "prevention" (education and promotion) than on "cure" and that primary and community care will be looked upon increasingly as a more efficient and effective alternative to some existing forms of hospital treatment.

4. Conclusion

4.1 An imbalance has developed between the availability of public finance and the potential for services in hospitals. The danger, in a modern society which has become accustomed (even educated) to demanding quality hospital treatment is, that the cost of those services may not justify the health gain outcome. At present, however, there remains a general acceptance of the principles of solidarity in health care financing, even if the patient who can afford it may have to pay more by way of personal "out of pocket" contributions.

4.2 Restructuring of hospital and community health care systems and the rethinking of the European idea of a welfare state will continue also in future. In insurance-based healthcare systems there is unlikely to be a significant shift in the method and principle of funding. Changes are therefore more likely to be at the margins, or incremental rather than fundamental. The position in the tax-based systems is different in that the option exists to switch to insurance contributions of which private compulsory or voluntary contributions may take an increasingly large share, thus reducing the burden on the state but, consequently, increasing it on individuals.

Austria

This description is a revision (December 2000) of the in '97 published leaflet "Trends in Hospital Financing"

General Statistics (1998)			Hospitals	Nber	Beds
Population:	8.1 million				
GDP/Capita:	23,483 euro		Acute care Long term incl.	195	50,927
Health/GDP:	8.3 %		Neurologic	129	21,151
Avg. life exp.					
M:	74.7		Total	324	72,078
F:	80.9				
Infant. mort.:	4.7 ‰				

Administration

In the Austrian health care system there is a division of responsibility between the Federal authorities on the one hand and the Provincial authorities of the nine autonomous provinces on the other, based on the Federal constitution. The Federal authorities are responsible for basic legislation on hospitals and nursing homes, while the provincial authorities hold reponsible for executive regulations and implementations.
In 1997 a fundamental healthcare reform process begun. The aim of the reform was to contain costs, without surrendering the political principles of equal access for all and solidarity in public health insurance. The core of the reform is an Austrian Health Care Plan and the introduction of a performance-related hospital financing system.
Primary healthcare is provided to a large extent by physicians in private practice, most of whom are under contract with the health insurance agencies.

Financing

At the same time as the performance-related hospital financing system was introduced, hospital financing was reformed. Hospitals are still financed jointly by the owners and by public sources. The main public sources are the newly-established Regional Funds, one in each of the nine provinces. In some provinces, these Funds provide the total amount of public support for the hospitals, while in other provinces comes from provincial and local governments. The Funds are collected through federal and regional taxes and public health insurance contributions and are budgeted for the years of 1997-2000. The Funds may also finance alternative healthcare facilities.

Access and quality assurance

The Austrian social insurance system is a compulsory system and provides health cover for nearly everyone. Some 40% of the population have supplementary private health insurance. The Federal authorities are working out a Quality Assurance Programme containing measures for quality standards, quality strategies are already being tested in a number of model hospitals.

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AUSTRIA

Belgium

This description is a revision (December 2000) of the in '97 published leaflet "Trends in Hospital Financing"

General Statistics (1999)			Hospitals	Nber	Beds
Population:	10.2 million				
GDP/Capita:	24,929 euro		Acute	177	57,532
Health/GDP:	7.6 %		Long term	70	16,684
Avg. life exp.					
M:	74.8		Total	247	74,216
F:	81				
Infant. mort.:	7 ‰				

Administration

There is a federal minister responsible for public health and social security including health care and also health ministers for the various communities. Primary health care is provided by private general practitioners, pharmacists, dentists and nurses. There are health care services (private and public) delivered at home.
Hospitals belong to either the private sector (mostly non-profit) or the public sector (this applies mostly to the social assistance centres run by the municipalities). There are also various preventive medicine services, such as industrial medicine and school medicine.

Financing

Primary health care is paid for on a fee-for-service basis and reimbursed by sickness insurance.
Hospital care and medical activities are covered by this insurance and receive subsidies for investment within a set of planned guidelines. Hospitals also charge within the framework of a budget which is decided upon annually by the hospitals.
The insurance system is financed by contributions (from employers and employees) and federal state subsidies. The system is subsidised for 80 % of the costs incurred by widows, disabled people, retired people and orphans. The State also contributes 25 % of the budgeted hospital charges per day.
Each citizen must choose his own mutual insurance company and the insurance system reimburses every one via these insurance companies. The insured has to pay his own fee for certain benefits.

Access and quality assurance

Patients normally have free access to health services and free choice, whatever the financial circumstances. In cases of poverty or. insolvency, health care is provided by social assistance centres.
Hospitals have to be accredited and, therefore, to conform to standards but these do not allow for a true quality assurance programme. However, a programme that will provide a comparison of hospitals activities is being established.

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Association des Etablissements Publics de Soins (A.E.P.S.)
Verbond van Openbare Verzorgingsinstellingen (V.O.V.)
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1040 BRUSSEL - BRUXELLES, BELGIUM

Belgische Federatie van Caritas Ziekenhuizen (V.V.I.)
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Germany

This description is a revision (December 2000) of the in '97 published leaflet "Trends in Hospital Financing"

General Statistics (1998)			Hospitals	Nber	Beds
Population:	82 million				
GDP/Capita:	25,018 euro		General	2,030	533,770
Health/GDP:	14.3 %		Psychiatric	223	37,859
Avg. life exp.					
M:	73.6		Total	2,263	571,629
F:	80				
Infant. mort.:	4.9 ‰				

Administration

The Federal Government has the authority to set legal guidelines for the hospital sphere. The responsibility for hospital planning and financing hospital investments rests with the states. The states may establish their own financing laws.
Financing of the current running costs is carried out by the health insurance system. The provision of health care is primarily a public function but carried out by local authorities, independent non-profit and private facilities.

Financing

The health insurance scheme is divided into two categories, based on earnings. Employees in the lower,income category must be insured under one of the statutory health insurance schemes. The statutory health insurance schemes are financed by matching contributions from insured employees and employers 13,6 % of gross wages and salaries, 1998). Anyone whose earnings are above the ceiling can opt for exemption from this insurance liability and join one of the 17 private schemes.
At present, almost 7.2 million people are privately insured out of a total work force of 34 million. The vast majority of the West German population is, therefore, covered under the National Health Insurance Programme (88%), which has been the main stay of German health policy.
Hospitals are funded by a combination of government subsidy for instruments (7%) and statutory and private health insurance sources (93%).

Access and quality assurance

Access to health care is available to all citizens regardless of financial status.
Quality assurance programmes for certain medical specialities (e.g. surgery, obstetrics) are established in most federal states. At national level, quality assurance programmes are established for heart surgery, ambulatory surgery and for certain surgical procedures (fee per operation and fee per case).
The further development of quality assurance is one of the most important priorities.

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40474 DÜSSELDORF
GERMANY

Denmark

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General Statistics (1998)			Hospitals	Nber	Beds
Population:	5.3 million				
GDP/Capita:	29,324 euro		Somatic	82	20,105
Health/GDP:	5.2 %		Psychiatric	12	4,161
Avg. life exp.					
M:	73.7		Total	94	24,266
F:	78.6				
Infant. mort.:	5.3 ‰				

Administration

The 14 counties and the municipalities of Copenhagen and Frederiksberg are responsible for running and planning the major health care services, such as hospital services and primary health services.
The 275 districts are responsible for the running and planning of most of the social care systems and some parts of the local health services, such as home nurses, infant health visitors, school health and dental services.
The Ministry of Health is the principal health authority and is responsible for legislation on various sectors (hospitals, health insurance, etc.). The government has a central agency, the National Board of health, which has certain executive functions in the administration of health services and has an advisory and supervisory role.
The County Councils and the municipalities of Copenhagen and Frederiksberg are required to establish those areas of health services which come under the National Security Scheme in accordance with the National Health Security Act.

Financing

The health care services are mainly financed by taxation. The following healthcare services are funded at county level: hospitals visits to doctors and specialities (100% paid by the counties for 97% of the population and subsidised for the rest) and visits to other health professions.
The districts fund almost all social arrangements for elderly, sick or handicapped persons and others: for those under the age of 67.50% paid by the counties and 50% paid by the districts. For those over the age of 67, all healthcare is paid by the districts. The district also fund infant health visitors, school health and dental services.

Access and quality assurance

Access to health services is available regardless of financial or insurance status of the patient. The country does not have a Quality Assurance programme, but there’s a lot of activities in this field at for example county level and hospital level.

Den Danske Delegation til Standing Committee of the Hospitals of the European Union

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Spain

This description is a revision (December 2000) of the in '97 published leaflet "Trends in Hospital Financing"

General Statistics (1998)			Hospitals	Nber	Beds
Population:	39.8 million		State	210	88;379
GDP/Capita:	13,115 euro		Regional authorities	32	6,927
Health/GDP:	7.4 %		Local authorities	42	7,296
Avg. life exp.			Other public	35	7,852
M:	74.4		Private	476	53,643
F:	81.6				
Infant. mort.:	5.5 ‰		Total	795	164,097

Administration

The Spanish Health System is public service defined by the General Health Law of 1986, This law was introduced in response to the requirements set out in article 43 of the Spanish Constitution, which states that healthcare is a right for all citizens.
The national health system is divided into 17 regional health services, one for each of the 17 Autonomous regions in Spain, which provide healthcare to all citizens. The regional health services fund hospitals, the primary care centres, the pharmaceuticals and any other services provided to the citizens of the region under the public healthcare scheme.

The basic characteristics of the national health system are :
- comprehensive healthcare, from promotion and prevention and to treatment and rehabilitation;
- public resources, collected through general taxes and distibuted to the regions according to their population;
- Quality assurance system to ensure that services have an acceptable quality and to enhance service quality;
- Services are free at the point of use except a small payment for outpatient drugs (some sectors of the population are exempt from such payment);
- Universal coverage.

Financing

In 2000 the Spanish Health System was financed by the Central Government, the Autonomous Communities and the Municipalities through their respective budgets, which have been increased 7.57% compared with 1999 with the aim of matching the real growth of Spain's GDP.

Access and quality assurance

There is a free and universal access to complete basket of services specified in a Royal Decree issued in 1995 (63/95). A Quality Assurance Programme is in operation in all public hospitals.

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SPAIN

France

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General Statistics (1998)	
Population:	58.5 million
GDP/Capita:	24,015 euro
Health/GDP:	9.8 %
Avg. life exp.	
M:	74.2
F:	82.1
Infant. mort.:	4.8 ‰

Hospitals (1996)	Nber	Beds
Acute care	-	260,976
Rehabilitation	-	92,204
Long term	-	80,700
Psychiatric	-	74,895
Total		508,755

Administration

Care which does not call for hospitalisation is supplied at a doctor's office or sometimes at the home of the patient. The patient calls upon a doctor of his choice - a generalist or a specialist, a private doctor or one of a public establishment - who has the right to prescribe, if necessary, further medical help and medicines. This care is paid for by the patient who is then partially reimbursed by Social Security and often by complementary insurance.
Hospital care is available in public, non profit-making and profit-making private hospitals, depending on the preference of the patient. Most patients are willing to accept the constraints of the public service. The patient is not required to pay for treatment in advance and is only required to pay a small amount (a fixed daily price for hospital accomodation). In the private hospitals which do not take part in the public service, medical fees are added to this charge. Public hospitals are independent, but controlled by the government on a local level. They are managed by administrators, not doctors.

Financing

The financing of health care varies according to the nature of the care and its provider. In 1996, Social Security (national health insurance system) financed 73.5% of care provided, complementary insurance 11.8%, and the patient himself 13.8 % of care. The social Security scheme derives its resources from compulsory contributions paid by the insured person and his employer. Every year parliament votes on the budget that social security spends on public hospitals. Regional hospital agencies manage the distribution of funds between hospitals on a regional basis.

Access and quality assurance

There is free access to the healthcare system and the majority of the population is covered by Social Security.
A Quality Assurance system has been launched and all private and public hospitals will have to be accredited by 2001. A national governmental agency is in charge to set quality standards and will visit hospitals to assess whether they are following the standards that have been established.

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Great Britain

This description is a revision (December 2000) of the in '97 published leaflet "Trends in Hospital Financing"

General Statistics (1997)			Hospitals	Nber	Beds
Population:	59 million		Acute		108,008
GDP/Capita:	23,427 euro		Long term		55,104
Health/GDP:	6.8 %		Psychiatric		82,492
Avg. life exp.			Maternity		15,577
M:	74.4			1,569	
F:	79.7		Total		261,181
Infant. mort.:	5.9 ‰				

Administration

The structure of the UK health system has undergone major change alongside the creation of devolved government. In England, the Department of Health, under secretary of state for health, is reponsible to the House of Commons for the National health Services (NHS). Since elections in May 1999, a Scottish parliament has taken over reponsiblility for the health services Scotland and a Welsh Assembly has acquired responsibility for the health service in Wales. The institutions of the newly-created Northern Ireland Assembly were in suspension at the time of writing. Within each health ministry there is an executive board with a chief executive, as well as a chief medicalofficer and chief nursing officer.
Movs have continued to transfer more responsibility for healthcare commissioning to groups of family doctors, nurses, community practisioners and social care professionals. In England, around 500 new primary care groups were formed in April 1999 to work with health authorities in commissioning services and to replace individual GP practice fundholding.

Financing

General taxation (85%), employers' and employees' compulsory national insurance (12.5%) and reciepts from charges (2.5%) fund the NHS. Seven million citizens purchase private health cover in addition to their contribution to the NHS through their taxes. In March 2000, the Government announced that futher £2bn would be spent on the health service each year over the next four years, alongside a programme of "fundamental reforms".

Access and quality assurance

Access to health services is free to UK citizens, regardless of the financial or insurance status. There are waiting lists for non-emergency care. A national Institute of Clinical Excellence in Englabd and similar bodies in other parts of the United Kingdom are strengthening existing quality assurance mechanisms. Clinical audit programmes exist at all levels.

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Greece

This description is a revision (October '99) of the in '97 published leaflet "Trends in Hospital Financing"

General Statistics (1997)			Hospitals	Nber	Beds
Population:	10.6 million				
GDP/Capita:	10,500 ecu		Governmental	140	36,467
Health/GDP:	8 %		Non Profit	4	269
Avg. life exp.			Private	218	15,052
M:	75				
F:	80		Total	362	51,788
Infant. mort.:	7 ‰				

Administration

Almost all public hospitals are NHS hospitals. These hospitals and the 180 rural health centres (plus doctors in every village) are administered by the Ministry of Health and Welfare. Private hospitals, diagnostic centres and private doctors are purely controlled by the districts. Public health programmes and other acrtivities are coordinated by the Ministry and the respective Centres or the National School of Public Health.
There are many things to be done concerning changes that the reform-law has already introduced (1997).

Financing

The Greek Healthcare System is a 3-tier system concerning the third party payers. Healthcare expenditure is funded: 1/3 by the State; 1/3 by the Social Insurance funds; and 1/3 by out-of-pocket or private insurance money.
The Hospital budget for the year 1999 amount 1.2 trillion drachmas or 4 billion Es. The average cost for a hospital day is about 300 Es. The labour cost is 60 % of the total cost. This cost has traditionally been covered by the state, and the rest of the cost by the insurance funds.

Access and quality assurance

Access to the national health service is quite easy and care is free of charge since practically all Greek citizens are covered by governmental or semi-governmental health insurance. It also holds true that citizens can get health services in the state hospitals at minimal cost compared to the European average. In terms of quality assurance there are plans under the new law for a foundation for accreditation of hospitals or other health care organisations.

Ministry of Health and Welfare
17 Aristotelous Street

101 87 ATHENS
GREECE

Italy

This description is a revision (December 2000) of the in '97 published leaflet "Trends in Hospital Financing"

General Statistics			Hospitals	Nber	Beds
Population:	57.6 million				
GDP/Capita:	19,595 ecu		Public	828	270,156
Health/GDP:	7.6 %		Private	532	57,402
Avg. life exp.			Psychiatric	18	5,704
M:	74.9				
F:	81.3		Total	1,378	333,262
Infant. mort.:	6.0 ‰				

Administration

Political and administrative services are organised on four levels: the state or national level, the regional level and the town and city councils. The health service is organised on three levels: national (Ministry of Health), regional and local.
The Ministry of Health set the three-year planning goals of the national health service. The regional councils are responsible for coordinating health service operations in their areas.
Districts (Local Health Care Units) may be set up by a single Town Council, several associated town councils, several associated suburban areas in a large city, or by a group of associated suburban areas and their relative town and city councils.
The State delegates the responsibility for establishing the areas under the control of the various different local health care units to the regional councils, which must do so in consultation with the local bodies concerned. The boundaries delimiting the local health units must usually coincide with those of the provinces with exceptions for particular population densities.

Financing

The Italian national health service is financed partly (around 40%) through taxation and partly (around 60 %) through regional taxation, which was introduced recently (1998).
Uniform levels of assistance are provided over the country and established at the national level. Regions can offer additional services, financed on their funds. The overall National Health Fund is distributed among the regions which distribute it among the local health authorities on a weighted pro-capita basis.

Access and quality assurance

There is free access to the health service and quality assurance programmes are monitored by regional authorities.

Ministero della Sanità Italiano (Ministry of Health)
Piazzale dell'Industria, 20
00144 ROMA
ITALY

Ireland

This description is a revision (October '99) of the in '97 published leaflet "Trends in Hospital Financing"

General Statistics			Hospitals	Nber	Beds
Population:	3.7 million				
GDP/Capita:	9,639 ecu		Acute	62	11,937
Health/GDP:	5.8 %		Psychiatric	51	5,798
Avg. life exp.			District	41	1,645
M:	73				
F:	78.6		Total	208	19,380
Infant. mort.:	7 ‰				

Administration

Healthcare is provided on a regional basis through eight health boards.
A number of voluntary (non-state) organisations also assist in the provision of some health services including hospital care and services for the handicapped.
The Department of Health is responsible for the development of health policy, the overall control of expenditure and the monitoring and evaluation of the performance of the executive agencies.
Responsibility for the provision of services at local level rests with the eight Health Boards, who are accountable to the Minister for Health.

Financing

Public health care services are financed from general taxation and an ear- marked health contribution.
The Department of Health allocates funds to the eight health boards which provide health services on a regional basis. The Department also provides almost all of the funds used by the acute voluntary hospitals and a proportion of the funds used by other voluntary organisations.
Completely free hospital care is provided to approximately 36% of the population who are issued with a medical card, entitling them to free health care. Non-medical card holders pay a charge of 20pound per day for in-patient care up to a maximum of 200 pound in any twelve months. A charge also applies to those non-medical card holders who attend at an accident and emergency department without having been referred from a general practitioner.
Casemix analysis, based on Diagnostic Related Groups has been used to determine a portion of the in-patient budgets of the larger acute general hospitals since 1993.

Quality Improvement

The Irish Society for Quality in Health Care co-ordinates activities in this area and serves as a clearing house for quality initiatives. The Minister for Health has introduced a charter for hospital patients.

Department of Health
Hawkins House
Hawkins Street
DUBLIN 2
IRELAND

Luxembourg

This description is a revision (October '99) of the in '97 published leaflet "Trends in Hospital Financing"

General Statistics			Hospitals	Nber	Beds
Population:	406,600		Acute	16	2,342
GDP/Capita:	26,856 ecu		Long term	10	1,044
Health/GDP:	6.9 %		Psychiatric	1	270
Avg. life exp.			psychiatric beds in acute hosp.		144
M:	72.6				
F:	79.1		Total	27	3,800
Infant. mort.:	5.3 ‰				

Administration

The Health Directorate of the Ministry of Health as well as the Ministry of Social Security and the Ministry of the Family are the main government bodies responsible for health policy in the Grand Duchy of Luxembourg.
At national level, a "National Hospital Plan" (statutory text) specifies the distribution of the services and the number of beds per institution as well as co-ordination between hospitals. Close collaboration with the above institutions, through the *Entente des Hôpitaux Luxembourgeois* (EHL) enables the Luxembourg hospital institutions to contribute to the balanced development of the sector.
Medical care is provided in hospitals by physicians practising their profession as self-employed workers within hospital structures, by means of contracts specifying particularly the number of beds at their disposal (with the exception of one public institution where the physicians are salaried).

Financing

Health care is ensured by a national insurance system financed by assessments from employers and employees and by contributions of the State.
The national insurance system consists of nine different insurance companies. Each citizen is a member of one of these companies.
In the hospital sector a new financing system has been introduced in 1995. A budget system covers national hospital costs and replaces the old "fee for service" system. The insured has to pay for certain extra benefits (like additional first class) and about 5.25 ECU per day for hospital charges. The physician’s fees are not included in the hospital bills.

Access and quality assurance

The patient normally has free access to health services and free choice regardless of his financial situation. For different examinations, he needs the approval of the medical control. For the destitute, health care is provided by social assistance centres. As part of the budget system a quality programme has to be worked out in the future. Laboratory activities are already subject to quality control.

Entente des Hôpitaux Luxembourgeois
13-15, rue Jean-Pierre Sauvage
2514 LUXEMBOURG
GRAND DUCHE DU LUXEMBOURG

The Netherlands

This description is a revision (December 2000) of the in '97 published leaflet "Trends in Hospital Financing"

General Statistics (1998)			Hospitals	Nber	Beds
Population:	15.6 million				
GDP/Capita:	19,341 euro		General	103	44,016
Health/GDP:	8.5 %		Psychiatric	105	30,514
Avg. life exp.			Specialist	32	3,989
M:	75.1		Teaching	8	7,121
F:	80.6				
Infant. mort.:	5.6 ‰		Total	248	85,640

Administration

The federal government (under the auspices of th Minister for Health, Welfare and Sports) has responsibility and financial control of most aspects of Dutch health care. It plays a regulating role in the field of planning, financing insurance, tariffs, prices and fees. Government policy is aimed at guaranteeing a system which is not only easily accessible and of high quality, but is also affordable and efficient. Hospitals have their budgets fixed by the federal government to ensure compliance with the goals of government.

Financing

About 8.5% of the gross domestic product is spend on health care. The money comes from different sources. About 10% of health care is directly paid from public funds. Approximately 80% of the costs is covered by insurance premiums and some 9% from patients own contributions. Healthcare is provided through both federally mandated programmes and private insurance. The Exceptional Medical Expenses Act (‘AWBZ’) is compulsory insurance for catastrophic services regardless of income. Employees with an income below a certain level have compulsory social insurance (about 60% of the Dutch population). Private medical insurance is available voluntary for those not covered by the general programme. The provisions which are covered not under the insurance schemes can be obtained by an additional private insurance.

Access and quality assurance

By law, the government is responsible for the accessibility and quality of health care for everyone. Every citizen in the Netherlands is entitled to health care. This is guaranteed by central goverrment regulation (see also Financing). The quality of care is guaranteed by two Bills: the Quality of Care Establishments Bill, which deals with institutionalised care and the Individual health Care Professionals Bill, which is concerned with all health care professionals. The Bills are based on the principle of self-regulation.

Nederlandse Zorgfederatie
Postbus 9696
3506 GR UTRECHT
THE NETHERLANDS

Portugal

This description is a revision (December 2000) of the in '97 published leaflet "Trends in Hospital Financing"

General Statistics (1998)			Hospitals	Nber	Beds
Population:	10 million				
GDP/Capita:	8,965 euro		General	79	21,556
Health/GDP:	7.9 %		Psychiatric	34	3,635
Avg. life exp.			Specialised	12	2,026
M:	72				
F:	78.8		Total	125	27,217
Infant. mort.:	6 ‰				

Administration

The Government and the Minister of Health are responsible for defining the health system and health policies, and thus are reponsible for the National Health Service (NHS). The Health ministry provides the functions of regulation, orientation, planning, evaluation and inspection through the central services.
Portugal is divided in five health regions (mainland) and two autonomous regions (islands of Azores and Madeira) which have autonomous health services. Each region is responsible for the co-ordination of all the activities in NHS hospitals and health centres in its area, in accordance with the policies and technical directions issued by the central government.

Financing

There are four sources of NHS financing:: general taxation, payroll taxes, private insuarnce and out of pocket payments. The NHS is financed mainly by taxes. All those using private healthcare do out of pocket payments. Around 5% of the population has additional private insurance coverage.
In Portugal user charges are widely implemented under the NHS. Howerver, there is a comprehensive exemption scheme, and most of the exemptions related to income. Hospitals are financed according to their production and based on previous year's budget. Primary healthcare is financed by a formula that considers previous year's budgetr and a capitation methodology.

Access and quality assurance

Individuals' rights to protection and guarantees of equality of access to health care are, regardless of socio-economic status and location, are enshrined in health laws. The NHS is free, in principle, to all beneficiaries - although some payments are levied to reduce undue use of health care. Citizens subject to greater risks and the economically disadvantaged are exempt from such payments. The Ministry of health is responsible for the inspection of public and private health institutions to guarantee the quality of care. The Ministry is also responsible for setting standards for the quality of care in the NHS.

Direcção-Geral da Saúde
Alameda D. Afonso Henriques, 45
1056 LISBOA CODEX
PORTUGAL

Sweden

This description is a revision (December 2000) of the in '97 published leaflet "Trends in Hospital Financing"

General Statistics (1998)			Hospitals	Nber	Beds
Population:	8.9 million				
GDP/Capita:	21,127 euro		Regional/County/District	78	31,626
Health/GDP:	8.6 %		Long term care	5	479
Avg. life exp.			Psychiatric care	5	655
M:	76.7				
F:	81.8		Total	87	32,760
Infant. mort.:	3.5 ‰				

Administration

There are three political and administrative levels in Sweden - central government, county/regional council and municipality. All these levels have important roles in the welfare system and are represented by directly elected political bodies. The central government lays down basic principles for the health and medical services through laws and ordinances. 18 county councils and 3 regions decide on the allocation of resources to the health services and are responsible for the overall planning of these services. The county and regional own and run hospitals, health centres and other institutions.
When it comes to highly specialised care the county councils cooperate in six medical care regions. The county councils also collaborate on the national level through the Federation of County Councils. The National Board of Health and Welfare is the government's central advisory and supervisory agency in the field of health services. The key task of this agency is to follow-up and evaluate the services provided to ensure they correspond with the goals laid down by the government.

Financing

The county/regional councils are entitled to levy a proportional tax on the income of their residents. The average tax rate is 10%. Approximately 69% of the county/regional council revenue is arising from these taxes. Other significant incomes are grants and payments for certain services coming from the central government, totalling 20%, other revenues 8 % and patients' fees 3% of the county/regional councils' revenue.
Inpatients have to pay a specific fee per day they stay in the hospital. For most children and young peolple under the age of 20 no fee is charged.

Access and quality assurance

The population shall be offered health and medical services of good quality which shall be provided on equal terms and be easily accessible to everybody. Quality committees at management level are working to produce systems to develop and improve the quality.

Landstingsförbundet (Federation of County Councils)
Box 70491
Hornsgatan 20
107 26 STOCKHOLM
SWEDEN

Finland

This description is a revision (December 2000) of the in '97 published leaflet "Trends in Hospital Financing"

General Statistics (1998)			Hospitals	Nber	Beds
Population:	5.1 million				
GDP/Capita:	22,400 euro		Acute general	59	11,468
Health/GDP:	7.0 %		Long term care	225	20,817
Avg. life exp.			Psychiatric	61	6,003
M:	73.5		Other hospitals	78	1804
F:	80.8				
Infant. mort.:	4.2 ‰		Total	423	40,092

Administration

The Ministry of Social Affairs and Health has the responsibility of the national health policy, legislation and the state share of financing. However, 452 local authorities organise, purchase and provide the major part of the health services for their residents.
The Primary Health Care Act, the Act of Specialised Medical Care and the Mental Health Act specify the obligations of the local authorities. Municipalities own and manage local health centres eitheer by themselves or jointly. A typical health centre serves a population of 10,000 - 20,000. Most of the special care hospitals are owned by 21 joint municipal authorities that are governed by the specialised care.

Financing

Taxes cover cover 75% of all healthcare expenditure: the government share is 20%, local government, 40% and social insurance institutions benefits, 15%. The remaining 25% is paid by healthcare users (pharmaceuticals and user fees). The average local tax rate is 17% on income (the overall tax rate is 47%).
the government subsidy to healthcare services is not earmarked and is based on a capitation formula. The stte reimburses hospitals directly only because of the costs of teaching and research. Local authorities' healthcare spending is at their own discretion. Private health services are available and are partly subsidised by the compulsory health insurance. user fees cover about 7%of public hospital incomes.

Access and quality assurance

All residents are entitled to equal access to public health services. One third of patients should be seen by a GP on the same day as they request an appointment and one third within two to three days. In specialised care 75% of patients are seen within three weeks and 75% receive care within three months. The national recommendation for health services' quality management is the EFQM model and the ISO quality system is the tool used for standard quality systems. Assessment of conformity to quality

standards in healthcare is directed by FINAS (the representative in the European Co-operation for Accreditation). Several quality bechmarking systems are used to improve hospital performance.

Suomen Kuntaliitto (**Association of Finnish Local and Regional Authorities)**
Toinen linja 14
00530 HELSINKI
FINLAND

Switzerland

This description is a revision (October '99) of the in '97 published leaflet "Trends in Hospital Financing"

General Statistics			Hospitals	Nber	Beds
Population:	7.0 million		Acute general		40,866
GDP/Capita:	30,972 ecu		Long term		25,175
Health/GDP:	10 %		Psychiatric		7,840
Avg. life exp.			Others		3,377
M:	75			780	
F:	82		Total		79,258
Infant. mort.:	5.1 ‰				

Administration

Responsibility for health services, especially for health care, prevention and supervision of training for health care personnel, falls mainly on the cantons. The enactment of laws regarding health and accident insurance, the control of epidemics (e.g. AIDS) and the supervision and the organisation of the federal medical examinations, etc., are dealt with by the Confederation.
The cantons are responsible for environmental health, welfare services in the health sector and for public health regulations, to the extent that they do not fall within the competence of the Confederation. The cantons have to provide inpatient and outpatient care. They are in charge of planning the hospital facilities. The cantons authorise qualified physicians to deliver primary health care on a private basis.

Financing

With the new federal health insurance law Switzerland introduced compulsory insurance. Every inhabitant of a region will have to pay a uniform insurance fee. This fee depends on the costs refunded by heath insurance in that region Patients with a minimum income are directly subsidised by the State. Health insurance refunds 100% of out-patient costs but max. 50% of in-patient costs in acute hospitals. The difference is paid by the cantons by means of global budgets or by funding of the deficit.

Access and quality assurance

The federal health insurance law guarantees free access for every inhabitant to the hospitals included in a cantonal list as well as free choice of private physicians for outpatient treatment. To benefit from more advantageous insurance payments, the insured can restrict his free choice. Good training of physicians and paramedical staff guarantees good quality.
The Swiss Hospital Association (H+) and the health insurance funds negotiated a federal plan for continuous promotion of the quality of hospital services; this plan is expected came into force by the end of 1998 and more than 50% of the hospitals already joined this frame contract on quality assurance.

H+ (Swiss Hospital Association)
Rain 32
5001 AARAU
SWITZERLAND

Cyprus

This description is a revision (October '99) of the in '97 published leaflet "Trends in Hospital Financing"

General Statistics (1997)			Hospitals	Nber	Beds
Population:	651,000				
GDP/Capita:	11,325 ecu		General	5	1,112
Health/GDP:	5.8 %		Rural	3	84
Avg. life exp.			Psychiatricl	1	559
M:	75.0		Private Clinics	103	1,345
F:	79.8				
Infant. mort.:	8 ‰		Total	112	3,100

Administration

Healthcare in Cyprus is provided through the government and the private medical sector. The Ministry of Heallth has the reponsibility for healthcare in the government sector through its departments which are:
- medical and public health services;
- pychiatric services;
- pharmaceutical services;
- dental services;
state government laboratory.
The private clinics and hospitals are run by private doctors who are usually the owners.

Financing

Public Health Care Services are financed by general taxation. The Private Sector is mostly financed by out of pockets and a small amount of private (employer based) insurance schemes.
In 1996, 44% of the total Health expenditure in Cyprus was financed out of general taxation.

Access and quality assurance

Access to Public Medical Services is free for Government employees (including pensioners), irrespective of income and for:
- individuals whose income is below 4760 ECU;
- families whose income is below 7,800 ECU;
- special groups i;e. refugees, thalassaemic patients etc.
Access, at 50% reduced fees, is for individuals whose earning are between 4,800 - 12,100 ECU. All others groups can use either public medical services or the private medical services upon payment of the fees charged by the providers. Acces to private insurance schemes is only for members. Quality assurance has not yet been introduced.

Ministry of Health
Department of Medical and Public Health Services
Nicosia
CYPRUS