Collection **Europe**

HOSPITALS

in the 27 Member States of the European Union

For the past several years, 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, in a context of limited public resources. The hospital sector plays an important and specific role. All in all, the European Union has some 15 000 hospitals, which account for 25% to 60% of health expenditure depending on the country. These hospitals play a key role in patient management, training of health professionals, and research.

Their constant adjustment to the social and economic context, as well as to technological advances, takes the shape of reforms to their type of governance and provision of care.

This book studies the major changes in the hospital sector using a cross-sectional analysis of 27 national health systems. The analysis is structured to illustrate common trends in hospital systems over the past years, while showing their diversity from country to country in terms of the distribution of powers, funding for hospital operations and investments, status, organisation of care, etc. Finally, the book examines the influence of the EU on hospital and healthcare systems.

It was written in close collaboration with the European Hospital and Healthcare Federation (HOPE). A major player in health affairs in Europe, HOPE lent its extensive knowledge of national health systems and community issues to the completion of this work.

We hope that this book - a meeting of HOPE's expertise with Dexia's - will be a valuable contribution to the considerations over the organisation and function of hospital systems, as it strives to spread good practice and highlight the most innovative experiments.

Collective work under the supervision of Dominique Hoorens, director of Dexia Crédit Local Research Department.

DEXIA

Price : 20 €

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DEXIA

Foreword

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PRESIDENT, HOPE

Europe is at a crossroads in so far as health policy is concerned. A new Directive proposed by the Commission is being discussed by Ministers and the European Parliament. There is no clear consensus about its potential value. Health policy remains firmly in the hands of national governments and they want to keep it that way. Given that health now absorbs 10% or more of the GDP of the richer countries perhaps this is not surprising. Many of the changes to health care systems in the past decade have been concentrated more on strengthening economic control than promoting good health. Ministries of Finance have a strong influence on health policy.

The variation in life expectancy across Europe does however show the scale of the political challenge. The citizens of Spain, Sweden, Italy and France all have an average life expectancy of over 80 years whilst Hungarians have less than 73 years with Poland, Slovak Republic and the Baltic states about the same. This level of variation is not politically sustainable for very long.

We have the science and the knowledge to radically narrow the gap in life expectancy. But this needs political commitment, organisation and funding to take decisive action. The market philosophy that is the core of the EU is actually making matters worse in the poor countries, at least in the short term, because they are losing skilled professional staff in large numbers as they migrate for better paid jobs. For the marketeers the long term benefits of free movement are obvious but the short to medium term negative impact on the poorer countries is very significant.

The best health interventions such as switching lifestyle require long term investment in other sectors of the economy as well as health. The OECD attributes the lower life expectancy in poorer countries to persistently higher mortality from circulatory disease and cirrhosis of the liver both of which reflect unhealthy lifestyles with regard to tobacco and alcohol consumption. High suicide rates in men add to the problem.

The policy dilemma is that expenditure on health does not decline when investments promoting lifestyle succeed and citizens live healthier and longer lives. There are always further years to gain and further improvement in quality of life that healthier citizens rightfully expect to attain.

In health, the market operates imperfectly. It is usually good at generating efficiency in non emergency surgical services but not so good at providing round the clock emergency care or long term care for the chronically ill. This may turn out to be very

significant if we see an acceleration of the current trend in Europe for governments to transfer public services to not for profit or private providers. Short term cost and efficiency gains may be balanced or offset by the difficulties generated for the remaining public sector hospitals who will be left with the more complex case mix and emergency care.

The cost of drugs remains a key talking point amongst politicians as the percentage of the overall health expenditure on drugs continues to rise. The first response has been to persuade prescribers to switch to generic medicines which have traditionally been cheaper. The industry claims its costs are high because of huge development costs and there is some considerable power to this argument. What the Industry will find harder to argue is that cost cannot be stabilised on an EU basis despite the huge and now very visible difference in price charged for the same product in different countries. A satisfactory conclusion to the current discussions about the Pharmaceutical industry in Europe is important for everybody.

Despite the lack of political enthusiasm for radical health policies in Europe, the day is fast approaching when Europe can no longer avoid to be radical in the field of public health: healthy lifestyles, disease prevention, and health protection. This should be the priority rather attempting to tinker with the operation of the hospital world which remains nationally focused and organised. There might be some value in developing EU networks for rare diseases and for country-to-country service agreements but that is as far as it should go. The added value that Europe can offer is in the field of public health.

Notice to the reader

SOURCES

This book was written based on different reports drafted by the WHO and OECD on the EU Member States. The authors also referred to the publications of the European Commission (especially the MISSOC of the Directorate General "Employment and Social Affairs"), as well as information gathered from French economic missions abroad. Statistical data were drawn from national (national bureaus or ministries) and international (OECD, WHO, Eurostat) sources.

GEOGRAPHIC SCOPE

Geographically, the metropolis was used for the study. This excludes Greenland and the Faroe Islands (Denmark), overseas departments and territories (France), overseas territories (Netherlands), and the Azores and Madeira (Portugal).

YEAR OF REFERENCE

For numerical data on the hospital sector, the reference year is 2004 unless otherwise stated. For tables and graphs, data prior to 2004 are marked by a superscript. Data "x" from 2003 will be marked "x^{-1}" (2003= 2004-1), data "y" from 2000 will be marked "y^{-4}" (2000= 2004-4).

In the summary table accompanying the book, the macroeconomic data (GDP, GDP per capita, population) are from 2006, while the reference year for health indicators is generally 2004.

STATISTICAL DIFFICULTIES

When possible, a single source for statistics was used for the EU Member States as a whole. However, at times we made use of statistics from different sources or for different years, in the same table or paragraph.

Units of measure could not always be standardised. For hospital employment, for example, statistics used either the number of positions or "full-time equivalents".

The EU averages shown are weighted averages. Each country's population was used as a weight. For WHO data, if there was missing data for a given country on a given year, this was estimated by the WHO (based on data available for the two closest dates before and after the date in question) to allow temporal comparability of the EU average. Consequently, these averages should be interpreted with caution.

CLASSIFICATION OF TABLES

Tables in the text are organised as follows:

- the column with the most recent data is on the right;
- countries are classified in decreasing order, using the said column with the most recent data.

EXCHANGE RATE

Conversions of national currencies to euros were carried out using the annual average exchange rates published by Eurostat.

PURCHASING POWER PARITY

Comparative data for more than 50 countries are available on the WHO database, in US dollars, in purchasing power parity. Purchasing power parity (PPP) is a monetary conversion rate that makes it possible to express the purchasing power of different currencies in a common unit. It is the ratio between the amount of monetary units needed to buy the same "basket" of goods and services in different countries (French National institute for statistics and economic studies - INSEE - definition).

CONTENTS

Introduction

An initial study presenting the hospital systems in the 15 Member States of the European Union was published by Dexia Editions in late 2003. Two major events have occurred in the five years that have passed, making an extensive revision necessary.

• **European Union enlargement:** In 2004, 10 new countries (Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia) joined the EU. In 2007, 2 more countries acceded to the Union (Bulgaria and Romania). All of them, with the exception of Cyprus and Malta, belonged to the former Soviet bloc. Consequently, their health systems are profoundly marked by a common political history, as remarkable as it is brief. While these countries had Bismarckian systems prior to 1940, the USSR imposed a very different rationale on them in 1945. The so-called Semashko system even served as an inspiration for Lord Beveridge. In short - a detailed discussion can be found in Chapter 1 - these countries inherited a mediocre health system. Their overall heath situation is inferior to that of the original EU15 Member States, and they have limited financial means. There is a glut of hospitals, but they are underfunded. Although significant efforts have been made over nearly two decades by the central and eastern European countries to bring their health system up to the mark, the gap still remains. The inclusion of these countries in the European Union makes the analysis more heterogeneous and more complex, but also enriches it considerably.

• **Construction of a Community health policy:** In a few years, health has become a real issue within the European Union. In article 152 of the Treaty of Amsterdam, signed almost a decade ago, a modest definition sketched the outlines of a European health policy. Since then, the EU has acquired a health strategy worthy of the name, in a community programme that has just been renewed (2008-2013), and has also developed an inter-sector approach, as health involves other areas of EU intervention. Community influence on national hospital systems has expanded since this work was published in late 2003.

As in the previous version, the choice was made to present a cross-sectional analysis instead of country monographs. The goal is not to provide an exhaustive study of hospitals in the 27 EU Member States, but rather, to attempt a comparison of systems without drawing conclusions about the performance of the different countries. To do so, a common working framework was defined so that the greatest amount of information on hospitals could be considered, without neglecting to render their diversity. The work is structured in four chapters.

Chapter 1: An analysis and comparison of hospitals in the 27 EU Member States requires a presentation, however succinct, of EU27 health systems, of which they are a major component. An understanding of the health system is needed to understand hospitals and vice versa. This chapter provides a brief presentation of the major health issues facing EU Member States today: addressing health challenges, in particular population ageing and the increase of non-communicable diseases, while controlling public spending on health. As hospitals account for at least 25% of health expenditure, they are at the heart of ongoing reforms.

Chapter 2: This chapter deals with the different forms of governance of hospital care in the 27 EU Member States, that is, who manages the hospital system in each of them. In other words, how are the different powers - regulation, financing and management - distributed between the sector's players: the State, local authorities deconcentrated administrative bodies, health insurance funds, and hospitals themselves? How are the different levels of responsibility organised in the country? There are as many possible configurations as there are countries, and they are constantly being reformed. That said, the comparative analysis shows two major trends: a continuous balancing act between decentralisation (or deconcentration) and centralisation, seen in most of the EU Member States, and a push to increase hospital automony, made possible mainly by the revision of their status. Such changes are natural in the sense that they address the constant search for greater efficiency while adhering to the shared principles of equity and accessibility. Rules for the allocation of public resources and hospital remuneration mechanisms are thus regularly being reformed. Today, country comparisons show that many approaches are common to the Member States. These include the spread of contractualisation between health financers and providers, and the increasingly widespread use of pathology-oriented payment for hospitals. Although the main principles of these reforms are shared, there is a striking difference in their implementation, as this is conditioned by the distribution of responsibilities inside the country. In addition, the private sector's role in healthcare provision varies greatly from one country to another.

Chapter 3: The third chapter is devoted to a comparative analysis of the way Member States manage the main issues confronting hospital care itself, in particular the streamlining of hospital care while maintaining access to safe, high-quality care for all. Several analysis frameworks were used for this. First, the reorganisation of hospital care in each country was carried out on the basis of an existing territorial network and using specific planning tools. The scope and duration of hospital reorganisation vary widely from one Member State to another, depending mainly on historical and political background, but a decrease in the density of acute care beds was observed everywhere. This was made possible mainly by technical developments in medicine, and thus more intensive use of production factors (beds, facilities and staff). Changes in hospital care

also led to changes in the management of hospital patients. As a result of government action, patient management in hospitals is increasingly focused on greater accessibility and quality.

Chapter 4: The last chapter discusses the EU's influence on health matters, particularly in the hospital sector. EU influence grew considerably in the 2000s, and will probably play a role in the convergence of national health systems. While Member States remain responsible for health policy and the provision of care on their territory, community action is more efficient in certain areas, such as the management of pandemics or all issues pertaining to the construction of the internal market. In recent years, the scope of Community competences in health has expanded and spread to other policies. However, because of the principle of subsidiarity, this trend is not obvious and continues to remain relative. Nonetheless, even though hospitals do not directly fall under an area of Community competence, they exist - without necessarily feeling the impact on a day-to-day basis - in a context that is highly structured by EU Community legislation on the internal market, whether they are purchasing goods such as medicinal products or medical devices, recruiting health professionals, or making investments.

Chapter 1

Health: A European challenge

1. HEALTH CHALLENGES IN THE EUROPEAN UNION MEMBER STATES

The overall goal of national healthcare systems is to improve the state of health of the populations they serve. An introduction to the topic thus requires a comparison, albeit brief, of the healthcare situation in the European Union Member States, within the EU as well as with several non-EU countries. Although some heterogeneity (relative, to be sure, given the differences on a global scale) can be observed between the different EU Member States based on the three criteria used for this analysis, the healthcare challenges that face these countries in terms of morbidity and demographic trends, are similar.

A- HETEROGENEOUS LEVELS OF HEALTHCARE

AT THE GLOBAL SCALE

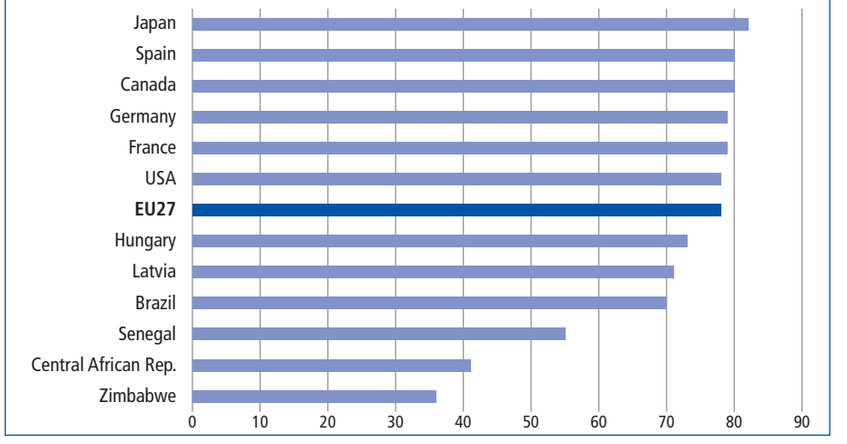
Health indicators for the EU Member States are quite good on average compared with the rest of the world. However, discrepancies are significant within the EU itself. This observation can be illustrated through two traditional indicators, life expectancy at birth and under-5 mortality rate.

These indicators reveal significant inequalities in health at a global level. In 2004, according to the health statistics published by the World Health Organization (WHO)[1], the indicator "average life expectancy at birth, for both sexes", expressed in years, more than doubles between the country with the shortest (Zimbabwe, 36 years) and the longest (Japan, 82 years). The disparities found within the European Union are less pronounced, with 9 years separating the countries with the longest average life expectancy (Spain, Italy, Sweden, around 80 years) from the shortest (Latvia, 71 years).

Under-5 mortality rates demonstrate even more marked global disparities. In 2004, they varied from 3 per 1000 live births in Iceland and Singapore, to over 250 per 1000 live births in Afghanistan, Angola, Niger and Sierra Leone.

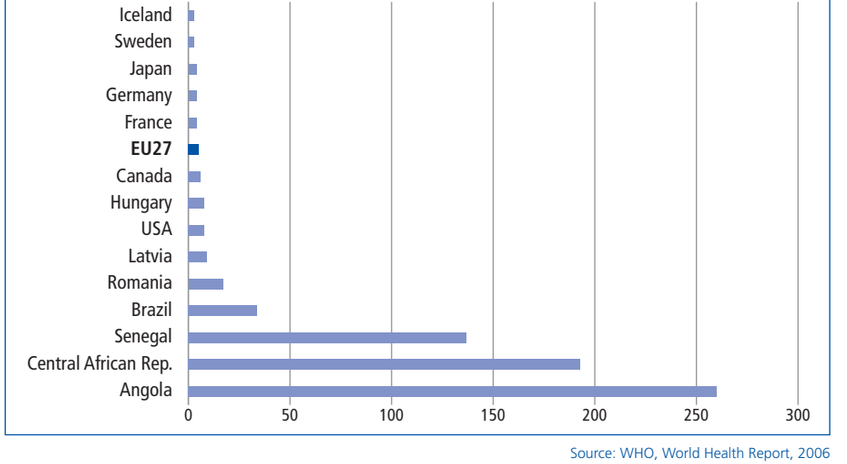
Compared with such extremes, the differences within the EU are slighter, varying from 20 per 1000 live births in Romania to 4 per 1000 in Sweden or Finland. However, a sharp difference exists between the 15 oldest Member States (where the average is 5 per 1000) and the following 10 Member States (with an average of 8 per 1000). The recent accession of Bulgaria and Romania has widened this gap[2].

AVERAGE LIFE EXPECTANCY AT BIRTH IN 2004
- in number of years -



Source: WHO, World Health Report, 2006

INFANT MORTALITY RATE BELOW FIVE YEARS IN 2004
- in number of deaths per thousand live births -



Source: WHO, World Health Report, 2006

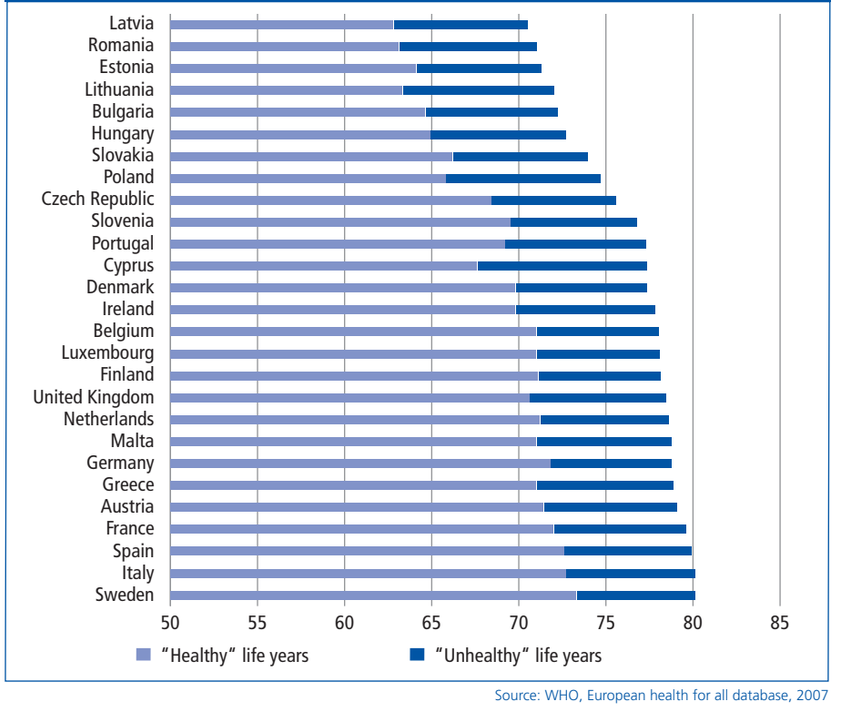
WITHIN THE EUROPEAN UNION

EU citizens have never lived as long as they currently do, but a comparison of their life expectancies still reveals some disparities. In 2004, average life expectancy for men was 78 years in Sweden, while it was only 66 years in Lithuania and Latvia. The gap decreases in women, but still remains significant. Spanish women have an average life expectancy approaching 84, while it is only 76 years in Romania.

The situation in the central and eastern European countries differs from the other EU Member States. Their economic recession in the 1990s had varying repercussions on their respective health situation. In the 1992-1998 period, as life expectancy[3] increased for the EU15, it decreased in several of these countries, particularly Latvia where it fell from 69 years in 1980 to 65 years in 1994. Today, the situation is improving thanks to healthcare system reforms and economic growth. In Bulgaria in 2004, life expectancy at birth for men returned to its 1980 level of 69 years. Since 1999, the overall difference between the EU Member States remains significant but seems to be decreasing.

As an indicator, life expectancy is increasingly being coupled with a second indicator known as "healthy life years"[4]. It measures the number of years that a person can, at birth, expect to live in good health. By combining morbidity and mortality data, it places the emphasis not just on the duration of life, as is the case for life expectancy, but also on the quality of life. In 2002, the "healthy life years" gap was 10 years between Latvia (almost 63 years) and Sweden (almost 73 years). With the emergence of chronic and degenerative diseases in the last years of life, the challenge for the EU Member States lies not only in prolonging life but also in reducing age-related disability. The evolution of the number of years in poor health, as well as ageing, will determine medical needs and long-term healthcare in the coming years. It is also a factor in productivity and economic prosperity, and as such, is one of the structural indicators in the Treaty of Lisbon, which represents the EU main policy for economic growth and productivity.

TOTAL LIFE EXPECTANCY IN 2002
- broken down according to healthy and unhealthy life years -



Source: WHO, European health for all database, 2007

B- SIMILAR HEALTHCARE CHALLENGES

Despite their differences in terms of health status, the EU Member States need to come to grips with similar health challenges today, particularly population ageing and the development of non-communicable disease.

CHANGING DISEASES

Affecting all EU Member States, non-communicable diseases represent a major risk today because they have surpassed communicable diseases as causes of mortality. They are often linked to individual lifestyles and are fostered by poorly balanced diets, lack of physical activity and tobacco or alcohol abuse. They affect mainly adults, rather than infants or children, who are usually affected by communicable diseases. Patient profiles

have thus shifted, as has morbidity[5]. Today, cardiovascular disease, cancer, diabetes and chronic pulmonary diseases constitute major health problems in the entire European area. Within the EU itself, situations vary widely because of differences in behaviour and healthcare structures. In 2004, the incidence of cancer in all its forms was thrice as high in Hungary (772/100 000, the highest in the EU) as in Romania (250/100 000, the lowest)[6]. The lifestyles of Hungarians, who consume more alcohol and tobacco than their counterparts in other EU Member States, explain this difference in part. The incidence of lung cancer is five times higher in Hungary than in Sweden.

As a general rule, treatment for these non-communicable diseases is long and costly because of their chronic nature. They make up a growing share of healthcare expenditure. In the EU15 countries, cancer accounted for almost 35% of deaths before the age of 65, making it one of the leading causes of death[7]. This is not simply the result of an increase in cancer cases, as their overall incidence rose only slightly, but also of a decrease in other causes of death. The consequences of poor diets are becoming increasingly worrying. Obesity rates are climbing in all EU Member States, and in the EU25, obesity is behind close to 7% of public healthcare expenditure[8].

Nevertheless, communicable diseases remain a major risk in the European Union. Some of them, such as tuberculosis, are rarer in the older Member States but remain fairly common in the newer ones, while the appearance of new diseases such as HIV/AIDS and SARS[9] have highlighted the necessity of co-ordinating action within the EU. In 2004, the incidence[10] of tuberculosis varied by a factor of 33 between the 27 EU Member States. Tuberculosis rates in Romania stood at 131 per 100 000 persons, while it was 4 per 100 000 in Cyprus. The movement of persons makes tuberculosis a problem shared by all 27 Member States. Consequently, the European Union health programme[11] has made communicable diseases one of its priorities, and a community monitoring network has been in place since 1999.

POPULATION AGEING

The proportion of persons aged 65 years or more in a given population varies from around 11% in Ireland to 19% in Italy. In March 2006, the European Commission published a report assessing the impact of an ageing population on public spending[12]. Falling fertility rates, longer life expectancies and the retirement of the baby boomers will result in the ageing of the population, which in turn will have an impact on wealth production and public spending. According to the report's projections, from 2010 to 2050, in the EU25 Member States[13], the active population[14] will decrease by 16% (that is, 48 million persons) while the over-65 population will go up by 77% (that is, 58 million). The ratio between the elderly and the "economically active"[15] is rapidly changing and threatens the viability of healthcare and pension systems that are founded on solidarity between the generations. The ratio may double for the European Union, from 25% in 2004 to more than 50% in 2050. It would be particularly high in Spain (66%), Italy (62%) and Greece (61%). This change in the demographic structure represents one of the main problems facing European healthcare and social protection systems. In addition, looser family ties and the quest for better management will shift this solidarity-based function to the community and health and housing establishments.

Close monitoring of such changes, particularly the increase in the number of the elderly (age 65 and up) and very elderly (80 years and above), can help prepare for increased need in medical and long-term care in the 27 EU Member States. This situation is not irreversible, however, because the age pyramid is likely to develop differently after 2050. With the disappearance of the baby boom generation, the demographic over-representation of elderly persons will probably decrease. Population distribution over different age groups would be more homogenous, but healthcare needs would differ from the present ones. One of the keys to reducing the financial impact of this development is to allow people to age in good health, which presupposes prevention campaigns and healthcare services that are suited to the population's new needs.

2. HEALTHCARE EXPENDITURE: ISSUES COMMON TO EUROPEAN UNION MEMBER STATES

Since 1980, the EU Member States have seen their healthcare spending increase more rapidly and regularly than their GDP. The weight of healthcare spending in GDP went up to an average of 8.7% in the EU27 in 2004. As healthcare spending is mostly drawn from public funds - 75% on average - the question of its financial "sustainability" and of healthcare system reforms needed to curb this increase is a source of lively debate. Without entering into this debate, two fundamental questions it has raised will be discussed. The first concerns the means by which healthcare systems are funded, as they vary depending on whether the country follows the Beveridge or Bismarckian model. The second will discuss the interactions between health and economic growth.

A- A GENERAL INCREASE IN HEALTHCARE EXPENDITURE

It is not easy to analyse healthcare expenditure, because the pertinence of comparisons depend on the similarity of definitions and data collection methods. The database built by the World Health Organization (WHO) Regional Office for Europe helps minimise some of these difficulties, allow comparisons, and identify major differences in actual healthcare expenditure, particularly at their level, expressed through two ratios: healthcare expenditure per capita and as a fraction of GDP.

HEALTHCARE EXPENDITURE OCCUPIES A GROWING PLACE IN EUROPEAN ECONOMIES

HEALTHCARE EXPENDITURE PER CAPITA

Since 1980, healthcare expenditure per capita has increased in all EU Member States, more than doubling in the majority of these countries since 1990. Several reasons can explain the sustained growth in healthcare spending, including the ageing population, improved standards of living - and consequently an increased demand for well-being -, and the appearance of new disabling diseases. That said, the main factors behind this growth are technological innovations in medicine[16] that have lead to increased complexity of equipment, new pharmaceutical products and wider deployment of surgical activity (ambulatory surgery, heart surgery, etc.).

TRENDS IN HEALTHCARE EXPENDITURE PER CAPITA[17]
- in US dollars PPP - [18]

	1980	1990	2000	2004
Luxembourg	640	1 530	2 980	5 090
France	700	1 530	2 450	3 160
Austria	770	1 330	2 670	3 120
Belgium	640	1 340	2 280	3 040[-1]
Netherlands	760	1 440	2 260	3 040
Germany	960	1 740	2 670	3 010[-1]
Denmark	930	1 520	2 380	2 880
Sweden	940	1 600	2 270	2 830
Ireland	520	800	1 810	2 600
United Kingdom	480	990	1 860	2 550
Italy	na	1 390	2 040	2 390
EU27	**na**	**1 110**	**1 830**	**2 310**
Finland	590	1 420	1 720	2 240
Greece	490	840	1 620	2 160
Spain	360	870	1 520	2 090
Portugal	290	670	1 620	1 810
Slovenia	na	310	1 390	1 800
Malta	na	na	1 380	1 740
Cyprus	na	na	1 230[+1]	1 440
Czech Republic	na	560	980	1 360
Hungary	na	590[+1]	860	1 320
Poland	na	300	590	810
Lithuania	na	160	430	790
Slovakia	na	na	600	780[-1]
Estonia	na	300[+2]	540	770
Latvia	na	160	340	730
Bulgaria	na	240	380*	635*
Romania	na	80	390*	570*

Source: WHO, European health for all database, 2007
(* WHO estimated figures)

Per capita healthcare expenditure is highest in Luxembourg, the wealthiest of the EU Member States, at over 5 000 US dollars a year. This amount represents almost nine times the amount spent per capita in Romania (570 US dollars per capita).

This table brings out a marked difference between the "EU15" Member States, where healthcare spending exceeds 1 800 US dollars per capita, and the other 12 Member States, where spending is at most 1 800 US dollars per capita. Nevertheless, such spending has increased in the central and eastern European countries, especially in Slovenia, where per capita healthcare spending has increased six fold since the country's independence in 1991.

TOTAL HEALTHCARE EXPENDITURE

The definition of "total healthcare expenditure" as used by international organisations (OECD, WHO, etc.) covers all spending, both public and private, for medical or paramedical purposes (healthcare promotion and disease prevention campaigns, disease treatment, actions aimed at decreasing early mortality rates, public administration, healthcare providers, etc.). This indicator thus measures end consumption of goods and services and investment in the healthcare sector.

The definition excludes activities related to public safety (such as road safety), food and sanitation, and training and research and development activities in the healthcare sector.

Total healthcare expenditure thus includes spending for:

- healthcare services;
- rehabilitation care services;
- long-term healthcare services;
- pharmaceutical products and other consumed medical goods;
- prevention and public health programmes;
- public health and health insurance administration;
- capital investment in healthcare infrastructure.

The scope of the "healthcare expenditure" definition used by international organisations for comparative purposes, therefore, generally differs from the one used in national health accounts.

Definition used in *A System of Health Accounts (SHA)*, a description of the methodology used for the OECD database, 2000

HEALTHCARE EXPENDITURE AND THE ECONOMY

The share of healthcare spending in national wealth has also increased in almost all of the EU Member States since 1980. The weight of healthcare expenditure varies from 5.5% of GDP in Estonia to twice that figure, 10.9% of GDP, in Germany. A difference can again be observed between the EU15 and the newer Member States. 10 of the 11 countries with the greatest share of GDP going to healthcare are in the EU15. Nevertheless, the share of national wealth devoted by some countries - such as Malta, Hungary and Slovenia - to healthcare is similar to that of the EU15 Member States.

In most of the Member States, healthcare expenditure represents more than 7% of GDP:

- 8 countries spend more than 9% of GDP on healthcare (Germany, France, Portugal, Belgium, Greece, Austria, Malta and Sweden);

- 12 countries spend between 7 and 9% of GDP on healthcare (Denmark, Netherlands, Italy, Slovenia, Hungary, United Kingdom, Spain, Luxembourg, Bulgaria, Finland, Czech Republic and Ireland);

- 7 countries spend less than 7% of GDP on healthcare (Poland, Cyprus, Latvia, Lithuania, Slovakia, Romania and Estonia).

The economic and budgetary context of each Member State, as well as the organisation of its healthcare system (regulation and infrastructure) should be kept in mind when interpreting these figures. For example, Luxembourg spends a smaller portion of its GDP on healthcare compared with the EU27 average (8.7%). This is explained in part by the country's especially high GDP. However, healthcare spending per capita is the highest in the entire EU (at almost 5 100 dollars). In the same manner, while healthcare spending expressed as a percentage of GDP is the same for the United Kingdom and Hungary (8.3% of GDP), healthcare spending per capita is very different, with the UK spending 2 550 dollars per person, almost twice the figure for Hungary (1 320 US dollars).

On average, for the period covering 1980-2004, healthcare spending rose at a faster rate than national wealth. Consequently, the economic weight of health-related expenditure increased. In Germany, from 1980 to 2003, GDP volumes rose at an average annual rate of +1.2% while healthcare spending rose by +2.0% a year. Healthcare spending represented 10.9% of GDP in 2003, a more-than-twofold increase compared with 1980. Note, however, that not all Member States saw such pronounced trends.

TOTAL HEALTH EXPENDITURE
- as % of GDP -[18]

	1980	1990	2000	2004
Germany	8.7	8.5	10.4	10.9[-1]
France	7.0	8.4	9.2	10.5
Portugal	5.6	6.2	9.4	10.0
Belgium	6.3	7.2	8.6	9.9[-1]
Greece	6.6	7.4	9.7	9.8
Austria	7.5	7.0	9.4	9.6
Malta	na	na	8.0	9.2
Sweden	9.0	8.3	8.4	9.1
Denmark	8.9	8.3	8.3	8.9
Netherlands	7.2	7.7	7.9	8.9
Italy	na	7.7	7.9	8.7
EU27	**na**	**6.9**	**8.0**	**8.7**
Slovenia	4.4	5.6	8.0	8.6
Hungary	na	7.1[+1]	7.1	8.3
United Kingdom	5.6	6.0	7.3	8.3
Spain	5.3	6.5	7.2	8.1
Luxembourg	5.2	5.4	5.8	8.0
Bulgaria	na	5.2	7.2*	7.7*
Finland	6.3	7.8	6.7	7.5
Czech Republic	na	4.7	6.7	7.3
Ireland	8.4	6.1	6.3	7.1
Poland	na	4.9	5.7	6.5
Cyprus	2.8	4.5	5.8	6.3
Latvia	2.1	2.5	4.8	6.3
Lithuania	na	3.3	6.0	6.0
Slovakia	na	na	5.5	5.9[-1]
Romnia	na	2.8	5.4*	5.7*
Estonia	na	4.5[+2]	5.5*	5.5*

Source: WHO, European health for all database, 2007
(* WHO estimated figures)

It is very high in Portugal, where healthcare spending rose by more than 4 GDP points in over twenty years, in Slovenia where the weight of healthcare spending doubled over the same period, from 4.4% to 8.6%, and in Lithuania. On the other hand, growth was very slow in Denmark and Sweden. Ireland is the only country where healthcare spending as a percentage of GDP decreased, from 8.4% in 1980 to 7.1% in 2004. In effect, after several difficult years, Ireland enjoyed an economic boom starting in the second half of the 1990s, hence its nickname, the "Celtic tiger". Its healthy economy grew faster than spending for healthcare, although the latter increased from 520 to 2 600 US dollars.

The 1990s were a transition period for the 10 central and eastern European countries, during which they shifted to a market economy and democratic political processes. The transformation took place at a time when the economic situation was difficult. Although all sectors were affected by reforms, the health sector, generally speaking, was not a priority. In Bulgaria, healthcare spending as a percentage of GDP even went down, from 5.2% in 1990 to 4.7% in 1994. Over the last ten years, most of these countries saw their healthcare spending climb. Slovenia, for instance, saw it increase from 5.6% in 1990 to 8.6% in 2004, while it rose from 4.1% to 6.3% in Latvia. The heavier weight of healthcare spending in these Member States are also characteristic of their catching up with the other EU Member States, akin to what was observed in Spain and Portugal in the 1980s and 1990s.

HEALTHCARE SPENDING IN THE OECD COUNTRIES

The countries represented in the OECD devote a significant albeit variable share of their national wealth (GDP) to healthcare spending. It ranges from 5.5% (South Korea) to 15.2% (United States).

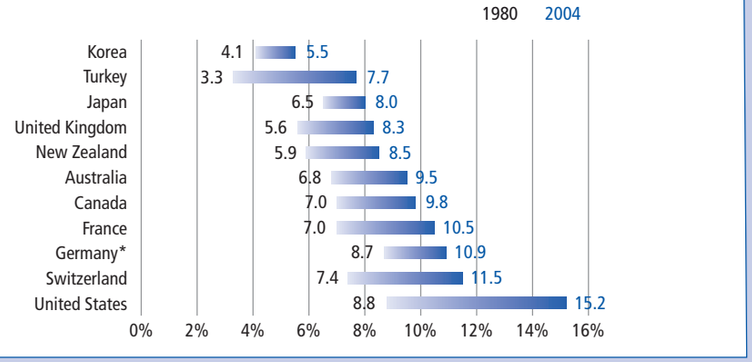
On average, since the 1980s, healthcare spending has been growing faster than GDP in the OECD countries. Consequently, the weight of healthcare spending on GDP never stopped increasing.

This trend can be broken down into several phases:

- in the 1980s: healthcare spending as a share of GDP grew very rapidly. In Canada, for example, healthcare spending increased from 7% of GDP in 1980 to 8.9% in 1990.
- in the 1990s: healthcare spending grew less rapidly, although it remained higher than GDP. In Korea, therefore, healthcare spending only increased by 0.3 points between 1990 and 1999.
- since 1999: the share of healthcare spending in GDP has once again sped up in the majority of OECD countries. In the United States, healthcare spending increased from 13.1% of GDP in 1999 to 15.2% in 2004.

Trends in expenditure on health in some OECD countries between 1980 and 2004

- as % of GDP -



Source: OECD, ECO-Health, 2008
*2003 data

This upward trend appears to coincide with an "independent time trend" in the healthcare sector, which aggregates several factors from both the demand and supply sides. Today, it reflects changes in the medicalisation and intensification of treatment more than it highlights the increase in drug prices or the ageing population. Many studies conducted in several countries reveal that the mechanical effect of ageing accounts for, at best, a twentieth of the increase in total healthcare spending over the last forty years. In some countries, deliberate policy choices are behind the increase in spending (United Kingdom and Spain, for example).

Indeed, it seems that medical progress is largely responsible for this increased spending for healthcare. Nevertheless, predicting future trends in healthcare spending appears to be a difficult task. Forecasts on progress are shaky and depend on the capacity of innovations to reach the general public. Innovations come in different forms. Some, like the prevention of type II diabetes or cardiovascular disease, will surely lead to a decrease in healthcare spending. Others, meanwhile, will either make more cases treatable or provide currently unavailable treatment, thus adding to the weight of healthcare spending.

According to "*Les dépenses de santé dans l'économie des pays de l'OCDE et la situation des dépenses hospitalières dans ce panorama*" (Healthcare expenditure in the OECD countries economy and hospital expenditure in this context) summary report on the study prepared by Michel Grignon and Philippe Ulmann, Dexia, March 2006

COMPLEX INTERACTIONS BETWEEN HEALTH AND ECONOMICS

Health plays a role in the economy, being a dynamic sector that generates jobs and wealth. In most countries, the healthcare sector is one of the most important in economic activity, with a large share of jobs - most requiring qualifications - and innovations. In the European Union, close to 9% of the active population work in the healthcare and social work sectors. Health also plays a vital role in the quality of the workforce, mainly by prolonging life spans, improving training and knowledge, and increasing the availability and profitability of economic agents. This role is even more important in modern economies where services account for more than 70% of GDP. Individual skills or "human capital" is therefore the main source of added value. According to a study based on the results of R. Barro[19], a 10% in life expectancy would lead to a 0.3% to 0.4% increase in GDP per year (all other growth factors being equal). On the other hand, poor health status is a major financial obstacle. Half of the difference in growth between rich and poor countries can be explained by the health status of countries.

Despite the health sector's role in economic growth (by generating economic activity and improving the productivity of the working population through better health), the relationships between the population's health status, the level of healthcare spending and economic growth are neither simple nor unequivocal. A high level of healthcare spending can weigh on public funds to the detriment of other "productive" spending, thus slowing economic growth, and have a negative impact in acquiring human capital. Increased spending can contribute to restricting growth and employment, especially in cases where contributions strain salaries, particularly the lowest ones. Moreover, some economists consider that beyond a certain level of health, the effects of public healthcare spending on the population's health and on economic growth are debatable[20]. There may be a "threshold effect" of health on economic growth, as well as a "threshold effect" of healthcare spending on a population's healthcare status.

Furthermore, a health budget is the result of bargaining on different items in the national budget (should we spend more on education or on health?) as well as different types of healthcare spending (what policies should be supported, care or prevention?).

B- FUNDING FOR HEALTHCARE EXPENDITURE

MOSTLY PUBLIC SPENDING

In all EU Member States, healthcare systems draw the bulk of their funding from "public" funds, whether from social protection bodies, the State budget, or local authorities. For 18 countries, the "public" share of healthcare spending exceeds 70%. The share is between 50% and 70% in only 8 of them. Only the Cypriot healthcare system draws a small majority of its funds from private sources.

For this reason, when public healthcare spending rises faster than national GDPs, the question of how the costs are met are a subject of great debate.

In some countries of central and eastern Europe, the share of private funding for healthcare grew during the 1990s. Of these countries, private funding is particularly heavy in Latvia, Bulgaria and Romania. Such funding is made up essentially of direct out-of-pocket payments from households, and, to a lesser degree, private insurance In Bulgaria, for example, only 56% of healthcare spending is publicly financed, more than 40% is funded directly by households (in the form of co-payment or informal payments) and close to 1% is funded by private insurance companies.

THE CONCEPTUAL FRAMEWORK OF HEALTHCARE SYSTEM FUNDING

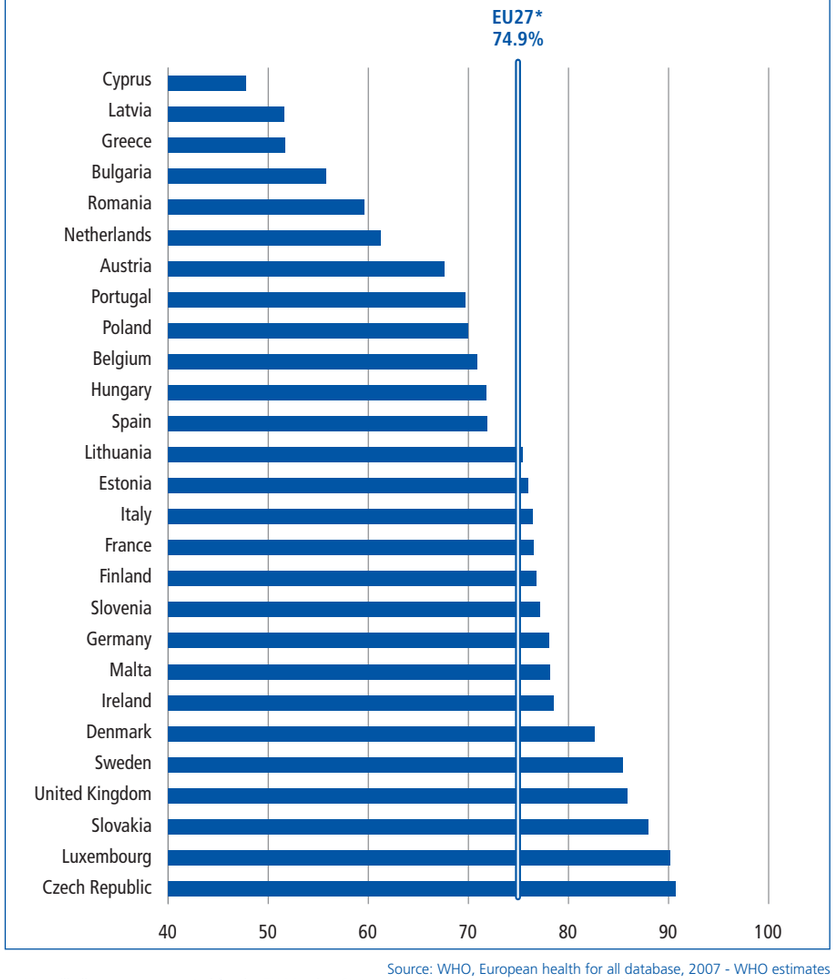
Within the EU Member States, the source of public funding for healthcare varies according to how social protection is organised. This may follow two schools of thought: funding through social insurance (known as the Bismarckian model) or funding through public administration budgets (known as the "Beveridge" and "Semashko" models). The different healthcare systems that resulted from them are also characterised by their conditions for access to healthcare, means of funding, and specific patterns of organisation.

- **A social insurance system, inspired by the Bismarckian model**, links the benefit of "health" protection to affiliation with a professional category (funding by employers and employees).

- **A Beveridge system** finances healthcare spending through fiscal means. Healthcare access is universal and depends on residency or citizenship. Healthcare services are, in principle, monopolised by a national health service.

A third model influenced the organisation of healthcare systems in some European countries: the "**Semashko model**", set up in the central and eastern European countries after the second world war (see boxed text next page). It is related to the Beveridge system in terms of its funding (by fiscal means) and by providing coverage for the entire population based on residency. However, the State has full control over the funding and organisation of the healthcare system in the "Semashko" model, whereas the private sector might hold a non-negligible role alongside the public sector in Beveridge systems. Over the past fifteen years, the Member States in question have shifted away from this type of organisation, primarily by changing the funding mechanisms for healthcare systems. The great majority of them have introduced funding via social insurance.

GOVERNMENT EXPENDITURE ON HEALTH AS % OF TOTAL EXPENDITURE ON HEALTH 2004



Source: WHO, European health for all database, 2007 - WHO estimates
*As will all averages computed for the EU Member States as a whole, this one is weighted according to each country's population.

These concepts were established in different periods, contexts and ways, as each country was marked by its social and political history, above and beyond the models themselves. For instance, of the countries with a Beveridge system, some do not have tax-based founding for all of the risks covered, while others do not provide universal coverage. Countries with Bismarckian systems are vastly different in their organisation of healthcare insurance. Many have introduced tax-based funding in order to make coverage universally available to their population.

CHARACTERISTICS OF THE SEMASHKO MODEL

The Semashko model was drawn up by Dr. Nikolai Semashko, who became People's Commissar of Public Health in 1918 in Russia. With the State's deciding role and the means of funding for healthcare spending, it is somehow comparable to the one later developed by Lord Beveridge.

It is characterised mainly by:
- universal, free coverage for the entire population;
- fully tax-based funding;
- highly extensive state control: the State owns, manages, and funds the healthcare system.

This type of healthcare organisation led to very hospital-centred healthcare services. Secondary and specialised healthcare were highly developed and care structures were often oversized, to the detriment of prevention and primary health care which were given little recognition. As such, the number of hospitals and hospital doctors in most of these countries still remains higher than the European average.

Since the 1990s, the systems that previously used this model have undergone significant reforms. While keeping the principles of free and universal care, they have focused on the following: rethinking State centralisation, developing primary care, authorising private medical practice, creating mandatory health insurance and introducing contractual relations between buyers and suppliers.

BEVERIDGE HEALTHCARE SYSTEMS

Despite their common roots, the so-called Beveridge systems can vary significantly from one country to the other. Universal social coverage is not provided in all of them (Ireland and Cyprus) and the funding system can range from a largely centralised scheme, as in the United Kingdom, to a significant decentralisation, as in Finland.

- *Dissimilar population coverage for each system*

In **Ireland**, coverage of the population depends on residency, although the right to services that are completely free of charge is based on individual resources. The population is split into two categories. Some 35% of those covered, with the lowest incomes, belong to Category I and are entitled to a wide range of free services. Most of the population belongs to Category II (65%) and pay directly for ambulatory care, or take out voluntary insurance.

THE BEVERIDGE DESIGN: THE NATIONAL HEALTH SERVICE

The United Kingdom is the cradle of this model, whose principles were laid down in 1942 by Lord Beveridge.

With the economic depression of the 1930s and 1940s, the lack of a national healthcare organisation during this period, the experience drawn from communal action during the war, and the success of the *Emergency Medical Service* (EMS), then organised in each region, it became evident that a national health service needed to be established. This prodded Lord Beveridge to propose a reform of the British mandatory healthcare insurance regime, which he found "too limited with the system of an affiliation threshold, too complex with the multitude of insurance funds, and poorly co-ordinated". The reform was based on pooling costs at a national level, and his report led to the establishment of the National Health Service (NHS) in 1948, by the Labour government.

It was based on the following principles:
- universal social protection, by providing coverage for the entire population and all social risks;
- uniform cash benefits, based on needs rather than incomes;
- financing through taxes;
- unity of social protection as a whole through state management.

In **Denmark**, healthcare coverage is universal and applies to all residents, but users have a choice between two insurance regimes for ambulatory care: "Group 1" and "Group 2". In Group 1 (almost 98% of Danes), healthcare is free of charge in exchange for certain restrictions. Patients must register with a general practitioner who has signed a collective agreement with the public health service and is located in a 10-kilometre perimeter around the patient's residence. At the end of the consultation, the GP may decide to refer the patient to a specialist, or have the patient admitted in a hospital. Patients can change their GP every six months maximum. Group 2 includes patients who have opted to leave the free healthcare system. These patients can freely consult the general practitioner or specialist of their choice, without being required to register. Professional fees are fixed freely and patients are only entitled to partial reimbursement, based on a "liability rate" not exceeding the fees charged by the doctor.

In **Cyprus**, the national healthcare service is mainly funded by the State budget. Nevertheless, healthcare coverage is not universal, but fragmented. Healthcare is free-of-charge for working and retired civil servants, as well as members of the police force, the army, national education, beneficiaries of social aid, persons whose incomes are below a given threshold, and their dependents. The rest of the population have access to healthcare at reduced rates. In April 2001, a law establishing a national social security system was enacted and was supposed to come into force in 2008, the time thought necessary for the reorganisation of the healthcare system. This regime will provide healthcare to the entire population and will be funded by contributions from the State, employers, employees, the self-employed and pensioners.

• *A more or less centralised fiscal system*

In the Scandinavian countries, the system for financing healthcare is traditionally decentralised.

In **Sweden**, healthcare is mainly funded by taxes levied at the county and municipality level. The State also contributes to funding by giving grants to counties, which are calculated according to a county's population and socio-economic situation. In theory, each county is free to set its tax rate. However, since the severe economic crisis of the 1990s, the State has introduced a ceiling.

In **Finland**, the municipalities are responsible for the health of their respective populations and enjoy a great deal of autonomy in their organisation. They levy the taxes needed for this. Grants from the State, based on demographic criteria (population, age structure and mortality rate) round out this mode of funding.

In **Denmark**, a movement to "re-centralise" the funding mechanisms took place very recently. Since the 2007 reforms, the new regions in charge of healthcare, which replace the counties, are not allowed to levy taxes. The main sources of healthcare funding are now the State, which contributes 80% of public healthcare spending, and the municipalities, which account for 20%.

In **the United Kingdom**, the tax system is organised at a national level. Despite the 1998 reform that decentralised the healthcare system between the four nations of the UK (England, Scotland, Wales and Northern Ireland), the financing system remained centralised. Each nation receives a general budget allocated by the Treasury and computed according to the Barnett Formula[21]. Ireland also organises its resource collection system in a highly centralised manner.

• *"Mixed" Beveridge-leaning healthcare systems*

In the southern European Member States (Greece, Italy, Portugal and Spain), healthcare should be thought of as mixed, with Beveridge tendencies. Taxes remain the principal source of funding, but social contributions were or are an important part of financing compared with the countries mentioned previously.

In these countries, the national healthcare systems were tacked on to the existing mosaic of social and mutual insurance regimes. **Spain** created the *Sistema Nacional de la Salud (SNS)* en 1986, enabling near-universal coverage. In **Portugal**, the *Servizio Nacional de Saúde (SNS*), integrated into the Ministry of Health, was created in1979 to provide universal healthcare coverage for the entire population. The Portuguese healthcare system is financed primarily by national taxation. In these countries funding for social protection, and more specifically healthcare insurance, is based both on social contributions (by employers and employees) and the State's budget contribution, in proportions that vary widely from one country to another. In **Greece**, for instance, the State now plays a decisive role in the healthcare sector, even though the latter was traditionally financed by employer and employee contributions. A national healthcare system (*ESY*) was instituted in1983 and almost a quarter of healthcare spending is directly financed by the State budget, which also sets the rate for contributions.

In **Italy**, the creation of the national health service (*Servizio Sanitario Nazionale*, *SSN*) in 1978 marked the transition from a mutual-insurance type healthcare insurance regime to a Beveridge-type healthcare system, with a major share of funding from taxes. The system was organised with decentralisation to the regions, which now have administrative, legislative and fiscal powers. Nevertheless, the "fiscal federalism" that was introduced in the early 2000s is not yet fully operational, and its full implementation is still under discussion. The Italian regions finance most of healthcare expenditure through different taxes: the regional tax on business activities (*imposta regionale sulle attività produttive, IRAP*), part of VAT attributed to the regions via a National Solidarity Fund, fuel taxes, and, to a lesser extent, an additional tax on personal income (IRPEF). The rate for *IRAP* is set by the central government, but regions can opt to modify its rate by plus or minus one point. The State continues to participate in financing healthcare, using part of income tax, of VAT, and by giving grants. Resources are collected at the national level through the National Solidarity Fund, which sees to it that all regions devote an equal level of resources for their inhabitants, plus or minus 10% from the national average. However, even if resources per inhabitant are practically equal from one region to another owing to these transfers, the quality of healthcare spending is highly variable. As a result of chronic regional budget deficits due to healthcare spending, the government created a sanction system in 2006, requiring regions in deficit to increase their tax rate to the maximum level. Regions that are unable to balance their health budgets must also implement a restructuring plan drafted in agreement with, and monitored by, the central government[22].

In **Latvia**, extensive reforms of the healthcare system did not radically modify its funding mechanisms. Some aspects of the Semashko model are still in force. In 1998, a national statutory healthcare insurance agency (*VOAVA*) was created with the goal of administrating and redistributing healthcare resources. Under the supervision of the Ministry of Social Affairs, its funding comes from the State budget. Healthcare resources are composed mainly of a share of income tax (28.4% of income tax goes to the health budget) and State aid.

BISMARCKIAN HEALTHCARE SYSTEMS

Bismarckian-inspired healthcare systems are organised in very different ways from one Member State to another. For instance, health insurance funds can be organised at the national (France) or infra-national (Germany's *Länder*) level. Affiliation with the basic insurance regime can also vary according to the country, being mandatory in France but optional for some categories of the population in Germany. In addition, many of these systems have undergone changes that have brought them progressively away from their founding principles in the strict sense.

THE BISMARCKIAN DESIGN: SOCIAL INSURANCE

Mandatory social insurance came into existence in Germany in 1883, under Chancellor Bismarck. The German State institutionalised social protection that was previously provided by many "emergency funds". Social protection is based on a principle of work-related insurance and is separate from assistance-based social protection systems.

The fundamental principles characterising the Bismarckian system:

- protection based exclusively on work: social protection, granted in exchange for professional activity, is financed by social contributions that are proportional to the salary;
- protection jointly managed by employers and employees.

In most of the Member States adopting a Bismarckian model, protection gradually became generalised with its expansion to population categories that were initially unprotected (students, the self-employed, etc.) and risks that were not originally covered.

- *The organisation of health insurance funds can differ significantly from one country to another*

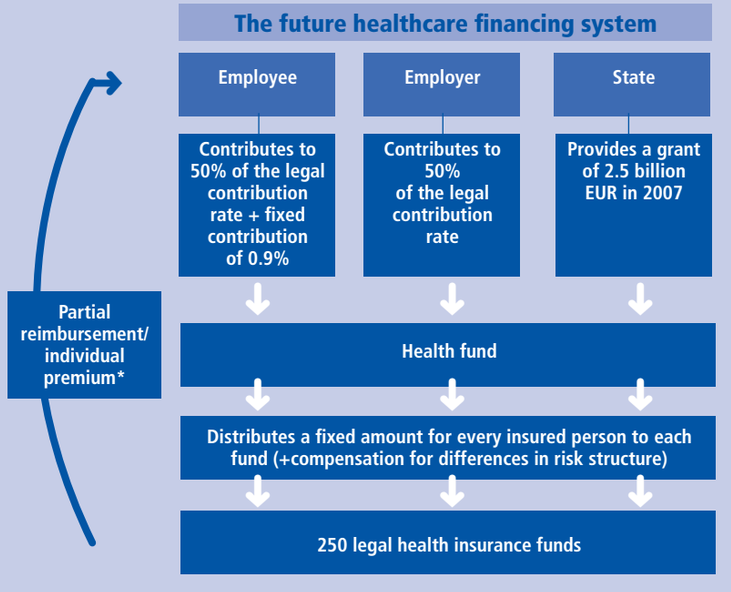
As a general rule, social contributions are deducted from salaries. They are set by the government (France, Czech Republic), by an association of insurance funds (Luxembourg), or by individual insurance funds (Germany). Depending on the Member State, there can be one or several legal health insurance funds. When several funds are present, affiliation may depend on the place of residence (at the regional level, in Austria), or the affiliate's free choice, thus creating competition between the different health insurance funds (as is the case in Germany, Belgium, Czech Republic and the Netherlands). When competition is present, a mechanism of risk sharing exists.

GERMANY: INCREASINGLY MIXED MEANS OF FUNDING

Founded on the principles of professional insurance in the framework of business and social welfare, the German healthcare system has found itself in a process of continuous reform since the late 1980s. The Bismarckian system gradually changed, especially in terms of funding, with greater recourse to taxes.

In 2003, a reform on the modernisation of the healthcare system already provided for taxes to finance the system in part. The law stipulated that a certain number of services would be financed by taxes (pregnancy-related benefits and care, voluntary termination of pregnancy, benefits for sick children, and death benefits). Tobacco taxes were raised to this effect and allocated in part to health insurance.[23]

In February 2007, a new reform furthered the transformation of the healthcare system and modified its means of funding. The law called into question some of the autonomy of health insurance funds, which could freely set their dues, by centralising the definition of a legal contribution rate for wage earners and employees at the level of the Federal State. This law, designed to make up for the disparities between the different public health insurance funds, introduced in April 2007 a system of equalisation between the insurance funds that will lead to the creation of a Healthcare Fund in 2009. Taxes will also play a more important role in financing the healthcare sector. In 2007, the Federal State was to release 2.5 billion euros, a contribution that will have reached 4 billion euros in 2009.



According to data collected from *Missions Économiques* (lettres de veille internationale, avril 2007)
*: in case of surplus, the fund can pay out the surplus amount to its insurance holders; in case of deficit, the fund can apply an additional premium not exceeding 1% of the insurance holder's income.

As such, in **Germany,** competition between the different insurance funds has existed since the 1992 Seehofer reform, and has increased since 1996. The system introduced in 1992 invited persons who earned more than a given income (now somewhere around 47 000 euros a year) to either subscribe to public healthcare insurance, private healthcare insurance, or not be insured at all. Those below this threshold, around 90% of the population must take out healthcare insurance with a public insurance fund. The public healthcare insurance funds (around 250 in early 2006) are highly autonomous in terms of management and have regulatory authority. For instance, they set the number of professionals in their geographic area or the rate for contributions.

In **the Czech Republic**, attempts to put insurance funds in competition with each other failed because some of them went bankrupt. Patients continue to choose their insurance fund freely, but the funds are obliged to provide the same coverage, in the same conditions, thereby limiting competition.

- *Increasingly mixed financing in Bismarckian-inspired Member States*

In **Germany**, contributions - half from the employer and half from the employee - are supplemented by greater recourse to taxes. Moreover, the Seehofer reform of 1992 introduced different funding techniques. This new system invites people with more than a given income to voluntarily take out insurance with a private insurance company, while others avail of third-party payment with co-payment.

In **France**, funding for healthcare is always drawn, to a large extent, from mandatory social contributions based on salaries, in accordance with Bismarckian principles. Nevertheless, since the early 1990s, the share from taxes has been growing, primarily through the generalised social contribution (*Contribution sociale généralisée, CSG*, created in 1991[24]) and the contribution for the reimbursement of the social debt (*Contribution pour le remboursement de la dette sociale*, *CRDS*, created in 1995[25]).

- *Central and Eastern European countries: a specific issue*

The situation in the Member States in central and eastern Europe differs from the other Bismarckian countries, in part due to their historical, political and economic heritage. Since the 1990s, their healthcare systems have been subject to rapid and radical reforms to break away from the Semashko model, closer to the Beveridge system than to the Bismarckian one. These reforms involved both the means by which individuals contributed, and the relationships between the different stakeholders. They drew inspiration from Bismarckian mandatory social insurance model and introduced health insurance funds with their specific budgets.

However, despite those reforms the government continues to play a significant role by remaining the trustee of these Funds (Hungary[26], Lithuania and Estonia) or being involved in the organisation of the insurance fund (Slovakia). In addition, the difficult economic situation, in particular rising unemployment, has showed the efficiency of financing that is based mainly on employer/employee contributions, justifying the State's role in collecting and allocating resources.

In **Hungary**, for instance, the reforms of the 1990s introduced a social insurance system that reconnected it with its former Bismarckian tradition, which existed until Hungary's was integrated in the Comecon under Soviet influence. The system has changed a great deal since 1990. After several reorganisations, the health insurance fund is now placed under the supervision of the Ministry of Health. It is financed mainly by social contributions (employer and employee) but State aid complements this source of funding. The central State covers all expenses for ambulance services, mandatory vaccination, prenatal care and the costliest tertiary care services.

RELAXING THE FOUNDING PRINCIPLES

Two models - Bismarckian and Beveridgian - hold sway over the organisation of healthcare insurance in the EU Member States. Their underlying philosophies are very different, which accounts in part for the diversity of European healthcare systems. None of the systems is a pure one, and recent social and demographic changes, such as rising unemployment and population ageing, as well as economic pressures, are forcing Member States to relax the principles behind their healthcare systems. Common health and economic challenges create a similar context for all Member States, spurring them to reform their healthcare systems along converging lines: ensuring social justice (providing universal healthcare coverage in Bismarckian-type healthcare systems), improving the efficacy of the healthcare system by decentralising it and increasing its efficiency by introducing market mechanisms (competition between health insurance funds, for example) and making stakeholders responsible for their actions (increased solicitation of financial participation from patients, for example).

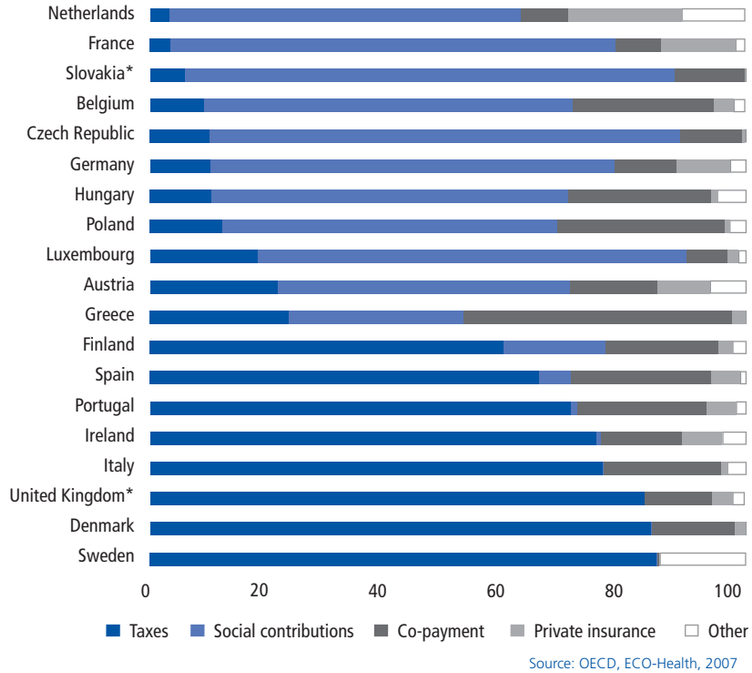
MECHANISMS FOR PATIENT CONTRIBUTIONS IN FINANCING HEALTHCARE EXPENDITURE: DIFFERENT BALANCES

The healthcare funding models are characterised primarily by the relative weight of four mechanisms for individual contributions toward healthcare expenditure: mutual public funds collected in the form of taxes or social insurance on one hand, and private funds from direct patient contributions or marginal sources in most of the EU Member States.

MUTUAL PUBLIC FUNDS

The financing of healthcare systems in all of the EU Member States is mainly based on public funds, whether they are handled by social protection bodies, the State budget or local budgets.

HEALTHCARE FINANCING IN SEVERAL EU MEMBER STATES - 2004



Source: OECD, ECO-Health, 2007
*: 2003 data[27]

- 11 Member States in the EU finance their health policies through **taxes** (Cyprus, Denmark, Finland, Ireland, Italy, Latvia, Portugal, Spain, Sweden and the United Kingdom). Taxes may be direct or indirect and collected locally or nationally. Local taxes are high in countries such as Denmark, Finland, Sweden and Italy.
- 13 other Member States use **social contributions** to finance their health expenditure (Belgium, Czech Republic, Estonia, France, Germany, Hungary, Lithuania, Luxembourg, Netherlands, Poland, Romania, Slovakia and Slovenia).
- 3 Member States have a very **mixed financing system**, combining the different means of financing (Austria, Bulgaria and Greece). For examples, resources for healthcare expenditure in Austria come from taxes (21%), social security (49%), out-of pocket household payments (15%), private insurance (9%) and other private sources (6%). In Bulgaria, the transition to a system financed primarily by social contributions is ongoing. Public healthcare spending is already financed primarily by social contributions (55%) but the share of national and local taxes in such public financing still remains high 45%).

HUNGARY: RETHINKING THE FREE HEALTHCARE SYSTEM

In 2006, as part of its Convergence Programme (aimed at rehabilitating public finances), the Hungarian government introduced direct financial participation of patients for healthcare access, in order to make them use healthcare in a responsible manner as well as increase the financial resources available for the healthcare sector.

This participation took the form of a «flat consultation fee» for medical consultations (around 1.20 EUR) and a «daily hospital fee» for hospital care (around 4.80 EUR), for a maximum of 21 days for the same hospitalisation. In addition, patients who did not adhere to the «care pathway», especially in terms of accessing the healthcare system via a general practitioner, risked paying higher fees. Some patients were exempted from financial participation. They included pregnant women, those of no fixed abode, minors under 18, and patients requiring dialysis or life-saving treatment aimed at stabilising the state of health (haemorrhage, aneurysm, syncope, septicaemia, etc.).

Under pression from the opposition, the Hungarian government was forced to organise a referendum in March 2008 on, among other things, the elimination of these two fees. Hungarians voted to eliminate them, and patient participation in financing the Hungarian health system is very limited today.

Although public financing covers most of the expenses in European healthcare systems, this varies between the Member States. As a consequence the share of private financing also varies.

DIRECT PARTICIPATION OF PATIENTS

Direct patient participation is a complementary mode of financing that is being increasingly adopted in most of the EU Member States. Though it is almost never the main source of funding, it nevertheless can constitute an important source.

The patient's financial participation (sometimes called "co-payment") is generally adopted with the stated goal of making patients responsible healthcare consumers, while providing new resources for healthcare expenditure. Some of the contributions that patients are charged may or may not be covered by insurance.

In contexts where healthcare insurance regimes are not balanced or where other budget difficulties exist, several Member States have recently modified the modalities to reimburse healthcare and medication. The financial participation of patients during hospitalisations can take on different forms: a fixed amount, as in Germany; a hospital flat rate established according to the patient's profession, as in Cyprus, or according to the disease, as in Slovenia.

In **Germany**, a reform that came into force on 1st January 2004 created a contribution of 10 EUR per quarter for outpatient consultations, a lump-sum contribution at the insured person's expense during drug purchases, and an increase in the contribution for hospital care (from 9 EUR a day for 14 days maximum annually, to 10 EUR a day for 28 days a year).

In **France**, the law of 13 August 2004 on social insurance introduced a flat-rate contribution of one euro per day for medical and laboratory procedures and consultations (with 2 caps per patient, of 50 EUR a year and 4 EUR a day)[28]. For persons with long-term diseases, exemption from this contribution now depends on the adherence to a care protocol.

In **Slovakia**, since 1st June 2003, the patient pays a contribution to the general practitioner, the hospital, or the pharmacy. The sum is marginal but aims to reduce physician consultation rates and improve their income.

In other countries, such as Malta and the Netherlands, there is no direct patient participation. In central and eastern European countries mainly, some direct payments are informal and not provided for by legislation. In principle, they make it possible to have faster access to healthcare and in better conditions. The assessment of the amount of these informal payments is tricky and difficult to carry out.

PRIVATE INSURANCE SYSTEMS

Private health insurance systems that cover individuals or groups, and whose risk premiums are computed according to socio-demographic criteria, generally play a secondary role to public financing in the EU Member States. The role and position of private insurance vary from one country to another[29]. Private health insurance can provide primary coverage, thus replacing public coverage for certain high-income individuals. This is the case, for example, in Austria, Germany, and the Netherlands. It can also complement State-sponsored coverage when the latter requires patients to make contributions, as in France, where individuals can take out private insurance to cover fees that are not refunded by the public system. Private health insurance can also supplement public coverage by financing excluded services. Finally, it can function alongside and as an alternative to the public system. For example, in the United Kingdom and Ireland, patients

can choose between the two systems if they have the means. Although complementary and supplementary private insurance systems have had a measure of success in Italy, Austria and Denmark (taken out by more than 15% of the population in these three Member States), they cover a tiny proportion of the population in Luxembourg (a little over 2%) and a negligible share of the populations in Poland, Slovakia and Sweden.

The role of private healthcare insurance is still too fragmented to allow identification of a specific trend in Europe or to predict its future role in healthcare systems. Nevertheless, according to OECD estimates, they will probably play a greater role in the financing of healthcare systems and penetrate countries where private funding within the legal system has not yet been developed. Although the fraction of the population covered by private insurance is still negligible in the central and eastern European countries, it is likely to grow, and the legal conditions for the provision of such insurance are being established. In **Hungary**, for example, private health insurance accounts for a negligible share of healthcare system financing (less than 1%). However, in late 2007, a bill proposed the establishment of 22 regional healthcare insurance funds where private healthcare insurance could own up to 49% of shares, with the rest belonging to the State. The bill was met by many protests, but is likely to increase the influence of private healthcare insurance on the Hungarian healthcare system.

C- HEALTHCARE EXPENDITURE AND HOSPITALS

There is not yet a European legal definition for "hospital"[30]. Healthcare activities carried out in hospitals of the EU Member States are very diverse and comparisons are difficult to make as the term can cover very different practices.

In 2004, the European Union counted almost 15 000 different hospitals of highly diverse types and sizes. The private sector is a minority, representing less than 20% of capacity of care in terms of hospital beds.

Regardless of this diversity, for most of the EU Member States, hospitals - both public and private - are essential components of the healthcare system in terms of healthcare services, infrastructure, and costs. They represent one of the top budget items in the healthcare sector, even if this appears to be going down. In 2004, in all of the EU Member States, hospital spending still represented more than 25% of total healthcare expenditure.

Hospital spending is loosely defined here. It includes public and private spending, and acute care as well as rehabilitative and long-term care. The inclusion of ambulatory healthcare in the category of hospital care expenditure depends on the country. Nevertheless, data from the WHO regional office for Europe enables an initial comparative

statistical analysis of the weight of the hospital sector in healthcare spending for a large part of the EU Member States.

SHRINKING WEIGHT OF HOSPITALS ON HEALTHCARE EXPENDITURE

The weight of the hospital sector in healthcare expenditure changes from one country to another, varying from 26% in Spain to 60% in Latvia where, despite a policy restructuring the healthcare system that led to a significant reduction in their number, hospitals remain the main cornerstone for healthcare[31]. These data should be taken with caution, as the accounting for hospital expenditure has been reformed in certain countries, leading to a drastic decrease in figures every time. Some changes should be qualified, as with Spain, for example, where changes in scope have changed the weight of hospital spending from 47.5% to 31% between 1994 and 1995. In Sweden, the abrupt reduction in hospital spending between 2000 and 2001 stems mainly from accounting reforms that excluded ambulatory care from hospital expenses, which now cover only those expenses for care provided to inpatients. A similar phenomenon took place in Denmark, with a very marked reduction in hospital spending in 2003.

Even when taking possible statistical biases into account, it still remains that between 1980 and 2004, the part of hospital expenditure in total healthcare spending has decreased overall, in varying degrees according to the Member State. Spending decreased from 55% to 44% in the Netherlands and from 47% to 44% in Italy. The decrease is a result of budget control policies for the hospital sector, as well as faster growth of spending for medications, mainly a consequence of drug innovations that make it possible to provide better treatment for major diseases (cancer, HIV/AIDS, hepatitis, etc.) and the replacement of some surgical treatments by medical ones, or, occasionally in the central and eastern European countries, the liberalisation of the price of medicines.

HOSPITAL SPENDING IN FRENCH HEALTHCARE EXPENDITURE

In France, as in most Member States, the hospital is the first budget item in national healthcare expenditure. Since the 1960s, the share of hospital expenses in the consumption of medical goods and care (*consommation de soins et de biens médicaux, CSBM*)[32], that is, spending directly tied to the care received by patients, has seen strong variations. It rose progressively until around 1980, from around 40% to over 55%, then fell again to settle at some 45% in 2006.

From 1960 to the mid-1980s, the hospital sector contributed the most to the volume growth of the CSBM[33], tied mainly to its relatively heavy weight. However, starting in 1982, this contribution started to decrease, as the share for medication and, to a lesser degree, ambulatory care, rose. Between 1997 and 2000, the item for medication was responsible for the growth of the CSBM. The other component in CSBM growth, the cost effect, diminished appreciably and regularly between 1960 and 2005 for medication, remained relatively stable for ambulatory care, and increased for hospitals.

Increase in consumption of medical goods and care per item

	CSBM volume growth rate - in points -	Contributions to growth - in points -				
		Hospital	Ambulatory care	Health transport	Medication	Other goods
1960-1965	9.7	6.1	2.0	0.1	1.3	0.2
1965-1970	7.6	4.0	2.0	0.1	1.3	0.2
1970-1975	8.6	5.1	1.7	0.1	1.4	0.3
1975-1980	6.1	4.1	1.2	0.1	0.5	0.2
1980-1985	5.4	2.4	1.6	0.1	1.1	0.2
1985-1990	4.7	1.4	1.7	0.1	1.2	0.2
1990-1995	3.1	1.1	0.7	0.1	1.0	0.2
1995-2000	2.5	0.4	0.6	0.0	1.0	0.3
1960-2001	5.9	2.8	1.5	0.1	1.4	0.3

Source: Drees, National health accounts, July 2005 and July 2006

This trend became more marked after 2000, with, for example, a 1.2 point contribution from medication to CSBM volume growth, which was compensated in value by a decrease in the price index for medications, and a 0.6 point contribution from ambulatory and hospital care.

TRENDS IN EXPENDITURE ON HOSPITAL SERVICES IN HEALTHCARE SPENDING
- in % -

	1980	1990	2000	2004
Latvia	na	78.0	57.2	60.1
Bulgaria	na	60.0[-1]	na	47.0
Romania	na	57.0[+2]	53.0[+1]	na
Slovenia	45.0	42.9	47.8	na
Italy	46.7*	42.4	41.2	44.1
United Kingdom	53.5**	43.9**	42.8**	na
Austria	na	41.3[+5]	39.3	41.7
Netherlands	54.6	49.2	36.5	39.6[-1]
Czech Republic	na	29.0[+5]	33.6	36.7
Finland	46.3	44.7	38.2	34.8
Belgium	33.1	32.8	32.0	34.8[-1]
Germany	33.2	34.7	35.8	34.7[-1]
France	49.4	44.3	39.9	33.8
Luxembourg	31.3	26.4	36.0	33.1
Estonia	na	na	36.2	32.5
Sweden	68.5*	49.8*	50.9	31.3
Slovakia	na	na	26.4	30.4[-1]
Denmark	61.6	55.3	53.2	30.1
Hungary	na	65.2[+1]	29.3	29.0[-2]
Poland	na	na	na	28.1
Spain	54.1	44.1	28.2	25.9
Portugal	28.7	32.3	na	na
Ireland	58.8	na	na	na
Greece	26.5*	28.4*	na	na

Source: WHO, European health for all database, 2007
**: source Eco-Health, OECD, 2006
*: national data

CONTINUED GROWTH IN HOSPITAL EXPENDITURE

Between 1980 and 2004, hospital spending per capita increased in all Member States[34]. In Germany, it grew from 320 US dollars per capita in 1980 to 1 040 US dollars in 2003, and from 570 to 870 US dollars between 1980 and 2004 in Denmark. In France, spending grew from 340 US dollars to 1 070 US dollars in the same period. Luxembourg saw the largest jump, from 200 US dollars in 1980 to 1 690 US dollars in 2004, mainly as a result of the hospital construction policy carried out by the government in the late 1990s.

With the growing weight of healthcare expenditure in public finances, governments have tried to contain spending, particularly the "hospital spending" component, with the help of several tools. The 1980s and 1990s were particularly marked by macroeconomic tools that led to restrictions: reductions in the number of hospital beds, budgeting of hospital expenses, restructuring of healthcare services, etc. Although such policies had some success for a while, to varying degrees depending on the Member State, a resumption of growth in healthcare spending since 2000 and the economic slowdown of the EU Member States revealed the limits of this solution. For this reason, microeconomic solutions are being favoured over macroeconomic ones, in the quest for better efficiency in healthcare organisation and building a greater sense of responsibility in the stakeholders.

TRENDS IN HOSPITAL EXPENDITURE PER CAPITA IN SOME EUROPEAN UNION MEMBER STATES
- in US dollars PPP -

	1980	1990	2000	2004
Luxembourg	200	410	1 070	1 690
Austria	na	na	1 050	1 300
Netherlands	410	710	820	1 180[-1]
France	340	680	980	1 070
Germany	320	600	960	1 040[-1]
Italy	na	590	840	1 010
Sweden	na	na	1 160	890
Denmark	570	840	1 270	870
Finland	270	640	660	780
Spain	200	390	430	540
Czech Republic	na	na	330	440[-1]
Hungary	na	300	250	320[-2]
Slovakia	na	na	160	240[-1]

Source: WHO, European health for all database, 2007

Today, European healthcare systems as a whole share a similar context of growing healthcare expenditure, and changes in disease patterns and medical technology. They need to manage increasingly strong demands for "well-being" from their populations. The question arises of how to finance this demand, and the part that public policy and policies of solidarity should play. Most of the EU Member States are faced with the same quandary. They need to reconcile the quest for good health status accessible to all with a mode of financing that does not weigh too heavily on economic growth. In this context, the hospital sector, which plays an important and specific role (admission, care, technology, training), is in transition, and the coming changes hope to reconcile the values common to the EU Member States (access for all to quality healthcare, equity and solidarity) and the constraints specific to each Member State.

NOTES

1 *World Health Statistics 2006*, World Health Organization (WHO).

2 The level of health in these countries is lower than that in other EU Member States. Their under-5 mortality rates are 15 per 1 000 live births for Bulgaria and 20 per 100 live births in Romania.

3 See table in appendix.

4 Also known as "life expectancy free from disability" (LEFD).

5 See Glossary page 198.

6 According to the WHO, the comparability of global data for cancer mortality may be affected by differences between countries in terms of physician training and medical practices, as well as in recording deaths. This observation may be extended to cancer incidence, which may explain in part the differences between countries.

7 European Commission report, *The health status of the European Union: Narrowing the health gap*, Luxembourg, 2003.

8 European Commission Green Paper: *Promoting healthy diets and physical activity: Towards a European strategy for the prevention of overweight, obesity and chronic diseases"*, December 2005.

9 Severe acute respiratory syndrome.

10 See Glossary page 198.

11 European Commission press release, 30 November 2006.

12 *The impact of ageing on public expenditure: projections for the EU-25 Member States on pensions, healthcare, long-term care, education and unemployment transfers, (2004-2050)*, European Commission, 2005.

13 Bulgaria and Romania were not yet EU Member States at the time the projection was made.

14 That is, persons between 15 and 64 years.

15 That is, of working age (15 to 64 years).

16 Grignon Michel and Ulmann Philippe, "*Les dépenses de santé dans l'économie des pays de l'OCDE et la situation des dépenses hospitalières dans ce panorama*" (Healthcare expenditure in the OECD countries economy), Dexia, March 2006.

17 The EU average is weighted according to the population of each Member State.

18 Comparative data for more than fifty countries are available in the WHO database, in US dollars, given as purchasing power parity (see: Notice to the reader, page 9).

19 WHO, 2001, *Health investments for economic development. Report of the Macroeconomics and Health Commission*, Geneva (Switzerland).

20 Grignon Michel and Ulmann Philippe, *op.cit*.

21 This mechanism was designed in the late 1970s by Joel Barnett, Chief Secertary to the Treasury. His goal was to compensate for the increased spending that came from transferring powers to the nations.

22 For more information, see "*Economic Survey of Italy*", Executive Summary, OECD, 2007.

23 Cigarette taxes were raised thrice by 1.2 EUR cents per cigarette (in March and December 2004, and January 2005) to increase social revenue.

24 In France the generalised social contribution is not a social contribution but a tax. It is withheld at source for most incomes, regardless of their nature and their status in terms of social contributions and income tax. Its rate varies according to the type of revenue and the situation of the party involved. The products of generalised social contribution are meant to fund part of Social Security spending on family services, non-contributing services of basic old-age insurance, and part of healthcare insurance spending.

25 The contribution to the reimbursement of social debt is a contribution created in France to absorb the Social Security debt. All physical persons that have their fiscal address in France for income tax purposes are liable for CRDS on their professional income and income substitution benefits.

26 In Hungary, for instance, the solvency of social protection funds is guaranteed by the State budget.

27 As data from this graph were derived from the databases of the OECD, not all European Member States can be represented. Nevertheless, other sources, such as reports written by the WHO regional office for Europe, have made it possible to establish the following classification.

28 In France, three new excess fees were created in 2008: 50 cents per box of medicines and per paramedical procedure, and 2 EUR per health transport. The excess is capped at 50 EUR a year, beyond which they will no longer be applied.

29 *The role of private insurance systems in OECD countries*, 2004, OECD.

30 See Glossary page 198 for the WHO definition.

31 In this country, mainly because of deeply-rooted habits, patients continue to seek treatment from hospital structures for primary healthcare.

32 The CSBM is the central aggregate of healthcare accounts for France. To this effect, its growth in value can be ascribed to a volume effect and a cost effect. In 2005, it represented close to 80% of total healthcare expenditure, the indicator used for international comparisons.

33 This major contribution to growth should be linked in part to the greater weight occupied by the hospital sector in the CSBM compared with other items.

34 Excluding Sweden and Denmark, where, as earlier explained, decreases in hospital spending between 2000 and 2004 reflect the introduction of accounting systems that exclude ambulatory care from hospital spending.

Chapter 2

The modes of governance in the hospital sector

1. ORGANISATION AND REGULATION OF THE HOSPITAL SECTOR

To differentiate health systems, and more specifically their hospital component, one must look at how responsibilities are divided between players and the ways in which health care is organised (definition of rules for organising the system and for regulation and planning) and financed, and how hospital services are managed. In short, the modes of governance in the hospital sector will be the key to understanding the differences. The distribution of responsibilities generally involves three levels: the State and its deconcentrated administrations, local authorities (elected bodies), and the hospitals themselves. Over the past few years, the EU Member States have all more or less engaged in the redistribution of health - and therefore hospital - powers, with the primary goal of becoming more efficient in resource allocation and hospital production. The general trends in the majority of EU Member States can be summed up in two main themes: on one hand, decentralising or deconcentrating regulatory, not to mention funding, powers; and on the other hand, increasing hospital autonomy. The second theme is often overshadowed by the first. Yet the changes in the status of hospitals, in the sense of increased decision-making power, make them real stakeholders in the health system. The role of the private sector in health production as well as recent statutory changes therefore needs to be understood.

A- ALLOCATION OF RESPONSIBILITIES BETWEEN DIFFERENT TERRITORIAL LEVELS

For almost thirty years, most of the EU Member States have been reexamining the different levels of governance for health systems and, consequently, of hospitals. In many cases, the decentralisation or the deconcentration of health powers has been one of the main pillars of reform. Nevertheless, reforms have not involved the same territorial scales, nor have they been carried out in the same manner in the different Member States. In certain cases, powers were deconcentrated to local representatives of the States rather than being decentralised to local authorities. Even when decentralisation occurred, local authorities in some Member States ended up with enough autonomy to define their health priorities and allocate the resources needed to achieve them (Autonomous communities in Spain or Finland's communes). In other Member States, local authorities were only responsible for executing policies that were decided upon at national level.

HIGHLY DIVERSE LOCAL STRUCTURES

The diversity of health systems in the European Union mirrors the heterogeneous nature of administrative and institutional organisation within the Member States. Since the Member State's territorial organisation generally served as the starting point for the decentralisation of health systems (and therefore hospitals), a brief overview is useful here.

TERRITORIAL ORGANISATION IN EUROPE

Federal structure	Three levels of local authorities	Two levels of local authorities	One level of local authorities
Austria	France	Czech Republic	Bulgaria
Belgium	Italy	Denmark	Cyprus
Germany	Poland	Greece	Estonia
	Spain	Hungary	Finland
	United Kingdom*	Ireland	Lithuania
		Latvia	Luxembourg
		Netherlands	Malta
		Portugal**	Slovenia
		Romania	
		Slovakia	
		Sweden	

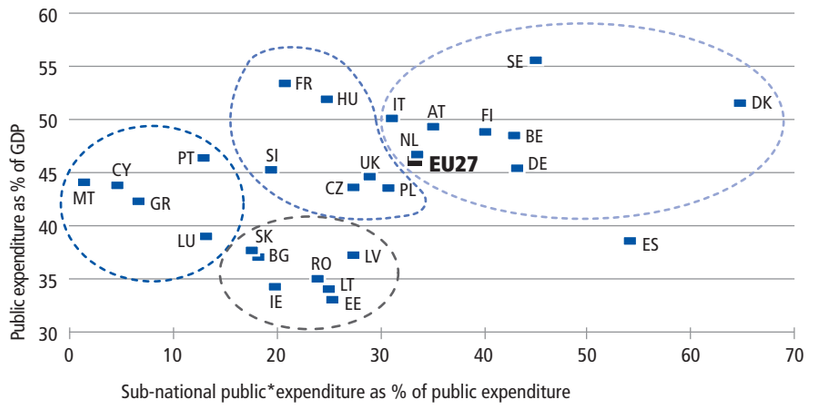
Source: Dexia, Research Department * The third level corresponds to Scotland, Wales and Northern Ireland.
** The second level corresponds to the 2 autonomous regions of Madeira and the Azores.

The role of local authorities in the public sector varies considerably from one country to another. It depends of course on the overall involvement of public powers in general in the economy of each Member State, but also and primarily on the distribution of powers between the different incarnations of these public powers, in the form of the different levels of administration.

The following graph gives an overview of the different EU Member States in terms of the public sector's role in the national economy (measured in terms of public spending as a percentage of GDP) and their degree of decentralisation (measured rapidly using the portion of public spending from infra-state authorities).

One group is composed of 3 federal States (Germany, Austria and Belgium) and highly decentralised countries (Denmark, Finland, Sweden, Italy and the Netherlands). In this group, not only is public spending high in relation to GDP, but more than 30% of it is covered by the infra-national public sector, with the rest paid for by the central government and social administrations. Denmark is the most extreme case, where spending from local authorities represents 62% of public spending, which in turn represents 53% of GDP.

THE SHARE OF THE SUB-NATIONAL PUBLIC SECTOR IN PUBLIC EXPENDITURE IN 2006



Source: based on Eurostat data, November 2007, Dexia, Research Department
For an explanation of acronyms used for each EU Member State, see page 104.
* local authorities and federated bodies

On the opposite side of the spectrum is another group of countries (Malta, Cyprus, Greece, Luxembourg and Portugal) where public participation is more moderate, as is the decentralisation of spending (less than 15% of government expenditure).

Midway can be found almost all of the new Member States, as well as traditionally centralised countries such as France, the United Kingdom and Ireland. In these countries, the local public sector is responsible for 15% to 30% of public spending, with relatively high (France, Hungary, United Kingdom, Poland, Czech Republic, Slovenia) or more moderate (Baltic States, Bulgaria, Romania, Ireland) government spending.

In the latter group, local spending as a percentage of total expenditure tends to be increasing, as most of these Member States have been engaged in a decentralisation process since the 2000s, with the creation of regions in the Czech Republic and Slovakia, or the transfer of powers in Estonia, Romania, Bulgaria, etc.

Finally, note the atypical case of Spain, where local authorities account for 54% of public spending in a backdrop of relatively low government involvement (39% of GDP).

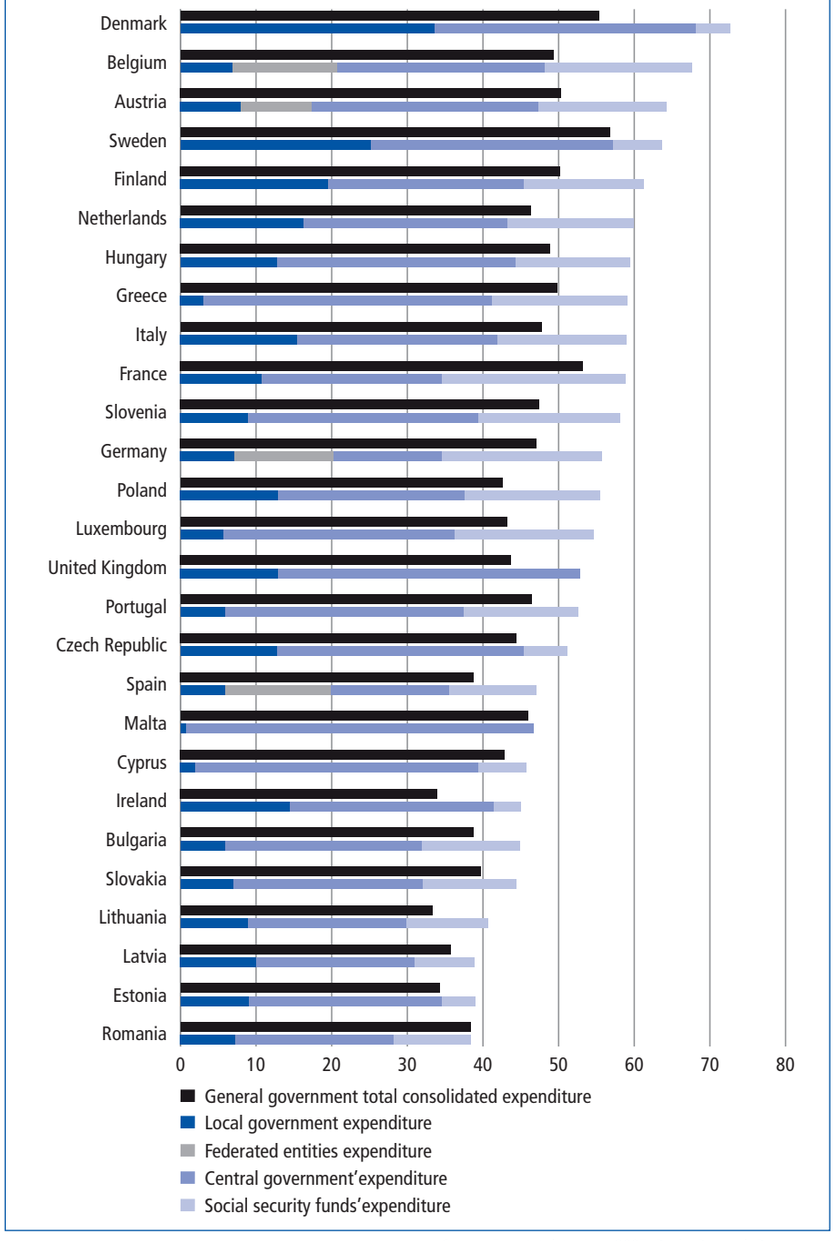
TERRITORIAL DIVISIONS OF EUROPEAN UNION MEMBER STATES

	1st level	2nd level	3rd level
FEDERAL STATES			
Austria	*2 357 Gemeinden*	*9 Länder*	
Belgium	*589 communes*	*10 provinces*	*6 communautés et régions*
Germany	*12 312 Gemeinden*	*323 Kreise*	*16 Länder*
UNITARY STATES			
Bulgaria	*264 obshtini*		
Cyprus	378 (24 municipalities/ 354 communities)		
Czech Republic	6 249 *obec*	*14 kraj*	
Denmark	*98 kommuner*	*5 regioner*	
Estonia	227 (194 *vallad*/ 33 *linnad*)		
Finland	416 *kuntaa*		
France	36 683 *communes*	*100 départements*	*26 régions*
Greece	1034 (914 *demos*/ 120 *koinotita*)	50 *nomarchiakes autodiikisis*	
Hungary	3 175 *települések*	*19 megyék*	
Ireland	114 (*5 city councils, 75 town councils, 5 borough councils, 29 county councils*)	*8 regional authorities*	
Italy	*8 101 comuni*	103 *province*	*20 regioni*
Latvia	*527 (7 republikas pilsetas/53 pilsetas/35 novads/432 pagasts)*	26 *rajons*	
Lithuania	60 *savivaldybe*		
Luxembourg	116 *communes*		
Malta	68 municipalities		
Netherlands	443 *gemeenten*	*12 provincies*	
Poland	2 478 *gminy*	314 *powiaty*	16 *wojewodztwa*
Portugal	308 *municipios*		
Romania	3 173 *autoritătile locale* (2 854 *comune*, 211 *orase et* 108 *municipii*)	*41 judete + Bucarest*	
Slovakia	2 891 *obci*	*8 vyssich uzemnych celkov*	
Slovenia	210 *občine*		
Spain	8 111 *municipios*	*50 provincias*	17 *communidades autonomas*
Sweden	290 *kommuner*	*20 landsting*	
United Kingdom	*434* (238 districts, 33 boroughs, 127 unitary authorities, 36 metropolitan districts)	*34 counties*	3 *devolved nations* (Northern Ireland, Scotland, Wales)

Source: Dexia, Research Department, 2007

Nonetheless, this interpretation of the degree of decentralisation of the Member States according to the place occupied by local administrations in overall public spending must be qualified. Indeed, measuring the spending of a level of administration does not indicate the origin of the resources used for such spending, nor does it give an idea of the leeway that local authorities have in using their spending powers. Resources may come from another level of administration, whether a central or federated State, or social security administration. As such, if the spending of local public administrations is made possible by financial transfers from a higher level of administration, it would not be far-fetched to believe that the degree of autonomy enjoyed by local authorities, and consequently the true degree of decentralisation, is affected. The size of the financial transfers between administrative levels can be seen in the following graph, which represents, for each Member State, the total expenses for each administrative level and the "consolidated" public expenditure, that is, after compensating for different financial cross-flows (or eliminating spending within the public administrative sphere). The difference between these two indicators shows the importance of these financial transfers, without identifying which administrative level is the source or the recipient.

CONSOLIDATED AND NON-CONSOLIDATED PUBLIC EXPENDITURE
- as % of GDP -



Source: Eurostat data, June 2007, Dexia, Research Department

DISTRIBUTION OF HEALTH POWERS: BETWEEN CENTRALISATION, DECONCENTRATION AND DECENTRALISATION

As a general rule, the more a health system is decentralised, the more the hospital system is as well. The concept of "decentralisation" (or "devolution") corresponds to the transfer of powers from the State to local political bodies. Decentralisation covers a wide range of situations in the EU, with varying degrees of transfer of powers to elected infra-national bodies. The concept of "deconcentration", meanwhile, corresponds to the transfer of decisions from the central administration to its local or regional representatives.

DECENTRALISED ORGANISATION OF HOSPITAL CARE MANAGEMENT

• **In the Federal States** (Austria, Belgium and Germany), a significant portion of health powers - and those for hospital matters in particular - is administered by the federated States (*Länder*, Communities) which have a great degree of autonomy from the federal government.

In **Germany**, each *Land* has its own Ministry of Health[1] whose legislative powers must be exercised in coherence with federal law. The Ministry of Health's responsibilities are significant and involve primary and hospital care. The *Länder* are the hospital sector's main regulators. They are responsible for planning availability of hospital care, according to criteria of their choosing, authorise the addition of beds and finance hospital investments, regardless of hospital status. Nonetheless, the federal State's role remains significant in the health sector - its scope of action includes the quality of care, patient rights, and the definition of "rights and duties of the insured". Hospital rates are also set by the federal government, which also dictates the operating principles of hospitals.

• **The Scandinavian countries (Denmark, Finland and Sweden) are traditionally highly decentralised.**

In **Finland**, for instance, which is one of the most decentralised Member States in the European Union, health services have been managed by the country's 416 municipalities since 1972. In the 1990s, reforms increased their decision-making and financial autonomy. The State's financial contribution to health expenditure was decreased. At present, the municipalities finance almost 43% of total health expenditure, while the State covers some 17% to balance the resources between municipalities. The remainder of health expenditure is funded by social contributions, private companies and households. 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. Operating and investment budgets for hospitals

are funded by the municipalities. They finance hospital care by negotiating the prices of services directly with the hospitals.

• **Some countries have recently regionalised their health and hospital systems.** A regionalisation process was carried out progressively in Spain and Italy.

In **Italy,** the already-extensive autonomy of 20 regions in health matters was reinforced with the state-regional agreement of August 2001. They were given sole responsibility for balancing their budget and, consequently, received exclusive legislative powers in health matters. Each region thus develops its own regional health services. On average, close to 80% of Italian regional budgets is allocated to health expenditure. At the national level, the Ministry of Health's main function is to draft a "national health plan", which defines the goals and main thrusts of the health policy for a three-year period, while setting a budget cap and listing criteria for the distribution of funds. The Ministry also determines the "basic levels of assistance" (*Livelli essenziali di assistenza*, *LEA*), that is, a minimum healthcare package common to all regions.

In **Spain,** the process of regionalising health powers to 17 autonomous communities took more than 20 years. Catalonia was the first autonomous community to enjoy such powers, in 1981. Now, each autonomous community manages and finances its health service. Because the transfer of powers was progressive, and because the regions made different choices, the autonomous communities have very heterogeneous hospital systems. The funding mechanisms, which are tax-based, were also decentralised. At present, close to 90% of health expenditure is paid for by the autonomous communities. The State still has an important role nonetheless. According to Article 149 of the Constitution, it ensures the general coordination of the health system, is responsible for policies on medications and legislates in healthcare matters (conditions for healthcare personnel, minimum applicable standards for health establishments, etc.). The State's financial contribution is modest but is likely to grow, as deficits in the health systems show that autonomous communities have difficulty in funding them on their own.

• **In certain central and eastern European countries**, reforms put the decentralisation process in place in the early 1990s, giving decision-making powers to new stakeholders (particularly health professionals and civil society). Generally speaking, the reforms also granted greater autonomy to hospitals. Some reforms have not yet been concluded, while others are more advanced, as in the Czech Republic, Hungary, Latvia, Lithuania, Poland, and Slovakia.

In **Hungary**, decentralisation was one of the main areas of reform, even if the central government remains the primary regulator of hospitals and health systems. The State supervises how the national health insurance fund is administered, can finance health investments through specific grants, regulates healthcare personnel (staff size, training, etc.) and defines the general health (including hospital) policy. The State

also owns and manages most tertiary care hospitals (university hospitals and national institutes). However, ever since local authorities were installed at two levels in 1990, they have become important players in the hospital sector. The municipalities (*települési önkormányzatok*) are owners and now manage primary care facilities, outpatient clinics, and, in larger municipalities, secondary care hospitals. The majority of secondary and tertiary care hospitals are under the counties (*megyék*). They are responsible for the day-to-day management and maintenance of these hospital establishments, as well as for access and planning of hospital care in their territory, although they are subject to territorial healthcare obligations as inscribed in Hungarian law.

In **Poland**, a process of decentralisation was also initiated when the Communist regime collapsed. The health system now hinges on the new, 3-level territorial organisation. The 2 478 communes (*gminy*) are responsible for primary care (local healthcare, diagnostic, and physical therapy centres and emergency services). The 314 departments (*powiaty*) and 16 régions (*wojewodztwa*) own secondary and tertiary care hospital establishments[2]. Regions are responsible for care planning and for drafting the overall health strategy in their territory. They establish healthcare plans (which include the population's health status, the priorities, and the outlines of the policy to be conducted). These plans are then used by the National Health Fund, the system's main source of funding, to plan health and hospital care at the national level. This plan is then approved by the Ministry of Health, which is ultimately responsible for general health policy. As in Hungary, the Ministry of Health is also responsible for the training of professionals and the largest investments, and still administrates some highly specialised establishments.

The Czech Republic reformed its health system in 2003. Prior to this reform, the districts - deconcentrated State bodies - owned and managed hospitals. When districts were abolished in 2003, ownership and management of health establishments was transferred to the 14 regions (*kraj*), which had autonomous powers. Only the university hospitals remained under State supervision. The State still has the power to set the level of medical coverage, continues to influence hospital operations by defining the mechanisms for their remuneration, and plays an important role in hospital investment. Nonetheless, the regions have obtained powers over employment and the planning of care. They make the decision to open or close hospitals, which they can privatise if they wish.

• **The United Kingdom** is made up of four "nations"[3]: England, Wales, Scotland and Northern Ireland. In 1998, a decentralisation process was launched in favour of the four nations, involving mainly the National Health Service (NHS). Today, health systems are managed at the level of the nations:

- in England by the Department of Health;
- in Wales by the NHS Wales Department of the Welsh Assembly Government;
- in Scotland by the Scottish Executive Health Department;
- in Northern Ireland by the Department of Health, Social Services and Public Safety. It is the only nation in the UK where social services and health are handled by the same administrative body.

Each nation is responsible for its expenditure, determines the priorities to be acted upon on its territory, and defines the manner in which the NHS is organised and managed. The hospital system is thus organised differently from one nation to another. Nonetheless, each nation receives its budget from the Treasury. Although they are fully independent in deciding how to use that budget, they have no control over its amount. British tax mechanisms are highly centralised, and the Treasury calculates the amount to be granted to the nations according to the Barnett formula[4].

UNITED KINGDOM: DECENTRALISING (OR DEVOLVING) THE NATIONAL HEALTH SERVICE

Ever since the *National Health Service (NHS)* was decentralised to the four nations of the United Kingdom in 1998, their health systems have taken on different forms. Regulatory powers in the four nations range from being highly deconcentrated, in England and Wales, to being less so, in Scotland and Northern Ireland.

England's NHS is the most deconcentrated of the four health systems in the United Kingdom. It is also the largest in terms of resources, as it covers over 80% of the country's population and thus uses more than 80% of the resources of the UK's NHS. The British Ministry of Health's main mission is to define the general health policy, ensure adherence to standards, and decide which major investments to pursue. Since 2002, the NHS has been managed at the local level by ten *Strategic Health Authorities (SHA)*. These deconcentrated NHS bodies have direct control over the activities of 245 hospital trusts - that is, the public hospitals that were transformed into not-for-profit organisations belonging to the public sector and under the supervision of the NHS - as well as 149 *Primary Care Trusts (PCT)* which comprise doctors, nurses, representatives of social services and patients, coordinate health care, and cover a population of 100 000 persons on average. However, the PCTs are responsible for managing healthcare in their territory. Through the SHA, the NHS makes a financial allocation to each PCT so it can negotiate healthcare contracts with specialists and hospitals. PCTs have extensive powers. They assess the needs of the local population, and plan and coordinate healthcare. PCTs thus manage close to 75% of the budget of the English NHS.

In **Wales**, the health system is similar to the English one. The Ministry defines the general health policy and supervises the NHS as a whole, relying on three devolved bodies to do so - the Regional Offices for North Wales, Mid & West Wales, and South & East Wales. They are tasked with relaying the minister's policy to the regional level. The Regional Offices monitor the activities of 22 Local Health Boards[5], which are equivalent to England's PCTs and receive most of the Welsh NHS's financial resources. Unlike the English PCTs, however, they are only responsible for the purchase and regulation of hospital care. Planning is handled by Secondary Care Commissioning Groupings, which are made up of several Local Health Boards or hospital trusts.

In **Scotland**, the NHS has been organised in a deconcentrated manner since 2004. The Scottish Ministry of Health sets the general policy, drafts the regulatory and financial frameworks, and supervises the devolved Health Boards. These 15 Health Boards manage health service resources at the local level, and plan healthcare and the distribution of care staff. They are also in charge of hospital management. The 2004 reform abolished the PCT and trusts and centralised their powers in the Health Boards.

In **Northern Ireland**[6], the health service, and hospitals in particular, are devolved. The Ministry concerned defines the general policy for health and social services for the entire nation. At the local level, four devolved bodies, the Health and Social Service Boards, are tasked with relaying this policy. They plan and purchase hospital care.

Information gathered from the Eurohealth and UK NHS websites

DECONCENTRATED ORGANISATION OF HOSPITAL CARE MANAGEMENT

As a general rule, Member States adopting this system have created state-supervised agencies to manage the health system at an infra-national level. This is the case in Portugal, France, Greece and Bulgaria. Deconcentration takes different forms from one country to another and depends on national law.

In **France**, public hospitals are *établissements publics de santé*, or public health establishments, and are legal persons governed by public law. They are under the supervisionof the regional hospitalisation agencies (*ARH, agences régionales de l'hospitalisation*) and are under State control. The ARH's mission is to set and implement regional policy for public and private hospital care. An ARH brings together at the regional level the services of the State and of health insurance funds. Agency directors are nominated by a council of ministers and report directly to the Ministry of health. These agencies grant the permits needed for the creation, conversion, or pooling of hospital activities, as well as for the installation of costly equipment as part of the regional health organisation plans (*SROS, schémas régionaux d'organisation sanitaire*). Projects to increase the regionalisation of the health system are currently being tried out. Regional health agencies (*ARS, agences régionales de santé*) should soon be created to replace the ARH. Their scope would then be expanded beyond the hospital sector, and include ambulatory care, the medico-social sector, and, possibly, preventive activities.

Since 1993, in **Portugal**, hospital systems are organised by the five administrative health regions (Norte, Centro, Lisboa, Alentejo and Algarve)[7]. The State regulates and finances the health system as a whole. At the regional level, regional health authorities relay the policy set by the Ministry of Health and divide the resources for their territory. A reform initiated in 2002 authorised the regions to transform the management of certain primary care centres (the entry point for the national health system) by granting them more administrative and financial authority to improve their operations, but the reform has since been abandoned.

In **Greece**, management of the hospital system has been devolved to the 17 DYPEs (regional health administrations) created in 2005, which more or less resembles the former PESY (regional health services). For its respective region, the DYPE draws up a "full system of healthcare services" and coordinates the actions, organisation, and administration of hospitals and clinics. The additional powers of DYPEs compared to the PESYs deal with the inspection of medical equipment, the improvement of relations between hospitals and users, and the computerisation of a single management system. A new reform seeks to bring down the number of regional health administrations from 17 to 7.

In **Bulgaria**, the State draws up healthcare plans based on the regional health maps for each of the 28 regional health administrations, which are devolved State agencies created in the 1990s[8]. At the regional level, these maps assign hospitals and doctors (general practitioners and specialists) based on criteria involving population and access to healthcare. Municipalities have very little power in health matters, even though they own the local hospitals and co-own regional hospitals with the State. Moreover, they provide part of the funding for local hospitals.

CENTRALISED ORGANISATION OF HOSPITAL CARE MANAGEMENT

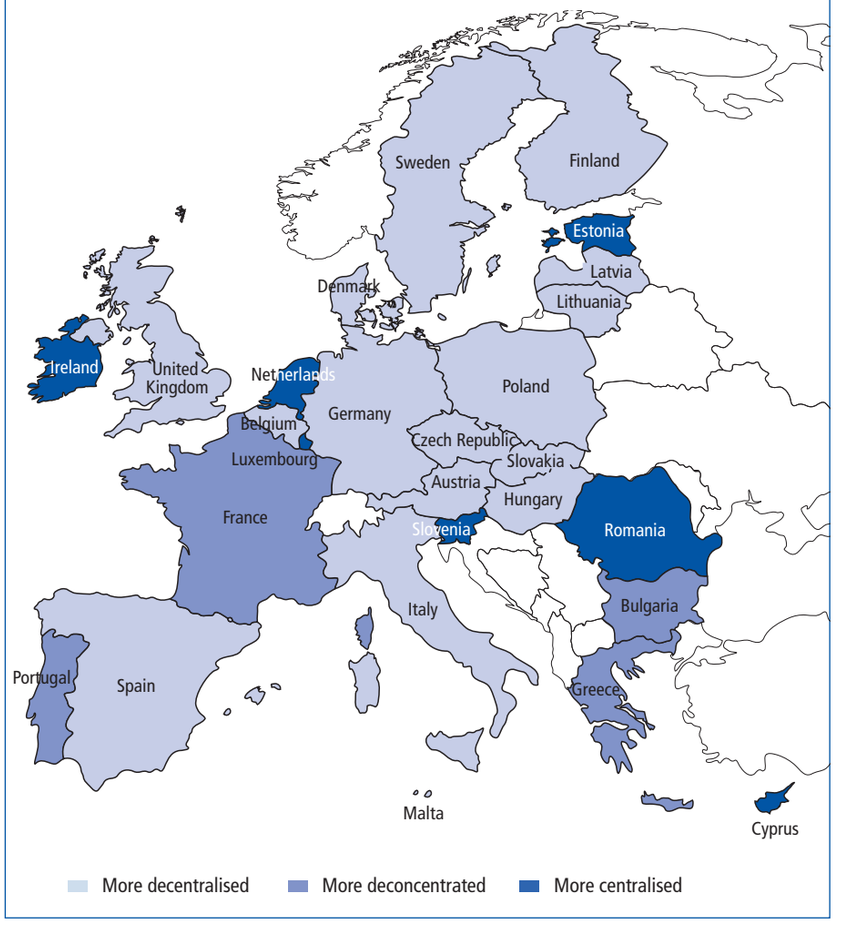
• **Some small Member States** such as Estonia, Luxembourg, Malta and Cyprus have maintained a centralised management of the hospital sector. In **Luxembourg**, the Ministry of Health coordinates both public and private hospital establishments. Grand-Ducal regulations are used to draw up a national hospital plan, and the Ministry updates a national health map which provides a snapshot of the activity and inventory of Luxemburgish hospital establishments (infrastructure, structures, equipment, human resources and organisation). In **Malta**, the health system is exclusively national. The creation of a health division in 1993 consisted primarily of internal reorganisation.

• **Slovenia** and **Romania** are the only countries in central and eastern Europe to have refrained from a policy to decentralise or deconcentrate their health systems. Slovenia's Ministry of Health finances all healthcare institutions and is directly responsible for them.

• In **Ireland**, a recent reform centralised the organisation of the health system. The eight health boards were abolished in January 2005, and at present, the *Health Service Executive (HSE)* centralises management of the country's health system and manages the Ministry of Health's budget on its own. Its mission is to develop the health sector, manage public hospitals and basic healthcare and health services, human resources, communication and finances. It is also responsible for centralising purchases.

• In **the Netherlands**, the ministry of health defines the general health policy and is responsible for regulations on health and healthcare planning. So healthcare regulations and organisation are mainly under the Ministry of Health's responsibility while the provinces and the municipalities only duty is to assess the needs of the population.

TERRITORIAL ORGANISATION OF EUROPEAN HEALTHCARE SYSTEMS IN 2004



TRENDS IN DECENTRALISATION

THE 1970s: MARKING THE START OF DECENTRALISATION

Historically present in some Member States, the decentralisation of health powers starting in the 1970s became one of the major areas of healthcare reform in the majority of EU Member States. During this period, the idea began to take root that decentralisation - or at least deconcentration - of decision-making and management would allow better understanding of local realities and make health systems more responsive. Since the 1990s, this view was shored up by the spread of the "proximity democracy" concept, which viewed the participation of citizen-users in the decision-making process as essential to the elaboration of public policies. This concept, recently introduced in "health democracy", called for increasingly local management of health systems. It should also be noted in addition to these factors that certain policy choices were driven by a desire to break with a centralised past.

Nonetheless, the permanent presence of a central regulator for the health system is seen as essential by all EU Member States. Even in countries with a tradition of decentralisation, such as Sweden, Finland and Denmark, critical prerogatives have been maintained at the level of the central government. In Germany, heightened decentralisation has not hindered the Federal Ministry of Health (*Bundesministerium für Gesundheit, BMG*) from remaining as the regulator of the entire healthcare system and defining its legislative framework. In regionalised countries such as Spain and Italy, the central government has maintained prerogatives that allow it to ensure the equity and coordination of healthcare at a national level[9].

The process of decentralisation has not had the same effect in all Member States. In those with an essentially Beveridge-type design, the decentralisation process is one of the main mechanisms transforming the governance of health systems. The different public administrations are the major players in this sector and take on the roles of financers, buyers, and at times producers of healthcare. Meanwhile, in Member States with a Bismarckian system, decentralising health systems to infra-national levels has had a lesser effect on their governance. In these countries, public intervention in healthcare is more limited, as the governance of health systems was mainly delegated to mutualised funds which are separate from public administrations.

That said, although the decentralisation process differed from one place to another, it nevertheless involved the same number of Beveridge and Bismarckian health systems. The many types of organisation demonstrated that no strict correlation can be made between the organisation of health system governance and the main modes of funding. A health system that draws funding mainly from taxes can be highly decentralised, as evidenced by Finland, or centralised, like Malta. Meanwhile, a health system that is funded mainly by social contributions can be based on a mode of governance that is decentralised (Germany), deconcentrated (France) or centralised (Romania). Moreover, the territorial organisation of health systems does not reflect that of their funding mechanisms. In Latvia, governance of the health system lies in the different local authorities, particularly the municipalities when it comes to secondary care, but funding mechanisms are fully centralised. Taxes levied by the state administration are first pooled in a national health fund before they are allocated to 8 territorial funds that are responsible for funding primary and secondary healthcare. Tertiary and specialised care is directly funded by the national health fund.

HEALTH SYSTEMS IN THE EUROPEAN UNION MEMBER STATES
- multiple modes of organisation -

PRIMARY MODE OF FUNDING / TERRITORIAL ORGANISATION OF THE HEALTH SYSTEM	Taxes	Very mixed	Social contributions
Decentralised	Denmark, Finland, Italy, Latvia, Spain, Sweden, United Kingdom	Austria	Belgium, Czech Republic, Germany, Hungary, Lithuania, Poland, Slovakia
Deconcentrated	Portugal	Bulgaria, Greece	France
Centralised	Cyprus, Ireland, Malta		Estonia, Luxembourg, Netherlands, Romania, Slovenia

Source: Dexia, Research Department

This table is a snapshot of the situation in 2007, and does not integrate the continuous reform processes that may transform the territorial organisation of hospital governance and the funding mechanisms. For instance, in Cyprus, a funding mechanism using social contributions is being introduced with the intent to replace the existing, tax-based mechanism.

RECENT CHANGES TO THE PROCESSES OF DECENTRALISATION

Since the early 2000s, some Member States have called into question certain aspects of decentralised organisation, such as the fragmentation of healthcare services and the risk of inequalities between regions. The decentralisation and deconcentration of management have not always been accompanied by increased efficacy and efficiency. High expectations for equitable access to quality healthcare, as well as rising costs of medical and Information Technology could also contribute to the larger-scale organisation and coordination of hospital care.

Consequently, some Member States have "reconcentrated" their health system to the national level, as is the case of **Ireland**, which created the Health Service Executive (HSE) in 2005. Other countries have not truly "recentralised" but are restructuring the assignment of health powers to other levels. Such is the case in **Denmark**, which increased the health powers of the abolished counties to the 5 newly-created regions in 2007 following a structural reform of its territorial organisation. The "health regions" have elected councils but do not have any fiscal powers. The State and the municipalities finance the health service. Health system financing has been "recentralised", with the State covering 80% of health expenditure by the new regions through subsidies and grants distributed according to socio-economic and demographic criteria. The municipalities finance the remaining 20% of public spending. The powers of the municipalities have been revised[10] and now mainly involve primary care, care for children and the elderly, rehabilitation after hospitalisation and prevention. In **Estonia**, after attempts in the early 1990s to decentralise health system management to the municipalities and counties (which are deconcentrated State bodies), the government backtracked on the reforms a few years later. Because of their limited means, the municipalities and counties turned out to be incapable of assuming their new functions. In 2001, the Ministry of Health reclaimed practically all health powers from them.

Reforms aimed at recentralising powers have also been observed in other EU Member States since the early 2000s. At the same time, greater autonomy has been granted to hospitals. This situation goes to show that the division of powers continues to shift between the three levels that are the State, the local authorities, and the hospitals.

B- DIVERSITY AND DIVERSIFICATION OF HOSPITAL STATUS

Along with decentralisation/recentralisation efforts, especially since the 1990s, reforms in several EU Member States have been aimed at making the management of hospital structures more autonomous from their supervising authorities, either through changing their status or creating new ones. More specifically, new financing mechanisms have become increasingly drawn up on a contractual basis, whereas they depended on hierarchical relations before. This process of hospital "autonomisation" is transforming the concept of hospital governance. While hospitals remain under the supervision of a public administration (autonomy does not mean independence), they have greater leeway in administrative and financial management. In some Member States, such "autonomisation" has led to new organisational forms of healthcare provision that involve public/private combinations (concessions, fee agreements, etc.).

PUBLIC AND PRIVATE HOSPITAL CARE

The role of public and private sectors in the hospital sector itself varies widely from one Member State to another. It is usually the result of the country's socio-political history and consequently covers different situations. Even the definitions for "public" and "private" hospitals are very different, making it difficult to draw a comprehensive and precise table of their relative shares. The only available data come from the WHO and concerns the total number of hospital beds. They do not permit a distinction between short-term activities and other types of hospital care, nor a distinction between for-profit and not-for-profit establishments in the private sector. This last point will be discussed on a case-to-case basis depending on available country data.

Two classifications will be retained to distinguish between hospitals:

- **public status**: the hospital is either a corporate public law body or owned by the State, by local authorities (more and more often) or by a social insurance organism (more rarely).

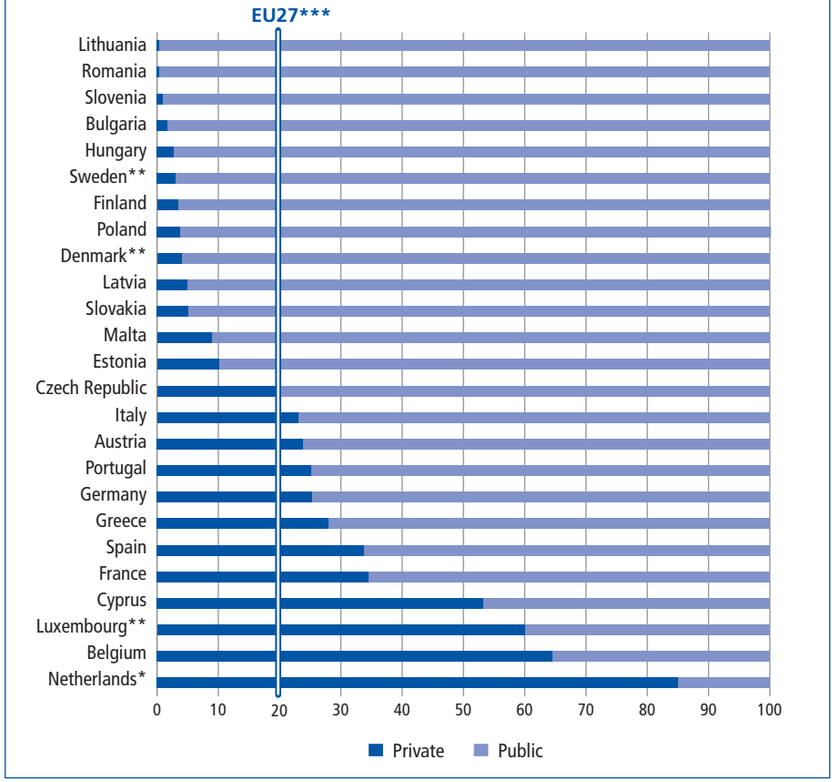
- **private, for-profit or not-for-profit status**: private not-for-profit hospitals belong to legal persons such as associations, foundations or congregations. Private for-profit hospitals can belong to legal as well as to natural persons.

If this classification is used, it can be seen that the public and private sectors have very different shares from one country to another, both in number of beds and number of hospitals.

In some countries such as Lithuania and Denmark, public hospital care is dominant, both in the number of hospitals and beds. In Belgium and the Netherlands, on the other hand, the private sector is much larger. Nonetheless, even though the number of private hospitals is very high in some EU Member States, these structures are often smaller and more specialised - mainly for scheduled healthcare - than public hospitals. There may be more of them, but their capacity in terms of bed number is often smaller.

SHARE OF PUBLIC AND PRIVATE SECTOR, IN NUMBER OF BEDS, IN 2004 (all activities combined)[11]

- % of total number of beds -



Source: WHO, Regional office for Europe, 2007.
*** : excluding United-Kingdom and Ireland
**: country data
*: estimates

- *More than half of the Member States have a very low number of private hospital beds (up to 10% of total):* Bulgaria, Denmark, Estonia, Finland, Hungary, Latvia, Lithuania, Malta, Poland, Romania, Slovakia, Slovenia, Sweden.

Member States whose health systems are traditionally set up around a national health service, such as the three Scandinavian countries, the United Kingdom, Ireland, and Malta, generally have a heavily public hospital sector, both in terms of beds and hospitals. In **Sweden**, the number of private hospitals is very low despite several legislative attempts to authorise a certain degree of privatisation in the hospital sector. Saint Göran Hospital, Sweden's main emergency hospital, was sold to Capio in 1999, but a law enacted the following year prohibited such privatisations. This remains a hot topic, as a new text from May 2007 backtracked on this prohibition. Counties can now entrust the management of entire hospitals or certain services to private undertakings. Taxes still finance medical care provided by such private structures, which have signed contracts with the supervising authority.

The situation is different for the central and eastern European countries. Up to the 1990s, all hospital establishments were owned by the State. As the political and economic transition progressed, the privatisation of part of the health system became one of the thrusts of reform. In some cases, the creation of private establishments was authorised, although this mainly involved primary care and pharmacies. Private hospital care is increasing but still remains very marginal in comparison with the public sector. In Poland, only 10% of hospitals are private, and private hospital beds represent less than 5% of the total number.

- *Member States with private hospital beds totalling 20% to 35% of total:* Austria, Czech Republic, France, Germany, Greece, Italy, Portugal, Spain.

In **Germany**, private hospitals represent almost 34% of all hospital establishments[12], but only 25% of the total bed number. The same holds true for Austria where, for 260 hospitals, almost 36% are private[13], and almost evenly split between not-for-profits (a little over fifty establishments) and for-profits (just under fifty establishments). Total capacity in terms of the number of beds, however, is much lower, with private hospital beds representing less than 24% of the total.

In **France,** the situation is unique because of the strong presence of for-profit private establishments, both in the number of beds and the number of hospitals. The hospital sector grew rapidly between 1940 and 1970. For-profit private hospitals increased in the post-war years, particularly in more profitable specialties (capacity doubled for surgery and trebled for obstetrics). Private sector growth only started slowing down when the first laws (health map law of 1970) on the opening of hospital establishments were enacted. The 1991 law, coupled with the agreement of 6 January 1992 setting a

"quantified national goal", increased the restrictions placed on private establishments (need for authorisation for real estate operations, investments, creation and extensions of private hospital establishments). At present, 34% of French hospital establishments are public, 29% are private not-for-profits, and 37% are private for-profits. Despite the larger number of private establishments, the capacity of public hospitals in terms of number of beds is much higher, representing two-thirds of the total, all activities considered.

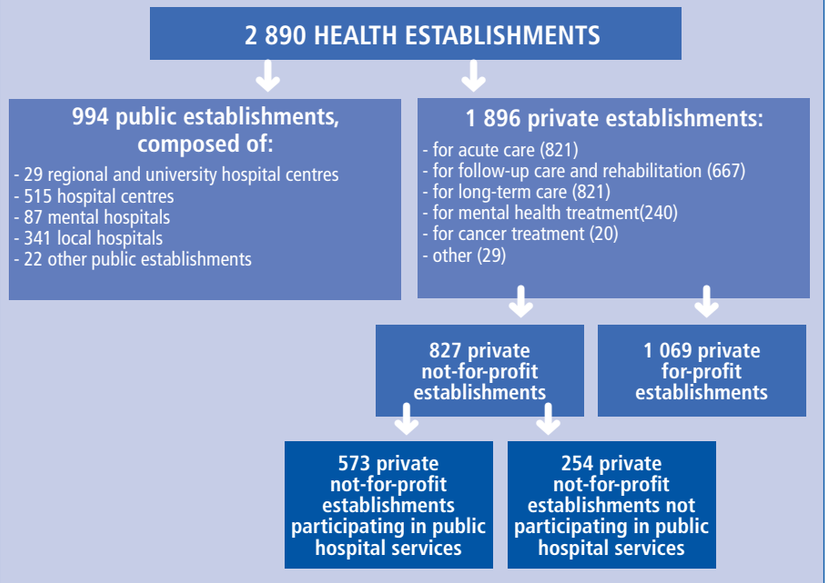
In **Spain**, more than half of all hospitals are private (57%). Nonetheless, most of healthcare is covered by the public sector, which owns larger hospitals. Private sector beds only account for about a third of the total. Within the private sector, hospitals are mainly for profit (40% of all hospitals). Not-for-profit private hospitals occupy a smaller share, representing 17% of the total. This situation is very different from one autonomous community to another - in Catalonia, 68% of hospitals are private, compared with only 30% in Cantabria.

- *Countries with a majority of private hospital beds:* Belgium, Cyprus, Luxembourg, Netherlands.

These 4 are the only Member States where hospital care is offered primarily by the private sector, in terms of both hospitals and beds. **Belgium** has a little over 200 hospitals in all, and 70% belong to the private sector; the number of private sector beds is close to 65%. There is a similar distribution pattern for acute care and specialty hospitals. 64% of acute care hospitals belong to the private sector and close to 36% are public. In **the Netherlands**, 88% of establishments are private not-for-profit hospitals, almost all of the rest are public university hospitals. Commercial private hospitals, which have been long prohibited by the 1971 law on hospital facilities, have recently seen their numbers grow, but most are small structures.

With the exception of some Member States such as France and Spain, where the private sector's share in terms of hospital care capacity has remained relatively stable since the 1980s, the role of the private sector in hospital care is increasing in the European Union. This trend is explained by the construction of new private healthcare establishments, for example in Romania and Bulgaria, and also by changes in the status of certain hospitals. In Sweden and the Czech Republic, local authorities can decide to privatise certain healthcare establishments. Such operations are nevertheless delicate and hotly debated in general, making them fairly rare as a result.

HEALTH ESTABLISHMENTS IN METROPOLITAN FRANCE ACCORDING TO LEGAL STATUS IN 2004



Public hospital services guarantee equal access to healthcare. Establishments that form part of these services must be open to all individuals requiring such services.
Public hospital services are provided by public health establishments as well as some private establishments, almost all of which are not-for-profit. These are referred to as establishments "participating in public hospital service" (PSPH in French), which include for instance cancer centres. On a more marginal level, public hospital services can be provided by private establishments that have concluded concessionary agreements for the execution of such services (only about thirty such agreements have been signed in this context).

Source: SAE 2004 and 2005, administrative data: Ministry of Health, Youth Affairs and Sports

THE EUROPEAN MOSAIC OF HOSPITAL STATUS

FROM PUBLIC TO PRIVATE SPHERES[14]

Hospitals obtain public or private status in different ways, depending on the Member State or even within the same country based on national legislation.

- *Public status*

Traditionally, a public hospital establishment is under the authority of the Ministry of Health or the competent deconcentrated public administration. This traditional model generally grants no autonomy to the hospital in terms of management. The organisation of hospital services, recruitment, and staff remuneration are determined by the surpervising authority. Such establishments are still found in many of the Member States for the management of the most technical types of care at the national level. In Romania, all but the smallest hospitals are public property and under the direct supervision of the central administration. In some Member States, during the different waves of decentralisation, ownership of these establishments was transferred to local authorities (e.g. in Finland, Italy and the Czech Republic), which then became partly responsible for managing the establishment and for investments.

A public hospital may have some degree of autonomy from its supervising authority. In this case, it remains under the responsibility of a public body, but has its own decision-making powers. It is thus a supervised form of autonomy. For instance, in **France**, since the law of 31 December 1970 was passed, hospitals have been "administrative public establishments" considered to be public legal persons. The law of 13 July 1991 confirmed this status and added a specific aspect - hospitals are now "public health establishments." This status bestows significant financial autonomy and they have their own budgets and decision-making structures. Nonetheless, they remain subject to State control. Hospital directors are nominated by the Ministry of Health and budgets must be approved by the regional hospitalisation agency (agence régionale d'hospitalisation, ARH). Public hospitals are also attached to a local authority, and the mayor of the latter presides over the board of directors. The situation is similar in Sweden. While public hospitals are owned by the counties and are under their supervision, they have management autonomy and have had their own budgets since the 1980s.

More recently, and particularly in the new Member States, hospital governance reforms have changed the status of hospitals by granting them some degree of autonomy. In **Poland**, for example, when ownership of establishments was transferred to departmental and regional public authorities, hospitals also became independent administrative bodies. Each establishment is now responsible for its administrative and medical management as well as its funding. In **Estonia** in 2002, a reform transformed hospital management. While public administrations (the State and local authorities) continue to own the establishments, management is governed by private law. The board of directors is responsible for the establishment's budget and management. Public supervision is only exercised through the presence of a representative from the public sector in the board of directors. Public hospital establishments are thus independent when it comes to decisions regarding loans from financial institutions, renovations, and staff recruitment and remuneration. The hospital can also generate revenues, by renting out spaces to private undertakings for example.

The degree of autonomy can also vary between public hospitals in the same country, as is the case in **Italy**. There, public hospitals are managed in two ways. In one case, they are under an *ASL* (*Azienda sanitaria locale*[15]). They are thus under its direct management - for instance, staff are employed and paid by the ASL. The latter is a territorial public establishment, with the status of a legal person, and with autonomy for financial and human resource matters. The hospital under its authority has no autonomy of its own. Meanwhile, another public status that of the *Azienda Ospedaliere*[16] (*AO*), gives the establishment more autonomy. Placed under the supervision of the region, which names the director, the establishment must adhere to the region's hospital policy. AOs are responsible for their budget and, in theory, cannot be at a deficit. The regions decide on the management type for hospital structures, so the prevalence of one status over another varies from one region to another. Lombardy has decided to separate hospitals from ASLs altogether, granting AO status to the vast majority of public hospitals. Other regions have decided to combine both models (Veneto, Tuscany, Emilia-Romagna), and still others have opted for hospitals run only by ASLs (e.g. Abruzzo).

- *Private status*

A hospital's private status depends on whether it belongs to the for-profit or not-for-profit sector, as the means of financing for the private sector as a whole differs from one Member State to another. In France, since the 1991 law creating the unique nature of the hospital sector, all health establishments regardless of status are entitled to public funding. As a general rule, in countries with a social security system such as Belgium or the Netherlands, hospitals conclude contracts with health insurance funds, which finance them. In other countries such as Spain, healthcare provided by the private sector is not reimbursed by public funding, unless the hospital has signed a contract with the autonomous community's health agency to, for instance, absorb waiting lists for the public sector.

Because of its specific nature, healthcare - even private - cannot be exempt from all forms of control. The private sector must meet certain care and safety standards. The supervising authority therefore grants authorisations to operate, mainly in order to ensure that staff is competent and facilities conform to standards.

NEW HOSPITAL STATUS: NEW BOUNDARIES BETWEEN PUBLIC AND PRIVATE

The traditional division between the public and private sector is no longer a reflection of the hospital scene. For one, since the 1990s, the status of public hospitals has been diversified in order to adjust healthcare services to local situations, improve performance and circumvent difficulties in financing. These new statuses are generally influenced by the principles of "new public management" and lead to greater flexibility in hospital management. Hospitals are freed in part from supervision authorities while maintaining public hospital services:

- Hospital care continues to be funded primarily by public funds;
- Standards - for quality and safety in particular - frame professional practices and healthcare services;
- The creation of new structures or the acquisition of major equipment is governed by the same standards as the traditional public sector and is under the supervision of the relevant public administrations for that area. These new statuses make it possible to introduce new management systems.

Multiple statuses therefore exist between public health establishments (managed by public authorities) and private health establishments, allowing more or less autonomy depending on the Member State and the existing legal framework[17]. A few examples follow.

- *Public hospital establishments with greater autonomy*

These healthcare establishments are owned by public authorities but have greater autonomy than traditional ones, because of operating modes that resemble those of the private sector.

In **England**, the 1991 reform transformed public hospitals to trusts, that is, not-for-profit organisations that remain the property of the public sector and under the supervision of the *NHS (National Health Service)* in matters of healthcare pricing and investments. This new status gives them budgetary autonomy from the NHS. The trusts, which numbered 245 in mid-2008, draw up contracts on the type and volume of specialist and hospital care with the 149 *Primary Care Trusts (PCT)* made up of doctors, nurses, representatives of social services and patients, and which coordinate healthcare and cover a population of 100 000 on average. PCTs have some leeway in setting remuneration for their staff and in healthcare delivery. Since 2004, a new status, that of Foundation Trust, grants even greater autonomy to healthcare establishments (in deciding, for instance, to invest in the expansion of health services) and decentralises decision-making centres. The Foundation Trust status describes a group of public hospitals that are legal persons and have financial autonomy. They are independent not-for-profit organisations that answer to local organisations rather than the central government. In addition, these hospital groups are no longer the property of the public administration (local or central), but rather belong to the local population which participates in the Board of Governors. As of mid-2008, Foundation Trust status has been granted to almost 100 of England's 245 trusts.

- *Public hospital establishments whose management is entrusted to a private undertaking*

These establishments belong to public authorities (usually local authorities) but their management is entrusted to private companies (either for-profit or not-for-profit ones).

In **Spain**, the "concession" (*concesión*) system allows a private company to manage a public hospital on a contractual basis. In 2001, for example, management of the biggest public hospital in Madrid was turned over to a private structure. Other examples of private management for public hospitals can be found in other countries, particularly Portugal (see boxed text).

- *Private hospital establishments exercising a public service mission*

The government can sign a contract with a private establishment so that the latter carries out all or part of its activities to fulfil a public service mission. In **Spain**, an autonomous community can draw up a contract with a private health establishment to provide a public health service. In this case, the private hospital receives a budget. This agreement, known as a "*concierto*", helps shorten waiting lists by allowing the private sector to handle cases for the public health service. Such agreements are common in Catalonia, where this type of contract represented more than 44% of its health budget in 2005.

PORTUGAL: CREATING A NEW STATUS FOR PUBLIC HOSPITALS

The current Portuguese health system was set up in the late 1970s according to the rationale of an integrated public system. The national health service (*Serviço Nacional de Saúde - SNS*) is both in charge of health insurance and providing healthcare services.

Since the 1990s, in the wake of budget restrictions and inefficient hospitals, reforms were introduced, particularly for hospital operations and management. The "New Public Management" trend inspired many of the adopted solutions.

In 2002, a series of reforms aimed at improving the quality of public health services without increasing costs, while slowing the growth of healthcare spending, and shortening waiting lists, marked a real departure from the previous healthcare model. The law of November 2002 (known as "*empresarializaçaõ*") created a new legal status granting public hospitals management autonomy from the public authorities and creating company-type governance. This status is that of a limited company with public capital only (shares are held by the State, which can transfer them to local authorities or public undertakings).

As a result of this law, which came into force on 1st January 2003, almost half of all public hospitals became limited companies, known as "*Hospitais SA*", with the State as the sole stakeholder. To allay fears of a privatisation of public hospitals brought on by the new status, the government had to convert the legal status of the "*Hospitais SA*" to public undertakings, the so-called "*Hospitais EPE*", although the applicable management rules inspired by the private sector were not affected.

These hospitals are governed by commercial law and enjoy financial and administrative autonomy, with an independent board of directors that is responsible for results. The government remains responsible for providing capital and healthcare services. New regulations have capped their debt burden at 30% of their capital. Since 2003, the new status has been granted to a growing number of structures, including the biggest Portuguese hospitals such as Lisbon's Santa Maria Hospital or the Santo Antonio hospital in Oporto. Today, no less than some fifty "*Hospitais EPE*" make up part of Portugal's public hospitals, which number about a hundred in all.

2002 reforms also introduced the public-private partnerships (PPP). The reform provided for the construction of 10 hospitals under the PPP framework, 8 of which will replace older establishments and 2 of which will be new ones.

- *Hospital establishments with mixed public-private capital*

In this set-up, hospitals belong to both public authorities and private businesses. This status was developed particularly in Germany and in some of the eastern and central European Member States to address the difficulties of funding investments in the health sector. This model is becoming more popular in Latvia, for instance. Nevertheless, they remain under the supervision of regional health insurance funds, with which they are under contract.

Relations between the public and private sectors are thus in constant flux, changing the usual divides. The two sectors are increasingly called upon to cooperate in producing services. Public hospitals can entrust private companies with some of their prerogatives, as is the case of the Spanish concession (*concesión*) model that allows a private company to manage a public hospital on a contractual basis. A public hospital can also outsource certain non-medical services, such as laundry, or even medical services, as some Austrian hospitals do.

A GEOGRAPHIC ISSUE: CROSS-BORDER HOSPITAL COOPERATION

- *Cross-border cooperation*

In border areas, the desire to structure patient mobility or make use of complementary services is increasingly taking form through cooperation projects. Framework agreements can be drawn up between service providers, healthcare financers or States in order to create a cooperation that organises healthcare provision on both sides of the border.

Such agreements - and more generally, cooperations as a whole - are signed on a case-to-case basis and are growing in number in border areas. Some noteworthy examples are:

- Sweden and Denmark, where health cooperation has been introduced since the Oresund bridge was inaugurated in 2000;
- Denmark and Germany, where Danish cancer patients are allowed to receive treatment in northern Germany, thus bringing them closer to healthcare centres and avoid waiting lists.

The EUREGIO project (Evaluation of Border Regions in the European Union)[18] thus identified more than 300 cross-border health cooperations in the EU, mainly involving training projects, equipment pooling, and prevention of health risks.

• *The cross-border hospital: a new status?*

Since 2001, in the Cerdagne region, which straddles Spanish Catalonia and the French Pyrenees, a new type of establishment is being created. In this isolated plateau, cut into two by the border, French patients do not have easy access to hospital care as the nearest French hospital is located about a hundred kilometres away in Perpignan. To improve patient management, an agreement was initially signed in 2001 between the Perpignan and Puigcerda hospitals to allow the latter's emergency services to handle French patients. After resolving issues stemming from the harmonisation of legal instruments, the first steps for the construction of a hospital structure began in March 2007 and is scheduled to finish in late 2009. It is funded by both Spanish and French funds, and will be managed by a European territorial cooperation grouping, which is an inter-administrative legal instrument drawn up by the European community. The short-term facility will have 50 beds, for medicine, surgery, obstetrics and emergency services. Staff will be French and Spanish.

2. TYPES OF FINANCING FOR HOSPITAL STRUCTURES

Hospitals can draw their financing from direct patient payments or private insurance reimbursements. In almost all of the EU Member States, however, public resources remain the main source of funding, whether they are collected via taxation or social contributions. In broad terms, public resource allocation to hospital establishments follows two main relationship models between financial backers (State/local authorities or health insurance funds) and healthcare producers: the integrated model and the contract model. Today, the contractual approach, which authorises a certain degree of competition between hospitals, is gaining ground. Another trend, also leaning toward greater efficiency, is the increasingly widespread use of "pathology-oriented payment" as a way of remunerating hospitals. It is used in Member States that have adopted a contractual approach as well as those that have maintained an integrated health system. Depending on the set-up of the health system, however, there are striking differences in the rules for the application of this type of payment from one country to another. Reforms in the financing of hospitals are accompanied by questions of how investments in facilities and equipment will be funded, in a context where progress in medical techniques is happening faster and faster. Expenditure for hospital investments often has special funding that is overwhelmingly public in most cases. When public resources are limited, however, sources of funding usually become more diverse, often with recourse to public-private partnerships (PPP).

A- HOSPITAL PAYMENTS

Since the 1980s, reforms in the financing of hospital systems have transformed relations between the healthcare service payment bodies and the providers of such services, as well as the way the providers are paid.

RESOURCE ALLOCATIONS FOR HOSPITALS

Hospitals in the European Union generally get their resources through one of two means of resource allocation: through a contract, or through an integrated health system. In the 1990s, with budget pressures on public finances and "state dirigisme" being called into question, public authorities were spurred into putting forward new market mechanisms, particularly in the health sector. The "new public management" model[19], which first gained a foothold in public administration, later spread to the public hospital sector by changing management types and structures in order to improve efficiency[20].

CHOOSING BETWEEN AN INTEGRATED HEALTH SYSTEM OR CONTRACTS

In most of the EU Member States, authorities closely monitor hospital operating expenses, so that its growth does not weigh too heavily on public funds. Hospital financing depends on two approaches. The first gives public authorities the means to monitor the volume of healthcare and its financing (the integrated approach), while the second is based on a contractual relationship between the hospital establishment and the healthcare financer (contractual approach).

In **integrated healthcare systems**, the same institution or "agency" in economic jargon - most often the local or central government - monitors both the production and financing of healthcare. In such vertical integration systems, medical staff is generally employed and hospitals are funded on the basis of a global budget. This system exists, with significant variations, in public hospitals in Denmark, Italy, Greece and Portugal.

In **the contractual approach**, healthcare producers are directly reimbursed by virtue of a contract drawn up with either the public authorities (or its offshoots) or the insurer. The contract between the two parties specifies the nature and volume of the healthcare services to be provided, and can also set the level and basis for the remuneration of the service provider. This is the method most frequently used by national health services such as those in Ireland or the United Kingdom, as well as by social security systems like the ones in Germany, Belgium, Italy, Luxembourg and the Netherlands. Patient choice is thus limited to healthcare producers that have signed contracts with the financers. In general, this method allows financers to monitor the total level of expenditure in an efficient way. In Germany, operating expenses for hospitals are covered by health insurance funds, and, to a much lesser extent, by patients. The nature, volume and price for the activities of each hospital are negotiated between the hospital and a committee representing all the health insurance funds that provide more than 5% of the hospital's activity. In Luxembourg, each hospital negotiates its operating budget with the Union of Health Insurance Funds, with no intervention from the State.

Finally, some Member States use both types of financing for their hospitals. With decentralised forms of management, local authorities can opt for either of the two systems. This is the case for Spain, Italy and Sweden.

DEVELOPMENT OF LIMITED CONTRACTING

The contractual approach has become more popular in recent years. In some Member States, relationships between healthcare service providers (health establishments) and purchasers of such services (the different paying bodies), which previously relied on an integrated approach, were reformed to add more competition between hospitals.

In **the United Kingdom** (and then in England only after the 1998 devolution), since the reforms provided for in the 1990 NHS and Community Care Act, hospital establishments have been reimbursed directly by virtue of a contract with the Primary Care Trusts (PCT), which purchase the healthcare services they provide. The 28 strategic health authorities, which are devolved bodies of the Ministry of Health, do not act as purchasers, but as supervisors of the PCTs. They give the latter a financial envelope with which to negotiate contracts with specialists and hospitals. PCTs therefore purchase healthcare services for their population from hospital establishments.

In other countries, such as Sweden or Italy, contractualisation is not imposed at the national level. Local authorities decide whether or not to adopt this approach. However, the introduction of this distinction has not always led to real changes. In Sweden, for example, most contracts were signed on the basis of the establishment's customary activity and competition has remained very limited.

In Member States with social security, the distinction between purchasers and services providers already existed, but the purchaser (health insurance) only had a passive role in the reimbursement of care. With these reforms, it has acquired a more strategic role, as it now has the power to negotiate with healthcare providers and pit them against each other. In some of the newer Member States, such as Bulgaria, Estonia or Hungary, mechanisms for concluding contracts were introduced to improve the performance of health systems.

In **the Netherlands**, a reform introduced the principle of double competition as part of the Dekker plan. The reform combines the competition between insurers (public and private) for patients, and the competition between healthcare service providers for insurers that act in their capacity as purchasers of healthcare. Its goal was to increase the efficacy of the management fund and improve the services offered to patients. However, the introduction of free market principles to the funding of health systems carries risks with it, economic (transaction and negotiation costs can be very high and make care more expensive) and even social ones (insurers can choose patients according to health or socio-economic profiles). Finally, these mechanisms for competition require the introduction of a comprehensive legal framework.

It appears, then, that having recourse to pure competition in the healthcare sector is difficult, not to mention inefficient at times. Contractualisation increasingly reflects a negotiation between service providers and purchasers that is supervised by the public authorities.

DEVELOPMENT OF PATHOLOGY-ORIENTED PAYMENTS

There are two ways of setting prices for hospital services, leading to ways of compensating hospitals that will influence the quality of care, efficiency, spending control and equity of the hospital system: **the retrospective payment system and the prospective payment system**. The terms "retrospective" and "prospective" refers to the moment at which the price for a healthcare treatment is determined in relation to the treatment itself.

Generally speaking, starting in the 1980s, retrospective systems, which placed the financial risks on the paying party[21], were gradually abandoned because they encouraged overuse of hospital care and had an inflationary effect. Prospective payment systems thus arose among the Member States of the European Union. The primary method used for this payment scheme is global budgeting. This allows cost compression by defining a spending envelope in advance. Hospital administrators are thus responsible for managing the budget and bearing the risk. There are several methods for establishing this budget, including the past record and the activity reference for the previous year, or negotiations between the hospitals and paying parties. Austria, Belgium, Denmark, France, Luxembourg and Spain have all used prospective payments for all or part of their hospital budgets. While global budgeting has allowed hospital cost control in some countries such as Denmark, it has some drawbacks, such as low incentives for productivity and the risk of creating waiting lists.

RETROSPECTIVE AND PROSPECTIVE PAYMENT SYSTEMS

The retrospective payment system consists of financing hospital care according to their actual observed costs and after they are produced.

The advantage of this type of payment is that it does not limit the healthcare offer, allows a high level of hospital care quality, and encourages the development of medical innovations. However, it allows for limited control of hospital spending and may even raise it.

Procedure-based payment is a type of retrospective payment.

The prospective payment system consists of financing hospital care according to a sum whose amount is based on rates set prior to the actual production of care. The hospital thus receives a payment based on a predefined cost and regardless of its actual costs.

This type of payment encourages hospitals to minimise their production costs and control spending to a certain degree. However, it can lead to patient selection, or quality of care may be neglected in order to limit costs.

Two examples of prospective payment are the global budgets allocated to hospitals, for which total amounts are defined for a year, as well as activity-based remuneration.

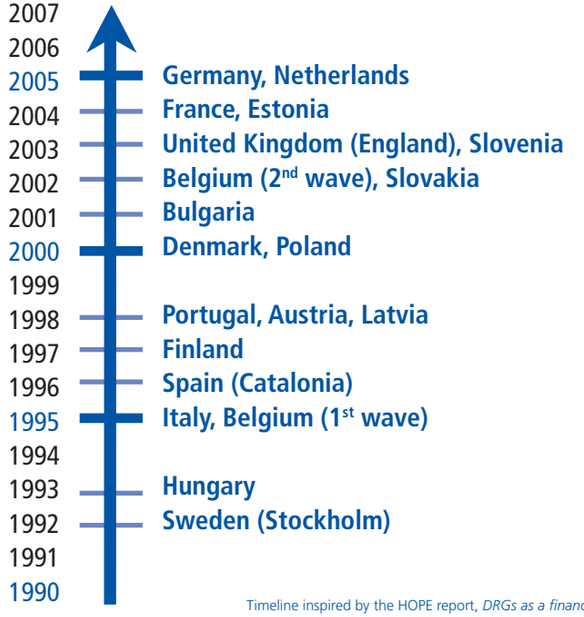
As a result, in the past fifteen years or so, pathology-oriented payment (also known as "payment by case" or "activity-based payment") has become more widespread in Europe, in a bid to combine cost control and better hospital budget and cost management. This mechanism is based on the classification of patient stays according to disease groups, defined according to the similar treatments and financial resources needed for their management. Pathology-oriented payments give the establishments incentives to optimise the use of their "production factors" and minimise patient treatment costs. Several classifications exist, the best-known of which are the pioneering "*Diagnosis-Related Groups" (DRGs)* from the United States.

Within the EU, several pathology-oriented payments are used. These are: the nomenclature for the Nordic countries (*Nord-DRGs*), Australian nomenclature (adopted in a highly modified form in Germany), American nomenclature (in Portugal) or national nomenclatures ("*groupes homogènes de malades"* (*GHM*) in France, "*Diagnose Behandeling Combinatie" (DBC*) in the Netherlands, and "*Healthcare Resource Group" (HRG)* in England).

In many Member States, the state initiated the drive to introduce pathology-oriented payments, which has led in some cases to a form of "centralisation" of some powers in decentralised countries[22]. In Austria, for example, the federal government made the decision with the agreement of the health insurance funds, which co-finance hospitals. In the same way, in Italy, the central government was at the root of this reform and also led its implementation - the project's technical development was conducted by the Ministry of Health, the national institute for health research, and a group of hospitals selected to test and adjust the nomenclature to local settings. During the 1990s, Italian regions only had the power to implement this new mechanism. They now have greater powers and can readjust the rates for DRGs according to their situation. Several DRG versions are currently in use in the country. This shows that a project may be advanced by central governments, but its application can be decentralised to an infra-national level and vary from one community to another within the same country.

As a general rule, tarification only affects part of a hospital's activities, and while its scope differs from one country to another, it is being rolled out gradually everywhere so that there is a smooth transition from the previous modes of financing.

TIMELINE OF PATHOLOGY-ORIENTED PAYMENT IN SOME EU MEMBER STATES



Timeline inspired by the HOPE report, *DRGs as a financial tool*, 2006

- *Member States where pathology-oriented payment was introduced in the 1990s:* Austria, Belgium, Finland, Hungary, Ireland, Italy, Latvia, Lithuania, Portugal, Spain, Sweden.

In **Belgium**, up to 1995, hospitals were paid by procedure and at the going daily rate. A global budget for laboratory and imaging fees rounded out this financing. Starting in 1995, hospital budgets were based on three components: financing according to the type of establishment (capacity, level of specialisation, university status); partial financing according to the number of hospitalisation days and procedures performed; and a flat payment according to activity. Since 1st July 2002, a reform has gradually put pathology-oriented payment in place, mainly in order to improve the transparency and readability of hospital expenditure. Hospital financing is now founded on "justified activities" instead of structural elements such as hospital capacity or level of specialisation. The nomenclature in use is based on the *APR-DRG (All Patient Refined-Diagnosis Related Groups)* system.

In **Hungary**, pathology-oriented payment has been in use since 1993 for hospital and rehabilitation care[23]. Only the costliest medical interventions, such as bone marrow transplants, are not included in the system. The diagnostic classifications used are an adaptation of the DRGs: Homogeneous Disease Groups (HDG). Initially, this new financing mechanism was aimed at encouraging the hospital sector to reorganise and reduce its capacity. Incentives were not strong enough, however, and the number of hospital beds hardly went down. According to this system of financing, the hospital needed to send an accounting of its activity to the healthcare information centre for analysis. This procedure made it possible to determine the hospital's performance in terms of HDGs, and medical insurance would reimburse the hospital according to the rates for these groups. Rates are established nationally every year. In order to contain hospital spending increases tied to pathology-oriented payment, a ceiling for health expenditure is set every year. Nonetheless, since 2004, faced with the inflation of hospital care and the poor regional distribution of healthcare, a new mechanism was introduced to contain, if not reduce, the overly rapid growth in hospital activity. Healthcare providers (hospitals as well as specialist doctors) are now reimbursed in full for activities corresponding to 98% of the previous year's figure, measured according to HDG. The reimbursement rate for activities above this threshold is then degressive.

In **Sweden**, with its strong tradition of local administration, the implementation of pathology-oriented payment was handled at the local level, with little involvement from the state. The use of the Nordic version of DRGs thus varies from county to county:

- for reimbursing the bulk of hospital care;
- for reimbursing a smaller share of hospital care, especially care requiring patient management by two different counties;
- as an instrument for internal hospital management, to know the volume and type of activity of the healthcare establishment;
- not used at all (two counties).

"DRGs AS A FINANCING TOOL"
- HOPE Report (2006) -

HOPE, the European Hospital and Healthcare Federation, has been working since its creation in 1966 on hospital financing issues. A recent study discussed the use of *Diagnosis Related Groups (DRGs)* as a financing tool (which, incidentally, is the report's title). Developed in the United States, DRGs were introduced in the hospital management of many European countries over the last twenty years. The study was carried out to describe their use as a financing tool, and to understand the reasons behind the introduction of DRGs in each of the Member States. It also hoped to reveal any links between the organisation of the health system and the way this new tool was used. To conduct the study, HOPE used a questionnaire that was completed by 14 countries: Austria, Belgium, Denmark, Finland, France, Germany, Italy, Luxembourg, Portugal, Sweden, Spain, Switzerland, the Netherlands, and, for the United Kingdom, England and Wales.

Results of the survey revealed the highly diverse ways in which DRGs are used - a natural result of the diversity of European health systems, which are heavily influenced by the culture and political history of the country. Some do not use DRGs at all, while others make use of them without including the financial aspect. Still others use DRGs as a financing tool to a minor extent, for instance in transferring patients inside the country. This diversity undoubtedly depends on the level on decentralisation for a given Member State (as this conditions the organisation of the health system), the availability of healthcare services, the financing - and thus the mode of application of the DRGs. In countries with a high degree of decentralisation for the health system, the use of DRGs addresses different objectives depending on the community. Even in the Nordic countries, which use a common system called the "Nord-DRGs", there is great variety in their application, because of different policy thrusts and different levels of investment for the development of this tool. It is worth highlighting that even when DRGs are developed in view of a future financing system, the main goal is to ensure the transparency of the system.

In any case, evaluating the true influence of DRGs on the production and organisation of health services appears to be a difficult task. HOPE's study shows that as of now, it is not possible to draw a direct link between the introduction of DRGs and the quality of care or the reduction of waiting lists. This study also highlights the fact that regular adjustment of the mechanisms for DRGs, both at national and regional level, is the key to its success.

- *Countries where pathology-oriented payment was introduced later, in the 2000s:* Bulgaria, Denmark, Estonia, France, Germany, Netherlands, Poland, Romania, Slovakia, Slovenia, United Kingdom.

In **Germany**, hospital financing has greatly changed in the past thirty years. The 1972 law on hospital financing introduced the "dual financing" system[24] and the principle of "full coverage of expenditure". The latter states that regardless of the total, hospital expenditure must be reimbursed in full. Hospital remuneration was based on a daily rate calculated retrospectively by the Länder for each hospital. With successive reforms, hospital remuneration by the insurance funds underwent major changes. In 1985, hospitals switched from a system based on a daily rate to one with flexible prospective budgets. Between 1996 and 2003, although expenditure was financed to a large extent by a global budget, three payment types coexisted: a per diem rate divided into two parts, one for medical expenses and the other for lodging costs; special rates for some procedures that were added on top of the daily rate; and payments per case that were set for certain diagnostics-treatment combinations and which covered all costs associated with the stay. At the same time, in 1998, a new reflection was carried out in order to achieve the successful introduction of pathology-oriented payments for all German hospitals. The Parliament passed a law in late 1999 that gave social partners - the federal hospital organisation and the association of health insurance funds - the task of defining a new type of financing, on the condition that it should be based on a mechanism that already existed abroad and be ready before 30 June 2000. The German version of pathology-oriented payment, which was inspired by the Australian DRG system, was slated for gradual introduction between 2003 and 2007 to finance the operating expenses of hospital services as a whole. The deadline was finally moved to 2009. The rate for each pathology is based on a points system defined at the federal level according to the complexity of the procedure and the gravity of the disease. The value of a point is set by each Land.

In **England**[25], a classification system based on the costs associated with diagnostics has existed since the mid-1990s. At the time, the primary objective of the *HRGs (Health Resource Groups)* that were created was to come up with a better classification of procedures and hospital treatments to improve the management and measurement of hospital activity. Pathology-oriented payment, integrated within the *Payment by Results (PbR)* framework, has been progressively introduced in hospital financing since 2003/2004 and is based on the HRGs, classifying healthcare procedures and matching them to national rates that are set every year. The *PCTs (Primary Care Trusts)* purchase healthcare services and negotiate hospital budgets on the basis of these rates. They can choose their contacts. This system is supposed to encourage healthcare producers to be more efficient and improve the quality of care. At present, Payment by Results involves acute hospital care. Certain services are excluded from the system, such as mental health care, chemotherapy, radiotherapy, ambulance services, etc. Rates for these services depend on local negotiations between the PCT and the hospital structure. Nonetheless, the expansion of HRGs to mental healthcare is under discussion.

In **Bulgaria**, the introduction of pathology-oriented payment took place in 2001, with a tool based on diagnostic groups called "clinical pathways." The roll-out was progressive. In 2001, 158 diagnoses were classified in 30 clinical pathways. Since January 2006, all hospital activities have been included in 299 diagnostic groups and reimbursed according to the rate associated with each group.

In **the Netherlands**, hospital financing reform was more recent, and the new payment mechanism was introduced in January 2005. Prior to this, Dutch hospitals were only paid by an annual flat budget, computed primarily according to the hospital's area in square metres, the size of the population served, the number of employees, beds and admissions, and the length of hospital stays. This budget excluded the financing of procedures carried out by the hospital's specialist physicians, whose payment came from the ambulatory care financing system. Since January 2005, annual budgeting has been gradually replaced by a DRG-related system. This new system, called the *DBC (Diagnose Behandeling Combinative)*, involves all hospitalisation-related costs, including the payment of hospital specialists. Remuneration is made according to the rate associated with a diagnosis. The introduction of this new form of remuneration is intended to improve knowledge of the volume and cost of hospital activities. The transition period from one system to another is slated to end in 2008.

In **Slovakia**, since the creation of health insurance, hospital payments have gone through several reforms. Since January 2002, a pathology-oriented payment system, using a variation of the DRG nomenclature, has been gradually introduced in hospital financing. This classification, which is based on hospital category as well as the specialty that handles the treatment, is accompanied by mechanisms aimed at shortening the average length of hospital stays.

The scope of application of pathology-oriented payment varies from one country to another, with very limited use in places such as Lithuania and Poland but great popularity in France, Germany and Hungary, where it tends to cover the financing of a large part of acute care activities, and even rehabilitation care in Hungary, or psychiatric care as is planned in England.

- *Member States where pathology-oriented payment is being considered:* Cyprus, Czech Republic, Greece, Malta.

As with most of the central and eastern European countries, the forms of hospital financing in **the Czech Republic** have undergone several reforms since the 1990s. Payment by hospital treatment and by date was introduced in 1993 for the hospital sector. This system had several drawbacks. It encouraged an increase in the volume of services offered by the hospital, without providing incentives for reducing hospital stays and thus, hospital spending. Certain specialties such as orthopaedics and ophthalmology were overpriced compared with others, and additional costs in terms of staff in some geographic areas, particularly in Prague, were not taken into account. Given its pitfalls, the system was replaced in 1997 by budgeting that was based on the activity level for the previous year, corrected for inflation. Designed in two parts (a number of points per hospitalisation day, with a corresponding fixed national rate and a global amount for medicines and pharmaceutical products), this budget, which provided little incentive for savings, was complemented in 2001 by a tool to encourage the reduction of average patient stays in order to curb hospital spending. As such, in addition to the annual budget, a sum is now allocated to the hospital according to the number of cases treated and for which a fixed price is assigned. If the volume of cases treated exceeds that of the previous year by more than 1%, the reimbursement rate for these additional cases will be below 100%. This mechanism, still in force, is modified regularly, while awaiting the introduction of a DRG-based financing system that is currently under study.

- *Member State for which this type of payment is not relevant:* Luxembourg

In **Luxembourg**, the hospital payment system has been based on global budgeting since 1995. At that time, to address the rapid and significant increase in hospital costs, the rate-based regime was replaced by provisional global budgets. These are negotiated every year by each hospital with the Union of Health Insurance Funds.

EFFICIENCY AND PATHOLOGY-ORIENTED PAYMENT IN EUROPE

In many cases, one of the major goals of adopting pathology-oriented payment as a financing tool is to improve the efficiency of health establishments. Changes in the productivity of health establishments were used to measure efficiency. Productivity is defined as the ratio between production[26] and the resources needed to achieve it[27]. For example, the ratio between revenue and medical staff is an indicator of work productivity. Note, however, that productivity and efficiency are not identical. Some strategies that can lead to the increase of a productivity may have perverse effects that decrease the efficiency of the system, like patient selection, intentional over-coding of the activity (DRG-creep) or segmentation of stays with no medical justification.

It seems that the introduction of pathology-oriented payment has led to productivity gains in many EU Member States. The reasons for such gains, especially in terms of organisational processes, have been less well-documented, and most references come from the United States. Reorganisations, mergers, absorptions, network creations, reductions in the average length of stays and development of day hospitalisation have been highlighted in several countries[28]. In this context, it should be noted that the introduction of pathology-oriented payment often took place alongside other health reforms and changes in the internal organisation of health establishments. As such, the nature of the relationship between the factors behind productivity gains and hospital financing is generally difficult to identify with precision.

At the European level, Sweden has produced the most literature on the changes in the productivity of health establishments following the introduction of pathology-oriented payment. Some of Sweden's 20 counties were among the first in the early 1990s to adopt this form of hospital financing. 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[29]. 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% of hospitals in terms of performance (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-oriented 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 patients.

Productivity gains for health establishments have also been seen in other European countries[30] in relation to pathology-oriented payment, especially in Italy, Finland, Austria, Portugal, Norway and Switzerland. In Italy, the hospital sector cared for twice as many patients in 1998 than in 1994[31] but spending did not grow at the same rate and this despite a reduction in the number of short-stay beds. No selection bias was noted for less demanding patients.

DIFFERENT FORMS OF HOSPITAL PAYMENTS

	Payment by procedure or by day	Payment by global budget	Payment by pathology
Advantages	- No limitations in the healthcare supply - Medical innovation facilitated by the absence of budget restrictions	- Control of spending	- Few limitations in the healthcare supply - Control of spending (adapted to the level of activity) - Productivity incentives - Increased competition between establishments
Drawbacks	- No spending control: uncontrolled inflation - Incentive to keep patients as long as possible or increase the number of interventions to increase revenue	- Weak productivity incentives - Limits to the healthcare offer: risks of waiting lists - Unfavourable to the reorganisation of the healthcare offer - Problem of equity in sharing of resources - Risk of reduced investment in new technologies to reduce costs in the budget envelope - Creation of «secure» income sources in some establishments	- No incentive to improve the quality of care, or even a risk of poorer quality - Risk of patient selection (avoidance of the most serious cases, multiple or chronic diseases) - In case of ambiguity, risk of attributing stays to the most costly DRGs - Risk of increasing the volume of cases to increase revenue (readmissions)

Source: Dexia, Research Department

B- FUNDING FOR HOSPITAL INVESTMENTS

Many EU Member States have been witnessing a revival in investments after a pause during the 1990s. This situation is even more marked in the countries of central and eastern Europe, where many of the structures built in the 1980s are now obsolete. In all EU Member States, investment decisions are overseen by the public authorities. There is increased diversification in the types of financing and greater recourse to the private sector.

TRADITIONAL PLAYERS

In the majority of EU Member States, special funds are used for investments in public hospitals. Funding is usually provided by the state, local authorities, the hospital itself, or, in many cases, a combination of these. With the enlargement of the European Union in 2004, then in 2007, international players such as the European Union and the World Bank can provide additional funding in some cases with the elaboration of assistance plans.

In Cyprus, Portugal, Ireland, Latvia, Luxembourg, Malta, Slovakia, Slovenia and Romania, the State is primarily responsible for hospital investments. In **Luxembourg**, the State covers up to 80% of assets and real estate investments, with the rest financed by the Union of Health Insurance Funds. In **Latvia**, the decision and financing of investments are centralised by the Minister of Health, which draws up national investment plans with the approval of the Ministry of Economics and Finance.

In the federal States (Austria, Belgium and Germany), this responsibility lies with the federated States. In **Austria**, investments by public and private not-for-profit hospitals are covered essentially by the regional funds. In **Belgium**, the regions finance 60% of investments by public hospitals in the form of subsidies. Nonetheless, the federal government plays an important role as it finances the remaining 40%. In **Germany**, the *Länder* plan and provide most of the financing for the investments of hospital structures, regardless of status. As a general rule, the costliest investments (construction and state-of-the-art medical equipment) are under their full responsibility. Financing for the maintenance and repair of facilities is covered in principle by the health insurance funds, which have included these expenses in the budgets negotiated with the hospitals (and which represent around 1.1% of those budgets). In Italy and Spain, the recently regionalised countries, public hospital investments are decided upon and financed primarily by the regions. In **Spain**, since the transfer of health powers was concluded, the autonomous communities draw up multi-year plans in which they define their priorities for health matters and investments.

Health system reforms in some countries of central and eastern Europe have transferred these powers to local authorities. As a general rule, investment is shared between the local authorities, which own the establishments, and the State, which finances the largest investments. For example, in **the Czech Republic**, the State finances investments for regional and university hospitals, while local authorities cover investments for municipal and district hospitals. In **Hungary**, hospital maintenance and construction are also covered by the local authorities, who own the hospitals. The State also has powers in this area and participates when investment spending is large. For example, in 2004, the State participated in the reconstruction of twelve local and regional hospitals, to the tune of 80 million EUR, in a programme that was partially subsidised by EU aid. In **Poland**, these powers are also shared - the smaller investments, relating to maintenance, are covered by the owners of the establishments, while heavier investments are covered by the State. In **Lithuania**, municipalities were responsible for making decisions on hospital investments in their area until 1998, when difficult economic conditions led the government to take over these powers.

Finally, in some Member States, public hospitals have greater autonomy, and can decide upon and finance their investments. In France and the Netherlands, hospital investment is mainly financed by the hospital budget, either by self-financing or through loans. Public authorities nevertheless monitor such decisions. In **the Netherlands**, hospital investments are financed by loans. The depreciation of investments and interest payments are included in the hospital's operating budget. As per the law on hospital structures, the government still maintains control over investments, which must remain equitably distributed over the country and meet the needs of the population. In **Estonia**, the 2000/2001 reform transferred the financing of investments of to the hospitals but the decision to invest remains under the control of the Ministry of Health. Estonian hospitals were built during the Soviet era and have not received funding to modernise since then, making them quite obsolete. But the resources they are currently provided for renovation are a far cry from their financing needs, estimated by the government to be 880 million EUR. The European Union has thus decided to provide its financial aid to Estonia for the renovation of its hospitals. Between 2004 and 2006, Estonia has received almost 25 million EUR from the European structural funds, which were invested in 5 hospitals. Over the 2007-2013 period, an additional 140 million EUR should be allocated by the EU.

NEW PLAYERS IN INVESTMENT FINANCING

The collaboration between the public and private sector has thrived in recent years with the latter's participation in the funding, construction and maintenance of hospital equipment and buildings in the framework of public-private partnerships (PPP). Such partnerships involved a wide range of operations, but their common point is the sharing of risks between the public sector and the private promoter. The public sector continues to manage hospitals but rents out buildings or equipment to the private entrepreneur. Contracts are generally concluded for periods of twenty-five to thirty years. Three advantages come from such arrangements. They are faster, with deadlines specified in the contract. The parties have the benefit of know-how from the private sector, as the hospital only sets objectives that are met by the constructor using what it views as the most appropriate means. Financial risks are limited, because the hospital pays rent while the private partner is liable for construction costs and any additional costs. However, they also raise some issues, as they are based on legal arrangements with risk-sharing that can be complex at times.

REFORMS IN THE FRENCH HOSPITAL SYSTEM: THE HÔPITAL 2007 AND 2012 GOVERNMENT PLANS

Launched in 2003, the so-called "*Hôpital 2007*" plan was created to achieve hospital modernisation in a few years, from their facilities and equipment to their management and form of financing. Three primary measures marked this first government plan:

- reform in the financing of acute care hospital establishments (public and private): implementation of activity-based tarification (known as "*T2A*");
- renewed hospital investments, pursued by the "Hôpital 2012" plan in 2007;
- new hospital governance.

1. Activity-based tarification (*T2A*)

Activity-based tarification (*T2A*) is not a pure form of prospective financing, as it blends elements of prospective (flat rate based on the type of stay for the clinical activity) and retrospective financing (daily rate for resuscitation and intensive care stays for example). In addition, activities such as teaching and research are financed by an overall allocation.

T2A came into force in 2004 for acute care establishments. Other activities, such as rehabilitation, psychiatry and long-term care are not covered by *T2A* at present and continue to be financed according to the type of reimbursement previously in force (essentially an overall allocation system). A progressive rollout of *T2A* over several years should enable health establishments to adjust their operations, especially their clinical activities, to the new tarification rules.

With *T2A*, each establishment proceeds with a budget projection at the start of the year, based on an estimate of its activity and the revenue that comes from it. Public hospital budgets cannot have more expenditure than revenue, except in extraordinary cases. However, it can record a deficit at the end of the year if its revenue for the year is below its expenditure, due to a decrease in activity, for example. Since 2006, public hospitals and private hospitals participating to public service draw up their budget according to the new budget framework of the provisional status of revenue and expenditure (called "*État prévisionnel de recettes et de dépenses*", *EPRD*) and according to a revamped accounting nomenclature, whose principles are closer to that of the private sector. With the implementation of *T2A* and the adaptation of the budgetary and financial framework, public hospitals are held responsible for their financial management.

2. Unprecedented revival in hospital investments

The two government plans, Hôpital 2007 and 2012, hope to stimulate hospital investment through direct State aid granted to regional hospitalisation agencies (*Agences régionales de l'hospitalisation*, *ARH*) as well as the promotion of innovative investment options, such as design-implementation and public-private partnerships (PPP). The proclaimed goal of each of the plans is to provide 10 billion EUR (in addition to current investments) over the next five years.

The Hôpital 2007 will exceed this target, with close to a thousand operations carried out in this framework. These investments have made it possible to upgrade outdated equipment and operations, as well as speed up hospital reorganisation provided for in the regional health organisation plans (*schémas régionaux d'organisation sanitaire, SROS*) because the eligibility of a project for aid from the plan was dependent on complying with the cooperation and specialisation aspects defined in the *SROS*.

The Hôpital 2012 plan, launched in 2007, is a continuation of the previous one, with three main priorities:

- continuation of the upgrading of establishments to standards (earthquake-proofing, asbestos, electricity, fire-proofing, etc.);
- modernisation of hospital information systems to facilitate the introduction of personal medical records;
- speeding up the update of the healthcare offer. This has to do with pursuing the convergence sought between public and private hospitals in the Hôpital 2007 plan. Emphasis is placed on:
  - support during the reconversion of underemployed surgery sites,
  - pursuing the regrouping and reorganisation of technical platforms.

The Hôpital 2012 plan also integrates a strong multidisciplinary dimension in terms of sustainable development.

3. New hospital governance

New governance is aimed at modernising hospital operations by decompartmentalising operations and involving health practitioners in management. It requires hospitals to reorganise in "activity hubs", whether for clinical, medico-technical or administrative services, and to introduce a contracting system between these hubs and management in exchange for the delegation of certain management powers. Moreover, it modifies administrative organisation by creating a new body, the executive council, and redistributing roles between the decision-making bodies.

The United Kingdom was the first EU Member State to make intensive use of PPP operations for hospital investments. They are also popular in Spain and Portugal, and can go as far as the operation of public hospitals by private enterprises. In **Portugal**, the 2002 reform, in addition to modernising the status of hospitals ("*hospitais EPE*"), provided for recourse to PPPs both for the construction and maintenance of hospitals and the management of clinical activities. In late 2003, 10 new establishments were slated for construction in the framework of PPPs, and 6 others are to follow soon. For the moment, the ongoing PPPs only cover construction, and exclude the management of clinical activities, following difficulties in reaching agreements between private sector operators and the Portuguese government.

This investment financing model has made great inroads in Europe. Germany, France, Italy, Greece, the Netherlands and Romania are either using these tools or adapting their legislation to allow them. In **France**, the ordinance of 4 September 2003 opened the hospital sector to PPPs in the form of a long-term lease (*Bail emphytéotique, BEH*), and the Hôpital 2007 government plan to revive hospital investment has deliberately encouraged the creation of these partnerships. In **Italy**, such operations have been possible since 2002 following an amendment to the Merloni-Quater law. In **Romania**, PPPs were authorised to meet investment needs in the public sector. The hospital sector has taken advantage of this form of financing, for example in Timisoara.

Other countries that have not yet seen these projects should soon open up to such arrangements. Either legislation already allows PPPs for other sectors and is likely to extend it to the health sector, or the legal framework is being modified to allow the existence of public-private partnerships. In **Slovenia**, in 2006, the Ministry of Health decided to turn to a PPP for the construction of a new hospital in the eastern part of the country, in Trbovlje, which should open its doors by 2009.

UNITED KINGDOM: SOME CONTROVERSY OVER PUBLIC-PRIVATE HOSPITAL FINANCING

Private Finance Initiatives (PFI), a specific type of PPP, have existed in the United Kingdom since 1992. The Labour government under Tony Blair then encouraged them starting in 1997. At present, almost 58 hospitals have been built through PPPs and another 30 are being created.

After analysis, the *National Audit Office*[32] *(NAO)* found in 2006 that some hospitals funded by PFIs were facing financial difficulties. According to the *NAO*, the main factors behind such difficulties are as follows:

- **this financial arrangement is ultimately more expensive than conventional funding**, due mainly to added negotiation or contract compliance costs. The increased cost also stems from the fact that the private sector takes out loans at higher interest rates than the public sector. These costs as a whole affect the repayment capacity of hospitals. As the latter are responsible for balancing their budget, they are forced to make cuts in their services, reduce salary costs, or request new subsidies from the public sector.
- **this financing plan does not necessarily guarantee a better quality building**. The National Audit Office has identified several technical deficiencies (inadequate sterility, defective plumbing, etc.).
- **private enterprises have the possibility of refinancing their loans** and taking advantage of lower interest rates, but hospitals do not necessarily benefit from them.
- **PPP contracts, which are often valid for more than thirty years, are not flexible enough.** They are most suited to facilities for which use does not change over time (transport, school, etc.). However, the health sector changes very rapidly. Hospital bed numbers keep going down, new treatments make it possible to turn to ambulatory care, etc.

Although PFI constructions have gone down for the health sector, they remain relevant. Given the need to build new establishments without having an immediate, direct effect on public finances, the Ministry of Health has launched a major construction programme for six new hospitals, financed through PFIs, worth 1.5 billion pounds, and covering the period up to 2010.

Overall, according to the NAO, the greatest advantage of this financing plan is its transparency and efficiency. Less than 10% of works have exceeded their projected construction costs or were delayed. The project to renovate the UK's largest hospital, Saint Barts and The Royal London, was finally signed despite having been questioned in February 2006. The government decided, however, to cut 250 beds from the initial project. Although it remains cautious, the Ministry of Health has thus reaffirmed its faith in such financial arrangements.

NOTES

1 Sometimes combined with another portfolio (social affairs, employment, etc.).

2 According to the principle of subsidiarity, these territorial authorities are responsible for health matters when exercising such powers is beyond the limits of the municipality. For instance, the region is in charge of organising health transport services.

3 In the United Kingdom, these entities are called «nations» or «constituent countries».

4 This mechanism was designed in the late 1970s by Joel Barnett, Chief Secretary to the Treasury, to compensate for the increased spending that came from transferring powers to the nations and to introduce a principle of cross-subsidisation.

5 Local groups of general practitioners.

6 In this nation, the trusts are called «Health and Social Services Trusts». Their number has been cut down to 8 in 2007, and they are not paid per activity.

7 The Azores and Madeira have a special status and have been the object of decentralisation trials.

8 The 28 health administrations cover the 28 Bulgarian regions, which have been devolved from the central powers.

9 In Spain, for instance, the 2003 decree on the Cohesion and Quality of healthcare is the expression of the central government's desire to exercise centralised regulation.

10 So have their numbers, from 271 to 98.

11 Excluding the United Kingdom and Ireland, for which there is no available data. The latest available statistics for the UK date back to 1999 and indicate that private beds account for 4.3% of the total number of beds. Data for Austria and Spain are from 2003.

12 In the case of Germany, the WHO database, counting private hospital beds, only retains beds owned by private for-profit hospitals. Private not-for-profit hospitals, called state-approved ("freigemeinntzig"), are looked upon as public hospitals by WHO. These hospitals make up more than 30% of German hospitals and beds.

13 In Austria, 49% of establishments are strictly public, with 15% belonging to social security (see table page 112), considered by the WHO and other bodies to form part of the public hospital sector.

14 Dr. Jean Perrot, *Contractualisation in the hospital sector*, AIM-HOPE international conference, 20-21 January 2005.

15 Local health enterprise.

16 Hospital enterprise.

17 See McKee Martin and Healy Judith (WHO, 2002) for a classification of hospitals according to proprietorship.

18 Initiated in June 2004, this project was cofinanced by the European Union's public health programme in order to log, analyse and present the different types of cross-border health cooperations in the EU.

19 Created in the United Kingdom in the 1980s, before spreading throughout Europe, «new public management» consists of introducing public authorities to management methods used in the private sector.

20 Efficiency translates to both productivity and yields. An efficient solution is one that uses the least - that is, the cheapest - means. It is not the same as efficacy, which concerns the ability of a solution to attain set goals.

21 That is, the State, local authorities, or health insurance funds. This system does not allow hospital spending to be limited because all activities are reimbursed after they are performed.

22 For more information on pathology-oriented payments in the different EU Member States, please see the HOPE Report: *DRGs as a financing tool*, HOPE, December 2006.

23 The rollout period took place between 1993 and 1997.

24 «Dual financing» refers to the fact that investment spending is covered by the *Länder* while operating expenditure is covered by health insurance funds and patients. For their investments to be eligible, hospitals must be registered on the hospital maps established by the *Länder*.

25 *Eurohealth* (July 2007).

26 For hospitals, the activity of health establishments is generally seen to be its production. It can be expressed in the number of stays or number of days.

27 «Utilised resources» refers to production factors, that is, essentially, work, technical capital, the capital used as well as intermediate consumption.

28 See for instance:
- MEDpac (Medicare payment advisory commission) (2006),
- *School of public administration*, Göteborg University (2005),
- Bazzoli G., Dynan L., Burns L. and Yap C. (2004), *Federal trade commission and the Department of Justice of USA* (2004).

29 The work of Charpentier C. and Samuelson L.A. (1996) and Håkansson S. (2000) can be consulted for the Swedish situation.

30 Refer to the following works:
- for Italy: Linna M. (2000), Aparo U., Lorenzoni L., Da Cas R., Nicolai P., Cristofani G. and Puddu P. (1999) and Louis D.Z., Yuen E.J., Braga M., Cicchetti A., Rabinowitz C., Laine C. and Gonnella J.S. (1999);
- for Austria: Sommersguter-Reichmann M. (2000);
- for Portugal: Dismuke C.E. and Sena V. (1999);
- for Norway: Biorn E., Hagen T.P., Iversen T. and Magnussen J. (2003);
- for Switzerland: Steinmann and Zweifel (2003).

31 Since 1998, there has been a relative stagnation in the number of admitted patients in the Italian hospital sector.

32 The National Audit Office is an equivalent of France's *Cour des comptes*.

ABBREVIATIONS

Acronyms were used for the map of European Union Member States on page 58:

AT: Austria
BE: Belgium
BG: Bulgaria
CY: Cyprus
CZ: Czech Republic
DE: Germany
DK: Denmark
EE: Estonia
ES: Spain
FI: Finland
FR: France
GR: Greece
HU: Hungary
IE: Ireland
IT: Italy
LT: Lithuania
LU: Luxembourg
LV: Latvia
MT: Malta
NL: Netherlands
PL: Poland
PT: Portugal
RO: Romania
SE: Sweden
SI: Slovenia
SK: Slovakia
UK: United Kingdom

Chapter 3

Hospital healthcare: differences and similarities

1. REORGANISATION OF HOSPITAL HEALTHCARE IN EUROPE

Since the 1980s, all EU Member States have worked to restructure their hospital care supply, each at their own pace and deadlines. Using the existing network of hospitals, governments used more or less coercive planning tools to streamline hospital care capacity. Although re-organisational efforts were primarily aimed at addressing the problem of rising health costs, they also made it possible to tailor healthcare services to the population's changing needs, the result mainly of ageing and changes in disease patterns, as well as progress in medical techniques.

A- TERRITORIAL ORGANISATION OF HOSPITAL HEALTHCARE

In all Member States, hospital care is organised on the basis of a country-specific network and scale. The principle behind such organisation is to offer the population equal access to the full range of hospital services in an optimal manner. This requires hospitals to be ranked according to the technical level of their services and, often, their specialties. Planning for hospital services over the territory, as carried out by the State or local authorities, may differ from one country to another, but is aimed at reconciling the need to satisfy the principle of geographic equity with the need to streamline the offer.

THE TERRITORIAL NETWORK

Regardless of their legal status or of their financing, hospitals can be classified according to the care they provide and their ranking within the healthcare system. Traditionally, acute care hospitals can be classified into three categories[1]: tertiary care hospitals, secondary care hospitals and local or community hospitals. At the same time, they can also be classified as general hospitals or specialty hospitals for certain types of acute care (oncology, cardiology, paediatrics, maternity, orthopaedic surgery, etc.) or other activities (mental care, rehabilitation or long term).

A TRADITIONAL THREE-LEVEL HIERARCHY

Local or «community» hospitals are small establishments performing basic diagnostics, minor surgical procedures, and nursing care. In many countries, despite strong local opposition, there is a trend to cut down on these establishments or convert them to rehabilitation and convalescent centres.

Secondary care establishments - referred to as general hospitals - provide more complex treatment that cannot be handled by local hospitals, primary care providers, or community-based specialist doctors. They usually provide surgical, medical, obstetric and paediatric care.

Tertiary care establishments are either regional or national. They are often associated with medical schools and play a key role in the initial training of medical professionals. They have costly equipment and receive patients that are referred by lower-level hospitals. They generally provide advanced cancer treatment, heart surgery, transplants and neurosurgery.

In addition, **specialty hospitals** have also increased in number, reflecting the different medical specialties. They can focus on one or several of these: oncology, cardiology, paediatrics, maternity, orthopaedic surgery, psychiatry, follow-up and rehabilitation care, etc.

In the United Kingdom, Sweden, the Czech Republic and France, for instance, hospital care is organised according to the traditional three-tier hierarchy.

In **the United Kingdom**, public hospitals are classified as regional or supra-regional hospitals, district hospitals, and community hospitals. Referral from a lower-level hospital is necessary for access to a higher-level hospital. At the same time, there are also specialty hospitals (oncology, cardiology, etc.).

In **Sweden**, hospitals are divided into three levels: regional hospitals, which - in addition to tertiary care - provide secondary care to residents of their county; county hospitals; and finally, district hospitals, which offer, at the very least, services in anaesthesia, surgery, internal medicine, and radiology.

In **the Czech Republic**, hospital categories also match the three-tier hierarchy for healthcare. Regional hospitals offer tertiary care, district hospitals specialise in secondary care, and, at the municipal level, hospitals handle initial patient management (surgery, internal medicine, paediatrics, and obstetrics and gynaecology).

In **France**, several types of hospitals address the population's needs over the entire territory. Among the public establishments, the regional hospital centres (*"centres hospitaliers régionaux"*) handle regional needs owing to their highly technical level. Almost all of these establishments have concluded an agreement with a medical school, thus becoming university hospital centres (*"centres hospitaliers universitaires"*). At the second level, hospital centres (*"centres hospitaliers"*) provide a range of acute care treatments in medicine, surgery, and obstetrics and gynaecology, as well as medium and long stay care. Local hospitals (*"hôpitaux locaux"*) provide basic medical care. They are generally not highly developed (for internal medicine as well as medium and long stays) and often call on the services of self-employed general practitioners. It should be noted that private for-profit and not-for-profit establishments generally do not fall within the bounds of this classification which is reserved for public health establishments. Some of them specialise in certain activities, such as oncology, surgery, gynaecology, or follow-up and rehabilitation care.

LESS COMMON TWO-TIER HIERARCHY

A two-tier hierarchy is also used in several countries. This is the case for Denmark, Spain, Hungary, Ireland, Luxembourg, the Netherlands, and Portugal. In some cases, the classification is similar to the three-level form, with secondary and tertiary care hospitals combined into a single level[2].

In **Hungary**, the hospital system's organisation was modified by the law on streamlining hospital capacity, enacted in late 2006. Previously, the hospital system was organised into three levels. Now, two principal levels structure hospital care. This law created around forty "principal hospitals" to manage the most seriously ill patients, while the rest of the hospitals became "territorial hospitals" offering a wide range of medical treatments.

In **Luxembourg**, hospitals are classified according to the number of beds and services authorised. A two-tier system is also used - local hospitals and general hospitals, with, in addition to this classification, the existence of specialty hospitals. The local hospitals have less than 175 acute care beds. They may have a polyclinic and provide basic medical and medico-technical services to manage patients with diseases that require neither special services nor equipment nor intensive care structures. General hospitals, meanwhile, have more than 175 acute care beds and cover a population of some 60 000 individuals. A general hospital may have the full range of hospital services, with the exception of national services, which are only available in specialty hospitals. Each hospital region[3] has at least one hospital like this. Specialty hospitals are single-discipline establishments, and are qualified as "national" when they have the country's only service for a given discipline (such as cardiac surgery), or, in other cases, "special" (maternity hospitals, for example).

In **the Netherlands**, the hospital sector is organised around the distinction between "university" and "non-university" hospitals. The latter are unique in that they are composed of both general and specialty hospitals.

In a number of central and eastern European countries, hospitals are classified according to the hospital services they provide. As a general rule, the first hospital level is composed of small rural structures that provide primary care. There are many such establishments, but they are usually poorly equipped. Secondary and tertiary care is provided by hospitals that generally practise a single specialty. They are located in the largest cities and towns. For example, in **Lithuania**, "general hospitals" are small municipal or district hospitals. "Specialty hospitals" providing tertiary care focus on a specialty (tuberculosis, infectious disease, oncology, psychiatry or rehabilitation). This way of organising the hospital system often leads to significant fragmentation. In **Slovakia**, hospital hierarchy is determined by a territorial rationale, but hospitals are organised into four categories. "Type I hospitals" offer treatment in internal medicine, paediatrics, gynaecology and emergency care, and cover a population size of between 30 000 to 50 000 persons. "Type II hospitals" provide tertiary care to populations of 150 000 to 200 000 persons. "Type III hospitals" provide specialised tertiary care, while "university hospitals" provide the costliest types of care. The latter two do so at a national level.

WAYS OF LISTING HOSPITALS IN AUSTRIA

In Austria, there are four main ways of classifying hospitals: according to their activity category, size, status, and owner.

DISTRIBUTION OF THE AUSTRIAN HOSPITAL SECTOR
- in 2003 -

	number of hospitals	as % of number of hospitals	as % of number of beds
HOSPITAL CATEGORIES	**Staff**	**%**	**%**
general hospitals	116	42.6	63.1
specialty hospitals	94	34.6	21.5
long-term care hospitals (convalescence, chronic disease, etc.)	62	22.8	15.4
TOTAL	272	100.0	100.0
HOSPITAL SIZE	**Staff**	**%**	**%**
< 200 beds	167	61.4	26.3
200-499 beds	75	27.6	31.7
500-999 beds	21	7.7	22.7
> 1 000 beds	9	3.3	19.3
TOTAL	272	100.0	100.0
HOSPITAL STATUS	**Staff**	**%**	**%**
public	133	48.9	67.7
belonging to social security	40	14.7	8.5
private not-for-profit	52	19.1	17.5
private	47	17.3	6.3
TOTAL	272	100.0	100.0
ESTABLISHMENT OWNER	**Staff**	**%**	**%**
federal government	10	3.7	0.8
länder and their agencies	89	32.7	52.3
local authorities and their associations	34	12.5	14.5
various social insurance systems	40	14.7	8.5
religious congregations	42	15.4	16.1
associations and foundations	10	3.7	1.5
individuals or private enterprises	47	17.3	6.3
TOTAL	272	100.0	100.0

Source: European Observatory on Health Systems and Policies, 2006

HOSPITAL PLANNING

To ensure that the entire population has access to hospital care that is adapted to its needs, the number and distribution of hospital establishments participating in a national public health mission are, in general, set out in a plan drawn up by public authorities, either at the central level by the Ministry of Health or at an infra-national level or by health insurance bodies, depending on the organisation of the health system and its level of decentralisation. Decisions on the volume of care offered, the type of care, and the amount of infrastructure are generally based on the local health status as well as estimated needs. European Member States have all introduced regulatory mechanisms aimed at tailoring the supply of care to different local contexts, and therefore ensuring geographic equity in terms of access to health care. This framework for hospital care is increasingly being used not only to ensure geographic equity over the national territory, but also to guarantee the quality of care throughout the country. In Luxembourg, planning is associated with monitoring of the quality of care.

Hospital planning may be handled by the central government, as is the case in Luxembourg, Cyprus, Malta, Estonia and Ireland. In **Luxembourg**, the plan drafted by the Ministry of Health involves the entire hospital sector, regardless of hospital status. The Ministry draws up a health map that summarises the needs of the population, particularly in terms of establishments, hospital services, and costly equipment. The Ministry of Health bases decisions to renew operating licences for hospitals on this health map. Authorisations are valid for a five-year period.

Countries with decentralised health systems rely on infra-national levels to plan the hospital supply. In Germany, for example, this is carried out by the *Land* which decides on the distribution and authorisation of hospital services in the territory after studying the opinions of health insurance funds. In Finland, such planning is even more decentralised, and is conducted at hospital district level.

Member States that have deconcentrated their health systems have seen the planning fall on the shoulders of deconcentrated administrative bodies, as is the case in France, Bulgaria, Greece and Portugal. In **France**, hospital planning is carried out at regional level. Ever since the ordinance of 4 September 2003, which simplified planning tools, the regional health organisation plan ("*schéma régional d'organisation sanitaire*", *SROS*) is the only planning tool, and all authorisations are now granted by the regional hospitalisation agencies ("*agences régionales de l'hospitalisation*, *ARH*"). The *SROS* distributes infrastructure at the regional level, according to the health needs perceived from epidemiological data. The appendix to the *SROS*, in particular, defines the quantified objectives for different activities in each territory, as well as the groupings or cooperation needed to achieve the *SROS*. Increasingly, the *SROS* includes goals for the improvement of healthcare quality and accessibility and the enhanced efficiency of health

system organisation. In **the Netherlands**, hospital planning is based on the law relating to hospital equipment (*Wet Ziekenhuis Voorzieningen* law) which transferred the task of evaluating needs in hospital matters and drafting local hospital care to the provincial authorities. These plans, however, must be approved by the Ministry of Health.

In the majority of Member States, hospital planning is also an instrument for the economic regulation of the hospital sector. It has made the implementation of cost reduction - or at least control - policies in this sector through the streamlining of admission capacity, mainly by emphasising alternatives to hospitalisation. As such, it has been the vector for a more rational hospital sector. In Belgium, for instance, a planning system was introduced in 1973 to address the capacity surplus and tailor hospital care provision to the health needs of the population.

Moreover, access to hospital care as well as the quality of the service can vary within the same territory. While planning seeks to regulate and adapt hospital care to the needs of the hospital's area of influence, territorial inequalities often persist in the Member States because of different historical and local backgrounds.

B- STREAMLINING HOSPITAL CAPACITIES

Since the 1980s, one of the main lines of action taken by the EU Member States in their quest to control healthcare spending has consisted of streamlining hospital capacity. The policy of streamlining healthcare provision has often relied on the planning tools mentioned previously, and has consisted of reducing the density of acute care beds (more or less drastically, depending on the Member State) without affecting the number of establishments on one hand, and developing alternatives to full hospitalisation - such as home or day hospitalisation - as well as structures for rehabilitation or long-term care on the other hand. The policy's efforts are visible. On average, over the 27 EU countries, the number of acute care beds per thousand inhabitants has gone down by a third, from 6.0 to 4.1 between 1980 and 2004. Meanwhile, the average length of stay in acute care has almost halved, from 11.1 to 6.8 days over the same period. The simultaneous nature of these trends is noteworthy. Such trends happened in all EU Member States, at different paces. In some of these countries, the streamlining of hospital capacity is still ongoing.

TRENDS IN HOSPITAL AND BED DENSITY

Comparing hospital services of the EU Member States is a complex task. It consists of assessing the existing differences in terms of healthcare organisation, diseases, and resources used to treat them. This analysis of hospital care services is based essentially on an indicator - the bed - which is a relatively crude unit of measure. The same importance is given to beds found in highly specialised services and to general medicine or long-term care beds. It does not reflect technical capacity, staff size, or staff qualifications. Moreover, it only defines admitting capacity for full hospitalisation (that is, a hospital stay that is at least overnight). Admission capacities in alternatives to full hospitalisation (generally defined by spaces or slots) are not analysed, as data are uniformly available in only a handful of the 27 EU Member States. It would nonetheless be useful to analyse them given the development in many countries of ambulatory management for hospitalised patients. That said, the "bed" still reflects the transformation of proposed hospital care services, and is the only available indicator for international comparisons.

DROPPING NUMBERS OF ACUTE CARE BEDS

An initial comparative approach, made possible by the use of data from the WHO Regional Office for Europe, reveals that the number of hospital beds per thousand inhabitants is highest in Germany, the Czech Republic and Slovakia, with more than six beds per thousand. At the bottom of the list are Sweden, Finland and Spain, with less than three beds per thousand inhabitants.

Since the 1980s, admitting capacity for acute hospital care has been going down in most of the EU Member States, both in terms of the number of beds and bed density for the population. This trend has been observed in the eastern and central European countries only since the 1990s, after the political transition and owing to political and economic pressures. Consequently, in the 27 EU Member States, the number of beds per thousand inhabitants went from an average of 6 in 1980 to a little above 4 in 2004[4]. In **Cyprus**, the decrease in the "beds per 1 000 inhabitants" ratio is a singular result of a marked increase in population, as the number of acute care beds actually increased by 13% over this period with the construction of new hospitals. Although all EU Member States have seen the number of acute care beds go down in relation to the population, changes have not had the same scope or pace, nor did they take place at the same time.

Germany has the highest acute care capacity among the EU countries, both in terms of establishments and bed numbers. In 2004, despite a sharp decrease, Germany still had 6.4 acute care beds per thousand inhabitants, compared with the EU average of 4.1 beds. This situation stems from a financing system that for too long did little to encourage healthcare spending control. The 1972 law on hospital financing, with its principle of "full coverage of expenditure", actually spurred the construction of a large number of healthcare establishments and the opening up of many beds[5]. Since 1992, the number of establishments and the admitting capacity of the acute care hospital network have been progressively decreasing, owing to technological advances that make shorter hospital stays possible as well as policies aimed at controlling hospital spending. The withdrawal of the principle of "full coverage of expenditure" in 1993 and the introduction

of fixed budgets as a financing method thereby prodded hospitals to streamline their provision of acute care. In tandem, a policy authorising the development of ambulatory care in hospitals also led the latter to reduce their admitting capacity in terms of bed numbers. The number of acute care beds thus fell by 18% between 1992 and 2004, from almost 647 000 beds to 531 000 beds. These different reorganisations initially involved the hospital system of the former GDR, which had to adjust to the standards of West Germany both in terms of infrastructure and planning.

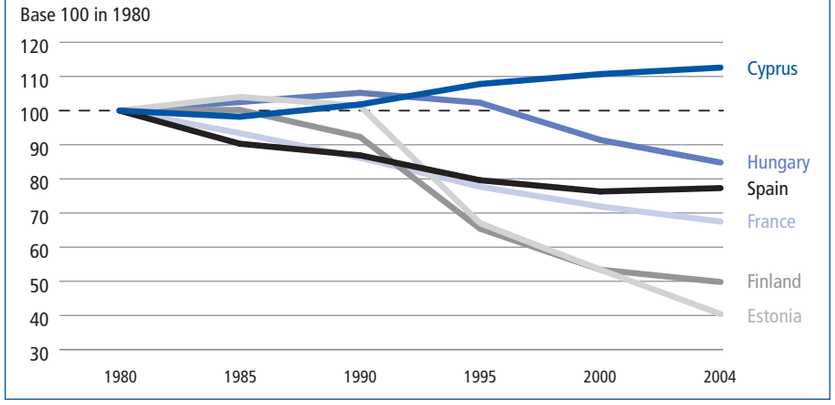
NUMBER OF ACUTE CARE BEDS IN THE 27 EU MEMBER STATES
- per thousand inhabitants -

	1980	1990	2000	2004
Germany	na	8.3[+1]	6.8	6.4
Czech Republic	8.6	8.1	6.3	6.2
Slovakia	na	7.4	6.9	6.1
Austria	na	7.0	6.2	6.0[-1]
Bulgaria	na	na	7.5[-4]	5.9.
Hungary	6.6	7.1	6.3	5.9
Lithuania	na	9.7[+2]	6.7	5.5
Latvia	na	na	6.1	5.4
Luxembourg	7.5	7.0	5.7	5.1
Belgium	5.5	4.9	5.1	4.8
Poland	5.6	6.3	5.1	4.7[-2]
Romania	na	7.0	5.4	4.4
Estonia	9.6	9.2	5.5	4.3
EU27	**6.0**	**5.4**	**4.5**	**4.1**
Slovenia	5.8	5.1	4.5	3.9
Cyprus	5.1	4.5	4.1	3.9
Greece	4.6	3.9	3.8	3.8
France	6.2	5.1	4.1	3.7
Italy	7.5	6.0	4.1	3.5
Denmark	5.3	4.2	3.5	3.1
Portugal	4.1	3.6	3.3	3.1
Netherlands	5.2	4.0	3.2	3.1
Malta	na	na	3.8	3.0
Ireland	4.3	3.3	3.0	2.9
Spain	4.0	3.3	2.8	2.7[-1]
Finland	4.9	4.3	2.4	2.2
Sweden	5.1	4.1	2.4	2.2
United Kingdom	3.5	2.7	2.4[-2]	na

Source: WHO, Regional office for Europe, 2007

Another example is **Finland**, and the Scandinavian countries in general. Despite the already low density of acute care beds in the 1980s (just under 5% compared with an EU average of 6%), it drastically fell in the 1990s following an extensive reorganisation of acute hospital care services. 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% in a short time, from 21 700 acute care beds in 1990 to 15 300 in 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 latter[6]. Nonetheless, problems with the 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. Similar changes took place in Sweden and, to a lesser degree, in Denmark.

TRENDS IN ACUTE CARE BED NUMBERS IN SEVERAL EU MEMBER STATES
- 1980 – 2004 -



Source: WHO, Regional Office for Europe, 2007

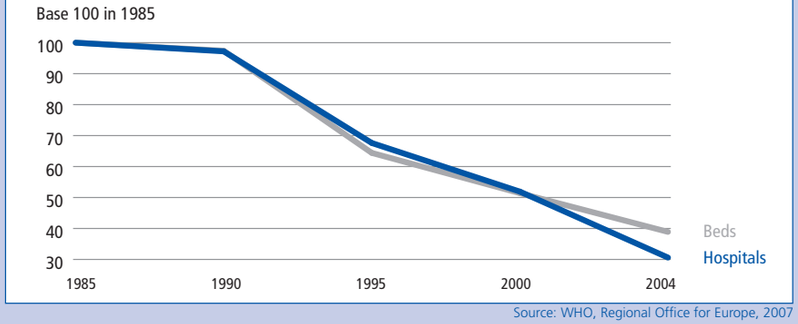
The central and eastern European countries set themselves apart from other Member States with their higher average bed density, a heritage of their Semashko past. The Czech Republic, Slovakia and Hungary had around 6 beds per thousand inhabitants in 2004, compared with an average of 4 beds for the EU. In these countries, in the early 1990s, the hospital sector - strongly influenced by the Semashko model - were oversized and characterised by surplus hospital care provision. The economic crisis during the political transition period, coupled with the oversized hospital care offer, triggered reorganisation policies for the hospital sector in the 1990s. Such policies were carried out at different paces. Estonia managed to reorganise its hospital sector rapidly, but **Hungary** encountered more difficulties. Political opposition to hospital reorganisation prevented a significant reduction in acute care hospital beds, despite numerous decentralisation

policies or the introduction of new modes of activity-based payment in the early 1990s. The number of acute care beds went down by only 12% in ten years or so. The reduction of hospital capacity is still a hot topic. A new programme to cut the number of beds was launched in late 2006, and the law intends to close almost 10% of beds in 2007 and optimise long-term care. To encourage this hospital reorganisation, structural reform is supported by financial incentives. As such, for a limited time, an extraordinary financial grant will be made to hospitals according to the number of acute care beds that are closed or converted to long-term care beds.

ESTONIA: STREAMLINING THE PROVISION OF HOSPITAL CARE

Like the majority of hospital systems that were a legacy of the Soviet Union, the Estonian hospital network was, up to the 1990s, characterised by a surplus capacity for hospital care. In 1980, the number of acute care beds per thousand inhabitants (close to 10%) was the highest compared to the present 27 EU Member States and far above the EU average of 6%. The radical reforms conducted over the past fifteen years have transformed the hospital setting.
In the 1990s, health sector reforms essentially involved primary care with liberalisation of this sector, as well as the financing of health expenditure with the introduction of social insurance based on work remuneration in 1991. Although the hospital sector was not at the core of these reforms, it nevertheless went through an upheaval, at the very least in terms of the healthcare network's organisation. In 1994, the law on the organisation of healthcare services introduced an authorisation system for acute care provision. The new requirements for authorisation to provide hospital services led to a very rapid drop in the number of acute care beds. Many small hospitals lost their authorisation to provide acute care. This change was accompanied by the closure of acute care hospitals, whose numbers fell by almost half between 1990 and 2000, from 105 to 56. Generally speaking, small hospitals were converted into retirement or care homes.

EVOLUTION IN NUMBER OF BEDS AND HOSPITALS IN ESTONIA
-1985 – 2004 -



Source: WHO, Regional Office for Europe, 2007

In 2000, the desire to restructure the hospital sector was reaffirmed in the «2015 Hospital Plan». The goal of the new programme was to reduce capacity for acute hospital care and improve hospital efficiency. According to the plan's objectives, the number of acute care hospitals should be down to 21 by 2015 (a drop of over 60% compared with 2000) and the number of acute care beds should be around 2 per thousand inhabitants. The plan is also aimed at encouraging the reorganisation of hospital operations and seeks to reach an 80% bed occupancy rate (compared with 70% at present) and an average length of stay of 4.5 days.
In total, between 1990 and 2004, Estonia saw the steepest drop in the number of acute care beds among the EU countries, with the closure of more than 60% of these. At the same time, hospital activity went through the following changes: average length of stay went down by some 8 days (from 14.3 to 6.2 days) and admission rates (ratio between the number of hospital stays and the number of inhabitants) remained highly stable.

LESS MARKED REDUCTION IN HOSPITAL DENSITY

The reduction of bed numbers generally happens through the closure of acute care hospitals. Although data is not as complete as for previous comparisons[7], it can still be noted that the downward trend in hospital numbers involves the great majority of Member States - at times in spectacular fashion, as in Lithuania and Estonia. It should also be noted that the lower number of hospitals in the central and eastern European countries is compensated by hospital size. There, hospitals are generally bigger, and often have more than 1 000 beds.

As with the reduction in the number of acute care beds, this change is a result of hospital care reorganisation policies. Nonetheless, beds are easier to close than a hospital that provides jobs and economic development to its region. Some countries, such as Estonia, Ireland, Greece and the United Kingdom, have managed to conduct major re-organisational policies. In **Belgium**, a 1982 decree capping the number of beds par establishment led to the closure of several beds, while a 1989 decree required accredited hospitals to have more than 150 beds. Many "small hospitals" thus closed their doors. In other countries like the Netherlands or the United Kingdom, forcing health providers to compete made it possible to reorganise healthcare to a certain degree. In **the Netherlands**, the reduction in hospital numbers resulted both from the competition between hospitals - to the detriment of small structures - and a policy encouraging mergers between establishments. Dutch hospitals numbered 140 in 1990. Only about a hundred existed in 2004.

Meanwhile, in the Czech Republic and Slovakia, the number of hospitals grew during the 1990s. In **the Czech Republic**, this change is probably tied to the process of healthcare system decentralisation, which encouraged local hospital care organisation and, consequently, its dissemination. In addition, the development of the private hospital sector probably contributed to an increase in the number of establishments. In **Slovakia**, despite difficulties in financing the healthcare system, several acute care hospitals were

created to address the new public health priorities defined by the government, particularly cardiovascular disease, cancer, and renal insufficiency among others. Since the late 1990s, the density of acute care hospitals has stopped increasing, and is even going down in the Czech Republic, partly as a result of the introduction of a hospital reorganisation government programme in May 1997. Similarly, in Slovakia, following the adoption of a plan in 2002, 3 acute care hospitals were closed and several other were converted to long-term care establishments. The increase in the number of structures in both countries during the 1990s was tempered by a reduction in acute care bed density, even though it remains above the EU average (around 6.1%).

These reorganisation policies, aimed mainly at cutting the number of hospital structures in order to improve healthcare quality and streamline costs, generally lead to increased patient waiting times for access to care. This issue of geographic accessibility is undoubtedly an important factor in deciding upon future hospital reorganisation policies, and must be taken into account along with quality concerns.

NUMBER OF ACUTE CARE HOSPITALS IN SEVERAL EU MEMBER STATES
- per 100 000 inhabitants -

	1990	2000	2004
Latvia	na	4.6	3.6
France	3.6^{+4}	3.0^{-1}	2.7^{-2}
Germany	3.0^{+1}	2.7	2.6
Estonia	6.7	4.1	2.5
Lithuania	4.3^{+2}	2.5	2.4
Greece	3.4	2.6	2.4
Malta	na	2.1	2.2
Austria	2.6	2.3	2.2^{-1}
Luxembourg	4.7	2.5	2.0
Czech Republic	1.6	2.1	1.9
Italy	2.5^{+1}	2.0	1.9
Slovakia	1.5	1.8	1.8
Portugal	1.9	1.8	1.6
Belgium	2.9	1.6	1.4
Hungary	1.6^{+3}	1.4	1.4
Ireland	1.7	1.4	1.3
Spain	1.6	1.5	1.3^{-1}
Slovenia	na	1.1^{+1}	1.1
Sweden	1.2	0.9	0.9^{-1}
Netherlands	1.0	0.7	0.7
Denmark	1.6	1.2	na

Source: WHO, Regional office for Europe, 2007

MORE INTENSIVE USE OF HOSPITAL CAPACITY

Reorganisation policies were imposed or made possible by the combination of two main factors: economic constraints weighing on health systems and medical progress. These two factors led to changes in the hospital management of patients, with the possibility of eliminating acute care hospital beds. This has been manifested as a regular reduction in the average length of stay since 1980 for all EU Member States. Bed occupancy rates, on the other hand, have seen more disparate changes.

SHORTER AVERAGE LENGTH OF STAY

The average length of stay in acute care hospitals has been going down in all EU Member States, bar none. Between 1980 and 2004, the EU 27 average has shifted from around 11 days on average to just under 7 days.

Average hospital stays are currently longest in Germany, Slovakia, Belgium and the Czech Republic. They all exceed the EU average by more than a day. In **Germany**, for example, even though the average length of stay has gone down by around 6 days between 1980 and 2004 - a 40% drop - it still remained the highest in the EU at almost 9 days. Meanwhile, in Denmark, Finland and Malta, the average length of stays, between three and five days, are among the shortest.

In the central and eastern European countries, average lengths of stay are markedly higher than those in the EU 15 Member States. Nonetheless, they are following the trends seen in other EU countries and the deviation from the EU average is gradually decreasing.

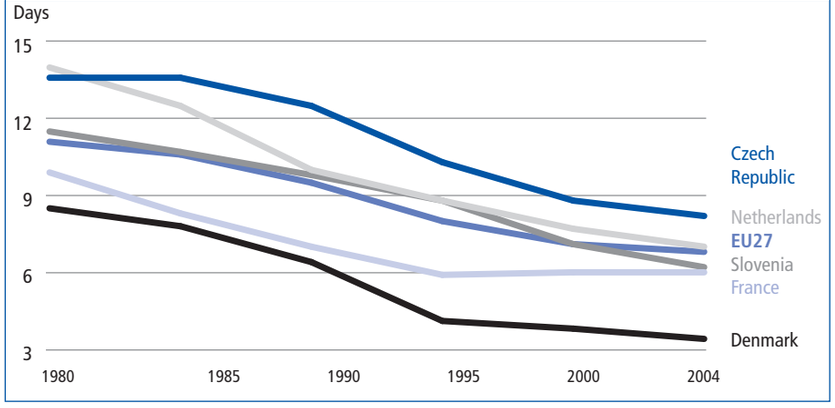
Several factors can explain the shorter average lengths of stay in acute care seen in the EU Member States. First, there has been improved coordination between acute care and "downstream" care (follow-up, rehabilitation care, long-term care or medico-social structures), even if this bears improving in a good number of countries. Moreover, medical progress and an enhanced technical environment make it possible to treat many diseases faster and, in some cases, even propose day or home hospitalisation to some patients. Finally, the replacement of daily payment - known to encourage longer stays - by prospective payment, mainly through the global budget, has served as a strong incentive to shorten the average length of stay.

AVERAGE LENGTH OF STAY IN ACUTE CARE HOSPITALS IN SOME EU MEMBER STATES
- in number of days -

	1980	1990	2000	2004
Germany	14.5	14.1	9.7	8.7
Slovakia	na	12.7	9.4	8.4
Belgium	10.0	8.7	8.5	8.3[-1]
Czech Republic	13.6	12.5	8.8	8.2
Bulgaria	na	na	na	8.2
Lithuania	na	14.7[+2]	8.4	7.3
Netherlands	14.0	10.0	7.7	7.0
Portugal	na	8.4	7.7	6.9
Spain	na	9.6	7.1	6.9[-1]
EU27	**11.1**	**9.5**	**7.1**	**6.8**
Italy	na	9.7[+1]	7.0	6.7[-1]
Hungary	11.2	9.9	7.1	6.5
Ireland	8.7	6.7	6.4	6.5
Austria	14.5	9.3	7.0	6.4[-1]
Slovenia	11.5	9.8	7.1	6.2
Estonia	na	14.3	7.3	6.2
Sweden	8.5	6.5	6.5	6.1
France	9.9	7.0	5.5[-1]	6.0
Cyprus	8.4	7.3	5.5	5.8
Malta	na	na	4.6	4.6
Finland	8.8	7.0	4.3	4.2
Denmark	8.5	6.4	3.8	3.4
Luxembourg	13.0	11.0	7.7[-2]	na
Greece	9.6	7.2	6.2	na
United Kingdom	8.5	5.7	na	na

Source: WHO, Regional office for Europe, 2007

DECREASE OF AVERAGE LENGTH OF STAY IN SOME EU MEMBER STATES
- in number of days -



Source: WHO, Regional office for Europe, 2007

MIXED CHANGES IN ACUTE CARE BED OCCUPANCY RATES

Generally speaking, the occupancy rate for acute care beds mirrors how intensively hospital capacity is being used. On average for the 27 EU Member States, this occupancy rate has been relatively stable since 1980, at around 75% of acute care beds. Such stability, however, belies the heterogeneous changes between the EU countries. This occupancy rate may have increased in Spain by almost eight points between 1985 and 2004, but it has fallen progressively and regularly by almost twenty-five points in the Netherlands since the early 1980s. In 2004, this country saw one of the lowest acute care bed occupancy rates in the European Union, which - according to the Dutch Council of Hospital Establishments - reflected a lack of hospital activity blamed mainly on the lack of personnel. The great majority of central and eastern European countries also saw a significant drop in acute care bed occupancy rates over the 1980s if not the 1990s as well. The trend is almost certainly tied to the surplus hospital capacity inherited from the Semashko system, as well as the difficulties encountered by these countries to adapt and modernise healthcare.

OCCUPANCY RATES FOR ACUTE CARE BEDS IN SOME EU MEMBER STATES
- in % of acute care beds -

	1980	1990	2000	2004
Malta	na	na	75.5	85.4
Ireland	82.2	84.5	83.2	85.4
Sweden	72.1	72.2	77.5[-4]	85.0*
Denmark	75.3	78.5	85.0	84.0[-3]
Cyprus	73.1	74.4	81.4	79.9
Spain	71.3[+4]	73.5	77.1	79.2[-1]
Bulgaria	na	na	64.1[-4]	78.0
France	79.0	77.3	77.4[-1]	77.1
Lithuania	na	73.3[+2]	75.4	76.6
Hungary	83.3	74.9	73.2	76.6
Austria	80.8[+2]	78.1	75.5	76.2[-1]
Italy	69.0	69.3	75.5	76.1[-1]
EU27	**76.7**	**76.3**	**76.7**	**75.9**
Germany	83.3	86.4	81.9	75.5
Czech Republic	81.8	69.6	70.7	74.8
Slovenia	88.2	81.5	70.6	73.2
Belgium	77.7	81.9	67.3	70.5
Portugal	na	66.7	71.3	69.8
Slovakia	86.2	77.2	71.0	68.6
Estonia	84.3	74.2	66.1	68.4
Netherlands	83.5	66.1	58.0	58.4[-3]
United Kingdom	75.1	76.2[-4]	80.8[-2]	na
Luxembourg	76.2	79.4	na	na
Finland	na	74.2	na	na
Greece	64.1	61.4	66.6[-2]	na

Source: WHO, Regional office for Europe, 2007 * country data

Different trends in bed occupancy rates from one country to another come from changes in the number of admissions, the average length of stay, and the extent to which alternatives to full hospitalisation have been developed. Given the reduction in bed numbers, an increase in the number of admissions may lead to higher occupancy rates for available beds, if not the appearance of waiting lists. Conversely, the development of alternatives to full hospitalisation makes it possible to reduce the number of admissions - and thus bed occupancy rates - all other things being equal. Depending on the degree of such events, which more or less compensate each other, the observed changes for occupancy rates are irregular.

ALTERNATIVES TO HOSPITAL CARE: THE DEVELOPMENT OF AMBULATORY CARE

Technological developments in medicine have made it possible to change the way patients are managed, making it even more necessary to improve coordination between hospital and ambulatory care. The concept of an "ambulatory shift" refers to the reorganisation of hospital management for a patient. Treatment that required full hospitalisation in the past can now be performed on an ambulatory basis (hospitalisation at home and day hospitalisation). Depending on how healthcare is organised, such treatment can be accounted for in hospital expenditure. This "ambulatory shift" of the hospital sector suggests that it leads not only to improved care and improved conditions for care administration (primarily because the patient stays at home), but also that it should allow hospital costs control, mainly by shortening the patient's hospital stay.

The International Association for Ambulatory Surgery (IAAS) carried out a study in 2003 on the use of ambulatory surgery for several procedures[8]. For the study, IAAS surveyed 9 EU Member States for which ambulatory surgery data could be compared: Germany, Denmark, France, Italy, the Netherlands, Portugal, Sweden, and, for the United Kingdom, England and Scotland. Denmark, Sweden and the Netherlands topped the list of 9 countries for the use of ambulatory surgery. This could be explained in part for Denmark and Sweden by the equivalent remuneration of surgery with full hospitalisation and day surgery. The 2 nations of the United Kingdom, as well as Germany, were in the middle. In England and Scotland, the development of ambulatory surgery was mainly tied to the desire of public authorities to shorten waiting lists. Italy, France and Portugal were at the bottom of the list in 2003. Ambulatory surgery was the least developed in these countries in general. For Portugal, the lag may be explained by the lower pay for ambulatory surgical treatment compared with surgical treatment with full hospitalisation.

In **Germany**, hospitals were traditionally expected to restrict themselves to care requiring hospitalisation. The creation of ambulatory care departments in German hospitals is only authorised in two cases: for research and teaching missions of university hospitals, and for certain hospitals in areas where community-based specialist care is insufficient. The 1993 law expanded the possibilities of ambulatory hospital care, and gave hospitals the right to provide highly specialised ambulatory treatment such as chemotherapy. Finally, the *Seehofer II* reform of 1996 authorised day hospitalisation and the development of other ambulatory departments in hospitals, in order to loosen the very strict sharing of skills areas between community-based physicians and hospitals, and to address the lack of coherence in the regulation of the two sectors.

FRANCE'S «AMBULATORY SHIFT»

As with many other countries, alternatives to full hospitalisation started gaining ground in France in the past few years. "Partial" hospitalisation - that is, hospital stays lasting less than one day - and home hospitalisation can be placed in this category. These activities lead to the creation of slots. In addition, the ordinance of 4 September 2003 removed the "exchange rate" concept - requiring the creation of slots for alternatives to full hospitalisation to have a corresponding closure of some beds - so that the development of such alternatives would not be unnecessarily restricted. Possible transfers of activity between the hospital sector and community-based care are much less widespread as of now. They are more complex to implement, in terms of organisation or due to separate budgets.

In 2004, 451 000 full-time hospital beds (acute care and other activities) were counted in French health establishments, corresponding to a drop of almost 15% compared with 1994[9]. This results in part from a desire to eliminate surplus beds, but also reflects the structural developments in the ways of managing patients, which are now increasingly focused on partial hospitalisation, particularly for surgical and endoscopic procedures. In exchange for the reduction in bed numbers, slots for partial hospitalisation increased by 17% between 1994 and 2004, to reach 50 000 slots in 2004. In this year, more than half o the 23.5 million stays handled by the French hospital sector lasted under a day. Between 2003 and 2004, the number of acute care hospital stays grew by 5% for partial hospitalisation, whereas the number remained stable for full hospitalisation.

As for partial hospitalisation for surgery (ambulatory anaesthesia and surgery), its development in France seems to lag behind other EU Member States, even though advances in surgical and anaesthetic techniques have encouraged its growth. This form of management would be beneficial, both organisationally and economically.

A survey was conducted for five of the most popular surgical interventions over a period of three weeks[10]. It found that, for these procedures, ambulatory care stays cost health insurance less than full hospital stays did (between 7% and 51% cost difference depending on the procedure and the financing of the healthcare establishment). This difference is thought to be related primarily to the length of stay.

Home hospitalisation has also been growing strongly in France over the last five years, even more than partial hospitalisation. Between 2003 and 2007, the number of slots authorised for home hospitalisation went up by more than 60%, to reach over 9 000 slots in 2007.

2. HOSPITAL CARE

In general, the reorganisation of hospital care provision was accompanied by changes in the way hospitals take care of patients. This can be summed up in three main points: revised conditions of access to care, from universal provision to financial participation; increasingly medicalised care with increased staff density and greater specialisation; better consideration of the quality of care provided.

A- CONDITIONS FOR THE ACCESS TO HOSPITALS

Although the principle of universal access to hospital care is shared by EU Member States, the ways differ from country to country. Patients have free access to hospitals in some Member States, while a doctor must act as an intermediary in others. Hospital care is not free-of-charge in all places, as some countries have introduced a system of flat-fee participation to hospital expenses.

THE GOAL OF UNIVERSAL HEALTH INSURANCE

All EU Member States share the goal of universal health coverage, as they adhere to Article 25 of the Declaration of Human Rights which states that "everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, housing and medical care and necessary social services, and the right to security in the event of [...] sickness [...]". Despite shared principles and declarations, however, not all countries have achieved this goal. Although the country may have rolled out a health insurance system covering the entire population, actual access to care is, in practice, not a given. For example, access to hospital care may be hampered by poor distribution of such care in the country, mobility problems for elderly patients, or inadequate dissemination of information on hospital services to the citizens. Moreover, universal medical coverage does not necessarily mean hospital care that is totally free of charge, as a flat-fee participation is often required of patients. Such participation, however, is rarely a deterrent.

In principle, Beveridgian health systems are based on the principle of universal healthcare access. **Italy**, for example, switched from a mutual-type insurance regime to a national health service in 1978, thereby guaranteeing universal health coverage. Bismarckian healthcare systems originally left part of the population without coverage, because access rights depended on the exercise of a paid professional activity. Nevertheless, over the 20th century, these countries gradually expanded the level of population coverage,

and it now covers nearly the entire population. **France**, for example, expanded its system of coverage in 2000 by creating "*Couverture Maladie Universelle*", or universal medical coverage, aimed at paying for the healthcare of persons with revenue below a certain threshold.

STRUCTURED ACCESS TO HOSPITAL CARE

With the exclusion of emergency care, the financial coverage of hospital spending by patients is structured by the organisation of each Member State's health system management. Access to reimbursable hospital care may be subject to formal referral by a doctor or insurance body, or the patient may be free to seek direct treatment in a hospital. In a large majority of countries, patients can turn to the private hospital sector without formal referral, depending on their financial resources, as all or most of the costs are at their expense[11].

FORMAL REFERRAL BY A DOCTOR

In Spain, Estonia or Ireland, patients have access to hospitals after they are referred by either a general practitioner or a specialist. In **the United Kingdom**, patients are referred mainly by the general practitioner (GP) to a hospital. Since December 2005, the GP has been required to suggest four or five establishments to the patient. Coverage of a hospital stay may also be subject to formal referral coupled with hospitalisation approval by the patient's health insurance fund, as in **the Netherlands**.

THE PATIENT'S FREE CHOICE

The freedom to choose a hospital has always existed in countries like Belgium, France or Greece. It was introduced more recently in certain new Member States, such as Latvia, where patients must limit their choice to hospitals that have signed a contract with the national health insurance fund. In other countries, patients can only go to the hospital of their choice in certain cases. In **Denmark**, the patient can only choose the hospital (including accredited ones in the private sector or even abroad), with the approval of regional health authorities, if the waiting period for treatment in a public establishment is longer than two months. In **Sweden**, patients can go to hospitals of their choice to receive healthcare and enjoy the same amount of financial coverage if the waiting time is longer than a certain period. Nonetheless, in those two Member States, when patients are able to choose a hospital, this is subject to medical advice recommending hospital care.

CONDITIONS FOR PAYMENT OF HOSPITAL STAY IN THE 27 EU MEMBER STATES
- excluding emergencies -

Austria	Free choice of public hospital if this does not lead to an increase in costs.
Belgium	Free choice among approved establishments.
Bulgaria *	Referral by general practitioner.
Cyprus	Referral by attending physician.
Czech Republic	Free choice of hospitals under a contract, after recommendation by a general practitioner or specialist.
Denmark	Free choice among public establishments, after medical recommendation. The patient may choose a private or foreign hospital with the agreement of regional health authorities, if the waiting period for treatment exceeds two months.
Estonia	Referral by referring doctor (general practitioner or specialist).
Finland	Referral for hospitalisation in public hospital establishments (in general, the municipality's). Free choice of patient for hospitalisation in private clinics.
France	Free choice among private and public contracted hospitals.
Germany	Free choice of approved establishments (hospital treatment can only be carried out on doctor's orders).
Greece	Free choice of public establishments, private contracted establishments designated by the insurance fund, or establishments of the social insurance institute.
Hungary	Referral by the doctor.
Ireland	Referral by general practitioner or specialist.
Italy	Free choice of contracted hospitals or clinics.
Latvia	Free choice among hospitals, as long as they have signed a contract with the National Health Fund.
Lithuania	Referral by general practitioner.
Luxembourg	Free choice among hospital establishments.
Malta	Referral by the doctor.
Netherlands	Free choice of hospital or institutions approved by the Ministry of Health. The admission must be authorised by the health insurance fund.
Poland	Free choice of approved hospitals. Hospitalisation upon recommendation of an approved doctor.
Portugal	Free choice among public hospitals and establishments approved by the Ministry of Health, if there is no waiting list.
Romania *	Referral by the family doctor or a specialist.
Slovakia	Free choice among hospital establishments. Medical prescription is required.
Slovenia	Free choice of public or private hospital that has a concession[12] and having signed a contract with the health insurance body. Patients are required to come with the recommendation of a general practitioner.
Spain	Referral by general practitioner; patients are assigned to a hospital according to their place of residence.
Sweden	After medical recommendation, free choice among public regional hospitals and approved private establishments, if the waiting period exceeds 90 days.
United Kingdom	Referral by general practitioner.

Source: MISSOC, 2006
*: European Observatory on Health Systems and Policies, 2007

RELATIVELY LOW FINANCIAL PARTICIPATION FOR PATIENTS

Unlike dental or optical care, hospital care is generally well-covered by basic insurance. In some Member States, however, patients are asked to pay a part of it. Such patient participation in hospital expenses varies from one country to another, and no correlation can be drawn between the amount of this participation, and the model (Beveridge or Bismarck) or the hospital financing model (global budget, activity-based tarification, etc.). In certain cases, this participation may be covered by voluntary private insurance or mutual insurance companies.

TOTALLY FREE HOSPITAL CARE

In almost half of EU Member States, the hospital system is totally free of charge: Denmark, Spain, Greece, Italy, Lithuania, Malta, the Netherlands, Portugal, the Czech Republic, Romania, the United Kingdom, and, very recently, Poland. As part of **Hungary**'s convergence programme (to rehabilitate public finances), the government introduced in 2006 a "flat consultation fee" for community-based care (around 1.20 EUR) and a "daily hospital fee" (around 4.80 EUR). This measure marked the end of free healthcare. Under pressure from the opposition, the Hungarian government was forced to organise a referendum in March 2008 on, among other things, the elimination of co-payment. Hungarians voted to eliminate it, and the health system is free-of-charge once again.

FIXED PATIENT PARTICIPATION: A FLAT HOSPITAL FEE

In some Member States, the hospital requires patients to pay a flat fee. This is generally in the form of a "daily flat hospital fee" and applies to a limited period. This is the case in about ten countries: Germany, Austria, Belgium, Estonia, Finland, Luxembourg, Slovakia, and Sweden. The fees vary, according to country, between less than 2 EUR in Estonia and Slovakia to around 12 EUR in Belgium and Luxembourg, and more than 25 EUR in Finland. These fees apply to all hospital patients, except those belonging to certain categories or with certain diseases. In **Estonia**, the patient participates in financing hospital care by paying 1.60 EUR per day for a maximum of ten days. Minors, maternity care and time spent in intensive care are exempted.

PATIENT PARTICIPATION IN HOSPITAL FEES FOR THE 27 EU MEMBER STATES[13]

	APPROVED PUBLIC AND PRIVATE HOSPITALS
Austria	Participation not exceeding 10 € / day.
Belgium	Participation of 12.30 € / day (in shared room).
Bulgaria*	Participation, per day, equivalent to 2% of minimum monthly revenue, up to 10 hospital days per year.
Cyprus	Hospital stay and treatment costs vary according to professional category. Military and medical personnel are exempted from any participation.
Czech Republic	No participation.
Denmark	No participation.
Estonia	1.60 € / day for a maximum period of 10 days. No participation for intensive care, pregnancy-related care and for minors.
Finland	Participation of 26 € / day. Participation in long-term treatment (more than three months) is set according to revenue, but must not exceed 80% of the patient's net monthly revenue.
France	Participation in costs by assured person: 20% of stay costs and a flat hospital fee of 16 € / day (including discharge date).
Germany	Participation of 10 € / day, for 28 days maximum (in shared room).
Greece	No participation.
Hungary	Elimination in 2008 of the 4.80 € / hospital day participation.
Ireland	Category I (full eligibility): no participation. Category II patients (limited eligibility) participation of 60 € /night for a maximum of 600 € for 12 consecutive months. Hospitalisation via emergency services with no formal referral will result in a 60 € participation.
Italy	No participation.
Latvia	Patient participation depends on the hospital category: - local general-care hospital: 4.31 € / day; - regional general-care hospital: 7.18 € / day; - specialist hospital : 5.75 € / day.
Lithuania	No participation for insured patients.
Luxembourg	11.74 € / day for a maximum period of 30 days.
Malta	No participation.
Netherlands	No participation for stays in standard rooms.
Poland	No participation.
Portugal	No participation.
Romania*	No participation.
Slovakia	1.32 € / hospital day for a maximum of 21 days. No duration limitations for patients with a chronic disease.
Slovenia	Up to 25% of hospitalisation costs.
Spain	No participation.
Sweden	8.51 € / day.
United Kingdom	No participation (unless the patient requests special arrangements or more expensive care that is not clinically needed).

Source: MISSOC, 2006
*: MISSOC, 2002

PATIENT PARTICIPATION IS DEPENDENT ON SEVERAL VARIABLES

In other countries, the patient's financial participation can vary depending on the disease, his profession, revenue, or the hospital category - this is the case in Bulgaria, Cyprus, Latvia, Ireland and Slovenia. In Bulgaria and Ireland, the hospital flat fee depends on the patient's income. In **Slovenia**, the fee depends on the treatment provided: patients pay for 25% of the fees incurred for treatment-related hospitalisation. In **Latvia**, the hospital flat fee depends on the category of the hospital providing care. While the daily flat fee is almost 4 EUR in a local hospital, it is almost 6 EUR for a specialty hospital.

FIXED AND VARIABLE PARTICIPATION

Still in other Member States, the patient's share is a combination of the two aforementioned types of payment. In **France**, the patient pays for 20% of the stay costs and a fixed fee of 16 EUR per day for all activities with the exclusion of psychiatry, where this fee is 12 EUR.

In all Member States requiring participation in hospital costs, there are exemptions for certain categories (pregnant women, children, war invalids or persons whose income fall below a certain threshold) or certain diseases requiring long and expensive treatment (diseases classified as "long-term conditions" in France, for example). In **Ireland**, the treatment of communicable diseases is free-of-charge for all. In **Estonia**, the patient is exempted from paying a share of hospital costs in case of intensive care, pregnancy-related care or when the patient is a minor.

Although participation in hospital care costs remains modest in the EU Member States, it is increasingly being used to provide more resources for this sector. For example, the flat hospital fee did not exist in Slovakia before 2003 and was only introduced in Hungary in February 2007. In other countries, like France and Germany, this fee has recently been raised. In France, it increased from 13 EUR in 2004 to 16 EUR as of 1st January 2007. In **Austria**, a 2005 reform modified the daily fee for hospital care. It increased from 8 EUR a day - for a maximum of 28 days per year - to 10 EUR per day, following a decision by the *Land*.

OCCASIONALLY PROBLEMATIC COORDINATION BETWEEN HOSPITAL AND COMMUNITY-BASED CARE

Given the diversity of cultural, historical and economic backgrounds, the place of the hospital in the health system varies widely from one country to another. The hospital can be the dominant player and main provider of care, as was the case of the countries formerly under Soviet influence. It can also be a real part of the overall organisation of healthcare provision, with specific coordination between hospital care and community-based care in each country.

Coordination between hospital and community-based care is unique to each Member State. Initially, in the Beveridge-type countries (like the United Kingdom and Finland), the role of general practitioners was wider and more significant than in countries following the Bismarck model, where patients were more free to consult a specialist directly. There are several reasons for this difference, but the distinction appears to be fading.

In **the Netherlands**, despite the country's Bismarckian roots, the general practitioner is not only the first link in the chain but is also a pillar of the healthcare system. Since 1941, the general practitioner has played the role of referring doctor, and patients must sign upon a patient list. GPs provide a wide range of treatment. These include certain minor surgical procedures (in dermatology, for example) or obstetric care (45% of deliveries are home births). General medical training includes training in surgery, gynaecology or psychiatry. In addition, since euthanasia legislation was passed, the GP has been at the heart of the system to support terminally-ill patients, most of who are cared for at home[14].

In the majority of central and eastern European countries, medical care was primarily provided inside hospital structures for a long time. They remain influenced by this tradition, despite reforms adopted in the 1990s. In **Poland**, for example, the function of general practitioner ("family doctor") was introduced in 1991 in an attempt to reverse this hospital-centric trend. Habits remain firmly entrenched, however. In Latvia, despite reorganisation policies for the health sector, including optimisation of general medicine, requirement of a referring doctor for access to specialist and hospital care introduced in 1996, and programmes to reduce hospital capacity, the hospital remains at the core of healthcare provision, with people continuing to consult hospitals for first-line care out of habit.

Coordination between hospital and community-based care is problematic at times and may lead to dysfunction. In **Spain**, except in special cases, patients must go through a GP to access the healthcare system (principle of formal referral, see below). However, the density of general practitioners in Spain is much lower than in many EU Member States. Difficulties in Spanish healthcare system organisation arose from the combination of low GP density and the principle of formal referral. Such problems highlight the issue of coordination between hospital care and community-based care. Waiting lists

appeared and became the main source of patient dissatisfaction. Moreover, in the early 2000s, the time spent by Spanish doctors on each consultation was among the lowest in some surveyed EU countries. Finally, more and more hospital admissions are made through the emergency room, thus saturating the latter. In the late 1990s, waiting lists for hospital admission became a real public health problem. The situation has improved recently, as several autonomous communities implemented several strategies to shorten waiting lists and waiting times (see boxed text).

WAITING LISTS AND WAITING TIMES: DIFFERENT MAGNITUDES AND POTENTIAL SOLUTIONS IN EU MEMBER STATES

A comparative analysis of waiting lists and times is not easy to make because of scarce data from international surveys.

A 2004 study compared waiting lists for scheduled surgery (among the operations studied: hip and knee replacement, cataract surgery, cholecystectomy, inguinal and femoral hernia) in 20 OECD countries, including 13 European Union Member States[15]. The main goal of this study was the comparison of statistical data concerning two groups of countries. A group of countries where waiting times pose a major health policy problem (almost all in Beveridge-inspired health systems: in the EU, Denmark, Spain, Finland, Ireland, Italy, the Netherlands, the United Kingdom and Sweden; outside the EU, Australia, Canada, Norway and New Zealand) was compared to another one in which waiting times are viewed as short (almost all of which have Bismarck-type healthcare: in the EU, Germany, Austria, Belgium, France, and Luxembourg; outside the EU, the United States, Japan and Switzerland).

The survey set out to examine the factors that may explain the absence of waiting times in the second group. It was found that on average, countries with no waiting times had higher healthcare expenditure, larger capacities (measured in terms of acute care beds and doctors) and more often use activity-based financing for hospitals, and treatment-based payment for doctors (instead of salaries). In terms of demand, the two groups had no notable differences in terms of need, if the latter is measured according to the proportion of elderly persons in the total population and the death rate. The participation of patients and private health insurance did not appear to be significantly different between those two groups.

Among the 12 countries for which waiting times were a major health policy problem, comparable waiting time statistics were available for 7 of them. Waiting times vary considerably from one country to another and from one operation to another. For instance, in 2000 England had the longest average waiting time[16] for hip replacement surgery, at almost 250 days. Finland's waiting time was just above 200 days. Other countries had shorter waiting times, at around 160 days for Australia, 130 for Norway and Spain, 110 for Denmark and a little under 100 days for the Netherlands[17] Overall, for the operations studied, the longest waiting times were seen in England and Finland, followed by Norway, Australia, and Spain. Denmark and the Netherlands had the shortest waiting times.

Another study sought to classify European healthcare systems according to different indicators, including some relating to waiting lists[18]. The classification obtained using this set of indicators appeared to be consistent for the 13 EU Member States analysed in the previous study (waiting lists led to more difficulties in countries in the first group than in the second). The study also showed that most of the central and eastern European countries are facing waiting list problems: Bulgaria, Estonia, Hungary, Latvia, Lithuania, Poland, Romania and Slovenia.

Only the Czech Republic and Slovakia are at a less disadvantaged position when compared with the other central and eastern European nations.

In Estonia, for example, since 1999 waiting times for community-based care have increased, especially in certain geographic zones and some specialties (e.g. gynaecology in Tallinn). Waiting times for scheduled surgery also grew, mainly due to strict regulation of activity volumes (some hospitals risked being ineligible for reimbursement of provided treatment, because they had already reached their activity ceiling).

Several strategies to cut waiting lists and times, generally related to healthcare provision, were introduced in countries facing these problems.

One of the first measures used by many countries was to promote the circulation among patients of reliable information on waiting times, as was the case in Spain or in Latvia.

In **Spain**, each autonomous community used different strategies to shorten waiting lists. Most, if not all, signed agreements with certain private establishments and offered financial incentives to public hospital doctors who agreed to work longer. Nearly half of the Spanish autonomous communities also gave patients who had waited a certain amount of time the possibility of choosing another hospital than the one they were assigned to because of residence.

It is also one of the preferred strategies in Scandinavian countries. Since 2002, in **Denmark**, a patient can choose a private or foreign hospital in lieu of the assigned hospital if the waiting list for the needed procedure exceeds 1 month.

In **Estonia**, several strategies have been adopted. Since 2001, goals specifying a maximum waiting period for some treatments are posted annually, and the inability to meet these goals led to additional financing in late 2006 and 2007 in order to cut waiting lists for certain geographic areas and specialties. These strategies include, for instance, the creation of a 24-hour call centre for primary care or the introduction of financial incentives pegged to the quality of care furnished by health service providers.

B- HOSPITAL STAFF

In the European Union, almost 9% of the working population work in the health and social work sectors. In most of the EU Member States, the health sector is characterised by strong job presence, mainly for qualified positions, despite stark differences between Member States. In Germany, the sector employs some 11% of the working population, i.e. more than 3.8 million workers. In France, 8% of workers work in the area of health, that is, almost 2 million individuals. The sector is least represented in Portugal, yet it still employs nearly 3% of the working population.

HEALTH SECTOR EMPLOYMENT IN SOME EU MEMBER STATES
- as % of total employment and employees -

	1980	1990	2000	2004	2004 (EMPLOYEES)
Germany	na	na	10.2	10.6	3 836 000
France	6.3[+2]	7.8[+3]	7.6	8.0[-1]	1 940 400
United Kingdom	4.6	5.0	6.5	7.1	1 993 000
Ireland	na	5.8	5.8	7.0[-1]	124 500
Finland	na	5.7	6.5	6.9[-1]	164 000[-1]
Netherlands	6.0	5.2	5.7	6.1[-2]	520 500
Czech Republic	na	5.2[+2]	5.2	5.5	256 600
Italy	4.1	4.6	5.3	5.2[-1]	1 145 300[-1]
Slovakia	na	na	5.7	4.9[-1]	107 100
Spain	na	4.4[+4]	4.4	4.6[-1]	790 700
Poland	na	5.1[+4]	4.7	4.4[-1]	593 800
Greece	2.6	3.7	4.1	4.1[-1]	163 700[-3]
Denmark	2.5	2.8	3.4	3.6[-1]	96 400[-1]
Portugal	2.2	2.3	2.8	2.8[-1]	142 300
Belgium	4.2	5.3	na	na	na
Luxembourg	na	2.4[+5]	na	na	na

Source: OECD, Eco-Health, 2006

Within this sector, hospitals account for a very large share of jobs. In 2004, the hospital sector employed almost a million and a half persons in the United Kingdom and over a million in France and Germany.

TRENDS IN HOSPITAL STAFF

The indicator «hospital staff», used by the OECD, refers to all persons working in a hospital. It is a set of very different professions, including health professionals, administrative workers and labourers. Health professionals are represented in the hospital sector mainly by doctors, nurses, nursing auxiliaries and midwives. Specific trends for each profession make it difficult to give a description of hospital staff as a whole. After a general description of staff, the rest of the chapter will discuss hospital doctors.

INCREASING STAFF SINCE THE 1980s

Statistical comparisons of hospital staff are often limited because of the lack of consistently-used measurement tools in different countries. Statistical methods counting health personnel vary significantly. While some countries use the number of workers employed, other countries use "full-time equivalents". This distortion is amplified by the growing number of women in the medical profession, with greater recourse to part-time work. Moreover, the development of public-private partnerships does not facilitate staff comparisons between countries. The use of such contracts generally leads to the outsourcing of auxiliary services (maintenance, catering, etc.) whose staff is no longer directly employed by the hospital, and thus no longer counted as hospital staff. Meanwhile, they are still paid by the hospital even though the expense does not fall under staff costs, but rather as part of the rent paid by the hospital to its private partner. Despite these methodological reservations, the database compiled by the OECD allows some light to be shed on this topic.

In the majority of European countries, the hospital is the main employer in the health sector, often providing jobs to more than half of health personnel. In **France**, almost 62% of workers in the health sector work in a hospital. This share is 55% in Ireland. In **Slovakia**, following hospital reform and the development of community-based care, the share of hospital staff in the health sector has shrunk considerably, from 80% of health sector jobs in 1994 to some 57% in 2004.

Since the 1980s, the number of hospital jobs has been climbing at different paces in the majority of Member States. Between 1980 and 2004, staff has doubled in Greece, from almost 50 000 to close to 100 000 persons, and has grown by almost 50% in the United Kingdom. In **Greece**, the doubling of staff over this period reflects the efforts to upgrade a highly degraded healthcare system conducted by the government in the 1980s. Greece was one of the countries in which the share of the active population working in the health sector was among the lowest (2.6% in 1980).

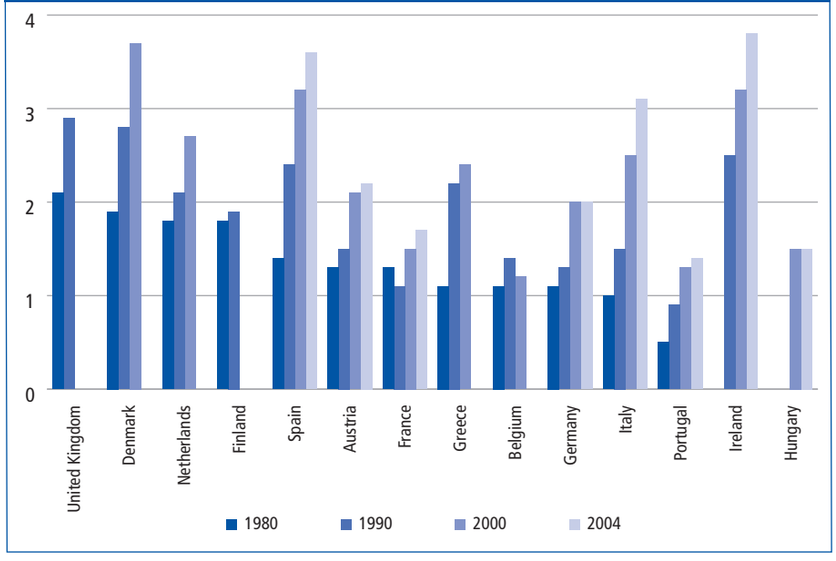
TRENDS IN HOSPITAL EMPLOYMENT IN SOME EU MEMBER STATES
- in number of employees -

	1980	1990	2000	2004	Changes between 1980-2004
United Kingdom	962 600	995 000	1 306 000	1 427 000	+ 48%
France	954 700[+5]	1 010 500	1 115 300[+1]	1 195 800	+ 25%
Germany	765 000*	1 226 100[+2]	1 225 500	1 194 100	+ 56%
Italy	549 800	617 000	650 800	660 600[-1]	+ 20%
Spain	272 100	348 200	390 300	421 300[-1]	+ 54%
Netherlands	177 100	210 200	266 500	287 700[-2]	+ 62%
Belgium	98 000*	115 000*	164 200	168 600[-2]	+ 72%
Czech Republic **	na	na	130 500*	135 000[-2]*	na
Austria**	na	102 800	126 800	127 200[-2]	na
Greece	53 000	87 900	101 900	107 800[-2]	+ 103%
Portugal	60 700	79 800	109 600	112 500	+ 85%
Hungary**	55 700	69 100	102 600	100 800	+ 81%
Finland	na	72 400[+2]	81 200	86 000[-1]	na
Denmark	44 800	60 400	66 300	70 900[-1]	+ 58%
Ireland	na	44 300	56 700	68 700	na
Slovakia	na	90 300[+4]	75 900	61 200	na

Source: OECD, 2006
*: OECD, 2004 - **: as full-time equivalents

Moreover, in most Member States, the increase in staff numbers combined with lower acute care bed numbers led to a rise in the number of staffers per bed. Despite different rates for each country, the general trend is the same. The ratio was markedly increased in the United Kingdom, where it grew by 4.4 points between 1980 and 2004, and in Spain where it grew by 2.2 points over the same period.

STAFF PER ACUTE CARE BED IN SOME EU MEMBER STATES
- in employees per bed -



Source: OECD, Eco-Health, 2007

HOSPITAL STAFF PROFILE

The health sector is changing because of the impact of population ageing, the development of new techniques, or new requests for services. Health professionals, especially those working in hospitals, are called upon to handle these changes. For example, since the population is ageing, health problems are no longer the same (increase in chronic diseases, for example); neither are expected health services (for instance, the management of dependency). Health staff sees their duties - and consequently their skills - changed as a result. In the same vein, technological innovation such as telemedicine, the modernisation of diagnostic procedures, or a growing trend to use innovative therapeutic strategies and techniques such as non-invasive procedures, are likely to modify hospital skills.

The profile of health professionals is, moreover, increasingly female and growing older. The nursing profession has always been strongly female, while the proportion of female doctors has been growing since the 1990s in the majority of the Western EU countries. This change is less significant in central and eastern European countries, which already had plenty of female doctors. The larger proportion of females in the medical professions is an important factor to be considered in managing hospital staff, in that women may be likely to suspend their careers momentarily or work part-time. The ageing of hospital staff is also an important trend that will affect countries in different ways, with the retirement of the Baby Boom generation combined with early staff retirement.

International migration and mobility of health professionals also contributes to the changes in hospital staff profile. The number of foreigners in staff has significantly increased in Western Europe these past few years. The movement of health professionals around the Member States was encouraged by the introduction of the free movement of persons inside the EU internal market.

SPECIFIC ISSUES IN CENTRAL AND EASTERN EUROPE

Central and eastern European countries need to address the same issues as the 17 other EU Member States. They must also address other difficulties. Because of their traditionally hospital-centric health systems, job opportunities in the health sector are often ill-suited to current needs. These countries generally have plenty of specialists compared with inadequately-developed general medical services, and nurses often suffer from insufficient training. The reforms conducted in the 1990s sought to address these gaps by creating new training programmes or encouraging future doctors to opt for general medicine. However, the low pay for health professionals, which often pushes them to migrate to other EU Member States, is a major stumbling block to the success of these policies.

A STATUS PATCHWORK FOR HOSPITAL DOCTORS

Most hospital doctors in the public sector are salaried. They may be employed by the hospital, local authorities, or the State. Their salary usually increases depending on their position and their seniority, but a variable portion of it may be pegged to the efficiency and quality of provided treatment.

Hospital medical staff in the public sector is generally employed by the public service, and their pay is determined by the supervising administration. This is the case, for example, in France, Cyprus, Portugal, Spain, Slovakia, Malta, Hungary, and the Czech Republic. In **France**, the majority of hospital doctors are employees of public hospitals. They are classified into several categories, which determine their type and amount of remuneration. These are: university hospital doctors, hospital practitioners (who may also be contract workers), and consultants who are outside practitioners that occasionally intervene in the hospital. Since the 1980s, full-time public hospital doctors can also have a private activity within the hospital. In **Cyprus**, all public sector doctors are employees of the Ministry of Health. They depend on a highly centralised system that manages and assigns public civil servants over the territory. In **Portugal**, doctors working in traditional public hospitals are directly employed and paid by the national health service as public civil servants. When they provide private treatments inside a public hospital, they are paid by treatment. In **Spain**, most of the staff working in the public health system are public civil servants, a status organised at the national level. Nonetheless, since the law of 16 December 2003 (law 55/2003), the autonomous communities have greater freedom to manage health staff, particularly in terms of staff mobility and remuneration. In other countries, doctors may be employees of the local authorities, for instance in Sweden and Finland, or the entire staff working in a public hospital establishment, including doctors, may be employed and paid by the counties.

Hospital doctors are not public civil servants in certain countries, like the United Kingdom, Estonia or Lithuania. In **the United Kingdom**, hospital staff has a special status that provides career protection and job security. Healthcare institutions, hospital trusts and Foundation Trusts are responsible for recruiting and managing their medical staff. Foundation trusts may set the pay scales for their staff. This independence is nevertheless bound by the principles of the NHS, to avoid destabilising the job market in this sector. In **Estonia**, the status of healthcare personnel has radically changed since the Communist era, where they were State civil servants. At present, they are employees of the hospital where they work. Their working conditions are based on an employment contract signed on an individual basis with the health establishment or healthcare centre, and payment is negotiated by the employer and employee. The State only sets a minimum salary requirement.

In certain countries where the hospital sector is essentially private (Belgium, Luxembourg and the Netherlands), hospital doctors are generally paid by treatment. In Belgium, the majority of doctors working in hospitals are paid by procedure. The fees for specialist doctors are set at the national level. In theory, fees are paid directly to doctors. In practice, however, the doctor generally signs a contract with the healthcare establishment to use its facilities. Fees are shared between the hospital and the doctor in a very variable manner. In the Netherlands, where conflicts between doctors and the government were significant in the 1990s because of pay issues, the payment system for hospital doctors has changed significantly. At present, specialist doctors are primarily paid by treatment[19], while doctors working in municipal and university hospitals, the only public establishments, are employees.

The creation of new forms of hospital status has also changed the status of health personnel. In **Spain**, for example, in public health foundations, staff are governed by the rules of private labour legislation. In **Portugal**, in EPE hospitals (governed by business law but with public capital), employees who were civil servants at the time the establishment changed status could opt to remain civil servants or decide to change status and sign an individual contract subject to private labour legislation.

In certain countries, since a few years back, salaries include a variable component to encourage health personnel, including doctors, to be more efficient. In **Austria**, for example, the *Länder* can give bonuses to hospital doctors on top of the fixed salary determined by the salary scale for civil servants. In **Bulgaria**, since the 2002 reforms, health staff working

in public hospitals received a fixed salary to which a variable portion is added depending on the doctor's "performance". In **Spain**, while the salaries of public sector employees depend on a salary scale fixed by the government at national level, the autonomous communities have the possibility of modulating a small component of this salary.

C- QUALITY OF HEALTHCARE

The availability of high-technology facilities, as a source of technical progress, contributes to the quality of care that patients receive when they are in a hospital. This is obviously not the only factor, but it is decisive and, more importantly, quantifiable. It falls under a more general approach which is the evaluation of the quality of hospital care, which has been developed in different EU Member States for the past few years.

AN INCREASINGLY SOPHISTICATED EQUIPMENT

Since the early 1980s, the hospital sector has gone through considerable technological changes, with the development - especially in larger establishments - of technical facilities per specialty around which services are structured. These include the intensive use of medical imaging (nuclear magnetic resonance, ultrasound, medical scanning, etc.) and the rollout of IT networks.

The availability rate of high-technology equipment gives an indication of the technological level of the services offered. This availability rate varies from country to country but has been increasing continuously in all EU Member States since the 1980s, or, for the central and eastern European countries, since the 1990s. The new EU Member States are not always the least-equipped. For example, the Czech Republic and Slovakia are better equipped in CT scan machines than France, because of significant investments in equipment starting in the late 1990s.

MAGNETIC RESONANCE IMAGING EQUIPMENT

In terms of MRI equipment (magnetic resonance imaging), Austria, Finland and Luxembourg are the best equipped countries. Meanwhile, Greece, Slovakia and Poland are the least-equipped. Availability is very diverse, from Austria's rate of almost fifteen machines per million inhabitants to Poland, which has only one per million inhabitants.

A country like **the Czech Republic**, which had very low availability rates for MRI in the early 1990s, has made large investments toward the acquisition of new equipment. Between 1997 and 2000, the country has added two machines on average every year.

Other medical equipment, such as ultrasound, machines for assisted respiration and lasers were also added. It should be noted, however, that the financial crisis of the Czech healthcare system since the mid-1990s has brought about a decrease in investments. As a result, medical equipment is ageing and being replaced less often.

MRI EQUIPMENT IN SOME EU MEMBER STATES
- per million inhabitants -

	1990	2000	2004
Austria	1.6[+2]	10.9	14.9
Finland	1.8	9.9	14.0
Luxembourg	2.6	2.3	11.1
Denmark	2.5	5.4	10.2
Sweden	1.5	7.9[-1]	na
Italy	1.3	7.6	10.2
Spain	1.8[+2]	4.8	7.7
Belgium	2.0	6.0	6.8[-1]
Germany	1.1[+1]	4.9	6.6
United Kingdom	na	4.7	5.0
Netherlands	0.9	3.9[-5]	na
Portugal	0.8	na	3.9[-1]
France	0.8	2.6	3.2
Czech Republic	0.2[+1]	1.7	2.8
Hungary	0.1	1.8	2.6
Greece	0.4	1.9[-2]	2.3[-2]
Slovakia	na	na	2.0[-1]
Poland	na	0.9[+2]	1.0[-1]

Source: OECD, Eco-Health, 2006

CT SCAN EQUIPMENT

Belgium, Luxembourg, Austria and Italy are the best-equipped countries, with more than twenty scanners per million inhabitants. At the bottom of the list are Poland, Hungary and the United Kingdom, with less than seven machines per million inhabitants, despite real efforts by Hungary to invest in facilities since the 1990s.

CT SCAN EQUIPMENT IN SOME EU MEMBER STATES
- per million inhabitants-

	1980	1990	2000	2004
Belgium	na	16.1	21.8	29.8[-1]
Luxembourg	2.7	5.2	25.2	28.8
Austria	na	11.7	25.8	28.5
Italy	na	6.0	20.8	20.6
Germany	na	6.4[+1]	12.7	15.4
Denmark	0.2	4.3	11.4	14.6
Finland	1.5	9.8	13.5	14.2
Spain	1.6[+4]	6.8[+2]	12.0	13.3
Portugal	na	4.6	na	12.8[-1]
Czech Republic	na	2.1[+1]	9.6	12.6
Slovakia	na	na	na	8.7[-1]
France	2.3[+5]	6.7	9.5	7.5
United Kingdom	na	na	4.5	7.0
Hungary	0.3	1.9	5.7	6.8
Poland	na	na	4.4	6.3[-1]
Greece	0.6	6.5	17.1[+2]	na
Sweden	1.9	10.5	na	na
Netherlands	2.6[+1]	7.3	na	na
Ireland	na	4.3	na	na

Source: OECD, Eco-Health, 2006

RADIOTHERAPY EQUIPMENT

Finland remains the best-equipped country for radiotherapy since the 1980s, but is also the only country where the availability of radiotherapy equipment has been markedly going down, from 11.3 per million inhabitants in 1980 to 8.8 in 2004. This decrease is not related to cancer incidence, as the latter increased in Finland over the same period, at a somewhat faster rate than most EU Member States. The Czech Republic and Slovakia are gradually catching up with Finland's level. Conversely, Hungary is still one of the least-equipped countries, alongside Portugal and Spain. Austria is in the top three EU Member States for MRI and CT scan equipment, but is less well-ranked for radiotherapy facilities, with only half of Finland's ratio.

RADIOTHERAPY EQUIPMENT IN SOME EU MEMBER STATES
- per million inhabitants -

	1980	1990	2000	2004
Finland	11.3	10.0	8.7	8.8
Netherlands	3.4[+1]	6.5[+2]	7.2[-1]	na
Slovakia	na	na	na	7.1[-1]
Czech Republic	na	5.4[+1]	6.3	7.0
Belgium	4.6[+1]	6.1[+1]	6.4[-3]	6.8[-1]
Denmark	5.5[+1]	na	5.4	6.3
France	5.7	6.0	6.1	6.0[-2]
Germany	na	4.3[+1]	4.8	4.7
Austria	na	na	4.2	4.6
Luxembourg	2.7[+1]	na	4.6	4.4
Italy	na	1.3	3.7	4.1
United Kingdom	na	na	3.9[+2]	3.9
Spain	2.6[+4]	2.6[+2]	3.7	3.9
Portugal	na	na	na	3.3[-1]
Hungary	0.7	1.5	2.3	2.7
Greece	na	5.4	4.0[-1]	na
Ireland	1.5[+1]	na	na	na

Source: OECD, Eco-Health, 2006

INTRODUCTION OF HEALTHCARE QUALITY EVALUATION PROCEDURES

Since the early 1980s, healthcare providers and the supervision and financing bodies have paid closer attention to the quality of care. To address the expectations of both patients and professionals, external quality validation processes, stemming from local initiatives and national or regional directives, were introduced. While the ways of determining hospital care quality differs from country to country, the reasons behind it all indicate a desire to improve the safety and quality of healthcare provided to patients. With this shared goal as a starting point, each country has developed its own tools to measure, monitor and improve quality.

In addition to the development of indicators to measure the quality of certain types of care, three main ways of promoting quality have been developed for or adjusted to the health sectors of the EU Member States: accreditation, certification based on ISO[20] 9 000 standards, and the "Excellence" approach of the *European Foundation for Quality Management*[21] (EFQM model). These three strategies have different rationales, but their common trait is that they are based on the idea of constant quality improvement, the introduction of references as a basis for the establishment's "quality culture", and the encouragement of self-evaluation.

THE MARQuIS PROJET

The "*Methods of Assessing Response to Quality Improvement Strategies*" (MARQuIS) project set out to assess the value of the different quality strategies in existence. Seven strategies were identified: external pressure (in the form of accreditation, certification, etc.), quality improvement programmes, audits and internal evaluations of clinical standards, patient safety systems, good clinical practice, performance indicators, and systems to measure the degree of patient satisfaction. A component of the project dealt specifically with quality in the perspective of patient mobility.

Developed between 2004 and 2008, MARQuIS allowed conclusions and recommendations to be drafted. According to the researchers, it would not be useful to create a unique quality improvement system for the European Union, as results favour an approach coordinating the different national systems. In the same vein, at the national, regional or local level, using a combination of different strategies is recommended, rather than focusing on a single one. Three strategies appear to be particularly fruitful: patient safety systems, performance indicators, and good clinical practice. They seem to have more results than strategies based on external pressure such as accreditation and certification. Finally, the project concluded that special attention needed to be paid to the quality of border region and transnational care. MARQuIS results are available on www.marquis.be.

• **Accreditation** is based on an independent, external evaluation procedure assessing the hospital establishment as a whole in terms of operations and practices. Often carried out through peer review, it refers to a set of specific standards.

Italy, for example, implemented this type of accreditation nationally in 1992 and then regionalised it in 1999. An *accreditamento* procedure based on required standards is now mandatory for all hospital establishments. In **France**, the supervisory authority must initiate accreditation, through the *Haute Autorité De Santé* (HAS). 75% of the members of the board of directors hail from the health professions. The on-site evaluation of HAS experts is preceded by a self-evaluation of hospital care quality and safety considerations, conduced by health professionals working in the establishment being assessed. Accreditation was introduced in France with the ordinance dated 24 April 1996. It does not influence funding but is mandatory for public and private establishments. It is now referred to as certification, but its main lines have changed very little. The term "accreditation" is now reserved in France for another procedure involving the medical professions.

In **the Netherlands**, health professionals are behind the move to take hospital care quality into account in the health delivery improvement process. Their initiative was encouraged by the government and made formal by the creation of the Dutch institute for hospital accreditation (NIAZ) in 1999. Hospital establishments were also obliged to adopt a quality approach by a law that took effect in 1995, according to which each establishment had to provide "responsible care" - that is, effective, efficient, and patient - oriented quality care. These four criteria are measured using the standards established by the CBO (institute for care improvement)[22] and the NIAZ.

While every Member State produces its own standards and accreditation criteria, the programmes developed may themselves be subject to international accreditation, in reference to international standards compiled by the ALPHA (*Agenda for Leadership in Programs for Healthcare Accreditation*) group, a gathering of healthcare accreditation bodies whose goal is to legitimise national efforts at the international level. Nonetheless, as accreditation procedures are based on country context, specifics of healthcare organisation, and the professional culture peculiar to each country, attempts to produce an international accreditation programme have come up against significant stumbling blocks.

• **Certification** is a procedure by which a third party gives a written assurance (a certificate) that a product, process or service meets specified requirements. This approach had its roots in mid-20th century industry and essentially covers the standardisation of procedures and organisational aspects. It is especially suited to technical services or those with a significant technological component (laboratory, radiology, sterilisation, as well as kitchen, laundry, etc.). Certification rarely applies to the hospital establishment as a whole, and mainly concerns specific hospital services.

• Finally, **the EFQM model,** founded in 1988, primarily concerns management quality and grants different "Excellence" awards every year. Initially designed for companies, it is growing in the health sector, especially the hospital sector. An "*EFQM* health group" was created in 1998 and several European Union establishments have followed this approach, like the *Salford Royal Trust Hospital* in Manchester, the United Kingdom, public hospitals in the Spanish Netherlands, the Alcorcon foundation-hospital in the Madrid region, the Saint Augustine hospital in Antwerp (Belgium) and the hospitals in Luxembourg.

In the new Member States like Poland, Bulgaria, Estonia and Romania, several initiatives have been tried out to make quality institutional. They use accreditation and certification procedures. In **Romania**, a 1999 law on the organisation of the hospital sector introduced a certification programme for the latter. A commission was created at that time, with two representatives of the Ministry of Health and two from the hospital sector belonging to the commission. In **Bulgaria**, a hospital accreditation programme was initiated in 2003 and some hospitals were also certified by the ISO international standard. However, the impact of accreditation, without any financial incentives and no gratification considering the efforts to be made, remains limited. In some countries, such an approach has not yet been introduced but is being studied, like in the Czech Republic.

RECOGNITION OF NEW PATIENT RIGHTS

The recognition of patient rights is a fairly recent development among European Union Member States. Since the 1990s, the patient's right to be an active participant in his or her treatment has become stronger, making it necessary to give the needed information and bestow the right to decide on treatment.

Hospital patients long remained at a disadvantage in their relation to the medical staff, because of their disease itself and of their lack of information. The desire to restore a form of balance between patients and healthcare establishments and to set up a "health democracy" where patients become stakeholders has led governments and institutions in charge of the hospital sector to introduce patient rights, by making it a requirement to have them participate in decisions involving their health. These new rights are affirmed by different texts of varying legal standing. They include charters of patient rights, laws, administrative regulations, service charters or conflict resolution procedures.

Today, many EU Member States have signed international treaties with direct implications on patient rights. The most significant one is the European Convention on Human Rights and Fundamental Freedoms of 1950. Moreover, many documents with no true legal value against institutions still have a moral value. They include the 1994 Amsterdam Declaration on the promotion of patient rights or the World Health Organization's "Health 21", 21 health goals for the 21st century, and its 16th goal on the quality of care and the wish for a measurement of patient satisfaction.

Patient rights are also formally written down in "charters" defining formal complaint filing procedures. Since the early seventies, several charters have been published, notably in France, the Netherlands and the United Kingdom. The 1995 French charter for the "hospitalised patient" states that *"the hospital patient is not simply a patient, but above all a person with rights and responsibilities"*. The *Patient's Charter for England*, from 1991, sets out ten recognised rights for patients and encodes the minimum standards that the patient has a right to expect from the *National Health Service*. This rights and standards have no legal value, however.

Some countries have strengthened these rights with laws or conflict resolution procedures. The Nordic countries, like Finland and Denmark, were the first to introduce such laws in Europe. For example, in **Finland**, the law on the rights and status of patients was passed in 1993, and primarily concerns the right to receive information and give consent for treatment. In **France**, these rights are recognised by the law of 4 March 2002.

Alongside such legislation, doctor-patient relationships have gradually become formally set out. The growing complexity of care and the need for neutral mediation between hospitals and patients led to the nomination of a "hospital" mediator, the ombudsman, in certain EU Member States. This ombudsman handles patient complaints, and his mission is to improve the quality of health services. If the mediation process fails, the ombudsman may be asked to bring the case before a court (e.g. in Finland) or before a mediation centre or a tribunal (e.g. in France or the Netherlands.) Although this type of legislation has yet to be developed in the central and eastern European countries, some of them have begun to include patient rights in their policy reform agenda for the health sector. In **Slovenia**, for instance, an ombudsman has existed since the transition period and is in charge of, among other things, the respect of patient rights. In Bulgaria, creation of an ombudsman is in the works.

NOTES

1 McKee Martin, Healy Judith, *Hospitals in a changing Europe*, European Observatory on Health Care Systems Series, 2002.

2 McKee Martin, Healy Judith, *op. cit.*

3 The Ministry of Health's health map divides the country into three hospital regions: North (15% of the resident population), Centre (53%) and South (32%).

4 The average number of beds per 1 000 inhabitants in the European Union in 1980 must be analysed with caution, because the average was calculated using estimates for many countries, as figures were not available for 1980 (particularly those whose densities were among the highest in 2004). Nonetheless, it should be noted that changes in density between 1990 and 2004 follow the same pattern as changes observed between 1980 and 2004.

5 According to this principle, hospital expenditure should be reimbursed in full by the health insurance funds. Hospital remuneration was based on a price per day, retrospectively calculated by the *Land* for each hospital.

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

7 The distinction between acute care hospitals and convalescence hospitals does not exist in all countries.

8 Toftgaard Claus, *World Wide Day Surgery Activity 2003: IAAS Survey of Ambulatory Surgery*, March 2007.

9 "*Les établissements de santé, un panorama pour l'année 2004" (Health establishments, a panorama for 2004),* DREES, Ministry of Health, 2006.

10 *Conditions du développement de la chirurgie ambulatoire (Conditions for the development of ambulatory surgery),* CNAMTS, MSA, CANAM, September 2003. This document can be consulted on www.ameli.fr. The five surgical procedures surveyed were: unilateral cataract surgery, knee arthroscopy with meniscectomy, unilateral carpal tunnel median nerve decompression, extraction of two wisdom teeth under general anaesthesia, and unilateral treatment for lower limb varicose veins.

11 Many countries have "several" private hospital sectors. A large share of the costs incurred during a stay in some private establishments is covered by a type of insurance, as is the case in France.

12 In Slovenia, care provided by a private status provider (health professional or establishment) are generally not reimbursed by the public health insurance, except in case of concession signed with the private providers.

13 This table, however, does not indicate if private or mutual insurance are able to cover this participation.

14 Regarding euthanasia, the law states that three doctors must be involved and provides for general practitioners to invoke a "conscience" clause.

15 Siciliani Luigi, Hurst Jeremy, *Tackling excessive times for elective surgery: A comparison of policies in twelve OECD countries*, OECD, OECD health working papers, 2003.

16 The definition and measurement of surgery waiting times are complex tasks. There are several possible starting and end points for the waiting period. The starting point used here is the moment at which the surgeon declares that surgical intervention is needed for a given patient, and schedules future treatment or enrolls the patient on a formal waiting list in view of an operation (provided that the patient has agreed to such a protocol). The interval between this starting point and the moment the patient is actually admitted for the intervention corresponds to the waiting time analysed here.

17 Country classification and gaps in number of days may be very different for other operations. For example, England has the shortest waiting times for prostatectomies (50 days compared with 80 days in Finland). Patients have to wait longest in Spain for a percutaneous transluminal coronary angioplasty (PTCA), a little more than 80 days, which is very close to waiting times in England, but four times longer than in the Netherlands (just under 20 days).

18 *Euro health consumer index*, Health Consumer Powerhouse, 2007.

19 The great majority of paediatricians agreed to remain hospital employees.

20 *International Organisation for Standardization.*

21 European foundation created in 1988 by 14 companies and based in Brussels. Its goal is to promote a methodological framework for the evaluation of quality improvement. Its EFQM model is based on a concept that consists of using 9 criteria to assess quality.

22 Institute created in 1979 and tasked with providing methodological and logistic support for quality control procedures in hospital structures.

Chapter 4

EU INFLUENCE AND OUTLOOK

1. COMMUNITY COMPETENCIES

Healthcare essentially falls under the competence of the Member States. They are responsible for organising, financing and providing healthcare services. Nevertheless, by virtue of the principle of subsidiarity, the Community is increasingly being called upon to play an active role in healthcare, by embarking on actions that round out national policies while adding European value. This is especially the case in the field of major trans-national health threats, such as food safety, as well as in issues with a cross-border impact or those relating to the free movement of goods, services and persons. Since the early 1990s, a true community health policy has been progressively formed, legitimised by a legal framework put in place during that same decade (Treaties of Maastricht and Amsterdam).

The health policy is not the only deciding policy in terms of healthcare. Other community policies, such as those on the environment, research, and the regulation of pharmaceutical products are also essential. The EU has given itself the objective of integrating health in as many of its policies as possible.

A- PRINCIPLE OF SUBSIDIARITY AND SHARED COMPETENCIES

SUBSIDIARITY

In European integration, health policy is essentially guided by the principle of national sovereignty. In keeping with the principle of subsidiarity, the Community only intervenes in areas that do not fall under its exclusive competency, such as public health, when and if its objectives can be better achieved at community level because of the breadth or effects of the planned action. As such, a function's appropriate level of administration is the most decentralised one, except in special cases.

Member States have thus decided that the national or regional level was the most appropriate for decision-making in terms of the organisation and financing of healthcare services. As a result, community actions in these areas are only legitimate if they round out and/or reinforce those that are carried out at a national level. On this account, and up to now, a large portion of community legislation in the area of healthcare has not fundamentally changed the way that healthcare systems function in the EU Member States, as the different treaties have provided the EU with very limited competencies in terms of healthcare systems.

HEALTH COMPETENCIES

Threats to health security stemming from the free movement of goods in the internal market were brought to light in spectacular fashion during the bovine spongiform encephalopathy ("mad cow") crisis in the late 1980s. They paved the way for an initial delegation of competencies to the Community when intervention in public health matters seemed more appropriate at a European scale.

The 1992 Treaty of Maastricht, in article 129, was the first to structure the European Union's approach to health issues, providing for the Community to "contribute towards ensuring a high level of human health protection". Nonetheless, community intervention in this framework remained limited. It favoured the prevention of diseases, major health threats and their transmission, and health information and education.

Article 152 of **the Treaty of Amsterdam (1997)** expanded the Union's competencies in public health by conferring decision-making powers in certain areas. This is the case, for instance, in setting standards for the quality and safety of organs and substances of human origin, blood and blood derivatives. The treaty also made public health a specific common objective of the Community, and a complementary element of other common policies, namely agriculture, industry and consumer protection. The EU is no longer enjoined to "contribute", but to ensure "a high level of human health protection (...) in the definition and implementation of all Community policies and activities.[1]"

Later, **the Charter of Fundamental Rights of the European Union** (appended to the Treaty of Nice, 2000) would refer to health protection. Article 35 of the charter states that "everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities."

With a legal basis at its disposal for public health intervention, the Community establishes a public health policy and attempts to integrate it in all Community policies and activities.

B- PUBLIC HEALTH PROGRAMMES AND POLICIES

COMMUNITY PUBLIC HEALTH POLICY

The Commission initially presented in 1993 a notice on its policy framework for health. A policy was truly established in 2000, when the Commission adopted a new strategy for a more coherent approach of public health issues.

The strategy focused on three priorities: improving health information and knowledge, responding rapidly to health threats, and addressing health determinants, particularly lifestyles and the environment.

Consumer health and food safety were taken into consideration in a single approach. The Commission reorganised its services, combining the consumer policy and health portfolios, and creating the Directorate-General for Health and Consumer Protection (DG SANCO) in 1999.

Other tools, including a number of agencies, were put in place for health. One of the most important ones was the European Centre for Disease Prevention and Control (ECDC), created in 2005. To improve EU capacity to cope with communicable disease and bioterrorism, its mission is to co-ordinate the laboratories of Member States. The purpose of the ECDC 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 health services.

The first legislative measure to take advantage of the new Community competence granted by the Treaty of Amsterdam (1997) involved blood products[2]. Inspired by the work of the Council of Europe, the directive required laboratories, hospitals, and other establishments collecting, handling and processing blood and blood components to introduce quality management systems.

The main requirements of this system are defined at European level on the basis of best practices, in view of the application of equivalent standards of management and safety throughout the Union. Staff working in these establishments and participating directly in the collection, testing, processing, storage and distribution of blood are required to undergo training that meets Community standards.

It was followed by a directive on human tissues and cells[3]. An ongoing discussion on organ donation and transplantation has followed a consultation and a communication by the Commission[4].

EUROPEAN UNION PUBLIC HEALTH PROGRAMMES

Article 129 of the Treaty of Maastricht (1992) made it possible to create or pursue the progressive development of European public health programmes, especially joint activities on smoking, HIV-AIDS, drug abuse, the surveillance of communicable diseases, and health promotion.

In 1993, the Commission presented a communication on the framework for action in the field of public health. On this basis, eight action programmes on health promotion, cancer, drug dependence, AIDS and other communicable diseases, health monitoring, rare diseases, accidents and injuries, and pollution-related diseases were adopted.

Later, as part of a new strategy, the Commission decided to bring together all public health initiatives in an integrated public health programme, adopted in 2002 and with an initial budget of EUR 312 million for the 2003-2008 period. This programme was based on a very critical evaluation of previous programmes. EU health action is now subject to three key principles that were not previously considered: integration of budget issues, sustainability, and concentration on priority issues. The need for European added value, mainly through the involvement of a large number of Member States and candidates, is also reinforced, as are large-scale, multi-year and multidisciplinary projects.

The three general objectives of the programme are closely tied to those of the Community public health policy: improving health information in order to promote public health, reinforcing the capacity for rapid and co-ordinated reaction to health threats, and promoting health and preventing disease by addressing health determinants through Community policies and actions.

These objectives provided a framework of reference for annual work plans and determined the priority actions for the tasks to be undertaken, as well as the resources allocated to them. That said, only 0.5% of the community budget is slated annually for calls for tender.

The second programme of community action in the field of public health is now in place for the 2008-2013 period. The financial envelope for the programme, at EUR 321.5 million, still falls short of the Commission's ambitions.

The new programme is intended to continue the actions of the previous one. Its major thrust is to support the integration of health goals in all community policies and activities. It especially hopes to undertake joint actions with other programmes, such as research, structural funds and consumer protection.

THE 3 MAIN OBJECTIVES OF THE NEW PROGRAMME OF COMMUNITY ACTION IN THE FIELD OF HEALTH 2008-2013

1. To improve citizens' health security

• Protect citizens against health threats

- develop strategies and mechanisms for preventing health threats from communicable and non communicable diseases and health threats from physical, chemical and biological sources;
- support the development of prevention, vaccination and immunisation policies;
- develop risk management capacity and procedures; improve preparedness and planning for health emergencies, including preparing for co-ordinated EU and international responses;
- promote the co-operation and improvement of existing response capacity and assets;
- develop strategies and procedures for drawing up and improving rapid intervention capacities.

• Improve citizens' safety

- support and enhance scientific advice and risk assessment by promoting the early identification of risks, analysing their potential impact, exchanging information on hazards and exposure, fostering integrated and harmonised approaches;
- help to enhance the safety and quality of organs and substances of human origin, blood and blood derivatives, promote their availability, traceability and accessibility for medical use;
- promote measures to improve patient safety through high-quality and safe healthcare, including in relation to antibiotic resistance and nosocomial infections.

2. Promote health

• Foster healthier ways of life and the reduction of health inequalities

- promote initiatives to increase healthy life years and promote healthy ageing;
- support initiatives to identify the causes of health inequalities within and between Member States.

• Promote healthier ways of life and reduce major diseases and injuries by tackling health determinants

- address health determinants to promote and improve physical and mental health, creating supportive environments for healthy lifestyles and preventing disease;
- promote action on the prevention of major diseases of particular significance in view of the overall burden of diseases in the Community, and on rare diseases;
- address the health effects of wider environmental determinants;
- promote actions to help reduce accidents and injuries.

3. Generate and disseminate health information and knowledge

• Exchange knowledge and best practice

- exchange knowledge and best practice on essential health issues within the scope of the programme;
- support co-operation to enhance the application of best practice within Member States, including, where appropriate, supporting European reference networks.

• Collect, analyse and disseminate health information

- develop a sustainable health monitoring system with mechanisms for collection of comparable data and information, with appropriate indicators; ensure appropriate co-ordination of and follow-up to Community initiatives regarding registries on cancer, based, inter alia, on the data collected when implementing the Council recommendation on cancer screening; collect data on health status and policies; develop, with the Community Statistical Programme, the statistical element of this system;
- elaborate mechanisms for analysis and dissemination; provide information to citizens, stakeholders and policy makers, develop consultation mechanisms and participatory processes; establish regular reports on health status in the European Union based on all data and indicators and including a qualitative and quantitative analysis;
- provide analysis and technical assistance in support of the development or implementation of policies or legislation related to the scope of the programme.

C- HEALTH IN OTHER EUROPEAN UNION POLICIES

OTHER COMMUNITY POLICIES

Many Community policies and activities have an impact on health, healthcare systems, healthcare services, and, consequently, hospitals. They are often devised according to a policy rationale outside of health, without necessarily knowing all the potential effects. Article 152 of the treaty may well clearly require the European Union to make sure that Community policies and activities contribute to ensuring a high level of health protection, but health policy cannot influence alone health determinants. Co-ordinated action with other policies - environmental, social and economic - is needed. There are ongoing partnerships, especially in the following areas: the pharmaceutical sector; demographic changes and ageing; the use of structural funds for health, and health in the information society.

The Lisbon programme is the EU main policy for economic growth and productivity Integration of health concerns in the programme is one of the most significant results obtained as part of the integration of health concerns in other EU policies.

The link between health and economic prosperity is more and more widely recognised, in particular in relation to the ageing population[5]. As such, the "Healthy life years" indicator, which measures the number of years lived in good health, is one of the European Structural Indicators of the Lisbon Agenda.

The other important element is the introduction of the "open method of co-ordination" (OMC) in the area of health, and more specifically, long-term stays. The OMC is one of the instruments that should make it possible to achieve the objectives of the Lisbon strategy for growth and employment (see boxed text next page).

THE OPEN METHOD OF COORDINATION

The "open method of coordination" (OMC) provides Member States with a novel instrument that should help them come closer to objectives defined at the European level, and to exchange good practices in the fields of labour, social protection, and social inclusion. Member States see their competencies respected within this co-ordination framework, as they are responsible for defining the suitable assets for achieving the goals set. The OMC should serve as a catalyst, by bringing about major policy changes throughout the EU.

In wide areas of economic, social and labour policy, Member States have to meet similar challenges throughout the EU. The convergence of these challenges can be explained by economic integration within the internal market, as well as the impact of demographic changes, technological innovation, and changes in the global economy. An instrument was therefore deemed necessary to aid Member States in their reform process, while respecting their legal competencies.

The OMC provides this framework for policy co-ordination without any legal constraints. It is based in part on the definition of common objectives and indicators, the benchmarking of performances, the exchange of best practices, and monitoring on the EU scale. In addition, Member States are free to select the resources to be implemented to achieve these common objectives. Nonetheless, they must make commitments in national reform programmes (or actions plans, strategic reports) that serve as a basis for evaluating their efforts. The concrete structures of the OMC differ from one policy area to another.

Defining lines of action or common goals at the European level, associated at times with specific timeframes, politically obliges Member States to make efforts to carry them out. In principle, national reforms are often more legitimised politically speaking. Adopting common indicators makes it easier to measure political efforts and their impact. The commitment of Member States to follow national reform programmes aids in centring their efforts while enhancing transparency.

By comparing national situations, it is easier to identify strengths and weaknesses and define priorities. Knowing the policies being carried out in other countries gives decision-makers a wider range of available solutions, encourages new political developments, and helps them avoid costly errors. It is also important to allow the comparison and systematic dissemination of information throughout the European Union.

The OMC therefore stimulates political development at the local, national and European scales. It also promotes a partnership-based approach within the Member States in terms of governance, including the way they work with social partners, local and regional authorities, and other stakeholders of the social economy and civil society.

After the OMC in the areas of pensions and social inclusion, the EU decided to expand the OMC to the area of healthcare and long term care, to deal with the common challenges of ageing and technological development that all national healthcare systems must face.

Joint strategies and initiatives with other health-related policy areas are also important tools to ensure that health concerns are being properly addressed. Such joint approaches have been developed, for instance, on health and the environment, health and social policy, eHealth, research on life sciences and on health policy, and health and pharmaceuticals policy. A health Inter-Service Group involving representatives from most Commission Directorates General is chaired by the Directorate-General on Health and Consumer Protection (DG SANCO), and meets every six months, to improve co-ordination and integration of health protection within the Commission services. This group allows different Commission services to present work in their areas of responsibility which could have a health impact, and also allows DG SANCO to share its own work with other Commission's Directorate Generals.

For **health** and the **environment**, a strategy was adopted on 11 June 2003 to reduce the impact of environmental factors on human health, specifically in children, who are most exposed to pollution. It aims to better understand the complex relationships between the environment and health, and thus cut the incidence of environment-related diseases. Three European Commissioners (Health, Research and Environment) are working together on this strategy, called SCALE (Science, Children, Awareness, Legislation and Evaluation). The initial cycle from 2004-2010 focuses on 4 areas: childhood respiratory diseases (asthma, allergies), neurodevelopmental disorders, childhood cancer, and endocrine disrupting effects. The environment also covers waste management policy[6], which concern the hospital sector for both household waste and hazardous waste (for which directives should soon be amended).

THE EUROPEAN HEALTH INSURANCE CARD

Following up on an agreement concluded during the Barcelona European Council, the Commission worked to replace the paper forms needed to avail of medical treatment in another Member State with a European health insurance card[7]. It also envisaged the introduction of a common approach to patient identifiers and the architecture of computerised medical records, and encourages the exchange of best practices in view of integrating new functions, such as the storage of medical emergency data or secure access to personal medical data.

In the field of **information systems**, the e-Health initiative of the Commission, along with the action programme for public health, form part of the European Union's strategy to provide European citizens with access to reliable, high quality information. The eEurope 2002 action plan adopted on 14 June 2000 sought to:

- ensure that primary and secondary healthcare providers have healthcare telematics infrastructure in place, including regional networks;
- identify and disseminate best practice in electronic health services in Europe, and set benchmarking criteria;
- establish a set of quality criteria for health related websites;
- establish health technology and data assessment networks;
- publish a communication on "Legal aspects of health on the internet".

Evidently, the other major aspect in this area is data protection, which has been the subject of directives that, while not specific to the health sector, integrate its issues[8].

Today, actions in this area focus not only on interoperability, but also on telemedicine and innovative technologies for chronic disease management.

Research policy is also an area where community policies cross, and raises questions in terms of clinical trials[9] or advanced therapy[10], even if the latter, like medicines, follow an internal market rationale.

OTHER PROGRAMMES

European financing usually conveys three preconceived notions. The first is that it is an inexhaustible resource. In truth, the European budget remains close to 1% of European GDP, and EU funding requires co-financing in most cases. Although it may correspond to a valuation of working time, an action is required in exchange. Financial return on investment is thus far from a given.

Another preconceived notion is that funding is obtained from Brussels. Community institutions are not limited to Brussels, and many programmes are organised and even managed at the national, if not regional, level.

Finally, the notion that all projects have potential for funding neglects the fact that these programmes are the result of defined policies, one of whose major aspects remains added value for Europe. The Common Agricultural Policy still uses up to a third of the EU budget. Structural and regional policies use 31.5%, while research accounts for almost 10%. Therefore, only negligible shares are allocated to other programmes.

The European programmes mentioned here are but a few of the full list. Before giving concrete examples, the policies behind them will be presented first.

• **The Framework Programme for Research and Technical Development (FPRTD)** covers many strategic areas of research in both life sciences and social sciences, as well as new information technologies and the environment. The sixth such programme, known as FP6 (2003-2006), was in line with a specific policy context surrounding the launch of the European Research Area (ERA) initiative. The main objective of the ERA initiative is to create an environment that fosters both the development of European research activities and innovation and, as such, their enhancement in terms of the use of scientific results.

The seventh FPRTD, or FP7 (2007-2013) departs in some important ways from previous EU research programmes. Its budget is higher than the previous one by over 60%. The other major aspect is its strong focus on major research themes, including health and information and communications technology.

• **European regional policy** was introduced by article 158 of the Treaty of Rome to reduce the inequalities between the different levels of development of the European regions. The 2007-2013 policy has three objectives: convergence, regional competitiveness and employment, and territorial co-operation. The main tools for the implementation of the regional policy are the **structural funds**: the European Regional Development Fund and the European Social Fund.

Convergence aims to help Member States and regions with GDP below the European average to attain this average. The convergence objective devotes more than 80% of resources on projects that may have an impact on health, such as physical and human capital and innovation. The second objective, using more than 15% of resources, aims at strengthening employment and the attractiveness of other regions. The third objective, territorial co-operation, will strengthen cross-border co-operation, especially for health, trans-national co-operation, and inter-regional co-operation. The actions include financing common solutions, creating networks, research activities, development, activities on the "information society" (information and communication technologies), the environment, risk prevention, etc. Regions eligible for cross-border co-operations are those found along borders, as well as some regions located along coastlines separated by a maximum distance of 150 kilometres. The European Commission draws up a list for trans-national co-operation areas, while all European regions are eligible for inter-regional co-operation.

2. PRINCIPLES OF THE INTERNAL MARKET

The European Union is above all an economic union, founded on the principles of the free movement of goods, services, persons and capital within an internal market. Through the competencies acquired in this framework, it intervenes in almost all sectors of activity, including the hospital sector. Although they do not necessarily measure its impact on a daily basis, hospitals thus exist in an environment that is governed to a great extent by community legislation, whether this concerns the goods and services they produce, the professionals they employ, the patients they admit, the financial resources they obtain and the investments they make. The EU influence, while not decisive, is nonetheless not negligible. Influence may be indirect but progressively become very direct, as evidenced by the consequences of community jurisprudence that considered healthcare a service. With the ongoing debate on the directive on cross-border care, the difficulties in reconciling these elements with the provisions of the treaty that restates the Member States' competency in organising and financing of health systems are now coming to light.

A- FREE MOVEMENT OF GOODS AND SERVICES

GOODS

The creation of an open market implies the free movement of goods. To prevent Member States from taking discriminatory measures based on product origin, the Community decided to harmonise national rules on merchandise that was likely to circulate.

Goods purchased by hospitals are highly varied, ranging from food, medicines, equipment, miscellaneous supplies, etc. All of them have more or less been targeted by legislation - general or specific - in the name of free movement. Two types of goods are particularly relevant to the health sector: medical devices and medicinal products.

Different national regulations on conditions for manufacture and distribution may be obstacles to the creation of a single market. Community authorities therefore worked to draw up common regulations for **medical devices**. Three directives cover this: one for medical devices (such as hip prostheses), another for active implantable medical devices (such as implantable pacemakers) and one for *in vitro* diagnostic devices[11]. Two of the directives have been amended recently[12].

THE COMMUNITY DIRECTIVE ON MEDICAL DEVICES

Council Directive 93/42/EEC of 14 June 1993 states that a medical device can only be placed on the market if it meets basic quality and safety requirements.

Requirements vary according to the purpose and potential risk. The manufacturer is responsible for demonstrating that its device meets these basis requirements, but health authorities have the power to subsequently test and evaluate either the manufacturer's quality assurance system or the safety and quality of the medical device itself. A EC marking attests the device's compliance with the basic standards.

For **medicinal products**, directives have been adopted since 1985[13] in order to create a single market for medicinal products. In addition to implementing free movement principles, it also strove to strengthen the European pharmaceutical industry while improving citizens' quality of life. Among other things, the regulations set the criteria that medicinal products must meet before they can be placed on the market, as well as criteria for drug monitoring, advertising, and data protection times.

EUROPEAN REGULATIONS ON MEDICINAL PRODUCTS

In 2001, the European Commission formulated proposals aimed at carrying out the radical reform of European legislation on medicinal products. There were multiple goals: to pursue the establishment of the internal market for medicinal products, to spur competition, and to address challenges stemming from enlargement and globalisation, while ensuring that European citizens would receive a high level of protection.

The aim was to simplify and speed up procedures - and therefore the availability - of new products. To achieve this objective, the European Commission proposed the expansion of the centralised procedure for matters involving marketing authorisation, shorter product evaluation times, accelerated registration of products with high therapeutic values, and reducing the possibilities for Member States to oppose the procedure on the basis of mutual licensing.

Many of the proposals contained in this reform were highly controversial: procedures would be sped up even more, to the detriment of the extensive assessment of product quality, safety and efficacy; data protection times would be extended; and the pharmaceutical industry would be allowed to inform patients directly of certain products.

The European Parliament and Council made significant amendments to the initial proposal[14]. Proposals concerning the dissemination of information on prescription-only medicinal products were removed, and shorter data protection times were indicated. Finally, provisions were put in place to ensure the transparency of procedures relating to licences.

Since January 1995, the new European system has offered two ways for medicinal products to gain marketing authorisation: a centralised procedure handled by the London-based European Medicines Agency, and a mutual recognition procedure that applies to the majority of conventional medicines. Strictly national authorisations remain possible.

Pricing and reimbursements for medicine are, in principle, among the competencies of the Member States. Nonetheless, European legislation stipulates that decisions in these areas should be transparent, based on objective criteria, and taken within reasonable timeframes.

In the years that followed, specific measures were taken for orphan medicinal products, while propositions on the paediatric use of medicinal products were recently legislated. Among other things, such measures provide for extending data protection for medicinal products that fall under these categories.

SERVICES

Hospitals are also service consumers. The freedom to provide services between Member States is provided for in Articles 49 and 50 of the treaty. Community provisions were adopted for the different services used by hospitals: finance, insurance, consultancy, etc. The re-launch of the internal market for this sector through the Services directive[15], which is currently being transposed, is a recent point reinforcing this policy.

But, most importantly, by virtue of their care activity, hospitals are now defined as service providers in terms of Community law. The European Court of Justice has recognised that health activities are services in the sense of article 49[16], whether this refers to ambulatory[17] or hospital care[18], or whether they are eligible for reimbursement from social insurance regimes or performed free of charge.

On the basis of this jurisprudence, health services were integrated in the first draft of the Directive on services, commonly known as the "Bolkestein Directive" named after the Commissioner behind the initial proposal. The subsequent exclusion of health services from the directive did not put an end to the application of internal market rules to the health sector. The Commission's proposal of a directive on cross-border care, postponed several times in late 2007 and promised for 2008, thrusts health right back into the framework of the internal market. The main argument of the Commission is founded on European Court of Justice jurisprudence, which defined hospital and ambulatory care as services (the aforementioned Kohll and Decker and Smits-Peerbooms rulings).

B - FREE MOVEMENT OF PERSONS

FREE MOVEMENT OF PROFESSIONALS

Both salaried and self-employed hospital workers are covered by general community provisions that are applicable to all workers, as well as more specific provisions for the healthcare sector in some cases.

Article 39 of the EEC Treaty states that "*freedom of movement for workers shall be secured within the Community*". It was a principle that should allow workers to seek employment throughout the Community. For self-employed persons, the right of establishment was defined in article 43. A Member State always has the possibility of establishing provisions for access to or the right to exercise a specific activity, but such provisions must meet four requirements: they should be applied without discrimination, be justified on imperative requirements in the general interest, be suitable for securing the attainment of the objective that they pursue and, finally, must not go beyond what is necessary in order to achieve the defined objective[19].

Five of the seven professions that are the object of so-called "sectoral" directives are in the health sector: doctors[20], nurses[21], midwives[22], dentists and pharmacists[23].

They were recently amended by Directive 2005/36/CE on the recognition of professional qualifications. Other professions found in the hospital are covered by the general system for the recognition of professional qualifications[24]. In both cases, the directives harmonise minimum training conditions and provide for the automatic recognition of professional qualifications.

Moreover, to ensure that disparities in training and professional qualifications do not constitute a barrier to the free movement of workers, a series of provisions were adopted for the protection of workers, all within the rationale of the internal market.

The free movement principle is the legal basis for community intervention regarding the safety and health of workers, in order to allow free movement of workers while guaranteeing them a "high level of health protection". In 1974, a resolution on a social action programme with a strand devoted to occupational health and safety was adopted for the first time. The Single European Act (1987) conferred the Community with real powers over occupational health and safety, allowing it to adopt measures through qualified majority voting[25]. Since then, a series of specific provisions have been adopted in this context. Some are specific to certain categories of hospital workers[26]. In the Commission's 2008 strategy, new provisions on musculo-skeletal risks at work, the directive on magnetic fields (MRI), and the simplification of legislation on protection from certain types of radiation were mentioned.

Provisions were also made for the working time of employees. Directive 93/104/EC on the organization of working time adopted in 1993[27] sets minimum conditions that Member States can choose to make more protective. The directive sets maximum working time, minimum periods of daily rest, rest breaks where the working day is longer than six hours, minimum weekly rest periods, and restrictions for night work. This directive is now being amended due to pressure from a controversial decision of the European Court of Justice.

COVERAGE OF MEDICAL CARE PROVIDED TO WORKERS IN ANOTHER MEMBER STATE

In the terms of Article 22 of Regulation 1408/71, medical treatment during (temporary) stays or travel to a Member State other than the competent Member State must meet a certain number of principles. The salaried or self-employed worker (or member of the family) whose condition necessitates immediate coverage (for hospital or non-hospital care) during a stay in the territory of another Member State, or who is authorised by the competent social protection institution to go to the territory of another Member State to receive treatment, is entitled to benefits in kind provided on behalf of the competent institution by the institution of the place of stay or residence in accordance with the legislation which it administers, as though he were insured with it. After providing the services in question, in accordance with its national legislation, the institution in the host Member State should then contact the competent institution to obtain reimbursement for costs of the care ("inter-fund" reimbursement carried out on the basis of Article 36 of Regulation No 1408/71). Except in cases where the state of health of the insured person requires emergency care during a stay in another Member State, the institution of the competent State shall cover the medical expenses, according to the scale of the Member State where the patient received care or purchased medical products, on condition that prior authorisation was granted (Regulation No 1408/71).

The co-ordination of social protection regimes, inscribed in Article 51 of the Treaty of Rome, was also put in place to prevent differences in social security from hampering the free movement of workers. Note that this does not concern harmonisation, but rather co-ordination, laid out in article 22 of Regulation (EEC) No 1408/71 of the Council of 14 June 1971 on the application of social security schemes to employed persons and their families moving within the Community. It guarantees, under certain conditions, coverage of medical expenses by the competent State according to the rates set by the Member State on the territory where care was delivered.

FREE MOVEMENT OF PERSONS

Initially limited to workers, the principle of free movement was expanded to all persons with the Treaty of Amsterdam (1997). The major challenge for health services was then to translate these services in terms of patient mobility.

There are now two systems for healthcare coverage: one from the Community law regime based on Article 22 of Regulation No 1408/71 (see boxed text), and one from a jurisprudence-based regime that initially drew on Articles 28 and 30 EC (free movement of goods) and articles 49 and 50 EC (free provision of services) that rounded out community law. This regime (the previously cited Kohll and Decker, and Smits & Peerboom rulings) includes the obligation of Member States to remove barriers to the free movement of patients. This especially covers measures such as requiring prior authorisation to avail of ambulatory care abroad, unless this is dictated by reasons of public order, such as public health protection, or imperative requirements in the general interest. The European Court of Justice has also made it clear that provisions on the free provision of services also apply in Member States whose healthcare systems are based on a national healthcare service[28].

Thus, according to the different judgements made by the European Court of Justice, the patient can avail of care in another Member State and obtain the fixed refund in the country of affiliation when the treatment in question does not exist on the territory, exists but is subject to significant waiting times, or are not sufficiently suited to the patient's situation.

EUROPEAN DEBATE ON PATIENT MOBILITY

The legal uncertainty that came from the Kohll and Decker ruling, which introduced provisions that did not dovetail with Community law, and the quest for political solutions to this uncertainly, prodded the Member States to focus on concerted efforts and closer collaboration in this area at the European level. In 2002, the European Commission opened a high-level process of reflection on patient mobility and the impact of the internal market on national healthcare systems. Almost all of the Member States participated in this reflection process, as did several European healthcare associations, including the European Hospital and Healthcare Federation (HOPE).

In December 2003, the final report of the process of reflection was presented[29]. It contained 19 recommendations for EU-level action. On 20 April 2004, the European Commission presented its response to the recommendations of the process in the form of a communication on patient mobility[30].

The Commission proposed European co-operation in four areas:

- rights and duties of patients: sharing capacity and trans-national care;
- mobility of health professionals;
- European centres of reference;
- health technology assessment.

To steer this co-operation process, the commission created a High Level Group on health services and medical care. The group is composed of representatives from the Member States, the Commission, and European associations, such as the European Hospital and Healthcare Federation (HOPE).

To date, the high level group on health services and medical care has drafted reports that were subsequently submitted to the council.

The reflection is expected to bear fruit in the near future, as the Commission has presented a draft directive on patient rights in trans-national care on 2 July 2008.

C- COMPETITION AND STATE AID

RULES OF COMPETITION

The application of European rules of competition are based on the notion of an "undertaking". For the purpose of EU antitrust law, the European Court of Justice defines an undertaking as "any entity engaged in an economic activity"[31], regardless of its legal status and the way in which it is financed. This general criterion is based on the type of activity accomplished, not the status or characteristics of the operator. In the 1990s, the Court was obliged to differentiate social protection regimes that could be assimilated into an economic activity, and therefore subject to European competition rules, from regimes that were exclusively social in function and therefore not subject to these rules.

CASE STUDY: FENIN, QUALIFYING AN ECONOMIC ACTIVITY

The *Federación Nacional de Empresas, Instrumentación Científica, Médica, Técnica y Dental* (FENIN), a Spanish association of businesses which market health products in Spain, complained to the European Commission in December 1997 about what it deemed the abuse of a dominant position by 26 entities (including three Spanish government ministries) that managed the Spanish national health service. In August 1999, the Commission rejected FENIN's complaint for two reasons: the ministries and bodies in question are not undertakings when they participate in the management of the health service, as their position as purchasers of health equipment cannot be separated from the ultimate provision of health services.

In November 1999, FENIN appealed against the rejection of its complaint to the Court. The appeal was also rejected. The Court's major ruling lies in its statement that only offering goods or services on a given market could be characterised as an economic activity. Simply making purchases on a market does not qualify. Therefore, when an entity purchases products for use in another activity (and not for subsequent use in offering goods or services in another economic activity), such as one that is purely social in nature, that entity is not acting as an undertaking as defined by EU competition rules.

The Court of First Instance of the European Communities[32] was led to answer the question of whether state entities acted as undertakings (in the sense of European competition rules) when they purchase health equipment for public hospitals, to provide medical care services covered by social protection. For the Court, once the qualification of non-economic activity is recognised, the entity is exempted from European competition rules, at least for the activities recognised as such. A Member State that entrusts exclusive management rights over medical coverage, organised according to a given regime, to a given body or a specific category of bodies does not confer that body with a dominant position in violation of European competition law.

Conversely, there may be cases in which bodies may, while being considered undertakings according to European competition law, be rightly entrusted with the exclusive right to manage their activity in a given sector. The provisions in Article 86 EC allows for justifying restriction, if not exclusion, of competition, owing to the need for the undertaking in question to accomplish the economic mission in the general interest that it has been granted under acceptable economic conditions.

This desire to avoid distorting competitive conditions is also at the root of community legislation on public works, supply and service contracts (Directive of 14 June 1993)[33].

EXEMPTION FROM COMPETITION RULES BY QUALIFICATION AS A MISSION OF GENERAL ECONOMIC INTEREST

The *Ambulanz Glöckner* ruling of the European Court of Justice[34] illustrates this case in the health sector.

Owing to a legislative provision, the transport of patients by ambulance in the German State of Rhineland-Palatinate was subject to authorisation from the competent district. The authorisation could be denied if granting could have negative effects on the operation and profitability of the emergency medical aid services whose management had been entrusted to health organisations.

Given that these organisations operated at a loss, and that their infrastructure was underused, the national legislation in question also granted them a monopoly on the transport of patients in non-emergency cases. The Court qualified these organisations as undertakings, and found that the monopoly they were granted was an exclusive or special right, to the extent that it could have a substantial effect on the capacity of other undertakings to exercise the economic activity in question in the same territory, and limit the offer to the detriment of users. Nevertheless, it considered that restriction of competition is necessary to enable the holder of an exclusive right to perform its task of general interest entrusted to these health organisations, and the need for such organisations to perform its services in conditions of economic equilibrium presupposes that it will be possible to offset less profitable sectors (emergency transport) against the profitable sectors (non-emergency transport) and hence justifies a restriction of competition from individual undertakings in economically profitable sectors.

STATE AID

Article 87 of the EC Treaty states that "*save as otherwise provided in this Treaty, any aid granted by a Member State or through State resources in any form whatsoever which distorts or threatens to distort competition by favouring certain undertakings or the production of certain goods shall, insofar as it affects trade between Member States, be incompatible with the common market.*"

The overwhelming majority of hospital financing is public, whether it comes from social insurance or public budgets from the State or local authorities. This raises the question of their place in view of these Community provisions.

The Community notion of entrustment was developed to address this feature of public financing. It is now at the heart of the transposition of the services directive, even though it provides for the exclusion of health services and certain social services. If the Commission's interpretation is to be believed, providers of these services should probably be subject to entrustment.

The act of entrustment, through its contents, is the act by which the authority confers responsibility for the execution of a specific task and the specific duties of the service of general interest that stem from it.

The official act of entrustment must specify: the definition of the specific task of general interest, the nature and duration of the public service obligations, the undertaking and territory concerned, the nature of any exclusive or special rights assigned to the undertaking, the parameters for calculating the compensation, and the arrangements for avoiding any overcompensation.

The compatibility of public financing, which is granted as compensation for the task of general interest, with the treaty's provisions is subject to the observance of the entrustment requirements. In the absence of acts of entrustment, this ruling on compatibility does not apply in principle, and the European Commission should be notified beforehand of State aid so that its compatibility with the treaty's rules can be verified.

The Altmark judgement[35] gives four criteria that must be met so that the compensation in question does not constitute State aid (the latter must be declared to European authorities):

- the public service obligations must be clearly defined;

- the parameters on the basis of which the compensation is calculated must be established in advance in an objective and transparent manner, so that it does not include an economic advantage that favours the beneficiary undertaking over competing undertakings;

- the compensation cannot exceed what is necessary to cover all or part of the costs incurred in the discharge of the public service obligations, taking into account the relevant receipts and a reasonable profit for the discharge of these obligations;

- Finally, where the undertaking is not chosen pursuant to a public procurement procedure which would allow for the selection of the tenderer capable of providing those services at the least cost to the community, the level of compensation needed must be determined on the basis of an analysis of the costs which a typical undertaking, well run and adequately provided with means of transport, would have incurred.

This ruling was followed by the Commission's adoption of a series of measures, the so-called "Monti package"[36] which defined the role of hospitals in this context: "*Hospitals and undertakings in charge of social housing which are entrusted with tasks involving services of general economic interest have specific characteristics that need to be taken into consideration. In particular, account should be taken of the fact that at the current stage of development of the internal market, the intensity of distortion of competition in those sectors is not necessarily proportionate to the level of turnover and compensation. Accordingly, hospitals providing medical care, including, where applicable, emergency services and ancillary services directly related to the main activities, notably in the field of research, and undertakings in charge of social housing providing housing for disadvantaged citizens or socially less advantaged groups, which due to solvability constraints are unable to obtain housing at market conditions, should benefit from the exemption from notification provided for in this Decision, even if the amount of compensation they receive exceeds the thresholds laid down in this Decision, if the services performed are qualified as services of general economic interest by the Member States*".

Two points are therefore very clear to the commission: a time frame ("*the current stage of development of the internal market*") and an essential condition: the qualification of "*services of general economic interest*" and hence entrustment.

3. HOSPITAL COOPERATION

A- INSTITUTIONAL COOPERATION

Hospital professionals and institutions have set up a large number of co-operation mechanisms and networks. They all contribute to the European effort, whether they are organised by theme or by profession, or funded by the European Union or not. Among these networks, one of the major representatives of institutional co-operation between the different hospital stakeholders at the European level (and which covers more than three-quarters of European hospitals) was created in 1966 to provide information - and encourage its dissemination between Member States - on the organisation and operation of hospital services. **HOPE**, the European Hospital and Health Care Federation, is a non-profit European association comprising national hospital federations and, when these do not exist, federations of local and regional authorities, owners of hospitals and healthcare services, and representatives of national health services.

In addition to acting as an adviser to its members, HOPE strives to encourage the dissemination of best practices in the organisation of health systems and the role played by the hospital, the organisation of the hospital itself, both in terms of healthcare and management, as well as economic and financial topics.

Institutional co-operation is thus established by the distribution of regular or one-off publications, as well as bilateral exchanges between federation members and study trips organised by HOPE. These actions are reinforced by an exchange programme that, since 1991, has given health professionals the opportunity to undergo a training programme of several weeks on a predefined theme, in a hospital structure in another EU Member State[37].

This institutional co-operation now extends beyond its members, as the Federation has established partnerships with other European health associations, and co-operates with various international organisations with an interest in health issues, such as the WHO regional office for Europe, the OECD and the Council of Europe. HOPE is also involved in the community decision-making process by taking positions on EU legislation on health issues, in order to defend the interests of hospitals and health services.

B- COOPERATION IN BORDER REGIONS

Member States have traditionally paid close attention to their borders, primarily to attempt halting epidemics there. Other factors are behind the more recent development of cross-border health co-operation[38].

For health professionals, the development of means of responding to catastrophes and other health emergencies (such as avian flu) have highlighted the need to work together across borders. The increase in cross-border flows in general, and specifically the existence of border workers, also alters the perception of patients. Awareness of the proximity of healthcare structures, compounded by the new expectations of populations, drives exchanges. The existence of innovative equipment and the perception of better or faster healthcare on the other side of the border are more factors in developing these exchanges. A stronger sense of the European ideal as well as access to community funding by the stakeholders adds to this.

Players in the healthcare sector began to mobilise little by little. Professionals and institutions created networks around border areas to work together. The exchange of best practices, joint training programmes, prevention activities, and organisation of patient flows are among the activities that help improve the medical environment of patients on both sides of the border, and in certain cases reduce the inequalities between territories.

The collaboration of health stakeholders in border regions soon came up against the obstacles tied to the fact that health systems were created in relative isolation (with a few community exceptions, such as the mutual recognition of qualifications). It became evident that instruments that allowed cross-border co-operation were needed.

Some Member States have recently adapted their health service planning tools to cross-border co-operation France, for example, integrated the cross-border aspect for the first time when it drafted its third regional health organisation plans in 2006. Some contracts of State-region projects also take the cross-border dimension into account. Agreements are also made between Member States, regions, and financial backers and players in the area of health. With regard to the mobility of patients and professionals, this may have to do with reimbursements for care or the authorisation to exercise an activity. Bilateral instruments have also been adopted at the national level. Their objective is to develop or facilitate existing cross-border co-operation. Three framework agreements have been signed by France - one with Belgium, one with Germany and one with Spain). Nonetheless, such agreements are not enough to eliminate all obstacles to the development of cross-border co-operation although they can be used as a means to move co-operation efforts to the national level, their application takes time and does not resolve all the difficulties encountered locally.

C- OTHER FORMS OF COOPERATION

Hundreds of European projects, with or without Community funding, have been put in place in the hospital sector. The examples presented here, financed as part of Community programmes, illustrate this European creativity.

TRANSNATIONAL COOPERATION

On 17 January 2003, the signing of a convention between the *Hôpitaux Universitaires de Strasbourg*, the *Centre Hospitalier Universitaire de Liège* and the *Centre Hospitalier de Luxembourg*, joined later by the *Centre Hospitaler Régional de Metz*, was the starting point for a trans-national hospital co-operation project. The three areas of activity chosen for this networking of hospitals were:

- the creation of a trans-national IT communication network;
- co-operation for technological innovation and patient management;
- co-operation for human resources and training.

This co-operation falls under the scope of the INTERREG IIIB 2000-2006 community programme[39] and constitutes a truly innovative experiment in this type of programme, which up to now has mainly financed projects such as communication pathways or regional economic development.

But hospital centres and university hospital centres in general, and these four in particular, among the biggest employers in their regions, have been recognised as playing crucial roles in territorial development. This is the reason why the co-operation project was validated as part of INTERREG IIIB. Half of the funding for this activity comes from the European Regional Development Fund (ERDF), while the remaining half is provided by the four hospitals. The *Hôpitaux Universitaires de Strasbourg* managed to acquire financial participation from the Alsace and Bas-Rhin regional authorities as well as the Strasbourg urban community.

RESEARCH

The *HESCULAEP* ("Health emergency national regional programmes for an improved co-ordination in pre-hospital setting") project contributes to networking national research programmes. This co-ordination effort was launched to address the fragmentation, duplication, dispersion and overlapping of research efforts, and to provide the infrastructure that would allow long-term co-operation in this area. By performing a comparative benchmarking of national programmes, the project partners will be able to determine the areas that may be opened to collaborative research and potential common programmes. The *HESCULAEP* project is co-ordinated by the French organisation SAMU 92 (*Assistance Publique-Hôpitaux de Paris*) and brings together a consortium of 13 members that include representatives of hospitals, regional authorities, and national authorities. The participation of a set of players involved in the planning and provision of medical emergency services should help see to it that research projects under *HESCULAEP* are as pertinent as possible for all members, while taking into account the specifics of health and emergency care infrastructure in each Member State.

E-HEALTH

Some examples of the projects financed under the *eTEN* programme are proof of the variety of the sponsored actions.

CITRON, a 1999 project, explores synergies from three technologies: the user number (through the chip card), access to information (through call centres) and information registries (electronic medical records). *E-MED* hopes to adopt e-commerce techniques to reduce the volume of transactions between patients and healthcare financiers. *EURAD* is a trans-European network that integrates teleradiology services into daily medical practice, in order to facilitate communication between distant points or across the border. *EURODONOR* aims to define and create a database and network for organ transplantation. *MEDICATE* is a telemedicine project for asthmatic patient home monitoring connected to a medical centre that transmits results via the Internet. *NETCARDS,* a trans-European network for access to health services for mobile citizens, focuses on European forms (E111 and E128 in particular) to test a simplified form on chip cards and secure environments. *VIRTUS* is a concept that aims to create a virtual hospital as an alternative to healthcare provision.

TRAINING

Europhamili, a three-month trans-national professional training programme created for healthcare managers, was set up and continues its activities with the support of the hospital sector. Its initial phase in 2002 and 2003 was financed by the *Leonardo da Vinci* programme of the European Commission. *Europhamili* is now a continuing education programme that is open to all health service professionals who wish to improve their skills in managing healthcare organisations: hospital managers, medical department heads, health care service administrators, public health physicians, medical and paramedical professionals, and nurse managers.

Its goal is to integrate the European dimension in the experiences and know-how of health service management. Bulgaria, Croatia, Denmark, France, Lithuania, Poland, Portugal, Spain and the United Kingdom are the 9 *Europhamili* Member State partners. Taught in English, it is founded on trading experiences and practices at the translational and multi-professional level. The *École des hautes études en santé publique* (EHESP) co-ordinates all the *Europhamili* activities, including a European Health Cooperation Database[40].

PUBLIC HEALTH

Orphanet is an information portal on rare diseases and orphan drugs for all target audiences. Its purpose is to contribute to improving the diagnosis, management and treatment of rare diseases. It comprises an online encyclopaedia written by European experts and a directory of services for patients and professionals. The directory includes information on specialised consultations, diagnostic laboratories, ongoing research projects and patient associations.

Orphanet was originally funded by the French national authorities. Starting in 2000, funding from the European Commission made it possible to expand data collection to other EU Member States.

In its current version, *Orphanet* contains information on the thousand or so ongoing research programmes, diagnostic laboratories, patient associations and specialist consultations. It also has details of orphan drugs used to treat them and links to websites on these diseases from around the world.

NOTES

1 Article 152 EC.

2 Directive 2002/98/EC setting standards of quality and safety for the collection, testing, processing, storage and distribution of human blood and blood components.

3 Directive 2004/23/EC on the traceability, and notification of serious adverse events and reactions, as well as certain technical requirements on the coding, processing, preservation, storage and distribution of human tissues and cells.

4 Commission Communication on Organ Donation and Transplantation: Policy Actions at EU level, COM (2007)0275 and Commission Staff Working Document accompanying the Communication: Impact Assessment SEC(2007)0705.

5 European Commission, The Relationship Between Demographic Change and Economic Growth in the EU, November 2006.

6 Council Directive 91/156/EEC of 18 March 1991 amending Directive 75/442/EEC on waste and Council Directive 91/689/EEC of 12 December 1991 on hazardous waste.

7 http://ec.europa.eu/employment_social/healthcard/index_en.htm

8 Directive 95/46/EC of the European Parliament and of the Council of 24 October 1995 on the protection of individuals with regard to the processing of personal data and on the free movement of such data.

9 Directive 2001/20/EC of the European Parliament and of the Council of 4 April 2001 on the approximation of the laws, regulations and administrative provisions of the Member States relating to the implementation of good clinical practice in the conduct of clinical trials on medicinal products for human use and Council Directive 86/609/EEC regarding the protection of animals used for experimental and other scientific purposes.

10 Regulation (EC) No 1394/2007 on advanced therapy medicinal products and amending Directive 2001/83/EC and Regulation (EC) No 726/2004.

11 Directive 98/79/EC on in vitro diagnostic medical devices.

12 Directive 2007/47/EC of 5 September 2007 amending Directive 90/385/EEC on active implantable medical devices and Directive 93/42/EEC concerning medical devices.

13 The first Directive, 65/65/EEC, dates back to 1965, and was followed by Directives 75/318/EEC and 75/319/EEC.

14 Regulation (EC) No 726/2004 laying down Community procedures for the authorisation and supervision of medicinal products for human and veterinary use and establishing a European Medicines Agency and Directive 2004/27/EC amending Directive 2001/83/EC on the Community code relating to medicinal products for human use.

15 Directive 2006/123/EC on services in the internal market.

16 C-159/90, Society for the Protection of Unborn Children Ireland of 4 October 1991.

17 C-158/96 Kohll and C-120/95 Decker of 28 April 1998.

18 C-157/99 Smits-Peerbooms and C-368/98 Vanbrackel of 12 July 2001.

19 C-55/94 Reinhard Gebhard *c/ consiglio dell'ordine degli avvocati e procuratori di Milano* of 30 November 1995.

20 Directive 93/16/EEC to facilitate the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications.

21 Directive 77/452/EEC concerning the mutual recognition of diplomas, certificates and other evidence of the formal qualifications of nurses responsible for general care.

22 Directive 80/154/EEC concerning the mutual recognition of diplomas, certificates and other evidence of formal qualifications in midwifery.

23 Directive 85/433/EEC concerning the mutual recognition of diplomas, certificates and other evidence of formal qualifications in pharmacy.

24 Directive 2001/19/EC amending Directives 89/48/EEC and 92/51/EEC on the general system for the recognition of professional qualifications.

25 Directive 89/391/EEC on the introduction of measures to encourage improvements in the safety and health of workers at work.

26 Directive 89/655/EEC concerning the minimum safety and health requirements for the use of work equipment by workers at work. Directive 2000/54/EC on the protection of workers from risks related to exposure to biological agents at work. Directive 2006/25/EC on the minimum health and safety requirements regarding the exposure of workers to risks arising from physical agents (artificial optical radiation).

27 Amended in 2000 by Directive 2000/34/EC consolidated in Directive 2003/88/EC.

28 C372/04 Watts of 16 May 2006.

29 "High Level Process of Reflection on Patient Mobility and Healthcare Developments in the European Union", HLPR/2003/16, 9 December 2003 (http://ec.europa.eu/health/ph_overview/Documents/key01_mobility_en.pdf).

30 Communication from the Commission "Follow-up to the High level process of reflection on patient mobility and healthcare developments in the European Union", COM (2004) 301 of 20 April 2004, (http://europa.eu/eur-lex/en/com/cnc/2004/com2004_0301en01.pdf).

31 C-41/90 Höfner and Elser of 23 April 1991.

32 T-319/99 FENIN/Commission of 4 March 2003.

33 Directive 2004/18/EC on the coordination of procedures for the award of public works contracts, public supply contracts and public service contracts.

34 C-475/99 *Ambulanz Glöckner* of 25 October 2001.

35 C-280/00 Altmark of 24 July 2003.

36 Commission Decision of 28 November 2005 on the application of Article 86(2) of the EC Treaty to State aid in the form of public service compensation granted to certain undertakings entrusted with the operation of services of general economic interest.

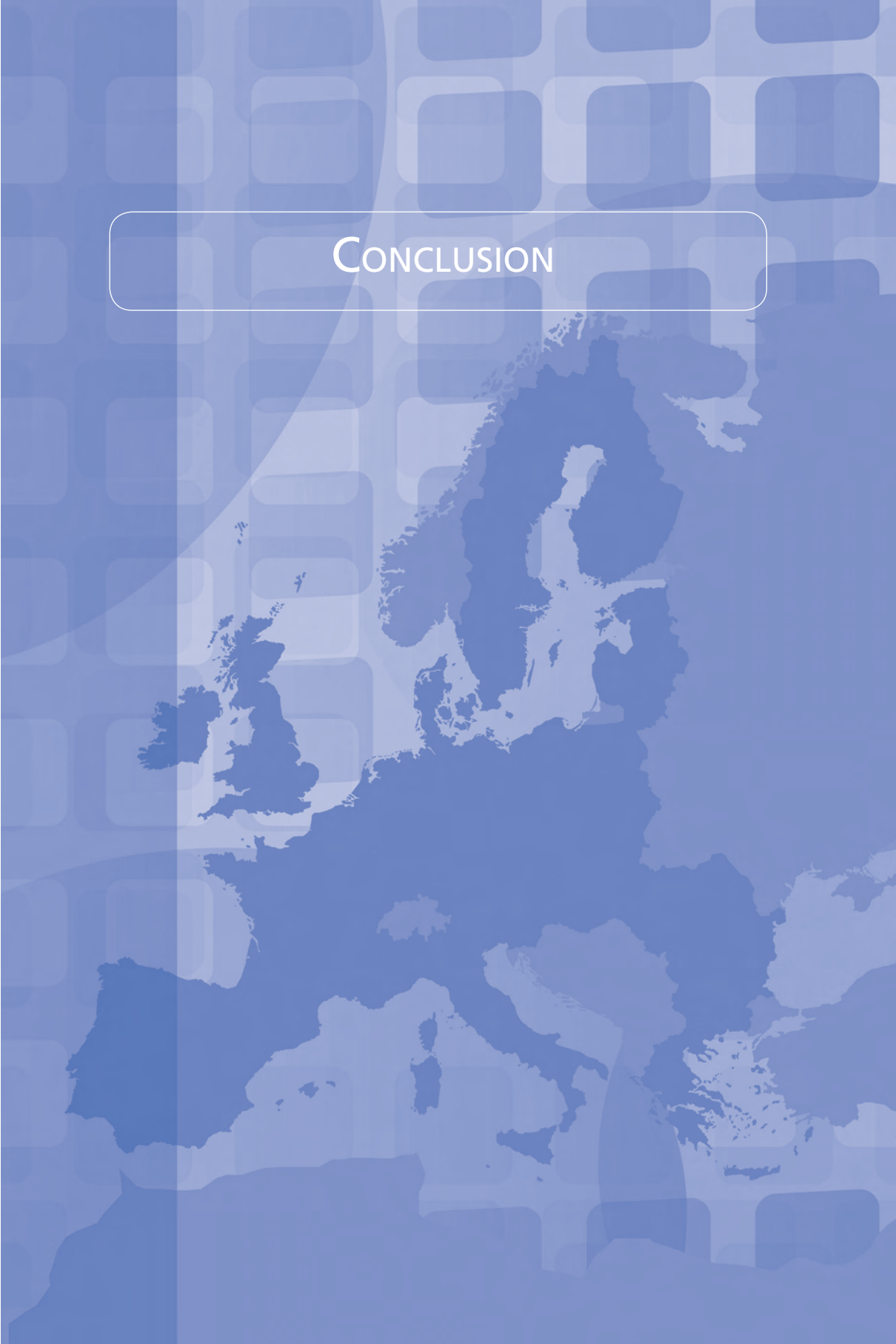
37 For more information, read the HOPE presentation on page 206 and visit their website www.hope.be

38 HOPE (2003), *Hospital co-operation in border regions in Europe et Free movement and cross-border cooperation in Europe: the role of hospitals & practical experiences in hospitals*, www.hope.be

39 INTERREG III is one of four community initiatives introduced by the European Commission to encourage harmonious, balanced and sustainable development of the continent over the 2000-2006 period. The programme is made up of three strands, the second of which concerns trans-national co-operation (http://www.interreg-atlantique.org/iiib/presentation/index.html)

40 www.europhamili.org

Conclusion



Health is one of the fundamental principles of the European Union, as enshrined in the Charter of Fundamental Rights of the European Union[1]. Article 35 stipulates that "everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices". The past few years have undeniably shown a European consensus on the principles of equity, universality and solidarity for healthcare systems. Guided by these common fundamental principles, while faced with similar health and economic challenges, EU governments also appear to share the main thrusts of the reforms to be undertaken. Nonetheless, behind this shared interest, differences in the health situation of the EU Member States remains, such as the diversity of their respective health systems.

As this analysis comes to a close, one wonders about the pertinence of the following question: are EU health systems converging? Is a European model of hospital care provision emerging? Health economists[2] generally demonstrate prudence and provide nuanced answers when discussing these issues, especially when they go beyond the framework of the health system and touch on the overall social organisation and political context. The purpose of this book is not to give a short, definitive answer to the question. Rather, it seeks to provide an extensive, well-documented comparative review of the situations and the questions that arise from them.

The enlargement of the European Union from 15 to 27 countries has reignited the debate on the convergence of health systems. This is above all a result of the accession of 12 new countries, which underscored the fact that significant differences in health status were possible despite geographic proximity, and that such gaps were becoming difficult to sustain in a European Community that allowed the free movement of goods, persons and services. In brief, these gaps involved the prevalence of serious diseases as well as differences in life expectancy. They may be explained by differences in lifestyle, medical practices, healthcare organisation or social coverage. Thus, to a large extent, the health system is at stake here, with the hospital as the backbone. As the new Member States work to catch up with the health status of the other countries, many questions are raised. What health reforms are needed to ensure that the health system is upgraded? What hospital model should be adopted? What is the European Union's role in this development?

Health policy is a matter for the State, and will remain so. States have a strong desire to organise their health systems freely, according to their health situation, their socio-cultural characteristics, and their political structure. This differentiation in health systems is real and significant enough to hinder cross-border hospital cooperation efforts at times. While health systems will continue to remain unique to their respective countries for quite some time, it is now obvious that Member States must face similar challenges: managing health expenditure that is expected to grow (population ageing, patient consumerism, medical progress, etc.) in a framework of limited resources. The answers put forth today in the different countries stem from a common theoretical body borne of liberal thought, the doctrine of rational public action. As such, are the health reforms initiated in recent years to tackle these very challenges, on the basis of similar principles of action, capable of leading to a convergence of national health systems? Whether for tarification or regulation, the tools used are similar, but they are used differently. For example, although pathology-oriented payment has been introduced in the majority of EU Member States to pay their hospitals, there are as many means of implementation as there are countries, because they need to take into account healthcare organisation, health insurance systems, the degree of decentralisation of hospital powers, the strength of professional organisations, etc. In the end, the new tool will turn into a new variable of the health system and increase the latter's differentiation. The goals and tools look alike but the way they are implemented, and thus their results, diverge.

At the same time, in a few years, an actual Community health policy has emerged. It is no longer marginal but has become a strategic point, and is at the heart of the Lisbon programme. Nonetheless, because of the principle of subsidiarity, it remains circumscribed to actions that complement national policies, while adding European added value, mainly those that deal with public health. The main difficulty for European health policy is preserving the cooperation dynamic that was begun in the late 1990s, while respecting the principle of subsidiarity for health matters to which Member States are particularly attached, as evidenced by the conflicts that arose from the Services directive. We could then raise the following question - can EU policies encourage a convergence of national health systems, whether through a Community public health policy or a policy on the integration of the internal market? To date, Community health policy has had little effect on the way national health systems and their hospitals operate, and the EU does not seek to harmonise them. However, following enlargement, the EU set a goal to act on long-term health determinants in order to improve the health status of citizens and most especially reduce the gaps observed between Member States. To achieve this, the EU uses recommendations, coordination actions, awareness campaigns, activities promote lifestyles or environments that would help avoid certain diseases, but does not use direct actions on the organisation of health systems. It is thus a gradual convergence through the production and spread of common hospital visions promoted by the European Union, and relayed at times by other international organisations such as the WHO and the OECD. The influence of the European Union in hospital care is also exercised through legislation generated by the growing integration of the single market. This has an occasional impact on hospital management, mainly in the standardisation of certain purchasing procedures for medical equipment, the collection of blood products, or the working conditions of professionals. Nevertheless, Member States remain attached to organising their health systems themselves, a situation the EU must face as it seeks to develop the internal market. For the moment, the EU's overall influence on the evolution of health systems remains modest.

NOTES

1 Adopted by the European Union on 7 December 2000 during the Nice European Council.

2 Polton Dominique and Duriez Marc, "La lettre du collège", *Le collège des économistes de la santé*, March 1999.
Majnoni d'Intignano Béatrice, with the collaboration of Ulmann Philippe, *Économie de la santé*, PUF, 2001.

Appendices

GROSS DOMESTIC PRODUCT for the 27 EU Member States

- in millions of euros -

	1980	1990	2000	2006
Austria	58 449	129 910	210 392	257 897
Belgium	87 726	155 311	251 741	316 622
Bulgaria	na	10 037	13 704	25 100
Cyprus	na	na	10 079	14 554
Czech Republic	na	na	61 495	114 021
Denmark	50 193	107 000	173 598	220 163
Estonia	na	1 474[+3]	6 103	13 234
Finland	38 305	109 911	132 272	167 062
France	497 623	980 054	1 441 373	1 791 953
Germany	na	1 463 562[+1]	2 062 500	2 322 200
Greece	35 018	66 168	125 892	213 985
Hungary	na	17 569[+1]	52 025	89 901
Ireland	na	37 248	104 553	174 705
Italy	331 149	892 261	1 191 057	1 475 401
Latvia	na	1 242[+2]	8 496	16 180
Lithuania	na	1 589[+2]	12 360	23 721
Luxembourg	na	8 728	22 001	33 852
Malta	na	na	4 221	5 025
Netherlands	128 314	232 228	417 960	534 324
Poland	na	na	185 714	271 530
Portugal	na	56 253	122 270	155 131
Romania	na	na	40 346	97 118
Slovakia	na	11 417[+3]	22 096	43 945
Slovenia	na	9 451[+1]	20 814	30 454
Spain	159 100	401 686	630 263	980 954
Sweden	93 281	189 006	262 550	305 989
United Kingdom	385 639	781 900	1 564 001	1 909 721
EU27	**na**	**na**	**9 149 931**	**11 604 743**

Source: Eurostat, 2007

PER CAPITA GROSS DOMESTIC PRODUCT for the 27 EU Member States

- in euros per capita -

	1980	1990	2000	2006
Austria	7 700	16 900	26 300	31 100
Belgium	9 600[+3]	15 600	24 600	30 000
Bulgaria	na	1 200	1 700	3 300
Cyprus	na	na	14 500	18 900
Czech Republic	na	na	6 000	11 100
Denmark	9 800	20 800	32 500	40 500
Estonia	na	1 000[+3]	4 400	9 800
Finland	8 000	22 000	25 600	31 700
France	9 000	16 800	23 700	28 400
Germany	na	18 300[+1]	25 100	28 200
Greece	3 600	6 500	11 500	19 300
Hungary	na	1 700[+1]	5 100	8 900
Ireland	na	10 600	27 500	41 100
Italy	5 900	15 700	20 900	25 100
Latvia	na	500[+2]	3 600	7 100
Lithuania	na	400[+2]	3 500	7 000
Luxembourg	na	22 900	50 200	71 600
Malta	na	na	10 800	12 400
Netherlands	9 100	15 500	26 300	32 700
Poland	na	na	4 900	7 120
Portugal	na	6 600[+1]	12 000	14 700
Romania	na	na	1 800	4 500
Slovakia	na	2 100[+3]	4 100	8 200
Slovenia	na	4 700[+1]	10 500	15 200
Spain	na	11 400[+1]	15 700	22 300
Sweden	11 200	22 100	29 600	33 700
United Kingdom	6 800	13 700	26 600	31 500
EU27	**na**	**na**	**18 900**	**23 500**

Source: Eurostat, 2007

TOTAL POPULATION of the 27 EU Member States
- in millions of inhabitants -

	1980	1990	2000	2006
Austria	7.55	7.68	8.01	8.28
Belgium	9.86	9.97	10.25	10.55
Bulgaria	8.86	8.72	8.06	7.68
Cyprus	0.51	0.58	0.69	0.77
Czech Republic	10.30	10.33	10.27	10.27
Denmark	5.12	5.14	5.34	5.44
Estonia	1.48	1.57	1.37	1.35
Finland	4.78	4.99	5.18	5.27
France	53.88	56.71	59.01	63.20
Germany	78.29	79.43	82.21	82.37
Greece	9.64	10.16	10.92	11.12
Hungary	10.71	10.37	10.21	10.07
Ireland	3.41	3.51	3.81	4.25
Italy	56.43	56.72	56.94	58.86
Latvia	2.51	2.66	2.37	2.29
Lithuania	3.41	3.70	3.50	3.39
Luxembourg	0.36	0.38	0.44	0.47
Malta	0.32	0.35	0.39	0.41
Netherlands	14.15	14.95	15.93	16.34
Poland	35.57	38.11	38.45	38.13
Portugal	9.77	9.98	10.23	10.59
Romania	22.21	23.20	21.89	21.58
Slovakia	4.98	5.30	5.39	5.39
Slovenia	1.90	2.00	1.99	2.01
Spain	37.44	38.85	40.26	44.07
Sweden	8.31	8.56	8.87	9.08
United Kingdom	56.31	57.25	58.89	60.53
EU27	**458.08**	**471.18**	**482.57**	**493.74**

Source: Eurostat, 2007

LIFE EXPECTANCY AT BIRTH for the 27 EU Member States
- in years -

	1980	1990	2000	2004
Austria	72.8	76.0	78.7	79.5
Belgium	73.2	76.3	77.55[-3]	78.0
Bulgaria	71.1	71.5	71.7	72.6
Cyprus	na	na	77.9	79.5
Czech Republic	70.3	71.5	75.2	76.0
Denmark	74.2	75.1	77.2	77.3[-3]
Estonia	69.3[+1]	69.9	71.0	72.3
Finland	73.7	75.1	77.9	79.0
France	74.9	77.6	79.4	80.5
Germany	na	75.5	78.4	79.4
Greece	75.4	77.2	78.2	79.1
Hungary	69.1	69.5	71.9	73.0
Ireland	72.5	74.8	76.6	79.0
Italy	74.4	77.2	79.8	80.4[-2]
Latvia	69.2	69.5	70.6	71.3
Lithuania	70.5	71.6	72.3	72.1
Luxembourg	72.7	75.5	78.6	79.6
Malta	70.4	76.2	78.2	79.4
Netherlands	76.0	77.2	78.3	79.4
Poland	70.4	71.0	74.0	75.0
Portugal	71.2	74.1	76.8	78.3
Romania	69.2	69.8	71.3	71.9
Slovakia	70.5	71.1	73.5	74.4
Slovenia	na	74.0	76.3	77.3
Spain	75.6	77.0	79.5	80.5
Sweden	75.9	77.8	79.9	80.6
United Kingdom	73.7	75.9	78.1	79.0
EU27	**73.7**	**75.2**	**77.5**	**78.5**

Source: Eurostat, 2007

CRUDE BIRTH RATE
for the 27 EU Member States
- in number of childbirths per 1 000 inhabitants -

	1980	1990	2000	2004
Austria	12.1	11.7	9.7	9.7
Belgium	12.7	12.4	11.4	11.1
Bulgaria	14.5	11.7	9.0	9.0
Cyprus	20.4	18.3	12.2	11.3
Czech Republic	14.9	12.6	8.9	9.6
Denmark	11.2	12.3	12.6	11.9
Estonia	15.0	14.2	9.5	10.4
Finland	13.2	13.2	11.0	11.1
France	14.9	13.4	13.1	12.7
Germany	na	11.4	9.3	8.6
Greece	15.4	10.1	9.5	9.6
Hungary	13.9	12.1	9.6	9.4
Ireland	21.8	15.1	14.5	15.3
Italy	11.5	10.1	9.5	9.7
Latvia	14.2	14.2	8.5	8.8
Lithuania	15.2[+1]	15.4	9.8	8.9
Luxembourg	11.5	12.9	13.1	12.0
Malta	17.6	15.2	11.3	9.7
Netherlands	12.8	13.2	13.0	11.9
Poland	19.6	14.4	9.8	9.3
Portugal	16.0	11.7	11.7	10.4
Romania	18.0	13.6	10.5	10.0
Slovakia	19.1	15.1	10.2	10.0
Slovenia	15.7	11.2	9.1	8.9
Spain	15.1	10.3	9.9	10.7
Sweden	11.7	14.5	10.2	11.2
United Kingdom	13.4	14.0	11.5	12.0
EU27	**14.0**	**12.4**	**10.6**	**10.4**

Source: WHO Regional Office for Europe, 2007

FERTILITY RATE
for the 27 EU Member States
- in number of children per woman -

	1980	1990	2000	2004
Austria	1.6	1.5	1.4	1.4
Belgium	1.7	1.6	1.5	1.7
Bulgaria	2.0	1.7	1.3	1.3
Cyprus	2.5	2.4	1.6	1.5
Czech Republic	2.1	1.9	1.2	1.2
Denmark	1.5	1.7	1.8	1.8
Estonia	2.0	2.1	1.4	1.5
Finland	1.6	1.8	1.7	1.8
France	1.9	1.8	1.9	1.9
Germany	1.4	1.5	1.4	1.4
Greece	2.2	1.4	1.3	1.3
Hungary	1.9	1.8	1.3	1.3
Ireland	3.2	2.1	1.9	2.0
Italy	1.7	1.4	1.3	1.3
Latvia	2.0	2.0	1.2	1.2
Lithuania	2.0	2.0	1.4	1.3
Luxembourg	1.5	1.6	1.8	1.7
Malta	2.0[+4]	2.0	1.7	1.4
Netherlands	1.6	1.6	1.7	1.7
Poland	2.3	2.0	1.4	1.2
Portugal	2.2	1.5	1.5	1.4
Romania	2.4	1.5	1.3	1.3
Slovakia	2.3	2.1	1.3	1.3
Slovenia	2.1	1.5	1.3	1.3
Spain	2.2	1.5	1.2	1.3
Sweden	1.7	2.1	1.6	1.8
United Kingdom	1.9	1.8	1.6	1.8
EU27	**1.9**	**1.7**	**1.5**	**1.5**

Source: WHO Regional Office for Europe, 2007

INFANT MORTALITY RATE [1] in the 27 EU Member States

- in number of deaths per 1 000 live births -

	1980	1990	2000	2004
Austria	14.3	7.8	4.8	4.5
Belgium	12.1	8.0	5.6[-3]	3.7[+1]
Bulgaria	20.2	14.8	13.3	11.7
Cyprus	na	11.0	5.6	3.0
Czech Republic	16.9	10.8	4.1	3.8
Denmark	8.5	7.4	5.0	4.6[-3]
Estonia	17.0[+1]	12.3	8.4	6.4
Finland	7.6	5.6	3.6	3.3
France	10.0	7.3	4.4	3.9
Germany	na	7.1	4.4	4.1
Greece	17.9	9.7	5.9	4.1
Hungary	23.2	14.8	9.2	6.6
Ireland	11.1	8.2	6.2	4.9
Italy	14.2	8.0	4.5	4.4[-2]
Latvia	15.3	13.7	10.4	9.4
Lithuania	16.5[+1]	10.2	8.6	7.9
Luxembourg	10.6	7.1	3.0	3.5
Malta	15.5	9.5	6.0	5.9
Netherlands	8.6	7.1	5.1	4.4
Poland	21.2	16.0	8.1	6.8
Portugal	24.3	11.0	5.5	3.9
Romania	29.3	26.9	18.6	16.8
Slovakia	na	12.0	8.6	6.8
Slovenia	13.9[+4]	8.4	4.9	3.7
Spain	12.4	7.6	4.4	4.0
Sweden	6.9	6.0	3.4	3.2
United Kingdom	12.1	7.9	5.6	5.1
EU27	**14.3**	**9.9**	**5.9**	**5.2**

Source: WHO Regional Office for Europe, 2007

(1) the infant mortality rate is the probability of death before the age of one year.

CRUDE MORTALITY RATE in the 27 EU Member States

- in number of deaths per 1 000 inhabitants -

	1980	1990	2000	2004
Austria	12.3	10.7	9.5	9.1
Belgium	11.6	10.5	10.2[-3]	na
Bulgaria	11.1	12.1	14.1	14.2
Cyprus	na	na	7.7	7.1
Czech Republic	13.1	12.5	10.6	10.5
Denmark	10.9	11.8	10.7	10.8[-3]
Estonia	12.4[+1]	12.5	13.4	13.1
Finland	9.3	10.0	9.5	9.1
France	10.2	9.3	9.0	8.4
Germany	na	11.6	10.2	9.9
Greece	9.1	9.3	9.6	9.5
Hungary	13.6	14.0	13.3	13.1
Ireland	9.8	9.0	8.3	7.0
Italy	9.7	9.4	9.8	9.8[-2]
Latvia	12.8	13.1	13.6	13.9
Lithuania	10.4[+1]	10.8	11.1	12.0
Luxembourg	11.4	10.0	8.5	7.8
Malta	10.4	7.7	7.7	7.5
Netherlands	8.1	8.6	8.8	8.4
Poland	9.8	10.2	9.5	9.5
Portugal	9.6	10.3	10.4	9.8
Romania	10.4	10.7	11.4	12.0
Slovakia	na	10.3	9.8	9.6
Slovenia	10.1[+5]	9.3	9.3	9.3
Spain	7.7	8.6	9.0	8.7
Sweden	11.1	11.1	10.5	10.1
United Kingdom	11.7	11.2	10.3	9.8
EU27	**10.5**	**10.4**	**10.0**	**9.7**

Source: WHO Regional Office for Europe, 2007

POPULATION AGED 65 AND UP in the 27 EU Member States
- as % of total population -

	1980	1990	2000	2004
Austria	15.5	14.9	15.5	15.7
Belgium	14.3	14.9	16.5[-2]	17.0[-2]
Bulgaria	11.9	13.0	16.3	17.1
Cyprus	na	na	11.3	11.9
Czech Republic	13.5	12.5	13.8	14.0
Denmark	14.4	15.6	14.8	14.8[-3]
Estonia	12.1[+1]	11.6	15.1	16.3
Finland	12.0	13.4	14.9	15.7
France	14.3	14.5	16.1	16.4
Germany	na	15.0	16.4	18.3
Greece	13.1	13.8	16.6	18.0
Hungary	13.4	13.4	15.1	15.6
Ireland	10.7	11.4	11.2	11.2
Italy	13.5	14.7	18.1	18.9[-2]
Latvia	12.9	11.8	15.0	16.4
Lithuania	11.0[+1]	10.9	13.9	15.1
Luxembourg	13.5	13.4	14.3	14.2
Malta	8.3	10.4	12.2	13.2
Netherlands	11.5	12.8	13.6	13.9
Poland	10.1	10.1	12.2	13.1
Portugal	10.5	13.4	16.2	16.9
Romania	10.3	10.4	13.3	14.5
Slovakia	na	10.3	11.4	11.6
Slovenia	na	10.7	14.0	15.2
Spain	11.2	13.4	16.9	16.8
Sweden	16.3	17.8	17.3	17.2
United Kingdom	15.0	15.7	15.8	16.0
EU27	**13.2**	**13.8**	**15.7**	**16.4**

Source: WHO Regional Office for Europe, 2007

INCIDENCE OF CANCER in the 27 EU Member States
- per 100 000 inhabitants -

	1980	1990	2000	2004
Austria	389.6[+2]	405.0	453.4	451.7
Belgium	na	322.0	464.6	500.0[-1]
Bulgaria	232.7	245.1	320.1	383.2
Cyprus	na	na	234.1	265.8
Czech Republic	349.5	436.2	586.2	683.5
Denmark	na	535.8	601.3	633.8[-1]
Estonia	272.2	315.6	438.7	473.3
Finland	311.3	355.8	431.4	501.1
France	na	390.5	472.5	na
Germany	na	422.3	494.5	514.4[-2]
Greece	na	na	na	na
Hungary	215.4	270.9	na	772.2
Ireland	na	na	578.1	548.3
Italy	na	438.8	510.9[+2]	429.9
Latvia	253.2	283.7	366.0	419.0
Lithuania	251.9	270.1	401.2	464.1
Luxembourg	279.5[+1]	369.0	412.3	450.3
Malta	na	308.9[+2]	408.2	428.1
Netherlands	na	384.9	433.0	451.1[-1]
Poland	182.6	219.0	297.2	317.7
Portugal	na	251.8[+1]	360.2	na
Romania	135.1[+2]	119.4	197.3	249.4
Slovakia	283.7	340.3	407.9	430.4[-1]
Slovenia	na	318.6	433.5	532.1
Spain	na	na	na	na
Sweden	421.3	474.3	512.6	560.2
United Kingdom	385.9	480.5	460.4	464.2[-1]
EU27	**na**	**376.4**	**449.3**	**460.1**

Source: WHO Regional Office for Europe, 2007

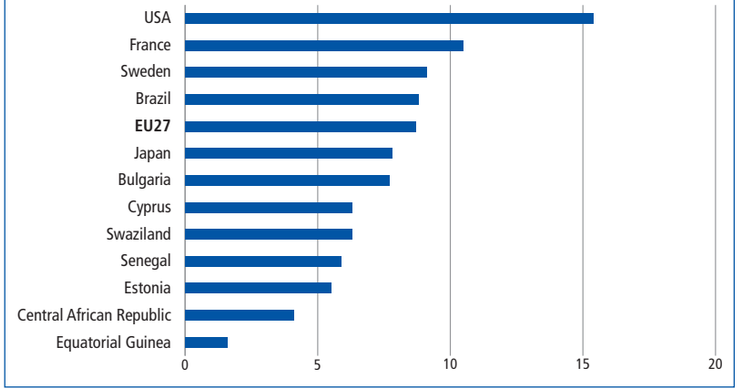
INCIDENCE OF TUBERCULOSIS in the 27 EU Member States - per 100 000 inhabitants -				
	1980	1990	2000	2004
Austria	29.2	19.7	14.7	11.0
Belgium	27.3	15.8	12.2	10.8
Bulgaria	37.0	25.1	41.0	38.9
Cyprus	na	na	5.7[+1]	4.1
Czech Republic	48.1	18.7	13.7	10.1
Denmark	8.4	6.8	10.8	6.6
Estonia	41.6	21.2	51.2	39.8
Finland	47.0	15.5	10.1	6.1
France	32.0	15.9	10.5	8.3
Germany	na	18.5	11.0	7.3
Greece	56.1	8.6	6.4	6.0
Hungary	50.5	34.6	30.5	22.3
Ireland	33.9	17.8	10.5	9.4
Italy	5.8	7.4	6.2	6.8
Latvia	47.5	34.0	79.4	68.3
Lithuania	47.9	39.8	72.9	59.3
Luxembourg	19.5	12.6	9.4	6.8
Malta	7.6	3.7	4.2	4.5
Netherlands	12.0	9.2	7.8	8.1
Poland	72.5	42.3	27.4	22.8
Portugal	69.5	62.2	41.3	34.3
Romania	61.1	70.1	117.0	131.8
Slovakia	49.5	27.3	18.7	12.3
Slovenia	57.2	36.1	18.5	12.5
Spain	12.9	19.5	19.9	14.1
Sweden	11.1	6.5	5.0	4.6
United Kingdom	18.6	10.3	9.8	11.8
EU27	**32.7**	**21.3**	**19.6**	**17.6**

Source: WHO Regional Office for Europe, 2008

TIMELINE OF ACCESSION TO THE EUROPEAN UNION	
Year	Country
1957 (founding members)	Belgium France Germany Italy Luxembourg Netherlands
1973	Denmark Ireland United Kingdom
1981	Greece
1986	Portugal Spain
1995	Austria Finland Sweden
2004	Cyprus Czech Republic Estonia Hungary Latvia Lithuania Malta Poland Slovakia Slovenia
2007	Bulgaria Romania

HEALTH SPENDING IN SELECTED COUNTRIES IN 2004

- as % of GDP -



Source: World Health Statistics. WHO, 2007

VARYING HOSPITAL SYSTEMS WITHIN THE EUROPEAN UNION

- in 2004 -

	Hospitals	Hospitals per 100 000 inhabitants Hospital beds	Hospital beds	Hospital beds per 1 000 inhabitants	Private in-patient hospital beds as % of all beds
Austria	270*	3.2	63 200	7.7	23.8[-1]
Belgium	210	2.1	55 600	5.3	64.5
Bulgaria	260*	3.9	45 500*	6.1	1.7
Cyprus	95[+1]	12.9	3 100	4.2	53.2
Czech Republic	360	3.6	86 500	8.5	19.9
Denmark	70[-1]	1.2[-1]	20 600	3.8	4.0
Estonia	50	3.8	7 800	5.8	10.1
Finland	370	7.1	36 100	6.9	3.4
France	2 890	4.8	450 700	7.5	34.5
Germany	3 460	4.2	707 800	8.6	25.3
Greece	320	2.9	51 900	4.7	28.0
Hungary	180	1.8	79 100	7.8	2.7
Ireland	180	4.4	23 100	5.7	na
Italy	1 295	2.2	231 900	4.0	23.0
Latvia	120	5.2	17 900	7.7	5.0
Lithuania	180	5.3	29 000	8.4	0.3
Luxembourg	15*	3.3	2 900	6.3	na
Malta	10	2.5	1 900	4.6	8.9
Netherlands	200	1.2	80 800[-1]	4.9[-1]	na
Poland	845	2.2	204 200	5.3	3.8
Portugal	210	2.0	39 300	3.7	25.2
Romania	415	1.9	142 000	6.6	0.4
Slovakia	145	2.7	37 700	7.0	5.1
Slovenia	30	1.5	9 600	4.8	0.9
Spain	740[-1]	1.7[-1]	144 900[-1]	3.5[-1]	33.8[-1]
Sweden	80[-1]	0.9[-1]	na	na	na
United Kingdom	na	na	233 200	3.9	na

Source: WHO, European Health for All Database, 2007
*: country data

Additional Information

Glossary

ACCREDITATION

A voluntary approach that includes a self-evaluation and/or external audit, and which makes it possible to recognise establishments for meeting quality and safety criteria in the eyes of referents. Accreditation involves all of the establishment's activities and may lead to the acquisition of a label.

ACUTE CARE

Acute care corresponds to medical care in a hospital setting over a relatively short period, aimed at treating a disease, or preventing its aggravation or complications resulting from it. The definition varies considerably from one country to another, depending on the functions taken into account in acute care and those which are excluded (for instance, the degree of exclusion of long term care or rehabilitation care). International comparisons based on the number of acute care hospital beds should thus be made with prudence.

ADVERSE SELECTION (ANTI-SELECTION)

Persons at higher risk tend to take out more insurance than lower-risk persons, resulting in selection that is unfavourable to the insurer. In economics, there is adverse selection or anti-selection when information is asymmetric and does not allow both parties to sign contracts in full knowledge of the facts.

AMBULATORY

Refers to care that may be provided without requiring full hospitalisation, such as outpatient surgery and outpatient consultations (orthopaedics, rheumatology, minor treatments, etc.)

AVERAGE LENGTH OF STAY

Average length of stay is defined as the ratio between the number of days and the number of admissions. This indicator has often been used as an indicator of healthcare organisation and productivity, but cannot be used as an indicator for healthcare quality.

BEDS

Beds refer to the number of beds installed at a given date. This number may differ from the number of authorised beds, as not all of the latter may be necessarily available.

CASE-MIX

The English term case-mix, introduced in the United States in the 1960s when studies were conducted to measure hospital activity was adopted in Europe with two meanings. Case-mix primarily refers to the range of cases treated in a health establishment. By extension, some use the term to designate the patient stay system classifying "disease cases", according to the resources needed for their management. Using this definition, the most well-known of the case-mix is the "Diagnosis Related Groups", or DRGs (American method).

CO-PAYMENT

When the reimbursement of costs related to the disease only covers part of the sums paid out by the insured person, the part that remains at the latter's expense is called co-payment.

DECENTRALISATION

Decentralisation refers to the transfer of powers from the State to local political entities which are legal persons and have their own decision-making structures. The term decentralisation is often a synonym of devolution.

DECONCENTRATION

Deconcentration refers to the transfer of a central government's decision to its local or regional representatives. The State's deconcentrated services thus implement public policies decided upon at a national level, apply or require the application of a regulation, or deliver services to users, within a given territorial scope.

DIAGNOSIS RELATED GROUP (DRG)

The *Diagnosis Related Groups* classification system, a concept created in the United States, is based on the classification of hospital stays in a deliberately limited number of groups, characterised by a twofold medical and economic homogeneity.

DIRECT SETTLEMENT THIRD-PARTY PAY

Principle according to which the patient does not make advance payment for all medical costs, but only pays the co-payment share when there is one. The service provider is then paid directly by the payment bodies.

EFFICIENCY

The notion of efficiency is close to that of yield and productivity, although they are not synonyms. Efficiency refers to achieving a result using the least resources, mainly financial. It is not the same as "efficacy", which measures the ability of a solution to achieve set goals, without specifying the resources used. For example, the development of alternatives to full hospitalisation address concerns of efficiency, as the costs for this type of management are generally lower than in full hospitalisation.

GLOBAL BUDGET

The rationale behind a global budget is to attribute a predetermined budget to a healthcare establishment or hospital service at the start of a given period. This budget is based mainly on previous expenditure, to which a general rate of increase modulated by the surveillance authority is applied.

GROSS DOMESTIC PRODUCT (GDP)

Sum of all values added of all residential institutional units engaged in production, plus the VAT on products and customs duties. The GDP is composed of commercial GDP (traded goods and services) and non-commercial GDP (services provided by public and private administrations free or nearly free of charge).

HEALTH

The World Health Organization defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

HEALTH EXPENDITURE

This aggregate covers the total expenses made by public and private financers for healthcare. It includes:

- consumption of medical care and goods;
- expenses for healthcare subsidies;
- prevention-related expenses;
- general health management expenses;
- health sector investment expenditure.

This aggregate is used for OECD countries to allow international comparisons.

HEALTHCARE PURCHASER AND PROVIDER

A healthcare provider refers to any person, physical or legal, that provides healthcare services to the population in exchange for remuneration: hospital establishment, community-based physician, self-employed nurse, etc. A healthcare purchaser is a person, physical or legal, who is liable for payment of the care provided by the provider. In the European Union Member States and depending on the type of care, healthcare purchasers may be: the State, local authorities, a healthcare insurance fund, patients, or other. The relationship between the healthcare purchaser and provider is often formally described in a contract. In certain EU Member States, purchasers may also be providers. Examples include the *USL (Unità Sanitarie Locali*) in Italy or the *Primary Care Trusts* (*PCT*) in the United Kingdom.

HEALTHCARE PROVISION

All services and goods made available by providers of healthcare.

HOSPITAL

A hospital is an institution for healthcare, where a patient receives medical or surgical care as soon as the possibility of ambulatory treatment is excluded due to the nature or gravity of the affliction. According to the WHO, this concept covers general hospitals, specialty hospitals, acute care hospitals and long-stay hospitals. The term excludes hydrotherapy centres, convalescence homes, sanatoriums, health centres for the physically and mentally handicapped, retirement homes, rest centres and day hospitals.

INCIDENCE OF DISEASE

Incidence refers to the number of new cases observed of a disease in a given period and specified population. It makes it possible to assess the frequency and speed at which a disease appears. It differs from prevalence, which refers to the number of cases in a given period and population, with no distinction made between old and new cases.

ISO CERTIFICATION

Certification is a procedure that calls on a competent, independent organisation to validate a system's compliance with ISO 9000 standards. Certification provides a written statement that a product, process or service is compliant with the specified requirements.

LIFE EXPECTANCY

Life expectancy is defined as the average number of years that a person can anticipate living at a given time, for a given population, on the premise that mortality conditions remain constant. The most commonly used indicator is life expectancy at birth, which designates the number of years a newborn baby is expected to survive. Life expectancy can also be computed for a given age (other than at birth), such as 65 years.

LONG-TERM CARE

Long-term care covers medical and nursing care provided to patients who need continuous assistance due to a chronic handicap and reduced autonomy in the activities of daily living. Such care generally requires long-term management.

MORBIDITY

Morbidity refers to the number of persons suffering from a given disease during a given period and a specified population. Incidence and prevalence are two ways of expressing the morbidity of a disease.

NUMERUS CLAUSUS

Limitation of the number of students allowed entrance into a training programme and health profession, used as a means of controlling health expenditure.

PRIMARY CARE

Basic health care, serving as the point of entry into the health system. Primary care also includes preventive care and health education.

PROSPECTIVE PAYMENT SYSTEM

The prospective payment system, proposed by a surveillance authority to an agent, is based on the attribution of an amount that is set prior to the production period. Agents received a lump-sum payment based on a cost defined *ex ante* and regardless of actual costs. The application of this system to hospitals is aimed at encouraging the latter to minimise the costs of treating patients. However, the system can lead to patient selection or decreased quality of care.

REHABILITATION

Rehabilitation covers services that are aimed mainly at improving the functional capacities of the persons being cared for, regardless of the source of their functional limitations (recent injury or disease or recurring limitations). Rehabilitation is more intensive than traditional nursing care, but less intensive than acute care. As a general rule, the length of stay in rehabilitation is longer than in acute care.

RETROSPECTIVE PAYMENT SYSTEM

The retrospective payment system, proposed by a surveillance authority to an agent, is based on the attribution of an amount that is set after the production period. Agents received a lump-sum payment based on a cost defined *ex post* and according to actual costs.

SECONDARY CARE

Specialised care that requires treatments and procedures that are more sophisticated and more complex than primary care. This includes general surgery, general internal medicine, and rehabilitation.

SUPERVISION

Exercise by the State administration, local authorities, or national funds, of powers to suspend or annul decisions made by healthcare providers.

TERTIARY CARE

Tertiary care refers to highly specialised or costly procedures and treatments such as neonatology, radiotherapy, neurosurgery and heart surgery.

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HOPE

HOPE, the European Hospital and Healthcare Federation, is a European non-profit association created in 1966. HOPE reflects the diversity and complexity of the health systems in European countries. It brings together national hospital federations and, where these do not exist, local and regional authorities, owners of hospitals and health services, and representatives from the national health systems.

Its mission is to promote improvements in the health of citizens throughout the Member States of the European Union. HOPE fosters efficiency, effectiveness and humanity in healthcare and hospital services.

A pioneer in the area of hospital patient rights, HOPE has tirelessly worked to strengthen the role of hospitals as key players in public health, throwing its support behind the network of Health Promoting Hospitals, participating in the consortium on patient safety, and joining the nutrition for health alliance, to name but a few.

HOPE has maintained two major objectives from its inception:

- **develop and provide information** on the organisation and the operation of hospital and healthcare services;
- **advise its members** on matters relating to standards of provision, organisation and operation of hospital services.

HOPE has been and continues to be involved in numerous comparative studies and in spreading good practices in the following areas:

- **healthcare organisation**: organ transplantation, disaster medicine, healthcare quality, benchmarking, organisation of emergency care, etc.;
- **economic and financial topics**: streamlining healthcare provision, cost control, alternatives to hospitalisation, health services as a growth factor, compilation of databases, etc.;
- **human resources**: hospitals and occupational medicine, hospital pharmacies, the nursing profession, social dialogue, etc.;
- **organisation of health systems**: role of the hospital, accessibility and solidarity, waiting lists, etc.

HOPE publishes texts, reports and books describing the situation in different Member States, as well as recommendations for improvement. Since 1998, its official yearly reference book has been called "*Hospital Healthcare Europe*".

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When HOPE was created, health topics were rarely discussed by the European institutions. With the creation of the internal market, the influence of Community legislation on hospital and healthcare services has markedly increased. As its mission is to defend the interests of hospitals and healthcare services in the European Union and in the health systems where they operate, HOPE has committed to participating in the European decision-making process. It takes positions by analysing the impact of Community provisions on hospitals and healthcare and the influence on the final result. Playing an active role at the European level also means organising alliances and partnerships with other European health associations.

HOPE is in contact and cooperates with various international organisations involved in health issues, such as the WHO Regional Office for Europe, the OECD, and the Council of Europe.

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