Europe and health – national health care systems and the effects of European integration

European law; European Union; health care system; health insurance; health policy, hospitals

The European integration coupled with growing financing problems causes trouble in the health systems of the European countries. National governments will be forced by the liberalisation of the European health market to disengage themselves from the principles of a planned economy as they develop health policy and to implement incentives based on principles of a social market economy instead. National health care providers should prepare themselves for international competition early enough and should not sit lax, lulled by state-protected national health markets. Increasing competition and the prospect of access to and engagement in cross-border medical treatment will strengthen the patient-centered perspective of health care systems so that patients will benefit from this progress.

I. Introduction

The growing together of Europe coupled with burgeoning financing problems makes for difficulty in the health systems of the European countries. This is as true for countries with tax-financed health systems (e. g. Great Britain) as it is for countries, like Germany, which fund their health systems through insurance contributions. What European countries all have in common is public health systems organised predominantly by the principles of a planned economy. In Germany, for example, the numbers of service providers (medical practices, hospitals) are regulated by the state and the number of surgeries that can be performed by a single hospital is fixed.

In this day and age, the consequences of a health system that relies on the elements of a planned economy are detrimental and impact providers and recipients alike. In Germany, physicians go on strike to demand better working conditions and "fair" remuneration; others move to countries that promise attractive salaries. In Great Britain patients must wait more than four months for non-emergency surgery.

The European Court of Justice in Luxembourg recently pronounced a judgment which allows patients to seek cross-border medical treatment, the costs of which have to be reimbursed by health insurances schemes. Other challenges to the European health care systems and their financing are demographic change, technological developments in medicine and high rates of unemployment caused by a stagnant economic growth in the European countries (Busse 2000, p. 120). At the same time a European market for health
care services that promises high growth rates is emerging. The expansion of the EU eastwards has strengthened this development and promises new opportunities for growth.

II. Health care – an analysis of different systems in Europe

1. European national health care systems – an overview

National health care systems in Europe can be distinguished according to their financing source (tax- or contribution-financed) and organisation. The health care systems in Great Britain, Ireland, Denmark, Sweden, Finland and Portugal for example are financed by tax revenues. In Germany, the Benelux states and France the health care systems are contribution financed. Other European countries, including Italy, Spain and Greece, have mixed systems.

In tax-financed systems, health care is often delivered via national or regional health services which take on the outpatient treatment of the population. Regional-level organised health services are to be found in Scandinavia and in Spain and Italy. Free services for the whole population by state-hired staff are provided by the National Health Service (NHS) in Great Britain (Oliver 2005).

<table>
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<tr>
<th>financing</th>
<th>organisation</th>
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<tr>
<td>tax-financed</td>
<td>national health service</td>
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<td></td>
<td>regional health service</td>
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<td>health insurance</td>
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<tr>
<td>tax-financed</td>
<td>Great Britain, Ireland, Portugal</td>
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<td>Denmark</td>
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<td>Sweden</td>
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<td>contribution-financed</td>
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<td>France</td>
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<td>Benelux states</td>
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*Tab. 1: Financing sources and organisation forms of the national health care systems in Europe*

*Source: Beske/Drabinski 2005, S. 21*

Nationwide, on-demand, in-patient care is guaranteed in almost all European countries by public authorities. The fact that the same public authority is responsible for the capacity planning and the financing of operating expenses in some countries causes local undersupply resulting in wait lists for patients. Queues for in-patient treatment exist in the Netherlands, Great Britain, Italy, Denmark, and Sweden (Beske/Drabinski 2005).
Germany and France where operating expenses are financed through social insurance schemes, in-patient health care provision is high.

Investment financing is a public matter with the exception of hospitals’ investments in Great Britain and in the Netherlands. In the Netherlands, capital expenditures are refunded by the operating cost rate; hospitals in Great Britain have to refinance their investment costs through revenues (Stapf-Finé/Schölkopf 2003, p. 77; McKee/Healy 2002, p. 127).

For the reimbursement of in-patient treatment a stepwise, Europe-wide adoption of case-based lump sum payments (based on diagnostic related groups or DRGs) has been put in place (Busse/Wörz 2002, p. 28). Germany, Sweden and Denmark, where case-based lump sum payments are fixed for most therapies, are at the forefront in this process. Other European countries use them to calculate their hospital budgets or they have a monitoring function for hospital-specific length-of-stay data. Not all treatment modalities have been included in the lump sum payment scheme. Very cost-intensive and non-standardizeable treatments in some areas of medicine are considered on a cases-by-case basis. In Germany, budget balances and quota restrictions are applied as well (Schölkopf/Stapf-Finé 2004, p. 196).

For the EU’s new member states in the east, the health systems of the older member states serve as models. While the Baltic States have orientated themselves towards the Scandinavian health systems, countries in Central Europe, including the Czech Republic and Poland, have established contribution-financed systems. At the same time the new states try to learn from the mistakes of the old. One measure in particular has been their attempt to install sustainability in the financing mechanisms of their health care systems by introducing competitive elements into the insurance market and integrating cost sharing in insurance tariffs for insured persons.

The statistics for health resources (Table 2) indicate that Germany has one of the highest levels of health care provision with regard to density of doctors and hospital capacity. Ascribing 10.7% of its GDP to health care, Germany also leads in terms of health care expenditures. The high level of medical care is also reflected in the high satisfaction of the population with the health system. Residents from countries with national health services, like Great Britain, show lower satisfaction values. A study conducted by the European Commission found that there is a clear, positive relationship between health expenditures and satisfaction with the health system (COM 1998).
Europe and health

<table>
<thead>
<tr>
<th></th>
<th>health expenditures in percent of the GDP 2001</th>
<th>total expenditure per capita US$ (public and privat) 2002</th>
<th>Physicians per 100,000 population (latest available year)</th>
<th>acute hospital beds per 100,000 population (latest available year)</th>
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<tbody>
<tr>
<td>Denmark</td>
<td>7.1 + 1.3</td>
<td>2580</td>
<td>364.6 (2001)</td>
<td>340.2 (2001)</td>
</tr>
<tr>
<td>Germany</td>
<td>8.0 + 2.7</td>
<td>2817</td>
<td>335.6 (2002)</td>
<td>627.0 (2001)</td>
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<tr>
<td>France</td>
<td>7.2 + 2.7</td>
<td>2736</td>
<td>333.0 (2002)</td>
<td>396.7 (2001)</td>
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<tr>
<td>Netherlands</td>
<td>5.7 + 3.2</td>
<td>2643</td>
<td>314.9 (2002)</td>
<td>307.4 (2001)</td>
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<tr>
<td>Great Britain</td>
<td>6.2 + 1.4</td>
<td>2610</td>
<td>163.9 (1993)</td>
<td>238.5 (1998)</td>
</tr>
<tr>
<td>Italy</td>
<td>6.3 + 2.1</td>
<td>2166</td>
<td>606.7 (2001)</td>
<td>394.4 (2001)</td>
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Tab. 2: Selected indicators for the national health systems in Europe
Source: Allin et al. 2005, p. 5

2. Political attempts to overcome structural problems in the European national health care systems

The national health care systems in Europe all face similar problems and the countries all tend to address rising health expenditures by cost-cutting exercises. Instead of solving the financial problems of the social security system through structural reforms, fixed budgets are introduced and costs are shifted to the patients in the form of additional co-payments and deductibles. Because of the need to economise in national health care systems, more and more medical services are being withdrawn from the catalogue of benefits (Wörz/Busse 2005, p. S133). In several European countries patients are being forced to pay out-of-pocket for dental treatment or to take out additional insurance. Free choice of medical service provider is limited by means of gatekeeper systems aimed at preventing double examinations and so reduce health benefit costs for in-patient and specialist treatment. Other measures include lowering production capacity for in-patient treatment. Decreasing lengths of stay for patients are a result of the discharge-based payment models for hospitals and cause a capacity adjustment that is realised by the closure of hospitals or reduction of beds (Mossialos/le Grand 1999). Cost containment policies are also based on service substitution. Outpatient treatment substitutes for the more expensive in-patient treatment (Healy/McKee 2002, p. 28). The reconfiguration of the hospital structure in Europe is proving to be difficult because of complex incentives and mixed ownership structures.

Planning approaches have been more successful in containing health care costs than have attempts to redevelop national health care systems by free-market coordinating mechanisms (Saltman/Figueras 1997). Despite the positive effect of governmental interferences in the short run, this procedure leads to the misallocation of resources and the quality of
health care is afflicted with the resulting decline of competitiveness. Rather than trusting in a competitive market to positively affect the quality of medical treatment, service quality is instead subjected to accreditation and stamps of approval by newly-founded institutes for quality in health care (Øvretveit/Gustavson 2002; Shaw 2000, p. 174).

The new East European member states face problems similar to those in the older member states. Rising health expenses are stabilised by cost-cutting exercises as more and more medical services are withdrawn from the catalogue of benefits. Above all, political instability and corruption constrain the development of stable national health systems. The presence of government representatives on health insurance committees and legal restrictions diminish the autonomy promised to the service providers (Knieps 2004, p. 30).

III. The relevance of European integration for the national health care systems in Europe

1. The development of a European health policy

The European Union, originally founded as a contractual community to preserve lasting peace in Europe, exerts more and more influence on the national legislation of the member states. Social policy, including health care policy, had until the late 1970s not been subject to a conciliation process. With the exception of specific regulations regarding insurance claims for travellers and border crossers, no interstate arrangements existed between the member states (Kowalsky 2000, pp. 17). The exclusion of social policy from the European agenda was due in great part by a fear of what the consequences of a European social policy would be. Beside the loss of national identity through the loss of the competence of established social systems, worries about the eradication of achieved social standards brought about by radical market deregulations at the European level played an important role. The organisation and financing of national health systems was seen by some as the factor that would complicate harmonisation. Because in the course of the European integration other issues took precedence over health care, the health policy was not integrated into the Treaty of the European Union until the 1990s. The objective was to promote and complement the social policy of the national administrations in conformity with the subsidiary principle (Hajen et al. 2006, p. 314).

The sole competence of national governments for the organisation and financing of their health care system remains indefeasible (Shaw 2000, p. 170). Only non-binding letters of intent, including expressions of a willingness to aim for a high level of health in the European Union, were constituted (COM 2001, pp. 11). However the EU-competition law and efforts to establish a Single European Market have had far-ranging consequences for the national health systems, even if governments still have sole competence for social policy (McKee et al. 1996).
2. The EU’s influence on national health care systems

Application of the European competition law can be restricted only if there are compelling reasons concerning the public welfare to do so. In Germany, hospitals as well as health insurance companies are considered firms that perform services of general economic interest. As they are legally obligated to guarantee the continuity of the German social security system and should not act with a gainful intent, they are not subordinated to the European competition law. But since the market for in-patient services, in Germany as in other European countries, comprises both private and public hospitals, restricting the competition law appears problematic.

Private hospital owners have a gainful intent but at the same time are integrated into their national systems of health care. Besides, the increased presence of competitive elements in the health systems conflicts with the special exceptions to the European competition law for this sector (Klaue 2006, p. 171). In Germany, special regulations (that differ from European state aid law) have been developed concerning investment aid for hospitals and the deficit balance in public hospitals. Hence, state aid to hospitals is not subject to restrictions with the exception that it can only be granted to the extent necessary to fulfil the common welfare obligations (Schwintowsk i 2006, p. 195). Nevertheless, the prudence of state aid is doubtful since poorly administered public hospitals can shift their business risk onto the general public leading to a distortion of the competitive balance between them and private hospitals. On the other hand, there is little risk that the discontinuation of state aid will lead to market failure (Kuchinke/Schubert 2002, p. 527). The present protected status of the health sector holds discrepancies which show that in the long run the health sector must also face the conditions of the free market in Europe (McKee/Nolte 2004, p. 1025).

Health insurance companies are also affected by the liberalisation of the European health care market. For a long time the costs of cross-border medical treatment were reimbursed only in exceptional circumstances and following prior approval by the health insurance on the basis of the benefit-in-kind principle (Kanavos et al. 1999, p. 1157). The European court of justice has judged in two leading decisions that the requirement for prior approval violates the free rendering of services in the EU. The argument that deregulation threatens the financial stability of health systems was rejected (Hajen 2002, p. 201). Because of these high court decisions, health insurance companies now have to reimburse the costs of cross-border treatment, without having granted prior approval, in an amount equal to what would have been charged by a national service provider (Mossialos/McKee 2002, p. 992). Utilisation of out-patient services abroad saddles German sickness funds with a double economic burden since the benefit is compensated once in a lump sum per-patient payment paid to the Federal Association of SHI-physicians but must be paid for again to the cross-border provider (Hajen et al. 2006, p. 316).

Presently the process towards establishing a Single European Market hits on the national protections in the service sector, in particular in the health care sector. The national service markets are diverse in their general conditions and cross-border offerings are subject
to approval by national competent authorities. Licensing requirements and orders complicate the permission and limit the freedom to provide services across national boundaries. The general EU Services Directive which was intended to promote competition in European service sectors should have originally also applied to the health sector. After numerous protests, however, the health sector was excluded from the directive and is to get its own directive which will take its particular market circumstances into account. In general, the directive addresses the conditions under which health services providers can offer cross-border services.

The basic message of the EU Services Directive is the approximation of laws for cross-border services in terms of freedom of establishment and the “country of origin principle”. The principle of freedom of establishment concerns the conditions under which a health care provider from country A can settle down in country B. Provision of service should be allowed as long as it is provided free of discrimination and is in the interest of the public welfare. The need for authorization should be the exception rather than the rule. The consequences of the implementation of this principle for national health care systems would have been far-reaching. In Germany for example its implementation would have put into question planned economic regulations directed at hospitals and general practitioners. Restrictions based on minimum distance requirements between providers or on population size would have conflicted with European law and been rendered illegitimate.

The second aspect of “the country of origin principle” refers to the possibility of a health care provider delivering cross-border services on the basis of the laws of its country of origin. For example, a German hospital could buy sterilisation and cleaning services from a Polish company. The Polish company would have to abide by Polish law in supplying the service (Heyder/Renzewitz 2005, p. 728). Opponents of such a regulation worry that competition between health care providers will force national authorities to scale down national standards resulting in a general drop in service standards for patients. The impact that the application of the EU Services Directive would have on the German health care system indicates the need for structural reforms to reduce barriers to competition.

Another important area in which European regulations have noticeable consequences for national health sectors is job safety and health protection. The regulation of doctors’ working hours in hospitals is particularly salient. Because doctors have to be fit for service when they are 'on-call' and must be physically present in the hospital, the current practice of differentiating between working time and being 'on-call' violates the European working directive. For German medical centres, labeling the time spent 'on-call' as labour time results in a shortfall of doctors and, in turn, to higher personnel expenditures for hospitals (Walger/Hurlebaus 2005, p. 5; Singh 2004, p. 1034).
IV. Assets and drawbacks of a European perspective focusing on relevant health care actors

1. Patients

For patients, the Europe-wide opening up of the health markets brings many benefits. Increasing competition strengthens the patient-centered perspective of the health systems. The possibility to claim benefits beyond one's country's frontiers helps patients in countries such as Great Britain forego waiting lists and gain access to medical treatment far earlier. Generally the liberalisation of the market enables patients to choose between competing health care providers with regard to treatment costs or quality (Kanavos/McKee 2000, p. 232). Patients are thereby able to exert pressure on service providers to improve their service offerings (Hoppman 1988, p. 242).

For patients with rare or serious illnesses, specialised medical centres become profitable because of the increased market volume. At the purely national level the market potential would be too low to establish them. If patients are made aware of the possibility of cross-border treatment and informed about their rights, then the pictured positive effects can be realized. The recently pronounced judgment of the European Court of Justice enables patients to engage in cross-border medical treatment and there and thereby bolsters the position of patients in Europe. The judgment concerned only an individual case of a patient who took legal action and is so far not part of a legal regulation. Therefore patients can only quote the precedent.

The EU needs to take action that strengthens the rights of patients so that they no longer have to justify seeking cross-border treatment. The introduction of the Europe-wide European Health Insurance Card (EHIC) is a step towards a simplified procedure of European health care utilization. The possibility to gather information via the internet facilitates choosing cross-border health services. A representative study for Germany indicated that the internet is in third place regarding the preferred channels of information when looking for a hospital (Dietrich/Gapp 2005, p. 229).

2. Health care personnel

Physicians and other health care personnel may find that the Europe-wide liberalisation of the health market increases their opportunity to find attractive employment conditions and better financial reimbursement. Physicians from highly regulated countries, like Germany, may be drawn to less regulated European countries with attractive prospects. Health care personnel now represent the most mobile manpower in Europe. In general, only 2% of the citizens of the European Union work in a European foreign country; in the health sector more than 5% work abroad (Anon 2006). The increased mobility and employment opportunities enhance the bargaining power in the current labour relations. On the other hand Western European physicians have to compete with physicians from
the new eastern EU states, who have fewer demands. Nevertheless, the expected rush of foreign labour from Central- and Eastern Europe triggered by the EU-east extension has failed to appear so far. The present discussion about the availability time of physicians and the Services Directive indicates that the terms of employment in the EU are in continuous flux and in the long run conform with a consistent European law.

3. Hospitals

Changing basic conditions in the German health care system as well as in broader Europe confront hospitals with new challenges (Dietrich 2005, p. 8). Hospitals in Europe have to face up to the rising competition. The cost coverage principle for the reimbursement of in-patient treatment is being increasingly replaced by discharge-based payment models in all European states and fosters economic behaviour of the hospitals management (Schölkopf/Stapf-Finé 2004, p. 196). In addition, the application of discharge-based payments facilitates performance comparisons among hospitals. In the medium term, this will be possible not only between hospitals at the national level but also throughout Europe.

The liberalisation of the health care market also includes opportunities to develop new market segments. The simplified cross-border health care utilisation in the future within an EU-legal frame gives more leeway to hospitals to tap the full market potential of foreign patients (Heyder/Renzewitz 2005, p. 730).

For public hospitals, particularly in Germany and Italy, pressure to change has come about because of European restrictions on government aid that has so far caused distortions of the market. Public hospital operators will no longer be able to balance their budgets at the taxpayers' expense. In the competition for patients in the European market health care providers would be well advised to use economies of scale and scope (Perillieux et al. 2006, p. 20).

German health care providers lead the way in the construction of clinic chains and the establishment of “medizinische Versorgungszentren” (medical care centers) in comparison to other European countries. International groups have not yet entered the market, with the exception of the pharmaceutical sector. Presently, American enterprises are prevented from entering on the grounds that they could destabilize the European national health care systems (Price et al. 1999). Nevertheless, national health care providers should be prepared for international competition early enough and should not sit back and assume that there will always be state protected national health markets.
V. Future prospects for the health care systems in Germany and Europe

Considerations about the future prospects of the health care system usually elicit heated and emotional debates. Social and economic aspects are emphasised by different health sector lobbies in the same breath. The failure thus far to separate efficiency and distributional issues, a marked characteristic of the present health care systems, constrains the construction of sustainable systems.

The present problems of various social security systems, in particular in countries like France and Germany, originate from the stagnant economic growth which goes along with high unemployment rates and the resulting decreasing social contributions. Changes in demographics and technical progress in medicine are other factors which cause rising costs in the health systems (Mendelson/Schwartz 1993; Victor et al. 2000; Zweifel et al. 1999).

For a long time economic experts recommend an iterative strategy: first an efficient health care system should be developed and then a socially-desired tax-financed rearrangement outside the system could be installed to account for welfare cases.

Despite the Europe-wide denouncement of the development of a two-class health care system, it is already present and its development is irreversible. The financial status of patients determines the scale of benefits and the quality of their medical services. Because of the need to economise in national health care systems, more and more medical services are withdrawn from the catalogue of benefits. In addition, primary health care patients are being forced to pay out-of-pocket for certain medical services.

As a result of numerous protests against the application of the Services Directive to the health care market, this sector was excluded from the guidelines. The protests and the subsequent exclusion of the health sector from the areas to which the Services Directives apply reflect the provisos against the liberalisation of the market. The European integration process will lead to changes in the health care systems. This is only a matter of time. While the changes may pose problems in maintaining high standards of medical treatment, the internationalisation offers numerous prospects which are often ignored. The liberalisation of the European health market entails chances for economic growth in the European countries.

The expansion of the single European market will be accompanied by an increase of growth rates. Studies forecast that the total revenue for pharmaceuticals, medical technology, and medical treatment on the European market will increase by about 6.4% annually from 2003 to 2008 (Frost & Sullivan 2004). The health market is one of the strongest growing sectors in the national economies. Increasing competition among the health care providers in Europe will positively affect medical quality and the job market chances of professional forces.

With regard to national manpower planning in the health care sector, the European states must take into consideration physicians’ increasing mobility in the future (Jinks et al. 2000, p. 63). Free mobility may lead to losses of highly qualified physicians and to short-
ages (McKee/Nolte 2004, p. 1025). Instead of maintaining and even increasing regulatory restrictions on mobility, the legal requirements for hospitals should be loosened (Buchan/O’May 2002, p. 236). Hospitals should be allowed to recruit the well-trained, highly qualified physicians by offering financial incentives and attractive conditions of employment. To improve the free movement of physicians across Europe, it is essential to develop regulations at the European level for improved mutual recognition of training and qualifications. McKee and Nolte (2004) point out that the conditions and consequences of the Europeanization of the health labour market have not been adequately researched.

National governments will be forced by the liberalisation to disengage from the elements of a planned economy as they develop their health policy and to implement incentives based on principles of a social market economy. In the long run this will strengthen the patient-centered perspective of the health systems.

Health services providers, regardless of where they are, will not get away with offering services of poor quality in a competitive market. Adhering to the principles of a planned economy in the health services sector on the grounds that health care quality and rising costs are issues for state control only raises suspicion that weak providers are protected while competitive providers of good quality service are constrained from realising financial success. The expansion of the legislative competence of the European Union on the area of social policy will cause an unrejectable adaptation need of the national social legislation. The member states can elude this process only on short notice (Ross 1998, p. 327).

The extent of the consequences following the liberalisation of the European health care market is overestimated. Indeed, a single European market will entail that patients make cross-border use of medical services. This will especially assign challenges to health insurances regarding the acceptance and payment of claims. However, the patients’ mobility will be by far lower than expected. The importance of cultural factors, linguistic barriers and the preference for close-by providers remain unaffected for the choice of physicians or hospital choice (Reichelt/Agabi 2003, p. 193). Hence, cross-border medical treatment will be restricted to the medical treatment of serious illnesses and to patients confronted with waiting periods in their countries (Breyer et al. 2002, p. 657).

Abstract

Dieter Tscheulin und Florian Drevs; Europa und Gesundheit – Nationale Gesundheitssysteme und die Auswirkungen des europäischen Integrationsprozesses

Europäische Union; Europarecht; Gesundheitspolitik; Gesundheitssystem; Krankenhäuser; Krankenversicherung

References

Allin, Sara, Vaida Bankauskaite, Hans Dubois, Josep Figueras, Christina Golna, Susanne Grosse-Tebbe, Nadia Jemiai, David McDaid, Annette Riesberg, Jonas Schreyoegg and Sarah Thomson (2005), Snapshots of health systems, European Observatory on health systems and policies, Kopenhagen.
Dietrich, Martin (2005), Qualität, Wirtschaftlichkeit und Erfolg von Krankenhäusern, Freiburg.

Kanavos, Panos and Martin McKee (2000), Cross-border issues in the provision of health services: are we moving towards a European health policy, in: Journal of Health Services Research Policy, Vol. 5, No. 4, pp. 231-236.


Kowalsky, Wolfgang (2000), Focus on European social policy, Brüssel.


Stapf-Finé, Heinz and Martin Schölkopf (2003), Die Krankenhausversorgung im internationalen Vergleich, Düsseldorf.


