Public Private Realities in Healthcare: An Analysis of European Hospitals

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This paper provides an analysis of European health systems in the United Kingdom, Italy, Sweden, Slovakia, France, Belgium, Germany, Finland, Portugal and Switzerland. In exploring the issue of how much hospital provision is in the private and state sectors it provides an overview of the diversity that is healthcare provision in today's Europe.

The United Kingdom

Below the radar screen of popular politics in the United Kingdom, healthcare is increasingly being seen by voters - and particularly by a greatly expanded and affluent middle class - as an area that demands greater consumer empowerment.

Today, some 7 million British people have private medical insurance and another 6 million are covered by private health cash plans.[1] Millions of others have no formal private coverage at all, preferring instead to self fund as and when the need arises. In 2003, more than 300,000 British people chose to privately self-fund for independent acute surgery without any private insurance.[2] Moreover, according to research published in the *Daily Telegraph*,[3] more than 3.5 million British trade unionists – more than 50 per cent of the Trade Union Congress's 6.8 million members – enjoy the benefits of private medical insurance or health cash plan schemes.[4]

At the dawn of the 21st century, more than eight million Britons pay privately for a range of complementary therapies. And in dentistry, more than a third of the population has abandoned the NHS, preferring instead to rely on private treatment.

While in 1948 the government nationalised more than 3,100 independent hospitals, care homes and clinics and promised that the state would provide 'all medical, dental and nursing care' it soon became clear that the state was unable to find the capital investment required to maintain and develop the institutions necessary to fulfil the promise.

That is why, following more than four decades of underinvestment, ever since the early 1990s most new capital in the UK's National Health Service hospitals has been arranged under the private finance initiative (PFI). Here, the private sector designs, builds, finances, owns and in some instances operates areas of NHS provision – including some clinical services.

Although this policy was initially adopted by John Major's Conservative government, it was subsequently embraced by Tony Blair's Labour administration. Moreover, under the rubric of public private partnerships the government has in recent years championed a whole raft of market-oriented reforms in NHS provision.

In 2000, the then Secretary of State for Health, Alan Milburn, signed a Concordat with the representative body of Britain's now resurgent independent health and social care sector – the Independent Healthcare Association (IHA).[5] Under this agreement, the NHS could send its patients to independent hospitals and clinics for treatment and care. Between 2000 and 2003 more than 250,000 NHS funded patients annually received treatment and care in the independent sector and others were sent to private hospitals abroad.

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[1] Some schemes offer private medical, permanent health or critical illness cover. Others offer private health cash plans that pay for services that include items such as dentistry, ophthalmics, physiotherapy, chiropody, podiatry, maternity services, allergy testing, hospital in-patient stays, nursing home stays, hospital day case admissions, convalescence, home help, mental health and psychiatric treatment, and even the use of an ambulance.

[2] This information was obtained from the Independent Healthcare Association.

[3] Daniel Kruger; 'Why half the members of trade unions have private health care'; *Daily Telegraph*; 11 September 2001.

[4] For a sound history of trade union and friendly society involvement in independent healthcare see: David Green; *Working Class Patients and the Medical Establishment – Self Help in Britain from the mid-nineteenth century to 1948*; 1985; Gower Publishing Company Ltd; Aldershot.

[5] This association closed in December 2003.

In 2001, the government made it clear that it wanted the private sector to design, build and operate a new generation of Independent Sector Treatment Centres for the benefit of NHS funded patients. The same year, the government also made it clear that it wanted to establish a new generation of Independent Foundation Hospitals. As such, it wanted the best NHS hospitals to be 'set free' from Whitehall control and to have a greater say over how they developed and from where they raised their capital.

Overall, the direction of travel in the NHS is clear. Selling off NHS land, the private finance initiative, acceptance of public private partnerships, the Concordat with the independent sector, independent sector treatment centres and foundation hospitals all point to an increasingly privatised future on the provision side.

Today, the NHS has effectively been redefined as a regulator and a key funder of healthcare but it is no longer deemed to be a necessary provider – or owner - of the facilities in which health services are delivered. As a recent Secretary of State for Health, Alan Milburn, commented:

> "For fifty years the NHS has been subject to day-to-day running from Whitehall. The whole system is top down. There is little freedom for local innovation or risk taking… A million strong health service cannot be run from Whitehall. Indeed, it should not be run from Whitehall. For patient choice to thrive it needs a different environment. One in which there is greater diversity and plurality in local services which have the freedom to innovate and respond to patients needs. Our reforms are about redefining what we mean by the National Health Service. Changing it from a monolithic, centrally-run, monopoly provider of services to a values-based system where different health care providers – in the public, private and voluntary sectors – provide comprehensive services to NHS patients… Who provides the service becomes less important than the service that is provided."[6]

In addition to state owned hospitals there are more than 200 private acute hospitals with more than 200 independent acute medical and surgical hospitals. With more than 600 operating theatres, 800 critical illness beds and over 10,000 acute medical/surgical beds, their numbers and quality are impressive.[7] Delivering more than 1 million surgical procedures a year and seeing more than 4 million people in out-patient's appointments the sector's hospitals offer substantial capacity to help ease pressures on the NHS.

Italy

As in the UK, Italy's health system is rooted in the theoretical principle that healthcare is a fundamental human right and a key part of a civilised society. Legislated for in 1978 and subsequently established in 1980, the Italian national health service - *Servizio Sanitario Nazionale* (SSN) – entitles all citizens to receive healthcare.

Today, after several reforms, it has three organisational levels: national (whereby the ministry of health oversees the national health plan); regional (the regional government oversees the way in which financial resources are allocated to local health units or hospitals and performs a controlling function regarding quality and efficiency); and local.

The aim of the SSN is to deliver a uniform healthcare system that covers the entire population irrespective of income or any pre-existing conditions. As such, it provides free or low-cost healthcare to all residents and their families including university students and senior citizens.

In 1998 the SSN was reformed and today is solely funded by central government via the *Imposta Regionale Sulle Attività Produttive (IRAP*) tax, which is paid by employers on behalf of employees. The self-employed pay for themselves through their taxation too.

While most Italian hospitals are operated by the state, there is nevertheless an historic tradition of diversity. As a result a significant number of Italian hospitals are in the private sector, with most bound to the national health service through various contracts.

Today, approximately 84 per cent of all hospital beds are in public hospitals with the remaining 14 per cent in the private sector.

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6 The Secretary of State for Health, the Rt. Hon. Alan Milburn MP, speech to New Health Network, 15 January 2002.

7 Data from the *Independent Healthcare Association Acute Hospital Survey 1999-2000*, London, Independent Healthcare Association.

Sweden

Similarly, in that most ardent of high-spending European welfare states, Sweden, the shift from a healthcare system previously dominated by a public sector monopoly characteristic of the UK, to one with diverse providers and powerful consumers has been profound in recent years – and most striking in the city of Stockholm.[8]

Across Sweden the number of contracted private healthcare providers has risen significantly in recent years, reflecting a new era of consumer choice and a preference on the part of many young doctors and nurses to work in the private sector. Indeed, Stockholm's revolutionary approach to healthcare – public funding, public-private cooperation in provision and freedom of choice – has started to attract international attention.

As in the UK and Italy, access to healthcare is a universal right in Sweden and coverage embraces doctors' visits, hospitals services, prescription medicines and dental care. While the national government sets overall policy direction, health services here are managed by county councils which generate most of the funding through taxation.

Although private medical insurance is legal in Sweden the number of people purchasing it remains relatively small – although growth has occurred in recent years as waiting lists have grown in the state sector.

Between 2000 and 2002 the number of private health care providers doubled to represent some 27 per cent of the nation's total. Today, there are nine private hospitals in Sweden – with most of these based in the larger cities.

However, more than 90 per cent of Swedish doctors remain salaried employees of the county councils. While the remaining 10 per cent work in private practice they are still compelled to sign agreements with a county council so as to be reimbursed by the public system. It is largely through these agreements that the county councils seek to regulate and control the private health market.

Slovak Republic

Today, across much of Eastern and Central Europe, private healthcare is booming as never before. After decades of massive state failure, people are beginning to see the emergence of a wide range of private hospital and health brands for the first time. A newly emergent middle class with an increasingly high disposable income means that a wide range of private health services look set to remain.

Following the manifest failure of Slovakia's nationalised healthcare system, since September 2003 citizens have been given the opportunity to pay privately for key elements of healthcare. A health law passed in March 2003 means that healthcare providers can now charge a range of direct-to-consumer payments, including Sk 20 per doctor visit, Sk 20 per drug prescription, Sk 20 per kilometre travelled in an ambulance, and Sk 50 per day spent in hospital.

While patients continue to receive some medications 'free of charge' from the state, some medicines are now paid for directly by consumers.

In Slovakia, there are 113 hospitals, sanatoriums and psychiatric centres. However, while the private sector is gaining a greater significance, under the law that governs healthcare providers (recently revised in 2005) private companies are not allowed to obtain a majority stake in larger hospitals. As a result the private sector is limited to primary care and the smaller hospitals sector.

France

Back in Western Europe, French healthcare sets very high standards and is without the waiting lists characteristic of many other national health systems. In a highly competitive system that balances market liberalism with a limited egalitarianism, consumer choice and empowerment are fiercely guarded principles.

To obtain health cover in France it is first necessary to have paid social insurance premiums based on a percentage of income. In addition, fees are payable at the time of use – and have to be claimed back from an insurer (or completely waived for the poor) at a later date.

Today, compulsory health insurance covers the whole population. While premiums are charged as a percentage of income and the total cost is nearly 20% of payroll (including the employer's and employee's contribution), the insurers are non-governmental, not-for-profit agencies, which owe allegiance to employers and employees.

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[8] Johan Hjertqvist; *The Health Care Revolution in Stockholm*; Timbro Health Unit; 2002 Stockholm.

Significantly, French national insurance makes no distinction between public and private hospitals and patients have complete freedom of choice. Today, public hospitals provide about 65% of beds and the remainder are private (about 20% are for-profit with some 15% run along not-for-profit lines).

Similarly, the French enjoy choice of doctor, whether a GP or a specialist, and all patients whether exempt from co-payments or not, may go directly to a specialist either inside or outside a hospital.

Overall, the French healthcare system is a pragmatic blend of consumer choice, professional autonomy, central regulation and a government-backed guarantee for the poor. Like the Belgians and the Germans (below), the French have found a distinct way of universalising the benefits of a competitive market. As a result, France performs well on almost all comparative health measures, and in 2000 was ranked number one by the World Health Organisation.

Belgium

Similar in many ways to the French system, Belgian healthcare is founded on a social insurance model whereby citizens have to become members of a sickness insurance fund - *a mutuelle*. Administration of the insurance fund is split between a small number of not-for-profit mutual benefit associations and one single public sickness fund.

Healthcare provision in Belgium has enjoyed a liberal history and independent medical practice means that doctors and consumers retain considerable freedom. As in France, patients are able to choose their general practitioner and their specialist, as well as having direct access to hospitals. With a comparatively large numbers of physicians at work in the country there are also few - if any - waiting lists.

In Belgium, politicians across the political spectrum treat as normal the idea that out of a total of more than 70,000 beds, the private sector provides a majority at more than 40,000 beds. Containing a mixture of for-profit and not-for-profit institutions, the Belgian private hospital sector is renowned for its responsive, high quality, provision.

Germany

In Germany, pressure is mounting for the government to reform the healthcare system and to enable people to more easily use private medical insurance. Already, more than eight million Germans have private medical insurance - some ten per cent of the population – and this figure seems set to rise as German state health benefits are increasingly restricted under the government's ongoing reform process.

With comparatively high taxes, uncompetitive social costs and some than four million unemployed, German opinion formers are united in the view that private sector solutions are now the way forward in healthcare.

Indeed, since the early 1990s, subsequent German governments have been trying to increase competition. Today, insurers can be compared on the Internet, and for those without web access, there are a host of magazines and rankings by independent consumer organisations. As a result many customers have moved away from the larger funds.

In Germany, hospitals are under diverse ownership. In 2002, around 54% of hospital beds were in the public sector, 38% were in the private not-for-profit sector, and 8% were in the private for-profit sector.

Moreover, Germans are free to visit any doctor they like, which further encourages competition and helps to raise standards. Invariably, they either walk in off the street or ring for an appointment (which will usually be set for the same or the next day). Importantly, like the French and Belgians, Germans do not have to see a GP before visiting a private specialist. Today, Germany has 2.3 practising specialists for every 1,000 people, compared with only 1.5 in the UK.

Finland

Over the last ten years, privatisation has been used extensively in many of Europe's smaller states and Finland is no exception. Here, it has been applied to every sector where the state has been traditionally active and at every level - national and municipal.

Since 1995, municipalities have been allowed to buy services from the private sector and whereas in 1989 the public sector employed some 215,000 people, by the late 1990s this number had fallen to 127,000.

In healthcare, contracting out has become commonplace – with one municipality privatising all of its healthcare provision over a relatively short period. However, this is only just the beginning. For as the OECD has recently made clear, if Finland is going to remain competitive and cope with the long term effects of an aging population, it is going to have to become even more radical in its reform process.

Today, municipally funded health services are still dominant in the country as they provide more than 70 per cent of health services as measured by share of expenditure. However, the share of municipal and private services varies from sector to sector. For example, with some outpatient services such as ophthalmology, dentistry, and obstetrics and gynaecology, the private sector delivers more than half the services available. On the other hand the private sector produces just 5 per cent of the total number of hospital inpatient admissions – although in some areas of surgery such as cataracts is much higher.

Unlike many other European countries most private hospitals delivering surgery for private patients are for-profit institutions. Indeed, there are only two not-for-profit hospitals providing services for patients contracted by municipalities.

Portugal

As with Finland, in the late 1990s the Portuguese government came under profound pressure to control an oversized public deficit against a background of sluggish economic growth.

As a consequence, in recent years they have increasingly contracted-out a range of public services, and in many areas of activity, turned to widespread privatisation.

In Portugal, many hospitals have been exposed to market reforms as the government has searched for liberally-oriented policy solutions.

While the Union of Portuguese Nurses initially led opposition to the privatisation implicit in recently enacted hospital management legislation, the government nevertheless won the day and today public private partnerships in provision are the norm.

Switzerland

When it comes to efficiency, responsiveness and consumer empowerment, probably the best healthcare system in Europe is to be found in Switzerland. An essentially liberal system with a highly federalised structure the state is actively restricted here to simply guaranteeing healthcare: “when private initiative fails to produce satisfactory results”.

Ultimately, the preferences of consumers determine the structure of the system to a degree found in few other countries around the world. With 23 cantons – and 3 of these split further into demi-cantons – there are in effect 26 slightly different healthcare systems in Switzerland.

While cantons are charged with regulation, hospital accreditation and finance, the overall system is nevertheless built on a high degree of competition. Insurers and providers compete for patients on the basis that they are customers, and insurers are allowed to selectively contract with primary care providers.

As with most developed countries around the world, Swiss healthcare is funded through a combination of public and private monies. That said, the relative expenditure of public money is one of the lowest in Europe. Significantly, when it comes to planning and funding purposes, the federal government has no planning authority for outpatient and short-stay impatient care and does not provide subsidies for these. Impatient care on the other hand, is subject to state planning and receives public subsidies.

As a result of the entrepreneurial nature of the system, the Swiss benefit from a lavish hospital infrastructure. With more than 400 hospitals in total, 130 are private for-profit and 270 are either public or publicly subsidised not-for-profit institutions.

Conclusion

When it comes to European hospitals and healthcare systems the real comparison is not simply between issues of public versus private funding and ownership, but the broader issue of monopoly and competition.

Across Europe, people have traditionally insisted that their own nation's health system is the best in the world. Attaching national prowess to health delivery, people in the United Kingdom, Italy, Sweden, Slovakia, France, Belgium, Germany, Finland, Portugal and Switzerland have all no doubt believed that their own system is the best in the world.

Yet today, in all of these countries, it is noticeable that the genuinely better systems – as defined by shorter waiting times, access to new medicines, and by consumer satisfaction [9]- are the ones that not only stress the benefits of a major element of private funding but the idea of competition between diverse providers.

With the more traditionally statist healthcare regimes of the UK, Sweden and Slovakia seeking ever greater efficiency and higher standards via greater diversity and competition it is countries like France and Switzerland that provide a genuine and proven beacon on the road to reform.

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[9] For details of consumer-focused health rankings, visit the Euro Health Consumer Index at: http://www.healthpowerhouse.com/archives/000499.html