Univerzita Karlova v Praze
Farmaceutická fakulta v Hradci Králové

Diplomová práce

Náhled na evropský zdravotní systém na základě existujících systémů zdravotní péče v rámci EU

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An outlook of a European Health System based on existing health care systems across EU

Diploma thesis

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Abstract

This thesis deals with common European Health System policies and attempts to compare them in order to present the different approaches to health care constitution in single European countries, aiming, primarily, to define common targets and goals to be met in creating European healthcare standards.

The main aim of composing this thesis is to characterize healthcare system trends within Europe through data provided by official institution, and furthermore, to interpret and evaluate them. This thesis also defines basic models of healthcare systems and their functioning as well as common action undertaken by European Union in the field of health systems. By assessing all gained information we created recommendations for further development and mutual recognition of healthcare policies.

Keywords:
Health Care, Health System, European Union, Cross-border Health Care

Abstrakt

Tato diplomová práce se zabývá společnými politikami v rámci evropského zdravotního systému a pokouší se tyto porovnat s cílem prezentovat různé přístupy k sestavení systémů zdravotní péče v jednotlivých evropských zemích. V tomto směru usiluje zejména o definování společných cílů a úkolů, kterých má být dosaženo při tvorbě evropských standardů zdravotní péče.

Hlavním cílem této diplomové práce je charakterizovat trendy v oblasti systémů zdravotní péče v Evropě na základě údajů poskytnutých oficiálními institucemi a dále tyto interpretovat a vyhodnotit. Tato práce rovněž definuje základní modely systémů zdravotní péče a jejich fungování, a dále společnou aktivitu, které se v oblasti zdravotních systémů ujala Evropská Unie. Na základě vyhodnocení všech shromážděných informací jsme vytvořili doporučení pro další vývoj a vzájemné uznávání politik v oblasti zdravotní péče.

Klíčová slova:
Zdravotní péče. Zdravotní systém. Evropská Unie. Přeshraniční zdravotní péče

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LIST OF ABBREVIATIONS AND SYMBOLS

EC	European Countries
ECDC	European Centre for Disease Prevention and Control
EHIC	European Health Insurance Card
EHPP	Ethics, History and Public Policy
EOPYY	Largest Social Security Organisation in Greece
EU	European Union
GDP	Gross Domestic Product
GP	General Practitioner
HIAP	Health in all Policies
HLY	Healthy Life Years
ICT	Information and communication technologies
KELA	Provider of Social security for all residents in Finland
NGO	Non-governmental organisation
OECD	Organisation for Economic Co-operation and Development
WHO	World Health Organisation

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Introduction

Health is important for individuals and for society. People expect to be protected against illness and disease. They want to bring up their children in a healthy environment, and demand their workplace to be safe and hygienic. They need access to reliable and high-quality health services. Therefore, health care is the prevention, treatment and management of illness and the preservation of mental and physical well- being through the services offered by the medical and allied health professions.

Health system represents the people, institutions and resources arranged together in accordance with established policies in order to improve the health for the population they serve, while responding to people`s legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health. It is a set of elements and their relations are designed to serve the health needs of the population. Health system fulfils three main functions: health care delivery, fair treatment to all, and meeting health expectations of the population. These functions are performed in the pursuit of three goals: health, responsiveness and fair financing, which will be discussed in part 1.2.

Life expectancy, roughly but comprehensively, measures overall population health, as it summarizes, in a standardized format, current information on the health situation of all age and sex groups of populations. As such, it reliably indicates overall health performance in a society at a specific team. This broad indicator reflects societies' performance in improving health and not solely the performance of health systems. This distinction is key as it links to public health's greatest idea: that human health and disease embody the successes and failures of society as a whole. Health care systems are designed to meet the health care needs of target populations. There is a wide variety of health care systems around the world. In some countries, the health care system planning is distributed among market participants, whereas in others planning is made more centrally among governments, trade unions, charities, religious, or other co-ordinated bodies to deliver planned health care services targeted to the populations they serve. However, health care planning has often been evolutionary rather than revolutionary. [1]

Having access to high-quality healthcare when and where it is needed is a priority issue for European citizens, and is recognised in the Chapter of Fundamental Rights of the EU. The benefits provided by different EU health systems are determined by Member States, not the Community. However, in accordance with Community free movement rules, care, to which citizens are entitled in their own Member State, may also be asked in another Member State and be reimbursed, subject to certain conditions. [7]

Aims of work

The aim of my diploma thesis is to analyse the fundamental principles and goals for European Countries action on health as well as the financing and management of quality health service and describe some EU Health programmes and campaigns that shed more light on the existing health services within Europe. Moreover, this thesis aims to present the Health Systems in 13 European countries and compare them and derive results on their quality and effectiveness. Furthermore, it aims to discuss the issues of community action on health services, cross-border healthcare and the proper impact assessment of EU legislation on health. Ultimately, in the conclusion this thesis aims to provide a number of recommendations for next steps ensuring that the specificity of health services is adequately reflected in any EU initiative and that sustainability and long term objectives of health services are reflected EU initiatives with impact on health.

1. Theoretical part

In this theoretical part there will be first an analysis of the fundamental principles, strategic objectives and goals for EC action on health, then a short reference to the various types of providers and the methods of funding healthcare systems and payment models for GPs, and, finally, a description of health informatics and ways of managing public care. In addition, a short description of European Health Insurance Card (EHIC) will be provided at the end of this part.

To start with, most competence for action in the field of health is held by Member States, but the EU has the responsibility, set out in the Treaty, to undertake certain actions which complement the work done by Member States, for example, in relation to cross border health threats, patient mobility, and reducing health inequalities.

More specifically, on 23 October 2007 the European Commission adopted a new Health Strategy, 'Together for Health: A Strategic Approach for the EU 2008-2013'. [19] Building on current work, this Strategy aims to provide, for the first time, an overarching strategic framework spanning core issues in health as well as health in all policies and global health issues. The Strategy aims to set clear objectives to guide future work on health at the European level, and to put in place an implementation mechanism to achieve those objectives, working in partnership with Member States. The Strategy focuses on four principles and three strategic themes for improving health in the EU, which will be discussed in the subsequent part. The principles include taking a value-driven approach, recognising the links between health and economic prosperity, integrating health in all policies, and strengthening the EU's voice in global health, discussed later in part 1.1. The strategic themes include Fostering Good Health in an Ageing Europe, Protecting Citizens from Health Threats, and Dynamic Health Systems and New Technologies, which will be analysed in part 1.2.

The Health Strategy has been in development over the past years. On May 2000 a Communication on health strategy at EU level was adopted. This Communication called for concentrating resources where the Community can provide real added value (principle 1), without duplicating work which can be better done by the Member States or international organisations. Supported by the public health programme, it led

to the development of public health activities and to strengthening links to other health-related policies (principle 2).

General health policy lines were set out in the concept of a Europe of Health in 2002. Work was undertaken on addressing health threats, including the creation of the European Centre for Disease Prevention and Control (ECDC), developing cross-border co-operation between health systems and tackling health determinants. The Community's health information system provides a key mechanism underpinning the development of health policy.

In 2004, in order to review the May 2000 Health Strategy and consider whether and how it needed to be revised in the light of developments, the Commission launched a reflection process on enabling good health for all. The results of this reflection process contributed to the development of the new Health Strategy. The EU Health Forum, which brings together organisations active in health to advise the European Commission on health policy, is also a key element of the EU Health policy. The Forum enables the health community to participate in health policy making from the start. EU health policy increasingly involves co-operation with and between the Member States, in particular on cross-border issues such as patient mobility. [3]

1.1 Fundamental principles for EC action on health

As mentioned above, there are four major principles for EC action on health. The first principle is a strategy based on shared health values. Health policy, both internal and external, should be founded on clear values. The Commission has been working with Member States to define a value-based approach to healthcare systems. In June 2006 the Council adopted a statement on common values and principles in EU healthcare systems, listing the overarching values of universality, access to good quality care, equity and solidarity. [7]

The second principle links health issues to economy as health is considered to be the greatest wealth. Health is important for the well-being of individuals and society, but a healthy population is also a prerequisite for economic productivity and prosperity.

In 2005, Healthy Life Years (HLY) was included as a Lisbon Structural Indicator, to underline that the population's life expectancy in *good health* – not just length of life – was a key factor for economic growth. More analytically, Healthy Life Years' indicator (disability- free life expectancy) measures the number of remaining years that a person of certain age is still supposed to live without disability. Healthy Life Years is a solid indicator to monitor health as a productivity/ economic factor and introduces the concept of quality to life because the emphasis is not exclusively on length of life, as is the case for life expectancy, but also on the quality of life. If HLY is increasing more rapidly than life expectancy in a population, then not only are people living longer, they are also living a greater portion of their lives free of disability.

The Commission report to the 2006 Spring European Council urged Member States to reduce the high number of people inactive through ill-health. It stressed that policy in many sectors has a role in improving health for the benefit of the wider economy. Spending on health is not just a cost, it is an investment. [13]

The third principle is embodying health in all policies (HIAP). The population's health is not an issue for health policy alone. Other Community policies play a key role, for example, regional and environment policy, tobacco taxation, regulating pharmaceuticals and food products, animal health, health research and innovation, coordinating social security schemes, health in development policy, health and safety at work, ICT, and radiation protection, as well as coordination of agencies and services regulating imports. Developing synergies with these and other sectors is crucial for a strong Community health policy, and many sectors will be cooperating to fulfil the aims and actions of this Strategy. HIAP is also about involving new partners in health policy. The Commission will develop partnerships to promote goals of the Strategy, including with NGOs, industry, academia and the media. [4]

Finally, the fourth principle refers to the strengthening of the EU's voice in health in times of global economic crisis. The EC and its Member States can create better health outcomes for EU citizens and for others through sustained collective leadership in global health. [8]

1.2 Strategic objectives and goals

Similarly, Health policy at Community level should foster good health, protect citizens from threats, and support sustainability. In order to meet the major challenges facing health in the EU, this strategy identifies three objectives as key areas for the coming years. The Commission will work with Member States to develop more specific operational objectives within these strategic objectives.

Therefore, the first objective is fostering good health in an ageing Europe. Population ageing, resulting from low birth rates and increasing longevity, is now well established. By 2050 the number of people in the EU aged 65+ will grow by 70%. The 80+ age group will grow by 170%. These changes are likely to raise demand for healthcare while also decreasing the working population. This could push up healthcare spending by 1 to 2% of GDP in Member States by 2050. On average, this would amount to about a 25% increase in healthcare spending as a share of GDP. However, Commission projections show that if people can remain healthy as they live longer, the rise in healthcare spending due to ageing would be halved.

The second objective aims to the citizens' protection from health threats. Protection of human health is an obligation under Article 152 EC. Improving safety and security and protecting citizens against health threats have always been at the heart of Community health policy, while at the same time the EU has a responsibility regarding the health of citizens in third countries. Community-level work includes scientific risk assessment, preparedness and response to epidemics and bioterrorism, strategies to tackle risks from specific diseases and conditions, action on accidents and injuries, improving workers' safety, and actions on food safety and consumer protection. The Commission will continue this work, but will also focus on challenges that have not yet been fully addressed.

The third objective is supporting dynamic health systems and new technologies. [14] EU Health systems are under mounting pressure to respond the challenges of population ageing, citizens' rising expectations, migration, and mobility of patients and health professionals. New technologies have the potential to revolutionise healthcare and health systems and to contribute to their future sustainability. E-health,

genomics and biotechnologies can improve prevention of illness, delivery of treatment, and support a shift from hospital care to prevention and primary care. E-Health can help to provide better citizen-centred care as well as lowering costs and supporting interoperability across national boundaries, facilitating patient mobility and safety. However, new technologies must be evaluated properly, including for cost-effectiveness and equity, and health professionals' training and capacity implications must be considered. New and unfamiliar technologies can generate ethical concerns, and issues of citizen's trust and confidence must be addressed. [1]

The actions in this Strategy will be supported by existing financial instruments until the end of the current financial framework (2013), without additional budgetary consequences. The annual work plans of the newly adopted Second Programme of Community Action in the Field of Health will be a key instrument to support the Strategy's objectives. Actions under other Community programmes and strategies, such as the Safety and Health at Work Strategy 2007-2012, will also play a major role. Several other Community programmes also provide funding relevant to health, e.g. the 7th Framework Programme on Research and Regional Policy programmes. [14]

As far as the goals for health systems is concerned, according to the *World Health Report 2000 - Health systems: improving performance* (WHO, 2000), these are good health, responsiveness to the expectations of the population, and fair financial contribution. Duckett (2004) proposed a two dimensional approach to evaluation of health care systems: quality, efficiency and acceptability on one dimension and equity on another. [7]

1.3 Providers, financing and payment models

Health care providers are trained professional people working self-employed or as an employee in an organization, whether a for-profit company, a not-for profit company, a government entity, or a charity. Organizations employing people providing health care are also known as health care providers. Examples are doctors and nurses,

paramedics, dentists, medical laboratory staff, specialist therapists, psychologists, pharmacists, chiropractors, and optometrists.

As far as financing is concerned, there are generally five primary methods of funding health care systems:

1. direct or out-of-pocket payments
2. general taxation to the state, country or municipality,
3. social health insurance,
4. voluntary or private health insurance, and
5. donations or community health insurance.

Most countries' systems feature a mix of all five models. One study based on data from the OECD concluded that all types of health care finance "are compatible with" an efficient health care system. The study also found no relationship between financing and cost control. [5]

The term health insurance is generally used to describe a form of insurance that pays for medical expenses. It is sometimes used more broadly to include insurance covering disability, long-term nursing or custodial care needs. It may be provided through a government-sponsored social insurance program, or from private insurance companies. It may be purchased on a group basis (e.g., by a firm to cover its employees) or purchased by individual consumers. In each case, the covered groups or individuals pay premiums or taxes to help protect themselves from high or unexpected health care expenses. Similar benefits paying for medical expenses may also be provided through schemes organized by the government and funded through contributions from users.

By estimating the overall cost of health care expenses, a routine finance structure (such as a monthly premium or annual tax) can be developed, ensuring that money is available to pay for the health care benefits specified in the insurance agreement. The benefit is administered by a central organization, most often either a government agency or a private or not-for-profit entity operating a health plan. [6]

Many forms of commercial health insurance control, their costs by restricting the benefits that are paid by through deductibles, co-payments, coinsurance, policy exclusions, and total coverage limits and will severely restrict or refuse coverage of pre-existing conditions. Many government schemes also have co-payment schemes but exclusions are rare because of political pressure. The larger insurance schemes may also negotiate fees with providers.

Many forms of government insurance schemes control their costs by using the bargaining power of government to control costs in the health care delivery system; for example, by negotiating drug prices directly with pharmaceutical companies, or negotiating standard fees with the medical profession. Government schemes sometimes feature contributions related to earnings as part of a scheme to deliver universal health care, which may or may not also involve the use of commercial and non-commercial insurers. Essentially the wealthier ones pay proportionately more into the scheme to cover the needs of the relatively poor who, therefore, contribute proportionately less. There are usually caps on the contributions of the wealthy and minimum payments that must be made by the insured (often in the form of a minimum contribution, similar to a deductible in commercial insurance models). In health care delivery system (primary health care) there are also providers in different ways; for example, Government, private, NGOs and traditional medicine. [2]

Regarding payment models, there are two ways to pay general practitioners. There has been growing interest in blending elements of these systems. Fee-for-service and salary-for-service.

Fee-for-service arrangements pay general practitioners based on the service. They are even more widely used for specialists working in ambulatory care.

There are two ways to set fee levels:

- By individual practitioners.
- Central negotiations (as in Japan, Germany, Canada and in France) or hybrid model (such as in Australia, France's sector 2, and New Zealand) where GPs can charge extra fees on top of standardized patient reimbursement rates. [3]

In capitation payment systems, GPs are paid for each patient on their "list", usually with adjustments for factors, such as age and gender. According to OECD, "these systems are used in Italy (with some fees), in all four countries of the United Kingdom (with some fees and allowances for specific services), Austria (with fees for specific services), Denmark (one third of income with remainder fee for service), Ireland (since 1989), the Netherlands (fee-for-service for privately insured patients and public employees) and Sweden (from 1994). Capitation payments have become more frequent in “managed care” environments in the United States.

According to OECD, "Capitation systems allow funders to control the overall level of primary health expenditures, and the allocation of funding among GPs is determined by patient registrations. However, under this approach, GPs may register too many patients and under-serve them, select the better risks and refer on patients who could have been treated by the GP directly. Freedom of consumer choice over doctors, coupled with the principle of "money following the patient" may moderate some of these risks. Aside from selection, these problems are likely to be less marked than under salary-type arrangements."

In several OECD countries, general practitioners (GPs) are employed on *salaries* for the government. According to OECD, “Salary arrangements allow funders to control primary care costs directly; however, they may lead to under-provision of services (to ease workloads), excessive referrals to secondary providers and lack of attention to the preferences of patients.” There has been movement away from this system. [7]

1.4. Health informatics, management and EHIC

Health informatics deals with the resources, devices and methods required to optimize the acquisition, storage, retrieval and use of information in health and biomedicine. Health informatics tools include not only computers but also clinical guidelines, formal medical terminologies, and information and communication system.

Public health is concerned with threats to the overall health of a community based on population health analysis. The population in question can be as small as a handful of

people or as large as all the inhabitants of several continents (for instance, in the case of a pandemic). Public health is typically divided into epidemiology, biostatistics and health services. Environmental, social, behavioural and occupational health are also important subfields.

Vaccination policy refers to the policy a government adopts in relation to vaccination. Vaccinations are voluntary in some countries and mandatory in others. Some governments pay all or part of the costs of vaccinations for vaccines in a national vaccination schedule.

Today, most governments recognize the importance of public health programs in reducing the incidence of disease, disability, and the effects of aging, although public health, generally, receives significantly less government funding compared with medicine. In recent years, public health programs providing vaccinations have made incredible strides in promoting health, including the eradication of smallpox, a disease that plagued humanity for thousands of years.

An important public health issue facing the world currently is HIV/AIDS. Another major public health concern is diabetes. In 2006, according to the World Health Organization, at least 171 million people worldwide suffered from diabetes. Its incidence is increasing rapidly, and it is estimated that by the year 2030, this number will double. A controversial aspect of public health is the control of smoking. Antibiotic resistance is another major concern, leading to the re-emergence of diseases such as Tuberculosis. [6]

A new EU-wide European Health Insurance Card (EHIC) was introduced in 2005, so that EU citizens can prove their entitlement to free or reduced-cost emergency medical treatment during stays in other EU countries. The EHIC replaces the previous E-forms, in particular the E111, being adopted in the UK on 1 September 2005. The European Health Insurance Card (EHIC) allows you to access state-provided healthcare in all European Economic Area (EEA) countries and Switzerland at a reduced cost or sometimes free of charge.

Everyone who is resident in the UK should have one and carry it with them when travelling abroad. Remember to check EHIC is still valid before you travel. Applying for the card is free and it's valid for up to five years.

Presenting the EHIC entitles you to treatment that may become necessary during your trip, but doesn't allow you to go abroad specifically to receive medical care. However, maternity care, renal dialysis and managing the symptoms of pre-existing or chronic conditions that arise while abroad are all covered by the EHIC.

Your EHIC will allow you access to the same state-provided healthcare as a resident of the country you are visiting. However, many countries expect the patient to pay towards their treatment, and even with an EHIC, you might be expected to do the same. You may be able to seek reimbursement for this cost when you are back in the UK if you are not able to do so in the other country.

The EHIC is NOT an alternative to travel insurance. It will not cover any private medical healthcare or the cost of things such as mountain rescue in ski resorts, repatriation to the UK or lost or stolen property. For these reasons and others, it is important to have both an EHIC and a valid private travel insurance policy. Some insurers now insist you hold an EHIC and many will waive the excess if you have one. [23]

2. EU Health Programmes and Campaigns

The following EU Health programmes aim to protect and promote human health and safety in general. Respectively, the campaigns aim to provide help and support to the target groups by delivering comprehensive information on health and social problems related to tobacco consumption, work-related accidents and the disease of AIDS, as presented below.

2.1 Programme of community action in the field of Public Health

The Public Health Programme (2003-2008) ran from January 1st 2003 to December 31st 2007. The Programme embodied for the first time an integrated approach towards protecting and improving health. It was based on three general objectives: health information, rapid reaction to health threats and health promotion through addressing health determinants. In total over 300 projects and other actions were financed by the first Programme of Community action in the field of public health (2003-2008). In addition, the programme built on the experience acquired in the international context, in particular co-operation with international organisations such as WHO and the OECD. [18]

2.2 Together for Health: Health programme

The Second Programme of Community Action in the Field of Health 2008-2013 came into force on January 1st 2008. This follows the first Programme of Community action in the field of public health (2003-2008) which financed over 300 projects and other actions. The Health Programme 2008-2013 is intended to complement, support and add value to the policies of the Member States and contribute to increased solidarity and prosperity in the European Union by protecting and promoting human health and safety and by improving public health. Under the new Programme, participation and consultation with stakeholders are promoted. The financial envelope for the programme is EUR: 321 500 000. Overall, the programme objectives are three: first, to improve citizens' health security by developing EU and Member States' capacity to

respond to health threats, for example, with health emergency planning and preparedness measures; also, by taking actions related to patient safety, injuries and accidents, risk assessment and community legislation on blood, tissues and cells. Secondly, to promote health, including the reduction of health inequalities; this can be achieved by action on health determinants - such as nutrition, alcohol, tobacco and drug consumption, as well as social and environmental determinants; by measures on the prevention of major diseases and reducing health inequalities across the EU, and by increasing healthy life years and promoting healthy ageing. Thirdly, by providing information and knowledge; this can be done by taking action on health indicators and ways of disseminating information to citizens, and by focusing on Community added-value action to exchange knowledge in areas such as gender issues, children's health or rare diseases.

In order to ensure full participation in the Programme by organisations which promote a health agenda in line with the Programme objectives, a wider variety of financing mechanisms are offered. These include:

- Co-financing of projects intended to achieve a Programme objective;
- Tendering actions to achieve a Programme objective;
- Co-financing of the operating costs of a non-governmental organisation or a specialised network;
- Joint financing of a public body or non-governmental organisation by the Community and one or more Member States;
- Joint actions with other Community programmes, which will generate coherence between this instrument and other Community programmes. [19]

2.3 HELP 2009/10

Help for a life without tobacco is following on from the first Help campaign (2004 - 2008). This campaign primarily targets young people and young adults and aims to provide help and support by delivering comprehensive information on health and social problems related to tobacco consumption.

It is an integrated campaign including television, the internet and new media such as mini-sites accessible through mobile phones. The main tool of awaking attention is the Help website with all the information on the dangers of smoking as well as the links to our partner organisations as the European Network of Quit lines. The website is available in 22 languages and the web and media campaign will be complemented by a series of European and national public and press relations events. [20]

2.4 Healthy Workplaces campaign

Every year in the EU there are 5,720 fatal work-related accidents and millions of people are injured or have their health harmed in the workplace. Through this campaign workers and employers are made aware of the risks that they face and how to manage them.

This campaign is run by EU- OSHA, whose central role is to contribute to the improvement of working life in the European Union. EU - OSHA is key player in the Community Strategy for Health and Safety at Work 2007 - 2012 and cooperates with governments, employers and workers to promote a risk prevention culture. Other aims are analysing new scientific research and statistics on workplace risks, anticipating new and emerging risks through European Risk Observatory, identification and sharing of information, good practice and advice with a wide range of audiences, such as social partners- employers` federations and trade unions. Healthy Workplaces campaign focuses on different theme every two years. [21]

2.5 Health Action Aids

Health Action AIDS is a campaign run by Physician for Human Rights. The HIV/ AIDS pandemic is arguably the greatest health crisis of our time. This campaign mobilizes health professionals to support the comprehensive AIDS strategy and advocates for unprecedented funds to combat the disease. [22]

3. Health care by country

3.1 Bulgaria

Bulgaria began overall reform of its antiquated health system, inherited from the communist era, only in 1999. In the 1990s.Most Bulgarians relied on communist-era public clinics while paying high prices for special care, so during that period, national health indicators generally worsened as economic crises substantially decreased health funding. The subsequent health reform program has introduced mandatory employee health insurance through the National Health Insurance Fund (NHIF), which since 2000 has paid a gradually increasing portion of primary health-care costs. Employees and employers pay an increasing, mandatory percentage of salaries. Private health insurance plays only a supplementary role. The system also has been decentralized by making municipalities responsible for their own health-care facilities, and by 2005 most primary care came from private physicians. Pharmaceutical distribution also was decentralized.

In the early 2000s, the hospital system was decreased substantially to limit reliance on hospitals for routine care. Anticipated membership in the European Union (2007) was a great motivation for this trend. Between 2002 and 2003, the number of hospital beds was decreased by 56 percent to 24,300. However, the pace of reduction slowed in the early 2000s; in 2004 some 258 hospitals were in operation, compared with the estimated optimal number of 140. Between 2002 and 2004, health-care expenditures in the national budget increased from 3.8 percent to 4.3 percent, with the NHIF accounting for more than 60 percent of annual expenditures.

3.2 Greece

The Greek Health Care System can be characterised as a mixed system. The health care branches of the various social insurance funds co- exist with the National Health System ESY (Ethiko Systima Ygeias). ESY guarantees free health care for residents of Greece. The system covers the entire Greek population, without any special entitlement condition, regardless of professional category or region. Within the ESY context, primary health care services are provided through rural health centres and

provincial surgeries in rural areas, the outpatients departments of regional and district hospitals, the polyclinics of the social insurance institutions and specialist in urban areas.

Today 176 rural health centres and 19 small hospital-health centres operate, covering the primary health care needs of about 2.5 million persons. However, staffing of the rural centres is considered inadequate. In urban areas, primary health care services are provided mainly by EOPYY(National Organization of Health Services) polyclinics for EOPYY members. There are also private providers who are contracted to the various insurance funds and hospitals. In 1987, there was a plan for EOPYY services to merge with the NHS. Three large university hospitals were established (Ioannina, Patras and Crete).

Furthermore, secondary care is provided by public hospitals, private for-profit hospitals and clinics or hospitals owned by social insurance funds. In general, if a foreigner is working in Greece and pays social security contributions, he/she is being allowed to receive a medical card and get medical treatment and free hospitalisation. Researchers from EU are advised to contact the Health Service Organisation in their country to get the necessary series E documents, namely E111, which offers the access to free treatment in a public hospital.

Main changes made in Greek health care system over last years are the following:

- Primary health care centres previously financed through hospital budgets now became autonomous and financed through district health budgets;
- Doctors employed in public hospitals became free to choose full- or part-time employment within the NHS, allowing some private practice;
- The establishment of new private for-profit hospitals and clinics was once again permitted, with certain requirements concerning quality of services;
- Patients' freedom of choice and initiative were emphasized. [11]

3.3 Denmark

Denmark's health care system has retained the same basic structure since the early 1970s. The administration of hospitals and personnel is dealt with by the Ministry of the Interior, while primary care facilities, health insurance, and community care are the responsibility of the Ministry of Social Affairs. Anyone can go to a physician for no fee, and the public health system entitles each Dane to his/her own doctor. Expert medical/surgical aid is available, with a qualified nursing staff. Costs are born by public authorities, but high taxes contribute to these costs. As of 1999, there were an estimated 3.4 physicians and 4.5 hospital beds per 1,000 people. The number of hospital beds, like that in other EU countries, has undergone a major decline since 1980, from around 40,000 to about 23,000 in 1998/99. Deinstitutionalization of psychiatric patients has contributed significantly to this trend. The ratio of doctors to population, by contrast, has increased during this period.

The total fertility rate in 2000 was 1.7, while the maternal mortality rate was 10 per 100,000 live births as of 1998. Studies show that between 1980 and 1993, 63% of married women (ages 15 to 49) used contraception. As of 2002 cardiovascular diseases and cancer were the leading causes of death. Denmark's cancer rates were the highest in the European Union. In 1999, there were only 12 reported cases of tuberculosis per 100,000 people. As of 1999, the number of people living with HIV/AIDS was estimated at 4,300 and deaths from AIDS that year were estimated at less than 100. HIV prevalence was 0.17 per 100 adults.

Danish citizens may choose between two systems of primary health care: medical care provided free of charge by a doctor, whom the individual chooses for a year, and by those specialists to whom the doctor refers the patient; or complete freedom of choice of any physician or specialist at any time, with state reimbursement of about two-thirds of the cost for medical bills paid directly by the patient. Most Danes opt for the former. All patients receive subsidies on pharmaceuticals and vital drugs; everyone must pay a share of dental bills. As of 1999, total health care expenditure was estimated at 8.4% of GDP.

Responsibility for the public hospital service rests with county authorities. Counties form public hospital regions, each of which is allotted one or two larger hospitals with

specialists, and two to four smaller hospitals where medical treatment is practically free. State-appointed medical health officers, responsible to the National Board of Health, are employed to advise local governments on health matters. Public health authorities have waged large-scale campaigns against tuberculosis, venereal diseases, diphtheria, and poliomyelitis. The free guidance and assistance given to mothers of new-born children by public health nurses have resulted in a low infant mortality rate of 4 per 1,000 live births (2000). Medical treatment is free up to school age, when free school medical inspections begin. As of 1999, children up to one year of age were vaccinated against diphtheria, pertussis, and tetanus (99%) and measles (92%). In 2000, life expectancy at birth was 76 years for males and females. The overall death rate was 11 per 1,000 people in 1999.

3.4 Finland

In Finland, public medical services at clinics and hospitals are run by the municipalities (local government) and are funded 78% by taxation, 20% by patients through access charges, and by others 2%. Patient access charges are subject to annual caps. For example, GP visits are (11€ per visit with annual 33€ cap), hospital outpatient treatment (22€ per visit), a hospital stay, including food, medical care and medicines (26€ per 24 hours, or 12€ if in a psychiatric hospital). After a patient has spent 590€ per year on public medical services, all treatment and medications thereafter are free. Taxation funding is partly local and partly nationally based. Patients can claim re-imbursement of part of their prescription costs from KELA. Finland also has a much smaller private medical sector which accounts for about 14 percent of total health care spending. Only 8% of doctors choose to work in private practice, and some of these also choose to do some work in the public sector. Private sector patients can claim a contribution from KELA towards their private medical costs (including dentistry) if they choose to be treated in the more expensive private sector, or they can join private insurance funds. However, private sector health care is mainly in the primary care sector. There are virtually no private hospitals, the main hospitals being either municipally owned (funded from local taxes) or run by the teaching universities (funded jointly by the municipalities and the national

government). In 2005, Finland spent 7.5% of GDP on health care, or US$2,824 per capita. Of that, approximately 78% was government expenditure. [11]

3.5 France

In France, most doctors remain in private practice; there are both private and public hospitals. Social Security consists of several public organizations, distinct from the state government, with separate budgets that refunds patients for care in both private and public facilities. It generally refunds patients 70% of most health care costs, and 100% in case of costly or long-term ailments. Supplemental coverage may be bought from private insurers, most of them non-profit, mutual insurers, to the point that the word "mutuelle" (mutual) has come to be a synonym of supplemental private insurer in common language. Until recently, social security coverage was restricted to those who contributed to social security (generally, workers or retirees), excluding some poor segments of the population; the government of Lionel Jospin put into place the "universal health coverage". In some systems, patients can also take private health insurance, but choose to receive care at public hospitals, if allowed by the private insurer.

In its 2000 assessment of world health care systems, the World Health Organization found that France provided the "best overall health care" in the world. In 2005, France spent 11.2% of GDP on health care, or US$3,926 per capita. Of that, approximately 80% was government expenditure. [11]

3.6 Czech Republic

The level of health in the Czech Republic has developed a lot the last years. The health programs of the government deal with the prevention of immunization, cancer, smoking and focus on the health checks.

The State Insurance System

Healthcare, including dental treatment is free to all citizens in the Czech Republic. Every citizen, except the direct risk groups, must make obligatory contributions to an

recognized Czech health insurance company. The General Health Insurance Company (GHIC), known in the country as Vseobecna zdravotni pojistovna, is the largest and only state-controlled insurance company in the country and it covers the majority of people.

All Czech citizens, registered foreign residents must make regular contributions. Students under 26, dependent children, old age pensioners and vulnerable groups like the disabled are not obliged to pay.

Foreigners who live in the Czech Republic but do not hold permanent residency cards do not qualify for treatment under the state funded system, but they can be connected with one of two health insurance schemes provided by the General Health Insurance Company.

The Czech healthcare service operates mainly as a private medical insurance system. There is no reason for citizens to seek reimbursement because they pay their contributions directly to their health insurance company and this one pays the treatment providers directly. Healthcare costs here are well below the European average, yet standards are in line with some of the best health centers in Western Europe.

Czech expenditure as a percentage of GDP is higher than the 5.8% average for central and eastern European countries but equally less than the 8.9% average for western EU countries.

The differences are much more pronounced if per capita expenditure is used as a basis. The Czech Republic's public expenditure as a percentage of total health expenditure is lower than that in most other central and eastern European countries, but is higher than that in western countries that use social insurance. [15]

3.7 Germany

Germany has a universal multi-payer system with two main types of health insurance: "State health insurance" (Gesetzliche Krankenversicherung) known as sickness funds and "Private" (Private Krankenversicherung). Compulsory insurance applies to those below a set income level and is provided through private non-profit "sickness funds" at common rates for all members, and is paid for with joint employer-employee contributions. Provider compensation rates are negotiated in complex corporatist social bargaining among specified autonomously organized interest groups (e.g. physicians' associations) at the level of federal states (Länder). The sickness funds are

mandated to provide a wide range of coverages and cannot refuse membership or otherwise discriminate on an actuarial basis. Small numbers of persons are covered by tax-funded government employee insurance or social welfare insurance. Persons with incomes above the prescribed compulsory insurance level may opt into the sickness fund system, which a majority do, or purchase private insurance. Private supplementary insurance to the sickness funds of various sorts is available. In 2005, Germany spent 10.7% of GDP on health care, or US$3,628 per capita. Of that, approximately 77% was government expenditure. [11]

3.8 Italy

According to WHO in 2000, Italy had the world's "second overall best" healthcare system in the world, coming after France, and surpassing Spain, Oman and Japan. In 1978 Italy adopted a tax-funded universal health care system called "National Health Service" (in Italian: Servizio Sanitario Nazionale), which was closely modelled on the British system. The SSN covers general practice (distinct between adult and paediatric practice), outpatient and inpatient treatments, and the cost of most (but not all) drugs and sanitary ware. The government sets LEA (fundamental levels of care, Livelli essenziali di assistenza in italian) which cover all necessary treatments, which the state must guarantee to all for free or for a "ticket", a share of the costs (but various categories are exempted). The public system has also the duty of prevention at place of work and in the general environment. A private sector also exists, with a minority role in medicine but a principal role in dental health, as most people prefer private dental services.

In Italy the public system has the unique feature of paying general practitioners a fee per capita per year, a salary system that does not reward repeat visits, testing, and referrals. While there is a paucity of nurses, Italy has one of the highest doctor per capita ratios at 3.9 doctors per 1,000 patients. In 2005, Italy spent 8.9% of GDP on health care, or US$2,714 per capita. Of that, approximately 76% was government expenditure

Despite a considerable prejudice even on the part of many Italians, Italy is in fact a country where you can expect to find low-cost health care and a good standard of medical assistance. Italian doctors are dedicated and well-trained, and the best private hospitals are the equal of any country. State hospitals, however, particularly in the south of Italy, are very patchy, with "creature comforts" be well below what Americans and northern Europeans may take for granted. To avoid this, many foreigners (and Italians) choose to take out private health insurance to cover the costs of hospitalisation and surgery and to get extra comfort when needed, and, above all, to avoid the long waiting lists that are customary in the state system.

Italy's national health system (Servizio Sanitario Nazionale or SSN, for short) is administered through local health authorities and provides low or no-cost health care to all EU citizens, including in-patient treatment (including tests, medication and surgery during hospitalisation), visits to family doctors and medical assistance provided by paediatricians, obstetricians and other specialists. It also pays for part, sometimes all, of the cost of drugs and medicines, out-patient treatment and dental treatment. Emergency health provision is available to all EU and non-EU visitors. Regardless of where you come from, you must have some form of health insurance as soon as you arrive in Italy. A permesso di soggiorno will not be issued without it.

If you need prescription drugs or medicines, your family doctor will issue you with a prescription (ricetta) which you can then take to a pharmacy (farmacia). Pharmacies in Italy are small family-run businesses and deal in medically-related items only. Pharmacies have the sign of a green or red cross on a white background and outside normal hours, at least one in every town or city will open late for emergency dispensing of drugs. If you have state health cover, you will qualify for the subsidised charge (known as ticket, if applicable: the government just (2001) abolished them) and pay reduced costs. Otherwise you will need to pay the full cost. If you take prescription drugs on a regular basis, you should ask your doctor in your home country for the generic name of the medicine as brands vary from country to country. [11]

3.9 The Netherlands

Health care in the Netherlands has since January 2006 been provided by a system of compulsory insurance backed by a risk equalization program so that the insured are not penalized for their age or health status. This is meant to encourage competition between health care providers and insurers. Children under 18 are insured by the government, and special assistance is available to those with limited incomes. In 2005, the Netherlands spent 9.2% of GDP on health care, or US$3,560 per capita. Of that, approximately 65% was government expenditure. [11]

3.10 Norway

Norway has a government run and government financed universal health care system, covering physical and mental health for all, and dental health for children under the age of 16. Hospitals are free and doctor visit fees are capped at a fairly low rate. Medicine is market price, but there is a yearly cap for people with high medical expenses.

Private health care exists: Dental care for adults has no public option, this is private only. Health-related plastic surgery (like burn damage) is covered by the public system, while cosmetic surgery in general is private. There is a number of private psychologists, there are also some private general practice doctors and specialists.

Public health care is financed by a special-purpose income tax on the order of 8-11%, loosely translated as "public benefits fee" (Norwegian: trygdeavgift og Folketrygden). This can be considered a mandatory public insurance, covering not only health care but also loss of income during sick leave, public pension, unemployment benefits, and benefits for single parents and a few others. The system is supposed to be self-financing from the taxes. Norwegian citizens living in Norway are automatically covered, even if they never had taxable income. Norwegian citizens living and working abroad (taxable elsewhere and, therefore, not paying the "public benefits fee" to Norway) are covered for up to one year after they move abroad, and must pay an

estimated market cost for public health care services. Non-citizens like foreign visitors are covered in full.

According to WHO, total health care expenditure in 2005 was 9% of GDP and paid 84% by government, 15% by private out-of-pocket and ~1% by other private sources.

3.11 Sweden

In Sweden, the publicly funded medical system is comprehensive and compulsory. Physician and hospital services take a small patient fee, but their services are funded through the taxation scheme of the County Councils of Sweden. The board of county councils are appointed by local elections. In 2005, Sweden spent 9.2% of GDP on health care, or US$3,727 per capita. Of that, approximately 82% was public expenditure. Sweden also has a smaller private health care, mostly in bigger cities, or as centres for preventive health care financed by employers. [11]

3.12 Switzerland

In Switzerland, compulsory health insurance covers the costs of medical treatment and hospitalization of the insured. The Swiss healthcare system is a combination of public, subsidized private and totally private healthcare providers, where the insured person has full freedom of choice among the providers in his region. Insurance companies independently set their price points for different age groups, but are forbidden from setting prices based on health risk. In 2000, Switzerland topped all European countries' health care expenditure when calculated as per capita expenditure in US dollar purchasing parity terms.

The Swiss health care system is interesting as it was the last for-profit system in Europe. In the 1990s, after the private carriers began to deny coverage for pre-existing conditions—and when the uninsured population of Switzerland reached 5%--the Swiss held a referendum (1995) and adopted their present system.

3.13 United Kingdom

Each of the four countries of the United Kingdom has a separate but co-operating public health care system.

Healthcare in England is mainly provided by England's public health service, the National Health Service that provides healthcare to all UK permanent residents that is free at the point of need and paid for from general taxation. Though the public system dominates healthcare provision, there is no restriction on the operations of private medical providers or insurers. Private health care and a wide variety of alternative and complementary treatments are available for those with health insurance or willing to pay directly themselves. Medical insurers do not usually cover chronic illnesses, though there is no restriction on them doing so, and only the services of specialists are usually compensable by the contracts offered.

Healthcare in Northern Ireland is mainly provided by the country's public health service, Health and Social Care in Northern Ireland that provides healthcare to all UK permanent residents that is free at the point of need and paid for from general taxation. Though the public system dominates healthcare provision, private health care and a wide variety of alternative and complementary treatments are available for those with health insurance or willing to pay directly themselves.

Healthcare in Scotland is mainly provided by the country's public health service, NHS Scotland that provides healthcare to all UK permanent residents that is free at the point of need and paid for from general taxation. Though the public system dominates healthcare provision, private health care and a wide variety of alternative and complementary treatments are available for those with health insurance or willing to pay directly themselves.

Healthcare in Wales is mainly provided by the country's public health service, NHS Wales that provides healthcare to all UK permanent residents that is free at the point of need and paid for from general taxation. Though the public system dominates healthcare provision, private health care and a wide variety of alternative and

complementary treatments are available for those with health insurance or willing to pay directly. [11]

4. Results

After having presented the Healthcare policies in 13 EU countries above, there will be an attempt to characterize and compare their healthcare system trends through data provided by official institution in order to derive some results and recommendations for a more harmonized health service within the EU.

To start with, considering five areas that are key to the health consumer, i.e. patient's rights and information, accessibility (waiting times) of treatment, outcomes, range and reach of services provided and pharmaceuticals, we can rank the national health care systems of these 13 EU countries as follows:

- Netherlands
- Denmark
- Sweden
- Switzerland
- France
- Norway
- Finland
- UK
- Germany
- Czech Republic
- Italy
- Greece
- Bulgaria

Moreover, we can divide Europe's health systems roughly into two different categories: the first one includes countries financed through taxes, where health services of these countries are financed through tax revenues; and the second one includes countries financed through fees, where health services of these countries are financed through social contributions.

A more differentiated division would be the following:

- mainly financed out of public funds: Great Britain, Ireland, Denmark, Sweden, Finland, Portugal
- financed through equal share of public funds and social insurance contributions
- mainly financed through social insurance contributions: Germany, Belgium, Luxembourg
- almost only financed through social insurance contributions: France, Netherlands

The optional health insurance replaces the compulsory insurance in Germany, Belgium, and Netherlands. The optional health insurance is an addition to the compulsory insurance; i.e. services, which are not covered by the compulsory insurance, can be offered: Examples: Germany, France, Belgium, Luxembourg

With the optional health insurance the insured party has more opportunities to choose and/or shorter waiting periods: Austria, Portugal, and Great Britain

- 20094 – Germany
- 5290 – France
- 4884 – Netherlands

They were also relatively high in Great Britain with 3490 and in Spain with 2360. Nominal premium income in other countries:

- Ireland – 660
- Austria – 1136
- Denmark – 282
- Finland – 222
- Luxembourg – 30
- Portugal – 172
- Belgium – 317
- Italy – 1163
- Sweden – 27

The chosen financial system also influences the supply of out-patient services. In Germany, France, the so-called extramural care (extramural – outside of the hospital walls) is guaranteed through doctors, who set up their own business. In Great Britain, Ireland, Sweden, Finland, Denmark, Greece, Italy, Spain and Portugal, however, the out-patient service will be offered through governmental health services.

Overall the different health systems represent a problem concerning the established liberality within the EU. It is planned to share and learn from the experiences as well to create more harmonization. [12]

Table 1: European Health Insurance System [11]

Health insurance system with private complete health insurance as an alternative to governmental health insurance

In

- Germany
- Belgium
- the Netherlands

the Netherlands it is possible to take out a private health insurance as supplement of a compulsory insurance

Heath insurance system without possibility to choose a private complete health insurance (only supplementary insurances are possible additions)

In

- France
- Belgium
- Luxembourg
- Austria
- Portugal
- Great Britain

an optional private health insurance can be taken out, which partly closes the gaps of a compulsory insurance

Health insurance systems financed through taxes (in these countries the health insurance is being paid through taxes and does not have to be paid extra)

- Great Britain

- Ireland
- Denmark
- Sweden
- Finland
- Portugal

Financed through equal share of public funds and social insurance contributions

- Greece
- Italy
- Spain

Health insurance systems mainly financed through social insurance contributions

- Germany
- Belgium
- Luxembourg
- France
- the Netherlands

Table 2: Quality of Health Systems in Europe

Country	Life expectancy men 2008	Life expectancy women	Practising doctors per 100.000 inhabitants	Costs of the health service in % of GDP	Hospital beds per 100.000 inhabitants	inhabitants older than 65 in %
Switzerland	77,8	83,0	362	10,7	596,1	15,5
Germany	75,4	81,2	336	10,6	901,9	17,5
Norway	76,4	81,5	364	7,8	380,8	14,8
Austria	75,8	81,7	333	8,0	853,6	15,5
GB	75,9	80,5	160	7,3	407,6	15,6
Hungary	68,4	76,7	319	6,8	806,3	15,4
Poland	70,4	78,7	224	6,0	717,5	12,8
Greece	75,4	80,7	451	8,3	487,9	17,3
Belgium	75,1	81,1	448	8,7	711,6	17,0
Denmark	74,8	79,5	365	8,3	422,6	14,8
Finland	74,9	81,5	316	6,6	747,8	15,3
Frankreich	75,8	83,0	333	9,5	820,6	16,3
Ireland	75,2	80,3	238	6,7	983,6	11,1
Italy	76,8	82,9	607	8,1	455,1	18,2
Luxembourg	74,9	81,5	259	5,8	651,7	14,0
Czech republic	72,1	78,7	350	7,2	1095,8	13,9

The advantages of the health care systems in the EU countries above, seem to be related, at least in part, to the higher level of life expectancy of men/women, the better practising doctors, the lower health care spending, the bigger number of hospital beds, the greater proportion of inhabitants older than 65%.

So, the public satisfaction from health care systems in the EU countries is as a result of these advantages. Specifically, the citizens of the southern European countries, in general show lower satisfaction with health care service provision than the northern countries of the European Union.

Table 3: Health Care Rankings [16] [17]

World Ranking	European Ranking	Country	% Public funding
1	1	France	76,9
2	2	Italy	57,1
5	5	Malta	58,9
7	6	Spain	90,6
9	7	Austria	67,3
11	8	Norway	82
12	9	Portugal	57,5
13	10	Monaco	62,5
14	11	Greece	65,8
15	12	Iceland	83,8
16	13	Luxembourg	91,4
17	14	Netherlands	70,7
18	15	United Kingdom	96,9
19	16	Ireland	77,3
20	17	Switzerland	69,3
21	18	Belgium	83,2
23	19	Sweden	78
24	20	Cyprus	38,8
25	21	Germany	77,5
31	22	Finland	73,7
34	23	Denmark	84,3
38	24	Slovenia	80,8
43	25	Croatia	79,7
48	26	Czech Republic	92,3
50	27	Poland	71,6
55	28	Albania	77,7
62	29	Slovakia	81,8
66	30	Hungary	84,9
70	31	Turkey	74
72	32	Belarus	82,6
73	33	Lithuania	75,7
77	34	Estonia	78,9
79	35	Ukraine	75,5
99	37	Romania	60,3
101	38	Moldova	75,1
102	39	Bulgaria	81,9
104	40	Armenia	41,5
105	41	Latvia	61
106	42	Yugoslavia	64,8
109	43	Azerbaijan	79,3
114	44	Georgia	8,6
130	45	Russia	76,8

In 2000 the World Health Organisation, WHO, published its rankings of 130 of the world's healthcare systems. France was ranked in 1st place worldwide. The rankings for the European countries are shown in the table above. The lowest ranking European country is Russia at 130.

5. Discussion

Based on the information presented in the previous parts of this thesis, there will be a presentation of a number of suggestions for improvements of community action on health services, with contributors seeing a need for more and clearer information to patients with regard to cross-border care, a need for greater clarity over patients' rights, a need for better monitoring of health professional mobility, among others.

5.1 Community action on health services

Despite some additional examples, there is a clear lack of up-to-date and complete data on cross-border care. Many contributors concurred with the estimate in the Commission consultation communication that about 1% of total healthcare expenses was spent on cross-border care and is expected to increase. This phenomenon can be significantly larger in certain circumstances, in particular for border regions, smaller Member States, rare diseases, and areas with high numbers of visitors from abroad.

The mechanism used for cross border care (through the regulations on coordination of social security systems, or through internal market rules) has different financial impacts for public funds and citizens depending, in particular, on the relative levels of the cost of care in the patients' home country and the cost abroad. And of course, though overall numbers of citizens using cross-border care remain relatively low, its importance for individuals can be high.

Contributors see a need for more and clearer information to patients with regard to cross-border care, and made a range of practical suggestions for achieving this. Greater clarity was also sought over instruments to control patient flows in cross-border care and, in particular, over the conditions under which prior authorisation for cross-border care is justified and can be refused. Suggestions by contributors for improvements include clear information for patients; effective and transparent decision procedures; a patient-centred approach; evidence based standards; the right to appeal against refusals; and exceptions for border regions.

Greater clarity was also sought over pricing for cross-border care, and the definition of 'health services' within the scope of any Community action. There is broad consensus that responsibility for clinical oversight should be with the country of treatment. However, cooperation with the relevant authorities in the patient's home country is important, and particular highlighted cases include managed cross-border care and international patient transport. There will also be particular cases where any division of responsibilities will leave difficulties in practice, such as with control of hospital-acquired infections. Many contributors also saw value in European support to national authorities in achieving a high level of quality and safety in healthcare, such as through developing guidelines and indicators; or the introduction of a no-fault patient safety reporting system. Practical suggestions for ensuring continuity of care included systems for exchanging patient data, an EU standard discharge letter and Europe-wide prescriptions. Many contributors also argued that there should be greater clarity over patients' rights. There is also broad consensus that the provider of treatment should be liable for harm and any redress arising. Contributors were divided, though, about the need for more legal clarity regarding liability issues for cross-border healthcare beyond that already provided by international private law. However, there were many practical suggestions made, such as putting in place alternative dispute resolution systems for cross-border care (perhaps building on existing networks such as SOLVIT), requiring mandatory insurance for healthcare providers, or the establishment of the Europe-wide no-fault compensation system. Some contributors were concerned about the potential for cross-border care to undermine the provision of healthcare within their countries, in particular with regard to how to prioritise different patients and setting fair prices for cross-border care provided. On the other hand, some contributors felt that increased cross-border care could have a positive effect on domestic care provision.

Many contributors felt that there was a need for better monitoring of health professional mobility. Issues were also identified in relation to Community rules on recognition of professional qualifications, but many contributors felt that the implementation of Directive 2005/36/EC should be awaited before taking any new action. How to manage the impact of health professional mobility was also identified as an issue, in particular by contributors from the newer Member States. Greater clarity about the rules governing the establishment of healthcare providers in other

Member States was also sought by a few contributors, with particular regard to pharmacies and dentist. However, most contributions were more concerned about practical issues in cross-border pharmacy services, and made suggestions such as developing ePrescriptions. Information and communication technology solutions in general were identified as a key area for the future by many contributors, though teleradiology was seen as a priority challenge where more analysis was needed. In addition to the issues identified elsewhere in the report, some contributors identified some particular issues related to the practical operation of the existing regulations on coordination of social security systems, and made a number of suggestions for improvements.

Furthermore, in addition to the other suggestions for practical support covered elsewhere in the report, contributors highlighted the scope for practical support on areas including European networks of centres of reference; an observatory for comparative data and indicators; health technology assessment; better sharing of healthcare innovations; and support for making effective use of potential investment in healthcare through the structural funds. However, many contributors argued for a rationalisation of activities and resources concerning healthcare at European level; others also argued that Community action should also involve regional authorities. [5]

Overall, contributors welcomed the initiative of the Commission regarding Community action on health services in general. The majority of national governments and many other stakeholders expressed the wish that any proposal of the Commission on health services should be based on the "*Council Conclusions on Common values and principles in EU Health Systems*". Many contributions (in particular from national governments, unions and purchasers) emphasised that any Community action that affects the health systems should respect the subsidiarity principle, referring in particular to Article 152 of the Treaty establishing the European Community, although others argued that the principle of subsidiarity should not prevent the application of EU fundamental freedoms. On the overall approach, the majority view of contributors was that a combination of both "supportive" tools (such as practical cooperation, or the 'open method of coordination') and legally binding measures would be the most efficient approach, although some contributors did not see a need for any legal measures. In terms of the preferred approach for any legal

instrument there were clearly two main approaches preferred by different contributors. Some contributors preferred to include any changes within the Regulations on the coordination of social security systems, while other contributors preferred a new Directive on health services. [9]

5.2 Cross-border health care

To begin, a patient may receive cross-border health care in a Member State different from the Member State in which he or she is insured, or, healthcare is a health professional provides in a Member State different from the Member State in which he or she normally resides or works. Concretely, cross-border healthcare occurs in many different ways. Health professionals train and practice abroad, citizens' travel abroad to receive care, for example patients living in border regions or requiring very specialised treatment. This can also be patients receiving services from abroad while staying in their own country, for example through the use of telemedicine (for specialised surgery support, radiology diagnosis, etc.).

When needed, using healthcare in another Member State will be made easier with clearer rules on reimbursements, procedural guarantees and information for patients. This will ensure more effective access to cross-border healthcare and greater choice for patients.

People in general prefer to receive healthcare close to where they live. Currently, only 1% of healthcare budgets are spent on cross-border healthcare. However, in certain circumstances, it can be beneficial to receive healthcare in another EU country, notably in border regions, where the nearest healthcare facility may be in another country, or when there is more expertise available, or a particular care or treatment can be provided faster. Whatever the reason, under certain conditions, patients have the right to receive healthcare in another Member State, as ruled by the European Court of Justice. This right derives from the Treaty itself. But it is essential to clarify how this right can be exercised. Providing such a legal framework is one of the objectives of this draft directive.

Focusing more on the proposed Directive, patients may seek medical treatment in another EU Country. In this case, they will have their costs reimbursed by their national health insurer or health authority as long as they have a right to such a treatment at home and up to the level of reimbursement for the same or similar treatment in their national health system. For hospital care, however, under certain circumstances, a Member State may decide to introduce a system in which patients require an administrative prior authorisation before seeking care abroad. Overall, patients will benefit from transparent and quick procedures, including the actual reimbursement of costs, and will have the right to ask for a review of any administrative decision regarding cross-border healthcare. Furthermore, patients will have easier access to relevant information about cross-border healthcare, in particular through national contact points, before they decide to seek treatment in another EU country. This will enable them to make informed decisions about using cross-border healthcare.

Helping patients to use their right to cross-border care a Eurobarometer survey revealed that many citizens are unaware of the possibilities of receiving care in another Member State. Indeed, the same survey showed that 30% of the EU population does not know that it is possible, under certain conditions, to receive healthcare abroad and to have the costs of the treatment reimbursed by their national health system or health insurer.

EU Member States share values and principles. As defined in the Council conclusions on Common values and principles in European Union Health Systems, universality, access to good quality care, equity and solidarity are common principles for healthcare in the European Union. It is important to determine who is responsible for ensuring that these principles are met for cross-border care. This clarity is crucial for patients and for the professionals who treat them.

Quality and safety standards in medical care are of a very high level in Europe. Citizens trust their medical services at home. When patients travel for treatment within the EU, they need the same confidence in the health service. However, they are not always provided with the necessary information and guarantees. The proposed Directive addresses precisely these issues.

More analytically, the country where treatment is provided is responsible for clinical oversight. Cross-border patients should be more confident if the quality and safety standards of the treatment they receive in another Member State are regularly monitored and based on the same good medical practices and international medical science. Moreover,

• information on all relevant aspects of care (including availability, prices, insurance coverage, etc.) will be made available to patients to allow them to make an informed choice about cross-border healthcare

• patients will have access to their medical records and the protection of their personal data will also be guaranteed in the cross-border healthcare setting

• if patients suffer harm from the healthcare they receive, they will be well-informed on how they can seek redress and compensation. Assistance will be provided, if necessary, by national contact points for cross-border healthcare

• patients coming from another EU country to benefit from cross-border healthcare will enjoy equal treatment with the nationals of the country in which they are treated. They should be treated in a non-discriminatory way on the basis of sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion, membership of a national minority, property, birth, disability, age or sexual orientation.

According to a Eurobarometer survey, citizens say they would need information about quality and safety of healthcare in another Member State before taking their decision to travel abroad to seek treatment.

Fostering cooperation between healthcare systems to achieve better healthcare for all
The European Union will support Member States in working together to achieve increased sharing of information, expertise and innovation. As all Member States face the same challenges in relation to their healthcare systems, more cooperation will bring benefits. It will allow them to share experiences and ideas about solutions to provide patients with the best possible care. Working together at the practical level increases the quality of care and the efficient use of resources. This proposal provides a solid basis for further cooperation.

Regarding the contribution of the proposed Directive to healthcare, it will enhance healthcare as it will be easier for patients to have prescriptions issued abroad recognised in local pharmacies. This will ensure continuity of care and benefit patients who have been treated in another Member State. Moreover,

- with increased cooperation in fields such as European reference networks to share expertise and innovation, patients will have access to highly specialised healthcare that they otherwise may not have access to. This is particularly true for people with a rare condition or requiring a high level of expertise for diagnosis and/or treatment
- by pooling analysis and evaluations undertaken on the effectiveness of new health technologies, Member States will save time and money. With these shared health technology assessments tools, the best and more efficient technologies can be made available more rapidly to health professionals and patients for better diagnosis and therapies
- through improved interoperability (compatibility of systems), more efficient and effective information technologies in the health sector (e-Health) will benefit everyone. Healthcare providers will be able to work together rapidly and easily. Patients will have the opportunity to benefit from services from abroad while staying in their own country, for example through the use of telemedicine. With gains generated in terms of productivity and efficiency, e-Health can also contribute to an increased financial sustainability of healthcare systems throughout Europe
- policy makers, stakeholders and citizens across Europe will benefit from an increase of available data and information about cross-border care.

The proposal of this legislation is of great importance as health is essential for everyone's well-being. Therefore, European countries devote great attention and resources to ensure a high level of health for their citizens. High quality healthcare systems are a vital part of our societies. Yet despite all their strengths, our healthcare systems face considerable challenges. Our society is ageing. Inequalities between regions and groups of citizens are large. It is crucial that high-quality care continues to be accessible for all. Member States have a primary and essential role to ensure this happens, but initiatives at European level can support their actions through the

development of synergies, cooperation and coordination. In recent years, the European Court of Justice (ECJ) clarified that even though Member States are responsible for organising and delivering health services, the free circulation of goods, services and persons in the internal market also applies to health products and healthcare services. But uncertainty has remained over how to apply these principles in an horizontal way.

The Commission's proposal for a services directive in the internal market presented in 2004 included provisions codifying the rulings of the ECJ in applying free movement principles to health services. The European Parliament and the Council however, considered this approach inappropriate, hence the eventual exclusion of health services from the scope of the Directive in 2006. Both institutions stressed then the importance of addressing this issue in a specific legal instrument on health taking into account patients' needs, commonly agreed principles on the provision of healthcare and finally the specificities of medical science and techniques.

The Commission is making a proposal for a Directive on the application of patients' rights in cross-border healthcare to contribute to the efforts of the Member States in order to improve health systems in the EU and open the door to better healthcare for patients across Europe. Overall, there are three reasons to act:

1. Clarify the right to seek cross-border healthcare
2. Make cross-border healthcare safer and better quality
3. Boost cooperation to tackle common challenges together, prepare the future, and make better health systems for their patients and professionals.

This draft legislation will not affect the existing coordination of social security in Europe. Therefore, this initiative will not affect the benefits offered to citizens through the EU Regulation on coordination of social security. More analytically, citizens needing urgent care abroad will continue to receive it. If they hold the European Health Insurance Card, they can benefit from a simplified procedure for receiving any necessary medical assistance. Furthermore, for planned care, rules remain unchanged: patients who receive authorization according to the conditions foreseen in the Regulation on coordination of social security can seek healthcare

abroad with costs covered at whichever rate is higher – the State where they are insured or the State where they are receiving treatment. The added value of this initiative is to clarify new options opened by the European Court of Justice to patients in relation to planned care in addition to the conditions of the Regulation on coordination of social security. Indeed, for most of non-hospital care, patients will be able to seek healthcare abroad without prior authorisation. The difference will be in relation to the reimbursement. Patients will pay up front and will be reimbursed at home as they would have been for the same or similar treatment in their national health system or social security schemes.

As far as the citizens used to systems in which care is provided for free, they will be able to get reimbursement for care received abroad. All EU citizens will have the same entitlements to cross-border care whatever their home health system. Citizens who usually do not make up front payments for domestic care will be reimbursed by their home system when they pay for care in another EU country. However the proposal does not prevent Member States from extending the benefits-in-kind system to healthcare received abroad. [10]

5.3 Proper impact assessment of EU legislation on health

The Treaty (Article 152) requires that a high level of human health protection shall be ensured in the definition and implementation of all Community policies and actions. As stated in a number of Commission Communications, from 2001 onwards, all proposals with a particular relevance to health should "*include an explanation of how health requirements have been addressed, normally by including a statement in the proposal's explanatory memorandum. The aim would be to show clearly how and why health considerations were taken into account and the expected health impact.*"

A proper impact assessment on health and health systems of any initiative at EU level is both a legal requirement and an essential aspect of policy-making. From the point of view of EHPF members, the Commission proposal for a Directive on Services in the Internal Market lacks of such an assessment. The EHPF encourages the Commission to continue developing the checklist for the screening of proposals for

possible health impacts set out in the DG Sanco document published in 2001 “Ensuring a high level of health protection: A practical guide”. Such impact assessment should be relevant not only to the protection of the health of the individual but also to the global effects on health systems as already recognised during the high level reflection process on patient mobility. The EHPF welcomes that the current Public Health Programme, [14] prioritises the development of health impact assessment methodologies and pilot projects.

6. Conclusion

Generally, the internal market regulations of the EU aim in general at freeing up markets to obtain economic benefits associated with free competition and reduced barriers to trade. However, the health sector operates under specific conditions and should not be defined under trade and market criteria:

- **The enjoyment of good health and the access to healthcare are fundamental rights**

  Health is a fundamental right in the legislation of the Member States and in the EU legislation. This right is also clearly recognised in Article 12 of the 1996 UN Convention on Economic, Cultural and Social Rights. [7] In addition, the access to health care is recognised in the Charter of fundamental rights of the EU adopted in Nice in December 2000 which has been incorporated to draft Constitutional Treaty.

- **Health services have a clear general interest aim**

  Health services fulfil a distributional welfare goal of health care coverage that includes all populations. In all countries it is the national authorities that retain the responsibility to ensure universal accessibility (both financially and physically), sustainability and quality of health services. This is recognised in Article 152 [5] of the EC Treaty and the draft Treaty establishing a Constitution for Europe maintains the same wording in Article III-278. [7]

- **The primacy of the solidarity requirement**

  Health is, in essence, a field where solidarity is necessary to cover the ill health of a minority through national tax systems or social contributions. National examples show that only a small part of the population is responsible for almost the total of healthcare or hospital costs. [8] Therefore, price cannot be the only factor to regulate the health care sector because treatment would be unaffordable for those who need care.

- **Health services commonly require the intervention of a third party**

  The health market is not limited to the relationship between purchasers and suppliers, as for most services, rather there is usually a third party who decides to which services the patient may have access and sometimes pays for the service. This third party can be the state, the competent regional authority or health insurance bodies depending of the national system. In consequence, patients often do not pay the full cost of the services they receive.

- **Patients are not ordinary consumers and health providers are not ordinary providers**

  Health providers are required to consider and protect the interests of the patients. They, therefore, have a great responsibility when they deliver services. Any "after sales" claims for poor quality service are unlikely to compensate for permanent health damage or loss of life. Therefore, it is essential that these special characteristics continue to be adequately taken into account by the EU institutions when examining health services as services of general interest or in the context of internal market legislation. [9]

Overall, our recommendation would be ensuring that the specificity of health services is adequately reflected in any EU initiative and that sustainability and long-term objectives of health services are reflected in EU initiatives with impact on health. Additionally, adequate consultation should take place in EU initiatives defining who is consulted and the comments should be taken into account depending on the representativeness and the weight of the respondents. Proper health impact assessment including health system impact assessment should be performed prior to any legislative initiative. There is also a need for coordination between Commission services to ensure consistency of initiatives.

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