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SUSTAINABILITY OF HEALTH CARE IN EUROPEAN DEMOCRACIES

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Executive Summary

In addition to the global economic crisis which broke out in 2008 the problems stemming from the ageing of the population in most European countries and the resulting increases in health spending call for reforms of the national health care systems. In addition to these problems a number of European counties are also facing difficulties caused by excessively bureaucratic structures in the health systems, imposing further burdens on the state budgets. The countries scrutinised in our first study are more or less following the basic principle that the majority of the population should have health insurance coverage and people can claim an entitlement to health services as a basic citizens' right. The range of available options however, seems to be limited, since it is not possible to withdraw unlimited funds from the health care system. In Germany for example in addition to the raising of the contribution rate the actions involved in the latest reform affected primarily the health funds, the drug market and the health service providers partly by intensifying competition and by curbing and freezing costs. Changes took place in the Czech Republic and in Portugal in drug financing though in Portugal some health services have also been restricted and a number of institutions have been closed. Spain, where the provision of health services is almost exclusively part of the competences of the provinces, costs are proposed to be cut by partial privatisation besides limiting some services and closing some institutions. Visit and hospital fees have been introduced and increased - often infuriating the population - in the Czech Republic and in Portugal. In France, where the health status of the population is notably better than the average, health service users pay an extremely high share of the costs.

Concerning the ownership and operation of their health institutions there is at least one similarity among the countries discussed in our second study, namely that the markets are being more or less opened up to private investors or that efforts are being made in this direction. Apart from a few exceptions it can also be concluded that the public sector also continues to play an important role. There are three main groups of owners in the 'market' of health institutions in the countries under review: state, provincial and local governmental owners running.

In Germany, for example, about equal one-third of the hospitals are maintained by representatives of each of the above three categories. In the case of prevention and rehabilitation institutions the private sector plays an outstanding role, while the number of institutions owned and run by non-profit organisations and the state or other public institutions or bodies has been increasing slightly. A similar trend has been observed in Portugal in the scheme of the ownership and running of hospitals: the involvement of the private sector in the provision of health services has increased during recent years. In the course of the reforms executed in the health sector during the recent years the health institutions have grown increasingly independent, the management of state-owned institutions became decentralised while the role of the private sector gradually increased in weight. In the Czech Republic - in contrast to Germany and Portugal - where the running and financing of in-

stitutions has been one of the most burning questions in politics and public life in general, municipal governments play a substantial role in the ownership and operation of health institutions. Local governments play a significant role in the ownership and running of health institutions in Poland as well. A reform of the management and supervisory system of state-run health institutions has taken place in France recently.

As the third section analysing the total health expenditures and the health reforms revealed, in the reviewed states the expenditures were rising almost continuously over the last few years, compelling politicians to adopt measures to break or at least mitigate this tendency. The purpose of such measures was often to reduce the costs or increase the revenues of health insurers. The available data indicate that health insurers spent the largest amounts on hospital services, pharmaceutical drug support and outpatient medical services. While in general the expenses of hospital and medical services were rising, some changes in the pharmaceutical market and in the system of pharmaceutical drug subsidies paid by insurers in some countries were able to reduce, or at least to slow down, the increase in those expenditures. The ageing society and a falling number of residents affect the reviewed countries to a lesser or greater extent, which also justifies further thinking about the underlying expenses and sustainability of the health system, as well as the introduction of the related measures

The UK is an interesting example, where the operating expenses of the National Health Service (NHS) active since 1948 have been rising fast and continuously, reaching even an approximately tenfold increase in the total expenditures. This figure is higher than the 4.8-fold real increase in the gross domestic product and the total budget of the island country. In relation to the financial and economic crisis and demographic changes, the reconsideration of health expenditures and the implementation of the required reforms became an increasingly urgent task also in Portugal over the last few years.

In Germany, the biggest item among the health expenditures is the mandatory Health Insurance Fund, which covered nearly 58 percent of the expenses in 2009. Naturally, as the total health expenditures were rising, the expenses of mandatory health insurers and other segments of the health sector were also increasing. Contrary to Germany, the decrease and ageing of population is not such a severe threat in Poland, at least for the time being, as the population of Poland has grown slightly over the next twenty years. According to the estimates, the demographic situation shows signs of stagnation, but according to forecasts the ageing process may soon accelerate within the Polish society parallel with a slow decline in the number of population. Nevertheless, the low birth ratio, the demographic indicators turning into negative figures, the significant poverty, the lack on the labour market of hundreds of thousands of people of active employment age, working abroad, may cause serious problems in the system of social services.

As in Spain health insurance is structured in a so-called mixed system, the public health sector is also financed through several channels. Over the last twenty years, tax-based financing generated most revenues for the public health sector. Based on the decentralisation of the health sector, such tax revenues are redistributed primarily through the provincial budgets. Part of the contribution-based financing was also retained in Spain which, similarly to the private insurers, is only a supplementary factor in the tax-based system. The third source of financing of the Spanish health system is private funds, mainly in the form of contributions to private insurance funds.

Content

Part I
Health Reforms in Europe

Health reforms in the Czech Republic

General information about the health system

The Czech welfare system consists of three segments: the social insurance, the public social support and the social aid systems. These three institutions have different tasks and financing instruments. The social insurance system is responsible for managing the projectable social risks. This segment is financed by contributions paid by the employees (including also private entrepreneurs), the employers and the state (for the people insured by it) and provides assistance in extraordinary social situations. The state social support and social aid are financed from the state budget.

The old-age pension, disability pension and widow pension, orphan allowance, sickness benefit, costs of benefits and services in the national employment policy, the expenses of administrative services required for the operation of the system and the health care services (also based on the right of relatives) are funded from the social insurance system.

The health care system is based on the British example and its main principle is equal access to health services based on mandatory health insurance and solidarity. Pursuant to the provisions of the contract established between the service providers and the financiers, the health services are free of charge based on the insurance paid from health insurance contribution.

The leading institution of the health sector is the Ministry of Health (Ministerstvo zdravotnictví). The ministry supervises also the activities of the health insurance funds, which operate as independent organisations. They cover the health services without realising any profit. In order to avoid any potential negative consequences of risk selection, the contributions are redistributed. The redistribution is based on the total revenues of the insurance funds and the state contribution.

At present, eight health insurance funds operate in the Czech Republic. The General Health Insurance fund (VZP) was established in 1992, and 70 percent of the Czech population uses its services. Apart from VZP, seven sectoral insurance funds were established also based on the 1992 act. As the system gradually expanded, the number of insurance funds grew to 27. However, in 2000, their number dropped to nine again, as certain insurance funds ceased to exist or merged with other funds. The drastic increase in the number of insurance funds, followed by a decline, was the result of the low standard of requirements set in the act on the foundation of insurance funds. According to the currently effective regulations, an insurance fund can be established with CZK 50 million (more than EUR 2 million[1]) capital and 50,000 contracted customers, the number of whom must be doubled in two years. Apart from VZP

1 in the study the CZK/EUR conversion was calculated at 24.78 CZK = 1 EUR exchange rate.

and the seven sectoral insurance funds, there are also some private insurers, the members of which are generally foreign citizens.[2]

Financing

The social insurance contribution covers, among others, health services. The Czech health system is based on mandatory health insurance, according to which each resident having a permanent address in the Czech Republic and employees of each company registered in the Czech Republic are members in one health insurance fund. The monthly mandatory health insurance contribution is 13.5 percent of the gross monthly wages. 4.5 percent of the contribution is paid by the employee and 9 percent is paid by the employer. Entrepreneurs pay 13.5 percent contribution based on 50 percent of the average wages. The contribution paid for individuals insured by the state (children, students up to the age of 26 years, pensioners, mothers on child raising allowance, pensioners, unemployed, etc.) is also 13.5 percent, calculated on the basis of 25 percent of the average wages paid in the national economy in the previous two years. Since 1 January 2011, the state has been paying CZK 723 (EUR 29.17) health insurance contribution. The group insured by the state makes up 57 percent of the population and they also use 80 percent of the health services. Individuals without any income (dependants, students over the age of 26) also pay contribution monthly at the rate of 13.5 percent of the minimum wages, currently CZK 1,080 (EUR 43.58).[3]

The health expenditures in the Czech Republic are growing faster than the economy. According to the Organisation of Economic Co-operation and Development (OECD) survey, the share of the Czech health sector in the GDP is one of the lowest among the OECD Member States, as Poland, Chile, Korea, Turkey and Mexico provide less money to cover the health services than the Czech Republic. However, Czech analysts warn about the risks of a simplistic approach to the published data. The GDP-proportionate health expenditures of the economically more advanced countries (e.g., Norway, Switzerland, France or Austria) are two or three times higher than the Czech figure, but it also reflects the higher prices of the health services, the higher income of the employees of the health sector and the more effective use of modern technology, new procedures and medical drugs.

The following table illustrates the regressive impact of the economic crisis on the gross domestic product. As a result of the economic crisis, which spread around in 2008, the health expenditures, which previously represented around 7 percent of the GDP, reached 8.2 percent in 2009, considering that the Czech national economy was also significantly hit by the regression that affected most of the world. As a result of the irresponsible waste of money, restrictive measures need to be introduced also in the health sector, which will be described later.

2 Ministry of Health website: www.mzcr.cz , website of the Institute of Health Information and Statistics: www.uzis.cz http://www.uzis.cz/publikace/zdravotnictvi-cr-2010-statistickych-udajich, online portal of daily news: www.aktualne.centrum.cz, Medical Tribune CZ: www.tribune.cz.

3 Institute of Health Information and Statistics: http://www.uzis.cz/publikace/zdravotnictvi-cr-2010-statistickych-udajich.

Year	GDP growth ratio on a year by year basis[4]	Health expenditures as a percentage of the GDP[5]
2005	6.3 %	7.22 %
2006	6.8 %	7.04 %
2007	6.0 %	6.84 %
2008	2.5 %	7.17 %
2009	- 4.1 %	8.2 %
2010	2.5 %	8.0 %[6]

Table 1: GDP growth and health expenditures form 2005-2010

Crisis and reform

The health reform measures reached a critical phase in the global financial crisis, which began in 2008. The required stability required restrictive measures. The so-called health regulatory fees were introduced on 1 January 2008, whereby each patient using a health service had to pay a fee for the service to the party providing it. There are three types of the regulatory fees, which vary from CZK 30 (EUR 1.21) to CZK 90 (EUR 3.63): mandatory visit fee, if it involves an examination and drug packaging fee is payable by people covered fully or partly by insurance; a daily fee is payable for each full day spent in any health institution and a fee is also payable for the use of emergency services.

The free of charge category includes doctor's visits for preventive purposes, dialysis, treatments ordered by the court (e.g., alcoholics or drug addicts), mandatory treatment of infectious diseases and services to socially disadvantaged people. The duties paid in one year under the title of health services cannot exceed CZK 5,000 (EUR 201.77). The introduction of the regulatory fees triggered a series of disputes, and therefore the payment criteria were eased. From August 2008, newborn babies, and from April 2009, children below the age of 18 are exempt from the fees. For patients over the age of 65, the duty threshold was lowered to CZK 2,500 (EUR 100.88). With the help of the regulatory fees, the revenues of the health system increased by CZK 5 billion (EUR 200 million). The secondary impact of the introduction of these fees was a further CZK 5.5 billion (EUR 220 million) drop in expenditure due to fewer visits paid to doctors' surgeries.

The centre-right government coalition (Civil Democratic Party, TOP 09 and Public Matters) had to face increasing dissatisfaction among the health employees. On 15 September 2010, a public protest was organised with the involvement of the trade union club of the Czech physicians (LOK) known under the title of 'Thank you - we'll leave'. The objectives included the improvement of living and work conditions, enhancement of further training opportunities and a wage increase to three times of the then effective Czech average wages.

4 Czech Statistic Office http://www.czso.cz/csu/2010edicniplan.nsf/engt/00002AB1F0/$File/1607100803.pdf.

5 OECD Health Data 2011 http://stats.oecd.org/Index.aspx?DataSetCode=SHA.

6 Ministry of Health website: www.mzcr.cz , website of the Institute of Health Information and Statistics: www.uzis.cz http://www.uzis.cz/publikace/zdravotnictvi-cr-2010-statistickych-udajich, online portal of daily news: www.aktualne.centrum.cz, Medical Tribune CZ: www.tribune.cz.

As no compromise was reached by the end of the year, on 1 January 2011, in total 3,800 Czech hospital physicians stated their intention to terminate their employment contracts. The statement of mass terminations accelerated the events, as a result of which the protest ended on 17 February 2011. The minister of health and the chairman of the trade union of physicians signed a joint memorandum, pursuant to which the physicians' requests can be granted gradually. Based on a decree issued by Leoš Heger health minister, the average wages of physicians will be raised to CZK 60,000 a month (EUR 2,421.3) in 2011; the wages of young physicians will increase by CZK 5,000 (EUR 201.77) and those of older physicians will rise by CZK 8,000 (EUR 322.84). The physicians' requests can be fully granted by 2013 when, according to the estimates, their wages will increase by 150 percent or will be trebled.[7]

Components of the reform packages

For the government led by Petr Nečas, the modernisation of the health sector and actions promoting its progressive development are important parts of the state budget. They aim at avoiding any deterioration in the quality of services, improving access to health services and more effective prevention initiatives.

The Czech president, Václav Klaus, signed off the legislative package, known as phase one of the health reform and consisting of the amendments of six acts on 29 September 2011. Pursuant to these modifications, Act 48 of 1997 on Health Insurance will be amended and the new act will enter into force on 1 January 2012. The Act on Regulatory Fees continues to be in effect. Heger's reform package intends to introduce changes in the Czech public health sector, which have not been observed for twenty years. Owing to the reforms, which can also be described as restrictive measures, the competent ministry may expect CZK 8 billion (approximately EUR 323 million) additional revenues. However, according to Heger's projection, the health expenditures will rise by CZK 10 billion (approximately EUR 403 million) in the next few years. This increase will be the result of, among others, an increase in the VAT rate and the wage increase of physicians and other employees of the public health sector. A further 2 billion CZK (approximately EUR 80 million) are required to cover the inflationary changes and the development projects to be implemented.

Changes approved in phase one of the health reform package:

1. Modification of the hospital fee paid by patients - from January the daily fee will be raised from CZK 60 (EUR 2.4) to CZK 100 (EUR 4) based on referrals.
2. The pharmaceutical fee paid by patients will also change - from next year CZK 50 (EUR 2) will have to be paid in pharmacies for a prescription in relation to medical drug purchases. According to the currently effective regulations, patients pay CZK 30 (EUR 1.2) by medical drug. The pharmacies will no longer be permitted to announce CZK 30 (EUR 1.2) discounts.
3. Patients will have to pay the total price of medical drugs, other products of medicinal effect, nutrition supplements and other medical aides, if the price is lower than CZK 50 (EUR 2). The

7 Medical Tribune CZ: http://www.tribune.cz/zpravy.

health insurance funds will longer provide any price subsidy for the products. According to the calculations of Heger's ministry, the revenues of the health sector may increase by more than CZK 1 billion (approximately EUR 40 million) as a result of this reform. According to the spokesman of the General Health Insurance Fund (VZP), at present 1,300 medical drugs and other health products cheaper than CZK 50 are available on the market. Generally they are the most frequently used supplementary products for pain relief, high blood pressure, dieting and heartburn.

4. The prices of pharmaceutical drugs will be established on a competitive basis, i.e., a drug with a particular agent that wins the 'price competition' is also granted the full price subsidy of the health insurance fund. The competitive drugs will receive only 75 percent price subsidy. The ministry hopes to save CZK 500 million (approximately EUR 20 million) each year with this innovation.

5. The public health system will be turned into a two-tier system, i.e., there will be a distinction between the average and higher standard of health services. According to the Czech experts, this is the key component of Heger's reform package. Ever since its establishment, the disputable legislative package has been heavily criticised: according to the criticism, it violates the Constitution as it violates the principle of general and equal access to health services. The standard health services involved those clearly defined public health norms to which everyone has a right. However, from January 2012, anyone will be entitled to higher-quality health services for a higher insurance premium, naturally provided that the users pay the total cost of the services. The ministry projects that patients may spend approximately CZK 200 million for higher-quality health services in the following year. A carefully established board of specialists will be responsible for preparing the classification of general and higher-quality health services. It may also happen that depending on the health condition of the patients there are significant differences in the definition of standard health services. The higher-quality services would include, e.g., a plaster or prothesis made of special materials, the cataract operations or operations performed with robots. The minister of health will publish a List of Procedures (Seznam výkonů) each year stating the cost of medical procedures applied in higher-quality health services. The prices stated in this list will be mandatory for all physicians with regard to procedures supported by the health insurance fund. However, for procedures that exceed the general level, the prices published by the ministry are only indicative.

6. Another point in Heger's reform package that triggered a lot of discussions is the possibility of the merger of health insurance funds for the purpose of making competition of the health insurance funds more effective. According to Heger, the main problem is the large gap between the revenues and expenditures of the health insurance funds (approximately CZK 10 billion, i.e., EUR 403 million) which the insurers intend to cover from the state budget. Pursuant to the solution suggested by the minister, the insurers should fund and eliminate their deficit within the health sector. At present, there are plans for the merger of the health insurance funds of the Ministry of Interior and the Ministry of Defence. Each insurance fund facing economic difficulties, even if they are only in an initial phase, must seriously consider a merger in order to be able to make responsible decisions. The Association of Health Insurance Funds also expressed its dissatisfaction with the act, criticised to be in violation of the Constitution.[8]

8 Website of the Ministry of Health: www.mzcr.cz, online portal of daily news: http://aktualne.centrum.cz/.

Health Reforms in France

Economy and health

According to the OECD statistics[9], the state of health in France is one of the best in the world. In 2010, life expectancy was 84.8 years, the second highest after Japan among the analysed countries, the number of infant deaths is extremely low and, exceptionally in Europe, the population is also growing. However, the economic crisis which broke out in 2008 had a huge impact also on the French economy. In 2009, the GDP decreased by 2.6 percent and growth began very slowly in 2010 (1.6 percent). This year's figures are also unfavourable: in summer the government was forced to modify downwards the estimated economic growth for 2011 to 1.75 percent. France also has a high deficit: the deficit, which has been increasing for years, reached 7.04 percent in 2010, although this year, according to the plans, the budget deficit will be lower, 5.7 percent. The national debt is also rather high, much higher than the 60 percent Maastricht threshold, as it is currently 81.68 percent. The government presently in office, whose mandate will expire in April 2012, intends to reach the 3 percent deficit required by the EU in 2013, and therefore announced strong corrective measures for the last year of its government cycle. The 2012 draft budget submitted in 28 September would reduce the deficit to 4.5 percent next year. In order to achieve this target, according to the government plans, the public expenditures may be lowered in nominal terms for the first time since 1945 compared to what they were in the previous year (not including the repayments and interest of the national debt) and the 1.2 percent rise in the total expenditures could still remain half a percentage point before the rate of inflation. The public sector will be streamlined, new tax types will be introduced, including, e.g., the extra taxes on refreshments with high sugar content or drinks with high alcohol content. The restrictive package introduced in summer also included changes in the social security contributions, as a result of which EUR 6 billion more can be paid into the insurers' accounts in 2012.

Aggregated health expenditures in France

The health sector, which has been operating with a deficit for years, is one of the causes of the national debt and the budget deficit. The good general health indicators of France have been traditionally accompanied with high GDP-proportionate aggregated health expenditures. According to the last OECD figures prepared in 2009[10], in France the state and the citizens spend 11.8 percent of the GDP on health related expenses, which figure is higher only in Holland (12 percent) and in USA (17.4 percent) but. e.g., Sweden (10 percent), Germany (11.6 percent) and the United Kingdom (9.8 percent) operate their own systems with lower expenditures. In addition, the GDP-proportionate expenditures have been rising continu-

9 OECD Health Statistics 2011: http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT&lang=fr.
10 The same.

ously according to the OECD figures, available since 2001. This tendency did not change in 2010 either: the latest figures, not yet processed by OECD, but available on the website of the French Ministry of Health[11], indicate EUR 223 billion expenditure in 2009, followed by EUR 234 billion health expenditure last year, i.e., the GDP ratio grew to 12.1 percent.

The French social security system

According to a relatively recent OECD report[12], one of the biggest problems of the French system based on many insurers is the extremely high administration costs. These costs make up 7 percent of the health related expenditures, i.e., they are much higher than the 4 percent OECD average. According to the report, this bad performance is partly the result of the fragmentation of the mandatory insurers. The mandatory social insurance services are provided by three large organisations, CNAMTS, serving employees, RSI, serving freelance people and entrepreneurs and MSA, protecting agricultural and rural employees. These organisations operate in 16 regional institutions and 128 local insurance organisations. Apart from compulsory social insurance, there are also supplementary insurers in France, which further increase administration. This dual system, described in more detail below, is a French special feature and, although it produces on average good results, it leads to considerable disparities.[13]

The basis of the currently prevailing French social insurance system was laid down in 1945, but since then it has been changed with the regular contribution increases to resolve the problems of financing, the restriction of the scope of medical treatments reimbursed by the compulsory social insurance system and the increase in the non-reimbursed ratio, i.e., the so-called co-payment ratio. Before 1991, the majority of the compulsory social insurance system was funded by employers, while employees paid lower contribution, equalling 0.75 percent of the gross wages. The employer contribution remained (12.8 percent of the gross wages in 2010) but due to an increase in expenditures, a general social contribution system (contribution sociale généralisée – CSG) was also introduced. This contribution is also paid by the employees, but it is payable on the basis of their total income and not based on the wages, i.e., it applies not only to wages, but also to capital income and income earned from gambling, although the rates are different. Thus from 1 January 2010 the CSG has been 7.5 percent of wages, 6.6 percent of pensions and 8.2 percent of capital gain, income from rent, etc. The introduction of CSG in 1991 was followed by the introduction of a separate tax type under the name of CRDS (contribution au remboursement de la dette sociale - contribution for the repayment of the social insurance debt) introduced in 1996 for the repayment of the accumulated debt of the social system. As a result of these changes, the structure of the revenue side of social insurance changed radically. According to a study

11 Statistics of the Ministry of Health: http://www.sante.gouv.fr/IMG/pdf/seriestat161_tableaux.pdf.

12 See the relevant article of the Le Figaro daily paper: http://www.lefigaro.fr/conjoncture/2010/11/30/04016-20101130ARTFIG00796-comment-ameliorer-le-systeme-de-sante-francais.php, We could not reach the OECD paper, quoted in the article, directly.

13 The French health system is described in detail in the Hungarian language on the website of the Health Strategy Research Institute on the following link: http://www.eski.hu/civiltajekoztatas/kepek/ho/anyagok/franciaorszag-2010.pdf.

published this year[14], while in 1991 86.8 percent of the mandatory social insurance was funded from contributions, in 2009 the respective ratio was only 67.3 percent.

Cost cutting measures

The governments, one after the other, tried to increase the revenues and also to control the increasing expenditures. In order to achieve this goal, more and more medical treatments were taken out from the scope of mandatory reimbursement from the social insurance and the cost reimbursement ratio also dropped significantly. These days only 70 percent of most health expenditures are reimbursed by the mandatory social insurance system, and 30 percent is funded by the insured (co-payment). 80 percent of the costs of hospital treatment are reimbursed, but for certain expensive interventions, EUR 18 contribution is payable on one occasion during the hospital stay. The EUR 2 visit fee for each visit to the doctor (up to EUR 50 a year) and the daily hospital fee of EUR 18 from 1 January 2010 were also introduced in France. A 2005 reform measure made it obligatory to choose a treating physician (the treating physician could be a general practitioner or a specialist, the local GP or a department doctor) after which time reduced reimbursement was provided for visits to specialists without referral (except ophthalmology, dental surgery, gynaecology or urgent cases).

Separate, so-called supplementary insurers were created to offset the increased costs of the insured under the comprehensive '*mutuelle*' Supplementary insurance is not mandatory, but at present 95 percent of the French people have supplementary insurance. The approximately 1,500 supplementary insurers operating in the country can be divided into three groups: organisations, the members of which operate on mutual basis (*mutuelle*s), in the strict sense of the concept, institutions providing care on non-profit basis (IP – Institut de prévoyance) and profit-oriented insurance companies. The supplementary insurers generally reimburse the 20-30 percent co-payment, but they do not cover the visit fee either. The supplementary insurer reimburses the hospital daily fee and the fee of the costly supplies based on an agreement. In general, the services not reimbursed by the mandatory social insurance, the ophthalmologic and dental interventions, are also covered by the supplementary insurers.

As a result of the cost-cutting measures, there has been a small change in the breakdown of the aggregated health expenditures on the financing side. The ratio of health expenses reimbursed by the social insurance has been gradually decreasing since 2005 falling from 75.05 percent to only 74.07 percent in 2010. However, during the same period, the ratio of costs of the supplementary insurers increased by half a percentage point and reached 13.01 percent in 2010. The ratio of the costs of the insured has also risen slightly, from 6.8 percent to 7.17 percent in five years, as the costs covered by the state have also increased slightly, from 4.84 percent in 2005 to 5.07 percent in five years.

As a considerable part of the financing of services was transferred from the social insurance to the competence of the supplementary insurers and they had to be covered by the insured, the services to the poorest became doubtful. The Jospin-government introduced the

14 Public Service on Social Security http://www.securite-sociale.fr/chiffres/chiffres_cles/2011_chiffres_cles.pdf 30.

concept of full coverage for them (couverture maladie universelle,CMU), and it became effective in 2000. The CMU works on the basis of the place of residence and not based on citizens. Each individual staying in the territory of France for more than three months is entitled to CMU, even if they do not have any employment with traditional contribution payment. The CMU contribution ratio is 8 percent of the household income, but for those whose income is lower than EUR 9,029 a year, the CMU is free. (The 8 percent contribution ratio is also calculated for the income portion that is also calculated for the income portion above this threshold.) Consequently, 99.9 percent of the population have mandatory social insurance. CMU-C (CMU with supplementary protection) provides supplementary insurance for citizens with low income free of charge, without the payment of insurance contribution (regardless whether or not they are employed). They can visit doctors or use hospital services without having to make any payment. People eligible to CMU-C do not have to pay the cost of treatment either in advance or subsequently. Those whose income is only slightly higher than the threshold of CMU-C eligibility receive support.

The streamlining efforts, that have been taken for decades, were unable to offset the additional expenses of the social insurance system which occurred year by year and which have generated a severe deficit since 2002. According to its own figures, the social insurance closed 2002 with EUR 3.5 billion deficit, which grew to EUR 11.6 billion in 2005 and then, following a temporary decline, began to rise sharply in 2007, accumulating EUR 23.9 billion deficit in the system in 2010.[15] Although the government was really pleased that the increase of the 'consumption of medical goods and treatments' (consommation de soins et biens médicaux – CSBM) representing three quarters of the aggregated health expenditures, has slowed down. In 2009, the CSBM increased by 3.2 percent, but in 2010 only by 2.3 percent, i.e., it was much lower than the growth rate observed at the beginning of the new millennium.[16] One of the most important items of CSBM, the growth rate of drug consumption, representing 19.7 percent, has also declined (partly because of the price decrease) but even so the in 2010 each French citizen spent on average EUR 525 on drugs, which is the fourth highest figure in the world (after the USA, Canada and Ireland). However, the amount spent on medical aides is increasing exponentially.

Decades of deficit and endeavours to resolve it

The holes caused by the deficit could not be filled in the budget for three decades, yet each year the government sets a separate target (L'Objectif national d'assurance maladie - ONDAM) for the health insurance expenses. The 3 percent public expenditure increase in 2010 was actually achieved, and the 2.9 percent rise projected for this year also seems feasible. The government plans to increase the expenditure by 2.8 percent next year compared to this year. The ONDAM plan for the deficit of the health insurance system projects EUR 5.9 billion deficit in 2012. The aggregated deficit of the mandatory social insurance

15 DIRECTION DE LA SÉCURITÉ SOCIALE, *Les chiffres clés de la Sécurité sociale 2010,* Paris, 2011, 29: http://www.securite-sociale.fr/chiffres/chiffres_cles/2011_chiffres_cles.pdf.
16 DREES, *Études et résultats, no 773, 2011/September,* 2-3: http://www.sante.gouv.fr/IMG/pdf/er773.pdf.

budget is projected to be significantly higher, EUR 13.9 billion.[17] The ONDAM target was achieved in 2010 for the first time since its introduction in 1997. The government also submitted its complete social insurance budget parallel with ONDAM. As expected, the budget prepared for the election year does not contain any major restrictions. The beneficial consequences of the pension reform, started last year, which can already be felt in the revenues, could be sufficient to achieve the deficit, planned at EUR 13.9 billion. In order to cut last year's deficit, approximately EUR 2.2 billion must be saved this year. The draft bill expects the pharmaceutical industry to make most of the efforts due to further cuts in drug prices. According to Jean-Marie Le Guen, a specialist of the left opposition[18], with this year's draft bill the government is postponing the relevant solution of the problem after the 2012 elections. The only truly unpopular measure will be a restriction in the sickness benefit system, which will be detrimental primarily for young employees earning minimum wages.

In order to create a durable balance, Le Guen and the Socialist Party propose further increases in the revenues in the presidential campaign, which will start in the near future, although none of the socialist nominees competing for the presidential position provided any details of how they envisaged reducing the social insurance deficit. The governing UMP focuses mainly on the good results of the recent past. Recently Valérie Pécresse budget minister declared that the social insurance deficit would be cut by 40 percent in two years. The government's rhetoric is in general similar to what was communicated in 2010, claiming success over last year's results, although that year was one of the worst years in the history of the social insurance system. The extreme right National Front would like to make controls stricter and more frequent in order to eliminate the allegedly extensive fraud from the system.

17 For the 2012 ONDAM, see the paper of the Health Strategy Research Institute, referred to above: http://www.eski.hu/new3/kutatas/healthonline-teteles.php?id=2667.

18 Le Monde online: http://abonnes.lemonde.fr/politique/article/2011/09/22/securite-sociale-le-budget-2012-menage-les-assures_1575739_823448.html.

Health Reforms in Germany

Legislation in Germany was driven by the principles of economic efficiency and cost cutting in the course of its latest major reform programme involving the health sector after a dramatic growth in the total health spending in 2009. The necessity of changes was justified by the problem of an ageing society which is a particularly serious issue in Germany, and which entails increases in health spending, by the development of medical technologies and the cost increases brought about by them as well as by the crisis in the health sector which broke out in 2009.

Aggregated health spending in Germany

The ratio of health spending as a percentage of GDP has not increased materially in Germany since 2000: it has remained unchanged at 10-11 percent during this decade. Expenditures increased by an average of 2.7 percent a year between 2000 and 2008. In 2009 the ratio of health spending grew to 11.6 percent of GDP, the highest ratio after the greatest increase during the period under review. It showed a 5.2 percent increase over the preceding year 2008 and the per capita spending increased from EUR 3,220 to EUR 3,400. The expenditure increase was explained by the higher than average increase in the costs of health services and by the performance of the economy in 2009. Although only estimated figures are available for 2010, the ratio as a percentage of GDP is expected to have decreased. (The data are established on the basis of the 'System of Health Accounts'). Also according to preliminary data the 2010 deficit of the statutory patient insurance institutions is estimated to have been some EUR 445 million despite the fact that in 2009 the annual balances still showed a sufficit of EUR 1.4 billion. According to the 2011 projections as a consequence of the actions taken by legislation concerning the health sector the funds can cover their expenditures with amounts to be transferred from the Health Fund. In contrast to the deficit of the funds the preliminary balance of the Health Fund ('Gesundheitsfond') - introduced in 2009 - stated a 4.2 billion euro sufficit after the increase of its revenues reaching 2 percent thanks to the economic upswing. In 2009 the deficit of the Health Fund amounted to EUR 2.5 billion. As a result of the drugs act which entered into force in August 2010 the amount spent on medicines increased by a mere 1.3 percent.[19]

19 The homepage of the German Statistics Office: http://www.destatis.de/jetspeed/portal/cms/Sites/destatis/Internet/DE/Grafiken/Gesundheit/Diagramme/AnteilBIP,templateId=renderPrint.psml,
http://www.destatis.de/jetspeed/portal/cms/Sites/destatis/Internet/DE/Navigation/Statistiken/Gesundheit/Gesundheitsausgaben/Gesundheitsausgaben.psml,
Press communication from the Federal Health Ministry: http://www.bmg.bund.de/fileadmin/redaktion/pdf_pressemeldungen/2011/11-03-07-15_GKV2010.pdf.

The Health Fund

Decision on the Health Fund was made in early 2007, during Angela Merkel's first term in office, and the Fund was launched on 1 January 2009. The establishment of the Fund - with assets separated by the Federal Insurance Bureau ('Bundesversicherungsamt') - was necessitated, according to government party politicians, in order to strengthen the competitiveness of the health insurers. While before the establishment of the Fund the insurers set their membership fees themselves, this function is, since January 2009, carried out centrally by the state. The essence of the operation of the Health Fund is that the contributions paid by the insureds are collected in a central fund from which amounts, fixed for one year in advance, are remitted to the funds on the basis of a risk compensation method. A flat rate amount is paid to the funds for every single insured, depending on his or her gender, age and health status. In 2009 the contribution amounted to 15.5 percent of the gross wage, in 2010 (during the crisis) it was 14.9 percent while from 2011 on it was 15.5 percent again. The employee bears 8.2 percent of the contribution while the share of the employer was frozen at 7.3 percent regardless of any future contribution rate increase. Owing to the Fund and the law-defined contribution rate the insureds lose the possibility of deciding on their patient insurance depending on the contributions to be paid, which used to be determined by the funds themselves. This is the very feature that is considered to be the drawback of the Fund: as the majority of the patient insurers used to keep contributions below the standardised contribution rate before the introduction of the Fund. Competition among insurers may be strengthened by the fact that besides the mandatory contribution rate prescribed by law they can charge supplementary contribution if the amounts allocated from the Fund turn out to be insufficient. So far none of the funds has claimed additional contributions from its members. If a fund generates a sufficit, it can pay a premium to its insureds.

Moreover, along with the introduction of the Fund an agreement was also reached on having the Federal budget make contributions to the costs of mandatory patient insurance in increasing ratios up to 2016, thereby financing, for example the free family insurance coverage for children and spouses. (In 2011 this amount was EUR 13.3 billion. In addition to the above, in 2011 the Federal budget contributed EUR 2 billion more to 'social compensation' during the period between 2012 and 2014.)[20]

The possibility of the bankruptcy of statutory mandatory patient insurers

Another component of the year-2007 reforms was the act making it possible - since early 2010 - for statutory patient insurers ('Gesetzliche Krankenkassen') as well to go bankrupt. According to the new regulation the statutory patient insurers must notify their financial difficulties to the supervisory body in good time. If due to its financial position a fund can no longer participate in competition it has two options to choose from: the supervisory body may close the fund down or may file for bankruptcy against the insurer. The insur-

20 Information page on the Health Fund: http://www.gesundheitsfonds-online.de/category/gesundheitsfonds, articles published by the Federal Health Ministry:
http://www.bmg.bund.de/krankenversicherung/finanzierung/gesundheitsfonds.html,
http://www.bmg.bund.de/krankenversicherung/finanzierung/finanzierungsgrundlagen-der-gesetzlichen-krankenversicherung.html.

ance coverage of the members is guaranteed even in the case of bankruptcy: if necessary, the costs are covered by the other insurers. According to the law bankruptcy proceedings or the closure of an insurer may only happen in extremely bad cases, the primary aim is to salvage the fund by fusion or reorganisation. This is carried out at the expense of the other patient funds of the same type within the provincial or the federal system. If a fund cannot be rescued, only the supervisory body may order the conducting of bankruptcy proceedings: no such petition may be filed by the insurer or by its creditors.[21]

The year-2010 health reform

The act on 'The sustainable and socially balanced financing of statutory patient insurance'[22] was adopted during Angela Merkel's second term in office (in coalition with the liberal FDP), which entered into force on 1 January 2011. The short term goals of the measures concerned included the elimination of the EUR 9 billion deficit threatening the patient insurance system, while the medium and long term goals included resolving the structural problems of the financing system. The factors that justified the reform include many years of increasing health spending as well as the cost increases entailed by the advancement of the medical profession.

The most important measures involved in the reform

One of the key points of the measures involving the health system was that the government restored the single universal 14.4 percent contribution rate that had been in place in 2009 before the crisis, raising it back to 15.5 percent from 1 January 2011. The government explained the raising of the statutory rate by referring to the impending immense deficit of the health insurers and the condition of the German economy. Moreover, the government was aiming at separating the health costs from the income levels by intending to equalise the unavoidable cost increases through supplementary contributions. Moreover, by introducing the possibility of supplementary insurance premiums the government intended to strengthen competition and the autonomy of the funds in terms of their contributions. In order to prevent overburdening certain contribution payers the government introduced what is referred to as 'social compensation' which is to be financed from taxes which is due to the insurers where the pre-set average supplementary fee exceeds 2 percent of the individual income on which contribution is payable (for 2011 the supplementary contribution was set at 0 euro).

In addition to the changes affecting the contributions the 2010 reform package comprised limitations of certain expenditure items as well: according to the law the operating costs of the mandatory patient insurers must not exceed the 2010 level in the first two years. Moreover, the act imposes a restriction on the increase in the costs of hospital treatment and those of the health services rendered doctors on the basis of contracts or by general prac-

21 Information Page on the Health Fund: http://www.der-gesundheitsfonds.de/index.php?id=120, homepage of health funds: http://www.krankenkassen.de/gesetzliche-krankenkassen/system-gesetzliche-krankenversicherung/finanzen/insolvenz-krankenkasse/.

22 Act on the sustainable and socially balanced financing of statutory patient insurance: http://www.bmg.bund.de/krankenversicherung/gesundheitsreform/inhalte/gkv-finanzierungsgesetz.html.

titioners as well, for the next two years. The reform is planned to generate savings of some EUR 3.5 billion in 2011 and EUR 4 billion in 2012. According to information supplied by the Health Ministry the autonomy of insurers in terms of setting their contribution rates will be restored in the future and according to the plans relating to doctors' fees a transparent and understandable system is intended to be created in health services. The government is planning no changes in relation to the Health Fund, future cost increases are intended to be financed by the supplementary contribution to be charged by the insurers.[23]

The drugs act

The so-called 'drugs savings package'[24], was part of the 2010 reforms and it was continued by the 2011 act on the 'Reregulation of the drugs market'[25]. Both acts were aimed at reducing drug prices as the increase in the amounts spent on medicines is a huge burden on the statutory health insurers. The measures adopted by the government affect primarily the pharmaceutical industry, wholesale trade in drugs and pharmacists in that they have to offer greater discounts to the health insurers.

The measures of the 'drugs savings package' came into force on 1 August 2010, and they were intended to counteract the growth in the prices of medicines by short term actions. Pursuant to the act the manufacturers increased the 6 percent mandatory discount provided by manufacturers to the mandatory health insurers to 16 percent in the case of the medicines whose prices are not fixed[26]. In order to make sure that the drug manufacturers cannot bypass the act by raising their prices, the drug prices were frozen at the 2009 level up to 2013 for the mandatory health insurers. The act also provided incentive for price decreases: if a manufacturer reduces its prices the rate of the decrease can be deducted from the manufacturers' mandatory discount. In 2011 the mandatory discount on certain drugs was increased from 16 percent to 20.5 percent.

The 2011 act is intended in essence to regulate the pricing of new innovative drugs. While before the entry into force of the act a manufacturer could freely set the price of its new preparations, now it must conduct price negotiations with insurers and must offer them discounts. Moreover, the manufacturers must prove the additional benefits of the new drugs on which decisions are made by a Joint Federal Committee ('Gemeinsamer Bundesausschuss') comprising doctors and insurers. The criteria of utility are determined by the Ministry of Health. One of the important impacts of this law is that the responsibility for the use of less expensive drugs is now more heavily assigned to health insurers again, than on the doctors themselves. Since insurers have more power to regulate prices by way of the so-called discount contracts, this action may result in lower costs. The act also sets out the

23 Articles published by the Federal Health Ministry:
http://www.bmg.bund.de/krankenversicherung/gesundheitsreform/inhalte/gkv-finanzierungsgesetz.html,
http://www.bmg.bund.de/krankenversicherung/gesundheitsreform/zeitplan.html,
http://www.bmg.bund.de/krankenversicherung/herausforderungen/einnahmen-und-ausgabenentwicklung.html,
24 Drug Savings Package: http://www.aok-bv.de/politik/gesetze/index_02066.html.
25 Act on the 'Reregulation of the drugs market':
http://www.bgbl.de/Xaver/start.xav?startbk=Bundesanzeiger_BGBl&bk=Bundesanzeiger_BGBl&start=//*[@attr_id=percent27bgbl110s2262.pdfpercent27] .
26 Fixed price: the maximum amount paid by an insurer for the given medicine.

rate of the mandatory discounts to be provided for insurers: in the case of pharmacies the mandatory discount was raised from EUR 1.75 to EUR 2.05 up to 2013, while wholesalers must provide a discount of 3.15 percent of the prices of the preparations and an EUR 0.70 fixed package fee discount for insurers. In the case of medicines of new active ingredients the rate of the mandatory discount was raised from 6 percent to 16 percent until the end of 2013. From 2011 the discount applies to private insurers as well.[27]

The act on the structure of health service provision

The cabinet agreed on the draft act on the structure of health service provision[28] in August 2011, which is necessitated by - among other factors - the shortage of doctors in certain rural areas, particularly in the East German regions. The actions provided for in the act would improve the costs of statutory patient insurance as well, by the reduction of the costs of the transporting of patients and of the referrals to hospital as a result of the improved supply of doctors in the areas concerned. Moreover, the act would strengthen the possibility of free choice of insurers and it would strengthen the powers of the supervisory bureau as well, in case an insurer is unlawfully rejected by an insurer. Moreover, the act would regulate smooth transition in the case of the closure of an insurer. To boost competition it makes it possible for funds to offer supplementary services in certain areas besides those regulated by law. The act would make the planning of the needs for ambulant medical services more flexible by making it possible for the plans to depart from the urban and rural district boundaries, unlike before.

Furthermore, the act provides for incentives for the doctors of the areas that are not sufficiently supplied, along with the support of mobile supply plans, increased possibilities for coordinating work with family life, it makes it possible to simplify the regulatory situation for the Federation of Contract Doctors for the operation of their own institutions and to involve communal carriers in the case of such types of institutions. Moreover, the draft act is aimed at making the system of the remuneration of contract doctors flexible and placing it on a regional foundation. The act is planned to enter into force on 1 January 2012.[29]

27 Press communication from the German government: http://www.bundesregierung.de/Content/DE/Artikel/2010/03/2010-03-26-arzneimittelpreise.html.
Press communication from the Joint Federal Committee (Gemeinsamer Bundesausschuss): http://www.g-ba.de/institution/presse/pressemitteilungen/377/.
28 Press communication from the Federal Health Ministry: http://www.bmg.bund.de/ministerium/presse/pressemitteilungen/2011-03/gkv-versorgungsstrukturgesetz.html.
29 Press communication from the Federal Health Ministry: http://www.bundesgesundheitsministerium.de/ministerium/presse/pressemitteilungen/2011-03/versorgungsstrukturgesetz-beschlossen.html.

Health Reforms in Great Britain

The main characteristics of the British health system

Health services in Great Britain are provided as a right associated with citizenship, in a tax-based system referred to as the so-called Beveridge model. The overwhelming majority of the services are provided by the public health institution system. The system is coordinated and governed by the National Health Service - NHS - which was established 63 years ago. According to the act providing for the establishment of the Service health services *that are equally accessible and free of charge* must be provided for all British citizens regardless of gender and financial standing. This principle has remained valid even in the wake of the health reforms implemented during the past decades.

The hierarchic structure of the NHS comprises three levels. At present the Department of Health (with the Secretary of State for Health, which position has, since May 2010, been held by Andrew Lansley, Conservative Party) is responsible for the central management of the health service. The regional level of management plays a key role in the planning of the health service providing system. The third pillar is made up of the District Health Authorities, directly in charge of the provision of health services for the public. [30]

The legal regulations governing the NHS make it possible fort the cabinet in office at any point in time to operate and to make service provision sustainable by reallocating tax revenues. One particular feature of the British system is that the ratio of public spending within the total health expenditure (over 90 percent) is among the highest in West Europe. The NHS is financed for the most part from tax revenues and from tax type insurance contributions. The remaining part of the revenues come from the amounts paid by patients to cover part of the expenses of the services they use as well as from the management of the assets of the system.

The medical services provided through the system have no 'prime costs' per se. This applies to hospital care as well within the framework of the NHS, apart from cases where the patient requests interventions that are not clinically necessary and those that qualify as convenience services. In the case of dental treatment the system may pay up to 80 percent of the cost but it cannot exceed 384 British Pounds.[31]

One of the key principles underlying the operation of the NHS is that it provides equal services for all with universal coverage which is based on justified needs and not on financial means.[32] In contrast to private systems the NHS does not exclude people owing to their financial standing

30 Website of the National Health Service: http://www.NHS.uk/NHSEngland/theNHS/about/Pages/NHSstructure.aspx.

31 Website of the National Health Service: http://www.NHSbsa.NHS.uk/Documents/ArchivePDF/NHS_dental_charges.pdf.

32 Website of the National Health Service: http://www.NHS.uk/NHSEngland/theNHS/about/Pages/NHScoreprinciples.aspx.

or health status. In Britain the NHS does not keep a list of services that would separate health services covered by private insurance from those covered by the social security.

In the current political situation when the cabinet is working on a very profound reform (see below) it needs to be noted that the role of the general practitioner is particularly crucial in the complex organisation structure of the NHS. Almost every single member of the population of Great Britain registers with a general practitioner who provides practically continuous preventive, diagnostic and curative health service. The status quo of the GPs is strengthened by their 'gate keeper' function in the system, as they are the ones with excusive competence to refer patients to clinics thus they bear full responsibility for filtering unnecessary, costly or difficult to access services.

The NHS is financed predominantly by reallocation of public revenues. It is worth taking a look first at the types of tax revenues that have been contributing to the budget of the Service and their relative proportions in the years under review. (Table 1)

Tax type	NHS budget
Income tax	29 %
Social security contribution	16 %
VAT revenues	16 %
Corporate income tax	8 %
Excise tax on fuels	6 %
Excise tax on tobacco products	2 %
Excise tax on alcoholic beverages	2 %
Other	22 %
Total	100 %

Table 1: The revenue side of the NHS budget[33]

Ever since its establishment in 1947 the NHS has - on account of its nature and significance - been a constant topic in British domestic politics. Even if looking back only over the past decades finds that there has been no election campaign, government term or year in which the modernisation of the NHS was not among the most important issues. For example, the Blair Cabinet which took office in 1997 announced in 2000 its NHS Plan programme for a 10 year period in the framework of which right in the first years they increased the health spending substantially. The victory of the Labour Party in 2005 was also followed by an increase in the real value of health expenditures. At the time of the outbreak of the crisis in 2008 funds were still found for increasing the real value of the financing of the NHS while public borrowing was also on the increase.

33 Website of the National Health Service: http://www.NHS.uk/NHSEngland/theNHS/about/Pages/NHScoreprinciples.aspx.

An analysis prepared by the Institute for Fiscal Studies (IFS) clearly reveals that at the beginning of the previous decade the real increment of the funds spent on the health sector was still growing intensively. By the end of the decade - and particularly when the cabinet headed by David Cameron, replacing the Brown Cabinet took office - the real increment of the health budget dropped from the nearly 7 percent of the preceding year to below one percent.

The decrease in the real value of financing however, was not mere matter of chance. After the three government terms when the Labour Party was governing, the conservative-liberal coalition that took office in 2010 took over the budget of the country in a disastrous condition. In terms of both the structural deficit and the public debt the Cameron Cabinet had only one option left and that was the execution of an economic policy based on marked spending cuts and on the restoring of the economy.

The NHS - today employing as many as 1.7 million persons - has not been left unaffected by the above measures.[34] The government is determined to render the health system sustainable. The objective of the health reform plan put out for consultation this year is to save some GBP 20 billion for the state up to 2015. In 2011 the NHS is facing major and profound changes. According to a number of health experts the conservative-liberal cabinet in office is preparing the most radical reform of the past 60 years.

The NHS reform which is referred to as the flagship of the Conservative Party's programme would improve sustainability by liberalising the sector and by boosting competition within it.[35] One of the key element of the draft is that the control of the NHS budget would also be reorganised and this function would be fulfilled by *consortiums* comprising general practitioners. In this way GPs could make decisions on the allocation of the health budget by purchasing services for their patients. According to the plans of the British cabinet from 2013 on the approx. 75,000 general practitioners working in the system of the National Health Service could purchase the diagnostic and therapeutic services for their patients directly from the hospitals and specialists. (Comment: in the course of consultations with the profession this 2013 date was dropped by the department.) All this would then mean that the general practitioners could decide indirectly on the allocation of the billions of pounds comprised in the health budget. After the transformation the general practitioner referring his patient to specialists would be directly responsible for the costs of the subsequent treatments. In this way in the course of 'shopping' the doctor would be interested in making sure that the price is reasonably proportionate to the service, since if the doctor exceeds the budget allocated to him by the NHS, in the next budget year he will face financial sanctions and budgetary restrictions.

The cabinet's standpoint is that the NHS is too bureaucratic and it is too slow, and the quality of the service is not focused on the patient either. The draft of the health reform was published by the cabinet back in the summer of 2010 in a so-called White Paper. According to that document hundreds of local health directorates and regional health authorities of the NHS are to be downsized. These bodies are currently engaged in harmonising the

34 Website of the National Health Service: www.NHS.uk.

35 The Guardian: www.guardian.co.uk/healthcare-network/2011/jun/08/NHS-reforms-david-cameron-cautious-welcome.

services on offer in the various regions to the projected future needs and they are also making sure that the necessary instruments from the health budget are allocated to where they are needed. [36]

After its announcement the draft was severely criticised on a variety of technical/professional platforms.[37] According to the British Medical Association the Cameron Cabinet published an 'unripe' paper that entails a potential threat to the future of the public health services. At this point the organisations also pointed out that the cabinet ignored all of the objections of the profession. The British union of nurses also made its voice heard. According to their preliminary calculations some 27,000 nurse jobs should be expected to be axed if the reforms are executed.

After its announcement the cabinet immediately started consultations with the British health unions on the Bill on the launching of the reforms.[38] Before the adoption[39] by the House of Commons on 7 September 2011 of the almost fully reengineered Health and Social Care Bill an agreement was reached on a number of important aspects within the governing coalition and between the cabinet and the unions.

The cabinet led by David Cameron set out three goals for itself to achieve sustainability of the health care system: [40]

1. Up to 2015 the NHS should save 20 billion pounds.
2. In a period of four years the cabinet should cut NHS management costs by 45 percent.
3. Radical curbing the overgrown NHS bureaucracy and eliminating parallel functions.

Moreover, he declared that the NHS can only meet the future financial, demographic and technological challenges if the savings resulting from improved efficiency are spent on the development of the 'first line' of the health care providing system. Although the cabinet clearly declares in the draft that in real terms it intends to increase the NHS budget, it is clear that no GDP-proportionate real increments of the like of the previous years can be expected.

Figure 1 shows the amounts spent in Great Britain on the health sector from 1985 to date. According to the official projections published by UK Public Spending the government continues to expect growing NHS spending in nominal terms, together with increasing GDP. Of course these figures include the funds to be saved as declared above, which are also intended to be spent on the development of the system.

36 White Paper on Liberating the NHS by the Department of Health: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353.
37 The Guardian: www.guardian.co.uk/healthcare-network/2011/jun/08/NHS-reforms-david-cameron-cautious-welcome.
38 Website of the Department of Health: http://www.dh.gov.uk/en/MediaCentre/DH_125865.
39 Health and Socail Care Bill: http://services.parliament.uk/bills/2010-11/healthandsocialcare.html.
40 The Guardian: www.guardian.co.uk/society/2011/may/16/david-cameron-NHS-only-saved-reform.

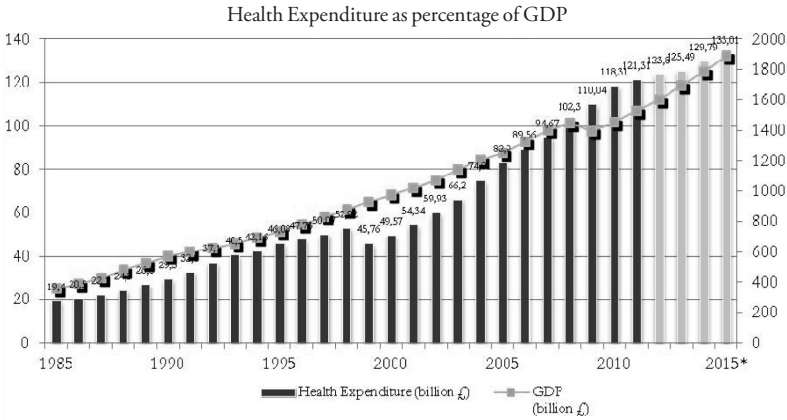


Figure 1: Nominal value of public health spending as a proportion of the British GDP. [41]

Year	GDP (£ billion)	Health spending (£ billion)
1985	361.758	19.4
1986	389.149	20.5
1987	428.665	22.1
1988	478.51	24.3
1989	525.274	26.8
1990	570.283	29.3
1991	598.664	32.8
1992	622.08	37.1
1993	654.196	40.5
1994	692.987	42.16
1995	733.266	46.08
1996	781.726	47.73
1997	830.094	50.07
1998	879.102	52.92
1999	928.73	45.76
2000	976.533	49.57
2001	1021.83	54.34
2002	1075.56	59.93
2003	1139.75	66.2
2004	1202.96	74.91
2005	1254.06	82.9
2006	1325.8	89.56
2007	1398.88	94.67
2008	1448.39	102.3
2009	1395.87	110.04
2010	1453.62	118.31
2011	1526.5	121.31
2012*	1602.8	123.8
2013*	1693.7	125.49
2014*	1789	129.79
2015*	1889.1	133.01

Table 1 [42]

Moreover, it is also clear from the data published by the Institute for Fiscal Studies (see Figure 2) that the real increase of the GDP-proportionate NHS budget adjusted by inflation is very likely to stagnate in the next years after the more generous previous years.

41 Public Spending: www.ukpublicspending.co.uk.
42 Public Spending: www.ukpublicspending.co.uk.

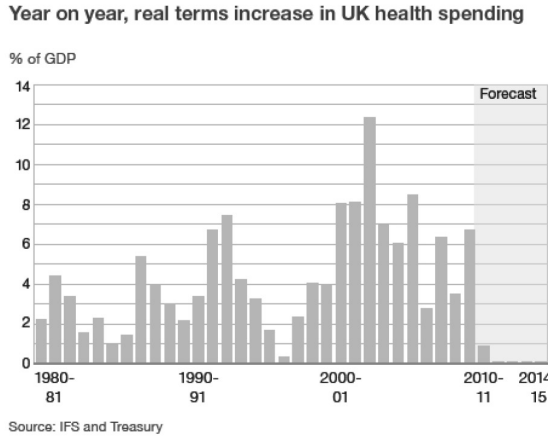


Figure 2: The real increment of health spending in Britain as a percentage of GDP.[43]

For the next years the cabinet expects health spending to decrease as a percentage of GDP. The health department intends to bring the funding of the NHS - the restructuring of which will have been completed by 2015 - back to about 7 percent, the ratio recorded in 2008 for the last time now.

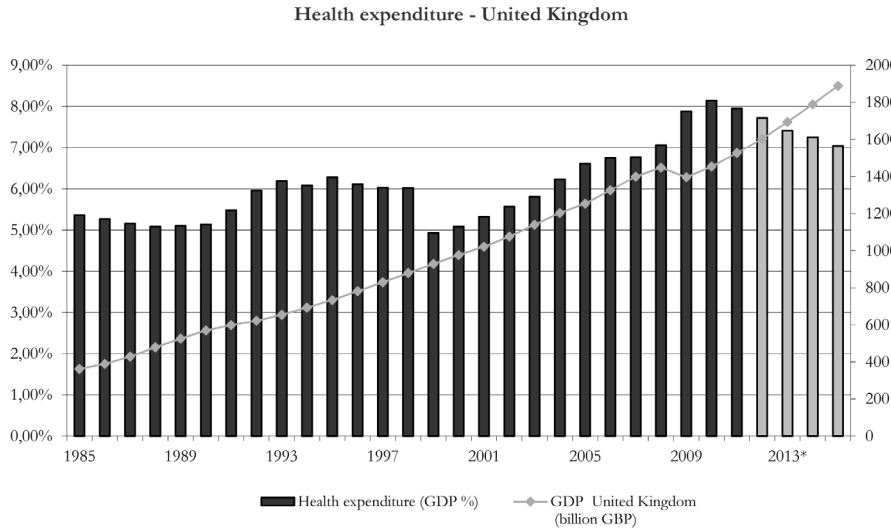


Figure 3: Great Britain, health spending figures as a percentage of GDP.[44]

43 BBC online: www.bbc.co.uk/news/magazine-11686396.
44 Public spending: www.ukpublicspending.co.uk.

Year	GDP Great Britain (£ billion)	Health spending (GDP %)	Year	GDP Great Britain (£ billion)	Health spending (GDP %)
1985	361.758	5.36 %	2000	976.533	5.08 %t
1986	389.149	5.27 %	2001	1021.83	5.32 %
1987	428.665	5.16 %	2002	1075.56	5.57 %
1988	478.51	5.08 %	2003	1139.75	5.81 %
1989	525.274	5.10 %	2004	1202.96	6.23 %
1990	570.283	5.14 %	2005	1254.06	6.61 %
1991	598.664	5.48 %	2006	1325.8	6.75 %
1992	622.08	5.96 %	2007	1398.88	6.77 %
1993	654.196	6.19 %	2008	1448.39	7.06 %
1994	692.987	6.08 %	2009	1395.87	7.88 %
1995	733.266	6.28 %	2010	1453.62	8.14 %
1996	781.726	6.11 %	2011	1526.5	7.95 %
1997	830.094	6.03%	2012*	1602.8	7.72 %
1998	879.102	6.02 %	2013*	1693.7	7.41 %
1999	928.73	4.93 %	2014*	1789	7.25 %
			2015*	1889.1	7.04 %

** estimated figures*
Table 3[45]

If the Bill is passed by the House of Lords as well during the next weeks, the most profound health reform Britain has seen during the past 60 years can be launched upon its entry into force.

The proposed actions will eliminate the congregations providing basic health care services (Primary Care Trust, PCT) and the strategic cooperation authorities (Strategic Health Authorities). Decentralisation will play a particularly important role along with the simultaneous elimination of the outgrowths of bureaucracy and the political control over the sector. As a consequence of the dissolving of the PCTs and the expansion of the competences of the general practitioners, thousands of management level and administrative jobs will be axed. The NHS will focus on patients who will have a choice as to the mode and place of their treatment. At the same time, they will have a broader control over their data and with the aid of the performance indicators that will be published online they will e able to compare the performance of different hospitals.

The government is bent on replacing the practice introduced by Labour, where the top-down goals are imposed on the system, with a system based on the output of clinics.

In the new structure the general practitioners' consortiums will be in charge of the procurement of NHS services. The purchases of the general practitioners will be effected by a newly established independent body called NHS Commissioning Board. Moreover, the

45 Public spending: www.ukpublicspending.co.uk.

operation of the Health Department will be streamlined and the quasi-civil society organisations - arms' length bodies - engaged in certain related activities, that have come to be superfluous, will also be removed from the system.[46]

46 Health and Social Care Bill, Department of Health: www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/HealthandSocialCareBill2011/index.htm.

Health Reforms in Poland

General features

The transformation of the Polish health sector began after the systemic change: The act regulating the health institutions was passed in August 1991, bringing along the independence of health institutions and permitting private investments in certain sectors (e.g., pharmacies). The next big step was the approval was the Act on Health Insurance in 1997, which entered into force on 1 January 1999 (this was one of the biggest reform actions of the government led by Jerzy Buzek. As a result, health funds were established (in the 16 provinces [Vojvodina] and one national fund for the armed forces). This system did not work for long, because the next left-peasant party government recentralised the health sector. Pursuant to the act passed in 2003, the health funds were replaced by the National Health Fund (Narodowy Fundusz Zdrowia, NFZ) with national competence (and representation offices in each province) with the responsibility to finance the health services in Poland ever since.

The NFZ is supervised by the Minister of Health and its Executive Officer is appointed by the Council of the Fund based on the proposal of the competent Minister. Pursuant to this act, those Polish citizens who live in the territory of the Republic of Poland and fall within the scope of the mandatory health insurance or are insured on voluntary basis are eligible for health services. NFZ receives the fund required for the operation of the system from the social insurance system (ZUS, Zakład Ubezpieczeń Społecznych), and from KRUSon (Kasa Rolniczego Ubezpieczenia Społecznego, the Agricultural Social Insurance Fund, which forms a separate system for agricultural producers). NFZ, the Polish health system is funded primarily from resources stemming from health contribution (additional funds also originate from taxes, employee contributions and also from the income of individuals). Apart from NFZ, there are also other much less important actors (budget, regional municipalities, private households, employees, private insurers) on the paying side of the health system (i.e. clients.) This centralised financing mechanism created a rigid system, and therefore a patient may need to wait weeks or even months, unless they need a lifesaving operation (the majority of the complaints about the Polish health sector stem from this situation).[47]

At present the health contribution equals nine percent of the gross wages in Poland (it was 8.7 percent until December 2006, and 8.5 percent until December 2004). The health contribution is payable by the insured people or in some cases it is assumed from them by the budget (e.g., for agricultural producers, unemployed or for individuals eligible for

47 Analysis of the functioning health care systems in chosen European Countries: http://www.ujk.edu.pl/studiamedyczne/doc/SM_tom_13/Analizapercent20funkcjonowaniapercent20systemowpercent20opieki.pdf, http://www.e-finanse.com/article.php?file=47,
Hungarian Health Strategy Research Institute, Summary of the Polish health care system: http://www.eski.hu/civiltajekoztatas/kepek/ho/anyagok/lengyelorszag_2011_julius.pdf.

insurance but without income, e.g., for students). Despite the global economic crisis, the Polish Government has not changed the contribution rate over the last few years even despite the fact that Prime Minister Donald Tusk made some statements implying it in 2011. However, Jacek Paszkiewicz, the current NFZ President, urged for 0.25 percent contribution increase in 2011 to stabilise the health system.[48]

The expenditures

Over the last few years the contributions collected by NFZ have been rising gradually. In 2009 the amount collected from health contribution made up PLN 53.5 billion[49] in the budget of the National Health Fund, and the amount only rose in the subsequent years: it reached PLN 55.4 billion in 2010 and PLN 58.05 billion in 2011. According to the press news in 2012 the total NFZ budget will be PLN 64.5 billion, of which PLN 60.9 billion will be used for the financing of services. This means that over the last few years and in the prior years the amounts spent on the Polish health sector have been rising gradually. According to the Health Act, if the NFZ budget is lower than the budget of the previous year, the difference must be made up from the state budget (it has never happened since the systemic change though). Nevertheless, decision-makers have already been forced to re-allocate funds from the general reserves of the Health Fund in order to maintain the standard of the services and the operation of the system.

According to the OECD figures, the per capita health expenses were on the rise in Poland between 2000 and 2009. According to the same data in 2011 in total 5.9 percent of the GDP was spent on the health sector, which went up to 6.4 percent in 2007, 7 percent in 2008 and 7.4 percent in 2009 (it should be noted that in the same year the OECD average was 9.5 percent). In figures: In 2009 the expenses of the sector amounted to USD 1,394 per person at purchasing power parity: within this total 72.2 percent were public expenses (this amount was funded from health insurance in 83.5 percent and from tax revenues in 16.5 percent). Consequently, over the last few years the funds spent on the Polish health sector increased both in proportion and in total.

Experts project an increase in private funds within the sector in the next few years too, because the average Polish citizens will have a higher income and citizens will spend more money on their health in order to avoid waiting for weeks or months for the health services. In 2009 NFZ covered 86.1 percent of the public expenditures in the health sector, while 85.9 percent of the private expenditures were covered by the households.[50]

The relative stability of the Polish health sector is primarily due to the country's favourable economic position. In other words, the 2008 global crisis did not reach Poland, the country managed to avoid recession, as a rare exception within the European Union. The fact that the Polish economy is not very open towards the foreign markets and that it has a huge internal market was an important factor of this situation (thus internal consump-

48 Wiadomosci 24, online portal of daily news: http://www.wiadomosci24.pl/artykul/rzad_nie_planuje_podwyzki_skladki_zdrowotnej_w_2011_roku_102937.html.
49 Currently PLN 1 = HUF 67.
50 OECD Health Data 2011: http://www.oecd.org/dataoecd/43/24/40905081.pdf, http://www.egospodarka.pl/68878,Narodowy-Rachunek-Zdrowia-2009,1,39,1.html.

tion contributed to economic growth). The Warsaw Government adopted numerous crisis management measures over the last few years, leading to a dramatic increase in the national debt as the main consequence (according to the figures of the National Bank of Poland, the Polish national debt was PLN 527.4 bln at the end of 2007, but the figure rose to PLN 787.8 bln by the second half of 2011). So, in terms of figures the Polish health sector was left unaffected by the global crisis, as the Polish economy grew after 2008 in term of the GDP (in 2009 the GDP ratio spent on health was 0.4 percent higher).

Impacts of the crisis

What puts some shade on the above picture is that in the Polish health sector the impact of the global crisis was a rather specific one, because the government did not extract funds, but tried other methods to pump funds into the sector. The list below contains the size of the crisis that occurred in the Polish health sector over the last few years:

1. Resources had to be taken from the reserve fund, which was kept by the decision-makers for 'emergencies'. In 2009 nearly PLN 700 million had to be taken out of the fund to finance the current account deficit of NFZ (in 2009 the budget of he fund also had to be modified several times during the year). The NFZ management would like to see an increase in the reserve fund in the future, thus dampening the impacts of any unpredictable event.

2. Over the last few months NFZ conducted stricter audits in the institutions funded by it (e.g., hospitals, pharmacies, health centres) checking whether or not the specific institutions were spending the money in compliance with their contracts. The strengthening of the financial discipline clearly indicates that the health fund is trying to identify points where money is leaking out of the system and to put a cap on them.

3. In 2010 and 2011 NFZ did not pay on time for treatments that exceeded the number of patients stated in the contract, i.e. 'excess performance'. If an institution overspends due to any reason not attributable to it and NFZ does not reimburse the treatment of an insured patient, the case is submitted to court. Such a lawsuit can take months or years, and usually the health fund loses it, but it gain some extra time to make the required payment. An institution did not receive an amount for its 'excess performance' in 2009 from NFZ even in 2011, although such cases destroy the financial balance of the hospitals. Whenever it happens, hospitals blame NFZ for the situation, yet such events also indicate inadequacies in the operation of the institutions. The amount of treatments and services performed over and above the contracts cost more than PLN 1 bln.

4. The Government has postponed for a while one of the reform projects, announced in this cycle, which would have permitted citizens to purchase supplementary insurance in private companies, and to use it in the public health sector (according to the news the project would have started as an experiment only in two western provinces). One of the objectives of this measure would have been to make health services more effective (e.g.,

to reduce significantly the number of patients waiting for certain treatments), yet would have made differences between patients even greater which, by the way violates the equal opportunities in having access to health services, stating in the Polish Constitution.

5. It is not an indirect impact of the global crisis, but when the sector is analysed, it should definitely be taken into account that the debt of hospitals grew dramatically over the last few years: In 2008 their debt was PLN 3.5 bln, and the figure reached PLN 9.9 bln in the second half of 2011, representing the biggest impediment of current liquidity for the institutions. Patients often have to wait weeks or months for special treatments: similarly to the other segments of the public sector, in the health sector wages are low, which leads to mass migration, because a specialist can earn several times as much as he earns in Poland in another West European Member State.[51]

Dispute on the reform

It should be noted that a health institution that performs public services cannot charge its patients for the services and must have an effective contract with the Health Fund for its health services provided to patients. There are no such limitations for privately owned institutions. The institutions are granted the contracts in tenders. The maximum effected period of a contract is three years, after which the contract can be extended. NFZ cannot make any distinction in terms of fund allocation based on the fact whether a particular institution provides public health services or not.

As it was mentioned above, NFZ has a monopoly on the market, neither the insured people, nor the health institutions have a choice. There was a public debate in the last few years over the possibility of breaking down NFZ into smaller insurers or raising a considerable amount of private investment (primarily through hospital privatisation) in the system. The privatisation of the complete health sector seems unlikely, because non of the relevant parties would undertake the process, because the majority of the society are against it. The Government of the middle-right-liberal Civilian Platform (PO) and the Polish Smallholders Party (PSL) focusing on the interests of the rural areas have already made two changes in the system towards partial privatisation in this cycle (2007–2011); in 2008 the Lower House of Parliament, the Sejm adopted a health reform package, but the then President Lech Kaczynski vetoed it and therefore it did not enter into force. In 2011 though an act was passed in Parliament, providing more opportunities to run health institutions more like corporate businesses (which does not mean that they are privatised). This act provides opportunities to commercialise hospitals, i.e. to operate them in a more business-like manner (e.g. supervisory boards). Thus, in the view of the legislators health institutions will operate more effectively (they will not accumulate infinite debts). In relation to this we should refer to papers written by various experts, who think that the central right-Smallholders Government would like to get rid of its responsibility and financing of the health sector

51 Money.pl, online news: http://news.money.pl/artykul/zadluzenie;szpitali;nieznacznie;spadlo;-;do;9;5;mld;zl,52,0,726580.html,
Polskie Radio online: http://www.polskieradio.pl/5/115/Artykul/322636,Boj-o-pieniadze-z-NFZ-Szpitale-przekroczyly-kontrakty-o-miliard-zlotych.

from public money, which was indicated by certain steps (e.g., permission of voluntary insurance policies, which practically meant that private investors were indirectly let into the public health sector through the 'back door'). When this Government entered into office, it also announced a lot of ambitious programmes radically changing the system (e.g., termination of the public health fund and establishment of 5-6 health insurance organisations, competing with each other, and a simultaneous appearance of private insurers), but to date almost nothing has materialised.[52]

Summary

In summary we can conclude that the Polish health sector has been gradually improving since the systemic change, partly due to the improving performance of the economy after 1991, accompanied with a GDP growth. Thus more money was available (also) for the health sector; this favourable tendency could not be broken even by the 2008 global crisis. There has been no change in the structure of expenditures, in other words, the public expenditures are higher than two-thirds of the total health expenditures, and this ratio was gradually rising in comparison to the private sector (in 2009 the public expenditure was rising faster than the household expenditures). Between 2003 and 2009 there was a consistent increase in the total expenditures (both in current expenditures and capital expenditures). However, in comparison to other EU Member States, the status of the Polish health sector cannot be considered satisfactory, as it is lower than both he EU average and the OECD average in terms of per capita expenditure. Consequently, it is not surprising that both patients and physicians report numerous inadequacies and problems in the Polish health sector and that people are not satisfied with patient care in Poland. Complaints about the system and the quality of services can be heard on a permanent basis.

During the PO-PSL Government (2007-2011) it has been clear that the Government does not intend to increase the health expenditures (in other words, it is not even considered that health contributions would be raised or funds would be reallocated from the central budget). It has also become clear over the last few years that no supplementation of funds in the health sector resulted automatically in any improvement in the quality or expansion of services. It is also remarkable though that the Polish economy and the Polish health sector have managed to overcome the critical years without any major dramatic changes, i.e. no resources were extracted from the health sector, and the National Health Fund, operating and financing the system received more funds than would be proportionate according to the economic growth.[53]

52 Online portal of daily news: http://www.rp.pl/artykul/208464,225382-Weto-dla-reformy-zdrowia-.html.
53 Bankier, online news: http://www.bankier.pl/wiadomosc/PO-proponuje-likwidacje-NFZ-1657538.html, Wiadomosci, online news: http://wiadomosci.wp.pl/kat,1342,title,Rzad-pozbywa-sie-odpowiedzialnosci-za-ochrone-zdrowia,wid,13747933,wiadomosc.html.

Health reforms in Portugal

Introduction

Particular attention is being paid in Portugal - a country badly in need of a financial rescue package - to the health sector and to the possible cuts of expenditures in the health sector, especially in view of the necessity of curbing the currently 8.3 percent budget deficit. Actions have already been taken in the recent few years towards improving efficiency and reducing costs but as part of the reconstruction programme further massive resources may be withdrawn from the sector in the coming months in accordance with the conditions prescribed by the European Union and the International Monetary Fund.

The financing of the health sector

According to the Portuguese Constitution of 1976 every citizen of the country is entitled to health which right is guaranteed through the 'universal and general national health service'. According to the original text of the constitution every citizen has free access to the services of the National Health Service (SNS) but this provision was altered as part of a constitution amendment in 1989: according to the text currently in effect the use of the SNS services is only 'typically' free of charge. The centre right PSD which is now in office noted earlier on that in the course of a possible next Constitution amendment even the text referring to the 'typically free of charge' availability of the health services should also be deleted and should be replaced by that 'nobody my be denied access to the service for financial reasons', but such type of modification of the Constitution is not very likely, for lack of adequate support.

Today's Portuguese health insurance system is comprised of three elements: a state health insurance system functioning through the National Health Service and applying to all, the health insurance sub-systems still maintained by certain trades, with state support, as well as a market-based voluntary private insurance system which, rather than being an alternative to the above two elements, offers only supplementary services and higher standard service provision. As a consequence of the parallel functioning of the systems some people may be covered by up to three or even four insurance contracts, including the state-run scheme, the insurance system of his or her spouse's trade organisation as well as the voluntary private insurance.

Most of the revenues of the public health insurance system are derived from the public budget through tax revenues, while the rest is made up of the fees payable by patients using the health services and by premiums paid under voluntary private health insurance contracts. Health contributions are paid only by the members of the health insurance sub-systems in their respective sub-systems: there is no contribution payment obligation applying to all in the public health insurance system.

The proportion of health spending to GDP has been growing steadily during recent decades, and consequently today nearly twice as much is spent in Portugal on health as had

been back in the eighties, though the rate of growth has declined during the recent years, indeed, some decrease has also been observed. In 2008 the total amount of health spending was EUR 17.287 billion or approx. 10 percent of GDP. The per-capita health expenditure was EUR 1,627.4. Some 65 percent of the aggregate health spending is covered by the state budget, corresponding to the ratio in place some 20-30 years ago. While however, it accounted for some 3.6 percent of GDP in the eighties, in the 2000s it equalled more than 7 percent of GDP, imposing twice as heavy a burden on the public finance system. The measures introduced in recent years to curb public spending have resulted in decreases of several percentage points year after year, while the ratio of private spending - primarily as a result of the increases in the 'visit fees' and the rising prices of medicines - has been growing steadily.[54]

Year	Total spending as a percentage of GDP	Public spending ratio (%)
1980	5.6	64.5
1990	6.2	65.5
2000	9.3	66.0
2001	9.3	70.9
2002	9.3	71.5
2003	9.8	71.9
2004	10.1	70.8
2005	10.4	70.5
2006	10.1	65.7
2007	10.0	65.5
2008	10.1	64.3

Table 1: Proportion ofhealth spending

The actions aimed at withdrawing funds from the sector have become increasingly urgent since the time of the deepening of the financial and economic crisis, and owing to the need for resolving the problems of the public finance system emphasis has been shifted on reforms offering quick results, though owing to the ageing of the population the guaranteeing of the possibility of sustainable financing of the health system in the long run is also among the most important goals of the sector's policies.

54 OECD and Eurostat data: http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT, Portuguese Statistical Office: http://www.ine.pt/ngt_server/attachfileu.jsp?look_parentBoui=102614273&att_display=n&att_download=y, Ministry of Health, report of the Commission on Financing SNS: http://www.portaldasaude.pt/NR/rdonlyres/050CB0A2-7ACC-4975-A1E4-4312A1FBE12D/0/RelatorioFinalComissaoSustentabilidadeFinanciamentoSNS.pdf.

The health reforms introduced in recent years

During the first years of its term in office between 2005 and the summer of 2011 the socialist Sócrates cabinet adopted major reforms in the health sector to cut public spending as a result of which the National Health Service closed year 2006 with a EUR 104 million sufficit - equalling nearly 0.1 percent of GDP[55]. The most important measure - the one that triggered the most incensed response from society - involved rationalisation of the health care system in the framework of which about a third of the gynaecologist departments were closed with reference to low levels of capacity utilisation and stand-by services were closed in a large number of villages. At the same time, the number of overtime hours that could be undertaken by doctors was reduced along with the overtime rates: the competent minister explained these measures by pointing out that 'by concentrating services it may be made sure that a sufficient number of doctors are available in every hospital and there is no need for so much overtime work'[56]. According to the cabinet's estimates the reorganisations saved EUR 486 million by cutting 5 percent off the total spending. Further reductions in the sector's expenditures resulted from austerity measures in drug financing as well, whereby - according to the cabinet's estimates - some EUR 300 million - or 0.2 percent of GDP - a year could be saved by the state.

On the expenditures side the Sócrates cabinet increased the visit fee by 23 percent first and then by smaller rates a few more times which has, since 2005, increased to nearly twice the original amount in some cases and which amounts to between EUR 2.25 and EUR 9.6 depending on the time and location of service provision. The amount raised from visit fees covers - according to data published by the Health Ministry[57] - about a mere one percent of the expenditures of the National Health System but the Sócrates cabinet always considered it important to maintain this type of contribution and to raise its amount in order to reduce the number of unnecessary visits at the doctor's office. Two other - quite short-lived - fees were introduced in 2006: a EUR 5 per day hospitalisation fee which was payable for the first 10 days of hospital care, and a EUR 10 contribution payable for ambulant operations. These were discontinued from 1 January 2010 under pressure by the opposition which had gained majority in Parliament after the cabinet's admission that they had failed to meet the expectations as only a disproportionately small income was derived from them.

No new fees or contributions were introduced thereafter despite a number of proposals made from time to time along this line. The most recent such proposal was made in early 2011 for the introduction of a 'health tax' should it be necessitated by the position of the public finance system by the expert committee scrutinising the existing financing model of the system. According to the proposal the National Health Service should be financed by mandatory income-based contributions besides the funds provided by the state budget. The minister then in office did not rule out the possibility of the introduction of such a con-

55 Website of the Portuguese Parliament, Stabilization and Growth Programme: http://www.parlamento.pt/OrcamentoEstado/Documents/pec/pec2007-2011.pdf.

56 Jornal de Noticias, online news: http://www.jn.pt/paginainicial/interior.aspx?content_id=549933.

57 Ministry of Health, report of the Commission on Financing SNS: http://www.portaldasaude.pt/NR/rdonlyres/050CB0A2-7ACC-4975-A1E4-4312A1FBE12D/0/RelatorioFinalComissaoSustentabilidadeFinanciamentoSNS.pdf.

tribution either but the issue was thereafter dropped. Instead, the Sócrates cabinet planned, as a short term measure, to set the amount of the visit fee in accordance with the income position of the citizen concerned in order to create a system in which the citizens 'using health services irresponsibly extensively' who can pay for such services should pay more for the services they use while those in need should be exempted from the obligation to pay fees.[58] No such system was introduced eventually during the term of the Sócrates cabinet but the plans of the centre-right cabinet which took office in June 2011 includes - as will be described below - the introduction of some similar measure.

The current reforms and further steps

The agreement of 17 May 2011 on the conditions of the financial rescue package for Portugal[59] set out a goal of significantly reducing the general government deficit by 'high quality, durable measures affecting vulnerable social groups the least'. According to the section on the health care system Portugal must achieve an EUR 550 million (0.3 percent of GDP) and an EUR 375 million (0.2 percent of GDP) spending cut in 2012 and in 2013, respectively, in the health care sector. Accordingly, the austerity measures to be executed in the health sector would account for a tenth of the total budgetary spending cut as according to the agreement Portugal must achieve an adjustment of 3 percent of GDP in all policy sectors in 2012, to be followed by a 1.9 percent adjustment in 2013.

According to the above agreement the state must achieve savings by - besides improving efficiency and effectiveness in the health sector - reducing public spending on drugs to 1.25 percent of GDP by end-2012 and to about 1 percent of GDP in 2013 and by cutting the operating costs of hospitals by at least EUR 200 million particularly in view of the fact that the amounts spent on hospital s may seriously impede the cutting of the general government deficit at an acceptable rate according to analysts.

Among the concrete requirements the agreement points out that in order to reform the health care system the government should review and revise the visit fee system before the end of 2011 by contracting the range of exemptions and by increasing the amount of the visit fee; it should substantially (by two thirds, on the whole) reduce the tax allowances relating to health services, including those relating to private insurance schemes; and by cutting the budgetary appropriations separated for the health insurance sub-systems in the public sector by 30 percent in 2012 and later on by another 20 percent, continuing to cut these appropriations until the sub-systems become self-sufficient, where they can finance themselves from employer and employee contributions without budgetary funds. Moreover, the government must take steps to promote the use of generic drugs and must monitor the prescription patterns of every doctor, introducing sanctions to those failing to comply with the guidelines. The September 2001 updated version of the agreement[60] contains

58 Economico, online news: http://diarioeconomico.sapo.pt/edicion/diarioeconomico/edicion_impresa/economia/pt/desarrollo/727126.html.

59 Memorandum of understanding specific economic policy conditionality: http://www.jornaldenegocios.pt/archivos/2011_05/memorando.pdf.

60 Memorandum of understanding specific economic policy conditionality: http://www.portugal.gov.pt/pt/GC19/Documentos/PCM/1R_MoU_20110901.pdf.

further restrictions such as that the spending on doctors' overtime work must be cut by at least 20 percent a year through a flexible working time schedule.

The centre-right cabinet headed by Pedro Passos Coelho embarked on the execution of the measures in September 2011. In the first step it made a resolution on adjusting the amount of the visit fee once every year in the future and on extending the range of those under obligation to pay this fee. The cabinet expects a EUR 400 million additional annual revenue from this measure. On the expenditures side they introduced a new pricing system in order to achieve a general reduction in drug prices and thereby to cut public spending on medicines. Moreover, the health ministry placed an obligation on hospitals to cut their operating costs by 11 percent - a smaller rate of spending cut is permitted only for institutions with an adequately balanced budget.

In addition to the steps prescribed by the European Union and the International Monetary Fund the cabinet is taking further cost cutting actions. In September 2011 the Health Ministry issued a decree prohibiting state hospitals and clinics to hire new doctors or nurses or to prolong their expiring contracts. Exceptions may be permitted only by the minister personally and hospital managers failing to comply may even be sacked. The goal of this measure, according to the ministry, is 'not to save money but to prevent spending increases and to reduce waste without affecting the quality and accessibility of the services'[61].

Besides the government, professionals working in the sector also make proposals for improving the financing of the health sector. One of the most recent such proposals was made by the Portuguese medical chamber for the introduction of a 'hamburger tax', pointing out that the crisis offers a good opportunity for the introduction of new tax types that can - besides securing additional income - contribute to the improvement of the health status of the population and to the reduction of drug consumption. This proposal however, failed to attract the ministry's and the parliamentary parties' support, thus the issue of the hamburger tax was dropped from the agenda.

The next measures to be taken by the government may however, include a significant increase of the hospital visit fees. According to news disclosed in late September[62] the amount of the fees payable in hospitals' special clinics may grow even up to a third of the costs incurred, i.e. the amount currently paid to hospitals' standby services may increase from the currently payable EUR 9.60 to as high as EUR 49 from which however, exemption may be granted to low income patients. This radical charge increase would be in line with the ideas elaborated in a volume of essays published in 2010 by Prime Minister Pedro Passos Coelho[63] according to which the costs of health services must be increasingly charged on to the patients in exchange for which the tax burdens should be eased. The Prime Minister, intending to reduce the role played by the state, argues that problems cannot be solved

61 Economico, online news: http://economico.sapo.pt/noticias/hospitais-proibidos-de-contratar-medicos-e-enfermeiros_126778.html.

62 Journal de Noticia, online news: http://www.jn.pt/PaginaInicial/Nacional/Interior.aspx?content_id=2027213&page=-1.

63 Homepage of Passos Coelho Mudar: http://www.passoscoelho-mudar.com/index.php, Informacio, online news: http://www1.ionline.pt/conteudo/42550-passos-coelho-defende-gestao-privada-pequenos-e-medios-hospitais.

merely by improving efficiency, therefore the private sector must be gradually involved in the running of the health care system in the long run and competition needs to be intensified in the sector. At the same time, more money must be left with people so that they can spend on their health care as they wish making sure however, that health services remain 'typically free' for low income citizens. These ideas however, cannot be expected to be fully implemented in the near future in view of the current deep economic crisis: in regard to the tight schedule set out on the agreement on the conditions of the financial rescue package what the next months will see is continuous implementation of the actions prescribed in the agreement.

Summary

The maintenance of its health care system - which is declared to be free for the population - has been imposing an increasing burden on Portuguese public finances. Although a series of actions have been taken since the mid 2000s to improve efficiency and the conditions of financing, these measures have not typically amounted to a profound restructuring, instead, they were aimed at improving the current position of the public finance system and at achieving immediate cuts in public spending. These trends are still evident in the course of the implementation of the Portuguese restructuring programme, when the primary goals include stabilisation of financing in the short run and keeping the health spending at a constant ratio of GDP. The issues of financing in the longer term may come under the limelight again after the resolving of the public finance problems.

Health Reforms in Spain

Introduction

In Spain, health spending was growing during most of the past decade but this trend was slowed down and then brought to an end by the economic crisis of 2008. The central government is using its best efforts to keep up the level of the health sector's funding despite the severe restrictions it has been forced to introduce in other sectors (public servant wages, pensions, other social allowances). The manoeuvring room of the central government is, however, rather limited as the financing of the health sector had been nearly fully transferred into the competency of the budgets of the provinces by 2009. In 2009 some 90 percent of the funding of the public health services came from the provinces while the central budget contributed some 7 percent to the expenditures.[64] Accordingly, the debt problems and budget deficits of the provinces in the wake of the crisis are having a major negative impact on health spending as well. The provinces however, had not adopted economic policies based on savings and financial austerity until the overwhelming victory of the political right in the provincial elections. The actual amounts or rates of the funds to be withdrawn from the sector as urged by the leaderships of the provinces cannot be predicted for the time being. Projections are still complicated by the congress election brought forward to the end of November as the health sector had become one of the key terrains of political skirmishes in the election campaign.

The following paragraphs of this analysis provide a description of the changes of health financing during the decades of democracy, along with the regulatory background of financing. The second part will outline the trend of increase in health spending and its end brought about by the crisis, on the basis of data on the past decade. The last section focuses on the difficulties of financing by the provinces and the responses to those difficulties.

The political and legislative background of health financing in Spain

The decentralisation of the organisation and infrastructure of the health sector in Spain was a process that took some 20 years and was closed in the early 2000s. It was carried out in parallel with the federalisation process in Spain in the course of which the provinces were allowed to take on an increasingly wide range of powers together with funds which they could utilise and distribute in accordance with the provincial budgets. Accordingly, besides the decentralisation of the organisation of the health sector the financing of the system is also part of the provincial budgets.

The Constitution adopted in 1978 assigns - besides other responsibilities - the raising and management of the budgets of the health services as well as the statutory regulation of drug distribution to the scope of powers of the provinces.[65] According to the normative

64 Sistema Nacional de Salud, Espana 2010: http://www.msc.es/organizacion/sns/docs/sns2010/Principal.pdf.
65 Chapter VIII, Article 149 1.16.

regulation comprised in the constitution the provincial health centres and the system of provincial health services were organised and developed from the early eighties on. By the end of the eighties the autonomous provinces of Catalonia, Andalusia, Basque Country and Valencia created their own health infrastructures. These provinces account for a substantial part of the population of Spain and thus the health service coverage took up a dual nature in that half of the population was catered for by the system financed by the provinces while the other half was provided for by the central health service (INSALUD) and the central budget. A standard framework for this mixed system was created by the 14/1986 General Health Act (Sistema Nacional de Salud, SNS), which provided for the universality of the citizens' right to health and which created the coordinating/reconciling organisation (Consejo Interterritorial del Sistema Nacional del Salud, CISNS). In this way the act brought about a suitable environment for further decentralisation.

By the early 2000s health financing had, for the most part, been transferred into the provinces' scopes of competence.[66] It was in awareness of this fact that the Congress - dominated by the popular party's majority - adopted the act on the cohesion and quality of the National Health System. The act laid particular attention in regard to cohesion on the coordinating role of the CISNS, improving the flows of information and the coordination of health services. Article 10 of the act[67] assigns the task of health financing to the provincial governments in accordance with the transfer of the function from the state to the provinces and as the function is integrated in the various provinces' budget regimes. Each province must file a report in advance on the possibilities of funding, which are sufficient for the maintenance of the services at the quality standards prescribed by the law. The burden of the new services approved in the SNS can be transferred to the budgets only to the extent to which a preliminary impact assessment is worked out of their budgetary implications.

The two decades of decentralisation and the reforms of the health system have resulted in a complicated financing system. The bulk of the health services are, on the one hand, paid for not in the form of state financing, but by direct (out-of-pocket) payments for the most part (22.5 percent) and a smaller proportion is paid for by private insurers. The public sector (central budget, provinces, cities etc.) bears 71 percent of th costs.[68]

Nearly the total cost (94 percent) of the health services is financed by the public sector from the tax revenues while the remaining part is collected in the form of contributions. The provincial governments are the most important participants of the public sector, financing the public health services through the provincial health service organisations and at the same time contributing to the maintenance of pharmacies, private hospitals and private practices as well. Support from the central budget is provided on the one hand to health institutions directly and on the other hand the organisation called INGESA, organising the health services of the towns of Ceuta and Melilla is provided with funding for its operations. Three national special health fund institutions are also provided direct support from the central budget. The contributions supplementing the tax revenues are transferred

66 Castile and León was the last province to regulate the functioning of its healthy system in a decree in 2001.
67 Ley 16/2003 de cohesión y calidad de Sistema nacional de Salud, Articulo 10: http://www.boe.es/boe/dias/2003/05/29/pdfs/A20567-20588.pdf.
68 Decentralisation of the health sector in Spain: www.eski.hu/hol/cikkh.cgi?id=2656.

in full to the above mentioned health funds. Finally, the central budget makes transfers to the provinces as well.

The third pillar of the public health system is made up - besides state and province financing - of the contributions paid by local companies and ventures, supporting public health services and public hospitals.

According to the year-2010 budget appropriations the provinces' health budget amounted to EUR 58.96 billion. The central budget's transfer amounted to EUR 4.68 billion while local businesses contributed somewhat more than EUR 1 billion to the total costs. The grand total included besides the above an amount of EUR 1.8 billion that could be called from the social security fund along with EUR 2 billion paid to the system in the way of contributions.[69]

Public health expenditure

The state's health expenditures have been increasing during the past decade. This trend definitely prevailed until 2009, the year on which the latest figures are available. In 2003 the total expenditure of the public health system amounted to EUR 42.95 billion, in 2004 it was EUR 46.34 billion, in 2005 it was EUR 50.58 billion, in 2006 it amounted to 55.68 billion while in 2007, 2008 and 2009 the corresponding figures were 60.22 billion, 66.62 billion and 69.84 billion. The increase in the health expenditures of the state is indicated by the following chart covering the 2003-2009 period[70]:

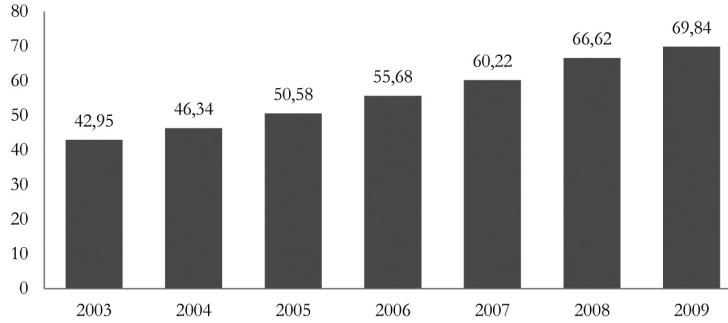


Table 1: Increase in public spending in EUR billion

The rate of growth was in the range of 8-10 percent year after year between 2003 and 2007. The rate of increase slowed down to below 6 percent between 2007 and 2008. The rates of increase in public spending are illustrated in the following chart[71] for the period between 2004 and 2009:

69 Data on the basis of Sistema Nacional de Salud, Espana 2010 published by the Ministry of Health, Social Policy and Equal Opportunities: http://www.msc.es/organizacion/sns/docs/sns2010/Principal.pdf.

70 Ministerio de Sanidad, Política Social e Igualidad, Diferentes Series de Gasto Sanitario, p. 7.: http://www.msc.es/estadEstudios/estadisticas/sisInfSanSNS/finGastoSanit.htm.

71 Ministerio de Sanidad, Política Social e Igualidad, Serie 2002-2009 (Gasto sanitario publicó según criterio de devengo: Gasto real), Table 1: http://www.msc.es/estadEstudios/estadisticas/inforRecopilaciones/gastoSanitario2005/home.htm.

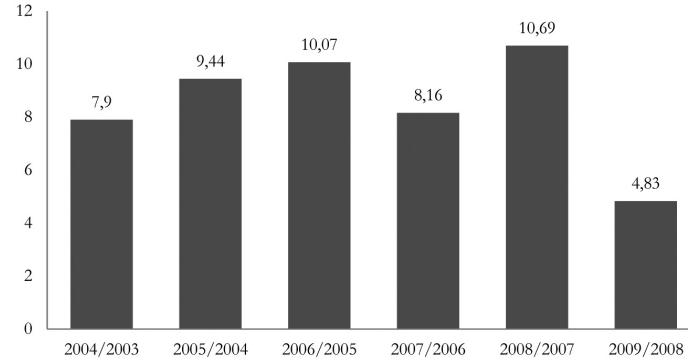


Table 2: Increase in public spending (percentage)

A similar growth trend was shown by the amount of the total cost of health services, that is the total of public funding and private (out-of-pocket, private pension funds) contributions: in 2003 it was EUR 58.88 billion, in 2004 it amounted to EUR 63.44 billion, in 2005 it was EUR 68.99 billion, in 2006 it amounted to EUR 75.32 billion while in 2007, 2008 and 2009 it totalled at EUR 81.39 billion, EUR 88.71 billion and EUR 91.43 billion, respectively. The growth in the total spending of the public and private sector is illustrated by the following figure[72]:

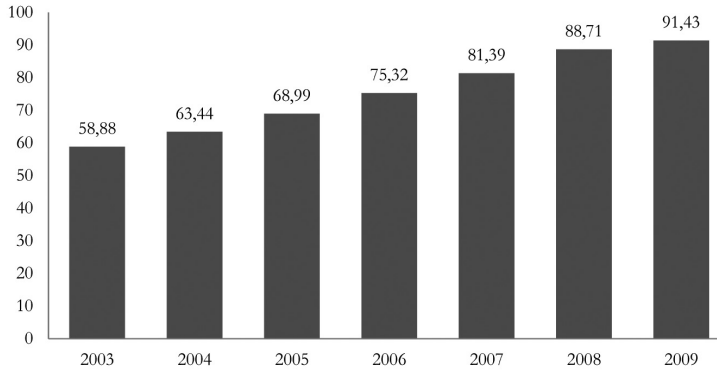


Table 3: Growth in total health spending in EUR billion

Although the rate of the growth of public financing dropped in 2008, which resulted in a slow-down of the increase of the expenditures in terms of the total health spending as well. The annual spending as a percentage of GDP increased lightly which showed a rather steep curve between 2007 and 2008, primarily as a result of the slump in construction, the main driving sector of the Spanish economy, which resulted in a stagnating GDP. At the

72 Ministerio de Sanidad, Política Social e Igualidad, Diferentes Series de Gasto Sanitario, p. 7.: http://www.msc.es/estadEstudios/estadisticas/sisInfSanSNS/finGastoSanit.htm.

same time, total of public spending did not follow the downward economic trend and this explains the growth in the ratio of spending. Public financing accounted for 5.5 percent of GDP in 2003, 5.6 percent in 2005, 5.7 percent in 2006, 5.7 percent in 2007, 6.1 percent in 2008 and 6.6 percent in the last year. The trend of public health spending between 2003 and 2009 as a percentage of GDP is illustrated by the following chart[73]:

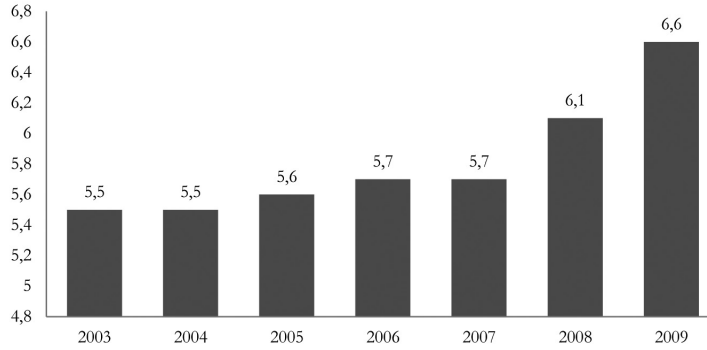


Table 4: Public health spending as a percentage of GDP

A similar trend was shown by the amount of total health spending relative to GDP and its changes during the past years. In 2003 and 2004 the amount spent on health in Spain equalled 7.5 percent of GDP, it was 7.6 percent in 2005, 7.7 percent in 2006 and 2007, 8.2 percent in 2008 and 8.7 percent in 2009. The trend of the total - public and private - health spending in Spain relative to the GDP figures between 2003 and 2009 is indicated in the following figure[74]:

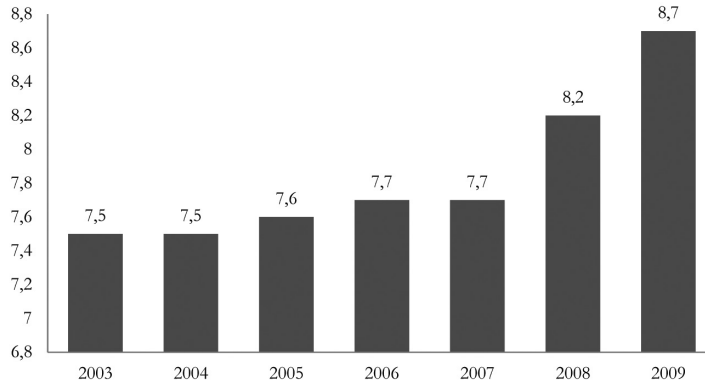


Table 5: Health spending as a percentage of GDP

73 Ministerio de Sanidad, Política Social e Igualidad, Diferentes Series de Gasto Sanitario, p. 8.: http://www.msc.es/estadEstudios/estadisticas/sisInfSanSNS/finGastoSanit.htm.
74 The same as above.

According to year-2006 figures published by WHO[75] Spain was in the 26th position in terms of the (total, not only public) health spending relative to the annual GDP figure, ahead of Portugal and New Zealand but behind Italy and Greece. The year-2007 OECD survey[76] found Spain to be at the 21st position in the same ranking, again ahead of the Portuguese but behind Italy and Greece.

Economic crisis and the problems of financing by the provinces

Since the provincial governments are the most important sources of financing of the Spanish health sector, the economic crisis of the provinces and their budget imbalance have an impact on the operation and budgets of the health system in Spain as a whole.

For this reason, any decision on savings in the health sector requires the consent of the governing bodies of the provinces. In 2010 the ministry headed at that time by Trinidad Jiméneze elaborated a cost cutting plan which it consulted and reconciled with the provinces. The essence of the state-induced savings programme was that the drug price subsidies for private individuals, hospitals etc. would be reduced, saving EUR 1.5 billion a year for the central and provincial budgets.[77]

The savings are becoming important for the provinces as well. In the wake of the local and provincial elections in 2011 the provincial governments also had to face an accumulation of debt on the provincial level. The President of the National Bank of Spain, international analysts and credit rating institutions had been making attempts even earlier to draw attention to the problem of the indebtedness of the provinces.

By October 2010 the total debt of the provinces had increased to EUR 104 billion, or up to 9.9 percent of the annual GDP of Spain and 17.4 percent of the total debt of the country.[78] In the course of the summer of 2011 a daily paper of the political left called El País drew attention to the record debt of the provinces - referring to data published by the National Bank - which had grown to 11.4 percent of the annual GDP. In the course of the summer the total provincial debt portfolio had increased to EUR 121 billion.[79]

Stopping the continued expansion of the total debt portfolio took a large scale austerity programme on the part of the previous and the new provincial leaderships. In Catalonia, where after the provincial elections in November 2010 the Christian Democratic Convergence and Union (CiU) replaced the left-of-centre tripartite coalition a programme had already been launched earlier on with the aim of curbing costs.

75 World Health Statistics, 2009. WHO: http://www.who.int/whosis/whostat/2009/en/index.html
76 OECD Health Data, 2009: http://www.oecd.org/document/16/0,3343, en_2649_34631_2085200_1_1_1_1,00.html.
77 María R. Sahuquillo: Sanidad y communidades acuerdan un paquete de medidas para recortar el gasto, El País. 2010. 03.18.: http://www.elpais.com/articulo/sociedad/Sanidad/comunidades/acuerdan/paquete/medidas/recortar/gasto/sanitario/elpepusoc/20100318elpepusoc_15/Tes.
78 Fernando Faces: La explósion de la deuda autonómica, Expansión, 2010.10.13.: http://www.expansion.com/2010/10/13/opinion/tribunas/1286996671.html?a=7c424fdc70bef59802a38e769f5e3352&t=1317684650
79 La deuda de las communidades marca un récord al subir al 11,4 percent del PIB, El País, 2011. 06.17.: http://www.elpais.com/articulo/economia/deuda/comunidades/marca/record/subir/114/PIB/elpepueco/20110617elpepueco_6/Tes.

The austerity measures adopted by Catalonia in March 2011 set out an aim of saving a billion euros. This amount equals 10 percent of the province's budget. The Catalonian government started the proves by temporary closures of hospital sections and surgery rooms and by suspending services. The most recent proposal was aimed at a dramatic reduction of the bonuses payable before the Christmas of 2011 and making redundant a large number of hospital deputies.[80]

The new leader of the province of Castile - La Mancha, Dolores de Cospedal announced her austerity programme in late August 2011, one of the key elements of which is the withdrawal of EUR 400 million of funding from the health sector. The provincial cabined headed by Cospedal is planning to achieve this by selling hospital sections and equipment or by leasing them to tenants.[81]

Just like in Catalonia and in Castile - La Mancha, the health sector is heavily affected by the restrictions. Similar austerity measures are expected in Madrid, Galicia, Murcia and Extremadura provinces as well which are intended to be implemented primarily by privatisation or by suspending certain services.[82]

Conclusion

It is difficult to supply data on the scale of the withdrawal of funds from the health sector. The reform of the health system was started somewhat late in Spain, a country which was just as hard hit by the crisis as the other European countries. The provincial governments and the central government have different concepts concerning the health sector. While the government is making efforts to salvage as much as can be and to maintain one of the most important pillars of the welfare state, the provinces have embarked on massive cost cutting programmes which are bound to lead to a temporary deterioration of the standards of services. In the current unstable political situation in view of the 2012 budget and the election results in late November a clearer picture may be drawn of the changes in the financing of the Spanish health system.

80 Ferran Balsells: Los recorted de Mas hacen crear un 23 percent la lista de espera en solo seis meses. El País. 2011.10.03.: http://politica.elpais.com/politica/2011/10/03/actualidad/1317674166_415933.html.
81 Cospedal hará el mayor recorte en los centros sanitarios: 400 milliones. El País, 2011.08.31.: http://politica.elpais.com/politica/2011/08/31/actualidad/1314799206_209348.html.
82 J. Gil- E. Sáiz: Las communidades encaran un recorte de más de 5.000 millónes, el mayor de la história, El País, 2011. 09.29.: http://www.elpais.com/articulo/espana/comunidades/encaran/recorte/5000/millones/mayor/historia/elpepinac/20110929elpepinac_5/Tes.

Part II
Owning and Operating Healthcare Institutes

Owning and operating healthcare institutes in the Czech Republic

In the Czech Republic the provision of healthcare services is based on the principles of solidarity and the equality of access to healthcare services. Czech residents have to join one of the eight state-run health insurers, among which they are, however, free to make their choice. The institution and the general practitioner providing the required health service can also be freely chosen (a patient may change his doctor after 6 months). The system of the ownership and running of health institutions is characterised by a significant participation of local governments and by the multiple funding sources of health institutions, the larger part of which is accounted for by public (compulsory) insurance.[83]

The ownership, running and financing of the health institutions has been one of the most burning issues for quite a few years in the Czech Republic. Problems are encountered in relation to the procurement of new medical equipment as well as to the payment of health employees. The variety of the arrangements applied in the financing of health institutions is illustrated by the fact that the range of organisations involved in the ownership and running of such institutions include the Czech Ministry of Health (Ministerstvo Zdravotnictví), other central bodies, county, town and other local governments, legal and natural persons, churches and other religious denominations. Also, there are both public and non-public health institutions. The key difference between the institutions owned and run by the state and those of other organisations lies in the fact that any profit earned from the operation of the institution is part of its owner's income.[84]

The health care provider system

The system of integrated health institutions fell apart in the early nineties. This radical change was a consequence of the decentralisation of the health care provider system and of rapid privatisation processes. The number of health institution started to grow dramatically from the earlier 300. As many as 27,959 independent health institutions were registered at the end of 2009, of which the number of independent special outpatient care provider institutions and undertakings was 24,236. A total of 261 institutions were owned and run by the state while the number of non-public institutions was 27,698. A total of 163 of the non-public institutions were owned by county governments, 170 by municipal and other local governments and 27,365 institutions were owned by natural or legal persons, economic organisations, churches or other religious denominations.

At the end of 2010, 19,885 of the total of 28,068 registered independent health institutions were providing independent special outpatient health services. The number of

83 ÚZIS (Institute of Health Information and Statistics of the Czeh Republic), Network of health institutes 2010: http://www.uzis.cz/publikace/sit-zdravotnickych-zarizeni-2010.

84 Catalog of stomatologists: http://www.katalog-stomatologu.cz/zajimavosti/55-financovani-zdravotnickych-instituci-a-zarizeni-a-kontrola-hospodareni/.

institutions owned and run by the state was 226 in 2010 which were operating under management by the Ministry of Health (Ministerstvo Zdravotnictví) or other central bodies. 152 of the 27,842 institutions owned and run by entities other than the state were owned by county governments, 170 by municipal and other local governments 27,520 were owned by natural or legal persons, economic organisations, churches or other religious denominations.

According to end-2010 statistics a total of 45,650 doctors worked in the entire sector of health institutions along with nearly 107,200 health employees with other technical/professional qualifications[85]. The average number of residents per doctor was 231 in 2010.

Some 20 percent of all doctors worked in state-financed institutions along with 26 percent of all other health employees. The institutions owned and run by the state accounted for 30 percent of the total number of hospital beds in 2010.

The doctors working in health institutions owned and run by territorial bodies (county, town or village governments) accounted for 10.5 percent of all doctors while the corresponding proportion of other health employees was 16 percent. Institutions under county administration were operating 11 percent of all hospital beds.

The health institutions run by public sector participants - i.e. institutions owned by natural or legal persons, churches or other religious denominations or economic organisations - operated 54 percent of the hospital beds. 70 percent of the doctors and 58 percent of health employees of other categories were working in this private sector.

Primary health care services

Town and village governments are in charge of providing for the primary health services. The category of general practitioners providing primary health services includes doctors taking care of children, adolescents and adults, dentists as well as obstetrician and gynaecologists. Most general practitioners work as private doctors, in more than 13,000 independent doctors' offices. They are paid in accordance with the terms and conditions of contracts concluded with the selected health insurance providers in which the dominant factor is the number of patients taken care of by the doctor concerned.

The distribution of institutions providing primary health services for adults, children and adolescents is adequately balanced in territorial terms. In terms of primary services provided by stomatologists and, particularly, obstetrician and gynaecologists however, there are significant inequalities across different districts. In 2010 the average number of Czech citizens per general practitioner was 1420. The number of patients per doctors is highest in the Central Czech Region where a general practitioner provided for as many as 1681 patients on average. The most favourable ratio was achieved in the capital city Prague, where one general practitioner serves not more than 1231 residents on average.

85 According to Articles 5 and 21 of act 2004/96 the following were included in the category of *employees with non-doctor health or medical qualifications:* general nurses, maternity assistant, occupational therapist, radiological assistant, health laboratory assistant, health social worker, optician, ortoptician, public health protection assistant, those providing orthotic and prosthetic services, nutrition experts, dental technicians, dental hygienic experts, pharmaceutical assistants, biomedical technicians, biotechnical assistants, radiological technicians, addictologists.

The uneven distribution of gynaecologists is indicated by the fact that in the Pardubice district as many as 5349 women are taken care of by a gynaecologist on an average, in contrast to the 2342 Prague and the 3844 national average.

The activities of general practitioners providing primary health care services are supervised by the Czech Medical Chamber.

Special outpatient health services

Specialised outpatient services are provided, for the most part, by private practitioners. They conduct their activities in private practices or in autonomous doctors' offices or in clinics owned by the state or local governments. The health employees assisting the work of the doctors are working either in the given doctors' offices, clinics or in the outpatient departments of hospitals. The fees of the specialised doctors are paid on the basis of a special scoring system depending on the service concerned.

According to 2010 data a total of 71.5 percent of all doctors (32,646 persons) and 51 percent of health employees carrying out other activities (54,558 persons) worked in special outpatient service provision. A total of 43.8 percent of outpatient doctors provide primary health care services (primary services for children, adolescents and adults, stomatology and gynaecology), while 56.2 percent of them work as special doctors taking care of outpatients. Specialised doctors work in about 189 clinics and 6753 autonomous special doctors' offices. The number of residents per outpatient doctor was 323.

A total of 81.4 percent of outpatient health care services were provided for by institutions belonging to the private sector, owned and run by natural or legal persons or church organisations. 13.4 percent of the same category of services were provided by state-owned institutions. 2.9 percent of the outpatient services were provided by institutions owned and run by county governments while 1.9 percent were delivered by institutions owned and run by town or village governments.

Inpatient health services

At the end of 2010 a total of 11,354 doctors and 41,538 other health employees were working in the inpatient segment (not including spas). A total of 79.7 hospital beds were available for 10,000 Czech residents on an average: 59.1 beds in hospitals and 20.7 beds in other specialised medical institutions. A total of 43 percent of the beds were operated in the ownership of private-type institutions.

There is a high level of hospital coverage in the Czech Republic. In 2010 there were 189 hospitals with a total of 62,219 beds, 52,590 of which were used in the provision of emergency services, 2231 beds were reserve for new-born babies and 7398 beds were available for the treatment of patients. In comparison to the figures of year 2009 the number of emergency beds dropped by 2.1 percent while the number of beds available for new-born babies increased by 45. The number of hospital beds available for the treatment of patients had been steadily growing for three years: their number increased by 308 over the number available in the preceding year.[86]

86 ÚZIS, Network of health institutes 2010: http://www.uzis.cz/publikace/sit-zdravotnickych-zarizeni-2010.

According to the latest study published by ÚZIS - summing up statistics on the first half of 2011 - the number of hospital beds had dropped radically despite the fact that the number of hospitals remained unchanged: the number of beds decreased by 685 to 61,534. There are 51,886 beds available for emergency services, which is 704 less than the number recorded one year ago. The number of beds available for new-born babies also dropped, where 2224 beds - 7 beds less than one year before - were available. The treatment of patients is an exception, where the number of available beds increased by 26, to 7424.[87]

Organisation owning/running health institutions	2010				2011 Q1			
	Number of hospitals	Number of beds	Number of beds %	Percentage of utilisation of beds	Number of hospitals	Number of beds	Number of beds %	Percentage of utilisation of beds
Health Ministry	19	17,161	27.6	76.0	19	16,918	27.5	75.9
County Governments	24	9,165	15		24	8,960	14.6	74.6
Town, other local governments	17	3,999	6.4	76.0	17	3,993	6.5	76.7
Legal or natural persons	121	30,479 +churches	48.4		121	29,899	48.6	74.1
Other central bodies	5	1,415	2.3		5	1,419	2.3	74.7
Churches	3		0.6		3	345	0.6	66.2
Total	189	62,219			189	61,534		74.8

Table 1: Hospitals and hospital beds by organisations owning/running hospitals[88]

The economic position of hospitals from the aspect of the organisations owning/running them

The Health Information and Statistics Institution of Prague (Ústavu zdravotnických informací a statistiky České republiky, ÚZIS ČR) has disclosed its latest statistics on the economic position of hospitals, covering the January - July 2011 period.

According to the summarised data the total costs of the 166 hospitals covered by the review amounted to CZK 63.3 billion (EUR 2.54 billion)[89]. In comparison to data on the first half of 2010 shows a 1.5 percent increase in the expenditures. The major items of the expenditure side comprised the amounts spent on wage costs, medicines and medical equipment. The wage costs of hospitals increased by 4 percent between the two periods while their ratio as a percentage of the total cost increased from 43.8 percent to 44.8 percent. The amounts spent

87 ÚZIS, Hospitals in the Czech Republic in the 1st half of 2011: http://www.uzis.cz/rychle-informace/nemocnice-ceske-republice-1-pololeti-2011.

88 ÚZIS, Hospitals in the Czech Republic in the 1st half of 2011: http://www.uzis.cz/rychle-informace/nemocnice-ceske-republice-1-pololeti-2011,
ÚZIS, Network of health institutes 2010: http://www.uzis.cz/publikace/sit-zdravotnickych-zarizeni-2010.

89 EUR/CZK = 24.9675. Eco.hu, Interbank currency rates: http://www.eco.hu/penzpiac/bankkozi/EUR , 05 November 2011.

on drugs increased by 3 percent and accounted for 12.5 percent of the total health expenditure. In comparison to the first half of 2010 the amounts spent on medical equipment and medical aids dropped by 4 percent, at the same time their percentage as a proportion of the total health bill also decreased (to 13.4 percent).

Economic organisations - owned by local governments of counties and towns - make up a significant group within the category of institutions owned and run by legal entities. The 44 commercially run county and town hospitals comprised in the ÚZIS survey booked a total expenditure of CZK 16.38 billion (EUR 656 million), which accounted for 72 percent of the total costs of the hospitals operating in the private sector.

The total revenue of the Czech hospitals amounted to CZK 63.8 billion (EUR 2.56 billion) in the first half of 2011, some 2 percent up on the preceding year's figure. On the whole, the Czech hospitals closed the first half with a positive balance of CZK 507 million (EUR 20.31 million). A total of 43 percent of the hospitals closed the year with a financial loss. The largest amount loss (CZK 198 million or EUR 7.93 million) was stated in the balance sheets of commercially run hospitals of counties and towns.

The hospitals are financed from a variety of sources, the bulk of which continued to be made up by the contribution received from health insurers which accounted for 82.1 percent of the total revenue. The revenues received from sources other than insurers, for health care services provided by hospitals, accounted for a 2.1 percent of the total revenue of hospitals. Such amounts were received in exchange for services provided for foreign citizens, for services provided as a supplement to the standard services, from examinations ordered by companies or factories as well as from regulatory fees. The amount received for products sold accounted for 7.6 percent of the total revenues, while funds from subsidies, grants and donations made up 1.5 percent of the total revenues. Other revenue items included amounts received in exchange for clinical studies, scientific and trading activities and lease arrangements, adding up to 6.7 percent of the total revenues.[90]

Hospitals by type of owner organisation	Number of hospitals	Expenditures (CZK million)	Revenues CZK million)	Balance
Health Ministry	19	29,768	30,478	710
County	24	6,557	6,450	-107
Town or village	17	2,882	2,908	25
Legal person, church	103	22,615	22,679	64
Of which county or town economic organisations	44	16,387	16,188	-198
Other central bodies	3	1482	1,296	-186
Total	166	63,304	63,811	507

Table 2: Hospitals' expenditures, revenues and financial balance in a breakdown by type of owner/operator (data as of 30.06.2011)[91]

90 Economical results of hospitals in the Czech Republic as of 30. 6. 2011: http://www.uzis.cz/rychle-informace/ekonomicke-vysledky-nemocnic-30-6-2011.

91 ÚZIS, Economical results of hospitals in the Czech Republic as of 30. 6. 2011: http://www.uzis.cz/rychle-informace/ekonomicke-vysledky-nemocnic-30-6-2011.

Other health institutions

Other health institutions include the various specialised medical institutions (e.g. institutions focusing on preventive or rehabilitation services, psychiatric institutions, sanatoriums), spas, special health institutions (infants' and children's homes, nursing homes for children and adults, crèches, ambulance and patient transport services), institutions supplying the sector (pharmacies and those trading in medical aids) as well as health protection bodies.

The number of beds operated by the above institutions decreased in 2010 has had been observed in preceding years as well. The 157 priority specialised medical institutions had a total of 21,764 beds. Psychiatric institutions provided 43 % of the beds while the institutions taking care of patients with chronic conditions operated 33 % of the total number of beds. The largest decrease in the number of beds was recorded in the institutions providing services for patients suffering from chronic illnesses (minus 149 beds) and from those suffering from TB and other respiratory diseases (minus 20 beds).[92]

Inpatient care services are supplemented by those provided by - nearly fully privately owned - spas with 26,432 beds. The number of beds decreased (by 73) in spas as well in comparison to the number recorded in 2009. In 2010 a total of about 376,000 patients were treated in spas in the Czech Republic, 253,767 of whom - including foreign citizens - used spa services at their own expense while health insurers contributed to the expenses of 122,099 patients. Health insurers paid CZK 3 203 (EUR 128.29) for this form of health care service.[93]

In regard to infants' homes the Czech Minister of Social Affairs and Employment Policy announced some radical changes. According to the recent plans the currently existing 34 institutions would be closed by the end of 2013 and infants would be transferred directly to individual caregivers. The restrictions would apply only to infants below the age of three by 2013 but from 2017 on even children below the age of 7 would not be allowed to be transferred to institutions.[94]

A total of 2 368 pharmacies were registered up to the end of 2010. The number of institutions distributing medical aids was 240. The average number of residents per pharmacy was 4,006. The network of pharmacies does not provide an evenly distributed coverage, higher densities are typically found in larger towns.

The figures in the following table illustrate that in the Czech Republic a significant proportion of other health institutions are owned and run by entities other than the state, such as county, town or village governments, natural or legal persons, churches or other religious denominations or economic organisations.

83 of the total of 157 health institutions providing various special health care services are owned and run by natural or legal persons or by churches or other religious denominations. An even higher proportion is observed among special health institutions (253)

92 ÚZIS, Network of health institutes 2010: http://www.uzis.cz/publikace/sit-zdravotnickych-zarizeni-2010.
93 ÚZIS, Health service as a part of national economy 2010: http://www.uzis.cz/publikace/zdravotnictvi-soucast-narodni-ekonomiky-2010.
94 Ihned.cz, online news: http://zpravy.ihned.cz/cesko-zdravotnictvi/c1-52668220-kojenecke-ustavy-budou-zruseny-individualni-pece-bude-levnejsi-mini-drabek.

or spas (75). Some 99 percent of pharmacies are privately owned and run. (Similarly to pharmacies, some 95 percent of dentists' and outpatient doctors' offices are also privately owned and run.)

Type of institution	MoH	Counties	Towns, villages	Legal or natural persons, churches	Central bodies
Specialised institutions	26	34	11	83	3
- chronic patients	5	14	8	42	1
- TB and respiratory conditions	2	4	1	2	X
- psychiatry – for adults	13	2	X	2	X
- rehabilitation – for adults	2	2	X	1	1
- psychiatry – for children	3	X	X	X	X
- hospice	X	X	X	15	X
- health institutes and sanatoriums (day)	X	5	X	2	X
- other - adults	1	3	2	7+9 (bed)	1 (bed)
- other - children	X	4	X	3	X
Spas	6	X	1	75	4
- for adults	5	X	1	75	4
- for children	1	X	X	X	X
Special health institutions	9	54	73	253	2
- infants' and children's homes	2	25	4	2	X
- crèches and other, for children	X	X	44	2	X
- caregiver homes – children	X	3	18	10	X
- caregiver homes - adults	5	4	1	24	X
- other special	2	5	3	10	1
- ambulance, patient transport	X	17	3	205	1
Supply institutions	24	22	9	2.516	4
- pharmacies	23	21	8	2.312	4
- medical aids	1	1	1	204	X
Health protection bodies	29	X	X	X	2
Other	9	X	3	37	X

Table 3: Other health institutions in a breakdown by owners/operators[95]

95 ÚZIS, Network of health institutes 2010: http://www.uzis.cz/publikace/sit-zdravotnickych-zarizeni-2010.

Owning and operating healthcare institutes in France

The health institutions operating in France fall into three large categories: public institutions, non-profit private institutions run mostly by religious or charity organisations and for-profit private institutions. Some of the non-profit private institutions participate in public hospital care provision under contracts concluded with the state: these are referred to as so-called PSPH[96] places.

According to the currently available latest - 31 December 2008 - figures[97] 983 of the total of 2,784 registered health institutions were public institution (35.3 percent), 754 non-profit private institutions (27.1 percent), (including 539 PSPH-places - 12.9 percent), along with 1,047 for-profit private institutions (37.6 percent). In the public institutions there are a total of 284,140 beds (64.6 percent) and 37,705 hospital places (61 percent)[98], non-profit private institutions have 61,432 beds (13.96 percent) and 10,511 places (18.0 percent) while for-profit institutions have 94.855 beds (21.6 percent) and 12,313 places (21.0 percent), i.e. there are a total of 440,027 hospital beds and 58,529 places available across the territory of France. As a consequence of the health financing reform introduced in recent years in France - to be detailed below - the participation of the private sector in the institutions is shrinking: a total of 449 private institutions have been closed since 1997.

The public institution hierarchy and competences

The top of the public institutions' hierarchy is formed of a total of 31 regional hospital centres and university hospital centres. The 511 simple Hospital Centres forming the level below them makes up the backbone of the public service providing system. There are 90 psychiatric hospital centres on the same level of the hierarchy, below which there are the so-called local hospitals, engaged primarily in social duties, including, among other tasks, caregiving for the elderly.

According to the health act in force public institutions 'qualify as legal persons with public administration and financial autonomy, under state supervision'[99]. The scope of

96 Based on the acronym formed of the definition: 'participant au service public hospitalier'. The introduction to the 2010 summary (see: http://www.sante.gouv.fr/IMG/pdf/etabsante2010.pdf). Otherwise the 2010 public health reform did not distinguish between non-profit private hospitals and PSPH-places, instead, it took both in the category of private institutions operating in the interest of the public (cf.: 44.), but in the year 2008 tables used by the text and presented herein as well the two types of institutions are still separately presented.

97 See the same source, particularly the two tables on page 55.

98 The hospital beds need to be distinguished from hospital places in order to make it possible to simultaneously analyse exclusively daytime institutions together with the 'full time inpatient' hospitals.

99 See Article 1 of Act L6141: http://www.legifrance.gouv.fr/affichCode.do?cidTexte=LEGITEXT000006072665&dateTexte=20111107.

competence of the hospital centres that are under state supervision however - as the Article continues - 'may be local governmental, inter-local governmental, county, regional, inter-regional or nationwide'. At the same time, the practical organisation of the operation of the health institutions takes place at a regional level by the regional health offices which coordinate the state-run and the PSPH institutions and through the so-called regional health plan and the regional draft of the organisation of the provision of health services they also integrate outpatient services in the system. Their scopes of competence apply to medical-social institutions. The regional health office integrates a number of institutions that used to carry out coordination tasks on their own earlier on and it organises the provision of services at the level of 27 regions, fully eliminating the earlier significant county level. The work of the director of the regional health office is controlled by a supervisory board of 30 members, including state officials and representatives of health insurers and various patient organisations. This body approves the budget submitted by the director, comments on the health strategy, supervises the observance of the rights of the users of the health system and those of patients, and whether access to health services is provided in accordance with the principle of equal opportunities. Moreover, it organises debates and consultations and it conducts prevention campaigns.

The work of hospitals - organised on a regional basis - is assisted by three central institutions, including the hospital association that has been carrying out tasks of interest representation and reconciliation ever since 1924, an state organisation coordinating and auditing institutional developments, real estate development projects, IT system development projects, called ANAP[100], and CNG[101], which is an administrative public institution subordinated to the Ministry of Health providing for the availability of the total of about 42,000 doctors and 5,000 institution managers by centralised competitions.[102]

The organisation structure of hospitals

As was noted above, the existing French hospital system was profoundly changed by the comprehensive health reform adopted in the summer of 2009, that is by the act entitled 'Hospital, patient, health, territories' - also referred to as Bachelot Act after the Minister of Health in office at the time[103]. The reform transformed the management and supervision system of the public institutions. A supervisory board was set up for every single institution instead of the earlier administration council, the 12-15 members of which are controlling the operation of the institution, organised in five colleges. The members of the body include the representative of the local government that has competence in

100 Agence Nationale d'Appui à la Performance des établissements de santé et médico-sociaux: www.anap.fr
101 Centre National de Gestion des Praticiens Hospitaliers et des Personnels de Direction de la Fonction Publique Hospitalière: www.cng.sante.fr.
102 It does not closely belong to our topic but in relation to the CNG it should be noted that France is facing a shortage of doctors, involving 22.3 % of full time positions and 37.2 % of part time positions (Cf. the data disclosed on the CNG homepage: http://www.cng.sante.fr/IMG/pdf/Statistiques_PH_JANV2010_.pdf).
103 For the ministry's materials relating to the act see: http://www.sante.gouv.fr/la-loi-hopital-patients-sante-et-territoires.html, the more detailed summary underlying our paper as well, is accessible at: http://www.sante.gouv.fr/IMG/pdf/vademecum_loi_HPST.pdf .

regard to the hospital (where there are more than one such local governments, the one from which the largest number of patients come), or a member of the council of that municipal government, some representatives of the doctors and other hospital employees, along with two persons delegated by the regional health office and three individuals nominated by the county prefect. The head of the regional health office participates in the work of the supervisory board with a consulting right along with the chairman of the institution's doctor interest representing body (CME). The board expresses its standpoint on the institution's strategy and it continuously monitors financial management on which it prepares regular reports to the regional health office. Moreover, the board can institute inquiries at any time and may call for the required documents and it also forms its standpoints on the most important decisions of the institution.

The directorate assists the director of the institution in managing economic affairs and in the management of the institution itself, it has at least 7 members, each an employee of the institution. It is chaired by the director himself, the chairman of the CME is the deputy chairman of the directorate - the 'second man' in the institution - taking care of the medical related issues and making proposals for the heads of departments to be appointed. The deputy chairman may organise internal evaluations, he supervises the execution of security and quality development projects and he submits the CME's action plan to the director of the institution. The head of the nursing committee is a member of the directorate *'ex officio'*. The other members are appointed by the director after informing the supervisory board. The director must consult the directorate on most issues relating to the management of the institution.

The scope of powers of the director heading the institution was significantly strengthened by the 2009 reform. He has the right to appoint, he can employ freelance doctors under contracts and after consultation with the head of the CME (but, in case of differences between their opinions, without having to take the latter's opinion into account on a mandatory basis!) he forms the institution's internal hierarchy. The director - who, in contrast to the earlier practice, does not need to hold diploma from a certain French health management college - if he is the head of a hospital centre, is appointed by the president of the CNG on the basis of the proposal made by the regional health office, but in the case of a regional hospital centre, he is appointed by the Minister of Health while the heads of university hospital centres are appointed by the Minister of Health and the Minister of Research.[104]

The Bachelot Act was heavily criticised, generally claiming that the new organisation structure laid too much emphasis on the aspects of economic operability and that the hospitals' management structure was approximated to the hierarchy customarily applied in the large companies in the private sector[105]. Health policy analyst Frédéric Pierru

104 The homepage of the Ministry of Health: http://www.sante.gouv.fr/IMG/pdf/vademecum_loi_HPST.pdf , 75.

105 It should be noted that the acceptance of the Bachelot Act was very negatively affected by the fact that in towards the crucial year of 2008 a number of tragedies occurred in public hospitals as a result of poor organisation or communication which were independent of the reform. For more detail on this see: Le Monde, 31 December 2008.

- a researcher of CNRS - for instance, in addition to claiming that the hospitals had been 'in the state of a permanent reform ever since the nineties', criticised in relation to the Bachelot Act primarily the vertical chain of power created by the act, which extended from the minister through the director of the regional health office to the heads of the institutions, bypassing the local and the medical professional interests.[106] One interesting aside is that the government party Jean-Louis Debré commenting on the issue also gave voice to criticism: 'We are indignant because we think doctors will no longer have a say in the hospital's medical plan: the director will decide on everything, and he will do so exclusively on the basis of accounting considerations.[107]". Some ten thousand doctors and hospital employees demonstrated against the act in April 2009. After the adoption of the act therefore, the government launched a reconciliation programme[108] affecting the future of public hospitals in the course of which a ten-strong technical/professional committee is visiting region after region, collecting experiences and comments on the new system. On the other hand, the ministry produced an official survey[109] as well, on the impacts of the reform, showing that the supervisory boards established to work with the hospitals are, for the most part, headed by local politicians, indeed in 72 percent of the cases the mayor himself chaired the boards. It was also found that the director strengthened by the act and the head of the trade interest representing organisation - the chairman of the CME - could effectively cooperate in most places, as is proven by successful appointments and the CME projects proposed in half of the institutions and the reports prepared reflected the actual operation of interest representation.

The reform of health financing

In parallel with the reorganisation of the institution system the financing of the health system was also transformed[110]. Earlier on, between 1983 and 2003, public institutions and private institutions participating the provision of public hospital services (PSPH) used to be provided with annual general subsidies calculated on the basis of the preceding year's practice, and only a small part of the amount concerned was the subject of negotiations between the institution concerned and the competent state body. The for-profit private institutions however, submitted their invoices for the material costs and the fees for the work involved in the provision of treatments, directly to the health insurer. The costs were calculated on a geographical basis, using tariffs set by the regional hospital office, taking national limit figures into account. Thus these institutions had been provided with performance-based financing for years, which fact lead to massive inequalities between the for-profit private sector and the public sector together with the PSPH.

106 Le Monde, 19 April 2009, 11.
107 La Tribune, 28 April 2009.
108 For details on the reconciliation processes, see the homepage of the Ministry of Health: http://www.sante.gouv.fr/mission-hopital-public.html.
109 The homepage of the Ministry of Health: http://www.sante.gouv.fr/gouvernance-hospitaliere.html.
110 For the official summary of the ministry of the changes in the system of financing, see: http://www.sante.gouv.fr/financement-des-etablissements-de-sante,6619.html.

The so-called T2A system of performance-based compensation was introduced in 2003, which spread gradually between 2004 and 2008 and since then exclusively the T2A is applied in relation to general internal medical, surgery and obstetrician treatments. The basis of the system is that the Minister of Health fixes the prices of the treatments each year, on the basis of the constantly changing so-called homogeneous patient groups (their current number is 2300) and in view of the time spent in hospital. In the case of the private institutions the earlier different regional tariffs must be harmonised by 2012, until which the differences are adjusted by a variety of coefficients fixed from time to time. It was also achieved in a similar way, by using coefficients applying to the results derived from the T2A, that pursuant to the provisions of the act every institution was provided in 2008 with the same funding as it had been under the preceding scheme in the previous year. These corrective coefficients must approximate 1.0 by 2012.

The T2A system was not introduced in some fields of the health services, such as preventive campaigns, screening campaigns and duty services or detoxification services which require permanent presence of doctors regardless of the level of activity. Nor does the T2A currently apply to institutions specialising in psychiatric treatments or local hospitals engaged primarily in social duties, but some adapted forms of performance-based financing are intended to be introduced in the near future in these areas as well. The transformation of the financing of university medical training and research along similar lines is also on the agenda.

Another important endeavour of the reform of financing is to approximate the private sector and the public sector to one another. Although both sectors are operating on the basis of the T2A system since 2008 in the case of the same treatment the state still applies 37 percent higher tariffs in the case of public hospitals than in the case of for-profit private hospitals. Due to the fierce objections from the Hospitals Alliance the government has practically given up this plan, and it set the target date for the equalising of financing beyond the end of its own mandate, i.e. from 2012 two governmental terms later, to 2018.[111]

In parallel with the reform measures, after the trend of decrease in the past decade, the proportion of funds spent on hospital treatments has began to grow within the total health spending: in 2009 a total of EUR 175.7 billion - 44.4 percent of the health spending - was accounted for by such expenditures. (As was seen in the earlier study, the health insurer financed some 90 percent of the expenditures in 2009.) The proportion of amounts spent on hospital treatments within the household expenditures also increased, to the current level of 5.5 percent. The deficit of public hospitals by contrast, has been decreasing in the past years: after the EUR 486 million recorded in 2007 it was EUR 345 million in 2008 and EUR 200 million in 2009. Besides reforms in organisation and financing the government also launched an infrastructure modernisation programme entitled Hôpital 2012, in the course of which EUR 10 billion extra funding from the central budget is mobilised. EUR 2.2 billion of the total amount had been disbursed by 2010 since the crisis slowed down the processes considerably.

111 For more on this, see an article by Cécile Prieur in Le Monde, entitled Le gouvernement recule sur la réforme de l'hôpital: Le Monde, 2 May 2009, 24.

Owning and operating healthcare institutes in Germany

The system of ownership and running of health institutions in Germany is rather varied: the ownership and running of hospitals, rehabilitation and prevention institutions and nursing homes are shared in varying proportions between communal, non-profit and private organisations. An even more complicated picture is found in the ownership and running of doctors' offices and medical service provider centres: in the case of these institutions even multiple forms of ownership may be combined. Ambulance services are also organised in an interesting system in Germany, where the provinces themselves are responsible for ambulance services and patient transporting but these functions may be delegated to non-profit organisations, associations or even private entities in some cases. The system of the ownership and running of pharmacies is a lot less complicated, as these are owned predominantly by business organisations, except for hospitals' own pharmacies but those supply patients directly to a lesser degree.

Hospitals

Hospitals in Germany are operated and - in most cases - also owned by natural and legal persons including state and communal organisations and private sector entities. Hospitals in public or communal ownership and operation may include university clinics, provincial hospitals, district and municipal hospitals and in some cases the hospitals of the federal armed forces. Public owners and operators may also include those running the mandatory accident insurance organisations that run the emergency hospitals of trade organisations. The public service or non-profit owners/operators include churches and other religious organisations, charity and social organisations as well as welfare associations such as the Evangelical or the Catholic Church or the Red Cross. The largest private owners/operators today include Asklepois, Rhön-Klinikum, Helios/Fresenius and Sana Kliniken.[112]

Accordingly, in 2010 the ownership and running of the total of 2065 German hospitals was shared between the above three groups in the following proportions according to the preliminary data put out by the German Association of Hospitals and the German statistics office: 30.5 percent of hospitals were owned and run by state and communal organisations, 36.6 percent was owned and run by public service and non-profit organisations and 32.9 percent were owned and run by private sector entities. Though these relative proportions changed slightly in comparison to the preceding year but they continued the previous year's trend of increase in the private sector entities (2009: 32 percent), while the proportions of the hospitals owned and run by state and com-

112 Federal centre of political education: http://www.bpb.de/sosi/popup/lexikon.php?id=143, http://www.bpb.de/themen/WZDR7I,0,Gesundheitspolitik_Lernobjekt.html?lt=AAB683&guid=AAB794.

munal organisations (2009: 31.1 percent) and those of public service organisations (2009: 36.9 percent) decreased. This very trend was observed during the past decade with slight variations, for example in 2004 the public sector still owned and run 36 percent of the hospitals with public service organisations taking care of 38.4 percent, while private sector participants owned and run only 25.6 percent of the hospitals. An even greater difference is found by comparing the data of 1991 to the preliminary data of 2010, as during this period the proportion of hospitals owned and run by state and communal organisations dropped from 46 percent to 30.5 percent while the share of private sector entities increased from 14.8 percent to 32.9 percent.[113]

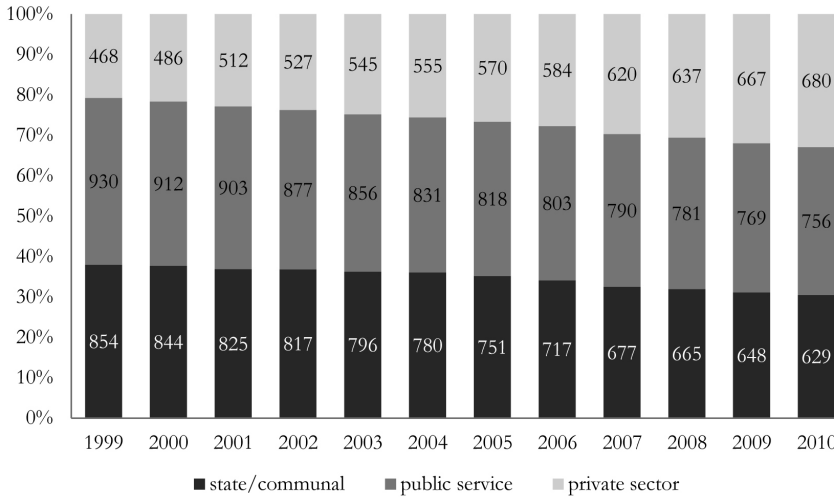


Figure 1: Changes in the relative proportions of hospitals owned and run by different categories of organisations between 1999 and 2010[114]

Another relevant indicator of the system of hospital ownership and operation is the distribution of hospital beds: in year 2009 48.7 percent of the total of 503,000 hospital beds were owned/operated by state and communal organisations while the percentage of beds owned/operated by private sector entities, though in accordance with the previous years' trends it increased slightly, was only 16.6 percent. Accordingly, the proportion of hospital beds owned/operated by public service organisations was 34.7 percent. Preliminary 2010 data show that the preceding years' trend continued: in 2010 a total of 17 percent of hospital beds were owned/operated by private sector entities, 48.5 percent of hospital beds were owned/operated by state and communal organisations while public service organisations took care of 34.5 percent of the total number of hospital beds. In terms of the rates of capacity utilisation of hospital beds the hospitals owned and run by

113 The office of the health reports of the Federation: http://www.gbe-bund.de/gbe10/owards.prc_show_pdf?p_id=12529&p_sprache=d&p_uid=gast&p_aid=71870590&p_lfd_nr=6.

114 Statistics of Association of German Hospitals: http://www.dkgev.de/dkg.php/cat/62/aid/8693.

state and communal organisations have been in the lead for years (preliminary data for 2010: 78.9 percent), while the lowest rates of utilisation were delivered by public service organisations (preliminary data for 2010: 75.4 percent). [115]

There are wide variations between the numbers of institutions and their ownership/operation across the provinces, as is indicated by the following figure.

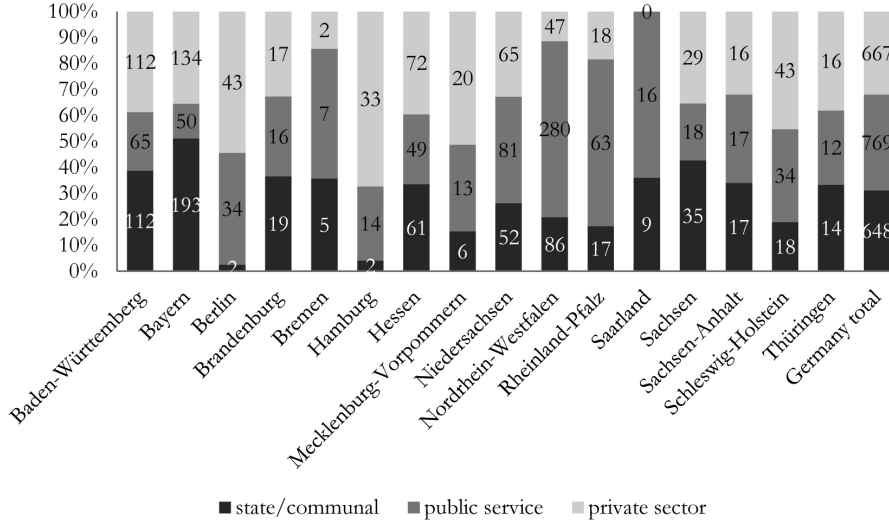


Figure 2: Organisations owning/operating hospitals in 2009, by province: [116]

Forms of association of doctors' offices, medical service providing centres and their ownership/operation

Outpatient care services are provided in Germany by autonomous practices, group practices or medical service providing centres, based on freedom of choice of physicians. The majority of autonomous doctors having their own practices have contracts with health insurance funds thereby obtaining their licences and becoming 'contracted doctors' (Vertragsarzt). Every contracted doctor and dentist is a member of the 17 Associations of Fund

115 Hospital Statistics Analysis of the Association of German Hospitals:
http://www.dkgev.de/dkg.php/cat/62/aid/8693,
Based on the data of the German Statistics Office
http://www.sozialpolitik-aktuell.de/tl_files/sozialpolitik-aktuell/_Politikfelder/Gesundheitswesen/Datensammlung/PDF-Dateien/abbVI32b.pdf,
Hospital statistics page and trade analysis of the German Statistics Office:
http://www.destatis.de/jetspeed/portal/cms/Sites/destatis/Internet/DE/Presse/pm/thematisch/231__GT,templateId=renderPrint.psml,
http://www.destatis.de/jetspeed/portal/cms/Sites/destatis/Internet/DE/Content/Publikationen/Fachveroeffentlichungen/Gesundheit/Krankenhaeuser/GrunddatenKrankenhaeuser2120611097004,property=file.pdf.

116 Statistics of Association of German Hospitals: http://www.dkgev.de/dkg.php/cat/62/aid/8001/title/Krankenhausstatistik_-_Grunddaten_2009.

Doctors operating across Germany. According to data released by the Federal Association Of Fund Doctors nearly 138,000 contracted doctors had licences at the end of 2009.[117]

The contracted doctors carry out their operations in separate practices, practice associations, in joint practices or in medical service providing centres, which differ from one another in the form of operations. In practice associations doctors and dentists collectively use the rooms and equipment of the doctor's office and in some cases they even jointly employ the assistant staff. In the case of an association of practices the aim is to reduce costs, however, the doctor are running their offices alone and they keep their own accounts separately. There is no need for any specific authorisation process for the establishment of a practice association.

Joint practices work in closer cooperation than do associations of practices, as joint practices involve an economic and organisational joining of two or more doctors who carry out medical practices under contracts, in shared doctors' offices. In the course of accounting they treat the shared practice as an economic unit, for the establishment of which they need to obtain the authorisation of the authorisation board.

In 2010 there were 20,044 shared doctors' offices and 66,922 individual doctors' offices.[118]

Since the introduction of the health reform in 2004 the so-called medical service providing centres (Medizinisches Versorgungszentrum, MVZ) can also participate in the provision of health services under contracts, and this form has been expanding most remarkably in the provision of specialised medical services. The number of MVZs nearly doubled between 2006 and 2008 but even between January 2009 and 2010 their number increased by some 20 percent. As a result of the introduction of the MVZ arrangement doctors can better coordinate their work since these institutions are a venue of interdisciplinary cooperation between doctors and non-medical but curative professions. The MVZ even enables cost cutting and it mitigates the risk entailed by one's opening of his own practice and at the same time doctors can also participate in outpatient services in employee status. Medical service providing centres may be founded and managed exclusively by doctors participating in the provision of medical services in the mandatory health insurance scheme, where doctors may work as employees or under contracts. Moreover, an MVZ may be owned and run by hospitals, other health service providers and management undertakings as well. According to 2010 data a total of 1,654 MVZs had operating licences, in which a total of 8,610 doctors were working, 1,332 of them under contracts and 7,278 as employees. Also according to 2010 data most MVZs are founded primarily by doctors and hospitals, 43.3 percent of them are owned by contracted doctors, 36.7 percent by hospitals and 19.9 percent by other entities. Most MVZs owned by hospitals are operating in Bavaria, Lower Saxony and Baden-Württemberg while the proportions of MVZs owned by hospitals are highest in Thuringia, Brandenburg, Mecklenburg-Vorpommern and Saxony -Anhalt.[119]

117 Data of the Federal Association of Fund: http://daris.kbv.de/daris/doccontent.dll?LibraryName=EXTDARIS^DMSSLAVE&SystemType=2&LogonId=ca14ba154911ef559638038c01eb6b09&DocId=003762101&Page=1.

118 Lexicon of the General Health Insurer (AOK): http://www.aok-bv.de/lexikon/p/index_00171.html.

119 Data of the Federal Association of Fund Doctors: http://www.kbv.de/koop/8791.html, http://daris.kbv.de/daris/doccontent.dll?LibraryName=EXTDARIS^DMSSLAVE&SystemType=2&LogonId=ca14ba154911ef559638038c01eb6b09&DocId=003764489&Page=1

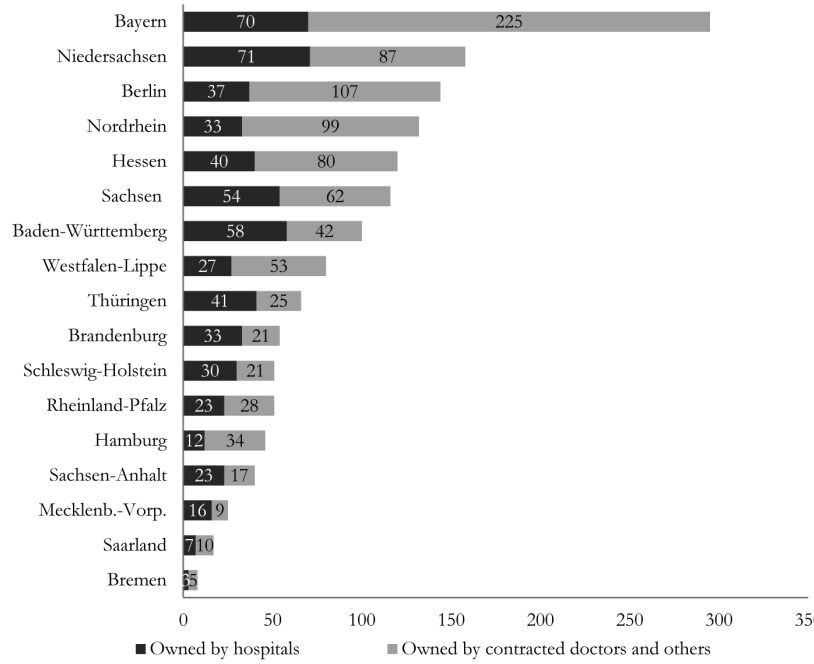


Figure 3: Distribution of the organisations that own/operate MVZs in 2009[120]

Prevention and rehabilitation institutions

Like that of hospitals, the ownership and operation of prevention and rehabilitation institutions is also shared between the above three groups, but in contrast to hospitals in the category of these institutions the proportion of institutions owned and run by state and communal organisations has increased during recent years. While in 2008 the number of institutions financed from public funds was 220, their number had increased to 224 by 2009 but by 2010 it had dropped back to 220. The number of prevention and rehabilitation institutions owned and run by public service organisations was 322 in 2008, by 2009 their number increased to 324 but by 2010 it had dropped to 321. The number of institutions owned and run by private sector entities was 697 in 2008 and it had dropped to 692 by 2009 and 688 in 2010. As in the case of hospitals as well, the distribution of the numbers of beds is also a relevant factor in the case of prevention and rehabilitation institutions among the different types of owner/operator entities: in 2010 66.9 percent of the total of 17.110 beds were owned and operated by private entities, 17.1 percent by state and communal organisations and 16 percent by public service organisations. The same trend was observed in regard to the utilisation of bed capacities, as in the case of hospitals: the rates of utilisation were highest in institutions

120 Physicians' Periodical: http://www.aerztezeitung.de/politik_gesellschaft/gp_specials/jahresendausgabe-2010/article/634669/mvz-bleibt-traeger-pluralitaet.html.

financed by public funds (90.4 %), while in the case of private institutions it was only 79.2 %.[121]

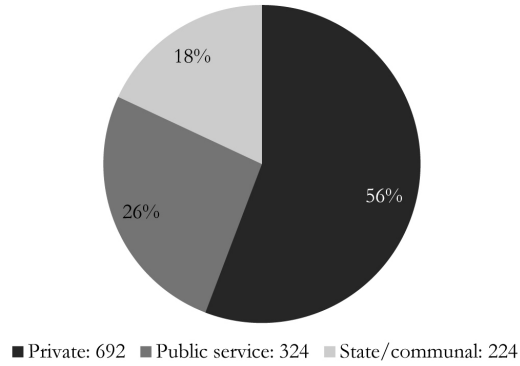


Figure 4: Proportions of prevention and rehabilitation institutions owned/operated by different categories of organisations in 2009[122]

Nursing homes

Nursing homes in Germany are institutions where people in need of nursing are taken care of by trained professional staff, as residents or as temporary service users. A person qualifies as one in need of nursing if he or she cannot provide for himself or herself owing to old age or serious chronic illness or serious disability. In the case of nursing homes it is also a clear trend that the share of private owners/operators has increased in the recent years. While in 1999 some 35 percent of the total of 8,869 nursing homes were owned/operated by private entities, 57 percent by public service organisations and 8 percent by state and communal organisations, ten years later, in 2009 some 40 percent of the 11,634 nursing homes were owned by private entities, 55 percent by public service organisations and only 5 percent were owned and operated by state and communal organisations. In terms of accommodation capacities, in year 2009 some 36 percent of the total of 845,007 places were to be found in institutions owned and run by private entities, 58 percent in institutions owned and run by public service organisations and 6 percent in institutions owned or run by state and communal organisations.[123]

121 Communications of the German Statistics Office: http://www.destatis.de/jetspeed/portal/cms/Sites/destatis/Internet/DE/Presse/pm/2010/08/PD10__286__231,templateId=renderPrint.psml, http://www.destatis.de/jetspeed/portal/cms/Sites/destatis/Internet/DE/Presse/pm/2011/08/PD11__304__231,templateId=renderPrint.psml,
Press Release of the General Health Insurer: http://www.aok-gesundheitspartner.de/bund/reha/meldungen/index_06392.html.

122 Statistics of Association of German Hospitals: http://www.dkgev.de/media/file/9649.Foliensatz_Krankenhausstatistik_20110531.pdf.

123 The Office of the Health Reports of the Federation: http://www.gbe-bund.de/oowa921-install/servlet/oowa/aw92/dboowasys921.xwdevkit/xwd_init?gbe.isgbetol/xs_start_neu/&p_aid=3&p_aid=4759087&nummer=570&p_sprache=D&p_indsp=-&p_aid=3322317.

Pharmacies

The majority of pharmacies are owned in Germany by private entities, with pharmacies of hospitals as possible differences which supply hospital ambulance services, wards and other hospitals. In their case only a small proportion of the products is sold to patients directly. The number of hospitals' pharmacies has been decreasing significantly during the recent period, while in 1991 there were as many as 665 such units, in 2005 their number was 492, while in year 2009 hospitals had only 428 pharmacies. Just the opposite trend was observed in the case of 'public' pharmacies, as in 1991 there had been 20,108 pharmacies, in 2005 there were 21,476 and in 2009 there were as many as 21,548 pharmacies in Germany.[124]

Ambulance services and patient transport

The segment of ambulance services and patient transport is operating in a complicated structure in Germany: financing, running and planning ambulance services is, in essence, the provinces' task but the federal state also contributes to financing and there is also a membership system such as ADAC, that is the German motorists' club. The operation of doctors' vehicles and ambulance vans also shows a mixed picture: the operators include provinces, public service organisations, private entities and even hospitals. There are differences across the provinces in terms of the regulations on ambulance services. Local governments can provide equipment and personnel themselves or to commission other organisations, such as full time fire brigades. An even more frequent arrangement is commissioning private entities functioning most frequently as public service organisations or associations and less frequently as private businesses. he most important participants of ambulance services include the German Red Cross (Deutsches Rotes Kreuz), The Johannite Accident Assistance (Johanniter Unfall Hilfe) which is a registered public service association of the Evangelical Church, the Arbeiter Samariter Bund which is an aid organisation and welfare association, the DLRG (Deutsche Lebens-Rettungs-Gesellschaft, German Life Saving Association), which provides primarily for water rescue as a registered association and the Maltese Assistance Service (Malteser Hilfsdienst), which is a registered association run by the Catholic Church.

Air rescue is also a special area, guaranteed primarily by operators, clinics and aid organisations. There are two large service providers, ADAC Luftrettung, a fully owned subsidiary of ADAC, and Deutsche Luftrettungswacht, which is operating as a registered association. Besides these two large service providers the federal armed forces, the Bundeswehr also participates when necessary. The costs of rescue and transportation can be charged to mandatory health insurance as 'transportation' but certain participants of the health sector complain that ambulant services and patient transportation does not, for the time being, qualify as health care service rendered to patients.[125]

124 The Office of the Health Reports of the Federation: http://www.gbe-bund.de/oowa921-install/servlet/oowa/aw92/dboowasys921.xwdevkit/xwd_init?gbe.isgbetol/xs_start_neu/&p_aid=i&p_aid=88693079&nummer=75&p_sprache=D&p_indsp=-&p_aid=41336530.

125 ADAC air rescue: http://www.adac.de/infotestrat/adac-im-einsatz/luftrettung/default.aspx,
German Red Cross: www.drk.de,
German Air Rescue: http://www.drf-luftrettung.de/,
Information platform on rescue: http://webcache.googleusercontent.com/search?q=cache:g2hfv0lrgyEJ:www.rettungsdienst.in/+rettungswesen+deutschland&cd=8&hl=hu&ct=clnk&gl=hu.

Owning and operating healthcare institutes in Great Britain

Before outlining the structure and organisation of the British health care system it is worth describing the general financing types of the social security system, along with the position in this respect of the National Health Service, which was established in 1948.

The financing types of the social security system can be categorised as follows: [126]

1) if social security is regarded as a **public good** and the private sector is not supposed to be able to provide a satisfactory solution, the adequate type of financing is funding from taxes, consequently social security is a public (state) task;

2) if social security is regarded as a **meritoric good**, then the adequate type of financing is through mandatory contributions where there is an equivalent relationship between contribution payment and the use of the services;

3) social security may also be regarded as an **exclusively private good** in which case the adequate means of financing is voluntary payment of insurance premiums.

Mention should also be made - by way of an introduction - of the European models of the welfare systems that can be observed across the world. G. E. Andersen[127] distinguished the following European organisational models:

- Continental European conservative
- South European
- The social-liberal democratic of the United Kingdom
- Social democratic of Scandinavia

The evolution of the existing structure of the NHS

The so-called National Health Security Act entered into force in October 1946, as a consequence of which the new health service structure came into being.The National Health Service was launched on 5 July 1948 as part of the programme package also referred to as 'The Welfare State'. The programme was based on the national risk sharing community principle, according to which in actuarial terms risk management covers the entire population. Consequently, the various service organising groups are financed from sources other than their own revenues or income (per capita quota or cross financing) and the various particularly high risks are borne by the whole of the society and not only by the entity financing the service concerned. The original structure of the NHS has been illustrated by many (including, among others, Rivett, Ham, and Baggott). Figure 1 shows the three tier structure worked out by Robert Baggott. The administrative structure adopted at inception was a result of the preceding years' bargains and agreements.

126 According to Winfried Schmahl.

127 Andersen-Esping: The Three Worlds of Welfare Capitalism, http://books.google.com/books?id=kSwy6f0PghMC&printsec=frontcover&hl=hu&source=gbs_ge_summary_r&cad=0#v=onepage&q&f=false.

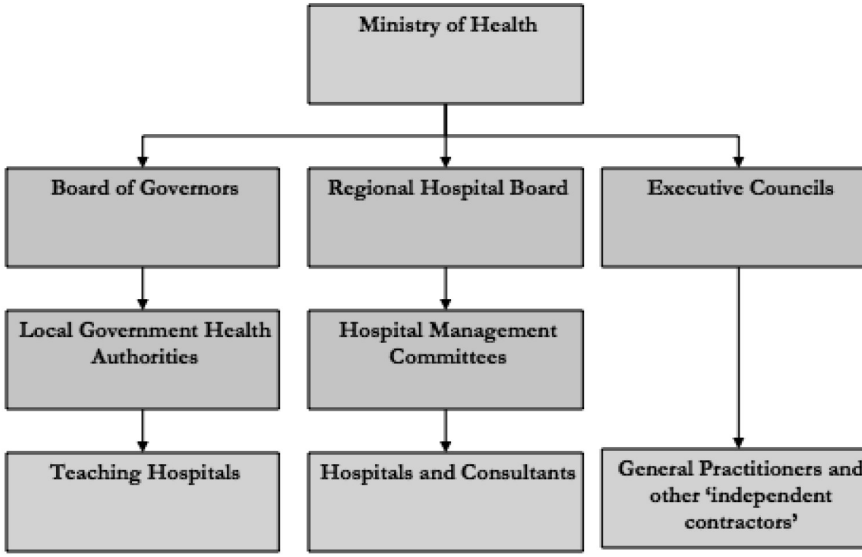


Figure 1: NHS structure in England, 1948[128]

In the first decades of its existence the structure and the management of the NHS underwent a number of transformations. A dramatic increase in demand during the 1950s (new insureds, new needs) placed hospitals under enormous pressure.

As a result of the demand's far outstripping the capacity limitations caused by the scarcity of funds a severe wage tension appeared by the middle of the decade. That was when the general practitioners' so-called 'gatekeeper' function developed, in which capacity the doctors took over the role of directing the patients i.e. patients could visit specialists or go to hospitals only with doctors' referrals.

The next milestone in the evolution of the system's existing structure was a hospital scheme worked out in 1962 in the framework of which district hospitals with hospital beds in proportion to the local populations were created.

1971 saw the development of a social security system based on income certification, and then the NHS Reorganisation Act of 1973 set up regional and area health authorities. The system was managed by the Department of Health, under which a system of Regional Healthy Authorities was operating. These Authorities supervised the 90 Area Health Authorities (AHA), which were in charge of the general management of hospitals.[129]

128 Baggott, R. (2004) Health and Health Care in Britain, 3rd Edition.
129 Rivett, http://www.nhshistory.net/chapter%203.htm.

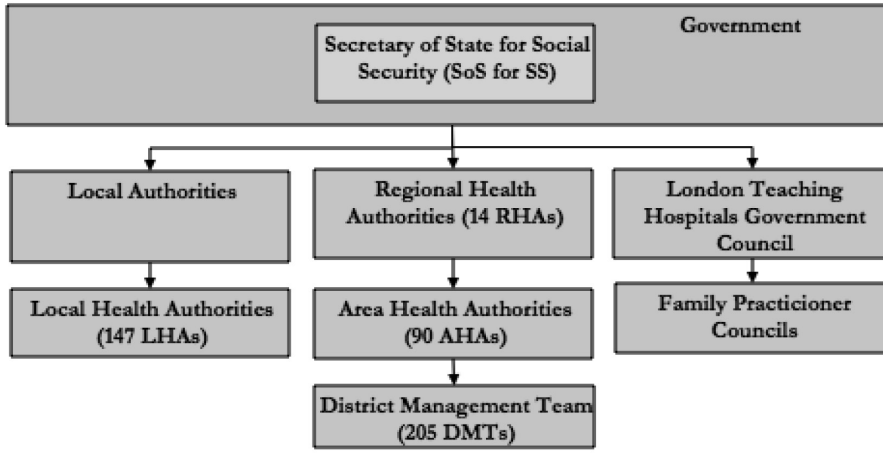


Figure 2: NHS structure in 1974[130]

The NHS came under extreme pressure by the seventies as a consequence of the difficult and complicated administration of the system and the recession caused by the oil crisis. The next major change was brought about the cabinet of Margaret Thatcher who took the helm in 1979. In the framework of the ambitious reforms the government started a privatisation programme involving the NHS as well, arguing that the country's economic difficulties were being caused by the high level of public spending and the extensive participation of the state.

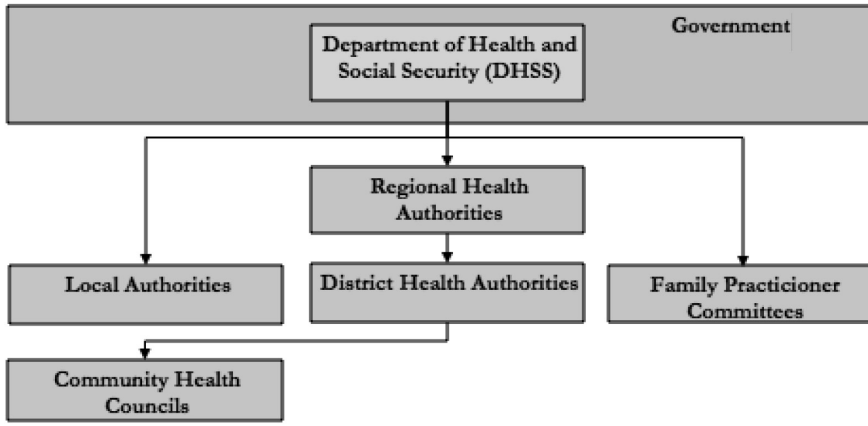


Figure 3: NHS structure in 1982 [131]

130 Charles Webster (2002): The National Health Service, A Political History.
131 Charles Webster (2002): The National Health Service, A Political History.

The first Thatcher cabinet eliminated the earlier NHS hierarchy and created a one-tier authority (192 DHAs). It also replaced the baseline budgeting scheme with what is referred to as distribution based on the sharing of funds. This is when weighted per-capita quota based financing was introduced where weighting was determined by the number of residents of the region concerned, their age profile, gender ratios and the demand for health services. This financing and distribution technique is still underlying the operation of the NHS.

No profound structural changes took place during the eighties: tax-based financing covered 90 percent of the costs while the remaining nearly 10 percent was contributed by the private sector.[132]

Up to 1990 the funding of the NHS had been determined on the basis of the previous year's budget and then the available amount was distributed among the hospitals by the DHS. Meanwhile, the doctors in charge of inpatient services were working for fixed salaries while the general practitioners were paid on the basis of the per-capita quota or what was referred to as fee-for-service.

The third Thatcher government launched another reform in the NHS in 1991, in the framework of the NHS and Community Care Act adopted in that year.[133] The reform introduced the institution of an internal quasi-market within the NHS. The providers of the service were separated from their buyers and then they could 'simulate' the market in what was essence a public framework. The institutions of the NHS, as service providers, competed for the buyers. The persons who functioned as buyers in this sense were general practitioner fund holders gradually replacing the earlier health authorities. The new general practitioner fund holding system made it possible for GPs to form groups which purchased the primary (basic) and secondary (specialised, hospital) care services for their patients while being financed on a per-capita quota basis.

In the wake of the introduction of the new distribution of tasks - though both the buyers and the providers continued to be owned by the state - price setting turned into a bargaining mechanism between fund holders and hospitals, clinics and specialised doctors' offices. Despite the real owner's missing from the system they managed to integrate competition and market mechanisms in the system of service provision, thereby creating incentives that improved efficiency and forced cost cutting. This form of financing was favourable for both sides because hospitals could work for prices set individually for the different services while general practitioners could purchase services from hospitals for more favourable prices. According to the law the hospitals could form trusts, which were bodies combining both ownership and management functions. The majority of general practitioners were working in an employee status, except for those who had contracts with one or another regional authority depending on whether they provided their services in the conventional (individual) or in the fund holding system.

132 Rivett, http://www.nhshistory.net/chapter_4.htm.

133 NHS and Community Care Act, http://www.legislation.gov.uk/ukpga/1990/19/contents.

The key elements of the Thatcher's reform launched in 1991:
1. introduction of an 'internal market' - market price bargaining mechanism - in a state-run framework;
2. the state remained the provider and the buyer (no real owner);
3. planning and not competition continued to be considered to be the most important factor.

By 1993 more than 300 GP association (funds) and 57 trusts (including outpatient, local governmental and hospital funds) were ready, awaiting the start-up of the new structure. The percentage of general practitioners who had joined collective practices (fund holding) had increased from 7 percent to 59 percent between 1991 and 1998.

NHS ORGANISATION FORMS AFTER THE REFORM

General Practitioners, GPs

The market-based solutions were introduced in the public environment through a gradual process of several steps in England. The new market oriented solutions were introduced usually among different heterogeneous groups of general practitioners (GPs). As a consequence of the nature of the service providing system a GP provides basic services on a continuous basis, he is the first one to meet the beneficiary and he not only provides curative treatment but also monitors the process of recovery.

Multifunds (only from 1996)

A multifund is a special British organisation form, comprising a group of doctors providing services for more than 11,000 people, with its own budget from which the doctors could purchase for their patients the non-emergency curative treatments from hospitals and diagnostic service providers.

Care holdings (consortiums)

Organisation of services not financed by multifunds (provision of services usually for patients suffering from chronic conditions). The organisation of these consortiums resulted in the development of cost-efficient and integrated patient routes and managed patient traffic in this area.

Creation of separate trusts

These were organisations referred to as 'trusts', launched from 1991, run either by foundations or by other organisations in their backgrounds. According to an Act adopted in 1990 which provided for their establishment the trusts are legal entities with the purpose of providing property elements and services in the framework of the NHS. The trusts were financed from the payments made by Primary Care Trusts (PCT) for the services prescribed by them and in line with the associated doctors' services concerned. The PCTs became most suitable typically for the provision of services for 100-200,000 people.

During the recent decades the NHS has been the most exposed to market-driven and market-oriented reforms among the European health care systems. This process accelerated particularly in 1997 after the victory of the Labour Party but the growing weight of private capital could be observed as early as after the elections in 1992 in the British health care system.

The so-called PFI (later on: PPP) system was introduced in 1992 whereby they created an insurance form that brought private capital into the health sector. During the following period - owing to the massive profit expectations of private capital - the number of hospital beds and the funds spent on labour input were reduced by 30 percent and by 25 percent, respectively. In 1994 the Conservative government reduced the number of regional centres from 14 to 8 and turned them into regional NHS Executive Offices. In 1996 they integrated the Family Health Service Authorities (FHSA) with the District Health Authorities in Health Authorities. The fund holdings of general practitioners were also changed. Different types of fund holdings were created, including the above mentioned multifund which comprised a number of different practices along with so-called Total Purchasing Projects which could purchase different services for their members (with a total membership of about 80,000). The number of general practitioner fund holdings increased more than 10 times during 1990 and 1998, to about 3,500.

Although the political left, which was in opposition during the early nineties, criticised the transforming health care system from a number of aspects, after their taking office in 1997 they continued the privatisation of the sector, if anything, even more intensely. The Blair government did away with all types of GP fund holdings and replaced them with what were called Primary Care Groups (PCG). The PCGs grouped general practitioners according to geographical location and they had typically much larger memberships than their predecessors (50-250,000 members).

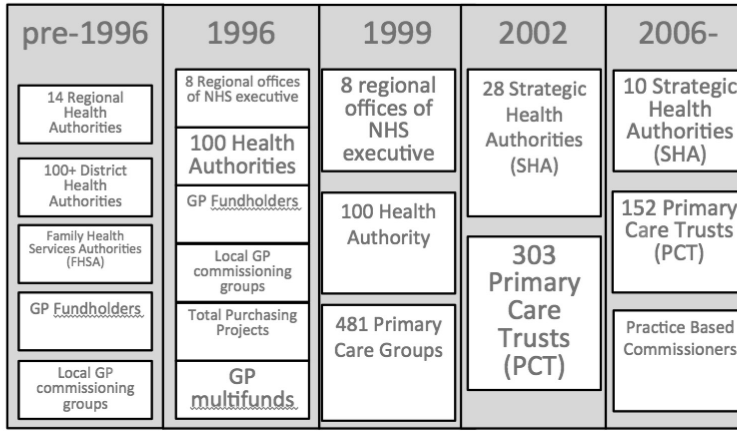


Figure 4: Changes in the NHS structure [134]

134 Rivett, http://www.nhshistory.net/chapter_6.html.

By continuing the PFI programme Tony Blair's Labour government also adopted the conservative privatisation policy. Moreover, in the framework of Public-Private Partnerships the Labour Party initiated market-oriented reforms in the NHS. In 2000 they signed the Concordat agreement with the association of private providers (Independent Healthcare Association), which made it possible for the NHS to send patients to private hospitals and clinics.

The relationship and cooperation between the private sector and the state health care system grew closer from 2005 on. In the wake of the elections in 2005 the government planned to double the involvement of the private sector in order to cut and eliminate the waiting lists. Under the plan they concluded contracts worth over GBP 3 billion up to 2010 with the Independent Sector Treatment Centres (ISTC).

The ISTC Programme was announced in 2002 as a part of the NHS Plan. The centres are providing services that could not be provided by the existing NHS providers and in which there is a shortage at a national level (e.g. orthopaedic operations, diagnostic procedures etc.). Some 25 such institutions had been opened by 2005, most of which are functioning within the buildings of state-owned hospitals.

At present the operation of the NHS is managed entirely by the Department of Health, headed by the Secretary of State for Health. It is the duty of the State Secretary of the Department of Health to report to the Prime Minister on the most important facts and circumstances of the sector's operation. The Department is controlling the operation of the NHS trusts through 10 Strategic Health Authorities. The NHS itself comprised of six different trusts. Basic services (PCT) comprise 152 trusts including dentists and family general practitioners. These basic care trusts are responsible for 80 percent of the budget. Also, there are 290 hospital trusts while the other trusts are far less significant: they include trusts providing ambulant and patient transportation services, nursing, psychiatric and information services.[135]

Health care provision is free for patients within the NHS, only a prescription fee is charged but those meeting certain age, diagnosis or low income criteria are exempted even from that fee. The NHS is accompanied by a parallel private service providing system but in the majority of cases this is used by patients only to supplement the public services. The largest private insurer is called British United Provident Association (BUPA), while the largest private hospitals are called Spire and Nuffield. Only about 8 percent of the total British population have private insurance coverage.

During the past two decades the reforms introduced in the British health care system have been focused on increasing the involvement of market participants and on boosting competition in order to improve the performance of the system and the access to optional services. This trend however, impeded the introduction of those business processes that could have rather operated - or could be operating - with integration. (A direction represented by the Cameron cabinet is typically such a field, aiming at 'integrating' procurements in the NHS). The various providers are still more encouraged to expand the portfolios of their activities than to prevent unnecessary hospital admissions or to carry

135 Rivett, http://www.nhshistory.net/chapter%207.htm.

out a population-oriented integration of service provision. One of the most important messages of the summary of a research programme conducted by the above mentioned Nuffield hospital (Nuffield Trust) published in September 2011[136] is that under the increasingly strong fiscal pressure PTCs are fighting to remove these 'false' incentives and move towards integration, combining different tasks and the services.

136 Research report: Commissioning Ingrated Care in a Liverated NHS: http://www.nuffieldtrust.org.uk/sites/files/nuffield/commissioning-integrated-care-in-a-liberated-nhs-report-sep11.pdf.

Owning and operating healthcare institutes in Poland

The ownership of health institutions in Poland is shared among the public, the local governmental and the private sector. In the case of public (state-owned) and local governmental institutions - which account for the majority of the health institutions - the institutions performing public tasks need to be distinguished from those performing non-public tasks.

The reform of hospitals and outpatient service providing institutions was started in 1999 in the wake of the decisions made by the cabinet headed by Jerzy Buzek on radical changes to be made to the health system (among other sectors). Pursuant to the decisions the institutions were transferred from the state to the local governments whereby so-called separate - autonomous - public health institutions (in Polish: samodzielny publiczny zakład opieki zdrowotnej, sp zoz) were created. These could be established (owned) by ministries or other governmental bodies, provinces (voivodeships) or other local governmental bodies, or by state-run medical universities. Poland has a three-tier local governmental system. Consequently, the local governmental unit of any relevant territorial unit (jednostka samorzadu terytorialnego) that may be the owner of a health institution, may be a province (voivodeship), a district or a village (or a municipality or some similar unit, such as a larger town's district).

In the wake of the 1999 reform the so-called autonomous public health institutions remained in full public ownership (no private investors were allowed to take shares of ownership) and they qualified as legal persons that could conduct their own financial management financed by funds received from the National Health Fund (NFZ) which is an organisation in a monopoly position and which is responsible for the financing of the sector. One important feature of the institutional form was that this type of institution could not go bankrupt and instead of the head of such an institution its owner was actually responsible for its financial management. Consequently, any deficit in the funding of an autonomous public health institution had to be covered by the relevant territorial local governmental unit which could intervene in the operation of its institution when it was facing bankruptcy. This financial management and operating system had a variety of drawbacks: it was characterised by inflexible and/or outdated decision making mechanisms and problems were often caused by the fact that although the heads of the institutions were appointed for indefinite periods of time, yet the owner local governments could fire them at any time with immediate effect which, besides other complications, made things difficult for hospital directors and could not protect them adequately against external pressures (from local governments, from trade unions).

From 1999 on it became possible for local governmental units to change the forms of operation of the health institutions in their ownership and in this way they could also

establish health institutions performing non-public tasks (niepubliczny zakład opieki zdrowotnej, n zoz) as well. The most profound difference between the two institutional forms is that those engaged in non-public tasks are functioning on the basis of the market economy's mechanisms (they are 'commercialised') and they qualify as economic associations of different forms, i.e. they may have supervisory boards in contrast to state/local government-run institutions. This then implies that such hospitals cannot become indebted without limitations since responsibility for their operation is assumed by a specific individual or a group of individuals. Hospitals may be established by - besides local governments - churches, religious denominations, foundations, trade unions, employers, domestic or foreign legal or natural persons as well but those are not fully private institutions (i.e. no transformation in terms of ownership or operation has taken place). It should be noted that commercialisation is by far not the same as privatisation, as in the former case the ownership of the institution is or may be retained by the founding organisation, which is the local government.[137]

According to official figures released by the Polish Health Ministry the ownership structure/form of operation of the health institutions in Poland was as follows:

Type of institution	Autonomous public health institution	Smaller institution providing outpatient services	Total
Performing non-public tasks	155	16171	16326
Of which: established by way of resolution made by territorial local governmental organisation	114	309	423
Public health institution	581	1691	2272
Total	736	17862	18598

Table 1: Ownership of health institutions[138]

It is clear from the above table that non-public service institutions account for a larger proportion of the total number of health institutions in Poland. It should also be pointed out that the predominant proportion of outpatient services is provided under non-state management, i.e. institutions controlled directly by the state or by local governments

137 Financial Online Quarterly: http://e-finanse.com/article.php?file=153, Periodical of local governmental units: http://www.eversheds.pl/articlesFiles/630_Monografia_Komercjalizacja%20zakladow%20opieki%20zdrowotnej_M.Duszynska_A.Kunkiel-Krynska_Wspolnota_17102009.pdf.

138 Homepage of the Polish Health Ministry: http://www.mz.gov.pl/wwwfiles/ma_struktura/docs/przeksztalcenia_marzec2011.pdf.

make up less than half of the total number of such institutions while most hospitals are still owned and run by the state or local governments. Some 65 percent of the institutions that changed their form of operation during the period between 1999 and 2010 were outpatient service providers, while hospitals accounted for only about 25 percent. It is also worth noting that this process was more characteristic of the district and town level institutions than at the provincial or village levels. In the category of hospitals 2010 was the 'record year' as the form of the operation of as many as 22 of the total number of 114 hospitals was changed in that year. The reason for this was a favourable change in the regulatory background (see below). The transformation of hospital wards was a less dynamic process, as the health institutions concerned reported only 55 such cases to the Health Ministry between 2001 and 2010.

The institutions (a total of 478) that opted for changing their forms of operation between the end of December in 1999 and the end of December in 2010 chose the following forms of operation: the overwhelming majority of the hospitals and hospital wards as well as the majority of outpatient service providers were turned into limited liability companies. In the latter category the most popular forms include joint ventures, general partnerships, and civil associations, with the shareholding company being the least favoured form. A relative majority among the founders of health institutions transformed during the above period is made up by towns (44 percent), followed by districts (30 percent), villages (18 percent) and then the provinces or voivodeships (9 percent).

The share of ownership of territorial type local governments in commercialised health institutions varies between 0 and 100 percent and the general trend in Poland is that the various levels of local governments retain the full ownership of their hospitals (including with it their say in the life and operation of the latter). The opposite trend is observed in the case of institutions providing outpatient services where the ownership of local governments is closer to zero percent (local governmental ownership has been retained only in 14 of the total of 309 such institutions where the local government's share of ownership varies between 0.25 percent and 100 percent). It is fairly safe to state therefore that the local governments do make efforts to keep some control over hospitals even after commercialisation but they tend to 'let go of' smaller outpatient service provider institutions.

The number of the transformed institutions was influenced at the provincial level by a variety of different (economic, legal, social) factors or in other words, by the mechanisms of the decision making process such as whether there is political consensus on the issue of transformation among the parties participating in the in the voivodeship's Sejm (provincial assembly), the financial position of the institution to be transformed or the dominant expectations and requirements prevailing in the province concerned. Commercialisation was undertaken primarily in the country's western and north-western provinces (the voivodeships of Silesia, Kujawia-Pomerania and Pomerania, Lower Silesia and the Greater Poland Voivodeship) while one finds hardly any example of institutions with transformed forms of operation in the least affluent provinces, that is in the eastern and south-eastern voivodeships (Podlasie and Podkarpacki).

It can be concluded in general that the commercialisation process has been chosen primarily by the institutions of unfavourable financial positions, i.e. with funding deficits.

The health institutions that are performing non-public tasks typically have smaller debt portfolios in the wake of the transformation and they tend to have larger incomes than the institutions engaged in performing public tasks. The question arises that if commercialisation has such a favourable impact on the financial management of hospitals, then why this course of action has not been chosen by the majority of institutions in Poland. The answer to this question is, as always in such cases, a complex one with a variety of relevant (legal, economic, financial management, social and political) aspects.[139]

The economic considerations include for instance that if a fully state/local government-controlled hospital's financial management is in order, then there is no sufficient drive for a change. In many cases the owner local governments fear that funds received from the state budget would be lost in the wake of commercialisation (as in that case they are turned into 'quasi-private' enterprises) and that they would not have enough money to cover the deficit of the predecessor association. Up to the most recent past even the central government has offered precious little assistance that would encourage local governments and facilitate commercialisation (e.g. state grants or loans). The social factors include the resistance on the part of the trade unions as well, which have traditionally significant - though recently weakening - positions in Poland in the world of work (some demonstrations organised by various trade unions turned out highly spectacular or even quite a scandal, deterring old/new owners from transformation). Another important factor is that local residents often have concerns that the availability of the hitherto 'free' services would be limited or even completely inaccessible in the new form of operation - and the opinions of voters need to be taken into account by the regional decision makers, particularly in the case of local governmental or general elections. It is also closely related to the above considerations that the concept of 'privatisation' is something of a 'bogeyman' in Poland which is suitable for manipulating large social groups, particularly those who found themselves as losers in the process of system change.

The toughest obstacle to commercialisation had been a gap in the applicable regulations, in other words, the regulatory conditions for the commercialisation of health institutions were missing, as it was not until the first half of 2011 that the Polish Parliament adopted the law that enabled such transformation in the health care segment. The regulatory arrangements introduced a few years earlier - the Bill of on the protection of health, submitted by the cabinet formed of the Civil Platform (PO) and the Polish Peasant Party (PSL) was adopted by the Sejm (the lower house of the Polish Parliament) in November 2008 - however, ended up in failure. That regulation stipulated that the cabinet would have 'transformed' the hospitals on a mandatory basis into associations performing non-public tasks (or more precisely, into shareholding companies). Those companies (their 'shares') would have been owned solely by the local governments concerned, which would have decided on what to do with the 'shares' (full or partial privatisation or retaining 100 percent ownership).

139 Homepage of the Polish Health Ministry: http://www.mz.gov.pl/wwwfiles/ma_struktura/docs/przeksztalcenia_marzec2011.pdf.

The then President of the Republic, Lech Kaczyński, however, vetoed that Act, in exercise of his right enshrined in the Constitution. In addition to voicing political arguments (before his election the President had been a member of the opposition Law and Justice Party which has, during recent years, been in a permanent conflict with the Civil Platform) Mr. Kaczyński claimed from a technical/professional aspect that commercialisation would easily lead to privatisation, i.e. the transformation of the hospitals into shareholding companies would directly lead to the introduction of private capital in the health sector in Poland. Eventually, the Sejm could not do away with the President's veto (which would have taken three-fifths of the votes of the MPs) and this outcome brought the transformation of the form of ownership of the health institutions to a temporary halt. The deadlock was resolved by the changes in the political situation, as in 2010 Polish citizens elected Bronisław Komorowski, supported by the PO, to be their new President, who was more cooperative with the PO-PSL cabinet on a number of issues. The new proposed health legislation was submitted to the Sejm again in March 2011 and it offered more room for private capital and market economy mechanisms. A while later the Sejm passed and the President also signed the new Act.[140]

Under the new legislation the newly established hospitals can be set up as shareholding companies already in the first place, the ones owned by the state or local governments need not be transformed on a mandatory basis but if the owner/operator does not transform its hospital then it has to settle the debts amassed by the institution (this is how the government is trying to prevent excessive indebtedness). The legislator also decided that no new autonomous public health service provider institutions (sp zoz) may be established in the future but the existing ones may remain in place. Thereby the Tusk cabinet is moving towards relieving the burdens of the state in regard to the repayment of the loan debts accumulated as a consequence of the poor financial management of hospitals.[141]

It should be noted that Polish hospitals continued to grow more and more deeply indebted in 2011, more than half of all health institutions had loan debts of varying amounts (those debts are being managed by so-called 'para-banks' - e.g. Magellan, Electus - which are specialised in dealing with hospitals), which - it should be noted repeatedly - is one of the key reasons for the altering of the previous form of ownership/operation. Since a hospital cannot save much on the costs of curative services, it is forced to save on operating expenditures, particularly wages. The easiest and most widely adopted approach is where the director suggests to the employee that he should continue working not as an employee but under a service contract (an employer may only offer this option but cannot force its employee to change). The indebtedness of hospitals was, by the way, affected by a variety of factors: shortage of funds in the health sector, the not quite reasonable distribution of hospitals, inadequate supervision by the owners or poor institution management.[142]

140 Rzeczpospolita daily, online news: http://www.rp.pl/artykul/208464,225382-Weto-dla-reformy-zdrowia-.html, Rynek zdrowia, Internet portal: http://www.rynekzdrowia.pl/Polityka-zdrowotna/Sejm-uchwalil-pakiet-ustaw-zdrowotnych-czyli-nadchodza-zmiany-w-systemie-ochrony-zdrowia,107615,14.html.
141 Weekly 'Wprost', online news: http://www.wprost.pl/ar/236286/Samorzady-beda-placic-za-dlugi-szpitali/.
142 Homepage of the Polish Health Ministry: http://www.mz.gov.pl/wwwfiles/ma_struktura/docs/przekształcenia_marzec2011.pdf.

Nearly all pharmacies in Poland are privately owned and their privatisation took place right after the system change, in the 1990s. Laws and regulations in Poland make it possible for any person who meets the applicable conditions (having qualified personnel and a store) to be a pharmacy owner. The legislator has, however, introduced certain restrictions: no single person may own more than 10 percent of all pharmacies in Poland (there were nearly 14,000 pharmacies or drug selling stores in Poland in the summer of 2011), i.e. the state is making efforts to prevent any enterprises' obtaining monopoly position in the market. A pharmacy may be in non-private ownership if it exists not on its own but as a part of a state-run hospital or that of a division of such a hospital. In regard to drug wholesale companies however, not only domestic and foreign private companies are present in the Polish market but the state as well, primarily through an only partly state-controlled company called Cefarm.[143]

143 Rzeczpospolita daily, online news: http://www.rp.pl/artykul/697705.html, http://www.rp.pl/artykul/636230.html.

Owning and operating healthcare institutes in Portugal

In Portugal health care services are provided by state-run and private institutions together. Basic - primary - services are provided typically by health centres owned and run by the state while in hospital treatment services the role of public facilities is supplemented by the massive role played by private hospitals and charity institutions as well, particularly in view of the fact that although the state-run health insurance scheme provides theoretically comprehensive services for citizens, certain services are available almost exclusively in private clinics or doctors' offices. The recent years have seen a number of reforms in the wake of which the autonomy of the health institutions has gradually expanded, the management of state facilities has been decentralised and the role played by the private sector has increased.

The system of hospitals and clinics

For centuries, the health sector in Portugal relied on charity hospitals, so-called *Misericórdias*. Their importance had not begun to diminish until as late as the mid-1970s, the time of the development of a public health care system, when state-run hospitals were opened and a system of clinics (health centres) providing primary health care services was developed. Charity institutions however, are still an important element of the Portuguese system, just like private hospitals and private clinics offering important supplementary services as well.

The number of health institutions has diminished significantly since the creation of the state-owned health care system. While back in 1975 there had been as many as 548 hospitals in Portugal with a total number of 52,268 beds, according to the latest figures by 2009 the number of hospitals had dropped to 186 with 35,593 hospital beds[144]. The proportions of public and private hospitals have also been changing; while in 1990 some 60 percent of the hospitals were owned and run by the state, by 2009 their proportion had dropped to 46 percent[145]. As is clear from the following tables as well, the main reason for this was a decrease in the number of public facilities resulting from the integration of hospitals during the recent years. The number of profit-oriented private hospitals has been fluctuating incessantly but a trend of growth has been observed in recent years while the number of non-profit oriented institutions has been relatively stable.

144 According to data of the Portuguese statistics office: http://www.pordata.pt/Portugal/Hospitais+numero+e+camas-142.

145 OECD Health Data 2011: http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT.

Year	Total number of hospitals	Public hospitals	For-profit private hospitals	Non-profit private hospitals
1990	240	145	44	51
1995	200	119	34	47
2000	219	125	42	52
2005	204	112	39	53
2006	200	107	44	49
2007	198	99	49	50
2008	189	92	48	49
2009	186	86	51	49

Table 1: Ownership of hospitals[146]

Unlike inpatient services, the whole sector of basic health care services is - for the time being - run by the state but the private sector may also be allowed to participate in the provision of such services in the future. In its election programme[147] the Social Democratic Party now in office proposed the 'opening' of basic - primary - health care services to 'professional cooperatives, private undertakings and charity institutions' in order to improve the quality of and to enhance access to health care services, which was, in May 2011, referred to as a possible option even by the Health Minister of the Socialist government then in office, emphasising that patients would also be taken care of in the clinics operated by the private sector in the same way as they are provided with health services today[148].

In contrast to basic services non-state-run facilities are already playing a major role in the provision of specialised health care services, indeed, certain outpatient services and particularly diagnostic tests are available primarily in private doctors' offices and clinics. In order to make such services accessible for all patients, since the 1980s the state has been concluding contracts with private facilities on the basis of which these - in return for state subsidies - offer services for any citizen as part of the public health care system. The number and volume of such services has been growing steadily: in 2003 the state health system already paid 11.9 percent of its total expenditures to cover the costs of outpatient health care services under such contracts.[149]. These contracts cover primarily services in the fields of ophthalmology, gynaecology and orthopaedics; such services are used (in addition to those having private insurance coverage) also by those covered only by the state-run insurance scheme in private hospitals for the most part, since access to such services in state-run institutions is rather limited. Dentists' services provided almost exclusively in private doctors' offices are, however, subsidised by the state only in the case of children, pregnant women and low-income elderly people.

146 Based on OECD data, ibid.

147 http://www.psd.pt/archive/doc/PROGRAMA_ELEITORAL_PSD_2011.pdf, p. 212.

148 An article that appeared in the 14 May 2011 edition of the daily Correio da manhã ('Private undertakings may also open general practitioner offices'): http://www.cmjornal.xl.pt/detalhe/noticias/nacional/saude/privados-podem-abrir-usf.

149 A Portuguese study of 2009 'The public and the private sector in health': http://www.janusonline.pt/2009/2009_2_11.html.

Medical field	All patients	Those with only state-run insurance
Cardiology	54.2%	46.1%
Gynaecology	67.6%	61.2%
Ophthalmology	66.9%	62.6%
Orthopaedics	45.5%	41.4%
Paediatrics	31.1%	31.1%
Dentistry	92.1%	90.9%

Table 2: The proportions of health care services provided by private doctors' offices (2005)[150]

Private hospitals perform even operations financed by the state. Its currently operating system was set up in 2004, where if a public hospital cannot guarantee that a certain operation can be carried out within a certain time limit, it can refer the patient to another public hospital or - if the operation cannot be performed in the framework of the public health care system - it may make out a 'cheque' for the operation with which the patient can go to a private hospital that has a contract with the Ministry of Health.

According to data released by the association of Portuguese private hospitals[151] as much as about half of the health care services provided for patients were already supplied by private doctors' offices in 2010, and even about a quarter of the inpatient services were delivered in private facilities, thus private health institutions accounted for some 40 percent of all health services in Portugal on the whole. The largest ones among the enterprises running private hospitals include José de Mello Saúde belonging to the José de Mello Group (with a EUR 265 million turnover in 2009 followed by EUR 357 million in 2010[152]), Espírito Santo Saúde belonging to the Espírito Santo banking group (with a EUR 220 million turnover in 2009), and HPP Saúde belonging to the Portuguese savings bank (Caixa Geral de Depósitos) (with a EUR 150 million turnover in 2009). These three enterprises cover 70 percent of the market and they have been delivering two-digit growth rates year after year.

To shorten the waiting lists in the fields of short supplies the Ministry of Health concluded an agreement in March 2010 with the association of non-profit oriented hospitals („Misericórdias") according to which the patients can use those private hospitals as well under the same terms and conditions as those applying to public institutions, only having to pay a visit fee. In the wake of the agreement the state contributes some EUR 22 million in 2011 to 12 such hospitals which carry out some 15-25,000 operations in exchange for the transfers and they provide specialised health care services - similarly to for-profit health institutions - in fields such as ophthalmology, dermatology or vascular surgery[153].

150 'Report on the sustainability of the public health system' commissioned by the Portuguese Ministry of Health, 2007: http://www.min-saude.pt/NR/rdonlyres/050CB0A2-7ACC-4975-A1E4-4312A1FBE12D/0/RelatorioFinalComissaoSustentabilidadeFinanciamentoSNS.pdf.

151 'Half of all health services for patients are provided by private doctors' offices': http://www.aphp-pt.org/index.php?option=com_content&view=category&layout=blog&id=38&Itemid=65.

152 Data disclosed by José de Mello Saúde: http://www.josedemellosaude.pt/vPT/PortalJosedeMelloSaude/AJosedeMelloSaude/InformacaodeGestao/Indicadores/Paginas/Indicadores.aspx.

153 Article in the 29 March 2011 edition of Diário de Notícias ('EUR 22 million for health services for patients at Misericórdias hospitals'): http://www.dn.pt/inicio/portugal/interior.aspx?content_id=1817853.

The strengthening of the role played by the private sector has been encouraged by the fact - besides the expansion in private insurance contracts - that in the course of the reforms introduced in order to improve the efficiency of the hospitals operating in the framework of the public health care system and to reduce wasteful practices undertakings have, since the 1990s, been increasingly involved in the operation of public institutions. As part of this process private enterprises were initially commissioned, on a temporary basis, to run certain public hospitals or some public hospitals were operated on the basis of private hospital models and then after this experimental phase a number of public hospitals were converted into fully state-owned for-profit hospital undertakings providing general hospital services („hospitais EPE"). These hospitals had a high degree of autonomy and their operations were of a commercial nature though they were fully operating under the supervision of the Ministry of Finance and the Ministry of Health. As many as 41 hospitals are operating in this form across Portugal today, including the largest hospitals of the country. Their organisation structures are determined by their internal bylaws and they are headed by Boards of Directors comprising 4-5 members. The central health cabinet concludes contracts with these hospitals in which they set out the services the hospitals undertake to deliver, in exchange for which the state disburses specific amounts. The public funding accounts for an average of some 80 percent of the total revenues of the state institutions operating in the form of commercial undertakings, with the rest of their revenues originating form the insurance subsystems and private insurers[154]. Any losses have to be financed - in theory - by the hospitals themselves, but 14 such institutions have already gone technically bankrupt and some 4-5 more hospitals are expected to follow them by the end of the year. The government is working had on resolving the situation of the institutions facing difficulties; analysts consider that the causes of the problems lie on the one hand in inappropriate cash management practices and on the other hand in the under-financing of the hospitals that have been turned into business undertakings[155]. In its relevant analysis[156] Deloitte also points out that the very system of hospital operation is in need of changes because in its current form it lacks adequate coordination, performance evaluation and a system under which heads of the institutions can be held liable for improper practices.

Management of public hospitals and clinics

The existing public hospitals and clinics have, ever since the 1990s, been managed in a typically decentralised way though decisions on key financial matters are made by the competent minister himself. The Ministry of Health oversees five regional health authorities (ARS), each covering a large region of the country (North Portugal, Central Portugal,

154 Data disclosed on the relevant homepage of the Ministry of Health: http://www.hospitaisepe.min-saude.pt/Hospitais_EPE/Perguntas_Frequentes/.

155 Article in the 9 September 2011 edition of the daily Expresso ('EPE hospital debt jeopardising agreement with the troika'): http://aeiou.expresso.pt/divida-dos-hospitais-epe-compromete-acordo-com-a-itroikai=f672833.

156 Deloitte's 2011 study 'Health in Focus', p. 53: http://www.deloitte.com/assets/Dcom-Portugal/Local%20Assets/Documents/PSLSHC/pt%28pt%29_lshc_saudeemanalise_04022011.pdf.

Lisbon and its Region, Alentejo south of Lisbon and Algarve in South-Portugal); no such authorities are operating in the island belonging to Portugal because the islands - as autonomous regions - have their own separate health care systems. The regional health authorities are, from an administrative and financial aspect, autonomous indirect public administration organisations reporting to the Minister of Health. According to the applicable act of 2007[157] their tasks include 'guaranteeing the given geographical area's population access to high quality health care services by assigning the available resources to the needs for health services', on the basis of the principles and guidance set out by the Ministry of Health. As part of these activities the regional health authorities coordinate, manage and evaluate the execution of the health policy in their respective areas, they participate in working out and implementing the national health plans, they express opinions, provide for the planning of human resources and for extension training for professionals, they organise organ transplants, they conclude and monitor the relevant contracts with the facilities financed by the public health care system and with the for-profit or not-for-profit private institutions supplying health care services and they make the payments relating to the various contracts. The scopes of duties of the regional health authorities include the management of the contracts relating to hospital constructions implemented in partnership between the public and the private sector, though the centre-right government that took power in June 2011 does not wish to launch such PPP investments in the future. Moreover, these authorities license the operation of the private health care service providers within their respective regions and they implement and monitor the investment projects and developments within the public health care system. The funds required for the performance of their tasks are received by the regional health authorities as parts of the public health system form the central budget, but they also have their own funding sources, including among others, the fees collected in exchange for certain services.

The question of local governmental operation

Local governments play a marginal role in Portugal's health care system. No hospitals are owned and run by local governments. Although in 2007 the Sócrates government then in office contemplated the concept of transferring some hospitals from state management to local governments or of involving local governments in the construction and maintenance of health centres[158], but these were later removed from the agenda in view of the reservations voiced by the national local governmental association. Though partnerships were created in some places between the central government and some local governments with more substantial technical and financial resources for the construction of new health centres with EU co-financing but this has not come to be a widely adopted

157 Article 3 of Act 222/2007 on regional health authorities: http://www.min-saude.pt/NR/rdonlyres/72FA84DB-067F-4D25-B379-55F69B23EA1E/0/35193523A.pdf .

158 Article in the 30 April 2007 edition of the daily Público ('Health centres and hospitals may be transferred to local governments': http://www.publico.pt/Pol%C3%ADtica/centros-de-saude-e-hospitais-podem-passar-para-camaras-1292529.

practice so far[159]. In health care services local governments have attracted attention only by some spectacular campaigns during the recent years, particularly by having patients regularly carried to Cuba - to help their residents left without service provision owing to the long waiting lists particularly in the field of ophthalmology - and by having the necessary medical treatments carried out there; to this end, the local governments concerned have concluded agreements with Cuba[160].

No major changes are expected in the operation of health institutions by local governments in the coming years either: the programme of the centre-right government currently in office makes no mention of strengthening the role of local governments, rather, efforts are being made to increase the involvement of the private sector. According to the document's chapter on health since the available resources need to be more reasonably and more efficiently utilised in order to ensure the sustainability of the health system, such basic principles need to be bolstered as responsibility for results and transparency of financial management using public funds. To this end, among the concrete actions to be taken, the government considers it necessary to contemplate the possibilities for giving hospitals in concession in all cases where that would be the most efficient solution 'maintaining the public institution nature of the institutions concerned and the essentially free access to the services supplied by them along with the universal access of the population to health care services' [161].

Summary

As was described above, lack of local governmental participation and the steady increase of the private sector's involvement in the ownership, running and operation of Portuguese health institutions has been observed in the past decades. The latter trend is expected to be continued in the coming decades, but it does not mean that the state would gradually withdraw from the health sector as the institutions operated by the private sector perform their tasks with substantial proportions of financing from the central budget, supplementing thereby the shortages in the capacities of public institutions. In this way the state continues to perform a triple role - that of the owner, the regulator and the financer - in the management and operation of the health sector. In this capacity its most important tasks will include during the coming months and years, in view of the financial and economic crisis, to improve the financial position and the efficiency of the existing facilities - being operated either in the form of business undertakings or in the conventional way - in view of the fact in particular that as a consequence of the financial difficulties of the different types of public hospitals and the debts of the state to health institutions in the private sector, the entirety of the system of the provision of health care services based on cooperation between state and private service providers may be jeopardised.

159 Health Care Systems in Transition – Portugal, 2004, p. 21: http://www.euro.who.int/__data/assets/pdf_file/0005/107843/e82937.pdf.

160 Article in the 1 August 2009 edition of the daily Diário de Notícias ('90 Portuguese on trips to Cuba for eye operations this year'): http://www.dn.pt/inicio/portugal/Interior.aspx?content_id=1322852.

161 Government programme for the Parliament term 2011–2015: http://www.min-saude.pt/portal/conteudos/a+saude+em+portugal/politica+da+saude/programa/programa+xix.html.

Owning and operating healthcare institutes in Spain

The structure of ownership and operation of the Spanish health care system is a result of a twenty-year decentralisation process in the course of which the ownership of hospitals and other medical aids has been transferred from the level of the state partly to the level of the provinces. The period after 2001-2002 has been no longer a period of continued devolution but of efforts made to eliminate the quality differences between the services provided by the different provinces. These differences are reflected by the ownership structure as well, because the process of taking ownership over from the central social security system has advanced more in some provinces than in others. This progress is observed primarily in the provinces where the development of provincial health care systems had already been provided for by law as early as during the 1980s. Another factor that should not be bypassed in analysing the ownership structure is that the private sector plays a significant role in ownership in the provinces concerned. At the same time, local governments participate in the ownership structure of the Spanish health sector as owners of hospitals only to a very limited extent.

The following sections of this analysis present a brief description of the legislative background of the ownership structure of the Spanish health care system. It will be followed by a description ownership structure of the Spanish health sector with the aid of summary data. Finally, the differences between provincial systems will be explored through analyses of the ownership structures of certain provinces.

Legislative background

The framework of the decentralisation of the health sector is enshrined in the organic Act of 14/1986[162], whose Articles 38-40 define and prescribe the state's scope of competence and powers. Article 40 which prescribes a broad range of competences and powers, from regulating a healthy environment to the regulation of the infrastructure of the public and the provincial health care systems, allows exercising the competences and powers only to an extent where it does not curb the competences and powers of the provinces' autonomous governments. The competences of the autonomous governments are regulated in Article 41 of the Act, according to which the provinces have all of the competences in the health sector that they set out in their own statutes along with those assigned by the central government to the provinces. Article 42 of the Act regulates the competences of the local governments, primarily by enumerating the minimum competences and powers ranging from the health supervision of the environment and the public institu-

162 Ley Organica 3/1986 de 14 de abril de Medidas Especiales en Materia de Salud Publica: http://www.boe.es/boe/dias/1986/04/29/pdfs/A15207-15224.pdf.

tions to the prevention of epidemics. At the same time, the same article identifies the provincial governments as the source of the above mentioned scopes of responsibilities and competences.

Articles 44-48 of the Act regulate the institutional structure of the National Health System (Sistema Nacional de Salud, SNS) enabling the construction and coordination of provincial health systems. The guidelines for the provincial health systems are set out in Articles 49-55 percent of the Act. Accordingly, the provinces must - in line with this Act - create health organisations, the provincial systems must integrate the health services in their particular areas, they have to separate scopes of responsibilities within the province, they must create the provincial body for the coordination of the system, they must work out a Health Plan for the provision of the services, etc.

Both the distribution and the mode of the distribution of the competences and the organisational regulations reflect the fact that the Spanish health system is focused on the provinces and the provincial governments. The delegation of the competences, the formation of the provincial health systems and the reorganisation of the financing sources had been started even before the adoption of the law. The following table presents decrees on the construction of the health systems of the provinces, in chronological order:

Autonomous government	Decree issued
Catalonia	1517/1981, 8 July
Andalusia	400/1984, 22 February
Basque country	1536/1987, 6 November
Valencia	1612/ 1987, 27 November
Galicia	1649/ 1990, 28 December
Navarra	1680/ 1990, 28 December
Canary islands	446/ 1994, 11 March
Asturias	1471/ 2001, 27 December
Cantabria	1472/ 2001, 27 December
La Rioja	1473/ 2001, 27 December
Murcia	1474/ 2001, 27 December
Aragon	1475/ 2001, 27 December
Castile - La Mancha	1476/ 2001, 27 December
Extremadura	1477/ 2001, 27 December
Balearic Islands	1478/ 2001, 27 December
Madrid	1479/ 2001, 27 December
Castile and Leon	1480/ 2001, 27 December

Table 1: Decrees on the construction of the health systems[163]

163 Ministerio de Sanidad, Political social e Igualdad, La proteción de la salud en España, 6 January 2010, p.19: http://www.msps.es/organizacion/sns/docs/proteccion08.pdf.

Hospital ownership structure in Spain

A total of 97,324 hospital beds were in state ownership in Spain in 2009. For comparison, the corresponding number in Germany was 274,502, in France it was 271,057, in the United Kingdom it was 203,379, in Italy it was 149,494 while in Poland and in Romania, EU countries following Spain in terms of population, the numbers of hospital beds in public ownership were 195,964 and 140,420, respectively.[164] Spain has fewer hospital beds than those countries with smaller populations which is a consequence of the dominance of the state in ownership in the health sectors of these two post-socialist countries.

The ownership structure of the 17 provinces, each of which has its own health system, and the two Spanish conclaves - Ceuta and Melilla, whose health systems are managed in the earlier public system - is revealed by an analysis of the structure of ownership of the hospitals and hospital beds, and the relevant statistics. The following sections of the analysis rely on the annual Hospitals' Catalogues released by the Ministry of Health, Social Policy and Equality.[165]

According to summarised data 144 (18 percent) of the total of 794 hospitals in Spain are owned by provincial governments. 107 hospitals (13.4 percent) belong to the state-run social security fund, while the majority of the hospitals - 439 (55 percent) - are owned by the private sector. 10 of the 439 hospitals (1.25 percent of the total number of hospitals) belong to the Red Cross which is subsidised by the state, 58 hospitals (7.3 percent of the total number of hospitals) belong to the also subsidised Catholic Church. Another 62 hospitals (7.8 percent of the total number of hospitals) are owned by non-public organisations (part or the whole of) the running/financing of which is also supported by the state. The fully profit-oriented private sector owns a total of 309 (38.9 percent) hospitals. The local governments hold the ownership of as few as 15 hospitals (1.8 percent) while the remaining hospitals are owned by the Ministry of Defence, public companies, public administration organisations etc.

A total of 161,022 hospital beds are available in Spain, in state, provincial and private ownership. The structure of the ownership of hospital beds is somewhat more evenly balanced. Provinces own a total of 34,855 hospital beds (21 percent), while the social security fund owns 42,417 beds (26.3 percent). Profit-oriented private hospitals have 30,733 beds (19 percent), while the Red Cross has 1,363 hospital beds (0.8 percent of the total number of hospital beds), the church has 11,226 hospital beds (7 percent of the total number of hospital beds) and other state-subsidised private organisations have 8,063 hospital beds (5 percent of the total number of hospital beds). Local governments have a mere 2,165 hospital beds (1.3 percent).

The ownership structure of the Spanish health system varies across the country's provinces. In the provinces where the process of decentralisation was commenced earlier or where it was a more intensive process, the provinces themselves are the main owners

164 Eurostat Public Health Database: Hospital beds by hospital ownership: http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_rs_bds2&lang=en.

165 Catálogo Nacional de Hospitales 2011. Closed on 31 December 2010, pp. 12-13: http://www.msc.es/ciudadanos/prestaciones/centrosServiciosSNS/hospitales/docs/CNH2011.pdf .

of public hospitals. In those provinces the processes have advanced more, local governments own more hospitals than in provinces where the health system were developed later on. A similar trend is reflected by the ownership structure of private hospitals as well. Undoubtedly however, the majority of the hospitals are owned either by the national social security fund or the provinces. Since the ownership structure of the provincial systems vary widely, it is worth discussing the different provincial health systems separately, as typical cases in themselves.

Catalonia

Catalonia was the first province to develop its provincial health system as a part of the National Health System. The Catalonian health system was separated from the national system in 1986 and then Catalonia's supreme health body, CatSalut, started operating pursuant to the 1996 act that created the provincial health organisation.

Catalonia has a total of 213 hospitals, the distribution of the ownership of which indicates a high degree of autonomy of the provincial government and the private sector. The province owns a total of 24 hospitals. The number of private hospitals that are operating without state or local governmental subsidy is 86. The number of private hospitals that are eligible for subsidy (owned by the Red Cross or the Church etc.) is 60. Catalonia has the largest number of hospitals owned by local governments, that is a total of 10 such institutions. The state social security fund also has a total of 10 hospitals.

Catalonia, whose population of 7.5 million is the second largest among the provinces of Spain, has the highest number of hospital beds - 33,793 - in Spain. The largest number of hospital beds is owned by private hospitals operating without state subsidy (9,696), while the province owns 4,107 and the social security fund has 4,383 hospital beds. The local governments are operating a mere 1,796 hospital beds, which is but a fraction of the total number of hospital beds in Catalonia.

Andalusia

Despite the fact that it was not one of the provinces that had the widest autonomy in Spain (Bask Country, Catalonia, Galicia), the development of a provincial health system was started quite early on in Andalusia as well. The province that has the largest population among the Spanish provinces (8.3 million people) quit the national system in 1986 to set about building up its autonomous health organisation. Thus the Andalusian Health Service (Servicio Andaluz de Salud) appeared as a kind of a model for the subsequent development of other provincial systems.

Patients are taken care of by a total of 102 hospitals in Andalusia, 47 of which are in private ownership. The province itself is the second largest owner with 25 hospitals. The state social security fund owns 9 hospitals while the local governments own a total of only 2 hospitals.

8,240 of the total of 21,930 hospital beds are owned by the province, 4,006 beds are operated by private hospitals, 2,569 hospital beds belong to the social security fund and the local governments are the owners of only 75 hospital beds.

Basque County

The construction of the health system of the Basque Country was also started early, in 1984, then in 1986 it detached itself from the state system. The health services of the Basque Country with its population of 2.15 are covered by the system of Basque Health Services, referred to as Osakidetza.

The hospitals owned by the province and those owned by private entities make a significant proportion of the total number of hospitals in the Basque Country. Of the province's total of 44 hospitals 17 qualify as private hospitals and 15 are owned by the province. The social security fund owns 9 hospitals in Basque Country while the local governments have none of their own.

In the case of hospital beds the hospitals owned by province have a significant lead, as more than half (4,300) of the total number of 8,356 hospital beds are owned by the provincial government. 1,535 hospital beds are owned by the social security fund and 1,292 are owned by private hospitals.

Valencia

The government of the province of Valencia joined the next wave of the development of provincial health systems. The province - with its population of about 5 million - started to develop its own system after the adoption of the health act in 1986, which is managed today by Valencia's Health Agency (Agènica Valenciana de Salut).

24 of Valencia's 64 hospitals are privately owned health centres. The second largest owner is the social security fund with its 17 hospitals, followed by the province as the owner of 12 hospitals. The local governments have no hospitals of their own.

Nonetheless, the largest number of the total of 14,198 hospital beds are owned by the social security fund (7,300 beds). The province has 2,626 hospital beds, the private hospitals have 2,094 beds..

Castile - La Mancha

The development of the organisation of the province of Castile - La Mancha took place in the late phase of the construction of provincial health systems. The independent operation of the health system of the province of a population somewhat over 2 million (Servicio de Salud de Castilla- La Mancha) was started in 2002.

In terms of its ownership structure Castile - La Mancha may be described as a typical 'late comer'. 10 of the province's 32 hospitals are private hospitals, 11 belong to the social security fund. The province, as the third largest owner, has 8 hospitals, while the local governments do not have hospitals of their own.

A total of 3,760 hospital beds are owned by the social security fund, 570 are in the ownership of private hospitals. The provincial government has the second largest number of hospital beds (1,268 out of the total number of 5,862).

Madrid

Finally, mention should be made of the special position of the province of Madrid, which developed its own health system just recently but its ownership structure is more like those of the systems set up earlier on. The Madrid Health Service (Servicio Madrileño de Salud) covers the whole of the territory of the province (of a population of 6.3 million).

The provincial government owns 19 of the province's total of 80 hospitals. 31 hospitals belong to the private sector while 12 institutions are owned by the social security fund. Local governments do not own hospitals in Madrid province either.

The provincial government owns 6,092 of the total of 21,440 hospital beds available in the province, while the social security fund owns somewhat more, a total of 7,450. The private sector owns 4,472 hospital beds.

Conclusion

The health system of Spain can be scrutinised in terms of the process of decentralisation, for which the legislative background was created in the eighties and the nineties by the state and by the provincial governments. This proves involves the organisational and regulatory system, the financing sources as well as the ownership structure. Three main owners are distinguished in the various provinces: the social security fund as a public owner, the provincial governments and the for-profit private hospitals. It is clear from the above examples that the early devolution - as is evidenced by Catalonia - shifted the ownership structure towards the provincial government and the private sector. In some cases - such as in the province of Madrid - the effects of the health privatisation policy can be identified. In those provinces the largest hospitals are still in state or provincial ownership but the majority of the hospitals are already functioning as private hospitals. Finally, there are provinces where the decentralisation process had not been started before the last decade, where the provincial governments have not been encouraging privatisation, the ownership structure is still closely tied to the public sector.

Part III
Structure of Health Spending and Ageing Society

Structure of Health Spending and Ageing Society in the Czech Republic

The structure of the expenditures of public health insurers

A study published by the Health Information and Statistics Institute of Prague (Ústav zdravotnických informací a statistiky České republiky, ÚZIS ČR) in September reviewed the distribution of the total spending of health insurers among the various segments of service provision. Based on the preliminary aggregate data of the Health Ministry (Ministerstvo Zdravotnictví) and the Ministry of Finance (Ministerstvo Financií) a total of CZK 215,804 million (EUR 8,391 million[166]) was spent by the public health insurers on health services, of which CZK 215,213 (EUR 8,369 million) was spent on the maintenance of the health services and CZK 591 million (EUR 22.98 million) was spent on the development of the health services. In comparison to 2009 the expenditures of health insurers increased by 1.1 percent, while 76 percent of the costs spent on health services was covered by public health insurers. In 2010 the average number of the clients of the public health insurers was 10,387,167 persons, 60.3 percent of whom belonged the General Health Insurer (VZP). The public health insurers spent an average of CZK 20,776 (EUR 807.87) on the provision of services for each of their insureds, which was 1.0 percent higher than in the preceding year.

Year	Average number of insureds	Proportion of VZP members, %
2006	10 297 439	63.87 %
2007	10 323 545	63.40 %
2008	10 364 804	62.63 %
2009	10 375 884	60.92 %
2010	10 387 167	60.31 %

Table 1: The average number of insureds between 2006 and 2010 and the number of the members of General Health Insurer (Všeobecná zdravotní pojišťovna ČR - VZP) as a percentage, relative to the other health insurers.[167]

Health insurers spent 51.8 percent of their total expenditures on the provision of health care services in an institutional framework, which is thus the largest expenditure item, the amount of which was CZK 111.814 million (EUR 4,348 million), much of which (47.7 percent) was made up of the amounts spent on hospital care (CZK 102,932 million or EUR 4,002 million). The funds spent on outpatient care services were distributed between the various high priority sectors providing specialised outpatient care

166 In the study the CZK/EUR conversion was calculated at 25.7 CZK = 1 EUR exchange rate.

167 ÚZIS: Zdravotní pojišťovny - náklady na segmenty zdravotní péče: http://www.uzis.cz/rychle-informace/zdravotni-pojistovny-naklady-segmenty-zdravotni-pece-5.

services: 4.6 percent of the total expenditures of the health insurers were spent on dentists, 5.8 percent on general practitioners and 9.4 percent for the outpatient care services provided by specialists (e.g. obstetricians).The subsidies provided for subscription rugs accounted for 15.9 percent of the total expenditures of the health insurers, in an amount of CZK 34,251 million (EUR 1,332 million). The expenditures of health insurers on drug subsidies dropped by 6.6 percent in comparison to the preceding year. The costs of prescription medical aids accounted for 3.2 percent of the total expenditures, in an amount of CZK 5,999 million (EUR 233,27 million).[168]

Changes in the segments of health care services between 2006 and 2010

The expenditures of health insurers increased steadily between 2006 and 2010 in the various segments of the health care services, by an average of 28.8 percent. From among the segments of health care services under review the costs of the health insurers increased by the highest rate in the specialised health care services segment - including obstetrician services - in relation to which the costs recorded in 2010 were 56.3 percent higher than in 2006.

The expenditures of health insurers increased radically in relation to the health care services provided by general practitioners as well, where the costs increased by 53.1 percent between 2006 and 2010. The costs of health insurers relating to emergency medical services increased by 51.9 percent between 2006 and 2010. A remarkable increase was noted in the costs of home care provision (47.3 percent up), rehabilitation services (44.5 percent up), the complete outpatient care services segment (40.2 percent up) and in institutionalised health care services in hospitals (38.3 percent up). The costs of the health insurers incurred in the way of the subsidies paid for prescription medical aids increased by 33.4 percent during the period under review.

The cost increase in certain segments, however, fell short of the average cost increase ratio: the amount allocated by health insurers to the maintenance of specialised medical institutions (OLÚ – Odborný léčebný ústav) increased by 21.0 percent between 2006 and 2010, while the costs of the ambulance services and patient transport increased by 18.7 percent. The costs of dental services grew by 17.4 percent while the costs of health care services in the various medicinal spas increased by a 15.1 percent rate, below average.

The situation regarding the drug subsidies paid by public health insurers - the amount of which had been growing steadily up to 2005 - is somewhat out of the ordinary. In the wake of the regulatory measures the spending of health insurers on drug subsidies did not exceed the year-2005 amount of CZK 37,181 million (EUR 1,446 million).[169]

The measures aimed at reforming the health sector reached a critical phase in the course of the global financial crisis that broke out in 2008, when austerity measures were

168 ÚZIS (Institute of health information and statistics of the Czech republic), Health Insurance Corporations - Costs spent on Health Care by Types of Health Care: http://www.uzis.cz/rychle-informace/zdravotni-pojistovny-naklady-segmenty-zdravotni-pece-5. The figures contained in the study are preliminary data which will be approved by the Government of the Czech Republic and the Parliament of the Czech Republic.
169 ÚZIS, Health Insurance Corporations - Costs spent on Health Care by Types of Health Care: http://www.uzis.cz/rychle-informace/zdravotni-pojistovny-naklady-segmenty-zdravotni-pece-5.

required for the achievement of the intended stability. The so-called health regulatory fees were introduced on 1 January 2008 - and were somewhat modified in 2011 - which must be paid by every single patient using any health care service in cash, to the party providing the health service. The regulatory fees fall in three categories: mandatory visit fee payable for a visit to the doctor, daily fee for a day spent in a health institution covered by the insurer, use of emergency health services and the prescription fee payable in the pharmacies. The introduction of the regulatory fees has resulted in an increase in the income of the health system, which the segment concerned has to use for financing its own operation and development. A secondary effect of the introduction of the fees results from a decrease in the number of visits to doctors' offices and clinics. Eventually, this has an impact on the structure of the costs of health insurers paid for health services.[170]

Inflation is an important factor in the substantial increase in the expenditures during the period under review, as between 2006 and 2010 the price level increased steadily by 17.6 percent.[171]

The constantly growing financing requirement of the provision of health care services is imposing increasing challenges to the health insurers, whose revenues have, during the recent years, not been enough to cover their expenditures. According to the Czech Statistics Office (Český statistický úřad -ČSÚ) the increase in the number registered by the labour office, the decrease in the wages of the active employees paying insurance premiums and the resulting lower contributions play a significant role in the unfolding of the current problematic situation.[172]

Accordingly in order to provide for the maintenance of the standards of the health care services and for progressive development other sources also need to be tapped. The basic pillars of the reform package worked out by health minister Leoš Heger - described in detail in the relevant part of the study - are comprised of the acts on the activities of health insurers, the services provided in the health sector and on emergency health services. Heger is convinced that the problems incurred in the health system must be resolved within the same system. According to the standpoint of the General Health Insurer (Všeobecná zdravotní pojišťovna – VZP ČR) - which is considered as highly relevant by the majority of its insureds - the growth of the costs of health services is a result of the improvement in the accessibility of health services, its expanding development and the introduction of new medical techniques, drugs and technologies.[173]

The following table shows the growth indices of the costs of the health insurers in detail, between 2006 and 2010:

170 Ministry of Health of the Czech Republic: http://www.mzcr.cz/Odbornik/obsah/regulacni-poplatky-_1197_3.html.
171 Czech Statistical Office: http://www.czso.cz/csu/redakce.nsf/i/mira_inflace.
172 Zdravotnické Noviny (Newspaper of Health): http://www.zdravky.cz/zpravodajstvi/z-domova/naklady-na-zdravotni-peci-do-brezna-presahly-prijmy-o-dve-mld-kc.
173 Public Health Insurance: https://vzp.cz/poskytovatele/infoservis-a-akcent/infoservis/infoservis-22-2011/vzp-letos-zaplati-za-peci-o-3-miliardy-vic-nez-loni.

Health segments	2006	2007	2008	2009	2010
Outpatient care	100.0	109.7	121.6	137.3	140.2
- dental services	100.0	106.8	108.3	115.1	117.4
- general practitioners	100.0	104.8	123.9	145.7	153.1
- rehabilitation care	100.0	106.9	117.5	141.2	144.5
- diagnostics	100.0	101.8	113.3	138.0	125.2
- special health care, including obstetrician	100.0	122.5	137.3	147.6	156.3
- home nursing care	100.0	114.1	119.0	152.8	147.3
Institutional health service provision	100.0	110.4	118.5	129.0	133.6
- hospitals	100.0	110.1	120.1	129.7	138.3
- specialised health institutions OLÚ	100.0	109.8	109.3	129.5	121.0
- specialised institutions for chronic patients – LDN	100.0	117.0	99.0	114.6	X
Spas	100.0	107.2	102.8	114.3	115.1
Transport, patient transport	100.0	103.5	120.4	120.5	118.7
Emergency health services	100.0	127.4	126.6	141.3	151.9
Prescription drugs	100.0	98.9	96.5	108.0	100.9
Medical aids for prescription	100.0	114.9	125.5	132.8	133.4
Total health care services	100.0	108.3	115.6	127.4	128.8

Table 3: The growth index of the growth index of the expenditures of the health insurers in detail, between 2006 and 2010.[174]

Ageing of the population

According to a study published by the Health Information and Statistics Institution (ÚZIS ČR) showing the health system of the Czech Republic in terms of the 2010 figures, the Czech population reached 10,532,770 by 31 December 2010. The number of Czech residents increased by 25,957 in 2010 thanks to migration and natural reproduction. Migration added 15,648 people to the Czech population, while child births increased the Czech population by 10,309. Despite the increase in the population the population growth rate dropped by about a third in comparison to 2009, when the number of people increased by 39.271. This regression trend is obvious both in growth by natural reproduction (618 persons less) and growth by migration (12,696 persons less).

The population's gradual ageing is a process that has been observed for quite some time now. The average age of men is 39.3 years, while that of women is up to 42.3 years. The proportion of people over 65 years of age has, since 2006, been higher than that of the 0-14 year old generation. In 2010 people over 65 years of age made up 15.5 percent of the Czech population, up 0.3 percentage points in comparison to the 2009 figure. Minors (0-14 years of age) make up 14.4 percent of the total population, 0.2 percent up on the previous year's figure. Although the number of children (0-14 years of age) has been increasing somewhat, it is still below the ratio of the elderly generation relative to the total Czech population. Accordingly, there are 107.8 elderly adults per 100 children. The corresponding ratio was only 107.0 in 2009.

174 ÚZIS, Health Care and Health Services in the Czech Republic 2010: http://www.uzis.cz/rychle-informace/zdravotni-pojistovny-naklady-segmenty-zdravotni-pece-5.

The number of childbirths has been diminishing since 2009 though during the preceding 7 years it increased continuously. 2010 was also a year of decrease when although the number of live births was 10,309, yet it was 618 below the number of children born in 2009. The number of children per woman - in view of their fertile period - was 1.49. It should be noted that the proportion of children born to women not living in marriage had increased to 40.3 percent, reflecting a 1.5 percentage point increase over 2009.

The number of weddings was 46,700 in 2010, somewhat below the preceding year's number. This shows a radical regression because since 1918 this has been a historical low, and is more or less equal to the number of marriages recorded some 200 years ago, when the population of the country was less than half of today's population. In regard to divorces, nearly 50 percent of the marriages end up in divorce. Most divorces take place 2-5 years after the wedding, on an average.

Abortions is not an insignificant factor contributing to the diminishing of the population either: a total of 39,300 abortions were recorded in 2010, some 1,300 less than in the preceding year. The number of natural or spontaneous abortions also dropped, from 14,600 to 14,000 which is also related to the number of intended pregnancies. The number of surgical abortions (about 24,000) made up 61 percent of the total number of abortions.

A total of 106,800 people died in 2010, some 600 less than in 2009. The number of mortalities per 100,000 men dropped to 940.8, while that of women dropped to 557.1. The composition of the causes of deaths remained unchanged in comparison to the preceding year: cardio-vascular diseases caused half of the mortalities (53,600 people), while tumours accounted for 26.4 percent (28.200 people). Some 5.8 percent of the mortalities (6,200 people) were caused by various respiratory diseases, while external factors - accidents, poisoning - caused 5.6 percent of the mortalities (6,000). Infant mortality (0-1 year-old babies) dropped significantly, by 2.7 percent to a historical low (313 cases).

Life expectancy at birth increased among men by 0.2 year to 74.4 years and by 0.5 year among women to 80.6 years. The available figures show that the gradual increase in the life expectancy at birth and the dramatic and constant decrease in the proportion of the minor age group (0-14 year generation) as well as the increase in the old age dependency ratio (over 65 years) poses a massive challenge to the Czech welfare state.[175]

Demographic processes qualify as a major factor from the aspect of the structure of the expenditures of health insurers. The Czech population has been ageing for quite some time, resulting in an increase in the frequency of the use of the health services and the costs incurred in the process. The increase in life expectancy at birth results in an increase in the chance of the need for permanent long term nursing care, primarily as a result of the chronic illnesses developing in elderly patients, and the potential users of the health services belong to the economically inactive age group. While the check health sector applies the principle of the reallocation of contributions from incomes - and the state contribution - according to the above quoted comment of the Czech Statistics Office the labour market is facing problems whereby it has a massive impact on the health system as well.[176]

175 ÚZIS, Health Care and Health Services in the Czech Republic 2010: http://www.uzis.cz/publikace/zdravotnictvi-cr-2010-statistickych-udajich.
176 Idem.

Structure of Health Spending and Ageing Society in France

The state social security organisation is the key element of the French social security system (Sécurité Sociale)[177]. The social security organisation manages the payments of state welfare services and the pension scheme, one of its twelve branches is the state health insurance fund (Assurance Maladie). State aids and cost reimbursements relating to hospital care, child birth, death and occupational illnesses are taken care of by the state health insurance fund. A number of state health insurance systems are functioning in parallel with each other in France: farmers and freelance professionals have traditionally had their own separate insurer schemes, but 89 percent of the population sign contracts with the general system. A significant part of the revenues of the state health insurance fund is made up of the employers' contribution making up 12.8 percent of the gross wage and the employees' contribution accounting for 0.75 percent of the gross wage, along with the generally so-called general solidarity contribution (contribution sociale généralisée) paid at 7.5 percent on the basis of income from investments, annuities, rentals, pensions etc. (the rate is slightly lower in the case of pensions and slightly higher in the case of revenues from capital gains.

The state health insurance fund does not at all provide coverage for all health expenditures and it reimburses only part of the costs payable by the patients. When using services provided by general practitioners the patients make payments in advance, while hospitals clear and settle their accounts directly with the health insurance fund. In the course of basic and outpatient care services the patients themselves pay 30 percent of the costs and since 2005 a one-euro visit fee. For hospital treatments they have been paying an 18 euro daily fee for a few years now, and the same amount is to be paid for particularly costly treatments. The system of a flat rate health care fee was introduced in 2008 under which the patient must pay 50 cents for drugs and paramedic services while in the case of patient transporting they are charged 2 euros. The annual amount of the flat rate fees cannot exceed 50 euros per patient.

Part of the costs so incurred may be reimbursed by the voluntary mutual, supplementary non-profit or for-profit insurers operating alongside the state health insurance fund but the visit fee and the flat rate fee must, by all means, be paid by the patients in order to reduce or at least keep the insurance of health spending - which is extremely high by international standards - under control. It was for the same purpose that the government introduced a new tax type a few years ago, which is called social debt reimbursement contribution (contribution au remboursement de la dette sociale), at 0.5 percent of the annual income.

177 See the Hungarian language summary drafted by the research institute called Egészségügyi Stratégiai Kutatóintézet: http://www.eski.hu/civiltajekoztatas/kepek/ho/anyagok/franciaorszag-2010.pdf, (Last download: 12.12.2011).

The 'comprehensive coverage' (CMU) was introduced in order to provide for those without income on which contributions could be paid, which guarantees the services provided by the state health insurance fund for 8 percent of the income of the individual. People whose annual income is below 9029 euros can access the CMU free of charge. The most disadvantaged social groups are also provided with the supplementary insurance (CMU-C) free of charge. According to most recent statistics[178] some 4.3 million people used the CMU-C services, 3 percent more than in 2009. To reduce the state's costs a new regulation was introduced in 2009, on the basis of which the state pays the CMU-C costs from taxes collected from supplementary insurers which however, is not fully accomplished as the CMU-C is generating a deficit.

Demographic indicators

France has outstanding demographic conditions. Women's life expectancy at birth is one of the highest in the world, behind only Japan, Spain and Switzerland according to 2009 OECD statistics[179] and men's life expectancy is also among the highest in the world. An unparalleled improvement has been accomplished in this field, because since 1950 women's life expectancy at birth has increased from 69.2 to 84.8 years, while that of men has grown from 63.4 years to 78.1 years, while the difference between the life expectancy of the two sexes has been decreasing since 1987. France has a favourable reproduction rate and the population has been growing steadily, yet as a result of the high life expectancy the population is still ageing. This process brings about a steady increase in the number of illnesses year after year and in regard to infectious diseases this increase has been rather alarming: it has nearly doubled since 1997.[180] The ageing of the population has also necessitated a reform in the pension scheme, as before this year's pension reform there were 12.2 million pensioners for 17.6 million contribution payers (contribution payer/pension rate = 1.44) while in 1975 there were 4.1 million pensioners for 13 million contribution payers (a rate of 3.14).

The social security deficit and the efforts made to balance it

As a consequence of the above circumstances France spends a lot - even by international standards - on its health sector (11.8 percent of GDP, while the OECD average is 9.5 percent). Moreover, the ratio of the health spending has been growing steadily year after year, as a consequence of which the social security system is producing a huge deficit. As a result of the financial crisis that broke out in 2008 the deficit topped at EUR 23.9 billion in 2010 while before the crisis it had been around EUR 10 billion a year. To control the deficit of the social security system the Parliament adopts a specific act of law each year on the deficit[181]. For 2011 the government expects a social security deficit of EUR 18.2 billion and

178 See the year-2010 national health accounts (Comptes nationaux de la Santé): http://www.sante.gouv.fr/IMG/pdf/Comptes_nationaux_sante_2010.pdf (Last download: 22.10.2011).
179 OECD, http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT&lang=fr (Last download 12.12.2011).
180 Source: http://www.ecosante.fr/index2.php?base=FRAN&langh=FRA&langs=FRA&sessionid (Last download: 12.12.2011).
181 See the so-called PLFSS (Projet de loi de financement de la sécurité sociale): http://proxy-pubminefi.diffusion.finances.gouv.fr/pub/document/18/11544.pdf ,(Last download: 12.12.2011).

for the next year - despite the deteriorating macroeconomic context: the expected GDP growth had to be reduced from 2.5 percent to 1.75 percent, while inflation may be 2.1 percent instead of 1.5 percent next year - it expects a deficit of EUR 13.9 million.

The 2010 pension reform has been an important element of the efforts made to balance off the social security system's operations, in which the general retirement age is to be gradually increased to 62 years of age by 2018 (and for those paying social security contributions irregularly, to 67 years) from which the government expects extra revenues in an amount of about EUR 5.5 billion as early as in 2012 already[182], but the austerity package announced a few months ago by Prime Minister François Fillon may bring about a more than EUR 6 billion revenue increase for the social security system. In parallel with the efforts made to increase the revenues, efforts have also been and are being made to cut the expenditures: the annual plan for the state health insurance fund scheme operating as a part of the social security system[183] would reduce the deficit by another one tenth of percentage point after last year's 2.9 percent, primarily by transforming the system of sick pay system and by cutting drug prices, of which the government expects to save, for example, EUR 670 million next year.

Health indicators and their changes

The French government publishes a comprehensive analysis of the health sector each year[184], including, in particular, the health spending. A number of different indicators are applied to this latter field, a brief explanation of which is indispensable for the understanding of the following sections. French statistics distinguish the category of *Consumption of medical goods and operations/treatments* (Consommation de soins et de biens médicaux – CSBM), which includes the costs of hospital and outpatient care services, other health expenditures (medical aids, laboratory analyses, thermal spa treatments etc.), along with the costs of medicines and other medical aids. Only the costs relating to temporary treatments fall in this category, the costs of the treatments and nursing of people with disabilities and elderly people living in homes are not include in this type of statistics[185]. The *current health spending* (Dépense courante de santé – DCS) indicator[186] is a much more comprehensive one. In addition to the CSBM it comprises the costs of sick pays, preventive actions and the state subsidies allocated to the health system, research and training as well. The total health spending indicator, the DTS (Dépense totale de santé - DTS[187]), is a joint OECD statistics. In contrast to the DCS it does not include

182 Idem.

183 The so-called Ondam (Objectif national de dépense de l'assurance maladie).

184 For the report on 2010 see: http://www.sante.gouv.fr/IMG/pdf/Comptes_nationaux_sante_2010.pdf (Last download: 20.11.2011). An abbreviated version of the several hundred page document is accessible here: http://www.sante.gouv.fr/IMG/pdf/er773.pdf, (Last download: 12.12.2011).

185 For an official definition of the CSBM see the homepage of the French Statistics Office at: http://www.insee.fr/fr/methodes/default.asp?page=definitions/conso-soins-biens-medicaux.htm, (Last download: 11.12.2011).

186 For a definition of the DCS see: http://www.irdes.fr/EspaceEnseignement/ChiffresGraphiques/Cadrage/DepensesSante/DefinitionsDepSante.htm, (Last download: 11.12.2011).

187 Compare: the definition of the statistics office: http://www.insee.fr/fr/methodes/default.asp?page=definitions/depense-totale-de-sante.htm, (Last download: 12.12.2011).

part of the sick pays and preventions, the costs of research and training but it does include investments underway in the health sector along with the expenditures relating to people with disabilities and those in permanent need of nursing care.

According to the year 2010 report the CSBM amounted to EUR 175 billion (that is EUR 2698 per resident), accounting for 9 percent of GDP. The rate of the increase of the CSBM has been decelerating; after the 3.2 percent increase in 2010 a 2.3 percent growth is expected for 2011. The 2010 calculations of the statistics office[188] clearly show the growth and the changes in the structure of the CSBM. During the past 15 years the CSBM has nearly doubled: in 2010 it was EUR 175 billion while in 1995 it was EUR 98 billion. During the period under review the costs of patient transport and the 'other health expenditures' (including optical instruments, prostheses, ortheses and medical aids for those with motoric disabilities and bandage materials) increased most, by more than three times. Doctors' costs and dental expenditures changed relatively moderately. Hospital costs and drug costs changed similarly to the change of the CSBM as a whole.

The DCS has been changing along similar patterns, though the purchase of the 50 million vaccines against the H1N1 pandemic resulted in a substantial increase in the statistics, but the growth rate has returned to a pattern similar that of the CSBM since then. The rate of growth of the hospital services has been decelerating in both the private and the public sector, just like the increase in the GP expenditures. The rate of the increase in drug consumption has been slowing down steadily, last year it was at 1.1 percent. Incidentally, the French spent a total of EUR 34.4 billion on drugs - 19.7 percent of the CSBM, or EUR 525 per capita. This is one of the highest figures in the world, exceeded only by the USA, Canada and Ireland. One of the major contributing factors to this was the aforementioned drug price cut enabled by the increasing use of generic drugs that are no longer protected by brand names, that can be distributed without having to pay royalty and that are thus a lot cheaper than the originals, the proportion of which increased from 4.1 percent to 13.3 percent during the past 10 years.[189]

The effects of the ageing of the population

The particular importance of the DCS ratio lies in the fact that it shows the increase in the cost of the provision of services for the elderly. During the past 10 years the DCS increased from EUR 146 billion to EUR 234 billion, though the rate of increase has been declining. The amount spent on institutional care provision for the elderly has increased dramatically during the past decade, from EUR 2.9 billion to EUR 7.7 billion and together with the costs of home care provision the change would appear even more striking. Only the amount spent on nursing care in hospitals has decreased, while the costs of all other institutional sectors have increased substantially. In 2008 for instance, the amount spent on the provision of care and services for the elderly increased by 13.3 percent in one year[190]. The bulk of the increased costs is paid by the health insurer (EUR 7.1 billion in 2010)

188 See the table on the data of the CSBM between 1995 and 2010: http://www.insee.fr/fr/themes/tableau.asp?reg_id=0&ref_id=NATFPS06302, (Last download: 2011.12.12.).
189 See the comprehensive report already referred to: http://www.sante.gouv.fr/IMG/pdf/Comptes_nationaux_sante_2010.pdf 210.
190 Idem., 223.

but since 2006 another state organisation called CNSA[191] has also been contributing to the financing of the sector (by EUR 896 million last year).

Despite the increase in the costs the proportion of financing has remained more or less unchanged in recent years[192], a total of 75.8 percent of the CSBM is financed by the social security system, 13.5 percent is financed by the supplementary insurers and 9.4 percent is contributed by households. In the case of hospital spending the social security system's contribution is higher (over 90 percent) and it is lower in the case of outpatient care services and drugs (63 percent and 66 percent). Patients' contributions increased only to a small extent.

The 2010 report discusses the changes in the DCS by age separately[193], along with the ratios of contribution payments and the payments made by the fund. The conclusion drawn by the report is that some three times as much is spent on health expenditures over the age of 75 than between 46 and 55 years of age. The standard deviation of the expenditures also expands with advancement in age. Over the age of 75 the health cost is EUR 6600 per capita, but the 10 percent of individuals in the poorest health conditions spend more than 18000 euros a year, while half of the population spend below EUR 2500. The costs reimbursed by the health insurer also increase significantly with age (5740 euros/person on an average in contrast to the 1460 euros/person in the 46-55 year age group), the reimbursements by supplementary insurers increase by a lower rate (EUR 640 per year, while in the 46-55 year age group it is 370 euros) but the patient's contribution also increases with age (EUR 310 a year, with 160 EUR/person/year in the 46-55 year age group). The ratios of payments to and by the funds also show significant differences by age in the case of the state health insurer and the supplementary insurers. The largest contribution payer 46-55 year age group pays 227 percent of their reimbursements, i.e. they are in an EUR 2580 negative balance each year, while the oldest age group pays only 14 percent of the state health insurance funds they use, i.e. they close their years in an EUR 4940 sufficit. The change is a lot smaller in the case of the supplementary insurers, where apart from the age group below 15 years pays more than they receive in the way of cost reimbursements, though the two figures are increasingly close to one another in the case of the oldest age group.

The changed costs of service provision, the increase of patients' contributions and the series of austerity measures have lead to a situation where some people decline to use certain medical services for financial considerations[194]. According to the latest data on 2008 a total of 15.4 percent of the adult population have made such decisions. Without the CMU and CMU-C introduced in 2000 - which provide services free of charge below a certain income level - a lot more people would be forced to decline to use some medical services.

191 Caisse nationale de solidarité pour l'autonomie, ,that is, Solidarity for Autonomy National Fund managing the so-called solidarity autonomy contribution accounting for 0.3 percent of the salaries and incomes.
192 See page 241 of the Report.
193 Idem, pp. 31-51.
194 Idem, pp., 85.

Structure of Health Spending and Ageing Society in Germany

The costs of the mandatory health insurance system have been growing practically unbroken for years, which are made up, for the most part, of hospital costs, drug costs and the amount spent on doctors. Besides the significant increase in the health spending, the population continues to grow older and to decrease and of course it also has and will have an impact on the costs.

A breakdown of the total health spending

According to data released by the German Statistics Office a total of EUR 278.3 billion was spent on health in Germany in 2009, which was 5.2 percent up on the corresponding amount of 2008, which was a significantly larger increase than in the preceding years, as between 2000 and 2008 the health spending increased by an average of 2.7 percent a year. The mandatory health insurance entailed the largest cost, the EUR 160.9 billion amount of which covered 57.8 percent of the total health spending. The costs of the mandatory health insurance scheme increased by 6.2 percent or EUR 9.4 billion in comparison to 2008. The expenditures in the field of nursing care also increased similarly where the costs increased by 6 percent to EUR 20.3 billion. The costs increased in the case of private health insurers as well, where the expenditures grew by 4.3 percent, contributing EUR 26 billion to the total health costs. A 3.7 percent cost increase was observed in the case of households and non-profit private institutions whereby they contributed EUR 37.5 billion to the total health bill. More than half of the expenditures was made up of the costs of services and products provided by outpatient institutions, such as doctors, pharmacies and outpatient care institutions which increased by 4.9 percent in comparison to 2008, to EUR 138.2 billion. A 5.8 percent cost increase was recorded in the hospital sector which increased the amount spent on this segment to EUR 100.2 billion. The 6.3 percent (EUR 4.3 billion) increase in the largest - EUR 71 billion - item within this resulted in a higher than average increase in the expenditures which was a result primarily of the restructuring of hospital financing in 2009 and of the improvement in the position of the nursing staff. A similar cost item is made up by the nursing institutions with EUR 21 billion and the prevention and rehabilitation institutions with EUR 8.2 billion.[195]

195 Based on data available up to 07.12.2011.
Communication by the Mandatory Health Insurance Network: http://www.gkv-netzwerk.de/templates/main.jsf?Select_id=f33c2cad-5692-4de4-bf4b-87d7847a4307&Filter_id=select&lang=de&Message_id=b2e726f7-c75d-457c-b649-7a648f3e6694&Filter_id=select&alias=true,
Communication of the German Statistics Office: http://www.destatis.de/jetspeed/portal/cms/Sites/destatis/Internet/DE/Navigation/Statistiken/Gesundheit/Gesundheitsausgaben/Gesundheitsausgaben.psml.

The expenditures of mandatory health insurance

More than 90 percent of the German population are members of the mandatory health insurance scheme, therefore in assessing the expenditures of the health insurers attention is to be focused on the cost structure of the mandatory health insurers, along with the changes in the revenue and expenditure side of the mandatory health insurers. While the balances of the mandatory health insurers were positive up to 2009, in 2010 - despite the governmental measures affecting health insurance - the balance turned negative despite the fact that the revenues of insurers - as a consequence of an increase in the contribution rates, among other things - grew continuously which however, could not offset the increased rate of growth in the expenditures side and the administrative costs. Although at the time of the preparation of the study no final data for 2010 were available, according to information released by the Federal Health Ministry the financial position of the mandatory health insurers was even worse than in 2009. While by the first half of 2009 the health insurers had a sufficit of EUR 1.2 billion by the end of the year it turned into a deficit and in first half of 2010 they only had a surplus of nearly EUR 112 million despite the fact that the state subsidy in the first half amounted to nearly EUR 3.9 billion. While the transfers from the Health Fund - described already in the previous study - were the same throughout the year, it must be taken into account that the costs of the first half are regularly below the average of the whole of the year thus the analysts expect a deficit of EUR 3.1 billion for the whole of the year in the mandatory health insurance scheme.[196] According to preliminary data applying to the first 9 months of year 2011 the financial position of the mandatory health insurance system was better than in 2010: between January and September the health insurers booked a nearly EUR 3.9 billion sufficit, as the revenues of EUR 137.7 billion were balanced by EUR 133.7 billion expenditures. In terms of the whole year's expected financial position it should be taken into account that in the fourth quarters of the years the expenditures regularly exceed those of the preceding quarters by EUR 1-1.5 million This is why the surplus of the preceding months is expected to decline substantially. [197]

The expenditure structure of the mandatory health insurers

The following figure clearly indicates that the bulk of the expenditures of the mandatory health insurance scheme is made up of hospital costs (EUR 56.2 billion) while the second and third largest items are made up of drugs (EUR 28.5 billion) and doctors' costs (EUR 26 billion). In 2009 the total expenditures of the mandatory health insurers amounted to EUR 170.8 billion of which EUR 160.9 billion was used for payments for services and the remaining amount comprises operating and other costs.

196 Data from the Federal health report: http://www.gbe-bund.de/oowa921-install/servlet/oowa/aw92/dboowasys921.xwdevkit/xwd_init?gbe.isgbetol/xs_start_neu/&p_aid=i&p_aid=3050384&nummer=627&p_sprache=D&p_indsp=-&p_aid=79752319,
Press communication of the Federal Heath Ministry:
http://www.bmg.bund.de/ministerium/presse/pressemitteilungen/2010-03/pressemitteilung-finanzentwicklung-der-krankenkassen-im-1-halbjahr-2010-ausgabenzuwaechse-deutlich-hoeher-als-anstieg-der-einnahmen.html.
197 Communication of the Mandatory Health Insurance Network: http://www.gkv-netzwerk.de/CMS/GKV-_Finanzentwicklung_im_1-_bis_3-_Quartal_2011-fe1d9c34-650b-4c4b-b3b8-a4834e324111_Meldung.html.

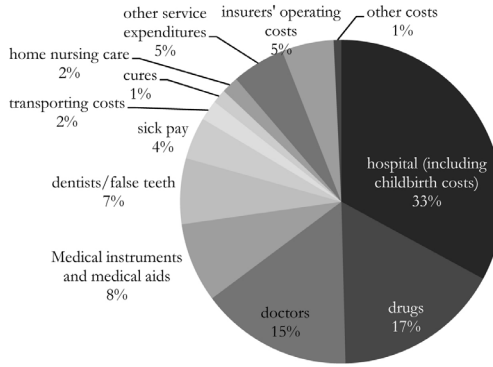


Figure 1: The cost structure of mandatory health insurance in 2009 in terms of percentages of the total cost and in EUR billion [198]

Changes in the costs of mandatory health insurance

As is clearly indicated by the following chart, the expenditures of the mandatory health insurers have been growing nearly continuously year after year, as in the case of Germany's total health spending. The following chart shows the changes in the spending of the mandatory health insurance system between 1999 and 2009:

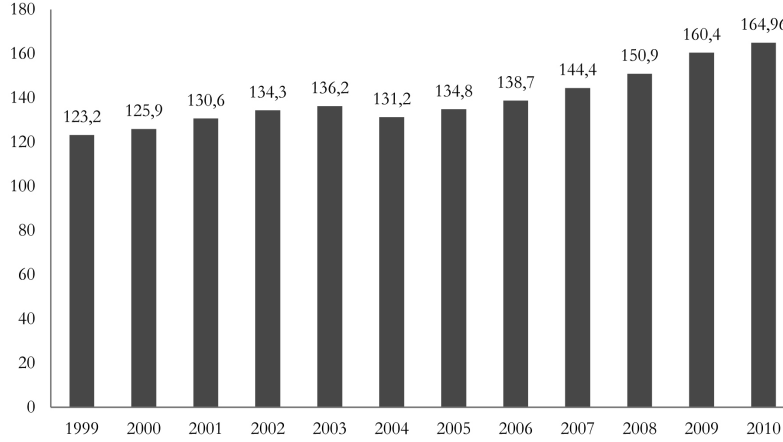


Figure 2: The expenditures of the mandatory health insurance scheme on service provision between 1999 and 2009 in EUR billion[199]

198 Data of the Association of Contracted Doctors': http://daris.kbv.de/daris/doccontent.dll?LibraryName=EXTDARIS^DMSSLAVE&SystemType=2&LogonId=7f8aaab644267d95acac34221c3f86a7&DocId=003762995&Page=1,
Social policy homepage of the Duisburg-Essen University: http://www.sozialpolitik-aktuell.de/tl_files/sozialpolitik-aktuell/_Politikfelder/Gesundheitswesen/Datensammlung/PDF-Dateien/abbVI25.pdf.
199 Data of the Health Ministry: http://www.bmg.bund.de/fileadmin/dateien/Downloads/Statistiken/Infografiken/Krankenkassen/Infografik_ausgaben_gkv_1.pdf.

It is also worth noting the reason for the cost increases - that have been rather disproportionate in some cases - in the three areas entailing the largest expenditure items. In the case of doctors' treatments and hospital treatments the improvement of the doctors' position - the increase in their pays - and the improvement of the financial positions of hospials resulted in cost increases for the health insurers. The costs of drugs have also been growing steadily for years, as a result of the shortcomings in competition in the sector and the disproportionate increase in the prices of drugs with fixed prices and those without such. According to statistics put together by the Federal Association of Contracted Doctors (Kassenärtzlicher Bundesverband, KBV) the costs of drugs sold by pharmacies and of medial aids have increased to nearly twice the amount recorded in 1991 at the time of the German reunification[200]. Despite the fact that a number of regulatory actions have been taken to restrict the steady increase in the costs, the trend continued, except for the period between 1997 and 2004. A number of governmental actions were taken to break this trend in 2009 and in 2010, including the act on the 'new regulation of the drug market' which was mentioned in the first part of the study already. According to latest figures as a result of these measures the costs of the health insurers on drugs decreased - by 5.7 percent - in 2011 for the first time in several years. Since however, no more savings are to be expected from the increase in the forced price discount of non-fixed price drugs after August 2011, no cost cutting is to be expected from this any longer, thus according to some data a slight price increase appears to be evolving. An increasing trend is found in sick pays resulting from the increase in the number of those entitled to sick pay as a result of the increase in the retirement age and the increase in the number of lengthy physical diseases.

The operating costs of health insurers began to increase again after a long period of stability up to 2008. To stop the continuation of this trend a measure was adopted in the framework of the earlier discussed health reform that froze these costs at the levels of 2010 for 2011 and for 2012. [201]

Ageing population and its impacts

Statistics have been showing the same picture of the trends affecting the German population: the number of people has been decreasing and the proportion of elderly people has been on the increase while the German society is one of the oldest ones of the world. This is reflected by the 2011 statistics yearbook as well: according to data disclosed by the Statistics Office some 20 percent (nearly 17 million people) of the German population is older than 65 years of age. The really alarming figure may, however, be that the corresponding ratio was only 10 percent in 1950. During the past 60 years however, not only the proportion of people over 65 has doubled but the life expectancy of the Ger-

200 Communication of the Association of Contracted Doctors: http://www.kbv.de/24852.html.
201 Press release of the Health Ministry:
http://www.bmg.bund.de/ministerium/presse/pressemitteilungen/2010-03/pressemitteilung-finanzentwicklung-der-krankenkassen-im-1-halbjahr-2010-ausgabenzuwaechse-deutlich-hoeher-als-anstieg-der-einnahmen.html
Communication of the Mandatory Health Insurance Network:http://www.gkv-netzwerk.de/CMS/GKV-_Finanzentwicklung_im_1-_bis_3-_Quartal_2011-fe1d9c34-650b-4c4b-b3b8-a4834e324111_Meldung.html.

man population has increased by 13-14 years, while the birth rate has dropped to nearly 50 percent of the original level. Accordingly, Germany is affected by demographic changes from two aspects: while the ratio of the elderly has been growing the population has been decreasing, which cannot be offset even by the high immigration rate. Moreover, according to forecasts, these trends are not only going to continue but accelerate, raising substantial issues in both health and the other social and welfare providing systems.[202] From the sustainability of the social and welfare systems it is also a relevant factor besides the potential increase in the costs that along with the ageing of the population the revenues of the social security system are also decreasing with the decrease in the number of contribution payers.[203]

Of course the trends in the health costs are related to the health status of the population and its composition in terms of age and genders. As to whether the increase in the proportion of the elderly necessarily results in an increase in the cots, different experts hold different opinions: some say that demand for health services will increase as the population is growing older, since many illnesses and condition deteriorations are related to age. Another cost increasing factor in the health sector is the development of therapeutic and diagnostic techniques. Another approach however, argues that as a result of the increase in the life expectancy people live in good health longer and some serious illnesses to do not occur before a certain time before death. According to this approach the years in live with higher mortality rates are related not to absolute age but to relative closeness to death. [204]

In relation to the hospital costs making up the largest item within the structure of the expenditures of health insurers - accounting for a quarter of the heath outlay - the German Statistics Office prepared a model calculation where for the sake of simplicy they assumed that the hospital treatments are correlated to age and sex, while the parameters of the treatments remain unchanged in the future even on the basis of the 2005 basis year. Based on the statistics the researchers found that by 2030 the number of people over 60 years of age will increase from 25 percent in 2005 to 37 percent. According to calculations in comparison to the 17 million hospital patients in the basis year the number of patients may increase by 2030 by 12 percent to 19 million. While in 2005 some 48 percent of hospital patients were over 60 years of age, by 2030 the corresponding ratio may increase to 62 percent. It should be noted that according to another theory relating to the ageing and the changes in health costs the number of people treated in hospitals will increase to 18 million in 2030. The difference between the two approaches is clearly indicated by the estimated percentage rates in the increase in the number of

202 2011 Statistics Year Book chapter 1 pp 22-23: http://www.destatis.de/jetspeed/portal/cms/Sites/destatis/Internet/DE/Content/Publikationen/Querschnittsveroeffentlichungen/Datenreport/Downloads/Datenreport2011Kap1,property=file.pdf.

203 Federal Agency for Civic Education: http://www.bpb.de/themen/GWGCUY,2,0,BevpercentF6lkerungsentwicklungpercent3A_Soziale_Auswirkungen.html.

204 2011 Statistics Year Book 2011 Chapter 9 p. 239: Effects of demographic changes - abstract from the official statistics: http://www.destatis.de/jetspeed/portal/cms/Sites/destatis/Internet/DE/Content/Publikationen/Querschnittsveroeffentlichungen/WirtschaftStatistik/BevoelkerungAuswirkungDemegraphischerWandel,property=file.pdf.

patients: while according to the 'status quo' model an increase of even 12 percent may occur, according to the 'decreasing treatment quotas' theory the ratio would be only 5 percent. In the course of the calculations of the status quo model the estimates of the number of those in need of nursing show that their number may increase by 58 percent 3.4 million by 2030 in comparison to the 2.1 million recorded in 2005. At the same time, 33 percent of the patients were over 85 years of age and by the time of 2030 this proportion may grow to as high as 48 percent. [205]

205 Effects of demographic change – abstract from the official statistics: http://www.destatis.de/jetspeed/portal/cms/Sites/destatis/Internet/DE/Content/Publikationen/Querschnittsveroeffentlichungen/Wirtschaft-Statistik/Bevoelkerung/AuswirkungDemegraphischerWandel,property=file.pdf,
Official report of the Federal Health Report: http://www.gbe-bund.de/gbe10/owards.prc_show_pdf?p_id=12529&p_sprache=d&p_uid=gast&p_aid=71870590&p_lfd_nr=6 p.20.

Structure of Health Spending and Ageing Society in Great Britain

The total spending of the British National Health Service (NHS) has been growing rapidly and steadily since its establishment on 5 July 1948. While in the year of its establishment the British government spent GBP 11.4 billion on the operation of the Service, in the 2008/2009 fiscal year the corresponding total exceeded GBP 110 billion. The past 63 years brought about an approximate tenfold increase in the total expenditure, far exceeding the approximate 4.8-time increase in both the gross domestic product and in the total budget of Great Britain.

The different 'constituent countries' - Scotland, Wales, Northern Ireland - are separately responsible for the provision of health care services in the United Kingdom. In regard to the per capita spending, the largest amount is spent on health services in Northern Ireland (GBP 2213) and the smallest amount is spent on the same by England (GBP 1875), according to 2009-2010 figures.

At present some 80 percent of the NHS budget is disposed over by a total of 152 Primary Care Trusts (PCT). The funds are allocated on the basis of population indicators and the needs for health care services. The PTCs spend the amounts allocated to them on satisfying local needs for health care services. The PCTs purchase services from the NHS for the most part, but the amount of purchases from the independent, private and voluntary sectors has also been on the increase.

The draft legislation (White Paper) put forth by the Department of Health, entitled Equity and Excellence reflects an ongoing transformation of the above form of financing. The adoption of the proposed new legislation could result in the disappearance of the PCTs and that would entail a change in the above roles in purchasing services. Part of the NHS budget may be transferred to GP groups in the near future.

As was detailed above, the bulk of the total NHS spending is focused on the following three areas: psychiatric care, cardiovascular care and the treatments provided for tumour patients. These three areas account for 30 percent of the total NHS spending.

The structure of NHS

The NHS was established 63 years ago with the aim of providing health services for all citizens of the United Kingdom, the financing of which should be provided for by reallocating the public tax revenues. At present the Department of Health is responsible for the central governance of the health service, together with the Secretary of State for Health, the position being held, since May 2010 by Andrew Lansley, Conservative Party), and with the Minister for Health and Community Care for Scotland, the Minister for Health and Social Services for Wales and the Minister for Health, Social Services and Public Safety for Northern Ireland. The Scottish Parliament has full power

of control over the health sector while the Welsh Parliament can influence the execution of the health services though in contrast to the Scottish Parliament it cannot regulate the functioning of the NHS. As for the Parliament of Northern Ireland, similarly to that of Wales, it lays a role in the development of the execution of the services.

The structure of the NHS is different in each of the 'constituent countries', but in regard to financing the four parts of the United Kingdom are based on a common platform, in that the bulk of the NHS budget is distributed among the PCTs on the basis of the so-called *needs-based funding formula* to make sure that they provide health care services equally accessible and free of charge for all British citizens regardless of gender or financial standing.

The differences between the four constituent states (England Anglia, Scotland, Wales and Northern Ireland) are to be found primarily in the internal market structures of the health care services and in the market roles that have evolved within those structures. In the health sector of England and Northern Ireland the respective roles of the principal (placing orders) and the service provider are separated. Accordingly, one part of the health service providing system concludes contracts with the NHS or with independent health care service providers in order to provide the necessary treatments for patients. In Scotland and in Wales however, this type of internal market simulation is not applied. The buyer/service provider structure of health care service provision was eliminated in Scotland in 2004 and in Wales in 2009. In the system adopted by these two states the so-called Local Health Boards are responsible for both financing and procurement.

Financing the NHS

The overwhelming majority of the expenditures of the NHS are financed through central tax revenues. The different parts of the country receive their shares of the central tax revenues on the basis of the so-called Barnett allocation mechanism (Barnett formula) and they decide how much they dedicate to the operation of the NHS.

In addition to the central transfers the NHS can raise other revenues as well, by charging various fees or contributions to treatment costs (co-payments). The revenues raised from such fees are maximised by the different parts of the country separately from each other. Other funding sources of the NHS include the prescription fee which is paid in England by a certain group of patients, along with fees payable for dental treatments. The budget of the English NHS received GBP 470 million from prescription fees in the 2009/2010 fiscal year, accounting for 0.5 percent of the total budget of health care services in England.[206] The English NHS raised GBP 597.6 million from fees relating to dental treatments in the 2009/2010 fiscal year[207], while in Wales the NHS budget booked GBP 26.9 million[208] from such fees.

In addition to the above there are other, less substantial revenue sources in place for the NHS. Such sources include, for instance, the provision of health care services at NHS prices for patients insured abroad or the revenues of hospitals from parking, phone use and other types of fees. The NHS trusts are also authorised to provide health care services for patients in private practices. While the amounts received through private specialised

206 NHS Business Services Authority, http://www.nhsbsa.nhs.uk/PrescriptionServices.aspx.
207 NHS Information Centre NHS Dental Services for England 2009/10.
208 Welsh Assembly Government NHS Dental Services 2009/10.

consulting hours account for 0.8 percent of the trusts in England, the corresponding ratio was 0.2 percent in Wales and only 0.1 percent in Scotland and Northern Ireland.[209]

Figures 1.a and 1.b show the total health spending of the central government in the United Kingdom at 2010/11 prices, and as a percentage of GDP. Though the data are shown by the figures from 1948/49 to date, it must be noted that the scope of the duties of the NHS has been increased/decreased on a number of occasions during the past decades thus the data presented in the figures are not fully consistent. At today's prices the 1949 budget of the NHS amounted to GBP 10.7 billion and it would have accounted for 3.5 percent of today's GDP. By the 2009/10 fiscal year the funding requirement of the NHS had increased to more than 10 times the original amount, to over GBP 122 billion or 8.5 percent of GDP. It is also clear from the figure that though the ratio of financing has been increasing steadily, the rate of increase did not accelerate dramatically before the past decade. The real value of the amounts spent on health between 1999 and 2010 increased by 88 percent.

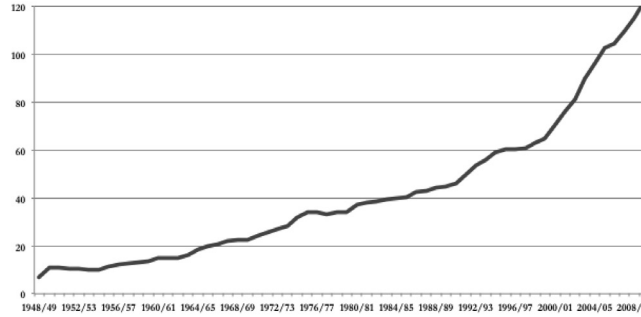


Figure 1.a: General government net health expenditure (£bn at 2010/11 prices)[210]

Figure 1.b: Net expenditure as a proportion of GDP[211]

209 NHS's Private Patient Revenues Grow Through Recession. http://www.laingbuisson.co.uk/LinkClick.aspx?fileticket=EWtTxZ0ci4Apercent3D&tabid=558&mid=1888.

210 Source: HM Treasury Public Expenditure Statistical Analyses 2011.

211 Source: HM Treasury Public Expenditure Statistical Analyses 2011, HMT, GDP deflator consistent with March 2011 budget.

Figure 2 outlines the changes in the real value of the funding of NHS from the 1950s. The figure shows that there were six years during the past 60 years when the funds allocated to the NHS fell below the amount of the preceding year. The most dramatic decrease took place in 1954 (6.3 percent). Up to 2011 the average annual increase of the financing of the health sector in real terms was 4.9 percent, but between 2000 and 2010 the real increase in financing exceeded 65 percent, which is a rate never before observed during the earlier decades of the history of the NHS.

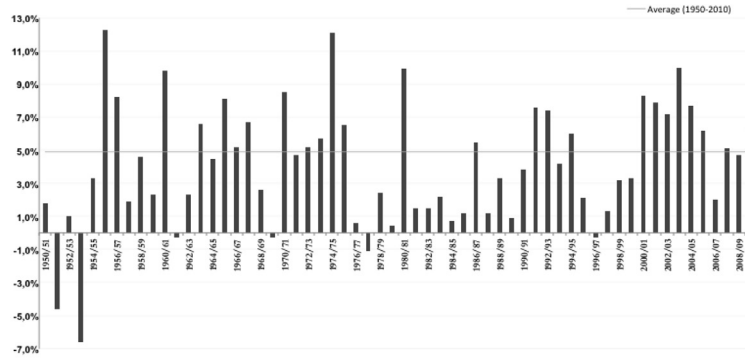


Figure 2: Annual changes in real terms general government expenditure on the UK NHS[212]

Analysis of the structure of the total NHS spending

Figure 3 shows the changes in the total NHS spending in England and its planned amount from 1974 on up to the 2014/15 fiscal year. In terms of 2010/11 prices the GBP 23.7 billion budget of 1975 increased to GBP 102 billion by 2010. The calculation and settlement techniques however, may have been modified during the past decades, so instead of scrutinising concrete numerical data one may arrive at a more consistent picture by assessing the increase in the real value of financing. This is meant to be illustrated by Figure 3.

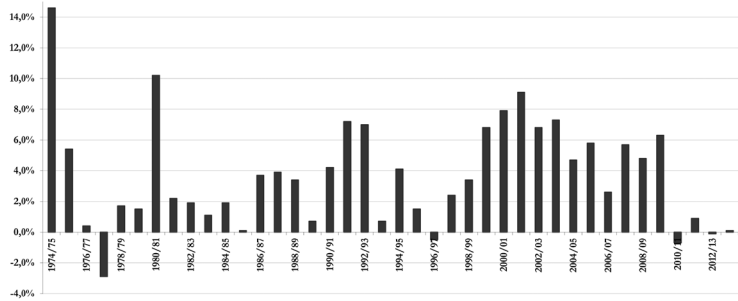


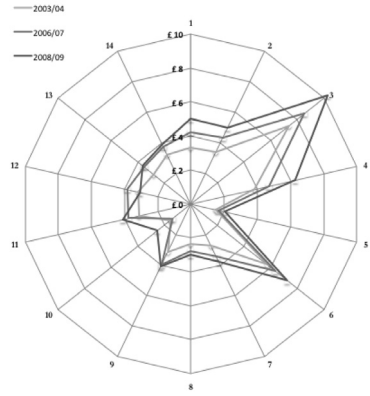
Figure 3: NHS net expenditure in England - real terms change[213]

212 Source: HM Treasury Public Expenditure Statistical Analyses 2011.

213 Source: HM Treasury Public Expenditure Statistical Analyses 2011, HM Treasury Spending Review 2010, HMT, GDP deflator consistent with March 2011 budget.

Categorisation of the total spending

Since the 2003/04 fiscal year the British Department of Health has been collecting and analysing total spending figures relating to various categories of health care services and types of conditions. Figure 4 shows the applied categories and the funds (in GBP billion) spent on those categories each year. The figure clearly shows that the bulk of the funds is concentrated on three areas: psychiatric care, cardiovascular care and the treatments provided for tumour patients.



1. Infections diseases, disorders of blood, endocrine, nutritional and metabolic problems
2. Cancers and tumours
3. Mental health disorders
4. Learning disabilities and neurological problems
5. Problems of vision and hearing
6. Problems of circulation (CVD)
7. Problems of the respiratory system
8. Dental problems
9. Problems of the gastrointestinal system
10. Problems of the skin, adverse effects and poisoning

Figure 4: Expenditure in £bn by programme budget category, selected groupings, 2003/04 to 2008/09[214]

Capital investments

The claim that owing to the changes during the past decades in the applied accounting procedures it is difficult to carry out any consistent analysis and comparison over a longer period of time of officially disclosed data applies to capital investments as well. Table 1 contains figures of the amounts spent on capital investments between 1997/98 and 2008/09, in terms of each year's nominal values and in terms of real value in 2008/09.

214 Source: HC Health Committee Public Expenditure on Health and Personal Social Services 2009.

Year	Cash (£m)	2008/09 prices (£m)
1997/98	1560	2030
1998/99	1308	1667
1999/00	1515	1894
2000/01	1870	2307
2001/02	2106	2541
2002/03	2411	2818
2003/04	1891	2150
2004/05	3206	3646
2005/06	3102	3369
2006/07	4236	4468
2007/08	4104	4207
2008/09	4585	4585

Table 1: NHS capital funding 1997-2009[215]

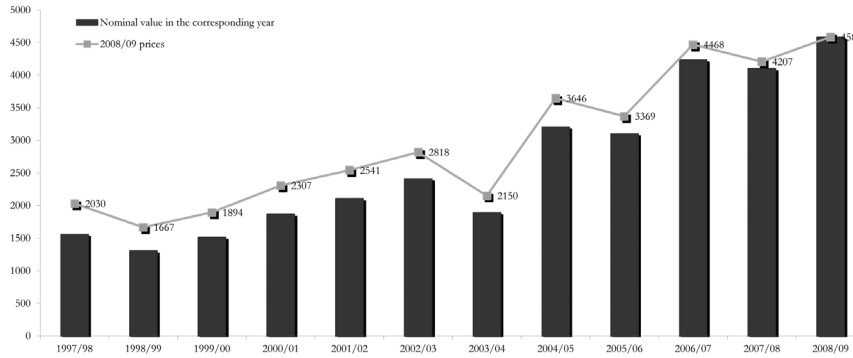


Figure 5: NHS capital funding 1997-2009 (£m)

PPP investment projects in the health sector

The number of PPP type investment projects organised in the framework of what is referred to as Private Finance Initiative (PFI) increased after the Blair cabinet took office in 1997. On account of their very nature, such types of capital injections were not sated in the financial accounts. The bulk of the funds of the PFI programme is still absorbed by the NHS as a natural consequence of which the resulting future central payment obligations are also linked to NHS PFI programmes. In the framework of the PFI programmes the NHS orders various large (construction) projects as well as project management from private enterprises forming consortiums. Most PFI contracts are concluded for 30 year periods, during which the operator NHS Trust re-leases the real estate

215 Source HC Health Committee Public Expenditure on Health and Personal Social Services 2009.

constructed under the arrangement. Until the expiry of the contract the obligation to make regular payments is borne by the NHS trust concerned.

At present there are as many as 103 contracts concluded under PFI arrangements in place, their estimated total cost is GBP 65.1 billion. The PFI payments made in fiscal 2009/10 exceeded GBP 1 billion.

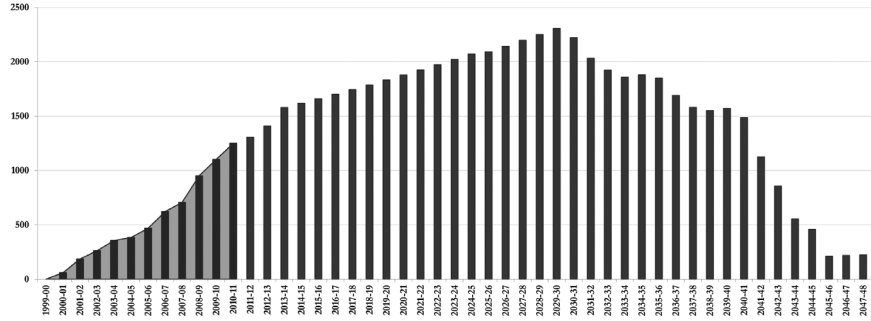


Figure 6: Yearly payment schedule for all NHS PFI schemes (£m) (signed before 15th June 2010, lifetime contracts)[216]

Resource allocation

A total of 80 percent of the NHS budget (GBP 84 billion) is allocated in fiscal year 2010/11 to the 152 PCTs. From the Primary Care Trusts the funds are transferred to the hospitals and other health service provider centres that have signed contracts with the PCTs on the basis of the so-called 'Payment by Results' allocation principle. The remaining 20 percent of the funds is used for financing capital investment projects and other nation-wide public health programmes. For example, the ten Strategic Health Authorities have been allocated GBP 6 billion from this year's budget for executing nation-wide public health programmes (e.g. the National Screening Programme), and to provide for the further training of NHS employees. The amounts dedicated to capital investment projects are also distributed among PCTs, each year after working out the budget.

The effects of the ageing of society

At present there are about 10 million senior citizens over 65 years of age in the United Kingdom and this number may, within the 20 years, increase by another 5.5 million according to the latest estimates and by 2050 it may reach 19 million. The number of citizens older than 80 years of age is increasing at a similar rate. Their number may increase from today's 3 million to 6 million in 20 years and on up to 8 million by 2050.[217]

Analyses show that the number of pensioners will also continue to increase during the next decades despite the fact that the retirement age of women will be raised to 65 years between 2010 and 2020 and that between 2024 and 2048 the retirement of both wom-

216 Source: Deposited Paper DEP2010-1307: http://deposits.parliament.uk/.

217 Source: http://www.gad.gov.uk/documents/demography/populationpercent20trends/population_trends_109.pdf .

en and men will be increased to 68 years. While in 2008 there were 3.2 British employees per pensioner, by 2033 this ratio may drop to 2.8.

The state is spending the largest part of its welfare budget on its pensioners. The Department for Work and Pensions spends 65 percent of its total expenditures - that is, about GBP 100 billion - on the oldest members of the society. This amount accounts for about one seventh of the 2010/11 budget.

The consequences of these trends will, of course, affect the health care services as well. According to 2008 data the health care services provided for a non-pensioner household cost about half as much to the NHS budget as those provided for a pensioner household. One warning sign may be that the Department of Health estimates that the provision of health care services for people over 85 years of age costs about three times (!) as much as the health care services provided for the 65-74 year age group.[218]

The benefits provided by the welfare system and the running costs of NHS take up about half of the total central budget, so the problems of the ageing of society are a challenge to both the 'service providers' of the welfare system and to governmental financial planning.

Analyses relating to the ageing of society rely, of course, on plans, forecasts and estimates. It must be noted however, that such forecasts are based on uncertain foundations in the majority of cases since they also involve projections concerning future changes in the population.

218 UK Parliament http://www.parliament.uk/documents/commons/lib/research/key_issues/Keypercent-t20Issuespercent20Thepercent20ageingpercent20population2007.pdf .

Structure of Health Spending and Ageing Society in Poland

The structure of the health fund

The 2010 and 2011 business plans of the Polish state health fund (Narodowy Fundusz Zdrowia, NFZ) shows that health spending increased by nearly 4 percent in comparison to the preceding year while its ratio remained unchanged. The largest (43 percent) expenditure item of the NFZ in 2010 (23,314 million zloty or EUR 5,140 million[219]) was made up of the amounts spent on hospital care, followed by the approximate 15 percent share of drug subsidies (in 2010: 7,695 million zloty or EUR 1,700 million; in 2011: 8,551 million zloty or EUR 1,890 million). The third largest expenditure item of the NFZ accounts for 13 percent of the total and is made up of the amounts spent on basic services (in 2010: 7,230 million zloty or EUR 1,600 million; in 2011: 7,347 million zloty or EUR 1,630 million). A total of 7.4 percent of the expenditures is accounted for by the financing of services provided by outpatient institutions while one specific item among the expenditures of the NFZ is made up of amounts spent in relation to the migration of patients. The reason for this is that when an institution specialises in providing a particular type of services and it admits patients from across the country, then that particular hospital is 'over-performing', i.e. it admits and provides health care services for patients beyond the limits set in its contract with the NFZ. In recent years the health fund has been hardly willing to reimburse institutions' costs incurred in providing services for patients in the framework of such 'over-performance'. 3 percent of the total expenditure is spent on dental care, on psychiatric care and the treatment patients with addictions, and on rehabilitation (the relatively low percentage of the spending on dental services reflects the increasingly wide-spread system of specialised dental service provider institutions in private ownership).[220]

Demographic situation and perspectives

Owing to its specific situation the Polish society does not feature one of the typical characteristics of the Central European countries as the Polish population is relatively young. The population of the country has been slowly increasing - with small fluctuations - during the past two decades (in 1990 the total population was 38,031,000, in 2000 it was 38,236,000 while in 2010 it was 38,204,000). Estimates show that Poland's population is practically stagnating at present (instead of decreasing dramatically or even moderately) which is quite a remarkable phenomenon in the Central and Eastern European region (incidentally, Poland has the sixth largest population in the European Union). In

219 The conversion rate used in the analysis is EUR/PLN = 4.46.

220 NFZ, financial plan for 2010: http://www.nfz.gov.pl/new/index.php?katnr=3&dzialnr=10&artnr=3962, NFZ, financial plan for 2011: http://www.nfz.gov.pl/new/index.php?katnr=3&dzialnr=10&artnr=4170.

regard to statistics, mention should be made of another specifically Polish phenomenon: years 1981 and 1982 saw quite a baby boom along the river Vistula when more than 700,000 babies were born in those two years while only half as many people died. This kind of radical change in the demographic indicators was closely linked to the political context, as in the wake of the banning of the 'Solidarity' union and the introduction of a state of emergency the majority of the Polish society retreated into 'passive resistance' and turned back to family life.

Accordingly, the proportion of the economically active population increased steadily after the system change: in 1990 it was 58.2 percent, in 2000 it was 60.8 percent, in 2008 i was 64.5 percent, while in 2010 it was 64.4 percent (at that time this proportion of the population was made up of 12.7 million men and 11.8 million women): the active-age population increased by 1.36 million between 2000 and 2009 (that is, by an average of 170,000 people each year). Similarly favourable figures are observed in regard to pensioners as well: in 1990 a total of 13 percent of the Polish population was made up of pensioners[221], while the corresponding figures in 2000 and 2010 were 15 percent and 16.5 percent, respectively (the latter percentage represented a total of 6.3 million people). While in 2010 there were 55 economically inactive persons per 100 economically active people, while the corresponding ratios were 72/100 and 64/100 in 1990 and 2000, respectively. In this regard Poland is - in comparison to other countries of West Europe and Central Europe - in a favourable demographic and labour market situation.[222]

The above picture is, however, affected by the fact that the figures quoted above show not the real situation but only a theoretical one, since the analyses were based on figures including even those individuals who had sought for and found jobs in other Member States of the European Union on a temporary or on a permanent basis or had even settled there. This applies primarily to Polish economic immigrants in Great Britain, Ireland and Germany who were absorbed by the European labour market which was opened as a consequence of Poland's accession to the European Union in 2004; an estimated total of 1,860,000 Polish citizens were working in other EU countries in 2007 either legally or illegally. Despite the fact that they are registered in Poland, they do not qualify as permanent residents of the country, they are not paying their taxes and contributions there but their cash transfers from abroad make a significant contribution to the sustenance of their relatives left behind.[223]

According to forecasts worked out by the Polish Statistics Office (Główny Urzad Statistyczny, GUS) the process of the ageing of the Polish society may soon gain momentum. Putting it more accurately and more to the point: the relative stagnation of the population is bound to be replaced by a slow but certain decline. The process is more likely to get underway in the medium run, rather than in the short run, and it must also be noted that according to GUS analysts ageing will occur primarily among urban populations, rather

221 Men over 65, women over 60 years of age.

222 The homepage of the Polish Statistics Office: http://www.stat.gov.pl/cps/rde/xbcr/gus/PUBL_rs_rocznik_demograficzny_2010.pdf.

223 Wirtualna Polska, online news http://polonia.wp.pl/title,Polacy-znow-emigruja-jest-nas-na-Wyspach-550-tys,wid,12718981,wiadomosc.html?ticaid=1cc71&_ticrsn=3.

than in rural Poland. The average age of those using the health services is definitely bound to increase though not dramatically and this may entail changes in the structure of the required health services as well - fewer children will be born so the need for gynaecologists' and obstetricians' services will decrease while the amount of services to be provided in the fields of oncology, cardiology, urology, rehabilitation and geriatrics will grow. The advancement of medical technologies which involves the introduction of new equipment and instruments that are increasingly effective and efficient but whose operating costs are also steadily increasing, is also entailing a continuous increase in health spending.

During the recent years - also according to data released by GUS - the average age (at death) of the Polish population has been growing slowly: in 2005 the average age at death among men and women was 70.8 years and 79.4 years, while in 2009 and in 2010 the corresponding figures were: 71.5 years and 80.1 years, respectively and 72.1 years and 80.6 years, respectively. According to estimates worked out by the Polish Statistics Office the total population of Poland will be 37.8 million in 2020 and 35.9 million in 2035, while according to Polish statisticians the proportion of people over 65 years of age will account for 22.3 percent of the total population in 2030 (8.2 million people), i.e. according to conservative estimates the number of those belonging to this social group will increase by some 3 million during the next 20 years.[224]

The impacts of demographic changes on the expenditures of the Health Fund

According to the National Health Fund's (NFZ) report on 2009 a total of 26,312,000 people used some health service out of the 37 407 000 insureds (70 percent) and the total value of those services was 26,764,000 zlotys (EUR 5,900), accounting for 48 percent of the total expenditures of the NFZ. The report found that the Pareto principle applying to the health sector also applies to Poland, in that the bulk of the spending is generated by the amounts spent on treatments provided or a relatively small number of patients. In terms of statistics, in 2009 some 60 percent of the total of the expenditures falling in this category was incurred in relation to the provision of health services for 5 percent of all patients, most of whom are, of course, elderly or very old patients. At that time 14 percent of the population was made up of people over 65 years of age (more than 5 million people), who made up 26.3 percent of all patients but the amount spent on providing them with curative services made up more than a third (33.6 percent) of the total of such costs. New-born babies, women of the child bearing age group (18-40 years of age) and men between 45 and 65 as well as men and women over 65 years of age are typically regarded as priority groups from the aspect of health spending. In regard to the ageing population particular attention is to be paid to the 45-65 year age group since the 'baby boom' generation of the eighties will reach this age within about 10 years which will have a negative impact on the balance of health spending over a longer period of time.[225]

224 The homepage of the Polish Statistics Office: http://www.stat.gov.pl/cps/rde/xbcr/gus/PUBL_rs_rocznik_demograficzny_2010.pdf.

225 NFZ analysis of the utilisation of health system: http://www.nfz.gov.pl/new/index.php?katnr=8&dzialnr=2&artnr=4092.

Decrease in unemployment and health financing

It is partly owing to the gradual decrease in unemployment that the financing of the health system is not decreasing materially. The economic structure change entailed significant sacrifices as well, since the ratio of unemployed people was extremely high in Poland (in 2004, for example, more than 20 percent of the working age population were unemployed). What Polish governments failed to remedy, was ultimately improved by Poland's accession to the European Union and the opening of the labour markets of older member states where a considerable number of Polish job-seekers - primarily those of the younger generation - managed to find employment on a temporary or on a permanent basis. Unemployment gradually decreased from 2004 on thus the state did not have to provide support for job-seekers from the budget in indirect forms (health contribution payments) or in a direct form (aid). Moreover, the newly created jobs supplied the service providing system with additional funding: by 2011 the unemployment rate had dropped to 12.2 percent. It should be noted however, that in comparison to the European average Poland has a high proportion of permanently unemployed people - those who have been unemployed for more than 12 months - which has a negative impact on the health and social status of those concerned and which, in turn, clearly has an impact on the relevant expenditures. It must also be noted that according to a 2011 report released by the Polish Statistics Office despite the steady rise in the living standards during the past 10 years about 2.2 million Polish citizens (including 600,000 children) are still living in deep poverty. Those living in relative poverty - some 6.5 million Polish citizens - accounted for 17.1 percent of the population in 2000 and this ratio remained unchanged by 2010. This social group includes the unemployed most typically, along with those living on disability pensions, agricultural prime producers, families with several children and families with family members living with disabilities. There are particularly large numbers of people living in deep poverty in regions that are relatively disadvantaged owing to the scarcity of - foreign or domestic - investments or in regions where structural unemployment has still not been eliminated since the system change. Consequently, the balance of health spending is not improved, but rather deteriorated by unemployment and, in relation to that, by the relatively high proportions of those living in deep poverty, since the state is spending larger amounts on this social group that is endangered from the aspect of their sustenance and way of life.[226]

Prime producers' social security

In relation to the ageing of the population mention should be made of a specifically Polish phenomenon, in that a separate social security system is in place for prime producers which is regulated by the health act adopted in 2004. The Agricultural Social Security Fund (Kasa Rolniczego Ubezpieczenia Społecznego, KRUS) provides for prime producers - and their family members - who are engaged in agricultural production along with recipients of agricultural pension or disability pension. In 2011 nearly one and a half million people belonged to the KRUS system. These people pay their health

226 Rzeczpospolita daily, online news: http://www.rp.pl/artykul/696066.html.

contributions in a lump sum once a year irrespective of their actual incomes, which is defined on the basis of the market price of 150 kg. rye, thus both the amount so paid and the composition of the group of insureds keeps changing from year to year. Unfortunately, this system offers numerous opportunities for abuse and irregularities since while a person is officially registered as a prime producer, he or she may actually be an entrepreneur evading his or her contribution payment obligation in this way. The discontinuation of the KRUS would definitely improve the financial position of the NFZ since it would channel more funds into the latter system. This however, would also trigger massive social discontent because hundreds of thousands of people would be left with less money to spend, in addition to which the small Polish Peasant Party (PSL) which is a small party but rather influential at the local (local governmental) level which has been a component of a number of governments, spares no effort in its fighting for the continuation of the KRUS.[227] The Polish Constitutional Court however, declared at the end of 2010 that the existence and operation of the KRUS is contrary to the principle of equality before the law which is enshrined in the Polish constitution, since members of a social group are paying smaller amounts in contributions than the majority of the population, purely on account of their belonging to that social group. Simultaneously with making this resolution the Constitution Court at the same time imposed an obligation on the government to amend the relevant statutory regulations within a deadline of 15 months. Accordingly, changes are expected in this area as well - in theory - which is corroborated by the fact that Prime Minister Donald Tusk announced radical reforms involving the KRUS in his end-2011 budget speech.[228]

On the whole, the low birth rate and the resulting negative turn of demographic indicators, the significant proportion of the population living in deep poverty and the missing from the domestic labour market of the group of economically active age citizens considered to be numbering in the hundreds of thousands, who are paying their taxes and contributions abroad, may, in time, lead to major problems in the social service providing system including the health sector in particular. Nonetheless, Poland needs not worry about a steady and substantial decrease in its population or a dramatic ageing of the society in parallel. The current structure of the Polish society, with a high percentage of economically active citizens with only a smaller proportion of economically inactive people makes it possible for the government to have no concerns about any negative change in the structure of the country's health spending in the short run since during the next few wears the amount of the health contribution revenues will increase somewhat or, at worst, it will either stagnate or only slightly decrease.

Drug subsidies

Drug subsidies are regulated in Poland by the health act adopted in August 2004. Accordingly, the list of basic drugs and the subsidised drugs (at 50 percent or 70 per-

227 The homepage of the Agricultural Social Security Fund: http://www.krus.gov.pl/, Interia, online news http://biznes.interia.pl/news/15-miliona-osob-na-krus-ie-zaplacze,1549563.

228 Dziennki-Gazeta Prawna daily, online news http://gospodarka.dziennik.pl/news/artykuly/306805,przelomowy-wyrok-krus-niezgodny-z-konstytucja.html.

cent) is determined by the minister of health in office at the time, along with - by decrees and in agreement with the finance minister - the maximum prices of the drugs and medicine preparations subsidised by the state. A report published by the NFZ at the end of 2010 revealed that the amount dedicated spent on drug subsidies has been increasing steadily within the budget of the health fund ever since 2004: in 2004 it was 6,118 million zloty (EUR 1,360 million), in 2005 it was 6,323 million zloty (EUR 1,405 million), in 2006 it was 6,669 million zloty (EUR 1,482 million), in 2007 it was 6,719 million zloty (EUR 1,490 million), in 2008 it was 7,349 million zloty (EUR 1,630 million), in 2009 it amounted to 8,241 million zloty (EUR 1,830 million), while in 2010 it was 8,531 million zloty (EUR 1,895 million). By contrast, Polish citizens spend about 5 billion zloty (EUR 1.1 billion) each year from their own incomes on non-subsidised drugs along with about 9 billion zloty (EUR 2 billion) on non-prescription products.[229]

The Polish Parliament amended the act on drug subsides in March 2011, with effect as of 1 January 2012, which was also confirmed by the signature of the President of the Republic, Bronisław Komorowski. The aim of the amendments is, in essence, to stop the practice whereby manufacturers are selling drugs - with state subsidy - for unreasonably low prices, by way of promotion. Accordingly, the new legislation will provide for centrally set prices and price margins for the subsidised products, from which no departure will be allowed. As for the price margin, it may not be higher than 5 percent, instead of the currently applied 9 percent. Other important changes introduced by the legislator include a 17 percent limit on the amount that can be spent on drug subsidies from the NFZ's budget and that subsidised drugs may only be sold in pharmacies that have concluded contrast with the NFZ. Analysts claim that drugs are relatively cheap in Poland but their subsidies are among the lowest in Europe.[230]

229 Rzeczpospolita daily, online news http://www.rp.pl/artykul/712149.html.
230 Rzeczpospolita daily, online news http://www.rp.pl/artykul/664160.html,
Raport na temat wydatków Narodowego Funduszu Zdrowia z tytułu refundacji leków w roku 2010. http://www.nfz.gov.pl/new/index.php?katnr=8&dzialnr=2&artnr=4487.

Structure of Health Spending and Ageing Society in Portugal

As a consequence of the financial and economic crisis and of demographic changes, the need for reconsidering health spending and for executing the necessary reforms has been growing increasingly urgent in Portugal as well. The process of taking the required actions was accelerated in 2011 by the tight schedule prescribed in this field as well by the restructuring programme set out as a prerequisite for the EU rescue package, the execution of which is being continuously monitored. Consequently, changes are already observed in some areas, but further major reforms may take place in the forthcoming years.

Distribution of the total expenditures of health insurers

The amount of health spending and its ratio relative to the gross national product have both been increasing steadily during recent years, without any remarkable changes in the distribution of the expenditures among the different areas of health care services. According to OECD data[231] the bulk (37.5 percent) of the total of EUR 16.38 billion health spending in 2008 was made up of amounts spent on hospitals (EUR 6,138 billion), followed by the amounts spent on outpatient care services (EUR 5,148 billion, 31.5 percent), and on drugs (EUR 4,189 billion, 25.6 percent). On the whole, these three areas absorb more than 90 percent of the total health spending year after year, with only one percent of the total being spent on institutions providing nursing care, including psychiatric and addictology units. As is indicated by the figures in the following tables the relative proportions have not changed materially during the recent years:

	Hospitals	Nursing care institutions	Outpatient care services	Drugs
2004	38.035 %	1.013 %	31.728 %	25.773 %
2005	38.807 %	0.981 %	31.593 %	25.233 %
2006	37.393 %	1.039 %	31.929 %	25.929 %
2007	37.992 %	1.129 %	31.383 %	25.73 %
2008	37.517 %	1.262 %	31.466 %	25.604 %

Table 1: Distribution of health spending among different forms of health care services[232]

The amount used for financing hospitals accounted for 3.569 percent of GDP, with nearly 3 percent of GDP being spent on outpatient care services and 2.44 percent on drugs. In 2008 these total expenditure figures were shared by the various insurers and other stakeholders:

231 OECD StatExtracts, Health Expenditure and Financing, http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT.
232 OECD data, idem.

	Percentage rate of the expenditures so covered
State, total	65.09
Central budget, health insurance fund	63.888
Social security insurance funds	1.202
Private sector, total	34.91
Private insurance coverage	4.889
Households (out-of-pocket)	27.164
Non-profit institutions	0.376
Other, non health insurance	2.481

Table 2: Relative shares of financing sources[233]

It is clear from the data presented in the above table that the overwhelming majority of the expenditures are covered by the state health insurance fund financed by the central budget, though some slight decrease has been observed in this during the recent years in comparison to earlier years: in 2006 and in 2007 the state financed 70.5 percent of the total health spending[234]. In parallel with the downsizing of the role played by the state, the proportion of the out-of-pocket expenditures, that is the contributions made by the users of the services, has been growing steadily, and it is regarded fairly in by EU standards. The role of private insurers is, however, still practically negligible.

The state health insurance fund - despite the growing presence of the private sector - plays a particularly important role in the maintenance and running of hospitals, as between 2000 and 2010 an average of 51.3 percent (in 2010: EUR 5 billion) of its total expenditures was spent on this function[235]. Hospital development and hospital construction projects have, since 2002, been typically executed in public and private partnership arrangements, for which the state health insurance fund spent EUR 146 million - 1.6 percent of its total spending - in 2010. The amount spent on PPP projects increased steadily and steeply during the past 10 years but after the change of government in July 2011 those projects came to a halt. The health minister promised not to start any new projects of this kind and to review those currently in progress, by end-2011. [236]

In addition to the above, the public health insurance fund system spends 27 percent of its expenditures on outpatient care services.[237]. Nearly two-thirds of such expenditures are allocated to public clinics with one-third going to private health service providers for whom the state provides funding for the provision of certain services that are not avail-

233 OECD data, idem.

234 Data published by the Portuguese Statistics Office, http://www.ine.pt/xportal/xmain?xpid=INE&xpgid=ine_destaques&DESTAQUESdest_boui=5544982&DESTAQUESmodo=2.

235 Report of the working group commissioned to prepare the hospitals reform, November 2011, p. 27, http://www.min-saude.pt/NR/rdonlyres/84FCFCE2-3C84-4ABE-8E5F-AD4DDB0B46F4/0/RelatorioGTRH_Nov2011.pdf.

236 Article in the 17 August 2011 edition of the Dinheiro Vivo ('The government will not start new PPP hospital projects'), http://www.dinheirovivo.pt/Estado/Artigo/CIECO011460.html?page=0.

237 The health satellite account of the Portuguese Statistics Office covering the period between 2000 and 20008, http://www.ine.pt/xportal/xmain?xpid=INE&xpgid=ine_publicacoes&PUBLICACOESpub_boui=102614085&PUBLICACOESmodo=2, p. 28.

able in the state-run system. In this way, 41.5 percent of the costs of the health care services provided in private clinics and doctors' offices are also paid by the state and patients pay an average of 49.6 percent of the costs. The costs of state-run institutions could be reduced during the recent years by reorganisation efforts and by closing large numbers of institutions: while between 2000 and 2005 the state health insurance fund spent 18.5 percent of its expenditures on state-run clinics and doctors offices and on the outpatient care services provided there, by 2008 this proportion had dropped to 16.5 percent. The proportion of the expenditures on health care services provided by private clinics and doctors' offices however, did not change materially.

The health insurance fund spends an average of 18 percent of its expenditures on drug supplies. During the recent years this ratio has been on the increase, partly as a result of a genera increase in the amounts spent on drugs: while in 2000 a total of EUR 2,324,227,000 was spent on drugs in Portugal, by 2008 this amount had increased to EUR 3,539,740,000. The state health insurance fund covers 44.2 percent of this amount while 39.8 percent of the costs are borne by the patients themselves. The state-run health insurance fund subsystems - mostly linked to specific trades - also play a significant role in this field, by financing 6.9 percent of the expenditures, along with other state administration units bearing 5.6 percent of the costs.

Accordingly, the distribution of the expenditures of the state health insurance fund is characterised by the following data:

	Hospitals	State outpatient care	Private outpatient care	Drugs
2000-2005	51.1 %	18.5 %	10.1 %	17.5 %
2006	51.1 %	17.4 %	10.7 %	17.9 %
2007	52.5 %	16.6 %	9.9 %	17.9 %
2008	51.6 %	16.5 %	10 %	18.6 %

Table 3: The relative proportions of the expenditures of the state health insurance fund[238]

In contrast to these proportions the bulk of the amounts spent by patients on health care services is made up of the costs of outpatient care services provided by private clinics and doctor's offices (37.4 percent) and drug costs (32.4 percent), along with a significant proportion of the costs of patients being spent on private hospital services (12.7 percent), and on other medical aids and instruments (11.4 percent).

As a consequence of the economic crisis the burdens borne by patients will continue to grow from 1 January 2012, as the government has decided to radically increase the visit fees. Accordingly, at units on stand-by duty a patient will have to pay EUR 20 instead of the earlier EUR 9.60 for treatment and the range of people enjoying exemptions will be significantly reduced[239]. This however, is only one among the measures whereby the state is trying to tackle problems stemming from the economic and demographic situation in the short, medium and long term.

238 Idem, p. 21.

239 Article in the 7 December 2011 edition of Diário Económico ('Changes in the visit fee'), http://economico.sapo.pt/noticias/o-que-muda-nas-taxas-moderadoras_133165.html.

Economic and demographic challenges

The budget strategy published by the Portuguese government in August 2011 for the period between 2011 and 2015[240] counts the health sector among the most expensive sectors, where services of today's standards could be provided with reduced funding input with the aid of adequate actions. Therefore in this strategy the government proposes - among other things - cuts in the costs of state hospitals, promotion of the use of generic drugs and a review of the price margins that can be applied by drug manufacturers and distributors, as well as equal distribution of the burdens among the different stakeholders. By the proposed measures the government aims at providing for the sustainability of the state health system in the medium term and, in the way of quantified objectives, it intends to reduce public spending on health - including, among other things, drug supplies and hospital financing - by 0.5 percent of GDP in 2012 and by another 0.3 percent of GDP in 2013.

In this regard, a ministerial decree adopted on 1 September 2011[241] prescribes that state-run hospitals and clinics must cut their operating costs by 11 percent in 2012. In the framework of this effort the health institutions must, in particular, strive to cut their costs relating to personnel, external services and the consumption of assets and drugs, thus for instance, hospitals and clinics may hire new employees only with the ministry's permit. The decree also refers to the agreement between the Portuguese government and the International Monetary Fund, the European Commission and the European Central Bank[242]; its chapter on the health sector prescribes that public spending on drugs must be reduced to 1.25 percent of GDP by 2012 and then down to 1 percent of GDP in 2013, which - according to experts' calculations - may result in the saving of EUR 500 million next year and EUR 400 million in 2013[243].

Demographic changes entail further problems in addition to those resulting from the economic crisis. As is pointed out in an analysis prepared by Deloitte[244] as well, although the population of Portugal has increased during recent years - the rate of which was as high as 5 percent during the past decade - it was a consequence primarily of immigration and therefore it entails no positive changes in the age structure of the population. Since the early 1990 the number of people aged 65 or over has increased by 35 percent while the number of people below 25 dropped by nearly 21 percent. The average life expectancy at birth was - according to 2008 data - 82.4 years among women and 76.2 years among men, both of which are higher than the EU average. By contrast, the number of years in good health is lower by EU standards: 57.2 years among women and 59 years

240 Budget strategy 2011-2015, Ministry of Finance, http://www.portugal.gov.pt/pt/GC19/Documentos/MF/Doc_Estrategia_Orcamental.pdf.

241 A 10783-A/2011 issued by the Ministry of Finance and the Health Ministry, http://dre.pt/pdf2sdip/2011/08/167000001/0000200002.pdf.

242 Memorandum of Understanding on Specific Economic Policy Conditionality (1 September 2011 version), http://www.portugal.gov.pt/pt/GC19/Documentos/PCM/1R_MoU_20110901.pdf.

243 Article in the 19 July 2011 edition of Diário Económico ('Hospitals' drug expenditures increased again'), http://mobile.economico.pt/noticias/despesa-com-remedios-volta-a-crescer-nos-hospitais_122888.html.

244 Deloitte's 2011 'Health in focus' study, p. 43, http://www.deloitte.com/assets/Dcom-Portugal/Localpercent20Assets/Documents/PSLSHC/ptpercent28ptpercent29_lshc_saudeemanalise_04022011.pdf

among men[245], while the rate of occurrence of certain diseases such as tuberculosis, is extremely high in comparison to other EU countries.

Thus, while the GDP is decreasing year after year as a consequence of the crisis, the number of elderly people increasingly in need of health care services is growing. For example in 2009 a total of 46 percent of the public expenditure on drugs was spent on pensioners, while the age group over 65 makes up only 19 percent of the total population. [246] As a consequence of this, the amounts spent by the health fund on drugs increased by another 6.3 percent in 2009, despite the government's constant efforts to reduce the burdens of the state in this aspect, particularly towards cutting the amounts spent on drug price subsidies and towards promoting the use of generic drugs. A slow but steady increase is observed in this latter area: the market share of generic drugs has reached 20 percent[247], while in 2005 it was still below 12 percent.

In the future however, even more significant reforms will be needed, for according to a report published by the European Commission in 2010 on the health systems[248] the population of Portugal will grow by 600,000 between 2008 and 2060 and at the same time the proportion of elderly citizens will grow at a rate exceeding the EU average, partly as a result of the fact that the life expectancy at birth will increase by 8.3 years among men and by 6.4 years among women in comparison to today's figures. As a consequence of the ageing of the population the public health spending figures may reach during the next 20 years even as high as 11.1 percent of GDP according to an estimate released by the International Monetary Fund[249] and without reforms only the United States of America, Luxembourg and Switzerland will spend more on health than Portugal. For later decades the Monetary Fund outlines an even more gloomy picture: by 2050 the spending may grow to 15.9 percent of GDP which would be the third highest percentage among the developed countries. This trend could be observed earlier on as well, for according to the report of the International Monetary Fund between 1981 and 2008 the only country in the world where the proportion of health spending increased faster than in Portugal was the United States of America. The increase in spending is explained by the International Monetary Fund by technological progress enabling an increasing number of types of medical operations and treatments and by the growth in the number of elderly people using more and more of the services provided by the health care system.

In order to deal with this situation and particularly to cut public spending the International Monetary Fund proposes liberalisation of the health market, including the strengthening of the freedom of choice among insurers and facilitation of the operation of health service providers in the private sector. These however, could raise constitutional

245 Year-2010 report published by the Economic and Financial Directorate General of the European Commission on health systems, (Joint Report on Health Systems), p. 368: http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf.

246 Data published by the Portuguese Statistics office, see Deloitte's above mentioned study.

247 Latest data of the state drugs authority Infarmed: http://www.infarmed.pt/portal/page/portal/INFARMED/MEDICAMENTOS_USO_HUMANO/GENERICOS/QUOTAS_GENERICOS.

248 Joint Report on Health Systems, 2010, http://europa.eu/epc/pdf/joint_healthcare_report_en.pdf.

249 Article of 9 February 2011 of Journal I ('Portugal will be 4th among those spending most on health in 2030'), http://www1.ionline.pt/interior/index.php?p=news-print&idNota=103518.

concerns in Portugal since according to the Portuguese constitution health - like education - must be free of charge for all, in essence. The state cannot be expected to radically reduce its role in the sector for the time being, and private insurers cannot be expected to move in quickly either, even if their role has been growing somewhat recently. The next two years are expected to see the adjustment actions that are also prescribed in the agreement signed with the International Monetary Fund and the European Union, the aims of which include reducing the burdens of the state health insurance fund as quickly as possible while maintaining the key structure of the existing system. An amount of EUR 600 million is going to be withdrawn from the state health insurance fund in 2012 as part of this programme, half of which will be saved on hospitals, which will have to keep running with EUR 300 less funding than in 2011.

The tasks to be carried out on the basis of the agreement also include tightening the controls over drug prescriptions and the introduction of adequate sanctions, elimination of the obstacles to the distribution of generic drugs, stepping up competition among private health service providers and cutting the amounts paid by the state to such service providers, tightening the criteria applied in the selection of hospital managers and rationalising the network of hospitals, along with increasing the flexibility of doctors' working hours and thereby further cuts in the amounts paid for their overtime work. The execution of the measures is regularly checked by the delegations of the International Monetary Fund and the European Union. Portugal has so far managed to keep to the schedule.

Summary

Like in many another segment, Portugal is facing a difficult situation in its health sector as well. While the Constitution adopted on the basis of socialist inspirations in the wake of the 'carnation revolution' declares that health care services are free - or 'for the most part' free - for every citizen, the provision of the funds required for this is growing increasingly difficult for the state, particularly as a consequence of the deteriorating demographic situation. The proportion of the expenditures of the state health insurance fund relative to GDP is growing steadily and although savings have been made in certain areas - including outpatient care services provided by state-run clinics - the costs are growing continuously in other areas including drug financing. Private insurers still do not play a substantial role but the fees payable by patients for the use of the services are making an increasing contribution to the financing of the system. One of the great challenges of the future is whether Portugal will manage to execute reforms whereby health services can be rendered sustainable in the long run despite the economic problems and the ageing of the population.

Structure of Health Spending and Ageing Society in Spain

The Spanish Health Insurance System

There is a mixed health insurance system in Spain, i.e., apart from the state insurance, health insurance policies may also be established with private insurers. The Spanish state health system is a universal system, i.e., it covers all Spanish citizens and individuals living in the territory of the country. Thus the purpose of optional private insurance is always to supplement the state insurance in hope for better services and shorter waiting times.

The Spanish national health system is financed through various channels. The most important channel is the tax-based financing, which represented the largest source of revenue in the national health sector over the last twenty years. As the Spanish health system is decentralised, the amounts available for health expenditures are collected primarily in communities (*Comunidades Autónomas*), and they are then reallocated through the community budget. The amounts redistributed by the central government (*Administración Central*) and the health expenses of the autonomous cities (*Ciudades con Estatuto de Autonomía*), i.e., Ceuta and Melilla, represent a fragment of the total national expenses.

It is a specific feature of the Spanish system that the tax-based financing is supplemented by the additional contributions, which increase the assets of the social security system (*Sistema de Seguridad social*) and the health insurance co-operatives of public administrative employees (*Mutualidades de funcionarios*). However, these contribution-based amounts are much smaller than the tax-based transfers made into the health sector by the communities. Thus the additional financing as well as the private insurers only supplement the tax-based financing system.

Lastly, the third largest source of funding of the Spanish health sector is the private funds, mainly in the form of contributions from private insurers (*Seguradoras privadas*). Apart from private insurers, the so-called out-of-pocket payments made both for public and private treatments are still important expenditure items. Private health insurance policies can be established in two types of insurance companies. In private insurers providing only health insurance and covering the largest portion of the market or in private insurers where health insurance is only part of the insurance profile.

National insurance and its expenses

Article 43 of the Spanish Constitution, which was approved 33 years ago, in 1978, states the right of Spanish citizens to health protection, while Article 49 makes protection of the right to health an obligation and the task of major importance of the agencies exercising executive power. The 4/2000 Organic Act granted similar rights to foreigners living in the territory of Spain.

However, Article 148 of the Constitution rendered the health system into the scope of competence of the autonomous communities without any specific definition. The very same article of the Constitution referred to above represented the basis of the more than twenty-year process during which Spanish health sector was decentralised. The process which began at the beginning of the 1980s and was completed in the first year of the new millennium also involved the decentralisation of collection and redistribution of resources to be allocated to the health system. More exactly, a dual process was implemented, during which the communities elaborated their own taxation and budget mechanisms and the contribution-based and centrally distributed health fund was transformed into a tax-based community financing system.

Thus the costs of communities grew gradually after the establishment of the decentralised system. Between 2002 and 2009 the health expenses almost doubled. In 2002, EUR 34.5 billion expenses were booked, which increased to EUR 38.5 billion in 2003, EUR 41.7 billion in 2004, EUR 45.6 billion in 2005, EUR 50.3 billion in 2006 and EUR 54.5 billion in 2007. In the next two years, the costs exceeded the EUR 60 billion limit, as in 2008 the total expenditure amounted to EUR 60.6 billion, and in 2009 to EUR 64 billion.[250] The first graph illustrates this increase.

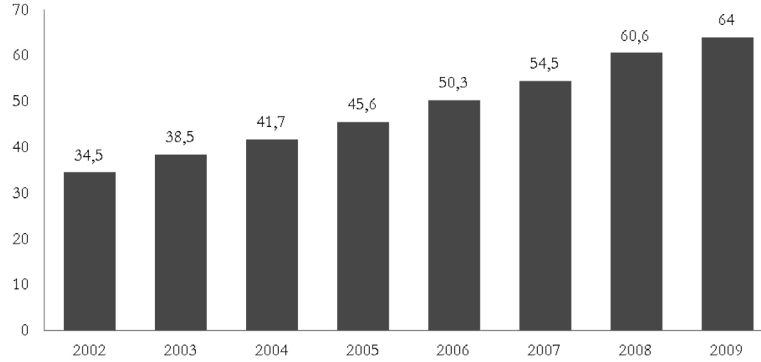


Figure 1: Increase in the health expenses of communities (EUR billion)[251]

Concerning the changes by year and the increase of the expenditures over the previous year, the last available data reflect the falling tendency of the last years. Between 2002 and 2008, the expenditures, compared to the previous year, rose between 8.25 and 11.6 percent, while in 2009 the increase was only 5.7 percent over the previous year. Nevertheless, the ratio of community expenses expanded, even if only slightly, among the total public health expenditure. In 2002, they made up 89.6 percent, and in 2009, 91.12 percent of the total expenditure.[252]

250 Ministerio de Sanidad, Politica Social e Igualidad: Cuenta Satélite del Gasto Sanitario Publico, first table. http://www.mspsi.gob.es/estadEstudios/estadisticas/sisInfSanSNS/pdf/egsp_gasto_real.pdf.
251 Ministerio de Sanidad, Politica Social e Igualidad: Cuenta Satélite del Gasto Sanitario Publico, first table. http://www.mspsi.gob.es/estadEstudios/estadisticas/sisInfSanSNS/pdf/egsp_gasto_real.pdf.
252 The same.

Communities spent more than 50 percent of their expenses, EUR 36.58 billion (57 percent of the community expenses) on hospital and specialist treatments in 2009. The second largest expenditure item was EUR 12.85 billion pharmaceutical subsidies (20 percent), and emergency services, with their EUR 9.34 billion expenditure, lay in third place (14.5 percent) Compared to the latter ones, the cost of public health services (EUR 717 million, 1.12 percent), community health services (EUR 1.4 billion, 2.2 percent) and the cost of implants, protheses and other pharmaceutical aid (EUR 1.17 billion, 1.8 percent) were minor items among the expenditure. Finally, the communities spent approximately EUR 2 billion (3.12 percent) on capital expenditure. With the exception of the latter item, an increase was registered in each sector in 2009 compared to the previous year. [253] The following figure illustrates the structure of community expenses.

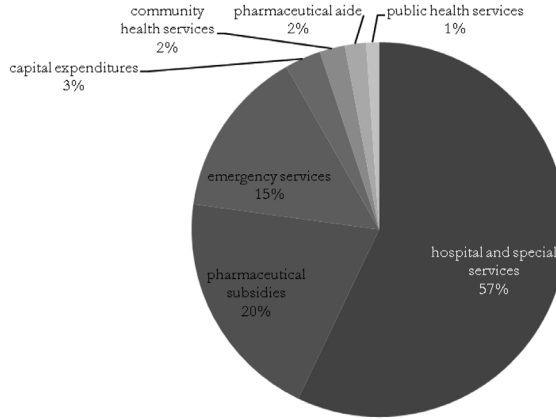


Figure 2: Structure of community expenses in percentage[254]

The major item among the expenses of the public system relates to the health insurance co-operatives and the social security system. Both forms are based on the payment of contributions. The purpose of the health co-operatives is to supplement the services provided to public administration employees, while the latter system provides supplementary funds for the most important trades and maternity. Their share is negligible compared to the community expenses, as health co-operatives managed 2.92 percent of expenses, 2.37 percent of health expenses in 2009. In addition, the importance of these funds is also declining as since 2002 the ratio of their expenses within the total public expenditure has dropped by approximately one per cent.[255]

253 Ministerio de Sanidad, Politica Social e Igualidad: Cuenta Satélite del Gasto Sanitario Publico, first table. http://www.mspsi.gob.es/estadEstudios/estadisticas/sisInfSanSNS/pdf/egsp_gasto_real.pdf.
254 Ministerio de Sanidad, Politica Social e Igualidad: Cuenta Satélite del Gasto Sanitario Publico, first table. http://www.mspsi.gob.es/estadEstudios/estadisticas/sisInfSanSNS/pdf/egsp_gasto_real.pdf.
255 Ministerio de Sanidad, Politica Social e Igualidad: Cuenta Satélite del Gasto Sanitario Publico, first table. http://www.mspsi.gob.es/estadEstudios/estadisticas/sisInfSanSNS/pdf/egsp_gasto_real.pdf.

The structure of expenses of the two funds is largely different. While the social security system spends most of its money on emergency services, specifically EUR 816 million (49 percent of the health expenses of the social insurance system) in 2009, this item was only in third place in the health insurance co-operatives with EUR 183 million (8.9 percent of the expenses of the health insurance co-operatives). Health insurance co-operatives spend significantly more on hospital and specialist services (EUR 1.1 billion, 54 percent) and on pharmaceutical subsidies (EUR 515 million, 25 percent). The second highest expenditure of the social security system relates to hospital and specialist services with EUR 505 million (30.25 percent).[256]

The remaining part of the public expenses are covered by the central government, the budget of autonomous cities and the local professional organisations. However, their expenses do not exceed 2% within the total public expenses. The following figure illustrates the breakdown of public health expenses by source.[257]

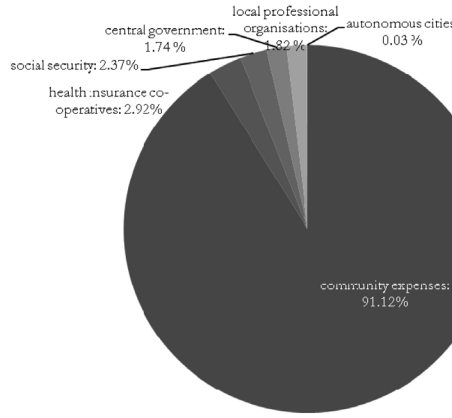


Figure 3: Structure of the social security expenditure in percentage

Private insurers and their expenses

Apart from the health expenses of the state, a large amount is circulated also in the private health sector. Over the last decades, the share of private health expenses increased significantly. Fifty years ago the private expenses made up only 0.6 percent of the domestic GDP. By the beginning of the subsequent decade, the ratio reached 1.2 percent, and then stagnated for almost twenty years. Since the middle of the 1990s, the private health sector has been growing intensively and offers an increasing number of services exceeding the public system. The privatisation policy of José María Aznar's government and the prosperous years of the Spanish economy played a very important role in this process. By

256 Ministerio de Sanidad, Politica Social e Igualidad: Cuenta Satélite del Gasto Sanitario Publico, third table.http://www.mspsi.gob.es/estadEstudios/estadisticas/sisInfSanSNS/pdf/egsp_gasto_real.pdf.
257 Ministerio de Sanidad, Politica Social e Igualidad: Cuenta Satélite del Gasto Sanitario Publico, based on the first table. http://www.mspsi.gob.es/estadEstudios/estadisticas/sisInfSanSNS/pdf/egsp_gasto_real.pdf.

the turn of the millennium, the private health expenses reached 2 percent of the GDP.[258] The 2006 data reveal that most private expenses relate to outpatient services (50.3 percent) and to the purchase of pharmaceutical aid (28 percent). Hospital expenses are only in third place, with 9 percent, although they make up the largest item in the public system.[259]

According to the 2006 data, the private expenses made up 28-30 percent of the total health expenses, equalling 2 percent of the GDP of the year. The public expenses described above represented 70-71 percent of the total expenses. However, these ratios reflect the status of the last year of Spain when the country on the Iberian peninsula recorded considerable economic growth (4 percent). Since then, the Spanish economy has declined significantly. Lack of revenues and unemployment hit also those Spanish communities where the number and ratio of private health services and private insurance was significantly higher than the national average, more specifically in Madrid, Catalonia and the Balearic Islands.

The private health expenses represent only 14.5 percent of the costs of private insurance. The out-of-pocket expenses, which make up 82.5 percent of the private expenses, are much greater.[260] Two groups can be distinguished among the Spanish health insurers: the group of those insurers whose main profile is health insurance is the larger category. In this category, three insurance companies, *Adeslas, Asisa* and *Sanitas* more or less cover the health insurance market and operate with a larger group of clients, physicians and institutions.

International insurance companies, such as *Aegon*, *Allianz* and *Axa Winterthur* could be mentioned among the insurance companies not specialised in health insurance. These companies compete on the Spanish market with other insurers, such as *Cigna*, *DKV, Mapfre* or *Caser*.

Demographic tendencies

The Spanish population has grown over the last one hundred years, as the Spanish population more than doubled in that period. In 2010, the total population reached 46 million, including 22.6 million men and 23.2 million women.[261] The estimated average life expectancy is 81 years in Spain, one of the highest among the European states. The life expectancy of women is 84 years, slightly higher than the average, while men can expect to live 78 years.[262]

258 Ministerio de Sanidad, Politica Social e Igualidad:Gasto Sanitario Privado, first table, page 7. http://www.mspsi.gob.es/estadEstudios/estadisticas/sisInfSanSNS/pdf/Gasto_Sanitario_Privado.pdf.
259 Ministerio de Sanidad, Politica Social e Igualidad:Gasto Sanitario Privado, fourth table, page 13. http://www.mspsi.gob.es/estadEstudios/estadisticas/sisInfSanSNS/pdf/Gasto_Sanitario_Privado.pdf.
260 Ministerio de Sanidad, Politica Social e Igualidad:Gasto Sanitario Privado, Figure 2, page 10. http://www.mspsi.gob.es/estadEstudios/estadisticas/sisInfSanSNS/pdf/Gasto_Sanitario_Privado.pdf.
261 Ministerio de Sanidad, Politica Social e Igualidad: Indicadores Clave del Sistema Nacional de Salud, Resumen Navional, Población General, first table. http://www.mspsi.gob.es/estadEstudios/estadisticas/sisInfSanSNS/iclasns_docs/InformeC_INCLASNS.pdf.
262 Ministerio de Sanidad, Politica Social e Igualidad: Indicadores Clave del Sistema Nacional de Salud, Resumen Navional, Estado de Salud, Indicadores Generales, third table. http://www.mspsi.gob.es/estadEstudios/estadisticas/sisInfSanSNS/iclasns_docs/InformeC_INCLASNS.pdf.

However, the growing population also involves an ageing society. Spain follows the West European example in that respect. According to the 2008 forecast of the National Statistical Institute (INE), the tax and contribution paying age group, required for maintaining the health system, aged between 15 and 64 years, will grow by approximately 4.7 percent, i.e., 1.44 individuals by 2018. 13.1 percent increase is projected within the age group of below 15, i.e., at the end of the decade there will be 921,000 more individuals of minor age. What is more important thought is that the size of the age group over 64 will expand even more. The number of people aged over 64 will rise by 19.2 percent by 2018, adding 1.44 million individuals to this age category.[263]

The 2005 projection of health expenses prepared by Fedea[264] economic research institute calculated the increase of the Spanish health sector by 2050 based on ageing, similar to the tendencies described above. According to Fedea results, the public health expenses may increase by approximately 40 percent by the middle of the century, involving on average 0.74 percent increase each year. The researchers projected 33 percent rise in the per capita expenses between 2004 and 2050. This means that while in 2004 the state spent on average EUR 980 a year on health services to citizens, the figure may reach EUR 1307 in 2050. According to the Fedea analysis, the health expenses would rise from 5 percent of the annual GDP (2004) to 6.7 percent by 2050.[265]

Naturally, the negative impacts of the economic crisis influence those medium and long-term processes. The high unemployment ratio (21.5 percent) affects primarily to younger generations (45 percent unemployment in the 18-26 age group).[266] This latter tendency encourages migration among the young people, which further reduces the number of potential contribution payers and narrows the scope of movement of the health budget, as well as holds back the growth of the private insurance market in Spain. However, they are only current processes and therefore we have no reliable data about them yet.

263 Instituto Nacional de Estadística: Proyección de la Población de España a Corto Plazo, 2008-2018, p.4. http://www.ine.es/prensa/np538.pdf.

264 Fundación de Estudios de Economía Aplicada: http://www.fedea.es/.

265 Ahn, Namkee- García, Juan Ramón- Jerce, José A.: Demographic Uncertainty and Health Care Expenditure in Spain, Fedea: Documento Trabajo, 2005 March. http://www.fedea.es/pub/papers/2005/dt2005-07.pdf.

266 Instituto Nacional Estadistica: Encuesta de la Población Activa, 2011/3T. http://www.ine.es/jaxi/menu.do?type=pcaxis&path=/t22/e308_mnu&file=inebase&N=&L=0.