FACTBOOK 2021

Creating resilient and sustainable health care in Europe: the role of Private Hospitals

2nd edition | A report by Hans Martens

Private Hospitals in Europe map

- Acute
- Ambulatory
- Psychiatry
- Rehabilitation
- Unspecified


Lithuania
Vitebsk
Vilnius
Kiel
Gdansk
Hamburg
Hrodna
Belarus
Szczecin
Bydgoszcz
Berlin
Poznań
Hanover
Poland
Chernihiv
Germany
Dresden
Wroclaw
Rivne
Kyiv
Krakow
Lviv
Czechia
Vinnytsia
Ukraine
Slovakia
Munich
Vienna
Chernivtsi
Austria
Hungary
Moldova
Mykolaiv
Cluj-Napoca
Odessa
Trento
Ljubljana
Romania
Croatia
Galați
Bologna
Bucharest
Sevastopol
Craiova
Bosnia and Herzegovina
Serbia
Constanța
Florence
Montenegro
Sofia
Bulgaria
Italy
North Macedonia
Rome
Bari
Istanbul
Albania
Naples
Bursa
Ankara
Igoumenitsa
Catanzaro
Greece
Izmir
Palermo
Denizli
Konya
Athens
Catania
Antalya
Tunis
Sousse
Malta
Heraklion
Cyprus
Mediterranean Sea
Tripoli
Misrata
Bayda
Benghazi
Nalut
Alexandria
Port Said

SUMMARY

PRESENTATION

This second edition of the UEHP Factbook was delayed due to the COVID-19 crisis. First of all because all our efforts, as healthcare professionals, were focused on responding to health needs, providing services capable of supporting the most critical patients in the acute stage of the disease; but also in rehabilitation care assisting patients with chronic COVID-19 symptoms, a condition now known as "long COVID». The second reason, more fundamental and structural, is that the European response to the public health problem has become a matter of course.

The private hospital sector has established itself as an essential and indispensable partner in pan-European health crisis situations, with a tremendous capacity for initiative. Private hospitals have transformed themselves to open intensive care units, using operating theatre staff and equipment for patients in acute distress. Doctors and nurses agreed to go and help in other hospitals, and some critical patients were cared for in hospitals in other regions or even other countries in the name of European solidarity.

The organisational revolution in health systems has taught us that a European response to public health threats has become essential. For the coordination of care as far as we are concerned, but also in information, in industrial health policies and in the ordering and distribution of vaccines. The European agencies involved in health have been a constant reference, a guide for practical solutions to be applied in the Member States.

Faced with a global health crisis, Europe was able to reform itself. From a Community principle perceived as too theoretical, the EU 27 showed its capacity to react and organise. This fundamental lesson learned from constraint must be applied to structural reforms that are essential to our common future. Too many inequalities persist in our common living space. This is illustrated in this book by the persistence of an «iron curtain» between Eastern and Western Europe to the detriment of people facing cancer. The difference in life expectancy, access to diagnostic and therapeutic means to fight cancer is an injustice that needs to be addressed. Without strategic investment in health, there is no salvation.

The private for-profit hospital sector represents 22% of all hospital beds in Europe. It is a dynamic, growing sector, capable of managing technological and managerial innovation. We all need efficiency to improve the quality of care and access by reducing territorial inequalities. These inequalities can no longer be tolerated in an area where solidarity must prevail among European citizens. Significant developments need to be considered, and the Europe of health remains to be built by pooling our skills and experience. The future requires, for the sake of future generations, that we transform ourselves so that tomorrow everyone will have easier access to modern, quality health services.

We have once again entrusted this edition of the UEHP Factbook to Hans Martens, a European health expert, whom we thank, giving him carte blanche to help us prepare for the future. May all our efforts converge towards efficient solutions that meet the challenges of tomorrow, within a Europe strengthened by its solidarity and its capacity to adapt. UEHP is a partner in these changes, at the service of European patients, and will be positioning itself as a driving force for change so that our health systems all together can provide the legitimate response to chronic diseases as well as in crisis situations.

UEHP wanted to include in this edition its commitment to cancer care in Europe. A special section dedicated to this subject is featured in the appendix after Hans Martens's text, emphasizing a positive investment strategy involving the private sector in order to reduce inequalities in the face of this public health scourge, a European priority of the EU4HEALTH plan. This section concerning cancer in EU was elaborated with the support of Dr. Joy Raynaud, Health Geographer.

Paul GARASSUS,
UEHP President

INTRODUCTION

The Covid-19 pandemic was and is a complete game changer in Europe and in the rest of the world. At the time of writing this introduction – towards the end of 2020 – we still do not know how the pandemic will evolve and how it will affect citizens, health systems, the economy and the social fabric. More than anything else, the pandemic has changed the way we live and work, it has affected our economies negatively in extreme ways, but it has also given us new information on how to better handle this and other similar pandemics in the future – not only in the clinical area, but also in the social, economic and behavioural perspective.

The Coronavirus has attacked different parts of Europe in many different ways at different times and with different degrees of intensity, and we have not yet been able to fully understand how and why. The pandemic hit us all with a severity that came as a surprise for all, including health professionals and policy-makers in the health and care sectors as well as in various areas of economic activity. From the outset, it was clear that preventing outbreaks as much as possible was necessary as no European health system could have dealt with the worst-case scenario – which we have been close to seeing in the hardest-hit areas which, in the beginning, included Northern Italy and parts of Spain and the UK. During the pandemic, however, this has changed so many times that nearly all European countries have, at one point, experienced strong spikes. Therefore, a large part of the pandemic fighting was not done by clinical but by social and economic means, such as lockdowns, which had a positive effects on the course of the pandemic, but also a very negative effect on many areas of economic activity and employment.[1]

Clearly the economic and social consequences of the lockdowns have been and, for a long time, will be very severe but failure to take those measures could have brought about nightmare scenarios even worse than the ones we have witnessed. The uneven way the pandemic has struck at different times – health-wise and socio-economically – has also demonstrated the strong need for more potential at European level to deal with this and similar threats in a coordinated way, where resources are shared and solidarity is demonstrated. This was not always the case all the way through the events of 2020, even in the area of vaccines, where the EU was mandated with purchases of vaccines, but many episodes of vaccine nationalism occurred – within the EU and most certainly beyond the EU. The new mandates for health policy in the EU, including a new and much-increased budget, mean that a European response can be much stronger in the future, and the strong focus on developing resilient health systems and resilient populations in Europe should also create more confidence for the future. It certainly seems that the European populations are backing the actions of the European Union during the pandemic.[2]

The unpreparedness did not help and, in many ways, prevented health systems from acting in an optimal way. Health professionals all over Europe worked incredibly hard to deal with the pandemic, but they often did not get optimal working environments for their efforts. The shortage of personal protective equipment and test materials was a problem in many places, but the lack of coherent strategies was an even bigger issue. That included the lack of cooperation between public and private hospitals which could have improved the health systems' response if utilised to its full potential – especially in those national systems where the possibility of working together across sectors does exist.

In this context, the issue of resilience has become central to the debate on the future development of

1 *For an excellent overview of the pandemic in Europe and the economic consequences, see Health at a Glance: Europe 2020, OECD Publishing, Paris. https://doi.org/10.1787/82129230-en*

2 *https://www.pewresearch.org/global/2020/11/17/majorities-in-the-european-union-have-favorable-views-of-the-bloc/*

health systems. It has also become central to the debate on how new EU-wide initiatives aiming to improve health systems should be framed.[3]

The concept of resilience goes far beyond the concept of efficiency. In some countries – mostly those with national health systems with only (or largely) public hospitals – traditional economic efficiency has been high because the hospital systems are set up to deal with normal and predictable situations with little or no extra capacity in order to protect public budgets. These systems often have quite short stays in hospitals and use waiting times as a buffer, so if for some reason the number of patients surges, waiting times go up. But this does not mean that the systems are resilient when something unexpected happens – like the Coronavirus pandemic.

A few examples can illustrate this.[4]

Average length of stay in hospitals, 2018		Hospital beds per 1 000 people, 2018		Intensive care beds per 100 000 people, 2017	
Portugal	9.1 days	**Portugal**	3.5	**Portugal**	-
Germany	8.9 days	**Germany**	8.0	**Germany**	33.9
France	8.8 days	**France**	5.9	**France**	16.3
Italy	7.9 days	**Italy**	3.1	**UK**	10.5
Spain	7.3 days	**Spain**	3.0	**Spain**	9.7
UK	6.8 days	**UK**	2.5	**Italy**	8.6
Sweden	5.7 days	**Denmark**	2.4	**Denmark**	7.6
Denmark	5.4 days	**Sweden**	2.1	**Sweden**	5.8

Note: Figures on intensive care units for most countries are from 2014-2018, but for the UK from 2020, so including the year of the pandemic with the additional emergency units established.

3 *See for example the views from the DG Santé Expert Panel: https://ec.europa.eu/health/sites/health/files/expert_panel/docs/026_health_socialcare_covid19_en.pdf*

4 *All data here is from Health at a Glance: Europe 2018 and 2020 by the OECD, the European Observatory and the European Commission.*

With these few figures in mind, it is not difficult to see that while you may say that, for example, Germany has excess capacity under normal circumstances, it is also clear that the German health system has large capacity for unforeseen events and thus a very high degree of resilience.

It is also very clear that countries with a mix of public and private hospitals – Germany, France, Italy and Spain – have a higher capacity than the typical national health system countries, such as the UK, Denmark and Sweden. So, in countries like the UK and Denmark it was clear that it would not be possible to handle a big increase in cases and therefore strict lockdown measures were implemented at different times as the pandemic threat was growing. The same could have been done in Sweden, but instead that country decided not to impose hard lockdowns, and the end result has been a dramatic – and for most other countries unacceptable – mortality rate, especially among the elderly.

Number of Coronavirus deaths by age group. Sweden. Cumulative data as at 24.03.2021[5]

Age	Deaths	% of all
0-59	242	4
60-69	415	7
70-79	1,279	8
80-90	2,491	49
90+	1,570	32
Total	**11,373**	**100**

To make a comparison, the number of Coronavirus related deaths per 100 000 people was over the same period 130 in Sweden, 41 in Denmark, 15 in Finland and 12 in Norway.

These experiences reveal important features for designing the future health systems so that they are more resilient. This includes having an ample supply of resources – perhaps not everywhere, but for example a pool of resources at EU level to be shared as the need arises. This would reduce the dependency on other parts of the world and increase Europe's strategic autonomy. The building of an EU-wide capacity – which has now been decided – will help to level out the differences between EU Member States and can help with extra resources where they are most needed. But the additional capacity can also be created through a mix of public and private hospitals, in particular now that public budgets have been hit very hard by the economic crisis following the pandemic in 2020, which can and will affect the public sector budget available for health services. It is also clear, however, that if we all should benefit from the advantages of having both public and private hospitals there need to be policies in place that ensure that society makes the very most out of having this coexistence of public and private hospitals. That was certainly not always the case during the first part of the pandemic, as the following chapters will show.

Other diseases do not take a break

The challenge has not only been to deal with the pandemic itself, but also to try to keep all other normal health system activities running. That has not happened during the worst spikes of the pandemic, and the price will be paid in the future because of delays in treating serious diseases, including cancer. Instead of making optimal use of all available resources, many private hospitals were relatively empty while public hospitals were struggling with capacity problems. Other attempts were made to separate Covid-19 patients from other patients – including letting private hospitals focus on the non-Covid-19 patients – but it did not work well in all cases, partly because of bad planning but also due to the fear of COVID-19 that kept patients from seeking medical care.

5 *https://www.statista.com/statistics/1107913/number-of-coronavirus-deaths-in-sweden-by-age-groups/*

INTRODUCTION

It is likely that one of the lessons learned from the first phase of the pandemic is the ability to use hospital capacity better to avoid an upsurge of diseases that were either not treated or treated too late. Preliminary figures from some core European countries show a large reduction in the volume of primary care consultations during the first wave in the spring of 2020 – up to 50% in Belgium, 33% in Portugal and Bavaria in Germany and 25% in France. Assuming that this reflects a more general picture – even when we look at non-COVID hospital activity – there are reasons to believe that there will be an increase in non-communicable diseases that were not treated early enough.[6]

All in all, lessons have been learned, and in future similar – or even worse – situations, we will know more about how lockdowns can work and not work. We are also facing a major upgrading of the European Union's health policy capacity, both budget and content-wise, where the existing priorities, including the Cancer Plan, will be supplemented with other activities, such as joint stocks of personal protective equipment, medicines, teams of health professionals for use in the hardest-hit areas, and indeed work on how to improve the resilience of European health systems.

This could, for example, mean learning from the best practices in Europe, but also learning from the good and bad experiences during the crisis, including how to look at and measure health system efficiency and indeed how to best ensure that the public and private components of health systems are best put to use. Many examples of how systems can be reformed to deliver more resilient systems will be described in the following chapters.

During a seminar organised by the European Observatory on Health Systems and Policies[7], the keynote speaker, Erin Webb from the Technical University in Berlin, summarised some of the core advice on how to use the health system capacity in an optimal way:

. Separate confirmed and suspected COVID-19 and non-COVID-19 patients

. Increase the use of virtual treatment and digital services

. Provide staff with regular testing

. Prioritise treatment based on medical indication, COVID-19 situation and/or severity

. Use private sector capacity.

The use of private sector capacity in this context has merged rather late in the period of the pandemic, but it seems that this solution has gained more respect, interest and recognition during the pandemic.

Another important factor – besides developing effective vaccines and drugs for treatment – is to better understand what factors determine not only the spread of COVID-19, but also how it affects different people, which factors are important in the severity of the disease, etc. Even if we do know more about the disease now than in the early days of 2020, there is still an enormous number of unanswered questions. Many of these questions could be answered if we decided to link the results of diagnostic tests with data about disease history, multi-morbidities, social conditions, ethnic conditions, behavioural patterns etc. Most countries already have some of these data available and linked to social security numbers, but other data could be added. Of course there are data security issues, including fear of misuse of data, but the question is whether we should put these worries aside and really exploit the full value of diagnostic tests by linking them to data so we can know more and therefore improve treatments and save lives. This should be done in a coordinated and harmonised way in Europe in order to respect the common data protection rules, and get results that are comparable across countries and systems.

6 *Health at a Glance, Europe 2020, page 62.*

7 *Seminar held on 3rd November 2020: Hospital care and COVID-19: Balancing surge capacity and regular services.*

Innovating during the crisis

There is no doubt that our societies and health systems have already gathered information and changed procedures in such a way that we are better equipped to handle new phases of the pandemic, and our societies and indeed our health systems have evolved and innovated significantly since the start of the pandemic. The same can be said about the developments at European level, where health policy has suddenly climbed up the hierarchy of importance with a record budget of more than € 5 billion for the next budget period and with a new willingness to share the purchasing of vaccines and operate joint stocks and health workforces.

Now, at the end of 2020, there are also new discussions about creating a European health data space and developing the exchange and use of health data across borders. This can provide new ground-breaking opportunities and reduce the need for the national lockdowns and border closures seen in the first half of 2020.

We will give examples of such innovations in the following chapters, but certainly one of the most important has been the switch to digital solutions and tele-consultations as well as other communication methods that were used during lockdowns or under restriction of movement orders.


SCAN
FILTER
REC

CHAPTER 1

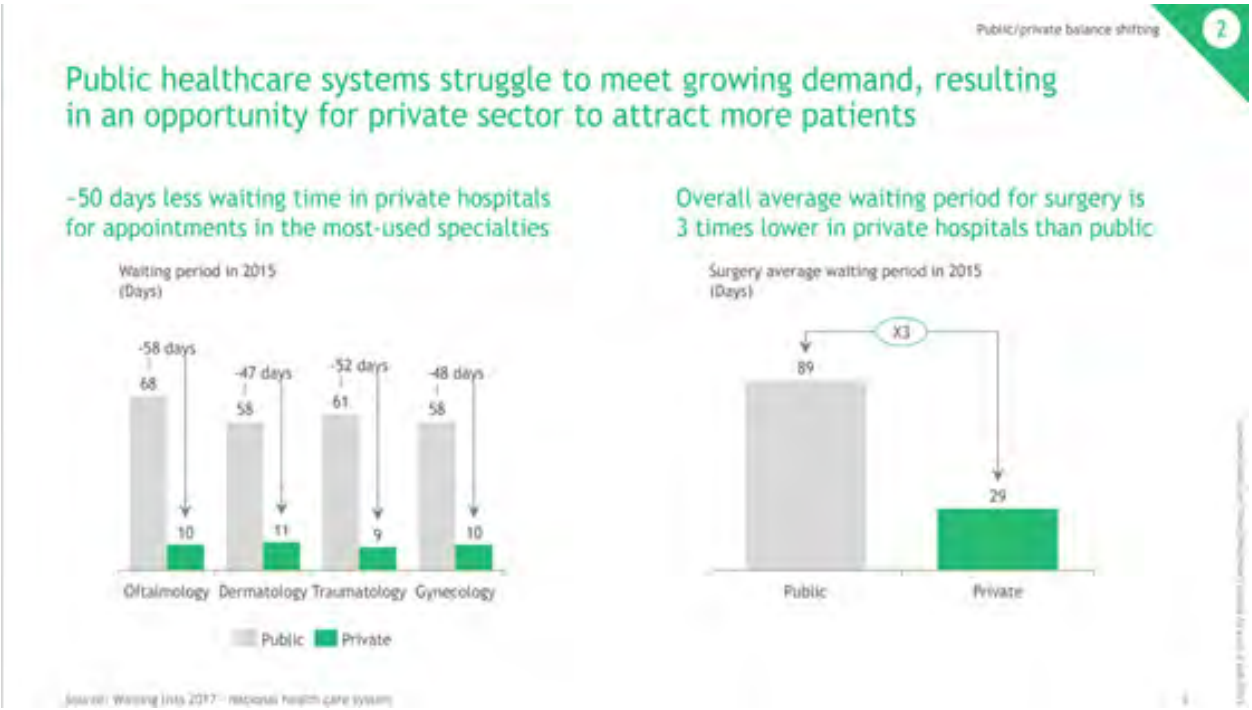
EUROPEAN HEALTH SYSTEMS NOW AND IN THE FUTURE

CHAPTER 1

European health systems are different in many ways, but they share important features that constitute a European model for healthcare – a model which has elements that most people see as being so important that they should never be given up – although different kinds of serious pressures on the systems are beginning to undermine some of these sacred principles.

A fundamental principle is that health systems are for all citizens, and that access should be universal and equal – or at least as equal as possible. Europeans are, in general, very critical of other systems in the world that do not have such advantages and a financing model based on solidarity among all citizens. However, the slow but steady undermining of equal access to health in Europe has not really moved into public debate – yet.

Inequality is driven by several factors. A fundamental principle in the European model is that health systems are largely financed by taxes and/or general insurance schemes – which means that all citizens are contributing, which again means that all citizens are economically affected by the performance of the health system in general, and that other citizens' health is everybody's business. But over recent years there has been a strong growth in private health insurance, especially in the so-called Beveridge systems where practically the whole health system is organised by the public sector, including its financing, and where the systems are tax-financed. In such systems, the public sector's inability to ensure sufficient supply has generated inefficiencies and long waiting times. Private insurance for those who can afford it is a solution – but a solution that leads to traditional, wealth-based inequalities.



The figure shows examples on the shift from public to private supply in Spain and Portugal – in systems with a tradition of a mix of private and public hospitals.

Eurofound has found that "barriers to accessing health and care services, either real or perceived, can result in health inequalities and greater healthcare needs in the future. Improving the access to and quality of services requires that the aforementioned disparities be addressed, so that the 'well-being effect' can extend across society".[8]

One of the biggest barriers is of course a limited supply of health services, which can occur for many reasons, as will be discussed in this book. One of the most serious reasons is the continued reliance on public-only financing of health services, as the increasing pressure on public finances has led to a strong focus on savings, cuts and reductions in investment in public health supply. This situation will be aggravated most certainly by the economic effects of the Coronavirus pandemic, which has drained the public coffers in almost all European countries – not only because of the costs of the health system, but also because of all the stimulus packages and loss of income due to reduced economic activity.

This will almost certainly lead to increased inequality as warned by Eurofound.

In addition, a new form of inequality has appeared in the transition from the industrial to the information society. Patient empowerment is a popular expression, but there are enormous differences depending on which part of the population can benefit from such empowerment. Patient empowerment requires health literacy and digital literacy, and there is now clear evidence that there is a direct link between knowledge levels and benefits from health services – and indeed life expectancy.

Gap in life expectancy at age 30 between people with the lowest and highest level of education, 2016 (or nearest year)

Women	Country	Men
5.1	Poland	12.0
4.5	Bulgaria	6.9
2.6	France	6.5
3.0	Austria	6.2
4.6	Netherlands	5.8
4.4	Belgium	5.8

Health at a Glance, 2018, page 85

8 *Eurofound (2019), Role of health and care services in improving well-being and economic performance: Perspectives from the European Quality of Life Survey, Publications Office of the European Union, Luxembourg.*

CHAPTER 1

Systems with mixed financing and mixed provision of services – private and public – are generally doing better, but the additional care provided by private hospitals could come under pressure if the financial stability of private hospitals is threatened. This is due to a series of factors, but in most countries discrimination against the private part of the heath system is certainly an important reason. This again calls for a review of how the necessary supply of health services is provided, and how reimbursement systems should be reorganised in order to secure not only the necessary supply, but also the sustainability of health systems that can live up to the fundamental criteria of the European model. The Coronavirus pandemic has added to these problems, as health authorities in some cases have lacked the ability – or will – to fully utilise the capacity of private hospitals during the crisis.[9]

The answer to this is most likely to be a move in the direction of more resilient health systems with a stronger patient and value-based focus, rather than the present systems where costs and traditional efficiency concepts are predominant.

These current trends are dangerous for two main reasons: first, it is a bad idea to reduce the ability of the private component of the health sector to perform on equal footing with the public sector, because having public and private hospitals working in the systems means both increased supply and increased competition and thus the possibility of moving forward by focussing on creating best practices and value (in terms of quality, efficiency, patient satisfaction, etc.). The second reason is that if the private hospitalś ability to perform is reduced, this will reduce the total capacity of health systems in Europe and thus lower resilience and create problems such as lack of capacity in crisis situations and waiting lists, which ultimately means higher mortality and more costly interventions. It is certain that private investments that cease, or are forced out, will not be replaced by public investments, because very few, if any, governments have the ability to provide these extra funds, especially post-Coronavirus.

So, in reality – and perhaps as opposed to what many people may think – health equality is supported by cooperation between public and private hospitals, provided of course that the payer is the public health insurance, as is the case in European countries. Wider provision of services reduces waiting times and thereby reduces the need to jump the queues with private insurance. So inequality is not related to who owns and runs the hospitals, but to who pays!

All health systems must constantly strive to become more cost-efficient and create higher value for patients and society, and in general private as well as public hospitals must embrace and adapt to the changes that our health systems are undergoing – and will undergo in the coming years.

Changing health systems

Public deficits and scarcity of public resources are widespread in most European countries, but the situation is especially difficult in the healthcare area and worsened during 2020.[10]

9 *The private sector is extremely concerned about the risk, already announced weeks ago, of healthcare and financial bankruptcy and denounces the disengagement by the current government from a sector that employs 266 000 people and makes up 3.4% of GDP. This risk has been exacerbated by the recent pandemic and is currently leading to the suspension of payments, competition and the closing of hundreds of health centres, mainly small clinics, unable to bear current expenses. It is currently estimated that about 2 400 outpatient clinics will be forced to close. This is a quote from the Spanish Association of Private Hospitals. See https://www.uehp.eu/newsletter/202006/index.html?ts=20200630114056*

10 *Fiscal deficits are expected to surge from an aggregate of 0.6% of GDP in 2019 to 8.5% of GDP in 2020. Having fallen to 86% in 2019, the euro area's aggregate debt-to-GDP ratio is now expected to climb to close to 103% this year. https://www.icaew.com/insights/viewpoints-on-the-news/2020/may-2020/covid19-prompts-a-step-change-in-european-public-finances*

Health is already a major component of public expenditure, but the pressures from demography (ageing population and fewer new taxpayers) puts special pressure on health systems, as does the changing demography due to moves from the countryside to cities and migrant inflows.

As mentioned above, we are also seeing the growth of a more knowledgeable, health literate and digitally literate part of our populations. These groups are very demanding and have very high expectations plus a strong demand for patient-centred health services. In addition, many new pharmaceuticals which deal with health issues in new and often very effective ways are very expensive and add to the increase in the costs of running the healthcare system.

Patient mobility – and indeed also that of health professionals – is increasing, posing new challenges to the health system, such as the transfer of health data across borders in Europe. The issues of data, how they can be used and how to make sure they remain private, is another factor that places new demands on health providers, as do the increasingly complex treatments with better diagnosis, more personalised interventions (including pharmaceuticals) and care, and finally the need to be able to document and measure the value of healthcare and its elements – for many different purposes – which again includes the ability to measure the outcomes of treatments as perceived by the patients and adapt accordingly.

The changes will affect health systems profoundly over the coming years, and rather than seeing the health sector as a series of discrete elements – such as primary health care establishments, hospitals, community care centre, etc. – it is more likely that the health system will be viewed as one system that needs to become integrated, to work seamlessly together. Private hospitals must broaden their scope by either joining this integration of healthcare and/or broadening their own operations into primary and social care. In order to be able to deal with health services generally, our societies need to be better at preventing illnesses and be better at optimising stays in hospital with stays at (cheaper) care centres. This will probably be emphasised by changes in reimbursement systems that will reward the optimisation of healthcare systems.

The big challenge is to build this new deal between the different healthcare providers on the basis of stronger patient involvement. Therefore, the first thing to be done is to analyse the patients' needs (we must remember that patients do not all have the same level of health literacy) in order to define targets and solutions. Too often policymakers lay down principles without providing solutions and leaving that to the healthcare providers.

Eurofound

The potential for preventing health and care problems is under-recognised. Prompt access to primary health care, social care and long-term care can stimulate early intervention, boost monitoring of ongoing needs and prevent a disproportionate concentration of problems in particular locations. Policymakers should look beyond the health (care) sector and its associated budget. For instance, more attention needs to be paid to the world of work, to more broadly sustain health and facilitate care needs and responsibilities. To promote health directly, a broad approach to prevention should cover the local areas where people live and work – from good-quality housing that can contribute to preventing mental and physical healthcare needs to healthy environment and healthy behaviours.

Eurofound (2019), Role of health and care services in improving well-being and economic performance: Perspectives from the European Quality of Life Survey, Publications Office of the European Union, Luxembourg.

On the prevention side, changes can be foreseen in the sense of the need to create health centres with better opportunities to perform a number of tests, more precise diagnosis, services and interventions without involving hospitals. This is particularly true in the area of fast-growing chronic diseases, where economic analysis clearly demonstrates how much more cost effective it is to prevent or delay, for example, diabetes than it is to deal with the consequences of full-blown diabetes. And that is not even mentioning the benefits for the patients![11]

This changing view of care, moving away from "sick care" towards "health care" will also help keep people out of the health system if possible. With increasing use of self-care and self-management, which has been made possible through the development and use of digital services and new digital (sometimes remotely connected) devices, this will lead to a discussion on how to reduce unnecessary use of health care services – and changes will most likely be introduced by altering the reimbursement systems.

Health systems must also support market innovation and development by embracing, testing and applying new innovations – and perhaps also contribute to the development of such services.

Sustainability

Besides contributing to the sustainability of health systems as such, which includes fiscal sustainability – i.e. responsible use of available resources and an obligation to avoid waste in the health systems – private hospitals are also preparing for actions required by the general concept of sustainability, which in addition to economically efficient behaviour contains elements of social and environmental behaviour.

Amongst the actions already taken by private hospitals in Europe, those on the environmental side are:

. Development of waste treatment programmes
. Policies for monitoring and reducing energy consumption
. Actions on water management
. Decrease in the use of dangerous substances
. Greenhouse gas emissions reduction
. Eco-design of buildings

In Germany, a number of private hospitals are working together on climate protection in a project called "KLIK Green"[12], and in Portugal the group Lusíadas became one of the pioneering entities in Portugal in 2020 for consuming electricity entirely from renewable sources.

On the social side, these are example of actions taken by private hospitals:

. Improving health and safety at the workplace
. Focus on quality of life at work
. Promotion of equality, meaning actions against discrimination based on gender, origin, age and disabilities
. Introduction of sustainable purchasing policies
. Development of the territorial anchoring of hospitals

11 *Many of these thoughts are also mentioned in the draft European strategy on the standardisation of healthcare services by the CEN Ad-hoc Group on Healthcare Services. CEN is the European Committee for Standardisation.*

12 *See for example https://aktuelles-aus-suederelbe.de/2020/09/11/asklepios-klinikum-harburg-engagiert-sich-im-klimaschutzprojekt-klik-green/ and https://www.klik-krankenhaus.de/klik-datenbank/suche-nach-massnahmen?tx_klikdb_search%5Baction%5D=show&tx_klikdb_search%5Bcontroller%5D=Hospital&tx_klikdb_search%5Bhospital%5D=107&cHash=335a6d677f92b45f9b65cb42578bc686*

Market developments across Europe

Health expenditure as a share of the total economy (GDP) has not changed considerably during the post-crisis years, but there has been an increase in health spending per capita from 2013 as opposed to the dramatic cuts in the period from 2008 to 2013 – the worst of the crisis years. This basically means that the effects of the dramatic cuts in expenditure over the crisis years have been levelled out, but, in any case, recent years have provided an increase in spending on health – and thus generally speaking a favourable market for offering health services.

Annual average growth rate (real terms) in per capita health spending, 2013 to 2019 (or nearest year)

Italy	+1.0
Greece	+0.4
Austria	+1.1
France	+1.0
Belgium	+0.9
EU-27	+3.0
Portugal	+3.0
Germany	+2.7
Spain	+2.3
Poland	+4.0
Bulgaria	+6.2

Health at a Glance, Europe 2020, page 159.

Although general health spending has increased over recent years, the number of hospital beds has decreased steadily; partly because of efficiency gains, partly because of general improvements in health system management (for example reduction in unnecessary hospitalisations, more efficient prevention, and optimisation of the flow between hospitals and social or home care). But it should also be mentioned that the rationale of the more traditional concept of efficiency may have to yield to the broader concepts of resilience and value orientation – as opposed to cost-efficiency – which has been demonstrated during the Coronavirus pandemic, especially in countries with mainly public hospitals as mentioned in the introduction.

It is worth noticing – besides the general trend towards reduction in the number of hospital beds – the dramatic difference between the numbers of hospital beds per 1000 inhabitants. Over 8 beds per 1000 inhabitants in Germany and around 2.5 in countries like UK, Denmark, Ireland and Sweden is a huge difference in countries that are rather similar in most other dimensions. There seems to be a basis here for trying to identify the best practice, because it is very likely that neither 8 nor 2.5 beds is the optimal solution.

Hospital beds by type of ownership

Country	2011	2014	2016
Germany			
Public	273,287	271,079	269,158
Not-for-profit	198,011	195,052	193,368
For-profit	200,280	200,206	201,206
Greece			
Public	33,383	30,157	29,550
Not-for-profit	1,314	884	880
For-profit	14,995	15,119	14,843
Spain			
Public	97,997	94,607	94,724
Not-for-profit	18,438	17,218	17,042
For-profit	26,207	26,113	26,242
France			
Public	258,444	256,229	250,104
Not-for-profit	57,717	57,176	56,994
For-profit	98,043	97,516	97,150

Country	2011	2014	2016
Croatia			
Public	24,887	24,628	22,508
Not-for-profit	0	140	140
For-profit	143	268	269
Italy			
Public	142,887	152,392	131,213
Not-for-profit	7,582	7,705	7,527
For-profit	58,385	62,918	58,225
Austria			
Public	45,381	44,123	44,910
Not-for-profit	11,450	11,263	11,195
For-profit	7,585	8,729	8,743
Portugal			
Public	25,828	24,206	24,056
Not-for-profit	7,014		7,222
For-profit	2,693	3,508	4,059

https://ec.europa.eu/eurostat/statistics-explained/index.php?title=File:Hospital_beds_by_type_of_ownership,_2011_and_2016_HLTH18.png

Hospital beds per 1000 population

Country	2011	2012	2013	2014	2015	2016	2017	2018
Germany	8.4	8.3	8.3	8.2	8.1	8.1	8.0	8.0
Austria	7.7	7.7	7.7	7.6	7.6	7.4	7.4	7.3
Lithuania	7.5	7.4	7.3	7.2	7.0	6.7	6.6	6.4
Hungary	7.2	7.0	7.0	7.0	7.0	7.0	7.0	7.0
Poland	6.6	6.6	6.6	6.6	6.6	6.6	6.6	6.5
Czech Rep	6.8	6.7	6.5	6.5	6.5	6.7	6.6	6.6
Belgium	6.4	6.3	6.3	6.2	6.2	5.8	5.8	5.6
France	6.4	6.3	6.3	6.2	6.1	6.1	6.0	5.9
Slovakia	6.1	5.9	5.8	5.8	5.8	5.8	5.6	5.7
Latvia	5.9	5.9	5.8	5.7	5.7	5.7	5.6	5.5
Estonia	5.4	5.5	5.0	5.0	5.0	4.8	4.7	4.6
Luxembourg	5.3	5.2	5.1	5.0	4.8	4.8	4.7	4.5
Slovenia	4.6	4.6	4.56	4.5	4.5	4.5	4.5	4.4
Finland	5.5	5.3	4.9	4.5	4.4	4.0	3.2	3.6
Greece	4.5	4.5	4.2	4.2	4.3	4.2	4.2	4.2
Portugal	3.4	3.4	3.4	3.3	3.4	3.4	3.4	3.5
Italy	3.5	3.4	3.3	3.2	3.2	3.2	3.1	3.1
Spain	3.1	3.0	3.0	3.0	3.0	3.0	3.0	3.0
UK	2.9	2.8	2.8	2.6	2.6	2.6	2,5	2.5
Denmark	3.1	-	3.1	2.7	2.5	2.6	2.6	2.4
Ireland	2,6	2.6	2.6	2.6	2.6	3.0	3.0	3.0
Sweden	2.7	2.6	2.6	2.5	2.4	2.3	2.2	2.1

Health at a Glance, Europe 2020, page 223 – OECD Health Statistics 2020 and Eurostat Database.

The trend is pointing towards a general reduction in the number of hospital beds and it seems that the number of public hospital beds has been reduced the most, while the number of private hospital beds is stable or increasing in many countries. This could indicate higher efficiency of the private hospital beds (more value for money), and/or reflect the scarcity of public funds for health services.

Observation by Paul Garassus, (President of UEHP):

All hospitals depend on public money, but the current cuts in regional or national budgets are limiting the fees (e.g. according to DRG prospective payments) or initiatives (based on P4P or P4O). In hard economic times for all, the quality of care could be limited for economic reasons. This situation was previously and seriously observed during the 2008 economic crisis in Greece, Portugal and Ireland. Such context leads to hospital deficits: for example, in France, where the public sector is now burdened by a € 30 billion cumulative debt. This debt will be paid by new taxes imposed by the government. Such a situation never occurs in the private sector where a deficit in a private hospital means closing down. Hospital management is thus not just a "virtue", but a strong necessity to remain open.

In any case, the health system of the future is likely to become more integrated; this will give a better chance to optimise the healthcare delivery system. For many years, hospitals have absorbed the lion's share of health system resources, but they might not be the alpha and omega of the health systems of the future, but rather a mere element in the system linked on one side to the primary part of the system (working on disease prevention) and on the other to the tertiary care sector.

Digitalisation will obviously be amongst the elements that can facilitate this process, and also help detect where the optimal place for treatment will be and what would be the optimal pathways. This will pose challenges for the health systems and will require – to be successful – the ability to think outside the box. To achieve full integration and reap its benefits, we also need vision and ability to act from policy makers. Optimising the health system – which will be an ongoing process – can best be incentivised by the reimbursement system.

In the future, the decisions on where to invest and spend in health should be increasingly based more on the value created at different levels, from the patient via the health systems to the societal economy, rather than mostly on pure cost considerations on one side and lobbying by various parts of the health systems as is often the case today. Directing the system to create more value – for patients and indeed also for society and the societal economy – and having the ability to be resilient, also in dealing with unexpected health threats, are probably the most important guidelines for investing in future health systems in Europe.

CHAPTER 2

EFFICIENCY IN HEALTH SYSTEMS

CHAPTER 2

Efficiency means many different things to different people and in different contexts. But for most it means doing things well, successfully and without waste – creating value for money. Taking the concept a step further, efficiency can be expressed in simple mathematics to demonstrate the extent to which a given input is used to produce a specific outcome. This, again, obviously means different things for different sectors, but in the health sector efficiency can be given a more specific and refined meaning – which will be done below – as the concepts of quality and value are being increasingly incorporated into measurement of efficiency, and to a much higher degree than in many other sectors, such as the mechanical industry.

Measuring efficiency in a simple, mechanical way will not work in the health sector. The issue is not (only) about, for example, the number of medical procedures per day, it is also about whether a high number of procedures leads to many re-admissions and, indeed, increasingly about the patient-reported outcomes in addition to the clinical outcomes. Thus the issue of quality and value creation is becoming increasingly dominant in the discussion about the performance of health systems, and not only at patient level but also in relation to the value created for societies and the societal economy. Another aspect that has emerged strongly during the COVID-19 pandemic is the issue of resilience in health systems and in populations and societies.[13]

It should also be noted that efficiency is different from effectiveness, which normally describes a much simpler concept of getting a desired result in quantitative rather than qualitative terms, for example by setting a quantitative goal for mechanical production. This may sound simple and obvious, but the distinction is not always made clear in discussions about health policies, in particular by policymakers, where arguments are often based on data that focuses on quantitative rather than qualitative indicators, such as length of stay in hospitals, number of specific procedures, etc.

The same can also be seen in reimbursement systems where quantity is often rewarded, while less consideration is given to quality and patient perception. Some uses of DRG systems come to mind, and this is rather central to the discussion about introducing value-based healthcare methods – also in determining the form and shape of reimbursements. Quality already plays an increasing role in the recent evolution of reimbursement systems, but it should be expected that patient-reported outcomes, and in general the concept of value[14], will play an increasing role in the coming years. This again means, firstly, that the individual units in the health systems – including hospitals – must work to define the optimum point of efficiency (or value creation) considering quite a large number of indicators and, secondly, that the health system as such will need to cooperate more closely if and when the so-called bundled payment systems are introduced.

It would be nice and easy for all of us in our societies if we could avoid all this discussion about how to improve the performance of health systems, and just concentrate on treating everybody to the highest existing standards. But the demands for higher efficiency in health come from the various pressures mentioned in the introduction, and presently three out of four euros spent on health are funded by governments (whether the services are provided by public or private entities) and health spending accounts for around 15% of all government spending across the OECD.[15]

13 *Se the excellent report on this from the DG Santé Expert Panel: https://ec.europa.eu/health/sites/health/files/expert_panel/docs/ev_20200916_mi_en.pdf*

14 *Value understood as outcomes divided by the costs involved in achieving the results (outcomes)*

15 *Health at a Glance, Europe 2020. Page 163*

With all the other needs for public financing, with the drain in public finances caused by the pandemic, and considering the changing balance between retired people and younger taxpayers, there is little room for additional reallocation of budgets to health spending, and there is a strong imperative for health systems to maximise value for money.[16]

The pressures for efficiency

All indications point to the need for health systems to become more efficient in creating higher value and reducing waste if the European model with equal access for all (in principle) is to be maintained. Public sector budgets are and will be under pressure, because of demographics, because of ever-increasing demands from populations (also for health) and because the havoc wrought by the economic and financial crisis was not yet over before the annus horribilis – 2020 hit and made a big hole in public budgets.

However, in the public debate this often leads to some easy conclusions. One is that health systems must have more resources to perform better, which again means more money from public budgets. Another argument – mostly coming from health professionals – is that they cannot "run faster" , that they are already overburdened and cannot perform better. But in reality this is not (necessarily) about more money or running faster, it is much more about thinking out of the box and thinking smart, on investing money in a clever way (guided by value creation for our societies), and indeed it is about breaking down silos and traditional perceptions about how health systems and their components should work, not only from a clinical perspective, but also from an organisational and management perspective.

Life expectancy at birth is a rather basic indicator of health systems, and figures from 2017 show that the top ten countries are quite different from those in the list of national health spending.

Life expectancy	Health spending (EUR PPP)
Spain	Germany
Italy	Austria
France	Sweden
Sweden	Netherlands
Malta	Denmark
Cyprus	France
Ireland	Luxembourg
Luxembourg	Belgium
Netherlands	Ireland
Austria	Finland

Data are from OECD/European Observatory on Health Systems and Policies 2019: State of health in the EU. The State of Health in the EU.

There is no direct link between the money spent on health and the results, so the efficiency equation is (often) not about spending more money, but about reorganising and doing things in a smarter way. As salaries make up a dominant part of health system costs, general costs and wage levels in the countries obviously also play a very large role, although this factor can be reduced by looking at the share of GDP and/or PPPs (Purchasing Power Parity).

This is not only about the individual units in the system (for example a hospital), but also about how the health system as a whole can perform better, create more value and reduce waste if it is a well-integrated system, if it is ready to break with traditions and if it is guided by optimising value rather than reducing costs.

16 *Francesca Colombo: Waste and inefficiency in healthcare need to be tackled across OECD countries in the report: Smart (Dis) Investment Choices in Healthcare, Friends of Europe, November 2018.*

Therefore, this is also a question of allocating available resources in the best possible way when making decisions on prevention, prevention of disease progression, more precise diagnostic equipment to guide precise interventions, using the best possible equipment and medicines, using as much as possible the data created in the health systems as a way to provide guidance on the best possible patient pathway, ensuring robust communication between parts of the health systems, and being prepared to accept reorganisation as a tool for creating more value. The theme of how to improve the tools that form the basis for investment decisions is discussed later in this book.

The need to think outside the box arises for many reasons. One is the rapid development of technologies which means that things can be done in new ways – often with increased efficiency as a result. But it can also mean accepting new roles for health professionals. In general, there is a much higher need than before for reviewing not only clinical procedures and the use of new technologies, but also the management of health systems. This of course involves hospitals to a very high degree, but also links to the primary and social care sector. But other institutions, such as pharmacies, can also take new roles to achieve increased efficiency. The issue of Task Shifting requires flexibility in the approach to health professionals' work and life and a willingness to break with (established) traditions, but the results can be substantial and contribute to the sustainability of health systems.[17]

EU countries only spend around 3% of their total health budgets on prevention efforts.[18]

Disease prevention has three dimensions: Primary health care (promoting good health and intervening before diseases ensue), secondary (screening efforts to detect diseases in the earliest stages before onset of signs and symptoms) and tertiary (managing disease after diagnosis to slow or stop disease progression). It seems logical that improving prevention creates value for individuals and for society, and the rapid technology developments, including digitalisation, provide instruments to improve disease prevention, for example by enhancing the value of diagnostic information by giving more accurate diagnosis and pathways for the most efficient treatment for different patient groups, which also implies personalisation of treatment.

An argument against these efforts could be that they are too costly, but perhaps these initiatives should be seen more as an investment than a cost, as preventing diseases or treating them in the early stages is not only best for the patients, but certainly also saves money for societies by reducing costs of treatment and increasing the productivity of patients.

To increase prevention efforts, health professionals must be interested in working on prevention rather than treatment, and incentives must be provided via reimbursement systems to make it financially interesting to work more on prevention. A task that might attract new interest from the private sector if the financial conditions are right.

17 *Task Shifting and Health System Design. Report of the Expert Panel on effective ways of investing in Health (EXPH). Luxembourg: Publications Office of the European Union, 2019*

18 *State of Health in the EU. Companion Report 2019. Page 17.*

But the enormous pressure on government budgets also means that private capital must be added – in addition to public funding – to ensure that the systems are sustainable and that the necessary investments can be made. Although the situation of public finances varies across Europe, the pressure exists in even the best-performing countries, particularly because of the effect of the Coronavirus pandemic and the societal lockdowns, but also due to demographic trends in Europe: longer life expectancy and fewer new taxpayers.

But there is no law of nature that says that private entities are more efficient than public ones, so the same rules apply for achieving the highest degrees of efficiency. There is, on the other side, no doubt that private capital will be a necessary element in sustainable health systems for the future, mainly to create a bigger supply of services that can cope with the increased needs without creating very long queues of patients waiting to be treated and to avoid the inequality that arises when wealthier groups of the population buy private insurance solutions that can allow them to jump the queue!

Long waiting lists also have negative consequences in themselves, for instance the longer patients have to wait before starting treatment, the worse their conditions will be. Another example is the frequent use of emergency rooms by patients who have poor access to health services, in particular primary care, which again means a more expensive solution stemming from savings – for whatever reason – in the health sector.

As mentioned in the introduction, it is often said that private hospitals increase inequality in the access to health services. The situation in Europe is now the opposite. If private hospitals operate on equal footing with public hospitals, this creates more supply and shorter waiting times for all.

In those systems where the public sector handles all (or nearly all) health services, the wealthy are increasing skipping the longer and longer queues for access by buying private services outside the normal health system.

Fighting waste

The OECD estimates that more than 20% of all spending in health systems (public and private) can be considered as waste because of incorrect treatment, unnecessary hospitalisations for conditions that could have been treated (more cheaply) in outpatient settings, wrong medications, low quality of diagnosis (for example poorly performed screenings) and many more reasons.

The OECD analysis[19] estimates that 1 out of every 5 euros spent on health is ineffective or wasteful. This is an average for the OECD countries, but it is a true scandal that around 20% of health costs are wasted – especially when considering the current financial pressure on health systems – but also that fraud and waste are taking care away from patients who really need medical attention.

There are many different things that can be done to address the issue of wasteful spending, and it is very important to underline that best practises should be analysed and described, and that national health systems – and individual hospitals – have a duty to look for best practices even if they take place across borders in other European countries and implement them if they can improve the national or local situation!

Information about the identification of low-value care, low-value interventions, drugs and equipment should be published, as should reports on adverse events. This could also be coupled to widespread dissemination of clinical guidelines. Exactly the same goes for best practices in digital solutions (for example in electronic prescriptions, connecting the dots in the health system, etc.) and then of course reimbursement systems should work on providing value-based incentives. An emerging trend of using more value-based procurement may also be a way to improve value for money when purchasing, for example medicines. Again, look at the best performance and implement the good ideas that work instead of rejecting them just because "they were not invented here".

19 *See for example https://www.oecd.org/els/health-systems/Tackling-Wasteful-Spending-on-Health-Highlights-revised.pdf*

Wasteful spending is not always an issue just for the individual elements of the health system, but also for the system as a whole and how it works and links its components. In summary, waste can be grouped under these headings:[20]

Wasteful clinical *care covers instances when patients do not receive the right care. This includes preventable clinical adverse events, driven by errors, suboptimal decisions and organisational factors, notably poor co-ordination across providers. In addition, wasteful clinical care includes ineffective and inappropriate care – sometimes known as low-value care, mostly driven by suboptimal decisions and poor incentives. Last, wasteful clinical care includes the unnecessary duplication of services.*

Operational waste *occurs when care could be produced using fewer resources within the system while maintaining the benefits. Examples include situations where lower prices could be obtained for the inputs purchased, where costly inputs are used instead of less expensive ones with no benefit to the patient, or where inputs are discarded without being used. This type of waste mostly involves managers and reflects poor organisation and co-ordination.*

Governance-related waste *pertains to the use of resources that do not directly contribute to patient care, either because they are meant to support the administration and management of the health care system and its various components, or because they are diverted from their intended purpose through fraud, abuse and corruption. It thus comprises two distinct types of waste. The first is administrative waste, which can take place from the micro (manager) to the macro (regulator) level. Again, poor organisation and coordination are the main drivers. Second, fraud, abuse and corruption, which divert resources from the pursuit of health care systems' goals, are also wasteful. Any of the actors can be involved, and in fact, a comprehensive analysis of the topic requires the inclusion of businesses/industries operating in the health sector. In any case, the intention to deceive is what primarily distinguishes this last type of waste.*

Lastly, it is very worrying that the OECD has also found that more than one third of citizens in OECD countries consider the health sector to be either corrupt or extremely corrupt. There are big differences among countries, which should prompt the need to identify the best methods to operate health systems without corruption. Earlier, we have said that the high amount of wasteful spending in health systems is a scandal. But if the citizens' perceptions of fraud are correct, we are talking about a terrible scandal!

How hospitals are doing on these aspects depends on many things, and not on the type of ownership alone. There are many examples of private hospitals being more cost-effective, and also of public hospitals improving their performance after being privatised.

In Germany, a study by the RWI research institute and the Fresenius University has shown that German private hospitals use less public funding and pay more taxes than hospitals under other ownership. At the same time, private hospitals are at par with other types of hospitals and clinics. In addition, private hospitals were found to have higher labour productivity than other types of hospitals.[21]

Length of stay

Measuring efficiency in health can be quite complicated, and one of the many factors that influence efficiency is the systemic context. We do not have all the data that is needed to shine a strong light on all these aspects, but from the emerging sets of data that are comparable from country to country (in Europe and/or in OECD countries) some patterns emerge that cannot easily be explained.

20 *Quoted from https://ec.europa.eu/health/sites/health/files/systems_performance_assessment/docs/2019_efficiency_en.pdf*

21 *http://www.rwi-essen.de/media/content/pages/publikationen/rwi-materialien/rwi-materialien_122.pdf*

EFFICIENCY IN HEALTH SYSTEMS

If we look at the average stay in hospitals, patients in France spend on average more than double the time than patients in the Netherlands. The two countries are similar in many respects, and they do not have big differences in the overall spending on health. But the difference in hospital stays is striking, and it undoubtedly covers differences within the two country systems as well. But what is the most efficient policy – the French or the Dutch? Does the Netherlands see many more re-admissions for the same disease? Or is it just a waste to keep people for as long as is the case in France? It cannot be possible that both systems illustrate the best practice. The answer as to which system delivers the best practice may give a very strong guidance for performance which could have really big consequences for costs in the health systems in Europe and thereby also for the value created for the society in question.

The table below gives examples from a sample of EU countries, but there do not seem to be any obvious correlations that can explain the huge differences. There is no distinction between public and private hospitals, but again there is no correlation between the mix of public and private hospitals (or between the Bismarck and Beveridge systems) and the length of stay. But all countries cannot have the best practice in hospital efficiency, so in this case the best practice must lie somewhere in between France and the Netherlands, but where exactly is far more difficult to determine.

However, there is no doubt that attempts to identify the best practice should be made (in this and many other areas of health), and a natural place to do so would be the European Union – perhaps in collaboration with the OECD and the European Observatory. Although the process of the State of Health in the EU[22] is moving in the right direction, we are not quite there yet. The end goal should be a catalogue of what works best in health systems around Europe, enabling us to benefit from identifying and emulating best practices. The fact that we have not used the EU system to do so is the responsibility of the EU Member States – in particular those that are determined to keep the EU out of health policies as much as possible. But by doing so, these members also bear a big responsibility for Europe's struggle for sustainability in our health systems.

22 *For more information, see for example http://ec.europa.eu/health/state*

Average length of stay in hospitals

Country	Average length of stay in days	Country	Average length of stay in days
Hungary	9.5	Malta	7.4
Czech Republic	9.4	Greece	7.3
Luxembourg	9.3	Spain	7.3
Portugal	9.1	Romania	7.3
Germany	8.9	Belgium	7.2
France	8.8	Slovak Republic	7.2
Austria	8.3	Poland	7.1
Latvia	8.3	Slovenia	7.0
Croatia	8.2	Ireland	6.1
Finland	8.1	Cyprus	5.9
Italy	7.9	Sweden	5.7
Estonia	7.7	Denmark	5.4
Lithuania	7.6	Bulgaria	5.2
EU-27	7.5	Netherlands	5.1

Source: Health at a Glance, Europe 2020 page 225

Another striking example is the spending on hospitals in European countries. However, even when the figures are made comparable by converting them to the same currency – the euro – and adapted to purchasing power (PPP), the differences are more linked to differences in cost levels, mostly for health professionals and equipment, and the general wealth level. There are big differences, but again there is absolutely no correlation with the mix of private and public hospitals or the fundamentals of the health system – Bismarck versus Beveridge.

The big difference is, as mentioned above, linked partly to the general cost and wage levels in the different countries, but whereas hospital spending is linked to the share of the total health costs, the differences are smaller.

Country	Hospital spending per capita in € (PPP) 2016
Denmark	1,663
Sweden	1,516
Austria	1,491
Ireland	1,407
France	1,349
Netherlands	1,331
UK	1,277
Germany	1,168
Belgium	1,166
Italy	1,149
Finland	1,087
EU-28	1,059
Spain	1,006
Portugal	885
Greece	722
Croatia	537
Hungary	530
Poland	459

Source: Health at a Glance, Europe 2018 page 139

A third example is the spending on pharmaceuticals in the different countries. On average, Germans pay more than double what is paid in Denmark, and there is no link between general cost and wealth level, as Denmark in general has substantial higher costs of almost everything than Germany. Why is it that we see such big differences between European countries that may be different, but are also a rather homogenous group? The answer will not be given here, but the question is why these considerable differences are not discussed more – why easily available data that show differences from which a best practice can be extracted are not applied to save large amounts of money in systems that urgently need to become more efficient in order to cope with pressures that in severely threaten the sustainability of the European health model.

Country	Expenditures on retail pharmaceuticals per capita in € (PPP) 2018
Germany	615
Belgium	518
France	467
Austria	463
Italy	434
Ireland	424
Greece	414
EU-27	381
Finland	374
Sweden	372
Spain	366
Portugal	317
Poland	306
Netherlands	282
Croatia	270
Denmark	236

Source: Health at a Glance, Europe 2020 page 170

It is better to prevent than to treat

The way our health systems have evolved, hospitals are the crown jewels of the health systems: the bigger, the better. This is where careers are made, and this is where young health professionals want to be. Health professionals are trained to treat illnesses and many of them are very good at it. They also have well-established ways of sharing experiences and learning from the progress of other health professionals and in that respect they belong to a robust and widespread professional community.

All citizens should be happy to have very good health professionals that can treat them when the need arises. But much less focus has been directed at preventing the need for treatment. Obviously, there are diseases that are difficult to prevent, while for others, prevention involves other areas of society. Traffic accidents can be prevented, but not via the

health systems. The same goes for work-related illnesses or for illnesses caused by environmental problems. But many of the chronic diseases that with an ageing population are becoming a bigger burden on our societies are preventable, especially those that are lifestyle-related.

What has this got to do with health efficiency? It has a lot to do with smart spending of the funds available for health systems – seen from the societal economic perspective of health systems. It is obvious that it is cheaper for society and much better for the patients if the need for serious treatment for type 2 diabetes is prevented via lifestyle changes. Much better than to have to deal with the consequences of fully developed type 2 diabetes, which include not only the cost of treatment, but also the cost of the patient being unable to perform socially and economically and, at the same time, requiring care.

In general, the preventable mortality rate in the EU is very high, and varies substantially across the EU, but on average we are looking at more than 150 lives per 100 000 inhabitants. This means lost lives, but it also means lower quality of life, and indeed productivity losses and demand for care in our economies. [23]

As mentioned above, only 3% of health spending across the OECD member countries is dedicated to health promotion and disease prevention. Seen from an economic value perspective, this does not seem to be the most rational way of spending scarce funds, but there are many obstacles to changing this, including existing traditions in the current system and the preferences of health professionals.

However, integrated systems where primary healthcare works closely with hospitals and care centres are producing good results, and this could possibly be improved by applying outcome-based reimbursements – bundled and shared between the institutions involved with the individual patients. Such systems can also encourage health institutions to deliver the best service for the patients rather than the best service for themselves. This again should lead to health systems performing more efficiently.

The Value of Diagnostic Information

The methods of diagnosing diseases have improved tremendously over recent years and seem to advance at an almost explosive pace – driven to a large extent by the rapid development of digital technology.

The importance of diagnostics goes all the way from early detection of illnesses, which makes it possible to deal with diseases at an early stage, to more precise information on what has caused more advanced diseases and how to deal with them. Obviously, this is good for patients, and clearly also for the societal economy in the sense of the ability to treat diseases as efficiently as possible. It is clearly also an advantage for health professionals and health institutions from a prevention and treatment point of view, but unfortunately not always from an economic or financial point of view. This is another good reason to change reimbursement systems so as to reward the most efficient solutions.

But the value of the diagnostic information itself should also be rewarded; it goes beyond the reimbursement of diagnostic costs since diagnostic information provides exceptional value to patients, health professionals and the whole health system and thereby to the societal economy. Thus, rewarding the true value of diagnostic information, instead of "just" the price of the tests, would stimulate further development of diagnostic equipment, which in itself can make our health systems work much more efficiently and also save lives and improve quality of life.

The more health systems become knowledge-based and move towards new innovative ways of using modern digital equipment, the better diagnostic information can be used. If coupled with big data processes and algorithms, diagnostic information can suddenly become even more valuable and useful, for example by illustrating optimal patient pathways for treatment.

23 *State of Health in the EU. Companion Report 2019, page 16*

Conclusions on efficiency

Many studies have been trying to find an answer to the question on whether private hospitals are more or less efficient than public or not-for-profit hospitals. Although one should imagine intuitively that private hospitals would be the most efficient because they have to satisfy investors' expectations of return on investment, nobody seems to have found a definitive answer to the question.

This is partly because of three main reasons:

1. It depends on what is meant by efficiency – and for whom.
2. It depends on the whole health system in whichhospitals operate. How they are structured, which role is given to individual components, how integrated the system is and how it reimburses for health services.
3. Finally, there will always be differences between organisations depending on how they are managed and structured – besides the issue of ownership.

Most European countries use both private and public providers, not only in primary care, but also in the hospital and social care sector. But there are very big differences in the role they play. In most of the so-called Bismarck-type systems, private hospitals play a big role, in many cases on a par with public hospitals, whereas in Beveridge-type systems private hospitals are not always integrated in the system on a par with public hospitals. Instead, they operate in parallel with public hospitals and provide services either as reserve capacity for public hospitals or as hospitals for those that can afford to pay for private healthcare, either out of their own pocket or via private health insurance.

Therefore, discussions between people living in different systems about the role of private hospitals usually reveal a very different perspective on that role. This has created a certain bias of inequality against private hospitals in mostly Beveridge-type systems, which, as mentioned above, is based on a misunderstanding. In reality, the Beveridge-type systems with nearly 100% public hospitals are increasingly becoming the reason for inequality as the pressure on public finances leads to long and, for many, unacceptable waiting times – in particular for cancer operations – so those that can afford it jump the queue to be treated at the "parallel" private hospitals. In contrast, systems where public and private hospitals are integrated have in general less waiting time problems because of the larger supply, and thus do not prompt people to seek other solutions via a private insurance or out-of-pocket payment.

The role given by health authorities of course also plays a role in how efficiently the services can be provided, and that especially points to reimbursement systems.

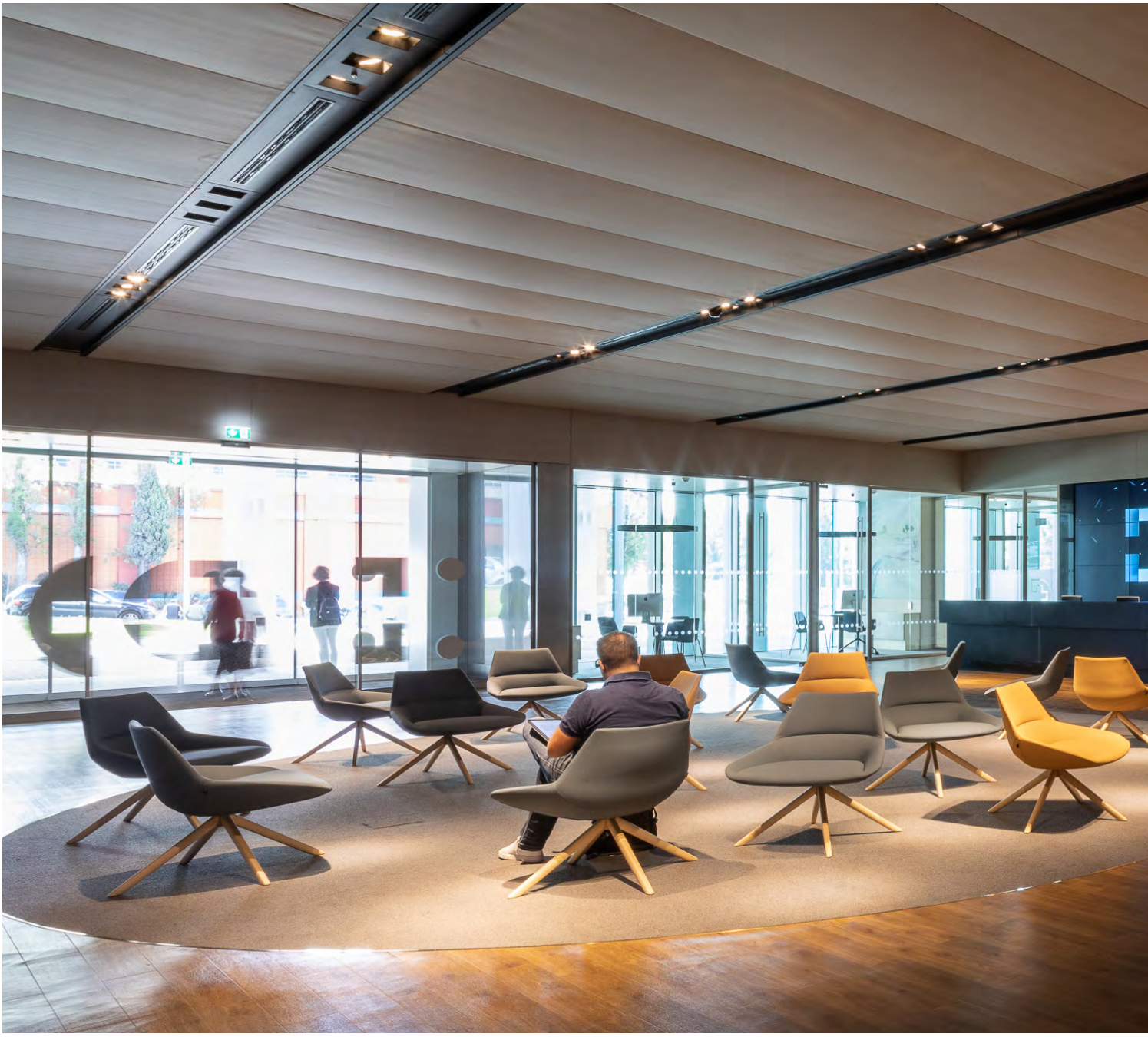
In Italy, for-profit hospitals were found to be less efficient because they use resources less efficiently. This might be due to the fact that private for-profit hospitals are confronted with specific regulations that set a limit to the number of subsidised admissions; since such limits fluctuate over time and are quite volatile, for-profit hospitals might face problems in adjusting their fixed input resources accordingly.

Another indication of the importance of funding schemes might be the fact that, after a DRG-based payment system was introduced in Italy, not-for-profit hospitals converged to the same levels of technical efficiency as public hospitals. In Germany, Herr et al. also found no statistically significant differences in technical efficiency between for-profit and public hospitals after a DRG-based payment system was introduced in 2004. Earlier, Herr had showed that private hospitals were on average less technically and cost efficient, maybe because at that time there was an incentive in increasing LOS to raise revenues. Nonetheless, for-profit hospitals were found to be more profit efficient than public hospitals, meaning that hospitals have certain output prices and input prices, and for-profit hospitals choose the best combination of both input and output factors. However, another study discovered that under the DRG payment system, efficiency gains among for profit-privatised hospitals were significantly lower compared with before the DRG payment system. The Austrian DRG system only covers up to 50% of hospital costs, and additional funds come from states and operational-deficit coverage, determined ex post

by the local authorities. Such funds disproportionally accrue to public providers, keeping the private sector at bay, but possibly also increasing their incentives to operate more cost consciously.[24]

The conclusion cannot be that either 100% private or 100% public can be the answer to release the pressure on our European way of providing health services. The relief that private involvement in the health system can bring is clear and it increases the potential for value creation in society as a whole. It would probably be a very good idea if the stigma against particular types of service providers was cast aside and replaced by a non-dogmatic discussion about what would serve our societies best, now and in the future. Therefore, systems should be geared towards producing value across the board, from patients (via the health systems) to societies, and regulations and incentives should build on best practices and provide stimuli to the systems to become as efficient as possible to fight against waste and focus on improving the quality of life of EU citizens.

24 *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6033142/. Do private hospitals outperform public hospitals regarding efficiency, accessibility, and quality of care in the European Union? A literature review. The International Journal of health planning and management, April-June 2018.*



CHAPTER 3

PATIENT SATISFACTION

CHAPTER 3

The primary function of a hospital will always be to address the clinical needs of any patient as quickly, as effectively and with as high-quality care as possible. This is about diagnosing and treating diseases with the purpose of curing the patient in such a way that the patient can return to a normal economic and social life as quickly as possible. However, in recent years the issue of patient satisfaction has become much more prominent, and the use of patient satisfaction data has entered the management of hospitals and the improvement of clinical procedures. It has also become a factor in attracting patients in places where free choice of providers exists and where data about quality and patient satisfaction are made public. There are also prospects of possible use of patient satisfaction data for payments for the services rendered, including the so-called bundled payments.

With the introduction of Value-Based Health Care (VBHC) the foundation for taking the patient satisfaction strongly into account has been cemented. The original Porter equation[25] defined value in health in relation to the "outcomes that matter to patients" and in relation to the cost of delivering these outcomes. Outcomes that matter to patients have, of course, a lot to do with patient satisfaction, and although most researchers and practitioners would agree that patient satisfaction cannot stand alone as a determinant for assessing hospital services, the systematic measurement of patient satisfaction, with all the aspects of hospital stays in order to estimate the outcomes that matter for patients, has become more and more a standard practice and a standard component in the gathering of health system data with the purpose of finding a basis for comparison of health system performance. This is, for example, the case in the OECD publication of data for the PaRIS project.[26]

This requires shared definitions and methods on how to measure the "outcomes that matter for patients" or, in general, patient satisfaction, because today different methodologies are being used at different hospitals and in different health systems.

Standardisation of patient-reported outcomes has been done for some years now, mainly with ICHOM – the International Consortium for Health Outcomes Measurements.[27] Besides the important traditional data on clinical outcomes, these measurements also include for example pain, functional capacity, and quality of life. Outcomes that matter to patients will provide a better and deeper understanding of the way hospital services are delivered. Such instruments are normally referred to as PROMs – Patient Reported Outcome Measures.

PROMs are, of course, of importance for the individual patient and his or her wellbeing, but the aggregated data can also play an important role in improving treatment, including clinical approaches. Obviously, finding methods for disease management and clinical interventions that can improve the general wellbeing of the patient is not only good (very good!) for the patient, but can certainly also benefit the hospital and its reputation as well as being a benefit for society if this leads to a quicker return to normal economic and social life with a minimal need for care.

So far, the use of patient-reported outcomes and patient satisfaction in general has been fairly limited, sporadic and based on different methodologies. The pioneering work done by ICHOM and the OECD with the PaRIS initiative should make it possible to base

25 *Michael Porter. See for example https://www.vbhc.nl/what-is-value-based-healthcare*

26 *The Patient-Reported Indicators Survey14 (PaRIS) initiative led by the OECD aims at addressing critical information gaps in PROMs, with a view to developing international measures and data collection standards that promote benchmarking of health system performance.*

27 *On ICHOM see https://www.ichom.org/*

future work on a standardised – and comparable – basis. As patients' ability to freely choose between hospital providers – even across borders in Europe – is increasing, the incentives to publish data on patient satisfaction will increase in order to attract patients and thereby payments for services. This will be true for both public and private hospitals, as public hospitals too will see the payments received go down with a decrease in the number of patients. It seems that the incentive for for-profit private hospitals to be able to publish data on high patient satisfaction is pretty obvious.

Patient Satisfaction: the French Hospital situation according to patient evaluation

Categories 2019	Class A		Class B		Class C		Class D		Total
e-Satis Score	>77.3		>74 and <77.3		>70.7 and <74		<70.7		
Public Hospitals	13	4.7%	49	17.6%	132	47.5%	84	30.2%	278
University Hospitals	5	5.1%	10	10.2%	49	50.0%	34	34.7%	98
Cancer Hospitals	17	85.0%	3	15.0%	0	0.0%	0	0.0%	20
Private For-Profit	82	21.3%	172	44.7%	96	24.8%	35	9.1%	385
Private Not-For-Profit	19	25.0%	28	36.8%	23	30.3%	6	7.9%	76
GCS (Coopera-tion Groups)	0	0.0%	1	100.0%	0	0.0%	0	0.0%	1
Total	136	15.9%	263	30.7%	300	35.0%	159	18.5%	858

e-Satis is a patient satisfaction score obtained by electronic record after a stay in acute care hospitals in France in the year 2019. All data are published by HAS (Haute Autorité de Santé).

Class A represents the best value. Private for-profit on Class A plus Class B scores have the best result (66%) compared to other hospitals (except the "Hospital for Cancer" group, which comprises only 20 facilities).

Haute Autorité de Santé :
Indicateurs de qualité et de sécurité des soins
Mesure de la satisfaction et de l'expérience des patients « e-Satis »
Patients hospitalisés plus de 48h dans un établissement de Médecine - Chirurgie - Obstétrique
Résultats annexes au rapport 2019
Campagne nationale 2019

A recent example from Portugal[28] also demonstrates that patient satisfaction can be on top of the actions to take to reorganise and improve the overall quality of a health system. In order to guarantee universal access to the health system, the report recommends, amongst other things, increased focus on Value-Based Healthcare and reorganisation of the health system to be centred on patients, including giving patients a higher degree of freedom of choice, in order to stimulate hospitals to improve quality and value creation. This, of course, also requires a transition towards value-based remuneration systems. The same report also recommends moving towards integrated health systems by including the primary sector, the hospital sector and the social care sector, in order to improve patient satisfaction and create a smooth transition in the health systems. It should be mentioned that although the Portuguese system is based on a Beveridge model with a national health system, private hospitals are playing an increasing role because investments from the private side are increasing in a system where the total investments (public and private) are declining. In discussions about proposals for reforming the system, very few – if any – distinctions are made between the public and the private players.

In Germany, more systematic ways of measuring and taking into account patient satisfaction are being introduced.[29]

While the focus here is on patient satisfaction in hospitals, it should not be forgotten that the total picture of patient experience also potentially includes what happens before and after the stay in hospital. In most cases, the patient does not go directly to the hospital but goes there on the referral of the primary health sector. The referral from the family doctor or other primary healthcare providers, the appropriateness of the initial diagnosis and the waiting time before hospital admission will certainly be a part of the patient experience, and these elements will become increasingly important for the health system when and if bundled payments are applied and systems become more integrated. The same goes for post-hospital care. Smooth links between the primary, secondary and tertiary part of the system are very important – also for a good patient experience – and this includes optimising stays in hospital in order to avoid re-admissions, which are often the result of a premature discharge from hospital, in particular if the reimbursement systems give incentives for that.

A precise diagnosis – possible with a big data-generated optimum pathway – is very important for the best possible and most efficient treatment, but certainly also for the patient experience.

Investing in the latest technologies in in-vitro diagnostic, digital and AI equipment may be a crucial factor to reach a high level of patient satisfaction.

28 *Health Cluster Portugal: Study on the organization and financing of the Portuguese health system, September 2020*

29 *https://www.helios-gesundheit.de/kliniken/boerdeklinik/unser-haus/aktuelles/detail/news/servicequalitaet-im-blick-neues-system-steigert-patienten-zufriedenheit/ and https://www.sana.de/remscheid/gut-zu-wissen/presse/remscheid-neues-portal-zur-klinikbewertung-sana-klinikum-remscheid-ist-mitglied-bei-qualitaetsklinikende-534*

Health literacy

There are many examples of how education and knowledge levels impact life expectancy in Europe. One could go as far as to say that "the number one factor that determines both health and educational outcomes is socio-economic status."[30] The reasons for this are somewhat subtle.

The gap in life expectancy between the lowest and the highest levels of education exists everywhere, but varies a great deal between countries.[31] 6

Gap in life expectancy at age 30 between men with highest and lowest level of education, 2016

Country	Gap in years	Country	Gap in years
Slovak Rep	14.4	Greece	6.0
Hungary	12.6	Netherlands	5.8
Poland	12.0	Belgium	5.8
Czech Rep	11.1	Finland	5.6
Latvia	11.0	Denmark	5.6
Romania	9.7	Portugal	5.6
Estonia	8.5	Croatia	5.2
Bulgaria	6.9	Italy	4.5
France	6.5	UK	4.4
Slovenia	6.2	Sweden	4.1
Austria	6.2		

30 *EuroHealthNet: Policy Précis Health and Education, 12th February 2020. www.eurohealthnet.eu/pp-eucation*

31 *Health at a Glance: Europe 2018. OECD and the European Commission, page 84 ff.*

Education levels also have a large impact on mortality rates in different age groups – "in Europe, by age 30, people with the lowest education levels can expect to live 4-8 years less that people with the highest level"[32] – and clearly patient experience will also be dependent on education or health literacy levels. Education level indicates on the one hand literacy level and on the other the degree to which complicated situations and issues are understood and put into context, but it is also a proxy for social level with all the behavioural aspects of life that are included in this.

It is difficult if not impossible to take these differences into account when measuring or estimating patient satisfaction but the result will be affected by the composition of the patient groups that hospitals are dealing with, and it is a plausible – if unproven – hypothesis that the higher the social /education level the higher the patient satisfaction results will be.

How to level out socio-economic differences is a political discussion that does not have a direct connection to health policies, but it is also clear that at least increasing health literacy by integrating health issues in educational systems could have an effect on, for example, the development of chronic diseases and thus become an important part of the preventative actions to avoid unnecessary costs and personal and economic burdens on the health systems.[33]

What does patient satisfaction include?

As mentioned above, ICHOM is working on defining an internationally recognised set of PROMs methods for each disease, focusing, on one side, on patient demographics, including the level of education, but also age, height, weight, etc. and, on the other side, on experiences related to the treatment of the disease and the experiences after the treatment, including pain levels, ability to move, etc.

ICHOM example

A broader angle, focusing more on the whole context of the hospitalisation, was included in a study[34] that looked into whether the ownership of hospitals was a factor in the level of patient satisfaction. The study took a broad approach to aspects of patient satisfaction, paying significant attention to non-clinical issues.

The authors of the study argued that "severe informational asymmetries imply that patients may not always be well placed to assess the clinical quality of health care. However, other dimensions of care quality such as cleanliness or privacy can be observed by patients. Indeed, it can be argued that certain aspects of quality are best measured by patients, as for example whether patients are given explanations they can understand about the operation or side-effects of medication, or whether they are treated with dignity". The elements in the survey were:

32 *EuroHealthNet, op.cit.*

33 *See also the discussion and recommendations in EuroHealthNet, op.cit.*

34 *Does hospital ownership affect patient experience? An investigation into public–private sector differences in England. Journal of Health Economics Volume 32, Issue 3, May 2013, Pages 633-646*

PATIENT SATISFACTION

Admission to Hospital

Choice of hospital
Choice of admission date
Waiting time to admission
Feeling about waiting time
Admission date changed by hospital

Care and Treatment & Pain

Contradictions between staff
Patient involvement
Family involvement
Privacy
Time since call button
Help to control pain

The Hospital and Ward

Shared room with opposite sex
Wait for bed since admission
Noise from other patients
Noise from staff
Food rating
Room cleanliness
Toilet cleanliness

Operations and Procedures

Explanation risks operation or procedure
Explanation before operation or procedure
Explanation after operation or procedure

Doctors

Answers from doctors
Trust in doctors
Doctors talk in front of you
Doctors clean hands

Leaving Hospital

Reasons for delayed discharge
Waiting time discharge
Explanation of purpose of medication
Explanation of side effects of medication
Explanation of danger signals
Explanation of contacts
Copies of letters between hospital and GP

Nurses

Answers from nurses
Trust in nurses
Nurses talk in front of you
Enough nurses
Nurses clean hands

Overall

Respect and Dignity

The study was done recently in England. It should be noted that England is perhaps not the country that can give the most precise results on this issue, as it is one of the European systems where private hospitals have traditionally existed "outside the normal hospital system" as a way for those with additional economic means to get a different treatment than offered by the National Health Service (NHS). However, recently private hospitals have been integrated with the NHS as a payer – mostly to reduce very long waiting lists for many kinds of treatment. So experience with private hospitals as part of the public health system is rather new, and not a tradition as it is in most continental European countries.

The study assumes that private for-profit organisations should be expected to have greater incentives to minimise costs at publicly-owned hospitals, and the study has found evidence that private hospitals are doing better when it comes to cost control. However, the study did not conclude strongly on the effect of ownership on quality and patient experience, but rather concluded that "A growing body of literature suggests that profit incentives may have complex effects in public service provision. Certain aspects of quality may be undersupplied by private firms commissioned to provide public services, while in other areas quality may improve with for-profit supply, depending on the contracting situation, the incentives provided to staff and staff motivation".

So while private hospitals can be expected to perform well when it comes to cost control, the outcomes may vary depending on the contracting situation, which includes the way payment and reimbursement schemes are designed. Overall, the link to other components of the health system, in particular the after-hospital care system, will also play a role.

In the actual study where the above questionnaire was used, private hospitals actually got the best score in the overall patient evaluation, but also on many of the individual issues such as communication with doctors and nurses, but also as far as the treatment and the after-treatment issues were concerned. So although the study does not set out a rule that private hospitals are perceived as better than public ones by the patients, the results indicate that patients felt a higher degree of satisfaction in private hospitals, which therefore in England have not only become a supplement to NHS hospitals, but are also setting a standard for the NHS to compete with.

Nancy Copyright Alexandre Marchi/L'Est Républicain (17)

PATIENT SATISFACTION

«PATIENT EXPERIENCE - FIRST MEASUREMENT STUDY IN PRIVATE HEALTHCARE IN SPAIN» by the IDIS foundation; private healthcare obtained an average score of 7.6 compared to public health, which was rated at 6.3 on average.

This study, carried out on 10 024 patients with health insurance, identified the prompt response, better functioning, comfort and availability of the doctor chosen by the patient as the main reasons for choosing private healthcare.

The "Sanitary barometer", carried out by the Ministry of Health, reflects an average satisfaction with the health system of 6.57 points out of 10. The methodology and composition of this study has been questioned by private healthcare providers, since it does not take into account whether the respondents are users of private health services or not.

A recent study by the German economic research organisation RWI[35] also looked into the issue of patient satisfaction, and also looked at the differences in the forms of ownership of the hospitals. On both the clinical and the care side, the private hospitals had a relatively small, but still significant, higher score than the publicly-owned hospitals. On a scale from 1 to 6, the public hospitals in average got a score of 5.08, while the private hospitals got a score of 5.19. On the quality of care, public hospitals scored 5.06 while private hospitals had a score of 5.14. Digging a bit deeper into the data shows, however, that the size of the hospital and its degree of specialisation actually influences the scores more than the issue of ownership. So a high degree of specialisation will often lead to a better wellbeing for the patients, also post-hospital, which is in line with many other studies that conclude that while the quality of the clinical results may be fairly similar across hospitals, the outcome for after-hospital life tends to be better when medical procedures are performed in highly specialised facilities.[36]

35 *RWI/hcb; Weisse Liste/AOK/BARMER (2017).*

36 *See for example https://sciencebusiness.net/healthy-measures/news/outcomes-matter-patients-derive-more-value-health-budgets*

CHAPTER 4

INVESTMENT IN HEALTH CARE

CHAPTER 4

Private hospitals are often "stigmatised" in public debate because of their ownership by private capital. "Nobody should make a profit from health services" is a popular saying, but in the real, and modern, world things are not that simple, and the truth may be completely different.

First of all, the issue of making money on healthcare is not (just) connected to the investment side. Suppliers of pharmaceuticals, medical equipment, and any other item used to run the health service are based on making money. Doctors, nurses, managers and all other staff are making money out of health services. The list could go on, but as health services are one of the big industries in European societies, they of course also involve making a lot of money. Europe is built on the principles of market economy and entrepreneurship, and private hospitals are an application of these principles in the health sector.

Behind some of the discussions there is also the fear that if private capital is behind the investments in health services, this will lead to inequality, and references to the US health system are common. But there are enormous differences between the European model of healthcare and the American model, and **the most important issue in this context is not who owns the hospitals, but who pays**. That is where the inequality comes into the picture, and the European model builds on (in principle) equal access for all, paid for by the public health system, whether it is based on general tax revenue (Beveridge system) or a public insurance system (Bismarck model). Therefore, it is universal coverage that creates equal access to the health system – not who owns the hospital or other components of the health system.

Health systems in Europe that are based on the Beveridge systems and with no (or a very small) private hospital sector have traditionally claimed to be free of private capital interests, and since all health services in these systems are paid for by the general tax system and do not have to include profits for the investors, this thereby establishes the most equal and fair health systems! This is the argument often used in the UK and in Scandinavian countries.

As mentioned previously in this book, the reality is that these systems are beginning to create huge inequalities, because they are no longer able to deliver as intended. The inability of these systems to deal with the increased pressure – because of demography and because of rising costs of health equipment and services – is creating intolerable waiting times, and this has meant that those with enough economic means are jumping the queue and reducing their own waiting times by using the private sector, and perhaps going abroad for medical interventions.

Even for less dramatic situations, incentives are being created because the public system does not work properly. In the Copenhagen area of Denmark, a new system was introduced some years ago for calling for medical care outside normal working hours. This system has been prone to all kind of criticism, and one of them is the very long waiting times for callers. This has led to the creation of several private doctors' practices who are easy to access by phone and who promise to be with the patient within a very short time. These so-called Uber-Doctors are gaining popularity – but for those who can afford to pay. So the health system, which is strongly built on the basis of equality, creates inequality because the public system does not deliver!

People who do not belong to the very rich are also moving in that direction via the enormous growth of private health insurance, mostly seen in Beveridge-system countries.[37] In many cases this is (partly) paid by employers who do not want their employees to experience long waiting times in the health system because of the ensuing productivity loss.

Waiting times often occur because of a cost-saving strategy pursued by health authorities. But the truth is that, although there may be immediate savings in policies that create waiting times, in the long run the result will be the opposite, because waiting times mean disease progression before interventions occur, so the argument for investing in reducing waiting times is the same as the argument for investing in preventing diseases: It is better for

37 *In a typical Beveridge system like Denmark the number of citizens with a private insurance is around 55%. This does not indicate satisfaction with the national health system.*

the patients, and it is better, and saves money, for the societal economy.

For patients, long waiting times are of course a really serious problem. Cancer is an obvious example; in general, early diagnosis is preferable for the patients, but indeed also for the societal economy. The loss of productivity, the deterioration of conditions and thus often more expensive long-term care, is a heavy cost for society in terms of lost productivity, lost tax revenues and additional health sector costs for dealing with the worsened conditions and subsequent long-term care. The Coronavirus pandemic in the first half of 2020 meant that hospitals closed down for many diseases not related to Covid-19, including cancer, or in many cases patients delayed appointments out of fear. Consequently, we are now building up a large number of disease cases which have been developing in a negative direction because of the postponement.[38]

Can public hospitals alone deliver what is needed for the future – with all the challenges facing the system – or would it be more beneficial for the patients and for the economies of our societies to build systems welcoming privately owned hospitals on the basis of fair competition and with an increased supply side as a consequence?

The public finance situation has not improved since the Coronavirus pandemic; the opposite has happened, as we have repeatedly mentioned. With the economic activity taking a plunge and with all the extra costs to the health system, almost all European countries can foresee extraordinary pressures on their public finances. In addition, there are countries in Europe where the state of public finances was so dire even before the pandemic, that proper financing of the health services in the future was already a real issue – even more so if the goal is to maintain the European model of health care.[39] So a preliminary conclusion is that a future for European health services without private engagement including private investment capital is unlikely to succeed, as the public sector will have difficulties in making the necessary investments in new facilities and equipment. This is a really serious matter: If health services cannot be supplied and be supplied to all citizens, Europe will not only face an economic decline but also the most serious attack on its welfare and life standards in the past centuries. In addition, there is a risk that inequalities will increase if the problems are addressed by increasing out-of-pocket payments in healthcare.

It is of crucial importance to understand that although it is (very) possible to get better results (outcomes) by finding new ways of doing things, health systems must rapidly adapt to changing circumstances. This means better efforts in prevention and preventing disease progression, more focus on patients and their wellbeing, leaner hospitals services and a smooth link between the primary, secondary and tertiary health sectors, and making use of all the latest technologies, including digitalisation. All of this requires investment capital. Without that, health system performance will drop and the number of avoidable deaths will increase.[40] To achieve the above goals, payment systems must be adapted to give the right incentives.

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38 *For one by many examples see https://khn.org/news/cancer-patients-face-treatment-delays-and-uncertainty-as-coronavirus-cripples-hospitals/*

39 *This was already being discussed before the Corona pandemic, but with the extreme strain on public finances after the pandemic, this situation has become even more serious. A related question is whether the public authorities have destroyed the possibility for some of the private investors to survive the effects of the pandemic.*

40 *For a development of this argument, see later in this chapter.*

Therefore, the public and professional discussion should turn more towards the real problems that could emerge from private investment capital, and address them instead of clinging stubbornly to traditional principles, and then consequently organise the reimbursement systems so they fit with the goals the health system should achieve rather than on whether the recipient of the reimbursement is privately or publicly owned. The issue is not to punish or reward the various types of suppliers, but to give incentives for the health system to provide value for patients and for society – in other words optimal outcomes for the lowest possible cost.

Strategy for investment to preserve our health systems

In 2017, the European Commission organised a seminar on "Strategic investments for the future of healthcare", which addressed the urgency of restructuring care delivery because of the pressures previously mentioned in this book. A very interesting issue in that seminar was the focus on a strategic investment plan, rather than looking at changes in the health care sector itself. Amongst the conclusions was of course the need for new healthcare models, but also the need for essential investments and investment strategies.

This, states the conclusion of the report, requires the involvement of a broad range of public and private partners and investors, and that again means that several communities have to start talking to each other, including investors, health providers, policymakers, regulators, universities, SMEs, etc. So a clear recommendation is to break down the silos, and indeed also give up prejudices. The European health systems are under severe threat, and new ways of thinking, cooperating, paying and investing are necessary.

In the financing mix, there are also elements of EU funds, including the European Fund for Strategic Investments (with public and private funds), but in order to attract other investors, the recommendation is to create the right incentives, including payments-for-results, outcome-based payments and value-based contracting.

The report also stresses the need for a long-term investment strategy in order to ensure real reforms in healthcare services and, indeed, investment planning.[41]

Private investments: Good or bad?

Private investment capital can indeed have both positive and negative impacts, and this issue is often very visible in political debates across Europe.

On the positive side, there is first the relief for public finances in lifting the increasingly heavy burden of financing the health systems – both for new investments and in running and managing parts of the health system. Another factor is that a hospital owned by private investors will normally look carefully at its efficiency and thus, for example, will try to eliminate waste and corruption.

41 *The report can be found and downloaded at https://ec.europa.eu. Document ev_20170227_mi_en.pdf. Report on Strategic investments for the future of healthcare. 27 February 2017. European Commission Directorate-General for Health and Food Safety.*

INVESTMENT IN HEALTH CARE

In past years, investor attention has focused on some of the most persistent problems in the health sector. The wasteful, siloed and fragmented nature of delivery systems lends itself to traditional private equity skills of enhancing value through eliminating inefficiencies, improving operating models and consolidating markets. And future opportunity will likely be strong.

Health care is poised to continue not only as a significant economic force, but as one subject to ongoing disruption. Providers and payers will continue to evolve their business models to respond to an aging population, to the increasing burden of chronic and lifestyle-driven conditions, and to policymakers' efforts both to expand coverage and to contain cost growth.[42]

The search for efficiency can also have negative consequences by making hospitals focus only on providing profitable services (cherry-picking) and thus not be involved in broader societal issues, such as education, preventative measures, etc. However, public authorities can decide what is profitable through the reimbursement systems, so if health authorities want private hospitals to be more involved in broader aspects of healthcare instead of only performing standard interventions (which will always help patients by shortening waiting lists), they can do so by including new fields, like prevention or after-hospital care, in the reimbursement systems. And then again, instead of having different scopes of reimbursement for the different types of hospitals (public and private) it would make more sense to look at the entire health system and determine incentives for the work (i.e. reimbursement systems) according to the value that is created – for patients and for society.

One thing that can affect the operation of private hospitals is the short-termism of many investors. If, for example, investors only stay with the same hospital for a relatively short period (for example five years) this forces the hospital to prioritise efficiency as seen from the shareholder side, and this will normally not be about value creation, but rather the direct profit created.

Other worries can be: *Private equity and health care can make for an uncomfortable pairing. Concerns have been expressed about possible implications of private equity investments, including the potential for conflicts of interest. While evidence suggests that companies taking on these investments can achieve strong financial and competitive performance, private equity is often viewed as a force that will, at best, have limited impact on clinician behaviours, clinical outcomes and patient satisfaction.*[43]

Another issue is that health systems in Europe need to be modernised and upgraded to incorporate value considerations. From the public administration side there is too much focus on costs without considering what you get for the money, and from the private side there is often too much focus on making profits rather than creating value. So, again, the solution is to manage health systems from a value creation viewpoint rather than from a pure cost or a pure profit viewpoint.

42 *What connections will move health from reimagining to reality? New Horizons/2019 edition. An E&Y NextWave Health Report.*

43 *What connections will move health from reimagining to reality? New Horizons/2019 edition. An E&Y NextWave Health Report.*

In any case, a report done for the European Investment Bank (EIB) **sets out a very serious warning to Europeans** by documenting the clear relationship between the availability of sufficient investment capital and the performance of the health system, and thus optimised survival rates in the population.[44] The report relates the per capita healthcare capital stock of EU Member States to the performance of the healthcare system – using amenable mortality as an indicator of health outcomes.[45]

On top of the list in the report are France, Spain and the Netherlands. Greece is just above the EU-28 average while all the countries from Eastern and Central Europe have below-average performance.

The available capital can obviously come from different sources – EU, national, regional governments, different forms of private capital – but the important point for this discussion is that if, and when, public financing dries out or comes under severe pressure, the performance of the health system will begin to decline, unless other forms of capital are made available, and that will mean private capital in the form of pension funds, private equity, corporate or other. Investment capital means better health!

Financing health care

European health systems are different in the way they are organised and in their history. But in all European countries the access to healthcare is, in the end, secured by the taxpayer's contribution, whether it is through a tax-only, a mixed or an insurance-only system. Public finances are crucial for health systems in all European countries, with their normal share at around 80%.[46]

44 *Health Sector Study EU. March 2019. European Investment Advisory Hub. https://eiah.eib.org. "report-health-sector-study-20180322-en-pdf"*

45 *Amenable mortality is the rate of deaths that could have been avoided if timely and effective healthcare had been provided.*

46 OECD: *Focus on public financing of health care. Feb 2020. https://www.oecd.org/health/Public-funding-of-health-care-Brief-2020.pdf*

INVESTMENT IN HEALTH CARE

Health expenditure as a share of GDP and Total Government Spending (2019)

Country	Share of GDP %	Share of total government spending %
Germany	11.7	15
France	11.2	20
Sweden	10.9	19
Austria	10.4	16
Denmark	10.0	17
Belgium	10.3	19
Netherlands	10.0	15
Portugal	9.5	13
Malta	9.4	13
Finland	9.1	13
Spain	9.0	-
Italy	8.7	15
Slovenia	8.3	-
Bulgaria	7.8	10

Country	Share of GDP %	Share of total government spending %
Greece	7.8	14
Czech Rep.	7.8	-
Cyprus	7.0	10
Croatia	6.9	20
Slovak Rep.	6.9	15
Ireland	6.8	13
Estonia	6.8	-
Lithuania	6.8	12
Hungary	6.4	11
Latvia	6.3	13
Poland	6.2	9
Romania	5.7	11
Luxembourg	5.4	-

Source: Health at a Glance: Europe 2020 and OECD: Focus on public financing of health care. Feb 2020. https://www.oecd.org/health/Public-funding-of-health-care-Brief-2020.pdf

Many different policy areas fight for their share of the public budgets, but in all European countries health issues are amongst the least controversial of all kinds of public spending, and it is easy for any government to get support for funding the healthcare system. Provided, of course, that the system is seen as reasonably efficient, that it does not have too many scandals of wasting money, corruption or mistakes in diagnosis and treatment. However, in recent years the demand has changed somewhat as patients have become more literate and more demanding, and with the increased focus on value-based healthcare building on patient-reported outcomes, the demands on the health system from the patients – who are also the taxpayers – will increase. This means increased demand for sophisticated procedures, advanced equipment and drugs. All adding to the costs, and increasing the pressure on financing healthcare systems.

This will be felt very clearly in countries with a low GDP, but increasingly in all countries. Besides the increased demands mentioned above, demographic changes will really begin to show their effects over the coming years. The combination of an ageing population – with longer demands for pension income and a high disease burden – and a relatively small generation of young taxpayers will put public budgets under continuous strain and scrutiny.

In most countries, policymakers and administrators have realised this, and often – without loud and noisy debates – they have had to either make treatments abroad possible and attractive, or outsource services to the private sector:

And there are clear signs that politicians are often happy to quietly contract out procedures to the private sector. Outsourcing of primary, acute and outpatient care is close to the ceiling of 30% of municipal budgets in Finland while Ramsay is striking deals with hard-pressed NHS hospital trusts in the UK to take on elective procedures on 3-5 year contracts. More than half of cardiological and neurological procedures in Turkey are done by the private sector and there are around 5-10 small hospital privatisations in the Czech Republic annually.[47]

But is there and will there be a solid business case for private investments in health in the future? Or will private investors only cherry-pick their investments and hold them for short periods and thus not really contribute long-term to the health care sector?

The CEO in the UK of one of the large international hospitals groups, Ramsay's, recently said that private payors can never sustain a multi-hospital chain. This shows that the only way large acute operators can grow to scale is by working with the public payor or private medical insurers.[48]

In other words: At least in Europe a private hospital sector based on private customers is not viable, and private sector investments can only be successful if private hospitals are integrated into national health systems, and in Europe that always means the publicly funded and supported healthcare system.

According to the McKinsey Study, "*Finding untapped potential in European healthcare service providers, there should clearly be a potential: Certainly, the amount of untapped value in the healthcare provider services sector should be exciting for investors. But it's exciting for another reason as well: their investments could very well help to improve the quality of care, access to services, and patient experience – all at a lower cost for individuals, insurers, and governments*".[49]

Investors in private hospitals in Europe

As it is clear that public finances will be under pressure to fund high-quality health services in Europe – and in particular assuming that we work to keep the European model's distinctive feature – equal access for all – keeping principles and high quality means that private capital needs to be involved, and increasingly so. Again, assuming that the European way of providing health services continues, will there then be a case for investing in hospitals – and broadly in healthcare – in Europe? Will the conditions for growing investments be fulfilled, or will private sources also dry out? If that should be the case, this could have a dramatic impact on developments in European healthcare and indeed on preserving the fundamental European ideals of equal access, high quality and solidarity as the public sector reduces its input and out-of-pocket payments increase.

European pension funds are growing for the same reason that is putting much of the pressure on health systems, namely demographics. The baby boomer generation in Europe is the largest, best educated and best paid generation in Europe, and has built pension funds at a scale never seen before. Now this generation is moving into retirement, and the question is where pension fund investments should go. Obviously, the funds need to generate revenue for the retired people; in principle, the highest

47 *From Max Hotopf: Hospitals EMEA overview. Healthcare Business International. www.healthcarebusinessinternational.com*

48 *Ibid.*

49 *https://www.mckinsey.com/industries/private-equity-and-principal-investors/our-insights/finding-untapped-potential-in-european-healthcare-service-providers*

revenue possible. However, there is also discussion about the particular directions that investments should take. For example, investing in promoting a green transition, investing in companies that fulfil certain social criteria, etc. But investing in health services is not very prevalent – maybe because so far it has been assumed that the public purse would take care of that, but as described above, just because the public purse has been able to fund the European health service so far does not mean it will be able to do so in the future! Thus, by investing in modernising healthcare systems and therefore not only generating pension revenue for themselves, the baby boomers could also help the younger generation to maintain quality health services and at the same time lift a big part of the burden of investments off the younger generation.

Although there are examples of pension funds investing directly in, for example, constructing hospitals, the typical way of investment from pension funds in health, if at all, is by investing indirectly by buying shares in big international groups that invest in healthcare – often amongst other things.[50]

As mentioned before, there is a need in our societies for a high interest from private investors to supplement the public purse in healthcare. And the picture is changing with many different developments at the same time across Europe. It seems that family-owned investment groups are increasing their investments in health and at the same time large groups – international or European-based – are investing more and more across Europe.

Some large hospital groups in Western Europe continue to enjoy organic growth. For-profit market-wide organic growth in 2018 was around 2% in France, 3-4% in Switzerland and Spain, just 1-2% in Germany and less than 1% in the UK, where outsourcing by the cash-strapped NHS has slowed massively.

But go east and north and it is another story. In 2018, we are told the Finnish and Hungarian markets grew around 10%, Russia 8%, Romania a whopping 12% and Bulgaria spectacularly so at 18%. The Italian market is flat due to savage cuts in tariffs and the Greek market is also stagnant, we hear.[51]

50 *Interview December 2019 with Max Hotopf, Chairman and Founder of HBI (Healthcare Business International)*

51 *Ibid.*

Hospital sales in Europe in millions of euros

Company	Total Hospital 2018 sales in country or region	Total 2018 Revenue of Company in all countries
Fresenius Helios	6,955	5,970
Asklepios Kliniken GmbH	2,879	3,407
Ramsay Health	2,631	2,982
Sana Kliniken	2,520	2,703
Elsan	1,647	2,000
Gruppo Ospedaliero San Donato	1,625	1,650
Mediclinic International	1,593	3,388
Rhoen-Klinikum	1,233	1,233
Spire Healthcare	1,099	1,099
HCA Hospitals UK	1,050	1,400
BMI Healthcare	1,033	1,033
Schoen Kliniken (Schön Klinik)	815	837
Humanitas	807	819
Acibadem (IHH)	761	795
Jose De Mello Saude/CUF	683	683
SRH Kliniken GmbH	655	655
Vithas Group	535	535
Luz Saude	521	544
Vivalto Sante	521	521
MLP Care (formerly known as Medical Park)	487	487
Sisio (Pole Sante Leonard de Vinci, Groupe Saint Joseph, Groupe Saint-Gatien)	465	465
Mehilainen Group	449	916
Hospital De Madrid S.A. "HM Hospitales"	415	415
Almaviva Sante	400	400
GVM Care&Research "Gruppo Villa Maria"	376	680

Source: HBI (Healthcare Business International) www.healthcarebusinessinternational.com

INVESTMENT IN HEALTH CARE

Private investors, whoever they are, want a return on investment, and they want the same kind of return they would get by investing in other areas. Therefore, changing rules and regulations, changing reimbursement systems frequently and in general reimbursing private hospitals less than public hospitals may indeed reduce the interest from investors.

This should be kept in mind by policymakers: if the interest is in attracting private investment capital to construct and run parts of the health sector, policies should be designed to favour the interest of private capital. No government in Europe can be confident that taxpayers' money will be enough in the future to ensure high-quality services with open and equal access, and therefore health policies and reimbursement schemes should be designed with this fact in mind, and that will inevitably mean attracting private capital for not only constructing parts of the health services, but also running it.

Whether this will be a part of renewing the healthcare sector remains to be seen. This is probably where it will start, since privatisation of public health facilities remains politically very difficult – or impossible – although there have been examples in Germany and indeed in Italy, where the large San Raffaele hospital in Milan was taken over – and saved – by a private group taking over a failing hospital.

From the investor side, various strategies have emerged. One of them is to work along the patient pathway in a more comprehensive way, for example on one side primary health services and on the other side the post-acute care sector. There is no doubt that it will be desirable to move the private sector into both of these areas, and the way to do so it is to make it attractive through the reimbursement schemes. A new path for moving in this direction is also being created through the gradual outsourcing of many health services as a result of the pressure on public hospitals.

The fact that it is cheaper to prevent than to cure is obvious, but why then is the performance of diagnostic tests only paid for at the cost of the test and not the real value that the test results create?

Another, and different, strategy for some of the private for-profit hospitals is to move into specialisation with the purpose of becoming leaders for high-value results and thereby attracting more patients. This can be a good strategy – also for society – as it can set the standards very high and can create a best practice to be emulated, but it will of course have negative effects if access is limited and conditioned by (high) out-of-pocket payment. Clearly, this strategy is becoming more and more interesting as we see a move towards more value-based healthcare and reimbursement systems increasingly tied to outcomes, but for it to become an important driver, we need to ensure that basic definitions of good outcomes are made and are well established. The development of special expertise is, in many ways, a characteristic of private hospitals, where top-level solutions, including robotic surgery, are often quite advanced, offering examples of innovative medical services.

CHAPTER 4

In general, for-profit hospitals are elective sausage machines which churn through a series of very similar procedures every day. The exception is Germany where big for-profit groups have large emergency facilities and treat a very wide range of patients, the big Portuguese PPPs and privatised research and university hospitals in Germany (Rhoen Klinikum) and Milan (San Donato and Humanitas).

The elective sausage machine model makes for-profit hospitals far more efficient than a big university hospital, where senior doctors do not know from one hour to the next what patients they will get through the door. They will also be doing some research and educating medical students, activities which typically do not take place in the for-profit sector. However, in emerging markets many hospitals do open training campuses, especially in India. Dubai's first university hospital is being opened by private Saudi operator Fakeeh Care.

There has been a strong trend for for-profit hospitals to move into more complex surgery and thus expand what they can offer in the private sector to PMI customers. This is seen particularly in Spain and Turkey.

Hospital operators in these private-pay markets have to offer the latest and brightest equipment in order to attract patients who tend to believe big machinery like the Da Vinci surgical system offers better outcomes than more traditional methods. This is often because of direct-to-consumer marketing by suppliers. This is not the case in statutory insurance markets like Germany where consumer choice is less important. Fresenius Helios has highlighted this as one of the main differences between Germany and Spain, its two markets.[52]

A recent report from McKinsey & Company[53] mentions the following reasons why healthcare is a golden opportunity for investors: Ageing populations, the drive for better preventive medicines and the increasing reliance on the private sector to help societies pay for ballooning healthcare costs continue to make the healthcare sector a prized sector, with returns higher than in most other industries.

52 *Interview December 2019 with Max Hotopf, Chairman and Founder of HBI (Healthcare Business International)*

53 *McKinsey&Company: European healthcare – a golden opportunity for private equity. June 2017.*

According to the report, healthcare has outperformed all sectors in the public markets, based on Total Shareholder return (TRS).

Global Total returns to Shareholders %		
Sector	1990-2015	2010-15
Healthcare	13	15
Consumer goods	11	13
Financials	10	7
Energy	10	-1
IT	9	11
Telecoms	8	9

The report also points to a future large potential to create value not only for investors, but for societies, since the healthcare sector has been lagging behind in transformation because of regulatory issues and – so far – lack of pressure to change. So, opportunities exist to take the lead when dealing with these issues. The report also points out that there is a potential from Private Equity for investing into European health (if conditions are conducive) as the average share of healthcare investments by large European Private Equity investors was around 8% of the total (in 2015).

Similar considerations have been made in Portugal, where a PPP model (Public-Private-Partnership) has been evaluated recently:

CHAPTER 4

It should be recalled that the basic problem was/is the sustainability of the health system, starting with the National Health Service (NHS). Public-Private Partnerships were one of the answers found to contribute to the sustainability of the NHS.

Fifteen years after the PPP Hospitals process began, the conclusion is that the goals have all been met and the State has gained more than anticipated. Today we have four PPP hospitals, NHS hospitals, delivered on time, modern and operating with high levels of efficiency, quality and patient satisfaction. These are hospitals that are not only properly licensed but are by far the most systematically and comprehensively monitored and audited healthcare institutions, whether clinically or financially, ensuring access, complying with procedures, etc.

Savings for the State are quite significant – over 20% compared to traditional management – and these results from the professionalism of the teams and the flexibility and incentives of private management rules, but also because the contract "demands" good performance.

Given the very positive assessments made by public bodies, one would expect that the least positive points should be resolved and overcome, and that the State and citizens could continue to enjoy the benefits of the PPP model.

Unfortunately, in Portugal the debate was totally skewed by ideological bias towards private initiative, which led the Government to pledge not to launch any more PPPs and out of the 4 existing ones, one was reverted to the public sector in September 2019 and, in relation to the other, the operator has already informed that, in view of all the political constraints and their financial consequences, there are no conditions to maintain the contract beyond May 2021.

Funding has to come from somewhere

Healthcare systems do not finance themselves. The money has to come from somewhere. As mentioned several times, the main form of financing in Europe comes from government budgets, with compulsory health insurance schemes being used in some systems in lieu of tax income. Apart from that, financing can come from voluntary insurances, or from charities and indeed from private investors. Finally, funding can come from the user in the form of direct out-of-pocket payments.

Sources of financing for providing healthcare goods and services (delivered by public or private entities)[54]

. Government schemes
. Social health insurance
. Compulsory private health insurance
. Voluntary health insurance
. Charities
. Corporations
. Out-of-pocket

The government schemes have been under pressure for a long time from rising costs, an ageing population and other factors, and will come under even stronger pressure because of the pandemic, so if the same delivery of services through public or private payers continues, the reduced public funding must be replaced by something else.

54 *OECD: Focus on public financing of health care. Feb 2020. https://www.oecd.org/health/Public-funding-of-health-care-Brief-2020.pdf*

A growth in voluntary health insurances and out-of-pocket payments suggests these as likely sources in Europe[55], but it is very important to note that both of these forms of funding increase inequality and reduce equal access. It is also likely that, in the end, many countries will have to reduce the services provided to the citizens, and this again will mean an increase in inequality with less services available for those who do not have the means to pay for services themselves, at home or abroad.

Unless Europe develops new strategies to ensure sufficient supply of health care, the European way, with its universal access, will break down and inequality will increase. Strategies must be based on new and smart thinking and investments rather than on the traditional way of believing in a direct link between money, quality and quantity.

Out-of-pocket payments in health as % of total expenditures. 2018

Country	OOP as % of total health expenditure	Country	OOP as % of total health expenditure
Cyprus	45	Belgium	19
Bulgaria	39	Austria	18
Latvia	39	Finland	18
Greece	36	UK	17
Malta	34	Denmark	14
Lithuania	32	Sweden	14
Portugal	30	Czech Republic	14
Estonia	29	Germany	13
Hungary	27	Ireland	12
Italy	24	Slovenia	12
Spain	22	Netherlands	11
Poland	20	Luxembourg	10
Slovakia	19	Croatia	10
Romania	19	France	9

Health at a Glance: Europe 2020, page 163

55 *In 2018, the out of pocket payments were around 22% on average in EU countries with some countries reaching as high as 45% (Cyprus). The lowest amount was in France with 9%. See Health at a Glance: Europe 2020 page 163.*

CHAPTER 5

HEALTH SYSTEMS DURING THE PANDEMIC

CHAPTER 5

Covid-19 hit European countries very differently, and it also hit different regions within countries differently. Even now, we have very few solid explanations as to why, but generally speaking there is no evidence that differences in the performance of health systems made the difference. What were probably more significant were the social and political responses, and their timing and implantation. But we are still in the dark in many areas. Children, for example, rarely get very ill when they get the virus, but to what degree are they able to spread the virus? How about those people that have had the virus and have recovered? The answer to such questions is crucial not only for medical treatment, but also for decisions over social measures, such as whether or not to close down schools or other institutions with children.

This is, of course, only one of many unanswered questions in relation to the pandemic. But in addition to health-related issues, there is also the issue of costs to society related to lockdowns. It is obvious that lockdowns had very serious economic consequences, but they also had a strong mental and social impact.

Italy – or rather some Northern Italian regions – was hit first by the pandemic, and they had to reinvent themselves along the way with consequences such as overburdened health systems, high numbers of deaths, in particular among the older generations, and personal, family and social suffering. The idea quickly drawn from the Italian experience, from the outset of the pandemic, was the need to promptly flatten the curve of infections. Putting a stop to the pandemic was not even considered because finding the means, including vaccines, in the short term was not an option. So in order to avoid a complete overburdening of the health sectors, flattening the curve was the short-term answer. Of course, it meant that the outbreak would last longer but with a lower intensity allowing hospitals to cope with the cases – including in intensive care facilities.

This was, of course, very much needed in countries with a low hospital capacity, but, in the end, every country in Europe had to introduce restrictions to economic and social activity although there was no uniform approach and decisions were made on the basis of discussions about the pandemic versus economic and social activity.

There is no direct link between hospital capacity and the severity of the consequences of the pandemic, so the shape of health systems as such does not provide an explanation. Even political initiatives do not provide a solid explanation, but it is likely that some social conditions (population density, housing and hygiene conditions) add explanatory factors. But experiences do show that lockdowns and other restrictions on interpersonal relations bring down – with a time lag – the number of infected persons quite dramatically. Good examples are Belgium, France and Spain. All three countries had significantly high numbers of infected people hospitalised at the start of November 2020, but by the beginning of December 2020 they had reduced the number of people infected by COVID-19 considerably.[56] This decrease was achieved through very severe and strictly enforced restrictions on interpersonal contacts and the closing of many normal aspects of societal life. A high price to pay, perhaps, but the dividend has been the reduction in COVID-19 cases. These three countries are also amongst those that felt the effects of the first wave very strongly, with the highest number of deaths in Europe. High on that list are also Sweden and Italy, but these countries have been less strict on social restrictions, and their numbers of infected people were therefore higher. On 4th December 2020 the number of infected people per 100,000 people was as shown in the following table:

56 *According to the Johns Hopkins University overview of infected people per 100,000 people, on 4 December 2020 Belgium had 158 infected people, Spain had 143 and France had 132, compared to figures around 1,000 a month before.*

Country	Newly registered infected per 100,000 people
Luxembourg	583
Croatia	551
Austria	361
Sweden	356
Portugal	315
Czech Republic	265
Netherlands	211
Belgium	158
Denmark	156
Germany	149
Spain	143
France	132
Norway	57
Finland	55

Johns Hopkins University daily figures on COVID-19 infections.

Hospital beds and Covid-19 related deaths

Country	Hospital beds per 1000 people (2018)	Coronavirus-related deaths per million people. 22.11.2020
Germany	8.0	178
Bulgaria	7.6	462
Austria	7.3	290
Hungary	7.0	410
Romania	7.0	536
Czech Rep.	6.6	703
Poland	6.5	377
Lithuania	6.4	147
France	5.9	740
Slovak Rep.	5.7	130
Belgium	5.6	1,388
Croatia	5.6	355
Latvia	5.5	91
Estonia	4.1	71
Luxembourg	4.5	-
Malta	4.3	-
Slovenia	4.4	554
Greece	4.2	169
Finland	3.6	70
Portugal	3.5	395
Cyprus	3.3	38
Netherlands	3.2	517
Italy	3.1	851
Spain	3.0	928
Ireland	3.0	410
Denmark	2.4	137
Sweden	2.1	632

Source: Health at a Glance: Europe 2020 page 223, and Statista.
https://www.statista.com/statistics/1111779/coronavirus-death-rate-europe-by-country

It is indeed very difficult to find an explanation of why the pandemic has developed so differently, but from the facts and figures there does not seem to be any link at all to the health systems – or at least to hospital capacity. It should be noted that some of the countries that were hit hardest have been some of the countries with the highest life expectancy in Europe, such as Spain and Italy.

Of the larger countries, Germany stands out with a relatively small number of deaths[57], and with a robust and resilient hospital capacity that allowed the country to take care of patients from other – overburdened – health systems, like Italy and France.

The Slovak Republic also stands out with an exceptional low death rate. This apparently has been partly a result of strict and effective policy initiatives, including lockdowns, but since its results set it apart (with the Baltic countries coming close) it might be worthwhile investigating this apparent success more closely.

The EU response to the crisis came late and became helpful only after some months into the pandemic, but it could be valuable if standard methods for measuring the various effects of the pandemic were agreed upon in order to make data highly comparable and therefore enable us to identify and learn from best practices.

In Scandinavia – where nearly all hospitals are publicly owned and managed – there were huge differences in performance, and as the four Scandinavian countries are very similar in their systems and lifestyles, this case might also be able to shed some more light on why the pandemic has developed so differently in very similar countries. This is particularly interesting because Sweden chose a different way to deal with the crisis than most other countries. But the light lockdowns did not help its economy, and apparently did not create the expected herd immunity. But since Sweden has a low-capacity hospital system (similarly to other Scandinavian countries) its approach resulted in many patients – among them, the elderly –not being given the same level of care as in other countries, and the high number of deaths in older age groups speaks for itself.

	Sweden	Denmark	Norway	Finland
Population 2020				
Hospital beds per 1000 people (2018)	2.1	2.4	3.7	3.5
Corona-related deaths per 100,000 people (updated on 24.03.2021)	130	41	12	15

Source: Health at a Glance: Europe 2020 page 223, and Statista. https://www.statista.com/statistics/1111779/coronavirus-death-rate-europe-by-country

57 *Please note that the UK (no longer a member of the EU) the number of deaths was the second highest by the end of August 2020, with 62.19 deaths per 100,000 people.*

CHAPTER 5

Public-private cooperation

Experiences from France:

It seems that although the private hospital sector responded quickly to the crisis by offering support to deal with the Covid-19 patients – including in intensive care – the health systems as such reacted late to take up the partnership.

In view of the crisis, private hospitals responded immediately to the government request to promptly deprogram non-urgent activity. We have postponed more than 500,000 interventions, making it possible to free up a large number of intensive care beds to absorb the first epidemic waves. However, the private sector was initially scarcely solicited even though public hospitals were said to be overloaded. In the Grand East, one of the most affected regions, clinics rapidly freed 70 beds in ICU high-care. And yet, these beds remained empty for several days even as public hospitals were approaching saturation. FHP made an appeal in the media to expose these dysfunctions. Thereafter, cooperation was established, even though it was not until the increase in the necessary resources could no longer depend on a single healthcare actor. From these early stages, regional health agencies in several regions have drawn lessons to organize the care of patients by relying on establishments of all legal nature. This was the start of a rebalancing with greater equality of treatment in the referral of Covid-19 patients and a better organization between healthcare actors, regardless of the legal status of the establishments. For example, at the end of March, in Île-de-France, the Regional Health Agency asked all health facilities to double their intensive care capacity in just three days to deal with the epidemic wave. In the end, more than a third of the new intensive care beds were created by the private sector, which received a third of the intensive patients in the region. We hope that this public-private cooperation, which proved its worth during the Covid crisis, will be set in stone, amplified and taken as a structuring element in health policy.

Christine Schibler, General Delegate of the French Federation of Private Hospitals (FHP) in the UEHP Newsletter, 28 May 2020

What happened in Germany?

From almost one day to the next, the 2,000 hospitals and 700 prevention and rehabilitation facilities in Germany were called upon to massively cease their operations in order to free up as much capacity as possible for COVID-19 patients. The aim of the German government was to prevent hospital overcrowding and supply shortages that could cost countless patients' lives. The measures were taken in response to images seen in Lombardy, where patients were housed in tents and chaos reigned with stressed health professionals. The virus didn't reach Germany until long after, which probably gave us a very helpful advantage in terms of experience.

In addition to shutting down regular operations, the hospitals were preparing for the pandemic: Staff was retrained, the stockpiling of protective equipment and medication was optimised and patient flows of infected and non-infected patients were separated. Above all, however, intensive care beds were significantly increased and centrally recorded for capacity control. The hospitals of private operators made a considerable contribution to this. The private hospitals alone provided more than 5,000 intensive care beds and are able to provide an additional 2,000 within 24 to 48 hours.

In addition to the cessation of regular activities, hospitals prepared for the pandemic: Staff was retrained, storage of protective equipment and drugs was optimized and the flow of infected and non-infected patients was separated. Most importantly, intensive care beds were significantly increased and centrally listed for capacity control. Private hospitals made a considerable contribution in this respect in providing more than 5,000 intensive care beds. They are able to provide another 2,000 care beds within 24 to 48 hours.

The closure of hospitals and rehabilitation facilities and the cessation of regular operations in the face of the impending wave was understandable at the time, but it had an immediate consequence: the expected COVID-19 patients did not arrive, hospitals and rehabilitation centers quickly got into economic difficulties and insolvencies were imminent. In order to prevent this, the German government adopted rescue plans which, among other things, included

flat rates for empty beds. We faced the crisis together, i.e. with all funding organisations, and were able to prevent the dreaded shortage of care. We have been able to admit and care for patients suffering from COVID-19 in France or Italy, for example.

We are currently facing the challenge of resuming regular operations. In the meantime, hospitals and rehabilitation centers are operating at 60-80% of their capacity, but normal operation is still unthinkable this year – hygiene measures and distance regulations do not allow for this. The question therefore arises: What is the next step? Will the emergency plan in Germany be extended beyond 30 September in order to prevent hospitals and rehabilitation centers from running into economic difficulties? To what extent will a second wave affect us?

Our conclusion from the last few months is that politicians have done a good job in the crisis and have carried out and eased an unprecedented stop of activity. Perhaps the shutdown was too drastic and the measures overcautious. However, in March it was not possible to predict the course of the pandemic in Germany and what hospitals and rehabilitation centers would actually face. Now it is necessary to act with a sense of proportion and reason and rely on the discipline of the population to avoid a new wave of infection. Then hopefully, not only in Germany, but in the whole of Europe, supply crises will be prevented. Because one thing is certain, the pandemic is not over yet!

Thomas Bublitz, Executive Director of the German Federation of Private Clinics (BDPK) in the UEHP Newsletter, 28 May 2020.

The experiences from Spain:

All health centres in Spain have cancelled ordinary medical activity to deal with the health emergency and all are subject to public health indications and protocols. It should therefore be noted that the private health sector has been providing a public service since the State of Emergency was declared with full dedication and responsibility towards Spanish society.

More specifically, private healthcare has cared for more than 25,000 hospitalized Covid-19 patients and has treated about 1,200 patients in ICU, sometimes reaching double of these units in areas such as Madrid and Barcelona. And all this with full and absolute collaboration, always at the full disposal of both the Ministry of Health and the Autonomous Communities.

However, now we advocate ***the maintenance of employment and full productive capacity*** *in the fight against* **COVID-19**, *and we need urgent measures to enable* ***the financial viability of private hospitals and clinics*** *in the face of the serious liquidity crisis that we are experiencing.*

UEPH Newsletter, 28 May 2020.

From the reporting across Europe, the cooperation between the public and private sector has been varied, most likely a result of the surprise and shock over the rapid development of the pandemic. Clearly it was incredible to see beds in private hospitals – even in intensive care units – empty while public hospitals could not deal with the number of patients they had to treat.

This is one lesson that has been learned from the first half of 2020, and which is likely not to be repeated in the future. Another factor is the postponement of other essential care, including serious diseases such as cancer. The future cooperation between public and private hospitals could possibly include better ways to accommodate patients, from diagnosis and/or treatment of other diseases to pandemic-related diseases, be it in private or public hospitals, but in any case, in a coordinated way.

There has been a lot of innovation going on during the pandemic, and many of the new ideas will most certainly stay with us also in the future. This includes the use of digital technologies in all steps of contact with the health system.

Innovation pointing to the future

Across Europe, the pandemic created many new situations. Meeting more than a few people was difficult or even illegal, so many had to adjust quickly to working from home and via the internet. This was a major change from previous pandemics as the widespread digital connections enabled contacts with family members, home working, virtual conferences, etc. But the pandemic also drove patients away from medical institutions since

they were afraid to seek medical care due to the risk of contagion, and thus video consultations started to be used and to be used rapidly. As opposed to teleconsultations, the use of various video applications made it possible to include visuals in the consultations, which helped health professionals to assist patients and at the same time protect themselves from the risk of contagion.

This is an example from France:

From the very first days of the epidemic, Doctolib committed itself to ensure continuity of care by equipping free of charge 35 000 private physicians and 70 hospitals with its video consultation service to enable them to continue monitoring their patients remotely. To get an idea of this acceleration, just look at the figures: 4.6 million appointments made through video consultation on Doctolib since early March (compared to 100 000 before the epidemic). This massive increase speaks for the usefulness of this tool, for practitioners as well as for patients, not only during confinement but also in the time after. Indeed, since the end of confinement, Doctolib has registered 30 times more video consultations than before the epidemic. But Doctolib's contribution did not stop at tele-consultation. We have also launched support plans for private practices to help them continue seeing their patients in their office, thanks to a new management of their calendars with areas dedicated to patients suspected or affected by Covid-19. This new management was especially designed to strengthen communication between patients and practitioners, a communication which is essential in normal times and even more vital in a crisis of such magnitude.

The crisis has highlighted the fragility and vulnerability of our health professionals at the heart of our healthcare system and has shown, to the French people, their major role. This crisis will quite probably, and rightly so, push us to consider the healthcare system as an investment and not as an expense: it is necessary to invest in people and in services, especially in the organization and the «logistics» of the healthcare system. These services already existed, and Doctolib has enabled an acceleration of this "logistics" to overcome the crisis.

Source: UEPH Newsletter, 30 June 2020.

Another example demonstrates the rapid reaction by private hospitals to connect with patients in a new way:

*The **Helios clinics** set up a video consultation at the beginning of April to secure outpatient treatment options during the corona pandemic. The offer can be used by patients regardless of their place of residence or state of health. One of the places where it was launched was the Helios Klinikum in Berlin-Buch, where patients can reach a team of 70 specialists via video consultation. All you need for the consultation is a device with a front camera, display and connection to the Internet, as well as a health insurance card or identity card with private health insurance. Prescriptions and sick notes, which are issued during the video consultation, then reach the patients by post. Unnecessary journeys and especially waiting times for check-ups can be avoided. The video consultation is a great relief especially for the oncological center of the clinic. Immuno-weak patients can be better protected against infection, but still receive the necessary care and treatment.*

Digital home visit

*It is not a substitute for rehabilitation, but it is a valuable aid for all patients who were unable to start their rehabilitation or had to stop it early due to the corona pandemic: The digital "Dr. Becker home visit" has been coming to the house six days a week since the beginning of April, completely in line with the rhythm of inpatient rehab. In the form of a patient newsletter, the **Dr. Becker clinic group** sends out impulses on sports exercises, mindfulness training, relaxation techniques or healthy nutrition. The concentrated knowledge comes from all indication areas that the clinic group offers: psychosomatics, neurology, orthopaedics as well as cardio- and psychocardiology. The focus is on psychosomatic content. Originally, the digital home visit was only designed for patients of the Dr. Becker clinics who were not allowed to come to rehab due to the corona pandemic. However, due to the strong positive feedback from its own patients, the clinic company decided after a short time to make the offer public.*

Source: UEPH Newsletter, 28 May 2020.

It is likely that many of the digital ways of doing things will stay with us even when things get back to normal. Online shopping, online meetings, working from home, travelling less, may be amongst the things that will stay, to a certain degree. But there are also signs that people want to get back to the pre-pandemic ways of doing things as soon as possible. They are, after all, the same people who created the lifestyles we had before the crisis!

It is highly likely that many innovations will remain in the health systems. First of all, there has been a steady growth in the use of digital technologies, artificial intelligence, robots, etc. in the health sector for a long period of time, and although teleconsultations may grow somewhat post-Corona virus, video consultations and other forms of telemedicine may be an even stronger instrument to keep for other highly contagious future pandemics.

As far as the wider use of digital information and artificial technology is concerned, there is overwhelming evidence that both disease prevention and treatment can be improved enormously with the help of such technologies. But there are some barriers for that to happen.

There may be some reticence concerning electronic records; data collection etc. amongst some health professionals, but this is probably not as big a barrier as the resistance in some population groups who fear misuse of their data. This is often happening on an emotional basis, on the basis of anecdotal evidence or just conspiracy theories rather than any form of fact-based thinking. The fear of data misuse is in many ways very similar to anti-vaccine movements. But if confidence is not restore to allow the development of these technologies, we will be missing instruments that can improve prevention and treatment of diseases to a very high degree.

A European framework is important – also to enable comparisons and exchange of data across borders, but data security issues should also be addressed at national level and indeed as close to people as possible. Discussions on the issue should highlight the benefits that data can bring to the individual, other citizens and society. Donating data has many of the advantages that donating blood or organs have.

Another issue is the vulnerability of digital systems, including hacking. Some of the large private hospital groups in Europe have been hit hard by cyber attacks, which can have a very negative and even dangerous impact on health institutions and their patients. It is therefore crucial to make a big effort to improve cyber security.

Additional issues relate to the capacity of the digital infrastructure, which needs to be improved considerably in many – or most – countries in Europe.

What about the inequality issue mentioned in previous chapters? Not the economic inequality, but the educational and knowledge-based inequality? Undoubtedly, an increased use of digital technology can benefit the literate part of the population the most, but on the other hand nearly all people – across generations – have a mobile phone with affordable access to phone and data services, and most of them – in all age groups – have found out how to communicate with family and friends via Skype, WhatsApp, Messenger, etc. and if they can do that, they can also connect with their healthcare contacts, be it their private practitioner or a doctor at a hospital. So perhaps using the most basic digital technologies will not necessarily create more inequality, but systems need to be made easy to use for all, so attention must be given to making these technologies user friendly for all user groups.

Getting out of the pandemic?

At the time of completing this manuscript – the end of December 2020 – Europe (and many other parts of the world) had lived through a second wave of the COVID-19 pandemic, which led to a huge number of infected people in many countries, but lower hospitalisations and death levels than in the spring in most parts of Europe. What's more, new vaccines developed at record speed, promising very high efficiency rates, were being approved – also with great speed – bringing some light at the end of a long tunnel. The pharmaceutical industry has probably never engaged in an effort of this magnitude before. Possible long-term side effects may occur but they are not evident at this point in time. But another factor has made the situation somewhat darker again, namely the many mutations of the virus – some of which highly infectious – that may or may not be resistant to the vaccines.

CHAPTER 6

CONCLUSIONS

CHAPTER 6

The year 2020, which in many ways was supposed to be the fresh start of a new decade in Europe, turned out to be one of the worst years for our economy, for public budgets and for many people who lost their loved ones and/or suffered – and are still suffering – from the virus pandemic that hit Europe and the world at the start of 2020.

The pandemic has changed global and local interaction by restricting movements, and has made large meetings and gatherings impossible. But we had an instrument that previous generations did not have during pandemics and lockdowns: the digital instruments that have allowed us to communicate – also visually – work and even organise big and small events without leaving our homes.

The pandemic has also contributed, at least indirectly, to creating a larger role – including funding – for health policies at EU level. If this can lead to more uniform approaches and more mutual assistance in the future, it will in itself help to make the EU more resilient in relation to future pandemics and indeed in relation to health systems in general.

There were also consequences for the health sector, both positive and negative, but it has been clear that the health sector has also been innovated during the crisis and thus is now better equipped to deal with future situations of a similar nature.

Although the pandemic has been fought as much with social measures as with clinical measures, we have learned that our health systems must be more resilient, deliver more value for money and work more to prevent diseases rather than only treat diseases.

. It needs to be widely understood that spending on healthcare should be seen as an investment, not a cost. This means recognising and measuring the economic value created by keeping the population in good health, and requires a responsible health sector with a focus on delivery and fighting unnecessary costs.

. Use investments in health to restart the economy after the pandemic. Sound investments in health will improve the resilience of both health systems and the populations as such and thus help to reduce the negative effects of unexpected health threats on the economy.

. Economic forecasts including for public sector budgets and debt – illustrating the need for private investment capital in the health sector and a more efficient use of healthcare expenditure – create value for money.

. Need for better management of cooperation between all the players of the health sector. The pandemic has demonstrated the need for better and more efficient public policies towards all players in the health area – public and private – and the importance of both sectors to create more resilient and better integrated health systems.

. Preserving the European model with equal access and minimal inequality. This requires more value for money, more integrated health systems and more patient-oriented systems. It also requires more autonomy for players and greater freedom of choice for patients to impose some level of competition between sectors.

. A renewed focus on how to make health systems – and the European population – more resilient and thus in a better shape to handle future unexpected threats. This also requires a clear and robust role of the European Union. The importance of cross-border cooperation was seen for example in the strengthening of cooperation and partnerships that allowed the development of vaccines in an unprecedented period of time.

. Reinforcement of the ability to share patient data across Europe to facilitate cross-border health services including in crisis situations. The development of the European Data Space should address this issue.

. European cooperation – sharing of cross-border experiences – not for "naming and shaming" but to identify and adopt best practices.

. The need to embrace digitalisation and make health systems resilient to cyberattacks and create confidence in data.

CONCLUSIONS

. Hospitals (and the whole health sector) must improve their "green" approach because the hospitals of the future should set a good example also in environmental terms.

. Improve European health systems dealing with prevention of diseases and disease progression and work on improving the value of diagnostic information to create value for patients and society and avoid unnecessary hospitalisations. In particular, in the area of cancer, backing the EU cancer plan.

EUROPEAN COHESION IN THE FIGHT AGAINST CANCER

JOY RAYNAUD, PhD, GEOGRAPHER
PAUL GARASSUS, MD, UEHP PRESIDENT

1. INTRODUCTION

Europe shares the same vision when it comes to Health: create conditions for equal terms of good health among the whole European population. But can we really talk of a united Europe when it comes to cancer? We need solidarity to fight Cancer in Europe but is it possible to integrate solidarity in the fight against cancer? Many efforts have been made and clear objectives have been put forward to develop cooperative projects to limit cancer incidence and to improve European citizen wellbeing.

The presentation at the European Parliament by Commissioners Von der Leyen and Kyriakides, expresses the real ambition for as renewed European health. But facts are facts... To improve global health for all citizens, a collaborative process is required. We need coordination between all stakeholders, policy makers, administrations, professionals, and providers. All forces must converge towards efficiency. But new practical solutions must be included in dated schemes, with new partners and an open mind. Therefore, we want to include the private sector as a regular and trusted partner to develop positive solutions and share its relevant experience in the health care sector.

EU inequalities in health, such as in Life expectancy, and more precisely Healthy Life Years (HLY) are still today a painful reality among EU27 Citizens and are not improving fast enough. Cancer deaths in Europe express this deep, sad, and unfair situation.

We seek to find solutions but first we must look at the current situation regarding three major points: Life expectancy, health expenditure, and death-by-cancer statistics in the EU.

2. LIFE EXPECTANCY, HEALTH EXPENDITURE IN THE EU

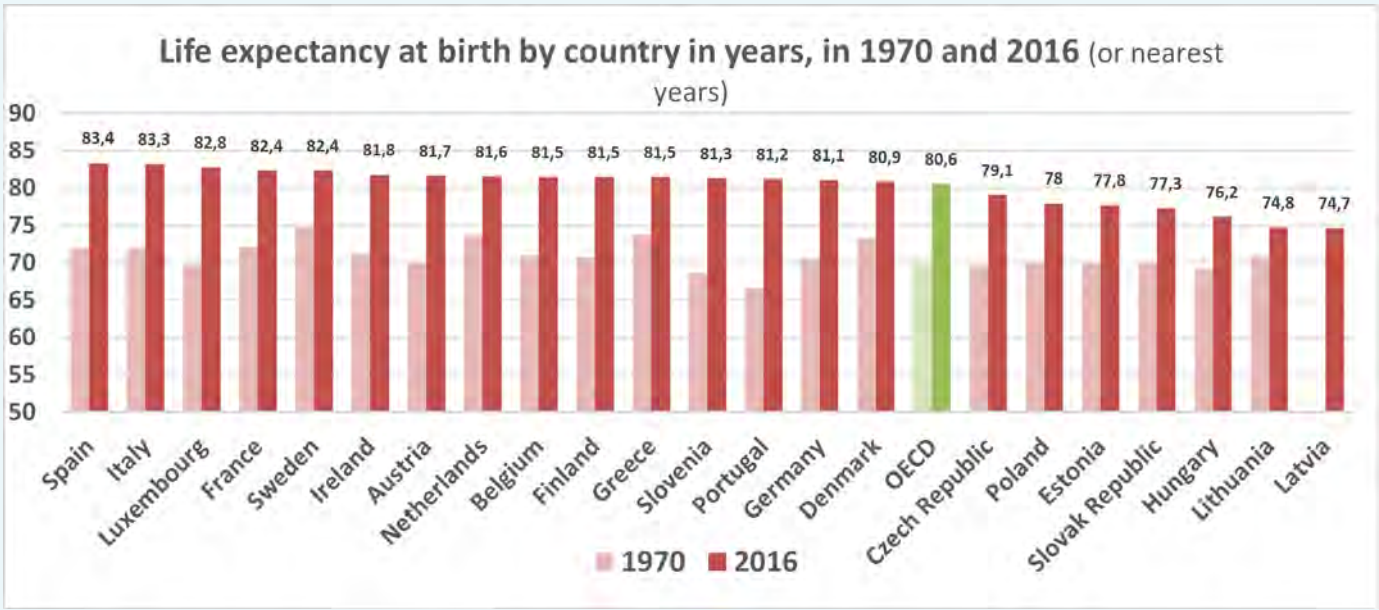
2. LIFE EXPECTANCY HEALTH EXPENDITURE IN THE EU

2.1. Life expectancy

a. By country

First, the evidence shows major discrepancies in life expectancy at birth between EU MS. Italy, Spain, France and Scandinavia have longer life expectancies for men and women, but Eastern Europe (Poland, Estonia, Slovak Republic, Hungary, Lithuania, Latvia) lags behind the European average, *Figure 1.*

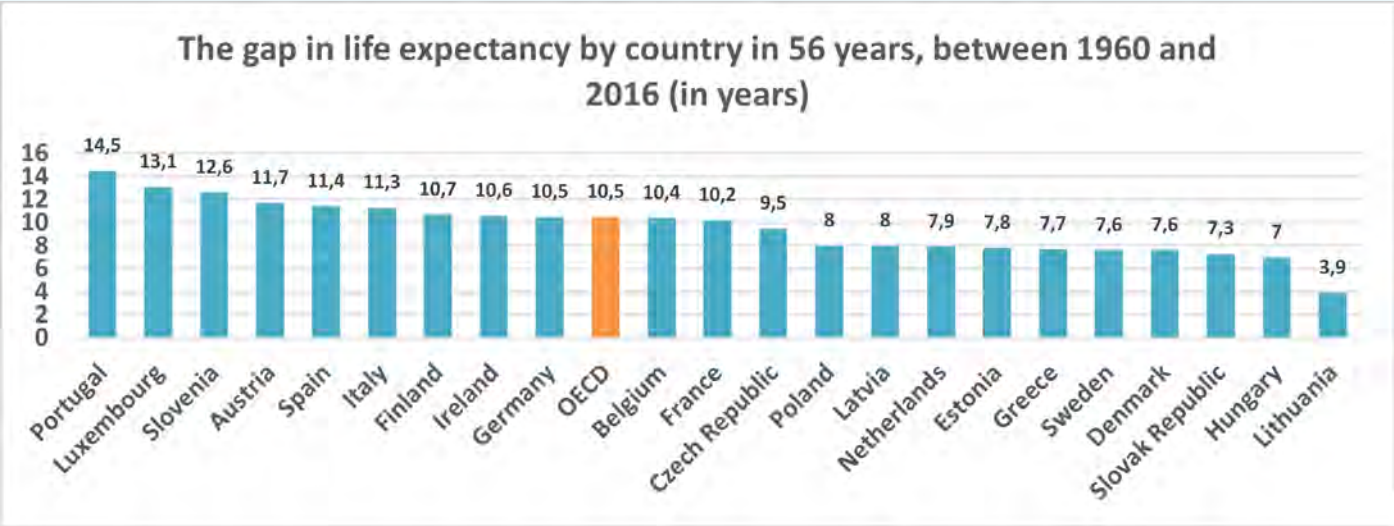
Figure 1 : Life expectancy at birth by country in years, in 1970 and 2016



Solidarity between Member States is required to correct this inequality, by coordinating a new "European way of life", giving the same opportunities to all inhabitants. But to date, major differences remain in our common space at Member State level, *Figure 2*, but also at the level of European regions, *Figures 3 and 4.*

Among the countries whose life expectancy has increased the most in nearly half a century are those in Western Europe: Portugal (+14.5 years), Luxembourg (+13.1 years), Austria (+11.7 years) and Spain (+11.4 years). Only Slovenia stands out with an increase of 12.6 years. Eastern European countries are at the low end of the EU group, with, for example, an increase in life expectancy of 3.9 years for Lithuania and 7 years for Hungary, two countries whose life expectancy was among the lowest in 1960.

Figure 2 : The gap in life expectancy by country in 56 years, between 1960 and 2016



b. By European region

Inequalities in life expectancy are particularly high at the regional level too. In France, in 2014, the maximum gap between metropolitan regions was 3.8 years, compared with 3.9 years in 2018. If we include overseas regions, it was 7.4 years in 2014 and 8.3 years in 2018. And in the European Union, a gap of 11.9 years was observed in 2018 between Severozapaden (Bulgaria) and Madrid (Spain).

2. LIFE EXPECTANCY HEALTH EXPENDITURE IN THE EU

Figure 3 : Map of men's life expectancy at birth in 2018

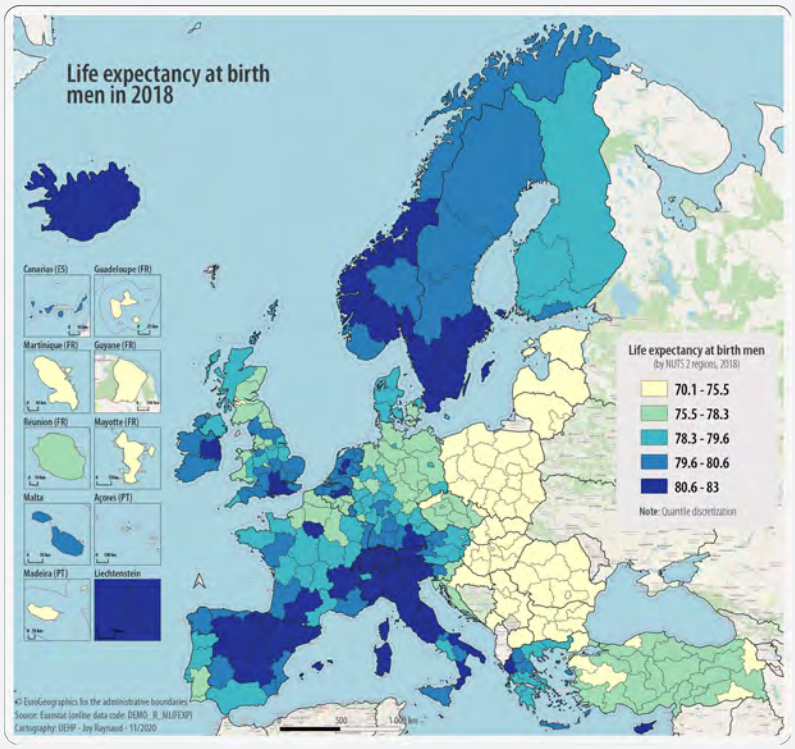
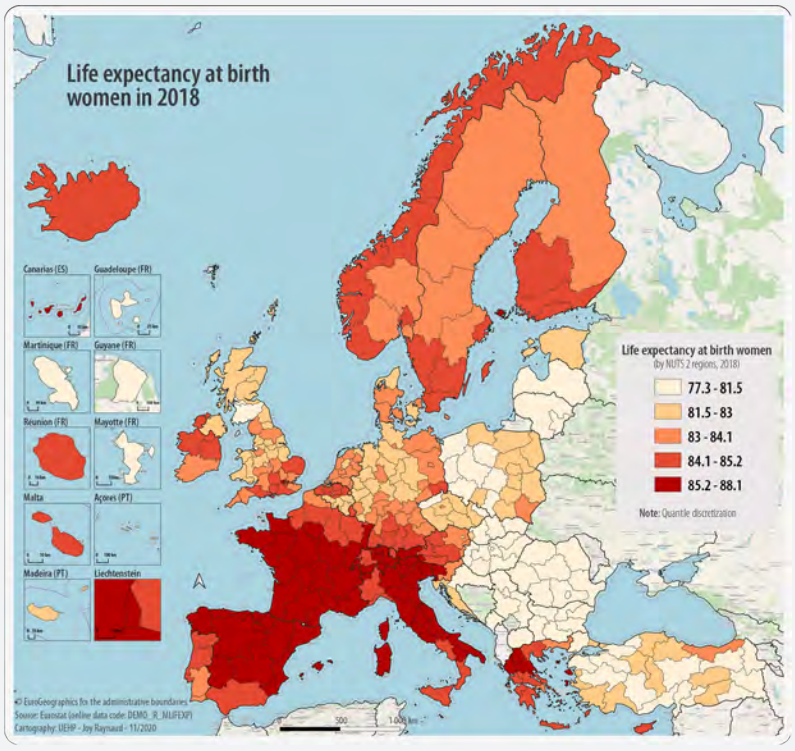


Figure 4 : Map of women's life expectancy at birth in 2018



Why do we observe these data at the regional level (NUTS 2)?

Western countries have been undergoing a process of transformation of their healthcare systems for several decades. We are witnessing deconcentration in centralised states and decentralisation in States where the regions already have strong political and administrative autonomy. Thus, France and Great Britain, whose public sector management is highly centralised, have implemented transfers of responsibility from the central level to the regional level. While Greece and Portugal still have a centralised health administration, Spain and Italy underwent a process of regional decentralisation in the 1990s. These dynamics can be explained by the partial disengagement of the central States from the health and social sector and the development of European integration, the desire to control expenditure through proximity to the territory and therefore knowledge of supply and needs (better allocation of resources, easier interaction with all health professionals, adaptation to demographic and epidemiological changes, etc.)[1].

Thus, the regions with the highest mortality rates need financial and technical support to help them strengthen their health systems. But while the regions of the Member States with initially higher mortality rates improved faster than those with more favourable starting conditions, this trend did not lead to an overall reduction in dispersion across the units, and may have even increased it[2]. This seemingly paradoxical result might be explained by the negative impact of the 2008 economic crisis on mortality developments in the EU Member States with a recent history of low mortality rates (e.g. Greece, Spain and Portugal). While the EU's cohesion policy focuses on areas with below-average outcomes, it might also be necessary to focus on regions with historically stagnant rates of mortality improvement. Thus, reducing geographic inequalities in mortality in the EU requires a better understanding of its determinants in order to harmonise approaches to measuring mortality convergence.

c. Comparison of life expectancy between men and women

It is quite clear that the iron curtain is still standing, and that people in the eastern EU States do not have the same chances as the people of the western or southern EU countries. Strong spatial inequalities remain at the level of European regions and concern both men and women. (2018 published data, Eurostat 2020).

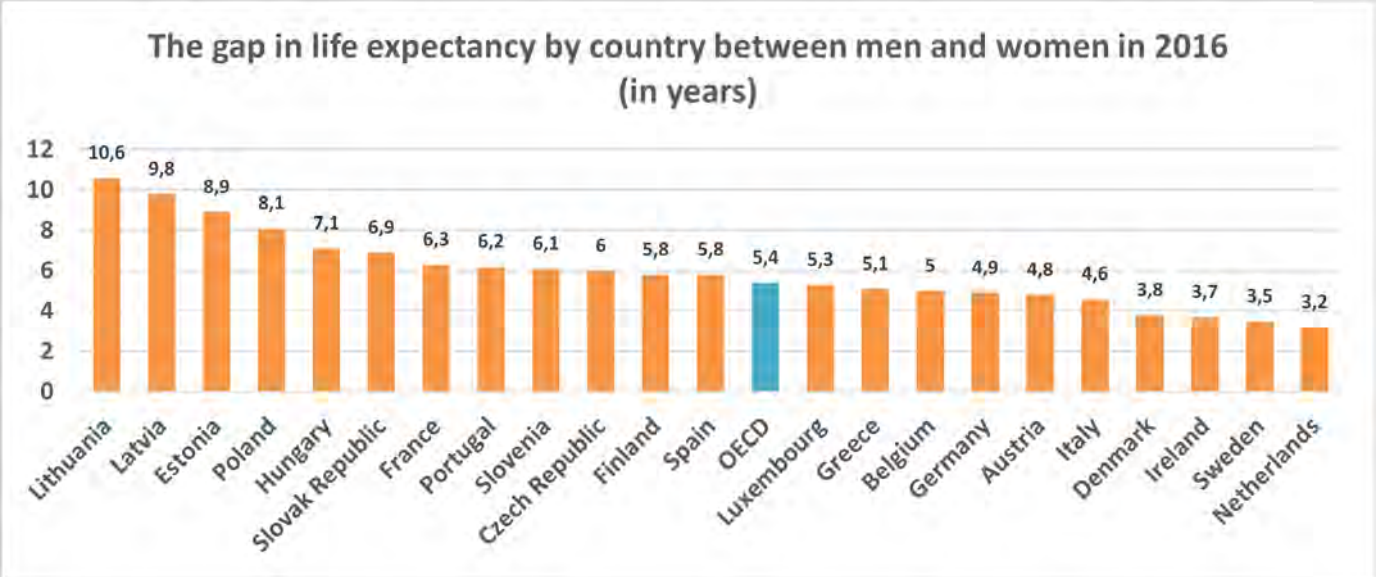
1 *Mallet, J. & Gayral-Taminh, M. (2011). Régionalisation des politiques de santé et prévention dans les pays d'Europe du Sud : l'exemple italien. Dans : Bernard Cherubini éd., Agir pour la promotion de la santé : Une politique ouverte à l'innovation ? (pp. 111-127). Toulouse, France: ERES*

2 *Rok Hrzic, Tobias Vogt, Fanny Janssen, Helmut Brand, Mortality convergence in the enlarged European Union: a systematic literature review, European Journal of Public Health, Volume 30, Issue 6, December 2020, pages 1108–1115.*

2. LIFE EXPECTANCY HEALTH EXPENDITURE IN THE EU

The gap according to the date of entry into the EU remains significant, more so for men than for women. No real improvement on this indicator has been observed so far. Most Eastern European countries display marked differences from Western countries, below the OECD mean value (5.4 years), *Figure 5.*

Figure 5 : The gap in life expectancy by country between men and women in 2016 (in years)



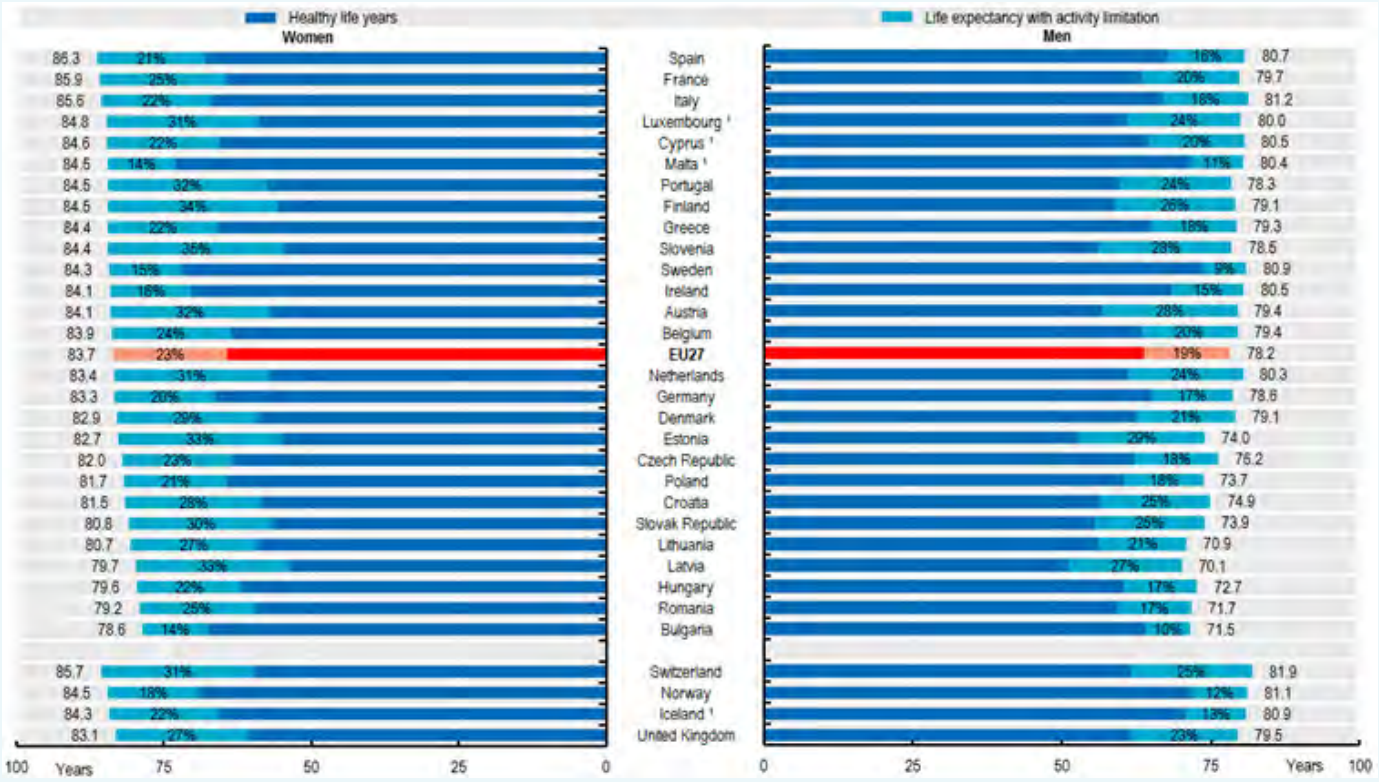
Society at a Glance 2019 - © OECD 2019. Figure 7.1. Life expectancy has increased over the past decades, but the gender gap remains considerable.

Life expectancy at birth, by gender, in years, 1970 and 2016 (or nearest years)

	1970	2016	Evolution	Men (2016)	Women (2016)
Spain	72.0	83.4	11.4	80.5	86.3
Italy	72.0	83.3	11.3	81.0	85.6
Luxembourg	69.7	82.8	13.1	80.1	85.4
France	72.2	82.4	10.2	79.2	85.5
Sweden	74.8	82.4	7.6	80.6	84.1
Ireland	71.2	81.8	10.6	79.9	83.6
Austria	70.0	81.7	11.7	79.3	84.1
Netherlands	73.7	81.6	7.9	80.0	83.2
Belgium	71.1	81.5	10.4	79.0	84.0
Finland	70.8	81.5	10.7	78.6	84.4
Greece	73.8	81.5	7.7	78.9	84.0
Slovenia	68.7	81.3	12.6	78.2	84.3
Portugal	66.7	81.2	14.5	78.1	84.3
Germany	70.6	81.1	10.5	78.6	83.5
Denmark	73.3	80.9	7.6	79.0	82.8
OECD	**70.1**	**80.6**	**10.5**	**77.9**	**83.3**
Czech Rep.	69.6	79.1	9.5	76.1	82.1
Poland	70.0	78.0	8.0	73.9	82.0
Estonia	70.0	77.8	7.8	73.3	82.2
Slovak Rep.	70.0	77.3	7.3	73.8	80.7
Hungary	69.2	76.2	7.0	72.6	79.7
Lithuania	70.9	74.8	3.9	69.5	80.1
Latvia		74.7	8.0	69.8	79.6

2. LIFE EXPECTANCY HEALTH EXPENDITURE IN THE EU

Life expectancy and healthy life years at birth, by gender, 2018 (or nearest year)



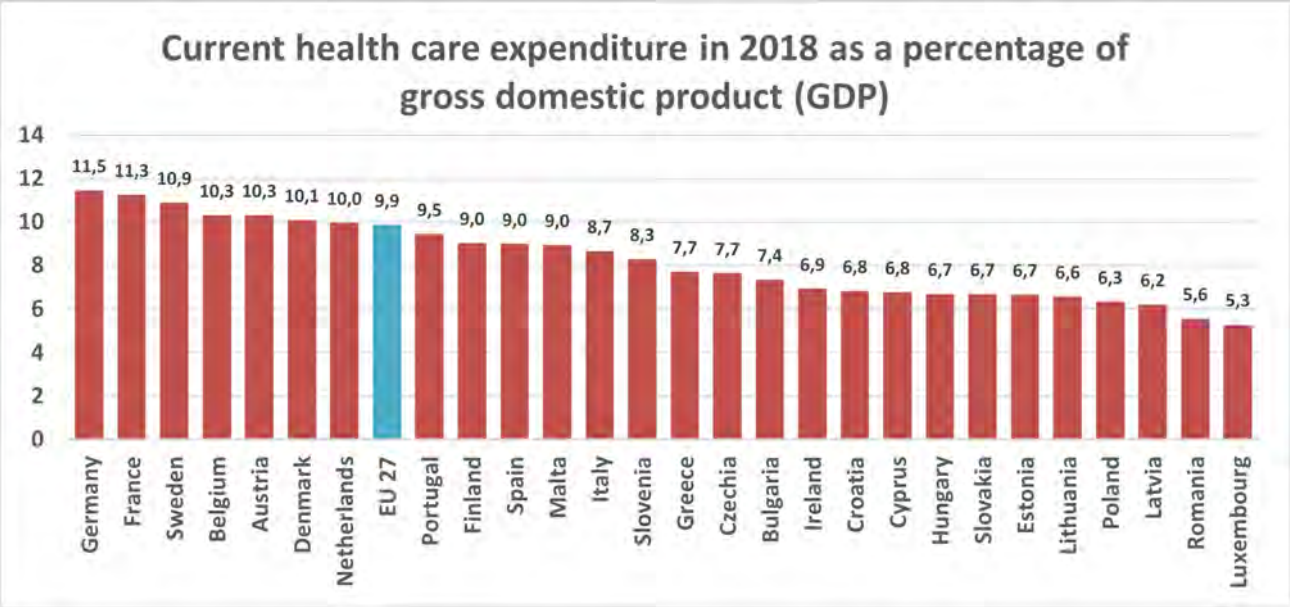
Inequalities in life expectancy by education level are generally larger among men than among women, and are particularly large in Central and Eastern Europe.../... (e.g.) Half of the gap in mortality rate among men in this age group is due to higher death rates from circulatory diseases and cancer (Health at a Glance, OECD 2020).

2.2. Health Expenditure

Statistics on healthcare financing and expenditure can be used to assess how a country's healthcare system is meeting the challenge of universal access to quality healthcare, by measuring financial resources in the healthcare sector and the distribution of these resources between healthcare activities (e.g. preventive and curative care) or between groups of healthcare providers (e.g. hospitals and outpatient centres).

Among the EU Member States, Germany recorded the highest level of current health expenditure: € 384 billion in 2018, or 11.5% of gross domestic product (GDP), (Figure 6). France recorded the second-highest level of current health expenditure (€ 266 billion, 11.3% of GDP), followed by Sweden (€ 51 billion, or 10.9% of GDP), Belgium (€ 47 billion, or 10.3% of GDP) and Austria (€ 40 billion, or 10.3% of GDP). On the other hand, current health spending in Eastern European countries (Hungary, Slovakia, Estonia, Lithuania, Poland, Latvia, Romania) and Luxembourg represented less than 6.7% of GDP. Romania recorded the lowest ratio at 5.1%.

Figure 6 : Current health care expenditure in 2018 (PPS)



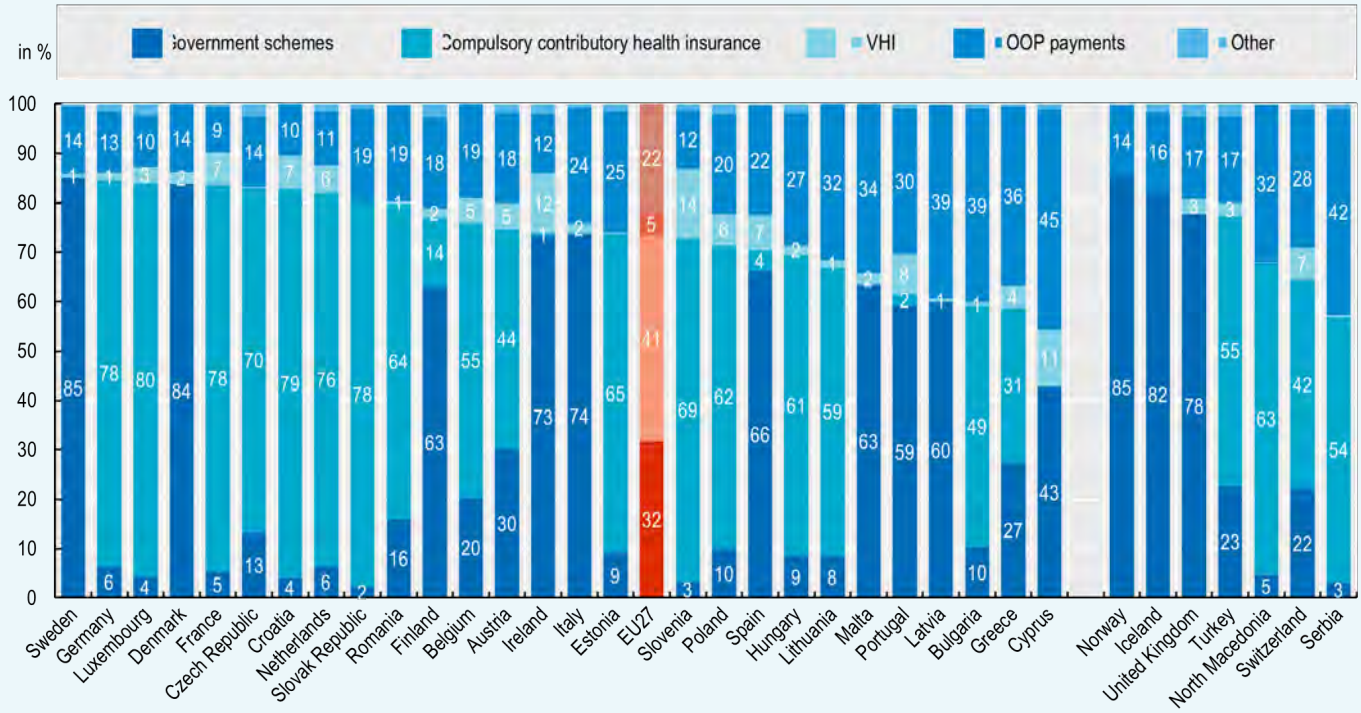
GEO	% in 2018	GEO	% in 2018
Luxembourg	5.29	Slovenia	8.30
Romania	5.56	Italy	8.67
Latvia	6.21	Malta	8.95
Poland	6.33	Spain	8.99
Lithuania	6.57	Finland	9.04
Estonia	6.66	Portugal	9.45
Slovakia	6.69	**EU 27**	**9.87**
Hungary	6.70	Netherlands	9.97
Cyprus	6.77	Denmark	10.10
Croatia	6.83	Belgium	10.32
Ireland	6.93	Austria	10.32
Bulgaria	7.35	Sweden	10.90
Czechia	7.65	France	11.26
Greece	7.72	Germany	11.47

Eurostat data, Year 2018, Health Expenditure in EU-27 as % GDP

2. LIFE EXPECTANCY HEALTH EXPENDITURE IN THE EU

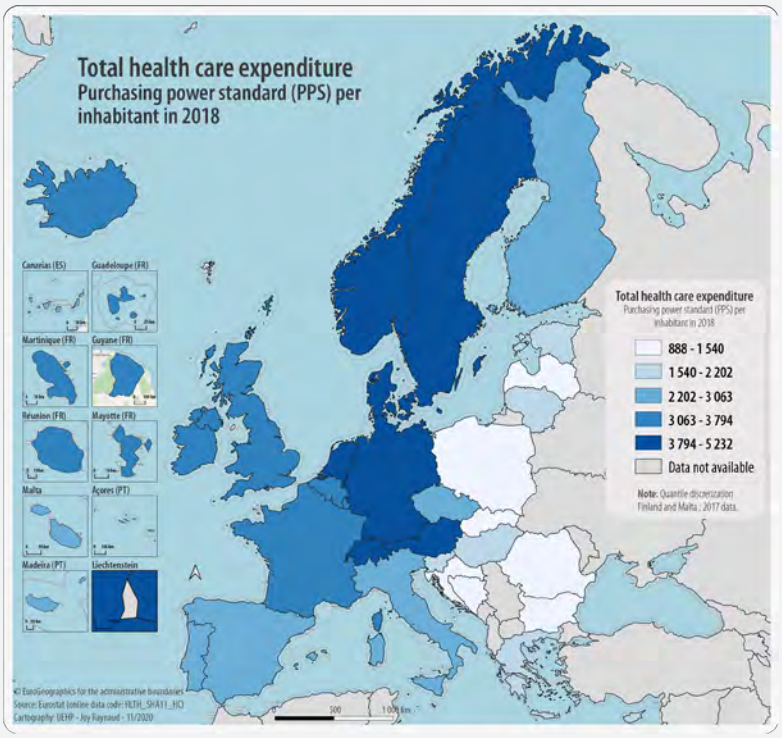
Thus, in the EU-27, the share of total current health expenditure (CHE) has remained stable since 2014 at 53.8%, and the rate of inpatient curative and rehabilitative care is 25.7%. Total health expenditure in 2018 was € 1 331 billion. Hospital care accounted for 36%, at € 484 billion. Within hospital expenditure, 72.25% was absorbed by acute and rehabilitative care, at € 349 billion. Over the past five years, health expenditure increased by 14%.

Strong inequalities are also observed when expenditure is expressed in purchasing power standards (PPS) per inhabitant, *Figure* 7. The four countries with the highest health expenditure in PPS per inhabitant (between 5 200 and 4 000) are Switzerland, Norway, Germany and Austria, while Romania, Bulgaria and Latvia have the lowest expenditure of between 1 200 and 1 300 PPS per inhabitant. We thus observe a difference in value of 4.3 between countries, with a value of 3 100 PPS per inhabitant for the EU-27. The remaining question of "Out-of-Pocket" payments by service users is central for citizens. The current situation in this respect is explained by the following graph.



Health expenditure by type of financing, 2018 (or nearest year). Health at a Glance. OECD 2020.

Figure 7 : Total healthcare expenditure in 2018 (in PPS per inhabitant)



Thus, a simple comparison of public health expenditure in the European Member States shows a major gap between the different countries: Germany and France are at the top, but in most Eastern countries the public health budget is quite low. Consequently, the "out-of-pocket" cost is high for citizens, and moreover, innovative medicine may be delayed when expensive. Due to the combination of these two problems, namely less public money and delayed access to modern treatment, the opportunity for better access to efficient solutions is limited. The EU has pledged to reduce inequalities, but national policy must resolve to adapt outdated systems to recent innovative solutions in social protection and health investment. The recent publication by the EXPH makes a strong case for a new deal in Health.

We know that health spending is growing all around the world. In the USA, the latest data show that *"healthcare spending increased 4.6 percent to $ 3.8 trillion in 2019, similar to the rate of growth of 4.7 percent in 2018. The share of the economy devoted to healthcare spending was 17.7 percent in 2019 compared with 17.6 percent in 2018. In 2019, the faster growth was due to spending for hospital care"*. All the facts are internationally convergent, and we have to adapt the needs and the resources towards efficient services.

Improving the quality of and access to healthcare and increasing life expectancy by promoting a healthy lifestyle will be possible thanks to the strong cooperation between public and private healthcare but also thanks to policy measures directed to investment in social protection expenditure[3].

3 *van den Heuvel, W. J., & Olaroiu, M. (2017). How Important Are Health Care Expenditures for Life Expectancy? A Comparative, European Analysis. Journal of the American Medical Directors Association, 18(3), 276.e9–276.e12.*

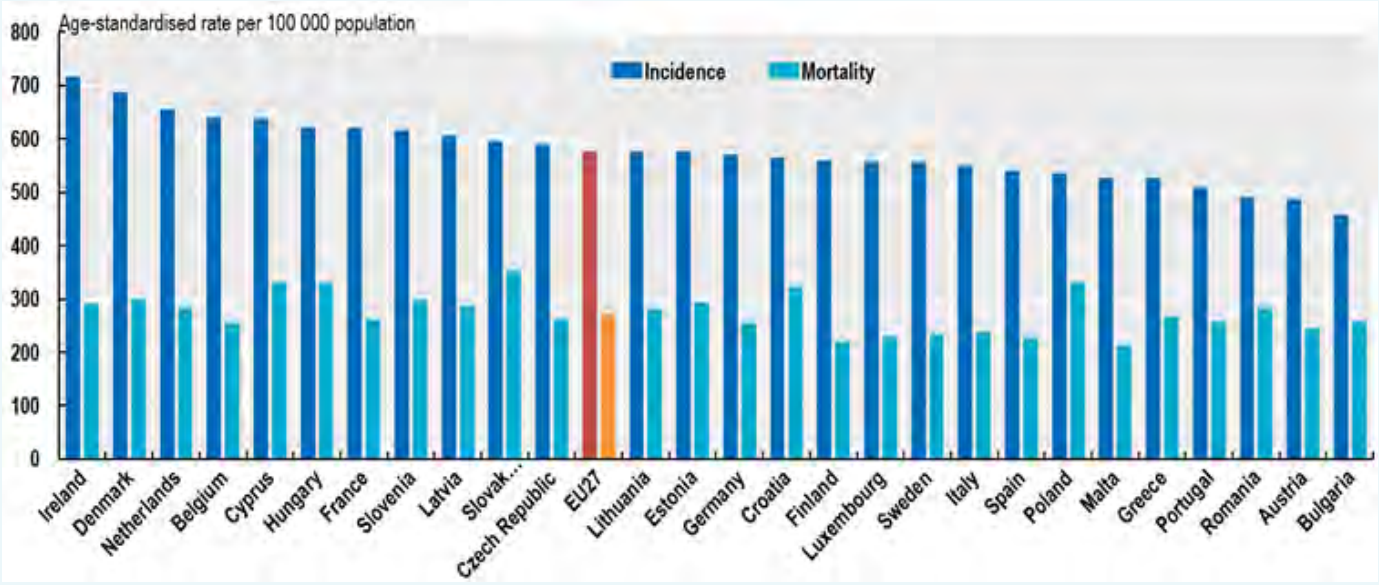
2. LIFE EXPECTANCY HEALTH EXPENDITURE IN THE EU

Indeed, health spending is not the main determinant of life expectancy at birth, unlike social protection spending. In those countries that spend a high percentage of their GDP on social protection, which have fewer curative beds and low infant mortality, whose citizens report fewer unmet healthcare needs and drink less alcohol, citizens have a significantly longer life expectancy.

2.3. Cancer

In 2020, 2.7 million people in the European Union were diagnosed with cancer, and another 1.3 million people lost their lives to it (Joint Research Centre, 2020), Figure 8. Over 40% of cancer cases are preventable, and mortality can also be reduced through earlier diagnosis and the provision of more timely and effective treatments.

Figure 8 : Expected cancer incidence and mortality in EU countries, 2020. Source: Health at a Glance: Europe 2020 - © OECD 2020. Data: ECIS – European Cancer Information System.



Note: The EU average is weighted. Data include all cancer sites except non-melanoma skin cancer.

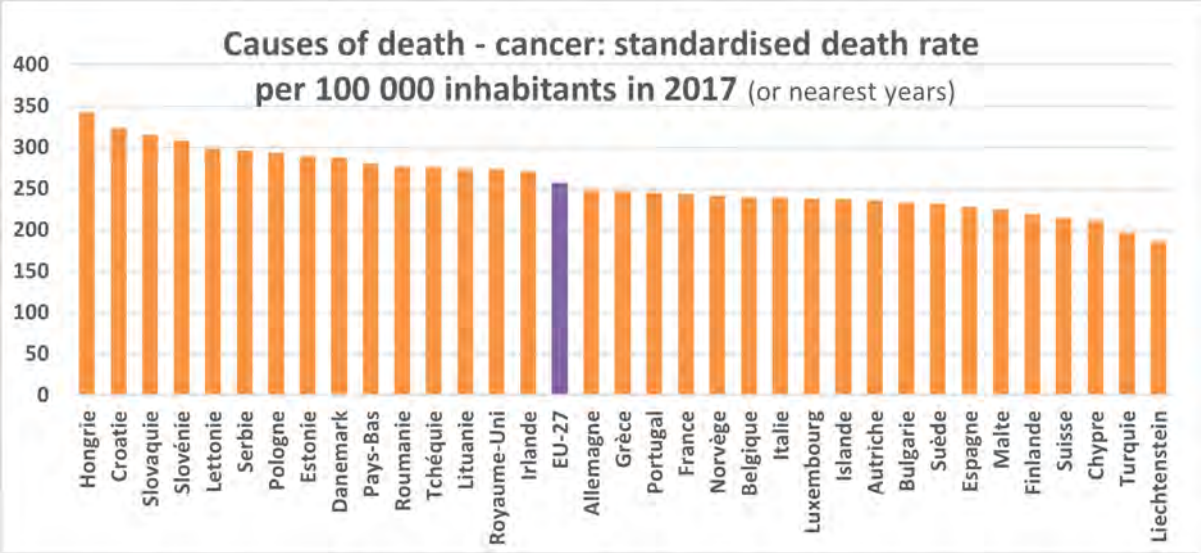
But the COVID-19 pandemic has severely impacted cancer care, disrupting prevention and treatment, delaying diagnosis and vaccination, and affecting access to medicines. Since the pandemic began, the number of cancer diagnoses has decreased, foreshadowing a future increase in cases. In addition, the number of lives lost to cancer in the EU is expected to increase by more than 24% by 2035, making it the leading cause of death in the EU. The overall economic impact of cancer in Europe is estimated at more than € 100 billion per year.

In this context, the EU is investing € 4 billion in an ambitious new programme, EU4Health (2021-2027), that will provide financial and technical support to Member States, helping efforts to strengthen their health systems. In 2021, the Commission also wants to create a Cancer Inequalities Registry to identify trends, disparities and inequalities between Member States and regions, and to propose investments and interventions at the European, national and regional levels according to the specific challenges and fields of action of each territory.

According to the OECD (2020), "*More men than women are expected to be diagnosed with cancer in 2020 across EU countries (54% men and 46% women). Cancer is the second leading cause of mortality in the EU after cardiovascular diseases. Reflecting mainly higher incidence, mortality from cancer is greater among men than women. Overall across EU countries, about 706 000 men and 555 000 women are expected to die from cancer in 2020 (JRC, 2020). Mortality rates from cancer are lowest in Finland, Malta, Spain, Luxembourg, and Sweden, with rates at least 15% lower than the EU average. They are highest in the Slovak Republic, Poland, Cyprus, and Hungary, with rates more than 20% higher than the EU average*".

Comparing the causes of cancer deaths in 2017, we observe that most often the Eastern Member States present a high number of deaths related to cancer, *Figure 9.*

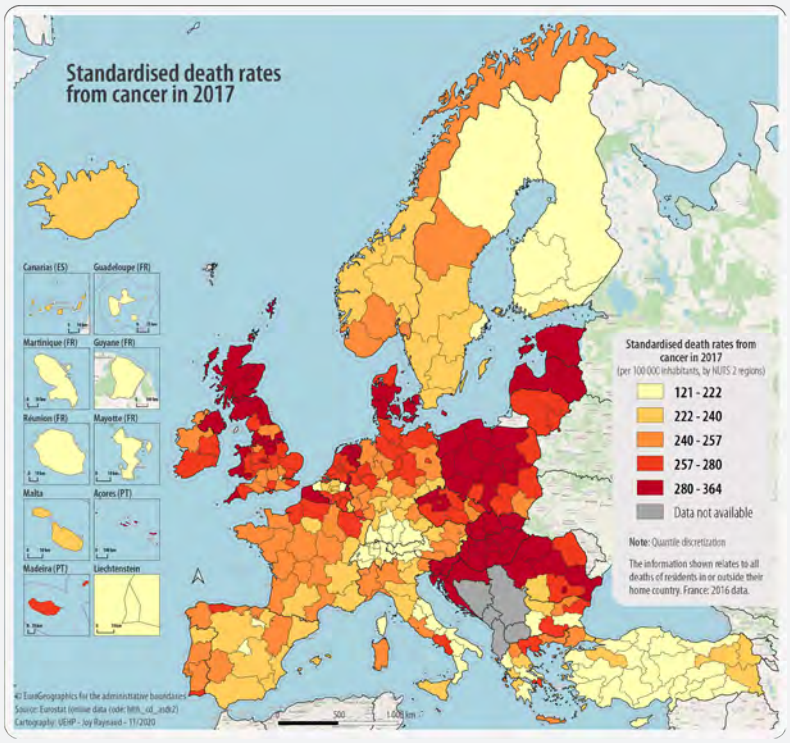
Figure 9 : Causes of death – cancer: standardised death rate in 2017.



When we study the cancer disease map at the regional level, Figure 10, here again the standardised death rates from the cancer index illustrate the same inequality. The solutions for European citizens facing cancer are not the same. While the North of the EU is not spared, the old Iron Curtain separates the former "East Block" countries, which have the highest cancer mortality rates. These figures are well-known yet striking if we consider that these countries are not new EU members. Most of the countries with a high cancer score joined the EU more than 15 years ago (2004 or 2005). It is very important to analyse these results carefully not only by Member State but also using the NUTS 2 region mapping. What we have to correct altogether is the lack of equal opportunities according to the territory.

2. LIFE EXPECTANCY HEALTH EXPENDITURE IN THE EU

Figure 10 : Standardised death rates from cancer in 2017.



Concerning the breakdown of cancer by type , we use again the OECD data (2020): "*among men, the main cancer sites are prostate cancer, which is expected to account for 23% of all new cancers diagnosed in 2020, followed by lung cancer (14%) and colorectal cancer (13%). Among women, breast cancer is the main cancer site, expected to account for 29% of all new cancer cases, followed by colorectal cancer (12%) and lung cancer (9%).*"

More recent data present the current situation for men and women together; the map shows a persisting "iron curtain" isolating the Eastern Member States struggling to fight cancer. This situation should be addressed with a multi-pronged approach, including public health recommendations, national and regional screening programmes and new treatments.

But for the UEHP, the goal is to develop new services adapted to the population's needs. Without a clear commitment to investments, workforce training and equipment upgrading there can be no solution. The lesson comes from "Ost Länder" in Germany: after the reunification, a major economic effort was made to improve living conditions and raise them to the western level. And it took time even in the richest European Member State. We must follow collectively at the EU level the same path, developing strategic investments geared towards the single objective of reducing the incidence of the disease and its severe consequences on people. The current situation is no longer acceptable and the challenge is to turn good intentions into action.


Clinique
Le Grand Parc

3. DISCUSSION

3. DISCUSSION

In line with a recent publication by the EXPH's Opinion on the organisation of resilient health and social care following the Covid-19 pandemic, we strongly support the recommendation to "*debat[e] methods for Member States to collect and share aggregate health data on ethnicity and socioeconomic status*" in the EU. The solutions are not only political. To follow the EXPH's recommendations, strategic investments are necessary to narrow the current gap. We clearly understand it is difficult for policy makers to increase health budgets in times of crisis. But the UEHP is strongly interested in new proposals to develop partnerships including private investments and coordination of providers able to optimise the services delivered to European patients and limit the inequalities among EU citizens.

We all know that cancer incidence and disease expression are dependent on multifactorial contexts: environmental conditions, prevention, screening, access to diagnosis and treatment, medical follow-up, social protection. All these conditions (and certainly more) are necessary to fight the disease. But the economic factor is not the least important. As shown on the map (Figure 7), health expenditure corrected by PPP shows a huge range of differences among European Member States.

3.1. Lessons from history

As reported by Hrzic concerning the reunification of West and East Germany, "*the two sides first established a monetary, economic and social union by the early summer of 1990*". The health benefits are clear for the former Eastern population but the result was not perfectly harmonised and important regional disparities can still be observed. So we ask policymakers to develop a strategy based on this common goal, keeping in mind that "*the lessons of German reunification are highly relevant to many questions the EU is facing after its eastern expansion, including how to engineer a convergence of health between the new and the old Member States*". Since it took so long to reach the solution in the richest EU Member States, we have to move carefully, step by step to propose a new deal with health regulators in the attempt to achieve the same result in less advanced economies. And it was a long process, which lasted 30 years. Using this relevant comparison in the EU, we have to coordinate all our economic and political resources to reach this target of a homogenous health status for all European citizens. We are aware of the difficulties, but cooperation between regulators and providers, including private investment, is the only solution.

3.2. Private Hospitals in the EU

The share of the public and private sectors in healthcare varies widely among Member States but, overall, public hospitals account for "only" 60.8% of beds, meaning that the private hospital market makes up about 40% of the European total, respectively 21.6% for profit and 17.6% not-for-profit hospitals (data Eurostat 2018*) (* excluding Ireland, Luxembourg and Sweden, data not available in those MS). From 2010 to 2018, the number of all hospital beds fell by 5%, while the decrease in the private sector was just 1%. As a consequence, the share of private beds increased by about 4.15 % in the same period. The future of the healthcare sector must include private hospitals, which are the only growing healthcare sector in the EU. National governments tend to make a narrow analysis of new initiatives, often focusing more on public plans than on the private sector's involvement. Public authorities must consider all providers if efficiency and access are the goals to be achieved. Based on the facts, the private sector is the future of hospitals in a contracting market related to early diagnostics, day care units and outpatient treatment, as the last decade has shown.

As stated, about 22% of all European hospital beds are privately owned. The size of the private hospital market is to be € 70 billion a year for curative beds alone, without including the income from consultation, diagnostic and imaging. Coordination with the workforce, more specifically medical doctors, is the major key to success. It will be fruitful to foster collaboration between providers and professional teams in developing and supporting medical projects. More initiatives based on practical experience and to be assessed by investors could provide an opportunity to complete public health provision.

3.3. Medical equipment

With regard to technical solutions, we present the maps of diagnostic imaging technology use in the EU MS, divided by CT-Scan, MRI and PET-scan (*Figures 11, 12, 13*). Cancer inequality is like an elephant in the room: we all see it but no one talks about it. And what we observe is no longer acceptable. We can reduce the gap by bringing to bear all our resources. It should be noted that in those Member States where cooperation and competition between providers are possible, positive results have been observed. The future of Europe depends on human wellbeing, which includes giving all Europeans the same access to accurate diagnostics and treatment. To fight cancer and to improve the opportunities of all, solidarity and partnership can join the goal of efficiency.

Figure 11 : Number of CT Scanners in 2018.

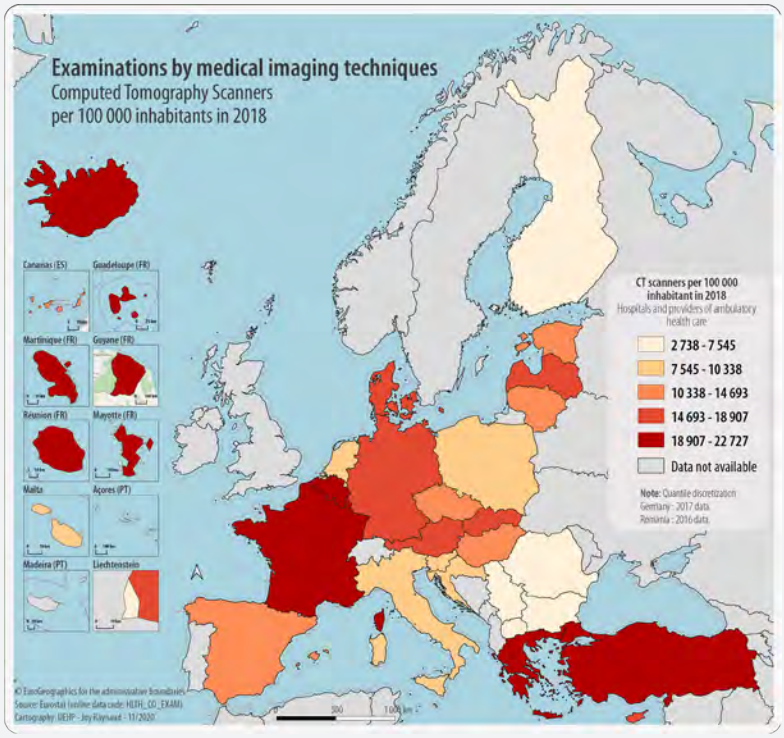


Figure 12 : Number of MRI in 2018.

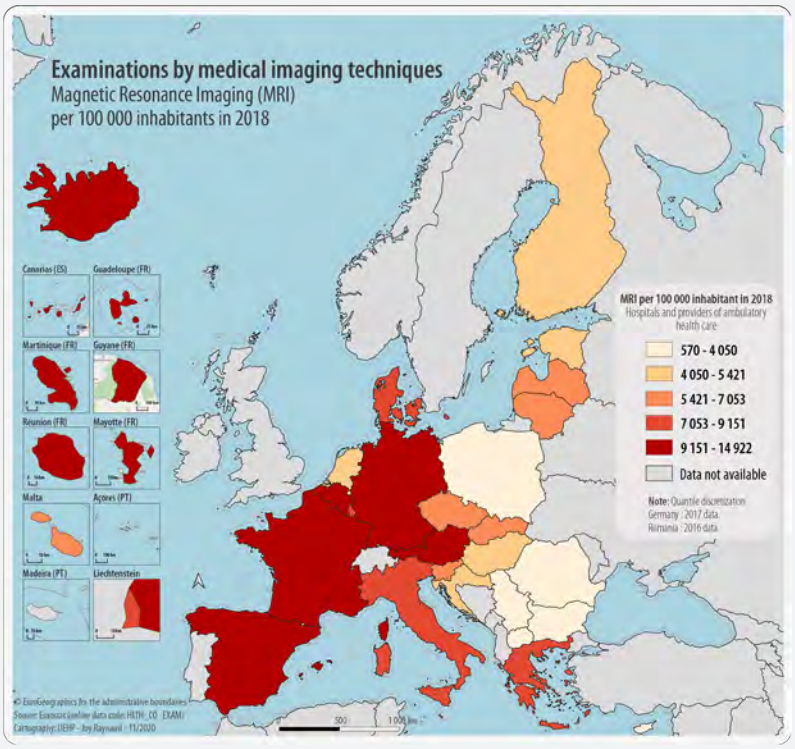
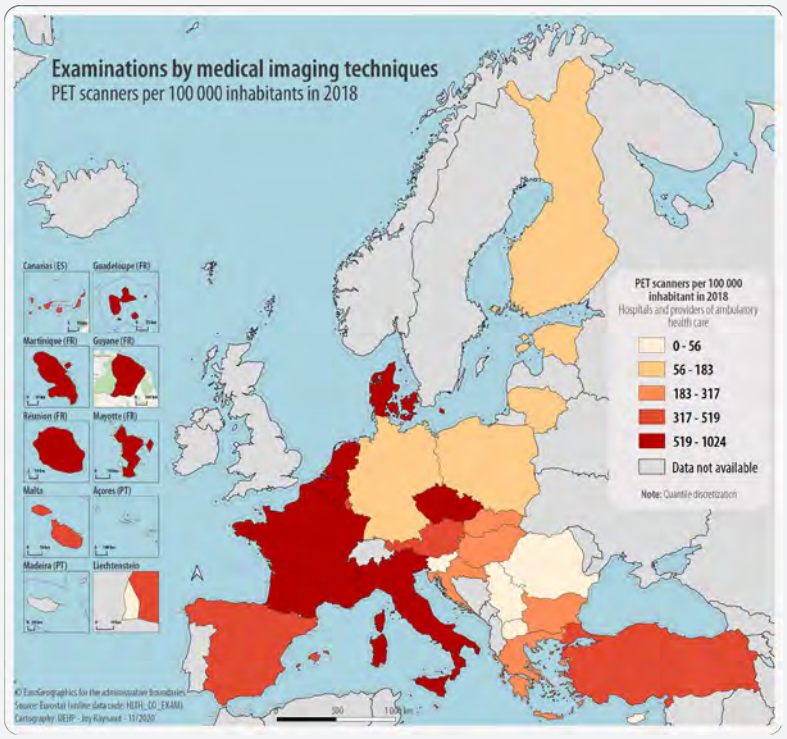


Figure 13 : Number of PET scanners in 2018.



3.4. Action coordination

EU COMMISSION 2020: *If no further action is taken, the number of people newly diagnosed with cancer every year in Europe will increase from the current 3.5 million to more than 4.3 million by 2035. Targets by 2030: more than 3 million lives saved, living longer and better, achieve a thorough understanding of cancer, prevent what is preventable, optimise diagnosis and treatment, support the quality of life of all people exposed to cancer, and ensure equitable access to the above across Europe (ECIS).*

All actors in the field must join the effort to find a common solution. Public ambition in healthcare requires investments, and the private sector is a strong force for sharing solutions. But economic forecasts have to be included in the strategy. Fair competition and efficient solutions must be assessed on the basis of results. As expressed in this paper, access to medical examinations is the "first door" which must be opened to give the best opportunities to patients facing cancer in the future. The private sector is at the forefront of imaging technologies.

For the future, coordination of care is the major challenge we have to manage. In cancer diseases, experts must interact with all the caregivers to define the best treatment for each patient using a multidisciplinary process. We can and must break down "psychological" barriers and fight the silo approach where each intervention is carried out in isolation. Based on medical projects responding to strategic incentives, with coordination of providers without any statutory constraints, new solutions could be developed. All future medical projects should be collaborative, as European patients now require access to expertise and not only local access. For example, in cancer treatment, the solution is to aggregate competences. New treatments associate high efficacy with high costs. The medical decision is then the outcome of a cost-effectiveness assessment. Only highly specialised consultations can offer the right service, firstly adapted to the specific medical case and secondly respecting the cost-effectiveness strategy. In the drive to reduce unnecessary solutions and ineffective healthcare spending on pharmaceuticals, the contribution of cancer disease experts is essential.

Photo credit RAMSAY

4. CONCLUSIONS

We know the complexity of the situation. With the increase in life expectancy and the improvement of diagnostic tools, cancer incidence is growing across the EU. But the consequences vary among Member States according to the resources each dedicates to healthcare. Early diagnosis and rapid access to new treatments are certainly the two major solutions to be developed. To reach this goal and to efficiently fight cancer, the private sector is clearly a relevant partner to compete for strategic investment and quality of care.

The lesson of history: In the former German "Ost Länder" after reunification, private investment supported hospital development and modernisation to improve services and meet emerging needs. That was exactly the purpose of Robert Schuman as the father of Europe. Therefore, to reduce the healthcare gap in the EU, a comprehensive approach is necessary, including civil society implications. When facing the recent major health challenges, the partnership of Big Pharma with national governments, but also the EU Commission, offered the best example of cooperation between private industry and public health policy. Pragmatic solutions in a changing world are required to limit the inequalities in healthcare services among European citizens. The EU Beating Cancer Plan will find a true partner in the private sector.

Private hospitals are delivering, including in the area of cancer screening and treatment, and can deliver more and in a more extensive way. Innovative solutions from prevention to treatment of severe conditions require coordination. To enhance the sustainability of health systems, regulators should support overall performance by exploring the role of private providers.

Cancer must be fought using all resources, including an open mind and policy reforms. The EU-27 is based on patient mobility and the free circulation of capital. Health must not be excluded from European progress and the ambition to achieve the best standards. The path ahead after COVID-19 times includes enhancing the European Commission's involvement. We have to base our analysis on facts and figures, to build a common perspective for all in the EU, and to narrow the unacceptable gap between us.

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Schuman Robert. Premier Président du Parlement Européen (1958-1960), 1963.
« Nous devons faire l'Europe non seulement dans l'intérêt des peuples libres, mais pour pouvoir y accueillir les peuples de l'Est qui, libérés des sujétions qu'ils ont subies jusqu'à présent, nous demanderaient leur adhésion et notre appui moral ».

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FULL MEMBERS

Austria

Number of public hospitals	143
Number of public beds	44.299
Number of private hospitals	121
Number of private beds	19.539

France

Number of public hospitals	1.354
Number of public beds	241.345
Number of private hospitals	1.030
Number of private beds	113.500
Number of doctors working in private hospitals	40.000

Germany

Number of public hospitals	545
Number of public beds	235.767
Number of private non-profit hospitals	645
Number of private non-profit beds	162.958
Number of private hospitals	724
Number of private hospital beds	95.601
Number of doctors working in private hospitals	26.881

Greece

Number of public hospitals	124
Number of public beds	33.630
Number of private hospitals	141
Number of private beds	15.584
Number of doctors working in private hospitals	32.428

Hungary

Number of public hospitals	85
Number of public beds	62.700
Number of private hospitals	25
Number of private beds	2.200
Number of doctors working in private hospitals	1.200

Italy

Number of public hospitals	436
Number of public beds	147.308
Number of private hospitals	561
Number of private beds	61.849
Number of doctors working in private hospitals	13.513

Principality of Monaco

Number of public hospitals	1
Number of public beds	845
Number of private hospitals	3
Number of private beds	168

Poland

Number of public hospitals	534
Number of public beds	143.800
Number of private hospitals	356
Number of private beds	19.600
Number of doctors working in private hospitals	13.300

Portugal

Number of public hospitals	109
Number of public beds	24.501
Number of private hospitals (including PPP)	129
Number of private beds (including PPP)	11.563
Number of doctors working in private hospitals (full time + part time)	15.529

Romania

Number of public hospitals	368
Number of public beds	131.157
Number of private hospitals	159
Number of private beds	12.704
Number of doctors working in private hospitals	23.065

Spain

Number of public hospitals	**339**
Number of public beds	**142.632**
Number of private hospitals	**460**
Number of private beds	**51.373**
Number of doctors working in private hospitals	**25.463**

Switzerland

Number of public hospitals	**58**
Number of public beds	**38.057**
Number of private hospitals	**221**
Number of private beds	**9.578**
Number of doctors working in private hospitals	**7.073**

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