

# Healthcare systems in the European Union – an evaluation

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## Structure of the German Healthcare-System

The German healthcare system includes at present three areas:

- primary healthcare performed by family doctors or medical specialists:
  - a) at present there are about 388 200 physicians,
  - b) there is a lack of physicians in some regions and in the new federal states (Bundesländer);
- acute health care by hospitals:
  - a) beds per 10 000 inhabitants in 2002 — 66.4,
  - b) general hospitals in Germany:

	1996	2002	Trend
Total	2,040	1,898	↓
Public	831	712	↓
Non-profit	835	758	↓
Private	374	428	↑

- rehabilitation by rehabilitation-clinics;
- 4<sup>th</sup> field will start during the next few years:
  - a) prevention.

Health-care in Germany is financed by a dual system:
- costs of investment are paid by public administration, which is more and more unable to do so, and:
- operating costs are paid by the patient's health insurance company (at present there are about 280 health insurance companies). A reform of the healthcare system in Germany was conducted in 2004.

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Cooperation between outpatient and inpatient care will be further promoted to avoid high numbers of patients being screened twice, and costs will be reduced by:

- integrated care;
- out-patient treatment in the hospital;
- medical health-care centres.

Measures of prevention will resume in the service-catalogue of the health insurance, because prevention is better than treatment. Patient rights will be reinforced; for example, patients are now able to get a receipt for physician services and costs.

Comprising measurements of quality assurance will introduce:

- quality management in all medical practices;
- physicians have to regularly take part in advanced training courses and meetings;

Further measures include:

- free price setting for medicaments without prescription;
- introduction of disease management programmes (DMP) for chronically ill patients;
- introduction of Diagnosis Related Groups;
- health-insurers are allowed to reward health-promoting behaviour of the insurants by bonus-programmes;
- contracts between health-insurers and single care-providers.

## The healthcare system in Poland

The National Health-Care Fund (NFZ) has existed in Poland since 2003. It acts as the only health-care insurance in Poland. It is the compulsory insurance for all employed Polish inhabitants. Two social-insurances settle the insurance premium and transfer it to the NFZ. It is divided into 16 regional units and has contracts with care providers to grant the medical care of the insurants. The Polish constitutional Tribunal declared the form of organization of the NFZ as unconstitutional. The Ministry of Health approves the continuous budgeting of the NFZ and decides on the offer of services of the NFZ and which medicines will be reimbursed.

The healthcare system in Poland is divided into:

- family doctors;
- specialists;
- in-patient care by hospitals and policlinics.

A family doctor should take care of max. 2,750 patients, but in regional areas the number averages 3,100. There are three times more medical specialists than family doctors in Poland. The patients will transfer into the hospitals. In 1999, flexible budget man-

agement for hospitals was introduced — now they are bound by contract to the NFZ. Hospitals often treat more patients at a higher price than the budget allows, so they have debts of up to 2 billion euro. Physicians frequently migrate to European neighbour countries, due to the better social and financial conditions.

### Common problems of the European systems

The healthcare systems of the European countries have similar problems:

- regional lack of physicians;
- waiting lists for treatment;
- financing of investments for the hospitals by public administration is difficult or even totally impossible; public or non-profit hospitals have a lack of investment;
- financing the hospital care services by health-insurance is restricted by:
  - a) possible cutback of services paid by the health insurance because of low insurance premium,
  - b) percentage excess of patients in Germany:
    1. each insurant more than 18 years old has to pay a practice-fee of 10 euro per quarterly period,
    2. for in-patient treatment, each patient has to pay 10 euro per day for a period of max. 28 days,
  - c) additional insurance or private financing of treatment are only possible for wealthy patients,
  - d) “two-class-medicine”;
- there are very few regulations and projects for trans-border patients or for cooperation concerning healthcare in regions close to borders.

### EU framework

According to the EU-contract, the organization and development of the healthcare system lies with each member. The healthcare systems in Europe are showing relevant differences concerning important principles, for example financing, service range and organisation. A harmonization is neither politically favoured nor would it be economically useful. But there are activities from EU-side to make the different systems comparable and to increase competition, even between member states.

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### EU-activities

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The „open method of coordination“ is characterized by:

- subject of the method:
  - a) exchange of experiences,

- b) mutual tuning and evaluation of development of best practices;
- ambition of the method:
  - a) assurance of access to healthcare: universality, adequacy and solidarity,
  - b) promotion of care quality,
  - c) ensuring long-term financial viability for long-term stable healthcare.

The European Court of Administration has strengthened the rights of patients. Now they do not need permission for out-patient treatment abroad. With more restrictive conditions, they can also use in-patient treatment abroad. The consequence of this is an increase in patient mobility.

The EU has picked-up the trend of the growing need for patient information through the Internet by promotion of quality standards.

### Room for manoeuvre for national health policy is restricted

The “Open method of coordination” is not legally binding, but perhaps it will develop its own dynamics, which will be transferred to national health policies. The demands on European competition law are not finally cleared. Restrictions of the free traffic of goods and services are only enforced if the patient mobility endangers the financial balance of the health insurance.

Because of a lack of regulations on how to refund treatment performed abroad, patient mobility is very low:

- emergency treatments with health insurance certificate E-111;
- planned in-patient treatments with health insurance certificate E-112 and prior permission from the health insurer;
- planned out-patient treatments have to be refunded by the health insurer up to the amount that the treatment would have cost in the domestic market.

### Prospects for the future

- the possibilities of patient mobility have to be used for cooperation in near-border regions for adequate healthcare;
- clearance of the financing of treatments abroad;
- cooperation in border regions for optimal healthcare;
- development of innovative forms of healthcare, for example in Germany:
  - a) medical health-care centres,
  - b) contracts of integrated healthcare
- liberalization of the hospital market for cost reductions by:
  - a) privatisation,
  - a) partial privatisation,
  - c) public-private partnership;
- active participation in the process of the “open method of coordination”, in order to learn from others and to use the best practice.