THE MARKETISATION OF HEALTH CARE IN EUROPE

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In contrast to the United States and other parts of the world, the financing and provision of health care in Europe is still very much based on public planning and the services are mostly delivered by public organisations, or private organisations that are not aiming to maximise profits. Surveys show continuously strong support for this system. With few exceptions citizens are rather critical of privatisation and marketisation in healthcare provision, and they have good reason to be. The public system not only ensures that the vast majority of citizens have access to health care, but comparisons with the US also show that the public provision of health care is cheaper than in private for-profit systems. However, despite the obvious superiority of public healthcare systems, the public nature of healthcare provision in Europe has been challenged through a series of reforms that amount to what can best be described as the marketisation of health care. Such developments include the introduction of purchaser-provider relationships, the establishment of internal markets, competition between different providers, performance-oriented compensation, individualisation of risks, outsourcing, the use of public-private partnerships, and the sale of public hospitals to private investors. While these reforms have officially been introduced to cut costs and improve efficiency, they have primarily served to create healthcare markets which promote inequality among patients and healthcare workers and erode the public nature of healthcare provision.

THE EVOLUTION OF PUBLIC HEALTH CARE IN EUROPE

The financing and provision of health care in Europe has always involved a variety of institutions and actors, some of whom were public, and others private. What makes the situation even more complicated is the fact that in several European countries there are also important non-profit private actors. And even where private providers predominate, as is the case with non-hospital care in many countries, they are mainly independent physicians...
who may earn a reasonable income but are not necessarily maximising profits. But what makes health care a public service, and what distinguishes Europe – at least western Europe – from the United States is that it is funded out of taxation and/or a compulsory insurance system; profit-maximising actors play a subordinate role, and the state plays a crucial role in planning and overseeing the system. In the United States, in contrast, almost 15 per cent of the population lack any health insurance and almost 75 per cent of those insured are covered by voluntary private insurance, mostly attached to their place of work.3

The compulsory character of the European healthcare system had two different roots and hence has taken two basic forms. One was the Bismarck model, named after the German chancellor who introduced social insurance in the nineteenth century, where contributions are deducted automatically from salaries and paid into social insurance funds, along with contributions by employers and the state.4 The other model, named after Beveridge, the mastermind behind the reorganisation of the British welfare system after 1945, was funded by tax revenue collected by the state. The Bismarck model has prevailed in continental Europe, while Britain, the Nordic countries and some southern European states have adopted versions of the Beveridge system. Both systems incline to some degree of redistribution, as high income-earners normally pay higher taxes and higher social insurance contributions.5 In both cases the state played a critical role in expanding the proportion of the population that had access to health care.

During the second half of the twentieth century European states continually enlarged their responsibility for the healthcare sector through a variety of measures, including the planning of supply, the funding of research and innovation, the regulation and training of medical professions, the establishment and control of medical standards and, not least, the extension of healthcare funding. ‘More or less as a universal trend, health care throughout Europe entered into what may be called the public domain. A by-product of this development was the rollback of the private sector in healthcare spending and, in some countries, healthcare provision’.6 The creation of the National Health Service in Britain after the Second World War involved the takeover and integration of 1,143 voluntary and 1,545 municipal hospitals.7 Patients with private insurance were offered the choice of being treated in NHS ‘pay beds’ (for which the physicians could directly charge the patients or their insurers, while the NHS received some compensation for the accommodation and nursing and technical services), or going to a private hospital. In any case during the 1950s and 1960s their numbers were rather low. Similarly, the creation of heavily subsidised outpatient clinics
in Sweden in the late 1960s meant that private practice virtually ‘dried up’, although patients could still visit private doctors.\(^8\) Public healthcare spending increased continuously during the post-war years. This was not perceived as a serious problem as long as GDP increased at the same pace.

**DRIVERS OF HEALTHCARE RESTRUCTURING**

Technological and organisational innovations, decentralisation, the need for new skills and qualifications, as well as a growing awareness of patients’ rights and the availability of better information, have certainly all played a role in the restructuring of the healthcare sector in the past three decades, but the most important driver of change has been the wish to contain costs. All European countries experienced difficulties covering increasing healthcare costs in the 1970s after the end of the long post-war boom. With economic recession, GDP growth was exceeded by the acceleration of healthcare costs, due to the possibility of more and more interventions as medical knowledge expanded, increasingly expensive equipment and medication, as well as growing needs and expectations. As a result a growing proportion of public budgets was spent on health care. In several countries the recession was also followed by a change in government: neo-conservative parties came to power that had promised tax cuts. This was part of a new neoliberal agenda which aimed at ‘rolling back the state’ in favour of private initiative and capital. The prime example was Margaret Thatcher’s project in Britain, but more moderate forms of economic austerity were also introduced in other European countries, including Sweden. Economic austerity in fact became a major goal of the European Union, and especially of those member states which joined the Growth and Stability Pact with its 3 per cent cap on budget deficits.\(^9\)

The combination of tax cuts and budgetary austerity not surprisingly resulted in a financial crisis in public healthcare systems. This not only concerned the tax-based systems, but also countries with social health insurance schemes. In the latter case hospital infrastructure was often funded by the local government while the costs of treatment were covered by the insurance funds. In federal systems such as Germany it was initially the municipalities that felt the strongest pressure to cut costs. However, in recent years the federal states (Länder) have also increasingly sold hospitals to private investors who promised to make long overdue investments.\(^10\) Social insurance funds also came under pressure, as they had difficulty in increasing the premiums paid by workers, who were already suffering from stagnating wages, while their total income was reduced by continuously high rates of unemployment and the growing number of workers in non-standard forms
of employment, who did not pay premiums. However, the same politicians who had introduced tax cuts also promoted the privatisation of health care as a solution to the healthcare funding crisis. Private healthcare providers, they maintained, could deliver the same if not better services at lower prices, thereby relieving the pressure on public budgets.

A second major driver behind the transformation of the healthcare sector has been multinational healthcare companies and the large amount of financial assets in search of profitable investment opportunities in health care. These assets have shrunk as a result of the 2008/2009 financial crisis, but they are still a powerful driving force: despite the crisis in public budgets and cost-containment efforts, the healthcare sector is expected to grow strongly in the future. What makes the healthcare sector so interesting for private investors is that the business is non-cyclical. Other sectors may suffer from a decline in demand, but patients need medical treatment regardless of the world economic outlook. As a result a growing number of multinational health companies have been pushing for liberalisation and privatisation, while companies from outside the health sector (e.g. private equity funds and facilities management firms) are increasingly investing in healthcare projects in order to add additional streams of income to their otherwise cyclical businesses. The increasing importance of health care as a profit-making sector can also be seen in its important role in the WTO talks on a General Agreement on Trade in Services.

HEALTHCARE RESTRUCTURING AND MARKETISATION

In the privatisation literature, authors often make a distinction between liberalisation and privatisation. While liberalisation refers to the introduction of competition, i.e. the admission of more than one provider for the same service, allowing customers to choose between different suppliers, privatisation involves the transfer of assets from public to private ownership. In reality, however, these are only two extremes in a rather complex and fluid process in which the nature of the provision of public services is altered. This is particularly true for social services, where markets and competition cannot easily be installed, and where the sale of public assets to private investors may not be easy for political reasons. In such cases, supporters of liberalisation and privatisation often look for alternative methods to achieve similar effects. The healthcare sector stands out because it comprises a wide range of processes that amount to a shift towards marketisation, including the introduction of buyer-purchaser relationships and prices, the pricing and individualisation of risks, the introduction of choice and consumer behaviour and the introduction of private business management tools and
goals, as well as the greater involvement of private actors through public-private partnerships, or privatisation.\textsuperscript{16}

All these developments have in common that they contribute in one way or another to the creation of healthcare markets, which itself is a precondition for the commodification of health care.\textsuperscript{17} Although the changes vary between countries and between different areas of healthcare provision, they can nevertheless be grouped into those affecting the financing of health care and others affecting its provision.

\textit{Changes in healthcare financing}

While total healthcare spending has increased in the 1990s after a temporary slowdown in the 1980s, the proportion of public health care expenditure as a percentage of total health expenditure decreased in the majority of European countries between 1980 and 2005.\textsuperscript{18} Among the countries that experienced the greatest proportional reductions are Sweden, the Netherlands, Spain, Greece and the new member states in Central Eastern Europe (CEE). However, while in Greece public healthcare spending accounts for barely more than 43 per cent of total healthcare spending, in Sweden the proportion is still 84.6 per cent and therefore among the highest in Europe.\textsuperscript{19}

The relative decrease in public healthcare spending went hand in hand with the increasing importance of private health insurance. Today private health insurance schemes are particularly important in the Netherlands, where in 2005 they accounted for at least 23 per cent of total healthcare financing, followed by France and Germany, where private insurance covered 13 and 10 per cent of total spending respectively.\textsuperscript{20}

Private insurance schemes are generally more important in countries with Bismarck-type social insurance funds. Some of these systems exclude particular groups, which are then dependent on private insurance, or they allow certain groups to choose between public or private insurance.\textsuperscript{21} In these cases private insurance functions as a \textit{substitute} for public health insurance. However, rather than substituting for public insurance, private insurance schemes are more often \textit{supplementary} to the public system, covering services excluded from, or not fully covered by, the public system, or for co-payments (fees payable by patients). Such schemes play an important role in France, where in 2000 85 per cent of the population were covered by supplementary health insurance; in the Netherlands, where more than 60 per cent had additional private insurance; and in Belgium, where the proportion was somewhere between 30 and 50 per cent.\textsuperscript{22}

The growing importance of supplementary health insurance in Europe is reinforced by another important trend: the ‘de-listing’ of treatments and
medication hitherto covered by public health insurance. The classic case
in all countries is dental care, which is now largely financed by private
insurance or by out-of-pocket payments (sometimes euphemistically called
‘cost-sharing’). Except for the Netherlands and France (the only country
where they have decreased since 1980), out-of-pocket payments are in fact
more important than private insurance in closing the financial gap left by
diminishing public resources.\(^{23}\) They are particularly important in Belgium,
Italy, Portugal and Spain, where in 2005 they accounted for more than 20
per cent of total health expenditures.\(^{24}\) Out-of-pocket payments have also
become an important source for covering healthcare costs after the regime
change in central and eastern Europe. In Hungary and Poland in 2005 they
accounted for 26 per cent of total health expenditure.\(^{25}\) However, in addition
to formal co-payments, patients in some central and east European countries
are also expected to pay ‘informal’ fees, and patients in public hospitals pay
‘tokens of gratitude’ for adequate treatment.\(^{26}\)

In addition to increasing competition from private insurers, in some
countries public or social health insurance funds have been forced to
compete with each other for customers. In the Netherlands the government
introduced a reform of the insurance system in 2006 enabling insurance
holders to switch insurers (public or private) and to select between individual
insurance plans. The government hopes that patients will profit from
competition between insurers, who are expected to lower premiums and
expand coverage in order to protect or expand their market share. In turn,
insurance funds are allowed to negotiate special contracts with particular
healthcare providers and require their clients to seek treatment at particular
facilities where they can negotiate better terms.\(^{27}\) These changes have already
triggered further liberalisation in the hospital sector, including a plan to lift
the existing ban on for-profit hospital care in 2012.\(^{28}\)

While the introduction of competition between different insurance funds
is typical of social insurance fund systems, in tax-based systems an important
trend has been a division between those charged with funding services,
and those providing them – the so-called ‘purchaser-provider split’. The
objective is on the one hand to improve control over spending, and on the
other to increase the autonomy and responsibility of the healthcare provider
in the interest of efficiency. In the British case this entailed a far-reaching
reorganisation of the NHS as an ‘internal market’. Hospitals and some
community health services were organised into semi-autonomous ‘trusts’,
and hospital trusts were no longer granted fixed annual budgets but were
expected to win contracts from decentralised ‘commissioning’ organisations
(the ‘purchasers’), acting for the Department of Health.\(^{29}\) The autonomy of a
The growing number of hospitals has since been further increased through making them ‘foundation trusts’, no longer accountable to the Department of Health but to a new healthcare market regulator: foundation trusts are allowed to generate income through establishing commercial arms or engaging in joint commercial ventures with private companies, and to borrow funds on the private financial market. It is intended that all NHS trusts will eventually have foundation status.

There are similar developments in other Beveridge-type health systems. In Sweden regional councils have created separate purchasing organisations for the funding of local hospitals, while the hospitals were granted more autonomy. In contrast to the British system, where hospitals have retained a special legal status (trusts and foundation trusts) even though they are expected to act more and more like independent businesses, in Sweden and other countries public hospitals have been converted into public limited companies. Having the legal status of private businesses has in turn facilitated the emergence of larger hospital networks, cooperation with private businesses and in some cases even the sale of public hospitals to private investors. The system of funding itself has also been altered in connection with the separation of funding and provision. In most European countries hospitals have been given global budgets for infrastructure maintenance and investment, with the effect that hospitals are forced to set spending priorities. On the other hand, compensation for the costs of treatments is increasingly based on flat-rate payments set for each procedure and category of patients (Diagnosis-Related Groups), rather than for the costs actually incurred in treating a particular patient. DRG systems have increasingly become a way to put pressure on hospitals to reduce costs through a reduction of the average length of stay in hospital – since compensation is the same regardless of the actual length of stay there is a financial incentive to discharge patients as early as possible. About a quarter of physicians interviewed in a German hospital said they believed that patients were often discharged too early.

In sum, the changes in healthcare financing, although not necessarily entailing a shift from a public to a private system, have profoundly altered the way health care is delivered in many European countries.

Changes in healthcare provision

While changes in financing have had a lasting effect on the provision of health care, the consequences have not necessarily been the same everywhere. In a number of countries cost containment led to a wave of decentralisation, with hospitals becoming increasingly independent. This, for example, has been an important element in successive healthcare reforms
in Sweden. In other countries the need for rationalisation had the opposite effect, with smaller hospitals being integrated into larger units or larger, centrally-controlled hospital networks. As a result of a wave of hospital mergers in Belgium, including mergers between public and private non-profit organisations, more than half of all hospitals have disappeared since 1981. In Germany, 10 per cent of all hospitals have been closed since 1990, eliminating 134,232 hospital beds. While the reduction in hospital bed numbers can partly be explained by technological developments such as day surgery, and the fact that smaller hospitals have often found it difficult to afford increasingly specialised and expensive medical equipment, the process has been accelerated by the financial problems caused by the changes in the funding schemes described earlier.

The most radical form of privatisation in healthcare provision is the sale of public hospitals to private investors. A number of countries have experimented with the privatisation of public hospitals. One of the oldest hospitals in Sweden, Saint Görans Hospital in Stockholm, with about 1,500 workers, was privatised in 1999. It is now owned by the Swedish healthcare multinational Capio. Several other hospitals, most of them in the Stockholm region, have been turned into independent commercial organisations, although they are still owned by regional governments. In 2002 this trend was, however, put on hold with the adoption of the ‘Stop Law’ initiated by the Social Democrats, prohibiting the sale of further hospitals to for-profit owners.

In Austria, two public hospitals have been sold to private investors. But Germany stands out as the one country in Europe where the sale of public hospitals has been carried out on a large scale and in a systematic way. Between 1991 and 2004 the number of private hospitals in Germany increased from 14.8 to 25.4 per cent of the total, while the share of public hospitals decreased from 46 to 36 per cent (the rest consisting of private non-profit institutions). Private for-profit hospitals tend to be smaller. In 2004 the public sector still accounted for 52.8 per cent of all hospital beds and employed nearly 60 per cent of all hospital workers. Yet more recently Germany has faced a number of stunning takeovers involving large and prestigious hospitals, including the takeover in 2005 of the seven local hospitals of the city of Hamburg (Landesbetrieb Krankenhäuser) with 5,688 beds, and in 2006 the university clinics of Marburg and Gießen with more than 2,400 beds. The wave of hospital privatisation is expected to continue. It is estimated that by 2020 between 40 and 50 per cent of German hospitals will be in private hands.

While in western Europe large public hospitals have been privatised, in
central and eastern Europe new private hospitals have been built. In the Czech Republic the number of private hospitals grew from 64 in 2000 to 122 in 2007, and in Poland from 38 in 2000 to 153 in 2006. These hospitals mainly treat patients who have private insurance, or sufficient personal funds, which means that only a small proportion of the population can afford them. In Poland in 2006, for example, private clinics (profit and non-profit combined) accounted for only 5.6 per cent of all hospital beds.

The purchaser-provider split and the increasing autonomy given to hospitals have been complemented by internal restructuring. In the British case, hospital departments became individual ‘cost centres’ charging for each completed procedure (significantly augmenting administrative work). This created a financial incentive to invest in the most profitable parts of a hospital, even if it was not the most important from the point of view of the local population’s health needs. Hospitals, or in some cases single units within hospitals, were increasingly obliged to ‘assess all [their] costs as if [they] stood alone, like a small or medium-sized business’. The creation of internal markets is a widespread development affecting hospital organisation across Europe.

The growing fragmentation of healthcare services and the introduction of prices paved the way for outsourcing and public–private partnerships. Initially outsourcing was limited to secondary services such as cleaning, portering and catering, gradually followed by more and more sophisticated services such as information technology and accounting. In recent years, however, an increasing number of medical services have been contracted out to the private sector. In Britain the government started a programme to set up new treatment centres specialising in a number of fairly standardised types of non-emergency surgery such as hip replacements. The idea was that the high degree of specialisation and the elimination of interruptions caused by emergency work would allow these centres to operate more efficiently and thereby help to reduce waiting times for elective surgery. The first treatment centres were operated by the NHS, but in 2002 the government started to invite private healthcare companies to establish additional so-called ‘independent sector’ – in practice, private for-profit – treatment centres (ISTCs). The official rationale was that the private sector would bring in additional capacity and perform the procedures ‘at competitive unit costs’ – the implication being that they would be cheaper than the NHS. In July 2007, 24 ISTCs operated by seven companies were up and running.

But far from helping to reduce costs, there is strong evidence that the cost of treatments in privately-run treatment centres has been higher than the standard tariffs paid to NHS hospitals for the same procedures. Similarly, the
predicted contribution of additional capacity turned out to be misleading. While private operators of independent treatment centres were initially barred from hiring NHS staff, the rules have been relaxed and qualified staff drawn from NHS hospitals, rather than brought in from elsewhere as initially envisaged, while the loss of patient income to the private centres destabilised NHS hospital finances. The real aim of the ISTC programme can be seen in retrospect to have been to use the public’s concern over waiting times to break the previous taboo on introducing private companies into the provision of NHS clinical care. The programme eventually evolved into a so-called ‘Extended Choice Network’ of some 150 private hospitals and clinics that now treat NHS-funded patients, and was also quickly succeeded by the extensive introduction of private firms into the provision of primary care in England.

Long-term outsourcing contracts can also result in what is described as Public Private Partnerships (PPPs). Like outsourcing, PPPs have become increasingly popular in the organisation of health care provision. PPPs can take different forms. In Austria, for example, several public hospitals are run in cooperation with private hospital companies and a number of new hospitals with private involvement are planned. One regional government disclosed plans to hire a private hospital company to manage its 21 provincial hospitals, with a total of some 13,000 employees. The plan had to be abandoned because of public resistance, but one of the bidders received a well-remunerated multi-year consultancy contract. The city of Vienna’s Hospital Association has recently established a joint venture with the regional social insurance fund and a private non-profit hospital with the aim of building a new dialysis centre. Because the centre will be managed by the private partner its employees will be covered by the less expensive (and so less favourable) private hospital collective agreement.

A special form of public–private partnership is the private finance initiative (PFI). Private capital has been involved in building (or refurbishing) and maintaining public hospitals in a number of countries, and notably in Spain, but nowhere has this policy has been pursued more vigorously and systematically than in the UK. The role of the private partners in PFI projects includes not just financing but also the design and construction of hospital buildings as well as the operation of services such as maintenance, catering, cleaning and security. Once the facility is up and running, the PFI consortium charges the public contractor – typically an NHS hospital trust – an annual fee during the 25- to 30-year lifetime of the project.

Since 1997 nearly all new NHS hospitals in England have been financed under the PFI. The main argument made in favour of the PFI is that
it allows the public sector to transfer risk to private capital, in particular making sure that project costs and deadlines are met. There are doubts about the transfer of risks, partly due to the questionable way in which the risks have been calculated, but also in view of the long duration of PFI contracts, which in several cases have had to be re-negotiated in order to adapt them to changing circumstances, causing additional costs. Furthermore, in contrast to government claims there is no evidence that private-sector involvement actually reduces time- and cost-overruns in hospital construction. Above all there is substantial evidence that total PFI costs are significantly higher than if the same project had been financed by regular public borrowing. The higher-than-expected yearly payments affect the provision of services, as hospitals struggling to meet their obligatory leasing payments have to cut services. The average reduction of hospital beds in the first wave of hospitals entering into PFI projects was 30 per cent, while the number of clinical staff was cut by 25 per cent.

A corollary of commercialisation in the European hospital sector is the emergence of European healthcare multinationals. In Germany it has resulted in the formation of four major private hospital chains through a series of mergers and acquisitions. The largest takeover so far took place when the dialysis-specialist Fresenius acquired the Helios group in 2005. Fresenius operates more than 2,000 dialysis centres around the world. Helios owned 58 hospitals with 15,800 beds and 27,000 employees. Foreign investors were also attracted by the privatisation of German hospitals. The Swedish Capio Group acquired Deutsche Kliniken GmbH in August 2006, and then in November of the same year a majority shareholding in Capio was bought by the British private equity fund Apax. As well as owning Saint Görans Hospital in Stockholm, Capio operates hospitals and other health institutions in at least five other EU member states. In Spain Capio is the largest private hospital operator, and in France Capio Santé is the second largest. In the UK the company owns 21 hospitals. Capio’s new owner Apax also holds shares in the South African healthcare giant Netcare. In Europe Netcare is primarily active in Britain as the owner of the largest private hospital operator, BMI Healthcare, with 49 hospitals. Apax and Nordic Capital also own shares in the French private hospital chain Vedici. However, Vedici and Capio Santé still fall considerably short of the 206 hospitals owned by Générale de Santé, the largest private hospital operator in France and one of the largest in Europe. In addition there are also a number of healthcare firms that have focused their activities on Central Eastern Europe. Swedish Medicover, for example, offers private insurance and private healthcare services. It is active in Poland, Romania and the Czech Republic. Another example of western healthcare
companies reaching into central and eastern Europe is Euromedic. Although the company headquarters is in the Netherlands it is owned by the American private equity funds Warburg Pincus and GE Capital. Euromedic operates in twelve countries, including Hungary, Bosnia-Herzegovina, Romania, the Czech Republic, Croatia and Russia.

**THE ROLE OF THE EUROPEAN UNION**

Member states have always been reluctant to cede their control over social and health policies to the European Union. With regard to health care, the European Treaty only mentions public health and demands that Community action and national policies should ‘be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health’. (Article 152, §1). Otherwise the EU has no mandate to interfere in national healthcare systems. However, the freedom of member states to design and administer their national health services increasingly conflicts with the ‘four freedoms’ that are the cornerstone of the European integration process: the free movement of goods, persons, capital and services. While member states have argued that health care is not an economic activity and should therefore not be subjected to economic rules, the European Court of Justice has repeatedly stated the opposite by judging in favour of patients who have gone to another country for treatment and applied for public reimbursement at home.\(^56\) The European Commission followed this interpretation by including rules on cross-border health services in the 2004 draft directive on services in the internal market (which became widely known as the Bolkestein Directive). Not least because of the strong public support that exists for non-commercial healthcare services, the directive met fierce resistance with a series of large public demonstrations and protests across Europe in 2005. The European Parliament subsequently voted to completely remove health care from the scope of the directive, and the Commission conceded this in early 2006.

At the same time, however, the Commission announced that it would propose a separate directive on health services. Since then the Commission has come forward with at least two proposals. Its latest proposal, of July 2008, focuses solely on cross-border health care, although only a very limited number of patients so far go abroad for treatment.\(^57\)

It is telling that the legal base for this draft directive is exclusively derived from the internal market provision (§95) of the European Treaty.\(^58\) The Commission argues that access to cross-border health care will greatly expand the choices of patients in Europe. Notwithstanding the small number of patients who up to 2008 had sought treatment outside their home countries,
the directive is important because it addresses the more fundamental question of whether healthcare systems should be planned and administered by public organisations, or should be left to be shaped by market forces. Cross-border health care poses a serious threat to healthcare provision because it erodes the capacity of national, regional and local governments to plan it. With the promotion of cross-border health care, demand will be increasingly dependent on external factors which member states themselves cannot control or even influence (such as, for example, the healthcare budgets of neighbouring countries). Conversely, the possibility of sending patients abroad may induce some countries to export their healthcare problems to others. Rich western European countries may attempt to solve their financing problem by sending patients to southern or eastern Europe, where treatments are significantly cheaper, while the populations of these countries in turn may be deprived of medical attention if the available resources are increasingly used to treat well-paying patients from abroad.

At the same time it must be questioned whose choices will increase as a result of being able to go to another country for treatment. Those who leave their home country for health treatments are most likely those who are able and accustomed to travel and live abroad, and who have families that can accompany them. Obviously, these are people at the upper end of the income scale. In contrast the choices of those who are not mobile, for language and cultural reasons, and who are dependent on neighbourhood support, may actually shrink as a result of local services becoming increasingly under-funded. Such patients will tend to be on low incomes. Hence liberalisation and deregulation of health care in Europe will likely fuel differences between countries and within countries, undermining the solidarity on which European healthcare systems are built.

While promoting cross-border health care provision, the European Union is also increasing pressure on member states to reform their national healthcare systems. Because it cannot do so directly it uses the open method of coordination (OMC) initially invented to streamline European social and employment policies. In a nutshell, the open method of coordination is a mode of governance based on the identification and dissemination of ‘best-practice’ examples. It is also a ‘soft-law’ approach. Countries are only advised to introduce certain measures; they cannot be forced to implement them. But because each national health system is a unique and extremely complex arrangement it is very difficult if not impossible to develop a set of common benchmarks to compare and evaluate them. Similarly problematic is the idea that a measure adopted in one system will have the same effect in a different institutional environment in another country. Because of these difficulties,
the only viable criterion of comparison for the European Commission is the impact on public budgets. Accordingly, it regards healthcare reforms as successful if they help to reduce costs or to shift costs from public to private funding, no matter what the consequences may be for the quality and accessibility of health care. Guideline No 2 of the Broad Economic Policy Guidelines for 2005-08 states that ‘Member states should, in view of the projected costs of ageing populations … reform and re-enforce pension, social insurance and health care systems to ensure that they are financially viable, socially adequate and accessible’. In reality, however, financial viability as perceived by the European Council and the Commission renders healthcare services increasingly inadequate and limits access for low income earners.

CONCLUSION

Marketisation of health care in Europe takes a variety of forms. Changes that can be associated with the shift towards a market-based provision of health care include the reduction of the share of public financing in total healthcare financing and, related to this, the increasing role of private insurance schemes and out-of-pocket payments; competition between different insurance providers, including competition between social insurance funds; a split between funding and provision of health care; the increasing autonomy of healthcare providers coupled with growing competition between providers and flat-rate-based compensation; decentralisation and concentration; the sale of public hospitals to private investors and the building of new private hospitals; and the creation of internal markets, outsourcing, PPP and the PFI. In several countries, these changes have been introduced on the basis of the claim that they will increase patients’ choice. In all countries they were meant to reduce healthcare costs. But the effect of the reforms has been not so much a reduction of costs as a shift from public to private healthcare spending. Increasing healthcare costs – in most countries the proportion of GDP spent on health care has continued to increase – are not considered a problem as long as they do not weigh on public budgets. The shift from public to private healthcare financing is not least the result of pressure from the European Union to reduce public deficits and to streamline national healthcare policies.

The most notable consequence of the shift towards private healthcare financing is the erosion of the redistribution built into the Bismarck and Beveridge systems of public healthcare financing. Private insurance premiums and out-of-pocket payments are the same for all citizens regardless of their income, with the effect that as a proportion of their income private healthcare
 premiums and out-of-pocket-payments are substantially higher for people on low incomes. However, marketisation not only amplifies inequality, it may also actually increase total expenditures. Research shows that private insurers have significantly higher administration costs than their public counterparts.\textsuperscript{63} Given their higher costs, it is difficult to see how private insurers can offer better coverage for less money unless they are allowed to offer different premiums to different risk groups. This again disadvantages those who are already at the bottom of the income scale. In the same way private hospitals can be more efficient than public operators mainly because they specialise in highly standardised low-risk procedures, while the more complicated cases are left to the public system. While private investors have therefore focused on small hospitals, the recent takeovers in Germany are attempts to make profits out of larger general hospitals. It is not clear yet if this strategy will pay off, but the input of long overdue investment, the reduction of staff numbers and the subsequent intensification of work, the payment of lower wages to nurses and non-managerial and non-medical personnel, as well as a move to outsource as many internal services as possible, have helped private owners to rapidly cut operational deficits.\textsuperscript{64} In addition to evidence from individual privatisation cases, national statistics show that private hospitals in Germany tend to operate with lower ratios of staff to beds. In 2007 the average ratio in private for-profit hospitals was 25 per cent lower than in public hospitals.\textsuperscript{65} The lower staff-to-patient ratio naturally increases the intensity of work (in hospitals the potential for greater rationalisation, other than in administration, is very limited). The intensification of work is typically accompanied by a greater division of labour, with the result that patients are confronted with frequently changing staff members, easily giving them the impression – perhaps with reason – that they are not being properly looked after. Not surprisingly five out of the six privatised hospitals in Hamburg were among the lowest-ranked clinics in a 2007 patient survey.\textsuperscript{66} The introduction of the PFI in British NHS hospitals has had a similar effect, with the important difference that in order to pay for their up to 70 per cent higher-than-expected PFI costs, NHS hospitals not only cut staff but also reduced bed numbers.

In any case, while the effects of marketisation on quality and access remain debated, it is clear that private capital has profited in many ways from the marketisation and commodification of health care in Europe. Profits derive from holding shares in the new European healthcare multinationals, from private–public partnerships, including the UK’s now notorious Private Finance Initiative, from outsourced services, from the provision of highly standardised elective surgery and the treatment of well-off patients with
private insurance, as well as from supplementary private insurance schemes that cover additional expenses and the costs of ‘de-listed’ services, while the basic and larger costs are covered by public funds or by the provision of new private insurance plans that charge customers according to the potential health risks they are carrying.

NOTES

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1 According to OECD Health Data, the US spent 15 per cent of its GDP on health care in 2006 whereas the ‘old’ EU 15 (15 western European countries) spent on average only 9 per cent. In terms of dollars per capita the US spent more than twice the average of the EU 15.

2 In Belgium and the Netherlands most hospitals are private non-profit, mostly affiliated with one of the major churches.


5 In the case of social insurance funds, some countries have a maximum contribution rate: above a certain income the contributions remain the same even for rich people.


7 John Lister, The NHS after 60. For Patients or For Profits?, London: Middlesex University Press, 2008, p. 27.


11 Both developments have resulted in a continuously falling proportion of wages as a percentage of GDP. See Simone Leibner, ‘Pragmatic Change in Social


There are, however, cases in Germany where public hospitals have been sold to private investors despite fierce resistance from local populations, and despite a majority of citizens voting against privatisation in local ballots. See Nils Böhlke, ‘The Impact of Hospital Privatisation on Industrial Relations and Employees: The Case of the Hamburg Hospitals’, Work Organisation Labour & Globalisation, 2(2), Autumn 2008.


Exceptions are Austria and Portugal, where public expenditures as a proportion of total expenditures actually increased between 1980 and 2005. This was also true, from the late 1990s, in the UK, due to the Labour government’s large increases in funding for the NHS, especially after the year 2000.


Ibid.


Ibid.

Out-of-pocket-payments include direct payments (payments for goods and services that are not covered by insurance), co-payments (insured patients are
required to cover parts of the costs for treatment and medication, which is also
referred to as user charges), and informal payments for preferential treatment.
See Nadia Jemiai, Sarah Thomson and Elias Mossialos, ‘An Overview of Cost
Sharing for Health Services in the European Union’, Euro Observer, 6(3),

24 André and Hermann, ‘Privatisation and Marketisation’.
25 Ibid.
26 Wieslawa Kozek, ‘Liberalisation, Privatisation and Regulation in the Polish
pique.at.
27 Hans Maarse and Ruud Ter Meulen, ‘Consumer Choice in Dutch Health
28 Hans Maarse, ‘Health reform – one year after implementation’. Health Policy
29 Allyson Pollock, NHS plc: The Privatisation of Our Health Care, London: Verso,
2005.
30 Monika Andersson, ‘Sweden’, Sozialpolitik in Diskussion No 5 (Privatisierung
von Gesundheit – Blick über die Grenzen), 2007, p. 69.
31 Sebastian Klinke and Rolf Müller, Auswirkungen der DRGs auf die
Arbeitsbedingungen, das berufliche Selbstverständnis und die Versorgungsqualität aus
Sicht hessischer Krankenhausärzte, ZES-Arbeitspapier No 4/2008, University of
Bremen, p. 91.
32 Dent, Remodelling Hospitals, p. 52.
33 Koen Verhoest and Justine Sys (2006): ‘Liberalisation, Privatisation and
Regulation in the Belgian Healthcare Sector/Hospitals’, Report produced
for the PIQUE project, http://www.pique.at/reports/pubs/PIQUE_
CountryReports_Health_Belgium_November2006.pdf.
34 Schulten, ‘Germany’, p. 36.
36 Martin Rümmele, ‘Die Privatisierung von Gesundheitsseinrichtungen und ihre
Privatisierung von Krankenhäusern. Gegenstrategien aus gewerkschaftlicher und
zivilgesellschaftlicher Perspektive, Hamburg: VSA Verlag, forthcoming.
39 Gröschl-Bahr and Stumpfögger, ‘Krankenhäuser’.
41 Ibid., p. 9.
42 Ulrike Papouschek und Nils Böhlke, Strukturwandl und Arbeitsbeziehungen
im Gesundheitswesen in Tschechien, Deutschland, Polen und Österreich, FORBA –
43 Pollock, NHS PLC, pp. 110ff.
44 Ibid., pp. 45-46.
45 Stewart Player and Colin Leys, Confuse & Conceal: The NHS and Independent
47 Ines Hofbauer, ‘Österreich’, *Sozialpolitik in Diskussion*, 5, pp. 31-2; Rümmel, ‘Die Privatisierung von Gesundheitseinrichtungen’.


49 In Wales and Scotland, where regional parliaments have become responsible for health policy as a result of devolution, enthusiasm for the PFI in the hospital sector has been less (see Lister, *The NHS after 60*, pp. 209ff). In particular the Scottish government has shown a growing willingness to re-examine existing PFI projects, whereas in England the authorities have repeatedly refused to disclose essential information (Allyson Pollock, ‘Finance Capital and Privatisation’, public lecture, Vienna, 23 April 2009). In general, many if not quite all of the privatisation measures described here for the UK apply to England only.


55 The frequent takeovers of hospitals in Germany alerted the Federal Cartel Office, which has repeatedly objected to the sale of public hospitals to particular buyers. In the case of Hamburg, for example, the new owner Asklepios was ordered to resell one of the seven hospitals to a competing private hospital provider (Schulten, ‘Germany’, p. 45).


58 An attempt to expand the legal basis of the directive by referencing public health as a second source for the legitimacy of the proposed measures was voted down in the European Parliament on 23 April 2009.

59 Dräger, ‘Bolkestein durch die Hintertür’.


65 Ibid. p. 170; Statistisches Bundesamt, ‘Grunddaten der Krankenhäuser 2007’ (Fachserie 12, Reihe 6.1.1), Table 2.3.3 (Personalbelastungszahlen nach Krankenhaustypen), Wiesbaden, 2008.