Economic Integration vs. Social Policy? The case of changing schemes of healthcare systems in the EU

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Abstract: The European Union (EU) has long been the most developed model of economic and political integration that has brought a common market, a common currency and a standardization of national policies in certain areas in consistent with EU values and principles for Sustainable Development. To this direction, there is a parallel process of social integration that effect public policy decisions of member states. Even though social policy, i.e. social protection and moreover healthcare policy, still remains in state's responsibility to develop, EU applies different mechanisms in order to influence health policy regimes since from a more federalist point of view, EU ought to expand its regulatory and legislative roles in as many policy areas as possible. The purpose of this research paper is to discuss the above issues and provide an insight on the impact of economic integration in formulating market oriented national healthcare systems.

Keywords: Economic Integration, European Union, Health Care Systems, Social Policy

Introduction

Healthcare provision in Europe has been challenged through EU-level policy pressures directed by the European model of economic and political integration. Moreover, resent economic and social challenges, such as population ageing, the economic crisis and the migration crisis guided reforms in healthcare systems that emphasize on decentralised decision-making initiatives, private provision, universal access and patient choice improvement. Although the overall tendency is not one of convergence towards a unique European model, neither one of persisting divergence, where traditional models simply keep growing apart, EU-level legal framework has an indirect impact on the development of the health care systems in EU countries. The purpose of this research paper is to identify whether there is a common social dimension in healthcare which is consistent with EU values and principles and to what extend this common social dimension affects Healthcare systems in EU countries.

Materials and Methods

Systematic literature review was conducted on EU binding legal documents (regulations, directives and decisions), non-binding documents (resolutions, opinions), other documents (EU institutions' internal regulations, EU action programmes, etc.) and research articles on healthcare policy issues. Data extraction and synthesis was performed with the use of thematic analysis in order to identify to what extend EU policies influence directly or indirectly healthcare provision in member states. The findings of this procedure, categorized into EU Binding legal instruments, EU Non-binding legal instruments, EU monitoring and assessment instruments and Instruments for co-financing, are presented in the first part of this paper.

In the second part of this research paper a comparative analysis was conducted. Comparative analysis of countries is a traditional approach in political science that has been widely used to study regimes and institutions. For the purposes of this current study, four countries were selected based on the Gosta Esping-Andersen's welfare state models. Owing to the fact that research in health care systems taxonomy is limited compared to the welfare state regimes research, Gosta Esping-Andersen's welfare state "ideal" types is the starting point for health care system classification. In his work "The three worlds of welfare capitalism" Andersen presents a typology that leads to the division of welfare states into three ideal welfare states regimes

the Liberal, the Conservative and the Social Democratic. Welfare state taxonomy research featured "prototypes" welfare state regimes, countries with a welfare state structure very close to the ideal types [1]. According to the literature the UK represents the Liberal regime, Germany the Conservative and Sweden the Social Democratic regime. An ongoing debate and the burgeoning comparative social policy literature revealed similar taxonomies. For instance, according to Bonoli, Ferrera and Liebfreid the Latin rim countries of the European Union (Spain, Portugal, Greece) represent a fourth type of welfare state regimes the Nordic type [2].
For the purposes of this research healthcare reforms in the representative countries, according to the literature, UK, Germany, Sweden and Greece of the welfare state regimes in Europe (Liberal, Conservative and Social Democratic and Nordic) are analyzed in order to reveal the characteristics of health care systems today. As a tool for comparison and analytical description of the health systems, a matrix was developed that contemplates the dimensions of EU policy interventions in health care systems development regarding six parameters, population coverage, decentralization of the healthcare system, state of ownership of the healthcare units, funding of healthcare system, the share of private sector in healthcare and doctor's right to practice medicine privately.

EU Binding legal instruments

Health policy and health care provision still remains on member states authority. While there is little to no European regulation or legislation directly aimed at influencing national healthcare policy, other areas of European regulation or legislation may indirectly affect national healthcare policy and systems formulation.
For instance, article 168 of the *Treaty on the Functioning of the European Union* gives the basis for the EU public health policy provision. According to the core legal document of EU, a high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities (article 168, paragraph 1) [3].

Moreover, the Union shall encourage cooperation between the Member States to improve the complementarity of their health services in cross-border areas (article 168, paragraph 2). At the same time, it makes it clear that the Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organization and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them (article 168, paragraph 7).

Furthermore, the *Charter of Fundamental Rights of the European Union* is referring to health care on article 35 where it is stated that everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities. Article 35 of the Charter of Fundamental Rights of the European Union recognizes that everyone has right of access to medical treatment and preventive healthcare under the conditions established by national laws and practices [4].

The arrival of the internal market and later the sovereign debt crisis in Europe incorporates health into the laws and policies of the internal market and causes remarkable institutional transformations that gives EU's institutions substantial new powers and a mission to enforce tough fiscal constraints on member states. The new fiscal and economic governance in the EU imposes a structure built that promotes economic stability through austerity.

The *Directive on Cross-border health care* reveals the above tendency. National concerns about the effect of internal market ruling resulted in the High Level Reflection Process on patient's mobility [5]. Patient's mobility and movement of professionals (EU Directives for free movement of health professionals) are areas where action in EU level can affect national healthcare systems.

Moreover, the *Directive 2011/24/EU "on the Application of Patients' Rights in Cross-Border Healthcare*, clarifies legal issues connected to the access of EU citizens to healthcare outside their home Member State. Despite the fact that there is still a lack of clarity about which "health services" are covered, the Directive still represents an important development in the growing role of the EU in healthcare sector by regulating patients' right in cross-border healthcare while preserving member states' right to organize their own healthcare systems [6].
The Directive does not directly encourage any convergence of standards in healthcare but Member States are required to adopt quality standards for the purpose of cross-border healthcare. Article 4(1) of the Directive also refers to the obligation of the Member States to take into account the principles of universality, access to good quality care, equity and solidarity when providing cross-border healthcare. This could mean that Member States are required to provide healthcare of a certain minimum quality level, and could even be to provide healthcare of a higher standard. In a European internal market for healthcare services, such an exchange could eventually result in a need for a European definition of quality of care.

EU Non-binding legal instruments

EU non-binding legal institutions and other bodies plays a significant role in setting up the EU agenda in healthcare provision.
In 2011, the *Council of Health Ministers* established an EU-level reflection process to help Member States provide modern, responsive and sustainable health systems [7].

In December 2013, the Council of Health Ministers endorsed the progress made and called for further work in this area, in its conclusions on the 'reflection process on modern, responsive and sustainable health systems' [8].

The *European Commission* supports the efforts of EU countries to protect and improve the health of their citizens and to ensure the accessibility, effectiveness and resilience of their health systems. This is done through various means, such as proposing legislation (the most important legislation is the Patients' rights in cross-border healthcare), as well as providing financial support, coordinating and facilitating the exchange of best practices between EU countries and health experts, health promotion activities.

In particular, on 20 February 2013 the European Commission adopted the Social Investment Package (SIP), a policy framework consisted of a series of non-binding documents, including a document titled *"Investing in Health"*, as a response to the economic crisis, threatening the achievement of the EU2020 poverty and employment targets. The Commission encouraged member states to invest in health in order to achieve smart sustainable and inclusive growth. This investment could be succeeded by promoting effective, accessible and resilient health systems. Member states were also recommended to invest in health through disease prevention, health promotion and by fostering health coverage as a way of reducing inequalities and tackling social exclusion [9].

Moreover, in 2014 in the document *"Communication from the Commission on effective, accessible and resilient health systems"* the Commission observes, especially after the entry into force of the Directive on cross-border healthcare, that health systems in Europe increasingly interact with each other. Due to the challenges health systems are facing, such as, the increasing cost of healthcare and the population ageing, the Commission points out that the effectiveness of the systems must be strengthened as well as the accessibility of the systems (affordable and available for all). Moreover, since there are differences between the depth of coverage in publicly financed healthcare systems, the European Commission identifies the need of the modern systems to remain accessible and effective while pursuing long-term sustainability. To do this, they have to remain fiscally sustainable. The Commission supports Member States, providing analysis and forecasts, and recommending reforms as part of the European Semester process [10]. The Commission also identifies resilience factors that helped some health systems safeguard accessible and effective healthcare services for their population by encourage member states to use European funding instruments. Moreover, the Commission proposes an EU agenda with a number of cooperation mechanisms to support national reforms and to improve the performance of health systems in the EU. Mechanisms include eHealth and digital health, health system performance assessment, workforce planning, European reference networks, etc.

The setting up on 2012 of an *expert panel by the Commission's Decision 2012/C 198/06* is also an important step for achieving smart sustainable and inclusive growth. The mission of the panel is to provide the Commission, upon its request, with independent and multisectoral advice on effective ways of investing in health in the fields of expertise [11].

In many cases the expert panel's opinions support common policies and common actions in health care provision and in some cases promotes private sector initiatives in order to strengthen health care provision within EU area.
Particularly, in the expert's panel opinion of 7th May 2015 on "Competition among health care providers - Investigating policy options in the European Union" it is stated that in the right context, introducing competition may help member states to meet some health system objectives. The introduction of competition in the provision of health care requires additional policy actions aimed at allowing the market to function properly followed by a careful, permanent evaluation of effects on relevant dimensions (qualities, prices, etc.) [12].

Moreover, in their report for "Benchmarking access to healthcare in the EU" the expert panel notices inequalities between member states in citizen's access to healthcare. Particularly in some countries that have duplicative private health insurance (e.g. in Italy, Spain and the UK) patients with private health insurance are able to get treatment after shorter waits and are able to choose their doctor. The panel is taking into account the fact that the right for access to healthcare as it is ensured in the European Pillar of Social Rights, fall under the competence of the EU, the Member States and social partners and provides guidance and a tool which could be used by Member States to progress on closing their gaps in access to healthcare. It also suggests that the

member states could facilitate exchange of good practice and investment in areas that can help reduce unmet need for healthcare [13]. It is also recommended to member states to analyze the effects of health reforms in relation to access, efficiency, equity, quality and sustainability and not only "cost-saving" as well as to identify violations of the human rights. It is also suggested to apply a common tool (template) that would generate evidence that can be the basis of discussion of health policies within the European Semester process. The template would enable policy-makers to evaluate the impact of reforms on coverage, equity, quality, efficiency, and availability of resources [14].

In "Health and Economic Analysis for an Evaluation of the Public- Private Partnerships in Health Care Delivery across Europe" opinion and in relation to the recommendation on the use of Structural Funds the expert panel concludes that only after having obtained evidence of the comparative advantages of current PPP-long term concessions, would the use of Structural Funds for this kind of investment be justified [15].

In "Best practices and potential pitfalls in public health sector commissioning from private providers" opinion the panel encourages member states to learn from other countries example such as UK and Sweden on commissioning in health care from private providers in order not to repeat mistakes. Moreover, The EU could facilitate more knowledge in this area and the spread of this knowledge to EU Member States considering introducing commissioning from private providers in their health care sector [16].

The *Committee of the Regions* in an opinion adopted at the plenary session of March 2017 of regarding Integration, cooperation and performance of health systems, the Committee emphasizes the role of adequate and sustainable funding of care in guaranteeing good coverage, access and quality.

The Committee of the Regions also underlined the importance of identifying local and regional organisational models that have proved to work effectively. European Commission is very much open to further discussions with the Committee of the Regions in the context of developing a more permanent infrastructure to meaningfully identify best practice examples for future iterations of the State of Health in the European Union cycle.

Mario Monti, a former European commissioner, on his report on a new strategy for the Single Market that was published on 2010, recommended that a number of supporting actions should be taken in order to foster market integration in the health sector. The Commission should launch, together with the Member States a detailed benchmarking of health systems across the European Union [17].

European Commission's Directorate-General for Economic and Financial Affairs and the Economic Policy Committee with a Joint Report on healthcare and long-term care systems (2016) identified a number of areas where improvements could increase the cost-effectiveness of health systems in the medium and long-term and their long-term sustainability. Appropriate policy levers include: Improving the governance of the systems, promoting the sustainability and efficiency of financing and expenditure, improving access, quality and effectiveness of care.

On 30 of April 2019 ahead of the meeting of EU27 leaders in Sibiu, Romania, on 9 May 2019 the European Commission set out a number of policy recommendations for how Europe can shape its future in an increasingly multipolar and uncertain world. On the recommendations for a competitive Europe the Commission emphasize on the need to make further progress on convergence between the economic, fiscal and social policies of Member States. Furthermore, the need for high-quality, affordable and accessible health care through the digital transformation of health systems is highlighted [18].

EU monitoring and assessment instruments

Health systems monitoring and assessment was introduced in 2004 as part of the open method of coordination.
The EU developed the *Open Method of Coordination* (OMC) a new governance mechanism that applied as well in social policies The OMC has been gradually introduced in the 1990s, in order to develop a European employment strategy by coordinating Member States' economic and fiscal policies, but since the Lisbon treatment of 2000, it is also applied to areas of social protection and social inclusion. The OMC is based on iterative benchmarking of national progress toward Community objectives, while still allowing the Member States to choose their own preferred approach to achieve these commonly agreed objectives [19]. Health was not directly included in the social investment agenda, but it was soon recognized that the goal of making Europe 'the most competitive and dynamic knowledge-based economy in the world' would depend crucially on the fiscal sustainability of European welfare states and in particular of their health systems.

The first health OMC was launched in October 2004 and resulted in the first European health strategy, published in 2007. In the *White paper 'Together for Health A Strategic Approach for the EU 2008–2013'*, the EC emphasizes on the unique European challenge of demographic aging and pointes out three strategic objectives: (1) fostering good health in an aging Europe; (2) protecting citizens from health threats; and (3) support

dynamic health systems and new technologies by the development of a Community framework for safe, high quality and efficient health services [20]. In order to develop this Framework, the Commission started to conduct its own health system analyses across European countries, in close collaboration with the OECD and the WHO. In collaboration with the Economic Policy Committee, the Commission published the Joint Report on Health Systems, which focused on the drivers of health expenditures beyond demographics through a series of detailed analyses of the organizational features of Member States' health systems. In the report which aims to understand the drivers of health expenditure and therefore expenditure differences across EU Member States was observed that differences between countries are narrowing due to a general trend towards convergence, with the largest increases over time occurring in countries with the lowest initial levels of health spending [21].

Whereas coordination, within the several processes of the OMC, was initially conceived to ensure soft convergence and to exchange best practices between Member States, the implementation of the European Semester changed its purpose. Coordination in this framework seeks to ensure the surveillance of national policies and their compatibility with budgetary requirements [22].

The EU has strengthened its monitoring capacity and its economic policy cycle by means of the introduction of the so-called *European Semester.* Its procedures build on, but also reformulate, the EU's pre-existing processes of fiscal, economic, employment and social policy co-ordination, as these had developed during the 1990s and 2000s, including the Stability and Growth Pact (SGP), the Lisbon Strategy and the Social Open Method of Co-ordination (OMC). The Stability and Growth Pact was established at the same time as the single currency in order to ensure sound public finances. However, as shown during the crisis, its enforcement did not prevent the emergence of serious fiscal imbalances in some Member States [23].

Since the outbreak of the Global financial crisis in 2008, the rules concerning the SGP have seriously been reinforced and complemented with a new venue for the European Council and the Commission to interfere with Member States' fiscal policies. Global financial crisis has resulted in a more enduring venue for the Commission to intervene in Member States' health systems' reforms through the annual budget cycle [24].

The European Semester was introduced in 2010. Each year the Commission publishes an Annual Growth Survey in which the targets of Europe2020 are translated into operational priorities, which are then to be translated in the National Reform Programs of the Member States. On the basis of these national reports, the Commission adopts a set of Country Specific Recommendations. The manner in which these recommendations are implemented by the Member States is closely monitored and the results of this monitor feed on their turn the next Annual Growth Survey.

Health care provision is affected by this procedure directly and indirectly. In 2012 Council Recommendations on the "Implementation of the broad guidelines for the economic policies of the Member States whose currency is the euro" is pointed out that reforms of long-term entitlements, in particular health and pensions, are urgently needed, to underpin the long-term sustainability of public finances [25].

In Council Recommendations on "Germany's 2012 national reform programme and delivering a Council opinion on Germany's Stability Programme for 2012-2016", is pointed out that despite the fact that the Federal Government has taken measures to improve the efficiency of public spending on healthcare and has proposed a reform of long-term care, additional efforts to improve efficiency in health care are necessary to contain expected further expenditure increases [26].

In the 2013 Annual Growth Survey it is recognized that in the context of the demographic challenges and the pressure on age-related expenditure, reforms of healthcare systems should be undertaken to ensure cost-effectiveness and sustainability, assessing the performance of these systems against the twin aim of a more efficient use of public resources and access to high quality healthcare [27].

Moreover, in the 2014 Annual Growth Survey where the top priority is to build growth and competitiveness, the Commission is making proposals to strengthen the social dimension of European Monetary Union (EMU). A well-functioning monetary union requires flexible markets and appropriate institutions to address the social situation and provide adequate national safety nets. Additionally, coordination and surveillance of employment and social policies should be reinforced within EMU governance, and convergence in these areas should be promoted [28].

In 2017 Annual Growth Survey it is pointed out that Member States need to continue to reform their health systems, thus ensuring universal access to cost effective public health and healthcare services. Protecting the population from falling into poverty or social exclusion due to ill-health and related expenditure is essential, both from a social and economic view-point [29].

According to the 2017 European Semester: Country Specific Recommendations, healthcare is an area in which progress has been slower. A combination of pension reforms, labor market policies, lifelong learning and health

policies is required to support a more active older population. Investment in public housing, education, health and social services should grow in those countries where there is room to increase public expenditure. Applying procurement procedures transparently and appropriately should help to maximise efficiency in the use of public sector budget resources [30].

Furthermore, in 2018 Annual Growth Survey it is pointed out that targeted investment in areas such as infrastructure, education, training, health, research, digital innovation and the circular economy can increase both productivity and employment. Reforms of health care and long-term care systems need to be pursued to enhance their cost-effectiveness, ensure their fiscal sustainability and ensure quality, affordable access [31].

In 2018 European Semester: country-specific recommendations it is pointed out that reforms of the pension, healthcare and long-term care systems are key reforms to ensure long-term sustainability of public finances. Health systems need to be reformed to offset the impact of an ageing population and to improve access to healthcare. The Commission is aware of the fact that many Member States have recently undertaken a number of reforms of their healthcare systems in order to increase cost-effectiveness, financial sustainability, resilience, affordability and accessibility and improve the health status of their populations. Recommendations though encourage Member States to further implement recently adopted or soon-to-be-agreed reforms for better cost-effectiveness and accessibility in Cyprus, Finland, Lithuania and Slovenia, take decisive action to ensure adequate and efficient budgeting in Portugal, increase fiscal sustainability and cost-effectiveness in Malta, Austria and Ireland, strengthen primary and outpatient care in Latvia, Lithuania and Romania, invest in disease prevention in Lithuania, improve the situation regarding health workforce in Bulgaria and Slovakia and reduce out-of-pocket payments in Bulgaria and Latvia [32].

According to the 2019 Annual Growth Survey to ensure fiscal sustainability and maintain universal access to quality healthcare, Member States need to increase cost-effectiveness by investing in innovation, improving the integration of healthcare at the primary, specialized outpatient and hospital care levels and strengthening links with social care to meet the needs of an ageing population [33].

In addition, in 2019 European Semester: country-specific recommendations it is pointed out that the government debt remains high in several Member States. It is pointed out that the impact of an ageing population poses additional challenges and calls for continued reforms of the healthcare systems to increase efficiency, effectiveness and adequacy and preserve their long-term fiscal sustainability. Member States are forced to continue their efforts, giving priority to the careful design of comprehensive measures and to stepping up the adoption and implementation of health service delivery reforms. Recommendations to improve effectiveness, accessibility and sustainability of health care are addressed to Austria, Bulgaria, Cyprus, the Czech Republic, Greece, Finland, Hungary, Italy, Latvia, Lithuania, Malta, Poland, Romania, Slovakia and Slovenia [34].

As we can see next to the goals of economic integration and the creation of the European Monetary Union (EMU), the EU develops a social policy frame. The Lisbon Strategy and its purpose to make Europe "the most competitive and dynamic knowledge-based economy in the world, capable of sustainable economic growth with more and better jobs and greater social cohesion", was the first integrated agenda of the EU that gave equal weight to full employment and social cohesion, alongside economic growth and competiveness, on the acknowledgment that social policy essentially should be conceived of as a productive factor for economic growth. The Europe 2020 strategy that followed presents a social market economy model. The core EU policy “social investment” aimed at reconciling social policy goals with economic goals in the EU.

Instruments for co-financing

In addition to the social policy frame developed through legal, and other instruments, the EU provided financial support to member states in order to promote public health, health care, equity and solidarity through actions under the different objectives and encourage the exchange of good practices. The first Programme of EUR 312 000 000, was adopted with the decision No 1786/2002/EC of the European Parliament and of the Council of 23 September 2002 adopting a programme of Community action in the field of public health (2003-2008) [35]. Afterwards, the second programme of EUR 321 500 000 was adopted with the decision No 1350/2007/EC of the European Parliament and the Council of 23 October 2007 establishing a second programme of Community action in the field of health (2008-2013) [36]. The third programme of EUR 449 394 000 was adopted with the Regulation No 282/2014 of the European Parliament and of the Council of 11 March 2014 on the establishment of a third Programme for the Union’s action in the field of health (2014-2020) and the repealing Decision No 1350/2007/EC [37].

Moreover, the Horizon 2020 research programme supports projects in areas such as biotechnology and medical technologies. EU cohesion policy supports investments in health in EU countries and regions. In the 2021-2027 multi-annual financial framework the European Commission plans to boost funding to improve workers' employment opportunities, and strengthen social cohesion through an enlarged 'European Social Fund Plus'. The

fund would also incorporate finance for the stand-alone health programme, with the aim of creating synergies with other financing areas, such as, equal opportunities and access to the labor market; fair working conditions; and social protection and inclusion [38].

Health care reforms in Germany, United Kingdom, Sweden and Greece

In the second part of this research the most significant healthcare reforms in UK, Germany, Sweden and Greece are presented regarding six parameters, population coverage, decentralization of the healthcare system, state of ownership of the healthcare units, funding of healthcare system, the share of private sector in healthcare and doctor' s right to practice medicine privately. Findings are summarized in table 1.

Health care reforms in Germany

Population Coverage

The statutory health insurance system in Germany was established with the Health Insurance Act of 1883. Chancellor Otto von Bismarck had created a welfare state based on solidarity and self-governance where insured people were entitled to free ambulatory care, medication, glasses and other medical aids and devices [39]. Alternatively, sickness funds could offer their members coverage of inpatient treatment. The 1883 act also defined the areas in which individual sickness funds could extend benefits, such as providing coverage to non-working dependants, increasing cash benefits, extending the maximum duration of sick pay to as much as one year, and offering additional benefits in-kind, including what today would be classified as complementary and alternative remedies. The breadth of coverage of the Bismarckian system has been extended since 1883 either by increasing the income ceiling for mandatory membership or by adding new occupational groups to the sickness fund system, such as white-collar workers from the transport and commercial sectors (1901), domestic servants, agricultural and forestry workers (1914) and farmers (1972).

With the Health Care Structure Act of 1993 on reform of the health care structure, people covered by SHI have free choice of sickness funds, and are all entitled to a comprehensive range of benefits [40]. Moreover, the 2007 Act to Strengthen Competition in SHI provided universal insurance coverage for all residents either a Social Health Insurance coverage or Private Health Insurance coverage [39]. Since 2009, health insurance has been mandatory for all citizens and permanent residents, through either statutory or private health insurance.

Funding of healthcare system

In the German health care system, decision-making powers are traditionally shared between national (federal) and state (Land) levels, with much power delegated to self-governing bodies. The German health care system is financed through a dual financing system. According to this system, the state is responsible for capital investment, whereas the sickness funds pay for operating costs, including those associated with salaries, the provision of services, and (since the late 1990s) building maintenance and repair. Before the Health Care Structure Act of 1993, hospital care expenditures were on a base of daily medical expenses. The law introduces a new way of financing the flat rate per medical treatment that depends in the medical diagnosis. The law also gave almost every person covered by SHI the right to choose between sickness funds and to switch to a new sickness fund on a yearly basis with three months' notice. In 1997, with the 1st and 2nd SHI Restructuring Acts cost-sharing was notably increased for drugs, preventive spa treatments and rehabilitation. Denture treatments were completely removed from the benefit package for everyone born after 1978.

With the 2002 Health Insurance Reform Act diagnosis related groups - DRG system was introduced in which the funding of hospitals is based. Under the same Act individuals have the right to choose a supplementary private insurance. In 2004, all acute hospitals were required to gradually implement a transition from general budget system to a price system. In 2004, co-payments and other out-of-pocket payments increased substantially for SHI-covered patients through the SHI Modernization Act. Co-payment amounts were increased and standardized to €10 per inpatient day and to €5–€10 for services and products in ambulatory care [40].

Moreover, the Act to Strengthen Competition in SHI in 2007 gave Social Funds greater purchasing power and the ability to offer market – based contracts while requiring private companies to offer services on Social Health Insurance terms.

Decentralization degree

The German public healthcare system is a highly decentralized system, with 16 municipalities (called Länder) sharing responsibility with the government for hospital planning, building and the upkeep of technical facilities. State-regulated health insurance providers and patients then fund the operating costs.

In 2004, self-governance was strengthened with the establishment of the Federal Joint Committee, a major payer–provider structure with responsibilities to distribute health care, benefits coverage, coordination of care

across sectors, quality, and efficiency [43]. The reform of 2012 revised some of the responsibilities of the municipalities and Länder, taking further steps towards decentralization.

Share of private sector in healthcare

As for the private sector involvement, in Germany there are public hospitals operating by the Municipalities or the Federal State, private non-profit or private for-profit hospitals operating by the church or non-profit organizations. With the 1981 Cost Containment Amendment Act the day cost for hospital services became subject of collective bargaining between representatives of sickness funds and hospitals. The law also introduces incentives to limit the number of hospitals and beds while envisaging some additional cuts to the allowance list. In 1986 the responsibility for investing in hospitals even private hospitals remains public responsibility. Public hospitals gained additional rights to provide outpatient healthcare with the 1997 1st & 2nd Statutory Health Insurance Restructuring Act. In 2004 the law on modernization of the system allowed the operation of primary care polyclinics.

State of ownership of the healthcare units

According to the Hospital Financing Act of 1985 hospital investment is in the responsibility of the State governments rather than being shared between the State and Federal government. There are three types of hospital ownership in Germany: public hospitals, non-profit hospitals and for-profit hospitals. There are also several different provider types for hospital care: general hospitals, university hospitals, focus clinics and specialized hospitals. The primary care in German health care system is private and hospitals are public (about 48% of beds), private non-profit (about 35%) and private for-profit entities (about 17%).

The Act to Strengthen SHI Health Care Provision gave municipalities the right to establish medical treatment centers and the patients the right to see a specialist within 4 weeks.

Doctor's right to practice medicine privately

Concerning doctor's right to practice private medicine, till 1993 private doctors were not allowed to work in hospitals or hospitals doctors did not have the right to practice private medicine. With the Health Care Structure Act of 1993 reform the two sections are connected. Patients have the right to choose their doctor or the hospital to be treated.

Health care reforms in the United Kingdom

Population coverage

The United Kingdom's health care system was established in 1946 with the National Health Service Act as a national system available to all residents at the point of use with no charge [42].

The English NHS saw in the early 1990s the introduction of the notion of "internal market", with competition between providers of health care but not between "health insurance". The late 1990s had an end to this "internal market" experience, with a move to a system with an emphasis on quality but not on price, with "prices" (tariffs) set by the Department of Health. Policy changes, in the mid-2000s, aimed at increasing patient choice and competition for hospital care generated evidence that better hospitals attracted more patients, that sicker patients responded more to quality differences in providers, that more patient choice did not end in increased inequalities, that some increase in productive efficiency resulted, that no impact on financial performance and on waiting times was found. The overall assessment is that pro-choice policies were able to deliver some positive effects even with only some patients actually exerting that choice. More recently, the Health and Social Care Act of 2012, brought further changes to the English National Health Service in the direction of further patient choice [41]. The patient choice policies adopted in Denmark, England, the Netherlands and Sweden share a common view of empowering patients and of market competition as the instrument to achieve it.

The 2014 Care Act defines how patients' needs should be identified and met and the right to be evaluated by everyone, including carers and patients.

Funding of healthcare system

The NHS is funded through general taxation and National Insurance Contributions. A small share comes from private medical insurance, in addition to out-of-pocket payments: direct payments for goods and private services and some co-payments for pharmaceuticals, dental care and ophthalmic care. The National Health Services and Social Care Act (1990) introduced the "internal market", which separated the purchasing ("commissioning") and provision of health care services across the United Kingdom [43].

The Health act of 1999 allowed the Secretary of State to increase funding to Health Care Authorities when they achieve certain goals.

Moreover, with the Health and Social Care (Reform) Act in 2009, the structures of health and social care was rearranged in an effort to streamline services and decrease the amount of administration cost of each service. With the Act the system of direct payments for health services was introduced in order to give patients greater control over the services they receive. Finally, a system of best practices award for health services providers was introduced [44].

Decentralization degree

The NHS is planned centrally with decentralized management of hospitals. The National Health Service act of 1946 gave the structure of a three part health care system where the primary health care covered by General Practitioners that had contracts and were paid with a cost per patient. The hospital care that was organized by 14 regional hospital board. And local authorities that are responsible for public health, vaccination programmes etc.

In 1974 the NHS in England and Wales was reorganized according to the National Health Service Reorganization Act 1973, resulting in the creation of regional health authorities, area health authorities and Family Practitioner Committees. The aim was to create organizations with defined responsibilities for populations (rather than hospitals), and to tackle the tripartite division between hospitals, primary care and community health services that had been a feature of the system since 1948. In 1982 a new decentralized system is introduced and the role or the local health authorities took 192 District Health Authorities.

With the White Paper "Equity and excellence: liberating the NHS", which led to the Health and Social Care Act 2012, England included decentralization of decision-making, choice and competition in the commissioning (i.e. strategic purchasing) of care, and meeting performance targets as stated goals. Scotland, on the other hand, maintains a national approach and formally emphasizes cooperation, collaboration and partnership over competition. It also makes meeting performance targets a priority.

Share of private sector in healthcare

The private sector has a significant role in the British health care system. In 1990 the National Health Service and Social Care Act, introduced the "internal market", which separated the purchasing (commissioning) and provision of health care services across the United Kingdom. Providers are the hospitals and the general family doctors and purchasers are the District Health Authorities, the Family Health Service Authority, the Family Practitioner Committees and the family doctors. The hospitals are self-governed entities that receive funding from the health regions or from the associations of general practitioners.

The goal was to increase the efficiency and quality of services by drawing on the principles of a competitive market. Under the same law, general practitioner (GP) fundholding, was introduced which means that GP practices with 11 000 or more patients could apply for their own NHS budgets to cover their staff costs, prescribing, outpatient care, and a defined range of hospital services, largely elective surgery.

The Health Act of 1999 created a duty of cooperation between NHS bodies and local authorities, which made it easier to purchase or provide care jointly, such as by pooling resources, delegating functions and resources to one another, and acting as a single provider of services [45]. Moreover, the 2001 act for social care gave the right to the Secretary of State to take part in public private partnerships with private health providers.

The Health and Social Care Act in 2012, furthermore removed some of the barriers for commissioners to purchase services from NHS trusts, the private sector, or the voluntary sector to provide NHS-funded services.
The contracting of private service providers in England under the same law could also be framed as a form of privatization, and although the volume of services provided in the private sector remains small relative to service provision by NHS providers, it is growing, mostly in community and mental health services.

State of ownership of the healthcare units

The primary care in UK is mainly covered by private GPs but there is also unlimited number of NHS-owned practices with salaried physicians. Hospitals are mostly public entities managed by NHS trusts or foundation trusts. Under the National Health Service Act of 1946 hospitals were managed by hospital management committees under regional hospital boards. According to the National Health Services Act of 2006 private healthcare can be provided either on private hospitals or in private units inside NHS hospitals.

Doctor's right to practice medicine privately

Concerning doctor's right to practice private medicine, most of general practitioners are self-employed doctors contracting with the Primary Care Trusts. In 1989 when General Practitioners became fund holders, they also have the right to provide their services to patients on their list as well as their own private patients.

Health care reforms in Sweden

Population coverage

Since 2010 and according to the Health and Medical Services Act of 2010, the Swedish system provides coverage for all residents of Sweden, regardless of nationality. In addition, emergency coverage is provided to all patients from the EU and European Economic Area countries, and nine other countries with which Sweden has bilateral agreements. The services available are highly subsidized and some services are provided free of charge.

Since 1995 patients have the right to choose their public or state funded private hospital [46]. On 2013 the emergency hospital care and maternity care was available also for the illegal immigrants. The 2017 law on Health and Health Services regulates health care so it is not necessary to be provided by the public administration while setting a timetable within which health services should be provided. According to the same law, the aim of health coverage is to provide good quality of health, equally to the whole population.

Decentralization degree

Decentralization of responsibilities within the Swedish health care system refers not only between central and local government, but also within each county council. During the latter part of the 1990s and the 2000s there have been efforts towards strengthening national influence again, partly driven by the need to better coordinate care and to reduce regional differences.

Local self-government has a very long tradition in Sweden and is intended to create opportunities for development in service provision throughout the country. Since the 1970s, financial responsibility has gradually been decentralized to providers within each county council. The county councils' financial and planning responsibility for health care services is clearly articulated in the 1982 Health and Medical Services Act, and has been further reflected in decentralization efforts within each county council. Previous national policies of decentralization have been replaced by the reverse trend of centralization and regionalization in the delivery of care during the 2000s [47].

With the 1992 ADEL reform the responsibility for hospital care and care for the elderly was transferred from Country Councils to the Regional Authorities.

Since the responsibility for provision of care is decentralized to the 21 county councils and regions the conditions for accreditation vary throughout the country. Regarding the 2009 Act on Freedom of Choice in the Public Sector, it is regulated by law that freedom of establishment applies to all (public and private) health care providers that fulfil the requirements decided by the local county council.

Funding of healthcare system

Health care in Sweden is largely financed by taxation (almost 80% of the cost). National subsidies as well as private funding (less than1%) cover the rest of the costs. Both the county councils and the municipalities levy proportional income taxes on the population to cover the services that they provide.

In 1985, the Dagmar Reform changed the basis of health insurance reimbursement for ambulatory care since this was to be paid directly to county councils. The reforms launched in 1992 were intended to reinforce the role of the patient within the system who is now free to choose his doctor, health center or hospital not only from local suppliers but also outside the area of responsibility or even individuals since now "money follows the patient".

Share of private sector in healthcare

In the 90s the role of private sector was significant in the health care system of Sweden. In 1994, the Family Doctor Act and the Act on Freedom to Establish Private Practice were introduced. However, both these acts were withdrawn in 1995, before they were fully implemented. Even though the acts were withdrawn after a short period of time, several counties had already started to make changes and in some cases continued with reforms as planned.

The reforms included the purchaser–provider split, new contracts for providers and increased choice of provider for inhabitants. In 1992, the responsibility for long-term inpatient health care and care for older people was transferred from the county councils to the municipalities.

In 2000 the stop law was introduced by national government to prevent privatization of emergency hospitals to profit-making companies across county councils. In 2007 the law was abolished.

In 2008 with the Act on Systems of Choice in the Public Sector, patient has the right to choose primary care provider. The cost of services is regulated, considering the demand for the same provider, by the public administration. Patients can register with any public or private provider accredited by the local county council and registration based on latest visit or shortest geographical distance is practiced in most county councils for individuals who do not make an active choice of provide.

Doctors and other staff are paid a salary while private doctors who have a contract, are paid by service. The Primary Care Choice Reform of 2010 supported innovation and private entrepreneurship, introduced quality assurance in primary care by adopting market mechanisms such as competition and patient's choice. Moreover, private providers have the right to enter the system and compete for public funding with primary care providers.

With the Health Law of 2017 a selection system is introduced where the patient has the right to choose a provider who has been assigned by the District Council to provide the services without discrimination.

State of ownership of the healthcare units

In Sweden most hospitals operates under the responsibility of the regional boards. In some cases the administration of hospitals has been assigned to private or non-profit organizations. Primary Health Care is provided by general practitioners and health centers. Patients can choose their family doctor, health center and hospital of their choice. The Adel reform in 1992 shifted the responsibility for long term inpatient health care and social welfare services to disabled individuals and to the elderly became the responsibility of local municipalities.

Doctor's right to practice medicine privately

Concerning doctor's right to practice private medicine, the 1994 law for family doctors allowed family doctors to practice private medicine on a fee for service basis. The law was abolished in 1995 but in 2005 the law on Freedom in Private Practice allowed practitioners to practice medicine privately as well as being civil servants.

However, a small percentage of doctors are private doctors with a contract with the public or private sector. The rest of the doctors are either paid civil servants (mainly hospital staff) or paid per service (mainly general practitioners).

Health care reforms in Greece

Population coverage

The Greek National Health System was introduced in 1983 with the 1397 law of Foundation of National Health System [48]. The Greek Health care system is a mixed system comprising elements from both the public and private sectors. In the public sector, a National Health Service model of compulsory social insurance scheme exists.

Since 1893 and the introduction of Greek National Health System with the 1397 law of Foundation of National Health System, the system is based on the principles of free and equitable access to quality health services for all citizens. In 1992 with the law on Modernization and organization of the health system, the role of the state is getting weaker and becomes more regulatory [49]. Moreover, with the 2519/1997 law the protection of patient's right is becoming more significant [50]. In 2014 with the 4238/14 law, universal access to health care is established and since 2016 EOPYY, the sole purchaser of health services in Greece, covers the cost of health care treatment for the uninsured and the vulnerable groups. As we can see universal coverage is established in Greek legislation as well as the protection of patient's right [51].

The law 4368/2016 on measures to speed up government business and other provisions adopted by the Greek parliament in February 2016 establishes the right to free access to all public health facilities providing nursing and medical care for all uninsured persons, those who have lost their insurance coverage and are not entitled to health benefits due to debts to the pension funds, and vulnerable social groups [52].

Funding of healthcare system

The health care system in Greece is financed by a mix of public and private resources. Today, the system is open to the free market, has a central planning and out of pocket payments are one of the mail sources of funding [53]. According to the core law of National Health System (1397/1983) the NHS is financed by social insurance contributions and the state budget. In the 90s however, there was a tendency for liberating the health system by decentralizing several areas such as the source of financing. For instance, with 2071/1992 law for the "Establishment of a National Health System", the District Administrative Regions were set responsible for

financing the regional Health Centers of their area. In 1997 with 2519/97 law on "Development and modernization of the National Health System and other provisions", the financing structure is again reregulated. The NHS health units are financed by the state budget, social insurance contributions, private insurance contributions and private payments. The Social Insurance funds are also free to co-operate in order to contract with the Ministry of Health and private hospitals [54]. In 2001 with 2889/2001 law the afternoon outpatient clinics in public hospitals were introduced where doctors offered care to private patients on a fee-for-service basis [55].

The most significant reforms were introduced in 2010 with 3868/10 law on “Improvement and Reconstruction of the National Health System”. A ceiling on public expenditure on health was set, which translated into cuts in pharmaceutical expenditure, as well as health care services, staff salaries, etc [56]. The law came as a result of the severe debt crisis in the history of Greece which led in 2010 to the signing of a Memorandum of Economic and Financial Policies with the so-called “Troika” comprising by the European Commission, the European Central Bank and the International Monetary Fund.

Moreover, in the same sense of reducing health care expenditures, EOPYY was created in 2011 representing a major shift towards a single-payer health insurance system, replacing the health insurance funds that previously covered the population. EOPYY acted as the sole purchaser of medicines and health care services for all those insured [57]. The user fees was also introduced for outpatient and emergency visits, which were later abolished.

Decentralization degree

Decentralization of National Health System has been a key issue since its inception in 1983. Reform legislation in 2001 and 2003 (Law 2889/2001 on the Regional Structure of Health Care Services and Law 3106/2003 on the Regional Structure of Welfare Services) established 17 regional health and welfare authorities [58]. The change in government in 2004 resulted in the abolition of the previous legislation and new provisions (Law 3329/2005 National Health and Social Solidarity System and other provisions) that created the Health District Administrations [59]. In 2007 the number of Health District Administrations was reduced to seven and in 2014 specific responsibilities over primary care facilities was formally transferred to them. Another major attempt to achieve greater decentralization of the health system occurred in 2010 in the context of the Kallikratis Plan, which reorganized the country’s administrative structure. With regard to health, certain competences were transferred from Health District Administrations to municipalities, in particular responsibility for primary health care units, the implementation of public health programmes, immunization and school health [60].

Despite the above efforts the public administration is still highly centralized, and District Health Authorities do not manage their own budgets.

Share of private sector in healthcare

The 1397 law of Foundation of National Health System turns hospitals into public bodies with the presence of private providers to be more obvious in operating diagnostic centers. The 2071/1992 law allowed non-profit hospitals to operate. The non-profit hospitals were funded by the state, operated under the rules of the private economy but under special rules set by the state. Under the same law, private practice doctors are allowed to contract with the public health insurance body.

Regarding private sector involvement in health care provision, in Greece a large part of the private sector, such as profit-making hospitals, diagnostic centers and independent practices, enters into contracts with EOPYY, providing mainly primary care for the National Health System [61].

State of ownership of the healthcare units

Since 1893 and the introduction of Greek National Health System, hospitals are not allowed to operate by the private section. Private hospitals are shut down or sold to the state. In 2014, legislation formally transferred all public primary care facilities, health centers and rural surgeries to the jurisdiction of the YPEs.

Doctor’s right to practice medicine privately

Since the introduction of 2071/1992 law, doctors in public hospitals were allowed to choose between part time or full time contract. This was abolished with the 2194/94 law of “Rebuilding of the National Health System and other provisions”. NHS doctors working in public hospitals are paid a monthly salary and are not allowed to practice private medicine but they are permitted to offer care to private patients visiting afternoon outpatient clinics of public hospitals on a fee-for-service basis. Doctors contacted by EOPYY are paid on a fee-for-service basis, which theoretically may encourage unnecessary demand for health care services.

Table 1. Significant health care reforms in Germany, United Kingdom, Sweden and Greece

	Germany	UK	Sweden	Greece
Population coverage	1883: health care system is based on solidarity and self-governance. Insured people are entitled to free ambulatory care, medication and other medical aids and devices. 1883: the income ceiling for mandatory membership is increased, new occupational groups are added to the sickness fund system. 1993: free choice of sickness funds is established. 2009: health insurance is mandatory for all citizens and permanent residents, through either statutory or private health insurance.	1946: a national system is established, available to all residents at the point of use with no charge. 2000: patient choice is becoming more significant and competition for hospital care is introduced. 2013: patient choice is reinforced. 2014: patients' needs should be identified and met. Services must be evaluated by everyone, including carers and patients.	1995: patients have the right to choose their public or state funded private hospital. 2010: coverage for all residents of Sweden, regardless of nationality. 2013: emergency hospital care and maternity care is available also for the illegal immigrants. 2017: health care is not necessary provided by the public administration. A timetable is set within which health services should be provided. The aim of health coverage is to provide good quality of health, equally to the whole population.	1893: free and equitable access to quality health services for all citizens. 1997: the protection of patient's right is becoming more significant 2014: universal access to health care is established 2016: the right to free access to all public health facilities providing nursing and medical care for all uninsured persons, those who have lost their insurance coverage and are not entitled to health benefits due to debts to the pension funds, and vulnerable social groups is established.
Decentralization degree	1972: the Federal State is responsible for investments and the States for planning. 2004: self-governance is strengthened with the establishment of the Federal Joint Committee, a major payer–provider structure with responsibilities to distribute health care, benefits coverage, coordination of care across sectors, quality, and efficiency. 2012: some responsibilities of the municipalities and Länder are revised in order to take further steps towards decentralization	1973: regional health authorities, area health authorities and Family Practitioner Committees are created. 1982: a new decentralized system is introduced with 192 District Health Authorities. 2012: decentralization of decision-making, competition in the commissioning of care and performance targets are introduced.	1970: financial responsibility is gradually been decentralized to providers within each county council. 1982: it is in the responsibility of the state councils and regional authorities to ensure the health care provision. 1992: hospital care and care for the elderly responsibility is transferred from Country Councils to the Regional Authorities	2001 & 2003: regional health authorities is established. 2005: Health District Administrations are created. 2007: the number of Health District Administrations is reduced 2014: responsibilities are formally transferred to District Administrations 2010: the country's administrative structure is reorganized 2011: single-payer health insurance system is introduced.
Healthcare system funding	1993: the flat rate per medical treatment is introduced that depends in the medical diagnosis. 1997: cost-sharing is increased for drugs and other care services. 2002: diagnosis related groups – system is introduced in which the funding of hospitals is based. 2004: co-payments and other out-of-pocket payments are increased. 2007: Social Funds have greater purchasing power and the ability to offer market – based contracts. Private companies are required to offer services on Social Health Insurance terms	1990: internal market is introduced, which separated the purchasing ("commissioning") and provision of health care services. 1999: the Secretary of State can increase funding to Health Care Authorities when they achieve certain goals. 2009: direct payments for health services is introduced in order to give patients greater control over the services they receive	1985: the basis of health insurance reimbursement is changed. Ambulatory care for the residents is paid directly to county councils. 1992: the role of the patients is becoming more significant within the system who is now free to choose his doctor, health center or hospital not only from local suppliers but also outside the area of responsibility or even individuals since "money follows the patient".	1983: the system is financed by social insurance contributions and the state budget. 1992: the District Administrative Regions were set responsible for financing the regional Health Centers of their area. 1997: The NHS health units are financed by the state budget, social and private insurance contributions and private payments. 2001: afternoon outpatient clinics in public hospitals are introduced where doctors offer care to private patients on a fee-for-service basis. 2011: single-payer health insurance system is introduced.
State of ownership of health care units	1985: hospital investment is in the responsibility of the State governments rather than being shared between the State and Federal government. 2015: Municipalities have the right to establish medical treatment centers.	1946: the Regional Hospital Boards and the Hospital Management Committees are responsible for hospitals management. 1973: the above are replaced by Regional Health Authorities & Area Health Authorities 2006: private healthcare can be provided either on private hospitals or in private units inside NHS hospitals. 2012: all hospitals and NHS trusts are expected to turn into Foundation Trusts	1992: the responsibility for long term inpatient health care and social welfare services to disabled individuals and to the elderly became the responsibility of local municipalities 2012: hospital mergers, with the creation of "hospital groups" under a joint management, were implemented	1983: Private hospitals are not allowed to operate. Private hospitals are shut down or sold to the state. 2014: all public primary care facilities, health centers and rural surgeries are transferred to the jurisdiction of the YPEs.
Share of private sector	1981: the day cost for hospital services becomes subject of collective bargaining between representatives of sickness funds and hospitals. 1986: the responsibility for investing in hospitals even private hospitals remains public responsibility. Public hospitals gained additional rights to provide outpatient healthcare. 2004: private primary care polyclinics are allowed to operate. 2007: Social Funds were granted more purchasing power and the possibility of offering market-like contracts while private companies were required to offer SHI-like services and premiums.	1990: "internal market" and General Practitioner fundholding is introduced. 1999: a duty is created for cooperation between NHS bodies and local authorities, which makes it easier to purchase or provide care jointly. 2001: the Secretary of State has the right to take part in public private partnerships with private health providers. 2012: some of the barriers for commissioners to purchase services from NHS trusts and for the private sector, or the voluntary sector to provide NHS-funded services are removed.	1994: freedom to establish private practice is introduced. Purchaser–provider split was introduced. 2000: privatization of emergency hospitals to profit-making companies across county councils is prevented. 2008: patient has the right to choose primary care provider. 2010: innovation and private entrepreneurship is supported, quality assurance in primary care by adopting market mechanisms is introduced. Private providers have the right to enter the system and compete for public funding with primary care providers. 2017: a selection system is introduced where the patient has the right to choose a provider who has been assigned by the District Council to provide the services without discrimination.	1983: private providers are allowed to operate diagnostic centers 1992: non-profit-making hospitals funded by the state are allowed to operate. Private practice doctors are allowed to contract with the public health insurance body. 2011: private sector, such as profit-making hospitals, diagnostic centers and independent practices, enters into contracts with EOPYY, providing mainly primary care for the National Health System
Doctor' s right to practice medicine privately	1993: private doctors are allowed to work in hospitals or hospitals doctors have the right to practice private medicine. Patients have the right to	1946: salaried physicians in NHS hospitals have the right to practice privately for as much as 10% of their	1994: family doctors are allowed to practice private medicine on a fee for service basis.	1992: doctors in public hospitals are allowed to choose between full or part time contract. 1994: doctors in public hospitals are

choose their doctor or the hospital to be treated	gross income. General Practitioners are in charge of primary care and act as "gatekeepers" for hospital and specialty care 1989: General Practitioners are fund holders, they also have the right to provide their services to patients on their list as well as their own private patients.	2005: practitioners are allowed to practice medicine privately as well as being civil servants.	full time employees. 2001: doctors can offer care to private patients on a fee-for-service basis in the afternoon outpatient clinics in public hospitals 2011: doctors contacted by EOPYY are paid on a fee-for-service basis, which theoretically may encourage unnecessary demand for health care services

Findings

The analysis of EU instruments and processes for identifying to what extend EU policies influence directly or indirectly healthcare provision of member states as well as the comparative analysis of health care system formulation in Germany, United Kingdom, Sweden and Greece, allows us to identify the following points that can summarize the main results of the analyses carried out and provide some tentative policy conclusions.

The European Union influence national healthcare systems significantly. The EU applies a range of regulatory and non-regulatory instruments or combinations of instruments to reach the objectives of the common market and the common currency as well as to boost European integration process.

All four healthcare systems, in order to meet the popular demands for better accessibility in health care and freedom of choice, together with the need for financial restraints, developed strategies for an increased diversity and competition created by procurement and freedom of choice. As a result in all four countries universal health coverage is established with patient's choice becoming more significant.

Germany, UK and Sweden obtained a high level of decentralization degree of their healthcare systems. In Germany the Regions, the District Authorities and the local government own and operate hospitals. Sickness funds have the responsibility to raise health care funds. In Sweden responsibility for healthcare provision is delegated to the Regions. Finally, UK preserves responsibility for raising healthcare funds to Central Government and grand other responsibilities of health care to Health Boards (owns primary care centers, contracting with hospitals, own secondary hospitals) and the private sector (GPs payment, long-term care institution ownership). In Greece thought, attempts to create more empowered decentralized regional authorities, either have not been implemented or have been substantially weakened.

The health care units are in most cases public entities with the private sector to get involved significantly. The primary care in German health care system is private and hospitals are mostly public entities, some private non-profit entities and lesser private for-profit entities. The primary care in UK is mainly covered by private GPs but there is also a limited number of NHS-owned practices with salaried physicians. Hospitals are mostly public entities. In Sweden on the other hand, most hospitals operates under the responsibility of the regional boards. In some cases the administration of hospitals has been assigned to private or non-profit organizations. Primary Health Care is provided by general practitioners and health centers. In Greece an effort has been made on order all public primary care facilities, health centers and rural surgeries to be transferred to the jurisdiction of regional health authorities.

Private sector initiatives are present in all four systems. The system of internal market and the purchaser–provider split, mostly introduced in UK and Sweden, is a policy measure implemented in the 90s in order to create competition between providers, maintain cost containment, greater efficiency, organizational flexibility, better quality and improved responsiveness of services to patient needs. In all four countries private sector enters into contracts with central or regional health authorities in order to provide health care services. Private providers have the right to enter the system and compete for public funding with primary care providers. In all four systems doctors have the right to practice private medicine either as well as being civil servants

This research has come to the conclusion that though the overall tendency for the European health care systems is not one of convergence towards a unique European model, there is a convergence tendency toward common initiatives concerning health care provision. Moreover, EU legal and regulatory instruments as well as economic and monitoring instruments does not necessarily influence the fundamentals of the national health care systems, but setts a policy framework toward efficient and sustainable national health care systems.

This policy framework developed by the European Union promotes sustainable healthcare systems of a high quality, affordable and available to all residents in the EU area. The protection of patients' rights in choosing their treatment as well as health care provider, the introduction of competition in the provision of health care, the benchmarking of healthcare policies across the EU healthcare systems in order to identify best practices, are also in the agenda of EU policy initiatives.

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