



# Symbiosis and Tension Between Profit and Purpose Across European Healthcare Systems

Emir Veledar<sup>1\*</sup>, Alejandra McGranaghan<sup>2</sup>,  
Lejla Trulja<sup>3</sup> and Peter McGranaghan<sup>4</sup>

<sup>1</sup>The University of Miami Miller School of Medicine, Miami, USA  
exv439@miami.edu

<sup>2</sup>Corvinus University School of Management, Budapest, Hungary

<sup>3</sup>University of Sarajevo, Sarajevo, Bosnia and Herzegovina

<sup>4</sup>Semmelweis University, Budapest, Hungary

\*Corresponding Author

**Abstract:** This paper examines the intricate relationship between profit-driven and purpose-driven healthcare actors within diverse European healthcare systems. It reviews how these entities coexist, identifying distinct patterns that shape their interaction and influence overall system performance. The analysis categorizes European countries into three models: Privately-Integrated Systems, Mixed-Governed Systems, and Public-Led Systems. Key findings indicate that while European healthcare is fundamentally grounded in principles of equity and universal access, the involvement of for-profit actors varies significantly. In Privately-Integrated Systems, stable coexistence is observed where roles and reimbursements are clearly defined and guided by aligned objectives. Mixed-Governed Systems balance access and flexibility through robust regulation and public funding. Conversely, Public-Led Systems, despite limited direct integration, increasingly rely on private capacity in specific areas, raising questions about efficiency and equity. The paper concludes that dynamics are not binary but reflect national priorities, institutional maturity, and policy design, critically shaping how effectively public and private sectors can serve patient-centered outcomes.

**Keywords:** for-profit actors, health policy, non-profit systems, public-private healthcare, service delivery.

## 1 Introduction

European healthcare systems are anchored in the principles of equity and universal access to high-quality care. This commitment is deeply embedded in the core values of the European Union, encompassing human dignity, freedom, equality, and solidarity (*Access to Healthcare, 2021; European Commission, 2021*). Legal frameworks, such as Article 168

of the Treaty on the Functioning of the EU (TFEU), provide the legislative foundation for proactive policy measures aimed at fostering health equity across all sectors, extending beyond traditional health policy into areas like employment, education, and environmental protection (*EuroHealthNet, 2024*). Organizations such as the European Patients' Forum (EPF) actively champion equitable access, emphasizing the vital role of patient empowerment and health literacy in addressing persistent health inequalities (*Access to Healthcare, 2021*).

Despite these fundamental ideals, the pursuit of universal access to quality healthcare for all EU citizens remains a constant challenge. The latest report, *Health at a Glance: Europe 2024*, highlights persistent disparities in unmet healthcare needs, disparities in coverage and significant health workforce shortages across the Union (OECD/European Commission, 2024). Economic downturns and persistent disparities continue to impede full realization of this objective (*Access to Healthcare, 2021*). The broader vision for European health policy aims for a "Wellbeing Economy," which recognizes and equally values not only economic capital but also human, social, natural, and cultural capital (*EuroHealthNet, 2024*).

The explicit emphasis on universal access and equity as foundational principles serves as a critical normative benchmark against which the performance and ethical implications of private sector involvement are consistently evaluated. The inherent nature of profit-driven entities, which prioritize financial returns, can create tension with these public-good objectives if not meticulously regulated. Thus, the overarching purpose of European healthcare systems, ensuring universal, equitable provision, becomes the default against which the contribution, or potential detraction, of profit-seeking endeavors is continuously assessed.

The integration of for-profit actors into European healthcare systems exhibits a wide spectrum of variation, broadly categorizing countries into distinct models. Common typologies include the Beveridge model, characterized by tax-funded, government-controlled systems prevalent in countries like the United Kingdom and Nordic nations, and the Bismarck model, which relies on social insurance, decentralization, and a mix of private and public non-profit funds, as seen in Germany, France, the Netherlands, Switzerland, and Austria (Greenhough, 2024). In practice, most health systems operate as mixed models, with both public and private sectors actively providing healthcare goods and services (World Health Organization, 2020).

In Beveridge models, healthcare services are typically provided free at the point of care, funded by taxpayers, though a limited private sector may still exist. Bismarck models, conversely, are distinguished by their decentralized structure, funding derived from mandatory employer and employee contributions, and a greater degree of individual choice among both private and public healthcare providers. The scale of private sector provision

can be substantial; the formal private sector, for instance, accounts for a large share of outpatient and inpatient services in some contexts (World Health Organization, 2020). Importantly, evidence from the European Observatory shows that while provider competition can bring efficiency gains, the benefits are not automatic and require strong regulation to prevent inequalities in access (Siciliani, Chalkley, & Gravelle, 2022).

While much of the existing research has concentrated on health inequalities or on the structural typologies of European systems, comparatively little attention has been given to how public and private actors are concretely embedded within these models. This paper addresses that gap through a focused comparative analysis. Its aim is to provide an objective assessment of how profit-driven and purpose-driven healthcare actors coexist across different European health systems. The analysis seeks to identify the patterns that shape this interaction and to evaluate their implications, with particular attention to issues of competition, complementarity, and the broader outcomes for system performance and population health.

A growing body of scholarship examines the interaction between profit incentives and public-interest objectives in mixed health systems. Classical welfare economics highlights the inherent tension between allocative efficiency and equity when private actors operate within services defined as public goods. New Public Management (NPM) and post-NPM governance theories further argue that introducing private incentives into publicly financed sectors requires sufficiently strong regulatory oversight to mitigate “mission drift” and maintain universalism. More recent work on hybrid organizations and public-private partnerships suggests that profit and purpose are not necessarily mutually exclusive; rather, their alignment depends on the institutional design of governance mechanisms, ownership structures, and the regulatory strength of the state.

This study adopts this theoretical lens by conceptualizing the relationship between profit-oriented and purpose-driven actors as a dynamic governance problem. Instead of treating private sector participation as a binary choice, the analysis interprets it as a continuum shaped by state capacity, financing arrangements, and political values embedded within the health system. This framework enables a scientific examination of how different European systems structure incentives, regulate private provision, and maintain- or fail to maintain- equitable access.

---

## 2 Methods

While the practical relevance of understanding how profit-driven and purpose-driven actors interact is clear, the paper reframes this issue as a scientific problem centered on identifying the institutional mechanisms that shape this interaction. The research question thus becomes:

Under what governance conditions do profit-oriented actors contribute to, rather than detract from, equity in European health systems?

This reframing situates the analysis within comparative political economy and health governance scholarship, enabling systematic evaluation rather than normative argument. The three-type framework (privately integrated, mixed-governed, publicly led) functions not merely as a practical typology but as an analytical device for testing theoretical expectations about the relationship between incentives, regulation, and equity.

### 2.1.1 Comparative Case Study Approach: Selection and Grouping of European Countries

This study is based on secondary data and adopts a comparative case study approach to examine the integration of for-profit actors within European healthcare systems. Building on cross-country evidence and previous comparative analyses of European health systems, countries were selected and grouped into three distinct categories according to the scale and nature of for-profit involvement in their healthcare landscapes. This structured grouping provides a clearer lens through which to analyze how different foundational models shape the balance between profit and purpose, and how regulatory frameworks adapt to varying levels of private sector integration.

The three categories are defined as follows:

- **Privately-Integrated Systems:** Characterized by a significant and often central role for for-profit actors, frequently involving mandatory private health insurance or a strong market-based approach to healthcare provision. The Netherlands and Switzerland are representative examples.
- **Mixed-Governed Systems:** Defined by a regulated coexistence of public and private entities. They typically operate under social insurance models with blended public and private provision and financing. France and Austria illustrate this approach.

- **Public-Led Systems:** Predominantly funded and delivered by public entities, with private involvement limited but strategically used to complement public capacity. The United Kingdom and the Nordic countries (Denmark, Finland, Iceland, Norway, Sweden) exemplify this model.

### **2.1.2 Analytical Framework: Regulatory, Funding, and Interactional Dimensions**

Each country group is analyzed through a consistent analytical framework, focusing on three interconnected dimensions to provide a comprehensive understanding of the symbiosis and tension between profit and purpose.

- **Regulatory Frameworks:** This dimension involves an examination of the legal and policy instruments, as well as the oversight mechanisms that govern the operation, quality, and pricing of both public and private healthcare providers. This includes an assessment of licensing requirements, accreditation processes, and the specific rules designed to manage competition or foster collaboration within the system.
- **Funding Models:** This aspect analyzes how healthcare services are financed, detailing the respective roles of general taxation, mandatory social insurance contributions, private insurance premiums, and direct out-of-pocket payments by patients. The analysis explores how these diverse funding mechanisms influence provider behavior, patient access to services, and the overall financial sustainability of the system.
- **Public-Private Interaction:** This dimension investigates the nature of relationships between public and private actors. It includes an examination of contractual agreements, the prevalence and structure of public-private partnerships (PPPs), the extent of outsourcing of public services to private providers, and the degree of patient choice between public and private healthcare options. This assessment aims to determine the balance between competitive dynamics and collaborative complementarity in achieving healthcare objectives.

This multi-dimensional approach makes it possible to identify structural features that support collaboration, mitigate conflict, and ultimately shape system performance. In doing so, it offers a nuanced perspective on the interplay between profit-driven and purpose-driven elements in European healthcare.

### 3 Results: Typologies of Profit-Purpose Coexistence

#### 3.1 Privately-Integrated Systems: Defined Roles and Regulated Coexistence

These systems are characterized by substantial involvement of for-profit actors, often through mandatory private health insurance. However, this private participation is embedded within robust regulatory frameworks that clearly define roles and responsibilities, fostering a stable coexistence between profit and public purpose.

##### 3.1.1 The Netherlands: Regulated Competition and Universal Coverage

The Netherlands operates a decentralized health system that relies on competing private health insurers and private providers to deliver care, yet it achieves broad universal coverage, extending to 99.9% of its population (*Netherlands Health System Information*, n.d.). The foundational philosophy of the Dutch healthcare system rests on principles of universal access, solidarity through compulsory medical insurance, and the provision of high-quality health services (*The Dutch Health Care System | National Health Care Institute*, 2025). This system is governed by a framework of key legislation, including the Health Insurance Act and the Long-Term Care Act. Within this structure, private health insurance companies play a pivotal role, operating under a model of "regulated competition" and adhering to specific public requirements (*The Dutch Health Care System | National Health Care Institute*, 2025). It is notable that most Dutch health insurance companies function as non-profit cooperatives for their basic insurance offerings, channeling any surpluses into required reserves or returning them to policyholders through lower premiums (*The Dutch Health Care System | National Health Care Institute*, 2025).

Financially, the system is predominantly publicly funded, with public sources accounting for 85% of health expenditure in 2021, resulting in comparatively low out-of-pocket spending, which stood at 9.3% of total health expenditure in the same year (*The Netherlands: Health System Summary 2024 | European Observatory on Health Systems and Policies*, 2024). A sophisticated risk-adjustment system is in place to equitably allocate funds among the competing private insurers, ensuring that they can effectively purchase curative care regardless of the risk profile of their enrolled population (*Netherlands Health System Information*, n.d.). The government retains significant oversight, setting the scope of benefits and available resources, and possessing the authority to intervene in cases of overspending (*Netherlands Health System Information*, n.d.). The system also incorporates a strict general practitioner (GP) gatekeeper mechanism, requiring patient referrals for specialist and hospital care, although patients retain the freedom to choose their hospital (*Netherlands Health System Information*, n.d.). Reimbursement for medicines is

meticulously regulated through the Medicine Reimbursement System (GVS), which includes limits for interchangeable products to manage costs (*Reimbursement of Outpatient Medicines* | *National Health Care Institute*, 2024). Furthermore, public-private partnerships (PPPs) are actively encouraged within the Life Sciences & Health sector. These collaborations are designed to accelerate innovation, enhance resource efficiency, foster knowledge sharing, and ultimately contribute to the accessibility, affordability, and quality of healthcare (Health~Holland, n.d.).

The Dutch model illustrates that substantial private sector involvement, particularly through competing private insurers, can effectively coexist with universal coverage and equity. This is achieved through strong, centralized government regulation and a non-profit mandate for basic insurance. The "regulated competition" framework is instrumental in directing profit motives towards achieving broader public health goals. This approach does not eliminate profit but rather channels and constrains it to serve public policy objectives, thereby demonstrating a stable form of coexistence where roles and reimbursements are clearly defined.

### 3.1.2 Switzerland: Mandatory Private Insurance and Subsidized Access

Switzerland operates a universal healthcare system regulated under the Swiss Federal Law on Health Insurance, which mandates compulsory private health insurance coverage for all residents (Mohajer-Bastami et al., 2025; Sturny, 2020). Unlike many European systems, the Swiss model does not provide free state-funded healthcare services; instead, insurers are legally required to offer basic insurance to all applicants regardless of age or health status. Basic insurance schemes function on a non-profit basis, while insurers are allowed to operate for-profit supplemental plans offering additional coverage options (Mohajer-Bastami et al., 2025). Patients bear the cost of insurance premiums along with an annual deductible, which ranges from CHF 300 to CHF 2,500, plus a 10% co-payment for costs exceeding the deductible, capped at CHF 700 annually (Mohajer-Bastami et al., 2025). To promote affordability, federal subsidies are available to low-income individuals whose premiums exceed 8% of their income. Despite comprehensive mandatory coverage, over 80% of the population elect supplemental private insurance, which provides benefits such as private hospital rooms, choice of physicians, and reduced waiting times for elective procedures (Sturny, 2020). Pharmaceutical reimbursement is governed through the Specialties List (SL) and individual case assessments, with the Federal Office of Public Health (FOPH) overseeing evaluations of medicines based on efficacy, medical appropriateness, and cost-effectiveness criteria (Indermitte, 2024). Switzerland exemplifies a system in which compulsory private insurance, combined with rigorous regulations ensuring non-profit operation for basic coverage and targeted government subsidies, achieves universal access while fostering competition and consumer choice. Profit-making activities are largely limited to supplemental services, clearly delineating the roles within the system. This structure, supported by established reimbursement mechanisms and regulatory transparency, facilitates a stable balance between fulfilling public healthcare needs and offering enhanced services driven by market demand (Table 1).

**Table 1.** Comparative Features of Privately Integrated Systems (Netherlands, Switzerland)

Feature	Netherlands	Switzerland
System Model	Regulated Competition (Bismarck-like)	Bismarck Model
Funding Mechanism (Primary)	Compulsory Private Health Insurance (Social Insurance for long-term care) <sup>1</sup>	Compulsory Private Health Insurance <sup>3</sup>
Key Regulatory Body	Zorginstituut Nederland, NZa, Government <sup>1</sup>	Federal Office of Public Health (FOPH), Swissmedic, FINMA <sup>3</sup>

Universal Coverage Mechanism	Mandatory basic package, sophisticated risk-adjustment system, low OOP <sup>1</sup>	Mandatory basic insurance for all residents, government subsidies for low-income <sup>3</sup>
Role of Private Insurers (Basic)	Competing private insurers, mostly non-profit for basic package <sup>1</sup>	Competing non-profit insurers for basic mandatory insurance <sup>3</sup>
Role of Private Insurers (Supplemental)	Offer supplementary insurance (content, conditions, reimbursements determined by insurer) <sup>4</sup>	For-profit on supplemental plans, risk-based premiums <sup>3</sup>
Patient Cost-Sharing	Low (9.3% of total health expenditure in 2021), cost-sharing for inpatient/outpatient pharmaceuticals <sup>2</sup>	Annual deductible (CHF 300-2500), 10% co-payment (capped CHF 700/year) <sup>3</sup>
Public-Private Interaction	PPPs stimulated in LSH sector, strict GP gatekeeper system, free choice of hospital <sup>1</sup>	Freedom of choice among recognized providers/insurers, PPPs for health access <sup>3</sup>
Key Features for S Coexistence	Regulated competition, non-profit basic insurers, risk adjustment, government oversight, clear reimbursement rules <sup>1</sup>	Mandatory universal basic coverage, non-profit basic insurers, subsidies, clear delineation of basic vs. supplemental <sup>3</sup>

<sup>1</sup>Netherlands health system information, accessed August 13, 2025, <https://eurohealthobservatory.who.int/countries/netherlands>

<sup>2</sup>The Netherlands: health system summary 2024, accessed August 13, 2025, <https://eurohealthobservatory.who.int/publications/i/the-netherlands-health-system-summary-2024>

<sup>3</sup> Mohajer-Bastami, A., et al. (2025). A comparison of the United Kingdom’s and Switzerland’s healthcare financing systems for achieving equity and efficiency goals. *Schweizerische Medizinische Wochenschrift*, 155(3), 4101. <https://doi.org/10.57187/s.4101>

<sup>4</sup>Kankerbestrijding, K. (2024, February 29). The Dutch health insurance system. KWF. <https://www.kwf.nl/en/forresearchers/toolkitfordevelopment/reimbursement/healthinsurance>

### 3.2 Mixed-Governed Systems: Balancing Access and Flexibility

These systems typically feature a social insurance model, where public funding is balanced with a significant public-private mix in service provision, often with a policy emphasis on flexibility alongside universal access.

### 3.2.1 France: Social Insurance and Public-Private Provision

France operates a national health insurance (NHI) system, which is a model of social security providing universal coverage to all legal residents (*The French Health Care System - PNHP*, 2008). This system is distinct from socialized medicine, representing instead a blend of public, social security, and private financing, coupled with a public-private mix in the provision of healthcare services (Rodwin, 2018). Funding is predominantly public, accounting for 79% of total health expenditure in 2016. This is primarily generated through mandatory contributions from employers and employees (e.g., 12.8% employer contribution, 7.5% employee Social Security tax), supplemented by national income taxes and other general taxes (*The French Health Care System - PNHP*, 2008). The system is administered by an autonomous authority comprising representatives from employers, unions, and the government, rather than being directly managed by the government. This authority is responsible for negotiating all medical fees with national unions and provider organizations (*The French Health Care System - PNHP*, 2008).

While the NHI covers the majority of healthcare costs, patients are typically responsible for a percentage of fees (e.g., 30% for doctor visits) and mandatory co-payments (e.g., 1 euro per visit) (*The French Health Care System - PNHP*, 2008). These out-of-pocket expenses are frequently covered by voluntary private health insurance (VHI), which is held by approximately 90% of the population (*The French Health Care System - PNHP*, 2008). Regional Health Agencies (ARS) play a crucial regulatory role at the local level, overseeing both public and private services. They control the volume and distribution of services through a system of authorizations required for new clinical services and equipment (*Ramsay Health Care*, n.d.). The French system values both liberalism, which emphasizes patient choice of doctors and hospitals, and pluralism, which is reflected in the diverse range of healthcare delivery options available (Rodwin, 2018).

The French system, while predominantly publicly funded via social insurance, relies significantly on a private provision sector and supplementary private insurance to offer flexibility and choice. This creates a delicate balance where basic access is universal, but the perceived quality or speed of access can be influenced by private top-ups. This dynamic can, in practice, lead to a subtle two-tier system. The regulatory function of the ARS is therefore critical in managing this public-private mix and preventing overt marketization from undermining the core universal principles.

**3.2.2 Austria: Two-Tier System and Decentralized Provision**

Austria operates a two-tier healthcare system in which virtually all residents receive publicly funded care, complemented by the option to purchase supplementary private health insurance (Federal Ministry of Labour, Social Affairs, Health and Consumer Protection, 2019). Enrollment in the public system is compulsory and typically linked to employment, with contributions calculated based on income. The system is primarily financed through the Krankenkasse (sickness insurance funds), which are overseen by the Federal Ministry of Labour and Social Affairs and implemented via 22 smaller, self-governed funds to enable decentralization and effective risk pooling (Federal Ministry of Labour, Social Affairs, Health and Consumer Protection, 2019). Austrian patients generally enjoy freedom of choice when selecting physicians. Supplementary private insurance provides additional benefits, such as access to private rooms and doctors, as well as reduced waiting times for certain procedures compared to those relying solely on statutory insurance (Pichlhofer & Maier, 2014). However, the system’s relatively unregulated access has been linked to overutilization of secondary and tertiary care services, while primary care remains comparatively underdeveloped (Pichlhofer & Maier, 2014). Reforms initiated since 2013 aim to increase capacity and improve care quality, addressing structural challenges within the system. Austria’s two-tier structure thus ensures universal public access while creating a de facto market for expedited or enhanced care through supplementary private insurance. This dynamic reflects an inherent tension: profit-driven supplementary options may undermine equity goals by introducing differential access based on ability to pay, even as universal coverage is maintained. The documented overutilization associated with less regulated access underscores the difficulty of balancing flexibility with efficiency and equity without stronger management frameworks (Table 2).

**Table 2:** Comparative Features of Mixed-Governed Systems (France, Austria)

Feature	France	Austria
System Model	National Health Insurance (NHI) / Social Security Model <sup>1</sup>	Two-Tier Social Insurance System <sup>2</sup>
Funding Mechanism (Primary)	Mandatory contributions (employer/employee payroll tax),	Compulsory employment-linked public health insurance

	national income tax, general taxes <sup>1</sup>	(Krankenkasse), income-based contributions <sup>2</sup>
Key Regulatory Body/Structure	Social Security Administration, Ministry of Health and Prevention, Regional Health Agencies (ARS), National Authority for Health (HAS) <sup>1</sup>	Federal Ministry of Labor and Social Affairs, Krankenkasse (22 smaller funds), Provinces <sup>2</sup>
Universal Coverage Mechanism	Mandatory coverage for all legal residents <sup>1</sup>	Compulsory enrollment linked to employment (also covers dependents, students, etc.) <sup>2</sup>
Role of Private Insurance (Voluntary/Supplementary)	Voluntary private health insurance (VHI) for ~90% of population, covers co-payments/balance billing <sup>1</sup>	Option for supplementary private health insurance ("comfort class" care, faster access, private rooms/doctors) <sup>2</sup>
Patient Cost-Sharing	Co-payments (e.g., €1 per visit, €0.5 per box of drugs), coinsurance (e.g., 30% for doctor visits), balance billing <sup>1</sup>	Deductibles, co-payments (for private supplementary insurance) <sup>2</sup>
Public-Private Interaction	Public-private mix in provision, fee negotiation with national unions, free choice of patient/GP referral <sup>1</sup>	Public and private sector provision, free choice of doctors, hospital doctors receive additional fees for private patients <sup>2</sup>
Key Features for Balancing Access/Flexibility	Regulated fee schedules, regional agency oversight, pluralism in delivery, incentivized gatekeeping <sup>1</sup>	Decentralized funds, compulsory membership for risk pooling, reforms to increase capacity, EHR opt-out <sup>2</sup>

<sup>1</sup>The French Health Care System - PNHP, accessed August 13, 2025, <https://pnhp.org/news/the-french-health-care-system/>

<sup>2</sup>Federal Ministry of Labour, Social Affairs, Health and Consumer Protection. (2019). The Austrian health care system: Key facts (3rd revised ed.). BMASGK. ISBN 978-3-902611-38-3.

### 3.3 Public-Led Systems: Limited Integration and Strategic Private Reliance

These systems are characterized by predominantly public funding and provision, with limited direct integration of for-profit actors. However, they increasingly rely on private capacity in specific areas, often to address systemic pressures.

#### 3.3.1 United Kingdom: The NHS and Evolving Private Sector Engagement

The UK's National Health Service (NHS) exemplifies a classic Beveridge model, primarily funded through taxation and providing healthcare free at the point of use (Greenhough, 2024). Despite its public foundation, private companies have consistently played a role, and their involvement has expanded considerably, particularly following the Health and Social Care Act 2012 (*Private Companies' Involvement in the NHS*, 2023). Private providers now operate a range of services, including GP surgeries, diagnostic services, elective surgery centers, and even entire NHS hospitals under contractual agreements (*Private Companies' Involvement in the NHS*, 2023). While the Department of Health and Social Care (DHSC) reported that spending on independent sector providers constituted just over 7% of its budget in 2019, other analyses suggest this figure could be as high as 26% when accounting for primary care and social care services (*Private Companies' Involvement in the NHS*, 2023). The value of contracts awarded to non-NHS providers has shown a significant upward trend (*Private Companies' Involvement in the NHS*, 2023).

The NHS is increasingly leveraging private capacity to address growing waiting lists, with private hospitals contracted to perform millions of procedures annually (*Private Companies' Involvement in the NHS*, 2023). However, this reliance introduces several concerns. There are documented issues regarding private companies "filching" staff trained by the NHS, which effectively amounts to a subsidy for the private sector (*Private Companies' Involvement in the NHS*, 2023). Furthermore, the "financialization" of certain NHS elements by private equity firms has raised alarms, as it can lead to aggressive profit extraction, high debt levels, and complex corporate structures that compromise transparency (Bayliss, 2022). The blurring of public and private boundaries is evident in initiatives like "GP at Hand," a private/public enterprise where patients remain NHS-registered but access digital consultations via a private app (*Private Companies' Involvement in the NHS*, 2023). Concurrently, growing waiting lists and difficulties in accessing NHS services are driving an increase in private spending by individuals, normalizing out-of-pocket payments and potentially exacerbating health inequalities (Holmes, 2023).

The UK NHS, a historical pillar of public healthcare, is undergoing a process of "financialization" where private entities, driven by profit, are increasingly embedded not

merely as service providers but as financial actors. This creates a fundamental tension: the public purpose of universal, free-at-point-of-use care is challenged by profit extraction, the diversion of public resources and staff, and the potential for inequities arising from a growing private pay market. This indicates that the profit motive, if unchecked, can erode the public purpose rather than complement it, especially in the context of austerity measures and capacity limitations.

### **3.3.2 Nordic Countries: Universal Public Care with Targeted Private Capacity**

Nordic countries—including Denmark, Finland, Iceland, Norway, and Sweden—generally provide universal, tax-funded healthcare characterized by predominantly public financing and provision (Greenhough, 2024). The private healthcare sector is relatively small, with private ownership accounting for only 2–10% of in-hospital beds across the region (Laugesen et al., 2021). The majority of hospitals are publicly run (Editorial group for NOSOSCO welfare statistics, 2024). Nonetheless, private providers frequently receive reimbursement through public economic contracts, reflecting a controlled integration within the predominantly public system (Laugesen et al., 2021). These systems operate in a highly decentralized fashion, with significant responsibility for care delivery and regulation of private providers resting with county councils in Sweden or regional and municipal governments in Norway and Denmark (Tsalampouni, 2022).

Universal access to healthcare remains a foundational principle. However, persistent challenges such as long waiting times for non-urgent care have contributed to increased uptake of private health insurance as a mechanism to circumvent delays; for instance, in 2017, approximately 6.5% of Swedes were covered by private insurance—a marked increase compared to previous decades (Kubini, 2023; OECD/European Commission, 2024). Private healthcare providers, including firms like Aleris, have consequently expanded their presence in the region, responding to growing demand. Public-private partnerships are also actively promoted to drive healthcare innovation and bolster international healthcare promotion, as exemplified by initiatives such as Healthcare Denmark (Healthcare Denmark, n.d.).

Despite the Nordic systems' strong public dominance and commitment to equity, a pragmatic tension persists, operational limitations, particularly long wait times in publicly delivered care, have catalyzed demand for private, profit-driven alternatives. This dynamic illustrates that even in highly egalitarian systems, market forces driven by individual preferences for faster or more convenient care can foster private sector growth. If unmanaged, such growth may gradually erode the foundational principle of equitable access. Thus, operational inefficiencies within public systems can unintentionally open

pathways for private sector expansion, challenging the sustainability of universal coverage ideals (Table 3).

**Table 3:** Comparative Features of Public-Led Systems (UK, Nordic Countries)

Feature	United Kingdom	Nordic Countries (General)
System Model	Beveridge Model (National Health Service - NHS) <sup>1</sup>	Beveridge Model (Universal, Tax-funded Welfare State) <sup>1</sup>
Funding Mechanism (Primary)	Taxation, National Insurance contributions <sup>1</sup>	Local/regional taxation (e.g., county councils), predominantly public <sup>2</sup>
Key Regulatory Body/Structure	NHS England, DHSC, CQC, ICSs <sup>3</sup>	County Councils (Sweden), Regional/Municipal Governments (Norway, Denmark) <sup>2</sup>
Universal Coverage Mechanism	Free at point of use for all residents <sup>1</sup>	Universal access for all citizens/residents <sup>2</sup>
Extent of Private Sector Involvement	Significant and growing, 7-26% of budget for clinical services, private companies running GP surgeries, diagnostics, elective surgery, entire hospitals <sup>4</sup>	Minor (2-10% of in-hospital beds private), private providers reimbursed by public system, increasing trend of private health insurance <sup>5</sup>
Reasons for Private Reliance	Tackle waiting lists, specific services, capacity gaps, financialization <sup>4</sup>	Address long waiting times, provide faster access, specific services (e.g., dental for adults) <sup>6</sup>
Role of Private Insurance	Supplemental (out-of-pocket spending increasing), for faster access, avoiding NHS queues <sup>6</sup>	Limited private medical insurance, increasing trend for faster access <sup>5</sup>
Public-Private Interaction	Contracts, outsourcing, PPPs (e.g., GP at Hand), blurring boundaries <sup>3</sup>	Economic contracts for reimbursement, PPPs for innovation (e.g., Healthcare

		Denmark), decentralized regulation of private providers <sup>5</sup>
Key Tensions/Concerns	Financialization, staff diversion, erosion of universal principles, inequities from private pay market, efficiency concerns <sup>4</sup>	Long waiting times, potential for two-tier system, challenges to equitable access, financial burden <sup>6</sup>

<sup>1</sup>Types Of Healthcare Systems Around The World | William Russell, accessed August 13, 2025, <https://www.william-russell.com/blog/healthcare-systems-globally/>

<sup>2</sup>Health systems in the European Union and policy responses to Covid-19: A comparative analysis between Germany, Sweden, and Greece - PubMed Central, accessed August 13, 2025, <https://pmc.ncbi.nlm.nih.gov/articles/PMC9596684/>

<sup>3</sup>(NHS England, 2022)

<sup>4</sup>'Private companies' involvement in the NHS | Patients4NHS, accessed August 13, 2025, <http://www.patients4nhs.org.uk/private-companies-involvement-in-the-nhs/>

<sup>5</sup>Nordic Health Registry-Based Research: A Review of Health Care ..., accessed August 13, 2025, <https://pmc.ncbi.nlm.nih.gov/articles/PMC8302231/>

<sup>7</sup>Holmes, 2023

## 4 Discussion

### 4.1 Cross-System Analysis: Competition, Complementarity, and Outcomes

The comparative analysis of European healthcare systems highlights the diverse ways in which competition and complementarity between profit and purpose take shape. In Privately-Integrated systems, such as the Netherlands and Switzerland, competition among insurers and providers is tightly regulated to secure universal access and safeguard quality standards (European Observatory on Health Systems and Policies, 2024; Sturny, 2020). The profit motive is thus carefully redirected through mandatory non-profit rules for basic insurance coverage, demonstrating a deliberate policy choice to align commercial activity with public health objectives (*The Dutch Health Care System* | *National Health Care Institute*, 2025).

Mixed-Governed systems, exemplified by France and Austria, show a form of complementarity where private providers operate within a publicly funded social insurance framework, offering patients a degree of choice and flexibility (Rodwin, 2018). However, this arrangement can inadvertently lead to a subtle two-tier system, where supplementary private insurance enables faster access or enhanced amenities, thereby raising concerns

about equity. This points to a dynamic where the desire for flexibility can create a parallel market that, while not explicitly undermining universal access, may differentiate the patient experience based on ability to pay.

Public-Led systems, including the UK and Nordic countries, primarily rely on public provision, with private capacity serving as a supplement, often to alleviate pressure points such as long waiting lists (*Private Companies' Involvement in the NHS*, 2023). This can be complementary in addressing capacity gaps, but it also introduces tensions related to staff diversion, the "financialization" of public services, and the potential erosion of universal principles if not tightly managed (*Private Companies' Involvement in the NHS*, 2023). The "symbiosis" in these systems often manifests as the private sector filling gaps or providing specialized services that the public system struggles to deliver, such as through innovation or capacity relief for waiting lists (Health~Holland, n.d.). However, the "tension" arises when profit motives lead to practices like "cream-skimming" (selecting healthier, more profitable patients), cost inflation, or the creation of a de facto two-tier system that undermines the core principle of equity. This suggests that the specific nature of private sector engagement, rather than its mere presence, is a determinant of the balance between profit and purpose.

The impact of profit on patient outcomes remains a subject of considerable debate. While some academic literature suggests that conversions to for-profit ownership can enhance efficiency and profitability, these changes may also be associated with a reduction in quality, including increased mortality rates and decreased staffing levels, in ways not readily observable by patients (Picone et al., 2002). Conversely, other evidence indicates that private ownership is not necessarily more efficient than public ownership (Picone et al., 2002). The COVID-19 pandemic further underscored the financial sustainability challenges confronting hospitals across Europe, irrespective of their ownership structure, highlighting the complex interplay between cost containment pressures and the imperative for quality improvement (Dubas-Jakóbczyk et al., 2024).

## **4.2 The Critical Role of Regulation and Policy Design**

Effective regulation and thoughtful policy design are paramount in mediating the complex relationship between profit and purpose within healthcare systems. In Privately-Integrated systems, the ability to maintain universal access despite significant private provision is contingent upon sophisticated regulatory frameworks. These frameworks mandate basic coverage, implement robust risk-adjustment mechanisms to ensure fair distribution of funds, and often enforce non-profit operations for essential services (*Netherlands Health System Information*, n.d.). This demonstrates that regulation is not merely a reactive measure but a proactive design tool that shapes the very nature of the profit-purpose

interaction. Well-designed regulation can transform potential conflict into a symbiotic relationship.

In Mixed-Governed systems, the regulation of fee schedules, co-payments, and the roles of supplementary insurance is crucial for balancing patient choice with equitable access (*The French Health Care System - PNHP*, 2008). The decentralized structure in Austria, for example, necessitates strong federal oversight to ensure consistent quality and access across regions (Federal Ministry of Labour, Social Affairs, Health and Consumer Protection, 2019). This illustrates how regulatory clarity can mitigate the inherent complexities of a mixed system.

For Public-Led systems, the challenge lies in precisely defining the boundaries of private involvement. This requires ensuring that outsourced services genuinely augment public capacity without diverting essential public resources or staff, and that the increasing "financialization" of healthcare does not compromise the ethical foundations of public service (*Private Companies' Involvement in the NHS*, 2023). Conversely, instances such as "unregulated access" in Austria 27 or the "blurring boundaries" in the UK 32 point to regulatory gaps or weaknesses that allow the inherent tension to manifest negatively. The evidence consistently suggests that private sources of healthcare funding, including out-of-pocket payments and private insurance, are often regressive and create financial barriers to access, contributing minimally to cost containment and potentially even encouraging cost inflation (World Health Organization, Regional Office for Europe, 2004). This underscores the critical necessity of robust regulatory oversight to protect fundamental public policy objectives.

### **4.3 Consequences of Poor Regulation: Inefficiencies and Inequity**

The absence or inadequacy of robust regulation within healthcare systems tends to exacerbate both inefficiencies and inequities, thereby creating a detrimental feedback loop. Regarding inefficiencies, Austria's unregulated access to healthcare has resulted in overutilization of secondary and tertiary care, while the primary care sector remains comparatively weak and underdeveloped (Pichlhofer & Maier, 2014). In the United Kingdom, concerns have been raised about the operational efficiency of private companies engaged within the National Health Service (NHS), with documented contract failures and financial difficulties negatively impacting service delivery (*Private Companies' Involvement in the NHS*, 2023). The increasing "financialization" of NHS components through private equity investments has led to aggressive profit extraction, high debt burdens, and the establishment of complex corporate structures that compromise transparency and divert public funds away from direct patient care (Bayliss, 2022). Similarly, in Nordic countries, persistent long waiting times for publicly provided care—

an unequivocal form of inefficiency—push patients toward private providers, fostering a parallel system that may undermine equity (Allianz Care, 2025).

In terms of inequity, private funding sources are frequently regressive and introduce financial barriers that hinder access to necessary care (World Health Organization, Regional Office for Europe, 2004). In Austria, supplementary private insurance enables individuals to access faster care, thus creating disparities in wait times for those reliant solely on statutory public insurance (Federal Ministry of Labour, Social Affairs, Health and Consumer Protection, 2019). Likewise, in the UK, increasing NHS waiting lists and accessibility challenges are compelling more patients to pay out-of-pocket for private treatment, normalizing self-payment and exacerbating health inequalities aligned with income and socioeconomic status (Holmes, 2023). Additionally, practices such as “cherry-picking” healthier and more profitable patients by private providers (e.g., GP at Hand in the UK) destabilize public services by diverting resources and healthier patient populations (Private Companies’ Involvement in the NHS, 2023). Experts warn that budget cuts and the ongoing healthcare workforce crisis across Europe risk prolonging wait times, reducing access, and diminishing overall quality of care, thereby creating a vacuum that private interests may fill with unpredictable consequences for the foundational principles of European healthcare (Anderson, 2023).

The ethical implications of profit-driven healthcare models, particularly concerns regarding restricted access and commodification of care, have been extensively questioned (Zeitouni, 2025). Empirical studies further suggest that private equity ownership in healthcare can correlate with adverse patient outcomes, including increased mortality rates, reductions in nurse staffing, poor patient well-being, and compromised compliance with care standards (Picone et al., 2002). This evidence demonstrates how inadequate regulation fosters a vicious cycle: inefficiencies within public systems generate market opportunities for profit-oriented actors who, in the absence of strong oversight, exacerbate existing inequities, weaken public systems, and perpetuate a cycle that undermines the core public purpose of healthcare.

#### **4.4 Towards Patient-Centered Outcomes: Challenges and Opportunities**

The overarching objective of European healthcare systems is to achieve patient-centered outcomes, ensuring high-quality, accessible, and equitable care for all citizens.<sup>1</sup> This pursuit is challenged by demographic shifts, including aging populations and the increasing prevalence of chronic diseases, alongside persistent resource constraints (Delnoij et al., 2002).

Despite these challenges, significant opportunities exist for fostering effective public-private collaborations. Well-designed public-private partnerships (PPPs) can align diverse

vested interests and actively engage the public as partners in healthcare delivery (Health~Holland, n.d.). When structured with shared risks and resources, PPPs possess the potential to accelerate innovation, enhance efficiency, and expand access to care, as demonstrated in the Dutch Life Sciences & Health sector (Health~Holland, n.d.). This suggests that achieving patient-centered outcomes within the dynamics of profit and purpose necessitates a proactive, strategic approach to public-private engagement, moving beyond mere reactive problem-solving.

Furthermore, leveraging advancements in digital health, personalized medicine, and integrated care models is crucial for improving patient outcomes and addressing health inequalities.<sup>2</sup> Empowering patients through digital health literacy and ensuring that the benefits of digitization are inclusive are vital steps to prevent the widening of existing disparities.<sup>2</sup> The European Health Report 2024 emphasizes the imperative to transform health systems to be resilient and sustainable in the face of emerging threats, advocating for a robust evidence base to inform policy-making (*Keeping Health High on the Agenda: The European Health Report 2024*, 2025). Achieving universal health coverage remains an unchanging goal, requiring sustained investment in human resources and a strategic shift towards preventive healthcare models (Ministry of Europe and Foreign Affairs, 2023). This implies actively harnessing profit-driven innovation and efficiency gains while rigorously safeguarding equity and quality through robust governance and shared accountability. The challenge lies in transitioning from a defensive stance against profit to a strategic one that responsibly integrates it as a tool for achieving public health objectives.

## 5 Conclusion

### 5.1 Reconciling Profit and Purpose: A Summary of Dynamics

The coexistence of profit-driven and purpose-driven actors within European healthcare systems is remarkably diverse, reflecting a complex interplay of national priorities, institutional maturity, and specific policy design choices. This analysis has demonstrated that the dynamics between these two forces are not binary but rather exist along a spectrum of public-private interaction.

In Privately-Integrated Systems, such as the Netherlands and Switzerland, a stable coexistence is observed. This stability is largely attributable to the structurally defined roles of private actors and clear reimbursement mechanisms, all guided by aligned objectives. For instance, the non-profit mandate for basic insurance, sophisticated risk-adjustment systems, and government subsidies ensure that universal access and solidarity are maintained even with significant private sector involvement.

Mixed-Governed Systems, exemplified by France and Austria, navigate a delicate balance between ensuring universal access and providing flexibility. These systems, typically based on social insurance models with a blend of public and private provision, utilize regulation to manage this mix. However, the presence of supplementary private insurance can inadvertently create subtle two-tier access, where those able to afford additional coverage may experience enhanced amenities or faster service.

Finally, Public-Led Systems, including the United Kingdom and the Nordic countries, exhibit limited direct integration of for-profit actors. Nevertheless, these systems increasingly rely on private capacity in specific areas, often driven by the need to address public sector limitations such as long waiting lists. This reliance has, in turn, sparked debates concerning the "financialization" of public services and potential implications for equity. Where roles are clearly defined and objectives are aligned through robust governance, cooperation between profit and purpose can indeed lead to improved efficiency and accessibility, demonstrating a symbiotic relationship.

## 5.2 Policy Implications for Sustainable and Equitable Healthcare

Drawing on these findings, several policy directions emerge for sustaining equitable healthcare provision across Europe:

- **Strengthening Regulatory Frameworks:** It is imperative to implement and enforce clear, comprehensive rules for private sector engagement. These regulations should encompass pricing controls, stringent quality standards, and, where appropriate, limitations on profit extraction for essential healthcare services. Such measures are crucial to prevent market failures, safeguard public accountability, and ensure that commercial interests do not undermine public health objectives.
- **Investing in Public Capacity:** Addressing the root causes of public sector strain, such as chronic workforce shortages and persistent funding gaps, is fundamental. By bolstering public healthcare capacity, systems can reduce their reliance on private alternatives that are often driven by existing inefficiencies. This strategic investment directly reinforces universal access and equity, mitigating the pressure to outsource core services.
- **Designing Purpose-Driven Partnerships:** Future public-private partnerships must be explicitly structured to achieve defined public health goals. This necessitates models that involve shared risks, pooled resources, and transparent accountability mechanisms, moving beyond purely profit-driven ventures. Partnerships should be designed to complement, rather

than compete with, public services, ensuring that innovation and efficiency gains directly benefit the entire population.

- **Prioritizing Health Equity:** Continuous monitoring and proactive mitigation strategies are essential to address the potential for private sector involvement to exacerbate inequalities in access, quality, or financial burden. Policies must ensure that all citizens, irrespective of their socioeconomic status or ability to pay, receive high-quality care. This requires a vigilant commitment to the foundational principles of equity and universal access.

The diverse experiences across European healthcare systems underscore that the effective integration of profit and purpose is a continuous policy challenge. It demands adaptive governance and flexible policy responses to serve patient-centered outcomes in an evolving and increasingly complex healthcare landscape.

This research shows that the European experience demonstrates that integrating profit and purpose in healthcare is not a one-time solution but a continuous governance challenge. It demands adaptive regulation, sustained public investment, and vigilant protection of equity as systems evolve under demographic pressures, technological change, and shifting economic realities. The task for policymakers is not to eliminate profit from healthcare, but to channel it strategically so that it serves, rather than undermines, universal and patient-centered outcomes.

### **5.3 Limitations and recommendations**

This research relies heavily on secondary sources, including information available on official websites of government institutions, international organizations, and health stakeholders. While these sources are useful for descriptive overviews and system comparisons, they are sometimes of limited academic character and may be subject to institutional bias or lack of timeliness. This means that the analysis cannot fully capture the complexity of policy implementation or the experiences of patients at the micro-level. It is recommended that future research include both academic, peer-reviewed papers, as well as empirical data collected through interviews, surveys, or quantitative indicators.

## References

1. A comparison of the United Kingdom's and Switzerland's healthcare financing systems for achieving equity and efficiency goals. *Swiss Medical Weekly* (n.d.). Available at: <https://smw.ch/index.php/smw/article/view/4101/6171>
2. Access to healthcare in the European Union. European Patients' Forum (2021). Available at: <https://www.eu-patient.eu/campaign/access-to-healthcare>
3. Allianz Care: Healthcare in Sweden (2025). Available at: <https://www.allianzcare.com/en/support/health-and-wellness/national-healthcare-systems/healthcare-in-sweden.html>
4. Anderson, S.: Europe is struggling to keep its health systems afloat. *Health Policy Watch* (2023). Available at: <https://healthpolicy-watch.news/europe-struggles-to-keep-health-systems-afloat/>
5. Bayliss, K.: Can England's national health system reforms overcome the neoliberal legacy? *International Journal of Health Services* 52(4), 480–491 (2022). <https://doi.org/10.1177/00207314221115945>
6. Delnoij, D., Klazinga, N., Glasgow, I.K.: Integrated care in an international perspective. *International Journal of Integrated Care* 2(2) (2002). <https://doi.org/10.5334/ijic.62>
7. Dubas-Jakóbczyk, K., Ndayishimiye, C., Szetela, P., Sowada, C.: Hospitals' financial performance across European countries. *BMJ Open* 14(1), e077880 (2024). <https://doi.org/10.1136/bmjopen-2023-077880>
8. Editorial Group for NOSOSCO Welfare Statistics: Healthcare services in general. *Nordic Health and Welfare Statistics* (2024). Available at: <https://nhwstat.org/welfare/sickness-and-health/healthcare-services-general>
9. EuroHealthNet: Improving health equity in Europe: Priorities for the 2024–2029 policy landscape (2024). Available at: <https://eurohealthnet.eu/improving-health-equity-in-europe-priorities-for-the-2024-2029-policy-landscape/>
10. European Commission: *State of Health in the EU: Companion Report 2021*. Publications Office of the European Union (2021). Available at: [https://health.ec.europa.eu/system/files/2022-02/2021\\_companion\\_en.pdf](https://health.ec.europa.eu/system/files/2022-02/2021_companion_en.pdf)
11. Federal Ministry of Labour, Social Affairs, Health and Consumer Protection: *The Austrian Health Care System: Key Facts*, 3rd edn. BMASGK (2019)
12. Greenhough, C., Greenhough, C.: What you need to know about different types of healthcare systems around the world. William Russell (2024). Available at: <https://www.william-russell.com/blog/healthcare-systems-globally/>
13. Health care systems—four basic models. Physicians for a National Health Program (n.d.). Available at: [https://www.pnhp.org/single\\_payer\\_resources/health\\_care\\_systems\\_four\\_basic\\_models.php](https://www.pnhp.org/single_payer_resources/health_care_systems_four_basic_models.php)
14. Health insurance. City of Vienna (2012). Available at: <https://www.wien.gv.at/english/health-socialservices/insurance/>
15. Health~Holland: Public-private partnerships (n.d.). Available at: <https://www.health-holland.com/public-private-partnerships>

16. Holmes, J.: Independent health care and the NHS. *The King's Fund* (2023). Available at: <https://www.kingsfund.org.uk/insight-and-analysis/reports/independent-health-care-and-nhs>
17. Kankerbestrijding, K.: The Dutch health insurance system. KWF (2024). Available at: <https://www.kwf.nl/en/forresearchers/toolkitfordevelopment/reimbursement/healthinsurance>
18. Keeping health high on the agenda: The European Health Report 2024. World Health Organization Regional Office for Europe (2025). Available at: <https://www.who.int/europe/activities/keeping-health-high-on-the-agenda--the-european-health-report-2024>
19. Kubini, U.: Why private healthcare is booming in Scandinavian countries. Foundation for Economic Education (2023). Available at: <https://fee.org/articles/why-private-healthcare-is-booming-in-scandinavian-countries/>
20. Laugesen, K., Ludvigsson, J.F., Schmidt, M., Gissler, M., Valdimarsdottir, U.A., Lunde, A., Sørensen, H.T.: Nordic health registry-based research. *Clinical Epidemiology* 13, 533–554 (2021). <https://doi.org/10.2147/CLEP.S314959>
21. Ministry of Europe and Foreign Affairs: *France Global Health Strategy 2023–2027*. Directorate General for Global Affairs (2023). Available at: [https://www.diplomatie.gouv.fr/IMG/pdf/a4\\_global\\_health\\_strategy\\_en\\_v2\\_cle477d3a.pdf](https://www.diplomatie.gouv.fr/IMG/pdf/a4_global_health_strategy_en_v2_cle477d3a.pdf)
22. Mohajer-Bastami, A., Moin, S., Sweetman, B., Ahmed, A.R., Head, M., Gelber, E., Ahmad, S.J.S., Exadaktylos, A.K.: A comparison of the United Kingdom's and Switzerland's healthcare financing systems. *Schweizerische Medizinische Wochenschrift* 155(3), 4101 (2025). <https://doi.org/10.57187/s.4101>
23. Netherlands health system information. European Observatory on Health Systems and Policies (n.d.). Available at: <https://eurohealthobservatory.who.int/countries/netherlands>
24. NHS England: Structure of the NHS (2022). Available at: <https://www.england.nhs.uk/long-read/structure-of-the-nhs/>
25. OECD, European Commission: *Health at a Glance: Europe 2024*. OECD Publishing (2024). <https://doi.org/10.1787/b3704e14-en>
26. Pichlhofer, O., Maier, M.: Unregulated access to health-care services and overutilization. *European Journal of Public Health* 25(3), 401–403 (2014). <https://doi.org/10.1093/eurpub/cku189>
27. Picone, G., Chou, S., Sloan, F.: Are for-profit hospital conversions harmful? *RAND Journal of Economics* 33(3), 507 (2002). <https://doi.org/10.2307/3087470>
28. Private companies' involvement in the NHS. Patients4NHS (2023). Available at: <https://www.patients4nhs.org.uk/private-companies-involvement-in-the-nhs/>
29. Ramsay Health Care: France healthcare overview (n.d.). Available at: <https://www.ramsayhealth.com/en/investors/our-markets/france-healthcare-overview/>
30. Reimbursement of outpatient medicines. National Health Care Institute (2024). Available at: <https://english.zorginstituutnederland.nl/about-us/working-methods-and->

[procedures/assessment-of-outpatient-medicines-for-the-benefit-of-the-medicine-reimbursement-system-gvs/reimbursement-of-outpatient-medicines](#)

31. Rodwin, V.: The French health care system. *World Hospitals and Health Services* 54(1), 49–55 (2018)
32. Siciliani, L., Chalkley, M., Gravelle, H.: Does provider competition improve health care quality and efficiency? *Policy Brief* 48. European Observatory on Health Systems and Policies (2023). Available at: <https://eurohealthobservatory.who.int/publications/i/does-provider-competition-improve-health-care-quality-and-efficiency-expectations-and-evidence-from-europe>
33. Sturny, I.: International health care system profiles: Switzerland. *The Commonwealth Fund* (2020). Available at: <https://www.commonwealthfund.org/international-health-policy-center/countries/switzerland>
34. The Dutch health care system. National Health Care Institute (2025). Available at: <https://english.zorginstituutnederland.nl/about-us/healthcare-in-the-netherlands>
35. The French health care system. Physicians for a National Health Program (2008). Available at: <https://pnhp.org/news/the-french-health-care-system/>
36. The Netherlands: Health system summary 2024. European Observatory on Health Systems and Policies (2024). Available at: <https://eurohealthobservatory.who.int/publications/i/the-netherlands-health-system-summary-2024>
37. Tsalampouni, A.: Health systems in the European Union and policy responses to Covid-19. *Deleted Journal* 11(4), 227990362211294 (2022). <https://doi.org/10.1177/22799036221129413>
38. World Health Organization: *Private Sector Landscape in Mixed Health Systems*. WHO (2020)
39. World Health Organization, Regional Office for Europe: *What Are the Equity, Efficiency, Cost Containment and Choice Implications of Private Health-Care Funding in Western Europe?* WHO (2004). Available at: <https://apps.who.int/iris/handle/10665/107623>
40. Your gateway to healthcare in Denmark. Healthcare Denmark (n.d.). Available at: <https://healthcaredenmark.dk/>
41. Zeitouni, J.: Is pursuing profit commensurable with providing good health care? *AMA Journal of Ethics* 27(5), E305–E307 (2025). <https://doi.org/10.1001/amajethics.2025.305>

**Open Access** This chapter is licensed under the terms of the Creative Commons Attribution-NonCommercial 4.0 International License (<http://creativecommons.org/licenses/by-nc/4.0/>), which permits any noncommercial use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons license and indicate if changes were made.

The images or other third party material in this chapter are included in the chapter's Creative Commons license, unless indicated otherwise in a credit line to the material. If material is not included in the chapter's Creative Commons license and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder.

