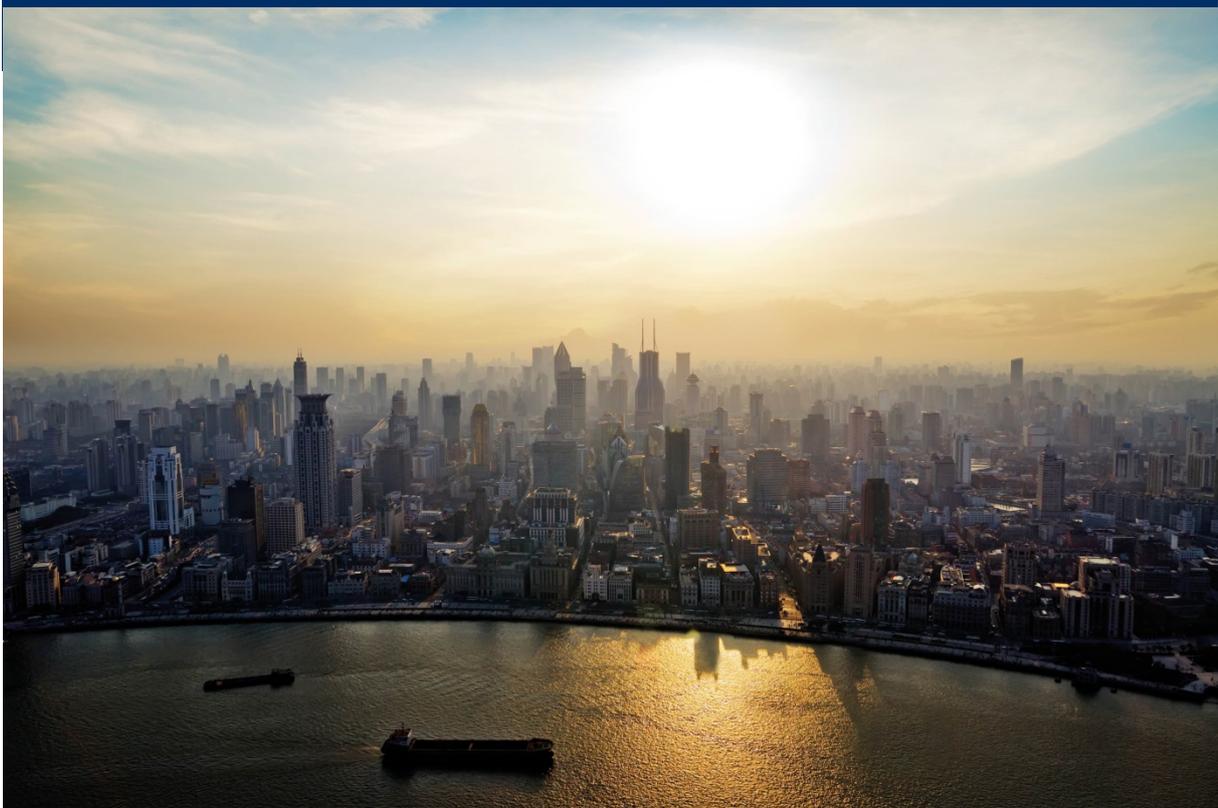


SGI

Sustainable
Governance
Indicators

2015 Health Report

Health Policy



Indicator

Health Policy

Question

To what extent do health care policies provide high-quality, inclusive and cost-efficient health care?

41 OECD and EU countries are sorted according to their performance on a scale from 10 (best) to 1 (lowest). This scale is tied to four qualitative evaluation levels.

- 10-9 = Health care policy achieves the criteria fully.
- 8-6 = Health care policy achieves the criteria largely.
- 5-3 = Health care policy achieves the criteria partly.
- 2-1 = Health care policy does not achieve the criteria at all.

Switzerland

Score 9

Health care in Switzerland is said to be qualitatively excellent. A policy making health insurance mandatory ensures that the total population is covered, but care is expensive. Cost efficiency is a potential problem, in particular with regard to the organization of hospitals. Life expectancy is very high, life expectancy at birth is 80.5 years for males and 84.8 years for females. As of 2013, a 65-year-old male could expect to live for another 19 years on average, while a woman of the same age could look forward to another 22 years. This is about two years more than in Germany. Obviously, the health care system is important in this respect but is not the only explanatory variable; differences may also be due to the country's socioeconomic resources, natural environment, or other variables.

Health insurance is managed according to a very liberal formula. Premiums for health insurance do not depend on income, and premiums do not take into account the number of family members. Hence, insurance must be bought for each member of the family, although premiums are reduced for children. In recent years, this liberal model has been modified through the provision of subsidies for low-wage earners and their families. Therefore, there is today some limited progressivity at the lower end of the income distribution. This varies by cantons, which can individually determine the degree of this progressivity. Nonetheless, health care reforms have not been particularly successful in terms of improving efficiency or controlling the structural rise in health expenditures.

Health care insurance is provided by a large number of competing mutual funds (nonprofit insurance programs), all of which are required to offer the same benefits. Hence, there is no competition in the area of benefits, but only in the field of premiums, which is largely a function of administrative costs and membership

structure. Considerable discussion has focused on whether this competitive market structure should be replaced by a single insurance company. In 2014, the people decided in a popular vote to retain present system

Even given these problems, the quality and inclusiveness of Swiss health care has shown itself to be outstanding, and there is no reason to expect any major change in this respect in the coming years.

Australia

Score 8

The Australian health care system is a complex mix of public sector and private sector health care provision and funding. Correspondingly, its performance on quality, inclusiveness and cost efficiency is variable across the components of the system. The federal government directly funds health care through three schemes: Medicare, which subsidizes services provided by doctors; the Pharmaceutical Benefits Scheme (PBS), which subsidizes prescription medications; and a means-tested private health insurance subsidy. Medicare is the most important pillar in delivering affordable health care to the entire population, but it has design features that decrease efficiency and do not promote equity of access. For example, the level of the subsidy is generally not contingent on the price charged by the doctor. The PBS is perhaps the most successful pillar of health care policy in Australia, granting the Australian community access to medications at a low unit cost.

Quality of medical care in Australia is in general of a high standard, reflecting a highly skilled workforce and a strong tradition of rigorous and high-quality doctor training in public hospitals. However, a number of medical procedures are difficult to access for persons without private health insurance. In particular, waiting periods for non-emergency operations in public hospitals can be many years. Public funding of dental care is also very limited and private dental care can be prohibitively expensive for low-income persons without private health insurance. Consequently, dental health care for low-income groups is poor.

Regarding inclusiveness, significant inequality persists in access to some medical services, such as non-emergency surgery and dental care. Indigenous health outcomes are particularly poor. In 2012, the federal government announced a dental scheme aimed at addressing inequity in access to dental care. Commenced on 1 January 2014, the scheme provides up to \$1,000 per two-year period for basic dental services for children of low and middle income families. The scheme also increased funding available to the states and territories for dental services for low-income adults. Lack of access to non-emergency surgery reflects, to a significant extent, the funding constraints of the states and territories, which are responsible for funding public hospitals. This was a significant motivation behind the 2011 National Health Reform Agreement, which sought to provide for more sustainable funding arrangements for Australia's health system. Key features of the agreement include

additional federal funding for hospitals from 2014 – 2015 to 2019 –2020 and for non-emergency surgery from 2009 – 2010 to 2015 – 2016; establishment of an Independent Hospital Pricing Authority to set a national efficient price for hospital services and a National Health Performance Authority to monitor and report on hospital performance; and the establishment of “Medicare Locals” nationally to coordinate and integrate primary care. However, in its first budget in 2014, the Abbott government reduced hospital funding by \$15 billion over the 2014 to 2024 period compared to what had been planned under the agreement. The Abbott government has also announced plans to replace Medicare Locals with a smaller number of ‘Primary Health Networks’. The 2014 budget also contained measures to introduce a \$7 patient co-payment for each doctor visit and clinical pathology service, which has the potential to reduce access to health care. However, the required legislation had not passed the Senate as of the end of the review period and does not look likely to pass.

Finally, concerning cost-effectiveness, the health care system is rife with inefficiency and wrong incentives. Total health care expenditure is relatively low, but as is the case in most developed countries, the government faces significant challenges due to rising costs from an aging population and development of new diagnostic tools and treatments. These rising costs have been key motivations for the National Health Reform Agreement and the proposed patient co-payment.

Citation:

National Health Reform Agreement 2011:

[http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nhra-agreement/\\$File/National%20Health%20Reform%20Agreement.pdf](http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nhra-agreement/$File/National%20Health%20Reform%20Agreement.pdf)

Austria

Score 8

The Austrian health care system is based on several pillars. Public health insurance covers almost all persons living legally in Austria, while a competitive private health-insurance industry offers additional benefits. However, major inequalities in health care have arisen, particularly between those able to afford additional private insurance and those who cannot.

The public insurance system differs in some aspects – sometimes considerably – between different professional groups. The various public insurance organizations work under the umbrella of the Association of Austrian Social Insurance Institutions (Hauptverband der Sozialversicherungsträger).

A second complexity in the system is produced by the division of responsibilities between the federal and state governments. Public health care insurance is based on federal laws, but the hospitals are funded by the states. This state-level responsibility affects both publicly owned and privately owned hospitals.

The complex structure of the Austrian health care system is in part responsible for the rise in costs. However, in recent years, cooperation between the insurance-providers' federation, the Federal Ministry of Health, and individual states seems to have succeeded in arresting the explosive rise in health care costs.

The development of the health care environment in Austria has echoed overall EU trends. Life expectancy is rising, with the effect that some costs, especially those linked to elderly care, are also going up. This implies ongoing debates but the principle of public health care is still undisputed.

Canada

Score 8

Like educational policy, health care is primarily the responsibility of the individual provinces. The quality of the Canadian health system is good, as evidenced by the high level of life expectancy, but is not as high as in comparable European countries. The inclusiveness of the Canadian health system is impressive, with high-quality health care freely provided for virtually the entire population. Lack of income is not a barrier to treatment. One effect of the equity in access to health care services is the small gap in perceived health between the top and bottom income quintiles. The most glaring problem with the Canadian system is timely access to care. Canadians regularly experience long waiting times for certain procedures (largely confined to those that are not life threatening). A recent report from the Health Council of Canada (2013) found only limited progress in reducing these wait times. One additional access issue is presented by the exclusion from Medicare coverage of dental care, vision care and drugs prescribed for use outside of hospitals, resulting in unequal access across income groups to these types of health-care services. Quality of care is also of some concern. Canada has relatively high rates of infant mortality, and according to a 2014 report by the U.S. based Commonwealth Fund that compared health care systems internationally, ranks poorly on some safe-care measures.

In contrast to the equity of access, the cost efficiency of the Canadian health system is not impressive. Canada's health spending as a share of GDP, while well below that of the United States, is above that of many European countries. The rationalization of health-care costs is a major goal of government policy at this time. The Health Council of Canada (2013) reported in 2012 that 57% of Canadian physicians reported using electronic health records. While this proportion is up from 23% in 2006, it is still below the incidence of use in many other countries.

Overall, Canada outperforms the United States but lags significantly behind comparable European countries such as Germany, the United Kingdom, and the Netherlands on the basis of many measures of quality, equity and efficiency of care. The Commonwealth Fund report ranked Canada second to last overall on a comparative score card of 11 health care systems.

Citation:

Health Council of Canada (2013) “Progress Report 2013: Health care renewal in Canada,” May. http://www.healthcouncilcanada.ca/r pt_det.php?id=481

Commonwealth Fund (2014), Mirror Mirror on the Wall - How the Performance of the U.S. Health Care System Compares Internationally, posted at

http://www.commonwealthfund.org/~media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf

Czech Republic

Score 8

The Czech health care system, based on universal compulsory insurance, ensures a wide range of choice for both providers and consumers of health care, and provides a level of service which is high by international standards. In 2012, a new health reform entered into force. Given the growing costs of current public health care and the aim of cutting public spending, the primary objective of the reform was to ensure financial sustainability both by cutting costs where possible and by increasing payments from the public. The aim was to increase charges on basic treatments (with exemptions for the lowest income groups), to increase charges on hospital stays and to allow for extra payment to receive “above-standard” treatment – all while maintaining free provision of the more expensive treatments. However, the Constitutional Court rejected the applicability of an “above-standard” category in July 2013. Further changes came both from subsequent Constitutional Court rulings and from decisions of the Sobotka government, removing many of the envisaged extra payments for patients. At the same time, the Ministry of Health started a debate on the sensitive issue of creating a system to evaluate the effectiveness of overall health care treatment.

Denmark

Score 8

The main principles of health care in Denmark are as follows: universal health care for all citizens, regardless of economic circumstances; services are offered “free of charge”; and elected regional councils govern the sector. Because financing through taxes depends on the state budget, regional authorities depend on annual budget negotiations with the Ministry of Finance.

Although Denmark spends a lot on health care, the OECD considers its performance to be “sub-par.”

While for a number of years health expenditures did not grow more than GDP, there was an upward trend during the period between 2000 and 2007, but health spending fell between 2008 and 2010. Since 2010 health spending has increased again. In 2012, health spending in Denmark was 11% of GDP, well above the OECD average of 9.3%. That puts Denmark in 7th place among OECD countries when it comes to spending. This increase is mainly driven by a change in policy from a top-down

system to a more demand-driven system. The latter has been motivated by a concern about long waiting lists and the move to offer a “time guarantee” where patients under the public system can turn to a private provider if the public health care system can’t meet the time limit for treatment in a public hospital. In addition, the previous liberal-conservative government took steps to bring more private providers into the sector. This is also reflected in the tax deductibility of employer-provided, private health insurance (abolished by the new government as of 2012).

The 2007 structural reform shifted the responsibility for hospitals and health care from the old counties to the new regions. Health care is financed by a specific tax, however, which is part of the overall tax rate and over which regions have no control. In the OECD Economic Survey in 2012, it was pointed out that there is “a lack of consistency in assignment of responsibilities across levels of governments, which generates waste through duplication, weak control over spending and lack of incentives to provide cost-effective services.”

Basic principles underlying the health care sector have thus changed in recent years. The changes reflect both ideological views but also the increasing demand for health care. A particular challenge for the future is how to manage and finance the need and demand for health care.

Life expectancy in Denmark in 2014 is 80.1 years, close to the OECD average of 80.2 years, but on a clear upward trend. There has been a marked decline in smoking in Denmark in recent years, but obesity rates have increased. The social gradient in health remains strong.

Citation:

OECD, “OECD Health Data 2012: How Does Denmark Compare,” (accessed 19 April 2013).

OECD, “OECD Health Statistics 2014: How does Denmark compare?” <http://www.oecd.org/els/health-systems/Briefing-Note-DENMARK-2014.pdf> (accessed 17 October 2014).

OECD Economic Surveys - Denmark, Overview, January 2012. <http://www.oecd.org/eco/49447668.pdf> (accessed 19 April 2013)

Estonia

Score 8

In terms of health care quality, Estonia can serve as a good example for how to achieve positive health outcomes with scarce resources. Public opinion surveys, regularly requested by the National Sick Fund, reveal that strong majority (above 85%) of the population is well satisfied with the services provided. The high quality of medical services can be attributed to two main factors: the long-standing universal health system that covers almost the entire population, and the high quality of training at medical schools and the University of Tartu.

In the 1990s, Estonia created a social-insurance-based health system. This included

some non-Bismarckian features such as general practitioners (GP). However, the principle behind the system affects access to health services. Members of the working-age population not employed or in school are not covered by the national health-insurance program. As a result, 6.2% of the total population does not have free access to health care.

Long waiting times to see specialists or receive inpatient care are another major problem. Patient satisfaction surveys (2014) reveal that while 85% of respondents are well satisfied in terms of getting appointment to see a GP, the total drops to 74% in the case of specialist care. In general, older people (50 to 74 years of age) tend to be more dissatisfied. The emigration of medical personnel due to work overload and inadequate salaries is further burdening the system. However, the most significant social problem with the Estonian health care system is inequality across income groups, especially in terms of self-perceived health status. Here, Estonia is at the absolute bottom among OECD countries. This problem has not been given sufficient policy or political attention.

Finland

Score 8

Health policies in Finland have led to improvements in public health, such as a decrease in infant mortality rates and the development of an effective health insurance system. Finnish residents have access to extensive health services, despite comparatively low per capita health costs. Yet, criticisms regarding life expectancy, perceived health levels, an aging population and inadequate provision of local health care resources are common. It is estimated that Finland's old age dependency ratio will be the highest among EU countries by 2025. Many clinics formerly run by municipal authorities have been privatized, which has led to increasingly attractive employment conditions for physicians.

Government planning documents outline preventive measures. For example, the 2015 Public Health Program is a central document which describes a broad framework to promote health across different sectors of government and public administration. Similarly, the Socially Sustainable Finland 2020 strategy, sets out the current aims of Finland's social and health policy. An action plan for gender equality was approved by government in 2012. A major structural reform plan (SOTE) seeks to move responsibilities for social welfare and health care services from municipalities to larger governmental entities. At the time of writing, however, final decisions concerning the implementation of the plan still remain to be taken.

Citation:

"Government Resolution on the Health 2015 Public Health Programme". Helsinki: Publications of the Ministry of Social Affairs and Health, 2001; Juha Teperi et al., "The Finnish Health Care System", Sitra Reports 82, 2009; "Socially Sustainable Finland 2020. Strategy for Social and Health Policy", Ministry of Social Affairs and Health, 2014.

Germany

Score 8

The German health care system is of high quality, inclusive and provides health care for almost all citizens. It is, however, challenged by increasing costs. Recently, the system's short-term financial stability was better than expected due to buoyant contributions resulting from the employment boom. However, long-term financial stability is challenged by the aging population. In its coalition agreement, the incoming grand coalition negotiated a variety of reform measures to increase the quality of the health care system, redefine some financial details, and reorganize the registration of physicians in private practices and the distribution of hospitals.

The most important reforms included the reduction of the contribution rate from 15.5% to 14.6% and the confirmation of a fixed contribution rate for employers of 7.3% (employee contributions are 7.3%, again equal to that of the employers' share). The additional contribution from employees, which was previously a lump-sum contribution, is now calculated as a percentage of their assessable income. This additional contribution rate can in future be set by each health insurance provider in accordance with its own financial needs, with the consequence of rising competition between insurers.

Concerning long-term care, the contribution rate for long-term care insurance will be raised by 0.3 percentage points in 2015 and by a further 0.2 percentage points in the course of the current legislative period. Thus, a total of €5 billion will additionally be available for improvements in long-term care. A part of the additional revenue will feed a precautionary fund intended to stabilize future contribution rates. In addition, families that wish to provide care at home are given greater support.

In general, the health and long-term care insurance systems are structures of continuing reforms that try to balance high quality and inclusive health care with increasing costs.

Israel

Score 8

Under the 1995 National Insurance Act, all citizens in Israel are entitled to medical attention through a health maintenance organization (HMO). This is a highly universal and egalitarian law, allowing for broad access to subsidized primary care, medical specialists and medicines. A 2012 OECD survey identified the Israeli health care system as one of the best in the developed world, ranking fifth with a score of 8.5 out of 10. Although the OECD noted Israel's low average level of public funding, nursing shortage and overcrowded hospitals, it cited the decreasing mortality rate and high doctor/population ratio.

The OECD also acknowledged the Israeli system's efficiency, characterized by a

unique auditing and regulatory system for HMOs, which offers constructive criticism and guidance as opposed to monetary inducements. However, it criticizes a lack of communications between HMOs and hospitals. Similar concerns are raised by NGOs arguing that recent privatization campaigns have led to a deterioration in efficiency, with Israeli facilities suffering from long waiting periods and exhausted personnel. Health professionals have publicly stated that the OECD survey was premature, as the deterioration in services has not yet become widely evident, but is starting to affect the quality of care.

Despite wide coverage, low-income families still have poor access to dental care and nursing. Israeli health services also experience privatization pressures. An increase in supplemental and private medical-insurance and health care plans has resulted in reduced equality within the system. This process has been aggravated by a contraction in public funding. In terms of ensuring access to health care and when adjusting for population age, Israel ranks 16th out of 24 OECD countries surveyed.. Furthermore, the quality of health services and facilities varies based on geographical location, with periphery facilities often struggling to attract skilled personnel. Still, the Israeli system is fairly equitable in international comparison.

In 2013, the minister of health chaired a special committee to strengthen the public health system. The committee offered its recommendations regarding public and private health care services, private insurance regulation, the dual role of the ministry as regulator and service provider, and medical tourism in hospitals. Some of its recommendations were implemented in the 2015 budget.

Citation:

Bowers, Liora, "Policy Brief: Hot Issues in Israel's Health care System", Taub center March 2014.

Sevirsky, Barbara, "The state is not keeping healthy," Adva center website, September 2012 (Hebrew)

Even, Dan, "The health care system in Israel: Diagnose positive, symptoms are negative," Ha-aretz website, 3.4.2012 (Hebrew)

Nisim Cohen, "Policy entrepreneurs and molding the public policy: The case of the national health insurance act," Social security 89 (July 2012), 5-42. (Hebrew)

"Israel: excellent primary health care, but hospitals must improve," OECD, 14.10.2012.

"OECD health data 2012: How does Israel compare," OECD.

"The insured population," Israeli ministry of health, 30.1.2012 (Hebrew)

Luxembourg

Score 8

Luxembourg's well-equipped hospitals offer a wide range of services, including high-end, expensive treatments, and waiting lists are rare, except for some services that are highly demanded, like MRI. Luxembourg also has the highest share of

patient transfers to other countries for treatment within the European Union. Due to the country's small size and the absence of a university hospital, it is not possible to provide every medical specialization. Necessary medical transfers to neighboring countries have the side effect of being beneficial for the finances of the state health-insurance program, as those services are in general less expensive abroad.

Drawbacks to the Luxembourg system include the aforementioned lack of a university hospital and the individual nature of doctor's contracts and treatment responsibilities. Most resident general practitioners and medical specialists sign contracts with individual hospitals and are responsible only for a certain number of patients (*Belegbetten*), which prevents any sort of group or collective treatment options. Some hospitals have organized in such a fashion as to keep doctors' offices "in house," but this has not changed their status as independent actors (*Belegarzt*).

Luxembourg's system of health insurance providers has been gradually unified; in January 2009, of the nine – typically corporatist – providers, six were merged into a single national health insurance (*Caisse nationale de santé*). The remaining three independent schemes are for civil servants, and while they operate independently, they offer the same coverage and tariffs for health care provisions. The overall objective is to end up with a universal system; the system up to now functions with equal contributions from employees and employers, plus an important contribution from the state. The same tariff structures exist for all doctors and patients (including for the three independent insurance programs). Access to treatment under the Luxembourg health care system is limited to contributors (employees, employers and their co-insured family members) only. It excludes newcomers without a work contract or those who do not have another form of voluntary insurance coverage. Applicants for international protection are insured via the competent ministry. Furthermore, Luxembourg's national insurer offers generous reimbursements; out-of-pocket expenses for patients in Luxembourg are the lowest within the OECD.

However, Luxembourg's health care system is also considered one of the most expensive within the OECD countries, ranked fourth after Switzerland, Norway and the United States. The reasons for this include the country's high wages, the high ratio of technical medical equipment to residents and the low out-of-pocket costs for patients. Furthermore, authorities for years have tried to limit general provisions offered by all hospitals, instead offering incentives to limit treatment in specialized centers, for example. The proposed introduction of the psychotherapists' law will improve the provision of health care, but also implies additional charges. While necessary health care reforms have been initiated, most of the details are still far from being implemented. During the coming year, the new government is expected to swiftly implement a comprehensive reform of the health-insurance system (for example, introducing digital patient files, a primary-doctor principle and state grants for sickness benefits) with the aim of improving the long-term budgetary sustainability the health care and statutory nursing care systems.

Citation:

<http://www.gouvernement.lu/3680390/cg.pdf>

<http://www.legilux.public.lu/leg/a/archives/2008/0060/a060.pdf#page=2>

http://www.mss.public.lu/publications/divers/health_glance.pdf

New Zealand

Score 8

Although there is both public and private provision of health care, access to the public hospital system is freely available to all New Zealand residents. Health care is not only generally of a high quality, it is also cost effective and relatively efficiently managed. At the same time, the sector faces growing expectations and rising cost pressures, partly as a result of an aging population, but also as a result of gradual increases in the numbers of immigrants. Gains have been made in terms of reducing the health status gap between Maori and non-Maori. Gaps in life expectancy have been reduced but more remains to be done, including changes in behavior and lifestyle. Concerns about health disparities have been an ongoing concern, as noted by Organization for Economic Cooperation and Development (OECD) reports. Concerns about rising costs and a lack of productivity gains in the sector led to the establishment of a ministerial review group and a national health board in 2009, with the task of improving coordination between the ministry and district health boards and to advise on the allocation of budgets. Health reforms since 2009 have encompassed regional consolidation of hospitals and primary care organizations, increased use of benchmarking and greater decentralization.

Citation:

OECD Economic Surveys: New Zealand (Paris: OECD 2013).

OECD Health Statistics 2014: How Does New Zealand Compare (Paris: OECD 2014).

South Korea

Score 8

There were no major changes in the health care system during the assessment period. South Korea has a high-quality and inclusive medical system, and experienced the highest increase in life expectancy among OECD countries – an increase of 27 years to 79.8 years between 1960 and 2008. Health spending per person increased significantly between 2000 and 2011, the highest growth rate among OECD countries. Yet, total expenditure on health as proportion of GDP was 7.4% in 2011, below the OECD average of 9.3%. The public sector provides slightly more than half of all health care funding. The universal health insurance system has relatively low premiums, but high co-payments. South Koreans can freely choose doctors, including private practitioners, but coverage for medical procedures is narrower than in most European countries. Out of pocket payments account for 32% of all health expenditure. High co-payments have the problematic effect that access to medical services depends on personal wealth.

Citation:

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OECD, Health Data 2013, Health at a glance 2013, <http://www.oecd.org/els/health-systems/Health-at-a-Glance-2013.pdf>

OECD, Health Data 2009 - Country notes Korea, <http://www.oecd.org/dataoecd/46/10/38979986.pdf>

OECD, Health Data 2011 - Country notes Korea, <http://www.oecd.org/dataoecd/46/10/38979986.pdf>

United Kingdom

Score 8

The National Health Service (NHS) remains a cornerstone of the United Kingdom's universal welfare state under the coalition government. However, a policy of reforming the system with a goal of decentralization to clinical commission groups has been controversial, and has affected all 8,000 general practices in England. Most health care provided by the NHS is free at the point of delivery, although there are charges for prescriptions and for dental treatment (with significant exceptions, e.g., no charges for prescriptions for pensioners). There is a limited private health care system.

While patient convenience may not be a central focus of NHS provision, attempts have been made to improve local healthcare by creating Health and Well-Being Boards to bring together representatives from all social services as well as elected representatives. The NHS's quality as measured by the HDI health index is very high (0.951).

As a universal service, the NHS scores very highly in terms of inclusion. The Health and Social Act 2012 now also allows patients to choose a general practitioner without geographical restrictions.

The NHS budget was ring-fenced in the coalition's budget cuts. However, due to faster rising inflation within the NHS, a spending squeeze took place. Given that the United Kingdom spent some 8.1% of GDP on health, it must be considered highly cost-efficient given outcome indicators. Some recent incidents (including underperforming hospitals) have provoked a debate about quality that is likely to lead to managerial reform. There has also been concern about rapidly rising demand for accident and emergency services, a change that has yet to be fully explained, although there is concern that the balance between primary care by general practitioners and secondary care in hospitals is becoming inappropriate. A further concern is that integration between care services and traditional health care institutions is unsatisfactory, especially for older patients, resulting at times in "bed-blocking" in hospitals. New mental-health initiatives have been promised, but have yet to be introduced.

Belgium

Score 7

In Belgium, public hospitals own and maintain good equipment and university hospitals offer advanced treatments, given the institutions' participation in medical research. Coverage is broad and inclusive. Access to health care is quite affordable, thanks to generous subsidies. Belgium fares quite well in terms of the efficiency of its health care system. It ranks close to Sweden, which is often considered as a benchmark of efficiency for affordable access to health care.

A problem is that costs have been contained by cutting wages and hospital costs in ways that do not seem viable for the future, even more so with an aging population. Too few graduating doctors are allowed to practice, and the short supply of doctors in the country may compel an increasing number to leave the public system and the constraints imposed by state subsidies and move to fully private practices. Inclusiveness may thus be threatened in the medium-term.

Another issue is that Belgium does not emphasize prevention, and spends more than similar countries on subsidized drugs, which generates a structural increase in health policy costs and hampers the long-run sustainability of the health care system.

Recently, entire areas of state competences regarding health care have been conferred to the regions (Wallonia, Flanders and Brussels) in order to allow them to tackle sustainability issues at a more local level. The hope is that this makes each of these governments more accountable. However, this devolution of competences risks a loss of coordination and increased costs (e.g., expensive large medical equipment) in a country where one can move from a hospital in one region to another in a 20-minute drive. There is also a risk of lost management competence, since the pool of ministers and experts is a lot smaller in the regions than in the country as a whole.

Chile

Score 7

For more than three decades, Chile has maintained a dual health system, with one pillar represented by private insurance and private health care services chosen by self-financing participants (typically upper middle-income and high-income groups), and another pillar of public, highly subsidized insurance and public health care services for participants who pay only part of their health costs. This system provides broad coverage to most of the population, but with large differences in the quality of health care provision (including waiting times for non-emergency services). A significant reform has been implemented gradually since 2003, expanding the range of guaranteed coverage and entailing a corresponding extension of government subsidies to low- and middle-income population groups. In contrast to other policies, this reform has been pursued in a very consistent and solid way, although some failures can be detected regarding the budget provided for public health and

administrative processes. Above all, primary health care within the public system has shown great advances in coverage and in quality. In the domain of the more complex systems of secondary and tertiary health care, a more problematic situation is evident. These levels show funding gaps and an insufficiency of well-trained professionals. There is still a huge gender gap with regard to health care contribution rates, since maternity costs are borne only by women.

For these reasons, the quality and efficiency of public health care provision (government clinics and hospitals) varies widely.

France

Score 7

France has a high-quality health system, which is generous and largely inclusive. Since its inception, it has remained a public system based on a compulsory, uniform insurance for all French citizens, with employers' and employees' contributions calculated according to wage levels. Together with widespread complementary insurances, they cover most individual costs. About 10% of GDP is spent on health care, one of the highest ratios in Europe. The health system includes all residents, and actually offers services for illegal immigrants and foreigners.

The problem is cost efficiency and the containment of deficits, which have been constant in recent years. Since 1996, parliament has voted on an annual expenditure target for the whole system but, in practice, this target has been regularly exceeded (it faced a deficit of €12 billion in 2014). The government has found it difficult to impose targets for the evolution of expenditures, pharmaceutical prices, medical treatment, physician remuneration and wages (for hospital employees). Savings have improved recently, but the high level of medication consumption is an issue still to be tackled with more decisive measures.

Italy

Score 7

Italy's national health system provides universal comprehensive coverage for the entire population. The health care system is funded primarily through the central government, but health care spending is administered by regional authorities. On average, the services provided achieve medium to high standards of quality (a recent Bloomberg analysis ranked the Italian system among the most efficient in the world), but, due to significant differences in local infrastructures, cultural factors, and the political and managerial proficiency of local administrations, the quality of public health care is not nationally uniform. In spite of similar levels of per capita expenditure, services are generally better in northern and central Italy than in southern Italy. In some areas of the south, corruption, clientelism and administrative inefficiency have driven up health care costs. In these regions, lower quality levels and typically longer waiting lists mean that wealthier individuals will often turn to

private-sector medical care. Regional disparities also lead to a significant amount of health tourism heading north. Early moves in the direction of fiscal federalism are now stimulating efforts to change this situation through the introduction of a system of national quality standards (correlated with resources), which should be implemented across regions.

Preventive health care programs are effective and well publicized in some regions such as Tuscany and other northern and central regions. However, such programs in other regions such as Sicily are much weaker and less accessible to the average health care user.

As is the case in Greece, increasingly more NGOs (e.g., Emergency) traditionally active in developing countries are providing services within Italy and providing essential health care to citizens who are falling through the cracks of the Italian public health care system. As household incomes are shrinking and citizens are increasingly burdened with additional medical services costs (e.g., dental medicine and general prevention) not covered by the public health care system, overall public health is expected to decline in the coming years.

Citation:

<http://www.bloomberg.com/visual-data/best-and-worst/most-efficient-health-care-2014-countries>

Japan

Score 7

Japan has a universal health care system. It also has one of the world's highest life expectancies – 80 years for men and almost 87 for women (at birth). Infant mortality rates are among the world's lowest (2.1 deaths per 1,000 live births). However, a prevailing shortage of doctors represents one serious remaining bottleneck. The number of doctors per capita is some 40% lower than in Germany or France. However, judging on the basis of fundamental indicators, Japan's health care system, in combination with traditionally healthy eating and behavioral habits, delivers good quality.

Nonetheless, the health care system faces a number of challenges. These include the needs to implement cost containment, enhance quality and address imbalances. Some progress with respect to cost containment has been made in recent years, but the LDP-led government seems determined to postpone adjustments for electoral reasons. In January 2013, the Supreme Court ruled against a ban on online sales of certain over-the-counter drugs. Despite Prime Minister Abe's stated intention of making, by means of deregulation, health care an area of strategic growth, the Ministry of Health, Labor and Welfare has dragged its feet on liberalizing the market (even after a lifting of restrictions on online non-prescription drug sales in mid-2013). A further easing of controls on medications was introduced in 2014, but considerable regulations remain in place.

Although spending levels are relatively low in international comparison, Japan's population has reasonable health care access due to the comprehensive National Health Care Insurance program.

Lithuania

Score 7

The Lithuanian health care system includes public-sector health care institutions financed primarily by the Statutory Health Insurance Fund as well as private-sector health care providers financed both by the fund and patients' out-of-pocket expenditures. According to the 2010 Eurobarometer report, only 40% of Lithuanians assessed the overall quality of the country's health care as good in 2009, compared to an EU-27 average of 70%. The Lithuanian health care system received the seventh-lowest rating in the European Union, with 58% of respondents saying that the overall quality of health care was fairly or very bad.

As reported in the 2007 Eurobarometer report, 65% of Lithuanians perceived gaining access to hospitals to be very or fairly easy, but this indicator was also below the EU-27 average of 76%. In the same survey, the Lithuanians assessed the affordability of hospitals less favorably than was the EU-27 average; 33% of Lithuanians asserted that hospital services were not very affordable or were not at all affordable, compared to the EU-27 average of 21%. Lithuania spent only about 7% of GDP on health care in 2010. This share increased during the 2007 – 2009 period, fell again in 2010 due to the economic crisis, with lower contributions by employees and their employers to the National Health Insurance Fund largely offset by budgetary transfers. Spending on preventive-care and other related health programs as a percentage of current health care expenditure is quite low, while spending on pharmaceutical and other medical non-durables (as a percentage of current health expenditure) is quite high.

Nevertheless, new prevention-focused programs were recently introduced by the National Health Insurance Fund. The provision of health care services varies to a certain extent among the Lithuanian counties; the inhabitants of a few comparatively poor counties characterized by lower life expectancies (e.g., Tauragė county) on average received fewer health care services. Out-of-pocket payments remain high (in particular for pharmaceuticals), a fact that may reduce health access for vulnerable groups. Seeking to improve service quality and cost efficiency, the previous government sought to optimize the network of personal health care organizations; the overall number of these bodies was consequently reduced from 81 to 62 by the end of 2012. The current government by contrast places more emphasis on the accessibility of health services, the role of public health care organizations in providing these services, and the issue of public health in overall health policy. If the country's primary-care system is strengthened, more patients could be treated at this level, thus increasing overall efficiency in the health system. However, instead of dealing with issues of efficiency and undertaking a restructuring of services

providers, the minister of health care simply criticized private health care service providers. In mid-2014, he was nominated by the government to the European Commission, and became a commissioner responsible for health and food safety.

Citation:

The 2010 Eurobarometer report is available at http://ec.europa.eu/public_opinion/archives/ebs/ebs_327_en.pdf

The 2007 Eurobarometer report is available at http://ec.europa.eu/public_opinion/archives/ebs/ebs_283_en.pdf

Murauskiene L, Janoniene R, Veniute M, van Ginneken E, Karanikolos M. Lithuania: health system review. *Health Systems in Transition*, 2013; 15(2): 1–150. http://www.euro.who.int/__data/assets/pdf_file/0016/192130/HiT-Lithuania.pdf.

Malta

Score 7

Malta provides quality health care to all its citizens, with quality inpatient and outpatient hospital services offered for free. This is reinforced by agreements with the United Kingdom, as well as additional contracts struck in 2012 with Italian hospitals to service patients in need of special treatment not available locally. The World Health Organization (WHO) ranks Malta's health care system among the top 10 in the world. A small number of private hospitals also exists.

All citizens are entitled to free hospital care, and vulnerable groups are entitled to state support for a list of prescription medicines. All citizens are entitled to free medicines in relation to specified chronic diseases such as high blood pressure and diabetes. However, other more expensive treatments – for instance, those required by oncology patients or necessitated by certain eye conditions – are given only limited coverage, and such patients face treatment costs amounting to thousands of euros. Long waiting lists tend to push many into the private health care system, though in 2012 the government fostered cooperation with private hospitals to reduce waiting lists for certain in-demand procedures. The private sector accounts for approximately two-thirds of the workload in primary health care; however, health care delivery in Malta is dominated by the public sector, with 96% (1,748 beds) of hospital beds publicly owned and managed, and the remaining 85 are privately owned. Inadequate managerial capacity and political interference sometimes undermine equity in health delivery and the unacceptable waste of medical resources has recently been brought to light.

Since 2013, efforts have been made to reduce hospital waiting lists, with success in some areas. The government is trying to remedy shortcomings associated with the new general hospital, such as the fact that the new facility offers less bed space than its predecessor. An ongoing building program is aimed at providing more wards and hospital beds, and a new oncology hospital. The reduction in waiting times achieved by these measures, if sustained, will lead to a more equitable health service.

In 2010, Malta's total health care expenditure amounted to 8.6% of GDP. This compares well to the EU-27 average of 9%. It is estimated that as much as 65% of Malta's total health care expenditure is financed by the government. Unfortunately, the lack of reliable data makes it difficult to evaluate cost efficiency. The European

Union has often stressed the need for reform to ensure sustainability. However, such sustainability is further threatened by high immigration rates and conflict in neighboring states.

Citation:

Three Health Agreements Signed With Italy. Times of Malta 05/09/12

The World Health Report 2000

Healthcare Delivery in Malta 2012 www.pwc.com/en_MT/.../healthcare/.../healthcare_delivery_august_2012

Times of Malta, Malta elected to WHO Executive Board, 16/09/2014.

John Cassar White, Times of Malta Fixing the Public Health Service, 08/09/2014.

Ivan Martin, Sunday Times of Malta, Hospital shake-up to create 400 new beds, 31/08/2014.

A National Health System Strategy for Malta 2014 - 2020 June 2013

Netherlands

Score 7

The hybrid professional market system for health care provision is no longer hotly contested, but this may change. A 2012 report by the Social and Economic Council of the Netherlands intends to strengthen outcome steering against input and throughput steering. A considerable expenditure rise in long-term care is expected and is of great concern to policymakers, as is an anticipated deficit in human capital. There are increasingly mixed feelings among policymakers about the privatization of the health care system. These mixed feelings are driven by the following developments:

Quality

Mortality from cardiovascular diseases for the first times since many years has slightly increased. While deaths from cancer were slightly up, preventive breast cancer screening for women is almost exhaustive. Average life expectancy (79.1 years for males, 82.8 for women) and perceived health remained the same; there are fewer heavy smokers and drinkers, and obesity seems to have stabilized. Patient satisfaction is high (between 7.7 and 7.9), especially among the elderly and lower-educated patients. Patient safety in hospitals, however, is a rising concern both for the general public and for the Health Inspectorate. In 2014, the Borstlap Commission's report clearly revealed that the Health Inspectorate was not up to its regulatory and monitoring tasks. The Inspectorate's independence, information and personnel management was undermined by scandals; its organizational culture has proven resistant to criticism.

Inclusiveness

Inclusiveness is very high for the elderly in long-term health care, and drug prescriptions are much lower for high-income groups than for low-income groups. However, there is a glaring inequality that the health care system cannot repair: life expectancy for the rich is 7–8 years longer. In terms of healthy life years, the difference is actually 18 years. Recent research also revealed considerable regional

differences in chronic illnesses and high-burden diseases; differences in age composition and education only partially explain these differences.

Cost Efficiency

In the new System of Health Accounts, the Dutch spend 15.4% of GDP for health care, or €5,535 per capita. This is largely due to the relative amount spent on long-term care – hence the concern among policymakers. On the plus side, it should be mentioned that care costs in 2012 were at +3.7% – lower than in the previous decade, but up again from 2010–2011; the number of people employed in care was less than in previous years. Labor productivity in health care rose by +0.6% annually – almost all in hospital care and none in long-term care. Private business profits for general practitioners, dentists and medical specialists in particular increased much more than general business profits. Part of the costs for health are just transferred to individual patients. Even with obligatory health insurance, care and medicine costs up to €75 (€60 in 2012) are considered a patient's own risk. Another means of increasing patients' cost awareness is through increased transparency of health institutes (e.g. rankings with mortality and success rates for certain treatments per hospital). The struggle for cost efficiency leads to increased centralized power between health institutes' managers and insurance companies, frequently at the expense of health professionals.

Citation:

CPB Netherlands Bureau for Economic Policy Analysis "Health care reform in the Netherlands" Retrieved from http://www.cpb.nl/nl/org/homepages/rcmhd/reform_english.pdf (April 16th 2010)

CBS (2013) Gezondheid en zorg in cijfers 2013, Den Haag/Heerlen

CBS (2012), Welvarende mensen leven langer in goede gezondheid (www.cbs.nl/nl-NL/menu/themas/gezondheid-welzijn/publicaties)

SER (2012) Naar een kwalitatief goede, toegankelijke en betaalbare zorg, Advies 12/06, uitgebracht aan de Minister van Volksgezondheid, Welzijn en Sport

Commissie Borstlap, Het rapport van de onderzoekscommissie intern functioneren NZa, 2 September, 2014

Norway

Score 7

Norway has an extensive health care system, providing high-quality services to its resident community. Anyone who is resident in Norway has a right to publicly provided economic assistance and other forms of community support while ill. Health care for mothers and children is especially good, as in other Scandinavian countries. Infant mortality is the sixth-lowest in the world. Per-capita health expenditures in Norway are more than 50% higher than the OECD average. The country's total health care expenditures total about 12% of GDP, a third more than the OECD average. The public share of this expenditure in Norway is also high, with 84% of health care spending financed by the government.

Yet though Norway offers high-quality health care services to the entire population, the efficiency of this system is questionable. In a major structural health care reform in 2002, ownership of all public hospitals was transferred from counties to the central state. Subsequently, new health care regions were established, which were larger than the previous ones. These regions were given responsibility for managing service delivery, but without ownership. The intention was for these regions to streamline and coordinate health care services, thus imposing a stricter regime of budget discipline. However, reorganization has been slow and costly; the process remains ongoing, and even after more than 10 years, is nowhere near complete. Vast amounts of resources are being consumed by procedural work and pervasive conflict, while efficiency gains, if they are to come, have yet to be identified. This reform has been uniquely unsuccessful by Norwegian standards. A previous reform, which came into effect in 2001, established a general-practitioner system for the first time, thus ensuring that all persons and households would have a designated primary-care doctor or practice. This was implemented with relative ease, and contributed to a notable improvement in access to high-quality primary health care.

Spain

Score 7

The Spanish national health care system is relatively well-thought out and it largely achieves the criteria of quality, inclusiveness and cost efficiency. According to a report published in 2014 by the OECD and the European Commission, the data regarding high life expectancy and low mortality rates from all causes of death (including heart diseases, cancer, transport accidents or infant mortality) demonstrate the effectiveness of the policy. However, rates of mental illnesses, diabetes and drug consumption are higher than the European averages, though HIV-AIDS, cocaine use and smoking have declined sharply in recent years. Thus, Spaniards' self-perceptions of their own health status and their opinions regarding the national health care system reflect a degree of satisfaction that is quite high in cross-OECD comparison.

The number of practicing doctors, nurses and hospital beds per 1,000 residents is relatively low, but access to a core set of high-quality health services is guaranteed through a public insurance system that covers 99% of the population. But the quality of this system has deteriorated in recent years. As in other southern euro zone countries, health care spending has fallen in Spain. The most recent reports emphasize deficiencies in waiting lists, patient rights and sickness prevention. There is also interregional inequality. Nevertheless, health care spending still accounts for a large share of public funds, representing approximately 9% of GDP – which is close to the OECD average.

Inclusiveness has suffered as a consequence of the Royal Decree Law of “Urgent Measures to Guarantee the Sustainability of the National Health System and Improve the Quality and Security of its Services.” This legal reform, approved in 2012, involves the (1) refusal to provide assistance to unregistered immigrants and (2) an

increase in the percentage of medicines paid for by users, including senior citizens (who must now pay 10%) and general workers (who must cover 40% to 60% of medicine costs, depending on their incomes). Conversely, the system has become more cost efficient, in particular with regard to pharmaceutical spending. Whereas the economic crisis given rise to problems for the short term, an aging population (one out of five Spaniards will be older than 65 years of age by 2025), increases in chronic diseases, new and highly expensive treatments, and a general abuse of free medical appointments are jeopardizing the system's sustainability in the medium and long term.

Citation:

OECD and European Commission. 2014. Health at a Glance: Europe 2014 Report http://ec.europa.eu/health/reports/docs/health_glance_2014_en.pdf

Sweden

Score 7

The health care system continues to be a problem area for Sweden, as is the case for most European countries. The media regularly reports on excessive waiting times in emergency rooms and scandals in long-term care, in which patients received sub-standard treatment. These weaknesses may be the consequence of far-reaching privatization measures during the most recent past. Another problem is that the administrative oversight of health care quality is weak.

The general account of Swedish health care is that once you receive it, it is good. The problem is access. Regional governments ("landsting") provide health care, allocating about 90% of their budgets to this purpose. Health care is divided into primary care, which is delivered locally (albeit under the auspices of regional government), and advanced care, which is provided by the hospitals.

The key problem, as pointed out in the 2011 report, is a governance problem. Health care is driven by three contending sources: elected officials, the medical profession and the market. These three sources governing the health care system send different signals, make different priorities, and allocate resources differently. This bureaucratic split at the top has the effect of reducing quality, inclusiveness and cost efficiency.

Partly as a result of these problems, a rapidly increasing number of people in Sweden purchase private health insurance. Estimates in 2014 suggest that about 575,000 Swedes, or about 15% of the working population, have a private health insurance policy, either purchased privately or provided by the employer. The rapidly increasing number of private health insurance policies clearly suggests a lack of faith in the expediency and quality of public health care.

Specific assessments:

- The quality of advanced medical care is generally quite good. The care provided by hospitals draws on close access to research centers and is of high standard.
- Concerning inclusiveness, eligibility to health care is generously defined in Sweden. Instead, the big problem is the waiting time from diagnosis to treatment. The previous, non-socialist government introduced a “care guarantee,” (“vårdgaranti”) which entitles a patient to seeing a GP within 90 days. Evaluations suggest that the guarantee has somewhat improved the situation but also that a large number of patients still have to wait beyond the stipulated 90 days for treatment.
- Properly assessing cost efficiency in the health care sector is extremely difficult. The medical profession advocates that evidence-based assessment of costs for treatment and medication are used to a greater extent than is presently the case, that is, costs should be related to expected patient utility.

Citation:

Socialstyrelsen (2012), Vårdgaranti och kömiljard - uppföljning 2009-2011 (Stockholm: Socialstyrelsen).

Kollega, 20 February 2014: “Sjukvård som förmån ökar” (<http://www.kollega.se/sjukvard-som-forman-okar>).

United States

Score 7

In March 2010, Congress enacted the Patient Protection and Affordable Care Act (ACA). The main goals of the legislation are to lower costs in the health care sector and extend health care coverage to more people. The design of the ACA is essentially to fill gaps in the patchwork of financing arrangements that are embodied in the existing health care system. Specifically, it provides a mandate for employers of a given size to provide coverage for employees; it requires individuals not otherwise covered to obtain coverage, providing subsidies for individuals who otherwise could not afford coverage; it expands the state-administered Medicaid program for low-income citizens, raising the income ceiling for eligibility; it requires health insurers to extend coverage of an insured family’s children through the age of 25; and it prohibits insurers from denying coverage on the basis of “pre-existing conditions.” It is projected to increase coverage from 83% to 94% of the population. According to calculations by the Congressional Budget Office, the ACA will reduce the federal deficit by \$85 billion.

Health care reform was a highly controversial topic before and during the policy’s passage, and remains a contested political issue. Republicans in the House have voted about 40 times to repeal “Obamacare.” Public opinion has been fairly evenly divided on approval versus disapproval of the bill – although a large fraction of those who disapprove believe that the bill did not go far enough. Some state governments headed by Republican governors have so far declined to provide the expanded Medicaid coverage to low-income families, even though the federal government would pay 90% of the cost. As of 2014, the program’s results continue to stoke

controversy. More than 7 million individuals have signed up for care; but many of these previously had coverage or did not pay premiums. A September 2014 Gallup poll indicates that the number of people without health coverage has declined from 18% to 16%; the approaching second sign-up period may significantly expand coverage. The Supreme Court has accepted a case that challenges some of the program's central financing practices as invalid.

Citation:

Kollipara, Puneet. "Workbook: Obamacare, by the Latest Numbers." Washington Post. The Washington Post, 25 Sept. 2014. Web. 25 Oct. 2014.

Cyprus

Score 6

High-quality medical services are provided by the public sector, which is the main system available, as well as by private clinics and individual doctors. Various health-insurance schemes also cover professional groups. A shift toward private health care in the early 2000s has now been reversed due to the recent income decline. Despite constraints and deficiencies in infrastructure and human resources (see OECD statistics) that lead to long queues, waiting lists and delays, the quality of services offered by the public system is acknowledged by the World Health Organization (WHO) to be high. A very low infant-mortality rate (3.5 per 1,000 in 2012) and a high life expectancy at birth (79 years for men, 82.9 for women in 2011) are indicative of this high quality. Preventive medicine is specifically promoted, with Cyprus ranking high worldwide with respect to expenditure in this area.

Access to public health care services has been subject to reform, leading to exclusion of groups with high income, those who own significant property, and some others, amounting to 20% – 25% of the population. A special income-based contribution to the system has been imposed on beneficiary groups, while minimum rates for services and medicines have also been introduced. For the first time, all employees and pensioners of the public service, who were previously eligible for free health services, are also required to pay contributions into the system. Public health care is available both in hospitals in the main towns and townships, and in rural medical centers.

The provisions of the MoU require that Cyprus cease being the only EU member lacking a national health system (NHS). Provision of basic NHS services are thus slated to start in 2015, and be completed in 2016. In its early stages, the ongoing reform of the Health Ministry and the health system is making the system less inclusive. However, the shape of the final outcome remains unclear, both in terms of service quality and cost in the public and the private sectors.

Citation:

1. Eligible for public health services reduced, <http://www.philenews.com/el-gr/koinonia-eidiseis/160/211347/meiothikan-kata-130000-oi-dikaiouchoi-dorean-perithalpsis> (in Greek)

Iceland

Score 6 On average, the health care system, in Iceland is very efficient and of a high-quality. However, there is considerable variation between regions. For example, health care services in Reykjavík and its surroundings as well as the northern city of Akureyri are much better than comparative services in more peripheral, rural areas where patients have to travel long distances to access specialized services. Since the 2008 economic collapse, the government has introduced substantial cutbacks for a number of regional hospitals, closed departments and centralized specialized care facilities. In addition, smaller regional hospitals and health care centers have had serious problems in recruiting doctors. Waiting times for appointments with specialized doctors can be as much as several months.

The University Hospital in Reykjavík, the largest hospital in Iceland, has for several years been in a difficult financial situation. The government has not provided additional public funds nor allowed the hospital to independently raise funds through, for example, patient service fees. The resulting shortage of nursing and other medical staff has increased the work pressures and working hours on existing staff. Despite being an issue in the 2013 election, the question of how to finance a redevelopment of the University Hospital in Reykjavík remains. Many of the buildings are old and dilapidated, yet investment is also required to fund the purchase of new equipment. In the aftermath of the 2008 economic collapse, it has been difficult to publicly finance both a redevelopment of the hospital buildings and the purchase of new equipment. Discontent with this situation led to a strike by the doctors in late 2013.

Citation:

The sentence “The government finally gave in, granting the doctors something like a 20% wage increase plus a promised new hospital.” has been deleted because this occurred in January 2015.

Portugal

Score 6 Portugal’s population shows comparatively good levels of overall health. However, the country’s National Health Service (NHS) came under particular financial pressure in the period analyzed here, as a result of the pressure on Portugal to curb public expenditure.

As such, health expenditure has been cut considerably. The OECD estimates a reduction in health expenditure of approximately 6% per year in 2011 and 2012. In 2013 and 2014, these cuts continued, with the 2013 budget forecasting a 5% reduction in the National Health Service budget, followed by a further 3.8% in 2014.

Moreover, the increases in fees associated with use of the NHS, originally adopted in 2012, remained in place during the period analyzed here.

Overall, these cuts have affected NHS inclusiveness and to a lesser extent quality, even if the Portuguese health-system standards remain relatively high.

This pattern is reflected in life expectancy at birth, with the latest data indicating this figure to be 77.3 years in 2012, the same value as in 2011 (Eurostat data). However, this stability means that Portugal diverged further from the EU average in 2012.

Citation:

Eurostat data -“Life expectancy at birth, by sex”

OECD, “OECD Health Statistics 2014 How does Portugal compare?,” available online at: <http://www.oecd.org/portugal/Briefing-Note-PORTUGAL-2014.pdf>

Slovenia

Score 6

The Slovenian health care system is dominated by a compulsory public-insurance scheme. This scheme guarantees universal access to basic health services, but does not cover all costs and treatments. In order to close this gap, citizens can take out additional insurance offered by Vzajemna, a mutual-health-insurance organization established in 1999, or, since 2006, by two commercial insurance companies. The quality of services, which are partly delivered by private providers and are organized locally, is relatively good, and total health spending is slightly below the OECD average. However, both the compulsory public health-insurance scheme and the supplementary health-insurance providers have suffered from severe financial problems for some time, resulting in rising losses among the majority of health providers. While the need for reforms has been broadly accepted, no major reforms have been adopted. The Bratušek government failed to adopt such a reform despite declaring this to be one of its most important policy goals. Health care reform has featured prominently in the announcements of the Cerar government, which has emphasized an intention to eliminate the need for the supplementary health-insurance schemes.

Turkey

Score 6

The 2003 Health Transformation Program has produced significant improvements in Turkey’s health care system in terms of access, insurance coverage, and services. As a result, the health status of Turkey’s population has improved significantly. Recently, new legislation was introduced restructuring the Ministry of Health and its subordinate units, while enhancing its role in health-system policy development, planning, monitoring and evaluation. A new Public Health Institution has been established to support the work of the Ministry of Health in the area of preventive health care services.

Turkey has increased access to and utilization of health services by expanding health-insurance coverage. The targeted Green Card Program for the poor and its integration into the social-security system in 2012 increased coverage considerably. The introduction of family-physician practices helped increase coverage further. By 2014, Turkey had achieved near-universal health-insurance coverage, increasing financial security and improving equity in access to health care nationwide. Health services are now free of charge; the scope of the vaccination program has been broadened; the scope of newborn screening and support programs have been extended; community-based mental-health services have been created; and cancer-screening centers offering free services have been established in many cities.

In 2012, total health spending accounted for 5.4% of GDP, increasing from 4.9% in 2000. In 2012, 76.8% of this spending was funded by public sources, as compared to a 62.9% public share in 2000. According to the OECD the supply of health workers has increased considerably over the last decade. The number of doctors per capita has risen considerably since 2000, from 1.3 doctors per 1,000 people in 2000 to 1.7 in 2012; similarly, the number of nurses has increased from 1 nurse per 1,000 people in 2000 to 1.8 nurses in 2012. In 2000, there were two hospital beds per 1,000 people, a figure that had risen to 2.7 beds per 1,000 in 2012. As a result of these achievements, life expectancy at birth has increased from an average of 71.1 years in 2000 to 74.6 in 2012 (72 years for men, 77.2 years for women).

Citation:

Ministry of Development (2013) '2014 Annual Program', Ankara

World Bank (2014) 'World Bank Group - Turkey Partnership: Country Program Snapshot', Washington D.C.

World Health Organization (2013) 'Country Cooperation Strategy at a Glance: Turkey', Geneva.

Croatia

Score
value_6

In Croatia, health care services are mainly publicly provided on the basis of a system of social health insurance paid through employer and employee contributions. The system is broadly inclusive. Primary care is widely available while specialized care is provided in regional hospitals and national clinical centers which divide work on the basis of the complexity of procedures. However, access to care is adversely affected by the regional variation in the range of care provided, and there is evidence of significant health inequalities between low and high income groups. Self-reported health status is worse among low-income groups than in the EU as a whole. Resources are not always used efficiently, and suppliers' interests often lead to duplication of resources or syphoning of funds. The low employment rate and the aging population has produced a persistent financial deficit within the system, which is covered from the central government's budget. Due to resource constraints, patients are expected to make copayments for an increasing range of services. The government adopted a National Health Care Strategy 2012 – 2020 in September 2012, which provided a list of detailed proposals for gradual improvement of the health care system, while ruling out any radical reforms. Reforms have focused on

funding mechanisms, service rationing and private incentives in the provision of services. Public spending on health care remains below the EU-27 average.

Citation:

Mastilica, M. (2012) "Health reforms in Croatia from the user perspective," in: W. Bartlett, J. Bozиков and B. Rechel (eds.) *Health Reforms in South-East Europe*, Basingstoke: Palgrave Macmillan, pp. 31-48.

Radin, D. (2013) "The effect of EU Membership on the Health Care Systems of Member Countries in Central and Eastern Europe," *Politička misao: Croatian Political Science Review*, 50 (5): 141-154.

Ireland

Score 5

Quality:

During the period under review, the task of rationalizing and streamlining the delivery of public health services has continued in the face of opposition from those living in areas that are losing their small-scale hospitals and units in favor of a smaller number of more centralized "centers of excellence."

The gradual improvement in the overall delivery of health care and outcomes has often received less than its deserved publicity. Measured in terms of outcomes (life expectancy, infant mortality rates, survival rates from major illnesses), the system compares reasonably well with those of other western European countries. Moreover, except possibly during 2009, most objective indicators of health have continued to improve despite the cuts in public-health spending.

Inclusiveness:

The Irish health care system is a two-tier system, with slightly more than half the population relying exclusively on the public health system and the rest paying private insurance to obtain quicker access to hospital treatment. The rising cost of private health insurance is leading to a steady increase in the numbers of those relying on the public system. Problems with access to health care provoke more complaints and controversies than any other public service in Ireland.

Confusion has marked the government's health strategy. The introduction of universal health insurance has been declared a priority, but in October of 2014, the newly-appointed minister for health expressed his opinion that this target was "too ambitious" to be achieved over the next five years. A commitment has been made to roll out free general-practitioner treatment for children aged 5 and younger, but this too appears unlikely to materialize soon. Finally, recently implemented restrictions on access to a "medical card" – that is, the implementation of means-tested access to free medical care – were reversed in October 2014.

Cost efficiency:

The Irish health system is costly relative to GDP despite the favorable (that is,

relatively young) population age structure. When spending is standardized for the population age structure, Ireland emerges as having the third-highest level of health expenditure relative to GDP within the OECD. In several reviews of its agreement with Ireland, the Troika expressed concern about continuing overruns in health spending. These have continued since Ireland exited the bailout program.

Citation:

For a recent study of the cost efficiency of the Irish health system see:

<http://www.publicpolicy.ie/wp-content/uploads/HealthSystemIreland.pdf>

Mexico

Score 5

The quality of health care varies widely in Mexico, and different regions show broad differences in the quality and variety of services available. Some U.S. citizens come to Mexico as health tourists, taking advantage of cheaper health care south of the border. Private, self-financed health care is limited for the most part to middle-class and upper-class Mexicans. This group encompasses about 13% of the total population, but receives about 33% of all hospital beds. A larger minority of around one-third of the population (most of whom work in the formal sector) can access health care through state-run occupational and contributory insurance schemes such as the Mexican Social Security Institute (Instituto Mexicano del Seguro Social, IMSS) and the State Employees' Social Security and Social Services Institute (Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado, ISSSTE). These are based on automatic contributions for workers in the formal sector and, in practice, work reasonably well, although with some variation across different parts of the country. The system has been decentralized to the state level.

More recently, the government has been attempting to make health care more affordable and extend it to more people outside the formal sector. In order to extend the insurance principle, the government has set up the so-called Popular Insurance (Seguro Popular) program, which is open to contributors on a voluntary basis, with means-tested contributions from citizens supplemented by substantial government subsidies in order to encourage membership. While not yet able to offer universal health care, the state is subsidizing the private system. Mexico currently enjoys a degree of demographic advantage, since the population is disproportionately young. Thus, health care spending accounts for a relatively small proportion of GDP. However, large-scale migration also increases the demand on public services.

Ironically, while many Mexicans suffer from poverty-related diseases, there is also a problem with obesity. Mexico has many overweight people – a problem the government is trying to combat via the tax system.

Poland

Score 5 Public health insurance covers some 98% of Poland's citizens and legal residents. However, access to health care is highly uneven, as public health insurance covers only a limited range of services, and out-of-pocket payments feature prominently in the system at large. Moreover, the poor quality of some services falls far under citizens' expectations, and for some services, patients must wait for an unreasonable duration. As a result, a 2012 survey found that only 11% of respondents had a positive opinion regarding the work of the country's National Health Insurance Fund (Narodowy Fundusz Zdrowia, NFZ). The Tusk government's reforms largely focused on the corporatization of hospitals. As this has not resulted in improvements to working conditions or the quality of health care, the reforms have been widely criticized. In October 2012, Health Minister Bartosz Arlukowicz announced a new round of reforms, with a focus on decentralizing decisions made by the NFZ. As of the time of writing, these reforms had not yet materialized, and Arlukowicz only narrowly survived a no-confidence vote in the Sejm in January 2014.

Citation:

N. Hipsz, *Opinie o funkcjonowaniu systemu opieki zdrowotnej* [Opinions on Functionality of the Health Care System], CBOS Report 2012. Available online on: http://cbos.pl/SPISKOM.POL/2012/K_034_12.PDF (accessed on 04.28.2014).

Slovakia

Score 5 Slovakia has a mandatory health-insurance system that provides all residents with primary, secondary and tertiary care, pharmaceuticals, and medical devices. The state covers the health-insurance costs of children, students, pensioners, the (registered) unemployed and women on maternity leave. Since 2004, citizens have been able to choose between a public insurance program and two private health-insurance funds. From a comparative perspective, the quality and efficiency of health care services are relatively low, and the high degree of politicization and frequent changes to health care policy have served as further barriers to improvement. When newly elected in 2012, Prime Minister Fico announced plans to return to a single public health-insurance fund, by nationalizing the two private health-insurance funds. This proposal drew harsh criticism by experts. However, in February 2014, the prime minister finally gave abandoned this plan, citing financial reasons. The Slovak population's improving health-status self-evaluations can be attributed largely to the technological modernization of hospitals. There are worrying signals that general practitioners and dentists, especially in small towns and villages, are dramatically over-aged due to the brain drain to wealthier countries. This trend is beginning to undermine quality and inclusiveness within the Slovak health system.

Bulgaria

Score 4

The Bulgarian health care system is based on a regulated dual monopoly: on the one hand a state-owned and state-controlled health fund financed through obligatory contributions by all income earners, and on the other, a union of health providers that negotiate a national framework health contract with the fund. Public health care spending relative to GDP is similar to other countries in East-Central Europe and increased by about one percentage point of national income in the last decade. The system is inclusive and provides at least some level of health care for all who need it. Inclusiveness, however, is undermined significantly by the fairly widespread practice of unregulated payments to doctors. Those who can afford to make these payments, receive faster, better care. The quality of health care services is average to lower. While life expectancy has risen and infant mortality has dropped, overall mortality has remained high. A major efficiency problem of the Bulgarian health system is the lack of incentives for preventive measures and for stimulating healthier lifestyles, given that prevention is by far the least costly way of improving the health situation.

Citation:

Atanasova, E., Pavlova, M., Moutafova, E., Rechel, B., & Groot, W. (2013). Out-of-pocket payments for health care services in Bulgaria: financial burden and barrier to access. *The European Journal of Public Health*, 23(6), 916-922.

Hungary

Score 4

Health care has been one of the most conflict-ridden policy fields in Hungary. Policymaking has suffered from the lack of a separate ministry to deal with health care issues. The Orbán government has failed to tackle the widespread mismanagement and corruption in the health sector, the large debt burden held by hospitals, the discretionary refusal of services by medical staffers, and the increasing brain drain of doctors to other countries. Cuts in public health expenditures have continued, with public spending in the sector falling from 6.0% of GDP in 2013 to 5.1% in 2014. No major organizational reforms were adopted during the review period.

Latvia

Score 4

In 2011, Latvia adopted a new Public Health Strategy for 2011 to 2017, setting a high policy priority on primary care, essential medicines, outpatient services, integrated emergency services and serving the poor via a new social safety net. The economic crisis resulted in a decrease in financial resources made available for health care and created new impetus for structural reforms aimed at reducing costs, for example, by shifting from hospital to outpatient care. Attempts to tie individual access to health services and income tax payments stalled at the political level. As of

2014, a “diagnosis-related group” system is being introduced to improve the financing of health care services.

Public expenditure on health care was equal to 3.7% of GDP in 2011. Latvia has one of the highest private, out-of-pocket health care expenditure rates among EU member states. Patients’ private expenditure on health care constituted 40% of total health care financing in 2011. Total expenditure on health care was equal to 6.6% of GDP for 2011, under the EU average for public health care expenditure.

Health outcomes for Latvia continue to lag behind those of most EU member states and dissatisfaction with the system remains high. Mortality rates for men, women and infants are higher than in most other EU countries. According to European Commission survey data, 66% of citizens evaluate their overall quality of health care as bad (2011) and 65% believe that the quality of care in Latvia is worse than in other EU countries (2010).

Latvia performs poorly in the Euro Health Consumer Index. In 2012, Latvia ranked 31 out of 34 countries and dropped another place to 32 in the 2013 index. The health care system is based on a residence principle. Residents have free access to a family physician, who approves state-paid further treatment. This system results in long queues. Health care benefits are available at state- and municipality-owned institutions as well as private inpatient and outpatient facilities. The large co-payment required to access services restricts access for low-income groups. The implementation of the Social Safety Net Strategy 2009 – 2011 sought to address this by introducing a compensation mechanism for low-income groups. Low-income and other at-risk patients receive full exemptions from co-payments and pharmaceutical charges. In total, 61,000 outpatient visits and 3,800 inpatient visits were covered for low-income and other at-risk patients under the program. However, lower income patients not qualifying for assistance continue to face steep co-payments and pharmaceutical charges, limiting access to care.

Financial constraints focus public funding on the provision of emergency care, while creating long waiting times for non-emergency care.

Private polyclinics and physician practices offer their services for higher prices, making them unaffordable for low-income groups.

In terms of cost efficiency, the European Observatory on Health Systems and Policies, in its evaluation of allocative efficiency in Latvia’s health sector, concluded that:

- the share of resources allocated to health care is inadequate
- the allocation of resources among different providers is improving – shifting from expensive hospital care to less costly ambulatory care, while also increasing the priority given to primary care. Inpatient care expenditures were reduced from 50% of

total health care expenditures in 2008 to below 35% in 2011

- the share of resources allocated to different types of services is not efficient, as evidenced by long waiting lists, a lack of attention to chronic conditions and a lack of focus on preventable lifestyle diseases.

Citation:

1. World Health Organisation and European Observatory of Health Systems and Policies (2012), Latvia: Health System Review, Available at: http://www.euro.who.int/__data/assets/pdf_file/0006/186072/e96822.pdf, Last assessed: 20.05.2013.

2. International Social Security Association (2010), ISSA Crisis Case Study: Latvia, p.1, Available at: www.issa.int/content/download/129030/2632870/file/2Latvia.pdf, Last assessed: 20.05.2013.

3. World Bank, Latvia - First Special Development Policy Loan: Safety Net and Social Sector Reform Program, Project Description, Available at: <http://www.worldbank.org/projects/P115732/latvia-first-special-dpl-safety-net-social-sector-reform-program?lang=en>, Last assessed: 20.05.2013.

4. Euro Health Consumer Index 2013, Available at: <http://www.healthpowerhouse.com/index.php?Itemid=55>

Romania

Score 4

Romania has a public health-insurance system with claim to universal coverage. However, the quality and equity of Romania's public-health system has been undermined by inadequate funding: Romania has the lowest health-budget allocation of any EU member state. Moreover, after a gradual increase from 3.5% of GDP in 2002 to 4.8% in 2010, health care spending declined again to 4.2% in 2014, and has been set at 4% in the 2015 budget despite rising health care demand. Due largely to this underfunding, the de facto availability of many medical services is severely limited, thereby leading to widespread bribe-giving by patients even for basic services. When an illness requires hospitalization, the Romanian patient typically has to bribe three or four health workers for sums often totaling a significant percentage of the family's monthly income. Moreover, for many specialized procedures patients have to resort to private providers, which offer higher-quality services but are often quite expensive, thereby leading to significant inequities in medical-care access. Cost efficiency is undermined by the failure of the National Health Insurance Agency (CNAS) and local authorities to monitor hospitals' performance and program investments in the sector. The complex and sometimes contradictory set of regulations concerning the relationship between the private and the public sector further aggravates this problem.

Citation:

http://ec.europa.eu/dgs/home-affairs/e-library/documents/policies/organized-crime-and-human-trafficking/corruption/docs/acr_2014_en.pdf

Greece

Score 3

Up until the onset of the crisis, mismanagement and corruption in state-run health insurance funds and public hospitals had led to runaway public expenditure on medical supplies and medicines. It is telling that the expenditure of public health insurance funds on medicines in Greece sprang from 0.9% of the GDP in 2000 to 1.8% in 2010 (EU-27: 0.8% in 2000, 1.1% in 2010).

After the crisis erupted, public spending on health care was subjected to cuts similar to those effected in other welfare policies. Moreover, the restructuring of Greek public debt in February 2012 negatively affected the finances of health insurance funds, which held parts of that debt. In other words, after 2010, the economic crisis became a severe crisis for health insurance funds.

Since 2010, pharmaceutical companies and suppliers of necessary goods and services to public hospitals have delayed making deliveries to such organizations. Additionally, the job motivation of doctors serving in public hospitals suffered from wage cuts imposed across the public sector. All this injured the capacity of the public health care system to meet demand for health care services. Some of this demand was met in various Greek cities by makeshift “social clinics” providing services to patients free of charge. Such clinics were staffed by volunteer medical doctors and nurses and hosted by municipal authorities.

Every large and small town in Greece has at least one public hospital. The number of doctors in the country is also quite high (in 2011 there were 4.4 doctors per 1,000 residents, in contrast to 3.8 for every 1,000 residents in Germany). However, ministry-level mismanagement of health services combined with the reluctance of doctors to serve in hospitals located away from Greece’s largest cities have resulted in highly uneven distribution of medical personnel. Moreover, major budget cutbacks for public hospitals have left some hospitals without enough medicines and medical supplies. In sum, the quality and inclusiveness of health care probably deteriorated in 2012-2014, but cost efficiency improved substantially; at the same time, gaps and inefficiencies in public health care in the period under study may negatively affect these health indicators in the future..

Citation:

The runaway costs of pharmaceuticals in 2000-2010 are documented in a study by Greece’s Center for Economic Programming and Research (KEPE), a think tank of the Ministry of Finance, published in February 2013. Data is taken from Table 3.3.1 in KEPE’s publication, available at http://kepe-server.kepe.gr/pdf/Outlook/teyxos_20gr.pdf

Data on the density of doctors per country is taken from the World Health Organization (WHO) and is available at <http://apps.who.int/gho/data/node.main.A1444>

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